We hope your experience of the discharge process was positive.

Please help us to continue to provide the best service we can by providing us with some feedback by completing this questionnaire:

Did you find this leaflet helpful? Yes / No

If not, why?

Was there any information you needed that was not provided in the leaflet? Yes / No

If so, what information was needed?

_____

Was the leaflet easy to understand? Yes / No

If not, what was unclear?

Did the leaflet reduce stress and anxieties regarding the discharge process? Yes / No

Comments:

Thank you for taking time to help us continue providing a good service.

Please return the completed questionnaire to the address below:

Contact information

St Catherine's Hospice,

Lostock Lane

Lostock Hall,

Preston,

Lancashire,

PR5 5XU

Tel no. 01772 629171

The discharge process explained:

A guide to help you plan for your future care

St Catherine's hospice care

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What can you do to help the discharge process?

Whilst we appreciate this is a difficult time, we hope you will understand the need for your cooperation in the process to ensure it occurs efficiently, and is a seamless transition from St Catherine's Hospice to your place of future care.

This is how you and your relatives can assist us with the process:

- Be prepared to attend meetings / case conferences to discuss future care plans.
- If a nursing / residential home is to be identified, please visit and identify a home in a timely manner.
- Identify a spokesperson for the relatives of the patient who can participate in key meetings and cascade the information to the other family members, to prevent repetition of information being discussed.
- Please respect the decision made by the nursing and medical team to commence the discharge process. The condition of you or your relative will be monitored throughout the process, and if felt discharge has become inappropriate, a review will be undertaken.
- Please express any concerns or worries you have, they can be discussed with an aim to address them.

Support for you following discharge

Following discharge, it is possible you will be followed up by a community service provided by St Catherine's Hospice. The service referred to will be dependent on individual need.

Community Clinical Nurse Specialists (CNS) – The team of nurses provides assessment, treatment and management of complex symptoms, and psychological support at community clinics and in your own home. They work closely with community services such as GPs, district nurses, and care home staff to help you achieve the best quality of life at home.

Befriending Service – Volunteers trained by the hospice can visit and provide company for a patient whilst their carer takes some time for themselves. The volunteers are not able to provide any personal care for the patient. Eligibility for this service would need to be assessed.

Day Therapy – You attend the hospice weekly, for an agreed period of time. It is an informal environment, with support from nursing staff, your condition can be reviewed and information and support can be provided. Access to complementary therapies, hairdresser, and diversional activities are available.

Medical Out Patient Clinic – You will have appointments with the medical team to review and monitor your condition, and address any concerns you may have.

Advice Line – St Catherine's Hospice operates a 24hour advice line that can be accessed for knowledge and advice related to palliative care - 01772 629171.

St Catherine's Specialist Palliative Care Service

St Catherine's Hospice is a local charity which helps people in our community affected by life shortening illness enjoy quality of life and have dignity in death. We serve a population of around 380,000 people across Chorley, Longridge, Preston and South Ribble, helping around 2,000 patients every year.

Our specialist palliative care service is provided for adults facing conditions such as cancer, heart failure and motor neurone disease, and can be delivered at the hospice, in the community, and at home.

Around 50% of people return home from St Catherine's Hospice after receiving care.

When you or your relative is admitted to St Catherine's Hospice, we appreciate this can be a difficult and emotional time.

At St Catherine's Hospice we provide 'specialist palliative care' which involves palliative care professionals providing a service for those whose symptoms cannot be managed in a timely way by their normal care team, and its availability is based on need, not diagnosis.

The team at St Catherine's strives to manage the complex symptoms patients can be admitted with. If a period of stability is reached and maintained, the medical and nursing team may initiate discussions with you about planning for future care.

Unfortunately, St Catherine's Hospice is not a long stay establishment.

Thinking about future care

Discharge may not have been something you thought would occur following admission to St Catherine's Hospice, but in order to continue providing specialist palliative care to those in greatest need, it is essential that inpatient beds are used as efficiently as possible. There is a high demand for admission to the inpatient unit for specialist palliative care.

Thoughts of discharge from St Catherine's can cause feelings of confusion and anxiety, as you or your relative may not be functioning at the same level you were at prior to the admission, and have a life-shortening diagnosis.

Each discharge from the hospice will be different and individual to the needs of the patient and their relatives. The nursing and medical team will be happy to discuss your current needs and the options available to you when considering future care with you and your relatives.

The process of discharge will be undertaken in a timely manner, and you will remain fully supported and involved at each step of the process.

There may be many options available to you, which can appear daunting and confusing. There is also potential for a change in condition to occur which may require reassessment of the planned future care and a possible need for this to be adjusted. A change in condition does not necessarily mean the discharge will be discontinued.

Who will support us through the process?

The nursing and medical team will be able to help you plan for future care by answering questions or signposting you to those who can assist.

