APPENDIX 1. Rapid Discharge Action Plan- Summary of Key Steps

Rapid Discharge Action Plan- Summary of Key Steps	Section
STEP 1: The dying patient chooses to die at home and no issues are identified regarding the potential need for a coroners post mortem	7.1 9 10
STEP 2: Doctor: ○ Confirms that it is appropriate to focus on palliation at home. ○ Family / carer support patient decision (where a family/ carer exist and patient has indicated that information may be shared). ○ Medical Consultant/designate records in the patients' health care record that they are satisfied that discharge can occur.	7.1
Step 3: CNM: ○ Identifies the lead nurse to manage the rapid discharge process ○ Supports the process	7.2
Step 4: Lead Nurse: **Initiation** ○ Contacts GP, PHN/DON and other members of the primary care or specialist team as soon as possible in order to inform them of the patient's prognosis and wishes and to discuss the potential for rapid discharge. ○ The GP and PHN /DON may confirm that rapid discharge is appropriate- *plan continues* ○ The GP and PHN /DON may state that rapid discharge is appropriate but that its feasibility is contingent on certain supports/ services being provided –*plan continues taking advice into consideration* ○ The GP and PHN /DON may state that in their considered opinion that rapid discharge poses a clinical risk to the safety or well-being of the patient or their carers- *every effort is made to reduce or eliminate the risk where possible. If not possible liaise with patient and family* ○ Communicate the outcome to the patient and family **Planning** ○ Liaise with PHN/ DON and develop care plan ○ Involve members of the MDT as required -Medical Social Worker, Occupational Therapist, Physiotherapist, Pharmacist, Palliative Care CNS, Community based Palliative Care, Community Intervention Team ○ Support family. Ascertain their level of understanding of what is expected of them. ○ Provide carer education as per Appendix 3 ○ Organise equipment and medical supplies ○ Organise transport ○ Write nursing discharge letter ○ Confirm prescribed medication is available in the home (New) **Hospital MDT** Physiotherapy ○ Assess patients re needs on discharge ○ Liaise with primary care Physiotherapist as appropriate Occupational Therapy ○ Assess patients re needs on discharge ○ Liaise with primary care Occupational Therapist as appropriate ○ Arrange for essential equipment to be set up at home to facilitate rapid discharge Medical Social Work ○ Assess and address patient and family psychosocial and essential practical needs Pharmacy ○ Liaise with community pharmacy re medications not licensed for use in the community or medications difficult to source in the community e.g. Buccal Midazolam ○ Liaise with community pharmacy re costly medications not available on the GMS which may require the 'Hardship Scheme'	7.2- 7.8

Palliative Care CNS o Assess if a Night Nurse is required. If so organise. o Assess if the Community Specialist Palliative Care Team are required o Contact the Community Palliative Care Team if required. o Advise re stat medication prescription NCHD o Write discharge letter o Write directions for Night nurse o Write prescriptions- regular medications/p.r.n. medications o Ambulance services letter, including DNAR order as appropriate o Contact GP re pronouncement and issuing of Death Notification Form Discharge: o Letters to GP, PHN/ DoN and other member of the primary care or specialist teams as appropriate o If patient is on a syringe pump, change immediately prior to discharge o Prescriptions and handover to family unless transferring to residential care facility	
Ambulance Provide transport to the patient's home	10