

**In this article...**

- Factors delaying the discharge of patients with end-of-life care needs
- Measures that can speed up discharge from hospital towards the end of life
- Advantages of a nurse role dedicated to discharge planning and coordination

# Improving hospital discharge for patients at the end of life

## Key points

**When patients deteriorate towards the end of life, rapid discharge can be used to get them from hospital to their preferred place of care quickly**

**Since 2016, NHS continuing healthcare funding is open to anyone with a life-limiting illness**

**Delayed discharge from hospital can be due to late equipment delivery, lack of staff training, lack of communication between teams and lack of beds in the community**

**Medical teams need to refer patients to palliative care early so advance care planning can take place**

**A palliative care team nurse coordinating fast-track discharges can help patients achieve their preferred place of care**

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**Abstract** In 2016, the quality of rapid discharges at North Middlesex University Hospital Trust was measured against the five 'priorities for care of the dying person'. This followed a first audit conducted in 2009 and improvements in equipment delivery, time of discharge approval, communication between hospital and community teams, and staff education. However, the second audit found that 15 out of the 40 patients, whose case notes were reviewed, died at the hospital waiting to be discharged. This article describes the audit and discusses the factors that contribute to delays in rapid discharges. One of the solutions recommended by the author is the appointment of a nurse who would act as rapid discharge coordinator.

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Towards the end of life, delayed discharge from hospital can decrease patients' quality of life, as well as leading to difficulties for their relatives and carers, who are eager to get them to their preferred place of care as quickly as possible (Venkataslu et al, 2015). When patients are rapidly deteriorating, fast-track assessments, also known as rapid discharges, are used to gain immediate access to NHS continuing healthcare funding. Fast-track applications allow health professionals to arrange urgent care packages to enable patients to be cared for, and eventually die, in their preferred place. This could be their own home or a care setting such as a nursing home or hospice (Department of Health, 2012, updated 2016).

In 2010, an article published in *Nursing Times* reported on an audit conducted in 2009 at North Middlesex University Hospital Trust. The audit revealed a variety of reasons for delayed discharge, including deterioration of patients' condition, delays in organising care packages, and poor

communication between hospital and community teams. One or a combination of these factors was contributing to poor transitions from hospital to home. This article revisits the same hospital and reports on a new audit conducted in 2016 to assess the quality of rapid discharges by measuring it against current guidance.

Since the 2009 audit, there has been one major change in NHS continuing healthcare funding: before 2016, applications were restricted to patients with a prognosis of less than three months; since 2016, applications can be made for any person with a life-limiting illness (Department of Health, 2012, updated 2016), which has led to an increased demand in fast-track applications.

## Improvements since the first audit

One of the conclusions of the 2009 audit was the need for a better understanding of the continuing healthcare funding process. Since the findings were published (Thomas and Ramcharan, 2010), the palliative care team at North Middlesex

## Nursing Practice Discussion

University Hospital Trust has trained ward nurses and medical teams to improve the discharge process. The training stresses that staff need to work cohesively to ensure safe and timely discharges.

To help them achieve this, a checklist was designed in 2016 for each clinical area (Fig 1). It explains the responsibility and role of each health professional involved in the discharge process. Designed to guide staff through the discharge process, the checklist is in a bullet-point format that allows each team member to clearly see what needs to be done by whom.

The 2009 audit had found that 25% of discharges were delayed due to problems with the delivery of end-of-life care equipment to patients' homes, including hospital beds, commodes, bed rails and pressure-relieving mattresses. A mapping exercise following patients' journey from hospital to their preferred place of care, which spanned hospital and community services (including district nurses and equipment providers), was conducted in 2010, as a result of the first audit to identify

any gaps and delays. One of delaying factors was found to be the delivery of equipment. In the past requests for equipment were made to the district nursing service and this often delayed discharge. It was agreed that the hospital palliative care team would order equipment directly, thereby speeding up the process. Equipment is now delivered within 24-72 hours in all boroughs covered by the trust, including those outside of London.

The 2009 audit had also suggested that communication between hospital and community teams needed to be improved, to ensure seamless discharges. One measure put in place in 2015 was the provision of 'just-in-case' bags given to patients for use by district nurses. These contain equipment and medication such as needles, syringes, a sharps box and sealed prescribed controlled drugs that district nurses may need for symptom control. The aim was to ensure patients had all the necessary equipment to relieve any pain or distress.

