Our patients matter

The University Hospitals of North Midlands aims to provide a high quality service which reflects the needs of our patients, carers and relatives. We are always looking for ways to improve.

If you have any comments, compliments or concerns you can speak with a member of the ward team.

Ward telephone number:

Alternatively, you may wish to contact our Patient Advice Liaison Team (PALS) on

01782 676450

Or via Email:

patientadvice.uhnm@nhs.net

Please speak to a member of staff if you need this leaflet in large print, braille, audio or another language

Approved February 2020 Review March 2022

University Hospitals of North Midlands NHS Trust

Patient Information Leaflet

Making End of Life Discharge Letters GREAT

U·H·N·M charity

Our Aim

- Our aim is to improve discharge letters for patients approaching the last 12 months or less of their life.
- We have introduced the acronym '**GREAT'** to help ensure key messages and decisions about your future care on discharge are communicated clearly to your Community Care Providers.
- You will always be consulted about decisions regarding your care. Your family and carers can also be included if this is your wish. Information in your discharge letter should already have been explained.

What does the GREAT acronym represent?

G **G**old Standards Framework (GSF). This is a framework used by many GP practices, care homes and hospitals to enable early recognition of patients with life-limiting conditions. The aim is to help you to plan ahead, to live as well as possible right to the end. This is to ensure that your GP places you on the GSF register.

R Cardio-pulmonary **R**esuscitation status: Has a decision about cardio-pulmonary resuscitation been made? This is a prompt for clinicians to communicate your wishes to your Community Care Providers.

E **E**nd of life care / anticipatory medications: This is a prompt to your ward team discharging you to ensure you go home with the correctly prescribed injectable supportive medications should you need them at home. For example pain relief medications.

A **A**dvance Care Planning: Let your Community Care Providers know of any plans you have made about your future care. This may include a ReSPECT conversation/ document, advance directives about treatments and information about anyone who has a lasting Power of Attorney in place for your health and welfare.

T **T**reatment escalation/limitation plan— If you suddenly become more unwell at home what would you like to happen and where would you like to be treated? For example future hospital admissions versus care in the community setting.