



MEETING PACK · PART 1: FOR YOU

Getting ready for Mabel's assessment

This part is for you. It sets out what's in the pack, how the meeting works, and what you could still ask for. Part 2 is the evidence. It's made to be handed to the assessment team.

Prepared

9 October 2026

This pack organises evidence. It does not predict the funding decision.

Example: fictional person

What's in the pack so far

This shows which of the 12 areas have something from the records. It is not a score.

Area	In the pack
1. Breathing	Evidence found
2. Nutrition – Food and Drink	Evidence found
3. Continence	Evidence found
4. Skin (including tissue viability)	Evidence found
5. Mobility	Evidence found
6. Communication	Evidence found
7. Psychological and Emotional Needs	Evidence found
8. Cognition	Evidence found
9. Behaviour	Evidence found
10. Drug Therapies and Medication: Symptom Control	Evidence found
11. Altered States of Consciousness (ASC)	Not yet
12. Other significant care needs to be taken into consideration	Not yet

Not yet in the pack

1. Any records of fits, blackouts or episodes, from the care home, ward or GP
2. The current care plan, from the care home or ward
3. Any breathing and observation charts, from the care home or ward

There's a request you can send for each one in "Records to ask for".

HOW THE MEETING WORKS

What to expect on the day

- A team of at least two professionals meets to look at Mabel's needs in 12 areas. They use a form called the Decision Support Tool. (National Framework paragraph 138)
- They look at how serious, how complex and how unpredictable the needs are, and how much care they take. (National Framework paragraph 169)
- The ICB should usually decide within 28 days of a positive checklist. (National Framework paragraph 182)
- The team looks at all of Mabel's needs together, and how they affect each other. (National Framework paragraph 144)
- The decision is about whether the NHS arranges and pays for all of Mabel's care. This pack cannot tell you what the decision will be. (National Framework paragraph 4)
- If you disagree with the decision, you can ask the ICB to look at it again. (National Framework paragraph 214)
- If that does not settle it, you can ask NHS England for an independent review. (National Framework paragraph 216)

What the guidance says you can expect

- You and Mabel should have a big part in the assessment. (National Framework paragraph 144)
- Mabel's own view should count, as well as the staff's view. (National Framework paragraph 145)
- You are not on the team that decides. But you should get every chance to have your say. (National Framework note 24.1)
- You can say if you agree with the level for each area. Your reasons should be written down. (National Framework note 24.2)
- What carers say out loud should count too, if it helps show the level of need. (National Framework note 31.4)
- A need that is well looked after is still a need. (National Framework paragraph 162)
- If a worry is not sorted out, ask for it to be written in the form the team fills in. (National Framework paragraph 172)
- After the ICB decides, you should get the decision in writing. It should give the reasons and a copy of the form. (National Framework paragraph 179)

Words you will hear

- **ICB:** Integrated care board. The NHS body that makes the decision. (National Framework paragraph 173)
- **MDT:** The team at the meeting: at least two professionals. (National Framework paragraph 140)
- **DST:** Decision Support Tool. The form the team fills in. It looks at 12 areas of need. (National Framework paragraph 155)
- **Level:** For each area the team picks a level, from lowest to highest need. This pack does not suggest levels. (National Framework paragraph 155)

How to use this pack

1. This pack brings together what the care records you gave us say about Mabel's care needs. It is set out under the 12 areas of need that the assessment team looks at.
2. Every point shows where it came from: the record, the page and the date. There is also a short quote, so you can check it and find it quickly.
3. Read the evidence for each area. If something is missing or wrong, say so at the meeting.
4. Use the requests to ask for any records that are missing. Send them as soon as you can.
5. Take the questions with you. You don't have to ask them all.
6. Fill in the family's view in your own words. You know Mabel in ways the records don't. Start with the areas you know best.
7. This pack is not legal or clinical advice. The assessment team and the ICB make the decision.

RECORDS TO ASK FOR

Not yet in the pack, and who to ask

These records usually exist for needs like Mabel's. Each request below can be copied into an email or letter.

