Liverpool Care Pathway for the Dying Patient (LCP)
supporting care in the last hours or days of life

Location: (e.g. hospital, ward, care home etc.):.....

As with all clinical guidelines and pathways the LCP aims to support but does not replace clinical judgement

- The LCP generic document guides and enables healthcare professionals to focus on care in the last hours or days of life. This provides high quality care tailored to the patient's individual needs, when their death is expected.
- Using the LCP in any environment requires regular assessment and involves regular reflection, challenge, critical senior decision-making and clinical skill, in the best interest of the patient. A robust continuous learning and teaching programme must underpin the use of the LCP.
- The recognition and diagnosis of dying is always complex; irrespective of previous diagnosis or history. Uncertainty is an integral part of dying. There are occasions when a patient who is thought to be dying lives longer than expected and vice versa. Seek a second opinion or specialist palliative care support as needed.
- Changes in care at this complex, uncertain time are made in the best interest of the patient and relative or carer and needs to be reviewed regularly by the multidisciplinary team (MDT). For example medical, nurses, specialist nurses involved with patient care and family.
- Good comprehensive clear communication is pivotal and all decisions leading to a change in care delivery should be communicated to the patient where appropriate and to the relative or carer. The views of all concerned must be listened to and documented.
- If a goal on the LCP is not achieved this should be coded as a variance. This is not a negative process but demonstrates the individual nature of the patient's condition based on their particular needs, your clinical judgement and the needs of the relative or carer.
- The LCP does not preclude the use of clinically assisted nutrition or hydration or antibiotics. All clinical decisions must be made in the patient's best interest.
- A blanket policy of clinically assisted (artificial) nutrition or hydration, or of no clinically assisted (artificial) hydration, is ethically indefensible.
- For the purpose of this LCP generic version 12 document - The term best interest includes medical, physical, emotional, social and spiritual and all other factors relevant to the patient's welfare.

The patient will be assessed regularly and a formal full MDT review must be undertaken every 3 days.

The responsibility for the use of the LCP generic document as part of a continuous quality improvement programme sits within the governance of an organisation and must be underpinned by a robust education and training programme.

References:

Ellershaw and Wilkinson Eds (2003) *Care of the dying*: *A pathway to excellence*. Oxford: Oxford University Press.
National Institute for Clinical Excellence (2004) Improving Supportive and Palliative Care for Adults with Cancer. London, NICE
MCPCIL (2009) National Care of the Dying Audit Hospitals Generic Report Round 2. www.mcpcil.org.uk

Name:..... URN no:..... Date:.....

Algorithm – Decision making in: diagnosing dying & use of the LCP supporting care in the last hours or days of life

Assessment

Deterioration in the patient's condition suggests that the patient could be dying

Multidisciplinary team (MDT) assessment

- 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 Specialist referral needed? e.g. specialist palliative care or a second opinion

Clinical Decision

Patient is **NOT** diagnosed as dying (in the last hours or days of life)

Review the current plan of care

Patient is diagnosed as dying (in the last hours or days of life)

Patient, relative or carer communication is focused on recognition & understanding that the patient is dying

Communication

Discussion with the patient and relative or carer to explain the new or revised plan of care

Discussion with the patient, relative or carer to explain the current plan of care & use of the LCP

Management

The Liverpool Care Pathway for the Dying Patient (LCP) is commenced including ongoing regular assessments

Reassessment

A full multidisciplinary team (MDT) reassessment & review of the current plan of care should be triggered when 1 or more of the following apply:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care

and or

Concerns expressed regarding management plan from either patient, relative or carer or team member

and or

It is **3 days** since the last **full** multidisciplinary team (MDT) assessment

Always remember that the Specialist Palliative Care Team are there for advice and support, especially if:
Symptom control is difficult and/or if there are difficult communication issues or you need advice or support regarding your care delivery supported by the LCP. The Team works Monday – Friday 9-5 01534 444234

Name:..... URN no:..... Date:.....

Healthcare professional documenting the MDT decision

Following a full MDT assessment and a decision to use the LCP:

Date LCP commenced:.....

