Nowadays, discharge planning is a common practice in the hospital. For some patients, it is straightforward but for others, it can be a complex and difficult process requiring much effort of a multi-disciplinary team.

**Case History**

Madam T was a 67 year old housewife who lived with her husband. She had diabetes mellitus, hypertension, and on thyroxine replacement for hypothyroidism subsequent to post-radioactive iodine. She was diagnosed to have nasopharyngeal carcinoma (NPC) in 2000 and she underwent radiotherapy and bilateral radical neck dissection. However, she had recurrence of the tumour in the nasopharynx in 2002 and a second course of radiotherapy was given. Her hearing was markedly impaired afterwards. Unfortunately, local recurrence occurred again in 2006 and she underwent nasopharyngectomy. At the same time, MRI of her brain showed bilateral temporal lobe necrosis. High dose steroid treatment was offered but was declined by patient.

In November 2006, she was started on PEG feeding for severe dysphagia and aspiration pneumonia. Her condition deteriorated and she became highly dependent at home. She was later admitted for headache and CT brain showed skull base bony erosion due to NPC recurrence. She was in severe pain. Pain Team was consulted and her pain improved with carbamazepine and paroxetine prescribed. During the hospital stay, she had two episodes of pneumonia requiring intravenous antibiotic treatment.

Our palliative care team was consulted and she was transferred to our unit for further management. Her elder daughter was interviewed before transferal, and she agreed with the goal of palliation and no performance of CPR when Madam T approaching death. On admission to the palliative care unit, she was bed bound and weak, with a Palliative Performance Score (PPS) of 40. There was difficulty in communication due to her severe deafness and general weakness. Her pneumonia resolved with antibiotic treatment, and her condition was stabilized. Our medical social worker explored the discharge plan with the relatives. They expressed difficulties in caring for Madam T at home, and so prefer to arrange a private old age home before discharge. The discharge, however, was deferred as Madam T acquired gastroenteritis due to norovirus infection. She was given hydration treatment and was nursed in isolation in accordance with the infection control protocol adopted by the Hospital Authority.

A week later, she recovered from the gastroenteritis. The ward nurse explored the discharge plan again with the relatives. They were frustrated and stressful and claimed that Madam T was very upset emotionally after hearing the discharge plan. They requested Madam T to stay for awhile in the hospital for two more weeks. They also had a wish that Madam T could undergo further rehabilitation so that she was able to sit up. However, as assessed by the palliative care team, Madam T did not have this expected potential and she was also not keen to undergo physical exercise. The team also reached a consensus that the clinical condition of Madam T was stable enough for discharge. The medical social worker was appointed as the single contact person for discharge planning and to allow a few more days for aged home arrangement.

However, within the next two days, Madam T deteriorated as she contracted nosocomial pneumonia again. As the team informed the relatives of possible deterioration, they expressed great emotions, requesting active resuscitation and denied previous agreement of DNR order. With repeated interviews to explain the disease prognosis and to align the goals of care in the presence of advanced cancer, the family eventually came to terms with DNR. Meanwhile Madam T improved with antibiotic treatment and was eventually discharged to aged home. Madam T was visited by the home care nurse at the aged home. Her condition remained stable till three weeks later, when she was readmitted for pneumonia. She died within the same day peacefully without performance of CPR. The family expressed gratitude to the care provided.
Discharge planning in palliative care setting

Discharge planning in palliative care is mentioned in many parts of the World. Palliative Care Australia, a major organization on palliative care service in Australia, published the Palliative Care Service Provision in Australia: A Planning Guide in 2003. Discharge planning is regarded as an essential part of palliative care in the inpatient setting. It includes working with patient and family to address and adjust to their changed social and financial circumstances, to negotiate benefits, to identify and consider available options, and to manage the clinical aspects of care.¹

According to Center to Advance Palliative Care, Mount Sinai School of Medicine in New York, discharge planning should begin on admission. Social needs assessment would help to identify family structure and relationships. Understanding patient and family’s condition (work setting, finances, living arrangement, caregiver availability etc) would help to determine needs and availability. Other factors affecting discharge decisions include access to transportation, prescription and over the counter medicines, as well as medical equipment arrangement.²

In Taiwan, Wang et al studied on the establishment of discharge planning in a hospital-based palliative care unit in Hualien.³ A retrospective survey was conducted in 2004 and found that only 46 nursing records had discharge plan recorded (38.3%). The standard of discharge planning and the discharge assessment tool were developed by hospice nursing experts. In-service education and team meeting were conducted. They found that the recording of discharge plan increased to 88.4% after 3 months of implementation.

