Your checklist

- ❑ Your care needs have been explained to you
- ❑ Your medication has been explained to you
- ❑ You have discussed your Advance Care Plan with a doctor or a member of the Palliative Care Team
- ❑ Stretcher risk assessment
- ❑ Equipment you may need
- ❑ You understand how to access advice and support when you go home

Contact information

0118 322 7826

rbb-tr.palliativecare@nhs.net

Monday to Friday 8am-4pm

Weekends and Bank Holidays (urgent service only) 8am-4pm.

To speak to the Team Co-ordinator, contact 0118 322 5111 and ask the Palliative Care Team Coordinator on Alertive (8am-4pm).

Feedback

If you would like to comment on or leave feedback about our service, you can e-mail us at: **rbb-tr.palliativecare@nhs.net**

Alternatively, you can write to:

Hospital Palliative Care Team
Royal Berkshire NHS Foundation Trust
Reading RG1 5AN

Please feel free to get in touch, we welcome any feedback.

Patient Advice and Liaison Service (PALS)
0118 322 8338
E-mail: PALS@royalberkshire.nhs.uk
royalberkshire.nhs.uk/about-us/contact-us/patient-advice-and-liaison-service-pals/

To find out more about our Trust visit www.royalberkshire.nhs.uk

If you need this information in another language or format, please contact us on 0118 322 7826 or email rbb-tr.palliativecare@nhs.net

RBFT Hospital Palliative Care Team, May 2026
Next review due: May 2028

NHS
Royal Berkshire
NHS Foundation Trust

The Hospital Palliative Care Team: Discharge Planning (West Berkshire and Oxfordshire)

Information for patients and relatives

0118 322 7826

rbb-tr.palliativecare@nhs.net

Provided by: _____

Date: _____

This leaflet provides important information for people who would like to go home for end of life care.

Care and support

- We can apply for carers to come and support you at home. The maximum care we can request is two carers visiting four times a day.
- However, we may refer you to the Hospice at Home service, who may be able to support you to get home sooner if they have capacity. This service is provided by the Community Palliative Care Team, Sue Ryder, and they can offer a maximum of two carers visiting three times a day.
- Carers can come to your house to help you with personal care and meals if family are unable to.

Access

If you are spending a lot of time in bed or are being nursed in bed, we will need to arrange for our transport team to assess your property to ensure there is appropriate stretcher access to get you home. This is called ‘a stretcher risk assessment’.

Equipment

We would usually recommend that you live and sleep at home, and we may recommend that you have a hospital bed with an air mattress, which we can provide. This ensures carers can support you safely and comfortably. Please note that we do not provide bedding.

Other equipment we are likely to recommend and provide are slide sheets (for carers to use) and an over-bed table. We can also arrange for key safes to be installed.

We will discuss any additional or alternative needs on an individual basis.

Medication

Your regular medications will be reviewed and discussed with you before you go home.

We may also send you home with some “just in case” subcutaneous medications. We then refer you to the district nurses and if any of these medications are needed, they would need to be called to administer them.

If you have a syringe pump, the district nurse will visit you daily at home to replenish this.

Community support

If you are not already known to them, we may refer you to the Sue Ryder Community Palliative Care Team in your area. Their triage team will review and manage your referral.

The Community Palliative Care Team will not be able to visit daily.

We would update your GP and, as mentioned, you will likely be referred to the district nurses.

We will provide you with a support plan with some useful telephone numbers.

We appreciate that this is a lot of information for you, at a challenging time, so please ask us if there is anything that you are unsure of or would like to clarify with us.