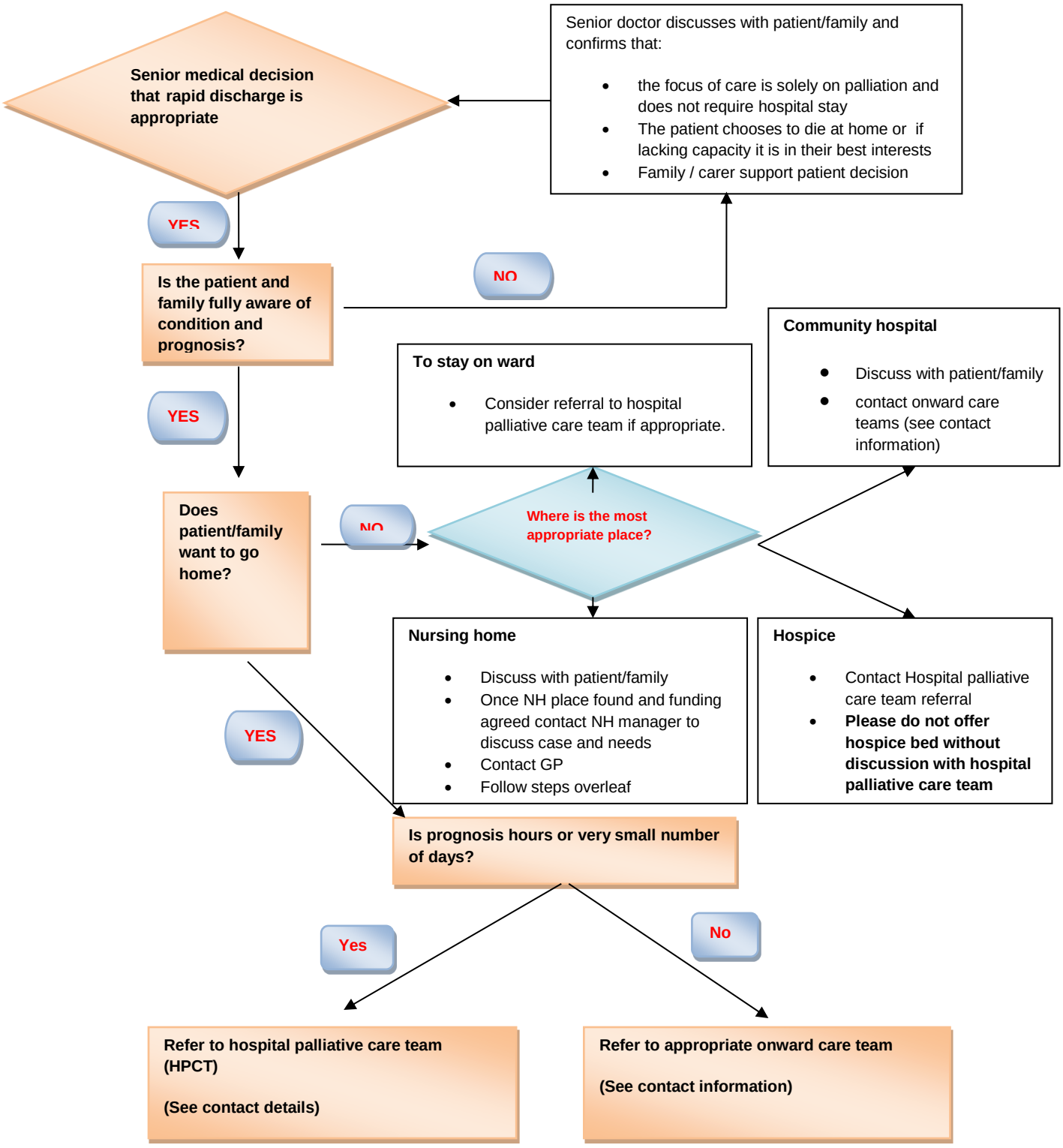
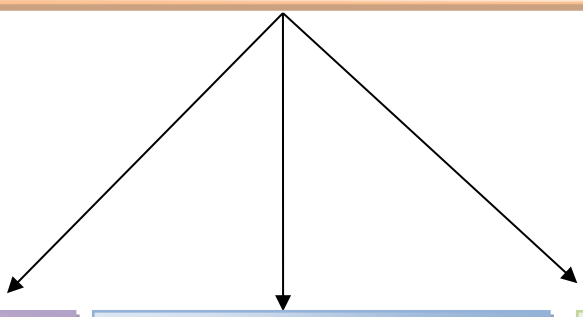
Rapid Discharge Process (RDP) for patients with limited prognosis

