Detention Services Order 03/2013

Food and Fluid Refusal in Immigration Removal Centres: Guidance

Preamble

This Order describes the procedures that must be adopted for handling food and fluid refusal by detainees in Immigration Removal Centres. The procedures apply to all Immigration Removal Centres.

It should be read in conjunction with the Department of Health Guidelines for the Clinical Management of People Refusing Food in Immigration Removal Centres and Prisons and the Code of Practice for the Mental Capacity Act 2005. Please see links below:

http://www.justice.gov.uk/protecting-the-vulnerable/mental-capacity-act

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PART A

Introduction

1. Under the Mental Capacity Act 2005 any individual over the age of 18 years has the legal right to refuse food and/or fluid. The Act assumes that a person has mental capacity to make their own decisions to refuse food and/or fluid unless it is established they lack that capacity.

2. Before the doctor provides medical treatment for a detainee who is refusing food and/or fluid, the doctor should ensure that they have the detainee’s consent to do so. For the detainee’s consent to be valid, the person must have the mental capacity to take that particular decision, in line with the Mental Capacity Act 2005 (see Part B). Mental capacity can only be established by a healthcare professional.

3. Seeking consent should usually be seen as a process, not a one-off event. Detainees who have given consent to a particular intervention are entitled to change their minds and withdraw their consent at any point if they still have the mental capacity to do so. Similarly, they can change their minds and consent to an intervention which they have earlier refused. It is important to let each detainee know this, so that they feel able to tell the doctor or other healthcare professional if they change their minds.

4. As long as a detainee retains mental capacity, legally it makes no difference whether detainees sign a form to indicate their consent, or whether they give consent orally or even non-verbally. However, it is important in practice that a written record is made of the detainee’s instructions, regardless of how they give those instructions.

5. Detainees with mental capacity to take a particular decision are entitled to refuse treatment being offered, even if this will clearly be detrimental to their health. Administering medical treatment to a person with full mental capacity, or forcing them to take food and/or fluid against their will, in the absence of consent amounts to common assault.

6. Detainees need to have enough information before they can decide whether to consent to, or refuse treatment. In particular, they need information about:
   - The benefits and the risks of proposed treatment
   - What the treatment will involve
   - What the implications of not having the treatment are
   - What alternatives there may be
   - What the practical effects on their lives of having, or not having, the treatment will be
7. Adults with mental capacity have the right to refuse life-sustaining treatment, both at the time it is offered and by making an “advance decision” (see Part C, paragraph 31) in the future. Where a detainee’s refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it, special care may be necessary to ensure that the prior refusal of consent can still properly be considered as applicable. To be valid, advance decisions must be signed and witnessed. If a detainee is unable to sign their advance decision themselves it may be signed by another person, provided that this takes place in the detainee’s presence and under the detainee’s own direction.

8. If a competent detainee has made an advance decision, whilst they have mental capacity, their views should be monitored to ensure that the advance decision continues to reflect their wishes for their future treatment when they have lost capacity to reach a decision for themselves. A person with mental capacity may withdraw or amend any advance decision that he or she has previously made.

9. Where a detainee refusing food and/or fluids is judged to lack mental capacity, and has not made an advance decision, doctors must consider administering whatever treatment is in the detainee’s best interests.

Status of this Guidance

10. In addition to information about advance decisions and how they should be presented to a detainee who is refusing food and/or fluid, this Order provides guidance about the procedures that should be followed in any case of a detainee refusing food and/or fluids, including case management (see Part D).

11. Where a detainee has made an advance decision, the wishes expressed in the advance decision must be honoured. It is a legal requirement to obtain a patient’s consent to treatment.

12. It must be acknowledged that there may be occasions when, assuming a serious question arises about the mental competence of the detainee, the situation facing the medical team may be so urgent and the consequences so desperate that it is impracticable to attempt to comply with this guidance. In such circumstances, it must be remembered that this note is procedural guidance. Where delay may itself cause serious damage to the patient’s health, or put their life at risk, then formulaic compliance with this guidance would be inappropriate.
PART B

Assessing Capacity

13. The doctor should ensure that they make as objective a judgement as is possible, based on the principle that the person should be assisted to make their own healthcare decision, if at all possible.

