

## What you should know about the discharge process

Discharge planning is a process that involves the patient, carer, family and any staff involved in the patient's care. The aim of discharge planning is to ensure a safe and smooth discharge from hospital - whether to home, residential care or another location.

Discharge planning is meant to start when patients are admitted (or even before), as the initial assessments can be used to highlight areas that will need consideration on discharge. In reality discharge planning often occurs at the last minute.

It is important for carers and families to have input into discharge planning. Ask for a discharge planning meeting, which should be held at least a day before discharge. Your family member's GP could also be involved, receiving a scheduled fee under Medicare for their time.

Discharge planning meetings may involve discussions about future care needs, equipment required, services available, referrals for ongoing therapy, follow-up appointments, medication changes and anything else that you may need to know when your family member is discharged.

## Discharge - a wider range of options

There is a range of discharge options available to older people that are worth considering. The social worker or aged care team can provide information on these and other services and organise for your family member to be assessed. These options include:

### Rehabilitation

- ▣ Active rehabilitation, usually at a faster pace than GEM.
- ▣ Anticipates capacity for faster recovery.
- ▣ Can be provided at an inpatient rehabilitation centre, in the person's home or as a day patient. The location will depend on the needs of the patient and the services available.

### Palliative care

- ▣ End-of-life care for people who are dying.
- ▣ Can be provided in hospital, at a hospice, in residential care or at home, depending on care needs and support available.

### Community care packages

- ▣ A package of services tailored to meet the individual needs of people wishing to remain living in the community.
- ▣ Services may include respite, personal care and home care.
- ▣ Coordinated by a case manager who organises care and support for the older person and their carer.

## Teamwork - services plus family support

Working together as a team and sharing the care of your family member can make the seemingly unworkable work. This might include one or more of the above services, but the key factor is the planned and regular support of family and friends.

How to do some planning for this:

- ▣ Hold a family meeting. Invite your GP or other health professionals. Discuss the challenges and plan around these.
- ▣ Ask each family member to be open and honest about the level of commitment they can offer.



- ☒ Make a list of all care needs and when support is required.
- ☒ Divide up the tasks and draw up a family roster.
- ☒ Organise referrals to any services you will need. Be realistic about the level of service available - it may be limited.
- ☒ Make a back up plan for days when things go wrong.

Patients being discharged from a public hospital to home may also be eligible for the Transitional Care Program. This provides short-term (usually 2-4 weeks) support to patients and carers and may include home care, personal care, community nursing or in-home respite.

## What is a discharge summary?

Upon discharge, the patient's GP is sent a discharge summary. This records the reason for admission, any investigations, the treatment provided, any new medications and the required monitoring.

Sometimes however, patients will see their GP before the discharge summary has arrived. To avoid this, make sure that your family member receives a nursing summary and a list of medications on discharge. This can be taken with you to the next GP appointment.

## Further information:

- ☒ [Territory Palliative Care](#) - ph: 8922 6761 (Darwin Office)
- ☒ [Community care packages](#) - information sheet.
- ☒ [Aged care assessment in hospital - what you need to know](#) - information sheet.
- ☒ [How and why to hold a family meeting](#) - information sheet.
- ☒ [Don't forget to make a back up plan!](#) - information sheet.

Contact the [Commonwealth Carer Resource Centre](#) on 1800 242 636\* to request the above information sheets be sent to you - or to find out about other information sheets in this series.

\*Free call except from mobile phones. Mobile calls at mobile rates.

We do our best to keep these links up to date, but the internet changes all the time. If you can no longer access any of the above resources, please go to our [Internet Troubleshooting Guide](#), or email us at [website@carersvic.org.au](mailto:website@carersvic.org.au)