Knevitt reviewed the discharge planning process from the patient’s perspective in the inpatient palliative care service at Sacred Heart in Australia through a Discharge Planning Committee.⁴ A semi-structured survey via phone calls was conducted by an independent Clinical Nurse Educator. A documentation audit tool was developed and implemented over one year for all patients who were discharged home. They received very positive responses and identified that no readmissions occurred that could have been prevented through changes to the discharge planning process. The tool was modified from the one (named PREPARED) developed by Grimmer and Moss which was validated in acute hospital setting.⁵ PREPARED refers to Prescriptions, Ready to re-enter community, Education, Placement, Assurance of safety, Realistic expectations, Empowerment & Directed to appropriate services. It consists of four domains: (1) Information exchange (community services and equipment); (2) Medication management; (3) Preparation for coping after discharge; (4) Control of discharge circumstances. A questionnaire on the four domains was completed by patients. The outcome data refers to the sum of responses to three underlying questions: (1) confidence on returning home; (2) whether worries have been addressed; (3) whether organized community services and equipment have met their needs. Out of 181 discharges, 112 (62%) was eligible for pilot survey (planned discharges to their place of residence and remained at home for 7 days post discharge). Among them, 57 patients (51%) completed the survey. The positive response rate was above 80% for all questions and 100% of patients considered worthwhile to be discharged home. Sixteen patients (9%) were readmitted to palliative care inpatient service within one week. The author proposed to include readmission within one week of planned discharge as a new palliative care service Key Performance Indicator (KPI).

Fainsinger et al had performed a prospective survey in Edmonton on discharge characteristics of palliative care patients in an acute hospital.⁶ They looked into patient demographics and social circumstances and to study their relationship with the place of discharge - home or inpatient hospice facilities. The inpatient hospice facility (which was for reasonably stable patients whose family physician is providing ongoing care with support from the Regional Palliative Care Program) was a step down facility from specialist palliative care. They found that younger patients were more likely to return home while the gender and the diagnosis did not affect the outcome. The factor of marital status and primary caregiver (e.g. spouse), but not the age of the caregiver, would also affect the outcome. Patients with higher MMSE score had higher chance of discharging home while patients with lower PPS score had lower chance of discharging home.

In Hong Kong, the public health care system takes care of the majority of sick patients requiring hospital admissions. Patients with acute or serious illnesses are attracted into the public health care system which is well developed and yet affordable to patients. For advanced cancer patients, there has been a common misconception that patients are transferred to a palliative care bed to wait for death to come. Although in practice, the average duration of stay in palliative care unit in Hong Kong is around 15 days, palliative care workers do find the discharge planning a very challenging part of the service delivery.
A survey of the patients discharged home from our palliative care unit in 2006 was conducted. Death episodes were excluded. A total of 275 episodes were identified. Their subsequent utilization of Hospital Authority medical services was reviewed. Twelve episodes were excluded with the following reasons: discharge cases directly transferred to other unit for management; clinical scheduled readmission within 7 days; death within 7 days; and unknown condition on day 7 due to defaulted follow up. Among the 263 discharge episodes, 164 episodes were discharged to home, while the rest were discharged to aged home. We found that 28 out of 164 home discharge episodes (17%) were readmitted to public (acute / palliative care) hospitals within 7 days. Direct comparison of data from different places is difficult as affected by various factors related to patient and family, the disease and the symptoms, the community supporting system in different places.

Locally, the success of such planning can be affected by multiple factors, including: (1) social or environmental factors e.g. the crowded living environment, inadequate support in the community; (2) family factors: e.g. lack of skills and knowledge of family members in caring for a sick person, distress in providing demanding care without relief or respite, long working hours of family members, lack of kinship; (3) patient factors: volatile symptoms e.g. severe dyspnoea, fear of burdening family, lack of security at home.

Looking to the future, there are multiple aspects that we can improve to facilitate a good discharge planning whereby patient can go home to spend more time with family and to stay at home for as long as possible. Development of assessment tools, audit of documentation of discharge planning, survey on patient’s or family’s unmet needs and satisfaction after discharge may be considered.

Reference
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From clinging on to letting go – a teacher’s journey
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Background
Madam Lee was a 71-year-old retired school teacher. She was Chinese in ethnicity, but was born in Indonesia. She was single and lived with her sister in a public housing estate.

She had history of hypertension and was diagnosed to have carcinoma of right breast in 1993. Right mastectomy was performed and she was given Tamoxifen after the operation. She developed bone metastasis and spinal cord compression in May 2002. Decompression of L3/L4, L5/S1 discectomy and L4 corpectomy were performed, followed by radiotherapy. Madam Lee became paraplegic despite treatment and she was later referred to Palliative Care Unit of Haven of Hope Hospital in June 2002. After a course of rehabilitation, Madam Lee was able to walk with frame.

Medical events
Madam Lee went through a series of medical events afterwards:

In October 2002, she developed pulmonary embolism and warfarin was started.
In January 2004, she suffered from acute left thalamic haemorrhage and therefore warfarin was stopped. A course of rehabilitation was completed.
In July 2004, she was diagnosed to have local recurrence of breast carcinoma over right chest wall and local excision was performed. She decided to take Aromasin ( exemestane) as a self purchased item, which cost HK$1200 per pack.
In February 2005, she sustained a fall, resulting in fracture of left hip. Dynamic hip screw was done. Histology of the bone showed no malignancy. A course of rehabilitation was also completed.