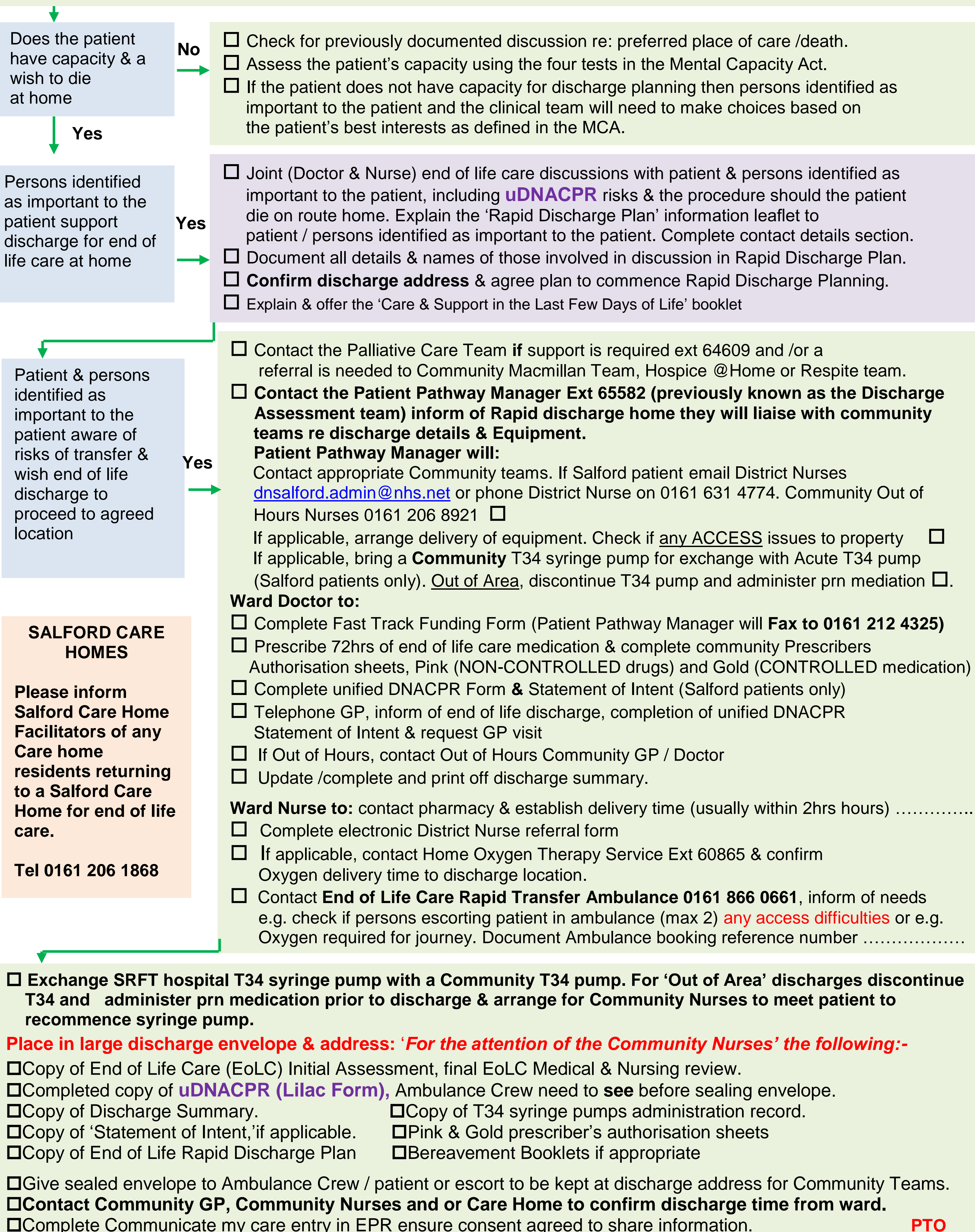
Last Days of Life Rapid Discharge Staff Guide: Hospital to Home

The rapid discharge of a patient from hospital to home requires sensitive discussions with the patient and persons identified as important to the patient regarding the risks at this uncertain time. With the patient's consent care discussions should be clearly documented in the Rapid Discharge Plan and Communicate my Care document in EPR,

The aim of this algorithm is to facilitate a safe, smooth and seamless transition of care from hospital to community for a patient who has expressed a wish to die at home. This algorithm should be used in conjunction with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards and National Guidance, End of Life Quality Standards **(**NICE 2011).



