Out of Hours Handover

Introduction

To ensure continuity of care in patients with palliative care needs, information needs to be shared to allow all services who may potentially be involved with a patient to have access to important clinical information and decisions.

When a patient is discharged home from secondary care it is important that relevant information is shared with the general practitioner (GP) and that this is in turn shared with those who may be involved in the patient’s care in the future when the GP is unavailable. Community nursing teams must be informed of a patient’s discharge home at end of life.

This information should cover:

- medical diagnoses
- patient and carers’ understanding of diagnosis and prognosis
- patient wishes
- prescribed medication, including oxygen
- information on medication and/or equipment left in patient’s home
- details of care provision
- appropriate levels of intervention.

Management

Key Information Summary

The Key Information Summary (KIS) is a shared electronic record which includes palliative care information. The information is selected by the GP from their record and updated every 2 hours when any changes are made to this. The KIS information goes from GP records to a central store, where it can be accessed by providers of unscheduled care. Unscheduled care includes NHS 24, the GP out-of-hours service, the Scottish Ambulance Service and hospital emergency departments or admissions units. The information can also be viewed by secondary care clinicians and hospices.

While the KIS is applicable for anyone with a chronic or a complex medical problem, there is a specific ‘palliative care’ tab which allows more detailed palliative and end of life care information to be uploaded and shared.

Currently, information can only be uploaded from GP practices (usually by GPs, but in some areas district nurses or community palliative care nurses have access to the GP system to upload information). Other agencies, such as heart failure nurses or hospices, may ask the practice to include specific information on their patients. Information may only be uploaded with explicit consent from the patient or someone who is legally appointed to act on the patient’s behalf. Information can be shared without consent of the patient if the
patient is a vulnerable adult or child, or is a danger to themselves or others and this must be documented on the record.

Where community nurses are unable to either upload information to KIS or to view the information out of hours, it is important that an alternative mechanism is in place to share clinical information. Many district nursing teams use the multidisciplinary information system (MiDIS) for this purpose.

Information extracted from GP records to KIS includes:

- patient and carer details
- patient’s own GP and nurse
- patient medical condition:
  - main diagnosis
  - other relevant issues
  - allergies and drug reactions
  - current drugs and doses
  - additional drugs available at home
- current care arrangements:
  - syringe pump at home
  - catheter and continence products at home
  - moving and handling equipment at home
- patient and carer awareness of condition:
  - understanding of diagnosis and prognosis
- advice for out-of-hours care:
  - care plan agreed
  - preferred place of care
  - should GP be contacted out of hours? (if yes, contact details)
  - resuscitation status agreed? (if yes, status)
  - will GP sign death certificate in normal circumstances?
  - additional useful out-of-hours information.
- the Anticipatory Care Plan (ACP) is not visible in secondary care:
  - ACP details must be added in special notes section.

Discharge

When patients are discharged from secondary care to the community, refer to Rapid Transfer Home in Last Days of Life guideline:

- contact GP about discharge; a request should also be made to add the patient to their Palliative Care Register and update electronic palliative care summary (ePCS)/KIS
- district nurses should be contacted by nursing team
• ensure original ‘Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR)’ form goes home with the patient
• send supply of current medication home with the patient
• consider prescribing “just in case” medications for patients being discharged for end of life care.

Practice points
• The original DNACPR form should be with the patient – this means it should also follow patients into a hospital or hospice from the community.
• The KIS can be printed so that a copy can be left with the patient.

Reference
Electronic Palliative Care Summary. 2010.