Time LCP commenced:.....

Name (Print):..... **Signature:.....**

This will vary according to circumstances and local governance arrangements. In general this should be the most senior healthcare professional immediately available. (Middle Grade)

The decision must be endorsed by the most senior healthcare professional responsible for the patient's care at the earliest opportunity if different from above. (Consultant who is looking after patient/ GP).

Name (Print):..... **Signature:.....**

All personnel completing the LCP please sign below

You should also have read and understood the guidance on pages 1 - 2

Name (print)	*Full signature*	*Initials*	*Professional title*	*Date*

Record all full MDT reassessments here (including full formal MDT reassessment every 3 days)

Reassessment date:..... Reassessment time:.....

Reassessment date:..... Reassessment time:.....

Reassessment date:..... Reassessment time:.....

Reassessment date:..... Reassessment time:.....

If the LCP is discontinued please record here:

Date LCP discontinued..... Time LCP discontinued.....

Reasons why the LCP was discontinued:.....

.....

.....

Decision to discontinue the LCP shared with the patient **Yes ☐** **No ☐**

Decision to discontinue the LCP shared with the relative or carer **Yes ☐** **No ☐**

Name:..... URN no:..... Date:.....

Section 1 Initial assessment (joint assessment by doctor and nurse)

Diagnosis & Baseline Information

DIAGNOSIS:..... Co-morbidity:.....
..... Ethnicity:.....
DOB:..... Age:..... URN no:..... Female ☐ Male ☐

At the time of the assessment is the patient:

In pain	**Yes** ☐ **No** ☐		Able to swallow	**Yes** ☐ **No** ☐		Confused	**Yes** ☐ **No** ☐
Agitated	**Yes** ☐ **No** ☐		Continent (bladder)	**Yes** ☐ **No** ☐		*(record below which is applicable)*	
Nauseated	**Yes** ☐ **No** ☐		Catheterised	**Yes** ☐ **No** ☐		Conscious	☐
Vomiting	**Yes** ☐ **No** ☐		Continent (bowels)	**Yes** ☐ **No** ☐		Semi-conscious	☐
Dyspnoeic	**Yes** ☐ **No** ☐		Constipated	**Yes** ☐ **No** ☐		Unconscious	☐
Experiencing respiratory tract secretions				**Yes** ☐ **No** ☐			
Experiencing other symptoms (e.g. oedema, itch)				**Yes** ☐ **No** ☐			

Communication

Goal 1.1: The patient is able to take a full and active part in communication
Achieved ☐ **Variance** ☐ **Unconscious** ☐

Barriers that have the potential to prevent communication have been assessed
First language..... Other issues identified.....
Consider need for an interpreter: (contact no) .....
Other barriers to communication.....
Consider: Hearing, vision, speech, learning disabilities, dementia (use of assessment tools), neurological conditions and confusion
The relative or carer may know how specific signs indicate distress if the patient is unable to articulate their own concerns
Does the patient have:-
An advance care plan?
An expressed wish for organ/tissue donation?
An advance decision to refuse treatment (ADRT)?
Does the patient have the capacity to make their own decisions on their own treatment at this moment in time?
Comments:.....
.....

Goal 1.2: The relative or carer is able to take a full and active part in communication **Achieved** ☐ **Variance** ☐
First language..... Other Issues identified.....
Consider need for an interpreter (contact no):.....
Other barriers to communication:.....

Goal 1.3: The patient is aware that they are dying **Achieved** ☐ **Variance** ☐ **Unconscious** ☐

Goal 1.4: The relative or carer is aware that the patient is dying **Achieved** ☐ **Variance** ☐

Goal 1.5: The Clinical team have up to date contact information for the relative or carer as documented below
Achieved ☐ **Variance** ☐

1st contact name:.....

Relationship to the patient:..... Tel no:..... Mobile no:.....
When to contact: At any time ☐ Not at night-time ☐ Staying with the patient overnight ☐

2nd contact:.....

