Proactive Discharge Planning

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Proactive discharge planning is critical to ensuring that your clients not only experience a smooth transition from hospital to home, but that they also receive all the support they need to maximize independence and quality of life post-discharge. The key to ensuring a successful discharge from hospital to home, or alternative residence, is a proactive approach that may include an experienced Rehabilitation Consultant and/or an Occupational Therapist. Referring early, before discharge day, and referring for an experienced Rehabilitation Consultant to coordinate required services can make all the difference!

To assist you in taking a proactive approach when you next have a client in hospital, here is an overview of what discharge planning is all about and how you can make sure the process is as well-organized as possible - ultimately addressing all your client’s needs!

What is Discharge Planning?
The goal of discharge planning is to successfully return a client back to his/her home or alternative residence (rehabilitation facility, convalescent home/retirement home or long term care facility), while ensuring that all of his/her needs are effectively addressed. Safety issues, attendant care needs, accessibility issues, and transportation requirements are addressed, as well as potential referrals for ongoing rehabilitation. The discharge planning process strives to proactively make a safe and comfortable transition from hospital to promote the client’s recovery.

Which clients benefit from Discharge Planning?
Most clients benefit from some degree of discharge planning. The extent of the discharge planning depends on the severity of injury/illness and, accordingly, the barriers present that may make discharge to his/her pre-accident home/previous residence difficult. For example, clients with mild injuries (i.e. admitted to hospital and discharged home without critical mobility and/or medical issues), may just require assistance with referrals for ongoing rehabilitation. By contrast, clients with serious injuries such as spinal cord injuries, head injuries/concussions, fractures, multiple injuries, will greatly benefit from more extensive discharge planning.

As emphasized earlier in this article, your first step is to be proactive by planning ahead for a client’s discharge from hospital well before the actual discharge date. This avoids the “rush referral” for discharge (e.g. 4:30pm on the Friday of the long weekend) and makes certain that your client’s needs are thoroughly assessed well before discharge day,
so that upon discharge all his/her immediate, as well as future needs, have been addressed.

**What type of professional is best suited for discharge planning?**

In addition to being proactive in referring for discharge planning, it is critical to refer for an experienced Rehabilitation Consultant and/or an Occupational Therapist. Discharge planning for clients with multiple injuries is especially complicated, necessitating a very experienced professional to handle the discharge planning. A consultant who has substantial experience will benefit your client in numerous ways:

- **Comprehensive Assessment** – an experienced consultant has the background and expertise to expertly assess your client’s initial discharge needs, as well as future support needs which, especially in severe or catastrophic cases, can be very complex.

- **“Match” to appropriate Services** – the consultant’s experience also enables him/her to accurately assess the health care system and determine which services will be most effective in meeting your client’s various needs. For example, an experienced consultant will be well aware of OHIP, Community Care Access Centre (CCAC) and Assistive Devices Program (ADP) services and other government services, as well as other private and not-for-profit services and be skilled at “matching” needs to services.

- **Established Community Contacts** – another benefit of years of experience is “quick connections”. Not only is an experienced consultant able to adeptly assess the services available and appropriately match client needs with specific services, he/she will be able to do this quickly!

**What is the Discharge Planning Process?**

It cannot be stressed enough that the ideal scenario is when referral for discharge planning is made early – while the client is still in hospital. It is logical that this critical first step makes the transition much smoother because it allows more time for an in-depth assessment and to ensure that all aspects of the client’s needs are addressed prior to leaving the hospital. It also provides the opportunity for the client to adjust to the idea of discharge and what the future will hold for him/her. Upon reviewing the following list of tasks that should be conducted to ensure all needs have been considered, it is difficult to imagine how it could all be completed on discharge day!

The Rehabilitation Consultant or Occupational Therapist should conduct the following tasks:

- **Receipt of Referral** - Receive referral and contact the hospital and client (or family if appropriate.)

- **Hospital Visit & Professional Consultation** – Visit the hospital prior to discharge day to proactively and comprehensively plan the discharge by obtaining signed waivers to speak with the various treating specialists (Physicians, Occupational Therapists, Physiotherapists, Social Workers, Speech Language Pathologists, Discharge Planner) and obtain all relevant medical documentation.
Occupational Therapy Home Visit - An Occupational Therapist will visit the client’s home prior to discharge (if possible) to address accessibility and safety issues and to determine appropriate equipment needs. Some aspects of discharge planning can be handled via telephone. For example, in cases where there are not a lot of medical / mobility concerns a hospital visit may not be necessary and arrangements can be made on the telephone.

- **Determine the need for Attendant Care** - Based on the hospital and home visit the client’s attendant care needs are assessed for personal care issues. The Attendant Care Assessment is ideally performed once the client has returned home. However, there are some instances when this assessment must be completed in advance of the client’s discharge from hospital and arrangements made for attendant care services to be provided in the client’s discharge location.