Does the patient have capacity & a wish to die at home

No →

- ☐ Check for previously documented discussion re: preferred place of care /death.
- ☐ Assess the patient's capacity using the four tests in the Mental Capacity Act.
- ☐ If the patient does not have capacity for discharge planning then persons identified as important to the patient and the clinical team will need to make choices based on the patient's best interests as defined in the MCA.

Yes ↓

Persons identified as important to the patient support discharge for end of life care at home

Yes →

- ☐ Joint (Doctor & Nurse) end of life care discussions with patient & persons identified as important to the patient, including **uDNACPR** risks & the procedure should the patient die on route home. Explain the 'Rapid Discharge Plan' information leaflet to patient / persons identified as important to the patient. Complete contact details section.
- ☐ Document all details & names of those involved in discussion in Rapid Discharge Plan.
- ☐ **Confirm discharge address** & agree plan to commence Rapid Discharge Planning.
- ☐ Explain & offer the 'Care & Support in the Last Few Days of Life' booklet

Patient & persons identified as important to the patient aware of risks of transfer & wish end of life discharge to proceed to agreed location

Yes →

- ☐ Contact the Palliative Care Team **if** support is required ext 64609 and /or a referral is needed to Community Macmillan Team, Hospice @Home or Respite team.
- ☐ **Contact the Patient Pathway Manager Ext 65582 (previously known as the Discharge Assessment team) inform of Rapid discharge home they will liaise with community teams re discharge details & Equipment.**

Patient Pathway Manager will:
Contact appropriate Community teams. If Salford patient email District Nurses dnsalford.admin@nhs.net or phone District Nurse on 0161 631 4774. Community Out of Hours Nurses 0161 206 8921 ☐
If applicable, arrange delivery of equipment. Check if any ACCESS issues to property ☐
If applicable, bring a **Community** T34 syringe pump for exchange with Acute T34 pump (Salford patients only). Out of Area, discontinue T34 pump and administer prn mediation ☐.

Ward Doctor to:

- ☐ Complete Fast Track Funding Form (Patient Pathway Manager will **Fax to 0161 212 4325)**
- ☐ Prescribe 72hrs of end of life care medication & complete community Prescribers Authorisation sheets, Pink (NON-CONTROLLED drugs) and Gold (CONTROLLED medication)
- ☐ Complete unified DNACPR Form **&** Statement of Intent (Salford patients only)
- ☐ Telephone GP, inform of end of life discharge, completion of unified DNACPR Statement of Intent & request GP visit
- ☐ If Out of Hours, contact Out of Hours Community GP / Doctor
- ☐ Update /complete and print off discharge summary.

Ward Nurse to: contact pharmacy & establish delivery time (usually within 2hrs hours) …………..

- ☐ Complete electronic District Nurse referral form
- ☐ If applicable, contact Home Oxygen Therapy Service Ext 60865 & confirm Oxygen delivery time to discharge location.
- ☐ Contact **End of Life Care Rapid Transfer Ambulance 0161 866 0661**, inform of needs e.g. check if persons escorting patient in ambulance (max 2) any access difficulties or e.g. Oxygen required for journey. Document Ambulance booking reference number ………………

SALFORD CARE HOMES

Please inform Salford Care Home Facilitators of any Care home residents returning to a Salford Care Home for end of life care.

Tel 0161 206 1868

☐ **Exchange SRFT hospital T34 syringe pump with a Community T34 pump. For 'Out of Area' discharges discontinue T34 and administer prn medication prior to discharge & arrange for Community Nurses to meet patient to recommence syringe pump.**

Place in large discharge envelope & address: '*For the attention of the Community Nurses' the following:-*

- ☐Copy of End of Life Care (EoLC) Initial Assessment, final EoLC Medical & Nursing review.
- ☐Completed copy of **uDNACPR (Lilac Form),** Ambulance Crew need to **see** before sealing envelope.
- ☐Copy of Discharge Summary.
- ☐Copy of 'Statement of Intent,'if applicable.
- ☐Copy of End of Life Rapid Discharge Plan
- ☐Copy of T34 syringe pumps administration record.
- ☐Pink & Gold prescriber's authorisation sheets
- ☐Bereavement Booklets if appropriate

- ☐Give sealed envelope to Ambulance Crew / patient or escort to be kept at discharge address for Community Teams.
- ☐**Contact Community GP, Community Nurses and or Care Home to confirm discharge time from ward.**
- ☐Complete Communicate my care entry in EPR ensure consent agreed to share information.

PTO

Useful Information:

Rapid Discharge Plan - Risks

Risks that need to be explained to the patient & persons identified as important to the patient:-

- a patient thought to be dying may live longer than expected.
- a patient may deteriorate and die sooner than expected.
- a patient's condition may change suddenly and a planned discharge may be unable to go ahead.
- a patient's condition changes suddenly and they may die during the journey home .

