



NATIONAL RAPID DISCHARGE GUIDANCE FOR PATIENTS WHO WISH TO DIE AT HOME

**National Clinical Programme for Palliative Care
Clinical Strategy and Programmes Directorate
Health Service Executive**

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1. Introduction

Enabling people to die where they choose is an important aim of palliative care. The issue of preferred place of death is a complex one. Numerous studies have suggested that patients most commonly express a wish to die at home, (Higginson, 2000) but a number of factors, in addition to preference also influence place of death (Gomes, 2006). Preferences around place of care can be challenging to elicit and record and patients may demonstrate an inclination towards one choice or another rather than expressing a preference in categorical terms (Thomas, 2004). Nevertheless, when a dying patient expresses a wish to die at home their request should not be simply viewed as impractical or impossible. Rather, a realistic evaluation of the feasibility of different options should be undertaken.

In many instances this may lead to a consensus decision being made by the patient, family and multi-professional team, that end-of-life care at home is now the priority. This document aims to support healthcare professionals by describing the model of discharge planning that should be adopted in such circumstances. **Rapid Discharge Planning (RDP)** is a form of integrated discharge planning that begins when a dying patient expresses the wish to die in their home environment. Rapid 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 a Rapid Discharge. The Rapid Discharge Pathway ensures that the process is undertaken within an appropriate governance and risk framework.

2. Rationale

This document acts as a supplement to the Health Service Executive (HSE) National Integrated Care Guidance (HSE, 2014). Rapid Discharge Planning is driven by the wishes of the patient and the carer and should be used in circumstances when a clinical situation has changed and there is an urgent request to enable a patient to die at home.

3. Purpose

3.1 The aim of the Rapid Discharge Guidance is to facilitate a safe, smooth and seamless transition of care from hospital to community for dying patients who wish to die at home rather than in a hospital or hospice.

3.2 Its purpose is to promote collaborative working across primary and secondary care and through effective communication, involve the correct professionals to coordinate the continuing care and support necessary for the patient and their family/carers.

The guidance is intended to support and formalise existing discharge planning practice while providing a template for local guidelines. Local policies and guidelines relating to rapid discharge planning should reflect the core elements of this guideline.

4. Scope

The scope of this guidance applies to:

4.1 All health and social care professionals working in the HSE and in any organisation providing services to patients.

4.2 People affected by the guidance are patients, the public, employees of the HSE or people providing services to patients.

5. Definitions

5.1 Discharge is the outcome of the decision made by the patient's consultant/medical team when the patient is deemed fit to leave the hospital/healthcare organisation. It also refers to the event of the patient leaving the hospital/healthcare organisation.

5.2 Discharge Plan refers to the documentation in the patient's healthcare record that demonstrates the key tasks from patient assessment to discharge.

5.3 End of life care/ terminal care is a continuum of palliative care and is usually used to describe the care that is offered during the period when death is imminent, and life expectancy is limited to days or hours.

5.4 Integrated Discharge Planning is a process that encompasses the key elements of discharge: written discharge information, provision of a discharge plan and an estimated length of stay (ELOS). Integrated discharge planning includes the patient and as appropriate, the family/carer in the development and implementation of the patient's discharge plan and ensures that steps are taken to address necessary linkages with other healthcare providers in order to achieve a seamless transition from one stage of care to the next, in accordance with patient need (*Guideline for Nurse/Midwife Facilitated Discharge Planning: HSE, 2009*).

5.5 Rapid discharge planning (RDP) is a form of integrated discharge planning guidance that begins when a dying patient expresses the wish to die in their home environment.

5.6 Rapid discharge pathway: The Rapid Discharge integrated care plan is a model of care to support healthcare professionals to coordinate the rapid discharge of a patient from hospital to home within a governance and risk framework.

6. Roles and responsibilities of team members in Rapid Discharge Planning

Each member of the multidisciplinary team has responsibility for assisting with the development and implementation of the Rapid Discharge Plan, and for communicating effectively and compassionately with patients and their families. Effective multi-agency and multidisciplinary working is essential to effectively manage the patient's discharge from hospital for end-of-life care and all components of the healthcare system should work together to serve the best interests of the patient and to support the family.

Hospital-based team members:

6.1 A Consultant has the primary responsibility for patient care and discharge in the hospital, although this may be delegated to appropriately trained staff. The Consultant or designated member of his/her medical team should document in the patient's healthcare record when they are satisfied that patient discharge can occur.

6.2 A Clinical Nurse Manager (CNM) - The CNM or a designate manages the rapid discharge process, assigning the registered nurse to patient care, thus undertaking nurse facilitated discharge planning at ward/department level.

6.3 A Nurse is responsible for maintaining his/her ability to assess and make critical decisions regarding patient discharge planning which is a generic competency and core clinical responsibility of all registered nurses (An Bord Altranais, 2005; HSE, 2007). Key responsibilities of the nurse include: acting as advocate for patient and family; contributing to the decision-making process which forms the basis for a rapid discharge plan; assisting in implementation of the plan as required by

their line manager; communicating progress at each handover; checking completion of relevant discharge documentation including the rapid discharge checklist (Appendix 1) and engaging in continuing professional development to maintain competence necessary for professional practice.

6.4 A Non Consultant Hospital Doctor assesses patients prior to discharge as required, communicates with patients and their families and follows through with actions arising from either the Consultant's rounds or the nurse facilitated discharge planning process.