Communication between hospital and community teams was also improved by

the introduction of Coordinate My Care (<http://coordinatemycare.co.uk>), an NHS clinical service that allows health professionals to electronically record patients' wishes and ensures patients' personalised urgent care plans are available to all involved, including community teams, GPs and ambulance services.

Another improvement made is that advance care planning (ACP) discussions are now documented in patients' discharge summaries; this is followed up with a phone call to GPs to ensure they are aware patients are at home. Finally, the local hospice has set up a palliative care support service for people who choose to die at home.

### Method for 2016 audit

The aim of the second audit in 2016 was to assess the quality of rapid discharges at North Middlesex University Hospital Trust by measuring it against the five 'priorities for care of the dying person' laid out in the guidance *Once Chance to Get it Right* (Leadership Alliance for the Care of Dying People, 2014) (Box 1).

Fig 1. Rapid discharge guidance for imminently dying patients preferring to die at home

#### Palliative care team

- Complete FTCC paperwork
- Order equipment
- Gain consent from patient for Coordinate My Care record
- Community palliative care team referral
- Provide community services contact numbers

If patient is recognised to be imminently dying (days to live) and their preferred place of care is home, the medical team should have a discussion with the patient (where possible) and family about this choice. This discussion should be documented in the medical notes. Contact the palliative care team for rapid discharge home

#### Ward nursing staff

- Refer to district nurses for EOL care. If advised by palliative care team, request PCSS or Marie Curie nurse. Has to undertake risk assessment
- Ensure all patients requiring PCSS/Marie Curie nursing are discharged before midday
- Discuss with family amount of care they would require for the patient prior to discharge
- Confirm equipment delivered
- Confirm with ward discharge nurse start time of first carers' visit
- Confirm district nurses aware of date of patient discharge home
- Ensure all discharge documents are emailed to appropriate teams
- Confirm there is a PCSS or Marie Curie carer available
- Confirm transport booked
- Nursing staff to supply carer/family member with:
  - Subcutaneous needles
  - Luer lock
  - Syringes (5 and 20mL)
  - Sharps bin
  - Incontinence pads and wipes

#### Discharge coordinator

- Coordinate with ward manager that fast-track forms are sent to appropriate clinical commissioning group
- Ensure all fast-track forms and referrals are filed in patient's medical notes
- Order equipment for all other patients; for example, hospital bed, pressure-relieving mattress, cot sides

#### Doctors

- Telephone GP (request visit as community DNACPR order needs completing)
- Prescribe EOL medication on TTA forms
- Complete authorisation form to administer EOL medications. Forms can be obtained from the palliative care team
- Ensure TTA medications are ordered well in advance
- Discuss with pharmacist if medication list is required
- Order home oxygen, if required, after gaining consent

Key: CCG = clinical commissioning group; DNACPR = do not attempt cardiopulmonary resuscitation; EOL = end-of-life; PCSS = palliative care support service; TTA = to take away

Source: North Middlesex University Hospital Trust

# Nursing Practice

## Discussion

The case notes of 40 patients with complex discharge needs were reviewed in June 2016 and were sourced from oncology, care of the elderly and general medical wards. Data was collected using a pro forma designed in 2009, which had been found to be a reliable tool for gathering information on why discharges are delayed. It includes:

- Patients' borough of residence (referred to here as A, B, C or D);
- Dates of fast-track application start and completion;
- Role of professional completing the fast-track application;
- Total number of days taken to arrange discharge/length of stay;
- Whether equipment was ordered and how long it took to be delivered;
- Time taken for continuing healthcare funding to be approved or declined;
- Patients' diagnosis categorised into cancer or non-cancer;
- Evidence of ACP and ceiling of care discussion (discussion that focus of care is comfort and palliative care rather than active treatment).

Unlike the previous audit, which had reviewed both continuing healthcare and social care packages, this audit excluded patients who required social care packages and only looked at rapid discharges.

Boroughs A and B are London boroughs; the hospital is located in one of them. Boroughs C and D are outside London.