Other health professionals will potentially be involved in providing you with support:

<u>Family Support</u>

- Provide support to patients, carers/relatives through the discharge process
- Assist with continuing health care assessments
- Work with health professionals and district nurses through the process
- Provide support, advice and information as required with debt, housing, wills and funerals
- Facilitate the installation of lifelines
- Attend case conferences as required

<u>Therapist</u>

- Assess mobility and advise on equipment needs

Following your discharge there will be on-going support in the community and your GP and district nurses, if appropriate, will be fully updated on recent events, medications you may be taking, and your current plan of care.

Fast track route

A discussion will take place with you to determine the destination for future care – home or care home placement.
A discharge date will be proposed.
A formal meeting with other health professionals, such as physiotherapist, may need arranging if risks or best interests are to be formally addressed.

Care home route

A list of provider care homes will be provided.

You will need to view and identify your preferred care home.

Home route

Care needs over a 24hr period will be discussed with you, identifying care needs and equipment required.

District nurse will be contacted and informed of care and equipment needs. They will help with the arrangement of equipment and patients care needs alongside the care package requested.

The Fast Track document will be completed and submitted by the nursing team to Continuing Health Care (CHC).

The nursing team will liaise with the CHC team regarding funding and availability of care package, and update you of the outcomes as the discharge process proceeds.
A discharge date will be confirmed.
The delivery date of equipment/oxygen will be confirmed with you then the delivery can be made in a timely manner.
The nursing staff will arrange transport for the patient, if required.
A week's supply of current medications will be ordered, to be sent home with the patient on discharge.
A discharge letter will be sent to your GP to update them about the current plan of care and current list of medications.

Health funding route

You will be invited to a meeting known as a case conference. The meeting will include you, a member of the nursing team, family support, and may include district nurses, physiotherapy or an occupational therapist.

During this meeting a document called a Decision Support Tool (DST) will be completed and agreed by all present, and signed. The DST identifies the current needs of the patient.

Equipment and care needs will be identified, how and where these can be met will be discussed, i.e. care home or home.

A discharge date may be proposed.

The nursing team may need to identify further information that is required to be submitted with the completed DST, to support the application.

You will be given an opportunity to review the completed DST prior to its submission to CHC for funding of future care.

The relevant documents will be submitted by the nursing team to CHC.

The nursing team will liaise with the CHC team regarding funding and availability of care package, and update you of the outcomes as the discharge process proceeds.
A discharge date will be confirmed.
The delivery date of equipment/oxygen will be confirmed with you then the delivery can be made in a timely manner.
The nursing staff will arrange transport for the patient, if required.
A week's supply of current medications will be ordered, to be sent home with the patient on discharge.
A discharge letter will be sent to your GP to update them about the current plan of care and current list of medications.

Social Funding Route

Nursing / residential home route

A Health Needs Assessment form will be completed by the nursing team, which is processed by Family Support and guidance will be provided about appropriate homes.

You will need to view and identify your preferred care home.

A discharge date may be proposed.

Home route

A discussion with you regarding your care needs over a 24hr period and equipment required will be undertaken, and a care package, will be agreed, if required.

A discharge date may be proposed.

A formal meeting maybe arranged if there any concerns regarding risks / best interests, then these issues can be formally addressed.

A discharge date will be confirmed.
The delivery date of equipment/oxygen, if appropriate, will be confirmed with you then the delivery can be made in a timely manner.
The nursing staff will arrange transport for the patient, if required.
A week's supply of current medications will be ordered, to be sent home with the patient on discharge.
A discharge letter will be sent to your GP to update them about the current plan of care and current list of medications.

A Guide to the Discharge Process

The patient is deemed to have a stable condition that does not require specialist palliative care in the inpatient unit, and can be managed in another environment.
Discussions regarding planning for future care will be initiated with you by the medical or nursing team.

A consent form will need to be completed to enable an application for funding of future care to be submitted to CHC.
A referral to the Family Support team will be made, with your consent, to provide support with the discharge process.
There are different routes of applications that can be made, dependent on the patient's current needs and prognosis.

Further information is available in the Department of Health leaflet – NHS Continuing Healthcare and NHS-funded Nursing Care: Public information leaflet, ask a member of staff for a copy or available at: https://www.gov.uk/government/publications/nhs-continuing-healthcare-and-nhs-funded-nursing-care-public-information-leaflet

Fast track route

This route will be taken if the patient has a rapidly deteriorating condition that could be entering the terminal phase.

See page no. 4

If the patient is considered stable and is not thought to be entering the terminal phase, the CHC screening process is to be undertaken at an MDT meeting.
The result will determine if the patient is for assessment for funding via HEALTH or SOCIAL. You will be informed of the outcome.

Health funding route

See page no. 5

Social funding route

See page no. 6