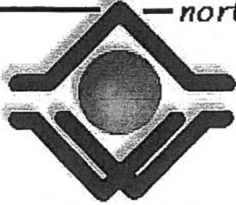


DISCHARGE PLANNING – R-I-3

POLICY:

Discharge planning will be started as soon as a decision has been made related to the discharge of a Recipient of Service.

PURPOSE:

1. To ensure the individual has a smooth transition from OPTIONS northwest.

2. To provide the new support provider with a complete and comprehensive profile of the individual.

PROCEDURE:

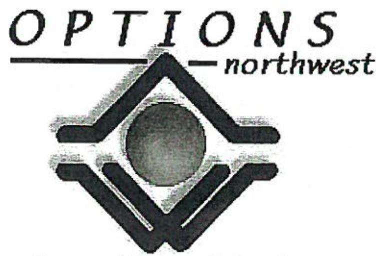
1. The Primary/Secondary Counsellor will complete the Personal History Form (see Appendix A). The Supervisor will review the form and send it to Clerical for typing.

2. An Authorization to Collect/Disclose Personal Information form (see Appendix B) will be completed by the Primary/Secondary Counsellor and placed in the Authorization Forms section of the individual's Support Plan Binder.

3. A discharge planning meeting will be called by the Supervisor. The meeting will involve the individual, the Primary/Secondary Counsellor and all persons/staff involved in supporting them, as desired by the individual. This may include family, friends, and support staff (from OPTIONS and, if applicable, the new support team).

4. At this meeting, the Supervisor and Primary/Secondary Counsellor will take the lead to coordinate discharge planning using the Personal History form. A copy of the Individual's Application for Developmental Services and Supports and their Supports Intensity Scale will be updated as required and, if applicable, forwarded to the new Support Provider.

5. The next steps to facilitate the individual's discharge shall be determined and documented at the meeting, including assignment of responsibilities.



6. The Supervisor will ensure all reports and important information the individual has consented to will be released to the receiving support provider.

7. The Supervisor will establish dates and times for the individual, family and staff as necessary, to visit the new location.

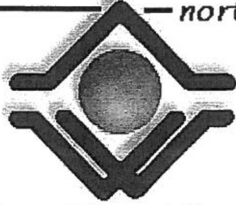
8. Review meetings will be scheduled every 1 – 2 weeks until the individual is discharged.

9. Once a discharge date is determined, the Supervisor will inform the following parties as required:
   a. Director of Finance and Administration
   b. Director of Human Resources
   c. Director of Clinical Services if the individual is involved with the Community Resource Team
   d. Executive Director
   e. Director of Personal Support Services
   f. Independence Plus will be notified by the Director of Personal Support Services if the resultant vacancy is in a home they operate
   g. Hagi
   h. Public Guardian and Trustee for Finances and Treatment Decisions
   i. Pharmacy
   j. Physician, Clinician and all other applicable professionals
   k. All placements and other organizations that support the individual

10. On the day of the individual's discharge from OPTIONS northwest, the Supervisor will ensure a final entry is made in their Personal Binder. The Supervisor will remove the Personal Binder, Individual Support Plan Binder and Financial Record Binder from the home and deliver them to the Director of Finance.

11. The Supervisor will follow the Vacancy Management Policy R-I-1 for the resulting vacancy.

12. Follow up will be done by the Supervisor, to ensure the transition to the new location is progressing satisfactorily. This shall be documented on the Discharge Follow-up Form (see Appendix C). Once the form is completed it will be sent to Finance for filing.



POLICY: R-I-3
DEPARTMENT: Personal Support Services
CATEGORY: Personal Planning and Supports
EFFECTIVE DATE: March 2014
SUPERSEDES VERSION DATED: June 2013

RECOMMENDED BY: Director, Personal Support Services **APPENDICES:** 3

OPERATIONAL ACCOUNTABILITY: Administration, Finance, Human Resources, Personal Support Services Administration, Personal Support Services, Community Resource Team

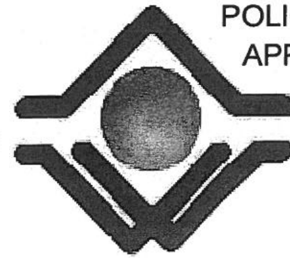
ORIGINAL POLICY DATE: March 2006

AUTHORIZED BY: Director, Personal Support Services

SIGNATURE: ______________________

OPTIONS northwest

Personal Support Services



PERSONAL HISTORY

☐Transfer ☐ Admission ☐ Discharge

PERSONAL INFORMATION

Name:

Telephone: Home: Health Card #:

Cell: Date of Birth: / /

Address: S.I.N.:

FAMILY INFORMATION

IMMEDIATE FAMILY

MOTHER: ______________________ FATHER: ______________________

FOSTER/STEP MOTHER: ________________

FOSTER/STEP FATHER: ________________

BROTHERS: ________________ SISTERS: ________________

________________ ________________

________________ ________________

________________ ________________

GRANDMOTHERS: ________________ GRANDFATHERS: ________________

________________ ________________

Do any family members <u>not</u> have visitation/custody rights? ☐ YES ☐ NO

NAME(S):

____

____

EXTENDED FAMILY AND CLOSE PERSONAL FRIENDS

The applicant has close relationships with the following people (Family and/or Friends). Please list the names, relationships, addresses and phone numbers and a brief description of the nature of the relationship.

