PATIENT ID LABEL

BARCODE AREA

BINDING MARGIN – NO WRITING

Section 2: Ongoing Assessment of the Goals of Care

Date ..... Day .....

Undertake a MDT review of the current care plan. If at any time there is a change in relation to any of the following:

- Improved conscious level, functional ability, mobility, ability to perform self-care.
- Concerns expressed regarding management plan from either the person, relative, whānau or friend or MDT member.

This care plan will be reviewed in its entirety daily.

When each goal is assessed mark with an 'A' if it has been 'achieved'. If interventions are required, mark a "IR" and enter that change on the "Interventions Required Sheet" pg 7.	0400	0800	1200	1600	2000	2400
	If using this in community enter visiting times below					
The person:						
Is pain free						
Is not agitated						
Has no respiratory tract secretions						
Is not breathless						
Is not nauseated						
Is not vomiting						
Has no urinary problems						
Has no bowel problems: Bowels last opened						
Has no other symptoms *(Record symptom here as applicable)*						
Medication and route remain appropriate						
Food and fluid have been provided as appropriate (see question 6 of page 5)						
Has a moist and clean mouth						
Skin integrity is maintained Braden score						
Personal hygiene needs met						
Receives their care in a physical environment adjusted to support their individual needs						
Personalised care needs met (see questions page 5)						
Relatives, whānau or friends*						
Personalised care needs met (see questions page 5)						
Other care needs						
Signature of the registered nurse per shift:	*Night*	*Morning*		*Afternoon*		*Night*

PATIENT ID LABEL

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Signature of the registered nurse per shift:	*Night*	*Morning*		*Afternoon*		*Night*

BINDING MARGIN – NO WRITING