Royal Cornwall Hospitals
NHS Trust

Transfers and Discharges in the Last Few Weeks of Life Clinical Guideline

V3.1

July 2024

1. Aim/Purpose of this Guideline

1.1. This guideline applies to all RCHT staff involved in transfer of care, or discharge of patients approaching End of Life. With regard to this guideline 'End of Life' is confined to patients with a prognosis of days, weeks, or short months.

1.2. The aim is to ensure a well understood well communicated and safe transfer of care.

1.3. All record keeping or sharing of information relating to the care of any particular patient at End of Life is subject to RCHT Information Use Framework Policy. The Framework is compliant with the Data Protection Act (2018)

1.4. **Introduction**

1.4.1. Achieving rapid discharge to a patient's preferred place of care at End of Life is identified as a priority action within the RCHT End of Life strategy. Preferred place of care and death is a national metric, being a proxy marker for quality in End-of-Life care (National End of Life Care Intelligence Network). This is supported by the 'One chance to get it right' document (Leadership Alliance for the Care of Dying People 2014) where the emphasis is upon individualized care planning in collaboration with the patient or proxy decision maker. NICE Quality Standard 144 (NICE QS144 2017) quality statement 2 makes explicit reference to identification of the 'preferred care setting as part of the individualized care planning process. This guideline is to support the process of discharging or transferring a patient approaching End of Life to a destination which accords with the patient preferences for End-of-Life care. This will have been identified as part of the care planning process with full collaboration and communication with the patient or their representative.

1.4.2. The guideline is in line with the RCHT adult discharge and Transfer Policy and the SAFER patient flow bundle.

1.4.3. Where a patient who is approaching End of Life requires transfer or discharge to an alternate Preferred Place of Care, all efforts should be made to fulfill this within a 24-hour timeframe.

1.4.4. For patients, whose prognosis is measured in hours to short days every effort should be made to achieve discharge within 12 hours

1.4.5. When transfer or discharge is to a non-healthcare setting there will be an obligation for the provision of the appropriate equipment, services, and medication.

1.5. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1. **Transfer of patients between Acute Trust hospitals to a Community Hospital:**

2.1.1. The patient is recognized as approaching End of Life by the Consultant overseeing the patient's management in consultation with the multi-disciplinary team. This opinion is communicated sensitively and honestly to the patient and their family.

2.1.2. Discussion should take place between the clinical team and the patient and family to establish the preferred place for End-of-Life Care.

2.1.3. A patient who is imminently approaching End of Life will be eligible for transfer to a community hospital if they are considered to have a prognosis of <2 weeks.

2.1.4. A STRATA should be completed and uploaded. This is located on the Discharge and patient flow shelf on the Intranet.

2.1.5. To take out (TTO) anticipatory prescribing should include medication to treat all of the common symptoms at End of Life should be prescribed. This should accompany the patient on discharge. This needs to be completed both by EPMA and on community prescription chart (CHA 2809). There should be a sufficient supply of injectable medication to cover 7 days and include water for injection. This should be in line with the current Cornwall and Isles of Scilly Anticipatory Prescribing Guidance (APG) (see appendix 1, or via Sister's shelf under the End-of-Life tab). For patients with established symptoms prescribing should reflect the individual patient's current medication regime.

2.1.6. If the patient has a syringe driver in situ or is transferring with anticipatory injectable medications, the Prescription sheet for Subcutaneous Syringe Driver and Injectable Drugs (CHA 2809) **must** accompany the patient. Without this prescription future administration will not be possible.

2.1.7. If the patient is to be discharged with a syringe driver a 'Record Sheet for Issuing Device outside RCHT form (MD11) should be completed. This form should be emailed to the Medical Equipment Library rch-tr.MedicalEquipmentLibrary@nhs.net and a copy should accompany patient home.