If the records have not arrived by the meeting, say so at the start. Ask which records the team has seen. Ask for any area with nothing in the pack to be noted on the form.

Altered States of Consciousness (ASC)

Not yet in the pack: Records about altered states of consciousness (ASC).

Usually held by the care home, ward or GP. Period: The last 3 months.

Request you can send:

Hello. I am helping Mabel get ready for an NHS Continuing Healthcare assessment. Could I please have a copy of any records of fits, blackouts or episodes for Mabel from the last 3 months? Thank you. [your name]

Other significant care needs to be taken into consideration

Not yet in the pack: Records about other significant care needs to be taken into consideration.

Usually held by the care home or ward. Period: The last 3 months.

Request you can send:

Hello. I am helping Mabel get ready for an NHS Continuing Healthcare assessment. Could I please have a copy of the current care plan for Mabel from the last 3 months? Thank you. [your name]

Breathing

Not yet in the pack: More records about breathing. The pack has some evidence for this area, but the records show a gap.

Usually held by the care home or ward. Period: The last 3 months.

Request you can send:

Hello, I am helping Mabel get ready for an NHS Continuing Healthcare assessment. Could I please have a copy of any breathing and observation charts for Mabel from the last 3 months? Thank you. [your name]

Nutrition – Food and Drink

Not yet in the pack: More records about nutrition – food and drink. The pack has some evidence for this area, but the records show a gap.

Usually held by the care home or ward. Period: The last 3 months.

Request you can send:

Hello, I am helping Mabel get ready for an NHS Continuing Healthcare assessment. Could I please have a copy of the food and fluid charts, weight records and any swallowing (SALT) assessment for Mabel from the last 3 months? Thank you. [your name]

Continence

Not yet in the pack: More records about continence. The pack has some evidence for this area, but the records show a gap.

Usually held by the care home or ward. Period: The last 3 months.

Request you can send:

Hello, I am helping Mabel get ready for an NHS Continuing Healthcare assessment. Could I please have a copy of any continence records and continence assessment for Mabel from the last 3 months? Thank you. [your name]

QUESTIONS YOU COULD ASK

To ask on the day, if they help

1. Which records has the team looked at for her breathing?
2. Has the team seen the care home's food and drink charts?
3. Would a diary kept by the care home help the team? (National Framework paragraph 164)
4. When in the meeting can we share what we have seen? (National Framework note 24.1)
5. If we disagree with the team, how will that be written down? (National Framework note 24.2)

Official guidance cited in this part

National Framework for NHS Continuing Healthcare and NHS-funded Nursing Care (July 2022, revised). Each quote is the exact wording. Contains public sector information licensed under the Open Government Licence v3.0.

- National Framework, paragraph 144: *"should be enabled to play a central role in the assessment process"*
- National Framework, paragraph 145: *"given appropriate weight alongside professional views"*
- National Framework, Practice Guidance note 24.1: *"they should be fully involved in the process and be given every opportunity to contribute to the MDT discussion"*
- National Framework, Practice Guidance note 24.2: *"It also asks for reasons for any disagreement to be recorded"*
- National Framework, Practice Guidance note 31.4: *"Oral evidence from carers or relevant professionals should be taken into account where it is pertinent to establishing the levels of need"*
- National Framework, paragraph 162: *"well-managed needs are still needs"*
- National Framework, paragraph 172: *"these should be noted within the DST so that they can be brought to the attention of the ICB making the final decision"*
- National Framework, paragraph 179: *"a copy of the completed DST"*

