

# MODULE 10

## DISCHARGE PLANNING

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- Introduction
- Definition of chronically/terminally ill patient
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### Learning Objectives

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The aim of this manual is to sensitise nurses on the importance of discharge planning in patient care and equip them with the necessary knowledge, skills and attitude towards discharge planning.

**Objectives** of the training manual are as follows:

- Identify chronically/terminally ill patient including HIV/AIDS patients.
- Identify the discharge needs of the chronic/terminal patients including HIV/AIDS patients
- Develop an appreciation of the discharge planning process for patients leaving the acute setting.
- Describe the discharge planning process
- Conduct a home assessment prior to discharge of a patient.
- Assessment of the support system and resources in the community for continued care.
- Give relevant information to patients upon discharge
- Refer discharge clients to appropriate agents for continued care.
- Complete all relevant documentation including discharge forms.

## **1. INTRODUCTION**

Following the public outcry for information and adequate preparation of patients for care in the community, discharge care plans were formulated in various sectors of health care. A collaborative team consisting of the Nursing Science Department and Ministry of Health and Child Welfare (MOH/CH), sponsored by the National AIDS Coordination Program (NACP) developed a manual that was meant to address this need (MOH/CH, 1998). This manual although published and circulated countrywide has not been implemented. Research has indicated that health care workers are either reluctant to use the document or do not know how to use the discharge plans or do not know of its existence (Chikuse, 2000). The advent of AIDS has increased the number of clients being discharged from the acute setting. Some of these patients are being discharged early and still require substantial Nursing and medical care in the home setting. Lack of coordination in the care of the patient in the home has led to substandard care. The CEU HAQOCI initiative saw it fit to revisit the discharge planning process as a part of improving the quality of care of chronically/terminally ill clients.

### **PURPOSE:**

The purpose of this module is to facilitate training on the concept of discharge planning and offer guidelines on the discharge planning process for patients who are chronically/terminally ill including those who are HIV/AIDS infected.

### **DEFINITION OF CHRONICALLY / TERMINALLY ILL PATIENT**

“Chronic” is a word that is used to describe an illness, or signs of an illness that lasts for a period longer than 3 months. Some people have a chronic illness that is there all the time but it doesn’t stop them doing things that they want to do. Some chronic illnesses or effects of an illness can make a person feel ill. Other chronic illnesses have effects which slowly get worse and which might result in severe disability the person may die from the illness. A person dying from a particular disease is said to have terminal illness. Terminal means the last part.

### **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. Thus:

- Discharge planning is that process by which hospitalised patients are provided services that will allow continuity of care so healing or health maintenance can occur outside the acute care hospital. All patients have discharge planning needs some more complex than others.
- Discharge planning is the process by which the patient is assisted to develop a plan of care for on-going maintenance and improvement of health care, even after he or she is discharged from the acute care hospital. Sometimes referred to as continuity of care, discharge planning seeks to provide services that will enable the patient to become as independent as possible.
- Discharge planning is a process in which it is essential to balance the palliative care elements of hope and reality. Many of the clients being discharged are in the terminal stage of illness and are unable to afford doctors clinic fees. These clients and their families need to be prepared for the inevitable time of death in order to facilitate advance planning.
- Discharge planning begins at the time of the individual's admission to the treatment. It is an interdisciplinary effort requiring the full participation of the individual the family and the treatment team. Through the discharge planning and evaluation process the individual is encouraged and assisted to develop a plan for maintaining an optimal level of physical, psychological and social functioning.
- A written discharge plan shall be initiated with the individual at the time of the initial assessment. The final discharge plan should fully describe those services and resources needed to support the psychosocial and medical elements of the treatment plan. Essential areas for description include family support, financial status, housing and personal assistance services plan (if indicated) as well as post-discharge follow-up plans.

- The individual's perception of readiness for discharge from both inpatient and outpatient programs should be formally assessed before discharge. Additional information education or referrals should be provided as needed.
- From the above definitions it can be summarized that discharge planning is a collaborative process that starts from admission and is completed on discharge and involves moving a client from one level of care to the other. The process should incorporate the multidisciplinary approach and involve all the appropriate health professionals and offer holistic patient care.