NAME	RELATIONSHIP	ADDRESS	PHONE #	NATURE OF RELATIONSHIP

MEDICAL INFORMATION

A Complete medical/physical is required prior to admission/discharge. The individual's Family Physician is to complete an Admission/Discharge Medical Examination Form.

FAMILY PHYSICIAN: ______________________________

ADDRESS: ______________________________

____

____

PHONE #: ______________________________

Medical Exam Form Completed and Returned: ☐ YES, DATE______________ ☐NO

Medical Exam Appointment Booked: ☐ YES, DATE______________ ☐NO

ALLERGIES

ITEM ALLERGIC TO	USUAL REACTION	USUAL CORRECTIVE ACTION

Height: ______________ Weight: ________________

IMMUNIZATION RECORD REQUIRED: Provided ☐ Date: ______________

To Be Obtained ☐ Must Be Provided By: ______________

RECORD OF CURRENT MEDICATIONS

DRUG NAME	DOSAGE	TIMES ADMINISTERED	USE/PURPOSE OF MEDICATION

SELF ADMINISTERED: ☐ YES ☐ NO

COMMENTS/SUGGESTIONS FOR ADMINISTERING MEDICATIONS

____

____

____

PAST MEDICAL HISTORY

Hospital Admissions/Surgeries/Illnesses (Include dates if known):

CONSULTANT: ____________________ SPECIALTY: ____________________

ADDRESS: ____________________ TELEPHONE: ____________________

____________________ LAST APPOINTMENT: ____________________

REASON FOR CONSULT: ____________________

CONSULTANT: ____________________ SPECIALTY: ____________________

ADDRESS: ____________________ TELEPHONE: ____________________

____________________ LAST APPOINTMENT: ____________________

REASON FOR CONSULT: ____________________

CONSULTANT: ____________________ SPECIALTY: ____________________

ADDRESS: ____________________ TELEPHONE: ____________________

____________________ LAST APPOINTMENT: ____________________

REASON FOR CONSULT: ____________________

DENTIST INFORMATION

DENTIST: ______________________________

, DRESS: ______________________________ TELEPHONE: ______________________________

______________________________ LAST APPOINTMENT: ______________________

COMMENTS/CONCERNS AND SUGGESTIONS WHEN DOING DENTAL CARE:

____

____

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NOTE: All new admissions/discharges are to have had a dental exam at least six (6) months prior to their admission/discharge. The Family Dentist is to complete an Admission/Discharge Dental Examination Form.

Dental Exam Form Completed and Returned: ☐ YES, DATE: ________________ ☐ NO

Dental Exam Appointment Booked: ☐ YES, DATE: ________________ ☐ NO

SUPPORT REQUIRED BY APPLICANT

Bathing:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

____

____

____

____

Feminine Hygiene:

Independent: ☐ Requires Assistance: ☐ Last Menstrual Period: ____________________

Comments/Suggestions/Support Required:

____

____

____

____

Eating:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

____

____

____

____

Dressing:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

____

____

____

____

Mobility:

Ambulatory: ☐ Non-ambulatory: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

ACTIVITIES OF DAILY LIVING

Meal Preparation:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

Toileting:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

ACTIVITIES OF DAILY LIVING

Tooth Brushing Skills:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

Shopping Skills:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

Household Skills:

Independent: ☐ Requires Assistance: ☐

Comments/Suggestions/Support Required:

GENERAL HEALTH & WELL BEING

Special Diet considerations:

Yes: ☐ No: ☐

Comments/Explain:

Food Likes:

Food Dislikes:

Physical Activity - Do you participate in regular activities such as exercise, walking, swimming, etc.?

Yes: ☐ No: ☐

Comments/Explain:

Are there concerns with elimination?

Yes: ☐ No: ☐

Comments/Explain:

Are there any vision concerns?

Yes: ☐ No: ☐

Comments/Explain:

Are there any hearing concerns?

Yes: ☐ No: ☐

Comments/Explain:

Are there any respiratory concerns?

Yes: ☐ No: ☐

Comments/Explain:

How does the individual communicate?

Words: ☐ Non-traditional Communication: ☐ Other: ☐

Include type of communication (i.e. Sign language, pictures, etc.), and what each behaviour means (ie. hits head when he has a headache, paces when anxious, etc.).

Are there circulatory concerns?

Yes: ☐ No: ☐

Comments/Explain:

GENERAL HEALTH & WELL BEING

Are there concerns related to sleep?

Yes: ☐ No: ☐

Usual Bedtime: ______________________________

Include any routine that should be followed (i.e. favourite blanket, position, night light, etc.)