- National Framework, paragraph 173: *"ICBs are responsible for decision making regarding NHS Continuing Healthcare eligibility"*
- National Framework, paragraph 140: *"two professionals who are from different healthcare professions"*
- National Framework, paragraph 155: *"recording the various needs in 12 'care domains', or generic areas of need"*
- National Framework, paragraph 155: *"The levels represent a hierarchy from the lowest to the highest possible level of need"*
- National Framework, paragraph 138: *"a multidisciplinary team must assess whether the individual has a primary health need using the Decision Support Tool"*
- National Framework, paragraph 169: *"provide statements about the nature, intensity, complexity and unpredictability of the individual's needs"*
- National Framework, paragraph 182: *"should, in most cases, not exceed 28 calendar days from the date that the ICB receives the positive Checklist"*
- National Framework, paragraph 144: *"looks at all of the individual's needs 'in the round'"*
- National Framework, paragraph 4: *"the NHS is responsible for providing for all of the individual's assessed health and associated social care needs"*
- National Framework, paragraph 214: *"this should be addressed through the local resolution procedure"*
- National Framework, paragraph 216: *"the individual may apply to NHS England for an independent review of the decision"*
- National Framework, paragraph 164: *"It may be necessary to ask the provider to complete a detailed diary over a suitable period of time"*

PART 2: TO SHARE

Mabel

Full assessment for NHS Continuing Healthcare

Prepared by the family to contribute to the assessment.

Every point is quoted from the records, with its source.

Points are numbered by area (for example 5.2 is the second point under area 5) so they can be found quickly. This is the full version, with every point.

Example: fictional person

SUMMARY

What the records show, area by area

Area	What the records show	See
1. Breathing	14 points from the daily care notes, hospital discharge letter and medicines chart (mar).	1.1 to 1.14
2. Nutrition – Food and Drink	11 points from the behaviour chart, daily care notes, hospital discharge letter and risk assessment.	2.1 to 2.11
3. Continence	4 points from the daily care notes, hospital discharge letter and medicines chart (mar).	3.1 to 3.4
4. Skin (including tissue viability)	7 points from the daily care notes, falls log and risk assessment.	4.1 to 4.7
5. Mobility	12 points from the daily care notes, falls log, hospital discharge letter and risk assessment.	5.1 to 5.12
6. Communication	6 points from the daily care notes, falls log and risk assessment.	6.1 to 6.6
7. Psychological and Emotional Needs	6 points from the behaviour chart and daily care notes.	7.1 to 7.6
8. Cognition	5 points from the daily care notes and hospital discharge letter.	8.1 to 8.5
9. Behaviour	7 points from the behaviour chart, daily care notes and risk assessment.	9.1 to 9.7
10. Drug Therapies and Medication: Symptom Control	7 points from the daily care notes, hospital discharge letter and medicines chart (mar).	10.1 to 10.7
11. Altered States of Consciousness (ASC)	Records not yet obtained.	None
12. Other significant care needs to be taken into consideration	Records not yet obtained.	None

THE FAMILY'S VIEW

In our words

Written by the family. Nobody has written it for you. Leaving boxes blank is fine.

What does a typical day look like for Mabel now?

What happens at night?

What has changed in the last three months?

What do staff do for Mabel that Mabel could once do alone?

Is there anything the records don't show?

EVIDENCE

Evidence by area of need

These are the 12 areas the Decision Support Tool uses. Each quote was checked word for word against the record it came from. The short summaries are written by software, which also checks them, but they can still be wrong. Check each one against its quote. Where the software was not sure a summary matched, it shows only the record's own words.

1. Breathing

14 points

1.1

Salbutamol nebuliser given after she woke very breathless and anxious. Effect recorded as good.

Source: Medicines chart (MAR), page 2, entry dated 7/9 02:20. Quote: *"Salbutamol neb 2.5mg woke v breathless, anxious good"*

1.2

Salbutamol nebuliser given for wheeze and shortness of breath. Effect recorded as good.

Source: Medicines chart (MAR), page 2, entry dated 10/9 10:40. Quote: *"Salbutamol neb 2.5mg wheeze, SOB good"*

1.3

A nebuliser was given at 10:40 for wheeze and shortness of breath, with good effect.

Source: Daily care notes, page 4, entry dated 10/09 day 10:40. Quote: *"Nebuliser given 10:40 for wheeze and SOB, good effect."*

1.4

During the hospital stay, she needed 2L oxygen through nasal tubes on days 1 to 4 and was then weaned to room air.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"Required O2 2L via nasal cannula days 1-4, weaned to room air."*

1.5

Walked slowly to the dining room with a zimmer frame and one staff member, and stopped twice to catch her breath.

