Rapid Discharge Pathway for the Dying Patient who would like to die at home – Additional guidance for Nurses

Rapid Discharge Pathway

For the dying patient who wishes to die at home or in a care home.

Additional guidance for nurses

A successful discharge for a patient wishing to be at home or in a care home when they die will only work if all of the tasks highlighted in the Rapid Discharge Pathway have been completed and communication is excellent. Without this, not only does the discharge fail, but an inappropriate readmission to hospital and avoidable distress for patients and families can occur.

As nurses you have a unique and essential role to play in future planning, for symptom control and well coordinated care. This section will take you through each of the tasks you specifically need to action on the Rapid Discharge Pathway (RDP).

Throughout the discharge process, it is your responsibility to ensure that the patients, family and carers are kept fully informed of the progress and any queries answered.

1. Medication

- Inform the doctor that pre emptive injectable TTO's need to be prescribed.
- The doctors will need to complete a community drug instruction chart, but these may differ depending upon where the patient lives. **These are available on the end of life care website page.**
- Inform ward pharmacist of the priority for dispensing TTO's.
- Highlight to the pharmacist the need to complete a medication record card, which should go home with the patient. This would be for the patients usual oral medication but you may need to consider whether liquid preparations are required.
- Ensure that doctors have completed HOOF form if oxygen is needed.

2. Community Nursing Care

- Refer to community nurses by telephone and explain that the patient is going home to die. The more information the community nurse has, the more help they will be able to offer. Discuss if a night sitter is needed as they may be able to arrange if given time to organise.
- If the patient is going to a care home ensure the care home staff have a nursing handover.
- Discuss whether the hospice at home team has been contacted and are involved.

- Discuss the needs of the patient and relatives and what medication will be sent home with the patient.
- Ensure OT has ordered hospital bed and Community nurses have ordered pressure relieving mattress if required.
- Paperwork to be faxed to community nurses or care home include: DNACPR, OOH, syringe driver instruction chart.

3. Community Specialist Palliative Care Services

- If a Community palliative care team have been previously involved and the hospital palliative care team has not, you can contact the relevant **Community palliative care services in Sussex** directly to update them.
- If the hospital palliative care team have been involved in the patients care, they will make the referral to or update the community palliative care team.

4. Transport

- Ensure that once the date is set for discharge an ambulance has been booked to transfer the patient. Explain that the patient is going home or to a care home to die and will need a two man ambulance.
- Highlight if oxygen is required and a DNACPR order is in place.

5. Day of Discharge

- It is a team decision to ensure that the patient is still fit for the journey home. The medical team in charge of the patients care need to assess and document that patient is fit for discharge and transfer to home/care home.
- Ensure that if a syringe driver is in situ, that it is fully functional and working. Make sure the McKinley syringe driver cover box is unlocked. The syringe driver should be refilled prior to discharge to ensure adequate medication until the next community nurse visit.
- Once the patient has left the hospital please let the GP, community nurses, hospice at home and other relevant teams involved know by telephone.

6. Documents

- **Fax Out Of Hours (OOH) palliative care handover Form, DNACPR form and syringe driver instruction chart to community nurses and telephone to confirm receipt.**

- Three **original** documents that **MUST** go with the patient:

  - **RDP contact information sheet – for family (if going home)**
  - **TOP RED COPY of DNACPR form – This is an important document that the family need to keep safe to present if necessary**
  - **Original Syringe Driver Drug Instruction Chart – without this, the recommended injectable medication cannot be provided out of hospital.**

If you need any additional advice please contact the hospital specialist palliative care team on extension 3021.