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Clinical Excellence Commission Last Days of Life Toolkit

Guidance for Accelerated Discharge to Die at Home – Adult Patients

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Acknowledgement:

This work was informed by a variety of sources including: NSW Health policy, Hastings Network Generalist and Palliative Care team Nursing Handover Form, and National Rapid Discharge Guidance for Patients who wish to Die at Home; National Clinical Programme for Palliative Care, Health Service Executive, Ireland; as well as the clinical expertise provided by the working group members.

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Version control and change history

Version	Description of Change	Created/Modified By	Date
1.0	Original Version	Bernadette King	April 2017

Introduction

Dying patients are cared for in many settings including intensive care units, general medical and surgical wards, aged care units and mental health units. Good management of symptoms in the terminal phase is one of the main concerns of patients and their families. Clinicians have a duty to ensure patients receive appropriate and timely relief from symptoms and distress. The general principles of symptom management the last days of life are:

- dying patients are assessed regularly to allow existing and emerging symptoms to be detected, assessed and treated effectively
- if symptom(s) are present, non-pharmacological measures are instigated in the first instance
- if non-pharmacological measures are ineffective, as required (PRN) medication is given
- if the medication ineffective, patients are reassessed and further intervention and/or escalation is implemented to manage the symptom(s)
- the likely cause and management of the symptom(s) is communicated and explained to patients and their families[1].

Purpose

Key principles of end-of-life care remain the same in all settings. Having inadequate family support and / or community-based palliative care services is often, in practice, a limiting factor for patients who wish to die at home. Planning the care for a patient dying in the non-acute care setting requires an assessment of the setting in which the person is being cared for, and of the capacity and needs of the caregivers. Caregivers, including the family, need to understand the plan of care, and be able to contribute to decision-making and ongoing assessment of the patient. Good teamwork, good documentation, and good communication are essential.

This document aims to support healthcare professionals by describing the model of discharge planning that should be adopted in such circumstances. The accelerated transfer to die plan is a form of integrated discharge planning that begins when a seriously ill patient expresses the wish to die in their home environment. Accelerated discharges are complex processes that require the input of multiple healthcare professionals and it is usually appropriate to involve or seek advice from local specialist palliative care services as part of the process. Effective communication with patient and carer and clear documentation is pivotal for the coordination of an accelerated discharge. The accelerated transfer to die plan ensures that the process is undertaken within an appropriate governance and risk framework[2].

[1] Clinical Guideline for the Pharmacological Management of Symptoms for Adults in the Last Days of Life, SA Health, 2015.
[2] National Rapid Discharge Guidance for Patients who wish to Die at Home; National Clinical Programme for Palliative Care, Health Service Executive, Ireland

Scope

'Home' can include the patient's home; home of their relative / carer; Residential Aged Care facilities; Hostel and Hospice.

It is important to highlight that both clinical staff and families/carers need to be realistic about the time frame to organise an accelerated transition home for last days of life care, particularly when care is complex

Documents available

The charts developed to support staff in enabling patients to be quickly and safety transferred home to die includes:

- Accelerated transfer to die at home plan – ADULT
- Accelerated transfer to die at home - Nursing transfer letter
- Accelerated transfer to die at home - Paramedic transfer letter

When to use this plan

- Focus of care switches from active treatment to supportive care.
- The anticipated prognosis of the patient is approximately 24 - 72 hours.
- There has been an open and honest **documented** conversation with the patient and their family/ carers / care establishment, and they recognise that the patient is in the last days of life.
- The community nursing team and/or care establishment have agreed to accept and to support the patient to die at home.

When NOT to use this plan

- The patient's comfort requires care not able to be provided at home
- The patient's prognosis is likely to be greater than 72 hours or considerably less than 24 hours.
- Insight of the patient and/or their family/carers into the patient's impending death is unknown.
- There is inadequate support available from the family/ carers /care establishment and from essential community services to safely support the patient to die at home.

Related Local and National Standards / NSW Health Policy

NSW Health Policies

- Verification of Death and Medical Certificate of Cause of Death – PD2105_040
- Using Resuscitation Plans in End of Life Decisions – PD2014_030

In line with Australian Commission National Standards

- National Consensus Statement: Essential Elements for Safe & High Quality End of Life Care
- National Standards – Standard 1, Standard 2; Standard 9.

Roles and responsibilities of the multi-disciplinary team in accelerated transfer to die at home planning

Each member of the multidisciplinary team has responsibility for assisting with the development and implementation of the Accelerated Transfer to Die at Home Plan.

Admitting Medical Officer or designated member of his/her team should document in the patient's healthcare record when they are satisfied that patient discharge can occur.

Nursing Unit Manager (NUM) or a designate manages the accelerated discharge process. . Key responsibilities include: acting as advocate for patient and family; contributing to the decision-making process; assisting in implementation of the plan; communicating progress at handover; checking completion of relevant discharge documentation including the accelerated discharge checklist (page 1 of plan).

Allied health services – includes a Social Work, Occupational Therapy and/or Physiotherapy assessment of the needs of patients and their families providing information and education with the aim to optimise patient comfort and minimise carer burden.

The Pharmacist reviews the discharge prescription in line with the drug chart and patient medication record making recommendations as appropriate. They contact the community pharmacist to organise ongoing supply of patients medication and provide them with appropriate transfer of information related to the patients medication management; assists in accessing medication which is not readily available in the community and may at the discretion of the pharmacy department arrange for supplies to take home until supply in the community may be organised.

