1. **Aim/Purpose of this Guideline**
   1.1. This policy applies to all RCHT staff involved in transfer of care / discharge of end of life care patients. With regard to this policy, ‘End of Life’ confined to patients with a prognosis of a few weeks or less.
   1.2. The aim is to ensure a well understood well communicated and safe transfer of care.

2. **The Guidance**
   2.1. **Introduction**
      2.1.1. Where a patient has been identified as likely to die within the next few days, to a few weeks maximum, and the patient and/or family have expressed a desire for end of life care to take place at home or in another health or social care setting different from whichever Acute Trust hospital they are presently within, all efforts should be made to fulfill this wish in a timely fashion and within 24 hours of the request if at all possible.
      2.1.2. To achieve this will necessitate negotiation of any care arrangements when transfer or discharge is to a non-healthcare setting and may also involve the provision of equipment, medication, or other provisions such as home oxygen therapy.

2.2. **Transfer of patients in the last few weeks of life between Acute Trust hospitals or from an Acute Trust to a Community Hospital requires the following steps as a minimum to be taken**
   2.2.1. An eBICA should be e-mailed via MAXIMS to Onward Care Team (OWCT) (and/or faxed x2658). There is a Registered Nurse (RN) on duty for the OWCT during the day at weekends, and there is an Early Intervention Service (EIS) Nurse who is contactable and on duty over weekends (name and contact details available via the District Nurse on duty, contactable via Bodmin Switchboard x1300). The PATIENT INTER HEALTH CARE TRANSFER/DISCHARGE INFORMATION FORM must also be completed and e-mailed or faxed marked URGENT to x2658 (OWCT), and must also accompany the patient to their destination. Order from Design and Publications CHA 2702.
2.2.2. Medical and/or nursing staff must ensure that the patient and/or family are aware of any possible risk of death during transfer. In this context, the patient transferred should not be accompanied by other patients in a shared ambulance, and a member of the family should be enabled to accompany the patient in the ambulance during transfer should they so wish.

2.2.3. A nursing and/or medical review should take place not more than 2 hours before the patient is moved, to check whether there has been a change in condition that puts patient at greater risk of death in transit. If this has occurred, further conversation with patient and family should occur 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.

2.2.4. There must be a specific assessment as to the level of ambulance staff qualification required to support the patient during transfer. This should be undertaken by the Registered Nurse, and an online request for ambulance transport should be completed +/- discussed with Patient Transport Services on x3274. The request should specify patient to travel alone and provision be made for someone to accompany if they wish. If discharge to a community hospital, the Registered Nurse must undertake a telephone ward to ward handover prior to the discharge occurring.

2.2.5. The appropriate steps on the RCHT DISCHARGE/TRANSFER CHECKLIST FOR PATIENT IN THE LAST FEW WEEKS OF LIFE must be completed. See Appendix 2.

2.2.6. The Hospital Palliative Care Team can be contacted for specialist advice on Ext. 8346 or 8347 or on Bleep 3055 for urgent palliative care team contact in working hours. Out of working hours, Specialist Palliative Care advice can be obtained via the SPC Advice Line 01736 757707, but face- to-face review and assessment may not be available. This advice will NOT cover the transfer or discharge process itself, but may include e.g. symptom control.

2.2.7. If transfer is to a Community Hospital, any Community Palliative Care Nurse or Community Matron having input to that hospital or the individual patient must be contacted. Referral forms for Community Palliative Care should be available on wards (updated March 2014), or are available via e-mail to Communitypalliative.Referral@pch-cic.nhs.uk

2.2.8. If death is expected in the next few days, an Individual Care Plan should be discussed, agreed and documented before transfer, and all documentation kept up to date to time of transfer. A copy of any agreed Care Plan should accompany the patient to their next place of care. A telephone handover of the main components of the Care Plan should take place to the Nurse in Charge at a Community Hospital Ward or Care Home, and/or to the GP and District Nursing service if patient being discharged home.

2.2.9. A copy of resuscitation documents (presently the Allow Natural Death – AND – document) which will be valid in transit within the ambulance and at destination of transfer, should accompany the patient. The RCHT AND document is valid Cornwall healthcare wide, and can be
ordered (CHA 2311 v2), but should be available on all RCHT inpatient wards.

