The CPDP aims to support but does not replace clinical judgement
Care outlined in the CPDP must be altered if it is not clinically appropriate for the individual person

This care plan document comprises:
• Commencement of Care Plan for the Dying Person
• Initial assessment
• Family / Carer(s) information sheet
• Ongoing assessment
• CPDP clinical notes
• Care after death

Commencement of Care Plan for the Dying Person
The following 3 items must be completed by a Medical Officer and co-signed by a Registered Nurse.

1. Person assessed by the MDT as being in the last days to hours of life (refer to the MDT review and decision-making guide on page 3)
   □ Yes

2. The person has a current Acute Resuscitation Plan (ARP) that states resuscitation is not to be provided
   □ Yes

3. The most senior treating doctor responsible for the person's care endorses use of the CPDP
   □ Yes

Treating Consultant / the most senior treating doctor* (print name):

Medical Officer* (print name): Signature: Date:

Registered Nurse (print name): Signature: Date:

Ward: Date commenced: Time commenced (24hr):

Evidence of Advance Care Planning (ACP) Documentation
Advance Health Directive (AHD) □ Yes □ No □ Copy reviewed and filed in the medical notes
Enduring Power of Attorney (for health) □ Yes □ No □ Copy reviewed and filed in the medical notes
Statement of Choices □ Yes □ No □ Copy reviewed and filed in the medical notes

Communication
Where relevant, the following are notified that the person is expected to die within days or hours:
General Practitioner: □ Yes □ No Residential Aged Care Facility: □ Yes □ No
Community Service Providers: □ Yes □ No Other members of the MDT: □ Yes □ No

Discontinuation of Care Plan for the Dying Person (complete only if applicable)
Care Plan for the Dying Person document discontinued – Date: _____ / _____ / _____ Time (24hr): _____ :

New treatment and care options reviewed by MDT* and discussed with person, and their substitute decision-maker(s)* / family / carer(s) as appropriate: □ Yes □ No

Document reasons why the CPDP was discontinued and new treatment and care plan in the person's medical notes.
Guidance for Health Professionals

Aim of the CPDP
• The CPDP document is a clinician guide for person and family care in the last days and hours of life.
• It supports the delivery of high quality care tailored to the individual’s needs, when their death is expected.
• It does not replace clinical judgment and must be altered if not clinically appropriate for the individual.
• It is used in conjunction with, but does not replace, documents or processes such as an AHD, Enduring Power of Attorney (for health), ARP or ACP.

Clinical / Communication Requirements
• Regularly review person supported by the CPDP. This includes regular discussion and critical decision-making by the MDT to ensure decisions are appropriate for the individual person.
• The recognition of dying is always complex irrespective of previous diagnosis or history. Uncertainty is an inherent part of dying, and there are occasions when a person lives longer or dies sooner than expected. Seek specialist palliative care support or a second opinion as needed.
• Comprehensive and clear communication is pivotal, and all decisions leading to a change in care delivery should be communicated to the person (where appropriate) and to the substitute decision-maker(s) / family / carer(s). The views of all concerned must be listened to and documented.

Food and Fluids
• The CPDP does not preclude the use of artificial nutrition and hydration (e.g. subcutaneous fluids). All clinical decisions must be made in the person’s best interest.

Documentation Instructions
• Family / Carer(s)* information sheet to be removed and provided to the family / carer(s) following a full explanation of the care plan.
• Clinicians should document in the CPDP clinical notes.
• This is a legal document and must be completed as per hospital documentation policy.
• All health professionals must sign the signature log upon initial entry.

Key:
▲ Nursing ■ Medical ◆ Allied Health
Symbols suggest care by a primary professional stream.
• Additional CPDP Ongoing Assessment (SW270a) pages are available for extended treatment.
• Additional CPDP Clinical Notes (SW270b) pages are available if more space is required for documentation.
• Occasionally the CPDP may be discontinued. If the person’s condition then deteriorates, a new document must be used.

