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Te Ara Whakapiri

Resident label

COMMENCING CARE PLAN

following a Multi-Disciplinary Team (MDT) assessment:

Recognition that the person appears to be in their last days/hours of life:

Is the 'Recognising Dying Person' Flow Chart Available to support decision making?

Consider the support of Specialist Palliative Care Team

Mercy Hospice - 24 hr Contact – Ph 09 361 5966

Date care plan commenced: ..... Time care plan commenced: .....

Name: ..... Signature: ..... Title: .....

This should be **the most senior GP/NP or Nurse (after discussion with dr.....) immediately available**. This decision must be endorsed by the most senior medical healthcare professional responsible for the patient's care at the earliest opportunity (if different to medical health care professional named above).

Endorsement by most senior Medical Health Care Professional responsible for resident (if different from above):

Name: ..... Signature: ..... Title: .....

All personnel completing the Care plan - please sign below

You should also have read and understood the 'Health Care Professional' leaflet. (Available in Resource folder or internet)

Name (print)	*Full signature*	*Initials*	*Professional title*	*Date*

Used second signing sheet if needed. Yes ☐ No ☐ See Pg 20.

Record all reassessments here

Reassessment date: ..... Reassessment time: ..... Signature .....

Reassessment date: ..... Reassessment time: ..... Signature .....

Reassessment date: ..... Reassessment time: ..... Signature .....

If the Last days of Life Care Plan is discontinued please record here:

Date care plan discontinued: ..... Time care plan discontinued: .....

Reasons why the Care plan was discontinued by MDT Team: .....

.....

Decision to discontinue this care plan shared with the resident **Yes☐** **No☐**

Decision to discontinue this care plan shared with the relative or carer **Yes☐** **No☐**

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Te Ara Whakapiri

Resident label

SECTION 1: INITIAL ASSESSMENT *(to be completed by GP/NP and nurse)*

DIAGNOSIS & BASELINE INFORMATION

PRIMARY DIAGNOSIS: : (e.g. Dementia, COPD, Cancer of...) .....

Contributing factors: .....

Ethnicity: ..... Female ☐ Male ☐ Other ☐ Age: .....

At the time of the assessment is the resident:

Conscious ☐ Semi-conscious ☐ Unconscious ☐ unable to talk ☐

In pain	**Yes** ☐ **No** ☐	Able to swallow	**Yes** ☐ **No** ☐	Confused	**Yes** ☐ **No** ☐
Agitated	**Yes** ☐ **No** ☐	Continent (bladder)	**Yes** ☐ **No** ☐		
Nauseated	**Yes** ☐ **No** ☐	Catheterised	**Yes** ☐ **No** ☐	Experiencing respiratory	
Vomiting	**Yes** ☐ **No** ☐	Continent (bowels)	**Yes** ☐ **No** ☐	tract secretions	**Yes** ☐ **No** ☐
Short of breath	**Yes** ☐ **No** ☐	Constipated	**Yes** ☐ **No** ☐		

Experiencing other symptoms (e.g. oedema, itch) ..... **Yes** ☐ **No** ☐

(GP/NP to complete Goal 1.1)

COMMUNICATION

Goal 1.1: The resident is able to take a full and active part in communication.

Achieved ☐ **Variance** ☐ **Unconscious** ☐ **unable to talk** ☐

Barriers that have the potential to prevent communication have been assessed.

First language: ..... Other barriers to communication identified .....

Consider: Hearing, vision, speech, learning disabilities, dementia (use of assessment tools), neurological conditions and confusion.

The relative or carer may know how specific signs indicate distress if the resident is unable to articulate their own concerns.

Consider need for an interpreter (contact no): .....

Does the resident have:-

An Advance Care Plan? **No** ☐ **Yes** ☐ .....

An advance decision to refuse treatment? **No** ☐ **Yes** ☐ .....

An expressed wish for organ/tissue donation? **No** ☐ **Yes** ☐ **24 Hr Contact number: 09 630 0935**.....

Does the resident have capacity to make decisions on their own treatment at this moment in time? **No** ☐ **Yes** ☐

If No: Consider the support of the Enduring Power of Attorney (EPOA) for **Personal Care & Welfare.**

Enduring Power of Attorney (EPOA) **Personal Care & Welfare:** activated: **No** ☐ **Yes** ☐ **N/A** ☐

Comments: .....

COMMUNICATION

Goal 1.2: The relative or carer is able to take a full and active part in communication.