2.2.10. Discharge medication for a minimum of 5 days (recommended 1 week) must accompany the patient to their destination, which MUST include an appropriate supply of injectable ‘as required’ medications for end of life care as recommended within the Prescribing Guidelines (Appendix 2 of RCHT End of Life Care Strategy on the Document Library), or as decided by medical team caring for patient, or using community agreed medication as below.

2.2.11. If the patient is on a syringe driver a valid community syringe driver prescription form (CHA2809 V2) MUST accompany the patient when discharged to home, Community Hospital or Care Home (i.e. not necessary if discharged to St. Julia’s Hospice Hayle, or Mount Edgecumbe Hospice St. Austell). District nurses will not be able to change a syringe driver without this document available.

2.2.12. In order to ensure continuity between community (e.g. Peninsula Community Health) and Acute Hospital Trusts the as required medications should include the following drugs UNLESS the patient has been prescribed alternative drugs by a member of the Hospital Palliative Care Team or the Ward based Medical team responsible for the patient’s care:

- Levomepromazine for nausea and vomiting
- Diamorphine for pain relief or shortness of breath
- Midazolam for restlessness and agitation or shortness of breath
- Hyoscine hydrobromide for respiratory tract secretions

If the patient is in renal failure Prescribing Guidelines as in 2.2.12 should be referred to.

2.3. Discharge for care in the last few weeks of life to patient’s home, Nursing Home or Residential Home:

2.3.1. This process differs between acute hospital sites due to availability of personnel on site. Processes for WCH differ from RCH and are highlighted in the text below.

2.3.2. When DISCHARGE in the last few weeks of life is to the patient’s home, Nursing Home or Residential Home is requested, the steps described on page 4 AND ADDITIONAL STEPS AS BELOW must be followed.

2.3.3. FIRST ACTION: eBICA must be e-mailed via MAXIMs to the Onward Care Team (OWCT) (phone x 2659, Fax x 2658). A member of the OWCT will be sent to complete appropriate NHS Continuing Healthcare assessment paperwork and will then arrange package of care either directly through liaison with care agencies, or via the District Nursing service where applicable.

WCH: Ward Discharge Nurse to complete the JACS and NHS Continuing Healthcare Assessment document, CHA 2844 and fax to Continuing Care Team on 01209 886621 (Tel: 01209 886600 for any advice). Ward Discharge Nurse to phone agencies to arrange Package of Care (POC), or liaise with Care Homes regarding admission.
2.3.4. An Occupational Therapy (OT) assessment should take place, performed by the Oncology and Specialist Palliative Care OT if available, accessed via Bleep 2122, requesting an 'End of Life Discharge / Transfer Urgent OT Assessment'. The OT will then be responsible for arranging appropriate delivery of equipment to serve the patients’ needs at home or in a care home setting.
If the Oncology and Specialist Palliative Care OT is on leave, a request for urgent assessment can be left as a voicemail message on x3725 (Rehab Team)

WCH: Contact Ward OT for assessment. They will arrange equipment assessment and delivery from Bodmin Loan Stores. If WCH OT on leave, ask advice from RCH Oncology and Specialist Palliative Care OT Nancy Squire or Gill Longworth, Bleep 2122 as above.

2.3.5. The patient’s General Practitioner must be made aware of the discharge plan and that the patient is likely to die in a very short time. The purpose of this is to ensure that the General Practitioner or a colleague is able to provide a death certificate (which requires that the GP has seen the patient in the previous 2 weeks).

WCH: the same.

2.3.6. If discharge to patient’s own home, the locality District Nursing Service must be informed of the details of the patient’s discharge, including if the patient is to be discharged with a syringe driver in situ. The appropriate multicoloured syringe driver prescription form (CHA2809 V2), plus yellow record forms, and white syringe driver checklist form, must accompany any patient discharged on a syringe driver. A 'Record Sheet for Issuing Device for use outside RCHT' must also accompany the patient home: Form MD11- Can be printed off from Intranet > A-Z Services > M > Medical Physics RCHT > CEMS > Contacts & Documents> Forms to use on loan of equipment to patient: 1) MD11 End-users form (also to be used when device is sent to any other location other than RCHT)

This form should be faxed to Equipment Library (x2909), and a copy should accompany patient home. There is an ‘End of Life Discharge and/or Transfer Resource folder on every inpatient adult ward in RCHT with copies of these forms. Please do not remove the final or MASTER copy from this resource file – photo copy or print off from Intranet as above.