6.5 A Social Worker assesses the psychosocial needs of patients and their families. He/she assesses risk, and supports families in identifying both their practical and emotional needs and provides psychological support to assist families in coping with loss and change. In rapid discharge planning, the social worker has a role in facilitating communication between the family and other members of the professional support team both in hospital/ specialist palliative care service and the community. He/she assumes a role as patient/family's advocate in identifying services and providing information, advice and support.

6.6 An Occupational Therapist provides practical advice and support to patients and their carers to enable the patient to be cared for safely at home. If appropriate or possible a pre discharge visit will be carried out to assess the suitability of the environment. The Occupational Therapist will make recommendations about necessary equipment and/or environmental modifications in order to get the patient home as quickly as possible. If it is not feasible to carry out a home visit the Occupational Therapist will liaise with the relevant multidisciplinary team (MDT) colleagues and/or family member to ensure a safe discharge. The Occupational Therapist will follow up as appropriate once the patient is discharged home.

6.7 A Physiotherapist provides information and education to the patient and carers regarding the patient's functional status. The aim is to optimise patient comfort and minimize carer burden. Where appropriate the physiotherapist makes recommendations about necessary equipment and liaises with colleagues for review post discharge.

6.8 A Pharmacist reviews the discharge prescription in line with the drug chart, discharge letter and patient medication record card making recommendations as appropriate; contacts the patient's preferred community pharmacist to organise ongoing supply of patients medication and provides the community pharmacist 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; provides individualised verbal and written medication instructions (if appropriate) for the patient and/or family.

6.9 A Director of Nursing/Midwifery is responsible for facilitating all identified requirements to support rapid discharge planning within the nursing and midwifery portfolio.

6.10 A Hospital Specialist Palliative Care team assesses the palliative care needs of the patient and his/her family, as required by Senior Responsible Consultant. They negotiate, agree and formalise the arrangements to meet the patient's needs; contribute to the decision-making process which forms the basis for the rapid discharge plan and assist in implementation of the plan as required by the referring team.

Community-based members:

Community-based members may work independently or as members of a primary care team. Primary Care teams are multidisciplinary groups of health and social care professionals who work together to deliver local accessible health and personal social services to a defined population. Where present, they provide the access point to the local health and personal social care services such as general practice (GP and Practice Nurses), public health nursing, physiotherapy, occupational therapy, social work, community pharmacies etc.

6.11 A General Practitioner liaises with the hospital team on the feasibility of rapid discharge to the community. Where this is the case the GP can facilitate the transfer through early patient review and prescribing as appropriate. The GP then plays a role in the care of patient's acute and ongoing medical needs on transfer to the community setting. They provide support to the patient, their family and carers alongside the other community based members. He/she may also inform the relevant GP out of hours service of the patient and likely concerns that may arise. In some individual settings the GP may wish to provide out of hours support directly. Completion of the Death Notification form may be undertaken by the GP where they have reviewed the patient after transfer to the community.

6.12 Public Health Nursing (which includes Registered General Nurses in the community) act as liaison between Hospital and Community to facilitate ease of Rapid Discharge. They can assist and support families in accessing information, equipment and Community Services which helps facilitate a seamless transition to home. They can assist in assessing patient and family dynamics and identify risk factors that may hinder the discharge process. Public Health Nursing also plans and implements care in partnership with the multi-disciplinary teams to ensure a robust discharge plan.

6.13 Ambulance Providers will manage the transfer of the patient from bed to ambulance trolley and vice versa at the designated location. They will support the patient and carer through their journey. The practitioners will liaise with the PHN/DON and/or GP on arrival at the destination, if present.

6.14 A Community Specialist Palliative Care team assesses the palliative care needs of the patient and his/her family, as required by the GP. They negotiate, agree and formalise the arrangements to meet the patient's needs and review the plan of care with the GP, community services, patient, carer and family as required.

6.15 A Night Nursing Service (provided by the Irish Cancer Society and the Irish Hospice Foundation) may be provided to patients who are receiving care from a Specialist Palliative Care team. This service is dependent on staff availability, however. The service is available to all patients regardless of their financial circumstances or geographical location for up to 14 nights over the course of the patient's illness. The Service can be accessed through referral from the Specialist Community Palliative Care Team, Public Health Nurse, GP or hospital based Specialist Palliative Care Team.

6.16 A Chief Executive Officer (CEO)/Manager (i.e. hospital CEO/manager or CHO manager) through the senior management team is responsible for ensuring that there are effective local arrangements for rapid discharge planning in their area of responsibility (including the provision of equipment and Home Care packages).

7. Rapid Discharge Planning Guidance

Integrated discharge planning (IDP) routinely starts prior to admission for a planned admission and on admission for all other patients (HSE ONMSD, 2009). Proactive care planning to meet palliative care needs should be included as part of this process for patients with life-limiting conditions, and should include opportunities for discussions about preferred place of care at the end-of-life. This is because timely care planning reduces the need for the crisis response of rapid discharge planning and is associated with improved quality of patient care. However, on occasion, the IDP process will be supplanted by the RDP process when the patient's condition suddenly changes such that his/her prognosis appears to be in the order of hours to days and he/she expresses the wish to die in his/her home environment.

Each member of the multidisciplinary team should demonstrate skill, sensitivity and cultural competency when engaging in communication with patients and their families about these issues. The patient's desire regarding direct communication and information should be respected. The patient also has a choice to

nominate someone to receive information on his or her behalf, or to exclude family member(s) from discussions and decision-making processes.

