

# Evaluation of an Integrated Model of Discharge Planning: Achieving Quality Discharges in an Efficient and Ethical Way

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Dans un contexte où les séjours hospitaliers sont écourtés, la planification des congés est une question qui prend de plus en plus d'importance. Selon les études, les pratiques en matière de congés comportent des difficultés à l'échelle des ressources et des problèmes d'ordre déontologique. Cette évaluation d'un modèle intégré de planification de congés (*integrated model of discharge planning – IMDP*) inclut une évaluation de l'utilisation des ressources, du respect envers les personnes dans la prise de décisions et de la capacité du modèle à répondre aux besoins des patients âgés, des familles et des professionnels. Deux études de cas portant sur un hôpital universitaire et un hôpital communautaire ont été mises à contribution pour illustrer le contexte dans lequel la planification de congés a été appliquée. Des analyses comparatives de cas et du processus même de planification des congés appliqué auprès de 48 patients indiquaient que l'IMDP était viable et que les patients étaient satisfaits. De plus, les ressources hospitalières ont été utilisées de façon efficace et les patients ont pu participer à la prise de décisions. L'étude fait état de la réussite d'une approche prometteuse en matière de planification des congés.

Discharge planning has become increasingly important in an era of shortened lengths of stay in hospital. Prior research demonstrated that discharge practices presented resource and ethical problems. This evaluation of an integrated model of discharge planning (IMDP) included an assessment of resource utilization, respect for persons during decision-making, and the impact of the model in meeting the needs of elderly patients, families, and professionals. Two case studies involving a university and a community hospital were used to illustrate the context in which discharge planning occurs. Within and cross-case analyses of the discharge-planning process for 48 patients indicated that it is possible to implement the IMDP and that participants were satisfied. Further, hospital resources were used efficiently and patients were involved in decision-making. The study represents a successful implementation of a promising approach to discharge planning.

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Discharge planning continues to be a critical issue in clinical practice and hospital administration. The challenge lies in achieving timely discharge while maintaining high-quality care in an ethical way. In response to a decade or so of budgetary cutbacks and large-scale restructuring, patient lengths of stay in Canadian hospitals have been drastically reduced. Data from the Canadian Institute for Health Information (2000) indicate that the average length of hospital stay in Canada dropped by more than 5% between 1994–95 and 1997–98, from 7.4 days to 7 days. Elderly patients have been the target of approaches aimed at earlier discharge, because they are the highest users of hospital services (34.7% of all hospitalizations in 1997–98) and because their lengths of stay are nearly double those of patients in other age groups (10.5 days vs. 5.4 days). Yet studies have shown that such discharge-planning practices raise pragmatic issues with regard to efficiency and are ethically questionable in that they can be disrespectful to elderly patients, families, and health professionals (Dill, 1995; Grimmer, Moss, & Gill, 2000; McWilliam, 1992; McWilliam & Sangster, 1994; Wells, 1997). Issues of inefficiency include misuse of the time and energy of professionals during the discharge-planning process, because their involvement is not carefully linked with the clinical trajectory of patients (Wells, 1997).

Lack of respect for patients and families in the discharge-planning process is related to the absence of involvement in the decision-making process (Dill, 1995; Grimmer et al., 2000; McWilliam, 1992; McWilliam & Sangster, 1994; Wells, 1997). The moral or ethical principles at stake here are informed decision-making and patient autonomy. As well, because of the hospital's emphasis on shortened stays, professionals have reported that sometimes they discharged patients before they felt that patients were medically ready (Wells, 1997). The ethical conflict for professionals resided in their conflicting loyalties: they had to choose between meeting the demands of the organization and providing quality patient care. When planning takes place too early and does not include the involvement of patients and families, discrepancies are reported between the needs identified and planned for in hospital and the actual needs of patients once they return home (Armitage & Kavanagh, 1997; Bull & Kane, 1996; Cummings, 1999; LeClerc, Wells, Craig, & Wilson, 2002; McBride, 1995; Mistiaen, Duijnhouwer, Wijkkel, de Bont, & Veeger, 1997; Perlman Simon, Showers, Blumenfield, Holden, & Wu, 1995; Prescott, Soeken, & Griggs, 1995; Proctor, Morrow-Howell, & Kaplan, 1996; Storer Brown, 1995).