The Specialist Palliative Care team assesses the palliative care needs of the patient and his/her family, and provides support to the home team as required.

The General Practitioner plays a pivotal role in the care of patient's acute and ongoing medical needs on transfer to the community setting. Completion of the medical certificate of cause of death may be undertaken by the GP where they have reviewed the patient after transfer to the community.

Community Nursing acts as liaison between Hospital and Community to facilitate ease of transfer. They assist and support families in accessing information, equipment and Community Services which facilitates a seamless transition to home. This can include assessing patient and family dynamics and identifying any risk factors that may hinder the discharge process.

Ambulance Service will manage the transfer and support the patient and carer through their journey from the hospital to place of care.

The Accelerated Transfer to Die at Home* Plan

Page 1: Inclusion Criteria/Checklist

Once the request has been made for an accelerated transfer to die at home the medical officer needs to confirm that:

- it is appropriate that the focus of care is palliative
- the decision is made in the patients best interests and reflects the patient's wishes (as much as possible) and the family / carer support the decision
- the GP and/or community services can support the patient at home
- the patient's destination has been assessed to identify any risk to the safety and/or wellbeing of the patient, the family/carers and the community staff visiting and caring for the patient.

The nurse caring for the patient is responsible for coordinating and documenting the discharge process – this should be handed over to the nurse taking over the patient's care on the next shift.

Issues to consider when completing checklist:

Is there a back-up plan if either the patient or the family find it difficult to cope at home?

- clarify and document a plan if this occurs – must be realistic and understood by all involved in the decision to take the patient home to die
- ensure the Authorised Care Plan clearly states the patient is dying and CPR is not appropriate

Will the patient be able to be cared for safety and comfortably in the home?

- consider equipment for nursing a bed-bound patient and ensure family/carers are taught how to work the equipment and provide care safely
- encourage family/carers to consider practical arrangements such as moving patient's bed to different room or even caring for the patient in a different home to their own
- the risk assessment looks at things such as access and home situation however, it is just as important to assess the safety of the care location for visiting staff.

Page 2: Transfer of care coordination

Effective multi-agency and multidisciplinary working is essential to effectively manage the patient's transfer from hospital for last days of life care and all components of the healthcare system (family, carers, hospitals, primary care providers, community services and social care services) should work together to serve the best interests of the patient and to support the family. Each person involved in the patient's plan to transfer home to die should be identified and their contact information noted.

*'Home' can include patient's home; home of family/carer; Residential Aged Care facility / Hostel / Hospice

Medical certificate of cause of death (death certificate):

In order to facilitate certification of death it is essential that prior to discharge, the GP / doctor at the discharge destination is contacted and involved in discussions about completion of the Medical Certificate of Cause of Death.

Page 3: Medication Management Guide

Discharge medications: The medication required to ensure comfort at the end of life can be quite complex and include controlled drugs, syringe driver prescriptions and anticipatory ('breakthrough') medication. It is essential that at least a 3 – 5 day supply of these medications are prescribed and dispensed prior to the patient's discharge. This will be dependent on local policy and the drugs and quantities on the plan are intended as a guide only. Where practicable this should be done 24 hours prior to the planned discharge date.

Page 4 Transfer checklist: equipment and documentation

A checklist of various actions required by medical and nursing staff on the day prior to discharge and the day of discharge is included to ensure that the patient/family/carer, and their primary health care team, has everything they need for ongoing symptom management for their transfer and ongoing care at home.

The day before discharge the team will ensure that all aspects of the discharge plan have been completed. The day of discharge, the doctor should confirm that the patient is fit to travel and a copy of the discharge letter containing medical and nursing summaries of treatment and the management plan for end of life care should be sent to the GP, Residential Aged Care Facility and other members of the primary care and specialist team as appropriate. The nurse will also confirm with community services, where appropriate, that the patient has left the hospital and that the required service provision needs to commence.

Timing of discharge

Discharge can take place at any time of day, any day of the week based on assessment and agreement with patients, carers and primary care services. Consideration must be given to the risks of discharging patients at an inappropriate time especially out of hours. The provision of last days of life care in the community is a complex and often challenging process that usually requires support from a number of healthcare professionals and agencies. It is important to ensure that these supports are available and accessible when discharging a patient out of hours or over a weekend period. If the healthcare professional responsible for the patient's care is not confident that it is safe to discharge the patient out of hours then he / she should advise the team, patient and family of this.

Communication tools to provide to patient and family/carer

Family members/carers role in providing and enabling quality care for people nearing the end of life should be recognised and supported. Verbal information should be supported, wherever practicable, by written information in the appropriate language and format and care should be taken to ensure understanding of all information provided. Useful information brochures form part of the toolkit and include:

- What to consider when your family member or friend has expressed a wish to go home from hospital to die at home
- Family / carer information regarding care in the last days of life
- Family/carer information regarding medications in the last days of life
- When someone dies at home
- Understanding your grief

Accompanying Documentation

Paramedic Transfer letter

This letter provides the paramedics with the aim of transfer. The completed resuscitation plan allows ambulance personnel to proceed to the discharge destination rather than commencing cardiopulmonary resuscitation and/ or diverting to the nearest ED if the patient acutely deteriorates or dies during transfer.

Nursing transfer letter

Provides receiving service/s information on the patient's relevant clinical history, outstanding problems and agreed care plan.

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