Source: Daily care notes, page 1, entry dated 4.9.26 day. Quote: *"Walked to dining room with zimmer frame + 1 staff, slow, stopped x2 to catch breath."*

1.6

During the hospital stay, she was still breathless walking short distances on the ward.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"Pt still breathless walking short distances on the ward."*

1.7

Short of breath after a wash, with oxygen saturation 89% on room air. It settled to 92% after 10 minutes' rest sitting up.

Source: Daily care notes, page 1, entry dated 3/9/26 AM. Quote: *"SOB on exertion after wash, sats 89% RA, settled to 92% after 10 mins rest sitting up."*

1.8

Shown as written

The record says: *"Trimbow inh 2 puffs BD 08:00"*

Other dose times are on the same chart.

Source: Medicines chart (MAR), page 1, no date on this entry (record starts 1 September 2026). Shown in the record's own words.

1.9

On discharge from hospital, oxygen saturation was 91-93% on room air. The target was 88-92%.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"Sats on discharge 91-93% on RA (target 88-92%)."*

1.10

The GP visited and recorded the chest as 'clear-ish' with crackles at the right base.

Source: Daily care notes, page 4, entry dated 8/9/26 AM. Quote: *"GP Dr Okafor visited. Chest clear-ish, crackles R base."*

1.11

Observations recorded included breathing rate 22 and oxygen saturation 90%. The GP (Farrowgate) rang and was to review on Monday.

Source: Daily care notes, page 2, entry dated 6/9 day. Quote: *"Obs T 37.1 P 88 RR 22 sats 90%. GP (Farrowgate) rang, to review Mon."*

1.12

Salbutamol nebuliser given for wheeze and shortness of breath after supper. Effect recorded as good, 30 min.

Source: Medicines chart (MAR), page 2, entry dated 4/9 19:30. Quote: *"Salbutamol neb 2.5mg wheeze + SOB after supper good, 30 min"*

1.13

Salbutamol nebuliser given for shortness of breath at rest, breathing rate 24. Effect recorded as partial.

Source: Medicines chart (MAR), page 2, entry dated 6/9 11:15. Quote: *"Salbutamol neb 2.5mg SOB at rest, RR 24 partial"*

1.14

Shown as written

The record says: *"Salbutamol neb 2.5mg still SOB, sats 88% partial, GP rang"*

Source: Medicines chart (MAR), page 2, entry dated 6/9 15:00. Shown in the record's own words.

2. Nutrition – Food and Drink

11 points

2.1

Shown as written

The record says: *"Mabel F: refused supper, pushed plate away, said 'I'm not hungry, I want to go home'."*

Source: Behaviour chart, page 2, entry dated 08/09 18:00. Shown in the record's own words.

2.2

Shown as written

The record says: *"Coughing on thin drinks at lunch - RN to discuss SALT referral w/ GP."*

Source: Daily care notes, page 3, entry dated 7 Sept 2026. Shown in the record's own words.

2.3

Hospital weights: 52.4kg on admission and 50.1kg on discharge.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"Weight 52.4kg on admission, 50.1kg on discharge."*

2.4

The plan was to encourage 1.5L of fluids and repeat observations every 4 hours. This is a plan, not a record of what was done.

Source: Daily care notes, page 2, entry dated 6/9 day. Quote: *"Plan: encourage fluids 1.5L, rpt obs 4 hrly."*

2.5

An undated risk assessment notes that she may be at risk of aspiration with thin fluids and that a speech and language therapy (SALT) assessment is awaited.

Source: Risk assessment, page 1, no date given. Quote: *"Choking: Mabel may be at risk of aspiration with thin fluids. Await SALT."*

2.6

Food was offered again at 19:00 and she ate a yoghurt.

Source: Behaviour chart, page 2, entry dated 08/09. Quote: *"Offered again 19:00, ate yoghurt."*

2.7

During the hospital stay, she needed encouragement and help with all meals. She was not seen by speech and language therapy.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"Needed encouragement and assistance with all meals. SALT not seen."*

2.8

A Fortisip supplement drink was given and she drank half.