In order to address these identified problems, several approaches to discharge planning for elderly persons have been developed and

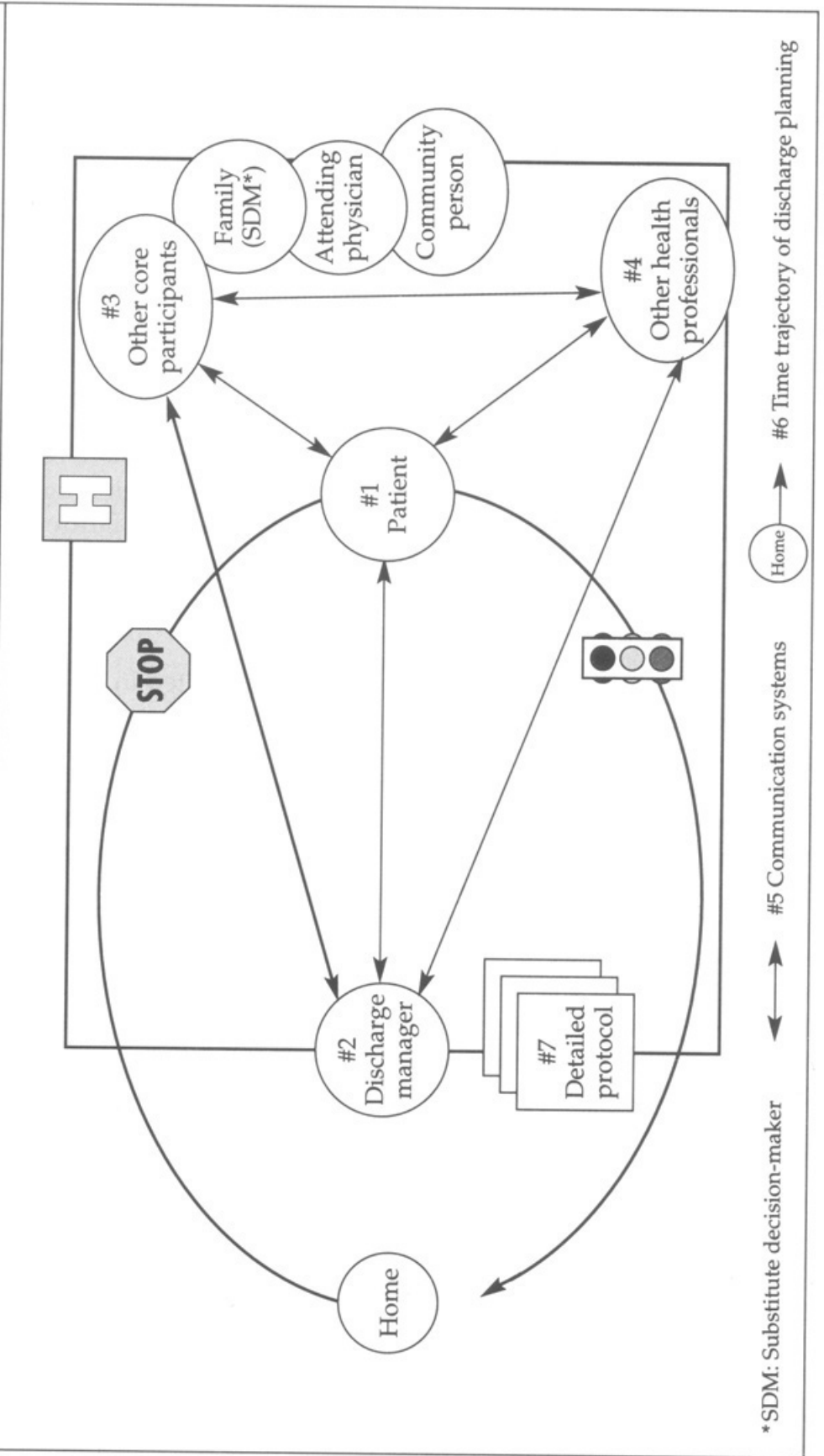
evaluated using a variety of designs, including five randomized controlled trials (Evans & Hendricks, 1993; Naughton, Moran, Feinglass, Falconer, & Williams, 1994; Naylor et al., 1994, 1999; Weinberger, Oddone, & Henderson, 1996) and two quasi-experimental projects (Bull, Hansen, & Gross, 2000; Haddock, 1994). These intervention studies, which involved a discharge planner or equivalent who had explicit responsibility for planning and which used an assessment and/or protocol, indicated such positive organizational outcomes as: increased numbers of patients discharged home (Evans & Hendricks); fewer re-admissions (Evans & Hendricks; Haddock; Naylor et al., 1994, 1999); fewer total days rehospitalized (Bull et al., 2000; Naylor et al., 1999); and lower total acute-care hospital costs (Naughton et al.; Naylor et al., 1999). In addition, these interventions resulted in increased patient and family satisfaction related to, for example, more continuity of information regarding managed care (Bull et al.; Weinberger et al.) and fewer unmet treatment needs post-discharge (Haddock). The reported findings regarding total length of stay are equivocal (Evans & Hendricks; Haddock; Naughton et al.; Naylor et al., 1999; Weinberger et al.).

