| 4 |
|---|
| Ч |

| 0                   |   |
|---------------------|---|
| <b>&lt;</b> Y318300 | • |
| ×                   |   |

| Family Name | UMRN |                |  |
|-------------|------|----------------|--|
| First Name  | DOB  | Gender         |  |
| Address     |      | Postcode       |  |
|             |      |                |  |
|             | ,    | First Name DOB |  |

## Section 4: Continuing goals of care – minimum every two (2) hours

|   | Care Plan day: Date: |              |        |            |      |      |   |      |      |      |      |      |
|---|----------------------|--------------|--------|------------|------|------|---|------|------|------|------|------|
|   | Symptom management   |              |        |            |      |      |   |      |      |      |      |      |
| Code a Y or N at each time assessment   | 0200                 | 0400         | 0600   | 0800       | 1000 | 1200 | 1400  | 1600 | 1800 | 2000 | 2200 | 2400 |
| Is the patient:   | Y = Ye               | s N=         | No     |            |      |      |   |      |      |      |      |      |
| Free of dyspnoea  |                      |              |        |            |      |      |   |      |      |      |      |      |
| Free of nausea and vomiting   |                      |              |        |            |      |      |   |      |      |      |      |      |
| Free of pain  |                      |              |        |            |      |      |   |      |      |      |      |      |
| Not troubled by respiratory tract secretions  |                      |              |        |            |      |      |   |      |      |      |      |      |
| Free of restlessness/agitation  |                      |              |        |            |      | 9,   |   |      |      |      |      |      |
| Free of other symptoms  |                      |              |        |            | d    |      |   |      |      |      |      |      |
| Free of urinary problems  |                      |              |        |            | 7    | 4    | Image: Control of the |      |      |      |      |      |
| Free of bowel problems  |                      |              |        |            |      |      |   |      |      |      |      |      |
|   | Р                    | erson        | al co  | fort       | C3.0 |      |   |      |      |      |      |      |
| Code a Y or N at each time assessment   | 0200                 | 0400         |        | 080        |      | 1200 | 1400  | 1600 | 1800 | 2000 | 2200 | 2400 |
| Have actions been taken to ensure   | Y = Ye               | s N          | No     | 1          |      |      |   |      |      |      |      |      |
| the patient/patient's:  | 1                    |              |        | <b>J</b> . |      |      |   |      |      |      |      |      |
| Receives fluids to support needs  | <b>\</b>             | _ 4          | 0      |            |      |      |   |      |      |      |      |      |
| Mouth is clean and moist  |                      | · <b>?</b> ` |        |            |      |      |   |      |      |      |      |      |
| Personal hygiene needs are met  Skin care needs are met  Eyes are clean and moist  Physical environment is adjusted to support needs  Emotional needs are met | _<                   | 1.           |        |            |      |      |   |      |      |      |      |      |
| Skin care needs are met   | .01                  |              |        |            |      |      |   |      |      |      |      |      |
| Eyes are clean and moist  |                      |              |        |            |      |      |   |      |      |      |      |      |
| Physical environment is adjusted to support needs   |                      |              |        |            |      |      |   |      |      |      |      |      |
| Emotional needs are met   |                      |              |        |            |      |      |   |      |      |      |      |      |
| Is comfortably positioned   |                      |              |        |            |      |      |   |      |      |      |      |      |
| _   |                      | Patie        | nt/fan | nilv ca    | are  |      |   |      |      |      |      |      |
| Code a Y or N at each time assessment   | 0200                 | 0400         |        |            | 1000 | 1200 | 1400  | 1600 | 1800 | 2000 | 2200 | 2400 |
| Have actions been undertaken to ensure that:  | Y = Ye               | s N=         |        |            |      |      |   |      |      |      |      |      |
| Procedures/care plan are explained  |                      |              |        |            |      |      |   |      |      |      |      |      |
| Information regarding change is provided  |                      |              |        |            |      |      |   |      |      |      |      |      |
| Family/carer is supported   |                      |              |        |            |      |      |   |      |      |      |      |      |
| If 'NO' is recorded for any of the above, a further action is required and must be recorded on the Action report, Section 7.                                  |                      |              |        |            |      |      |   |      |      |      |      |      |
| Nurse's name (print) and signature  |                      |              |        |            |      |      |   |      |      |      |      |      |

