Government of JERSEY

Health and Community Services

Rapid Discharge for Patients Approaching the End-of-Life Guideline

September 2021

DOCUMENT PROFILE	
Document Registration	**HSS-GD-CG-0612-01**
Document Purpose	**Guideline**
Short Title	**Rapid Discharge**
Author	**Anna Haslam, Carmel O'Donnell, Kim Hancock**
Publication Date	**September2021 2021**
Target Audience	**All Health Care Professionals**
Circulation List	**JHC, HCS, FNHC, PCB, Ambulance Service, Hospital Mortuary.**
Description	**Policy and Procedure for discharge of patients in their last days of life to their preferred place of death.**
Linked policies	Personalised Care Record Policy for Dying Adults in the Expected Last Days of Life 2020 (Island wide policy). Adult Palliative and Supportive Care: Ambulatory Syringe Pump Policy including Symptom Management Guidelines 2016 (Island wide policy). Adult Palliative and Supportive Care: Policy for Anticipatory Prescribing in the Community, 2017. (Island wide policy). Jersey Multi-agency Unified Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) 16 years and over Policy 2021 (Island wide policy). Capacity and Self Determination (Jersey) Law, 2016. Code of Practice. Policy and Procedure for the Recognition of Expected Death (Adults) by a Registered General Nurse, 2017. (JHC policy). Multi-agency Framework for Managing Allegations in respect of People working with Adults in a Position of Trust 2020 (Island wide policy).
Approval Route	**PPRG**
Review Date	**1 year from approval**
Contact Details	**kimhancock@jerseyhospicecare.com**

CONTENTS LIST

1. INTRODUCTION

1.1 Rationale

End of life care is high on the Government agenda both nationally and locally to allow patients choice as to where they wish to die (Department of Health, (DH), 2008; States of Jersey, (SOJ), 2012.

Patients should be supported to die in the place of their choice, respecting the patient's individual choice along with co-ordinated care whereby each community is prepared to help. (Ambitions for Palliative and End of Life Care 2015)

"Up to 74% of people say they would prefer to die at home but currently 58% of people die in hospital." (NICE, 2017)

This guideline sets out a safe and effective procedure for staff to follow when a patient in their last days of life makes the choice to be discharged from Secondary Care (JGH) or from Jersey Hospice Care's In-Patient Unit (JHC IPU) to their preferred place of death, be that in their own home or a care home. This discharge would be expected to take place within 24 hours.

This guideline aims is to ensure effective communication, co-ordination, and continuity of care for the patient / carer / family and between the Multidisciplinary Team in the Hospital / Hospice and community setting and to ensure the patient receives end of life care in their preferred setting.

Whilst this guideline has been developed to facilitate a rapid and safe discharge from JGH / JHC IPU, it is recognised that this may not always be possible.

This guideline also acknowledges that there are specific risks involved in discharging patients who are dying. These are highlighted in the risk assessment / Aide Memoire section of the "Rapid Discharge procedure for the Dying Patient" of this guideline in appendix 1.

1.2 Scope

This guideline applies to all multidisciplinary Health Care Professionals (HCP) involved in the patient's care in the hospital / hospice and community setting who as part of multidisciplinary team working have identified the clear need for a rapid discharge to be instigated.

Where this guideline refers to the Key Worker, this would be the Registered Nurse responsible for the care of the patient.

This guideline is applicable to all adults aged 18 years and over.

It is expected that this guideline will be initiated at any time of the day or out of hours with the agreement of the care team receiving the patient, to accommodate the patient's wishes and to enable the discharge to take place within 24 hours.

Whilst it is recognised that patients would normally be discharged within daytime hours, there may be occasions when it is appropriate to discharge a patient outside of normal working hours.

It is acknowledged that there are risks associated with this and every attempt should be made to ensure safe transfer utilising the support and resources available at the time, for example, referral to Family Nursing and Home Care (FNHC), voluntary services / family and friends.

