

29. GUIDELINES ON DISCHARGE PLANNING

29.1 Definition of discharge planning

Discharge planning is the process of moving the patient from one level of care to another. The process should start on admission of the patient by assessing the patient's needs and identifying resources available. The process should incorporate the multidisciplinary approach and involve all the appropriate health team professionals and offer holistic patient care.

29.1.1 Vision of the planners

The vision of discharge planners is to ensure continuity of quality of patient care by preparing the family and / or refer the patient to a relevant community based care program.

29.2 Objectives of discharge planning

The objectives of discharge planning are to:

- Identify the patient's needs
- Identify the resources and support available to the patient
- Identify the level of involvement of the patient and his/her family in the preparation of continued care
- Educate the patient, family and caregiver on the patient's condition, management, potential environmental changes and lifestyle, e.g. wheelchairs, catheters and nasogastric tube
- Strengthen the coordination and communication within the family and between the various carers
- Identify the discharge team members
- Develop a framework for the support of the health care worker and other service providers in the discharge process.
- Monitor and evaluate the discharge process.

29.3 Stages in discharge planning

The following areas should be considered when planning the discharge of any patient:

- Health assessment
- Planning
- Implementation
- Evaluation and monitoring
- Discharge and handover of the patient

The activities that need to be conducted in order to address these areas may be grouped into a number of stages that are described further:

29.3.1 Stage 1 - Health Assessment

These activities start on admission or at first contact with the patient and are on-going and sometimes overlapping

- History taking: demographic data collection, (including bio-social and medical).
- Physical examination
- Data analysis
- Medical diagnosis/ nursing diagnosis.

29.3.2 Stage 2 - Support systems assessment

An assessment of support systems should include:

- Home assessment
- Assessment of availability of community resources
- Assessment of caregivers' needs
- Accurate and comprehensive documentation of information

Communication of findings to relevant multidisciplinary team members should be undertaken.

29.3.3 Stage 3 - Setting short and long term objectives

The short- and long-term objectives of care should be clear and should be based on the health assessment carried out. Important components are:

- Prioritization of the needs of the patient and family
- Use of the multidisciplinary approach to plan for interventions
- Consideration of available human, financial and material resources.
- Drawing up of the schedule for implementing interventions such as counseling, physical home adjustments etc.

29.3.4 Stage 4 - Implementation

Care needs of the patient will need to be individualized for each patient:

- Identification and provision of services required by the patient
- Information giving and counseling about services offered on the community home based care program
- Assessment of the patient on an ongoing basis and adjustment of care plan.
- Mobilization of resources e.g. drugs, bandages
- Record keeping of care plan
- Liaison and coordination of patient care with other team members i.e. pharmacy, TB coordinators, physiotherapist, social workers, counselors etc.

29.3.5 Stage 5 - Evaluation

The efficacy and feasibility of the care plan should be monitored and evaluated periodically. This may be carried out by:

- Using a checklist to assess progress of implementation.
- Review of records
- Re-planning where necessary.

29.3.6 Stage 6 - Discharge and hand over of the patient

When a patient is moved from one care level to another or from one care provider to another sufficient details should be passed on:

- The results of the final assessment should be documented
- Filling in of discharge and referral forms (see Section 29.5)
- Remind clients and relatives of follow up system and the need to attend for review on specified dates and for replenishing drug supplies
- Advise patient and relatives of the need to seek hospital assistance when worried
- Make transport arrangements if applicable
- Collaboration with relevant disciplines for the referral and further management at the next level
- Liaise closely with the Discharge Plan Coordinator who will plan, coordinate and link closely with the appropriate receiving institution, such as, Island Hospice, community home based care teams, health institutions, homes and others
- Discharge and hand over of patients

Identified Resources and Support Systems

- Relevant community home based care programs
- Immediate family caregiver
- Health care provider
- Social services
- Physiotherapy/rehabilitation
- NGOs and churches for spiritual and material support
- Community – mobilize people and provide resources, transport etc
- Nutritionist
- Basic care items in the homes (gloves, disinfectant, dressings etc).

29.4 Discharge plan checklist

1. On admission

- Health assessment
- History and Physical examination
- Laboratory results

2. During hospital stay

- Identify the patient's needs
- Involvement of the client and family in preparation for continued care
- Education of the patient and family or caregiver
- Home and community resources assessment

3. Discharge and handover of the patient

- Final Health assessment
- Fill in the discharge and referral forms
- Facilitate or supply or prescribe the patient with the relevant drugs
- Educate the patient and caregiver about their drugs
- Coordination with the relevant community support groups
- Facilitate transport needs
- Hand over the patient

29.5 Discharge form

The following is an example of a **Patient Discharge Summary**
(To be completed in triplicate)

- Copy to the patient
- Copy for the receiving institution
- Copy to the discharging institution

Section 1

Demographic Data

Name of Facility From:

Name of Facility To:

Name of Patient:

Hospital Number:..... ID Number:..... Age:

.....Sex:..... Marital status:

Number of dependants:.....

Home Physical address:

Home Telephone Number:

Address of nearest School/ Kraal Head or Chief:

Occupation:

Name And address of Employer:

Telephone Number of Employer:

Name of Caregiver / Next of Kin:

Attending Doctor:

Date of Admission: Date of Discharge:

Date of next appointment:

Section 2

Discharge Considerations

Attending Doctor:

Date of admission: Date of discharge:

List Problems/Complaints:

Key clinical findings:

Key results:

Doctors /Final Diagnosis:

Discharge to:

- Home
- Nursing home
- Other

Condition on discharge:

- Able to walk
- Able to eat
- Passing urine well
- Passing stool well
- In pain
- Wounds

Key concerns on discharge:

Condition on discharge:

Activities of daily living:

Bathing.....

Feeding.....

Dressing.....

Mobility.....

Communication.....

Ability to cope at home:

Specific Instructions

<u>List Drugs Prescribed:</u>	<u>Supplied</u>	<u>Prescription given</u>
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..... Yes /No	Yes / No
..... Yes / No	Yes / No
..... Yes / No	Yes / No
..... Yes / No	Yes / No

Relevant Dietary advice (specify):
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Other special instructions:

Wound Care.....
Infection control (universal precautions).....
Prophylactic drugs.....

The condition has been explained adequately and counseling given.

Signature of Patient / Significant Other

Signature of Discharging Doctor/Nurse

Follow up Instructions: Review Date: Review Person

29.6 Basic Essential Hospice Drugs

Antiemetics: Metoclopramide, Prochlorperazine
Analgesic: Paracetamol, Aspirin, Codeine, Morphine
Laxatives: Bisacodyl, Glycerine suppositories, Liquid paraffin
Antibiotics/Antifungals: Cotrimoxazole, Metronidazole, Miconazole oral gel, Miconazole topical cream, Cotrimazole paint
Dressings: Crepe bandages, Plaster/ Micropore – gauze, packs, Betadine solution, Betadine scrub, Gloves
Miscellaneous: GV paint, Soda Bicarbonate, Mercurochrome, Zinc and Castor oil, Methylated spirits, Indomethacin, Ibuprofen, Diclofenac, Haloperidol, Atropine, Infusion sets for the syringe driver, Water for injection, Dexamethasone, Prednisolone, Catheters: Foley catheter – Sizes 12, 14, 18, 20, 22, 24, 26, Silicon Catheter – Sizes as above, Urine Drainage Bags – Bottom drain / Leg Bags, Peniflows- Sizes Small, medium, Large, Syringes- Sizes 2ml, 5mls, 10ml, 20ml, Needles – Sizes 21g, 23g, 25g.