NSW GOVERNMENT Health

Facility:

ACCELERATED TRANSFER TO DIE AT HOME PLAN - ADULT

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. ______ / ______ / ______	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

The Accelerated Transfer to Die at Home Plan can be used to support those few patients and their families/carers whose request to return home to die is **urgent** and discharge has **not** already been planned, or because circumstances have changed and there is a need to get the patient home within 24 hours. 'Home' can include the patient's home; their relative or carers home; Residential Aged Care facility; or Hospice.

It is important to highlight that both clinical staff and families/carers need to be realistic about the time frame to organise an accelerated transfer home for last days of life care, particularly when care is complex.

This document is placed in the patient's notes and forms part of the patient's health care record. Please ensure a completed copy is sent with the patient on discharge. Treating medical team and/or nursing staff can sign off the following mandatory criteria.

For the patient to be suitable for Accelerated Transfer Home all of the following criteria must be met:

Inclusion Criteria	✓ Yes	Staff name	Signature	Date
The patient expresses the wish to die at home				___/___/___
The patient's family/carer or care establishment supports the decision				___/___/___
The multidisciplinary team have agreed that the patient is in last days of life				___/___/___
The transfer location poses a low risk to the patient and staff who will attend/visit (a Work Health & Safety risk assessment must be completed and include the home environment, access, pets, equipment etc)				___/___/___
The medical team have completed/ updated a Resuscitation Plan				___/___/___
The family/carer are aware of arrangements if patient dies in the ambulance				___/___/___
Community nursing team/s / RACF has been informed of plan to transfer patient home and is able to support the patient to die at home Name and phone number of main contact person: ____________________ ____________________				___/___/___
GP is aware of transfer home and is able to support the patient to die at home Name and contact number of GP receiving care: ____________________ ____________________				___/___/___
Family/carer have been informed and educated as to what to do after an expected home death				___/___/___
Name of lead clinician (nurse or doctor) who will coordinate accelerated transfer home				___/___/___

NO WRITING

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SMR010.060

Training Only

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Equipment / medical supplies	Required (Y/N/NA)	Provided	Comments
Pressure relieving mattress			
Oxygen			
Dressings/ostomy equipment			
Nebulisers			
Syringe driver			
Mouth care equipment			
Urinary catheterisation equipment			
Needles, syringes, alcohol wipes, sharps bin			
Gloves			
Continence pads			
Bed bath wipes			
Other			

To be completed on day of transfer home

Action	Prompts	Provide	Completed by
Doctor confirms patient fit to travel	Confirm patient can be transferred / is not fit for transfer	☐ Discharge letter ☐ Completed Resuscitation Plan **SMR020056** ☐ Blank Verification of Death form **SMR010530** ☐ Completed Death Certification Arrangements for Expected Home Death **SMR010531**	Sign: __________
Carer preparation	• Discuss concerns • Explain medications • Teach family how to give subcut medications	☐ Prescriptions ☐ Medications ☐ Information leaflets ☐ Contact numbers	Sign: __________
Nursing handover	Confirm patient can be transferred / is not fit for transfer	☐ Provide verbal handover to Community team ☐ Copy of home risk assessment ☐ Fax nursing handover letter	Sign: __________
Medical handover		☐ Provide verbal handover to GP ☐ Fax copy of Medical Discharge to GP	Sign: __________
Transport	Ambulance booked	☐ NSW Ambulance Authorised Adult Palliative Care Plan (if completed) ☐ Paramedic Transfer letter	Sign: __________

If the transfer discontinued

Date: ____ /____ / _____ Time: _____:_____

Name: ____________________ Designation: ______________ Signature: ____________________

Please ensure all relevant persons/professionals are notified that the transfer has now been discontinued

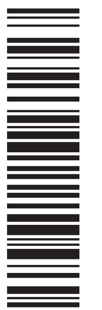
Reason/s for discontinuation

- ☐ Patient died before arrangements complete
- ☐ Transport issues
- ☐ Unable to access all equipment / supplies
- ☐ Family / carer issues
- ☐ Other (provide details): ____________________