Source: Daily care notes, page 1, entry dated 3/9/26 PM. Quote: *"Fortisip given, drank half."*

2.9

Ate about a third of a fish pie. She needed a lot of prompting, and staff loaded her fork.

Source: Daily care notes, page 1, entry dated 3/9/26 PM. Quote: *"Ate approx 1/3 of fish pie, needed prompting ++ and staff to load fork."*

2.10

The discharge summary advises considering a speech and language therapy referral if she coughs on fluids. This is advice, not an event.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"Consider SALT referral if coughing on fluids."*

2.11

Weight recorded as 49.2kg.

Source: Daily care notes, page 4, entry dated 10/09 day. Quote: *"10/09 day. Weight 49.2kg."*

3. Continence

4 points

3.1

The medication chart lists one Laxido sachet once daily.

Source: Medicines chart (MAR), page 1, no date on this entry (record starts 1 September 2026). Quote: *"Laxido 1 sachet OD"*

3.2

Bowels had not opened since 1/9. A Laxido sachet was given as prescribed.

Source: Daily care notes, page 2, entry dated 05/09/26 early. Quote: *"Bowels not opened since 1/9 - laxido sachet given as prescribed."*

3.3

Her past medical history in the hospital summary includes recurrent urine infections.

Source: Hospital discharge letter, page 1, no date on this entry (record starts 28 August 2026). Quote: *"PMH: COPD, vascular dementia, osteoarthritis both knees, HTN, recurrent UTIs."*

3.4

Pad was wet twice and changed.

Source: Daily care notes, page 1, entry dated 3/9/26 PM. Quote: *"Pad wet x2, changed."*

4. Skin (including tissue viability)

7 points

4.1

Shown as written

The record says: *"Heel boots on, 2 hrly turns overnight L-back-R."*

Source: Daily care notes, page 3, entry dated 7 Sept 2026. Shown in the record's own words.

4.2

Shown as written

The record says: *"skin intact apart from L heel."*

Source: Daily care notes, page 3, entry dated 7 Sept 2026. Shown in the record's own words.

4.3

Shown as written

The record says: *"Airflow mattress, heel boots, 2 hrly repositioning."*

Source: Risk assessment, page 1, no date given. Shown in the record's own words.

4.4

The left heel was red and non-blanching, about 2cm.

Source: Daily care notes, page 2, entry dated 05/09/26 late. Quote: *"Left heel red, non blanching, approx 2cm."*

4.5

Heel boots were put on, the nurse was informed and a wound chart was started.

Source: Daily care notes, page 2, entry dated 05/09/26 late. Quote: *"Heel boots on, informed RN. Wound chart started."*

4.6

After the fall, a bruise of about 3cm on the left elbow was recorded. No head injury was seen.

Source: Falls log, page 1, entry dated 09/09/2026 06:10. Quote: *"Injuries: bruise L elbow approx 3cm, no head injury seen."*

4.7

An undated risk assessment records a Waterlow score of 22, which it calls very high risk.

Source: Risk assessment, page 1, no date given. Quote: *"Skin: Waterlow 22, very high risk."*

5. Mobility

12 points

5.1

Found on the floor beside her bed at 06:10 and moved with a hoist.

Source: Daily care notes, page 4, entry dated 9th Sept 06:10. Quote: *"Found on floor beside bed 06:10, see falls log. Transferred w/ hoist."*

5.2

She was lifted from the floor with a Mangar Camel lift, then hoisted to bed by 2 staff.

Source: Falls log, page 1, entry dated 09/09/2026 06:10. Quote: *"Moved from floor w/ Mangar Camel lift then hoisted to bed, 2 staff."*

5.3

Walked a few steps to the commode with a frame and 2 staff, very unsteady.

Source: Daily care notes, page 4, entry dated 10/09 day. Quote: *"Walked a few steps with frame + 2 staff to commode, very unsteady."*

5.4

Shown as written

The record says: *"Low bed, crash mat, sensor mat when delivered."*

Source: Risk assessment, page 1, no date given. Shown in the record's own words.