Achieved ☐ **Variance** ☐

First language ..... Other barriers to communication identified .....

Consider need for an interpreter (contact no): .....

Goal 1.3: The resident is aware that they are dying. **Achieved** ☐ **Variance** ☐ **Unconscious** ☐

Goal 1.4: The relative or carer is aware that the resident is dying. **Achieved** ☐ **Variance** ☐

Goal 1.5: Family / Whanau, carer, contact information updated: **Achieved** ☐ **Variance** ☐

If the person's condition changes, who should be contacted first?

First contact name:

Relationship to resident: ..... Phone (H) ..... (Mob) .....

When to contact: At any time☐ Not at night-time☐ Stay overnight ☐

2nd contact name: .....

Relationship to resident: ..... Phone (H) ..... (Mob) .....

When to contact: At any time☐ Not at night-time☐ Stay overnight ☐

Enduring Power of Attorney (EPOA) for Personal Care & Welfare: N/A ☐

Name: .....

Contact details: .....

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SECTION 1: INITIAL ASSESSMENT continued *(to be completed by GP/NP and nurse)*

Goal 2: Family / whānau / carer has had an explanation of the facilities available to them.

Achieved☐ Variance☐

Facilities may include: car parking, toilet, bathroom facilities, beverages, WiFi password, accommodation etc.

TAHA WAIRUA - SPIRITUAL HEALTH

Goal 3.1: The resident is given the opportunity to discuss what is important to them at this time eg. their wishes, feelings, faith, beliefs, values.

Achieved ☐ Variance ☐ Unconscious ☐ unable to talk ☐

Preferred place of care during the dying phase: Current place of care☐ Acute Care Hospital☐ Hospice ☐ Home ☐

Comments: .....

Religious / Faith Taha wairua - Spiritual Health tradition identified, please specify: .....

Resident's own Minister/Priest/Spiritual adviser: Name: .....

Phone no: ..... Date/time: ..... Contacted Yes☐ No☐ N/A ☐

Consider referral for religious and spiritual needs: Yes☐ No☐ N/A ☐

Spiritual support adviser: Name: .....

Tel no: ..... Date/time: ..... Contacted Yes☐ No☐ N/A ☐

Information obtained: Verbally ☐ Previous care plan ☐ ACP ☐ Family/whānau/carer ☐

Does the person need access to outdoors, pets, touch therapy, music, prayer, rituals, literature etc.? (as appropriate)

Is there any specific request / ritual you would like now, at death and after death?

.....

.....

Is resident for burial or cremation? Document at top of 'Section 3 - Care After Death'

Goal 3.2: The relative or carer is given the opportunity to discuss what is important to them at this time e.g. their wishes, feelings, faith, beliefs, values.

Achieved ☐ Variance ☐

Did the relative or carer take the opportunity to discuss the above? Please document. Yes ☐ No ☐

Comments: .....

.....

CULTURAL NEEDS

Goal 3.3: The resident is given the opportunity to discuss their cultural needs at this time. (Consider referral to Cultural Support)

Achieved ☐ Variance ☐ Unconscious ☐

Are there any specific requests / rituals you would like now, at death and after death?

.....

.....

.....

Goal 3.4: The relative(s) or carer(s) is given the opportunity to discuss their cultural needs at this time. (Consider referral to Cultural Support)

Achieved ☐ Variance ☐

Are there any specific requests / rituals you would like now, at death and after death?

.....

.....

.....

.....

SECTION 1: INITIAL ASSESSMENT continued *(to be completed by GP/NP and nurse)*

(GP/NP to complete Goal 4.1)

MEDICATION

Goal 4.1: The resident has medication prescribed on a 'prn' basis for <u>all</u> of the following 5 symptoms which may develop in the last hours or days of life.

Achieved☐ Variance☐

Pain	☐
Agitation	☐
Respiratory tract secretions	☐
Nausea / Vomiting	☐
Dyspnoea	☐

Anticipatory prescribing in this manner will ensure that there is no delay in responding to a symptom if it occurs. See Symptom Control Guidelines in resource folder

Current Medication assessed and non-essentials discontinued: **Yes☐** **No☐**

Medicines for symptom control **<u>MUST ONLY BE GIVEN</u>** *when needed* (after assessment) to manage the symptom.

Check: Right resident; right drug; right dose; right time; right route.

MEDICATION

Goal 4.2: Equipment is available for the resident to support a continuous subcutaneous infusion (CSCI) of medication where required.