NO WRITING

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING



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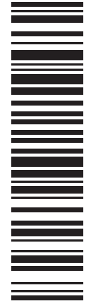

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This record should be completed by the identified lead clinician and filed in the patient's health care record

Accelerated Transfer To Die at Home record	Address patient being discharged to:
Main carer:	______
Relationship:	______
Phone no:	______
Attending senior medical officer who reviewed the patient and agreed to transfer: Name: ______ Contact details: ______ ______	GP name: ______ Address: ______ ______ Phone no: ______

Family/Carer discussion outcomes (e.g. patient / family / carer understanding of diagnosis / prognosis):

Lead nurse/doctor comments/actions:

NSW Ambulance Authorised Care Plan completed and faxed to **02 9320 7380** or scanned document emailed to **protocolp1@ambulance.nsw.gov.au**

☐ Yes ☐ No ☐ Not Applicable

Medication checklist commenced (see page 3) ☐ Medications ordered ☐

Health team members involved to assess patient's situation and liaise with community based colleagues

	Name	Phone / page number / contact details
Community Nurse:		
Palliative Care Nurse:		
Residential Aged Care Facility Manager/RN:		
Specialist Palliative Care MO:		
Other specialist nurse (specify):		
Social worker:		
Occupational therapist:		
Physiotherapist:		
Pharmacist:		
Other:		

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Medication Management Checklist

One Day Prior to Transfer	✓ / X
Transfer date and time is confirmed	
Last days of life anticipatory medications (PRN, regular / syringe driver) are prescribed by medical team / Nurse Practitioner on Community Health services medication chart (as per LHD policy)	
Transfer medications (including 5 days' supply of medications) are prescribed and dispensed for next day collection at hospital pharmacy or community pharmacy if discharging hospital / MPS does not have on-site hospital pharmacy See **PRESCRIBING GUIDE FOR LAST DAYS OF LIFE MEDICATIONS**. For advice, contact local Specialist Palliative Care Team.	
Confirm home medication storage requirements/protocol for injectable medications with receiving Community Health service	
Arrange for home medication storage container (if required) to be brought to ward prior to discharge or manage as per LHD policy	

Medical Officer / nurse completing this section

Print______________________ Signature ______________ Designation ______________ Date___/___/ _____

Day of Transfer	✓ / X
Collect home transfer medications from hospital pharmacy or Community pharmacy	
Put S8 and S4D transfer medications into home medication storage device (or transport as per LHD policy)	
Provide transfer medications and completed medication chart to family/carer (as per LHD policy)	
Check subcutaneous line(s) for patency and secure appropriately for transfer	
If being transferred **WITH** syringe driver, change the pump immediately prior to discharge and notify Community Nurse of time pump due	
If being transferred **WITHOUT** syringe driver, give PRN dose(s) for symptom management 30-60 minutes prior to transfer and document on Nursing and Paramedic transfer letter	

Medical Officer / nurse completing this section

Print______________________ Signature ______________ Designation ______________ Date___/___/ _____

The following list provides guidance regarding the quantities for a minimum recommended 5 days' supply of medications

MEDICATION PRESCRIBED	STRENGTH OF AMPOULE	NUMBER OF AMPOULES
MORPHINE	10 mg / 1 mL (ten milligrams in one milliliter)	10 amps
METOCLOPRAMIDE	10 mg / 2 mL	20 amps
HALOPERIDOL	5 mg / 1 mL	5 amps
MIDAZOLAM	5 mg / mL	10 amps
CLONAZEPAM (ONLY prescribe if on regular benzodiazepine WITHOUT syringe driver)	1 mg / mL	5 amps
GLYCOPYRROLATE (ROBINUL)	0.2 mg / mL	30 amps
OR		
HYOSCINE BUTYLBROMIDE (BUSCOPAN)	20 mg / mL	30 amps

NO WRITING