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| Name: | …… |
| NHS no: | …… |
| Address: | …… |
| …… | |

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| **Multi disciplinary team assessment (MDT)**<br><br>**Include**<br>• current condition<br>• reasons for deterioration<br>• nutrition and hydration<br>• current symptoms<br><br>**Please see guidance** | **If further support or advice is needed, please contact Specialist Palliative Care team** |
| **Medical management plan**<br><br>**Include**<br>Management goals<br><br>**Consider**<br>• Hydration & nutrition<br>• Treatment escalation<br>• Observations<br>• Blood test<br>• Blood glucose monitoring<br>• Medication review<br>• Oxygen<br>• Management of ICD<br>• Resuscitation status | **Remember to review if the person's condition changes (deteriorates/improves) and reassess** |
| **Assessment of comfort needs**<br><br>**Consider**<br>• Personal care<br>• Mouth care<br>• Skin integrity and pressure area management<br>• Bowel and bladder management<br>• Environment preferences e.g. music, lighting, privacy. | |

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| Name: | …… |
| NHS no: | …… |
| Address: | …… |
| …… | |

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| **Pre-emptive medications prescribed** | Pain Yes ☐ No ☐ Respiratory tract secretions Yes ☐ No ☐<br>Nausea/vomiting Yes ☐ No ☐ Breathlessness Yes ☐ No ☐<br>Agitation/fear Yes ☐ No ☐ |
| **Communication** | **MDT members involved in assessment and planning discussion**<br>Name: …… Designation: …… Contact no: ……<br>Name: …… Designation: …….. Contact no: ……<br>Name: …… Designation: …….. Contact no: ……<br>Name: …… Designation: …….. Contact no: ……<br>**This has been discussed with the person and those important to them.**<br>Discussed with the person Yes ☐ No ☐ If No, state why<br>……<br>Professional leading discussion. Name: ……Date & time ……..<br>Discussed with those important to the person. Yes ☐ No ☐<br>If No, state why ……<br>If Yes, name …….. relationship ……<br>Professional leading discussion. name: …… date/time …….. |
| **Where would you like this care plan to be kept?** (ask the person) | **Please state** (e.g. bedside, with other medical notes)<br>…… |
| **Does the person consent to sharing this plan with other professionals?** | Yes ☐ No ☐ Unable to consent ☐<br>**If yes and in hospital or hospice inform GP of current condition** |

**Community and care home teams please complete the Palliative Care Handover Form and fax to:**

| | | | | |
|---|---|---|---|---|
| **Rapid Response** | Fax 01226 433315 | Yes ☐ | No ☐ | N/A ☐ |
| **Care UK** | Fax 01709 379844 | Yes ☐ | No ☐ | N/A ☐ |
| **End of life care team** | Fax 01226 734903 | Yes ☐ | No ☐ | N/A ☐ |

**Senior Doctor responsible for care**

Name: …… Designation: ……

Signature: …… Date & time ……

**Registered Nurse responsible for assessment**

Name: …… Designation: ……

Signature: …… Date …… time ……