

Care of the Imminently Dying Pathway Nursing Symptom and Care Assessment and Documentation

Last Name	First Name
Personal Health Number	Date of Birth (yyyy-Mon-dd)
Site	

RN/RPN/LPN to assess, monitor and evaluate symptoms:

- for **Acute Care, Facility Living and Designated Supportive Living** at least every 4 hours;
- for **Private Supportive Living and Home Care** settings a minimum of once daily.

Date Pathway Initiated (yyyy-Mon-dd)		<input type="checkbox"/> Day 1 <input type="checkbox"/> Day 2 <input type="checkbox"/> Day 3 <input type="checkbox"/> Other: _____							
Date (yyyy-Mon-dd)	Time → (hh:mm)								
Legend		Y = Goal has been met		N = Goal has not been met		NA - symptom is not applicable to condition			
Pain	Goal: person's pain is controlled								
	<ul style="list-style-type: none"> • Verbalized by person, if able. • Observe for non-verbal cues (<i>facial grimacing, furrowed brow, guarding</i>); however, these may also be present with delirium. • If pain is identified, address any contributing factors such as urinary retention, constipation, need for repositioning. • Consider use of pain assessment tool. • Educate family if patient settles quickly after repositioning. Moaning may be related to person's awareness rather than discomfort. 								
Dyspnea (shortness of breath)	Goal: person's dyspnea is controlled								
	<ul style="list-style-type: none"> • Verbalized by person, if able. Only reliable measure of dyspnea is the person's self-report. • Observe for non-verbal cues of distress (<i>nasal flaring, use of accessory muscles</i>). • Consider upright positioning. Avoid crowded room. • Consider use of fan directed across the face and/or open window. • High flow oxygen may increase discomfort and restlessness. For history of known symptomatic hypoxia, try oxygen 2 to 5 L/min via nasal prongs for comfort as tolerated. • Educate family that Cheyne-Stokes breathing and apnea are normal changes in breathing during the dying process. • Utilize opioids for dyspnea. 								
Agitation	Goal: person is calm and settled								
	<p>If able, person verbalizes they do not feel restless or unsettled (<i>presence of these symptoms may indicate early signs of extrapyramidal side effects from medications such as metoclopramide, haloperidol and methotrimeprazine</i>).</p> <ul style="list-style-type: none"> • Observe for restlessness, picking at the air, twitching (<i>myoclonus</i>). • Rule out reversible contributing factors such as urinary retention, opioid neurotoxicity, and need for position change. • Promote quiet and calm environment. Limit noise and avoid crowded room. • Provide education and support to family/others. 								
Respiratory Secretions	Goal: person is at ease despite the presence of noisy respiratory secretions								
	<ul style="list-style-type: none"> • If person is receiving artificial hydration, request review by the MRHP to consider decreasing or discontinuing artificial hydration. • Reassure the family and others if person appears comfortable, noisy secretions are unlikely to be distressing to the person (<i>much like snoring</i>). • Consider positioning on side. • Utilize medications only for severe distressing respiratory secretions as medication may thicken secretions and aggravate restlessness. • If person has copious amounts of secretions limit to oral suctioning only. 								
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Nausea &/or Vomiting	Goal: person is free of nausea and/or vomiting									
	<ul style="list-style-type: none"> If able, person verbalizes does not feel nauseated. No evidence of vomiting. Meticulous mouth care. Eliminate fragrances/scents and odors. Rule out constipation. 									
Hydration & Nutrition	Goal: fluids and food are provided according to person's preferences									
	<ul style="list-style-type: none"> Offer and support the person to drink and eat if they wish and are able to. Monitor for changes in swallowing ability and adapt to person's wishes. Provide meticulous mouth care. Monitor hydration status daily considering artificial hydration benefits (<i>prevention of opioid neurotoxicity</i>) and risks (<i>respiratory secretions, progressive edema</i>). Note: Evidence is conflicting whether artificial hydration hastens or prolongs dying. 									
Mouth Care	Goal: person's mouth is moist and clean									
	<ul style="list-style-type: none"> Mouth care every two hours and as needed for comfort. Recommend cleaning mouth at least 4 times daily with club soda. Inspect oral cavity and mucus membranes for dryness, sores and oral candida at least once daily. Ensure dentures are removed and cleaned once daily. Use mouth moistening products as needed. Educate and include family/others in mouth care if they wish to be involved. Refer to your organization's mouth care policy. 									
Skin Integrity	Goal: person's skin integrity is maintained									
