Order reference	WOE1263
Issue date	March 2016

Booklet №:	

Colchester Hospital University NHS
NHS Foundation Trust

Individual Care Record For The Last Days Of Life (ICRLDL)

These are the 5 Priorities for Care according to the Leadership Alliance for the Care of Dying People (2014):

- The possibility that a person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly
- Sensitive communication takes place between staff and the person who is dying, and those identified as important to them
- The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants
- The needs of the families and others identified as important to the dying person are actively explored, respected and met as far as possible
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, coordinated and delivered with compassion

Patient's name			
NHS №		Hosp №	
Date of birth		Date commenced	/ /
Care setting		Time commenced	:
Consultant		GP name	
Next-of-kin details (please highlight 1st point of contact)	Name 1) 2) 3)	Relationship	Tel №
Patient's religion	Record any religious or cultural needs below:		

	Print name	Signature	Designation	GMC №
Decision to start Care Record by Senior Doctor				
Decision to start Care Record by Nurse	**Print name**	**Signature**	**Designation**	
Decision to start Care Record by MDT member	**Print name**	**Signature**	**Designation**	

GP notified of deterioration The patients' GP/primary health care team is notified that the patient is dying.	GP Name: Surgery address: Tel №: ❑ GP called *(Ask receptionist to tell GP that Patient is dying on ward)* SinglePoint Tel №: 01206 890360 Name of person who called GP/SinglePoint:

This Care Record is a multi-organisational document and each organisation needs to use it.

- **For CHUFT Patients, please leave a message on ext.6272 with patients name and ward when commencing this ICP.**
- **CHUFT Hospital Specialist Palliative Care Team available from 9am to 5pm, 7 days a week on 01206 746272.**
- **ACE & Out of Hours, please contact SinglePoint Tel №: 01206 890360**

Guidelines for staff

1. This replaces all other medical and nursing assessment documentation.
2. The views of patient, family/carers must be listened to and documented on the multidisciplinary notes and significant conversations page.
3. A senior medical/nurse review should take place daily.
4. At the time of death the verification/certification should be documented on the daily record as well as the Care After Death Checklist.

Healthcare professional record *(All personnel completing the care record must sign below.)*

Full name (print)	Signature	Initials	Professional title	GMC №	Contact №

Mental Capacity Assessment and Consent

Treatment explained to patient and consent obtained?	☐ Yes ☐ No
Is there any impairment or disturbance in the functioning of the persons mind or brain?	☐ Yes ☐ No
Is there any impairment or disturbance sufficient that the person lacks capacity to make a decision?	☐ Yes ☐ No
Does the patient understand information given to them?	☐ Yes ☐ No
Can the patient retain the information long enough to make a decision?	☐ Yes ☐ No
Can the patient way up and discuss the pros and cons of the decision or action?	☐ Yes ☐ No
Can the patient communicate the decision (by any means)?	☐ Yes ☐ No
Does the patient have the capacity?	☐ Yes - end assessment here ☐ No - answer next question
Is there a Lasting Power of Attorney or Court of Protection Appointed Deputy (CAD)? (If 'Yes' name and copy of LPA / CAD):	☐ Yes ☐ No ❑ Don't know

Has a DOLS application been made for this patient? ☐ Yes ☐ No

Actions taken in the best interest of the patient must be documented in the clinical plan of care.

If the person lacks capacity, day-to-day interventions can be delivered in their best interest and must be documented. An MCA2 form must be used for documenting capacity assessments for serious medical treatment, accommodation changes, financial issues & safeguarding concerns.

Recognising dying assessment

The term 'recognising dying' is used to define a time when someone is thought now to be approaching the last days of their life and requires care focused on the 5 Priorities for Care. Please explore with the patient what their needs and concerns are with particular reference to food and drink, symptoms, spiritual, social and psychological support. Also explore how much they want to be involved in their day to day care.

