DISCHARGE AND TRANSFER OF CARE POLICY

1 Purpose

A discharge policy is necessary to ensure safe, timely and effective discharge and transfer of care for all patients admitted to the Hospice. It should be an ongoing process from or prior to admission actively involving patients, family/carers, and health and social care parties. The policy is based on current legislation and recommendations taken from "Discharge from hospital – pathways, processes and practice DOH 2003", "The Community Care (Delayed Discharges etc.) Act 2003", the "The National Framework for NHS Continuing Healthcare and NHS Funded Nursing Care Revised November 2012 – implemented April 2013" and DoH Guidance "Ready to go? March 2010" for best practice in discharge planning.

2 Area

The contents of this policy will apply to all personnel working in the Inpatient area and Day care at Lindsey Lodge Hospice.

3 Principles/Objectives

The principles/objectives on which the policy is based are that:

- A safe and timely discharge to preferred place of care.
- Planning for appropriate discharge is part of an ongoing process and should start prior to admission for planned admissions and at the earliest opportunity for other admissions.
- The engagement and active participation of individuals and their family/carers is central to the delivery of care and in the planning of a successful discharge.
- Staff should work within a framework of integrated multi-disciplinary and multi-agency team working to manage all aspects of the discharge process.
- The assessment for, and delivery of, continuing health and social care is organised so that individuals understand the continuum of health and social care services and their rights, and receive advice and information to enable them to make informed decisions about their future care. This should include information about their right to appeal against decisions reached.
- Effective and timely discharge requires the availability of alternative, and appropriate, care options including Home Health Care team [H.H.C.T] individualised home care support to ensure that any rehabilitation, recuperation, re-enablement and continuing health and social care needs are identified and met.

4 Duties and Responsibilities

4.1 Chief Executive

Has overall responsibility for ensuring that this policy is effectively implemented.

4.2 Consultant and Medical Team

i. Has the primary responsibility for patients care and discharge although this may be delegated to appropriately trained members of the multi-disciplinary team following certain discharge criteria.
ii. Has the responsibility for the medical appropriateness for transfer/discharge out of hospice care and to develop a clinical management plan for every patient within 24 hours of admission. Decisions that the patient is clinically stable and an estimated date of discharge discussed each day as part of daily senior reviews that take place outside of the regular rounds.

4.3 Unit Manager / Nurse in Charge

i. Has overall responsibility for the transferring/discharging of patients from the hospice care setting in a safe and timely manner.
ii. Has responsibility for ensuring that appropriate allied health care professionals are involved and discharge planning is considered on admission ensuring timely referrals are made and nursing notes are accurate and up to date.
iii. Responsible for ensuring that the patient and carer/family are involved throughout the transfer/discharge process and any information is given in an appropriate and timely manner.
iv. Fully engage and communicate with the Macmillan Home Health Care team and the Macmillan Therapy team on admission through to discharge.

4.4 Allied Health Professionals

i. Responsible for ensuring patients reach their optimum potential for transfer/discharge from hospice care with the appropriate support and equipment required.
ii. Team working is integral to ensure that all parties involved in the transfer/discharge of the patient are informed of any care needs of the patient and recommendations are highlighted to all members of the team, patient and family/carers.
iii. Responsible for equipment and organising home adaptations in a safe and timely manner so as to prevent delayed transfers/discharges from the Hospice.

4.5 Fast Track and Social Care Team

i. Referral to Home Health Care and MacMillan Team criteria met.
ii. Commissioning services to meet the identified needs and involving patient and family/carer in the entire process of discharge planning.
iii. Co-ordinating the appropriate level of care required, liaising with other members of the multi-disciplinary team to ensure all needs are met on transfer/discharge from acute care.

4.6 All Staff

i. Everyone involved in the patient's journey has a responsibility to actively plan the patients discharge and involve the patient, and family/carer when appropriate.
ii. Make timely referrals to allied health professionals.
iii. Responsible for ensuring any documentation is amended and up to date with any involvement of staff through the patient's admission and transfer/discharge process.
iv. Responsible for ensuring continuing health care funded care is considered for every patient as part of discharge planning when appropriate.

