Brighton and Sussex University Hospitals NHS Trust

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

Rapid discharge pathway for a patient going HOME for end of life care

(also applies to residential care home)

Criteria for use

Patient is recognised to be in the last days or short weeks of life
The patient wishes to die at 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, OT and social worker
- ☐ Refer to BSUH palliative care team (Ext. 3021)

Professionals involved in arranging rapid discharge

Name	Professional role	Initials	Signature

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File in : Miscellaneous

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 ☐
- **Telephone** GP - inform of discharge for end of life care, request home visit with in 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 Injection Medicines chart to GP ☐
- Fax OOH to numbers on top of form - if NOT Brighton and Hove, seek advice from palliative care team ☐

Please tick box ☐ initial and date each task as completed

e.g. JM 10/6/11 ☑

Discharge Co-ordinators

- Complete NHS funded CHC Fast track application ☐
- Confirm eligible for NHS CHC funding ☐
- Confirm NHS CHC funding agreed ☐
- Confirm POC arrangements ☐
- Confirm any equipment required is in place ☐
- Complete contact info. sheet for patient / family including plans for POC first visits ☐

Palliative Care Team

- Refer to community palliative care team if required ☐
- Refer to hospice at home if required ☐

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

OOH = palliative care out of hours handover form

POC=Package of care

Ward Nursing Team

- Inform pharmacist of need for injectable medication TTOs and priority for dispensing ☐
- Request pharmacist complete MEDICATION RECORD CARD for patient ☐
- Refer to District nurses and request night sitting if appropriate ☐
- Book ambulance ☐
- Fax copy of DNACPR, OOH and Instructions for Injectable medicines chart to DNs ☐

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 go with patient ☐
- Ensure **Active Red DNACPR** form goes with patient ☐
- Ensure contact information sheet goes with patient ☐
- After discharge, call GP, DN and family to confirm patient has left the ward ☐

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Rapid discharge pathway contact information sheet

To be completed by discharge coordinator and/or ward nurses and given to patient/family at discharge

Address for discharge:

Patient telephone number:

Nominated NOK (and relationship):

NOK address:

NOK telephone number:

Agency (not all will be applicable)	**Location**	**Contact number**
GP		
Out of hours GP		
District nurses		
Out of hours district nurses		
Hospice at home (If in place)		
Community Palliative Care Team		
Care agency		
Planned care and district nurse visits		

Once completed, please leave a copy in the health records with other discharge planning documents

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