

Terminal Discharge From Hospital Back Home to Die: Experience and Perspectives From a Home Hospice

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Abstract

Background:

Terminal discharge is an emergent procedure for dying patients in hospital to return home. While reports on hospital staff experience exist, perspectives from community partners are lacking.

Aim:

We profile a cross section of decedent patients, and report clinician experience from a community hospice service.

Design:

A mixed-methods approach. Electronic medical records were analysed for characteristics, trajectories and service utilisation, comparing terminally discharged and regular care patients over one year. Hospice care coordinators participated in an open-ended questionnaire and responses were analysed qualitatively.

Settings/participants:

The study was conducted in the largest home-based hospice service in Singapore. 260 referrals were received for terminal discharge in 2020, out of 3700 patients served. All five discharge coordinators responded to the questionnaire.

Results:

Only 228 of 260 terminally discharged patients reached home; 18 died before home visits could be made, and 10 outlived their prognoses. The ratio of cancer to non-cancer patients (1:1) in the terminal discharge group differed from the service's norm (4:1). Moreover, median length of service for this group (4 days) was 10 times shorter compared to decedents from regular service. This group also received on average three times higher service touchpoints (phone calls and home visits). Thematic analyses of survey responses revealed varying understanding of terminal discharge with concomitant implications; patchy handover between services that compromised care quality; and areas for improvement are suggested.

Conclusions:

Given its primacy and potential impact, active engagement of all stakeholders to optimise the management of terminal discharge is indicated.

Introduction

Trajectories of patients with life-limiting conditions are unpredictable. The illness may become refractory to treatments, or adverse effects from interventions may overwhelm the vulnerable patient. Either way, complications whether from disease progression or medical treatments can cause sudden and

irreversible deterioration of the patient to the extent that survival is threatened.^{1,2} When that happens, the patient or family are confronted with the bad news that death is anticipated and imminent, and their hopes and wishes revisited. If requested, rapid discharge from hospital to home is an option that some healthcare providers render at this time.^{3,4}

End-of-life care at home alongside family caregivers allows these patients or their families to fulfil aspirations for a home death.⁵ Dying at home carries religious and cultural significance; and meeting these preferences is associated with greater family satisfaction.⁵⁻⁷ In 2013, the Lien Foundation commissioned a survey of 1,000 people to examine death attitudes and preferences in Singapore. Of those polled, 77% reported that when given a choice, they preferred dying at home; 76% would still want a home death even without support from family, friends or medical professionals.⁸ This preference to die at home is similar to that elsewhere.^{5,6}

With involvement of multiple providers, care transitions between settings are in reality complex interventions, especially to facilitate dying at home in a critically ill hospitalised patient where time is of the essence.^{3,9-12} This process is variably referred to as rapid, fast-tracked or terminal discharges in the literature.^{4,13,14} While the underlying premise is compelling, in our experience terminal discharge can go wrong if not expertly handled, compromising patient safety or leaving regrets among informal and professional caregivers alike. Staff in hospital often perceive terminal discharge stressful to execute. Owing to its sporadic nature, nurses find it difficult to maintain newly acquired knowledge and skills.¹⁵ A local study reported commonly faced issues like pressure of time, problems arranging discharge and inadequate family preparation.³ Unfamiliarity with workflows and disrupted ward routines were specifically cited. Quality of caregiver training was also perceived to be compromised due to carer emotional lability or general rush for time.¹⁶ In Singapore, these discharges are routinely supported by community hospice services as partners. With continuity of care within this collaboration paramount, the perspectives from community providers however have not been widely solicited nor documented.^{12,17} These insights if obtained can inform effective resource planning and utilisation among community providers in similar settings. Most of all, when combined with perspectives from institutional providers reported previously, terminal discharge as a systemic healthcare intervention may be optimised for overall quality, safety and impact.¹⁸

Objectives

We profiled a group of dying patients discharged home from hospital, supported by a large specialist palliative home care service in Singapore, with a view to uncover underlying trends and resource use. Additionally, we explore the experiences and perspectives of care coordinators in that service while facilitating terminal discharge with partners.

