Rapid Discharge Guidance for Patients who are in the Last Days of Life

AIMS
- Seamless discharge from hospital to home, care home or hospice within normal working hours
- Prevent re-admission where possible
- Facilitate a peaceful death

**NHS GGC Guidance at End of Life (GAEL) available http://www.palliativecareggc.org.uk/professional/eolc**

**STEP 1 – COMMUNICATION AND ANTICIPATORY CARE PLANNING**

**MEDICAL and NURSING (See guidance overleaf)**
- Holistic assessment – physical including optimising symptom control, psychological, emotional and spiritual needs
- To promote as natural and peaceful death as possible. All patients should have DNACPR
- Significant conversations with patient (if appropriate) and relative/carer/friend, clearly document within medical and nursing notes
- Communicate above conversations and decisions to appropriate teams
- Assess urgency of discharge and identify potential estimated discharge date
- Consider discussion with palliative care team and/or discharge team

**STEP 2 – SYMPTOM CONTROL AND 24 HOUR CARE NEEDS**

**MEDICAL**
- Contact GP and update them on clinical condition and DNACPR status
- Rationalise medications
- Identify continuing need for oxygen and nebulisers – if oxygen required follow ‘SHOOF Guidance’ (Scottish Home Oxygen Order Form Guidance)
- Prescribe anticipatory end of life drugs minimum 7 day supply
- Send discharge script to pharmacy 24hrs prior to discharge if possible (refer to prescription guidance overleaf)
- Highlight urgency and identify from pharmacy when drugs will be available to prevent delay in discharge

**NURSING**
- Contact DN re: patient’s clinical condition, care needs of patient and carer, care package required and need for essential equipment
- Communicate significant conversations with DN
- Consider care package from Social Work following discussion with DN
- Consider referral to community specialist palliative care team
- If patient is on Continuous Subcutaneous Infusion (CSCI) – (refer to guidance overleaf)

**PHARMACY CONSIDERATIONS**
- Check all items are in stock
- Ensure appropriate formulation prescribed
- Ensure appropriate anticipatory as required medications are prescribed
- If patient on Continuous Subcutaneous Infusion (CSCI): check safe doses, compatible combination and correct diluents prescribed.
- Check that total volume of CSCI does not exceed 22mls
- Minimum 7 days supply – original packs where possible
(Refer to prescription guidance overleaf)

**STEP 3 – DOCUMENTATION**

**MEDICAL**
- Contact GP to complete NHS GGC Community Palliative Care Prescription Kardex.
- DNACPR Form completed as per policy (refer to guidance overleaf)
- Complete IDLS

**NURSING**
- Complete the discharge checklist and Part 2 NHSGG&C Discharge Letter/Transfer Plan documentation
- If possible photocopy Continuous Subcutaneous Infusion (CSCI) prescription and monitoring chart for case notes and send home original with patient
- Send original DNACPR form home with patient/relative/carer/friend. (Refer to guidance overleaf)

**STEP 4 – TRANSPORT**

**NURSING**
- Request ambulance for patient going home to die as soon as estimated discharge date agreed
- Escalate any transport issues to discharge team and/or ambulance service
- Provide ambulance service with an update of patients clinical condition, DNACPR status, mode of transfer i.e. chair/trolley, if oxygen is required and if patient has a syringe pump in situ for Continuous Subcutaneous Infusion (CSCI)
- Provide patients weight if required, be aware of access/stairs into patients home
- Inform relative/carer/friend if patient being transferred on trolley there is a possibility that they will be transferred to a chair to get into the home
- Do relative/carer/friend wish to escort patient? – If so, please discuss with Scottish Ambulance Service

**MEDICAL and NURSING**
- Regularly review patient’s condition. Identify risks of discharge and discuss with patient (if appropriate), relative/carer/friend and primary health care team
- If patient deteriorates further review Discharge Plan, identify risks for transfer and discuss with patient if appropriate, relative/carer/friend
- Contact GP/DN re: estimated arrival home where appropriate
- Ward to contact GP / DN to inform of partial supply of medication
- If patient to be discharged out of hours contact Out of Hours GP service and DN
- If discharge cancelled contact relevant teams

**STEP 5 – IMMEDIATE DISCHARGE**

**PHARMACY**
- If unable to dispense full quantities of discharge medication – contact nursing staff and consider partial supply of prescription to avoid delaying discharge
- If medication is not ready when an ambulance arrives for the patient please consider using the palliative care courier to deliver medication direct to the patients home – contact the Specialist Palliative Care Pharmacist
STEP 1 – COMMUNICATION and ANTICIPATORY CARE PLANNING

Significant conversations:
- Conversations should be done as sensitively as possible with the patient and their relative/carer/friend as appropriate
- Conversations should include: patient’s current condition, estimated prognosis, plan for symptom control, 24 hour care needs, level of support available and any potential problems including the risk of a significant event. Refer to Scottish Palliative Care Guidelines: http://www.palliativecareguidelines.scot.nhs.uk/
- Contact numbers for Out of Hours service and support will be given.
- Discussions with the patient and their relative/carer/friend may be necessary about preferred place of care if remaining at home becomes difficult. This should include the provision of information about alternative place of care e.g. hospital, hospice or community hospital (if a bed is available).