5.5

Drowsy on waking. She was hoisted from bed to chair by 2 staff, was unable to stand that day and said her legs were 'like jelly'.

Source: Daily care notes, page 2, entry dated 6/9 day. Quote: *"Pt drowsy on waking, hoisted bed to chair with 2 staff, unable to stand today, legs 'like jelly'."*

5.6

On discharge from hospital, she walked short distances with a zimmer frame and 1 to 2 staff.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"Walks short distances with zimmer frame and 1 to 2 staff."*

5.7

The falls log records her found sitting on the floor next to her bed. Bed rails were not in use (per MCA), and she had moved the crash mat.

Source: Falls log, page 1, entry dated 09/09/2026 06:10. Quote: *"Found sitting on floor next to bed, bed rails not in use (per MCA), crash mat had been moved by pt."*

5.8

Shown as written

The record says: *"Falls: HIGH. Mabel is at risk of falls due to poor balance, breathlessness and confusion."*

Source: Risk assessment, page 1, no date given. Shown in the record's own words.

5.9

The falls log lists previous falls at home on 16/8/26 (went to hospital) and 22/7/26 (no injury).

Source: Falls log, page 1, entry dated 09/09/2026. Quote: *"Previous falls: 16/8/26 at home (to hospital), 22/7/26 at home, no injury."*

5.10

The hospital physio recorded that she needs 2 people to go from sitting to standing when tired.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"Physio: needs 2 for sit to stand when tired."*

5.11

The falls log lists actions: a sensor mat ordered, hourly checks overnight, and the GP and daughter informed. The overnight checks are a plan, not a record that they were done.

Source: Falls log, page 1, entry dated 09/09/2026. Quote: *"Actions: sensor mat ordered, 1 hrly checks overnight, GP + daughter informed."*

5.12

Shown as written

The record says: *"Presenting complaint: Found on floor at home by her carer after unwitnessed fall, increased SOB and productive cough for 3/7."*

Source: Hospital discharge letter, page 1, entry dated 16 Aug 2026. Shown in the record's own words.

6. Communication

6 points

6.1

Had a good morning, chatting to a carer about her garden.

Source: Daily care notes, page 1, entry dated 4.9.26 day. Quote: *"Good morning, chatting to carer about her garden."*

6.2

Unable to say where her pain was. She pointed to her chest, then her leg.

Source: Daily care notes, page 4, entry dated 8/9/26 AM. Quote: *"Mabel unable to say where pain was, pointed to her chest then her leg."*

6.3

An undated risk assessment records that she is hard of hearing and uses a left hearing aid.

Source: Risk assessment, page 1, no date given. Quote: *"Communication: Hard of hearing, uses L hearing aid."*

6.4

Shown as written

The record says: *"hearing aid L ear put in (R aid lost on ward, dtr aware)."*

Source: Daily care notes, page 1, entry dated 3/9/26 AM. Shown in the record's own words.

6.5

The risk assessment says she often uses the wrong word, for example calling a cup "the shoe", and needs short questions with yes/no answers.

Source: Risk assessment, page 1, no date given. Quote: *"often uses wrong word (calls cup 'the shoe'). Needs short questions, yes/no."*

6.6

After the fall, she said she needed the toilet.

Source: Falls log, page 1, entry dated 09/09/2026 06:10. Quote: *"Pt said 'I needed the toilet'."*

7. Psychological and Emotional Needs

6 points

7.1

A carer stayed with her for 30 minutes, holding her hand.

Source: Behaviour chart, page 2, entry dated 09/09 07:00. Quote: *"Carer stayed 30 mins, holding hand."*

7.2

Awake from 01:00 to 04:00 shouting 'help me' repeatedly. She did not settle with reassurance or tea.