Context and setting

This study was conducted in HCA Hospice Care, Singapore (HCA). It is the largest local home hospice, serving up to two-thirds of the country's patients with life limiting illness and less than one year prognosis.^{19,20} Multi-disciplinary teams of doctors, nurses, medical social workers, and allied health professionals provide specialised palliative care at no charge to the patient and their family. The service includes home visits, a 24/7 helpline, equipment loans, caregiver training, as well as bereavement support.

Patient referrals come from hospitals, specialist outpatient clinics or primary care like general practitioners. In the context of terminal discharge, patients discharged home are either (i) prior hospice patients recently admitted to acute hospitals for treatment of reversible medical complications, or (ii) more commonly, newly referred patients not seen previously. Some clinicians may not specifically label a new referral as terminal discharge but would state in the referral form an anticipated prognosis of less than seven days. For the purpose of this study, these hospital discharges were also classified as terminal discharge.

Within HCA, an established workflow is in place to manage all terminal discharges, whether for existing or new patients. A senior clinician routinely communicates on the phone with the referring source to make clarifications and obtain further information. Initial care plans are then made. The team-in-charge is assigned according to the patient's residence or alternative destination for terminal discharge. A triage nurse registers new cases into the electronic medical records and informs the assigned teams to standby. To ensure active issues are timely managed, hospice staff assigned will often adjust their schedules for the day to accommodate that patient. This however can be challenging when staff are already out in the field, particularly if equipment like syringe pumps or emergency drugs needed to be prepared ahead.

Methods

Study design

A parallel mixed-method design was employed.²¹ The quantitative arm analysed retrospective data to describe the characteristics, trajectories and service utilisation patterns of patients who were emergently referred from acute hospitals to the home hospice for terminal care. All terminal discharge seen by HCA in the year 2020 were included. Electronic medical records were accessed to obtain data for pre-registered patients that had terminal discharge from hospital, or patients newly referred for terminal care at home (explicitly labelled as terminal discharge during handover or given an estimated prognoses of 0-6 days). Patients were tracked till death or discharge (if they survive their terminal diagnoses) up to one week beyond 31 December 2020 for the purpose of computing length of service or survival. To evaluate service utilisation, frequencies of home visits and phone calls were collated.

The qualitative arm drew data from surveys of hospice staff who acted as liaison between referring hospital clinicians and individual teams in the hospice. Perspectives were solicited through an open-ended electronic questionnaire survey which sought understanding of (i) what defines a terminal discharge, (ii) variations from norms encountered in practice, (iii) critical information they often did not get in referrals (and needed to ask), and (iv) suggestions for improving care in a terminal discharge. Four senior physicians (three palliative medicine registrars performing their hospice rotations and a principal resident physician in HCA) and one triage nurse were surveyed. Study information and links to the survey were shared with participants through email. If the staff had not replied after two weeks, a single reminder was sent. This method of data collection was deemed most appropriate during the Covid-19 pandemic; it additionally facilitated unhurried and reflective response to questions posed.

Data analysis

Quantitative data were statistically analysed to describe baseline, process and outcome characteristics in this special group of patients. Where appropriate, key attributes or factors were compared against another group of patients that died during the same period who received regular care. To compute 'mean contacts per service day' for each group in particular, individual patient ratios of 'total contacts' over 'length of service' were averaged. We used SPSS 21 for statistical tests (e.g. independent t-test, chi-squared test). Qualitative data was thematically analysed for common threads that addressed questions posed. We used Excel 2016 to facilitate this component of data analysis.

Ethics

This study was reviewed by the *SingHealth Centralized Institutional Review Board* (Reference number: 2021/2272) and was determined to not require further ethical deliberation as a service evaluation. This decision was received on 4th May 2021.