Relationship to the patient:..... Tel no:..... Mobile no:.....
When to contact: At any time ☐ Not at night-time ☐ Staying with patient the overnight ☐

Next of kin - this may be different from above N/A ☐
Contact details:.....
.....
.....

Name:..... URN no:..... Date:.....

Section 1 Initial assessment (joint assessment by doctor and nurse)

Facilities

Goal 2: The relative or carer has had a full explanation of the facilities available to them and a facilities leaflet has been given **Achieved ☐ Variance ☐**

Facilities may include: car parking, toilet, beverages, payphone

Spirituality

Goal 3.1: The patient is given the opportunity to discuss what is important to them at this time eg. their wishes, feelings, faith , beliefs, values **Achieved ☐ Variance ☐ Unconscious ☐**

Patient may be anxious for self or others. Consider specific religious and cultural needs

Consider music, art, poetry, reading, photographs, something that has been important to the belief system or the well-being of the patient

Did the patient take the opportunity to discuss the above **Yes ☐ No ☐ Unconscious ☐**

Religious tradition identified, please specify: .....

Support of the chaplaincy team offered **Yes ☐ No ☐**

If no give reason:.....

In-house support Tel/bleep no: .....Name: ..... Date/time: .....

External support Tel/bleep no: .....Name: ..... Date/time: .....

Needs now:.....

.....

.....

.....

.....

Needs at death:.....

.....

.....

Needs after death:.....

.....

.....

Goal 3.2: The relative or carer is given the opportunity to discuss what is important to them at this time e.g. their wishes, feelings, faith, beliefs, values **Achieved ☐ Variance ☐**

Comments.....

.....

.....

Did the relative or carer take the opportunity to discuss the above **Yes ☐ No ☐**

Medication

Goal 4.1: The patient has medication prescribed on a prn basis for all of the following 5 symptoms which may develop in the last hours or days of life **Achieved ☐ Variance ☐**

Pain ☐
Agitation ☐
Respiratory tract secretions ☐
Nausea / Vomiting ☐
Dyspnoea ☐

Anticipatory prescribing in this manner will ensure that there is no delay in responding to a symptom if it occurs

Current Medication assessed and non essentials discontinued

Medicines for symptom control will only be given when needed, at the right time and just enough and no more than is needed to help the symptom

Goal 4.2: Equipment is available for the patient to support a continuous subcutaneous infusion (CSCI) of medication where required

Achieved ☐ Variance ☐ Already in place ☐ Not required ☐

If a CSCI is to be used explain the rationale to the patient, relative or carer. Not all patients who are dying will require a CSCI

Name:..... URN no:..... Date:.....

Section 1 Initial assessment (joint assessment by doctor and nurse)

Current Interventions

Goal 5.1: The patient's need for current interventions has been reviewed by the MDT **Achieved ☐ Variance ☐**

	Currently not being taken/ or given	Discontinued	Continued	Commenced
5a: Routine blood tests	☐	☐	☐	
5b: Intravenous antibiotics	☐	☐	☐	☐
5c: Blood glucose monitoring	☐	☐	☐	
5d: Recording of routine vital signs	☐	☐	☐	
5e: Oxygen therapy	☐	☐	☐	☐

5.2: The patient has a Do Not Attempt Cardiopulmonary Resuscitation Order in place **Achieved ☐ Variance ☐**
Please complete the appropriate associated documentation according to policy and procedure
Explain to the patient, relative or carer as appropriate

5.3: Implantable Cardioverter Defibrillator (ICD) is deactivated **Achieved ☐ Variance ☐ No ICD in place ☐**
Contact the patient's cardiologist. Refer to the ECG technician & refer to local/ regional - policy/procedure.
Information leaflet given to the patient, relative or carer as appropriate

Nutrition

Goal 6: The need for clinically assisted (artificial) nutrition is reviewed by the MDT **Achieved ☐ Variance ☐**
The patient should be supported to take food by mouth for as long as tolerated
For many patients the use of clinically assisted (artificial) nutrition will not be required
A reduced need for food is part of the normal dying process
If clinically assisted (artificial) nutrition is already in place please record route NG ☐ PEG/PEJ ☐ NJ ☐ TPN ☐
Is clinically assisted (artificial) nutrition Not required ☐ Discontinued ☐ Continued ☐
Consider reduction in rate / volume according to individual need if nutritional support is in place
Explain the plan of care to the patient where appropriate, and to the relative or carer