Source: Daily care notes, page 2, entry dated 6/9 night. Quote: *"Awake 01:00 - 04:00 shouting 'help me' repeatedly. Did not settle w/ reassurance or tea."*

7.3

Shown as written

The record says: *"Tearful at 16:00, calling for 'Ron' (late husband). Sat w/ her 20 mins, settled."*

Source: Daily care notes, page 1, entry dated 3/9/26 PM 16:00. Shown in the record's own words.

7.4

On 10/09 she had a calm day, joined the music group and sang "Daisy Bell".

Source: Behaviour chart, page 2, entry dated 10/09 16:20. Quote: *"Mabel F: calm day, joined music group, sang 'Daisy Bell'."*

7.5

On 09/09 she was crying and frightened after a fall, and wanted staff to stay with her.

Source: Behaviour chart, page 2, entry dated 09/09 07:00. Quote: *"Mabel F: crying, frightened after fall, wanted staff to stay."*

7.6

Enjoyed singing along to the radio.

Source: Daily care notes, page 4, entry dated 8/9/26. Quote: *"Enjoyed singing along to the radio."*

8. Cognition

5 points

8.1

When her daughter Linda visited, she did not recognise her at first, then said 'oh it's you love'.

Source: Daily care notes, page 4, entry dated 8/9/26. Quote: *"Daughter Linda visited PM, pt did not recognise her at first, then 'oh it's you love'."*

8.2

Asked 3 times in one hour whether this was her house. Staff reoriented her each time, and she was calmer with the radio on.

Source: Daily care notes, page 1, entry dated 3/9/26 AM. Quote: *"Pt asked 3x in one hour 'is this my house?' Reoriented each time, calmer w/ radio on."*

8.3

The hospital recorded delirium on a background of vascular dementia, diagnosed in 2021.

Source: Hospital discharge letter, page 1, no date on this entry (record starts 28 August 2026). Quote: *"3. Delirium on background of vascular dementia (dx 2021)."*

8.4

The hospital recorded that she lacked capacity about where to live on discharge, and a best interest decision was made with her daughter.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"Lacks capacity re discharge destination, best interest decision made with daughter (see MCA form)."*

8.5

Memory test (AMTS) score was 3 out of 10 on discharge from hospital.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"AMTS 3/10 on discharge."*

9. Behaviour

7 points

9.1

She refused a wash, pushed a carer's hand away and said 'leave me be'. RN Tomasz re-approached 30 minutes later, and she accepted the wash with a step-by-step explanation.

Source: Daily care notes, page 2, entry dated 05/09/26 early. Quote: *"Pt refused wash, pushed carer's hand away and said "leave me be". Re-approached 30 mins later by RN Tomasz, accepted wash w/ explanation step by step."*

9.2

Shouted 'help me' repeatedly for 3 hours and was not settled by reassurance, drinks or repositioning.

Source: Behaviour chart, page 1, entry dated 06/09 01:00. Quote: *"Shouting "help me" repeatedly for 3 hrs, not settled by reassurance, drinks or repositioning."*

9.3

During a pad change, she grabbed a carer's wrist tightly, leaving a red mark. The carer explained, 2 staff were used, and the pad change was completed.

Source: Behaviour chart, page 1, entry dated 07/09 14:10. Quote: *"Mabel grabbed carer's wrist tightly during pad change, left red mark. Carer explained, used 2 staff, completed."*

9.4

The risk assessment says staff should approach slowly, explain, offer choices and use 2 staff if needed. This is guidance for staff.

Source: Risk assessment, page 1, no date given. Quote: *"Approach slowly, explain, offer choices, 2 staff if needed."*

9.5

Shown as written

The record says: *"Behaviour: may become verbally aggressive or resist care when frightened, could hit out."*

Source: Risk assessment, page 1, no date given. Shown in the record's own words.

9.6

At tea time, with the lounge busy and the TV loud, she shouted 'stop it' and banged the table with her hand. She was moved to a quiet room and settled with a carer and the radio in 15 minutes.

Source: Behaviour chart, page 1, entry dated 04/09 17:45. Quote: *"Tea time, lounge busy + TV loud. Mabel shouting 'stop it' and banging table w/ her hand. Moved to quiet room, settled w/ carer + radio in 15 mins."*

9.7

During personal care, she pushed a carer's hand away and said 'leave me be'. Care stopped, a nurse re-approached after 30 minutes, and she accepted.

