Caring for the Dying Patient (CDP) Document
Caring for the Dying Patient (CDP) Document

The Care for the Dying Patient documentation has 5 core components:

1. Relatives’ / Carers’ Contact Information and healthcare professional’s signatory information (C 1 – 2) ................................................. 3
2. Medical Assessment (M 1 – 4) ................................................................. 5
3. Initial Holistic Nursing Assessment (N 1- 4) ............................................ 9
4. Ongoing Assessment (A 1 - 4) ................................................................. 13
5. Verification of Death .................................................................................. 17
6. North Tees and Hartlepool Symptom Control and Palliative Care Medication Chart

Please document what the patient’s needs are in relation to the following aspects of care, and what actions are being taken/are required, and please explain and give out the Family’s voice diary and offer the ‘When someone is dying’ leaflet to the patient’s family:

1. Family’s voice diary (HCR260) Version: .................................................. Yes No
2. ‘When someone is dying’ leaflet (Corp/247) Version: ............................. Yes No
If not given, state reason: ...............................................................................

Hospital use only

Referral to chaplaincy:
Upon commencing this paperwork, please notify chaplaincy on extension 22515 for all inpatients and community patients on request.

When this document is commenced, the patient’s details should be entered onto the Trust End of Life Virtual Ward. This is the method by which the End of Life Coordinator will be made aware of dying patients in order to review all dying patients in hospital.
Caring for the Dying Patient (CDP) Document

Relatives’ / Carers’ Contact Information

<table>
<thead>
<tr>
<th>1st Contact</th>
<th>2nd Contact</th>
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<tbody>
<tr>
<td><strong>Name:</strong> ...........................................................................................................</td>
<td><strong>Name:</strong> ...........................................................................................................</td>
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<td><strong>Home telephone:</strong> .................................................................</td>
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<td><strong>Work telephone:</strong> .................................................................</td>
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<tr>
<td><strong>Mobile telephone:</strong> ...............................................................</td>
<td><strong>Mobile telephone:</strong> ...............................................................</td>
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<tr>
<td><strong>Relationship:</strong> .................................................................</td>
<td><strong>Relationship:</strong> .................................................................</td>
</tr>
</tbody>
</table>

**Times to be contacted**

- [ ] Any time
- [ ] Between specified hours: .....................

- [ ] Any time
- [ ] Between specified hours: .....................

All professionals using this document **must** print and sign their name

<table>
<thead>
<tr>
<th>Date</th>
<th>Print Name (BLOCK CAPITALS)</th>
<th>Signature</th>
<th>Initials</th>
<th>Designation</th>
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Name: .................................................................
Address: .................................................................
DOB: .................................................................
CRN/ Hospital No: .................................................................
NHS Number: .................................................................
Caring for the Dying Patient (CDP) Document

Contact numbers

University Hospital of North Tees and Hartlepool

Specialist Palliative Care Team (North Tees Hospital and community)
Monday – Friday, 9.00am – 5.00pm
telephone: 01642 383895

Specialist Palliative Care Team (Hartlepool community)
Monday – Friday, 8.00am – 5.00pm
telephone: 01429 522154

Chaplaincy
telephone: 01642 617617 and ask for the on-call chaplain

Bereavement Support Officer
Monday – Friday, 8.00am – 4.00pm
telephone: 01642 383286

GP Out of Hours Service
you should contact your GP’s surgery for the GP Out of Hours Service number.

Mortuary Department
Monday – Saturday, 8.00am – 4.00pm
Outside these hours you should call the hospital switchboard on 01642 617617 and ask for the Mortuary staff member on call.