Hydration

Goal 7: The need for clinically assisted (artificial) hydration is reviewed by the MDT **Achieved ☐ Variance ☐**
The patient should be supported to take fluids by mouth for as long as tolerated
For many patients the use of clinically assisted (artificial) hydration will not be required
A reduced need for fluids is part of the normal dying process
Symptoms of thirst / dry mouth do not always indicate dehydration but are often due to mouth breathing or medication. Good mouth care is essential
If clinically assisted (artificial) hydration is already in place please record route IV ☐ S/C ☐ PEG/PEJ ☐ NG ☐
Is clinically assisted (artificial) hydration Not required ☐ Discontinued ☐ Continued ☐ Commenced ☐
Consider reduction in rate / volume according to individual need if hydration support is in place. If required consider the s/c route
Explain the plan of care to the patient where appropriate, and the relative or carer

Skin Care

Goal 8: The patient's skin integrity is assessed **Achieved ☐ Variance ☐**
The aim is to prevent pressure ulcers or further deterioration if a pressure ulcer is present. Use a recognised risk assessment tool e.g. Waterlow / Braden to support clinical judgement. The frequency of repositioning should be determined by skin inspection, assessment and the patient's individual needs. Consider the use of special aids (mattress / bed)
Record the plan of care on the initial assessment MDT sheet where appropriate

Explanation of the plan of care

Goal 9.1: A full explanation of the current plan of care (LCP) is given to the patient
Achieved ☐ Variance ☐ Unconscious ☐

Goal 9.2: A full explanation of the current plan of care (LCP) is given to the relative or carer
Achieved ☐ Variance ☐
Name of relative or carer(s) present and relationship to the patient:.....
.....
Names of healthcare professionals present:.....
Information sheet at front of the LCP or equivalent relative or carer information leaflet given Yes ☐ No ☐
Parents or carer should be given or have access to age appropriate advice and information to support children/adolescents

Goal 9.3: The LCP Coping with dying leaflet or equivalent is given to the relative or carer
Achieved ☐ Variance ☐

Goal 9.4: The patient's primary health care team / GP practice is notified that the patient is dying
Achieved ☐ Variance ☐
G.P practice to be contacted if unaware that the patient is dying, message can be left or sent via a secure fax

If you have recorded a variance against any of the goals of care please record on the variance sheet, see page 8

Name:…… URN no:…….. Date:……

Section 1	***Initial assessment***	
Signatures	**Please sign here on completion of the initial assessment**	
	Doctor's name (print):……	**Nurse's name (print):……**
	Doctor's signature:……	**Nurse's signature:……**
	Date……Time……	**Date…… Time……**

***Section 1 Initial assessment* MDT progress notes**	
Date	***Supportive information: Plan of care to monitor skin integrity, nutrition / hydration - include here any specific information regarding this patient; relative or carer that has not been captured in the initial assessment that you believe needs to be highlighted.***

Name:.. URN no:... Date:..

Variance analysis sheet for initial assessment		
What variance occurred & why? (what was the issue?)	**Action taken (what did you do?)**	**Outcome (did this solve the issue?)**
Goal: ***Signature:......................................*** ***Date / Time:..................................***	***Signature:......................................*** ***Date / Time:..................................***	***Signature:......................................*** ***Date / Time:..................................***
Goal: ***Signature:......................................*** ***Date / Time:..................................***	***Signature:......................................*** ***Date / Time:..................................***	***Signature:......................................*** ***Date / Time:..................................***
Goal: ***Signature:......................................*** ***Date / Time:..................................***	***Signature:......................................*** ***Date / Time:..................................***	***Signature:......................................*** ***Date / Time:..................................***
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Goal: ***Signature:......................................*** ***Date / Time:..................................***	***Signature:......................................*** ***Date / Time:..................................***	***Signature:......................................*** ***Date / Time:..................................***

Name:…… URN no:…….. Date:……

Section 2 Ongoing assessment of the plan of care – LCP DAY……..