- Is there a potentially reversible cause for the patient's condition e.g. exclude opioid toxicity, renal failure, hypercalcaemia, infection?
- Could the patient be in the last hours or days of life?
- Is a Specialist referral needed, e.g. specialist palliative care or a second opinion?
- Be aware that improvement in signs and symptoms or functional observations could indicate that the person may be stabilising or recovering

DNACPR completed – give details:

ICDs have been deactivated? ❑ Yes ❑ N/A ❑ No – instruction/action to arrange this been done? ❑ No ❑ Yes – signed by:……..
Print name: ……

Communication regarding recognising dying and acknowledged uncertainty

Communication with the person thought to be dying and those important to them:

Whom did you talk to? Name:

What did you say?

Any concerns voiced, by whom and action?

Have they got a preferred place of death? ❑ No ❑ Yes - specify:

Communication around change in goals of care

Document which medically futile interventions you may want to stop, which may be blood tests (including BM monitoring), X-rays/scans, NEWS observations chart and rationalising regular medications. What are the person's goals and wishes?

Document discussion around medication review. This will include an explanation of anticipatory medications prescribed for common symptoms (pain, dyspnoea, agitation, respiratory rattle secretions, nausea/vomiting), ensuring appropriate route (e.g. syringe pump). If already in place (some community patients) ensure understanding of use is clear. Consider impact of significant co-morbidities on prescribing, for example renal failure (eGFR is less than 30).

The patient has medication prescribed on a prn basis for all of the 5 symptoms (see flow charts) which may develop in the last hours or days of life. (If already in place check doses and dates against current medication.)

Document discussions you have had around what to expect with the dying process, with regards to food and fluid:

Document discussion about who to contact in the event of death or any other important information

Print name	Signature	Grade	Date	Time
			/ /	:

Transfer of Care to Another Clinical Team

Ensure direct communication with care team including telephone/fax/email including Out of Hours.

Name of New Responsible Doctor/Senior Nurse:

Print name	Signature	Grade	Date	Time
			/ /	:

North East Essex Guidelines for Care of the Dying

Management of Pain

- **Opioid naïve** = Currently not taking any opioid preparations
- **Weak opioid** preparations examples = Dihydrocodeine, Codeine, Co-codamol, Tramadol
- **Strong opioid** preparations examples = Oramorph, MST, Oxycodone, Fentanyl, Buprenorphine

If eGFR is less than 30 please consider changing opiate to Oxycodone or seek Specialist Palliative Care advice

- **If unable to swallow, convert to subcutaneous route via syringe pump**
- **If patient on alternative opioids or Fentanyl/Buprenorphine patch and seek specialist advice**

Is patient currently on opioids?

YES – on strong opioids

Syringe pump.
- If taking oral morphine, consider prescribing equivalent dose of subcutaneous diamorphine or morphine sulphate to be delivered via syringe pump over 24 hours (calculated as1/3rd of 24 hour oral morphine dose).
- Give 1/6th of 24 hour dose of opioid **stat** s/c as loading dose at the same time as syringe pump is commenced.
- Prescribe 1/6th of 24 hour dose of opioid **prn** for episodes of increased pain. Repeat prn dose until pain is controlled.
- Review syringe pump daily and consider increase dose of opioid dependant on number of prn doses given.

YES – on weak opioids

- Consider converting to Diamorphine or morphine sulphate over 24 hours via **syringe pump.**
- Prescribe **prn** Diamorphine or morphine sulphate
- See conversion chart for opiate conversion to syringe pump.

NO – opioid naive

Is patient in pain?

