Brighton and Sussex University Hospitals NHS Trust

Affix label
Name: D.O.B: NHS Number: Trust ID:

Rapid discharge pathway for a patient going to a CARE HOME with nursing for end of life care

Criteria for use

Patient is recognised to be in the last days or short weeks of life
The patient wishes to die in a care home
The family / carers support the patient's preference
This document is to be used in addition to purple discharge planning booklet
Keep the patient and relatives up to date with plans and document any progress or changes
If discharge is cancelled, all stakeholders must be updated and planned visits cancelled

All Patients: ☐ Refer urgently to discharge coordinator and social worker
☐ Refer to BSUH palliative care team (Ext. 3021)

Professionals involved in arranging rapid discharge

Name	Professional role	Initials	Signature

V3 approved by Health Records Sept–2014

Any information sent by fax must be followed up with a phone call to ensure it has been received by the appropriate person / team.

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Rapid discharge pathway tasks

Ward doctors
(For additional guidance see Palliative Care Team web page on Info-Net)

- Order **continuous** oxygen using HOOF if required ☐
- Establish GP (as may be different for care home) then **telephone** - inform of discharge for end of life care, request visit within 24 hours of discharge ☐
- Complete TTOs for injectable medication* ☐
- Complete the Instructions for the use of Injectable Medicines chart ☐
- Ensure there is a **valid** DNACPR form (active RED copy goes with patient) ☐
- Fax OOH, DNACPR and Instructions for Injectable Medicines chart to GP for Care Home ☐
- Fax OOH to numbers on top of form - if NOT Brighton and Hove, seek advice from palliative care team ☐

Discharge Co-ordinators

- Complete NHS funded CHC Fast track application ☐
- Confirm eligible for NHS CHC funding ☐
- Confirm care home chosen ☐
- Confirm care home have equipment and skills to provide end of life care ☐
- Confirm NHS CHC funding agreed ☐
- Clarify which GP provides covers for care home residents and that patient will be registered there by care home ready for discharge ☐

OOH = palliative care out of hours handover form

POC=Package of care

Please tick box ☐ initial and date each task as completed
e.g. JM 10/6/11 ☑

Palliative Care Team

- Refer to community palliative care team if required ☐

*Palliative care team can advise on appropriate medication and completion of Instructions for Injectable Medicines chart.
Additional information on RDP web page.

Ward Nursing Team

- Inform pharmacist of need for injectable medication TTOs and priority for dispensing ☐
- Book ambulance ☐
- Fax OOH, DNACPR and Instructions for Injectable Medicines chart to care home ☐

On day of discharge, ward nurses

- Ensure doctor has reviewed patient and deemed fit for transfer within 2 hours of discharge (if any change in clinical state, request further assessment) ☐
- Ensure syringe driver (if being used) is recharged prior to discharge and cover box is **unlocked** ☐
- Ensure TTOs and **original** Instructions for Injectable Medicines chart go with patient ☐
- Ensure **ACTIVE RED DNACPR** form goes with patient ☐
- Telephone care home **before** patient leaves ward to confirm agreed discharge to them ☐
- After discharge, call GP, care home and family to confirm patient has left the ward ☐

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