

Integrated and Coordinated Discharge Planning for Palliative Patients

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BACKGROUND

- Palliative patients are a unique group whose needs change with the advancement of disease. According to National and Local Strategy, patient care should be delivered at home for as long as possible, including End of Life Care if that is the patient's wish.
- Following a period of admission, the window for discharge is narrow due to the progressive nature of disease. Timely, effective discharge planning is essential to ensure that palliative patients achieve discharge within a suitable timeframe with the support of a coordinated, individualised care package and with the necessary equipment in place.

AIM

- To develop and deliver an efficient, effective discharge planning process to ensure patients are well supported to remain at home for as long as they wish

We focussed on the following key areas:

- Weekly multidisciplinary Discharge Planning Meeting
- Development of a multidisciplinary Discharge Preparation Checklist
- Development of a Steps to Discharge flowchart
- Dedicated Community Care Team (Avenue) funded to provide home care if prognosis <42 days

RESULTS

SOCIAL WORK INPUT

- Dedicated Social worker at weekly discharge planning meeting

AVENUE COMMUNITY CARERS

- Avenue have capacity and flexibility (for example shorter more frequent visits) to provide timely, individualised care
- Avenue home carers up-skilled in providing palliative care through education and experience with client group
- Negotiations in progress to extend Avenue's remit to patients with a prognosis of 72 days



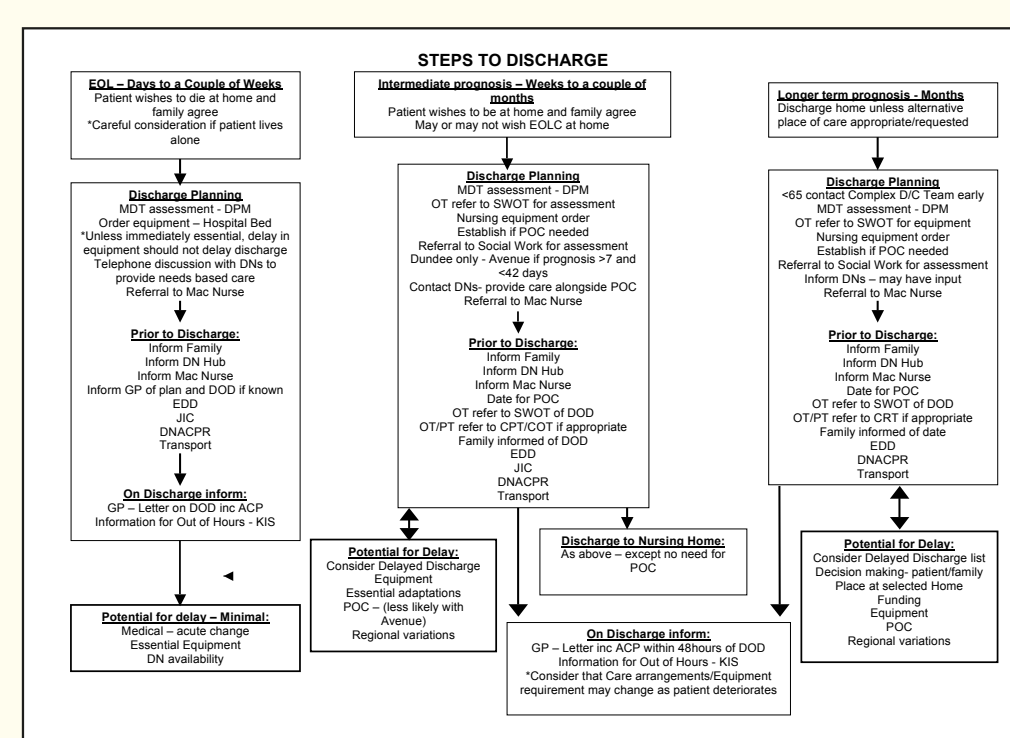
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DISCHARGE CHECKLIST

- Multidisciplinary
- Comprehensive
- Ensures all aspects of planning addressed
- Basis for coherent communication with Primary Care

STEPS TO DISCHARGE FLOWCHART

- Categorises patients according to prognosis
- Guidance on steps required to plan discharge



STEPS TO DISCHARGE CHECKLIST

DISCHARGE CHECKLIST

Business	Yes	No	N/A	COMMENTS
Equipment				
Continence products				
Prescriptions obtained				
Transport arranged				
Access to property established				
Hub contact				
SBAR completed				
Discharge Home informed				
Macmillan Day Care updated				
Primary carer				
Pharmacy	Yes	No	N/A	COMMENTS
Just in Case medications				
Diets				
Special requirements				
Discharge (HAT)				
EOD				
Medical	Yes	No	N/A	COMMENTS
OT				
DNACPR discussed				
DNACPR forms completed				
EOD including ACP				
GP advice received				
Letter to GP (incl ACP)				
Post-discharge arrangements				
Discharge to Home (incl GP)				

DISCHARGE PREPARATION CHECKLIST

Business	Yes	No	N/A	COMMENTS
Service arrangements				
Continuity of care				
Kin care				
Laundry services				
Meal provision				
Household				
Shopping Service				
Occupational Therapy	Yes	No	N/A	COMMENTS
Equipment in place				
Education in Community OT				
Physiotherapy	Yes	No	N/A	COMMENTS
Training with Equipment				
Education in Comm. Physio				
Respite	Yes	No	N/A	COMMENTS
Articular Nutritional Support (e.g. HIC, FIC)				
Therapeutic/structure modified diet				
Other nutritional supplements				
One week supply given Added to EOD				
Thickening fluids				
One week supply given of appropriate products				
Thickener added to EOD				

DISCUSSION

- Audit is in progress therefore data to evidence the impact of the implementation of this discharge planning initiative is awaited
- According to professional and patient feedback, advantages of a coherent and integrated approach to discharge planning appear to be:
 - Timely discharge for patient and relatives
 - On-going care at home delivered by skilled, empathic carers
 - Enhanced communication with Primary Care:
 - Written and verbal
 - Documentation of ACP
 - Use of eKIS
 - Improved patient flow through the in patient unit improving capacity
- We look forward to presenting our data following completion of audit