Guidelines for Discharge Planning for People with Mental Illness

These procedural guidelines for the discharge of people requiring ongoing treatment and community support, have been developed by the Mental Health Services Section of the Ministry of Health and issued on the instructions of the Minister of Health. They provide an outline of the services and considerations required of mental health clinicians for this group and form the basis for the development of protocols by each mental health service. Protocols are to be subject to approval and audit by RHAs and the Ministry of Health.

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MINISTRY OF
HEALTH
MANATŪ HAUORA

Foreword

Government has asked for processes to be put in place to ensure that when people with psychiatric disorders leave hospital they receive adequate treatment and care in the community. Discharge planning is an essential prerequisite to achieving this outcome.

These guidelines have been developed by the Ministry of Health to set out the basis for good practice in discharge planning. Using the guidelines each hospital that treats people with mental disorders is expected to put in place its own discharge planning protocol. The protocols will be monitored by regional health authorities and the Ministry of Health.

In these guidelines emphasis is placed on each patient having an identified key worker, both in hospital and after discharge, where follow-up treatment and care is needed. This provides accountability for active planning and management of each patient's needs.

As well as discharge planning there are other processes now in place for addressing community placement of long-stay patients of psychiatric hospitals. These are:

- establishing the principles that underlie the deinstitutionalisation process
- designating a senior Ministry of Health official to co-ordinate and monitor the process
- establishing an interdepartmental advisory group
- requiring financial and service development plans to be prepared for each hospital that is intending to close a long-stay psychiatric ward
- requiring this planning to specifically address issues for Mäori including reporting requirements in the RHA funding agreements.

The adequacy of community treatment and care must be an important consideration in any decision to discharge a patient from hospital. This has not always been the case in the past. with greater attention to discharge planning and with better information and monitoring systems the situation can be improved for people with psychiatric disorders who leave hospital in the future.

Rt Hon WF Birch
Minister of Health

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1 Introduction

Discharge planning is a formal process that leads to the development of an ongoing, individualised programme of care and support which meets the objectively assessed needs of a patient/consumer on leaving hospital. It addresses the social, cultural, therapeutic and educational interventions necessary to safeguard and enhance that person's health and wellbeing in the community.

Discharge planning involves the patient, family, whänau, the treatment team, and other service providers. It is required when a patient leaves any inpatient facility, and it is particularly important in the case of patients with mental health disorders (including substance abuse) who have been in hospitals* suffering from chronic mental illnesses with residual psychiatric disability.

The inpatient multidisciplinary team has the responsibility for developing and documenting an appropriate discharge plan. In the case of patients who are assessed as requiring continuing care and/or support there should be a designated key worker who is responsible for co-ordinating the implementation of the plan.

These guidelines are intended to assist the development of discharge planning for all patients. It is recognised, however, that for patients who are treated voluntarily and who choose not to comply with a discharge plan, it is only the nature and quality of the clinical relationship which can influence this.

* As defined in the Hospitals Act 1957.

2 Purpose

All mental health services in area health boards were requested in May 1993 to forward policies and protocols that are in current use for discharge planning and needs assessment, to the Department of Health Thirteen area health boards responded by 14 June. All 13 boards had procedures in place but there was a considerable lack of uniformity partly due to the differing patient groups with whom they are dealing (eg, some boards were not confronted with the 'deinstitutionalisation' of large hospital populations). Others used overseas protocols without necessarily adapting them to meet priorities in New Zealand.

A degree of flexibility in the types of protocols to be used by different providers is desirable at this stage in order to take advantage of improvements and innovations that are taking place both overseas and in New Zealand.

The Ministry of Health has formulated these guidelines on discharge planning as a basis for the development of comprehensive protocols for each mental health service.

3 Key Principles of Discharge Planning

1 The principal aims of discharge planning are to achieve:

- continuity and co-ordination of care and treatment
- provision and mobilisation of a level of support that will correspond to the assessed needs of the patient for community living
- early intervention during crises and relapse of illness
- optimal health and well-being for the patient/consumer.