### **THE IMPORTANCE OF DISCHARGE PLANNING**

- The hospital discharge plan is a critical instrument for improving the quality of care that the chronically/terminal ill patients including those with HIV/AIDS receive for monitoring the discharge process and ensuring continued medical and nursing supervision of patient care (consensus meeting Oasis hotel 13th May 2002).
- The American Nurses Association once described discharge planning as “the part of the continuity of care process which is designed to prepare the patient or client for the next phase of care and assist in making any necessary arrangements for that phase of care whether it be self-care, care by family members or care by an organized healthcare provider”
- Early attempts at discharge planning usually involve informing patients about their illness what may make them better and what may make them worse notifying patients of their next physician's appointment and explaining medication schedules. Later some discharge planning focused on liaison with home based care, particularly in hospitals where there were hospital-owned home care agencies.
- The goal of discharge planning is to promote continuity of care, improve the quality of care and maximize the use of healthcare resources. It is usually the doctor/ nurse's task to coordinate activities for the patient's benefit at discharge.
- The role of the nurse/doctor at discharge then is not only to write the discharge order, but to ensure that every possible effort has been directed toward the best possible continuity of care for the patient.

- The admitting nurse/doctor is the first to identify and document a discharge planning problem because he/she can tell that Mrs Mathe will not be able to return to her prior living arrangement immediately after discharge from the acute care hospital. Other members of the healthcare team will address issues involved in Mrs Mathe's plan but the discharge doctor/nurse will coordinate and facilitate the plan.
- The discharge planning team consists of the following personnel; the nurse, the physician, the physiotherapist, the nutritionist the pharmacist, the social worker, family and caregiver as indicated.

### **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.

### **PRINCIPLES OF DISCHARGE PLANNING**

The main principles of discharge planning are as follows:

- Identification of client needs
- Identification of resources and support systems within and outside the health care system.
- Involvement of the client and family in the preparation for continued care
- Education of the patient, family or care-giver on the patient's condition, management, potential environmental changes and lifestyle for example, use of wheel chairs, catheters or naso-gastric tubes.
- Identification of the discharge team members, the coordination and communication within the various disciplines of the health delivery systems.
- Development of a framework for the support of the healthcare workers and other service providers in the discharge process.

### **THE DISCHARGE PLANNING PROCESS**

There are five steps involved in the discharge planning. These are assessment, planning, implementation, monitoring and evaluation and handover of the client.

## A. Assessment

This is the first stage in the discharge planning. The stage consists of:

- Health assessment of the client
- Assessment of the Support systems

### **Health Assessment:**

Health assessment includes initial and subsequent assessment of the client while in acute setting. These activities start on admission or at first contact with the patient and are ongoing.

Health assessment consists of the following activities:

- History taking: collection of demographic and health history data
- Physical examination
- Medical/Nursing diagnosis
- Listing of patient's needs and prioritising them.

### **Assessment of the support system:**

Assessment of the support system consists of the following activities:

- Home assessment
- Assessment of available community resources

### **Home Assessment:**

Home assessment is done so that the home conditions are known before the patient is discharged. This is done with the assistant of the client, family and caregiver who will know the physical address of the client. Depending on the degree of disability the following are some of the questions that may be addressed to obtain a full picture of the home conditions.

**DISCUSS THESE QUESTIONS ON HOME ASSESSMENT WITH PARTICIPANTS.**

### **Questions**

- Does the patient share a bedroom with others?
- Are there stairs inside the house?
- Does the patient live alone?
- Are there toilet facilities in the home?
- Are there bathing facilities in the home?
- Are there laundry facilities on the premises?
- Is there someone available to prepare the meals?
- Does the patient need special a diet?
- Are there any changes needed in the home setting?

Is there someone available to do housework?  
Does the patient have significant others who will help with post-hospital care?  
Is there a caregiver available for home- based care for the client?  
Is there someone to bring the patient to the hospital when necessary?  
Can the patient afford the necessary care/

**Assessment of available community resources**

**DISCUSS ASSESSMENT OF AVAILABLE COMMUNITY RESOURCES WITH PARTICIPANTS**

**Questions**

Are facilities are such as shops, clinic, clean water etc available to meet the needs of the patient in the community?  
Can the patient afford services provided in the community?  
Are there facilities for counselling after discharge?  
Are there facilities for patient education in the community?  
Are there any support groups in the community?  
Are there home-based services for the client in the community?

Now you will have a better idea of how the patient will be able to manoeuvre around his or her home. There is a larger problem if there is no one to call, but most people will have a neighbour to call.