No

- Consider prescribing **prn** Diamorphine or morphine sulphate
- **Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay in responding to a symptom if it occurs**

Yes

- Give a stat dose of Diamorphine or morphine sulphate
- Prescribe **prn** Diamorphine or morphine sulphate and review
- Syringe pump may be required after 24 hours if 3 or more doses have been required

Patient name: Date of birth: NHS №:

Management of Nausea & Vomiting

Present

If well controlled on oral anti-emetics

- Consider prescribing the same drug at the same dose and give by continuous s/c infusion over 24 hours via a **syringe pump**
- Consider prescribing **prn** Levomepromazine 6.25mg s/c

If not well controlled on oral anti-emetics

- Discontinue present treatment.
- Consider giving stat Levomepromazine 6.25mg s/c and commencing syringe pump of Levomepromazine 12.5mg s/c over 24 hrs.
- Prescribe prn Levomepromazine 6.25mg s/c.

Absent

- Consider prescribing prn Levomepromazine 6.25mgs s/c. If more than three doses given in 24 hours consider commencing or adding Levomepromazine 12.5mg to syringe pump.
- Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay in responding to a symptom if it occurs

- **Review drug/ dose/ frequency for patients who are elderly, frail, have dementia or renal failure.**
- **Other antiemetics are available.**

If symptoms persist, please contact:

- **CHUFT Hospital Specialist Palliative Care Team available from 9am to 5pm, 7 days a week on 01206 746272**
- **ACE- contact patients GP**
- **Out of Hours, please contact SinglePoint Tel №: 01206 890360**

Management of Respiratory Tract Secretions

Present

Consider giving **stat** dose and prescribing **prn**

Glycopyrronium 0.2mg s/c. Commence a **syringe pump** of Glycopyrronium 0.6mg s/c over 24 hours

Continue to give prn doses until symptoms controlled

If symptoms persist after 24 hours consider increasing dose of:
Glycopyrronium to 1.2mg s/c over 24 hours

Absent

Consider giving prn Glycopyrronium 0.2mg s/c

Anticipatory prescribing in this manner will ensure that in the last hours or days of life there is no delay in responding to a symptom if it occurs

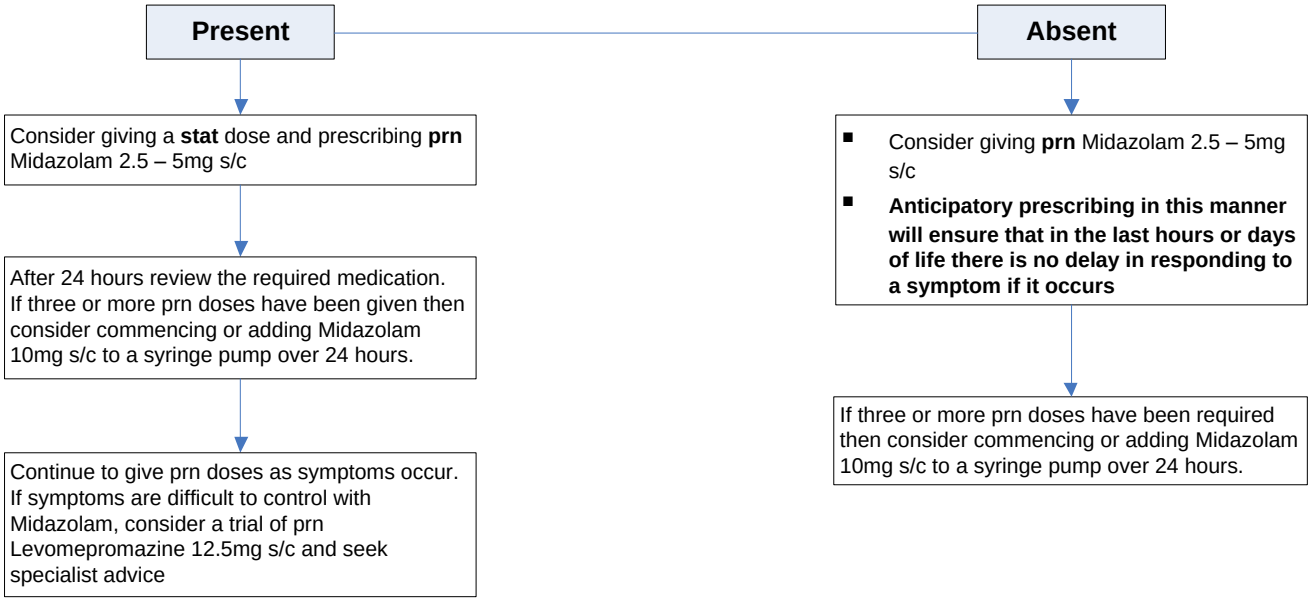
Review after 24 hours. If three or more doses given consider commencing or adding to **syringe pump**:

