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## CONFERENCE ABSTRACT

### **Integrated Rapid Discharge Planning for palliative patients and their families/carers when a patient expresses a wish to die in their home environment**

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Previously, the absence of a rapid integrated community healthcare service response, for patients/family and carers alike, prevented the opportunity to take home a loved one to care for them on their final journey at home. The Caredoc Community Intervention Team (CIT) service in collaboration with the HSE Specialist Palliative services have introduced a new discharge pathway to accommodate a rapid nursing supported discharge for patients in line with National Guidelines.

The Caredoc CIT service, Hospital Specialist Palliative care services, Waterford Hospice Homecare Services, Patient's General Practitioner, and Community Pharmacist worked together to develop a holistic interdisciplinary care pathway to facilitate a rapid palliative patient discharge home.

This new pathway provides the mechanism for the patient to return home ensuring practice alignment and patient centred care between the hospital and community services. Central to the pathway is effective communication and planning between secondary and primary services.

The Caredoc CIT Integrated Rapid Discharge palliative pathway provides for the "safe, smooth and seamless transition of care from hospital to community for dying patients who wish to die at home rather than in a hospital or hospice".

This pathway results in the integration and collaboration between primary and secondary care while supporting the patient and their families at home.

The CIT provides the rapid discharge pathway to imminently dying patients in the Waterford area, over the age of 16 with an incurable illness, who wish to make a choice in relation to end of life care, including where to die.

Caredoc CIT initiated discussions with key stakeholders in May 2018 and following development and sign off, the pathway has been operational since February 2019.

The highlight of this integrated community services pathway is being able to respond rapidly to a patient's wish and choice to die at home. Caring for a loved one at home can be a highly distressing time but with the right care and support in place from CIT, families and carers fears about managing symptoms can be alleviated.

The individual services which have collaborated and integrated successfully through this pathway and continue to participate, nourish, foster and enhance the strong network and links that are now in place to support the patient and their families/carers.

This pathway can seamlessly be introduced into other regions.

With the introduction of this rapid pathway the opportunity to take home a loved one and to care for them on their final journey at home is now in place. The integrated services are now in a position to respond rapidly to a patient's expressed wish and choice to die at home where death is imminent.

It was important to establish that existing services were unable to meet the requirement. Because of the nature of the challenge, key stakeholders engaged quickly. While families/carers were keen to honour the wish of their dying relative to die at home, supporting their needs and expectations was identified to be equally as important. The patient/family/carer remained at the centre of care to develop this pathway.