St Helena Hospice
your time...your hospice
Registered Charity Number 280919

CORE CARE PLAN

Patient Name____ **Date of Birth** ___________________________ **NHS number**_________________

Name of person completing the careplan__________________________________ **Signature**_______________________________ **Designation**____________________________

Ward/community base ____ **Date**__________________

Consent MUST be obtained from the patient at each visit before commencing any intervention.

Assess the patient at each visit and report significant changes to the case manager/keyworker.

Nursing need	Objective	General Plan	Individual Plan
1. Assistance with personal hygiene.	• For patient to feel clean and comfortable. • To promote independence • To maintain dignity.	a) Assist the patient to wash all areas of their body as they desire, taking into account their usual personal care habits. b) Patient may be assisted to bath or shower if they are safe to do so and if appropriate aids and equipment are in situ. c) Bed bath patients who are unable to get out of bed to enable them to maintain their personal hygiene, allowing them to participate in their care as much as possible.	
2. Assistance with oral hygiene.	• For patient to have a clean, hydrated mouth. • To promote independence.	d) Encourage and if necessary, assist the patient to brush their natural teeth using toothbrush and toothpaste. Assist to rinse mouth using water or mouthwash if preferred. e) If dentures are worn, assist patient to clean them using their usual method. f) If the patient is unable to do this, once the dentures are removed, brush them with a brush and proprietary cleaner, or toothpaste. Rinse well. Clean mouth and gums using a soft toothbrush or pink mouth sponge and replace dentures.	

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3. **Assistance with elimination.**	• To maintain dignity. • To promote independence. • To prevent infection.	a) **If the patient is continent** assist them to use the toilet or commode provided it is safe to do so. (Patients must be able to weight bear). b) For non-weight bearing patients, assistance may be needed to facilitate the use of a urinal or bed pan. c) **Patients who are incontinent** will need a pad check at each visit. Change pad as necessary, gently cleaning the area and applying barrier cream/spray appropriately if available. d) **For patients with an indwelling catheter:** Observing standard hygiene precautions: e) Use a jug or suitable container to empty urine drainage bags. Disposable night bags should be removed after closing the valve at the bottom of the leg bag. Tear at allotted marking, empty urine down the toilet and discard bag in household waste. f) Check around catheter entry point for any sore red areas, discharge or offensive odour. g) Gently clean the area with warm water, cleaning away from the body to help prevent bacteria from entering the body via the catheter entry point. Dry thoroughly. h) Leg bags, valves and drainable night bags should be changed every 5-7 days. Document and highlight date of each change in the notes to alert other members of the team. Mark catheter bag with date of change. i) **For patients using a convene:** Observing standard hygiene precautions: j) Empty drainage bags as above. Replace convenes as need arises or every third day. k) **For patients with a stoma:** Observing standard hygiene precautions: l) Encourage patient to retain as much independence as possible. m) Check stoma bag at each visit and empty as necessary. Non drainable, one piece bags will need to be changed twice a week as per the patient's usual pattern. n) At each bag/flange change, wash and dry the area thoroughly using supplied stoma products. o) Observe for signs of discomfort that may indicate constipation or urine retention. **At each visit please record in the notes urine output and any bowel action**.	

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4. Prevention/management of pressure ulcers.	• To prevent pressure damage to skin • To effectively manage any pressure damage.	a) Observe skin for any red, sore, blistered or broken areas at every personal care contact. b) Apply barrier cream/spray appropriately to any vulnerable areas. c) At each visit, check that any pressure relieving equipment is operating effectively at the correct setting. d) Encourage patient to change position regularly, or if they are unable to do so, position them comfortably, changing position at each visit to reduce the risk of pressure damage. e) Observe correct moving and handling techniques – use a slide sheet to prevent friction and shear. f) If indicated by the Community Nurse, dressings on pressure areas may be changed 'like for like' if soiled or disturbed. Report each change to Community Nurse so that dressing may be replaced.	
5. Assistance with dietary needs.	• For patient to receive food and fluids to fulfil their nutritional needs appropriate to their stage of life.	a) Assist patient with food/drink preparation as required at time of visit. b) Ensure that patient has fresh fluids within reach at each visit, providing they are able to swallow safely. c) Feed patient, if they can safely eat and are unable to feed themselves and have no one else to help them. d) Encourage consumption of any nutritional supplements that have been prescribed.	
6. Assistance to mobilise/change position.	• For patient to be able to mobilise safely at all times. • To maintain as much independence as possible.	**a) H@Home to complete a manual handling risk assessment at the first visit.** b) Reassess for any changes before moving the patient, giving consideration to the safety of the patient, the AN and the family or any other carer. c) Only use approved equipment and moving and handling techniques. d) Patient needs to be hoisted. (Add individual care plan to last page)	

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7. Pain and symptom control	• For patient to be comfortable and for pain and symptoms to be well controlled.	a) Observe for signs of pain noting verbal and non- verbal indications. b) Note existence of other symptoms such as nausea, agitation, anxiety and breathlessness and report to appropriate professional to address. c) Help patient to achieve a comfortable position to facilitate ease of symptoms.	
8. Assistance with medication.	• To support patient to self-medicate. • To encourage independence. • To prompt medication as appropriate in the absence of family.	a) Prompt medication adhering to your organisation's Assisting with Medication Policy and Procedure. **Where applicable the assessor must have completed the approved medication sheet.** b) If patient is on oral medication assess swallowing ability daily and report to key worker any problems with taking or non-compliance.	
Hospice at Home and Marie Curie staff only **9. Administering medication**	• To ensure patient is able to receive the appropriate medication to control pain and symptoms, during respite or night care, or if it is necessary to administer medication as part of the personal/oral care visit.	a) Medication **administration** by Hospice at Home and Marie Curie is only permissible by staff who have completed the Medication Administration training. b) All medication that needs to be administered must be entered on an appropriate MAARS sheet and signed by an authorised prescriber. c) Administer medication adhering to your organisation's Policy and Procedure for Medication Administration.	
10. Syringe driver observations.	• To ensure that medication is being delivered effectively via the syringe driver.	a) At each visit, check the unit to check that it is delivering the medication. A green light will flash above the on/off switch and the display unit will read <<<<< Pump Delivering. b) Check that the box is locked. c) Check entry point of needle into skin for any redness, soreness, swelling or leaking. d) Report any concerns promptly to the Community Nurse.	

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11. Recognition of patient's spiritual needs.	• For the individual to be able to express their spirituality in their own way according to their own personal beliefs and practices.	a) Seek opportunities to communicate with the patient to learn more about what is important to them. Give them time to express their inner thoughts and feelings if they so desire. Consider whether they may need help to access other services to help them achieve spiritual fulfilment.	
12. Support of family.	• For patient's family to feel supported while caring for their relative at home.	a) Be available to listen to the family's concerns. Reassure and direct to appropriate members of the palliative team for advice when necessary. b) Utilise the support services of the whole Hospice team as appropriate.	
13. Facilitating patients and families in acquiring knowledge about end of life care	• For patient and their family to make informed choices.	a) Provide appropriate approved written information, when this may help the patient or a family member. b) Direct patient or family to appropriate professionals and/or the SinglePoint service to gain further information if needed. **Hospice at Home only:** c) If an appropriate window of opportunity presents, introduce the patient to the PPC, or if it has already been introduced assist them if they need further information or help to complete it.	

Please use this page to record additions to the care plan.

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