These discharge-planning approaches are limited in that they lack an explicit theoretical underpinning. As well, the authors do not describe the rationale for their selected interventions. Furthermore, the research does not explicitly identify the importance of addressing issues of efficiency as well as moral and ethical issues related to informed decision-making and patient/family and professional autonomy. Moreover, none of the studies was conducted in Canada.

### **The Integrated Model of Discharge Planning**

To address the shortcomings of existing approaches, the Integrated Model of Discharge Planning (IMDP) was developed. This model evolved from a study with 130 professionals, patients, and families who were asked in focus groups or interviews to describe an ideal approach to discharge planning (Wells, Martin, Moorhouse, Craig, & Foley, 1999). The IMDP (Figure 1) consists of seven principles that together constitute an integrated approach to discharge planning, namely: (1) the patient is at the centre of the process; (2) a single person manages the planning; (3) the patient, family, discharge manager, physician, and a community person are the key participants; (4) other health professionals are involved only as the need arises; (5) communication is open and oriented to mutual agreement; (6) discharge planning is directly linked to the patient's clinical and social circumstances; and (7) planning is

**Figure 1** Integrated Model of Discharge Planning for Acutely Ill Elderly Patients



guided by a practice protocol comprising 24 activities (see Appendix 1). Participants in this study believed that this integrated approach would be resource-efficient and facilitate high-quality discharge care. In 1997 a pilot project was undertaken to examine the feasibility of implementing the empirically derived IMDP in the hospital setting (LeClerc & Wells, 2001). Findings revealed that the IMDP could be operationalized in practice.

Jurgen Habermas's (1984, 1987) critical theory, detailed elsewhere (Wells, 1995, 1997), also underpinned the design of the IMDP. Specifically, the theory offered a rationale for the need to balance imperatives related to the pragmatic issues of efficiency and moral or ethical issues related to professional and patient autonomy in the discharge-planning process. In accordance with Habermas's communicative action perspective, the reasons behind particular discharge-planning activities, the purposes or ends to be achieved, and the motives of participants were open for discussion by all those involved. This reflective process could, it was believed, foster greater accountability in, and lend legitimacy to, discharge planning, as participants would be responsible for coming to an agreement on the adequacies of particular decisions. Habermas's concept of discourse ethics was applied to the IMDP as a procedural guide to communicative action in discharge planning, which involves the application of discursive rules (i.e., the commitment to truth or accuracy; sincerity or being true to your words, taking conflicting values into account; and comprehensiveness or completeness of the information leading to decisions) to communication. In the present study, discursive rules in the discharge planning of elderly patients included: considering the opinions of participants, engaging appropriate people at the right time, and ensuring the adequacy of information used in decision-making.