Results

In 2020, the hospice served a total of 3,711 patients; 2,928 of these patients were new admissions in the year. In total, 2,062 records of deaths were captured in the data, 1,844 for regular patients and 218 for those with prior terminal discharge.

Figure 1 presents the flow of terminal discharge referrals between 1st January 2020 and 7th January 2021. The service received a total of 260 referrals for terminal discharge in 2020. This translates to a mean of one terminal discharge per workday, though in reality there were peaks and troughs. Majority of terminal discharge referrals were new patients (n=199; 76.5% of 260 referrals). The remainder (61 patients) involved prior admitted patients known to the service.

228 patients (87.7% of terminal discharge referrals) made it home. 18 patients (7%) died before any home visit could be conducted, and only telephone support was rendered. 195 patients (75% of 260 patients) eventually died under home hospice care. One patient was a resident of a nursing home and

died there. Four patients did stay home for varying periods, but finally died in hospital following readmissions. As of 7th January 2021, ten patients 'survived'; five patients were discharged stable from the service, while five continued receiving regular home hospice care.

Table 1 compares the characteristics and service utilisation between terminal discharge patients and non-terminal discharge patients. 1,844 patients who died in the same period (non-terminal discharge patients) were used as a comparator group. The mean age of terminal discharge patients was about 76 years, with an older cohort noted in the non-cancer group (difference=10 years; $p<.001$). Terminal discharge patients presented with a near-equal distribution of cancer and non-cancer diagnoses; this differed from HCA yearly service's norm of 80% cancer patients to 20% non-cancer patients. More females were referred for terminal discharge compared to males. Otherwise, terminal discharge patients were similar to the non-terminal discharge cohort in terms of age, ethnicity and religion.

Deeper data analysis revealed an interesting observation. Most terminal discharges were arranged for patients who had sudden irreversible deterioration. Albeit ending with the same outcome of death, a small group was discharged home however under extraordinary circumstances. In this cohort, six patients (0.03% of 200 deaths) were discharged from hospital intensive care for ventilator withdrawal or terminal extubation at home.

Findings on service utilisation patterns are presented next. The median length of service for deceased terminal discharge patients ($n=200$) was four days. In fact, 75% of terminal discharge patients (150 out of 200) died within seven days of discharge from hospital (IQR: 4-7 days; range 0-121 days). In contrast, deaths occurring less than one week after admission among patients on regular hospice care constituted 179 out of 1,844 deaths (9.7%).

During the year, a total of 54,981 contacts (including phone calls and home visits) were made for all 3,711 home hospice patients served. 1,778 of these contacts were related to 210 terminal discharge patients supported. Out of those, 1129 were phone calls (63.5%) while 649 were home visits (36.5%). Terminal discharge patients received an average of 1.78 contacts per service day ($SD=1.44$) compared to non-terminal discharge patients who received 0.62 contacts per day ($SD = 1.08$). After a terminal discharge, patients hence needed 2.9 times more service contacts from home hospice staff than regular patients ($p <.05$).

In the remaining sections, findings from thematic analysis of survey responses are reported. All five home hospice staff who acted as terminal discharge liaisons completed the survey. One registrar replied after a reminder was sent. Their profiles are shown in Table 2 below.

Three key themes were located. Given the volume and diversity of information contained within, individual elements are tabulated for better clarity.

Means different things to different stakeholders

Apart from minor differences around exact prognosis that qualifies for a terminal discharge, respondents shared almost similar understanding of what defines a terminal discharge and its implications. Myriad facets from their collective perspectives are summarised in table 3.

Their experience interacting with other stakeholders within the healthcare system indicated wide deviations from this construct. Patients were referred to them sometimes with an expected life remaining measured in months. These could be instances where there was an anticipated crisis that might result in premature or sudden death, like a possible tumour rupture in someone with advanced liver cancer. What frustrated them most were times when there was no communication nor coordination, and the patient was simply discharged home, only to be picked up later during a crisis call on the hospice helpline.