4.7 Discharge planning following admission

i. A thorough assessment of the patient's needs is undertaken at the point of admission. The assessment process should identify the reasons for the admission, including any social care issues and any recent changes in these. It may be appropriate to involve the family/carer as part of this assessment, at this time, to ensure that the assessment is fully informed. Relevant allied health professional team referrals should be made at this time. These should give a clear reason for the referral.
ii. The initial assessment is a good opportunity to underline expectations about a person's stay in hospice and possible transfer if appropriate to Community Care.
iii. A discharge planning meeting may need to be held prior to discharge involving the patient and carers and the allied health professionals from within the Hospice and the community. This would include the Macmillan Health Care team and the Macmillan Therapy team but would extend to others who may have involvement. Notes from the meeting should be kept.

4.8 NHS Continuing Healthcare

i. NHS continuing healthcare is the name given to a package of care which is arranged and funded solely by the NHS for individuals outside of hospice with ongoing healthcare needs. Anyone assessed as having a certain level of care needs may receive continuing healthcare. A patient should be eligible if their overall care needs show that their primary need is a health need.
ii. The patient (and family/carer if appropriate) should be fully involved in this process and informed of all decisions. Patients should be included in the process throughout. Patients have a right of appeal if they are unhappy with the process.
iii. Further information about the National Framework for fully funded NHS care is available at: http://nww.nlg.nhs.uk/DocumentManagement/display.asp?department=bed+management

4.9 Social Care Assessment

i. When it has been identified that a patient's level of need requires a social care assessment to support their needs on transfer out of hospice setting care a social care referral should be made.
ii. Patient's (or family) consent should be obtained before making the referral to Social Care. It should be clear on the referral as to what is being asked and what the patient's abilities are at the present time.
iii. Social Care will need to complete an assessment of the patient's needs to ensure safe transfer out an appropriate setting.

iv. The Social Care worker will need to be involved in assessments of patients at an early stage, in consultation with other appropriate members of the multi-disciplinary team, to ensure the appropriate and timely arrangements can be made for discharge.
v. When the patient is considered fit/safe to transfer and agreed by the allied health professional teams, Social Services should be informed.
vi. The patient/family/carers wishes will be taken into account. The patient has the right to make decisions for him/herself (even against medical advice) and this may mean them taking risks. The patient's capacity to make this decision may need to be assessed in line with the Mental Capacity Act.

5 Delayed Transfer of Care

i. A delayed transfer of care is defined as a patient who is considered medically and allied health professional safe to transfer out of hospice care and there is undue delay in achieving discharge/transfer

6 Transfer of Patients – Hospice to Hospital

i. When site to site transfer of patients is necessary there should be an agreement to transfer and handover of clinical details between the speciality medical staff before any arrangements are made.
ii. Transfer of patients is necessary if a patient needs speciality input that is not provided within the hospice.
iii. It should be determined that a patient requires ongoing input from acute care before any agreement to transfer a patient into hospital takes place.
iv. When a patient is to be transferred to another hospital there should be an agreement to transfer and handover of clinical details between the speciality medical staff.
v. All diagnostic investigations and results should be reviewed by the transferring medical team to ensure an in depth medical handover can take place with the receiving team.
vi. There needs to be an in depth discussion between the referring and receiving area to ensure that the transfer of care is seamless. This should be evidenced in the nursing documentation.
vii. All medical, nursing and other documentation should be up to date and a copy accompanies the patient transfer. Notes should be sent with the patient but a copy of the relevant paperwork retained.

7 Transfer of Patients – Out of Hours

i. If there is a clinical urgency for a patient to be transferred to an alternative health setting, this should be arranged at the earliest opportunity between on call medical/surgical specialities regardless of the time of day if this is in the interest of the patient's wellbeing. The patient should be transferred to Accident and Emergency in an acute setting.
ii. All medical, nursing and other documentation should be up to date. For transfers within hospitals the notes should accompany the patient and the notes tracked on the computerised system to the new location.

8 Discharge of Patients

1 Arrangements for discharge must be checked against the discharge checklist appendix 1.

8.2 The documentation that should be completed in preparation for discharge includes:

- Where there is on-going social or health care needs to be met a detailed plan of how the patient's current needs are being met and any details of on-going follow up arrangements.

- Discharge letter detailing the medical discharge summary and prescription is sent to the GP electronically and a copy is given to the patient. Details of medication; type, dose, frequency, route, side effects [Medicines information Sheet] should accompany any prescription provided.

- Details of any specific requirements following input from any specialist service including health educational literature and contact details of the service.

