PALCARE
There's no place like home

THE JIMMY S BILIMORIA FOUNDATION

PALLIATIVE CARE
GUIDELINES
FOR A HOME SETTING IN INDIA

RAPID TRANSFER OF TERMINALLY ILL PATIENT TO THE HOME

INTRODUCTION

While most patients at end of life prefer to die at home, in reality this is not achieved. Communication and collaboration between hospital, hospice and community teams can help patients spend their last days in their preferred place. The aim of the guideline is to enable a rapid response to fast track referrals for transfer of a terminally ill patient home and deliver palliative care at home at the end of life.

MANAGEMENT

A nurse coordinator from the palliative care team should be designated to coordinate rapid transfer home, of patients at end of life. To facilitate the rapid transfer of terminally ill patient to home, the guideline defines the role and responsibilities of the health-care team/professionals involved in the transfer of patients to home.

Nursing staff (hospital, hospice)

- If the patient is terminally ill and the patient's wish is to be cared for and die at home, then the medical team should review this decision with the patient (if possible) and the family
- Inform the Palliative Nurse coordinator of the fast track referral of patient at end of life
- Ensure that medications needed for symptom control and anticipatory end of life medications are provided
- Ensure that detailed discharge plan/summary and medication list are given to the patient/family and the same are electronically transferred to the Palliative Nurse coordinator
- Ensure that the primary care giver is empowered and supported to take care of the patient at home and is familiar with the administration of regular and anticipatory medications
- Ensure that the patient is discharged and reaches home before noon
- Ensure the availability of the local general practitioner (GP)/family physician (FP) and provide the contact details of the local GP/FP to the Palliative Nurse coordinator
- Plan and ensure transportation for the transfer of patient in a time-bound manner
- Inform the Palliative Nurse Coordinator and local GP/FP of the estimated time of arrival home
- Confirm the time of the home care visit with Palliative Nurse Coordinator and inform patient/family

- Review patient's general condition and the discharge plan. If the condition deteriorates and family/carers should be informed on the risks involved during the transfer including the possibility of death during the transfer home
- If discharge is deferred, then inform the Palliative Nurse coordinator and local GP/FP

Palliative Nurse Coordinator

- Coordinate with the nursing staff (hospital/hospice) that the fast track referrals are routed to the appropriate home care teams and to assess the feasibility of delivering home care within the stipulated time
- Ensure that all fast track referrals are accepted within half an hour
- Ensure that detailed discharge plan/summary and medication list have been transferred by the nursing staff (hospital/hospice)
- Coordinate with the home care team to ensure that home care visit is done within four hours
- Ensure that the family has been provided with the following:
  - Luerlock syringes, diapers, wipes etc.
- Coordinate with out-of-hour services and ensure the availability of equipment e.g. hospital cot, air bed, nebulisers, oxygen etc. and other services/resources such as professional caregivers ***(refer to the Guideline - Out of Hours Handover)***
- Ensure that there is availability of 'If needed medications' boxes containing appropriate medications in the patient's home during the home care visit ***(refer to the Guideline - Anticipatory Prescribing)***
- Technical support necessary to administer medications for use through subcutaneous route after an appropriate clinical assessment by a doctor ***(refer to the Guideline - Syringe Driver)***

Doctor (palliative home care team)

- Communicate and coordinate with the local GP/FP on care of the patient
- Ensure holistic assessment of patient, who are at the end of life ***(refer to the Guideline - Care in the last days of life)***
- Provide signed prescriptions and medication information charts that last for 48 - 72 hours period to avoid unnecessary hospital admissions and enable patient to be in the preferred place of care ***(refer to the Guideline - Anticipatory Prescribing)***

REFERENCES

Healthcare Improvement Scotland. Scottish Palliative Care Guidelines – Rapid Transfer Home in the Last Days of Life. Retrieved online from https://www.palliativecareguidelines.scot.nhs.uk/guidelines/end-of-life-care/rapid-transfer-home-in-the-last-days-of-life.aspx on 9 January 2019

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