Handover for continuity

Again, experience accumulated managing transitions from hospital to home for many frail and vulnerable patients produced a list of must-have data in the process of handing over. See table 4. These were sometimes left out in a standard referral and frequently requested by coordinators at handover.

Recommendations on reflection

When prompted to suggest how the process of terminal discharge could be improved, respondents shared their suggestions on areas for improvement, presented in table 5.

Discussion

Intrinsic to its primary motivation, there is abrupt change in care plans among different stakeholders to honour a patient or family's wishes for death to occur at home; in every instance, there is expectation of a prompt response to accelerate routine processes on the community provider's part. Study findings show terminal discharge can be a daily affair, sometimes up to a few a day. A better understanding of caseload, trajectories and needs associated with terminal discharge will benefit service leads or commissioners in designing equitable and effective use of limited resources. One in 14 patients seen by the home hospice team is in this unique situation, majority of whom are seen for the first time at home as new patients. They are supported intensively over a short period, compared to their non-terminal discharge counterparts. Voices from coordinators on the ground highlight a need to standardise understanding of what makes a terminal discharge, given its primacy and ramifications on care. Pain points and areas for improvement are flagged. Healthcare providers in relevant domains, whether at the institutional level or in the community setting, could apply some of these recommendations to devise new ways to optimised quality and even safety whenever terminal discharge as a medical intervention is offered.

A key finding that came up was how hospital providers had interpreted terminal discharge differently, with implications on survival after terminal discharge and ultimately, overall care burden and length of service. Consistently extending already strained resources to respond to an urgent terminal discharge and then

discovering otherwise could stretch hospice providers further, potentially leading to apathy or even burnout.²² Among all palliative care providers locally, the phrase ‘terminal discharge’¹⁴ invokes a context similar to that described by Gambles et al in their rapid discharge pathway,⁴ targeted at patients who were in their last hours to days of life.⁴ Hospitalists who care for critically ill patients however might not be aware. A systematic review by Hui et al noted that although the terms ‘actively dying’, ‘end of life’, ‘terminally ill’ and ‘terminal care’ are regularly used, they are not always clearly or consistently defined.²³ The interpretation ascribed to ‘actively dying’ in the article is pertinent here: “The hours or days preceding imminent death during which time the patient’s physiologic functions wane”. That said, another fast-tracked discharge program in United Kingdom that aimed to send patients home within 72 hours, the hospital palliative care team involved had extended eligibility criteria from two to six weeks when they realized significant numbers of patients had not made it out from hospital in time.²⁴ In our cohort, terminal discharge was not ‘completed’ for one in four patients referred.

Findings derived using a mixed study approach have raised points of contention and areas for improvement that are contextualised to the real-world setting. With strong ecological validity²⁵, these observations and recommendations have practice implications among all types of community providers. Available evidence indicated yet another aspect that did not surface here, which is that of pre-discharge stakeholders’ meetings.^{3,4,12,24} These provide platforms for joint assessment of patients, open discussion of risks and limitations in a terminal discharge, address caregiver ambivalence or any change of mind, and finally, coordination with community providers, including arranging equipment and supplying medications. The opportunity for stakeholders to connect beforehand is desirable, since the majority of terminal discharge referrals (three in four here) are made for new patients not previously known to the hospice. In our experience, problematic issues around definition alignment, patchy handovers and differential expectations raised in this study are always minimised in the process.

Study Limitations

Although a fair number of terminal discharges were accrued as data points, this study was conducted within one hospice in Singapore. Results may not be fully generalisable to healthcare systems elsewhere. Only five terminal discharge coordinators in the hospice were interviewed. Members of the multi-disciplinary team that attended directly to these patients could provide even deeper insight into the area on ‘needs’, particularly challenges around service flexibility and job burden that might have compromised other patients’ care.¹² Similar to what other authors reported, there is a need to obtain the voice of family caregivers—the other major stakeholder.^{11,14} After all, they are the ones that will live with meaningful memories (or sometimes regrets) in bereavement.