____

____

____

____

Usual Waking Time: ______________________________

Include any routine that should be followed (i.e. slow riser, grumpy when first waking up, etc.)

____

____

____

____

Special Equipment Required:

Yes: ☐ No: ☐

Include type of communication (i.e. Sign language, pictures, etc.), and what each behaviour means (i.e. hits head when he has a headache, paces when anxious, etc.)

____

____

____

____

GENERAL HEALTH & WELL BEING

Are there any emotional concerns?

Yes: ☐ No: ☐

Comments/Explain:

____

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BEHAVIOUR INFORMATION

Are there any repetitive or recurring behaviours? Yes: ☐ No: ☐

Do you have any written strategies for these situations? Yes: ☐ No: ☐
es, please provide these strategies)

Do certain behaviours correlate to specific problems?
(i.e. crying at the onset of menses, rubbing head to indicate headache or discomfort, etc.)

Yes: ☐ No: ☐

Comments/Explain:

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BEHAVIOUR INFORMATION

Describe any repetitive or recurrent behaviour exhibited by the applicant:

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Below give a detailed description of the behaviours:

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How are these Behaviours prevented and supported if required? Please comment in detail:

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Does the applicant have Behaviour habits, which should be monitored closely to prevent injury to self or others? (e.g.: biting, pinching of self or others)

Yes: ☐ No: ☐

Comments/Explain:

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PERSONAL CARE INFORMATION

Please list and comment on any likes (besides food) and favourite Leisure Activities.

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Please list and comment on any dislikes (besides food).

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Does the applicant have any routines or a schedule currently in effect? Please comment and provide copies of these routines or schedules if available.

____

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____

PERSONAL CARE INFORMATION

'sonal Needs:

Is the applicant's clothing in good repair?

Yes: ☐ No: ☐

Does the applicant need to purchase any of the items listed below prior to admission/discharge?

	Yes	No		Yes	No
Bed	☐	☐	Toiletry Items	☐	☐
Mattress	☐	☐	Hair Dryer	☐	☐
Dresser	☐	☐	Shaver	☐	☐
TV	☐	☐	Shampoo	☐	☐
DVD Player	☐	☐	Perfume	☐	☐
Stereo	☐	☐	Makeup	☐	☐
Winter Clothing/Boots	☐	☐	Jewelry	☐	☐
Summer Clothing	☐	☐	Hair Accessories	☐	☐
Linens	☐	☐	Other: ______________	☐	☐

Will briefs, hygiene items, etc. be sent with applicant?

Yes: ☐ No: ☐

If so please state brand name and size used:

____

____

____

____

DAILY ROUTINE

TIME	ACTIVITY

DAILY ROUTINE

cational Involvement (AVE II, Integration Services, etc.)

Please state person's level of involvement with other agencies.
(e.g.: Number of times per week at placement, location and a brief description of placement, pay if applicable and continuation of service)

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Transportation

State current transportation used by person and any pertinent information related to transporting applicant to and from various locations.
j.: wheelchair, walker, should not be placed close to another person due to behaviours, etc.)

____

____

____

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____

Has transportation been arranged to new residence?

____

____

____

OPTIONS northwest
95 N. Cumberland Street Thunder Bay ON P7A 4M1
Tel: (807) 344-4994 Fax: (807) 346-5811

AUTHORIZATION TO COLLECT / DISCLOSE PERSONAL INFORMATION

I hereby authorize OPTIONS northwest to ☐collect ☐ disclose the personal information of: ________________________________
(print full name of person to whom information applies)

Specifically: ________________________________

____

____

____

____

____

____
(Describe the personal information to be disclosed and the purpose)

From / To: ________________________________
(Print name and address of person, agency, or facility having / requiring the information)

I understand the purpose for obtaining / disclosing this information from / to the person/agency/ facility noted above. I understand that I can refuse to sign this consent form.

________________________________ ________________
Signature of Individual or authorized representative/ substitute decision-maker* Date

________________ ________________ ________________
Witness Name (Print) Witness Signature Date

*If signed by an authorized representative/substitute decision-maker, print name and indicate relationship: ________________________________

This authorization will be obtained yearly for individuals who remain on the Community Resource Team's caseload and for Client Services, at the time of the annual planning meeting.

Important Information. Please read:

An individual can withdraw their authorization at any time by writing to the Privacy Officer of OPTIONS northwest, subject to legal and contractual restrictions and reasonable notice. The withdrawal of authorization, however, shall not have a retroactive effect.

OPTIONS northwest's Privacy Officer is available to provide information on our Privacy Policy and to respond to any questions you may have.

- OPTIONS northwest -
DISCHARGE FOLLOW-UP

CASEBOOK #: ________

RECIPIENT NAME: ______________________________

DISCHARGE DATE: ______________________________

NEW ADDRESS: ____

NEW PHONE: ______________________________

SUPERVISOR COMPLETING FOLLOW UP: ________________________________

Date	Comments
ONE WEEK POST DISCHARGE:	
ONE MONTH POST DISCHARGE:	
THREE MONTHS POST DISCHARGE:	