Appendix 2: Rapid discharge algorithm

Rapid discharge guideline

To activate:
- Focus of care is solely on palliation
- Patient’s choice is to die at home; discussion reflects patient’s previously expressed wishes
- Family care support decision

If activated, the ward manager/deputy contacts the GP and PHN DON within 24 hours

Confirm RDP is appropriate

- Contact PHN/DON to finalise care plan involving GP, SW, CIT, SPC as needed
- If support is required, develop clear action plan
- Agree planned date of discharge
- If same day contact with PHN/GP not achieved, reason must be documented

Communicate care plan with patient/family

Agree

Disagree

Organise the following, as needed:
- Equipment, SPC, CIT, Night nurse; discharge medications; education/support; transport; timing or discharge; handover

Day before discharge – nurse confirms all aspects of care

Day of discharge:
- Doctor: confirms it is appropriate for the patient to travel
- Nurse: confirms with community services that the patient has left the hospital and services should commence
- Discharge letter, prescription and care plan faxed to GP & PHN

Usually not appropriate for
- Patients who wish to act as organ donors
- Patients for whom it is anticipated that a coroner’s post mortem will be required

Poses a risk to patient/carers

- Clinical risk to safety must be considered carefully
- Efforts made to address concerns
- Case conference convened if necessary
- Patient and family kept informed of progress

Family support is usually needed to care for patient at home;
Consensus approach to care planning

In the event of the patient dying while being transferred home:
- Ambulance should continue to the approved destination
- GP should be contacted to verify death
- Coroner should be informed of circumstances of patient death, prior to completion of death certificate or commencement of funeral arrangements
- Community services, including PHN, should be reminded of death

PHN= public health nurse; DON= director of nursing; GP= General Practitioner; SW= social work; SPCs= specialist palliative care; CIT= community intervention team