1.3 Principles

This Rapid Discharge guideline must meet the following criteria:

- The patient wishes to die in their preferred place of death and is an adult over the age of 18.
- The patient has the capacity to make an informed decision and is aware of the risks associated with a rapid discharge such as, no 24-hour social / nursing care available (in patient's own home) unless privately funded.
- If the patient lacks capacity but the family are advocating for the patients wishes, then the family must be advised about the risks associated with a rapid discharge such as, no 24-hour social / nursing care available unless privately funded.
- The MDT has agreed and documented that the patient is for supportive / palliative care only and is thought to be in the last hours / days of life i.e., / Gold Standards Framework (GSF) red category.
- The patient's family / carers support the decision.
- The MDT believes the needs of the patient can be met at home and that the patient will be in a place of safety.

1.4 Rapid discharge

A Rapid Discharge is not appropriate if:

- The Patient is thought to be in their last weeks of life (GSF Amber category,) in this instance, usual discharge planning should continue.
- The patient is assessed by the responsible Medical Practitioner or Senior Nurse as being too unwell to survive the transfer.
- The patient lives alone.

Rapid discharge may be appropriate but feasability is contingent on certain supports / services being provided.

For patients who require rapid discharge to their preferred place of death (usually their home from hospital), there is a need for a clear process that allows for the timely initiation of resources with which to facilitate this care planning. This may or may not necessitate rapid access to specialist palliative care.

It is dependent on the patient's wishes being known to health care professional and relatives usually in the form of and Advance Care Plan (ACP) and Do Not Resuscitate (DNR) orders and the ability of local system processes to enable the prompt implementation of support services once the patient has arrived at their preferred place of

death. As with all rapid discharges what underpins them is effective communication with all parties and clear, concise documentation that allows for a smooth transition of care. (Nice, 2019)

2. GUIDELINE PURPOSE

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.

Its purpose is to promote collaborative working across Primary and Secondary Care and through effective communication, involve the correct professionals to co-ordinate the continuing care and support necessary for the patient and their family / carers.

This guideline should only be used for patients deemed to be in their last hours or days of life (GSF Red category).

It is essential that patient's wishes are always respected and any decision made without the patient should endeavour to reflect their best interests.

3. CORPORATE PROCEDURE

All staff must follow the Rapid Discharge Procedure for the Dying Patient when a rapid discharge is required for a patient in the last hours / days of life.

A rapid discharge should ideally take place within normal working hours which are Monday to Friday from 9am to 5pm. This is to ensure adequate planning and support takes place.

Out of hours or weekend transfer to the hospice may occur in the case of a rapid deterioration if the hospice is the patients preferred place of death (PPD).

The patient should not be transferred regardless of the PPD if deemed too unwell to survive the transfer by a Health Care Professional.

This must be agreed with the Senior Nurse on the in-patient unit prior to transfer and the patient and family must be made aware that there is limited medical cover at the hospice after 5pm and at weekends.

An out of hours Jersey Doctor on call (JDoc) would be called to clerk the patient which would likely incur a cost to the family.

Rapid transfer to a care home or nursing home from the acute setting may occur. This would be at the discretion of the nurse accepting the patient to the care home. Each individual home will have internal policies on accepting patients out of hours and this should be discussed with the care home in question.

Discharge out of hospital over night would be unsafe and against medical advice and should be avoided due to a lack of 24-hour care and equipment in the community.

4. ROLES AND RESPONSIBILITIES

The MDT may consist of:

- Ward Staff
- Medical / Surgical Team
- General Practitioner (GP)
- Discharge Co-ordinator
- Social Worker
- Specialist Palliative Care Team (SPCT
- Occupational Therapist (OT)
- Physiotherapist
- Chaplaincy
- Family Nursing and Home Care (FNHC)
- Pharmacist
- Out of Hours GP (JDoc)
- Clinical Investigations
- Ambulance Control
- Home care agency
- Voluntary sector

The MDT should recognise that the patient is in their last hours / days of life and reversible causes have been excluded.

The MDT should discuss the possibility of a rapid discharge and establish if this is feasible weighing up any risks associated with the rapid discharge.

4.1 Key Worker

The **Key Worker** is identified as the Registered Nurse (RN) responsible for the patient's care on either the ward in the secondary care setting or on Jersey Hospice Care in-patient unit (JHC IPU).

The Key Worker co-ordinates the discharge by following these steps outlined:

1. If the patient is in a secondary care setting, contact the Discharge Co-ordinator through switchboard and inform them of the plan to facilitate a rapid discharge for end-of-life care in line with the patient's / family's wishes.