MR723A - CONTINUING GOALS OF CARE





| Department of Health Western Australia WA Cancer and Palliative Care Network | Family Name | UMRN |          |  |  |
|--|-------------|------|----------|--|--|
| CARE PLAN FOR THE DYING PERSON - INPATIENT                                   | First Name  | DOB  | Gender   |  |  |
| Hospital:  | Address     |      | Postcode |  |  |
| Doctor:  |             |      |          |  |  |

## Section 4: Continuing goals of care – minimum every two (2) hours

|  | Care Plan day: |          |       |        |         | Date: |        |          |      |      |      |      |
|--|----------------|----------|-------|--------|---------|-------|--------|----------|------|------|------|------|
| Symptom management   |                |          |       |        |         |       |        |          |      |      |      |      |
| Code a Y or N at each time assessment  | 0200           | 0400     | 0600  | 0800   | 1000    | 1200  | 1400   | 1600     | 1800 | 2000 | 2200 | 2400 |
| Is the patient:  | Y = Ye         | s N=     | No    |        |         |       |        |          |      |      |      |      |
| Free of dyspnoea   |                |          |       |        |         |       |        |          |      |      |      |      |
| Free of nausea and vomiting  |                |          |       |        |         |       |        |          |      |      |      |      |
| Free of pain   |                |          |       |        |         |       |        |          |      |      |      |      |
| Not troubled by respiratory tract secretions   |                |          |       |        |         |       | ~      |          |      |      |      |      |
| Free of restlessness/agitation   |                |          |       |        |         | •     | 9      |          |      |      |      |      |
| Free of other symptoms   |                |          |       |        |         | 0     |        | 2        |      |      |      |      |
| Free of urinary problems   |                |          |       |        |         | 6,    | ~      | <b>9</b> |      |      |      |      |
| Free of bowel problems   |                |          |       |        |         |       | 1      |          |      |      |      |      |
|  | Р              | erson    | al co | mfo    | care    | 00    |        |          |      |      |      |      |
| Code a Y or N at each time assessment  | 0200           | 0400     |       | 1800   |         | 1200  | 1400   | 1600     | 1800 | 2000 | 2200 | 2400 |
| Have actions been taken to ensure the patient/patient's:   | Y = Ye         | s N=     | No    |        | 00      |       |        |          |      |      |      |      |
| Receives fluids to support needs   |                |          |       | 70     |         |       |        |          |      |      |      |      |
| Mouth is clean and moist   |                | 120      | O     |        |         |       |        |          |      |      |      |      |
| Personal hygiene needs are met   |                |          | 1     |        |         |       |        |          |      |      |      |      |
| Skin care needs are met  Eyes are clean and moist  Physical environment is adjusted to support needs |                | ~        |       |        |         |       |        |          |      |      |      |      |
| Eyes are clean and moist   | <u> </u>       | O        |       |        |         |       |        |          |      |      |      |      |
| Physical environment is adjusted   | 3              |          |       |        |         |       |        |          |      |      |      |      |
| to support needs   | <b>O</b> .     |          |       |        |         |       |        |          |      |      |      |      |
| Emotional needs are met  |                |          |       |        |         |       |        |          |      |      |      |      |
| Is comfortably positioned  |                | <b>—</b> | 4.00  |        |         |       |        |          |      |      |      |      |
|  |                |          |       | nily c |         |       |        |          |      |      |      |      |
| Code a Y or N at each time assessment  Have actions been undertaken                                  | 0200           | 0400     | 0600  | 0800   | 1000    | 1200  | 1400   | 1600     | 1800 | 2000 | 2200 | 2400 |
| to ensure that:  | Y = Ye         | s N=     | : No  |        |         |       |        |          |      |      |      |      |
| Procedures/care plan are explained   |                |          |       |        |         |       |        |          |      |      |      |      |
| Information regarding change is provided   |                |          |       |        |         |       |        |          |      |      |      |      |
| Family/carer is supported  |                |          |       |        |         |       |        |          |      |      |      |      |
| If 'NO' is re<br>is required and   |                |          |       |        |         |       |        |          | 7.   |      |      |      |
| io roquirou una  | maot           | 50100    | 01404 |        | 7 10110 | Пор   | 11, 00 |          | -    |      |      |      |
| Nurse's name (print) and signature   |                |          |       |        |         |       |        |          |      |      |      |      |