|  |
| --- |
| **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 |  |  |

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| --- | --- | --- |
| 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** |
|  |  |
|  |  |

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| **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:** |  |

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