### **Purpose of Study**

The purpose of the present study was to evaluate the process and impact of the IMDP in: (a) achieving the hospital's goals concerning the efficient use of resources given fiscal constraints; and (b) facilitating high-quality discharge planning that meets the needs of elderly patients, their families, and health professionals. The primary objective of the process evaluation was to determine whether all of the relevant activities of the discharge-planning protocol were implemented as planned and within the predetermined time frames. Also, we assessed the barriers and facilitators to implementation and assessed whether there was a workable plan at discharge. As well, we evaluated the



effects or outcomes of using the IMDP in terms of (a) resource use, and (b) respect for persons. The research questions related to resource use were: How much time is required for the core participants to plan for discharge? What is the length of involvement for other professionals? What are patient outcomes related to use of health-care resources/services (e.g., length of stay in hospital, re-admission, and unanticipated events)? The research questions related to respect for persons were: What is the relative involvement of core participants? Are patients, families, and discharge managers satisfied with the discharge-planning process and the final plans that are made? Are there any disagreements between core participants concerning the discharge-planning process and the final plans that are made, and are these resolved? Is the final discharge plan adequate post-discharge? Are patients and families provided with information and instruction about the discharge services to be provided, the patient's medical/health condition, and related treatments?

## Research Design and Methods

### *Design*

A program evaluation approach (Patton, 1997) was used to determine (a) whether the activities of the IMDP could be implemented in two different hospital settings, and (b) the related use of resources and whether respect for persons could be demonstrated.

A case study design constituted the specific research approach, which permitted an in-depth investigation of a phenomenon (i.e., discharge planning using the IMDP) within context (i.e., hospital medical units) (Ragin, 1987; Yin, 1994). The units of analysis were: the IMDP implemented on two general medical units, the patients and their family members who participated in the evaluation of the IMDP, and the discharge managers who implemented the IMDP.

### *Sample*

Two sites were purposively selected for the evaluation: one university acute-care hospital and one community acute-care hospital in the metropolitan Toronto area of the province of Ontario. Two discharge managers, one from each hospital, were purposively selected to implement the IMDP. They used the model to guide discharge planning and completed all relevant forms for all patients who met the following criteria during the study period: admitted to a general medical unit, aged 65 years or over, not awaiting placement in a long-term-care facility,

acutely ill and expected to be discharged home, agreeable to participation in a telephone interview, and no diagnosis of dementia. Every third completed patient case was selected for evaluation. This method was chosen to ensure that (a) the discharge managers would remain blind to patient cases subjected to analysis, and (b) the desired sample would be obtained within the study time frame based on anticipated number of admissions to the study sites. A sample of 25 patient cases was obtained from the university hospital and 23 patient cases from the community hospital.

### *Data Collection*

Following ethical approval by the Office of Research Services at the University of Toronto and the ethical review boards of both participating hospitals, data collection took place over a 9-month period between April 1999 and January 2000. A research assistant hired for the study trained the two discharge managers in how to use the IMDP and its related protocol, and how to complete all data-collection forms, which included: One Stop Client Access Assessment form (OSCA) (Haliburton-Kawartha-Pine Ridge District Health Council, 1991); the record of meetings/contacts form; and the initial, updated, and final discharge plans. With the exception of the OSCA, all of these forms were developed for the study and tested in a pilot study (LeClerc, 1998; LeClerc & Wells, 2001).

As well, structured telephone interviews were conducted 6 weeks post-discharge with 16 patients and three family members from the university hospital and 18 patients and five family members from the community hospital. Despite numerous attempts, we were unable to reach the remaining subjects by telephone. Patients and their family members provided verbal consent to be telephoned by the research assistant for interview purposes. The structured interviews were focused on patients' and families' satisfaction with the discharge-planning process and the final discharge plans, their level of involvement in planning, the adequacy of final plans, and any unanticipated events. The interviews lasted 30 minutes and were hand recorded as close to verbatim as possible.

Face-to-face structured interviews were conducted with the two discharge managers. These interviews were concentrated on the discharge manager's perceptions of the IMDP and the facilitators and barriers to its implementation. With the verbal consent of the discharge managers, these interviews were audiotaped and transcribed for data analysis.