2 The strengths and aspirations of the patient and his/her goals for achieving a sense of wellbeing will be identified through maximum possible patient participation in the discharge planning process.

3 Family, whänau, and caregivers should be jointly involved with the patient and the treatment team in developing a discharge plan. This process as well as the discharge options will however be subject to cultural, ethical and legal constraints.

4 Discharge planning must incorporate mental health services that are currently safe for all the people that use them. The patients, when using a service provided by people of another culture, should be able to do so without risk to their own cultural needs.

5 A needs assessment of the patient should be a preliminary step in the development of a discharge plan.

6 Relevant clinical issues need to be addressed in discharge planning.

7 Discharge planning must be individualised for each patient.

8 A designated key worker should be responsible for co-ordinating the implementation of the discharge plan using 'case management' methods. In doing this the key worker must involve persons with extensive knowledge of community services.

9 The service to be responsible for the care of the patient after discharge must be involved in the planning.

10 Managers of mental health services will be responsible for:

(a) regular audits of discharge planning to ensure that there is continuing improvement of its format and implementation

(b) providing an effective 24-hour 'acute response system' for dealing with psychiatric emergencies

(c) ensuring that patients with chronic mental illness are able to re-enter specialised residential care without delay if this becomes necessary on clinical grounds

(d) ensuring that contracts entered into with trusts and private organisations providing residential accommodation must have either approval or registration as set out in the HOMES process.

4 The Process of Discharge Planning

Discharge planning should not be a rushed activity which takes place a day or two before a patient leaves hospital. This does not permit adequate consultation, gathering of requisite information or proper needs assessment. Policies of at least two area health boards indicated that discharge planning should commence soon after a patient is admitted to hospital. The Joint Commission on Accreditation of Healthcare Organisations in the USA requires evidence of discharge planning throughout the treatment planning process. This policy is in keeping with research evidence that a patient's pre-illness level of adaptive social functioning is a better predictor of future (post-illness) functioning than the severity of acute symptoms.

The aim of discharge planning is to address the following areas:

- adequacy of the services to meet post-discharge needs, including highest level of independent function and quality of life possible
- individual level of functioning and response to treatment
- compliance with the discharge treatment programme
- appropriate modification in treatment programmes to reflect changes in the individual's condition with careful monitoring of medication side effects
- appropriate support for family or other care providers.

The following procedure that has been adapted from *Discharge Planning* (Babich and Brown 1991) is recommended. There is an initial treatment plan, a comprehensive treatment plan and a discharge plan.

4.1 Initial treatment planning

The following discharge planning activities should be reflected in the initial treatment plan which starts on admission. This is not intended as an exhaustive list of activities related to discharge planning. It provides guidelines that will be useful in the planning process.

- Involve patient as much as possible in identification of discharge needs and goals.
- Contact family (where appropriate), significant others, GP and/or community treatment team about functioning prior to this episode of illness and the pattern of illness.
- Identify needs and plan goals of treatment and support with patient and others significant to him/her.
- Formulate provisional discharge plan.

4.2 Comprehensive planning

The following discharge planning activities should be reflected in the comprehensive treatment plan.

- Use the initial treatment plan and expand on it.
- Continue the maximum possible participation by the patient and others significant to him/her in the development of the plan.
- Perform individual needs assessment with particular reference to needs on discharge.
- Devise plan based on needs assessment.
- Initiate ongoing contact with community-based follow-up services.
- Initiate illness management training including use of medication. Include family/ whänau or caregiver in education about the disorder and how it affects the patient and his/her family.
- Implement initial steps of discharge plans including patient and key worker visits to possible community accommodation, patient attending community-based services etc.

4.3 Discharge planning

At this stage the following planning activities have been undertaken.

- The key worker/case manager for post-discharge care has been identified.
- Discharge preparation as in the comprehensive plan should have been completed.
- The various needs of the patient's care in the community have been addressed (see initial treatment plan).
- An integrated approach is taken in planning services to meet the patient's needs.
- There is clear communication of the completed plan to the post-discharge key worker/case manager.

