East Cheshire NHS Trust

End of Life Care Discharge

(For patients in the last days of life)

The aim of this care plan is to facilitate a safe and timely discharge home for the patient expressing a wish to die in a place of their choice.

Patient Name_____ **NHS Number**_____

Consultant_____ **Named Nurse** _____

Ward_____ **Telephone Number of Ward/Unit**_____

Date of commencement_____ **Time of commencement** _____**(use 24hr clock)**

Actual date of discharge _____ **Actual time of discharge** _____

GP_____ **GP Practice**_____

If the discharge was not successfully completed;
Date and time that the discharge was discontinued _____

(N:B Please ensure relevant persons/professionals are notified that the pathway has now been discontinued)

Reason for discontinuation:

_____

Initiators of Discharge	Name_____Role_____Signature_____ Doctors Name_____ Bleep_____Signature_____

For further information/support with End of Life Care Discharge please contact

In hours advice / support:	**Out of Hours advice / support:**
Macmillan Nurses ext 3177 **Lung Macmillan Nurse ext 1997** **Patient Journey Team ext 1459 bleep 3524** **Hospital Matrons** **Macmillan Pharmacists ext 1183 bleep 5138 or 3514.**	**Bed Manager bleep 3011** **Night Sister bleep 7203 / 3011** **Site Manager bleep 7203** **East Cheshire Hospice 24/7 Advice Line 01625 666999**

PATIENT NAME_____**NHS NUMBER**_____

ALL PERSONNEL COMPLETING THE PLAN PLEASE SIGN BELOW

Name (Print)	Full Signature	Initials	Professional Title	Date

PATIENT NAME_____**NHS NUMBER**_____

End of Life Care Checklist – DR TO COMPLETE			
Diagnosis	…… ……		
For discharge to take place the following 5 criteria's must be met	**1. The Multidisciplinary Team have agreed that the patient is in the last days of life** **Are the patient & their family/carers aware of this?**	**YES** **YES**	**Initials**
	2. Has the patient expressed a wish to die at home & are the family supportive of this? *Please circle:* **HOME HOSPICE NURSING HOME RESIDENTIAL HOME** *Other (please specify)_* _____	**YES**	**Initials**
	3. Does the MDT support the need for the patient to be discharged for end of life care? **Is there documented evidence within both the nursing & medical notes which support the discharge of this patient?**	**YES** **YES**	**Initials**
	4. Does the patient/family/carer support and understand the discharge plan? **Has any written information been given to the patient/family/carer** *Please state*_____	**YES** **YES**	**Initials**
	5. Is the NWAS DNA-CPR form completed?	**YES**	**Initials**
Specialist Palliative Care	**Is the patient already known to the Macmillan Specialist Palliative Care Team or any other Specialist Nursing/Community Matron Team?** *Please state* _____ _____ **Is a referral to the Macmillan Specialist Palliative Care Team required?** *Please state* _____ _____	**YES NO** **YES NO**	**Initials**
PROPOSED DATE OF DISCHARGE_____			
Dr's Name _____**Signature**_____ **Designation**_____**Date**_____**Time**_____			

PATIENT NAME_____**NHS NUMBER**_____

End of Life Care Checklist – NURSE TO COMPLETE **Please refer to guidance for further information**			
Communication with the patient	**Is the patient able to take part in active communication?** *Please circle* **YES NO UNCONSCIOUS** **Is the patient aware that they are dying?** *Please circle* **YES NO UNCONSCIOUS** **Additional Comments** …… …… …… ……		**Initials**
Communication with family/main carer	**Is the discharge address and date confirmed with family/carer?** **Name/phone number**…… Relationship to patient…… *Comments*…… …… …… ……	**YES NO**	**Initials**
Community Referrals	**District nurses contacted via telephone and informed of discharge plans?** *Comments*_____ _____ **Has a District Nurse referral form been completed?** *Comments*_____ _____ **Out of Hours District nurses contacted and informed of discharge plans?** *Comments*_____ _____ **Patients G.P. contacted and informed of discharge plans?** *Comments*_____ _____ **Out of Hours G.P's contacted and informed of discharge?** *Comments*_____ _____ **Chaplaincy team contacted via switchboard to arrange a community visit?** *Comments*_____ _	**YES NO** **YES NO** **YES NO** **YES NO** **YES NO** **YES NO**	**Initials**