	<ul style="list-style-type: none"> The frequency of assessment, repositioning and special aids (<i>e.g. pressure relieving mattress</i>) should be determined by a skin inspection and the person's individual needs. Monitor for edema as may require artificial hydration to be reviewed by MRHP. With each parenteral medication administration, and at least once daily, monitor site(s) for redness, edema and leakage on administration. Reposition every 2 hours for comfort and to minimize risk of pressure ulcers and wounds. Educate family if patient settles quickly after repositioning, moaning may be related to person's awareness of movement rather than discomfort. 									
Personal Care	Goal: person's personal hygiene needs are addressed									
	<ul style="list-style-type: none"> Provide skin care; bed bath; eye care at least once daily. Skin and mucus membranes are clean and free from odors. Involve family/other in caregiving if they wish to be involved. 									
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Bowel Care	Goal: person's bowel elimination needs are addressed									
	<ul style="list-style-type: none"> If able, obtain person's bowel movement history to determine individual assessment and care needs. Monitor for signs of constipation or diarrhea. Ensure person has a bowel movement at least every 3 days. Document frequency, amount and consistency of bowel movement(s). 									
Urinary Care	Goal: person's urinary needs are addressed									
	<ul style="list-style-type: none"> Monitor and assess for signs of urinary retention (<i>distension, agitation/restlessness, pain, catheter bypassing</i>). Utilize incontinence products and catheter as needed. 									
Psycho-social & Spiritual Support for the Person	Goal: person's psychosocial and spiritual needs are addressed									
	<ul style="list-style-type: none"> If able to communicate ask the person about their mood (<i>feelings of anxiousness or sadness</i>). Identified questions and worries will urgently be addressed by the appropriate team members. Support the person's wishes and preferences regarding visitors. Inquire about wishes and foster opportunities to visit with those important to them (<i>including pet visitation</i>). Support spiritual, religious and cultural beliefs and practices. Offer Spiritual Care referral and/or contact person's faith organization. Identify individual communication needs (<i>i.e. visual and hearing aids and language preferences</i>). If person unresponsive, speak in a calm manner and use gentle touch when providing care. Continue to explore the understanding and wishes of the dying person and update the care plan as needed. <p>Conversation Prompt "We want to ensure we respectfully honor your wishes at all times. It is important for us to know if you have any questions or wishes about how you want us to care for you and your family; at this time, at the time you die and afterwards."</p>									
Psycho-social & Spiritual Support for Family/ Others	Goal: family's psychosocial and spiritual needs are addressed									
	<ul style="list-style-type: none"> Listen and respond to questions, worries and fears, referring to interdisciplinary team members for specific questions and needs (<i>e.g. coping and bereavement care</i>). Use clear and direct language. Provide the opportunity to reminisce. Offer information of what to expect when someone is dying. Provide information and caregiver resources. For those visiting the dying person, explore their wishes, comfort and opportunities to interact (<i>e.g. talking, touching</i>) and participate in care (<i>e.g. offering food and fluids, mouth care</i>). Encourage self-care (<i>nutrition, rest breaks, support from family & friends</i>). 									
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**Care of the Imminently Dying Pathway
Nursing Symptom and Care Assessment
and Documentation**

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Other	Goal:									
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* See Progress Notes for additional documentation

Initial									
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On DAY 3, and every subsequent third day, i.e. DAY 6, DAY 9 and so forth, a review is required to ensure the medications, care plan, and the Goals of Care Designation (GCD) Order remain consistent with the person's/ ADM's/family's wishes and the person's prognosis.

This review requires a conversation between the MRHP, appropriate members of the health care team, and the person/ ADM/family. This conversational review is to be documented on the Advance Care Planning/Goals of Care Designation Tracking Record form located in the person's Green Sleeve.

Decision made to continue with the Care of the Imminently Dying Pathway

Yes No **Date** (yyyy-Mon-dd) _____ **Time** (hh:mm) _____ **Initial** _____