4.4 Post-discharge planning

Responsibility for planning after discharge depends on the organisation of the follow-up programme. If ongoing treatment is provided by an agency or individual not associated with the hospital, that agency assumes the responsibility for continued planning and may include the hospital staff as appropriate.

> *'In summary, specific discharge planning activities are important at each stage of treatment planning, including the initial and comprehensive plans that are a part of inpatient treatment. Continued monitoring and planning is required as the patient moves into community-based treatment. Responsibility for ongoing planning after discharge rests with those providing the treatment'* (Babich and Brown 1991).

5 The Content of Discharge Plans

The content of the 'discharge plan' can be summarised into four different components. These are:

- client details
- needs assessment
- service arrangements
- checklist of necessary patient-related and administrative actions to be taken to ensure a well-managed discharge.

5.1 Client details

This information can be taken from the mental health information system and includes:

- name
- DOB
- NHI identifier
- legal status
- summary of hospital admissions
- current residential address
- name of key worker
- name of clinician (if different from key worker)
- record of incident reports (date and reference).

5.2 Needs assessment

There are a number of tools available for needs assessment. A needs assessment schedule (NAS) prepared for the Department of Health by the Christchurch School of Medicine was distributed in 1990. A residential rehabilitation assessment format developed for use at Ngawhatu Hospital from January 1993 is attached as Appendix 1.

An assessment working group has been set up as part of disability support services (DSS) reform. It is developing protocols for assessment processes for all people with disabilities, including people with psychiatric disabilities. These protocols will be finalised by 30 June 1994.

The needs assessment process used for discharge planning should ensure the following areas are addressed.

1 Strengths and aspirations

Needs assessments often tend to be lists of handicaps and disabilities. Identifying the strengths and aspirations of the patient and assisting him/her to formulate realistic goals is critical to the success of rehabilitation.

2 Clinical needs

An individual patient has particular needs for appropriate treatment which depend on the nature of the condition(s) from which he/she suffers. These should be identified and procedures for meeting them specified.

The clinical needs can be compiled from case notes or a case summary and from the initial and comprehensive treatment plans. These needs include:

- diagnosis and clinical problem list
- precipitants to illness
- pre-illness level of functioning
- treatment history, and response to treatment
- capacity and willingness of the patient to co-operate in the safe administration of treatment
- willingness of the patient to be involved in discharge planning
- identification of factors that may predispose to relapse of illness
- family understanding of illness and treatment
- family needs related to illness
- specification of recommended further treatment and monitoring procedures
- identification of the procedural requirements where compulsory treatment is undertaken pursuant to the Mental Health (Compulsory Assessment and Treatment) Act 1992
- education of the patient and caregivers with regard to treatment, including side effects of treatment
- identification of risk factors which predispose the patient to distress, relapse of illness or behaviour which may endanger him/her or the public
- specification of procedures to deal with risk factors and adverse incidents
- specification of dates for clinical reviews.

3 Generic needs

All patients who move into community living situations have basic needs that should be identified using needs assessment and they should be considered in developing discharge plans.

(a) Living arrangements

- Living situation prior to hospitalisation.
- Adequacy and the availability for return to living situation.
- Housing (and type).
- Capacity to manage daily living activities.

- Supervision, support (family, health professional, other).
- Encouragement and skill development for achieving an adequate level of independent functioning.

(b) Economic needs

- Education or employment opportunities.
- Work skills development.
- Accessing appropriate income support.
- Budgeting assistance.

(c) Personal health care

- Timely and affordable access to primary health care services and specialist health professionals as required.
- Access to dental examinations and treatment.

(d) Social, cultural and spiritual needs

- Opportunities for meaningful social, cultural and religious activities including leisure activities.
- Social skills and leisure skills development programmes.
- Opportunities to participate in self-help groups and survivor networks.
- Facilitation of family, whänau and iwi support.

5.3 Service arrangements

For each area of identified need there should be a statement about:

- the service to be provided, or
- the action to be taken.

A general service plan is a way of recording this information. An example of a plan currently in use at Ngawhatu Hospital is attached as Appendix 2.

