Planning Guide for a Home Death

Adapted from Pallium Canada (2021) Planning Guide for a Home Death

1. **Who are the members of your health care team that will do home visits?**

Profession	Name	Contact information
Nurse		
Doctor (family physician or palliative care physician)		

Make sure your pharmacist is aware of your plan to die at home.

2. **What medical equipment/supplies are needed at the home?**

Type of equipment/supplies	Where to get it?	Who will get it?

3. Have you had a conversation with the health care provider to ensure that you and the team are knowledgeable about what dying from this illness might look like? If you have not yet done so, please have this conversation so that you and the team are better prepared.

Record what to expect below:

4. Is there a Do Not Resuscitate (DNR) or Allow Natural Death (AND) order in place?

Yes ___ No ___

If yes, communicate this information with the health care team and end-of-life care team and

keep it with this plan.

If no, have this important discussion with the patient while ultimately accepting their decision.

5. Find out what the 24/7 contact number is for questions that are not a 911 emergency.

Record the number here: _____

For example, if the patient seems in more pain than usual, you can call the above number to speak to a nurse or doctor for support in getting their pain under control.

6. Do you have an end-of-life team in place for the final weeks and days? This team can include

family, friends, and parish and community members. Know who the members of the team are and when they are scheduled to accompany the patient (for example, Monday from 8 a.m. until noon). This will be of comfort for the primary caregivers and will allow them to try and get some rest.

Name	Contact information	Scheduled time slot

7. Do you have a Plan B in place if dying at home is no longer the best option? Consult your health care team for guidance.

There could come a point when dying at home is no longer the ideal location and the patient should be moved to a hospice or hospital for additional support. If the patient needs to be moved out of the home, please do not feel that this means you have failed them. Ensuring that they get the best care, even if it is outside the home, shows you have *not* failed them.

Note your Plan B option below