Rapid Transfer Home in the Last Days of Life

Management

Follow five steps below to:

• facilitate a peaceful death in the patient’s preferred place
• facilitate seamless transfer from hospital or hospice to home within normal working hours. Prevent re-admission where possible.

Step 1 – Communication and anticipatory care planning

Holistic assessment – physical, including optimising symptom control, psychological, emotional and spiritual needs.

Significant conversations with patient, and relatives, friends and carers as appropriate, and clearly document within medical and nursing notes.

Communicate above conversations and decisions to appropriate teams, including social care.

Assess urgency of discharge and identify potential estimated discharge date.

Consider discussion with palliative care team, discharge team or both.

Regularly review patient’s condition. Identify risks of discharge (including risk of death during transfer) and discuss with patient (if appropriate), relatives, friends, or carers, primary healthcare team and social care.
### Step 2 – Symptom control and 24-hour care needs

<table>
<thead>
<tr>
<th>Medical</th>
<th>Nursing</th>
<th>Pharmacy considerations</th>
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</table>
| - Contact general practitioner (GP) and update them on clinical condition, 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) status and significant conversations.  
- Rationalise medications.  
- Identify continuing need for oxygen and nebulisers – arrange if required.  
- Prescribe anticipatory end of life medications, minimum 7-day supply.  
- Send discharge script to pharmacy 24 hours prior to discharge if possible (refer to prescription guide in further information section below).  
- Contact pharmacist/dispensary directly to highlight urgency and ensure discharge medication is available before discharge. | - Liaise with community nurse (CN) about patient’s clinical condition, care needs of patient and carer, care package required and need for essential equipment.  
- Communicate significant conversations to CN.  
- Consider care package from social work following discussion with CN.  
- Consider referral to community specialist palliative care team.  
- If patient is on continuous subcutaneous infusion (CSCI), refer to symptom control guidance in further information section below. | - Check all items are in stock.  
- Check appropriate formulation prescribed.  
- Ensure appropriate ‘as required’ and anticipatory end of life medications are prescribed with appropriate dose and route.  
- If patient is on CSCI: check appropriate doses, compatible combination and correct diluents prescribed.  
- Minimum 7-day supply – original packs where possible (refer to prescription guide in further information section below). |
### Step 3 – Documentation

**Medical**
- Contact GP to request medicine administration documentation for community nursing staff is provided in patient’s home and that electronic key information summary (KIS) is updated.
- DNACPR form completed as per policy (refer to further information for step 1 below and national DNACPR policy).
- Complete immediate discharge letter/transfer plan.
- If patient has an end of life care plan ensure it is comprehensively completed (refer to guidance below).

**Nursing**
- Complete immediate discharge letter, transfer plan or both.
- If possible photocopy CSCl prescription and monitoring chart for case notes and send original home with patient.
- If patient has an end of life care plan ensure it is comprehensively completed. If possible photocopy this. Send original documentation home with patient, relative, friend or carer and keep copy in case notes.
- Send original DNACPR form home with patient, relative, friend or carer (refer to further information for Step 1 below and national DNACPR policy).

### Step 4 – Transport

**Nursing**
- Request ambulance for patient going home to die as soon as estimated discharge date is agreed.
- Refer any transport issues to local discharge team and/or ambulance service for speedy resolution.
• Provide ambulance service with an update of patient's condition, DNACPR status, mode of transfer such as chair or trolley, if oxygen is required and if patient has a syringe pump in situ.
• Provide patient’s weight if required, be aware of access or stairs into patient’s home.
• Inform relatives, friends or carers if patient being transferred on trolley that there is a possibility that they will be transferred to a chair to get into the home.
• Do relatives, friends or carers wish to escort the patient? If so, discuss appropriateness of escort with Scottish Ambulance Service.

Step 5 – Immediately prior to transfer home

**Medical and nursing**
- Regularly review patient’s condition. If patient deteriorates further, review discharge plan. Reassess risks of discharge (including risk of death during transfer) and discuss with patient (if appropriate), relatives, friends or carers and primary healthcare team.
- Contact GP/CN about estimated time of arrival home (if appropriate).
- If patient to be discharged out of hours (OOH), contact OOH GP service and CN.
- If discharge cancelled, contact relevant teams.