7.1 Medical discharge decision

A patient whose condition deteriorates such that their prognosis appears to be in the order of days and who expresses the wish to die in his/her home environment should be reviewed promptly by a Consultant or deputised senior doctor. In many cases, the diagnosis of dying is a complex process and may require the input of the MDT. Uncertainty is an integral part of dying and therefore flexibility and responsiveness must be central to the care planning process. For some conditions, patients or their families need to be aware that there is also a remote possibility of longer term survival despite the expectation that the patient will die.

In order for the rapid discharge pathway to be activated, the doctor should confirm that:

- It is appropriate that the focus of care should be solely on palliation in the patient's home environment,
- The patient chooses to die at home (where the person possesses capacity) or that the decision being made reflects the known beliefs and values of the person and is of benefit to the individual (where the person lacks capacity)
- Family / carer support patient decision (where a family/ carer exist and patient has indicated that information may be shared)

7.2 Initial communication between hospital and primary care services

Communication is the key to delivering effective care co-ordination. Working with primary care services and sharing information is essential and will ultimately influence whether a patient achieves their preferred place of care. Once the rapid discharge pathway is activated, the patient's GP and PHN (and other relevant member of the primary care or specialist team) should be contacted as soon as possible in order to inform them of the patient's prognosis and wishes and to discuss the potential for rapid discharge. In the case where the patient's home is a residential care setting contact should be made as soon as possible with the Director of Nursing so that the necessary arrangements can be made for the patient's transfer. If the GP, PHN or DON is not contacted on the day that the pathway is activated, the reasons for this should be documented in the patient's healthcare record.

There are three possible outcomes to the communication between the CNM, GP and PHN/DON:

- **The GP and PHN/DON may confirm that rapid discharge is appropriate,**
- **The GP and PHN/DON may state that rapid discharge is appropriate but that its feasibility is contingent on certain supports/ services being provided,**
- **The GP and PHN/DON may state that in their considered opinion that rapid discharge poses a clinical risk to the safety or well-being of the patient or their carers.**

The remainder of this section (7) outlines the processes to be followed in the event of the GP and PHN confirming that rapid discharge is appropriate.

If the GP or PHN do not consider rapid discharge to be appropriate, then skip to section 8.

7.3 Preparing the Rapid Discharge Plan

In the event of the GP and PHN/DON confirming that rapid discharge is appropriate, the ward manager (or deputy) should make same-day contact with the PHN/DON in order to finalise the care plan. The contact may include the Palliative Care CNS, Social Worker and Community Intervention Team, where appropriate. If discharge is dependent upon supports being provided, then a clear action plan should be agreed that results in these supports being put in place. A provisional date for discharge should be agreed; it is important to be realistic about the time frame to organise a rapid discharge, particularly if care needs are complex and if there is a short length of time available to organise home care services, provide equipment and medical supplies.

If same-day contact is not made with the PHN/DON, then the reasons for this should be documented in the patient's healthcare record.

7.4 Communicating with Patient and Family about the Rapid Discharge Plan

In the event of the GP and PHN/DON confirming that rapid discharge is appropriate the Ward Manager (or deputy) should communicate this to the patient and/or family and seek their agreement to the proposed care plan.

The remainder of this section (7) outlines the processes to be followed in the event of the family agreeing to the care plan.

If there is disagreement between patient, family or healthcare professionals, then skip to Section 8

7.5 Implementing the Rapid Discharge Plan

(a) Equipment: Members of the MDT should assess the patient's care needs prior to discharge and make arrangements for the provision of necessary equipment in the home e.g. pressure relieving devices, continence products, dressings etc. In the case of the patient returning to a residential care setting discussion about equipment requirements should take place between the ward manager (or deputy) and the Director of Nursing.

(b) Services: The following community-based services have particular roles to play in the provision of end of life care in the community. Members of the MDT should assess the patient's care needs prior to discharge and make arrangements for the provision of appropriate packages of care, if required. A rapid discharge is a complicated process and generally speaking, referrals to both hospital-based and community specialist palliative care teams are advised.

Night Nurses – Up to 14 nights of a free Night Nursing Service (provided by the Irish Cancer Society and the Irish Hospice Foundation) may be provided to patients who are receiving care from a Specialist Palliative Care team. This service is dependent on staff availability, however.

Community Intervention Team (CIT) – Where available, this 7-day service supports the provision of fast-tracked access to Nursing and Home Help services for patients who have been medically assessed and it has been determined require the additional services of the CIT.

Priority Home Care Package – The scheme is aimed mainly at those requiring medium to high caring support. Support packages are tailored to the patient's individualised care needs.

(c) Discharge medications: Medication required to ensure comfort at the end of life is often complex and may include controlled drugs, injectable medication for the syringe pump and anticipatory ('breakthrough') medication. Often this medication is not held as routine stock by community pharmacists and must be ordered. Ideally 24 hours prior to the planned discharge prescriptions

should be completed and the patients nominated community pharmacy contacted by phone to order the appropriate medication. Prescriptions should then be faxed to the community pharmacy and the original prescriptions given to the patient's family / carer for presentation to the community pharmacy for dispensing. If the community pharmacy is unable to supply the medication within the time-frame required to facilitate the rapid discharge a request should be made to the hospital pharmacy department to dispense the medication. At least 3 days of medication should be prescribed, dispensed and available in the home prior to the patients discharge. This should be confirmed by the Ward manager before discharge occurs.