PATIENT NAME_____**NHS NUMBER**_____

Care	**Does the family/carer need any additional support?** **If YES please refer to appropriate services such as Crossroads** *Comments*_____ _____ **Has CHC funding been applied for?** *Outcome*_____ _____ **Has a care package been arranged?** **Date of first visit:**……**Contact Details**:……__ **Additional comments**…… …… …… _____ **Does the family/carer understand the level of required care?** *Leaflet given/Comments*_____ _____	**YES NO** **YES NO** **YES NO** **YES NO** **YES NO**	**Initials**
End of Life Medications	**If required involve a Macmillan Pharmacist for support with end of life prescribing & use of blue booklet ext: 1183, Bleep 5138 or 3514** **Have all medications been reviewed and unnecessary medications discontinued?** **Has the community drug administration record (blue booklet) been completed and the anticipatory drugs prescribed and dispensed?** **If syringe driver in use, what time does the syringe driver require to be changed?** **Additional medication comments**…… …… …… ……	**YES NO N/A** **YES NO N/A** _____	
Equipment	**Does the patient have all of the equipment they need for the last few days of life at home?** *(Please note minimal equipment may be acceptable in the last few days of life if it enables that patient to be care for in the place of their choice, providing the discharge remains safe)* **Is an OT and/or Physiotherapy assessment required?** **List of equipment ordered**…… …… …… **Ward** please supply for 5 days *(please circle)* **Catheter supplies Continence pads Dressings Stoma bags** **Other**_____ _____	**YES NO N/A** **YES NO N/A** **YES NO N/A**	**Initial**

PATIENT NAME_____**NHS NUMBER**_____

Transport	**Have North West Ambulance (0151 261 4322) been contacted and informed of the need for an ambulance for a patient to be discharged from hospital for end of life care?** **Booking Number**……..**Time of booking**……. **Property accessible for a stretcher transfer?** **Are there stairs?** ***Please highlight any issues when booking the transfer*** *Comments*…… …… …… **Do any of the family wish to escort the patient in the ambulance and if so are transport aware of this/ can they accommodate this?** *Comments*…… ……	**YES NO** **YES NO** **YES NO** **YES NO**	**Initial**

Please ensure this completed document is sent to the following:

District Nurse **Faxed to……. Signed…….**

Out of Hours DN's **Faxed to……. Signed…….**

Patients G.P. **Faxed to……. Signed…….**

Out of Hours G.P. **Faxed to……. Signed…….**

Specialist Nurse **Faxed to……. Signed……..**

PATIENT NAME_____**NHS NUMBER**_____

PLEASE COMPLETE ON DAY OF DISCHARGE

		Initial
Discharge medications obtained and given to patient or carer?	**YES NO NA**	
End of Life Care Discharge Plan photocopied and sent with patient	**YES NO NA**	
Consider administration of PRN medication prior to the transfer of the patient to minimize discomfort. If given: Drug_____ Dose_____ Time_____	**YES NO NA**	
Community DNA-CPR form to accompany patient. File copy in hospital medical notes and inform GP, DN and community care providers of DNA-CPR via ERISS	**YES NO NA**	
Contact family/main carer when ambulance arrives on ward	**YES NO NA**	

Date / Time of discharge……

Signature of discharging Healthcare Professional…….

Additional Comments (please sign)

PLEASE COPY THIS COMPLETED PATHWAY AND FILE IN PATIENTS NOTES, SEND ORIGINAL HOME WITH PATIENT.

PATIENT NAME_____**NHS NUMBER**_____

Useful Phone Numbers

- NWAS – 0151 261 4322 Remember to state that patient is for rapid discharge home/hospice to die
- Cheshire East Crossroads - 01260 292850
  help@crossroadsce.org.uk
- Specialist Palliative Care Team ext 3177
- Macmillan Pharmacy team ext 1183
  bleep 5138 or bleep 3514
- Out of Hours GP can be contacted via switchboard – 0
- Evening and Night service District Nurses Tel: 01625 430906 Fax: 01625 661827
- Acute End of Life Facilitator – 01625 666996 (external)
- East Cheshire Hospice 24 hour advice Line – 01625 666999