Making an “impossible” discharge possible: an integrated rapid discharge planning approach to fulfil a patient's wish
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Introduction
• Numerous studies have suggested that patients most commonly express a wish to die at home (Higginson, 2000)
• However, a number of factors influence place of death (Gomes, 2006)

Case Presentation
• MC
• 43 year old man
• Diagnosis: End-stage heart failure secondary to dilated cardiomyopathy
• Unsuitable for cardiac transplant.
• Prolonged inpatient stay with disease complications
• Specialist Palliative Care (SPC) referral received for symptom control
• Treatment on intial review included high dose intravenous diuretic therapy, and a sympathomimetic inotrope, dobutamine, via intravenous infusion.
• Estimated prognosis once inotropic support discontinued very short (hours)
• MC’s goal, supported by family: discharge home for remaining time

Management and Outcomes
• Interdisciplinary meeting held
• Explored the place of care possibilities
• Concern expressed by primary specialist team MC may die in transit home.
• Proposed continuing dobutamine infusion, his “life-line”, for the transfer journey.
• Discussed the “Rapid Discharge Planning” (RDP) pathway to be activated and followed to facilitate a timely and smooth transition to home
Our Cardiology colleagues had never taken this approach in the past, but acknowledged the rationale, and were agreeable to supporting this plan.

Discussion
• Overall, the concept and process were novel to both Cardiology and Palliative Medicine Teams
• MC was ultimately discharged home, not without the collaborative team work and support of the health care providers at hospital and community level
• Following the National RDP pathway guided the discharging team(s) through the relevant steps as outlined above
• This collaborative approach between primary and secondary care is paramount in facilitating seamless transition home for the patient

Conclusions
This case illustrates the importance of:
• exploring patient' wishes when approaching end of life
• determining what is possible
• employing strong unified team work in our attempt to achieve a common goal for patients

References
• HSE.ie/ National Clinical Programmes’ Palliative Care/ Rapid Discharge Guidance
• Higginson, 2000
• Gomes, 2006