2.1.8. For patients undertaking an End-of-Life discharge and requiring medication via another route, a community prescription sheet (CHA 1525) may also be required i.e., patients requiring continuation of a Fentanyl patch or patients still using occasional doses of prn Oromorph.

2.1.9. For patients requiring palliative oxygen therapy a Hoof form will require completion: https://www.airliquidehomehealth.co.uk/hcp/hoofa

2.1.10. The Treatment Escalation Plan (TEP) should be reviewed and updated in concordance with the RCHT TEP policy. This must accompany the patient during ambulance transit to their destination.

2.1.11. In line with the RCHT Adult Discharge and Transfer Policy and the SAFER patient flow bundle the aim should be for patient discharge to take place as early in the day as possible.

2.1.12. Transport should be booked online via the desktop application 'Medical Patient Transport.' The request should specify 'End of Life transfer with escort' if a significant other will be travelling with the patient.

2.1.13. Discharge documentation should clearly document the patient's management plan in relation to End of Life Care. The medical notes should travel with the patients to enable seamless continuity of care. If death is expected in the next few days the 'Caring for patient's at the end of life' care plan (CHA3739) should be discussed, agreed with the patient/family, and incorporated into the patient notes

2.1.14. A Special Palliative Patient note should be completed electronically identifying the patient as an End-of-Life Care transfer, alongside any additional significant information. This should be completed electronically and emailed to: kernowhealthcic.patientnotes@nhs.net

2.1.15. A pre-notified death form should be completed electronically by a member of the medical team that has been caring for the patient. **The doctor completing the form should be able to assist with the certification of death in the rare occurrence that this should this be necessary. This requires the Doctor completing the form to be available for up to 5 days post the patient's discharge**. A copy of this form should be completed electronically and emailed to the patient's GP and kernowhealthcic.patientnotes@nhs.net

2.1.16. Telephone handover should be undertaken by the RCHT ward nurse with the nurse who will be responsible for the patient's care following transfer, including any information essential to the patient's ongoing care.

2.1.17. Telephone handover should be undertaken by the RCHT ward Doctor and the Doctor who will be responsible for the patients care following transfer, including any information essential to the patient's ongoing care.

2.1.18. For advice, the RCHT Specialist Palliative and End of Life Care Team can be contacted for via switchboard on bleep 3055 (usual working hours 8am – 4pm daily). Out of hours Specialist Palliative Care advice can be obtained via the Palliative Advice Line for healthcare professionals on (01736 757707). This advice will not cover the transfer or discharge process itself but is available for advice on symptom control issue.

2.1.19. If the patient is known to the community Specialist Palliative Care team (CPCT) or to a Community Matron or alternate specialist nurse a contact should be initiated via the Bodmin switchboard (1300) to inform them of discharge/transfer.

2.1.20. If the patient requires a new referral to the CPCT electronic ref forms are available on the End-of-Life care shelf which can be accessed via the clinical shelf on the Intranet.

2.1.21. **A medical review should take place within 2 hours prior** to transfer to identify a deterioration in the patient's condition that puts patient at greater risk of death in transit. If this has occurred, this should be communicated to patient and family to check if they still wish the transfer to go ahead. The contents and results of this communication should be clearly recorded in the nursing and/or medical notes.

NB. In regard to information/equipment/medication there may be different/lesser requirements for community Hospital sites, for example West Cornwall Hospital. Where there is doubt, please clarify with the Nurse in charge at the receiving location.

2.2. **Discharge of patients between Acute Trust hospitals to home or Nursing home:**

2.2.1. Where a patient is returning home, and appropriate package of care should be agreed with the patient/family.

2.2.2. An Occupational Therapy (OT) assessment should be completed. The Occupational therapy team will arrange the supply and delivery of equipment. If the Specialist Palliative Care OT is not available, please contact the Occupational Therapy department for advice on ext. 3725.

2.2.3. An End-of-Life care application form should be completed. This is situated on the End-of-Life care shelf on the intranet. The completed form should be emailed to: lat.mcsw.cornwall@nhs.net
Guidance in completing the document is available on the End-of-Life shelf.