Undertake an MDT assessment & review of the current management plan if:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care

and or

Concern expressed regarding management plan from either the patient, relative or team member

and or

It is 3 days since the last **full** MDT assessment

Consider the support of the specialist palliative care team and/or a second opinion as required. Document all reassessment dates and times on page 3

Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)

Record an A or a V not a signature	**0400**	**0800**	**1200**	**1600**	**2000**	**2400**
Goal a: The patient does not have pain Verbalised by patient if conscious, pain free on movement. Observe for non-verbal cues. Consider need for positional change. Use a pain assessment tool if appropriate. Consider prn analgesia for incident pain						
Goal b: The patient is not agitated Patient does not display signs of restlessness or distress, exclude reversible causes e.g. retention of urine, constipation, opioid toxicity						
Goal c: The patient does not have respiratory tract secretions Consider positional change. Discuss symptoms & plan of care with patient, relative or carer Medication to be given as soon as symptom occurs						
Goal d: The patient does not have nausea Verbalised by patient if conscious						
Goal e: The patient is not vomiting						
Goal f: The patient is not breathless Verbalised by patient if conscious, consider positional change. Use of a fan may be helpful						
Goal g: The patient does not have urinary problems Use of pads, urinary catheter as required						
Goal h: The patient does not have bowel problems Monitor – constipation / diarrhoea. Monitor skin integrity Bowels last opened:……						
Goal i: The patient does not have other symptoms Record symptom here……. *If no other symptoms present please record N/A*						
Goal j: The patient's comfort & safety regarding the administration of medication is maintained If Ambulatory syringe driver in place – monitoring sheet in progress. S/C butterfly in place if needed for prn medication location:…… The patient is only receiving medication that is beneficial at this time. *If no medication required please record N/A*						

Name:…… URN no:…….. Date:……

Section 2 Ongoing assessment of the plan of care – LCP continued DAY….						
Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)						
	0400	**0800**	**1200**	**1600**	**2000**	**2400**
Goal k: The patient receives fluids to support their individual needs The patient is supported to take oral fluids / thickened fluids for as long as tolerated. Monitor for signs of aspiration and/or distress. If symptomatically dehydrated & not deemed futile, consider clinically assisted (artificial) hydration if in the patient's best interest. If in place monitor & review rate/volume. Explain the plan of care with the patient and relative or carer						
Goal l: The patient's mouth is moist and clean See mouth care policy. Relative or carer involved in care giving as appropriate. Mouth care tray at the bedside						
Goal m: The patient's skin integrity is maintained Assessment, cleansing, positioning, use of special aids (mattress / bed). The frequency of repositioning should be determined by skin inspection and the patient's individual needs. *Waterlow score :……*						
Goal n: The patient's personal hygiene needs are met Skin care, wash, eye care, change of clothing according to individual needs. Relative or carer involved in care giving as appropriate						
Goal o: The patient receives their care in a physical environment adjusted to support their individual needs Well fitting curtains, screens, clean environment, sufficient space at bedside, consider fragrance, silence, music, light, dark, pictures, photographs, nurse call bell accessible						
Goal p: The patient's psychological well-being is maintained Staff just being at the bedside can be a sign of support and caring. Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. Use of touch if appropriate. Spiritual/religious/cultural needs – consider support of the chaplaincy team						
Goal q: The well-being of the relative or carer attending the patient is maintained Just being at the bedside can be a sign of support and caring. Consider spiritual/religious/cultural needs, expressions may be unfamiliar to the healthcare professional but normal for the relative or carer – support of chaplaincy team may be helpful. Listen & respond to worries/fears. Age appropriate advice & information to support children/adolescents available to parents or carers. Allow the opportunity to reminisce. Offer a drink						
Signature of the person making the assessment						
Signature of the registered nurse per shift	**Night**	**Early**		**Late**		**Night**

Name:…… URN no:…….. Date:……

Section 2 Ongoing assessment of the plan of care – LCP DAY……..