The complexity of discharge planning in the case of persons with multiple or complex disabilities makes the co-ordination of necessary services a critical issue. This is best managed by a suitably skilled key worker/case manager who would ideally be from a community mental health team.

Good case management will include such factors as:

- treatment of co-morbid conditions such as alcohol and drug abuse, which may lead to the patient being at risk
- active follow-up when scheduled appointments are missed or when even minor adverse incidents are reported

- efficient information systems that can identify patients currently at risk (eg, patients of concern, patient alert). Records should be readily available.

5.4 Checklist

A predischarge or discharge checklist is a useful way of ensuring that all necessary actions are taken to make arrangements for the patient's discharge, notify all concerned parties and to ensure that patient information systems and hospital administrative procedures are updated.

Two examples of checklists are attached as Appendix 3.

6 Information Systems and Monitoring Patients

A significant difficulty in the discharge and community treatment and support is monitoring the whereabouts of patients to ensure that they continue to have access to the necessary services. Information systems need to be developed or improved to enable this.

Mental health services information systems:

- should ensure that details are kept of each patient who is to be discharged and requires ongoing community treatment and support
- must be kept current by mental health providers to record personal details such as:
  - name
  - DOB and NHI identifier
  - date of discharge plan and file reference
  - legal status
  - current residential address
  - name of key worker
  - a record of incident reports (date and reference)
- need to facilitate access to each patient's file/case notes for follow-up purposes
- should record all attendances/follow-up activities and active follow-up used if the patient has not attended
- should review, at least six monthly, the patient's clinical state and aspects of care outlined in their individual plans and a record made as to whether the patient remains on the information system
- should remove the patient from the information system only in response to the patient clinical review or if the patient formally transfers to another psychiatric treatment service. The date and reason for removal must be recorded.

Patients who are not subject to compulsory treatment orders are free at any time to discharge themselves from treatment. However, due to the nature of mental illnesses and some patients' limited understanding of the consequences of ceasing treatment, it is important that every effort be made to continue to maintain contact and offer the necessary treatment services.

Regional health authorities will be ensuring the development of appropriate information systems by psychiatric services with whom they contract, in their region. They should also ensure that the information systems, where appropriate, can relate to each other and access care information for a central file. This will enable integration of services and continuity of care for patients.

Reference

Babich KS, Brown L (eds). 1991. *Discharge Planning*. New Jersey: Slack Inc (ISBN 1/55642/201/6).

Appendix 1:
Residential Rehabilitation Assessment Format

Personal management	1.0	Physical care
	1.1	Safety/emergency
	1.2	Use of medication
Home management	2.0	Cleaning
	2.1	Care of clothes
	2.2	Maintenance
Meal preparation	3.0	Planning
	3.1	Shopping
	3.2	Cooking
Budgeting	4.0	
Transport and travel	5.0	
Leisure skills	6.0	
Community skills	7.0	
Social and personal skills	8.0	
Occupational/vocational skills	9.0	

Score

1 = Yes

2 = Yes with prompting

3 = No

Comments as required

Personal management

1.0 Physical care	Date				Initial comments
Can you manage self-grooming? This includes: teeth, showers/ baths, clothes and general hygiene					
Are you able to recognise the need for, and make appointment for physical needs (ie, doctor, dentist, etc)?					
Can you apply simple first aid (eg, to cuts, sprains, etc)					

1.1 Safety and emergency skills	Date				Initial comments
Can you use household appliances and equipment safety?					
Do you seek assistance when necessary?					
Do you know the appropriate person/service to contact in an emergency?					
Can you relay necessary information to emergency contacts?					
Are you safety conscious in your home?					

1.2 Use of medication	Date				Initial comments
Do you take the required amount of medication?					
Do you take your medication at the correct time?					
Do you understand the reason for taking your medication?					
Do you understand the consequences of not taking your medication correctly?					
Do you understand the side effects and precautions?					
Do you recognise the symptoms of oncoming illness?					
Can you ask your doctor for a review of your medication?					