WCH: the same.

2.3.7. If a need for Marie Curie (Tel: 08450567899) night sitting at patient’s home is identified, this can be arranged via Onward Care Team Clinical Nurse Specialist (CNS) for Adult Discharge, Hospital Palliative Care Team CNS or District Nurse (e.g. out of hours via Bodmin Switchboard x1300) If discharged out of hours, the on呼叫 District Nurse, Community Matron or Community Palliative Care Nurse MAY be able to arrange.

WCH: The Discharge Nurses at WCH (and OWCT CNS nurses) can also arrange night sitters through the Health Brokerage Carer’s Break night sitting
service subject to Continuing Health Care funding agreement. Again they may be able to arrange out of hours via District Nurse or Community Palliative Care Nurse.

2.3.8. If discharge to a Nursing or Residential Home the Registered Nurse must undertake a telephone handover from ward to Nursing or Residential Home Manager/Nurse in charge prior to the discharge occurring.

WCH the same.

2.3.9. The relevant out of hours service, (Serco Health or other future provider), must be notified of discharge, usually by fax/phone. A ‘Pre-notified Death’ form and/or a ‘Cornwall Palliative Care Out of Hours Handover form / Special Patient Note’ must be completed by an appropriate doctor within the Acute Trust and returned by fax to Serco or other provider. These forms can be found within the End of Life Transfer / Discharge Resource folder as above, or obtained from Serco Health via numbers below. A copy of these forms should be faxed to the patient’s GP, Community Palliative Care Nurse, District Nursing Service and SWAST in addition to returning to Serco. The purpose of this is to make sure all services aware that death is expected, triggering attempts to find a doctor who can certify, rather than have police and/or Coroner involved thinking a ‘sudden death’ has occurred. In case no doctor in the community able to provide a certificate because has not seen patient recently, information on this form should include contact details of a hospital doctor who could legally supply such documentation (allowed by RCHT in recognition this would be a rare occurrence). If it is felt likely that care at home might not be successful and that hospice admission might be sought, or Specialist Palliative Care Advice be sought by health professionals in the Community, then the same forms can also be faxed to the appropriate hospice via fax numbers below

- Serco Health Telephone number: 01872226703
- Speed dial Ext. 4463 FAX: 01872275688
- Community Palliative Care Service Telephone via Bodmin Switchboard x1300 Fax:01872 246948
- SWAST Fax: FAO Features Department; 01392 360199
- GP fax – contact relevant GP surgery / practice
- Relevant District Nursing Fax available via the patient’s GP practice / Bodmin Switchboard x1300
- St. Julia’s Hospice Hayle: Fax 01736 759567;
- Mount Edgecumbe Hospice St. Austell: Fax 01726 71504

WCH the same

2.3.10. A referral to a Community Palliative Care Nurse should take place via a faxed referral form, marked URGENT, which is available on all wards and in Resource Folder, but may be supplemented by a telephone call from the ward or from the Hospital Palliative Care Team if involved. To contact Community Palliative Care Team by telephone from RCHT, phone x1300 (Bodmin switchboard), and leave a message for the relevant Community Palliative Care nurse to phone you back (which nurse determined by GP surgery), or ask for the
Palliative Care nurse on-call over weekends to phone back. The Community Palliative Care fax referral form can also be faxed to other numbers as above for further information, but this not essential.

WCH the same.

2.3.11. If the patient has a Community Matron he/she must also be informed by the registered nurse of the details of the patient’s discharge (Contact via x1300, Bodmin Switchboard).

WCH the same.

2.3.12. If there is a wish to obtain advice from a Consultant in Palliative Medicine (out of hours or at weekends) or to inform them of the discharge, they can be contacted via the SPC Advice Line (01736 757707) - the caller’s details will be taken and they will be phoned back promptly by the Consultant on-call.