Note:

- Prescriptions for controlled drugs should be handwritten in accordance with legislative requirements.
- For patients with a medical card a community pharmacy can dispense 7 days of medication on receipt of a hospital prescription written and presented for dispensing within 24 hours.
- Useful information on Dispensing of Emergency Supplies on a Hospital Prescription Form for a GMS Patient may be found at the following site:

<https://ipu.ie/wp-content/uploads/2015/01/Dispensing-of-Emergency-Supplies-of-Medicines-TCs.pdf>

(d) Carer education and support:

Carers should be recognised as key partners in the care team and their role should be recognised and supported (Appendix 5). While caring for someone who is dying can be a rich and rewarding experience, it can also adversely affect family caregivers who are not sufficiently supported and lack adequate resources. Carers' needs for supports in the following areas should be assessed as part of the discharge planning process: psychological and emotional support, help with personal, nursing and medical care of the patient, out-of-hours and night support and informational support. 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 may be found at the following sites:

<http://familycarers.ie/>

https://www.cancer.ie/sites/default/files/content-attachments/time_to_care_2010-1.pdf

(e) Transport: The patient's ability to travel home should be assessed and appropriate transport arrangements made. Most, though not all, patients will require ambulance transfer and all pertinent information regarding the patient's condition should be given to the ambulance service transporting patients (e.g. infection, infusions, issues regarding transferring and in respect to patient handling). A letter detailing actions to be taken in the event of a cardiopulmonary arrest should accompany the patient on discharge. The letter should document the DNAR decision and also should detail whether the ambulance should continue to the discharge destination or return to the hospital (see appendix 4). This is because ambulance personnel require Do Not Attempt Resuscitation (DNAR) documentation in order to proceed to the discharge destination rather than commencing cardiopulmonary resuscitation and/ or diverting to the nearest Emergency Department in the event of the patient dying while being transported home. Best practice guidance on DNAR decisions can be found in the National Consent Advisory Group National Consent Policy at:

http://www.hse.ie/eng/about/Who/qualityandpatientsafety/National_Consent_Policy/consent.html

(f) Timing of discharge: Discharge can take place at any time of day, any day of the week based on an assessment and agreement with patients, carers and primary care services. However, consideration must be given to the risks of discharging patients at an inappropriate time when discharging patients out of hours. The provision of end 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 patient and family of this.

7.6 Handover

At all stages during the inpatient period, the progress of the discharge plan will be communicated at handover. It is the responsibility of each clinician on any specific inpatient day to be fully aware of the progress of the discharge plan of patients in their direct care. Refer to the NCEC guideline on handover in the acute hospital setting

Further details can be found at:

http://health.gov.ie/wp-content/uploads/2015/12/Summary_Clinical-Handover-No-11-FINAL-APPROVED-FOR-WEB.pdf

7.7 Immediately prior to discharge

Prior to discharge, the nurse should check that all aspects of the discharge plan have been completed. 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 in a timely manner to the GP, PHN/DON and other members of the primary care and specialist team as appropriate. The nurse should also confirm with community services, where appropriate, that the patient has left the hospital and that the required service provision needs to commence. The format of this communication should be agreed locally. This is documented in the discharge plan section on the transfer/discharge communication record.

8. In the event of the GP, PHN or a family member considering that rapid discharge poses a risk to the safety or well-being of the patient or their carers.

8.1 Concerns raised by GP or PHN:

A patient is not simply discharged from a hospital; rather, he/she is discharged from a hospital *into the care of a GP or primary care team*. Therefore, the support of primary care services is pre-requisite to any rapid discharge process. If a GP or PHN considers rapid discharge to pose a clinical risk to the safety or well-being of the patient or their carers, then this **must** be considered carefully. Intensive efforts should be made to address the concerns of the primary care services and, providing this is achieved, discharge may proceed. If it does not prove possible to satisfactorily address the concerns of the primary care services, then a case conference between hospital and primary care services should be convened to consider the matter further. The patient and family should be kept informed of the stages of this process.

8.2 Concerns raised by family/carers/those important to the person:

Disagreements between family members or between the patient and family members can sometimes occur when making decisions about place of care at the end of life. Ideally, patients are able to determine their own decisions for place of care at the end-of-life and these decisions are respected. However, the situation is frequently complex either because patients lose decision-making capacity towards the end-of-life or because a significant part of the responsibility for providing care falls on family members. In such situations, family support is often necessary to ensure that a person is safely cared for at home. A consensus building approach to care planning should be adopted. The approach should consider the patient's wishes and best interests as paramount but should also recognise the needs of family members. This collaborative process aims to develop agreement on a plan of care that is as consistent with the patient's wishes and values as possible, and which also supports the family in the degree of involvement it wishes to have.

It should be remembered that decision-making at the end of life is often stressful and circumstances frequently change. As a result, patients and their families may sometimes change their mind about their participation with the rapid discharge planning process and this should be respected.

9. Certification of death, role of the coroner, and cremation

9.1 Medical certification of Cause of death

Medical Certification of cause of death is the process of completing the **Death Notification Form**, and can only be completed by a doctor who has looked after the patient during their last illness. This is usually interpreted as a doctor who has seen the patient within the last 28 days of life. The doctor who completes the Death Notification Form does not have to see the patient after death, if the death has been pronounced by another professional.

The Death Notification Form is then presented to the Registrar of Deaths at the Civil Registration Office by the next of kin. Subsequently, the Death Certificate is issued, which declares the date, location and cause of a person's death, as later recorded in the official Register of Deaths.