2.2.4. Marie Curie will update the ward once a suitable package of care is available.

2.2.5. For patients requiring a nursing home placement Marie Curie will email the ward team detailing the nursing home availability in the patient's preferred area. The ward team will discuss the options with the patient and family to establish their preference and will liaise directly with the home to establish costings. The ward team return the EOL care application form to Marie Curie detailing the preferred place of care and costings for agreement (see flow chart).

2.2.6. To take out (TTO) anticipatory prescribing should include medication to treat all of the common symptoms at End of Life should be prescribed. This should accompany the patient on discharge. This needs to be completed both by EPMA and on community prescription chart (CHA 2809). There should be a sufficient supply of injectable medication to cover 7 days and include water for injection. This should be in line with the current Cornwall and Isles of Scilly Anticipatory Prescribing Guidance (APG) (see appendix 1, or via Sister's shelf under the End-of-Life tab). For patients with established symptoms prescribing should reflect the individual patient's current medication regime.

2.2.7. If the patient is on a syringe driver or is transferring with injectable medications the Prescription sheet for Subcutaneous Syringe Driver and Injectable Drugs (CHA 2809) **must** accompany the patient. Without this prescription drug administration will not be possible.

2.2.8. If the patient is to be discharged with a syringe driver a 'Record Sheet for Issuing Device outside RCHT form (MD11) should be completed. This form should be emailed to Medical Equipment Library rch-tr.MedicalEquipmentLibrary@nhs.and a copy should accompany patient home.

2.2.9. For patients undertaking an End-of-Life discharge and requiring medication via another route a community prescription sheet (CHA 1525) may also be required i.e., those patients' requiring continuation of a Fentanyl patch or patients still using occasional doses of prn Oromorph.

2.2.10. For patients requiring palliative oxygen therapy a Hoof form will require completion: https://www.airliquidehomehealth.co.uk/hcp/HOOF

2.2.11. The Treatment Escalation Plan (TEP) should be reviewed and updated in concordance with the RCHT TEP policy. This must accompany the patient during ambulance transit to their destination.

2.2.12. In line with the RCHT adult discharge and Transfer Policy and the SAFER patient flow bundle the aim should be for patient discharge to take place as early in the day as possible.

2.2.13. Transport should be booked online via the desktop application 'Medical patient transport'. The request should specify 'End of Life transfer with escort' if a significant other will be travelling with the patient.

2.2.14. Discharge documentation should clearly document the patient's management plan in relation to End of Life Care. This may include any Advance Care Plan, Living Will, Advance Directive, Advance Decision to Refuse Treatment or Preferred Priorities of Care document if these have been previously agreed.

2.2.15. A Special Palliative Patient note should be completed electronically identifying the patient as returning home for End-of-Life Care alongside any additional significant information. This should be completed electronically and emailed to: kernowhealthcic.patientnotes@nhs.net

2.2.16. A pre-notified death form should be completed electronically by a member of the medical team that has been caring for the patient. **The doctor completing the form should be able to assist with the certification of death in the rare occurrence that this should this be necessary. This requires the Doctor completing the form to be available for up to 5 days post the patient's discharge**. The form should be completed electronically and emailed to kernowhealthcic.patientnotes@NHS.NET and to the GP.

2.2.17. Ward Nurse to District Nursing Service handover should take place on the day of discharge informing the community nursing service of the patient's management plan.

2.2.18. Ward doctor to General Practitioner (GP) telephone handover should take place prior to transfer. **The patient's General Practitioner must be made aware that this is an End-of-Life discharge and that a home visit will be required in order to support certification of death.**

2.2.19. For advice, the RCHT Specialist Palliative and End of Life Care Team can be contacted for via switchboard on bleep 3055 (usual working hours 8am – 4pm daily). Out of hours Specialist Palliative Care advice can be obtained via the Palliative Advice Line for healthcare professionals on (01736 757707). This advice will not cover the transfer or discharge process itself but is available for advice on symptom control issue

2.2.20. If the patient is known to the community palliative care team (CPCT) or to a Community Matron or alternate specialist nurse, contact them via Bodmin switchboard (1300) to inform them of transfer.