Glycopyrronium 0.6mg s/c over 24 hours

- **Review drug/ dose/ frequency for patients who are elderly, frail, have dementia or renal failure.**
- **Consider changing patients position and if on an IV/SC fluids, consider slowing rate or stopping. Ensure family are spoken to regarding this symptom as often worse for the family than patient.**

Patient name: Date of birth: NHS №:

Management of Agitation and Restlessness



- **Exclude reversible causes e.g. urinary retention.**
- **The management of agitation does not usually require the use of opioids unless agitation is thought to be caused by pain.**
- **Review drug /dosage/ frequency for patients who are elderly, frail, have dementia, or renal failure.**

If symptoms persist, please contact:

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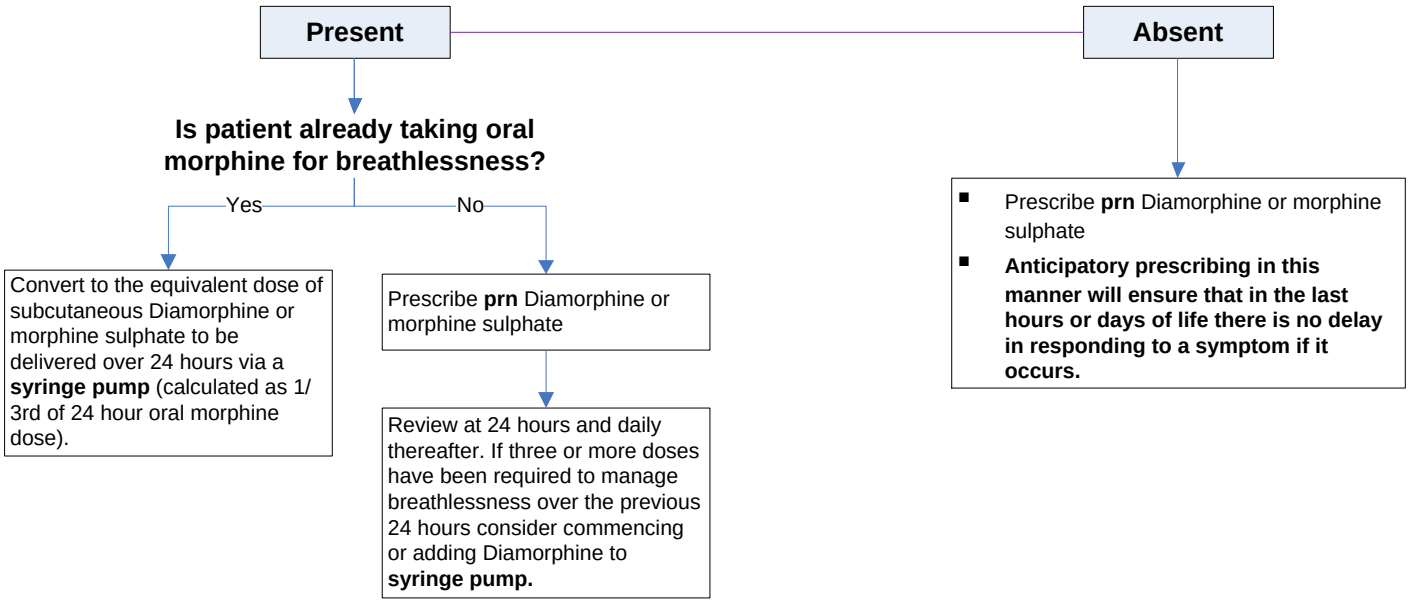
Management of Breathlessness