Where rapid discharge home to die is being considered and planned, a doctor who will act as the certifying doctor should be identified. They should know what the expected cause of death is, and whether reporting the death to the Coroner will be required. This can be either the GP caring for the patient at home, or the hospital doctor who cared for the patient during their last illness.

The GP at the discharge destination should be contacted prior to patient discharge. The GP should be provided with information on the disease or condition that has caused the patient's deterioration and be asked to review the patient at home following transfer (as this will be required in the event of the GP completing the Death Notification Form if he/she has not seen the patient in the preceding 28 days, or in the case of cremation being planned).

Otherwise, the hospital doctor who cared for the patient during their last illness will be required to complete and issue the Death Notification Form after the death (and possibly to travel to the community to see the body after death, if cremation is planned). This doctor must be identified in advance of the rapid discharge, and the doctor's name and contact details must be documented on the rapid discharge pathway and the medical transfer letter.

9.2 Cremation

Where cremation is planned, additional documentation (cremation forms) must be completed by a doctor. The doctor who completes the cremation forms must have seen the patient *both before and after death*. Because the cremation forms include a section relating to cause of death, it is generally preferred that the same doctor who completes the Death Notification Form also completes the cremation forms, but it need not necessarily be so.

9.3 The Coroner

Certain deaths are reportable to the coroner, and a smaller number of these deaths require a coroner's inquest and/or post-mortem examination.

If it is anticipated that a coroner's inquest or post-mortem will be required or there is any concern expressed around the expected cause of death from either medical staff or those important to the dying person this often means that rapid discharge for end of life care at home cannot occur due to the complexity of issues surrounding the requirement for a coroner's post-mortem. Cases must be considered on an individual basis by the responsible consultant in order to determine whether rapid discharge at home can or should occur.

10. In the Event of a Patient Dying While Being Transported Home By Ambulance

Sensitive discussion should take place with those important to the dying person regarding the possibility of a cardiopulmonary arrest taking place in transit and agreement sought regarding the actions that will be taken in such event (e.g. that the ambulance staff will allow natural death to occur and whether the ambulance should proceed to the planned discharge destination or return to the hospital).

10.1 In the event of a patient dying while being transported home by ambulance

The following actions are recommended:

- The patient should be transported to the planned destination.
- The ambulance personnel should inform those important to the dying person at the destination that death has occurred (if they have not accompanied the patient).
- The patient's remains should be placed in the bed prepared for receiving the patient.
- The GP should be contacted to pronounce death.
- The hospital doctor should be contacted to liaise with the Coroner, and thereafter to complete the Death Notification Form,
- The discussion with the Coroner will ordinarily result in a decision to name the destination (usually the patient's home) as the place of death
- The PHN should be notified that death has occurred.

10.2 Discharge summary and letter

A discharge summary and letter detailing actions to be taken in the event of a cardiopulmonary arrest must accompany patients who are transported home by ambulance. This letter should form part of the record generally, and all people caring for the patient need to be aware of it. This is because ambulance personnel will need this documentation in order to proceed to the discharge destination rather than commencing cardiopulmonary resuscitation and/ or diverting to the nearest accident and emergency department.

11 Implementation

11.1 This guideline for rapid discharge planning will be disseminated through the Palliative Care Programme to all HSE services and any facility providing services on behalf of the HSE. It is available to download from the HSE webpage: www.hse.ie/palliativecareprogramme

12 Audit and Evaluation

12.1 Audit of discharge practices should occur as part of the implementation of the national HSE Code of Practice for Integrated Discharge Planning (2013).

12.2 This associated guideline is for review two years from approval or earlier if required. Audit of staff views and experience of the guideline will inform any required changes.

13. This document must be read and used in conjunction with:

An Bord Altranais (2000) Code of Professional Conduct. An Bord Altranais, Dublin.

An Bord Altranais (2000) Scope of Nursing and Midwifery Practice Framework. An Bord Altranais, Dublin.

An Bord Altranais (2001) Guidelines for Midwives. 3rd Edition. An Bord Altranais, Dublin.

An Bord Altranais (2002) Recording Clinical Practice Guidance to Nurses and Midwives. An Bord Altranais, Dublin

Department of Health. Communication (Clinical Handover) in Acute and Children's Hospital Services. National Clinical Guideline No. 11 Summary. November 2015. ISSN 2009-6267.

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Health Service Executive (2014) Integrated Care. A practical guide to discharge and transfer from hospital. Retrieved November 21st 2016, from <http://www.hse.ie/eng/about/Who/qualityandpatientsafety/safepatientcare/integratedcareguidance/>