2. Discuss with the patient's family or Care Home Manager that the patient wishes to die in their usual place of residence and establish if this is feasible.

3. Discuss with the patient's family / Care Home Manager the risk of the patient dying in transit to preferred place of death.

4. Communicate and share any risks with the family / care home and document accordingly in the Rapid Discharge Procedure for the Dying patient Booklet.

5. Liaise with Palliative Care Social Worker if a care package is going to be required at home.

6. If no care package is required; ensure the family have been shown how to care for their family member, on the ward, prior to discharge. They are going to be providing care overnight. A risk assessment is required if a patient is discharged home with no care overnight clearly stating a back up plan if the family are unable to manage without the help of a care agency.

7. If the patient is returning to their own home, ensure the family are aware that there is not 24 / 7 nursing care in the community. Family Nursing and Home Care twilight service is available until 11pm. After this time, the out of hours Jersey Doctors (JDOC) are available if advice or a home visit is required. The patient and family should be made aware that this would incur a cost.

8. Telephone the Community Nursing Team at FNHC on +44 (0) 1534 443600 to ensure they can meet the needs of the patient and send written referral via email if in JGH or via EMIS if in JHC. Consider when the patient will require their first visit, (Consider a twilight visit depending on the time of day). Out of hours contact FNHC via the switchboard by dialling 0 from inside the hospital or +44 (0) 1534 442000 externally.

9. Ensure it is documented on FNHC referral and handed over verbally if patient has a syringe driver or 'just in case medications' and clarify what time the infusion is due for renewal.

10. Fax the referral and 'recognition of expected death' form to Specialist Palliative Care Team (SPCT) on +44 (0) 1534 720292.

11. Liaise with Occupational Therapist (OT) / medical suppliers concerning any equipment that may be required. A patient may refuse this, or this may not be available out of hours. If the patient does refuse equipment, ensure a risk assessment is carried out and documented in the case notes and in the rapid discharge plan (appendix 1).

12. Consider Rapid Response for basic equipment that could be delivered on a weekend. E.g. a commode.

13. Liaise with the Medical Team for a prescription of 'just in case' medications for discharge. (SPCT can provide advice on this as required) see the anticipatory prescribing guidance from JHC.

14. Liaise with Pharmacy in JGH to inform them the patient is for due for rapid discharge for end-of-life care and GSF code is Red. If medications are required at JHC, liaise with Le Quenses Pharmacy within working hours.

15. Liaise with Clinical Investigations if home oxygen required and explain it is for a patient who is GSF red and for rapid discharge. Outside of working hours, an oxygen concentrator is held at switchboard at JGH – **HOOF still needs to be faxed to Clinical Investigations if concentrator is used from switchboard to facilitate recall of this equipment.** (appendix 2)

16. Provide the family with the Coping with Dying which is available on the Jersey Hospice Care website if no hard copies available on the ward.

17. Contact Ambulance Control and request transport for a rapid discharge for a patient wishing to die in their usual place of residence.

18. Ensure a DNACPR form is completed and given to the Ambulance Team when leaving the ward with the patient.

19. Ensure Ambulance Control is informed if there are property access issues.

20. Complete the 'Rapid discharge procedure for the dying patient' document and ensure that all discharge arrangements in place. Send the original with the patient on discharge and retain a copy and file in their medical notes.

21. If the patient is on the Personalised Care Record for the expected last days of life (PCR) this should be photocopied, the original sent with the patient and a photocopy filed in the patient's medical notes.

22. The Key Worker is responsible for the safe and effective discharge of the patient from the ward or JHC IPU.

4.2 Medical Team

- Prescribe Anticipatory Medications on the 'To Take Out' (TTO) chart if in JGH. Controlled drugs are to be completed on a separate TTO sheet to other medications (as per anticipatory prescribing guidelines).
- Complete Medication Administration Record (MAR) sheet for anticipatory prescribing and / or syringe pump prescription if indicated (Medical Registrar or above).
- Ensure patient has a valid Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order. This must be completed by the medical registrar or above.
- Ensure the GP is informed the patient is to be discharged from JGH / JHC IPU for end-of-life care, GSF code Red and arrange GP home visit at soonest opportunity following discharge. Provide information about the current situation, patient's needs, and any anticipated needs.
- Comprehensive discharge summary to be sent home with patient to support out of hours continuing care.

