

## **SAFE DISCHARGE CHECKLIST**

PATIENT NAME/LABEL

DISCHARGE DATE:

|    |  | Date | Yes | No | N/A |
|----|--|------|-----|----|-----|
| 1  | Patient is medically fit for discharge   |      |     |    |     |
| 2  | All appropriate family/carer training/education completed  |      |     |    |     |
| 3  | Rehab goals completed, including safe transfers and safe use of equipment  |      |     |    |     |
| 4  | GP/District Nurse & other relevant community services aware of discharge date and care needs                     |      |     |    |     |
| 5  | Discharge destination identified and accessible  |      |     |    |     |
| 6  | Appropriate care package in place  |      |     |    |     |
|    | Functioning essential equipment in situ  |      |     |    |     |
| 7  | ○ Bed  |      |     |    |     |
| 8  | ○ Mattress   |      |     |    |     |
| 9  | ○ Wheelchair   |      |     |    |     |
| 10 | ○ Cushion  |      |     |    |     |
| 11 | ○ Hoist  |      |     |    |     |
| 12 | ○ Sling  |      |     |    |     |
|    | Discharge destination has access to essential facilities   |      |     |    |     |
| 13 | ○ Toileting  |      |     |    |     |
| 14 | ○ Washing  |      |     |    |     |
| 15 | ○ Feeding  |      |     |    |     |
| 16 | ○ Living space   |      |     |    |     |
| 17 | Patient provided with relevant information/contact details   |      |     |    |     |
| 18 | Patient to have completed relevant Patient Learning Plan (including awareness of own care needs, medication etc) |      |     |    |     |