Future development and research

A critical piece would be around defining “terminal discharge”, including its indication, assumptions and workflows. Only then can a robust framework be built for its smooth delivery. This mandates a multi-

prong approach in training and education, not only of healthcare providers but also care recipients offered a chance at terminal discharge, for right expectations from the outset. Individual recommendations offered here could be trialled to study effectiveness and value. Quality improvement methodologies are not only appropriate yet pragmatically feasible for that purpose.²⁶ From the perspective of hospice providers, proper medical handover remains a priority for seamless transfer of care. Collaboration between hospital and hospice is ideal in this instance, potentially to design a care protocol jointly, followed by formal evaluation. To test the terminal discharge model further, any future research could study it from a systems perspective²⁷, using a realist framework²⁸ for example, and involving all key stakeholders. Lastly, considering societal preoccupation with dying at home and apparent prevalence of terminal discharge, policy makers would be interested in its cost and impact evaluation.^{5,6}

Conclusion

When all else fails and the medically ill in hospital is anticipated to die in days, the patient may be offered a rapid discharge home, supported by a dedicated family caregiver and assisted by a hospice at home team. Although fraught with much stress and many challenges, when appropriate goals are set and intervening procedures coherently managed, different stakeholders can deliver a good death at home as a parting gift to the dying, leaving enduring meaning and satisfaction afterwards.^{4,11,29}

Declarations

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Not applicable.

Authorship

Study conception and design: PHC, IH. Data collection: ZZY. Data analysis: PHC, ZZY. Clinical Interpretation: PHC, IH. All authors made substantial contributions in conducting the study and producing the findings. All authors contributed to drafting and revising the manuscript, and approved the version to be published.

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Declaration of conflicts of interest

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

Ethical approval

This study was reviewed by the *SingHealth Centralized Institutional Review Board* (Reference number: 2021/2272) and was determined to not require further ethical deliberation as a service evaluation. This decision was received on 4th May 2021.

Availability of data and materials

Deidentified data used in this study is available upon reasonable request. Requests may be submitted to research@hcahospicecare.org or the corresponding author.

References

1. Etkind S, Koffman J. Approaches to managing uncertainty in people with life-limiting conditions: role of communication and palliative care. *Postgraduate medical journal*. 2016;92(1089):412-7.
2. Gray TF, Temel JS, El-Jawahri A. Illness and prognostic understanding in patients with hematologic malignancies. *Blood reviews*. 2020:100692.
3. Tan YY, Blackford J. 'Rapid discharge': issues for hospital-based nurses in discharging cancer patients home to die. *Journal of Clinical Nursing*. 2015;24(17-18):2601-10.
4. Gambles M, Cannell L, Bolger M, MurpD. Development and implementation of the Rapid Discharge Pathway Version 12 to enable imminently dying patients to die in the place of their choice. *International Journal of Care Pathways*. 2012;16(1):14-8.
5. Shepperd S, Gonçalves-Bradley DC, Straus SE, Wee B. Hospital at home: home-based end-of-life care. *Cochrane Database of Systematic Reviews*. 2016(2).
6. Gomes B, Calanzani N, Gysels M, Hall S, Higginson IJ. Heterogeneity and changes in preferences for dying at home: a systematic review. *BMC palliative care*. 2013;12(1):1-13.
7. Coolen PR. Cultural relevance in end-of-life care. *Ethno Med*. 2012.
8. Lien Foundation. Death Attitudes Survey 2014 [Available from: http://lienfoundation.org/sites/default/files/Death%20survey%20Presser%20Final%20-%20Combined_0.pdf].
9. Abrashkin KA, Cho HJ, Torgalkar S, Markoff B. Improving transitions of care from hospital to home: what works? *Mount Sinai Journal of Medicine: A Journal of Translational and Personalized Medicine*. 2012;79(5):535-44.
10. Naylor MD, Aiken LH, Kurtzman ET, Olds DM, Hirschman KB. The importance of transitional care in achieving health reform. *Health affairs*. 2011;30(4):746-54.

