|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Local logo |  | Patient name: |  |
| NHI: |  |
| DoB: |  |

# Discharge checklist

This checklist will help facilitate a safe, smooth and seamless transition from hospital/hospice care for the dying person who chooses to be cared for at home.

* Hospital/hospice staff must prioritise the discharge as URGENT to minimise any potential delays.
* Involve the person and their family/whānau and/or carer in the discharge details and the plan of care.
* Contact the person’s general practitioner (GP) and ensure the GP is supportive of the discharge. Advise the person and their family of the importance of a GP visit soon after discharge if death is imminent.
* Refer to the relevant community nursing service(s) in good time and consider arranging for referral to specialist palliative care / hospice.
* Where appropriate, ensure sufficient subcutaneous medications are prescribed and available in the home, with the relevant authorities.

| **Checklist** | **Yes** | **No** | **N/A** | **Comment** |
| --- | --- | --- | --- | --- |
| The person has a preferred place of care. |  |  |  |  |
| The person and their family/whānau and/or carer are aware of the prognosis and expectation that death might be imminent. |  |  |  |  |
| The family/whānau and/or carer support the decision for the person’s discharge and are aware of the plan of care and any arrangements for services/visits/equipment. |  |  |  |  |
| Other multidisciplinary team (MDT) members have contributed to the person’s discharge plan and support the discharge. |  |  |  |  |
| Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decision documentation has been completed or photocopied. |  |  |  |  |
| An ambulance has been booked and is aware of any DNACPR decision. |  |  |  |  |
| The district nurse has been informed and is aware of the person’s care needs and discharge date and time. |  |  |  |  |
| The person’s GP has been informed and has made arrangements to visit the person. |  |  |  |  |
| Hospice/community palliative care are aware of the discharge and will review the person’s needs as soon as possible. |  |  |  |  |
| The Needs Assessment Service Coordination (NASC) organisation / the person’s social worker have reviewed the person’s needs, and an individual care package is in place. |  |  |  |  |
| Occupational therapy (OT) has reviewed the person’s needs, and equipment has been delivered / is planned, eg, electric bed, mattress, etc. |  |  |  |  |
| Discharge medications have been prescribed, including subcutaneous AND anticipatory medications. |  |  |  |  |
| Non-essential medications have been discontinued. |  |  |  |  |
| The NIKI T34 discharge checklist has been completed (if used). |  |  |  |  |
| The person and their family/whānau and/or carer have been asked if they would like a copy of the medical discharge letter. |  |  |  |  |
| The person and their family/whānau and/or carer understand the discharge medications that the person requires. |  |  |  |  |
| Domiciliary oxygen has been arranged. |  |  |  |  |
| The family/whānau and/or carer have been advised to contact their community nurse after the death for help, as needed, and to relieve them of any equipment.  |  |  |  |  |