14. For a patient to have the requisite mental capacity to refuse medical treatment (including refusal of food and/or fluids), a doctor must be satisfied that the patient is able to:

i) comprehend and retain information about the treatment offered;

ii) believe that information; and

iii) weigh up the information, balancing risks against needs.
PART C

Handling Food and Fluid Refusals

Reporting

15. Immigration Enforcement staff in centres holding detainee(s) refusing food and/or fluid must complete the food and/or fluid refusal escalation log at Annex B each day to notify of all new and continuing food and/or fluid refusers, as well as individuals who have recommenced eating and/or drinking in the previous 24 hours.

16. The completed log must be emailed by 5pm each day to the Deputy Director for Detention Operations, the Assistant Director for Detention Operations and the senior “on call” manager. In the absence of any of these individuals the log must be emailed to their nominated deputy.

General guidelines

17. When a detainee is known to have refused food and/or fluid for over 24 hours they should be offered a routine medical appointment. If the detainee appears unwell, an urgent appointment should be offered on clinical grounds. If the detainee prefers an appointment with a nurse this should be arranged. The purpose of the initial appointment, which is in most cases not an urgent appointment, is to ensure that the detainee:

- Has no undiagnosed mental illness causing the refusal
- Has no physical illness causing the refusal
- Understands the consequence of their action
- Is offered care from any appropriate source
- Has base line weight recorded and is advised of any interference of the food and/or fluid refusals with other medical problems or medication

18. Informed decision-making by the detainee is central to the consent process. The healthcare professional at this initial stage must therefore outline the risks and consequences of refusing food and/or fluids over time. Consideration should be given to obtaining a psychiatrist’s assessment, particularly if there is any uncertainty over the individual’s mental state.

19. If the detainee is found to be physically or mentally unwell at the routine (or urgent) appointment, they will be managed by the healthcare professionals in line with normal practice.

20. Detainees who are refusing food and/or fluid will be fully entitled to confidentiality, to retain responsibility for their own health wherever
possible and their ability to give informed consent will be assessed by appropriately trained healthcare staff.

21. If the healthcare professional considers that the detainee is refusing food and/or fluids as a way of pursuing a grievance, he or she should arrange for the IRC manager or the HO Immigration Enforcement Manager (as appropriate, depending on the nature of the grievance), to speak to the detainee as soon as possible to explain that engaging in a food and/or fluid refusal protest will not necessarily result in their grievance being resolved in the manner the detainee wishes, or will not result in their release from detention.

22. Healthcare appointments are available to food and/or fluid refusers whenever they wish to make one. Such appointments are made in the usual way as any other appointments within the centre.

23. A sample food and/or refusal assessment record is attached at Annex C and healthcare professionals are encouraged to use this standard form.

24. Detainees who are refusing food do not necessarily require to be seen on a daily basis by healthcare staff. However, Immigration Enforcement staff in the IRC will need to be regularly informed of the state of health of a food and/or fluid refuser after food has been refused for more than five days and will require a daily update of the state of health of any detainee who has been refusing food and fluid for more than 24 hours. It is important that Immigration Enforcement staff at the centre maintain a full written record of events and information passed on to them.

25. Food and/or fluid refusers who are clinically assessed as requiring full-time or frequent nursing care should normally be managed in one of the centres with in-patient healthcare facilities. Centres without such facilities are advised to request the transfer of fluid refusers at the 48 hour point and food refusers at the 14 day point, or at an earlier point in either case if such a transfer is considered necessary on clinical grounds, if the individual concerned is clinically assessed to require full-time or frequent nursing care. Transfers should not be sought for individuals who do not require such nursing care, and the expectation is that they should continue to be managed in their current location. Immigration Enforcement staff in the centre should normally follow advice given by centre healthcare teams and, if it is agreed that the detainee should be transferred, contact DEPMU. Form IS91 RA Part C should be completed giving full details of the food and/or fluid refusal so that the most appropriate accommodation can be arranged.

26. On arrival at a centre with in-patient facilities the food and/or fluid refuser will be medically assessed. A detailed medical history and examination is appropriate. If, in the event, they are assessed as not immediately in need of full-time or frequent nursing care they will be managed in the main centre until such time as admission to the centre’s healthcare beds is
clinically indicated. Consideration may, if appropriate, be given to a return to their previous centre.