If symptoms persist, please contact:

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- **ACE- contact patients GP**
- **Out of Hours, please contact SinglePoint Tel №: 01206 890360**

- **If the patient is breathless and anxious, consider addition of Midazolam 2.5mg s/c prn.**
- **Review drug/ dose/ frequency for patients who are elderly, frail, have dementia or renal failure.**

For ACE use only - Initial assessment

Initial assessment – ADL's for **ACE use only**

№	Assessment	Detail (add to whenever new information emerges)	Sign & date
1a	**Pain** Site / location / duration / analgesic effect		
1b	**Tissue viability** District nurse / equipment at home	❑ The patient's skin integrity is assessed.	
1c	**Invasive devices** Hickman line / PICC line		
1d	**Self-administration of medicine (SAM)** Pharmacy aids / support at home		
2	**Breathing** Cough / Sputum / O_2 at home / nebuliser/inhaler		
3	**Communicating**		
4	**Nutrition** Diet / supplements	❑ The need for clinically assisted (artificial) nutrition & hydration is reviewed by the MDT.	
5	**Eliminating** Normal pattern / catheter / stoma		
6	**Washing & dressing** Aids / assistance required / staff gender preference required?		
8	**Resting & sleeping** Normal pattern / № of pillows / sleeps in chair		
9	**Emotional & spiritual needs** Religion / spirituality / significant others involvement / mood / mental health / sharing of diagnosis	❑ Discussed with patient ❑ Discussed with relative or carer Where does patient want to die? ❑ Hospital ❑ Hospice – refer to Hospice Team ❑ Home / Care home – follow Rapidly Deteriorating Patient process	
1a	**Falls**	**See Falls ICP**	
7	**Mobility**	**See Manual Handling Risk Assessment**	

Patient name: Date of birth: NHS №:

Daily nursing care record

Day №

Ward	*Early shift:* *Moved to:* @ :	*Date*	/ /

Food/diet intake *(food chart is to be completed predominantly in the inpatient setting)*

Food chart required?	❑ No - Unconscious	❑ Yes – record details below
Patient requires assistance at mealtimes?	❑ No	❑ Yes
Red food tray?	❑ No	❑ Yes
Jug lid required?	❑ Blue	❑ Red

Breakfast	Eaten	⊕ ⊕ ⊕
Drinks		

Reason for not eating and action taken:

Snacks/supplements	
Assisted by *(print name)*	

Lunch	Eaten	⊕ ⊕ ⊕
Drinks		

Reason for not eating and action taken:

Snacks/supplements	
Assisted by *(print name)*	

Supper	Eaten	⊕ ⊕ ⊕
Drinks		

Reason for not eating and action taken:

Snacks/supplements	
Assisted by *(print name)*	

Patient rounding– *only to be completed at inpatient settings*

If patient is unconscious, please continue to assess needs and discuss any concerns with nurse in charge of patients care.

A = Achieved *Time →* *V = Variance*	*8.00*		*10.00*		*12.00*		*14.00*		*16.00*		*18.00*		*20.00*		*22.00*		*24.00*		*2.00*		*4.00*		*6.00*	
	A	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*
If patient is asleep or unconscious, tick box →																								
No pain at present. "Are you in pain?"																								
Toileting needs met "Do you need assistance to go to the toilet?"																								
Pressure area care needs met. "Do you need to change your position?" If at risk of PU record key position code: Key: R = right L = Left B = back C = chair P = prone A = ambulant																								
Jug and glass are in reach. If prescribed, supplements assistance given. "Do you need something to drink?"																								
Call bell is working and in reach. "Can you reach your call bell?"																								
Staff initials																								

Patient name: Date of birth: NHS №::

Daily nursing care record

Day №:

