end-of-life ESSENTIALS®
education for acute hospitals

My Toolkit

Checklist

The Importance of Coordinating Patient Care

- [ ] Are you aware and mindful of the wide range of health care services patients utilise? What is the bigger picture for patients' health care experience? Consider how you can alter this for the better. Have you acknowledged to patients the complex experience of health care?

- [ ] Essential to safe and quality end-of-life care is knowing patient wishes and their goals for the future, including dying. How is this communicated in your ward, organisation, or hospital?

- [ ] Are you comfortable in talking through questions and topics about life's meaning, purpose and relationships? If not, where can you obtain support and/or education?

- [ ] When patients are being admitted, transferred, or discharged, it is important that you don't assume that someone else is managing important conversations or recognising dying. Who coordinates these aspects of care and service?

- [ ] Tell your colleagues about the End-of-Life Essentials education modules and Toolkit. Add end-of-life care issues to your team meeting agenda. Make a training request via your supervisor, or via your organisation's training manager, for specific workplace training on end-of-life care as an ongoing consideration.

- [ ] Which population is at risk of not being identified as being at the end of life or having multiple hospitalisations? Is this known in your organisation?

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- [ ] Check your patient is still happy with their care plan. Let them know they can revisit this. A trigger for this might be consideration of a transfer to another setting such as a hospice.

- [ ] If you have a patient who is to be discharged, have communication pathways been established with health care professionals who will take over the care? (such as Hospice, Aged Care Facility). Does the GP know that they are being discharged?

- [ ] Have you considered a family meeting to ensure that care is coordinated and the family are also involved? Family meeting: Fast Facts and Concepts #223, Palliative Care Network of Wisconsin: https://www.mypcnow.org/blank-u77fm provides an overview for running a family meeting to discuss end-of-life care goals

- [ ] Are you aware of what is available locally in the community to refer your patients and their families to, such as specialist palliative care services or to bereavement support?

- [ ] Does the patient have an Advance Care Plan in place? Check on admission and make sure that it is transferred with the patient.

- [ ] Did you know that Advance Care Plans require revision and updating from time to time? Have you offered this with patients?

For resources go to the My Toolkit pages in End-of-Life Essentials website: https://www.endoflifeessentials.com.au/

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Resources

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The Pharmaceutical Journal: Communication during transfer of care of older people

Monash University. How can we improve the decision to transfer patients from regional or rural hospitals? Briefing document January 2019

Health Improvement Scotland: Continuity and care co-ordination in palliative and end of life care. Evidence for what works. March 2019.

palliAGED: Care coordination

Social Care Institute for Excellence (UK). End of life care: why it is essential to coordinate care (video).

Palliative Care Network of Wisconsin:
Please do be aware that these resources are for the American audience with information relevant to their health care system, however the principles still apply. For example, how will the patient continue to pay for and access medications? Also bear in mind that specialist palliative care may be considered as well as hospice (e.g., do you have a palliative care team in the hospital)?

- Fast Facts #94: Writing Discharge and Outpatient Opioid prescriptions
- Fast Facts #139: Hospice referral: Moving from hospital to home
- Fast Fact #246: Emergency Department Management of Hospice Patients
- Fast Fact #247: Initiating a Hospice Referral from the Emergency Department

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Resources

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Further Reading

Brooten JK, Buckenheimer AS, Hallmark JK, Grey CR, Cline DM, Breznau CJ, McQueen TS, Harris ZJ, Welsh D, Williamson JD, Gabbard JL.Risky Behavior: Hospital Transfers Associated with Early Mortality and Rates of Goals of Care Discussions. West J Emerg Med. 2020 Jul;21(4):935–942. doi:10.5811/westjem.2020.5.46067

Harrad-Hyde F, Armstrong N, Williams C. Using advance and emergency care plans during transfer decisions: A grounded theory interview study with care home staff. Palliat Med. 2022 Jan;36(1):200-207. doi:10.1177/02692163211059343

Killackey T, Lovrics E, Saunders S, Isenberg SR. Palliative care transitions from acute care to community-based care: A qualitative systematic review of the experiences and perspectives of health care providers. Palliat Med. 2020 Dec;34(10):1316-1331. doi: 10.1177/0269216320947601

Mertens F, Debrulle Z, Lindskog E, Deliens L, Deveugele M, Pype P. Healthcare professionals' experiences of inter-professional collaboration during patient's transfers between care settings in palliative care: A focus group study. Palliat Med. 2021 Feb;35(2):355-366. doi:10.1177/0269216320968741

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