2.2.21. If the patient requires a new referral to the CPCT electronic referral forms are available on the End-of-Life shelf.

2.2.22. **A medical review should take place within 2 hours prior** to transfer to identify a deterioration in the patient's condition that puts patient at greater risk of death in transit. If this has occurred, this should be communicated to patient and family to check if they still wish the transfer to go ahead. The contents and results of this communication should be clearly recorded in the nursing and/or medical notes.

2.2.23. The patient/family should be supplied with form RCHT 1686 ‘’Out of hours treatment for patients with palliative care needs. This will ensure that symptom relief can be administered safely out of hours.

2.2.24. In the exceptional circumstances that a patient dies in a community setting prior to a review from a primary care physician, **an eligible doctor who has previously participated in the patients care within the 28 days prior to death may be released to undertake the certification of death.**

2.3. **Discharge of patients between Acute Trust hospitals to Hospice:**

2.3.1. The patient is recognized as approaching End of Life by the Consultant overseeing the patient’s management in consultation with the multi-disciplinary team. This opinion is communicated sensitively and honestly to the patient and their family.

2.3.2. Discussion should occur between the clinical team and the patient and family to establish the preferred place for End-of-Life Care.

2.3.3. For patients requesting a hospice placement for End-of-Life Care and assessment will need to be undertaken by the RCHT SPC team. A referral can be made via Maxims or for urgent advice the team can be Contacted via switchboard on bleep 3055 (usual working hours 8am – 4pm daily). Out of hours Specialist Palliative Care advice can be obtained via the Specialist Palliative Advice Line for healthcare professionals on (01736 757707).

2.3.4. To take out (TTO) anticipatory prescribing should include medication to treat all of the common symptoms at End of Life should. This should accompany the patient on discharge. This needs to be completed both by EPMA and on community prescription chart (CHA 2809). There should be a sufficient supply of injectable medication to cover 7 days and include water for injection. This should be in line with the current Cornwall and Isles of Scilly Anticipatory Prescribing Guidance (APG) (see appendix 1, or via Sister’s shelf under the End-of-Life tab). For patients with established symptoms prescribing should reflect the individual patient’s current medication regime.

2.3.5. If the patient has a syringe driver in situ or is transferring with anticipatory injectable medications, the Prescription sheet for Subcutaneous Syringe Driver and Injectable Drugs (CHA 2809 V4) **MUST** accompany the patient. Without this prescription future administration will not be possible.

2.3.6. If the patient is to be discharged with a syringe driver a ‘Record Sheet for Issuing Device outside RCHT form (MD11) should be completed. This form should be emailed to Medical Equipment Library rch-tr.MedicalEquipmentLibrary@nhs.net and should accompany patient home.

2.3.7. The Treatment Escalation Plan (TEP) should be reviewed and updated in concordance with the RCHT TEP policy. This must accompany the patient during ambulance transit to their destination.

2.3.8. In line with the RCHT adult discharge and Transfer Policy and the SAFER patient flow bundle the aim should be for patient discharge to take place as early in the day as possible.

2.3.9. Transport should be booked online via the desktop application 'Medical patient transport'. The request should specify 'End of Life transfer with escort' if a significant other will be travelling with the patient.

