Checklist – discharge guidance for patients   
going home for end-of-life care

This document is **a checklist** for an integrated **end-of-life care** discharge plan for **patients** **in hospital** whoexpress the wish to die in their home or residential aged-care facility (if this is their primary residence). This includes patients who are imminently dying (expected in 24–72 hours) or those, with a longer prognosis, being discharged home with a plan not to be readmitted to hospital as their health declines.

The checklist helps you to prepare a patient for discharge home to die, which will vary between patients and situations. The list prompts you to consider steps involved but should not be a barrier to discharge.

Advice or support for completing actions required in the checklist may be sought from:

* Palliative Care Consultancy teams (including after hours on call support where provided)
* Victorian Palliative Care Advice Service (VPCAS)#

|  |  |  |  |
| --- | --- | --- | --- |
| **DISCHARGE** | | | |
| **Unit record number** |  | **Date (XX/XX/XXXX)** |  |
| **Ward** |  | **Treating Doctor** |  |
| **First name** |  | **Last Name** |  |
| **Date of birth** |  | **Age** |  |
| **Address** |  | | |
| **Phone** |  | | |
| **Or affix patient label here** |  | | |

Please file copy in the patient’s health record and send a copy home with the patient.

**Section 1 General considerations**

|  | **Y / N /**  **NA / U**  **(yes, no, not applicable, unknown)** | **Initial** | **Date** |
| --- | --- | --- | --- |
| Is the patient expected to die within 24 to 72 hours? |  |  |  |
| Has multidisciplinary team discussed with the patient and family the patient’s current goals of care for symptom management or comfort care only, and established end-of-life care will occur at home? |  |  |  |
| Does family/carer support patient’s decision, and are able to provide care for the person dying at home with support of community agencies and General Practitioner (GP)? |  |  |  |
| Copy of goals of care, discharge summary or letter given to patient/carer? |  |  |  |
| Funeral planning discussed? |  |  |  |
| Need for expedited death certification (e.g. cultural reasons)? |  |  |  |
| Transport service/ambulance aware of potential for death en route (if death imminent) and, if this occurs, arrangements communicated to GP, family and community service? |  |  |  |
| If there is an implanted cardioverter defibrillator (ICD) in place, ensure deactivation to avoid ICD shock |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **GP handover:** | **Y / N /**  **NA / U** | **Initial** | **Date** |
| Does patient have available GP? |  |  |  |
| If no, or unavailable GP, alert community palliative care provider, suggest family find another GP (highlighting challenge of providing Medical Certificate Cause of Death (MCCD) without a GP). |  |  |  |
| Confirm GP aware of discharge and that an expedited discharge summary or written communication is being sent, with likely cause of anticipated death clearly described |  |  |  |
| GP agrees to providing end-of-life care and completing MCCD? |  |  |  |
| GP confirms plan for out-of-hours end-of-life care including completion of death certificate, and communicated this to family/carer? |  |  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Community Palliative Care Service handover:** | **Y / N /**  **NA / U** | **Initial** | **Date** |
| Referral or update to community palliative care completed, with expedited discharge summary or written communication, including plan to die at home? # |  |  |  |
| Has a date for initial visit to patient from palliative care service been confirmed? |  |  |  |
| Handover of medical roles/responsibilities in palliative care plan, including who signing MCCD? |  |  |  |
| Plan for completion of MCCD established (with confirmation) prior to discharge? |  |  |  |

**Section 2 Medication**

|  | **Y / N / NA** | **Initial** | **Date** |
| --- | --- | --- | --- |
| Medication orders for anticipatory medicines, or syringe drivers communicated to community service and hard copy of directions and medication list provided to family? |  |  |  |
| Medications and/or scripts dispensed to family/carer before discharge (ensuring 5 days of supply)? |  |  |  |
| Advice provided on how to obtain further scripts and local pharmacies that can provide palliative care medications? |  |  |  |
| If transferred with Continuous SubCutaneous Infusion (CSCI) in place, ensure a new full syringe commenced before discharge and notify community nurses when CSCI or Surefuser due for changing |  |  |  |
| If transferred without CSCI, give doses of medications (as needed) for symptom management before transfer |  |  |  |
| If death imminent (within 24–72 hours), has a subcutaneous device/butterfly been inserted before discharge (for administering medication if needed)? |  |  |  |

**Section 3 Equipment/medical supplies**

|  |  |  |
| --- | --- | --- |
|  | **Y / N / NA** | **Comments** |
| Allied Health consultation on equipment needs undertaken? |  |  |
| Has equipment been supplied/organised (including hospital bed, air mattress, oxygen, Nikki pump (CSCI), mouth swabs, needles, syringes, sharps bin, continence aids)? |  |  |

**Section 4 Carer preparation**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Y / N / NA** | **Initial** | **Date** |
| Care plan communicated clearly to carers, and education provided on medications and their administration? |  |  |  |
| Equipment availability discussed with treating community palliative care team and carers? |  |  |  |
| Family provided information about symptom management and the signs and symptoms of dying and death? |  |  |  |
| Transport – Non-emergency patient transport/ambulance booked? Transfer day/time confirmed with carers? |  |  |  |
| Provided telephone support contact numbers, including community palliative care, VPCAS#, and GP? Ensure support (including out of hours) is available/organised for before initial visit by the service. |  |  |  |
| Family/carer informed about process to be put in place at time of death (including if death occurs in transit) and contact numbers (including out of hours)? Family advised to contact Ambulance (000) as last response for verification of death? |  |  |  |
| Has the family care been provided with bereavement support information (e.g. <https://www.flipsnack.com/palcarevic/ldgw-2018-edition-ebook/full-view.html>)? |  |  |  |

**Section 5 Clinical handover**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| |  | **Y / N / NA** | **Initial** | **Date** | | --- | --- | --- | --- | | Expedited discharge/written summary provided to GP, Community Palliative Care Service, and other care providers (such as residential aged care facility), including:  -goals of care/limitations of treatment  -escalation plan for completing MCCD  -anticipated cause of death and causes (with supporting evidence)? |  |  |  | | Verbal handover to GP and nursing staff (particularly important when no confirmation of receipt of written handover)? |  |  |  | | At the time of booking, transport service/ambulance made aware of potential for death en route and, if this occurs, plan communicated to GP, family and community service? |  |  |  | |

**Section 6 Contacts: Health team member contacted and outcomes**

*Indicate name of person designated to complete MCCD in notes column below*

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Name** | **Outcome/notes** | **Initial** |
| GP |  |  |  |
| Community Palliative Care Service |  |  |  |
| Residential aged care facility (Manager/RN) |  |  |  |
| Pharmacist |  |  |  |
| Funeral Director |  |  |  |
| Other |  |  |  |

^Adapted with permission from: Rapid discharge guidance for patients who wish to die at home. October 2020. Gippsland Region Palliative Care Consortium Clinical Practice Group. Available at: <https://www.grpcc.com.au/health-professionals/resources/end-of-life-care>

# If referring organiser requires help or support to organise palliative care, they should first contact their inpatient palliative care consultancy team. If this team is not available, they should contact Victorian Palliative Care Advice Service (VPCAS) on 1800 360 000, 7am–10pm, 7 days a week.

**Other helpful resources**

* Client’s local palliative care service (<https://www.pallcarevic.asn.au/page/91/useful-websites>)
* Anticipatory medicines guidance (<https://www.safercare.vic.gov.au/clinical-guidance/palliative/anticipatory-medicines>)
* Caring at Home project (<https://www.caringathomeproject.com.au/>)