Going home from hospital for end of life care

An information
leaflet

**Palliative Care
Team**

You and your family / carer have expressed a wish to go home for end of life care. We will do our very best to achieve this.

We need to act quickly to organise this discharge and will make sure you and your family / carer are included in all discussions and plans.

This may be a worrying time for all of you. It is important for us to make sure you fully understand what is involved in the transfer home.

The hospital and community team will work together to organise your discharge.

Things that we will discuss with you are:
• Your plans and wishes
• Who will support you at home
• Care available in the community on discharge
• Equipment that might be needed
• Medicines that might be prescribed
• What may happen if your condition changes suddenly

Please speak to the team on the ward looking after you if you or your family / carers have any questions, they are here to support you at this time.

ReSPECT
As we plan your discharge together, we may discuss whether or not readmission to hospital for treatment would help you and if you would want to be readmitted. Recommendations about care and treatment, including hospital readmission, will be recorded on a form called ReSPECT. This form is given to you to keep in your house and the information is recorded on the computer system for community professionals to be able to read (such as Neighbourhood Team, GP and the hospital team involved in your care).

These recommendations can help the people looking after you make treatment decisions if you are too unwell to say what your wishes are.

Equipment

Equipment might be needed at home, e.g. hospital bed, pressure relieving mattress, prescription items and oxygen. If needed, staff will discuss this with you and your family / carer. Space may be needed for essential equipment / oxygen, this may involve moving / storing furniture. The equipment will have to be delivered and someone will need to be there to accept the delivery.

Medications

Medicine that is not helpful at this time may be stopped and new medicines prescribed. If needed, the hospital team will prescribe these medicines to go home with for symptoms such as pain, agitation or sickness. Injectable medicines will be given by a registered nurse in the community when needed, at the right time and just enough for comfort.

Transport

A dedicated Palliative Care Ambulance Service may be able to respond at short notice to transfer you to your preferred place of care. If the Palliative Care Ambulance Service is unavailable, other patient transport will be used as an alternative. Your family / carer will be able to go in the Palliative Care Ambulance with you during the journey home if they wish to do so.

Once home, if you do not understand anything, please talk to your GP or Community Neighbourhood Team.

Useful contact details
(to be completed on discharge by ward nurse)

Patient's GP: ....

Community Neighbourhood Team:

....

**Community Neighbourhood Team out of hours (Leeds only)
Tel. 0300 003 0045**

For out of hours advice, you can also telephone the Leeds Palliative Care emergency helpline (part of NHS 111): 0345 605 0621 or contact: NHS 111 directly if out of Leeds area.

This space can be used for you or your family / carer to list any questions you may wish to ask the doctors or nurses:

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You or your family / carer might find the Leeds Palliative Care website a useful place for more information and support.

www.leedspalliativecare.org.uk

A family / carer information leaflet 'Supporting care in the last days or hours of life' is available on the ward.

We hope you have found this leaflet helpful at this difficult time.

If you would like this information leaflet in another language, please visit: **https://www.leedsth.nhs.uk/patients-visitors/patient-and-visitor-information/patient-information-leaflets/** and select the BrowseAloudTM Icon.

What did you think of your care?
Scan the QR code or visit **bit.ly/nhsleedsfft**

Your views matter