2.3.10. Discharge documentation should clearly document the patient's management plan in relation to End of Life Care. The medical notes should travel with the patients to enable seamless continuity of care. If death is expected in the next few days the 'Caring for patient's at the end of life' care plan (CHA3739) should be discussed, agreed with the patient/family, and incorporated into the patient notes.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Transfer and discharge guidance
Lead	Specialist End of Life Lead Practitioners
Tool	The DATIX incident and complaints system will be monitored for items relating to End-of-Life transfers and discharge
Frequency	Via Datix reporting
Reporting arrangements	Datix will be reported bi-monthly to the RCHT End of Life Care Group
Acting on recommendations and Lead(s)	The RCHT End of Life Care Group reports to the Trust Management Committee (Governance) Group
Change in practice and lessons to be shared	Via the RCHT End of Life Care Group

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity and Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Transfers and Discharges in the Last Few Weeks of Life Clinical Guideline V3.1
This document replaces (exact title of previous version):	Transfers and Discharges in the Last Few Weeks of Life Clinical Guideline V3.0
Date Issued/Approved:	17 July 2024
Date Valid From:	July 2024
Date Valid To:	June 2025
Directorate / Department responsible (author/owner):	Sue Adams, Specialist End of Life Lead Practitioner
Contact details:	01872 254969
Brief summary of contents:	Guidelines for the transfer and discharge of patients felt to be in the last few weeks of life
Suggested Keywords:	Discharge; Transfer of Care; Last Few Weeks of Life, End of Life Care
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Dual Chief Nursing Officer / Deputy CEO RCHT
Approval route for consultation and ratification:	RCHT End of Life Care Group
General Manager confirming approval processes:	Deputy Director of Nursing, Midwifery and AHPs
Name of Governance Lead confirming approval by specialty and care group management meetings:	Deputy Director of Director of Nursing, Midwifery and AHPs
Links to key external standards:	NICE Quality Standard 144 (NICE QS144 2017)
Related Documents:	Leadership Alliance for the Care of Dying People: One Chance to Get it Right
Training Need Identified?	No

Information Category	Detailed Information
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Palliative and End of Life Care

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
Not known	V1.0	Initial Issue	Dr Rachel Newman, Palliative Care Consultant and RCHT End of Life Care Lead
01 July 2014	V2.0	Full rewrite.	Dr Rachel Newman, Palliative Care Consultant and RCHT End of Life Care Lead
16 August 2018	V3.0	Reformatted and major updates made to contact details and documentation numbers	Sue Adams/Liz Thomas, SPEOL Lead Practitioners
June 2024	V3.1	Reformatted and minor updates to process.	Sue Adams, Specialist End of Life Lead Practitioner

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance, please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Transfers and Discharges in the Last Few Weeks of Life Clinical Guideline V3.1
Directorate and service area:	Palliative and End of Life Care
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Sue Adams and Liz Thomas, Specialist End of Life Lead Practitioners
Contact details:	01872 254969

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	Its aim is to ensure safe discharge/transfer of care.
2. Policy Objectives	To ensure a well understood, well communicated discharge.
3. Policy Intended Outcomes	Planned, Co-ordinated, communicated, and safe discharge.
4. How will you measure each outcome?	Monitored by RCHT End of Life Care Group.
5. Who is intended to benefit from the policy?	Residents of Cornwall and Isles of Scilly being discharged from RCHT services.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** End of Life Care Group
6c. What was the outcome of the consultation?	Guidelines approved
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No.

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	

Protected Characteristic	(Yes or No)	Rationale
Marriage and civil partnership	No	
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