WCH the same.

2.3.13. **Written documents as below must also accompany the patient on discharge to home or care home facility** (Summarised in Appendix 2 Checklist):

WCH the same.

- Completed INTER HEALTHCARE TRANSFER/DISCHARGE INFORMATION FORM. CHA 2702
- A medication timetable recording drug names, doses, times of day and purpose, completed by a member of the medical team or Palliative Care CNS (acts as a prescription for District Nurses so requires Doctor’s - or appropriate non-medical prescriber CNS with palliative care prescribing competencies - signature) for the patient to take home. (This may be via a copy of the patient discharge and take home medication form, with added information regarding the purpose of each medication, or as a Record of Medication for Community Nurses Form, CHA1525)
- A list of health professionals involved recording name, role and contact number should also accompany the patient. This may for example include a site-specific oncology CNS or member of the Hospital Palliative Care Team, and the patient’s Consultant details. Within this list there should also be a named specific doctor who could provide appropriate death documentation (certificate and cremation form) in the rare event that this documentation cannot be provided from the Primary Care setting. This information should at minimum be recorded on any ‘Pre-notified Death’ form faxed to SERCO and GP.
- A copy of any agreed and documented Individual Care Plan (original to remain in medical notes)
- Any record of patient wishes, for example within an Advance Care Plan, Living Will, Advance Directive, Advance Decision to Refuse Treatment or Preferred Priorities of Care document.
- A community syringe driver prescription form if the patient is being
discharged with a syringe driver (completed by the ward doctor or a member of the Hospital Palliative Care Team). CHA2809
- A copy of resuscitation document (AND form). The RCHT AND form is valid ‘Cornwall Healthcare wide’ i.e. across all settings, including by transport services
- A copy of the Community Palliative Care referral form as faxed above

2.3.14 If such a discharge or transfer in the last few weeks of life is taking place over a weekend or Bank Holiday, then the Clinical Site Co-ordinator should be notified. They are also in a position to offer advice and guidance to the care team - Bleep 2634.

Within working hours, a member of the Onward Care Team, involvement triggered by receipt of eBICA via MAXIMs, an Occupational therapist – either ward based or Oncology and Specialist Palliative Care OT via bleep 2122 (and, if appropriate, a Hospital Palliative Care Team (HPCT) member) should be involved in the discharge or transfer of a patient in the last few weeks of life and can be approached with any questions regarding the discharge by any member of the ward team.

WCH: Such discharges from West Cornwall Hospital could be discussed with a member of the HPCT to advise if a visit is required for assessment. WCH discharges should always have the advice and guidance of an OT for equipment needs, but, as above, the role of the Onward Care Team member may be fulfilled by nurses on the ward.

2.4. Contact numbers:

2.4.1. Useful contact details in working hours:
- Lorna Wood / Onward Care Team member x3869, Bleep 2249
- Occupational Therapist on bleep 2122. If on leave x3725 and leave message / referral on answer phone
- Hospital Palliative Care Team (HPCT) on Ext. 8305 / 8346 / 8347 or message can be left via Bodmin Switchboard on x1300 if not urgent
- HPCT bleep 3055 for urgent referrals, including ANY referral on a Friday by as early in the day as possible. If referral not received by 10.30am on a Friday then discharge before or over weekend highly unlikely to be achieved due to inability to arrange equipment / care.
- Community Matron, Early Interventional Service or District Nurse via Ext. 1300.
- WCH: Continuing Care Team on 01209 886621 (Tel: 01209 886600 for any advice). Night sitting may be available via Health Brokerage Carer’s Break night sitting service subject to Continuining Health Care funding agreement.
- Marie Curie: 0845 0567899. Night sitting can be arranged via OWCT member, or HPCT CNS, or sometimes DN via Bodmin Switchboard (x1300) out of hours / at weekends

2.4.2. Useful contacts Out of Hours:
- Specialist Palliative Care Advice Line 01736 757707
- On-call Community Palliative Care Nurse via x1300, identifying where patient lives and which GP practice registered with
On-Call District Nursing Service via x1300, again identifying where patient lives and which GP practice registered with

2.4.3. Should the patient die at home or in a care home setting before appropriate review by a medical practitioner in the community, such that a death certificate cannot be provided, RCHT gives permission for a doctor who knew the patient within the acute setting to visit the family’s chosen funeral director in order to complete the necessary paperwork on the following working day. It is anticipated that this will be a rare occurrence if communication as stated has taken place.