### Second audit's results

Out of the 40 patients, 100% had fast-track applications made; 90% of patients had a cancer diagnosis and 10% had a non-cancer diagnosis; 80% of patients lived in boroughs A and B, and 20% in boroughs C and D. All patients with a non-cancer diagnosis lived in boroughs A and B.

The total number of days taken to arrange discharge varied between 3 and 24 days for patients from boroughs C and D and the same day to 16 days for boroughs A and B. This suggests that the borough of residence has an impact on the length of stay and discharge process, with those living outside London often waiting for longer.

The audit shows that 40% of applications were completed by a specialist nurse, 37.5% by a doctor, 2.5% by a ward nurse and 2.5% by both a specialist nurse and a doctor; 17.5% of notes did not document this information. The role of the professional completing the application does not appear to affect the length of the discharge process.

After completion of the fast-track application four (10% of patients) were discharged on the same day, 11 (27.5%) within

### Box 1. Priorities for care of the dying person

The guidance *Once Chance to Get it Right* features five 'priorities for care of the dying person':

- This possibility (that a person may die within the next few days or hours) is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly
- Sensitive communication takes place between staff and the dying person, and those identified as important to them
- The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants
- The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible
- An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion

Source: Leadership Alliance for the Care of Dying People (2014)

Fig 2. Discharge outcomes

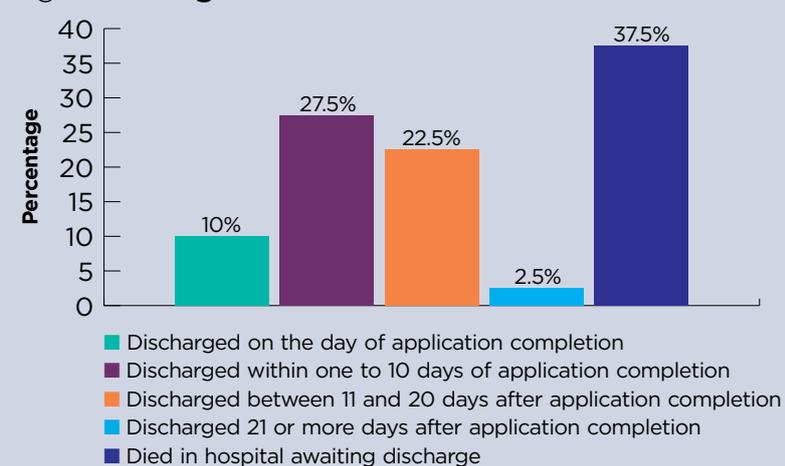
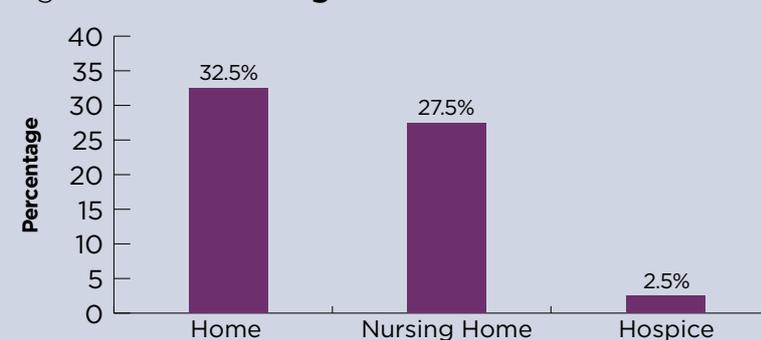


Fig 3. Place of discharge



one to 10 days, nine (22.5%) after 11-20 days and one (2.5%) after 21 days or more. In total, 25 (62.5%) patients were discharged; the remaining 15 (37.5%) died in hospital awaiting discharge (Fig 2).

Among the 25 patients discharged, 13 (52%) went home, 11 (44%) went to a nursing home and one (4%) went to a

hospice (Fig 3). They were all discharged to their preferred place of care. Among the 15 patients who died in hospital awaiting discharge, the preferred place of care was home for six (40%), a nursing home for four (26.5%) and a hospice for two (13.5%); for the remaining three (20%) the preferred place of care was not documented.