Hospices

Butterwick Hospice
Monday – Friday, 9.00am – 5.00pm
telephone: 01642 607742

Hartlepool and District Hospice
Monday – Friday, 9.00am – 5.00pm
telephone: 01429 855555
24 hour Helpline telephone: 01429 855558

District Nursing
Single Point of Access (SPA) – based in Hartlepool (to refer/discuss both Hartlepool and Stockton patients)
telephone: 01429 522277

Tissue Donation Services
telephone: 0800 4320559

Cardiology Services (for advice regarding Implantable Cardioverter Defibrillators)
telephone: 01429 522167
Caring for the Dying Patient (CDP) Document

Medical assessment – Recognition that the patient is dying

The decision relating to the patient’s prognosis must be endorsed by the most senior clinician responsible for the patient’s care (Consultant / GP).

Date of assessment: ........................................ Time of assessment: ........................................

Place: [ ] House [ ] Hospital [ ] Residential home
[ ] Nursing home [ ] Hospice [ ] Other, please state: ........................................

Consultant: .......................................................... ..........................................................

GP name: .......................................................... GP Practice: ...........................................

If the current clinical impression is that the patient is ill enough that they may die in the next hours or days, and any reversible causes have been considered, please document the key information which supports this decision:

........................................................................................................................................
........................................................................................................................................
........................................................................................................................................

Does the patient have a valid DNACPR document? [ ] Yes [ ] No

If not, please state reason: ........................................................................................................

Who has this been discussed with? [ ] Patient [ ] Relative [ ] Carer

Patient preferences

Does the patient currently have capacity to make decisions regarding current and future treatment plans? [ ] Yes [ ] No

(If the patient currently lacks capacity, decisions should be made using a best interest process, taking into account the patient’s expressed preferences. Further information about all these issues is available in the Deciding right resources section on the Northern England Strategic Clinical Network website: www.nescn.nhs.uk)

Are there any of the below documents in place? Location

[ ] Advance Decision to Refuse Treatment (ADRT) .............................................................
[ ] Advance Statement ........................................................................................................
[ ] Emergency Health Care Plan (EHCP) ...........................................................................

Is there a Lasting Power of Attorney (LPA) for Health and Welfare? [ ] Yes [ ] No

If yes, name: ...........................................................................................................................

Are there any additional expressed wishes or decisions? e.g organ / tissue donation: ...........................................................

Patient’s current preferred place of death: .............................................................................

If not expected to achieve this, please state reason: .................................................................
Caring for the Dying Patient (CDP) Document

Medical assessment – Developing a Plan of Care
In certain circumstances it may be appropriate to continue certain medications / interventions:

<table>
<thead>
<tr>
<th>Current interventions</th>
<th>Currently not being taken or given</th>
<th>Discontinued</th>
<th>Continued / commenced</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine blood tests</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antibiotics</td>
<td></td>
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<tr>
<td>Blood glucose monitoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Recording of routine vital signs</td>
<td></td>
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<tr>
<td>Oxygen therapy</td>
<td></td>
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<tr>
<td>Other</td>
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</tbody>
</table>

Does the patient have an Implantable Cardioverter Defibrillator (ICD) or other device in place?  
☐ Yes  ☐ No

Document any actions required: ........................................................................................................................................
......................................................................................................................................................................................
......................................................................................................................................................................................

Review of regular medications
Review all medication and decide whether it is necessary or is beneficial for symptom control. Consider alternative routes if patient is unable to swallow.  
☐ Yes  ☐ No

Remember to prescribe anticipatory medication for the following (refer to NECN Palliative and End of Life Care Guidelines):

☐ Pain  ☐ Nausea and vomiting  ☐ Agitation/distress/delirium
☐ Breathlessness  ☐ Respiratory secretions

Please consider the impact of pre-existing, new or worsening renal dysfunction when prescribing regular and as-required medication.

Does the patient have any long term condition? e.g. diabetes, seizures  
☐ Yes  ☐ No

If yes, please document plan for managing this:
......................................................................................................................................................................................
......................................................................................................................................................................................
......................................................................................................................................................................................
Caring for the Dying Patient (CDP) Document

Medical assessment – Nutrition and Hydration

If the patient expresses a wish to eat or drink, staff should offer assistance when required. Even if there are concerns that a patient’s swallow is impaired or unsafe, he/she may still elect to eat and drink. If the patient has mental capacity and understands the risk of aspiration, oral food and fluids must NOT be withheld from a patient who wishes to eat and drink.