2.4.4. In the future it is hoped that an electronic shared care record or palliative care / end of life database will be established across all settings of care. It will then be possible for any appropriate health or social care professional to access information from this IT resource. If the patient to be discharged or transferred is not already on this record / database, then the appropriate details should be entered onto it before the discharge or transfer from hospital. Once the record / database is established, appropriate training will be given to personnel who are likely to need to input to the record / database or access patient information from the record / database.
3. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Transfer and discharge guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>The RCHT End of Life Care Group will support local audit at ward level to inform and improve best practice in the care of the dying. In concordance with the recommendations of this document. It is hoped that someone will be in a longer term education and training role for end of life care, including support of pilot projects and audits, before the end of 2014.</td>
</tr>
<tr>
<td>Tool</td>
<td>May include, direct monitoring of use of guidance and documents recommended at ward level, mortality review forms, pilots of prompts and guidelines for end of life care, or use of AMBER Care Bundle (commenced as part of Wellington project in June 2014).</td>
</tr>
<tr>
<td>Frequency</td>
<td>To be confirmed – hopefully some form of contemporaneous end of life audit occurring at some place within RCHT at all times from late 2014. May include staff within the palliative care link forum contributing to such audit</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>The RCHT End of Life Care Group will review end of life risk at divisional level</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>The RCHT End of Life Care Group reports to the Trust Management Committee (Governance) Group</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>Via the RCHT End of Life Care Group</td>
</tr>
</tbody>
</table>

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 & Human Rights Policy’ or the Equality and Diversity website.

4.2. Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 1.
## Appendix 1. Governance Information

<table>
<thead>
<tr>
<th><strong>Document Title</strong></th>
<th>Guidelines for Transfers and Discharges in the Last Few Weeks of Life</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date Issued/Approved:</strong></td>
<td>1 September 2014</td>
</tr>
<tr>
<td><strong>Date Valid From:</strong></td>
<td>1 September 2014</td>
</tr>
<tr>
<td><strong>Date Valid To:</strong></td>
<td>1 September 2017</td>
</tr>
<tr>
<td><strong>Directorate / Department responsible (author/owner):</strong></td>
<td>Dr Rachel Newman, Palliative Care Consultant and RCHT End of Life Care Lead</td>
</tr>
<tr>
<td><strong>Contact details:</strong></td>
<td>01872 258316</td>
</tr>
<tr>
<td><strong>Brief summary of contents</strong></td>
<td>This policy applies to all RCHT staff involved in transfer of care / discharge of end of life care patients. With regard to this policy, ‘End of Life’ confined to patients with a prognosis of a few weeks or less. The aim is to ensure a well understood well communicated and safe transfer of care.</td>
</tr>
<tr>
<td><strong>Suggested Keywords:</strong></td>
<td>Discharge; Transfer of Care; Last Few Weeks of Life, End of Life Care</td>
</tr>
<tr>
<td><strong>Target Audience</strong></td>
<td>RCHT, PCH, CFT, KCCG</td>
</tr>
<tr>
<td><strong>Executive Director responsible for Policy:</strong></td>
<td>Medical Director</td>
</tr>
<tr>
<td><strong>Date revised:</strong></td>
<td>1 July 2014</td>
</tr>
<tr>
<td><strong>This document replaces (exact title of previous version):</strong></td>
<td>Guideline on End of Life Transfers and Discharges</td>
</tr>
<tr>
<td><strong>Approval route (names of committees)/consultation:</strong></td>
<td>RCHT End of Life Care Group, Consultant Nurse for Older People and Associate Director of Nursing.</td>
</tr>
<tr>
<td><strong>Divisional Manager confirming approval processes</strong></td>
<td>Consultant Nurse for Older People and Associate Director of Nursing.</td>
</tr>
<tr>
<td><strong>Name and Post Title of additional signatories</strong></td>
<td>Janet Gardner, Governance Lead CSSC</td>
</tr>
<tr>
<td><strong>Signature of Executive Director giving approval</strong></td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td><strong>Publication Location (refer to Policy on Policies – Approvals and Ratification):</strong></td>
<td>Internet &amp; Intranet</td>
</tr>
<tr>
<td><strong>Document Library Folder/Sub Folder</strong></td>
<td>Clinical/Palliative Care</td>
</tr>
<tr>
<td><strong>Links to key external standards</strong></td>
<td>CQC Outcomes1, 2, 4, 6, 9</td>
</tr>
</tbody>
</table>
Guideline for Transfers and Discharges in the Last Few Weeks of Life

