## Recognising the dying person flow chart

Changes that can indicate dying is starting to occur Profound weakness Recognition of the person's deterioration Reduced intake of food/fluid Difficulty swallowing/taking or al medications Bed bound after progressive decline over days and weeks Peripheral shut down (cold hands and feet) Poor improvement to medical interventions · Near-death awareness (stories, travel, visitations). Changes that can indicate the person is closer to death Increased drowsiness/sleepiness, diminished consciousness, delirium, terminal restlessness Pallor of nose and top of ears, increased respiratory mandibular movements, relaxed forehead, hyperextension Extremities cool, increased cyanosis and mottling of lips and fingers Cardiovascular changes (tachycardia, bradycardia, hypotension) Respiratory changes (persistent secretions in pharynx/trachea/bronchus, Cheyne-Stokes, apnea, ataxic Multidisciplinary team (MDT) assessment (lead health practitioner, nursing and allied health, cultural and spiritual support staff) Is there a potentially reversible cause for the person's condition (eg, exclude opioid toxicity, renal failure, hypercalcaemia, infection)? Has there been a poor response to medical interventions? Is a specialist referral needed (eg, specialist palliative care or a second opinion)? Could the person be in the last days or hours of life? The person is NOT recognised as dying The person IS recognised as dying (not in the last days or hours of life). (ie, is in the last days or hours of life). Review the current plan of care. Explain the new or revised plan of care with the Agree on the current plan of care with the person person and their family/whānau. (where appropriate) and their family/whānau. Focus the discussion on recognising and understanding that the person is dying or approaching the last days of their life. Commence the Te Ara Whakapiri Plan of Care, including the Baseline Assessment and Ongoing Care of the Dying Person chart. A MDT review of the current plan of care should be performed if: the person's conscious level, functional ability, oral intake, mobility, ability to perform self-care the person, their family/whānau, carer or team member expresses concerns about the person's management plan it has been three days since the last MDT assessment.