- It is the responsibility of any discipline involved in planning a patient's discharge to provide any relevant information e.g. specialist nurse input/ongoing therapy plans to relevant community disciplines involved.

- The person/s completing the discharge documentation must ensure that the information is accurate, understandable, without abbreviations and medical terminology where possible and legible on all copies.

- The nurse will explain the contents of the discharge documentation to the patient. Every effort will be made to ensure that the patient understands the information given. The nurse to document in the nursing notes that this has happened.

- All discharge letters should be completed on SystmOne. When the patient's General Practitioner is using SystmOne a task is sent to the GP to see the paperwork. Where the GP is not using SystmOne the paperwork is printed and posted out or emailed to the GP.

9 Discharge of Patients to Care Homes

9.1 Discharge Information

i. If a patient is assessed as needing to be discharged to a care home, whether they are health or social care funded, the choice directive should be followed.

ii. The patient may have a preference for one home rather than another. However, the patient should not wait in the hospice for a vacancy in their preferred home to become available, as it is important that they move to somewhere tailored to meet their needs once they are stable enough to transfer out of hospice care. A suitable alternative to hospice will be identified whilst the preferred option becomes available. This may be a temporary placement in another care home.

iii. For patients being discharged to a care home the Discharge Summary should be detailed to such a level that the care home can compile their own care plan from this.

9.2 Infection Control Arrangements on Patient Discharge

i. If a patient is being discharged with a known infection control problem/condition, e.g. MRSA, the patient's General Practitioner and, any other health care agencies should be informed prior to the patient's discharge/transfer from the hospice.
ii. If the patient is being discharged/transferred to a nursing/residential care facility, both the medical and nursing/community staff should be informed in advance. An Inter Healthcare Infection Control Notification Form will be sent on discharge with the patient.

9.3 Medications and Dressings

Patients will be provided with sufficient drugs for a minimum of 14 days (where appropriate) and dressing for up to 14 days (where appropriate) following discharge. Consideration should be given to providing extra drugs/dressings over a Bank Holiday period. Advice relating to take home medicines will be given by the registered nurse. A patient's prescription to take home should be a planned integral part of the discharge process and should not delay a discharge/transfer from hospice care.

9.4 Involving patients and family / carers

i. The engagement and active participation of individuals and their family/carers is central to the delivery of care and planning of a successful discharge.
ii. There should be opportunity for the patient and/or family/carer to express any concerns about being discharged from the hospice so that they can be addressed and any assessments can be achieved in parallel with the patient's condition where appropriate.
iii. Where a carer will be undertaking tasks that need training to ensure that the carer or patient is not put at risk, staff should ensure that appropriate training is provided.

9.5 Information provision for patients and family/carers

i. Information provision for patients and family/carers about discharge planning should be provided throughout the patient's stay.
ii. All staff must ensure that the patient and their family/carers are fully informed of the discharge arrangements. This requires a proactive approach to ensure the plan is progressing smoothly and to take immediate action to address problems with the allied health professional team.
iii. On discharge a registered nurse will ensure the patient has all the information they require. They will fully explain ongoing care needs including out-patient appointments and any further service provision. Written information will be provided where appropriate.

9.6 Transport

i. All patient eligibility and transport requirements must be assessed.
ii. A patient is eligible for provision of transport where the medical condition of the patient is such that they require the skills or support of PTS staff on/after the journey and/or where it would be detrimental to the patient's condition or recovery if they were to travel by any other means.

9.7 Patients taking their own discharge against medical advice

i. It is recognised that patients have the right to discharge themselves from the hospice. If the patient expresses this wish it is important to establish that the patient has the capacity to make the decision. If the patient does not have capacity for this decision, after careful assessment and it is felt to be in their best interests not to allow self-discharge, then staff can detain the patient under common law and can use 'reasonable force' [the minimum required] to return the patient to the building.

ii. Any patient who has the capacity to make this decision and who wishes to take their own discharge should be informed of the consequences and risks of discharge against medical advice. The risks associated with early unplanned discharge must be discussed with the patient and if appropriate their family/carer and the content of these discussions are to be documented in the patient's medical records. The patient must be asked to sign a disclaimer 'Discharge against medical advice form' by a Doctor or other senior member of clinical staff and this should be witnessed. It is imperative that the appropriate people are informed of the discharge to ensure that the appropriate care is in place. The patient will be advised that self-discharge does not preclude them from further treatment. Test results received following discharge will be communicated to the GP. It is the responsibility of the patient to arrange their own transport when the discharge is against medical advice (staff may use discretion with this). All input should be provided to support the discharge.

iii. If patients refuse to sign a disclaimer and/or listen to explanations with regard to risks or consequences, this should be documented clearly in the patient's medical noes and on the disclaimer. This should not preclude the patient's GP being informed or from the patient being offered follow up if necessary. Every effort should be made to ensure that there is appropriate care for the patient in the community.

iv. Patients, who take their own discharge against medical advice, should be offered the same aftercare service as other patients.