Definitions* (for the purposes of the CPDP document)
• The most senior treating doctor: The most senior doctor (e.g. treating consultant or registrar) responsible for and familiar with clinical care decisions related to this dying person.
• Medical Officer: Doctor with delegated responsibility from the most senior treating doctor to make decisions related to commencing this dying person on the CPDP.
• MDT: MDT minimally consists of a Medical Officer and a Registered Nurse (Div 1) who is responsible for the care of this dying person, and should involve Allied Health as appropriate.
• Family / Carer(s): This term includes any people who are important to the dying person, whether they are spouse, sibling, friend or carer.
• Substitute decision-maker(s) (SDM): Is a person legally permitted to make important decisions on behalf of someone who does not have capacity to make the decision required. The decision can be about personal, health, and financial matters. A person can have more than one SDM. The SDM may not be the person’s family / carer(s).
Specialist palliative care services are available for advice and support regarding any aspect of care especially if symptom control is difficult and / or there are other communication issues.
### Signature Log

**Care Plan for the Dying Person (CPDP)**

Supporting care in the last days and hours of life

<table>
<thead>
<tr>
<th>Initials</th>
<th>Signature</th>
<th>Print name</th>
<th>Role</th>
</tr>
</thead>
</table>

(Affix identification label here)

- **URN:**
- **Family name:**
- **Given name(s):**
- **Address:**
- **Date of birth:**
- **Sex:**
  - [ ] M
  - [ ] F
  - [ ] I

**EXAMPLE ONLY**
Initial Assessment Joint assessment by Medical Officer and Nurse (and Allied Health as required)

Key: ▲ Nursing  □ Medical  ◆ Allied Health

Communication with the person ▲ ■ ◆

1.1 Is the person able to participate in the discussion?
- Yes □ No ☐
  - If no, describe why the person is unable to participate (e.g. semi-conscious, unconscious, hearing, vision, speech, learning disabilities, dementia (use assessment tools), neurological conditions, confusion or other):

  - Interpreter required: □ Yes ☐ No
  - Language:

  - If the person is unable to participate in the following discussion, complete section 1.3 with family / carer(s) to identify what is important to the person or refer to prior advance care planning completed by the person.

  Initials: ___________ Date: __/__/____

1.2 Does the person understand they are dying?
- Yes □ No ☐

Initials: ___________ Date: __/__/____

1.3 It is now important to ask the person the following questions:
- What is important for your care now (e.g. spiritual, cultural, social, emotional and practical needs / dying at home or home-like environment)?

- What is important to you at the time of death?

- What is important to you after death?

- Who else do you want us to share this information with?

- Is there anything else you need to tell us or ask us?

Initials: ___________ Date: __/__/____

Communication with the person’s family / carer(s) ▲ ■ ◆

2.1 Does the person have a SDM (as identified in ARP)?
- Yes □ No ☐
  - Name of SDM:
  - Relationship to person:

Initials: ___________ Date: __/__/____

2.2 Is the person’s SDM able to participate in the discussion?
- Yes □ No ☐
  - If no, describe why the SDM is unable to participate:

  - Interpreter required: □ Yes ☐ No
  - Language:

Initials: ___________ Date: __/__/____

If ‘No’ or further documentation required, document in CPDP Clinical Notes.
2.3 Does the person’s SDM understand the person is dying?

- Names of other persons present: 

Initials: .................................................. Date: / / 

2.4 It is important to ask the family / carer(s) the following questions:

- What is important for you now (e.g. spiritual, cultural, social, emotional and practical needs)?  

- What is important for you at the time of the person’s death?

- What is important to you after the person’s death?

- Who else do you want us to share this information with?

- Is there anything else you need to tell us or ask us?

Initials: .................................................. Date: / / 

2.5 Family / Carer(s) need for support and bereavement risk assessed: (tick all that apply)

- Limited social support
- Emotional distress
- Family conflict
- Mental illness
- Cumulative losses
- Sudden or unexpected deterioration/death
- Nil identified

- Name of family / carer(s) assessed / comments:

Initials: .................................................. Date: / / 

2.6 Allied Health / Support Services referred to:

<table>
<thead>
<tr>
<th>Tick all that apply</th>
<th>Person</th>
<th>Family / Carer(s)</th>
<th>Name / Contact details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Indigenous Liaison Officer / Health Worker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual Carer / Chaplains / Cultural Advisor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Additional Information:

Initials: .................................................. Date: / / 

If ‘No’ or further documentation required, document in CPDP Clinical Notes.
All health professionals must sign the signature log upon initial entry

Initial Assessment Joint assessment by Medical Officer and Nurse (and Allied Health as required) (continued)