**B. PLANNING**

The planning process involves the following activities;

- i. Prioritisation of client and family needs
- ii. Formulation of multidisciplinary strategies to meet client and family needs
- iii. Identification of material and personnel resources needed
- iv. Specify identified support systems such as community based programmes immediate family care giver social services physiotherapy/rehabilitation, nutritionist NGO and spiritual support basic care items (kits)
- v. Formulation of evaluation strategies for care
- vi. Drawing up an activity schedule for implementing the strategies.

### C. IMPLEMENTING

- Implementation phase involves the provision of services that have been identified and planned for the discharged patient. The patient and family should be notified about the discharge date early so that preparations for the client can be arranged on time. The services provided during implementation phase may vary according to an individual patient. However these services may include the following:
  - Confirming the place where the patient is going to be discharged to and availability of the caregiver for the client.
  - Confirming that available home and community resources have been mobilised for the client.
  - Notifying client, family and caregiver about the discharge date and time.
  - Liase with identified support systems such as community based programmes immediate family caregiver social services physiotherapy/rehabilitation nutritionist NGO and spiritual support system.
  - Giving relevant information to client and family about patient condition, management, drug treatment etc.
  - Giving appropriate reading material such as pamphlets if available.
  - Giving relevant drugs on discharge and information on where to obtain repeat prescription when to come for review what to do in cases of emergency.
  - Where available offer basic care items like kits that will be used at home. If these are not available in hospital contact organisations that will provide them to the client. When you refer the client make sure that a contact name is given and a referral letter introducing the client.
  - Complete all required documentation and discharge checklist.
  - The client is handed over to the caregiver.

### D. THE PROCESS OF HANDOVER

- This is the final stage of discharge planning from an acute setting. It does not however mean that the acute setting abandons the client at this stage. There will be constant follow up and referral after the discharge. Before the acute setting hands over the client

it is essential to ensure that all necessary steps have been done and all team players have been involved appropriately.

Hand over involves the following:

- A final health assessment.
- Ensuring all facts on home and support services are available
- Reminding of client and relatives of review dates, procurement of drugs diet information.
- Coordinating with receiving institution and caregiver.
- Arrangement of transport where applicable.
- Discharge and handover of the client. Ensuring that the discharge forms are filled in.

#### ACTIVITY 1

Mrs Mathe is a 40-year-old schoolteacher who is admitted to the hospital with Pulmonary Tuberculosis. She is married and has two children, a teenage boy and a five- year old girl. Her husband works in South Africa and only visits home every Christmas holiday.

- 1. Draw up a list of possible Nursing and medical problems that can be identified for Mrs Mathe.**
- 2. Draw a time schedule activities that will meet Mrs Mathe's needs on discharge.**

## E. EVALUATION AND MONITORING

Monitoring and evaluation helps to ensure the client received the best care and continuity from institutional to community care. Evaluation and monitoring does not only come at the end but must be done throughout the process of discharge planning. Evaluation strategies are usually planned during the planning stage. Once the specific objectives are formulated for each client outcome measures are stated and these will be indicators of successful accomplishment of the objectives. Evaluation strategies such as review of records and care plans using checklist are done to assess progress and accomplishment of objectives. The discharge evaluation and monitoring checklist enclosed assists the nurse in evaluation of

Prevention of opportunistic infections

care of the client. The form has items that are assessed at discharge. These items are also assessed at the first and subsequent visits following discharge. Based on findings of evaluation, re-planning for new identified needs is done whenever necessary. The client may be requested to fill in a form indicating their level of satisfaction with care in various areas.

**DISCHARGE MONITORING AND EVALUATION CHECKLIST**

	ON DISCHARGE			AT HOME VISIT		
	Yes	No		Yes	No	
<b>MEDICATION</b>						
Has adequate supply of Medication						
Knows condition; drugs and how to take medication, what makes them worse and what promotes well-being						
Follows special instructions						
<b>RESIDENCE</b>						
Lives in a nursing home						
Lives in a family residence						
Is renting a room in a home						
Lives alone						
Requires assistance with housework						
Requires assistance with preparation of meals						
<b>FOLLOW-UP PSYCHOSOCIAL HEALTH CARE</b>						
Has access to a community health team						
Has access to a counsellor						
Has access to a care facilitator						
Has access to a social worker						
Has access to a community support group						
Has access to Hospice						
<b>ACTIVITIES OF DAILY LIVING</b>						
Adheres to safe Hygiene standards						
Is resting well during the day						
Is sleeping well at night						
Requires assistance with walking						
Requires assistance with toileting						
Can work, go to school, perform social duties						
<b>FOLLOW-UP MEDICAL CARE</b>						
Aware and keeping review appointment						
Will have access to community nurse						
Knows and follows Diet/fluid instructions						
Has access to Dental care						
Has access Eye care						
Special instructions						
<b>SPECIAL NEEDS</b>						
STD and AIDS prevention education given						
Transportation needs discussed						
Financial needs discussed						
<b>HEALTH ASSESSMENT</b>						
<b>ADDITIONAL COMMENTS</b>						