Table: Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1.0</td>
<td>Initial Issue</td>
<td></td>
<td>Dr Rachel Newman, Palliative Care Consultant and RCHT End of Life Care Lead</td>
</tr>
<tr>
<td>1 Jul 14</td>
<td>V2.0</td>
<td>Full rewrite.</td>
<td>Dr Rachel Newman, Palliative Care Consultant and RCHT End of Life Care Lead</td>
</tr>
</tbody>
</table>

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

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document
This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
## Appendix 2. Initial Equality Impact Assessment Screening Form

Name of service, strategy, policy or project (hereafter referred to as *policy*) to be assessed: Guidelines for Transfers and Discharges in the Last Few Weeks of Life

<table>
<thead>
<tr>
<th>Directorate and service area:</th>
<th>Is this a new or existing Procedure?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative Care</td>
<td>Existing</td>
</tr>
</tbody>
</table>

Name of individual completing assessment: Rachel Newman  
Telephone: 01872 258305 (sec)

1. **Procedure Aim***  
   Its aim it to ensure safe discharge / transfer of care

2. **Procedure Objectives***  
   To ensure a well understood, well communicated discharge

3. **Procedure – intended Outcomes***  
   Planned, Co-ordinated, communicated and safe discharge

4. **How will you measure the outcome?***  
   Monitored by RCHT End of Life Care Group

5. **Who is intended to benefit from the Procedure?***  
   Residents of Cornwall and Isles of Scilly being discharged from RCHT services

6a. **Is consultation required with the workforce, equality groups etc. around this procedure?***
   b. If yes, have these groups been consulted?  
   c. Please list any groups who have been consulted about this procedure.
   Members of Onward Care Team, Hospital Palliative Care Team and RCHT End of Life Care Group have been consulted in updating this policy

7. **The Impact**  
Please complete the following table.  
Are there concerns that the policy **could** have differential impact on:

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sex</strong> (male, female, trans-gender / gender reassignment)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Race / Ethnic communities /groups</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Disability - Learning disability, physical disability, sensory impairment and mental health problems</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Guideline for Transfers and Discharges in the Last Few Weeks of Life  
Page 11 of 17
Guideline for Transfers and Discharges in the Last Few Weeks of Life

<table>
<thead>
<tr>
<th>Religion / other beliefs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage and civil partnership</td>
<td></td>
</tr>
<tr>
<td>Pregnancy and maternity</td>
<td></td>
</tr>
<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
<td></td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. **Yes**  **No**

9. If you are not recommending a Full Impact assessment please explain why.

<table>
<thead>
<tr>
<th>Signature of policy developer / lead manager / director</th>
<th>Date of completion and submission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Names and signatures of members carrying out the Screening Assessment

1. Dr Rachel Newman
2. 

**Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead,**
c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed ________________

Date ________________
## Appendix 3 RCHT Discharge/Transfer Checklist for Patients in Last Few Days or Weeks of Life

The lists below should serve as a checklist and trigger to ensure communication and provision of written materials to support discharge or transfer of patients from RCHT who are expected to die in the next few days, to few weeks maximum. **Not all items in each list will be necessary for all patients, but appropriate items should be selected.** The emphasis should be on individual patient and family/carer needs, with support tailored to those needs.