- **Ongoing Communication with Adjuster** – Contact with the adjuster to discuss the file status and obtain approval for initial recommendations ensures ongoing effective communication as well as obtaining authorization for the implementation of urgent recommendations.

- **Coordination of Community Services**– Determine which services are available to the client after discharge from organizations such as CCAC (Community Care Access Centre) and ADP (Assistive Devices Program). Implement referrals to community-based services, treatment providers and physicians.

- **Transportation** - Arrange for transportation home if needed and for future medical treatment/follow-up if required.

- **Follow-up Visit** - Immediately after discharge, the Occupational Therapist should visit the client at home to ensure that all safety, accessibility and equipment issues have been addressed.

- **Follow-up Communication with Adjuster** – the adjuster should be kept informed throughout the process, as well as regarding final arrangements after discharge, such as transportation to medical follow-up appointments (as applicable) and information about any treating health care professionals involved in the client’s care post discharge.

**Issues related to Safety, Accessibility & Equipment** -
It is imperative that the client’s pre-accident home is assessed to ensure that the pre-accident environment is appropriately adapted to meet his/her specialized needs. Regardless of whether the client’s needs are temporary, short-term or long-term, it is essential that the barriers to accessibility be addressed to ensure a comfortable and safe transition between hospital and home, as well as maximizing future independence.
The Occupational Therapist’s skills in assessing the client’s functional capabilities and limitations can be complimented by the skills of an Accessibility Consultant who can expertly assess the existing environment and devise an appropriate plan to modify the home to eliminate its existing accessibility barriers.

For example, adaptive modifications that may need to be considered could include the construction of a pressure-treated wood ramp or inclusion of a residential porch-lift at the home’s main entrance to provide the client with a safe way to negotiate the change in levels. Internal modifications could include an accessible bathroom (complete with wheel-in shower enclosure, wheel-under vanity and height-appropriate toilet) and adaptive kitchen modifications to allow wheel-under access to the kitchen sink, etc.

The collaborative effort between the Occupational Therapist and the Accessibility Consultant not only ensures that all of your client’s needs are appropriately addressed and that he/she is provided with a safe and functional environment, it also ensures that the recommended modifications are reasonable, necessary and conform with local building authorities.

Whether there is the need for temporary home modifications and/or longer term solutions, in addition, the client will often require special equipment to safely maneuver post injury. During the discharge planning process, the consultant will coordinate delivery of equipment, such as personal care devices (transfer aides, dressing aides, etc.) and mobility devices (hospital bed, wheelchair, walker, cane, etc.). The combination of the right equipment and the right modifications will promote recovery and maximize independence.

**Issues related to Attendant Care and other attending Services** –
As emphasized concerning all tasks related to discharge planning, being proactive is critical when arranging for attendant care services because to ensure the services are as effective as possible, the Rehabilitation Consultant/Occupational Therapist must be aware of the client’s needs prior to sending an agency to the client’s home.

For example, in some cases, the attendant care needs may simply be related to bathing and dressing, whereas, in other cases, the client may also require services, such as wound care, catheterization and bandage changing. The attendant care might also take on a supervisory role if the client has exhibited behaviour change that necessitates assistance concerning this issue.

The only way the Rehabilitation Consultant/Occupational Therapist can be fully prepared to effectively address all the client’s needs is by planning ahead and appropriately matching the right attendant care services with the client’s specific needs. In addition, the Rehabilitation Consultant/Occupational Therapist must have open and ongoing communication with the adjuster, hospital/internal discharge planner and rehabilitation team so that appropriate attendant services are in place at the right time.
Communication, Communication, Communication -
In summary, communication that results in early referral to an experienced Rehabilitation Consultant/Occupational Therapist ensures smooth discharge planning:

**Ongoing communication between Adjuster & client** -
Ongoing communication with the client from the time of application/contact to discharge ensures you are aware of the client’s situation. As his/her treatment progresses, you are better able to forecast discharge. As a result, you can proactively refer for discharge!

**Ongoing communication between Rehabilitation Consultant/Occupational Therapist & Adjuster** - Ongoing communication with the rehabilitation consultant also promotes a smooth transition as the Rehabilitation Consultant/Occupational Therapist should keep you informed of his/her assessment so you can critique/approve necessary equipment or services as appropriate.

Communication ensures your client will receive a smooth, uneventful and successful transition from hospital to home or alternative living environment! Additional information about this topic is available through Sibley & Associates’ Resource Library and Educational Seminars. Please contact Angela Veri, National Director of Customer Relations at 1.800.363.8900 (Ext. 356).