Undertake an MDT assessment & review of the current management plan if:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care

and or

Concern expressed regarding management plan from either the patient, relative or team member

and or

It is 3 days since the last **full** MDT assessment

Consider the support of the specialist palliative care team and/or a second opinion as required. Document all reassessment dates and times on page 3

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Name:…… URN no:…….. Date:……

Section 2 Ongoing assessment of the plan of care – LCP continued DAY….						
Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)						
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Signature of the person making the assessment						
Signature of the registered nurse per shift	**Night**	**Early**		**Late**		**Night**

Name:…… URN no:…….. Date:……

Section 2 Ongoing assessment of the plan of care – LCP DAY……..

Undertake an MDT assessment & review of the current management plan if:

Improved conscious level, functional ability, oral intake, mobility, ability to perform self-care

and or

Concern expressed regarding management plan from either the patient, relative or team member

and or

It is 3 days since the last **full** MDT assessment

Consider the support of the specialist palliative care team and/or a second opinion as required. Document all reassessment dates and times on page 3

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Goal j: The patient's comfort & safety regarding the administration of medication is maintained If Ambulatory syringe driver in place – monitoring sheet in progress. S/C butterfly in place if needed for prn medication location*:……* The patient is only receiving medication that is beneficial at this time. *If no medication required please record N/A*						

Name:…… URN no:…….. Date:……

Section 2 Ongoing assessment of the plan of care – LCP continued DAY….						
Codes to be recorded at each timed assessment (a moment in time) A= Achieved V = Variance (exception reporting)						
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Goal o: The patient receives their care in a physical environment adjusted to support their individual needs Well fitting curtains, screens, clean environment, sufficient space at bedside, consider fragrance, silence, music, light, dark, pictures, photographs, nurse call bell accessible						
Goal p: The patient's psychological well-being is maintained Staff just being at the bedside can be a sign of support and caring. Respectful verbal and non-verbal communication, use of listening skills, information and explanation of care given. Use of touch if appropriate. Spiritual/religious/cultural needs – consider support of the chaplaincy team						
Goal q: The well-being of the relative or carer attending the patient is maintained Just being at the bedside can be a sign of support and caring. Consider spiritual/religious/cultural needs, expressions may be unfamiliar to the healthcare professional but normal for the relative or carer – support of chaplaincy team may be helpful. Listen & respond to worries/fears. Age appropriate advice & information to support children/adolescents available to parents or carers. Allow the opportunity to reminisce. Offer a drink						
Signature of the person making the assessment						
Signature of the registered nurse per shift	**Night**	**Early**		**Late**		**Night**

Name:…… URN no:……..

***Section 2 Ongoing assessment* MDT progress notes**		
Date/time	**Record significant events/conversations/medical review/visit by other specialist teams e.g. palliative care / second opinion if sought**	**Signature**

Name:…… URN no:……..

***Section 2 Ongoing assessment* MDT progress notes**		
Date / time	**Record significant events/conversations/medical review/visit by other specialist teams e.g. palliative care/second opinion if sought**	**Signature**

Name:…… URN no:…….. Date:……

Section 3 Care after death

Verification of death

Time of the patient's death recorded by the healthcare professional in the organisation:……..
Date of patient's death: ……/……./…….
Verified by doctor ☐ Verified by senior nurse ☐ Date / time verified:……
Cause of death……..

Details of healthcare professional who verified death

Name:…… (please print) Signature:…… Bleep No:……..
Comments:……
……..
Persons present at time of death:……..
Relative or carer present at time of death: Yes ☐ No ☐ If not present, have the relative or carer been notified Yes ☐ No ☐
Name of person informed:…… Relationship to the patient:……..
Contact number:……
Is the coroner likely to be involved: Yes ☐ No ☐
Consultant /GP:…… Doctor:…… Bleep No:…… Tel No:……

Patient Care Dignity

Goal 10: last offices are undertaken according to policy and procedure **Achieved ☐ Variance ☐**