Communication with the person's family / carer(s) (continued) ▲ ▼ ▼

2.7 Ensure up-to-date contact information for the person's family / carer(s) is documented below:

<table>
<thead>
<tr>
<th>Primary contact person</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Relationship to person:</td>
</tr>
<tr>
<td></td>
<td>Phone number:</td>
</tr>
<tr>
<td></td>
<td>Staying with person overnight? □ Yes □ No</td>
</tr>
<tr>
<td></td>
<td>Contact: □ Anytime □ Not at night □ Other</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary contact person</th>
<th>Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Relationship to person:</td>
</tr>
<tr>
<td></td>
<td>Phone number:</td>
</tr>
<tr>
<td></td>
<td>Staying with person overnight? □ Yes □ No</td>
</tr>
<tr>
<td></td>
<td>Contact: □ Anytime □ Not at night □ Other</td>
</tr>
</tbody>
</table>

2.8 The person's family / carer(s) is given a full explanation of the facilities available to them (e.g. after hours access, staying overnight, tea and coffee facilities and toilets)

Yes □ No □

Initials: Date: / / 

Review of the person's individual medical care ▼

3.1 The person's diagnosis

• Primary diagnosis: ..........................................................................................................................
• Associated co-morbidities: ..................................................................................................................

Initials: Date: / / 

3.2 Baseline information about the person's condition

□ Alert □ Semi-conscious □ Unconscious
□ Confused □ Agitated / Restless □ Emotional distress
□ Pain □ Respiratory tract secretions □ Unable to swallow
□ Vomiting □ Bladder problems □ Bowel problems
□ Dyspnoea □ Other: ..........................................................................................................................

Initials: Date: / / 

3.3 Medications to manage the person's symptoms

• Current medication assessed and nonessentials discontinued □ Yes □ No
• Convert appropriate oral medications to subcutaneous / alternative route □ Yes □ No
• PRN subcutaneous medication written up for symptoms below:
  □ Pain □ Agitation
  □ Nausea and vomiting □ Dyspnoea
  □ Respiratory tract secretions
• If ordered, continuous subcutaneous infusion set up within 4 hours □ Already in place □ Not required

Initials: Date: / / 

If 'No' or further documentation required, document in CPDP Clinical Notes.
All health professionals must sign the signature log upon initial entry.

**Initial Assessment** Joint assessment by Medical Officer and Nurse (and Allied Health as required) (continued)

**Key:** ▲ Nursing  ■ Medical  ◆ Allied Health

**Review of the person’s individual medical care (continued) ■**

3.4 The person’s need for interventions is reviewed by the Medical Officer

<table>
<thead>
<tr>
<th>Intervention</th>
<th>N/A</th>
<th>Discontinued</th>
<th>Continued</th>
<th>Commenced</th>
</tr>
</thead>
<tbody>
<tr>
<td>Artificial nutrition – type:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artificial hydration – type:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine blood tests</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intravenous antibiotics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood glucose monitoring</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine recording of vital signs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oxygen therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oropharyngeal suction therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anticoagulant therapy</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressings</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other(s):</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Implantable Cardioverter Defibrillator (ICD) is deactivated (if applicable):*

- Yes
- No
- N/A

**Initials:** ..................................
**Date:** .......... / .......... / ..........

**Review of the person’s individual nursing care ▲**

4.1 Nursing assessment of the following is undertaken:

- Mouth
- Eyes
- Skin integrity
- Hygiene

**Initials:** ..................................
**Date:** .......... / .......... / ..........

**Explanation of the plan of care ▲ ■ ◆**

5.1 Full explanation of current care plan discussed with the person

- Yes
- No

**Initials:** ..................................
**Date:** .......... / .......... / ..........

5.2 Full explanation of current care plan discussed with the family / carer(s)

- Yes
- No

**Initials:** ..................................
**Date:** .......... / .......... / ..........

5.3 Family / Carer(s) Information Sheet provided

- Yes
- No

**Initials:** ..................................
**Date:** .......... / .......... / ..........

*EXAMPLE ONLY*
The doctors and nurses will have explained to you that there has been a change in your relative or friend’s condition. They believe that the person you care about is now dying and in the last days or hours of life. The Care Plan for the Dying Person is a document that supports the healthcare team to provide the best possible care to your relative/friend. The person and their care will be reviewed regularly.

