Patients Name: …… DOB: …… Hospital no: …… Date……

Personalised Care Plan (Daily)

Each intervention to be recorded with the time, and initialled by the member of staff providing care

Initial at time of each assessment/intervention	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00

Goal 1: The patient is pain free Observe for; verbalised pain, pain on movement, non-verbalised pain cues. Consider the need to reposition the patient. *Referral to palliative care if pain persists*	
Initial at time of each assessment/intervention	00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
Goal 2: The patient is not agitated Consider and exclude reversible causes e.g. urinary retention, opioid toxicity, hypercalcaemia; etc.	
Initial at time of each assessment/intervention	00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
Goal 3: The patient does not have respiratory tract secretions. Consider change of position. Medication should be given at early signs of symptom.	
Initial at time of each assessment/intervention	00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
Goal 4: The patient is not nauseated or vomiting If the patient is comatose, unable to swallow, or vomiting consider continuous subcutaneous infusion (csci)	
Initial at time of each assessment/intervention	00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
Goal 5: The patient is not breathless Consider change of position and the use of a fan. Low dose opioids can be beneficial for breathlessness	
Initial at time of each assessment/intervention	00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
Goal 6: The patient's mouth is moist and clean Mouth care should be offered at least hourly. Mouth care tray to be kept at bedside. Involve relatives/carers as appropriate.	

Patients Name: …… DOB: …… Hospital no: …… Date……

Initial at time of each assessment/intervention	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00
Goal 7: The patient receives fluids and nutrition to support their individual needs **Patients able to take oral fluids will be offered and assisted with drinks at least hourly and offered food as appropriate**. Patients unable to take oral fluids will have MDT assessment daily to determine need for artificial hydration and nutrition																								
Initial at time of each assessment/intervention	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00
Goal 8: The patient does not have urinary problems																								
Initial at time of each assessment/intervention	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00
Goal 9: The patient does not have bowel problems **Bowels last open _ _/ _ _/ _ _ _ _** Record action to be taken if no bowel movement for 3 days																								
Initial at time of each assessment/intervention	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00
Goal 10: The patient's skin integrity is maintained Frequency of repositioning should be determined by individual patient assessment. Use appropriate aids.																								
Initial at time of each assessment/intervention	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00
Goal 11: Patient's personal hygiene needs are met Relatives/carers should be involved as appropriate																								
Initial at time of each assessment/intervention	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00
Goal 12: The patient's religious, spiritual, psychological and emotional needs are met																								
Initial at time of each assessment/intervention	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00
Goal 13: The well-being of the relative or carer is maintained																								
Initial at time of each assessment/intervention	00.00	01.00	02.00	03.00	04.00	05.00	06.00	07.00	08.00	09.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00
Goal 14: The patient does not have other symptoms (record symptom ……)	**(If no other symptoms record N/A)**																							
	Night								**Early**						**Late**						**Night**			
Signature of registered nurse per shift																								