Date: / /

Focus №	Assessment: Min of once at beginning of each 8 hr period and on transfer/ acceptance of patient. Community – once every 24 hours.	1st assessment time: Assessment	1st assessment time: Action	2nd assessment time: Assessment
1a	**Observations** *May continue for comfort e.g. temperature*			
1a	**Pain** *Score / location / analgesic effect*			
1a	**Falls** *Increased risk / equipment / bed rails / Falls Prevention ICP*			
1b	**Tissue viability** *Pressure relieving mattress / turn patients as tolerated*			
1c	**Invasive devices** *Removal / insertion / site / VIP x 3 daily*			
1d	**Administration of medicine** *SAM / omitted doses / prn medications prescribed*			
2	**Breathing -** *Breathlessness / cough / O_2*			
3	**Communicating** *Hearing / confusion / speech*	`		
4	**Nutrition** *Offer food as able / feeding at risk*			
5	**Eliminating** *Catheter / stoma / bowels* Bladder			
	Date bowels last opened: / / Bowels			
6	**Washing & dressing** *Assistance required / staff gender preference / Mouth care assessment*			
7	**Mobility** *Activity / Manual Handling Protocol / weight-bearing*			
8	**Resting & sleeping** *Number of pillows / sleeping side preference*			
9	**Emotional & spiritual needs** *Require faith leader visit?*			
NB Co-ordination, assessment and intervention are the responsibility of the Registered Nurse. HCA's may record activities in the multidisciplinary notes and in the time box to show that an intervention has been performed.		Sign & time		Sign

Symptom observation chart (S=Severe, M=Moderate, N=None or mild) & ID bracelet check

	Initial	08	09	10	11	12	13	14	15	16	17	18	19	20
ID bracelet check/replacement														
Pain														
Nausea & vomiting														
Agitation														
Respiratory secretions														
Shortness of breath														
Mouth care														

Patient name: Date of birth: NHS №: Day №:

	3rd assessment time:	
Action	**Assessment**	**Action**
Time	RN sign & time	

Please insert initial and 'S, M or N'

21	22	23	24	01	02	03	04	05	06	07

Severe/distressing symptoms (action)

- Give medication for symptom
- Look for reversible causes
- Consider non-pharmacological treatment e.g. positioning
- Regular review until mild/none level is achieved

Moderate symptoms (action)

- Give medication and review until mild/none level achieved
- Look for reversible causes
- Consider non-pharmacological treatment

Mild or no symptoms

- No intervention required

Assess patient daily and record daily medical plan had with patient & family:

Daily review with Consultant/Doctor/Nurse record

Dr/Nurse name	
Signature	

Patient name: Date of birth: NHS №:

Multidisciplinary notes

Date/time	Record significant events / conversations / medical review / visit by other specialist teams e.g. palliative care / second opinion if sought	Signature

Patient name: Date of birth: NHS №:

Daily nursing care record

Day №

Ward	*Early shift:* *Moved to:* @ :	*Date*	/ /

Food/diet intake *(food chart is to be completed predominantly in the inpatient setting)*

Food chart required?	❑ No - Unconscious	❑ Yes – record details below
Patient requires assistance at mealtimes?	❑ No	❑ Yes
Red food tray?	❑ No	❑ Yes
Jug lid required?	❑ Blue	❑ Red

Breakfast	Eaten	⊕ ⊕ ⊕
Drinks		

Reason for not eating and action taken:

Snacks/supplements	
Assisted by *(print name)*	

Lunch	Eaten	⊕ ⊕ ⊕
Drinks		

Reason for not eating and action taken:

Snacks/supplements	
Assisted by *(print name)*	

Supper	Eaten	⊕ ⊕ ⊕
Drinks		

Reason for not eating and action taken:

Snacks/supplements	
Assisted by *(print name)*	

Patient rounding– *only to be completed at inpatient settings*

If patient is unconscious, please continue to assess needs and discuss any concerns with nurse in charge of patients care.