Any other locally approved guidelines relating to integrated discharge planning

14. REFERENCES

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15. APPENDICES

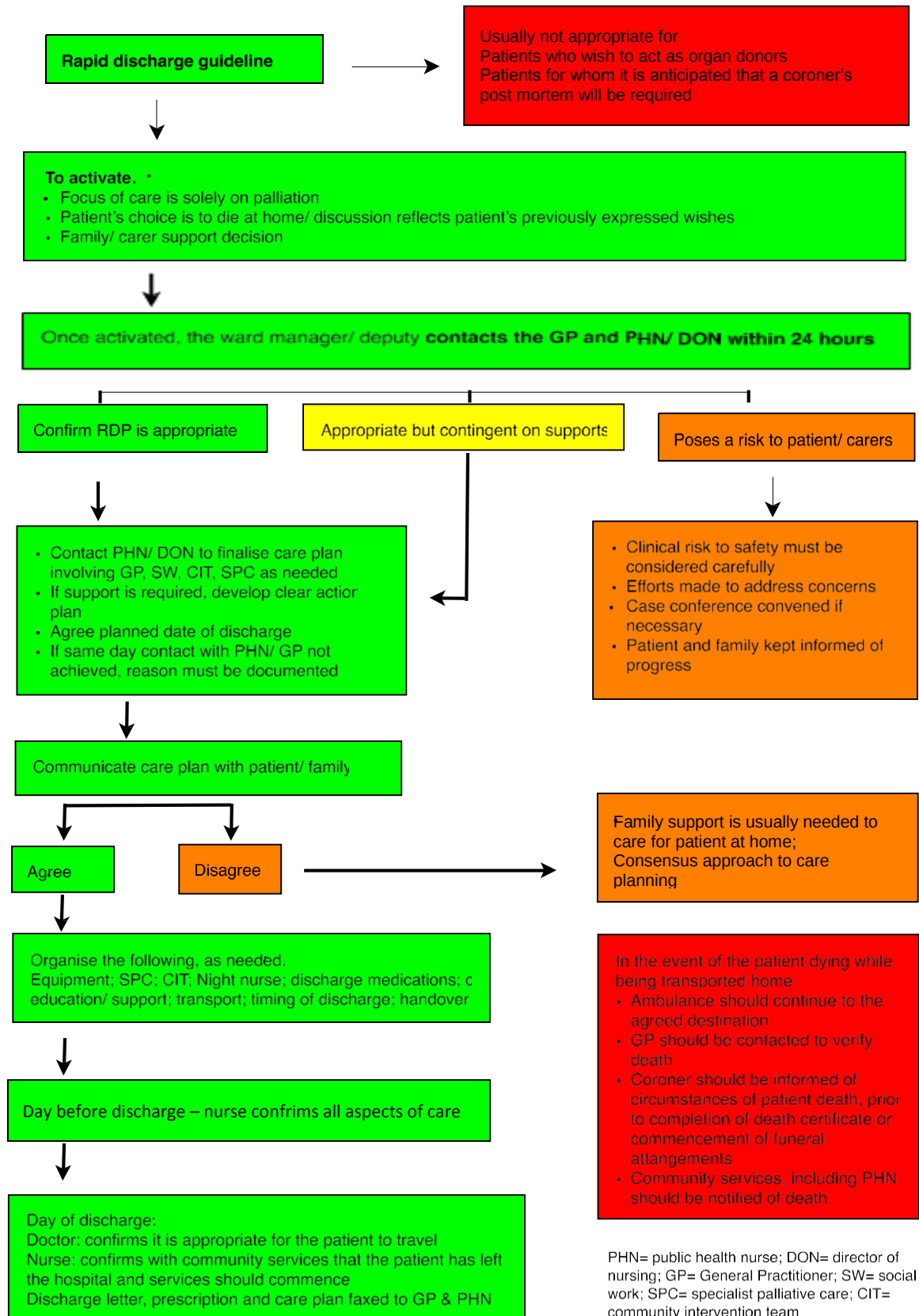
APPENDIX 1. Rapid Discharge Action Plan- Summary of Key Steps

Rapid Discharge Action Plan- Summary of Key Steps	Section
STEP 1: The dying patient chooses to die at home and no issues are identified regarding the potential need for a coroners post mortem	7.1 9 10
STEP 2: Doctor: - Confirms that it is appropriate to focus on palliation at home. - Family / carer support patient decision (where a family/ carer exist and patient has indicated that information may be shared). - Medical Consultant/designate records in the patients' health care record that they are satisfied that discharge can occur.	7.1
Step 3: CNM: - Identifies the lead nurse to manage the rapid discharge process - Supports the process	7.2
Step 4: Lead Nurse: Initiation - Contacts GP, PHN/DON and other members of the primary care or specialist team as soon as possible in order to inform them of the patient's prognosis and wishes and to discuss the potential for rapid discharge. - The GP and PHN /DON may confirm that rapid discharge is appropriate- <i>plan continues</i> - The GP and PHN /DON may state that rapid discharge is appropriate but that its feasibility is contingent on certain supports/ services being provided –<i>plan continues taking advice into consideration</i> - The GP and PHN /DON may state that in their considered opinion that rapid discharge poses a clinical risk to the safety or well-being of the patient or their carers- <i>every effort is made to reduce or eliminate the risk where possible. If not possible liaise with patient and family</i> - Communicate the outcome to the patient and family Planning - Liaise with PHN/ DON and develop care plan - Involve members of the MDT as required -Medical Social Worker, Occupational Therapist, Physiotherapist, Pharmacist, Palliative Care CNS, Community based Palliative Care, Community Intervention Team - Support family. Ascertain their level of understanding of what is expected of them. - Provide carer education as per Appendix 3 - Organise equipment and medical supplies - Organise transport - Write nursing discharge letter - Confirm prescribed medication is available in the home (New) Hospital MDT Physiotherapy - Assess patients re needs on discharge - Liaise with primary care Physiotherapist as appropriate Occupational Therapy - Assess patients re needs on discharge - Liaise with primary care Occupational Therapist as appropriate - Arrange for essential equipment to be set up at home to facilitate rapid discharge Medical Social Work - Assess and address patient and family psychosocial and essential practical needs Pharmacy - Liaise with community pharmacy re medications not licensed for use in the community or medications difficult to source in the community e.g. Buccal Midazolam - Liaise with community pharmacy re costly medications not available on the GMS which may require the 'Hardship Scheme'	7.2- 7.8