11. Eggen AC, Jalving M, Bosma I, Veenhuis DJ, Bosscher LJ, Geerling JI, et al. A methodology to systematically analyze the hospital discharge of terminally ill patients. *Medicine*. 2018;97(46).
12. Jones S, Hamilton S, Nicholson A. Rapid discharge from hospital in the last days of life: an evaluation of key issues and the discharge sister role. *International journal of palliative nursing*. 2015;21(12):588-95.
13. Gerrard R, Campbell J, Minton O, Moback B, Skinner C, McGowan C, et al. Achieving the preferred place of care for hospitalised patients at the end of life. *Palliative medicine*. 2011;25(4):333-6.
14. Tan YY, Xu ZZ, Pang GS, Qu L, Xu Y, Zhang AM, et al. Facilitating terminal discharge: fulfilling the hospitalised patient's wish for home death in the final hours. *International journal of palliative nursing*. 2016;22(11):541-8.
15. Davidoff F. Checklists and guidelines: imaging techniques for visualizing what to do. *JAMA*. 2010;304(2):206-7.
16. Pirani SSA. Prevention of delay in the patient discharge process: an emphasis on nurses' role. *Journal for Nurses in Professional Development*. 2010;26(4):E1-E5.
17. Smith R, Porock D. Caring for people dying at home: a research study into the needs of community nurses. *International journal of palliative nursing*. 2009;15(12):601-8.
18. Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW. Deficits in communication and information transfer between hospital-based and primary care physicians: implications for patient safety and continuity of care. *JAMA*. 2007;297(8):831-41.
19. Grey H. A Complete Guide to Hospice Care in Singapore. *Singapore: Homage*, [Available from: <https://www.homage.sg/resources/hospice-care/>].
20. Chi E. HCA Hospice Care offers free services at new premises. *The Straits Times*. 2019.
21. Shorten A, Smith J. Mixed methods research: expanding the evidence base. *Evid Based Nurs*. 2017;20(3):74-5.
22. Koh MYH, Chong PH, Neo PSH, Ong YJ, Yong WC, Ong WY, et al. Burnout, psychological morbidity and use of coping mechanisms among palliative care practitioners: A multi-centre cross-sectional study. *Palliative medicine*. 2015;29(7):633-42.
23. Hui D, Nooruddin Z, Didwaniya N, Dev R, De La Cruz M, Kim SH, et al. Concepts and definitions for "actively dying," "end of life," "terminally ill," "terminal care," and "transition of care": a systematic review. *Journal of pain and symptom management*. 2014;47(1):77-89.

24. Moback B, Gerrard R, Campbell J, Taylor L, Minton O, Stone PC. Evaluating a fast-track discharge service for patients wishing to die at home. *International journal of palliative nursing*. 2011;17(10):501-6.
25. Miles MB, Huberman AM, Saldaña J. *Qualitative data analysis: A methods sourcebook*: Sage publications; 2018.
26. Thomas C. Improving hospital discharge for patients at the end of life [online]. *Nursing Times*. 2017;113(10):53-6.
27. Friedman BD, Allen KN. Systems theory. *Theory & practice in clinical social work*. 2011;2(3):3-20.
28. Pawson R, Tilley N. *Realistic evaluation*: Sage; 1997.
29. Ewing G, Austin L, Jones D, Grande G. Who cares for the carers at hospital discharge at the end of life? A qualitative study of current practice in discharge planning and the potential value of using The Carer Support Needs Assessment Tool (CSNAT) Approach. *Palliative medicine*. 2018;32(5):939-49.