(i.e. prognosis is short weeks or less)



For a safe and efficient discharge please follow steps below



Nursing Staff

1. Does patient need a POC?

If so does **fast track for CHC** funding need completing?
Refer to the discharge team for funding of care, explain the urgency

2. Does patient need **urgent OT review**

If appropriate refer for assessment and advice (state it is a rapid discharge patient).
Contact **Tissue Viability** if high grade pressure mattress is essential

1. Arrange ambulance

– show the TEP/DNAR order to the crew

2. **Does patient need referral to District Nurse team?**

Confirm that they will liaise with GP and clarify timing of syringe driver change if appropriate

3. **Consider referral to HPCT** if not already involved

(If there are specialists palliative care needs.)

4. Refer directly to the **community Palliative care team** if required.

5. Use check list for discharge

Doctors

1. Senior Doctor to **document in medical notes** that patient has a rapidly deteriorating condition,

Document the likely prognosis.
Document all discussions with the family/patient

2. Write up TTA's including syringe driver and anticipatory drugs preferably at least the day before discharge to prevent delays with waiting for TTAs.

Consider **'Just in case' prescription.**

Include **water for injections** with syringe driver prescriptions

Ensure pharmacy understands the need for rapid discharge

3. Prescribe appropriate syringe driver and anticipatory medications on the community prescription chart

4. Ensure **TEP/DNACPR** is complete,

Ensure that this has been **discussed** with patient/family and that they understand the form.

Ensure the **original form goes home with the patient**

5. Ensure **discharge summary** is up to date.

Include clear diagnosis, treatment plan and clear End of Life discussions that are relevant for community teams.

6. If prognosis is likely to be short **(days) Telephone GP** to inform them of the impending discharge and to arrange a home visit.

Occupational Therapist/ (or appropriate healthcare professional)

1. Review pt care needs/equipment in conjunction with family / carers

2. **Discuss with family** space available for equipment,

Please assess **viability of choice for long term care** i.e would the patient like to be located on the 1st floor of property even in last days of life?

Ensure environment will physically accommodate equipment i.e hoist / moving and handling equipment are compatible with other environmental considerations e.g. armchair.

3. Order equipment;

If complex moving and handling involved then a **'moving and handling' plan** to be forwarded to appropriate care agency on discharge.

4. Discuss discharge plans with onward care team;

Including equipment requirements and ordering.

5. Consider property access issues;

Including **guidance for ambulance**/ transport crews, (i.e transport crews will not hoist patients)

6. Train family/carers for use in moving and handling/equipment as appropriate.

7. Consider onward referral to therapy teams/DN's

Check List

At Discharge

- ☐ TEP form
  - ○ reviewed and completed,
  - ○ discussed with patient/family
  - ○ sent home with patient
- ☐ Appropriate TTAs (including anticipatory sub cut medications) completed and with the patient
  - ○ include water for injections for subcut prescriptions including syringe drivers
  - ○ Just in case medications prescribed **(follow proforma)**
- ☐ Community prescription chart completed
  - ○ Given to patient at discharge with TTAs
- ☐ Discharge summary compete and clear explanation of aims of treatment and any EOL discussions taken place
- ☐ District nurses informed and management of syringe driver clarified.
- ☐ Syringe driver form completed and returned to MEMS, if patient is going home with a McKinley syringe driver.
- ☐ Community palliative care referral made if appropriate.
- ☐
- ☐

Contact details

1. Onward care
   a. Plymouth **ext 37476, 37474**
   b. Devon **ext 31179**
   c. Cornwall **ext 32011**
2. District Nurse **(as per guidance)**
   a. Plymouth and West Devon (Livewell Southwest)
      i. If urgent via DN Hub 01752 434629
      ii. If non urgent via the appropriate no. **(see guidance)**
   b. North-east Cornwall
3. Specialist palliative care
   a. Plymouth and West Devon, St Luke's Hospice
      i. St Luke's at Derriford **ext 36744**
      ii. St Luke's at home **01752 964200**
      iii. St Luke's Crisis team **01752 964230**
      iv. St Luke's at Jennycliff (inpatient) **01752 401172**
   b. North-east Cornwall **01208 251300**
4. Out of hours GP service
   a. Devon (DevonDoc) **0845 5049113**
   b. Cornwall (Serco) **0845 2000227**