

section 4.2.1 discharge to metropolitan Adelaide

planning considerations and related questions

A valuable component of discharge planning is the use of targeted questions that focus on particular aspects of the patient and family/caregiver's strengths and needs. Aspects to consider include:

Functional status of the patient

Ask:

- what is the patient's current functional status?
- how mobile is the patient?
- what personal care and assistance with activities of daily living (ADL) will be required?
- what is the likely impact of disease progression on their status?
- what is the likelihood for the patient to deteriorate?
- what are the likely complications of disease and have the patient and caregiver been advised of these?
- if outpatient follow-up is planned, is the patient able to travel and who will drive them, if this is required?

Caregiver characteristics

Ask:

- is there someone at home to provide care?
- if a caregiver has been identified, do they live at home or live out of the home?
- is the caregiver clear about what they are required to do?
- has the caregiver had the opportunity to be involved in providing care during the admission – see section 4.3 – *Including caregivers in discharge planning*
- what is the age and general health of the caregiver – do they have an existing back or other injury?
- is the caregiver safe in provision of home care?

Personal goals

Ask:

- what personal goals has the patient identified?

Family characteristics

Ask:

- what are the communication patterns and dynamics which are evident within the family and/or caregivers – do they appear to promote cohesion or is there evidence of conflict?
- would offering to arrange a family meeting be of benefit? – see Section 2.1.2- *The role of the family meeting*

Facilitating care provision at home

Ask:

- are there community supports already in place?
- what supports for the patient's personal care are required?
- what equipment and house modification is required?
- has an occupational therapist or physiotherapist reviewed the patient and their living situation?
- will access to home oxygen be required?
- what training or education has been provided for use of nebulizers, oxygen therapy- see Section 4.3 – *Including caregivers in discharge planning*
- is complex equipment required? eg suction equipment, lifting machines – if yes, has prior contact with community nursing occurred so that education for the family can be provided prior to discharge?
- will volunteers have a valuable role to play, particularly for socially or geographically isolated patients

Community based medical and nursing staff involvement

Ask:

- will assistance from community nursing or personal caregivers be required? – if yes, has the RDNS or other nursing organisation's liaison nurse spoken with the caregiver to outline services, planned visits and fees?
- has the GP been involved in the discharge plan? see Section 4.4 – *Communicating with General Practitioners*

Home environment and household issues

Ask:

- what is the home environment like? eg 2 storey, stairs which require a ramp
- will equipment from domiciliary care be required?
- is the patient safe to be at home?
- how will meals be provided?
- who will wash the clothes and bedding?
- who will clean the home?
- are there pets to consider?
- have supports in the local region including domiciliary care, local councils, sporting, charitable or church groups (with which the patient or caregiver have a relationship) and volunteers been explored

After hours assistance

Ask:

- do the caregivers have clear instructions about accessing help after hours should symptoms change or worsen?
- do the family have a list of contact numbers , in order of priority, that is located in an easily accessible place and is easily read?

Social supports

Ask:

- do the family have contact numbers for social support, either by visit or by phone?
- has there been active encouragement for the caregiver to set up their own "support network" based on friends, family, local groups, church etc

Planning for the future

Ask:

- has there been an open discussion with patient, caregiver and GP regarding the site of ongoing care, especially should the patient's condition deteriorate? – it is important to be clear with the caregiver that agreeing to take the patient home does not imply that this is forever, nor that it is a failure if it does not work
- have promises been made about home care that do not take account of declining physical status or caregiver exhaustion?
- does the patient have ambulance cover, given the likelihood for readmission or transfer to home via ambulance is likely and the costs associated with transfer can be very high?
- what are the options available should care at home not be sustainable?
 - return to hospital via casualty
 - remain at home with community supports
 - consideration for hospice admission (any hospice admission must be negotiated with a Specialist Palliative Care Consultant)
 - admission to a Residential Aged Care facility/ supported care facility.

referrals to other staff members

- **Allied health staff**

The input and assessment of allied health practitioners can be of immense value with each discipline making a specific contribution to providing a focused assessment, identifying and meeting care needs and subsequently referring and liaising with appropriate services. This of special significance when patient and/or caregiver needs are complex.

See Section 2.1.1 – *The role of the multidisciplinary team* for detail of the specific skills offered by each discipline

- **Specialist Palliative care team**

Would early referral to the local specialist palliative care service be of benefit? Has the palliative service been notified that a patient already known to them has been admitted? - this assists in negotiating a timely medical review (if required) and prompt and timely transfer of information to the appropriate community team.

See Section 3 – *Referring to specialist palliative care services* for more information

related resources and information

Palliative caring at home

This is a booklet which simply outlines information and tips for caregivers of palliative people in the community – is available free from the Palliative Care Council of South Australia. See online resources at www.pallcare.asn.au or call 08 8291 4137.