If this happens the ambulance crew will confirm that the patient has died and either transfer the patient directly to the mortuary at Salford Royal Hospital or continue the journey home providing a * 'Statement of Intent' is in place. This should be discussed and agreed with the ward team and the ambulance staff before discharge from the ward. Care and understanding for both the patient and persons identified as important to the patient is a priority at this complex and uncertain time.

Fast Track Form for NHS Continuing Health Funding

The Patient Pathway Manager (PPM) will bring a Fast Track Funding Form to the ward for the ward doctor to complete. The PPM will fax on completion.
This form is used where an appropriate Clinician considers that a person should be fast tracked for NHS Continuing Healthcare because that person has a rapidly deteriorating condition and the condition may be entering a terminal phase.
The person may need NHS Continuing Healthcare Funding to enable their needs to be urgently met (e.g. to enable them to go home to die or to provide appropriate end of life support to be put in place either in their own home or in a care home setting).
Community Nurses will support the patient and persons identified as important to the patient and may provide up to four visits a day, presently there is not a 24hr Community Nurse Service.

* 'Statement of Intent' (SoI) for use in hospital (for patients with a registered Salford GP)

The aim of completing a 'Statement of Intent' is to prevent the unnecessary attendance of the Police in circumstances where a death has been anticipated but occurs at a time when the patient's regular GP has not seen the patient in the last 14 days or is not immediately available to issue a Medical Certificate of Cause of Death (MCCD).
If a SRFT Doctor completes a 'Statement of Intent' they are declaring that they will be available as a Medical Practitioner to issue a Medical Certificate of Cause of Death until **5pm the next working day**.
A 'Statement of Intent' form is available on the Palliative Care intranet page or by contacting the Palliative Care Team on ext 64609 who will e-mail a copy of the form to you.
Statement of Intent (SoI) to be completed and saved and e-mailed (NHS secure sites only) or faxed as appropriate to:-

- Patient's GP surgery
- Salford Out of Hours GP service gp.ooh@nhs.net
- Salford Out of Hours Evening Nurse Service evening.service@nhs.net
- North West Ambulance Service nwasnt.eolgmm@nhs.net

Print a copy for the Community Nurse, place in large discharge envelope with other documentation marked:- **'For the Attention of Community Nurse'**

unified DNA-CPR (Unified Do Not Attempt Cardiopulmonary Resuscitation)
SRFT have introduced a document that facilitates a seamless transition between primary and hospital/secondary care. Enabling a patient's 'ceiling of care' document to be valid both in the community and in the hospital setting. This should enhance communication and decision-making with patients (unless deemed harmful to the patient) and persons identified as important to the patient. Lilac copy stays with patient. One white copy stays with patient notes. Final white copy sent to the Palliative Care team for audit purposes.

Hospice transfers: Remember to check with the hospice the latest time for patient's admission (Usually 13.00hrs) as a delay in transfer could prevent a Hospice admission on the day. Ensure urgency of hospice admission relayed to
End of Life Care Rapid Transfer Ambulance 0161 866 0661.

Rapid Discharge SALFORD Community FEEDACK form

Patient hospital number……………………….. Date…………………………………

The palliative care team would value your feedback on this Rapid discharge home to enable SRFT staff to continually improve end of life care discharges.

Was the patient symptom controlled on arrival at the discharge address? YES ☐ NO ☐

If 'NO' please state the reason for this

Were all 4 End of life medications available to you? YES ☐ NO ☐

If 'NO' please state the reason for this

Did the patient arrive at the discharge address within the time frame? YES ☐ NO ☐

If 'NO' please state the reason for this

Was the patient seen by the GP on the day of discharge? YES ☐ NO ☐

If 'NO' please state the reason for this

Copy of End of Life Care (EoLC) Initial Assessment	YES	NO	N/A
Final EoLC medical review & final EoLC nursing review	YES	NO	N/A
Completed uDNACPR (Lilac Form)	YES	NO	N/A
Discharge Summary	YES	NO	N/A
T34 syringe pump administration record	YES	NO	N/A
Statement of Intent	YES	NO	N/A
Rapid Discharge Care Plan	YES	NO	N/A
Bereavement Booklets	YES	NO	N/A
Rapid discharge leaflet with persons identified as important to the patient	YES	NO	N/A

Please document any other concerns, issues, reflections over the page, place completed feedback form in addressed envelope and return via internal mail.

Reflect and record what happened

What are the issues relevant to this significant event?

Record what was Positive

What was negative?

What needs were identified?

Appreciative thanks for your time and support