National Rapid Discharge Guidance for Patients Who Wish to Die at Home

Palliative Care CNS ○ Assess if a Night Nurse is required. If so organise. ○ Assess if the Community Specialist Palliative Care Team are required ○ Contact the Community Palliative Care Team if required. ○ Advise re stat medication prescription NCHD ○ Write discharge letter ○ Write directions for Night nurse ○ Write prescriptions- regular medications/p.r.n. medications ○ Ambulance services letter, including DNAR order as appropriate ○ Contact GP re pronouncement and issuing of Death Notification Form Discharge: ○ Letters to GP, PHN/ DoN and other member of the primary care or specialist teams as appropriate ○ If patient is on a syringe pump, change immediately prior to discharge ○ Prescriptions and handover to family unless transferring to residential care facility	
Ambulance Provide transport to the patient's home	10

Appendix 2: Rapid discharge algorithm



Appendix 3. CHECKLIST FOR RAPID DISCHARGE OF A PERSON WHO WISHES TO DIE AT HOME

Please refer patient to the palliative care service before using this list

- **Discuss discharge with patient if appropriate**
- **Confirm discharge date with family, preferably key contact or next of kin**

Medical Team

1. Prescriptions:
 - If possible scripts to be issued at least 24 hours in advance of discharge date
 - Ensure all relevant regular and PRN medications prescribed
 - Make sure all MDA scripts are correctly written (on MDA prescription)
 - Tell family to bring prescriptions to pharmacy IMMEDIATELY in order to ensure medications in the house before patient's arrival
 - If a patient has a medical card (GMS) the pharmacist will require also the GP to re prescribe the medication on a GMS prescriptions but a short term supply can be dispensed by the pharmacy at the outset without this if the hospital prescription is presented to the pharmacy within 24 hours of the date it is written.
2. Home Oxygen:
 - If necessary, organise Home Oxygen/nebulisers
3. Resuscitation Status:
 - Clarify resuscitation status
 - Document resuscitation status for the ambulance staff (use Hospital headed notepaper)
 - Has patient ICD device? If so, is it and the alarms switched off?
4. G.P. and Documentation:
 - Discuss discharge with G.P. by telephone in advance of discharge- notifying a GP of a rapid discharge by letter after the event is not acceptable.
 - Organise discharge letter
 - Complete Community Palliative Care referral form
 - Complete documentation for Night Nurse if required

Nurses & Ward Staff

1. Transport:
 - Organise ambulance transfer
2. PHN:
 - Discuss discharge with Public Health Nurse, including proposed date and request all necessary equipment (e.g. hospital bed, pressure relieving mattress, dressings, suction if required)
3. Prescriptions:
 - Ring community pharmacist on day before discharge to make sure all drugs are available to dispense to family
 - If community pharmacist perceives any delay with medications being in house on discharge, contact ward pharmacist who may dispense a short supply
4. Syringe Pump:
 - Replenish pump prior to leaving ward
 - New battery to be put into syringe pump

5. Ensure documentation & equipment for Night Nurse is provided

Palliative Care Team

- Communicate with Community Palliative Care Team to agree date of discharge and care plan
- Make a request to the Irish Cancer Society for a night nurse, if needed

Irish Cancer Society Night Nurse:

A patient who has cancer and who is under the care of the specialist palliative care team is eligible to night nursing support from the Irish Cancer Society but is NOT guaranteed a nurse. A patient without cancer may have a Night Nurse funded by the Irish Hospice

Foundation. This is organised by the Irish Cancer Society but is also NOT guaranteed.

- Request for night nurse usually is made by the hospital palliative care team
- Nursing transfer letter by ward staff should be given to family for night nurse
- Written documentation of drugs and dosages, to be administered to the patient if required, signed by a doctor should be included in Palliative Care Night Nurse Letter
- Community palliative care team should be advised of name of Night Nurse and contact details by the hospital specialist palliative care team or ward staff

Equipment to be supplied by ward and given to family to facilitate provision of personal care at home:

- Gloves X 6 pairs
- Aprons X 3

Equipment required when a patient is on a Syringe Driver (also known as McKinley pump)

- 1 Small sharps box.
- 6 Orange needles, green and blue needles
- 6 2ml syringes
- 2 10ml Luer Lock syringes
- 6 Alcohol wipes (e.g. Mediswabs)
- 1 Giving set for subcutaneous pump and 9 volt battery
- 2 Transparent adhesive dressings
- 4 Water for Injection 10ml vials

If you have any queries regarding any aspect of this checklist please do not hesitate to contact any member of the Hospital Specialist Palliative Care Team

Appendix 4. Sample letter for ambulance transfer

Destination address:

Destination address in event of patient dying en route (*please detail whether the ambulance should continue to the home destination/ divert to the nearest hospital/ return to the original hospital*):

Date:

Dear Advanced Paramedic / Paramedic / EMT,

Mr/ Ms (*please complete*) is being transported to the above address for the purpose of facilitating his/ her wish to die at home. Therefore, the focus of care is solely on palliation and cardiopulmonary resuscitation should not be attempted in the event of a cardiopulmonary arrest.

In the event of Mr/ Ms (*please complete*) dying while being transported home by ambulance, you should:

- Follow PHECC Clinical Practice Guidelines 5/6.4.8 and 4.4.8 (End of Life – DNR; 2017)
- Contact NAS Control to confirm geographic location at time of death.
- Inform NAS Control of intent to complete journey to destination, as per Rapid Discharge Planning Pathway.
- Transport the deceased patient to the destination address detailed above.
- Inform the family/carer sensitively at the destination that death has occurred (if family/carer have not accompanied the patient).
- Place the patient's remains in the bed prepared for receiving the patient.
- Request for NAS Control to contact the GP to verify the death (unless diverting to hospital destination in which case hospital doctor will verify death).
- Request for NAS Control to notify the PHN of the death (unless travelling to a residential care facility, in which case a Nurse Manager will contact GP/PHN).