For patients who do not have mental capacity, decisions regarding: whether to allow eating / drinking should be made using the best interests process (further information is available in Deciding right via www.nescn.nhs.uk).

Are there any concerns that the patient’s swallow is impaired/unsafe?  ☐ Yes  ☐ No

Nutrition
Please document decisions regarding oral, enteral or parenteral nutrition: .................................................................
.............................................................................................................................................................................................
Hydration
Please document decisions regarding oral or parenteral hydration: .................................................................
.............................................................................................................................................................................................

Plan of Care and Communication

Document the plan of care and discussion that has taken place with the patient and relative / carers, including any specific concerns or issues.

This should include the discussion regarding the changing of medication (including use of syringe drivers, if needed), plan of care for provision of fluids and nutrition, and any treatments which are discontinued or should continue.

If conversations about the treatment plan have already been documented in main notes or electronic patient record, please provide a brief summary here, and state the date(s) and time(s) that are documented in the patient record for reference:

Summary of key issues and plan of care: ..........................................................................................................................
Caring for the Dying Patient (CDP) Document

Medical assessment continued:

Communication with patient / relative / carer:

Please state who was present during discussion

☐ Patient
☐ Staff member
☐ Relative / carer
☐ Other

Can this patient’s death be verified by a registered nurse?  ☐ Yes ☐ No
If no, please state the reason and plan for care after death:

Does this patient’s death need to be referred to the coroner?  ☐ Yes ☐ No
If yes, please state reason:

Signature: ........................................... Date: .................... Time: ...................
Print name: ...................................... Designation: .................. GMC No: ....................

If appropriate, discussed plan with senior clinician:

Consultant’s signature: ......................... Date: .................... Time: ...................
Print name: ...................................... Designation: .................. GMC No: ....................

(Print name: ........... Designation: ......... GMC No: .......... (If applicable))
Caring for the Dying Patient (CDP) Document

Initial Holistic Nursing Assessment

Please complete with the patient and relative / carer if appropriate. If the patient is unable to contribute to their care assessment, complete on their behalf. Tick any identified problems.

Physical problems

Do you have any problems with your comfort? □ Pain / discomfort
☐ Breathlessness  ☐ Mouth – sore / dry / painful  ☐ Chest secretions
☐ Sputum  ☐ Cough  ☐ Swallowing difficulties
☐ Feeling sick / being sick  ☐ Constipation / diarrhoea  ☐ Urinary problems
☐ Catheter care  ☐ Sweats / hot / cold  ☐ Oedema (swelling)
☐ Sleep  ☐ Mobility
☐ Skin – sores / wound / dry / itch / weeping  ☐ Personal care – washing / hair care
☐ Other: ........................................................................................................................................

Social / environmental concerns

Do you feel the needs of yourself and your family / carers are being met?

☐ Eating / drinking facilities  ☐ Quiet environment  ☐ Comfortable surroundings
☐ Worries / fears  ☐ Written information  ☐ Update on plan of care
☐ Support for children  ☐ Support for relative/carer/friend
☐ Financial concerns  ☐ Parking facilities
☐ Other: ........................................................................................................................................

Emotional wellbeing

Do any of these words describe how you feel? □ Distressed
☐ Lack of dignity / respect  ☐ Upset / sad  ☐ Lack of privacy
☐ Lack of peace / calm  ☐ Agitated / restless  ☐ Not listened to
☐ Frightened / worried  ☐ Angry / frustrated
☐ Other: ........................................................................................................................................

Spiritual / religious needs

Are the things important to you being considered? □ Faith / spirituality
☐ Support from faith leader  ☐ Prayers / rights / rituals  ☐ Culture
☐ Music  ☐ Values  ☐ Things that help you cope
☐ Other: ........................................................................................................................................