27. When a food and/or fluid refuser becomes physically unwell as a consequence of their food and/or fluid refusal their health needs will be met by the healthcare staff as far as the food and/or fluid refuser allows.

28. At no time should coercion to eat or drink be applied to a detainee refusing food and/or fluid.

29. Detainees who are refusing food and/or fluid should be encouraged to maintain family contact through telephone calls, letters or emails (where applicable).

30. It is likely to be unlawful to treat a detainee should they lose consciousness if their previous, clearly stated intention was to continue food and/or fluid refusal to death. Please see the following section about advance decisions.

**Advance decisions**

31. A detainee who is currently mentally competent may wish to make an “advance decision”. This enables someone aged 18 and over, while still capable, to refuse specified medical treatment, nutrition or hydration in future when they lack capacity to consent or refuse it. Where a detainee refusing food and/or fluids wishes to make such an advance decision, they may want their own legal adviser to draw it up. This is acceptable. Alternatively, a model version is attached to this Order.

32. To be valid, advance decisions must be signed and witnessed. If the detainee is unable to sign their advance decision themselves it may be signed by another person, provided this takes place in the detainee’s presence and under the detainee’s direction.

33. Detainees are unlikely to be aware of the ability to make an advance decision. As soon as a detainee begins to refuse food and/or fluids, and after a detainee has refused food for five days, they should be made aware of the facility to make an advance decision. It is preferable that both the IRC healthcare professional and the HO Immigration Enforcement Manager are present when the ability to make an advance decision is being explained to the detainee. The purpose of an advance decision should be spelt out to the detainee, as well as the fact that once an advance decision is made, whether written or oral, the detainee has the right to reverse this decision at any time during which they retain mental competence.

34. Case law requires that previously expressed written wishes regarding medical treatment made by a detainee who is not, at the time of the treatment, in a state to express his wishes, shall be taken into account. An
advance decision of this kind is only valid if made voluntarily, by an appropriately informed person, with full capacity. Failure to respect such an advance decision may result in legal action against the practitioner.

35. The decision should be made in writing, signed by the detainee and the healthcare professional determining capacity.

36. Other forms of care, provided they are consistent with the terms of the advance decision, should continue to be provided. Basic or essential care includes keeping the detainee warm, clean and free from distressing symptoms such as breathlessness, vomiting and severe pain. However, some detainees may prefer to tolerate some discomfort if that means they remain more alert and able to respond to family and friends.

37. Medical practitioners must not administer treatment to a food and/or fluid refuser who made a valid advance decision refusing treatment at the time they still had mental capacity and a court declaration is not needed to establish this.

Role of the healthcare professionals

38. Where a competent detainee refusing food and/or fluids is also refusing medical treatment at a time when a doctor judges it is becoming necessary, whether or not an advance refusal of treatment has been made, the doctor must explain the consequences of these refusals to the detainee, in the presence of another healthcare professional. These explanations must include the following information:

- that the deterioration in their health will be allowed to continue without medical intervention unless they request it;

- that continuing food and/or fluid refusal will lead to death. This must include a description of the process of dying in terms of pain, what can be offered to ameliorate those symptoms and the physical effects of refusal of nutrition; and

- that prolonged food and/or fluid refusal which does not result in death may lead to permanent disability and organ damage.

39. It is important that this information is provided in a form that the detainee can understand. This may involve using an interpreter and every effort should be made to obtain the services of an interpreter as soon as possible. Should the detainee wish to use a fellow detainee or member of their family to interpret the doctor’s explanation then this would be acceptable.

40. The doctor must write a full record of what has been said to the detainee, and the doctor, the second healthcare professional and the interpreter, if
Role of the Home Office Immigration Enforcement Manager

41. A detainee who is refusing food and/or fluids may be using this as a way of pursuing a grievance about the way in which their case is being handled, their conditions of detention or other matters.

42. It will be for the HO Immigration Enforcement Manager to establish whether there is a grievance and what this may be. They must ensure that the detainee will be supported in pursuing a grievance through all legitimate channels (e.g., the established complaints process as set out in the relevant Detention Services Order on complaints handling, legal representatives, the centre manager or the relevant Independent Monitoring Board). Detainees using food and/or fluid refusal as a means of protest may be prepared to eat and drink once they have access to an alternative means of pursuing a grievance. The HO Immigration Enforcement Manager will wish to check every couple of days that the detainee’s grievance or concern is being pursued.