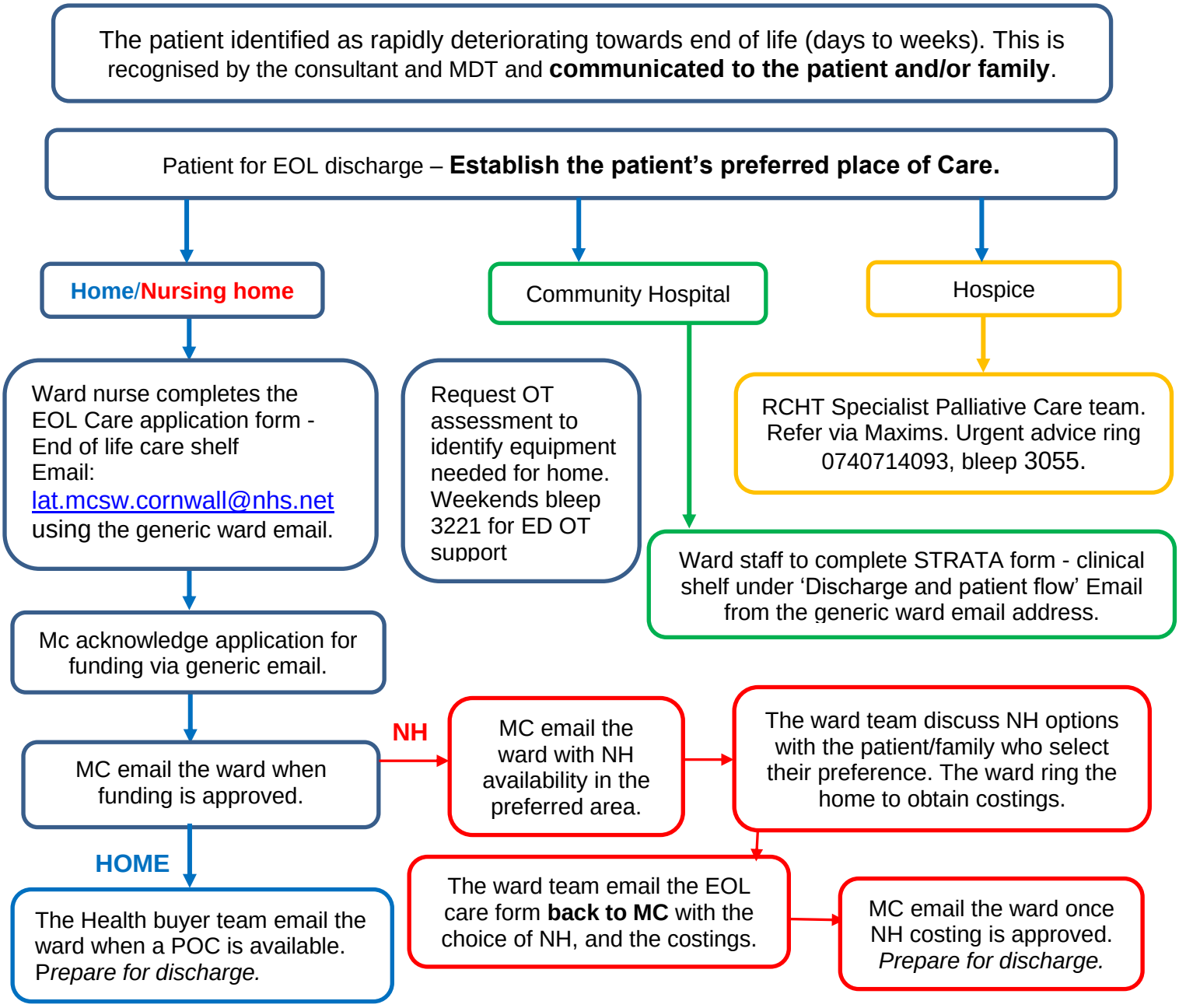
A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Sue Adams and Liz Thomas, Specialist End of Life Lead Practitioners.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. End of Life Discharge



- When planning care, it is essential to speak directly to any supporting family.
- Sensitively and realistically identify what support families may be able to offer, ensuring that they fully understand the patients current and anticipated care needs.
- Any referrals from personal work email addresses should copy in the band 6/7
- Update Marie Curie where the patient is deteriorating more rapidly
- When planning for discharge ensure the minimum required care package is selected to avoid delay.
- Where time is short some families may choose to support a patient at home whilst awaiting a POC. In these instances, comfort packs and small equipment items may be available. Bleep occupational therapies on 3221.
- For urgent advice regarding the progress of an End-of-life discharge ring 01209 700862.

