**N1 Notification Form**

N1 forms should be sent to the discharge planning office if a patient is identified as having ongoing care needs and consents to having their information shared with the local authority

If a patient does not require any changes to an existing care package, then the same package can be reinstated **if the patient is discharged within 14 days of admission**.

If admitted from a res home and not able to be cared for safely back there after, a N1 should be submitted so suitability for a nursing home can be assessed.

**N2 Notification Form**

Letting the local authority know what a patient will need on discharge and when that patient is ready to be discharged. Itshould be completed when a d/c date can be accurately predicted. On receipt, the local authorities will work to ensure the package can start on the specified date. If unable to start on that date then the local authority will contact the ward to tell them when the actual date of discharge will be

If the discharge date or requirements changes, the original N2 should be resent with the new date and/or requirements.

# The CRR (Community Rehab Referral) form

# The CRR is an assessment by the MDT to enable rehab providers to decide on the most appropriate level of care for the patient. Either a physio or OT should be involved in a CRR. In some instances, only one may be involved. In this situation, it is the responsibility of the ward nurses to ensure all sections of the form are complete (this may include therapy sections if they have not been involved).

**Continuing Healthcare Checklist**

A tool to determine if the patient has a primary health need making them eligible for funding by NHS Continuing Health Care (CHC). It is completed by 2 or more members of the MDT and has one of two outcomes – positive or negative. Family must be offered the option of participating in the CHC assessment before it is undertaken. If the checklist is positive and identifies the patient as needing a full assessment, a referral to Discharge Planning Specialist Nurses (DPSNs) must be made asap.

**Fast Track home to die assessments**

These are carried out on patients who have a rapidly deteriorating condition, usually within their terminal stage of life, with an increasing level of dependency. Patients are identified as appropriate candidates for Fast Track home to die assessments by the senior decision maker within the MDT. As soon as this decision is made; an N2 form should be completed and the Fast Track team should be paged on **07623614629.**

Patients may be discharged home or to another preferred place of care (not a hospice)

A consultant or registrar must take responsibility for completing the medical declaration on the Fast Track documentation. Once completed, the DPSN managing the case will use the documentation to secure funding for ongoing care provision and will assess the patient for nursing & equipment needs as required.

A CHC checklist is not required for Fast Track applications.