10 Discharge/Transfer Requirements of Specific Patient Groups

10.1 People with mental health problems

i. Patients with mental health problems may need additional support and input from specialist services including assistance with medications, activities of daily living, follow up health care and financial assistance. Discharge planning should take this into consideration from the start of the discharge planning process.

ii. Some patients may already be known to mental health services. Mental Health Care Workers should be informed of their client's admission and potential length of stay, and subsequent discharge date. The Mental Health Care Worker should also be informed of any transfers between clinical areas or hospital sites.

10.2 People with learning disabilities

i. When planning the discharge of anyone with a learning disability it must be recognised that the patient may require more time or support to understand the implications of the plan. Family/carers' needs must be considered as outlined in sections 9.4 and 9.5.

ii. The Learning Disability Service should be contacted to assist with the planning, agreement and transfer/discharge arrangements of a patient. This can be especially valuable if the patient is already known to the service. A

family/carer or social care worked involved with the patient would be able to assist by:

- Offering specialist information when discharge plans are being prepared.
- Ensuring the patient with Learning Disability has understood and is following discharge instructions including medication requirements, awareness of contraindications; follow up appointments, accessing other services such as practice nurse, GP and therapies.
- Ensuring practical issues or difficulties are addressed and resolved when necessary.
- Accessing other workers who may be able to assist patient/family/carers.
- Assisting with the monitoring of a patients progress following discharge and provide feedback where appropriate.

10.3 Patients with complex needs

i. When a patient's level of abilities indicate that support will be required on discharge appropriate referrals should be made so that members of the allied health professionals can complete their assessments and ensure that the patient's needs are met, for example , provision of equipment, home care services, community health involvement to enable a safe transfer/discharge in a timely manner.

ii. The referral guide should be completed to ensure that patients with a high level of need are referred for an assessment and further consideration for continuing health care funding.

10.4 Fast Track discharge of patients

If a patient has a rapidly deteriorating condition which may be entering a terminal phase, with an increasing level of dependency, a Fast Track Pathway Tool for NHS Continuing Healthcare should be completed and signed by an appropriate clinician and referred to the Continuing Healthcare Service.

10.5 Vulnerable Adults

Where there is a suspected physical, emotional and/or financial abuse of an adult, the appropriate multi-disciplinary, multi-agency referrals and discussions should take place before discharge occurs.

10.6 Homeless

i. People who are homeless are entitled to an assessment of need for community care services, if they meet Adult Social Care eligibility criteria. Usual social service referral methods should be followed and completed at the earliest point following admission. Homeless people are the responsibility of the local authority to which they reside providing they have a care need identified.

ii. The Mental Capacity Act should always be considered and where appropriate involve the Safeguarding team before obtaining the patient's consent to act on their behalf or prior to offering suitable alternative accommodation.

iii. Consent from the homeless person should be obtained before any contact with the Homeless Office is made as some people exercise their right of choice to be homeless.

iv. It is vital there is good communication and liaison between hospice and service providers particularly around people in temporary accommodation.

11 The Mental Capacity Act 2005

Listed below are the key points of the Mental Capacity Act (2005) that influence discharge planning.

11.1 Introduction.

The Mental Capacity Act 2005 provides a statutory framework for acting and making decisions on behalf of individuals who lack the mental capacity to do so for themselves. The Act specifies the principles that must be applied by everyone who is working with or caring for adults who lack capacity. It also provides options for those who may choose to plan and make provision for a future time when they may lack capacity.