43. The HO Immigration Enforcement Manager must explain to the detainee, in the presence of a second Home Office member of staff, that continued food and fluid refusal:

- will not lead to the progress of the detainee’s immigration or asylum case being halted or delayed;
- will not lead to removal directions being deferred;
- will not lead to permission to stay in the UK; and
- will not lead to release from detention.

44. The HO Immigration Enforcement Manager must write a full record of what has been said to the detainee, and both the Manager and the second Home Office member of staff must sign to say that they were both present when this advice was given. This procedure should be repeated periodically to reinforce the message.

45. It is important that this information is provided in a form that the detainee can understand. This may involve using an interpreter and every effort should be made to obtain the services of an interpreter as soon as possible. Should the detainee wish to use a fellow detainee to interpret then this would be acceptable.
PART D

Case Management

46. Some detainees choose to refuse food and/or fluids as a protest against their detention. The law presumes that an adult has the capacity to take their own healthcare decisions unless the opposite is proved. A decision to refuse food and/or fluids will not automatically entitle that individual to be released from detention. Genuine refusal of food and/or fluids can, however, in some cases lead to medical conditions that are so serious that they can no longer be satisfactorily managed in detention. In such a case, the detainee may become unsuitable for detention (although other factors may also be relevant to this decision). It is therefore important that sufficient information is available to enable a decision to be made as to continued detention.

47. This section of the guidance sets out steps to be taken in order to manage cases of actual or claimed food and/or fluid refusal to ensure that the person responsible for reviewing detention has sufficient information available to them. They are also intended to ensure that the detainee is properly informed as to the likely consequences of their actions.

48. The following actions, which are intended to facilitate the safe and satisfactory management within detention of individuals refusing food and/or fluid and any resulting medical conditions, should normally be considered and, if relevant and appropriate, implemented in all cases of food and/or fluid refusal at the 48 hour point for food only refusal and 24 hour point for fluid refusal, unless there are particular reasons in an individual case not to do so. They do not need to be considered or implemented in strict sequence although that may be appropriate. Individual actions may take place in parallel with each other.

Information to detainee

49. As a first step, the HO Immigration Enforcement Manager should inform the detainee, by letter and in person, of the following interventions that are likely to take place in their case. This is in addition to the information provided by the manager to detainees about the practical consequences of their action (ie that it will not lead to a different decision on their case, deferral of removal, permission to stay in the UK, or release from detention), and the advice provided by healthcare professionals on the medical consequences of food and/or fluid refusal.

Encouragement to resume eating and/or drinking

50. Whilst detainees must not be coerced into resuming eating and/or drinking, it is entirely appropriate for them to be actively encouraged to do so (provided this is not inconsistent with medical advice). Such encouragement should take the form of ensuring that detainees are fully
aware of both the practical and medical consequences of their action (as indicated above), but should also include more positive encouragement, such as ensuring that attractive food is made readily available.

**Expedite case**

51. All instances of food and/or fluid refusal that have reached the 48 hour (food only) or 24 hour (fluid) point must be escalated by Immigration Enforcement staff at the centre to senior managers in Detention Operations and in the business areas responsible for the cases of the individuals concerned for information and for case management review using the food and/or fluid refusal escalation log at Annex B. Managers should identify whether there are actions that can be taken or extra resources deployed that may bring forward a conclusion to the individual’s case, including expedited removal from the UK. They should also consult Country Returns, Operations and Strategy (CROS) in any cases where documentation or similar issues are presenting a barrier to removal, and liaise with appeals and litigation team to see if any action can be taken to expedite cases with outstanding legal barriers.

**Close observation and monitoring**

52. An Assessment Care in Detention and Teamwork (ACDT) plan must be opened when an individual has been identified as refusing food for a period of 48 hours, or refusing fluid for a period of 24 hours, or has claimed to have done so. The plan must include a requirement for all staff coming into contact with, or observing the detainee, to note whether there is any evidence or indication of food and/or fluid being consumed (from whatever source); and to note any behaviour or activity by the detainee which might be relevant in assessing their general well-being.