A = Achieved *V = Variance* *Time →*	*8.00*		*10.00*		*12.00*		*14.00*		*16.00*		*18.00*		*20.00*		*22.00*		*24.00*		*2.00*		*4.00*		*6.00*	
	A	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*	*A*	*V*
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Toileting needs met "Do you need assistance to go to the toilet?"																								
Pressure area care needs met. "Do you need to change your position?" If at risk of PU record key position code: Key: R = right L = Left B = back C = chair P = prone A = ambulant																								
Jug and glass are in reach. If prescribed, supplements assistance given. "Do you need something to drink?"																								
Call bell is working and in reach. "Can you reach your call bell?"																								
Staff initials																								

Patient name: Date of birth: NHS №::

Daily nursing care record

Date: / /

Day №:

Focus №	Assessment: Min of once at beginning of each 8 hr period and on transfer/ acceptance of patient. Community – once every 24 hours.	1st assessment time: Assessment	1st assessment time: Action	2nd assessment time: Assessment
1a	**Observations** *May continue for comfort e.g. temperature*			
1a	**Pain** *Score / location / analgesic effect*			
1a	**Falls** *Increased risk / equipment / bed rails / Falls Prevention ICP*			
1b	**Tissue viability** *Pressure relieving mattress / turn patients as tolerated*			
1c	**Invasive devices** *Removal / insertion / site / VIP x 3 daily*			
1d	**Administration of medicine** *SAM / omitted doses / prn medications prescribed*			
2	**Breathing -** *Breathlessness / cough / O_2*			
3	**Communicating** *Hearing / confusion / speech*			
4	**Nutrition** *Offer food as able / feeding at risk*			
5	**Eliminating** *Catheter / stoma / bowels* Bladder			
	Date bowels last opened: / / Bowels			
6	**Washing & dressing** *Assistance required / staff gender preference / Mouth care assessment*			
7	**Mobility** *Activity / Manual Handling Protocol / weight-bearing*			
8	**Resting & sleeping** *Number of pillows / sleeping side preference*			
9	**Emotional & spiritual needs** *Require faith leader visit?*			
NB Co-ordination, assessment and intervention are the responsibility of the Registered Nurse. HCA's may record activities in the multidisciplinary notes and in the time box to show that an intervention has been performed.		Sign & time		Sign

Symptom observation chart (S=Severe, M=Moderate, N=None or mild) & ID bracelet check

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Pain														
Nausea & vomiting														
Agitation														
Respiratory secretions														
Shortness of breath														
Mouth care														

Patient name: Date of birth: NHS №: Day №:

	3rd assessment time:	
Action	**Assessment**	**Action**
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- Give medication for symptom
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- Consider non-pharmacological treatment e.g. positioning
- Regular review until mild/none level is achieved

Moderate symptoms (action)

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Assess patient daily and record daily medical plan had with patient & family:

Daily review with Consultant/Doctor/Nurse record

Dr/Nurse name	
Signature	

Patient name: Date of birth: NHS №:

Multidisciplinary notes

Date/time	Record significant events / conversations / medical review / visit by other specialist teams e.g. palliative care / second opinion if sought	Signature

Patient name: Date of birth: NHS №:

Daily nursing care record

Day №

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Assisted by *(print name)*			
Lunch	Eaten		⊕ ⊕ ⊕
Drinks			
Reason for not eating and action taken:			
Snacks/supplements			
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Date: / /

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Respiratory secretions														
Shortness of breath														
Mouth care														

Patient name: Date of birth: NHS №: Day №:

	3rd assessment time:	
Action	**Assessment**	**Action**
Time	RN sign & time	

Please insert initial and 'S, M or N'

21	22	23	24	01	02	03	04	05	06	07

Severe/distressing symptoms (action)

- Give medication for symptom
- Look for reversible causes
- Consider non-pharmacological treatment e.g. positioning
- Regular review until mild/none level is achieved