Home management

2.0 Cleaning	Date				Initial comments
Do you keep a tidy bedroom (vacuum, make bed, change linen)?					
Do you keep a cleaning living area (sweep, mop, dust, vacuum)?					
Do you keep a clean kitchen (wipe benches, clean stove/oven, dispose of garbage)?					
Do you keep a clean bathroom (bath, shower, sink, washbasin, toilet)?					

2.1 Care of clothes	Date				Initial comments
Do you wash, dry and iron clothes according to the instructions on the label?					
Can you use a washing machine and dryer?					
Can you use a laundromat?					
Do you purchase personal items (clothing) as required?					
Can you do simple sewing repairs to clothing (buttons)?					

2.2 Maintenance	Date				Initial comments
Can you change a light bulb?					
Can you replace a fuse?					
Can you locate and turn off the power main?					
Do you know who to contact for general/emergency repairs?					
Can you clean a blocked sink?					

Meal preparation

3.0 Planning	Date				Initial comments
Can you prepare a menu appropriate to the number of people eating the meal?					
Can you prepare a shopping list for a given menu?					
Can you adhere to a weekly food budget?					
Can you plan a balanced menu?					

3.1 Shopping	Date				Initial comments
Can you choose the appropriate shop for your needs and locate the items you need?					
Do you compare prices and check used-by dates?					
Do you buy appropriate quantities?					
Do you seek assistance if required (from other residents, staff or shop assistants)?					
Do you select the amount of money required to cover the cost and check change?					

3.2 Cooking	Date				Initial comments
Can you prepare different size menus (snacks, simple or difficult meals)?					
Can you understand and use kitchen equipment (oven, microwave, scales, blender, utensils)?					
Can you follow a recipe (noting cooking time, preparation time, items required)?					
Can you set the table?					
Do you clean up after cooking?					

Budgeting

4.0	Date				Initial comments
Do you know what you earn?					
Can you estimate the cost of items?					
Can you budget your total income and identify priorities (eg, bills, rent, food, etc)?					
Can you manage personal banking (eg, use bank book, automatic teller, cheque book)?					
Are you able to save for specific items?					

Transport and travel

5.0	Date				Initial comments
Can you use public transport on familiar and unfamiliar routes?					
Do you seek help from others if necessary (eg, the Met, drivers, others)?					
Can you plan trips effectively?					
Do you drive and maintain your own car/motorbike/bicycle?					

Leisure skills

6.0	Date				Initial comments
Do you have an interest at the moment or are you actively playing sport?					
Are you currently pursuing any hobbies?					
Do you use any community recreation facilities?					

Community skills

7.0	Date				Initial comments
Can you use public telephones?					
Can you use the phone book?					
Are you aware of the location of main council and government service agencies (eg, DSW legal advice, NZ Employment Service)?					
Do you feel you know your rights as a citizen (eg, re voting)?					
Can you locate and use local facilities (eg, shops, restaurants)?					

Social and personal skills

8.0	Date				Initial comments
Can you identify realistic personal goals?					
Can you initiate and maintain conversations?					
Are you able to establish and maintain relationships?					
Can you recognise the need for others' personal rights and space?					
Do you demonstrate assertiveness and self-confidence when necessary?					
Can you cope with problem-solving and decision-making?					

Occupational/vocational skills

9.0	Date				Initial comments
Have you identified realistic employment options?					
Have you sought out avenues to develop vocational skills or to obtain employment (voluntary or paid)?					

