Name:

Date of Birth:

Address:

NHS Number:

gofal lliniarol CYMRU – WALES palliative care

Care Decisions for the Last Days of Life

Patient Symptom Assessment Chart/ Symptom Early Warning Score (SEWS)

Record patient symptoms and the time of your assessment, as per usual local practice (or a minimum of daily).

Mark each symptom 'score' in the appropriate section:

KEY: 0 = None, 1 = Mild, 2 = Moderate, 3 = Severe, 4 = Overwhelming

See overleaf for more guidance on scoring symptoms and advised actions.

Year: ( ) dd/mm														
Use 24 Hour Clock Time														
Pain *If patient unable to verbalise, observe facial expressions, body language and guarding.*	4													
	3													
	2													
	1													
	0													
Agitation / Restlessness This may be due to **Delirium** and/or **Anxiety** *(Separate these out if required and use 'other' box below.)*	4													
	3													
	2													
	1													
	0													
Breathlessness	4													
	3													
	2													
	1													
	0													
Noisy respiratory secretions	4													
	3													
	2													
	1													
	0													
Nausea (score 0 if unrousable)	4													
	3													
	2													
	1													
	0													
Vomiting	Yes													
	No													
Dry mouth	4													
	3													
	2													
	1													
	0													
Add other symptoms below to monitor e.g. seizures, wound care														
	4													
	3													
	2													
	1													
	0													
	4													
	3													
	2													
	1													
	0													
Initials														

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Care Decisions for the Last Days of Life

Patient Symptom Assessment Chart/ Symptom Early Warning Score (SEWS)

General guidance / Prompts for all care settings:

- **Action**: Consider non-pharmacological measures to relieve symptoms as appropriate e.g. reassurance, repositioning, checking for bowel/bladder issues, offer oral care for dry mouth etc.
- **Action**: Consult the Care Decisions Symptom Control Guidance for information on managing symptoms or anticipatory medication prescribing.
- **Action:** Assess and record symptoms as per usual practice in your care setting.
  If symptoms worsen, increase the frequency of monitoring and update colleagues.
- **Action:** If symptoms persist, or patient scores at level 3 or 4 on 2 or more consecutive occasions, a review is required. Review symptoms and medication with a senior colleague and/or your local prescriber.
  If further support is needed contact your local SPCT. Contact numbers for SPCT OOH advice line are shown in the CDG Symptom Control Guidance.
- **Action:** Continue to assess symptoms regularly.
  Review symptoms as per usual local practice or at least daily (as per NICE Guidance (NG31), 2015).

Symptom score	**What does this score mean?** Patient has:	**Advised ACTIONS for this score**
4 – Overwhelming	Severe symptom(s)	Give prescribed PRN medication immediately and wait with patient to assess response. (It may take 20-30 mins for PRNs to take effect.) If symptom not settling as expected within 30 mins, contact a senior colleague, explaining fully the situation.
3 - Severe	Constant, unrelieved symptom(s)	Give prescribed PRN medication, and review after 30 mins to see if PRN has had required effect. Consider giving further PRN medication. If symptom(s) not adequately controlled within expected period consult a senior colleague, request a medical review or seek further advice from SPCT.
2 - Moderate	Frequent episodes of symptom(s)	Consider 'as required' PRN medication relating to symptom(s). If symptom(s) not adequately controlled within expected period consult a senior colleague, request a medical review or seek further advice from SPCT.
1 - Mild	Occasional symptom(s)	Consider 'as required' PRN medication, reviewing symptom(s) as agreed with patient. Agree review time / required action with patient to ensure symptom(s) resolves / remains under adequate control.
0 - None	Nil symptom(s)	Ongoing reference to patient's care plan.

NB. This guidance does not replace the need for you to use your clinical judgement.