53. Consideration should be given to placing the detainee on frequent or constant watch to aid this process. The HO Immigration Enforcement Manager may require this of the centre operator, or agree to a request from the operator. Where circumstances at the centre permit, the detainee may additionally or instead be re-located to accommodation within the centre that would be better suited to support closer observation and monitoring. Again, this will be at the direction or with the agreement of the HO Immigration Enforcement Manager.

54. All relevant information gathered as a result of this close observation and monitoring must be recorded and must be included in the daily food and/or fluid refusal log submitted to HO Immigration Enforcement. Relevant information could include but is not limited to:

- food and/or fluid taken
- shop purchases
- physical activity undertaken.
Clarify medical assessment

55. Where the IRC doctor has given an opinion that a detainee is no longer fit to be removed and/or no longer fit to be detained as a consequence of their food and/or fluid refusal, the doctor should be asked by the HO Immigration Enforcement Manager for details, if they have not been provided or are unclear, of the basis on which this assessment has been made. In particular, the doctor should be asked whether the assessment is based on:

- physical examinations or tests and, if so, their results and the conclusions drawn from them; or
- limited or visual observations only and, if so, the information obtained and conclusions drawn; or
- the detainee’s own account or information alone.

56. This will ensure that the doctor’s opinion can be given due weight in deciding how to proceed, particularly when balanced against other evidence or information that may exist (eg that the detainee is in fact eating and/or drinking, even if only covertly or infrequently, or that their generally observed demeanour or behaviour does not support the doctor’s assessment). Use by healthcare professionals of the sample food and/or fluid refusal assessment record attached to this guidance will assist this process.

57. This is not about challenging the doctor’s professional opinion on medical grounds. It is simply to ensure that the basis for that opinion is clear and is understood by HO Immigration Enforcement so that it can be given due weight in deciding how best to manage the detainee. Whilst it is important for doctors to express their professional view as to whether a detainee is unfit to be removed or detained as a consequence of prolonged food and/or fluid refusal, and such views must be considered very carefully, the Secretary of State has an independent decision to make in such cases, specifically, is the individual concerned suffering from a serious medical condition (ie the consequences of prolonged food and/or fluid refusal) which cannot be managed satisfactorily in detention and, if so, are there nevertheless very exceptional reasons for maintaining detention (eg high risk of public harm if released)?

Additional medical advice

58. In all cases where an IRC doctor has assessed that a detainee is no longer fit to be removed or detained as a consequence of food and/or fluid refusal, consideration may be given to seeking a second clinical opinion from a doctor with more experience of assessing or managing food and/or fluid refusal cases in custodial settings (eg a doctor from another IRC or a prison doctor). Again, this is not about challenging an IRC doctor’s
assessment or competence.

59. A review and further assessment by a second doctor may be arranged by HO Immigration Enforcement in any case where the reasons for the IRC doctor's assessment are unclear, or it is based on limited or no examination or observations; where there is other evidence or information available that tends not to support the doctor's assessment; or in any other case where it is considered appropriate. Where a second doctor is asked by HO Immigration Enforcement to attend, in order to review the case and/or carry out a further assessment, the visiting doctor should do so in consultation with the IRC doctor as the treating physician.

Transfer to prison medical facility

60. Consideration may be given to transferring detainees to a prison medical facility at the point where they are clinically assessed to require in-patient care. Such a transfer may be appropriate or necessary for clinical reasons in order to access the more extensive medical facilities available in the prison estate and to ensure the better care and management of the individual in question. The decision to arrange such a transfer must be taken by the Director of Returns or the Deputy Director, Head of Detention Operations, with advice from the IRC doctor, and must be agreed with NOMS Population Management Unit.

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Operational Policy and Rules Unit
Home Office
May 2013
Annex A

Model Advance Decision

<table>
<thead>
<tr>
<th>PORT REF.</th>
<th>DC REF.</th>
<th>HO REF.</th>
</tr>
</thead>
</table>

I, [name] currently detained at [ ], Immigration Removal Centre, wish to state the following:

1. [I do not intend to eat]*.

2. [I do not intend to drink or otherwise receive fluids]*.

3. I do not wish to receive any medical treatment.

4. I do not consent to the administration of nutrition or hydration or any form of medical treatment whether resuscitation or otherwise designed to keep me alive, in the event that there is a deterioration in my condition:
   - [unless there is a loss in consciousness]* [and/or in the event of a loss of consciousness]*
   - [unless I sustain any injury to my person howsoever caused]* [and/or in the event that I sustain any injury to my person howsoever caused]*.