DNA CPR:
In the context of agreed goals of care an objective of the DNA CPR policy is to encourage and facilitate open, appropriate and realistic discussions with patient/relative/carer/friend about resuscitation issues.
- The patient/relative/carer/friend should be aware that DNA CPR is a clinical decision because CPR is contraindicated.
- The patient/relative/carer/friend should not be burdened with the feeling that they are responsible for the DNA CPR decision.
- Sensitive conversations should take place with the patient (if appropriate), relative/carer/friend, GP and DN regarding arrangements should the patient die in the ambulance. If no plan has been agreed then the patient will be taken to the Local Emergency Department. Please ensure the ambulance section on the DNA CPR form is completed to reflect this plan.
- If further guidance is required please refer to DNA CPR policy at: http://www.palliativecareggc.org.uk/professional/dnacpr
- The GP/Out of Hours service must be aware of the decision to ensure emergency services are not called inappropriately where the patient’s death is expected.
- If in exceptional circumstances the DNA CPR form is not to accompany the patient home, the ward doctor to contact GP to update and the ward nursing staff to update DN and the ambulance crew.

STEP 2 – SYMPTOM CONTROL and 24 HOUR CARE NEEDS

NURSING
Continuous Subcutaneous Infusion (CSCI) via Syringe Pump
- Refill syringe pump just prior to patient discharge – notify DN when pump has been changed.
- Record date of Sel - T - Intima/ line change on part 2 NHSGG&C Discharge Letter/Transfer Plan and syringe pump documentation.
- Ensure syringe pump is correctly labelled.
- Send patient home with jiffy envelope with return details to ensure syringe pump is returned.
- Ensure there is a ward record of patient name, CHI, DN contact, syringe pump serial number and discharge date.

MEDICAL/PHARMACY
- If patient is already stable on an opioid prescribe current dose and route.
- If oral route still in use ensure parenteral opioid medication is also prescribed as well as other anticipatory as required medications - see prescribing guidance below. Doses quoted are suggested starting doses.

DILUENT
- For Just in case anticipatory medicines ensure water for injection is ordered.
- If patient going home on CSCI prescribe diluent as per CSCI chart

Example prescriptions of Just in Case Anticipatory medication below (includes mandatory requirements). Good Practice to also specify indication.

<table>
<thead>
<tr>
<th>Pain/breathlessness (if opioid naive and if normal renal function)</th>
<th>Controlled Drug Prescription Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphone Sulphate 10mg/1ml injection</td>
<td>• In own handwriting/ electronic prescribing follow local procedure for ordering controlled drugs</td>
</tr>
<tr>
<td>2mg SC hourly if required up to 6 times in 24 hours</td>
<td>• Must state formulation and strength</td>
</tr>
<tr>
<td>Supply 10 (Ten) ampoules</td>
<td>• Must state dose and frequency</td>
</tr>
<tr>
<td></td>
<td>Total amount of ampoules must be specified in <strong>words and figures</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Anxiety/Agitation</th>
<th>Controlled Drug Prescription Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midazolam 10mg /2ml injection</td>
<td>• In own handwriting/ electronic prescribing follow local procedure for ordering controlled drugs</td>
</tr>
<tr>
<td>2mg SC hourly if required up to 6 times in 24 hours</td>
<td>• Only 10mg / 2ml formulation should be prescribed in palliative care</td>
</tr>
<tr>
<td>Supply 10 (Ten) ampoules</td>
<td>• Must state dose and frequency</td>
</tr>
<tr>
<td></td>
<td>Total amount of ampoules must be specified in <strong>words and figures</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Respiratory Tract Secretions</th>
<th>Nausea and Vomiting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyoscine butylbromide 20mg/1ml injection</td>
<td>Levomepromazine 25mg/1ml injection</td>
</tr>
<tr>
<td>20mg SC hourly if required up to 6 times in 24 hours</td>
<td>2.5mg SC if required 8 hourly</td>
</tr>
<tr>
<td>Supply 10 ampoules</td>
<td>Supply 10 ampoules</td>
</tr>
</tbody>
</table>

Approved by acute Clinical Governance Group Jan 2017