<table>
<thead>
<tr>
<th>People/Agencies/Teams whom you may need to contact, including Contact Numbers</th>
<th>Written Information Documents to accompany Patient Home, or for faxing or e-mailing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Onward Care Team</strong> ext: 2659; Lorna Wood x3869, Bleep 2249</td>
<td><strong>FIRST ACTION:</strong> e-BICA: e-mail to Onward Care Team via MAXIMs, Fax x2658</td>
</tr>
<tr>
<td>X Occupational Therapy Bleep 2122, x3725 if SPC OT on leave</td>
<td>Continuing Health Care Fast Track Tool (CHA 2844) (OCT Member RCH; Ward Discharge Nurse WCH)</td>
</tr>
<tr>
<td>Hospital Palliative Care Team – HPCT (if appropriate) ext: 8346 or 8347, Bleep 3055, or via Bodmin x1300</td>
<td>Medication Timetable or copy of e-discharge and take out medication. Record of Medication for Community Nurses (Doctors or CNS Pall Care NMP) CHA1525 NB remember to prescribe prn injectable meds</td>
</tr>
<tr>
<td>X *General Practitioner (may need to see patient once home to be able to certify death – Doctor to contact)</td>
<td>List of Health Professionals involved E.g. name(s)/role/job/contact number(s) (Nursing Staff)</td>
</tr>
<tr>
<td>Out of Hours Service (e.g.SERCO) 01872-222400</td>
<td>Patient Inter-healthcare transfer / discharge information form (CHA 2702) (Nursing Staff)</td>
</tr>
<tr>
<td>X District Nurse and/or Community Matron (via x1300)</td>
<td>Documentation of resuscitation status (AND order) Hospital version valid across all healthcare settings including ambulance transport</td>
</tr>
<tr>
<td>X *Ward/NH/RH Manager (if transfer to Community Hospital or Care Home)</td>
<td>Expected Death form/Special Patient note – available from SERCO 01872-222400 Copy to SERCO, CPC, SWAST, DN and GP (Doctors)</td>
</tr>
<tr>
<td>Hospices</td>
<td>Syringe Driver multicolour prescription forms (Doctors/Hospital Palliative Care Team) CHA 2809</td>
</tr>
<tr>
<td>SJH ext: 8881 or 01736-759070 MEH 01726-65711</td>
<td>Acute Care at Home 01872-354480 Urgent HOOF (oxygen) if needed (Doctor)</td>
</tr>
<tr>
<td>SPC Advice Line 01736757707</td>
<td>Pharmacy ext: 2588 Faxed Referral to Community Palliative Care Team: (CPC) 01872 246948 (Nursing Staff) if appropriate</td>
</tr>
<tr>
<td>Community Palliative Care Nurse, Ext: 1300 &amp; give name of GP Practice Fax 01872 246948</td>
<td>Any agreed and documented Care Plan: may include Preferred Priorities (and Place) of Care, Living Will, Advance Directive, Advance Decision to Refuse Treatment, Lasting Power of Attorney</td>
</tr>
<tr>
<td>Marie-Curie – booking only via OWCT or HPCT CNS WCH possible night sitting via Carer’s Break if funding agreed</td>
<td>e-Discharge letter, including Medication list (Doctors)</td>
</tr>
</tbody>
</table>

*from patient contact details O please tick these boxes when completed
Appendix 4a: Useful Contacts including Telephone/Fax Numbers

Onward Care Team x2659, Fax x2658

Palliative Care / End of Life Specialist contact within Onward Care Team (July 2014):
Lorna Wood x3869, Bleep 2249

Patient Transport Services Must be requested on-line, stating End of Life / Palliative Care patient, must travel alone and accommodate a relative to travel with if wished for, x3274

Hospital Palliative Care Team:
Nurse Specialists x8346 or x8347, or Bleep 3055 (urgent referrals), or via x1300
(Bodmin Switchboard). Team admin personnel x8305
Consultant via RCH Switchboard, 01872 250000

Oncology and Palliative Care Occupational Therapist (RCH): Bleep 2122
If Specialist OT away, refer via x3725 (rehab team)
WCH Ward OT

Specialist Palliative Care Advice Line 01736 757707 (out of hours, advice to healthcare professionals any setting of care)

