|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Initial Assessment (joint assessment by doctor and nurse)** | | | | | | | | |
| **DIAGNOSIS & BASELINE INFORMATION** | **Diagnosed as in last few days / hours of life by : (Name)** | | | | | | | |
| **DOB:** | **M/F:** | | **Ethnicity:** | | | | |
| **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: | | | | | | | | | | |
| **COMMUNICATION** |  | | | | | | **Y** | **N** |
| **The patient is able to take a full and active part in communication** | | | | | |  |  |
| **If NO –why?** | | | | | | | |
| **First Language:** | | **Interpreter Y/N –Contact Number:** | | | | | |
| **Does the patient have:** | | | | | | **Y** | **N** |
| An Advanced Care Plan | | | | | |  |  |
| An Advanced decision to refuse treatment (ADRT) | | | | | |  |  |
| **Does the patient have the capacity to make their own decisions at this moment in time?** | | | | | |  |  |
| If **NO** - Consider the support of an IMCA –please document below. | | | | | | | |
| Name: | | Contact details: | | | | | |
| **The relative/carer is able to take a full and active part in communication** | | | | | |  |  |
| If **NO –**why? | | | | | | | |
| **The patient is aware that they are dying?** | | | | | |  |  |
| **Comment:** | | | | | | | |
| **The relative or carer is aware that they are dying.** | | | | | |  |  |
| **Comment** | | | | | | | |
| **Specialist Nurse for Organ Donation has been contacted?** | | | | | |  |  |
| **Comment** | | | | | | | |
| **Explored preferred place of death** – if wish to go home refer to **Discharge Home to Die Guidelines** | | | | | |  |  |
| **Comment** | | | | | | | |
| **Contact information:** | | | | | | | |
| **1st Contact:** | | **At any time** | |  | **Not at Night-time** | |  |
| **Relationship** | | **Telephone** | | | **Mobile** | | |
| **2nd Contact:** | | **At any time** | |  | **Not at Night-time** | |  |
| **Relationship** | | **Telephone** | | | **Mobile** | | |
| **N:O:K:** - if different from above. | | | | | | | |
| **Name:** | | **Contact Number:** | | | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **FACILITIES** | **The relative/ carer have had a full explanation for the facilities available to them and have been given the visitor information. (Car parking / beverages / accommodation)** | | | | | | | | | | | | | | | **Y** | | N |
|  | |  |
| **Comment:** | | | | | | | | | | | | | | | | | |
| **SPIRITUALITY** | **The opportunity is given to patient / carers discuss what is important to them. (wishes, feelings, faith, values, organ donation) These are respected as far as practically possible.** | | | | | | | | | | | | | | | Y | | N |
|  | |  |
| **Comment:** | | | | | | | | | | | | | | | | | |
| Religion identified: | | | Chaplaincy Service offered: | | | | | | | | | | | |  | |  |
| External support: | Name: | | | | | Contact No: | | | | | | | Date: | | | | |
| **Comment:** | | | | | | | | | | | | | | | | | |
| **Needs now:** | | | | | | | | | | | | | | | | | |
| **Needs at death:** | | | | | | | | | | | | | | | | | |
| **Needs after death:** | | | | | | | | | | | | | | | | | |
| **MEDICATION** | **The patient has medication prescribed on a prn basis for the following symptoms which may develop in the last hours of life.** | | | | | | | | | | | | | | | **Y** | | **N** |
|  | |  |
| **Pain** | | | | |  | | Comment: | | | | | | | | | | |
| **Agitation** | | | | |  | |
| **Respiratory tract secretions** | | | | |  | |
| **Nausea / vomiting** | | | | |  | |
| **Dyspnoea** | | | | |  | |
| **Ensure the following is explained:** | | | | | | | | | | | | | | | | | |
| * **The patient is only receiving medication that the MDT agrees is beneficial at the time.** * **Anticipatory prescribing in this manner will ensure that there is no delay in responding to a symptom if it occurs.** * **Medicines for symptom control will only be given when needed, at the time and just enough and no more than is needed to help the symptom.** * **That when new medication is commenced (especially via infusion) rationale for this will be explained.** | | | | | | | | | | | | | | | | | |
| **Comment:** | | | | | | | | | | | | | | | | | |
| **Current Interventions** | **The patient’s current interventions has been reviewed by the MDT and discussed with the patient, relatives/carer.** | | | | | | | | | | | | | | | **Y** | | **N** |
|  | |  |
| **Comment** | | | | | | | | | | | | | | | | | |
|  | | **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)** | |  | |  | | | |  | | |  | | | | | | |
| **Current ventilatory support** | |  | |  | | | |  | | |  | | | | | | |
| **Current ventilator support:** | | | | | | | | | | | | | | | | | |
| **Changes:**  Silence alarms (remember apnoea alarm) | | | | | | | | | | | | | | | | | |
| **Comment:** | | | | | | | | | | | | | | | | | |
| Has patient has a DNACPR in place | | | | | | | | | YES | | |  | | NO | |  | |
| This has been explained and discussed with patient, relative or carer. | | | | | | | | | YES | | |  | | NO | |  | |
| **Please complete the appropriate associated documentation according to the policy and procedure.**  **Comment:** | | | | | | | | | | | | | | | | | |
| Implantable Cardiovertor Defibrillator (ICD) is deactivated | | | | | | | | | YES | | |  | | NO | |  | |
| This has been explained and discussed with patient, relative or carer. | | | | | | | | | YES | | |  | | NO | |  | |
| **Contact patient’s cardiologist. Refer to the ECG technician and refer to local/regional – policy and procedure**  **Comment** | | | | | | | | | | | | | | | | | |
| **Nutrition** | **The need for clinically assisted (artificial) nutrition is reviewed by MDT** | | | | | | | | | | YES | |  | | NO | |  | |
| **Comment:** | | | | | | | | | | | | | | | | | |
| **Decision discussed with patient / relative / carer.** | | | | | | | | | YES | | |  | | NO | |  | |
| **Hydration** | **The need for clinically assisted (artificial) hydration is reviewed by MDT** | | | | | | | | | YES | | |  | | NO | |  | |
| Comment: | | | | | | | | | | | | | | | | | |
| **Decision discussed with patient / relative / carer.** | | | | | | | | | | YES | |  | | NO | |  | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Skin Care** | **The patient’s skin integrity is assessed** | YES |  | NO |  |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | Risk Assessment score: |  | | | | | Existing Pressure damage | YES |  | NO |  | | Mattress in use / type |  | | | | | Frequency of positional changes |  | | | | | | | | |
| **Comment:** | | | | |
| **Explanation of Care** | **A full explanation of plan of care is explained to the patient.** | **YES** |  | **NO** |  |
| **Comment:** | | | | |
| **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 commenced and left at the patient’s bedside** | **YES** |  | **NO** |  |
| **Comment:** | | | | |
| **The patient’s primary health care team / GP practice is notified that the patient is dying.** | **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:** |  | | | | | |