Checklist for Discharge of First Nations Patients Returning to Home Communities

Key Community Health Contact(s): _____

Action	**Completed**
Meeting between hospital care team (clinical staff, palliative care, patient navigator, interpreter) & community team (home and community care, nursing station, health director, other caregivers) held with patient, substitute decision maker, family, and primary in-home caregivers **List of Attendees**:	
Discharge to home community determined to be feasible Tentative discharge date:	
Equipment required for care identified, accessible and available Vendor:	
Oxygen(If needed)– ordered, approved and available Vendor:	
Medications – ordered, approved, dispensing pharmacy identified, arrival in community confirmed, safety concerns addressed Pharmacy:	
Specialized Medical Supplies (dressings, lines) – ordered, approved, arrival in community confirmed Vendor:	
Care in home – providers identified (including informal caregivers), training available, support available – confirmed with key community health contact(s)	
Care in home – home environment discussed – heating source, access to running water, room for equipment (e.g. hospital bed), need for repairs/modifications to home	
Transportation to home community arranged and approved	
DNRC documentation completed and shared with key community health contact(s)	
Contact information for hospital team members shared with home community team members	
Follow up meeting/ phone call arranged with community team	
Telemedicine consultation offered Referral to telemedicine nurse for scheduling	
Care plan completed including plans for current and anticipated symptoms (e.g. loss of oral route)	
Plans for care after death reviewed including care and handling of body after death	
Completed care plan given to patient, SDM, primary caregiver, and faxed to community contact	
Family and patient aware of discharge date	
Discharge date communicated to community team	