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Discharge Planning in End of Life Care

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Introduction

"I want to be cared for and die in a place of my choice" (NHS England, 2015).Exploring and achieving peoples' preferences for place of care and death are acknowledged to influence the quality of end of life care (Department of Health (DH), 2008; DH, 2010; MacLeod, 2011, National Institute for Health and Care Excellence (NICE), 2019). Moreover, achieving preferred place of death (PPOD) has become a marker of the quality of end of life care (DH, 2010; Macleod, 2011) with existing evidence claiming that most people wish to die at home (Gomes, Calanzani & Higginson, 2012). However, some literature and anecdotal evidence challenges this orthodoxy and proposes that high quality alternatives are needed as the concepts of preference and choice are complex and conflicting (Hoare et al, 2015; Pollack, 2015). Nevertheless, for some patients home will be preferred hence the need for robust discharge processes. Therefore, this article will provide a practical overview, explore the key considerations and the role of the nurse in effective discharge planning for patients who have expressed a wish to die at home. This will be done by using the Five Priorities of Care for the Dying Person (Leadership Alliance for the Care of the Dying Person (LACDP), 2014) as a framework to promote safe discharge in end of life.

Priority 1 – Recognising

Recognising that a patient may be nearing the end of their life or imminently dying is a key consideration. Early recognition of dying is vital to allow for discussions to be started about the patient's wishes, for example their preferred place of death and for discharge planning to be initiated (National Institute for Health and Care Excellence (NICE), 2019). If recognising dying is delayed, then there is a risk that these wishes are not identified soon enough and discharge home may not be achieved.

Rapid discharge home in the patients' last days of life is possible and involvement of local specialist palliative care teams for support in facilitating these complex discharges can be helpful (NHS England,2015) A senior doctor should assess the patient if there has been a sudden or unexpected

deterioration in a patient's condition to ascertain whether the deterioration is potentially reversible, or confirm that the patient may be dying (Leadership Alliance for the Care of the Dying Person (LACDP), 2014).

Priority 2 - Communication

Sensitive communication needs to take place between the dying person, those identified as important to them and members of the health care team. Early, effective communication, both verbal and written is essential in aiding a seamless transition of care by ensuring that patients receive timely, coordinated care, with involvement from the appropriate services and members of the multi-disciplinary care team (Fig 1). In particular, if a patient is expected to die soon, there needs to be an explanation about how death might be expected to occur, whilst accepting the uncertainty of the prognosis, as well as discussing the plan of care and giving the dying person (and those identified as important to the dying person) the opportunity to ask questions (LACDP,2014). It is also important to discuss with the patient and the family, the potential risk of dying in transfer to their preferred place of death.

Fig.1: Key members of the Multidisciplinary Team (MDT)

Priority 3 – Involve

Patients have a right to be involved in decisions about their care and consideration should be given to what extent the patient wants to be involved, appropriate information should be given to enable decisions to be made and should include those important to the patient and carers (DH 2015). There are national initiatives such as ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) (2019), which is aimed at encouraging patients and their families to be involved in decision making about their care and preferences, in order to ensure that they receive the right care and treatment in a future emergency. Important conversations to have may include, Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR), Advance Decision to Refuse Treatment (ADRT) and Emergency Health Care Plans (EHCP). However, there may be occasions where patients lack the capacity to make a decision regarding PPOD, and in this situation, decisions should follow a best interest process (Mental Capacity Act, 2005).

Priority 4 – Support

Caring for a dying relative or friend at home can place an enormous strain on people, as what can appear routine, normal everyday practice to health care professionals can be challenging to family members as they may not have experienced caring for someone before. Research has shown that the odds of a patient dying at home are reduced by two thirds if carers prefer otherwise or are reluctant to support on discharge (Alonso – Babarro et al, 2011, Grande & Ewing, 2008).Therefore, nurses have a responsibility to support the family from an emotional perspective by preparing the family for the possibility that the patient will die at home, and allowing them to voice any fears or concerns that they may have regarding discharge. From a practical perspective, the family should be provided with:-

- Names of key members of the health care team involved in the patient's care, e.g. District nurse, Specialist Palliative Care Team
- Contact numbers including out of hours
- Information regarding medications, formal care package and equipment

Priority 5: Plan & Do

Once the decision has been made for discharge home and Priorities 1 – 4 as stated above have been implemented, an individual plan of care has to be devised in order to ensure that the patients' individual needs are addressed. The following case study illustrates a safe, rapid discharge home for end of life

care. In order to preserve confidentiality in line with the Nursing and Midwifery Council (NMC) (2018), the patient's name has been changed.

Sally was a 72 year old lady with metastatic lung cancer. She had been admitted to hospital with increasing shortness of breath and chest pain. She was diagnosed with community acquired pneumonia and was started on intravenous antibiotics and oxygen. Despite these treatments, she continued to deteriorate, and the ward team recognised that Sally was dying. A DNACPR was implemented and this was clearly communicated to Sally and her family. During this discussion Sally identified that her preferred place of death was home; this decision was supported by her family. Anticipated emergencies, for example increasing shortness of breath were discussed, and an Emergency Health Care Plan (ECHP) was written.

The following steps (Box 1) facilitated Sally's safe discharge within 24 hours.

Immediately following the decision for discharge home

1. An urgent referral was made to the

    - Hospital Specialist Palliative Care Team

    - Occupational Therapist (OT)

2. Continuing Health Care (CHC) Fast Track Funding paperwork was completed and sent

3. District nurses (DN) were contacted to discuss the pending discharge

4. Discharge medication ordered by the ward doctors, including end of life anticipatory medications. Liaison with pharmacy in order to prioritise prescription

5. Home oxygen ordered and delivery time arranged with family

6. Case manager identified and care package arranged to meet the identified needs of the patient and family

7. Equipment ordered and delivered – this included hospital bed, commode, pressure relieving mattress

On day of discharge (following day)

1. Reassessment and exploration of any concerns with the patient and family regarding PPOD

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2. Communication with key professionals to confirm equipment and services are ready to receive patient in place

3. Transport arranged – ambulance service contacted and informed of discharge for end of life care

4. General Practitioner (GP) contacted by ward doctors and pending discharge discussed

5. Medication checked and discussed with Sally and family

6. Relevant documents including DNACPR, Emergency Health Care Plan (EHCP), discharge letter, discharge medication list, relevant trust documentation to support caring for the dying patient and DN letter given to family

7. Contact details for DN and care providers including out of hours support given to Sally and her family

8. DN, care providers and family contacted when Sally left ward.

Sally died peacefully three days later at home surrounded by her family. Whilst understandably sad at losing their loved one they were grateful that her wish to die at home had been achieved.

Conclusion

This article has highlighted the key considerations necessary for facilitating a safe and timely discharge home for end of life care. The nurse has a pivotal role in communicating, collaborating and coordinating the discharge, to ensure a seamless transition from hospital to community, ensuring that preferred place of death can be achieved.

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