Appendix 2: Kowhai General Service Plan (Ngawhatu Hospital)

Attach label:

Patient's name:

Status:

Step 1: Profile

1) Note only *major* problems under the five headings:

- Self care
- Non-violence
- Social contact
- Communication
- Responsibility

2) OTs MOHO and COTE models assist in noting person's *main* strengths and weaknesses:

- Strengths
- Weaknesses

Step 2: Needs analysis

Note *major* unmet needs:

<table>
<tr><td colspan="2">• Health
• Housing
• Income
• Employment
• Social
• Recreational
• Legal
• ADL
• Transport
• Educational</td><td></td></tr>
<tr><td colspan="2">(Mutual Care) – has family or significant others available?</td><td></td></tr>
<tr><td colspan="2">(Professional Care) – consider usual Kowhai input, which quadrant?</td><td rowspan="3"></td></tr>
<tr><td>Acute</td><td>Rehab</td></tr>
<tr><td>Safe care</td><td>Deinstn (longer term)</td></tr>
</table>

Step 3: Actions

- Consider various ways to meet the person's needs
- Note actions to be taken (by whom, by when) under headings derived from needs analysis.
- Note review date for specific actions and for review of whole GSP.
- Sign the GSP at end of this section (Note Participants).

Actions

Social worker's assessment

Interim reviews

Action no.	Evaluation and recommendation

6/12 OT/NSG progress report

(i) LSP-based comments by nurse	
(ii) MOHO/COTE-based comments by OT	

Appendix 3: Checklists

* Communicate plans as soon as possible to key people. *

Kowhai discharge checklist (Ngawhatu Hospital)

☐3 ☐7 and/or comment on each box.

Patient's name.....

Status .....

Case manager.....

Key worker(s).....

☐ Patient (well-informed, knows case manager, key worker's names, phone numbers)

☐ Case manager – key worker(s) liaison

☐ Patient's family (well-informed, as above)
- Significant others
- Next of kin
- Property manager
- Welfare guardian

☐ Caregiver
- Patient signed release of information form
- Discharge transport arranged

To caregiver:
- Medical hx:
  (risks, vulnerability, diagnosis, idiosyncracies and recommended responses)
- Information sheet – include *series* of contact numbers (case manager etc so they can always find someone)
- Community card, other membership cards, valuables (record on property sheet, patient to sign)

☐ NS advisor informed
(Mention manager–employee organisation agreements re discharge of long-term patients)

☐ MDT (in-unit members)
- medical officer
  – CTO
  – Discharge letter(s)
  – Prescriptions
- psychiatrist
  – OPD appointment
- Occupational therapist

– Programme
– ORA liaison

- Social worker

– Finances
– DSW
– Public Trust
– Property manager
– Welfare guardian
– Cashier/trust officer
– GP

☐ Admin

- Medical information officer

– Community services card

- Cashier/trust officer

☐ Paramedical

- Psychologist
- Dentist
- Physio
- Dietitian

☐ In-unit administration

- Nursing notes
- Medication cards (top of file)
- IMI and TMT sheets
- SCU records
- Data card
- Patient sign property sheet as okay

} Collate and send latest file
Older file(s)

- Ward daily report
- A/discharge book including:

– case manager
– key worker
– meds
– IMI due
– OPD appointment
– new address/contact number

- Medications ordered

– fax med chart to pharmacy
– fax unsigned $_{RX}$ to pharmacy (specify number of tablets, indicate type of leave. If discharge do five-day Rx. Note date leave starts. Send signed Rx via yellow bag).
– five-day Rx
– 2/52 Rx

– stock book

- Delete name from fire board:
  – bed state boards (2)
  – dining board
  – med tray
  – file cover (red file)
  – file divider (cabinet)

☐ Comments
(date and initials)

Predischarge checklist (Porirua Hospital)

Confidential

Patient's sticky label

Villa:.....

Accommodation:

(a)		Client choice:	Family recommendations:
	– Area		
	– Level of support		

(b) Clinical team recommendations:
– area
– level of support

Type of day activity required

(a) Client choices

(b) Clinical team recommendations

Expected date of discharge:.....

Name of primary caregiver:.....

Psychiatric review

Tick when completed

- ☐ Date of first admission.....
- ☐ Date of last admission.....
- ☐ Number of admissions .....
- ☐ Notes reviewed date .....
- ☐ Last patient reviewed date.....
- ☐ Last medication reviewed date.....
- ☐ Typed case summary completed date.....
- ☐ Manchester scale completed date .....

Problem list:

Early signs of relapse:

DX DSM IIIR

I
II
III
IV
V

Medications :

Name of outpatient doctor (psychiatrist):.....