You may like to be involved in elements of care at this time and the staff will talk to you about how you can help. This information sheet is to help you understand what to expect. If you need more information or support, or do not agree with something, please ask the healthcare team. They are there to support you.

Treatment and medications
Medications and tests that are not helpful may be stopped and new medicines to help manage symptoms will be prescribed. Medications for symptom control will only be given when needed. If the person cannot swallow medications they require, a small pump called a syringe driver may be used to give a continuous infusion under their skin.

Food and drink
Your relative/friend will be supported to eat and drink as long as possible; however, a loss of interest in, and reduced need for food and drink, is a normal part of the dying process. This can be hard to accept, even when you know the person is dying. Good mouth care is important at this time and the nurses may ask if you would like to help with this care.

Spiritual, cultural and emotional care
As the person prepares to die they may go through a process of looking back in search of meaning – saying goodbye to people and places, forgiving and being forgiven, expressing joy and gratitude, facing regrets and accepting death. Some people may not want, or be able to, do these things. It is important to take cues from the dying person and be able to listen, share memories and find ways to say goodbye. Let the healthcare team know if you would like spiritual or emotional support, or if you have important cultural practices at this time.

Caring for yourself
Caring for someone who is dying can be a tiring and stressful time. The experience may bring up unresolved feelings or upsetting emotions. It may help you to talk through your thoughts and how you can look after yourself. Please ask the healthcare team for advice.

Changes you may notice
The dying process is unique to each person. Whilst it is almost impossible to predict the exact time or how a person will die, there are several signs and changes that often occur.
Confusion and restlessness

Shortly before death some people become confused and restless. This is known as terminal restlessness and it affects nearly half of all people who are dying. There may be a variety of causes and sometimes medications are needed. A calm, quiet and peaceful environment, with reassurance from those close to the person, can often help to relieve this symptom.

Communication

Your relative/friend may find it hard to sustain a conversation. While it may be easier for them to talk after they have rested, just being there will help comfort and support them. You may also wish to hold or gently massage their hands or feet, or play their favourite music softly. If they become unconscious they may not be able to respond to you; however, they may still be aware of your presence and the voices around them.

Becoming unconscious

When or if this happens, repositioning can help prevent soreness and stiffness from lying in the one position for too long. A special mattress may also be used to improve their comfort.

Sometimes an indwelling catheter (tube) is inserted to relieve the feeling of a full bladder; however, it is normal for urine production and bowel movements to slow down or stop.

Sometimes people are unable to cough and secretions can build up at the back of their throat. This causes a rattling or gurgling noise as they breathe, but is unlikely to cause the person discomfort. Repositioning and medications may help.

Breathing and circulation

There may be periods of rapid breathing followed by short periods of no breathing at all. This is known as Cheyne-Stokes respirations and is very common towards the end of life. Again, this type of breathing is normal and is unlikely to cause discomfort. It is also normal for a person’s hands, feet and legs to feel cool or cold as their circulation slows down.

Once death has occurred

When people die they stop breathing and their heart stops beating. They will not respond to any stimulation and their mouth may fall slightly open. Their eyes may be open but the pupils will be large and fixed on one spot. They may also lose control of their bladder and bowel. When this happens a doctor will usually attend and confirm their death. During this time you may wish to contact a close friend or relative, spiritual carer or cultural advisor to be with you. Take your time saying goodbye. The healthcare team will explain what the next steps are and help you access extra support if you need it.

Ward phone number:

Questions:

Please provide this information sheet to the family / carer(s).
## Symptom Assessment

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Severe</th>
<th>Moderate</th>
<th>Mild</th>
<th>Absent</th>
<th>Action required? Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Restlessness and agitation (delirium)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nausea and/or vomiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distress related to respiratory secretions</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distress related to breathlessness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other symptoms (specify)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Symptom Rating Scale**

- **Severe**: Escalate to medical/palliative care team
- **Moderate**: Escalate to nurse-in-charge
- **Mild**: Routine symptom management
- **Absent**: No symptom/problem

**Action required?** Y / N

---

## Comfort Observations

- The person does not have urinary problems
- The person does not have bowel problems
- The person’s comfort and safety regarding the administration of medication is maintained
- The person receives fluids to support their individual needs
- The person’s mouth is moist and clean
- The person’s skin integrity is maintained
- The person’s personal hygiene needs are met
- The person receives their care in a physical environment adjusted to support their individual needs
- The person’s psychological and spiritual well-being is supported
- The well-being of the family or carer or advocate attending the person is supported

---

### Instructions for Symptom Assessment and Management

- Observations must be performed routinely at a minimum of 2 hourly
- When graphing observations, place a dot (●) in the appropriate box and join the preceding dot (e.g. [● ● ● ●])
- If any treatment or escalation initiated more regular observation should occur.

