

section 4.2.3: discharge to hospice

hospice objectives

The primary objectives of hospice care focus on enabling people facing life limiting illness and death to:

- be as free as possible from unnecessary suffering (physical, emotional or spiritual)
- maintain their dignity and independence throughout the experience
- have their grief needs recognised and responded to
- be assured that their family's needs are also being met.¹

patient and family considerations

An awareness of the significance of a transfer to hospice is important – while hospital staff may be very aware of the benefits that hospice can provide, the patient's and family's readiness to accept this change must also be considered.

Expectations of the admission require honest and sensitive discussion with the patient and family, including the fact that hospices are acute facilities that face the same length of stay pressures as acute wards. Information brochures are available from most hospices and provide a written document that can be referred to after an initial discussion.

admission considerations

- prior to admission it is essential that the patient is assessed by the palliative care team and there is agreement from the palliative care medical specialist that transfer would be appropriate and offer benefit to the patient and family
- the family may wish to visit the facility prior to admission – this may either allay the family's fears and assist in adjusting to what can be a difficult transition, or make clear that a transfer is not in the best interests of either the patient or the family
- occupancy rates in hospice are very high, accordingly there is often a list of patients awaiting admission to hospice – this list is reviewed as a bed becomes available and the next admission will be considered on the basis of identified needs of the patient and their caregivers – patients who are at home will ordinarily be given priority
- hospice beds are limited across the metropolitan regions and accordingly admissions are usually considered in terms of short weeks – the average length of stay in palliative inpatient facilities across Australia in 2003 was 12.5 days²
- units may provide an initial assessment period (approximately 2 weeks) – should the patient's condition stabilize and their needs be able to be met elsewhere, then staff will actively seek the best available alternative site of care which is matched to patient need
- transfer of information via the nursing transfer summary is critical so that the transition of care is seamless during what may be a stressful time for all concerned

Reasons for hospice admissions generally fall into one of the following 4 categories:

- management of complex symptoms which are proving too difficult for the primary caregivers
- transitional care following transfer from an acute ward while supports at home are established and functional status is optimised
- care in the final phases of life which cannot be managed either at home or in another facility
- respite care, usually of 1-2 weeks duration, but will be limited by other competing patient needs.

Hospices are mainly public facilities, however there may be the opportunity to nominate as a private patient – fees may apply depending on the individual facility. The Phillip Kennedy Centre is an inpatient hospice facility located in the western suburbs that is subject to Residential Aged Care Facility (RACF) requirements, including high level ACAT approval prior to admission and RACF fees during admission. It is best to enquire about these details prior to transfer so that patients and family have access to relevant information.

Facilities may have both double and single rooms – room allocation will be determined by the coordinating nurse, following an assessment of identified patient and family needs and discussion with the multi disciplinary hospice team.

Staffing and application of an interdisciplinary team approach

- palliative inpatient units utilise an interdisciplinary team based approach to care – this includes access to social work, counselling, bereavement follow-up and volunteers – some facilities also have access to complementary therapies
- inpatient palliative units generally have a higher staff to patient ratio in comparison with general hospital wards and a focus on flexibility around ward routines

Specific issues that require consideration prior to transfer discussions

- while the focus of care is on living as well as possible, units do care for patients on a continuum of illness trajectories – family (and possibly patients) are likely to be exposed to loss and death during their time in the unit
- resuscitation status – most units do not offer full resuscitation and this requires discussion prior to any planned transfer – should the patient want full measures which include resuscitation, then their needs are likely to be better met in a general hospital ward

references

¹ Palliative Care Australia - about us, can be accessed via www.pallcare.org.au

² A Snapshot of Palliative Care in Australia (2003), Australian Government Department of Health and Ageing, Commonwealth of Australia, ACT.