Equipment Library Fax: x2909

Continuing Care Team (for WCH) Fax: 01209 886621 (for JACS form) Tel: 01209 886600

Community Matron, Early Intervention Service or District Nurse via Bodmin Switchboard x1300
Early Intervention Service via Bodmin hospital switchboard x1300 out of hours

Serco Health: 01872 226703, x4463 FAX: 01872275688

Community Palliative Care Service: via x1300 to ask relevant nurse to get back to you.
Fax 01872 246948

Clinical Site Co-ordinator: Bleep 2634

RCH Tissue Viability: x2673 (voicemail referrals), or mobile 07909 930765 in working hours
WCH: Community Tissue Viability: x5652 or via Bodmin Switchboard x1300

Acute Care At Home: 01872 354480

Mount Edgecumbe Hospice: 01726 65711; Fax: 01726 66421

St. Julia’s Hospice: 01736 759070; Fax 01736 759567
Marie Curie: 0845 0567899 (check who can request night sitting service before phoning)

SWAST Fax: FAO Features Department; 01392 360199
Appendix 4b: Document CHA numbers and Document names if no CHA number known (and where to source them)

ALL FORMS SHOULD BE AVAILABLE ON WARDS OR IN END OF LIFE DISCHARGE AND / OR TRANSFER RESOURCE FILE (PURPLE FOLDER). PLEASE IF TAKING FROM THE RESOURCE FILE, DO NOT TAKE LAST COPY / MASTER COPY. PHOTOCOPY IF NECESSARY

Patient Inter Healthcare Transfer / Discharge Information Form CHA 2702

Allow Natural Death Form (Hospital form acceptable across all healthcare settings) CHA 2311 v2

Community Syringe Driver Prescription Form CHA 2809 v2

NHS Continuing Healthcare Fast Track Tool Form CHA 2844

Record of Medication for Community Nurses CHA 1525


Serco Health Pre-Notified Death Form and Cornwall Palliative Care Out of Hours Handover Form Special Patient Note. Both available from Serco via 01872 226703
May also be available from Hospital Palliative Care Team – see contact numbers above

Yellow forms for syringe driver checks. Should accompany syringe driver prescription forms, CHA as above. If difficulties obtaining, copies may be available from Hospital Palliative Care Team – see contact numbers above

Community Palliative Care faxed Referral Form. Available on all wards RCHT. Check updated version March 2014, headed Community Specialist Palliative Care Team Referral Form, NOT Macmillan

Specialist Palliative Care Advice Line posters. Should be present on all wards RCHT. Also available from Hospital Palliative Care Team – see contact numbers (Appendix 3a) above
Appendix 5 EMERGENCY DISCHARGE (AIM WITHIN 24HRS) FOR END OF LIFE CARE AT HOME – WHERE DEATH EXPECTED IN NEXT FEW DAYS TO FEW WEEKS. NB AVOIDANCE OF INAPPROPRIATE PATIENT / FAMILY EXPECTATIONS PARAMOUNT IN WORKING HOURS ONLY – OUT OF HOURS CONTACT DISTRICT NURSING SERVICE FOR ADVICE IN FIRST INSTANCE

- Need for Syringe Driver assessed by Medical Team or Hospital Palliative Care Team

- Discharge medication ordered including prn injectable drugs.

- Onward Care Team member +/- Registered Nurse (RN) (RN alone WCH) to assess patient’s care needs. OT to assess equipment needs and perform risk assessments

- Patient’s/Relatives’ wishes for discharge home confirmed. Estimated prognosis few weeks max

- Onward Care Team / WCH Discharge nurse assess & confirm eligibility via fast track pathway tool for NHS Continuing Healthcare, giving rationale for decision.

- Identify & Refer to Community Staff
  - Phone District Nurse (DN) or Comm Matron – Key Worker
  - Comm Palliative Care Nurse (CPC) – Advice & Support/Symptom Control
  - Fax ‘Pre-notified Death’ and ‘Special Patient Note’ to SERCO, GP, CPC, DN service and SWAST

- Patient is assessed as safe to make the journey (nursing +/- medical final assessment within 2hrs of discharge)

- Patient is discharged home

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