### Instructions for Comfort Assessment and Management

- Assess and manage comfort at least every two (2) hours.
- Assess each care need and document with Yes or No (Y / N) – note N/A if after assessment no action required.
- No should always prompt an action. Document problem, action and outcome of action in CPDP clinical notes.
Instructions for Response to Symptom Rating

- Use standardised medication management guidelines to respond to symptoms
- If no PRN medication charted, liaise with Medical Officer
- Any symptoms present (even mild) require action to address; moderate or severe symptoms require escalation
- Reassess symptom at least 1 hour following treatment - if symptom not adequately addressed a change in the plan of care may be required
- Record actions and outcomes in the CPDP Clinical Notes

Prescribed Frequency of Symptom Assessment and Comfort Observations

Observations must be performed routinely at a minimum of 2 hourly
If any treatment or escalation initiated more regular observation should occur

Refer to your local hospital procedure for instructions on how to escalate care

Symptom Rating – Absent

- Problem / Symptom distress absent
- Continue with current care

Symptom Rating – Mild

- Problem / Symptom distress present, but managed by existing plan of care

If the person has any yellow zone observations you must:
1. Treat problem / symptom according to service protocols
2. Increase the frequency of symptom assessment and comfort observations

Symptom Rating – Moderate

- The person has more than one ‘Mild Symptom Rating’
- The person has not responded to treatment as expected and symptoms are persisting
- Problem / Symptom distress requires a change in plan of care

If the person has any orange zone observations you must:
1. Consult promptly with the NURSE-IN-CHARGE to:
   a. Discuss the problem / symptom and agree on a plan of care
   b. Decide whether a MEDICAL / PALLIATIVE CARE REVIEW is required
2. Increase the frequency of symptom assessment and comfort observations

Symptom Rating – Severe

- Problem / Symptom distress requires urgent intervention and escalation
- Plan of care is ineffective, and change is required

If the person has any red zone observations you must:
1. Initiate appropriate clinical care
2. Initiate a MEDICAL / PALLIATIVE CARE REVIEW
3. Increase the frequency of symptom assessment and comfort observations

Prompts for Symptom Management

<table>
<thead>
<tr>
<th>Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider position change</td>
</tr>
<tr>
<td>Consider PRN analgesia for incident pain</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person should only receive medication that is beneficial</td>
</tr>
<tr>
<td>If continuous subcutaneous infusion in place complete 4 hourly checks</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restlessness and / or agitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess the person for reversible causes including pain, incontinence, fever, breathlessness, urinary retention, faecal impaction</td>
</tr>
<tr>
<td>Consider position change</td>
</tr>
<tr>
<td>If no urine output for &gt;6 hours consider a bladder scan</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nausea and / or vomiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consider anti-emetics</td>
</tr>
</tbody>
</table>

Respiratory tract secretions:

- Consider position change (use semi-prone position)
- Anticholinergic medication more effective if given as soon as symptom occurs

Breathlessness:

- Consider position change and use of fan

Fever:

- Consider cool sponges and use of fans
- Consider antipyretics PO or PR

Family / Carer(s) distress:

- Consider the severity of the problem the family / carer(s) is experiencing (e.g. anger, family conflict)
  - If score is mild, reassure the family / carer(s) with explanation and support as required
  - If score is severe, escalate to senior staff and consider referral to Social Worker, Palliative Care Service, Spiritual Carer

Prompts for Comfort Assessment and Management

<table>
<thead>
<tr>
<th>Food and fluids</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person should be supported to eat and drink for as long as tolerated and consider the use of thickened fluids</td>
</tr>
<tr>
<td>Monitor for signs of aspiration and / or distress</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin care</th>
</tr>
</thead>
<tbody>
<tr>
<td>The frequency of assessment, repositioning and special aids (e.g. pressure relieving mattress) should be determined by skin inspection and the person’s individual needs</td>
</tr>
</tbody>
</table>

Mouth care:

- Frequency of mouth care depends on individual need
- Aim is to keep the person’s mouth clean and moist