Tick when completed

- ☐ Transferred to community treatment order if required.....
- ☐ Doctor notified of patient's discharge and medical responsibility transferred Date:.....
- ☐ Letter to outpatient's psychiatrist Date:.....
- ☐ Script written Date:.....

Doctor's name and signature:.....

Medical review

- ☐ Full physical examination Date:.....
  By whom:.....

Special tests and examinations specify:

- ☐ 1. Date:.....
- ☐ 2. Date:.....
- ☐ 3. Date:.....
- ☐ 4. Date:.....
- ☐ Glasses/contact lens Date:.....
- ☐ Hearing aides Date:.....
- ☐ Others (specify) Date:.....

.....

Dental review

Name of dentist:.....

- ☐ Examination Date:.....
- ☐ Dentures Date:.....
- ☐ Plates Date:.....

Social

Next of kin (family/whänau/significant other)

Name:.....

Address:.....

.....

Phone number:.....

- ☐ Next of kin (family/whänau/significant other) notified of discharge date Date:.....
- ☐ Chaplain notified of discharge date Date:.....
- ☐ Name of chaplain:.....

Skills acquisition

These skills needs to be taught and practised on a regular basis. (Some clients will not be able to acquire or practise some of these skills due to some physical disability.)

Domestic

Can make a:			Regularly given opportunity to make:			
	Yes	No		Yes	No	Frequency
Hot drink Sandwich Breakfast			Hot drink Sandwich Breakfast			
Washes Dishes Clothes (in a washing machine)			 Dishes Clothes			
Makes own bed			Makes own bed			

Safety

	Yes	No	
Knows the name of medication			Length of time
Is self medicating			

What method of self-medicating is being used?.....

Community

Can use:			Regularly given the opportunity to use:			
	Yes	No		Yes	No	Frequency
Public transport: • Bus • Train • Taxi The telephone • Card phone • Coin phone			Public transport The telephone • Card phone • Coin phone			
Can cross road safely			Cross road			

Financial/legal

Tick when completed	Benefits applied for and date application sent to DSW:		
☐	1.		Date:.....
☐	2.		Date:.....
☐	3.		Date:.....
☐	Birth certificate obtained	Yes/No	Date:.....
☐	IRD number obtained	Yes/No	Date:.....
☐	Clothing allowance obtained	Yes/No	Date:.....
☐	Bank account opened	Yes/No	Date:.....
☐	Benefit paid into bank account		Date:.....
☐	Money from hospital trust fund paid into bank account		Date:.....
☐	Public Trust notified of discharge		Date:.....
☐	Community services card obtained		Date:.....
☐	Understand the concept of money		Yes/No
	PPPR Act applied for:		
	• property		Date:.....
	• welfare		Date:.....
☐	A will is required	Yes/No	Date:.....
☐	Will has been made	Yes/No	Date:.....
☐	Client wishes caregivers to have list of significant contacts		Yes/No
☐	Funeral arrangements :		

Documentation

Tick when completed

- ☐ Accommodation referral sent Date:.....
- ☐ General practitioner discharge letter sent Date:.....
- ☐ Psychiatrist referral sent Date:.....
- ☐ District nurse referral sent Date:.....

Day activity referrals sent. Specify:

- ☐ 1. Date:.....
- ☐ 2. Date:.....
- ☐ 3. Date:.....

Other referrals sent for specialist follow-up. Specify:

- ☐ 1. Date:.....
- ☐ 2. Date:.....
- ☐ 3. Date:.....

Outpatients appointments made:

- ☐ Psychiatrist Date:.....
- ☐ District Nurse Date:.....

Others (specify)

- ☐ .....
- ☐ .....
- ☐ .....
- ☐ Nursing notes and file completed
- ☐ Ward daily report completed
- ☐ Entered in discharge book
- ☐ Bed list adjusted
- ☐ Fire list adjusted

Resident's property

Property list : Date:

The above property is in the client's possession on discharge.

Signed:..... Date:.....