Adapted from A Discharge Checklist, Journal of Psychosocial Nursing, 1995

## **THE ROLE OF A NURSE IN DISCHARGE PLANNING.**

The role is mainly to coordinate activities and is summarized as follows:

- He/she screens the client for appropriate discharge planning process
- He/she performs the initial assessment of the client on first contact. He/she must make an accurate assessment with regards to functional ability, support system financial and mental state.
- He/she performs identification after interviewing the patient, reviewing medical records and speaking to the family members.
- Documents the discharge needs of the client.
- He/she initiates the documentation of the discharge plan.
- Identifies and liases with health professionals including caregiver) who should be involved in the implementation of the discharge planning.
- Collaborates with the client, family and caregiver to perform a home and support services assessment.
- Identifies potential continuity of care problems. Draws a plan of implementation that consists of all health professionals involved in the discharge plan.
- He/she performs the final assessment before the client is handed over to the next level of care.

### **ACTIVITY**

Discuss the role of the discharge nurse/doctor in the case of Mrs Mathe. What problems would you encounter in performing your role?

## **PALLIATIVE CARE: FOR NURSES**

### **Palliative Care**

#### **Preamble**

Quality of life is a central concept in palliative care and in health care in general. As such palliative care strives to meet the physical, psychological, social and spiritual needs of ill people and caregivers. It requires a team approach including the ill person, family, health and social welfare workers and community volunteers. Children however, have special needs that evolve around communication, reassurance and emotional expression in issues related to illness and death.

#### **Objective**

To advise and provide direct care of terminally ill patients in hospitals, clinics and the home with particular reference to pain and symptom management as well as attention to psychosocial and spiritual needs.

#### **Pain Management**

Pain is what the patient says hurts and therefore it is subjective. Pain relief is paramount for people living with HIV/AIDS (PLHWA).

It is easier to treat pain if one views a patient's Total Pain i.e. it is essential to acknowledge and assess the physical and non-physical elements that constitute pain.

An appropriate analgesic should be started as soon as possible. These drugs range from:

- a) Analgesics for Mild Pain e.g. Paracetamol and Aspirin.
- b) Analgesics for Moderate Pain e.g. Paracetamol with Codeine, and Dextropropoxyphene
- c) Analgesics for Severe Pain e.g. strong opioids such as Morphine.

## **Symptom Management**

Apart from pain, many PLHWA suffer from symptoms such as mouth sores, fever, cough, diarrhoea, nausea, vomiting, skin problems, sore throat, thrush and genital problems. Most opportunistic infections (OIs) are easy to treat provided they are detected and managed early. Therefore, availability of drugs such as antibiotics etc. is crucial in palliative care.

## **Psychosocial support**

People living with HIV/AIDS frequently experience emotional problems. They require support from health workers, family members and other carers. Depression and anxiety are common symptoms which normally respond to counselling, by discussing their fears and worries. Only in extreme cases may drugs be used. Another area of support is bereavement support, which is the provision of counselling and practical assistance to those who are facing or anticipating the death of a family member or have had a death of a family member.

## **Spiritual Support**

Spirituality is about concern with life or death issues that is; What life really means or what it is about and each person's relationship with their Creator. While the patient is thinking about the meaning of his/her life, he/she needs the carer to take part in this by listening and helping him/her to talk about his feelings, without being judgemental.