11.2 The Five Key Principles

1. **A person is assumed to have capacity.**
2. **A person is not to be treated as unable to make a decision unless all practicable steps to help them do so have been taken without success.**
3. **A person is not to be treated as unable to make a decision merely because they make an unwise decision.**
4. **An act done or decision made on behalf of a person who lacks capacity must be done or made in their best interests.**
5. **Before any such act or decision is made the person making or taking it must consider whether the purpose for which it is needed can be effectively achieved in a way that is less restrictive of the person's rights or freedom of action.**

11.3 Independent Mental Capacity Advocates (IMCAs)

i. The Secretary of State is to make such arrangements as to enable IMCAs available to represent and support persons who do not have capacity and have no other appropriate representative to consent concerning what would be in their best interest.

ii. The appointment of IMCAs only relates to the provision of one of the following:
- Serious medical treatment by the NHS
- Change of accommodation in hospital or care home for the person by the NHS.

- Change of residential accommodation by the local authority.

iii. The function of the IMCA is to:

- Provide support to the person to ensure they participate as fully as possible in any relevant decision.
- Obtain and evaluate any relevant information in health records.
- Ascertain what the person's wishes were likely to be
- Ascertain if alternative courses of action are available to the person.
- Obtain alternative medical opinion where treatment is proposed and the advocate thinks one is required.

11.4 Lasting Power of Attorney

This replaces Enduring Power of Attorney. The person who has LPA will be able to make decisions about the person's health and welfare should the person become incapacitated, if such power is conferred.

11.5 Advanced Decisions to refuse treatment

These have also been known as 'advanced directives' or 'living wills':

- Advanced decisions can be withdrawn or altered at any time when the maker has the capacity to do so.
- Where it is clear that an Advanced Decision exists in writing, this should be attached to the patient's file.
- Advanced decisions need not be in writing to be valid, withdrawal or partial withdrawal need not be in writing.
- Alteration of Advanced decisions need not be in writing unless it refers to life sustaining treatments.
- The Advanced Decision has to be valid in that it must address current circumstances and current treatment.

12 Monitoring Compliance and Effectiveness

In order to ensure that this discharge policy is fit for purpose there will be at least an annual monitoring and audit of this policy either in full or in part. Any omissions or actions required will be monitored and the policy updated in line with this.

13 Associated Documents

- Discharge Summary checklist
- Day care Discharge
- Appendix 4

14 Definition

Multi-disciplinary team– refers to a range of staff from both hospice and community e.g. consultant, nurse/midwife, mental health worker, therapist, GP, district

nurse, social care worker or any other body of staff involved in the care and transfer/discharge of a patient.

REFERENCES:				
Lead Author of Policy **Responsible Sub-group** **RATIFICATION DATE BY TRUSTEES** Review interval				
To Be reviewed	Review completed	By	Approved By	Circulation

Appendix 1

DISCHARGE SUMMARY CHECKLIST

Patient's Name……DOB……..…..NHS No…….……

Adm for ……Respite care …… Symptom management …….

Provisional discharge date …… Confirmed discharge date ……

Discharge Details	Yes	Date	Signature
DPM Meeting arranged? (If applicable) Date/Time?			
Patient notified of discharge date?			
Relative notified of discharge date?			
Fast Track completed			
Day care arranged (If appropriate) **Day:**			
Transport arrangements: **Please tick appropriate one** Own: Hospice driver Booked am/pm Ambulance/car booked am/pm			
Sufficient supply of medications/dressings			
Photocopy of treatment sheet if patient discharges to a nursing home			
Discharge Summary			
Discharge transfer details to include DNA CPR statement			
Oxygen ordered (If appropriate)			
Oxygen delivered (If appropriate)			
All medications returned including CDs			
Patient/Relative aware of any changes in medication			
Pressure area record completed			
Drug information sheet completed & given to patient/relative			
Anticipatory medication ordered (If appropriate)			
Anticipatory medication delivered (If appropriate)			
Syringe Driver Loaned: **Please add: Serial Number**			
Infection Control Form (If appropriate)			
Have the following people been informed			
District Nurse Date and Time of next visit (if applicable)			
District Nurse's Notes Returned			
Macmillan Nurse			
GP			
Social Services			
MHCT			
OT/Physic			
Other Professionals			
DNACPR in place?			
System1 entry done?			
Patient Questionnaire given			
Patient Questionnaire completed and received			

Appendix 2

DAY CARE DISCHARGE

From the time of admission it is important that the patient understands that review is on-going and that if their condition improves they will be discharged although they will be able to access the service again in the future if the need arises.
The following guidelines apply when a patient is discharged from the Day care unit:

- The patient and their family (if appropriate) should understand the Rational for the discharge
- The patient and their family (if appropriate) should be reassured that if the patient's condition deteriorates and meets with the Hospice admission criteria their status will be reviewed
- When a discharge is planned the support nurse and key worker should be informed
- The GP should be informed in writing
- Discharge may be delayed for a short while to allow services in the community to be set up.
- Patients may be fully discharged or if staff are concerned that the future seems precarious a soft discharge will be arranged and the staff will contact the patient every few months.