Requirements during transport:

Mr/ Ms _____ requires the following to be present during the transport:

Syringe Driver: Yes / No (circle as appropriate)

Portable oxygen: Yes / No (circle as appropriate)

Family/friend present: Yes / No (circle as appropriate)

Other equipment/requirements: _____

Yours sincerely,

.....

Doctor.

MCRN:

Appendix 5. Carer education and support- useful prompts

Care information that may assist families to continue care on discharge.	
Medication Management <i>Note- it is advisable that written advice is also provided on medication management</i>	Provide information on: • What the medications are for • When the medications should be given • How the medications should be administered • Any specific plans for symptom management including use of a continuous subcutaneous infusion
Patient comfort	Provide information on how to: • Deliver simple mouth care • Deliver simple eye care • Deliver simple pressure area care prevention • Move the patient in a safe manner • Change sheets while the patient is in the bed • Attend to the patients hygiene • Manage reduced hydration and dietary needs
What to do if the patient becomes distressed?	Provide advice on which healthcare providers should be contacted in the event of the patient becoming symptomatic. Explanation that if the family dial "999" this will usually result in admission of the patient to hospital. Remember to give the contact numbers of the GP and out of hours services (and the Community Palliative Care Team if involved)
What to expect as the patient approaches death?	Explanation that the person is expected to die following discharge but that this may not happen immediately and there may be an interval of hours or days at home. Discuss the usual changes to expect as death approaches • The patient weakens, sleeps more • He/ she has reduced interest in food or fluid • Eventually he/she becomes less responsive and changes in breathing pattern and circulation occur ○ Breathing becomes more shallow and irregular ○ Breathing may become more noisy ○ The person's colour changes and he/ she may become cool to touch • Eventually his/her breathing will stop and pulse will disappear. Discussion and explanation that cardiopulmonary resuscitation should not be attempted as this is not appropriate.
What to expect/do around time of death?	Important to reassure death is not usually dramatic and to encourage the family to spend time with the patient, if this is what they want Describe how to recognise death has occurred Contact GP or Out of Hours service as appropriate Contact funeral director +/- Contact spiritual advisor +/- Take battery out of the continuous subcutaneous infusion but do not

National Rapid Discharge Pathway for Patients Who Wish to Die at Home

	remove the needle of the continuous subcutaneous infusion Turn off the heating in the room
How to organise the funeral/burial?	Discuss the patient's preferences if possible Involve the appropriate people Choose and contact a funeral director Contact the religious advisor (if indicated) If cremation is chosen, cremation form must be completed before funeral arrangements progress by the responsible doctor.
Support	Provide information on who family can contact if they are worried e.g. GP/ PHN/ Specialist Palliative Care Team /Hospital Advise to try to pace themselves and that it is alright to accept offers of help.

APPENDIX 6. Troubleshooting - frequently asked questions

1. What should I do in the situation where a patient states that they want to be discharged for end of life care but their family/ carers state that they do not wish this to happen?

- Investigate the family's fears and reasons.
- It may be possible to provide reassurance or allay fears
- If unable to support discharge, discuss with patient

2. What should I do in the situation where a patient states that they want to be discharged for end of life care but carers are not available?

- Investigate what services are available in the community to support discharge
- If unable to support discharge, discuss with patient

3. What should I do in the situation where a patient states that they want to be discharged for end of life care but a member of the MDT feels it is not appropriate?

- Investigate reasoning.
- If unable to support discharge, discuss with patient

4. What should I do in the situation where a patient states that they want to be discharged for end of life care over a weekend period?

- Find out what supports are available and accessible over the weekend
- Weigh up the benefits and risks of discharging patients at this time
- Make a decision on whether to support the discharge or not, that is in the best interests of the patient
- If unable to support discharge, discuss with patient

5. What should I do in the situation where a patient states that they want to be discharged for end of life care but they live in an upstairs flat and are unable to climb the stairs?

- Liaise with ambulance service to determine feasibility of transfer

6. How can I best prepare carers?

- Explore carer expectations around care delivery
- Explore carer fears.
- What to do if the patient is symptomatic
- What to do when the patient dies
- Involvement/impact on children
- Ensure patient goes home with enough medications for the short term and a prescription for refill
- Check that prescribed medications are available in local pharmacy.
- If on a syringe driver/pump, provide a prescription.
- Provide medications/administration equipment/prescription for night nurse to use
- Go through medications with carer so that they recognise when to administer and for what reasons.

- Ensure there are stat medications available to treat for nausea, pain, secretions, anxiety.

7. What do I do in the situation where a patient does not have a medical card?

- In cases where a medical card is required in emergency circumstances, such as when a patient wishes to be discharged home to die, an emergency medical card may be issued.
- No means test applies and cards will be issued within 24 hours
- Liaise with Social Work or the individual's GP in order to arrange for its provision.
- Ensure that the GP is informed of the GMS number if the Social Worker has made the application prior to discharge.

8. Who do I advise carers to contact in the event of an emergency?

- Ensure carer is aware of which professionals are available to support them and how to contact them.
- Check who is available to give support within their social circle