## **BASIC ESSENTIAL HOSPICE DRUGS**

### **Antiemetics**

Metoclopramide

\*Prochlorperazine

Haloperidol with morphin

### **Analgesic:**

Paracetamol

Paracetamol with codein

\*Aspirin

Codeine

Morphine

**Laxatives**

Bisacodyl

Glycerine suppositories

Liquid paraffin

**Antibiotics/Antifungals**

Cotrimoxazole

Metronidazole

Miconazole oral gel

Miconazole topical cream

Cotrimazole paint

Nystatin drops/cream/pessaries

**Antiinflammatory**

Indomethacin

Ibuprofen

Diclofenac

**Dressings**

Crepe bandages

Plaster/ Micropore – gauze, packs

Betadine solution

Betadine scrub with liquid paraffin

Gloves

**Miscellaneous**

GV paint

Soda Bicarbonate

Metronidazole tablets crushed to powder

Zinc and Castor oil

Methylated spirits

Haloperidol

Atropine

**\* Not generally recommended for use in children**

**Catheters:**

Foley catheter – Sizes 12, 14, 18, 20, 22, 24, 26

Urine Drainage Bags – Bottom drain

Peniflows- Sizes Small, medium, Large

Syringes- Sizes 2ml, 5mls, 10mls, 20mls

Needles – Sizes 21g, 23g, 25g

## APPENDICIES

### Appendix 1:

Discharge planning training course for doctors & nurses: Pre and post training test

**Instructions**  
Please read the questions carefully and answer appropriately. The first 9 questions require true/false responses. Tick (✓) your answer on the appropriate box. The rest of the questions require you to choose a response. Insert the number of the response you choose on the box on the right

REVIEW QUESTIONS	TRUE	FALSE
1. Discharge planning is a patient's right.		
2. Discharge planning begins as soon as the patient's condition has stabilized.		
3. It is beneficial to hospital finances to keep a patient as long as possible.		
4. Admission screens are used to rule out patients who will not need discharge planning assistance.		
5. The four main parts of discharge planning are screening, assessment, problem identification, and plan development.		
6. All patients with chronic illness qualify for funding from the social dimension fund		
7. Discharge planning is transferring clients from home to an acute setting		
8. Terminal patients have no discharge planning needs		
9. Home assessment is done to assess whether the family is ready to accept the patient in the community		
10. The family should be informed of the patient's discharge on the date of discharge		
11. Family members are encouraged to walk the client home to save funds for medicines		
12. Patients are encouraged to set review dates once they get home		
13. The client can work with the primary caregiver on what foods to eat/not eat		
<b>14. The purpose of discharge planning is to:</b>		
1. provide continuity of care for the patient		
2. reduce the patient's length of stay		
3. reduce hospital readmissions		
4. all of the above		
<b>15. Early attempts at discharge planning usually involved</b>		
1. teaching the patient about medications and:		
2. notification of the next physician's appointment		
3. education about insurance programs		
4. home health care for dressing changes		
5. none of the above		
<b>16. Discharge planning is a multidisciplinary process that includes:</b>		
1. a social worker		

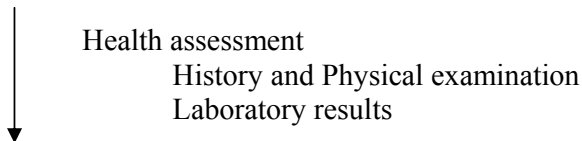
Prevention of opportunistic infections

2. staff nurses	
3. doctors	
4. all of the above	
<b>17. Discharge planning begins:</b>	
1. as soon as the discharge order is written	
2. on the third hospital day	
3. when the patient reaches the required length of stay	
4. before or at the time of admission	
<b>18. A discharge planner is usually:</b>	
1. a registered nurse	
2. a social worker	
3. neither a nor b	
4. both a and b	
<b>19. A good discharge planner needs several traits. Among them are</b>	
1. assessment ability,	
2. organization skills, and:	
3. experience as a home health nurse	
4. communication skills	
5. a BSN certification in gerontology	
<b>Admission screening is a tool for identifying:</b>	
6. potential discharge planning needs	
7. inappropriate admissions	
8. the only patients a discharge planner needs to see	
9. none of the above	
<b>20. An assessment includes:</b>	
1. a medical record review	
2. a patient interview	
3. family involvement	
4. all of the above	
<b>21. During the initial assessment, it is helpful to try to determine</b>	
1. the patient's mental state,	
2. pre-hospitalization arrangements,	
3. educational needs, and:	
4. possible equipment needs	
5. date of next physician's appointment	
6. date of discharge	
7. patient's knowledge of his or her prognosis	
<b>22. If a patient indicates that he or she has help from a neighbour and will need no other assistance, the discharge planner should:</b>	
1. chart that response and see other patients who will really need help	
2. verify this information with the neighbour	
3. refer the case to adult protective services	
4. attempt to locate blood relatives to verify this information	