Assessment completed by:

Signature: .................................................. Date: .......................... Time: ......................
Print name: .................................................. Designation: .................... GMC No: ..................
(BLOCK CAPITALS) (If applicable)

Completed and discussed with: □ Patient  □ Relative  □ Carer

Signature: .................................................. Date: .......................... Time: ......................
Print name: ..........................................................................................................................
(BLOCK CAPITALS)
Caring for the Dying Patient (CDP) Document

Initial Nursing Assessment Summary

Please record your assessment of the patient's identified problems below. Ensure that there is a care plan for each identified problem, including review date and time.

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Problem identified / Care Plan</th>
<th>Summary of Assessment</th>
<th>Signature and Designation</th>
</tr>
</thead>
<tbody>
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</table>
Caring for the Dying Patient (CDP) Document

End of Life Core Nursing Care Plan

Goals
The goal’s for ………………………………. ’s care are:

● to receive a holistic assessment of their needs at the end of life
● for the patient and / or relative / carer to be involved with decision making
● for care to be delivered with compassion
● that the focus of care is to maintain comfort and dignity

Interventions:

1. The patient is supported to eat and drink for as long as they want and /or are able to. The registered nurse will assess the patient if he / she is symptomatically dehydrated, and consider artificial hydration if it is in the patient’s best interest.

2. Regular mouth care is offered to promote the patient’s comfort. The registered nurse should teach, supervise and encourage health and social care assistants / carers / relatives, where appropriate, to offer mouth and lip care, sips of fluid / ice.

3. Skin care to be provided to ensure the patient’s skin is clean, dry and comfortable. The patient is moved for comfort only, using pressure relieving aids as appropriate, eg. a special mattress. The registered nurse should teach, supervise and support health and social care assistants / carers / relatives to assess, monitor and report to nursing staff regarding skin condition and integrity.

4. Personal care to be provided according to individual needs. Involve relative / carer in care giving, if they wish. The registered nurse to supervise and support health and social care assistants / carers / relatives to provide personal hygiene.

5. The registered nurse will assess, monitor and, where appropriate, manage bowel evacuations to ensure comfort. If appropriate, medication and / or continence products to be provided to maintain dignity.

6. The registered nurse will assess, monitor and, where appropriate, manage the patient’s urinary continence needs by use of continence products, urethral catheter, commode, urinal and / or bed pan. The registered nurse will teach, monitor and supervise health and social care assistants / carers / relatives where appropriate.

7. The registered nurse to liaise with medical practitioner and / or specialist palliative care team if psychological or symptom management support needed.

Care Plan completed by:

Signature: …………………………… Date: …………………. Time: …………………

Print name: …………………………… Designation: …………………………… GMC No: ……………………………

Care Plan agreed and discussed with: ☐ Patient ☐ Relative ☐ Carer

Signature: …………………………… Date: …………………. Time: …………………

Print name: …………………………… Designation: …………………………… GMC No: ……………………………

If applicable)
Nursing Communication with patient and/or relative / carer

Please document discussions with the patient and / or relative / carer regarding:

- Patient / relative / carer understanding of the current situation
- The plan of care
- Any questions or concerns which have been raised
- Who to speak to or contact if worried or concerned

Written information

What written information / leaflets have been given to the patient and / or relative / carer?

Assessment completed by:

Signature: ...........................................  Date: .......................  Time: ..................
Print name: .................................  Designation: .................  GMC No: ...............  
(BLOCK CAPITALS)

Completed and discussed with:  □ Patient  □ Relative  □ Carer

Signature: ...........................................  Date: .......................  Time: ..................
Print name: ..........................................................  
(BLOCK CAPITALS)
## Caring for the Dying Patient (CDP) Document

### Ongoing Nursing Assessment

Place of care: ............................................................