## *Data Analysis*

Descriptive statistics were used to describe the sample of patients and the outcomes related to the process and resources expended in using the IMDP. Analysis involved within- and across-case comparisons at each hospital using the logic of comparative case analysis described by Marshall (1997) and Ragin (1987). Following this logic, similarities and differences are identified within and across cases (on the same analytic issues or research questions) in order to establish patterns and draw conclusions about the cases under investigation.

## **Results**

### *Demography of the Sites, Discharge Managers, and Patient Sample*

Table 1 summarizes the demographic characteristics of the sites, discharge managers, and patient sample. The university hospital, an acute-care facility located in downtown Toronto, was a mid-sized medical complex with 277 beds. The general medical unit on which the IMDP was evaluated comprised 32 beds. The discharge planner who implemented the discharge-planning protocol at this site was a full-time, master's-prepared social worker with 19 years of post-degree experience in a hospital setting. The 25 patients who participated in the evaluation ranged in age from 66 to 89, with an average age of 79.2. Forty percent of patients were female, 28% were non-English-speaking, 32% were married, and 52% lived alone. Stroke (20%), congestive heart failure (12%), and chronic obstructive pulmonary disease (COPD) (8%) were the three most frequently occurring admission diagnoses. Patients had an average of 2.7 co-morbidities. The average length of hospital stay was 13.9 days. At discharge, 68% of these patients returned to their homes.

The community hospital, an acute-care facility located in a Toronto suburb, was a large complex with 553 beds. The evaluation was conducted on a 30-bed medical unit. The discharge planner who implemented the IMDP at this site was a full-time, college diploma-prepared registered nurse with 22 years of hospital experience, 19 of which were at this site. The 23 patients who participated in the evaluation ranged in age from 66 to 96 with an average age of 78.1. Fifty-two percent of patients were female, 8.7% were non-English-speaking, 47.8% were married, and 39.1% lived alone. Pneumonia (13%), renal failure (13%), and COPD (8.7%) were the three most frequently occurring admission diagnoses. Patients had an average of 0.8 co-morbidities. The average length of hospital stay was 7.2 days. At discharge, 95.7% of these patients returned to their homes.



**Table 1** Demographic Characteristics of Patients, Discharge Managers, and Hospital Sites

	University Hospital	Community Hospital
<b>Patients</b>	<i>n</i> = 25	<i>n</i> = 23
Sample size	66–89 ( <i>X</i> = 79.2)	66–96 ( <i>X</i> = 78.1)
Age (years)	40.0% women, 60.0% men	52.0% women, 48.0% men
Gender	28.0% non-English-speaking 72.0% English-speaking	8.7% non-English-speaking 91.3% English-speaking
Linguistic background	52.0% live alone 28.0% live with spouse 20.0% live with other relative	39.1% live alone 30.4% live with spouse 30.5% live with other relative
Living arrangements	20.0% CVA 12.0% CHF 8.0% COPD (60.0% various diagnoses)	13.0% pneumonia 13.0% ESRF 8.7% COPD (65.3% various diagnoses)
Diagnoses (top 3)	2.7	0.8
Co-morbidities (number)	2.7	0.8
<b>Discharge managers</b>	master's in social work	diploma in nursing
Education	full-time	full-time
Job status	19	22
Experience (years)	277	553
Total beds in facility	32	30
Total beds on case unit	medicine	medicine
Type of unit	medicine	medicine

*Process Evaluation*

In both case studies, all discharge-planning protocol activities were implemented. However, some of these were not completed as fully as others or within the predetermined time frames. Specifically, the least consistently implemented activity was involving a relevant community person (including homemakers, home-care liaison workers, hospital-based staff from a regional geriatric program, and staff from rehabilitation facilities) and the attending physician as core participants. One discharge manager explained that "if we had to involve outside resources...depending on what their schedules and case loads were like, that could cause delays just because they couldn't get down to us right away." The other said, "Physicians do not like to participate too early in the discharge-planning process."