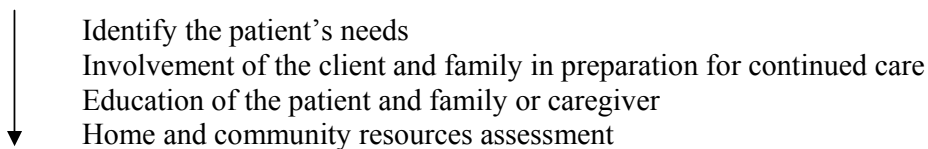
Appendix 2:

## DISCHARGE PLAN FLOW CHART

### 1. On admission



### 2. During admission



### 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

Appendix 3:

## DISCHARGE FORM

### Patient Discharge Summary

(To be completed in triplicate)

1. Copy to the patient
2. Copy for the receiving institution
3. Copy to the discharging institution

**Section 1**  
**Demographic Data**

Name of Facility :  
From:..... To:.....

Name of Patient ..... Hospital Number:.....  
ID Number:..... Age:.....

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

Number of dependants:.....

Home address:..... Physical  
.....  
.....

Home number:..... Phone  
.....

Address of nearest School/ Kraal Head or  
Chief:.....

Occupation:.....

Name And address of  
Employer:.....

Phone number of  
Employer:.....

Name of Caregiver / Next of  
Kin:.....

Attending Doctor :.....  
Admission:.....

Discharge Date:..... Date of next  
appointment:.....

**Section II 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:..... on

Condition on discharge:..... on

Activities of daily living:

- Bathing.....
- Feeding.....
- Dressing.....
- Mobility.....
- Communication.....

Ability to cope at home:

Specific Instructions

List Drugs Prescribed:

.....  
 .....  
 .....  
 .....

Supplied  
 Yes /No  
 Yes / No  
 Yes / No  
 Yes / No

Prescription given  
 Yes / No  
 Yes / No  
 Yes / No  
 Yes / No

Relevant Dietary advice (specify):

.....

Other special instructions:

Wound Care.....

Infection control (universal precautions).....

Prophylactic drugs.....

The condition has been explained adequately and counselling given.

Signature of Patient / Significant Other:

Signature of Discharging Nurse:

Follow up Instructions:

Review Date:

Review Person

#### **Appendix 4:**

#### **SUMMARY**

#### **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.

#### **Objectives of Discharge Planning**

1. To identify the patients needs.
2. Identify the resources and support.
3. Involvement of the client/family in preparation for continued care .
4. Education of the patient, family or caregiver on the patient's condition, management, potential environmental changes and lifestyle, e.g. wheelchairs, catheters naso-gastric tube etc.
5. Strengthening the coordination and communication within the various.
6. Identification of the discharge team members
7. Development of a framework for the support of the health care worker and other service providers in the discharge process.

8. Monitoring and evaluation of the discharge process.

## **Stages in Discharge Planning**

1. Health assessment
2. Planning
3. Implementation
4. Evaluation and monitoring
5. Discharge and handover of the patient

### **ACTIVITIES IN EACH STAGE**

#### **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.

#### **Stage 2. Support Systems Assessment**

This includes;

- 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

#### **Stage 3: Setting Short And Long Term Objectives**

Based on the findings in stage 1

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

#### **Stage 4: Implementation**

1. Provision of services required by the patient
2. Information giving and counselling about services offered on the community home based care program
3. Assessment of the patient on an ongoing basis and adjustment of care plan.
4. Mobilization of resources e.g., drugs, bandages
5. Record keeping of care plan
6. Liason and coordination of patient care with other team members i.e. pharmacy, TB coordinators, physiotherapist, social workers, counselors etc.

#### **Stage 5: Evaluation**

1. Monitoring and evaluation of the care plan
2. Use of checklist to assess progress of implementation.
3. Review of records and re-planning were necessary.

#### **Stage 6: Discharge And Hand Over Of The Patient**

1. Carry out final assessment
2. Filling in of discharge and referral forms (see appendix I & II)
3. Remind clients and relatives of follow up system and the need to review dates and replenishment of drugs.
4. Advise patient and relatives of the need to seek hospital assistance when worried.
5. Make transport arrangements if applicable.
6. Collaboration with relevant disciplines for the referral and further management at the next level.

7. Discharge Plan Coordinator plans, coordinates and liaises with receiving institution as appropriate e.g. island hospice, community home based care teams, health institutions, homes and others.
8. Discharge and hand over of patients.

**NB: Identified Resources and Support Systems**

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