REFERENCES: NLaG Discharge Policy Lead Author: Karen Griffiths Ratified by QA sub-committee 13th July 2017				
review 2 yearly				
TO BE REVIEWED	REVIEW COMPLETED	BY	APPROVED BY	CIRCULATION
July 2019				

Appendix 3

DISCHARGE OF PATIENTS INTENDING TO UNDERGO ASSISTED SUICIDE

We must remember that our patients are entitled to discharge themselves from the service for many reasons, one of which may be to travel abroad for the purposes of assisted suicide.

Although there have been no successful prosecutions of individuals under the Suicide Act 1961, there have been no cases which have tested the boundaries of the law in terms of organisations. Legally it remains unclear what the potential liability would be for an organisation such as the Hospice in such circumstances, but with the DPP guidelines, it does appear that professionals could be prosecuted.

If we have a patient who says they want to travel abroad for an assisted suicide we should be aware that accurate documentation of all conversations is vital. If possible staff should ensure that a senior member of the clinical team is present during these discussions. If this is not possible they should listen but not comment.

Staff may not become involved in finding out details, helping make arrangements or make any contribution to the process at all.

Discussions should take account of the Mental Capacity Act, the Mental Health Act and Safeguarding Vulnerable People guidance.

Hospice staff must ensure that the conversations are documented and that the patient signs a self-discharge form, unless the patient was fit for discharge from the hospice in all other respects which would serve the purpose of summarising the decision taken by the patient, and demonstrating that the decision was the patient's own. This should be witnessed.

This documentation may be required for any subsequent police investigation.

Appendix 4: IPU Discharge

Discharge Summary

Name:

NHS:

DOB:

Address:

GP/Clinician

Date Admitted From Home/Hospital/Day Care

Date discharged To Home/Nursing Home/Other

Dear Doctor

Your patient was recently an inpatient at Lindsey Lodge Hospice.

Background

Problems during admission and management

Medications on discharge

Drug	Dose/Route/Frequency	Drug	Dose/Route/Frequency

Anticipatory Medication

Drug	Dose/Route/Frequency	Drug	Dose/Route/Frequency

Medication discontinued during admission and reason

Drug discontinued	Reason

Allergies

Advanced care plans

Patient insight

Preferred place of care

Preferred place of death

DNA CPR status

Fast track status

ADRT/Power of attorney

Follow up arrangements

I would appreciate if you could please add this patient to your Gold Standards Framework register if they are not already included.

If you have any further questions please do not hesitate to contact us on 01724 270835.

Yours sincerely

Cc (Hospital consultant, community macmillan nurse etc)

Providing Local Services For Local People

PATIENT DISCHARGE/TRANSFER DETAILS

DATE:

NAME:

D.O.B:

NHS number :

ADDRESS:

TEL:

NEXT OF KIN:

NEXT OF KIN TEL:

GP: GP/Clinician,

DATE OF ADMISSION……..……..

DATE OF DISCHARGE……..……

BREATHING
COMMUNICATION
PERSONAL HYGIENE
EATING/DRINKING
MOBILITY/MAINTENANCE OF A SAFE ENVIRONMENT
ELIMINATION
SLEEPING

SYMPTOM MANAGEMENT
PRESSSURE AREAS/TREATMENT
OTHER SERVICES INPUT: MHCT …… (describe care package) OT D/N SALT MACMILLAN NURSE REHAB DAYCARE PHYSIO DIETICIAN OTHER ……..
ADDITIONAL INFORMATION

Please do not hesitate to contact us if any further information is required regarding this patient and their treatment.

Lindsey Lodge Hospice 01724 270835

Staff Name: …… Role:……

Date: …….

Appendix 6: Patient medicines information leaflet

NAME AND STRENGTH OF MEDICINE	REASON FOR MEDICINE	NUMBER AND WHEN TO TAKE				SPECIAL DIRECTIONS	SOME POSSIBLE SIDE EFFECTS