Although the initial assessment using the OSCA was completed for 100% of patients at both hospitals, it was not completed within 3 days of admission for 64% of patients at the university hospital and 30.4% of patients at the community hospital (see Table 2). The higher percentage of delayed completions at the university hospital can be accounted for by the complexity of those patients' medical conditions. They had an average of 2.7 co-morbidities, as compared to 0.8 for patients at the community hospital. Hence, more of them could not be interviewed early in their hospitalization. Furthermore, a higher percentage of patients at the university hospital did not speak English (28.0% vs. 8.7%), and the greater need for interpreters there caused delays.

The discharge managers at both sites were able to use the process outlined in the IMDP to generate a workable discharge plan for all patients. The plans were reflective of the initial and/or ongoing patient assessments.

**Table 2** *Completion of the OSCA*

	University Hospital (%)	Community Hospital (%)
Completed	100	100
Not completed	0	0
Completed within 3 days of admission	36.0	69.6
Completed after 3-day time frame	64.0	30.4

### **Outcomes Evaluation**

**Resource use.** At the university hospital, the core participants required an average of 94.5 minutes over the course of 5.2 meetings to plan for each patient's discharge. At the community hospital, planning for each patient's discharge required an average of 139.4 minutes over the course of 4.4 meetings. Almost all of the difference in discharge-planning time was accounted for by the time spent completing the OSCA (39.4 vs. 72.4 minutes). In both hospitals, the average amount of time spent per day per patient on discharge planning was relatively small — 6.8 minutes at the university hospital and 19.3 minutes at the community hospital.

The average amount of time that other health professionals were involved was 20.2 and 13.3 minutes, respectively, at the university and community hospitals. These other health professionals included various members of the multidisciplinary team and specialists/consultants. On average, more professionals at the university hospital were required to elaborate the final discharge plan than at the community hospital: four versus one.

Patients at the university hospital exceeded the national average length of stay for elderly patients by 3.4 days, whereas those at the community hospital fell short of the national average by 3.3 days. Of the 34 patients reached by telephone at 6 weeks post-discharge, none had experienced a re-admission. However, two patients from the university hospital had experienced a fall: one at home and one during inpatient rehabilitation.

**Respect for persons.** At both sites, patients were involved, across the hospital stay, in more than 70% of the total amount of time required for discharge planning, whereas families were involved approximately 40% of the time. Patients and families were involved more often than either the physician (39% at the university hospital and 4% at the community hospital) or the community person (< 10% at both hospitals).

The majority of patients and all family members were satisfied with the discharge-planning process. Three patients at the university site who were not satisfied stated, respectively:

*Not a piece of cake, you know. I was told to go, that's it. I was planning to stay till my legs were down to normal size but Dr. C. insisted that I had to go.*

*I'm not satisfied. The doctor said that I had to go. I'm still sick but they said that I had to go. I had no choice.*

*They told me I'm going home and I said okay. What I say no matter.  
Nobody believed me. [crying]*

These were the only disagreements noted throughout the entire discharge-planning process.

Patients were satisfied with the process for a variety of reasons: people were kind, they got to decide, there was nothing to complain about, and they got to go home. Family members were satisfied because they were involved with the discharge planner in making decisions and were provided with information. They also said that the planning was well done, they were prepared, and they knew what to expect. One patient's son said:

*We — my sister and me — were presented with the options. My father was given the choice to decide which decision was best for him. We did not want him to think that just because he was old we were going to put him away in a nursing home. Everyone was very supportive and encouraging. There were no surprises. We were kept very informed.*

Results were somewhat equivocal with regard to the discharge managers' satisfaction. The university site manager favoured the model because it articulated the steps in planning, made it easier to describe the plan to someone else, and ensured standardization of practice. The community site manager rated the protocol as "very good" but expressed the following concerns: too much documentation; protocol difficult to incorporate into daily activities because time required for assessment; and large case loads made it difficult to utilize the IMDP.

Overall, the final discharge plans developed in hospital were adequately meeting patients' needs at 6 weeks post-discharge. However, four patients said that they would like to have more help in the following areas: housework, nursing care, and medical care.