Eye care:

- Eyes are clean and moist
- Swab with normal saline PRN

Bladder care:

- Use of pads, urinary catheter or penile sheath as required
- Monitor for constipation and diarrhoea

Bowel care:

- Monitor for constipation and diarrhoea
- Bowel movements documented

Environment:

- Single room; curtains / screens; clean environment; sufficient space at the bedside; consider fragrance; silence; music; lighting; pictures; photographs; nurse call bell accessible

Spiritual / Cultural needs:

- Staff just being at the bedside can be a sign of support and caring. Respectful verbal and nonverbal communication; use of listening skills; information and explanation of plan of care given
- Use of touch if appropriate
- Spiritual / Cultural / Emotional needs supported

Support:

- Offer food / drink / rest
- Check understanding of all visitors
- Listen and respond to worries and fears; provide age appropriate information
- Use clear language; avoid euphemisms or jargon
- Allow the opportunity to reminisce
- Assess bereavement risk and refer as needed
Please document all multidisciplinary notes within the CPDP Clinical Notes

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CPDP Clinical Notes

URN:
Family name:
Given name(s):
Address:
Date of birth:
Sex:  □ M  □ F  □ I
Please document all multidisciplinary notes within the CPDP Clinical Notes.

**CPDP Clinical Notes**

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**Care Plan for the Dying Person (CPDP)**

Supporting care in the last days and hours of life

---

### Care After Death (this section MUST be completed)

<table>
<thead>
<tr>
<th>Verification of the person's death</th>
<th>A Medical Officer and / or Registered Nurse(s) can verify death. (Refer to hospital policy / procedures)</th>
</tr>
</thead>
<tbody>
<tr>
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<td>• Where a Medical Officer is unavailable immediately to sign a Death Certificate or to document that a person has died, other health professionals (Registered Nurses and Midwives) can verify the fact of death.</td>
</tr>
<tr>
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<td>• There is a minimum guideline for the clinical assessment necessary to establish that death has occurred.</td>
</tr>
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<td>• Please refer to the 'Queensland Health Care Plan for the Dying Person Health Professional Guidelines' for further guidance.</td>
</tr>
</tbody>
</table>

#### 6.1 Date of death:

- [ ] No palpable carotid pulse
- [ ] No heart sounds for 30 continuous seconds
- [ ] No breath sounds heard for 30 continuous seconds
- [ ] Fixed dilated pupils

**Time of death (24hr):**

- [ ] No response to centralised stimuli
- [ ] No motor (withdrawal) response or facial grimace response to painful stimuli (e.g. pinching inner aspect of the elbow)
- [ ] Option ECG strip shows no rhythm

**Medical Officer / Registered Nurse name:**

**Signature:**

---

**Coroner ▲ ■

7.1 Is this likely to be a reportable Coronial death? If yes, refer to hospital policy / procedures**

- [ ] Yes
- [ ] No

**Notifying and supporting family / carer(s) ▲ ■ ■

8.1 Person(s) present at time of death:**

- [ ] Yes
- [ ] No

**If family / carer(s) not present, have they been notified?**

- [ ] Yes
- [ ] No

**Name of person informed:**

**Relationship:**

**Initials:**

**Date:**

---

**8.2 The family / carer(s) can express an understanding of what they will need to do next**

- [ ] Yes
- [ ] No

**The family / carer(s) are given relevant supporting information:**

- [ ] Yes
- [ ] No

**Bereavement referral required and completed?**

- [ ] Yes
- [ ] No

**Initials:**

**Date:**

---

**Care of the deceased ▲

9.1 Care of the deceased person has been undertaken according to the person's / family / carer(s) wishes and hospital policy / procedures**

- [ ] Yes
- [ ] No

**Initials:**

**Date:**

---

**Other communication ▲ ■ ■

10.1 The person's death is communicated to (where relevant):**

- [ ] Community Service Providers
- [ ] Residential Aged Care Facility
- [ ] Other members of the MDT
- [ ] General Practitioner

**Initials:**

**Date:**

---

**10.2 Death certificate completed according to hospital policy / procedures**

- [ ] Yes
- [ ] No

If 'No' or further documentation required, document in CPDP Clinical Notes.

---

**Following the death of this person, do you need any support? Consider seeking support from colleagues. Support is also available through the Employee Assistance Program. Phone number:**

---

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