Source: Behaviour chart, page 1, entry dated 05/09 07:40. Quote: *"Personal care. Pushed carer's hand away, said 'leave me be'. Stopped, RN re-approached 30 mins, accepted."*

10. Drug Therapies and Medication: Symptom Control

7 points

10.1

The as-needed record lists lorazepam for severe distress not settling after 1 hour of non-drug measures, maximum 1mg in 24 hours. It is recorded as not yet given. This is a prescription, not an event.

Source: Medicines chart (MAR), page 2, no date on this entry (record starts 1 September 2026). Quote: *"Lorazepam 0.5mg PO if severe distress not settling after 1 hr of non drug measures. Max 1mg/24h. (not yet given)"*

10.2

The hospital added a salbutamol nebuliser, up to four times a day as needed. This is a prescription, not an event.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"Salbutamol nebs 2.5mg QDS PRN added."*

10.3

On 5/9 she refused amlodipine and her evening Trimbow inhaler, saying she 'didn't want any more'. The GP was informed.

Source: Medicines chart (MAR), page 1, entry dated 5/9. Quote: *"5/9 amlodipine + Trimbow PM refused, pt 'didn't want any more', GP informed."*

10.4

She said her heel was 'throbbing', and as-needed paracetamol was given.

Source: Daily care notes, page 2, entry dated 05/09/26 late. Quote: *"Pt reports heel 'throbbing'. PRN paracetamol given."*

10.5

The discharge summary says hidden (covert) giving of essential medicines was agreed with the GP and pharmacist if she refuses them. This is a plan.

Source: Hospital discharge letter, page 2, no date on this entry (record starts 28 August 2026). Quote: *"Covert administration agreed with GP and pharmacist if refusing essential meds."*

10.6

Started on a 5-day course of doxycycline.

Source: Daily care notes, page 4, entry dated 8/9/26 AM. Quote: *"Commenced on doxycycline 5 days."*

10.7

In an undated entry, the tablets were crushed in yoghurt as per the covert medicines plan and GP letter, and taken on the third attempt.

Source: Daily care notes, page 4, no date on this entry (record starts 3 September 2026). Quote: *"Crushed with yoghurt as per covert meds plan and GP letter, taken on 3rd attempt."*

11. Altered States of Consciousness (ASC)

Records not yet obtained.

12. Other significant care needs to be taken into consideration

Records not yet obtained.

Example: fictional person

RECORD INDEX

Records used, and where each point comes from

Record	Pages cited	Points
Daily care notes 4 pages, from 3 September 2026	1, 2, 3, 4	1.3, 1.5, 1.7, 1.10, 1.11, 2.2, 2.4, 2.8, 2.9, 2.11, 3.2, 3.4, 4.1, 4.2, 4.4, 4.5, 5.1, 5.3, 5.5, 6.1, 6.2, 6.4, 7.2, 7.3, 7.6, 8.1, 8.2, 9.1, 10.4, 10.6, 10.7
Hospital discharge letter 2 pages, from 28 August 2026	1, 2	1.4, 1.6, 1.9, 2.3, 2.7, 2.10, 3.3, 5.6, 5.10, 5.12, 8.3, 8.4, 8.5, 10.2, 10.5
Medicines chart (MAR) 2 pages, from 1 September 2026	1, 2	1.1, 1.2, 1.8, 1.12, 1.13, 1.14, 3.1, 10.1, 10.3
Falls log 1 page, from 9 September 2026	1	4.6, 5.2, 5.7, 5.9, 5.11, 6.6
Behaviour chart 2 pages, from 4 September 2026	1, 2	2.1, 2.6, 7.1, 7.4, 7.5, 9.2, 9.3, 9.6, 9.7
Risk assessment 1 page, no date given	1	2.5, 4.3, 4.7, 5.4, 5.8, 6.3, 6.5, 9.4, 9.5