The patient is treated with respect and dignity whilst last offices are undertaken
Universal precautions & local policy and procedures including infection risk adhered to
Spiritual, religious, cultural rituals / needs met
Organisational policy followed for the management of ICDs, where appropriate
Organisational policy followed for the management & storage of patient's valuables and belongings

Relative or Carer Information

Goal 11: The relative or carer can express an understanding of what they will need to do next and are given relevant written information **Achieved ☐ Variance ☐**

Conversation with relative or carer explaining the next steps
Grieving leaflet given Yes ☐ No ☐
Information given regarding how and when to contact the bereavement office or support services, funeral director to make an appointment – regarding the death certificate and patient's valuables and belongings where appropriate
Wishes regarding tissue/organ donation discussed
Discuss as appropriate: viewing the body / the need for a post mortem / the need for removal of cardiac devices / the need for a discussion with the coroner
Information given to families on child bereavement services where appropriate – national & local agencies

Organisation Information

Goal 12.1: The primary health care team / GP is notified of the patient's death **Achieved ☐ Variance ☐**

The primary health care team / GP may have known this patient very well and other relatives or carers may be registered with the same GP Telephone or fax the GP practice

Goal 12.2: The patient's death is communicated to appropriate services across the organisation **Achieved ☐ Variance ☐**

e.g. palliative care team / district nursing team / hospice or Others (where appropriate) are informed of the death
The patient's death is entered on the organisation's IT system

Healthcare professional signature:……
Date:…… Time:……

Please record any variance on the variance sheet overleaf

Section 3 Care after death MDT progress notes - record any significant issues not reflected above

Date	

Name:…………………………………………………………… URN no:………………………………………….. Date:…………………………………

Variance analysis sheet for section 2 and 3 of the LCP		
What variance occurred & why? (what was the issue?)	**Action taken (what did you do?)**	**Outcome (did this solve the issue?)**
Goal: ***Signature:……………………………………*** ***Date / Time:…………………………………***	***Signature:……………………………………*** ***Date / Time:…………………………………***	***Signature:……………………………………*** ***Date / Time:…………………………………***
Goal: ***Signature:……………………………………*** ***Date / Time:…………………………………***	***Signature:……………………………………*** ***Date / Time:…………………………………***	***Signature:……………………………………*** ***Date / Time:…………………………………***
Goal: ***Signature:……………………………………*** ***Date / Time:…………………………………***	***Signature:……………………………………*** ***Date / Time:…………………………………***	***Signature:……………………………………*** ***Date / Time:…………………………………***
Goal: ***Signature:……………………………………*** ***Date / Time:…………………………………***	***Signature:……………………………………*** ***Date / Time:…………………………………***	***Signature:……………………………………*** ***Date / Time:…………………………………***
Goal: ***Signature:……………………………………*** ***Date / Time:…………………………………***	***Signature:……………………………………*** ***Date / Time:…………………………………***	***Signature:……………………………………*** ***Date / Time:…………………………………***

Name:………………………………………………………… URN no:…………………………………………. Date:…………………………………

Variance analysis sheet for section 2 and 3 of the LCP		
What variance occurred & why? (what was the issue?)	**Action taken (what did you do?)**	**Outcome (did this solve the issue?)**
Goal: ***Signature:……………………………………*** ***Date / Time:………………………………***	***Signature:……………………………………*** ***Date / Time:………………………………***	***Signature:……………………………………*** ***Date / Time:………………………………***
Goal: ***Signature:……………………………………*** ***Date / Time:………………………………***	***Signature:……………………………………*** ***Date / Time:………………………………***	***Signature:……………………………………*** ***Date / Time:………………………………***
Goal: ***Signature:……………………………………*** ***Date / Time:………………………………***	***Signature:……………………………………*** ***Date / Time:………………………………***	***Signature:……………………………………*** ***Date / Time:………………………………***
Goal: ***Signature:……………………………………*** ***Date / Time:………………………………***	***Signature:……………………………………*** ***Date / Time:………………………………***	***Signature:……………………………………*** ***Date / Time:………………………………***

LCP SUPPORTING INFORMATION

Medication Guidance