### Discussion

Caution must be exercised regarding any generalizability of the results because of the limited number of hospital and patient cases. Also, there were no control units allowing us to confidently claim that the results were a direct consequence of the IMDP. Furthermore, the discharge managers had many years of experience in this role. Therefore, it is possible that our results were a reflection of their skilfulness rather than the IMDP itself.

### *Process Evaluation*

The results of the process evaluation confirmed the findings of our pilot study (LeClerc & Wells, 2001): that the IMDP can be operationalized in practice. For patients with several co-morbidities, however, the 3-day time frame to complete the initial assessment may not be achievable. Patients with a number of co-morbidities or those who do not speak English would likely delay the assessment process. Future research could determine whether these factors influence length of stay.

Involving community personnel and the physician in the process was a challenge. This did not negatively affect the quality of the discharge plans for the patients reached on follow-up in our study. However, we believe that their involvement positively affects patient satisfaction with the outcome. Computer technology may facilitate the early and ongoing involvement of community personnel and the physician by virtue of not requiring their physical presence.

### *Outcomes Evaluation*

*Resource use.* Overall and on a daily basis, discharge planning is not a time-consuming process, despite the common understanding. The most time-consuming portion of the planning process is the initial assessment. Yet if this critical component of planning is compromised it may be to the detriment of the final plan and other patient outcomes. Hospital administrators must consider appropriate case loads to allow for this activity. Also, a future study might examine whether and how individual characteristics of patients and/or discharge managers affect the length of time taken for various protocol activities.

Other health professionals were used less efficiently at the university hospital than at the community hospital (20.16 vs. 13.26 min.), which may be explained by the discharge manager's communicating with professionals during team rounds rather than on an as-needed basis, as prescribed by the IMDP. The challenge for those interested in implementing the IMDP may be to rethink current patient-care practices that employ regular team meetings as the primary mode of communication and decision-making, which may be inefficient from a time perspective.

For those patients we were able to contact via telephone, we found no untoward effects associated with the IMDP's implementation and at 6 weeks post-discharge except for falls in two patient cases. However, we are unable to conclude that the IMDP provides for a safe discharge



plan, given that we lack information on the post-discharge experience for 14 patients in the study.

**Respect for persons.** Patients can assume a central role in discharge planning, with their input sought at each stage of decision-making. The patient's situation can be captured in a way that ensures a workable and sustainable plan at discharge through the use of the OSCA and regular meetings. Even though it may be seemingly inconvenient, community persons and the physician must be involved, because the information they can provide is essential to patients' and families' informed decision-making.

The majority of patients and families were satisfied with the process because of their involvement and their being well informed, factors also noted by LeClerc and Wells (2001) and Bull et al. (2000). Despite one discharge manager's concern about the time-consuming nature of the IMDP, it would not be prudent to change the protocol, given the positive outcomes reported for patients and families.

### Conclusions

The IMDP offers a promising approach to the discharge of elderly patients in that it is comprehensive; resource-efficient in terms of patient, family, and professional involvement; and respectful of persons. It seems that open communication can be balanced with concerns about conserving resources. In moral or ethical terms, the IMDP provides a fair method of making discharge decisions, and it respects the right of elderly patients to become involved in planning and decision-making. It also constitutes a way to ensure accountability with regard to discharge planning. The next logical step in the study of this model is further evaluation in the Canadian and broader context with a larger sample and an experimental design.

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<b>Appendix 1 Discharge Planning Practice Protocol: Protocol Elements, Sequence of Activities, and Timing of Activities</b>		
<b>Protocol Element</b>	<b>Sequence of Activities</b>	<b>Timing of Activities</b>
1. Assessing the discharge situation	<p>A. Conduct pre-admission and/or admission assessment of the patient and family (use "One Stop Access Client Assessment" form).</p> <p>B. Through personal communication, discuss and determine the initial expectations of the following persons about the patient's discharge needs and goals:</p> <ul style="list-style-type: none"> <li>• the patient and the family member most responsible for assisting with the discharge</li> <li>• the attending doctor</li> <li>• the relevant community person</li> <li>• other health professional(s) directly involved in the care of the patient.</li> </ul>	<p>Within 3 days of admission</p> <p>Within 3 days of admission</p>
2. Developing and writing initial discharge plan	<p>C. With the community person, provide the patient and family member with information about programs and services that can potentially meet their needs at discharge and determine the basis of their preferences.</p> <p>A. Ensure that the patient, family, attending doctor, relevant community person, and other professional(s) directly involved in the patient's care have the opportunity to provide input into the writing and discussion of the initial discharge plan.</p> <p>B. Write the initial discharge plan (use "Initial Plan" form).</p>	<p>Within 3 days of admission</p> <p>Within 3 days of admission</p> <p>Within 3 days of admission</p>