End of life discharge

- ☐ Ensure any STRATA/EOL care application and OT assessment is complete.
- ☐ Book ambulance- 'End of Life discharge, not for resuscitation', with escort if indicated.
- ☐ For patient's requiring palliative oxygen therapy complete HOOF**

Medical actions

- ☐ Short prognosis- Ward doctor to ring GP to handover and request visit.
- ☐ **Update TEP** (to travel with the patient).
- ☐ Expected death form* to GP and OOHs.
- ☐ Special Patient Note* to GP and OOHs.
- ☐ Use prescription sheet CHA2809 for anticipatory prescribing of EOL drugs (paper chart to pharmacy).
- ☐ Use form CHA1525 for any other medication i.e. oromorph.
- ☐ E-discharge summary/care plan.

Nursing actions

- ☐ If a syringe driver is in situ, ensure this will not need renewing OOHs. Complete MD11 form and email to: rch-tr.MedicalEquipmentLibrary@nhs.net
- ☐ Ensure medication and prescription sheet travel with the patient.
- ☐ Check any equipment has been delivered and any POC is due to start.
- ☐ Nurse to District nurse/care home staff verbal handover.
- ☐ 'Out-of-hours treatment for patients with palliative care needs' leaflet to patient/family (RCHT1686- documents library).

The patient should have a medical review <2hrs prior to discharge to ensure that the patient is safe to transfer. For patients at risk of death in transit discuss with the patient/ family Patients/families may still choose to transfer if this was the patient's wish.

- Ensure 7 days' supply of injectable medication is prescribed according to local anticipatory prescribing guidance or in accordance with the patient's current regime (see End of Life Transfers and discharges Pharmacy recommendations on the EOLC shelf).
- Medication must travel with patients discharged to home, nursing home, hospice, or community hospital setting.
- Hoof - https://www.airliquidehomehealth.co.uk/hcp/hoofa (link on EOL shelf).
- *Expected death form and special patient note are located on the EOL care shelf. Email these to kernowhealthcic.patientnotes@NHS.NET and to the GP.
- The Expected death form must be completed by a doctor who will be available to certify the patient within 5 days if required.
- Please ring the specialist palliative care team if advice is required to support a complex discharge X 8346 or bleep 3055.

Appendix 4. List of Contacts

Onward Care Team: Ext 3869, rcht.onwardcare@nhs.net

SWAST: 0300 369 0130

Hospital Specialist Palliative and End of Life Care Team: Bleep 3055.

Bodmin Switchboard: 1300 (for District Nursing, Specialist Palliative Care and Community Matron services).

Specialist Palliative care OT: Bleep 2122.

Occupational Therapy: 01872 25 Ext.3725.

Cornwall Hospice Care Specialist Palliative Care Advice Line: 01736 757707.

Equipment Library: rch-tr.MedicalEquipmentLibrary@nhs.net

Out of Hours GP Service: 01872 224050, kernowhealthcic.patientnotes@nhs.net

Mount Edgcumbe Hospice: 01726 65711; Fax: 01726 66421.

St. Julia's Hospice: 01736 759070; Fax 01736 759567.

Appendix 5. Document CHA numbers and Document names if no CHA number known (and where to source them)

Patient Inter Healthcare Transfer / Discharge Information Form- **CHA 2702.**

Prescription sheet for subcutaneous syringe driver and injectable drugs - **CHA2809 V2.**

NHS Continuing Healthcare Fast Track Tool Form – **Sister's Shelf, End of Life tab.**

Record of Medication for Community Nurses- **CHA1525.**

MD 11 Form: Record Sheet for Issuing Medical Device for use outside RCHT– **Sister's Shelf, End of Life tab.**

Pre-Notified Death Form- **Sister's Shelf, End of Life tab.**

Special Patient Note- **Sister's Shelf, End of Life tab.**

Community Palliative Referral Form- **Sister's Shelf, End of Life tab.**