Tables

Table 1. Characteristics and service utilisation

Characteristic	Terminal Discharge patients (n=210)	Non-terminal discharge patients (n=1844)
Mean age in years (SD)	75.60 (12.7)	72.93 (14.89)
Disease type		
Cancer (%)	103 (49.0%)	1507 (81.7%)
Non-cancer (%)	107 (51.0%)	337 (18.3%)
Gender*		
Male (%)	93 (44.3%)	980 (53.2%)
Female (%)	117 (55.7%)	864 (46.9%)
Ethnicity		
Chinese (%)	156 (74.3%)	1439 (78.0%)
Malay (%)	28 (13.3%)	220 (11.9%)
Indian (%)	12 (5.7%)	78 (4.2%)
Others (%)	14 (6.7%)	107 (5.8%)
Religion		
Buddhist-Taoist (%)	97 (46.2%)	918 (49.8%)
Muslim (%)	46 (21.9%)	315 (17.1%)
Christian-catholic (%)	29 (13.8%)	283 (15.3%)
Hindu (%)	5 (2.4%)	58 (3.1%)
Others (%)	16 (7.6%)	80 (4.3%)
Free-thinker (%)	8 (3.8%)	95 (5.2%)
<i>Missing data</i> (%)	9 (4.3%)	95 (5.2%)
Service utilisation	Terminal discharge patients (n=210)	Non-terminal discharge patients (n=1844)
Mean length of service in days (SD)*	10.82 (23.18)	91.7 (66.08)
Median length of service in days (IQR)	4 (2-8.5)	40 (16-83)
Mean contacts per service day (SD)*	1.78 (1.44)	0.62 (1.08)

* $p < 0.05$

Table 2. Characteristics of hospice coordinators for terminal discharge

Hospice coordinators	#1	#2	#3	#4	#5
Age	34	42	36	35	65
Gender	Female	Female	Female	Male	Female
Appointment	Physician	Physician	Physician	Physician	Triage Nurse
Clinical experience	10	14	11	11	27
Years in palliative care	1.5	3	4	4	7

Table 3. Conceptual understanding (and assumptions) in a terminal discharge

Concept	Description
Illness	Any diagnosis or condition (refractory and terminal)
Intent	For patient to die at home
Goal	Fulfil patient's wish
Prognosis	Hours to days (less than a week)
Alignment	Mutual decision between patient and caregivers
Interim care	Availability of caregiver/s at home
Target	Focus only on providing comfort (to stop active therapy)
Disposition	Never to return to hospital (assessed to be futile)
Planning	Partnering with another healthcare service e.g. home hospice
Contingency	Chance of dying in transit acknowledged and prepared for

Table 4. Critical information at time of referral

Item	Description
Bio	Name, gender, identity number, means of contact, medical diagnosis
Contact	To reach referring nurse and doctor
Destination	Landing location (including estimated time of arrival)
Trajectory	Brief medical history, progress in ward and short-term outlook
Status	Patient's physical/mental function (including swallow) and vital signs
Symptoms	Distress (if any) and medication provided (continued and anticipated)
Nursing issues	Dressings or tubes (if needed) and equipment like oxygen tank (if any)
Spokesperson	And also caregiver if different, to be identified beforehand
Family	Understanding and expectations made explicit
Others	Special concerns or instructions (often most important!)

Table 5. Possible ways to optimised transition of care

Area	Improvement
Medication list	Guide hospital providers who may not be familiar or trained to prescribed drugs (to bring home) in anticipation of emerging symptoms in the dying phase.
Transfer memo	Template for hospital providers to follow; minimally, it must contain medication list, specific concerns or instructions, and how to certify death if it occurs enroute.
Caregiver diary	Written instructions for caregivers who may not retain everything shared before going home. Helpful for home care providers to continue briefing where it was left off.
Palliative team	Primary teams unfamiliar with organising a terminal discharge should consult their hospital palliative care team for assistance, either through a referral for direct consult or remote advice on the phone.
Single contact	Hospice teams to consider a single point of contact for all terminal discharge referrals, and possibly use a dedicated team to handle terminal discharge if prevalent so as to minimise disruption to regular patient care.

