|  |
| --- |
| **MDT Daily Full Assessment**  |
| **DIAGNOSIS & BASELINE INFORMATION** | **Diagnosed as in last few days / hours of life by : (Name)** |
| **At the time of assessment is the patient:** |
|

|  |  |  |
| --- | --- | --- |
|  | **Y** | **N** |
| In pain  |  |  |
| Agitated |  |  |
| Vomiting |  |  |
| Dyspnoeic |  |  |
| Restless |  |  |
| Distressed |  |  |
| UTI problems |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Y** | **N** |
| Able to swallow |  |  |
| Continent (bladder) |  |  |
| Catheterised |  |  |
| Continent (bowels) |  |  |
| Constipated |  |  |
| Aware |  |  |

|  |  |  |
| --- | --- | --- |
| Experiencing respiratory tract secretions |  |  |
| Experiencing other symptoms (e.g. oedema, itch)………………………………………………………………………………………………… |  |  |

|  |  |  |
| --- | --- | --- |
|  | **Y** | **N** |
| Confused |  |  |
| *(Record below which is applicable)* |
| Conscious |  |  |
| Semi-conscious |  |  |
| Unconscious |  |  |
| Intubated |  |  |
| **Respiratory Support** |
| Ventilated |  |  |
| CPAP |  |  |
| BIPAP (NIV) |  |  |
| Face Mask |  |  |
| Other: |

 |
| **CURRENT INTERVENTIONS** |  | **Currently not being taken / or given / or in place** | **Discontinued** | **Continued** | **Commenced** |
| **Routine Blood Tests** |  |  |  |  |
| **Intravenous Antibiotics** |  |  |  |  |
| **Blood Glucose Monitoring** |  |  |  |  |
| **Recording of routine vital signs** |  |  |  |  |
| **Oxygen therapy** |  |  |  |  |
| **Physiotherapy** |  |  |  |  |
| **I.V. vasoactive medications** |  |  |  |  |
| **Electronic Monitoring /alarms** |  |  |  |  |
| **Renal Replacement Therapy** |  |  |  |  |
| **NG tube (gastric secretions)** |  |  |  |  |
| **Artificial Nutrition** |  |  |  |  |
| **Artificial Hydration**  |  |  |  |  |
| **Current ventilatory support**  |  |  |  |  |
| **Changes:**Silence alarms (remember apnoea alarm) |
| **Comment:** |
| **Plan of Care**  | **Plan:** |
| **Explanation of Care** | **Patient in the last hours/days of life?** | **YES** |  | **NO** |  |
| IF **YES** continue with End of Life GuidelinesIf **NO** discontinue End of Life Guidelines – review DNACPR |
| **A full explanation of plan of care is given to the relative / carer** | **YES** |  | **NO** |  |
|

|  |  |
| --- | --- |
| **Name of relative(s) / Carer (s) present** | **Relationship to patient** |
|  |  |
|  |  |
|  |  |
|  |  |
| **Names of Healthcare professional present:** | **Position** |
|  |  |
|  |  |

 |
| **Comment:** |
| **Communication log completed** | **YES** |  | **NO** |  |
| **Comment:** |
| **Please sign on completion of the initial assessment** |
| **Signature** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Doctor’s Name:** |  | **Nurse’s Name:** |  |
| **Position:** |  | **Position:** |  |
| **Signature:** |  | **Signature:** |  |
| **Bleep:** |  | **Extension Number:** |  |
| **Date:** |  | **Date:** |  |
| **Time:** |  | **Time:** |  |

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