5. I do/do not* consent to any medical or nursing care designed to keep me comfortable and free from pain in the event of serious deterioration in my condition. [If there is consent to some care, give details of any particular care that is offered and accepted by the detainee].

6. It has been explained to me that if I refuse treatment in this manner, that my medical condition could deteriorate, that I could be in a great deal of pain, that I could lose consciousness and that I could die as a result of the refusal to consent to treatment.

7. I have read and had the contents of this directive read over to me [in [language], a language I understand] and I fully understand its contents and its effects.

8. I have been advised to take legal advice from an independent legal adviser on the contents and effect of this Advance Decision. I have carefully reflected on the terms of this Advance Decision and have been advised to discuss its terms with my next of kin before signing it.

9. I am aware that I can change my mind and revoke this Advance Decision at any time if I remain capable of making decisions about my medical treatment.

Signed ........................................Date..............................

Date of Birth ....................................
<table>
<thead>
<tr>
<th>Witness A</th>
<th>Witness B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Signature:</td>
<td>Signature:</td>
</tr>
<tr>
<td>Address:</td>
<td>Address:</td>
</tr>
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Ideally one of the two witnesses should be the healthcare professional determining capacity

* Delete as appropriate
Sample food/fluid refusal assessment record

Annex C

To be completed by a GP

<table>
<thead>
<tr>
<th>Name of Resident</th>
<th>CID Reference</th>
<th>Date of Birth</th>
<th>Male*/ Female*</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Assessment</th>
<th>Cardiac History Yes*/No*</th>
<th>Renal History Yes*/No*</th>
<th>Respiratory History Yes*/No*</th>
<th>Circulatory History Yes*/No*</th>
<th>Gastrointestinal History Yes*/No*</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Current Medication:</th>
<th>[ ………………………………………………………………………. ]</th>
</tr>
</thead>
</table>

The medication named above has*/ has not* been taken throughout the food refusal

<table>
<thead>
<tr>
<th>Date of last Menstrual Period</th>
<th>Normal*/ Abnormal* bleed</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Current Weight</th>
<th>Current BMI</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Weight at onset of food refusal</th>
<th>Date weight recorded</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Weight loss</th>
<th>Percentage weight loss</th>
</tr>
</thead>
</table>

Comment:
BP today ………………….. Heart Rate………………….bpm

Temperature ……………………………

Respiratory Rate ……………./min Random BM …………………..mmol/l

ECG Performed today: Normal*/ Abnormal*

Urine diptest result……………………………………………………………………………….

Venous Bloods taken today:

<table>
<thead>
<tr>
<th>Test</th>
<th>Tick if bloods taken</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>U&amp;E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calcium</td>
<td></td>
<td></td>
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<tr>
<td>Glucose</td>
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<td></td>
</tr>
<tr>
<td>FBC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phosphate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Circumference of upper arm: Left …………….. Right ……………

Gait Normal*/ Other*…………………………………………………………………………

General appearance: Apathy* / Disorientated*/ Normal*/ Other*…………………

Speech: Normal*/ Slurred*/ Other* ……………………………………………………

Eyes moist Yes* / No*

Eye movement disorder Yes* / No* (E.g. Nystagmus)………………………………

Mouth: Buccal Mucosa examination Normal* (Pink and moist)/ Pale* / Ulcerated*/

Other* ………………………………………………………………………………………

Skin Turgor : Normal*/ Dehydrated*/ Other* …………………………………

Any open wounds? Yes* / No*

Oedema to the extremities Yes* / No* (If yes, state where)……………………

Hair: Brittle* / Normal*/ Other*…………………………………………………………

Nails: Brittle*/ Ridged*/ Clubbed*/ Normal*/ Other*………………………………
Chest auscultated: Normal*/ Other.................................................................

Abdomen examined Soft and non-tender*/ Tender*/ Guarding*/ Hard*/ Other*....... 
......................................................................................................................

(*Delete as appropriate)

Further Notes from the examination:

Assessment taken by:

Name .......................................................................................................................

Signature ..............................................................................................................

Status..................................................................................................................

Date.......................................................................................................................