|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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 Guidelines  If **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:** |  | | | | | | | | | |