**Pharmacy**
- If unable to dispense full quantities of discharge medication – liaise with nursing staff and consider partial supply of prescription to avoid delaying ambulance.
- Request GP/CN is informed if unable to dispense all discharge medication.
Further information for Step 1 – Communication and anticipatory care planning

Significant conversations

- Conversations should be carried out as sensitively as possible with the patient and their relative, friend or carer as appropriate.
- Topics should include: patient’s current condition, estimated prognosis, plan for symptom control, 24-hour care needs, level of support available, any identifiable potential problems including risk of a significant event where present (refer to emergencies guideline) and DNACPR decision (refer to DNACPR section below).
- Contact numbers for OOH advice and support should be provided to the relative, friend or carer.
- Discussions with the patient (where appropriate) and relative, friend or carer may be necessary about preferred place of care and the agreement of a plan if home is not appropriate. This may include discussion of hospice/community hospital/hospital admission if this is what the patient would like and if a bed is available there.

DNACPR

- The patient, relatives, friends and carers should be aware that DNACPR decision is a clinical decision as CPR is unlikely to be successful.
- The patient, relatives, friends and carers should not be burdened with feeling they are being asked to make a resuscitation decision but should be encouraged to discuss any issues or concerns that they may have.
- It may be judged to be harmful to have an explicit conversation about the DNACPR form with a patient who is clearly in their very final days of life. Gently seeking their permission to discuss “important issues about their care at home” with family members allows the DNACPR conversation to happen with the family without causing distress to the patient.
- The patient, relatives, friends and carers should be informed that the DNACPR form will go home with them to enable the patient to die without unwanted interventions.
- The GP/OOH service must be aware of the decision to ensure emergency services are not called inappropriately where the patient’s death is expected.
- In the unusual circumstance that the decision has been made not to send the DNACPR form home with the patient, the ward doctor should speak to the GP and the nurse to the ambulance crew to communicate the clinical decision and the reason why the patient has not been informed.
• Following a recent legal judgement the only acceptable justification for having a clinical DNACPR decision in place without informing the patient is where it is clear that informing them would cause physical or psychological harm and the importance of documenting this in the clinical notes cannot be overemphasised.

• If further guidance is required, please refer to the national DNACPR policy.

Further information for Step 2 – Symptom control and 24-hour care needs

Nursing

• CSCI via CME T34 ambulatory syringe pump.

• Refill syringe pump just prior to patient discharge – notify CN of the time pump was changed.

• Record date of giving set/line change on discharge/transfer plan documentation/syringe pump documentation.

• Ensure syringe pump is correctly labelled.

• Confirm arrangements for return of syringe pump to ward.

• Ensure there is a ward record of patient name, community health index (CHI) number, CN contact, syringe pump serial number and discharge date to facilitate return of pump.

Medical

• Medical staff should inform GP if anticipatory medication will be provided with discharge medication.

• Medical staff should contact GP to ensure ‘Direction to Administer’/medicine administration documentation is available at patient’s home.

• If patient is already stable on an opioid and pain is controlled, prescribe current dose and route.

• If oral route still in use, ensure parenteral opioid medication is also prescribed on discharge prescription.

• Consider prescribing medication to control the following symptoms (it is good practice to specify dose, frequency and indication):
  - pain
  - anxiety/agitation
  - nausea/vomiting
  - respiratory secretions
- terminal restlessness.

For guidance on anticipatory symptom management, refer to Last Days of Life guideline.

Medication

**Example prescription templates** may assist junior medical staff in completing discharge prescriptions timeously (refer to examples below although different doses may be required depending on previous prescription/use). For opioids and midazolam, controlled drug prescription requirements apply: the formulation and strength of preparation desired must be stated and dose and frequency are also required. The total amount of drug to be supplied must be specified in both words and figures.

It is also important to remember to prescribe adequate diluent, for example 10 ampoules of 10ml water for injection.

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<tr>
<th>Pain/breathlessness</th>
<th>Anxiety/agitation</th>
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<tbody>
<tr>
<td>Morphine sulfate 10mg/ml injection</td>
<td>Midazolam 10mg/2ml injection</td>
</tr>
<tr>
<td>2mg subcutaneous (SC) 1 hourly as required for</td>
<td>2mg SC 1 hourly as required for anxiety or agitation (max 6 times in 24 hours)</td>
</tr>
<tr>
<td>pain or breathlessness (max 6 times in 24 hours)</td>
<td>Supply 10 (ten) ampoules</td>
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<tr>
<td>Supply 10 (ten) ampoules</td>
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<tr>
<td>...........EXAMPLE PRESCRIPTION ONLY ...........</td>
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<tr>
<th>Respiratory secretions</th>
<th>Nausea/vomiting</th>
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<tr>
<td>Hyoscine butylbromide 20mg /1ml injection</td>
<td>Levomepromazine 25mg/1ml injection</td>
</tr>
<tr>
<td>20mg SC 1 hourly as required for respiratory</td>
<td>2.5mg to 5mg SC 12 hourly as required for nausea</td>
</tr>
<tr>
<td>secretions (max 6 times in 24 hours)</td>
<td>Supply 10 ampoules</td>
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References

