

Recommendations for Collier County Discharge Planning Policy

January 2007

Effective discharge management is when:

- a) both individual and staff are satisfied knowing that adequate plans have been made for discharge, with the outcome of the individual's discharge taking place without unforeseen difficulties, and
- b) the process is considered in the context of ensuring equity and the efficient use of resources.

Aims and Objectives of Discharge Management:

- Clients are discharged to an appropriate environment
- Adequate information is given to all relevant health and social services.
- All relevant health and social services are ready to receive the individual on discharge.
- Information is given to the individual and where relevant, to the program staff so that they are fully involved in the discharge process.
- The right equipment and medication is available to assist the process of transition and rehabilitation.
- The discharge is timely and ordered.
- Human and financial resources are utilized cost effectively.
- Individuals must be fully involved where appropriate and their concerns noted and taken into account.

Key Principles:

- Discharge procedures are of consistently high standard.
- Discharge planning is commenced at the earliest possible stage.
- Central to the discharge management process is the individual.
- Discharge management is coordinated by a team leader.
- Members of the multi-disciplinary team are contacted early on in the discharge process.
- Professionals are responsible for recognizing the role of other members of the multi-disciplinary team.
- Each professional is responsible for responding to requests for assessments and/or services within the time limits set by service contracts and professional standards.
- Verbal and written information relating to the discharge is given to the individual.

Implementation of the Discharge Plan:

Strategies to ensure continuity of care (the 4 C's: Communication, Coordination, Collaboration, Continual reassessment)

Communication

- Should occur multi-directionally
- Should occur between the multi-disciplinary team and the individual
- Should occur at admission, ongoing, and prior to discharge
- Should eliminate all barriers

Recommendations for Collier County Discharge Planning Policy

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- Should be written in the individual's file
- Should be verbalized with individual and multi-disciplinary team, referring agencies

Coordination of services/case management

- Case manager or designated team member should coordinate the multi-disciplinary team in the discharge planning process.
- Case Manager will link the person with the most appropriate services postdischarge.
- Case Manager should ascertain understanding of all communication with individual.

Collaboration

- Multi-disciplinary team members should be used for specialized assessments, recommendations, and case conferences.
- Individual should be involved at all levels of planning.

Continual reassessment

- The discharge planning process is dynamic, not static.
- Change in housing, placement, or other should be communicated to all team members.

Benefits of Implementing Discharge Plan for Individual

- Status will be maintained or improved; including physical, functional, and emotional.
- Individual confidence and self-perception will be improved.
- Individual will be able to re-iterate discharge plan and implement in home.
- Follow up appointments will be maintained, with transportation easily accessible.

Benefits of Implementing Discharge Plan for Providers

- Program staff can identify discharge assessment needs, intervention strategies, and follow up of clients.
- Program staff will increase knowledge base regarding unique learning needed of their target population.
- Program staff will accurately identify individuals at high risk for poor outcomes, who benefit most from which referrals and are referred most often.
- Multidisciplinary team members will collaborate on a regularly scheduled basis.
- Any change of status will be communicated among team members.

Benefits of Implementing Discharge Plan for Institutions

- The number of hospital readmissions and ER visits will decrease.
- Rating of caregiver and patient satisfaction with care will increase.
- Cost containment will improve.

Individuals with Special Needs:

Recommendations for Collier County Discharge Planning Policy

January 2007

For those individuals whose first language is not English, the following must be provided:

- a) Translation/interpretation services, when appropriate.
- b) Information in the main ethnic languages of the local community should be available.

For those individuals with sight and hearing impairment or learning difficulties:

- a) Information must be presented in a user-friendly format; and
- b) Extra care is taken to ensure that individuals understand and agree with the discharge care planned.

Assessment and Discharge Care Planning

Planning for discharge will commence at the earliest possible stage for each individual patient. In most cases, this will be on, or some time before, admission. In some complex cases, it will be as soon as professional judgment can be made on the individual's anticipated capabilities on discharge.

All information relating to the discharge care planning process should be recorded in the patients records, according to local protocols. Each professional will be responsible for recording their own actions and progress towards discharge care planning goals. However, the team leader has overall responsibility for coordinating the discharge care plan.

The Discharge

The final discharge date must be agreed between all professionals involved and the individual.

On occasion, discharge may take place before some non-essential services or equipment are in place, but this can only be with the agreement of all professionals involved.

Discharge of individual should not take place until the responsible clinician is satisfied, following consultation with the multi-disciplinary team, individual that the individual can be safely discharged. This consultation will consider whether:

- a) plans are in place to meet the individual's housing, health and social needs
- b) where the patient lives alone, adequate arrangements have been made to provide access, heating and food.

This information will be recorded in the discharge planning documentation.

Provision Of Information To Individual

Information leaflets and posters should be on display that set out statutory, voluntary and private sector services available to meet discharge needs locally. This should include details of the financial implication for the individual receiving such service and literature relating to appropriate benefits. Local protocols should set out who is responsible for keeping this information up-to-date.

Recommendations for Collier County Discharge Planning Policy

January 2007

Individuals should be given written information advising on appropriate self-care and lifestyle post discharge, setting out details of the community care package arranged for them and explaining local mechanisms for them to comment on the care and services they have received.

TRANSFER TO POST DISCHARGE LOCATION

Transport

When transport is to be used, this should be booked at least 24 hours, where feasible, in advance of discharge. The Transport Service should be informed of the individual's mobility and should be given details of any equipment that need to accompany them.

The maximum waiting time for such transport, after the booked time, should be no more than the locally agreed time.

Discharges should be planned to take place in the morning.

Items To Be Given To The Patient On Transfer Or Discharge

All, or some of the following may be required and should be available at least one hour prior to the planned discharge time:

Copy of Discharge Letter

The individual should be given, either detailed in the immediate notification or clinical summary:-

- a) the name of the responsible doctor to whom they may obtain further information;
- b) information detailing packages of care, professional involvement and who else has been informed of the discharge.

Prescription medication /card as required.

Out-patient Appointment Card.

Property / valuables previously held in safe keeping.