**Barriers to rapid discharge**

Scott (2010) suggests that discharge processes need to be standardised and improved. Issues include incomplete needs assessments, lack of patient and carer education and information, medication errors such as controlled drugs prescribed incorrectly, and poor communication between hospital and community teams. Benzar et al (2011) state that these gaps in discharge planning result in poorer quality of life for patients and lack of support for carers.

*“Advance care planning discussions allow patients and families to make their wishes known.”*

A persistent barrier to end-of-life care planning is the lack of discussions between health professionals, patients and family. In acute hospital settings, there is often a curative intent (Gott et al, 2011; Willard and Luker, 2006), so the focus remains on treatment, which makes it difficult to have open conversations about end-of-life care.

ACP is a process of formal decision making that aims to help patients to make decisions about their future care, particularly if they lose mental capacity. ACP discussions allow patients and families to make their wishes known. However, until patients are aware that they are at a palliative stage in their disease trajectory, it is difficult to have open discussions about end-of-life care. The audit shows that 37.5% of patients died in hospital and not in their preferred place. Perhaps earlier discussions and involvement with palliative care services could have helped ensure a smooth transition between hospital and the preferred place of care before patients' condition deteriorated.

The process of planning a complex end-of-life discharge involves professionals working together to ensure a safe and seamless process, with effective communication being at the heart of the process. Day et al (2009) state the importance of multidisciplinary working, coordination and early assessment of patients' needs and home circumstances.

There is evidence that location can have an impact on discharge and length of stay in hospital – an end-of-life care ‘postcode lottery’ (Venkataslu et al, 2015). This could be due to different local policies and procedures when ordering equipment and organising packages of care. In the audit, it is likely that the closure of a local accident

and emergency department and other acute services increased the number of terminally ill patients presenting to the hospital from boroughs outside London.

One issue faced when discharging patients to nursing homes and hospices is the high occupancy rates and lack of available beds (Scott, 2010). This potentially causes delays. By the time a bed is offered, a patient's condition may have deteriorated and it may become unsafe to transfer them to their preferred place of care, meaning they will die in hospital.

Yatim et al (2017) conducted a study on the role of nurse navigators in discharge and follow-up. The nurse navigators had five main tasks: patient monitoring, helping patients to navigate to various other clinical pathways, managing technical problems, explaining protocols, and collecting and transmitting patient data. This shows that patients need ongoing support after discharge (Yatim et al, 2017).

**Discharge facilitator role**

A trust in the north of England appointed a Macmillan nurse as palliative care discharge facilitator, with the aim of reducing the problems encountered when trying to discharge terminally ill patients early. The role involves helping patients and families transition from hospital to community settings, generally providing support and ‘arranging practicalities such as transport, beds, anticipatory medications and equipment such as syringe drivers’ (Venkatasula et al, 2015).

After the success of this role and similar initiatives across the UK (Moback et al, 2011), the palliative care team at North Middlesex University Hospital Trust is planning to submit a business case for a palliative care discharge facilitator.

The discharge nurse would attend multidisciplinary team meetings and train other professionals to recognise early warning signs that patients' condition may be deteriorating. This would allow palliative care teams to become involved earlier, leading to more timely end-of-life care discussions and better ACP. Having a dedicated discharge nurse would also reduce the amount of time other clinical nurse specialists spend arranging discharges – a process that can take several hours out of a working day.

Having a palliative care team nurse whose role is to coordinate fast-track discharges would ensure that patients get to their preferred place of care and carers receive more support (Yatim et al, 2017; Venkatasula et al, 2015).

**Conclusion**

The audit shows that the discharge of patients with complex palliative care needs still needs to be improved. Earlier referral to the palliative care team and joint team working are needed to achieve high-quality end-of-life care for patients and families. Clinicians can find it difficult to refer patients early due to the curative nature of hospital care, but delaying referral can prevent timely ACP discussions. Due to staff turnover, there is always a need for education on the continuing healthcare framework, rapid discharges and ACP.

To improve the service, the appointment of a nurse who would be in charge of ACP, staff education, patient discharge and liaison with community care has been suggested. There is also the wider issue of the lack of beds in the community; until this is also addressed, patients will continue to deteriorate and eventually die in hospital. **NT**

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