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| **MDT Decision / Diagnosing Dying** |
|  | **YES** | **NO** |
| **Would Intravenous therapy be an appropriate treatment?** |  |  |
| **If NO-why?** |
| **Would enteral nutrition be an appropriate treatment?** |  |  |
| **If NO-why?** |
| **Would oral antibiotics be an appropriate therapy?** |  |  |
| **If NO-why?** |
| **Would intravenous antibiotics be an appropriate therapy?** |  |  |
| **If NO-why?** |
| **Would physiotherapy be an appropriate therapy?** |  |  |
| **If NO-why?** |
| **Would blood transfusion be an appropriate treatment?** |  |  |
| **If NO-why?** |
| **Would cardiovascular support with inotropes be an appropriate therapy?** |  |  |
| **If NO-why?** |
| **Would non-invasive ventilation be an appropriate therapy?** |  |  |
| **If NO-why?** |
| **Would invasive ventilation be an appropriate therapy?** |  |  |
| **If NO-why?** |
| **Would renal replacement therapy be an appropriate therapy?** |  |  |
| **If NO-why?** |
| **Would it be appropriate to defibrillate a “shockable” dysrhythmia in a monitored patient?** |  |  |
| **If NO-why?** |
| **Would CPR be an appropriate treatment?** |  |  |
| **If NO-why?** |
| **IS THIS PATIENT FOR A CARDIAC ARREST CALL?** |  |  |
| If **NO**, please complete a **DNACPR** form and file in the notes with discussion with the patient / family |
| **IS THE PATIENT IN THE LAST FEW DAYS / HOURS OF LIFE?** |  |  |
| If **YES** – commence **GUIDELINES FOR END OF LIFE CARE**If **NO** – review form daily or if the clinical condition alters or the patient views are changed |

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| **Signature** | **Print Name** | **Position** | **GMC** |
| **Date** | **Time** | **Review Date** | **Time** |

**Decisions reviewed: reconfirmation/cancelled/changed –if changed complete new form**

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| **Signed** | **Print Name** | **Date** | **Time** |
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