<b>Appendix 1 (cont'd)</b>	
<b>Protocol Element</b>	<b>Sequence of Activities</b>
<b>Protocol Element</b>	<b>Timing of Activities</b>
3. Involving consultants in the patient's care and discharge plan	<p>C. Negotiate and confirm initial plan with all those involved in the patient's care (see 2A).</p> <p>D. Record all meetings/contacts with participants (use "Discharge Planning Meetings / Contacts" form).</p> <p>A. Ensure timely referral to consultants identified as important to the patient's care by those directly involved in that care (see 2A).</p> <p>B. Through personal communication, determine the consultant's expectations regarding the patient's discharge needs and goals.</p> <p>C. Record all meetings/contacts with consultants (use "Discharge Planning Meetings/Contacts" form).</p>
4. Developing, writing, and modifying the updated discharge plan	<p>A. Ensure that the patient, family, attending doctor, relevant community person, other professional(s) directly involved in the patient's care, and consultants have the opportunity to provide input into the development, writing, and modification of the initial discharge plan.</p> <p>B. Write the updated discharge plan (use "Updated Plans" form).</p> <p>C. Negotiate and confirm updated discharge plan with all participants (see 5A).</p>



<p>D. Record all meetings/contacts with participants (use "Discharge Planning Meetings/Contacts" form).</p>	<p>At time of meeting/contact</p>
<p>E. Monitor updated discharge plan so that it is congruent with knowledge about the patient's evolving clinical, social, and functional condition.</p>	<p>As knowledge about the patient's clinical, social, and functional condition emerges</p>
<p>F. Modify the discharge plan as new information is obtained, in collaboration with participants immediately involved in the patient's care (use "Updated Plans" form).</p>	<p>Within 24 hours of receiving new information</p>
<p>5. Developing and writing the final discharge plan</p>	<p>48 hours prior to discharge</p>
<p>A. Coordinate the involvement of patient, family, attending doctor, relevant community person, and other professional(s) directly involved in the patient's care in negotiating and writing the final discharge plan.</p>	<p>48 hours prior to discharge</p>
<p>B. Write the final discharge plan (use "Final Discharge Plan" form).</p>	<p>48 hours prior to discharge</p>
<p>C. Negotiate and confirm the final discharge plan with participants.</p>	<p>48 hours prior to discharge</p>
<p>D. Record all meetings/contacts with participants (use "Discharge Planning Meetings/Contacts" form).</p>	<p>At time of meeting/contact</p>
<p>E. Ensure that medications, treatments, and supplies and other services are available and will be in place at discharge.</p>	<p>48 hours prior to discharge</p>
<p>F. Ensure that the discharge order is written.</p>	<p>24 hours prior to discharge</p>

Appendix 1 (cont'd)	Sequence of Activities		Timing of Activities
Protocol Element	Sequence of Activities		Timing of Activities
6. Implementing and monitoring the discharge plan post-discharge	<p>G. Determine the readiness of the patient and family for discharge. Do they have a good understanding of the medical condition and related treatments, and of the programs and services that will be provided at discharge?</p>	48 hours prior to discharge	
	<p>A. Maintain telephone contact with patient and family (initiated by discharge director and/or by patient and/or family), in order to:</p> <ul style="list-style-type: none"> <li>• monitor patient's progress and the appropriateness of the final discharge plan,</li> <li>• modify plan with the community-based professional who is involved, and</li> <li>• record patient and family events post-discharge.</li> </ul>	Contact at 2 and 6 weeks post-discharge	