

Lets Get It Right Time First Time.....

Discharge Pathway for Patients' who are in the Last Days of Life

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Introduction

Shifting the Balance of Care (2009) endorses 'Anticipatory Care Planning' an approach to planning ahead for patients living with a life limiting illness. This approach is a priority of Living and Dying (2011).

Research by Ryder (2013) has shown that the majority of individuals wish to die in their own home, however within NHS Greater Glasgow and Clyde 52% of deaths are within the acute care setting (ISD, 2011). Anecdotal evidence suggests for some discharges this may be due to deficits in knowledge, confidence and facilitation skills in staff coordinating the discharge.

At the end of life, discharge from hospital can be hurried and sometimes complex with Specialist Palliative Care Teams and Hospital Discharge Teams not always involved in the process.

Aim

NHS Greater Glasgow and Clyde (NHS GG&C) set up a multi-disciplinary short life working group whose aim was to develop a pathway promoting:

- Facilitation of a peaceful death in the patients preferred place of care
- Seamless discharge from hospital to home within normal working hours
- Prevention of re-admission where possible

Method:

The pathway was developed for healthcare professionals to use when discharging patients home to die. It provides guidance on significant conversations including Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR), symptom control including syringe pumps and essential communication with the wider multidisciplinary teams. The pathway details responsibilities of medical, nursing and pharmacy staff in arranging a discharge at end of life, and signposts users to sources of further more detailed guidance if required.

Eleven wards throughout NHS GG&C are piloting the pathway and have received teaching on the core components of the pathway below.



Data Collection

A questionnaire was developed for completion by hospital staff co-ordinating the discharge. A second questionnaire was developed for the community nursing team and GP's which also included specific questions for carers to feedback on the discharge experience. Feedback to date has been positive with quotes highlighting areas of good practice as well as areas for improvement. Below are quotes taken from the feedback received:

Hospital Team Feedback

"It is a good tool to use when organising a safe discharge, it is good to remind staff of everything that is required for the patient when they get home so that everything they need is in place"

"It is helpful that all nursing aims are broken into sections"

"The algorithm prompts you to ensure that the patient and family are prepared. The most helpful part of the algorithm is the discussions around DNACPR"

Community Team Feedback

"Overall everything was positive however the family were not shown how to administer PRN medications"

"Information regarding the DNACPR form was communicated, however it was not signed by the hospital consultant"

"Everything was updated to us by the hospital team"

Carer Feedback

"Everything was discussed with us regarding going home"

"I felt everything was a bit rushed especially regarding information on what to do with the medications"

Conclusion

Future work will be the completion of the pilot with continued feedback from healthcare professionals across NHS GG&C as well as the essential feedback from carers on their experience of the discharge. The feedback will also inform any changes required to the information held within the pathway.

Acknowledgements

This pathway was written by staff from NHS Greater Glasgow and Clyde. Grateful thanks to those individuals who have given valuable comments during the consultation process

References

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