Moderate symptoms (action)

- Give medication and review until mild/none level achieved
- Look for reversible causes
- Consider non-pharmacological treatment

Mild or no symptoms

- No intervention required

Assess patient daily and record daily medical plan had with patient & family:

Daily review with Consultant/Doctor/Nurse record

Dr/Nurse name	
Signature	

Patient name: Date of birth: NHS №:

Multidisciplinary notes

Date/time	Record significant events / conversations / medical review / visit by other specialist teams e.g. palliative care / second opinion if sought	Signature

Syringe Pump 4 hourly checklist

Syringe pump ID:												
Record Y = Yes N = No Date:												
Time:												
Infusion rate in ml / hr & volume to be infused												
Time left of infusion												
Is the indicator lamp flashing & pump delivering message on screen?												
Percentage of battery left?												
Is site inflamed?												
Is tubing kinked?												
Infusion site changed?												
Are syringe & line contents clear?												
Is pain controlled?												
Is there nausea or vomiting?												
Is there agitation?												
Are there secretions?												
Syringe pump screen locked?												
Medication label applied to line?												
Nurse initial												

Patient name:

Date of birth:

NHS №:

Syringe Pump 4 hourly checklist

Syringe pump ID:												
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Are there secretions?												
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Medication label applied to line?												
Nurse initial												

Patient name:

Date of birth:

NHS №:

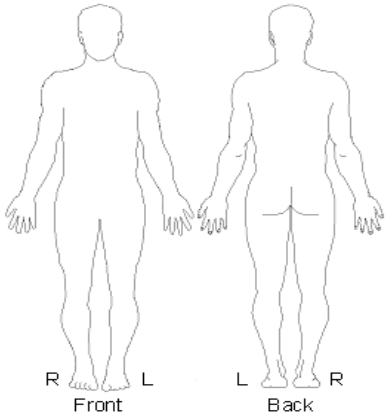
Patient name: Date of birth: NHS №:

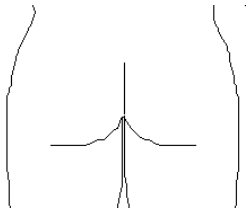
Wound Assessment & Care Plan

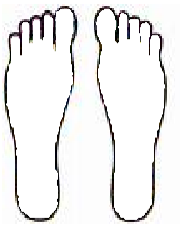
Body Map

Body map

Consider vulnerable pressure points e.g. ears. Please document if the patient prefers one position as this could increase risk of acquiring a pressure ulcer.







Brief history of wound(s)

How long have they had the wound?

How did they get the wound?

Who's been looking after the wound?

Wound assessment

Wound assessment

Date and time:	Wound assessment – One column per wound assessment			
	/ / :	/ / :	/ / :	/ / :
Signed:				
Print name:				
Size & description of wound/s *(e.g. location, sloughy, dry, infected etc.)*				
Type of wound/s *(e.g. pressure ulcer, moisture lesion, leg ulcer, surgical wound etc)*				
Intervention as necessary *(e.g. TVN referral, pressure relieving mattress, Datix, removal of sutures, removal of clips, etc)*				
Pain *(e.g. assess pain management, consider analgesia before dressing change)*				
Type of dressing and rationale				
Frequency of dressing change				

After death

Date of patient's death: / / Time: :

Who was present at death? ……

……

……

Nurse present at death: Name:……

If no relative / Carer present at time of death:

Next-of-kin notified? No ☐ Yes ☐ - *please give details:*

Name of next-of-kin notified: ……..

Relationship to patient: ……

Verification of death: ……

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Doctors name: …… Date: / /

Doctors signature: …… Time: :

❑ Last Offices completed
❑ Care After Death Checklist completed
❑ Information leaflets given to family

If this Care Record is discontinued please record here:	Date & time Care Record is discontinued: / / : Reasons why the Care Record is discontinued:

❑ Continuation booklet required.