4.3 Discharge Co-Ordinator (if patient is in hospital)

- Works closely with the Key Worker to support discharge.
- Provides support and management for all patients who have complex discharge planning needs
- Provides additional support and information around discharge planning.

The Discharge Co-ordinator works with all members of the MDT, relatives, and external agencies to provide an integrated approach to discharge planning.

4.4 Specialist Palliative Care Nurse

- Work supportively and collaboratively as a clinical expert with all members of the MDT to facilitate a rapid discharge for the patient from JGH or IPU to their preferred place of death.
- Provide support and guidance for staff on any complex symptom control issues the patient may be experiencing.
- In conjunction with the ward staff offer emotional, psychological and pre-bereavement support to the patient and their families.
- Liaise with Specialist Palliative Care Nurse in community to arrange review in the community.
- If required, support the Medical Team with anticipatory prescribing for discharge.
- Advise the Medical Team to contact the GP to inform them of rapid discharge of their patient who is in the last hours / days of life outlining any complex symptoms and highlighting when follow up GP visit is required.

4.5 Family Nursing and Home Care (FNHC)

- Liaise with the Key Worker by telephone to facilitate a rapid discharge for the patient from JGH or JHC IPU to their preferred place of death.
- Agree an appropriate date and time for first the visit from FNHC with Key Worker. This may be a twilight visit on the day of discharge.
- Provide support and guidance for families / residential care home staff in relation to symptom management, psychological and pre-bereavement support.
- Ensure they have received written referral and handover of patient's condition and the expectation that the patient will die in the next few hours / days. Plus any nursing needs, medication requirements and family needs from ward / JHC IPU prior to patient's imminent discharge.
- Liaise with the Occupational Therapist (OT) regarding equipment. Be aware the patient may refuse equipment or that this equipment might not be available out of hours. If the patient refuses equipment, a risk assessment should be completed, one copy is sent with the patient on discharge and one is to be filed in medical notes. Following risk assessment, if the discharge is deemed unsafe it is advised that the patient remain in hospital / JHC IPU for end-of-life care.
- Any equipment required should be sought at the soonest opportunity ideally before discharge or as soon as possible following discharge.
- Liaise with Specialist Palliative Care Team for complex symptom control advice and support as required.
- Offer support, advice and information to patient / family / carers as required.

4.6 Allied Healthcare Professionals (occupational therapists, speech and language therapists, physiotherapists, and chaplaincy)

- Liaise with MDT to establish the needs of the patient.
- Access and arrange appropriate equipment during working hours.
- Provide advice and education to family / carers re moving and handling, positioning, and transfers if appropriate.
- Liaise with FNHC and update them on findings of assessment to ensure safe delivery of care needs.

- Chaplaincy offer support to patients and families earlier than death if they ask for it and can also liaise with Parish Clergy with the patient's permission.

4.7 General Practitioner (GP)

- Establish with treating medical team when a home visit is required.
- Ensure anticipatory end of life medications are prescribed by the treating team on discharge for use in the community.
- Visit the patient / family at home as soon as possible after discharge.
- Ensure patient / family is aware that the patient is likely to die in the next hours / days.
- Ensure valid DNACPR order is in place.
- Review symptoms and PRN anticipatory medication requirements; consider a syringe pump if clinically indicated.
- Liaise with Specialist Palliative Care Team for advice and support as required.

5. DOCUMENTATION AND COMMUNICATION

- The Rapid Discharge Procedure for the Dying Patient document should be followed, completed, and signed by the Registered Nurse / Key Worker.

- A DNACPR form must be completed by the doctor and the original copy sent with the patient.

- FNHC to be contacted via hospital switchboard on +44 (0) 1534 442000.

- The GP should be contacted by telephone by a member of the patient's medical / surgical team and verbal handover to be given.

- The original copy of the Rapid Discharge Procedure for the Dying Patient document must accompany the patient home and one copy to be retained in the patient's medical notes.

- If the PCR is in use, a copy must be retained in the medical notes and the original to be sent with the patient on discharge. Any health professionals providing care for the patient at home should document their visits in the PCR.

- All Health Care Professionals involved in the care for patients who are dying should demonstrate empathy and good communication skills at all times.