<table>
<thead>
<tr>
<th>Date and Time:</th>
<th>Record your assessment <strong>Y</strong> (Yes) <strong>N</strong> (No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient’s pain adequately controlled?</td>
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<tr>
<td>Is the patient calm, and not agitated or distressed?</td>
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<tr>
<td>Does the patient have excessive respiratory tract secretions?</td>
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<tr>
<td>Does the patient have any nausea and / or vomiting?</td>
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<tr>
<td>Is the patient’s breathing clear and comfortable?</td>
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<tr>
<td>Are there any problems with the patient’s bladder or bowels?</td>
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<tr>
<td>Is the patient’s mouth comfortable, moist and clean?</td>
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<tr>
<td>Have you any concerns about the patient’s current hydration and nutritional needs?</td>
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<tr>
<td>Does the patient have any other symptoms? Please state:</td>
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<tr>
<td>Do you have any new concerns about the patient’s skin integrity?</td>
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<tr>
<td>Are the patient’s personal hygiene needs being met?</td>
<td></td>
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<tr>
<td>Are the patient’s psychological needs being met?</td>
<td></td>
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<tr>
<td>Are the patient’s spiritual needs being met?</td>
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<tr>
<td>Is the physical environment adjusted to support the patient’s individual needs?</td>
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<tr>
<td>Is the wellbeing of the relative / carer being supported?</td>
<td></td>
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<tr>
<td>Are care decisions being shared with the patient and / or carer(s)?</td>
<td></td>
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<tr>
<td><strong>Signature of the person making the assessment</strong></td>
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</tbody>
</table>

If a problem is identified, ensure that the care plan is updated or a new care plan is developed.
Caring for the Dying Patient (CDP) Document

Ongoing Nursing Assessment

To be completed if problem(s) identified.

<table>
<thead>
<tr>
<th>Date and time</th>
<th>Problem / Care plan</th>
<th>Intervention</th>
<th>Outcome</th>
<th>Initials</th>
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<tbody>
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Ensure a care plan is written for all new problems identified.
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Named consultant/GP: ..........................  Date: ..................  Time: .................

<table>
<thead>
<tr>
<th>ASSESS</th>
<th>Clinical Assessment, Communication and Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient / relative / carer concerns</td>
<td></td>
</tr>
<tr>
<td>• Events, changes in symptoms</td>
<td></td>
</tr>
<tr>
<td>• Hydration, nutrition, continence, cognitive status</td>
<td></td>
</tr>
<tr>
<td>• Examination: mouth, skin, presence or absence of</td>
<td></td>
</tr>
<tr>
<td>• Pain/nausea/distress/upper respiratory secretions/ breathlessness</td>
<td></td>
</tr>
<tr>
<td>CHECK</td>
<td></td>
</tr>
<tr>
<td>• Has there been a significant deterioration or improvement in the patient's condition?</td>
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<tr>
<td>• Drug chart for prn use of any medications</td>
<td></td>
</tr>
<tr>
<td>• Are necessary PRN medications prescribed and those which the patient cannot take discontinued?</td>
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<tr>
<td>• Do the nursing staff have any concerns?</td>
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<td>• Has spiritual care been considered?</td>
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<tr>
<td>• Needs of carers including after death</td>
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<tr>
<td>MANAGEMENT</td>
<td></td>
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<tr>
<td>• Does the current management plan need to change?</td>
<td></td>
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<tr>
<td>• Do any drug doses or routes require adjustment?</td>
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<tr>
<td>DISCHARGE/ SETTING</td>
<td></td>
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<tr>
<td>• Is the patient in their preferred place of care?</td>
<td></td>
</tr>
<tr>
<td>ESCALATION</td>
<td></td>
</tr>
<tr>
<td>• Do you need to discuss this patient with a more senior colleague?</td>
<td></td>
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<tr>
<td>COMMUNICATION</td>
<td></td>
</tr>
<tr>
<td>• What does this patient/carer want to know about what is happening?</td>
<td></td>
</tr>
<tr>
<td>• Do they have any questions or concerns?</td>
<td></td>
</tr>
<tr>
<td>• Have you handed over any key information to other team members?</td>
<td></td>
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</tbody>
</table>

Signature: ..................................  Date: ..................  Time: .................
Print name: .................................  Designation: ................  GMC No: .................
Caring for the Dying Patient (CDP) Document

Multi-disciplinary progress notes

Contemporaneous record

<table>
<thead>
<tr>
<th>Date and Time</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(All entries must have Signature/Print Name/Description/GMC Number (if applicable))</td>
</tr>
</tbody>
</table>

Name:  
Address:  
DOB:  
CRN/ Hospital No:  
NHS Number:
Caring for the Dying Patient (CDP) Document

Care after death

This is the beginning of the final phase of care for the patient and their family.

