RESIDENT CARE PLAN—END-OF-LIFE CARE
Physical Domain

NAME:

Date	Issues/Nursing Dx	Goal/Expected Outcome	Goal Date ST LT	Team Intervention	Initial
	Common changes in physical status related to dying process.				
	Alteration in functional status	Resident will remain safe		Monitor safety	
	Alteration in cognition	Family understanding		Seek assistance if behaviour a risk to self or others Provide quiet environment Treat reversible causes: Assess for fecal impaction, urinary retention, fever, pain. Review medications. Provide calm reassurance to resident and family, limit visitors prn. Be alert for symbolic language. Administer medications as ordered	
	Altered swallowing ability	Prevent aspiration		Reassess medications/food texture Obtain alternate medication routes in advance (s/c, s/l/pr) Educate family re: foods, fluids, and swallowing ability	
	Potential for Impaired integrity mucous membranes	Maintain moist mouth		Provide frequent mouth care Saliva substitutes Educate family	
	Potential for impaired skin integrity	Maintain skin integrity		Implement turning schedule. Turn less frequently if death is imminent Pressure reduction mattress prn. Reassess frequency of dressing changes.	
	Altered respirations: terminal secretions	Comfort		Avoid suctioning if possible Position side lying with head of bed down to facilitate drainage of secretions if appropriate. Reassure family that resident is not “drowning.” Provide mouth care. Administer medications to reduce secretions prn.	

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