6. DEATH IN TRANSIT

6.1 From JGH to Care Home

If the patient dies in transit from JGH to a care home, the ambulance crew should notify the care home immediately and a collaborative decision will be made to continue to the destination or return to JGH in accordance with the patient's previously expressed wishes in relation to preferred place of death if known.

6.2 From JGH to home

- If the patient dies in transit from JGH to home, the ambulance crew will call for a paramedic (if not already on board) to verify death and complete a R.O.L.E form (Recognition of life extinct) and admit the patient to the Mortuary Department, leaving the R.O.L.E form on the desk and completing the admission register.

- A Doctor will not need to attend the Mortuary to verify death. Confirmation can be completed by a paramedic at time of death.

- The Registered Nurse in charge on the ward of origin will alert all parties involved with the discharge (including family / carers) that death has occurred in transit.

- JGH does not offer out of hours viewings. In hours, it is by appointment only and appointments can be made by calling the Mortuary on +44 (0) 1534 442599 / 442600.

- The family should be advised to contact their chosen funeral director and notify them that their loved one has passed away and is in the care of the Hospital Mortuary.

- The Mortuary Team will make arrangements for the death certificate and if required, cremation paper to be completed with the relevant medical team.

- If appropriate, enlist in the support of Hospital Chaplaincy.

6.3 From JHC

- If the patient dies in transit from JHC IPU, the ambulance crew should contact JHC IPU to inform the nurse in charge and advise that the patient is being taken back to the hospice with all the relevant paperwork from the crew.

- The nurse in charge will contact one of the Palliative Care Medical Team during core hours 9am- 5pm Monday to Friday or JDoC if after 5pm or at weekends / bank holidays to confirm death has occurred.

- The IPU nurse in charge will alert all parties involved in the discharge (including relatives) that death has occurred in transit.

7. DEVELOPMENT AND CONSULTATION PROCESS

7.1 Consultation Schedule / Trail

Name and Title of Individual	Date Consulted
Peter Gavey – Chief Ambulance Officer	30/04/2020
Adam Leversuch – Pharmacist	30/04/2020
Irene Campbell- Resuscitation Manager	30/04/2020
Val Mee – Resuscitation Officer	30/04/2020
Lorraine Dyer – Team Lead CNS JHC	30/04/2020
Tia Hall- FNHC Operational Lead DN Services	2020
Maureen Turner – JGH Chaplaincy Dept.	2020
Mel Penny- Discharge Co-ordinator	2020
Karen Eloury – Ward Sister JHC	2020
Isobel Hamon- Senior Sister Emergency Dept.	
Wendy Baugh- Lead Nurse	12/06/2020
Kim Hancock, Senior Nurse JHC	19 /05/2021
James Mason, General Manager	16/07/2021
Judith Gindill, General Manager	16/07/2021
Claire Thompson, General Manager	16/07/2021
Kate Southern, General Manager	16/07/2021
Rachel McBride, General Manager	16/07/2021
Jessie Marshall, Associate Chief Nurse	16/07/2021
Geoff White, Associate Chief Nurse	16/07/2021
Jo Poynter Associate Managing Director	16/07/2021

Name of Committee / Group	Date of Committee / Group meeting
Clinical Effectiveness Group Meeting	

8. REFERENCE DOCUMENTS

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10. GLOSSARY OF TERMS / KEYWORDS AND PHRASES

DNACPR	Do Not Attempt Cardio-Pulmonary Resuscitation
FNHC	Family Nursing and Health Care
RN	Registered Nurse
OT	Occupational Therapist
GP	General Practitioner
HCS	Health and Community Services
JGH	Jersey General Hospital
IPU	In-Patient Unit
JHC	Jersey Hospice Care
SPCT	Specialist Palliative Care Team
GSF	Gold Standards Framework
MDT	Multi-Disciplinary Team
PCR	Personalised Care Record

11. IMPLEMENTATION PLAN

Action	Responsible Officer	Timeframe
Policy to be taken to MEX for ratification.	Hilary Hopkins, Registered Manager, JHC & Acting Director of Palliative Care Services.	W / C 12th July 2021.

12. APPENDICES

Appendix 1: Procedure Rapid Discharge Procedure for the Dying Patient

Appendix 2: Risk assessment / Patient declaration Aide Memoire