Achieved ☐ Variance ☐ Already in place ☐ Not required ☐

If a CSCI via a syringe driver is to be used explain the rationale to the resident, relative or carer**.**

NB: Not all residents who are dying will require a CSCI via a syringe driver – 'prn' medications should be available (see Goal 4.1). Medicines for symptom control **<u>MUST ONLY BE GIVEN</u>** *when needed* (after assessment) to manage the symptom

(GP/NP to complete Goals5.1, 5.2, 5.3, and 6)

CURRENT INTERVENTIONS

Goal 5.1: The resident's need for current interventions has been reviewed by the MDT.

Achieved☐ Variance ☐

	Currently not being taken/ or given	Discontinued	Continued	Commenced
5a: Routine blood tests	☐	☐	☐	
5b: Antibiotics	☐	☐	☐	☐
5c: Blood glucose monitoring	☐	☐	☐	
5d: Recording of routine vital Signs	☐	☐	☐	
5e: Oxygen therapy	☐	☐	☐	☐

5.2: The resident has a "Do Not Attempt Cardiopulmonary Resuscitation" Order in place.

Achieved☐ Variance☐

Please complete the appropriate associated documentation according to policy and procedure.

Explain to the resident, relative or carer as appropriate.

5.3: Implantable Cardioverter Defibrillator (ICD) is deactivated.

Achieved☐ Variance☐ No ICD in place ☐

Contact the resident's cardiologist if ICD not deactivated. Contact number ……

Information leaflet given to the resident, relative or carer as appropriate.

NUTRITION

Goal 6: The need for clinically assisted (artificial) nutrition is reviewed by the MDT.

Achieved☐ Variance☐

The resident should be supported to take food by mouth for as long as tolerated and appropriate.
A reduced need for food is part of the normal dying process.

For many residents the use of clinically assisted (artificial) nutrition will not be required.

If clinically assisted (artificial) nutrition is already in place please record route: **NG☐** **PEG/PEJ☐** **NJ☐** **TPN☐**

Is clinically assisted (artificial) nutrition? **Not required☐** **Discontinued☐** **Continued ☐** **Commenced ☐**

Consider reduction in rate / volume according to individual need if nutritional support is in place.

Explain the plan of care to the resident (where appropriate), and to the relative or carer.

SECTION 1: INITIAL ASSESSMENT continued *(to be completed by GP/NP and nurse)*

(GP/NP to complete Goals 7)

HYDRATION

Goal 7: The need for clinically assisted (artificial) hydration is reviewed by the MDT.

Achieved ☐ Variance ☐

The resident should be supported to take fluids by mouth for as long as tolerated and appropriate.
A reduced need for fluids is part of the normal dying process.
For many residents the use of clinically assisted (artificial) hydration will not be required.
Symptoms of thirst / dry mouth do not always indicate dehydration but are often due to mouth breathing or medication. Good mouth care is essential.

If clinically assisted (artificial) hydration is already in place please record route: IV☐ S/C☐ PEG/PEJ☐ NG☐

Is clinically assisted (artificial) hydration: **Not required ☐ Discontinued ☐ Continued ☐ Commenced ☐**

Consider reduction in rate / volume according to individual need if hydration support is in place. If required consider the s/c route.

Explain the plan of care to the resident (where appropriate) and the relative or carer.

SKIN CARE

Goal 8: The resident's skin integrity is assessed. **Achieved ☐ Variance ☐**

The aim is to prevent pressure ulcers or further deterioration if a pressure ulcer is present. The frequency of repositioning should be determined by skin inspection, assessment and the resident's individual needs. Consider the use of special aids (mattress / bed).

EXPLANATION OF THE PLAN OF CARE

Goal 9.1: A full explanation of the current plan of care is given to the resident.

Achieved☐ Variance☐ Unconscious☐

Goal 9.2: A full explanation of the current plan of care is discussed with relative or carer.

Achieved ☐ Variance ☐

Name of relative(s) or carer(s) present and relationship to the resident:.....

.....

Names of health care professionals present:.....

Goal 9.3: The supportive leaflets- been given to the relative or carer. Achieved ☐ Variance ☐

- Relative / Carer Information' sheet **Yes☐ No☐**
- What to Expect when Someone is Dying **Yes☐ No☐**
- Why won't they eat **Yes☐ No☐**
- Planning a funeral **Yes☐ No☐**
- Age appropriate advice. Parents or carer should be given or have access to age appropriate advice and information to support children and adolescents. www.skylight.org.nz **Yes☐ No☐**

Goal 9.4: The resident's primary health care team/GP practice is notified that the resident is dying. **Achieved ☐ Variance ☐**

a) G.P. Practice to be contacted if unaware resident is dying. (if out of hours leave a voice message or send a fax, write in 'Variance Sheet' for staff follow up the next working day).

b) Consider notifying the resident's medical specialists/consultants if unaware the resident is dying.

Record any "VARIANCE" on VARIANCE ANALYIS Sheet.

SIGNATURES

Please sign here on completion of the 'Initial Assessment'	Please sign here on completion of the 'Initial Assessment'
GP/NP's name (print):	**Nurse's name (print):**
.....	.....
GP/NP's signature:	**Nurse's signature & designation:**
.....	.....
Date.....**Time**.....	**Date**.....**Time**.....

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The CARE PLAN IS A LEGAL DOCUMENT
Have you documented in the progress notes that the "person is on Last Days of Life Care Plan all documentation now in Care Plan". **Check List: Have you SIGNED:** • **Signature or front page** • **Signatures after initial assessment** • **Signatures after goals on the 'ongoing assessment'** • **Date, time & signatures on variance analysis pages** • **Signature 'care after death' page**

Consider HealthPathways website for assistance:

https://aucklandregion.healthpathways.org.nz/

Ministry of Health

Te Ara Whakapiri: Principles and guidance for the last days of life

https://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life

Internet assistance – printable resources and family information

https://mercyhospice.org.nz/services/health-professionals/last-days-of-life-care-plan/

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SECTION2 ONGOING ASSESSMENT OF THE PLAN OF CARE

Undertake an MDT assessment & review of the current management plan if:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care

and
or

Concern expressed regarding management plan from either the resident, relative or team member

and
or

It has been 3 days since the last full MDT assessment

Consider the support of the Mercy Hospice specialist palliative care team. 24hr Contact 361 5966
Document all reassessment dates and times on page 1 of this document.

Codes to be recorded at each timed assessment (a moment in time) **A= Achieved V = Variance** *(i.e. exception reporting)*

Consider HealthPathways website-see pg 6	***0400***	***0800***	***1200***	***1600***	***2000***	***2400***
Goal a: The resident does not have pain Verbalised by resident if conscious, pain free on movement. Observe for non-verbal cues. Consider need for positional change. Use an appropriate pain assessment tool. Consider PRN analgesia for pre-cares and/or incident pain.						
Goal b: The resident is not agitated Resident does not display signs of restlessness or distress, exclude reversible causes e.g. retention of urine, opioid toxicity.						
Goal c: The resident does not have respiratory tract secretions Consider positional change. Discuss symptom & plan of care with resident, relative or carer. Medication more effective when given as soon as symptom occurs.						
Goal d: The resident does not have nausea Verbalised by resident if conscious.						
Goal e: The resident is not vomiting						
Goal f: The resident is not breathless Verbalised by resident if conscious, consider positional change and use of a fan.						
Goal g: No urinary problems identified Monitor for urine retention and **agitation**. Reduced urine output is normal during the dying phase. Use of pads, urinary catheter as required. Amount of urinary output may be documented here						
Goal h: No bowel problems identified Reduced bowel motion is normal during the dying phase. Monitor – constipation with **agitation** / diarrhoea. Monitor skin integrity. Bowels last opened: ……						
Goal i: The resident does not have other symptoms e.g. itch, dry skin, hiccups or wounds (Continue with wound care plan) Record symptom here: …… ***If no other symptoms present - record N/A***						
Goal j: The resident's comfort & safety regarding the administration of medication is maintained The resident is only receiving medication that is beneficial If CSCI via **syringe driver** in place a **monitoring sheet** must be in progress. S/C administration set in place for PRN medication (if required) ***If no medication required - record N/A***						

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SECTION2 ONGOING ASSESSMENT OF THE PLAN OF CARE continued						
Codes to be recorded at each timed assessment (a moment in time) **A= Achieved V = Variance** *(i.e. exception reporting)*						
Consider HealthPathways website-see pg 6	***0400***	***0800***	***1200***	***1600***	***2000***	***2400***
Goal k: The resident is offered oral fluids The resident is supported to take oral fluids / thickened fluids for as long as tolerated and appropriate. Monitor for signs of aspiration and/or distress. If appropriate consider clinically assisted (artificial) hydration. If in place use intake/output chart. Monitor & review rate/volume. **Explain the plan of care with the resident and relative or carer.** (why won't they eat pamphlet available)						
Goal l: The resident's mouth is moist and clean See oral care in palliative care resources – HealthPathways. Relative or carer might want to assist with oral care as appropriate.						
Goal m: The resident's skin integrity is maintained (excludes pressure wounds) The frequency of assessment, repositioning & special aids (eg. an air mattress) should be determined by skin inspection and the resident's individual needs. *Waterlow /Braden score:*……						
Goal n: The resident's personal hygiene needs are met Skin care according to individual needs. Relative or carer involved in care giving as appropriate.						
Goal o: The resident receives their care in a physical environment adjusted to support their individual needs. Consider physical environment & space at bedside. Ensure nurse call bell accessible. RESTRAINT – Follow local policy/procedure.						
Goal p: The resident's psychological well-being is maintained Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. Use of touch if appropriate. For spiritual/religious needs – consider support of the spiritual support team.						
Goal q: The well-being of the relative or carer attending the resident is maintained **Listen & respond to worries/fears.** Discuss with, and reassure relatives. Age appropriate advice & information to support children/adolescents made available to parents or carers. www.skylight.org.nz						
Goal r: The resident's cultural needs are met Cultural needs are recorded (Goal 3.3), referred to, reviewed as necessary & respected.						
Goal s: The relative(s) or carer(s) cultural needs are met Cultural needs are recorded (Goal 3.4), referred to, reviewed as necessary & respected.						
Signature of Registered Nurse						
Signature of the Enrolled Nurse or student nurse making the assessment (where relevant)						

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Te Ara Whakapiri

Resident label

Date: ……

Day: 1 2 3 4

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SECTION2 ONGOING ASSESSMENT OF THE PLAN OF CARE

Undertake an MDT assessment & review of the current management plan if:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care and/or **Concern expressed regarding management plan from either the resident, relative or team member** and/or **It has been 3 days since the last full MDT assessment**

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SECTION2 ONGOING ASSESSMENT OF THE PLAN OF CARE continued						
Codes to be recorded at each timed assessment (a moment in time) **A= Achieved V = Variance** *(i.e. exception reporting)*						
Consider HealthPathways website-see pg 6	***0400***	***0800***	***1200***	***1600***	***2000***	***2400***
Goal k: The resident is offered oral fluids The resident is supported to take oral fluids / thickened fluids for as long as tolerated and appropriate. Monitor for signs of aspiration and/or distress. If appropriate consider clinically assisted (artificial) hydration. If in place use intake/output chart. Monitor & review rate/volume. **Explain the plan of care with the resident and relative or carer.** (why won't they eat pamphlet available)						
Goal l: The resident's mouth is moist and clean See oral care in palliative care resources – HealthPathways. Relative or carer might want to assist with oral care as appropriate.						
Goal m: The resident's skin integrity is maintained (excludes pressure wounds) The frequency of assessment, repositioning & special aids (eg. an air mattress) should be determined by skin inspection and the resident's individual needs. *Waterlow /Braden score:*……						
Goal n: The resident's personal hygiene needs are met Skin care according to individual needs. Relative or carer involved in care giving as appropriate.						
Goal o: The resident receives their care in a physical environment adjusted to support their individual needs. Consider physical environment & space at bedside. Ensure nurse call bell accessible. RESTRAINT – Follow local policy/procedure.						
Goal p: The resident's psychological well-being is maintained Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. Use of touch if appropriate. For spiritual/religious needs – consider support of the spiritual support team.						
Goal q: The well-being of the relative or carer attending the resident is maintained **Listen & respond to worries/fears.** Discuss with, and reassure relatives. Age appropriate advice & information to support children/adolescents made available to parents or carers. www.skylight.org.nz						
Goal r: The resident's cultural needs are met Cultural needs are recorded (Goal 3.3), referred to, reviewed as necessary & respected.						
Goal s: The relative(s) or carer(s) cultural needs are met Cultural needs are recorded (Goal 3.4), referred to, reviewed as necessary & respected.						
Signature of Registered Nurse						
Signature of the Enrolled Nurse or student nurse making the assessment (where relevant)						

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MULTIDISCIPLINARY PROGRESS NOTES		
Consider the support of the Mercy Hospice specialist palliative care team. 24hr Contact 361 5966		
Most of the nurses documentation will be documented on the 'ongoing assessment' or 'variance recording/residents story'		
DATE & TIME	Record other significant events/conversations/medical review/visit by other specialist teams e.g. palliative care / second opinion if sought, that have not been written on 'Variance Analysis Sheet.	**SIGN.**

Resident label

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Te Ara Whakapiri

Resident label

VARIANCE ANALYSIS SHEET / RESIDENT'S STORY

A **VARIANCE** is not just recorded at assessment times but **at any time** you see a change.

WHAT VARIANCE OCCURRED & WHY? (what was the issue?)	**ACTION TAKEN** (what did you do?)	**OUTCOME** (did this solve the issue?)
Goal/s ..... Signature ..... Date/time	Signature ..... Date/time	Signature ..... Date/time .....
Goal/s ..... Signature ..... Date/time	Signature ..... Date/time	Signature ..... Date/time .....
Goal/s ..... Signature ..... Date/time	Signature ..... Date/time	Signature ..... Date/time .....
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Te Ara Whakapiri

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Te Ara Whakapiri

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Te Ara Whakapiri

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Te Ara Whakapiri

Resident label

Section 3: CARE AFTER DEATH

VERIFICATION OF DEATH

NURSES NOTES

Time of the resident's death: .....

Date of resident's death: ...../...../..... **Burial** ☐ or **Cremation** ☐

Persons present at time of death:

.....

Relative or carer present at time of death: Yes ☐ No ☐

If not present, has the relative or carer been notified Yes ☐ No ☐

Name of person informed:.....Relationship to the resident:.....

Contact number:.....

Name of patient's Consultant /GP:..... Tel No:.....

GP/NP NOTES

Place, Date & Time Death Verified: .....

Cause of death: .....

Is the coroner likely to be involved: Yes ☐ No ☐

Comments: .....

.....

.....

GP/NP's Name: ....GP/NP's Signature: .....

Contact phone no:.....

PATIENT & FAMILY/ WHĀNAU CARE & DIGNITY

Goal 10: Last offices (i.e. care of the deceased/tūpāpaku) are undertaken according to policy and procedure.

Achieved ☐ Variance ☐

The body/tūpāpaku is treated with respect and dignity

Are valuables to be left on body/tūpāpaku? Yes ☐ No ☐

If No, where art the valuables? .....

Organisational policy followed for the management & storage of resident's valuables and belongings

Universal precautions adhered to

Spiritual, religious, cultural rituals/needs met (Refer to patient & relative/carer wishes in Goals 3.1, 3.2, 3.3, & 3.4)

Organisational policy followed for the management of ICD's, where appropriate

Goal 10.1: Arrangements for blessing room/bedspace made. **Achieved ☐ Variance ☐**

Karakia / prayer are offered in respect of cultural needs of family/whānau

RELATIVE OR CARER INFORMATION

Goal 11: The relative or carer can express an understanding of what they will need to do next

Achieved ☐ Variance ☐

Explanation regarding how to contact the funeral director to make an appointment regarding the death certificate and resident's valuables / belongings where appropriate

Bereavement (or equivalent) leaflet given Yes ☐ No ☐

'Before Burial or Cremation' booklet (by NZ Dept of Internal Affairs) given Yes ☐ No ☐ N/A ☐

Discuss as appropriate:

- **wishes regarding tissue/organ donation**
- **viewing the body / tūpāpaku**
- **the need for removal of cardiac devices**
- **the need for a post mortem**
- **the need for a discussion with the coroner**

Information given to families/whānau on child bereavement services where appropriate www.skylight.org.nz

ORGANISATION INFORMATION

Goal 12.1: The primary health care team / GP is notified of the resident's death.

Achieved ☐ Variance ☐

Consider previous GP that may have known this resident very well if the resident was in your facility for a short period.
Telephone or fax the GP practice. (if out of hours leave voice message or send fax, with contact details)
Write in 'Variance Sheet' for staff follow up the next working day). Contact number.....
Name (of RN) who notified GP Practice .....

Goal 12.2: The resident's death is communicated to appropriate services. **Achieved ☐ Variance ☐**

e.g. palliative care team / district nursing team / hospice service /Organ tissue coordinator(where appropriate) are informed of the death. Contact number .....

Funeral Director/Services: Name .....Contact number: .....

The Facility Manager/Clinical Manager is notified of the resident's death and info is entered on the organisations IT system .

If you have recorded a "VARIANCE" against any goal, complete VARIANCE SHEET before signing below.

Health Care Professional 's Signature:	..... **Title:** ..... **Date:** .....

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Name (print)	*Full signature*	*Initials*	*Professional title*	*Date*