Verification of death

Date of death: ........................................ Time of death: ........................................
Verified by doctor [ ] Verified by senior nurse [ ] Date / Time verified: ........................................
Cause of death (as it will be written on death certificate): ..............................................................

Details of healthcare professional who verified death (details of verification to be documented on multidisciplinary continuation sheet)

Signature: ........................................ Date: ........................................ Time: ........................................
Print name: ........................................ Designation: ........................................ GMC/NMC No: ............
(Block Capitals)
Comments: ........................................................................................................................................

Doctor ........................................ Telephone: ........................................ Bleep no:.................................
Staff present at time of death: .............................................................................................................

Family/friends present at time of death [ ] Yes [ ] No
If yes, please state: ...............................................................................................................................

If not present, have the relative or carer been notified [ ] Yes [ ] No
Name of person informed: ..................................................................................................................

Relationship to patient: ................................. Contact number: ..............................................
Is the coroner likely to be involved? [ ] Yes [ ] No
If coroner is to be involved please state reason: ..................................................................................

Patient care dignity

Have care after death procedures (Last Offices) been undertaken according to policy and procedure? [ ] Yes [ ] No Name: ......................... If no, why?: ........................................
The patient is treated with respect and dignity whilst last offices are undertaken. Universal precautions and local policy and procedures including infection risk adhered to, including appropriate removal and disposal of any sharp objects prior to transfer to Funeral Director or Mortuary. Spiritual, religious, cultural rituals / needs met. Organisational policy followed for the management of ICD's, where appropriate. Organisational policy followed for the management and storage of patient’s valuables and belongings.

Relative or carer information

Can the relative or carer express an understanding of what they will need to do next and have they been given relevant written information? [ ] Yes [ ] No
Information should be given regarding how and when the bereavement office / funeral director will contact and give contact number to make an appointment – regarding the death certificate and patient’s valuables and belongings, where appropriate.
Discuss as appropriate: viewing the body / the need for a post mortem / the need for removal of cardiac devices, radioactive implants or intramedullary ‘Fixion’ devices/ the need for a discussion with the coroner.
Caring for the Dying Patient (CDP) Document

Relative or Carer Information (continued)

Information to be given to families on child bereavement services where appropriate – national and local agencies.

Given ‘Practical help and advice after a death’ leaflet – (Corp/119) Version:................ Yes No

DWP1027 'What to do after a death’ (England and Wales) or equivalent is given Yes No

Have wishes regarding tissue/organ donation been discussed (if appropriate)? Yes No

Comments: ........................................................................................................................................................................................................

Organisation Information

Has the primary health care team / GP been notified of the patient’s death?

Yes No If no, why?: ................................................................................................................................................................................................

The primary healthcare team / GP may have known this patient very well and other relatives or carers may be registered with the same GP - telephone or fax the GP practice.

Has the patient’s death been communicated to appropriate services across the organisation?

Yes No If no, why?: ................................................................................................................................................................................................

e.g. Bereavement office / palliative care team / chaplains / mortuary department / district nursing team / social services / community matron (where appropriate) are informed of the death. The patient’s death is entered on the organisation’s IT system.

To be completed by healthcare professional

Signature: .......................... Date: .................. Time: ..................

Print name: .......................... Designation: .................. GMC/NMC No: ...........

(BLOCK CAPITALS)

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Name:
Address:
DOB:
CRN/ Hospital No:
NHS Number: