MINISTRY OF HEALTH
MANATŪ HAUORA

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.				

Checklist	Yes	No	N/A	Comment
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.				