Figures

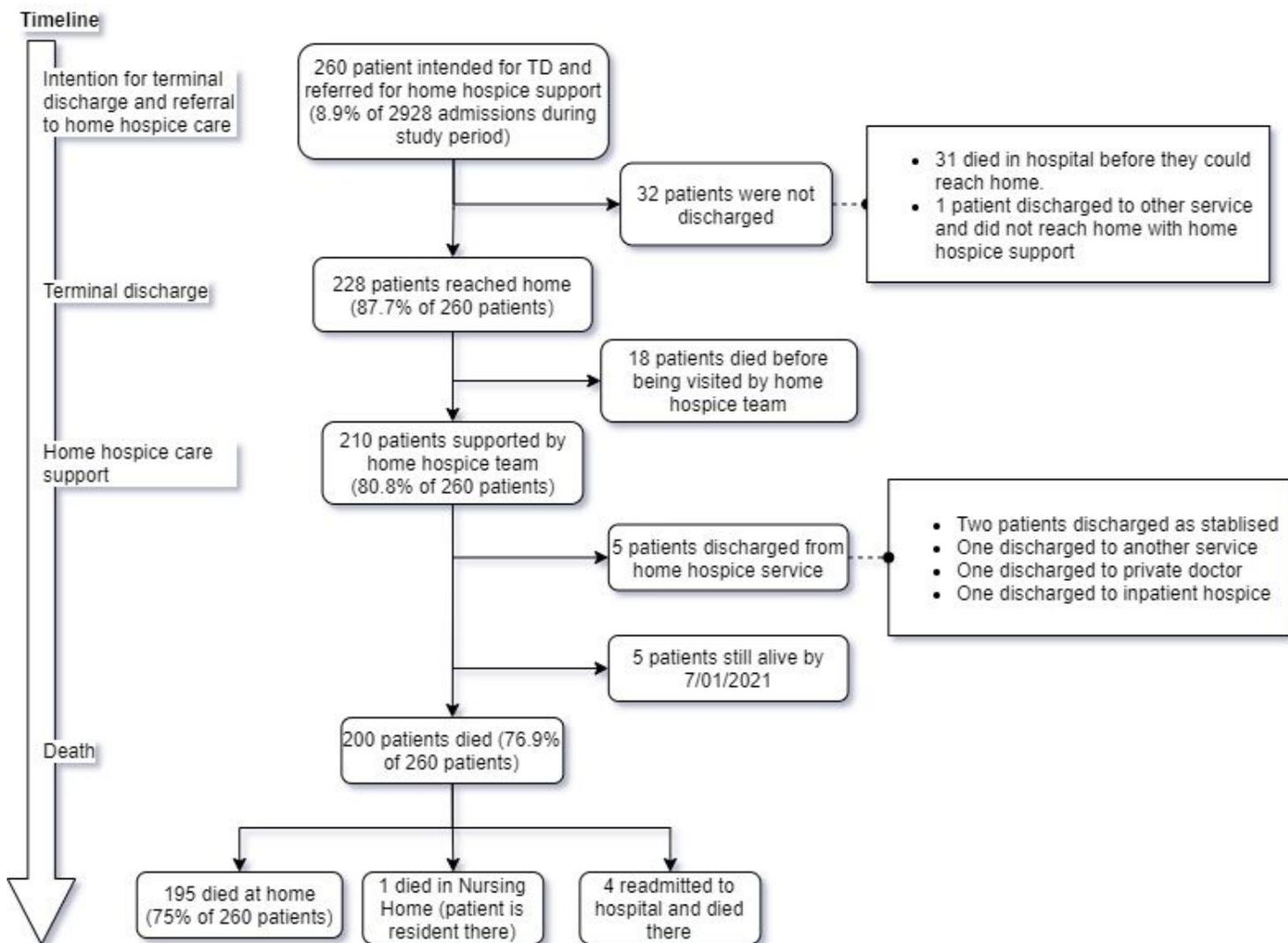


Figure 1

Breakdown of Terminal Discharge cases between 1 Jan 2020 -31 Dec 2020, N=260