



MOOD DISORDERS ASSOCIATION OF MANITOBA INC.

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WHAT WE NEED TO KNOW ABOUT HOSPITAL DISCHARGE PLANNING

Discharge planning is when a specific plan is made for what happens with a recovering person when they leave the hospital.

Family members need to know that Discharge Planning for a patient with a mental illness is an important part of psychiatric nursing care. Discharge planning should begin as soon as possible after someone has been admitted to hospital.

A patient's discharge plan may involve a number of people. Overall coordination of the plan, however, should be the responsibility of one person -- a designated nurse, case manager, team leader, social worker, or other team member -- depending on the hospital's patient care system. It is important to find out who this "person in charge" is.

The "Discharge Checklist" (see below) can help families make sure that the six main areas essential to a good discharge plan are covered. These six areas are:

Medication - It is a good idea to list medication information on the form as soon as you know what it is. Any information the professionals give you about the medication is also good to write down and keep track of. This hopefully will include instructions about dosage, times and any special instructions - such as the need to take the drugs with food or milk. This information is generally given by doctors or registered nurses, but anyone helping the ill person can help encourage them to take their medication and follow the instructions. This is particularly important because stopping taking antipsychotic medications is a frequent cause of relapse and rehospitalization.

Residence - Planning a suitable place for the person to live after they leave hospital can help give patients with mental illness the basic support they need to remain in the community and to avoid having to be readmitted to hospital. Some boarding homes will help make sure the person takes their medication while others do not. Group homes may expect clients to be able to be responsible for their own medication.

Follow-up Community Care - Continuity of care (where necessary information is passed on to new people working with the person who need it.) and medication monitoring are necessary for all people with severe mental illness such as schizophrenia. As well as an appointment with

a private or team psychiatrist, some patients may require referrals to day programs, support groups, or alcohol and drug misuse programs.

Activities of Daily Living - Most people with a severe mental illness must relearn social skills. These and other basic life skills and retraining are important aspects of recovery for people with schizophrenia. This is called 'psychosocial rehabilitation'. All psychosocial rehabilitation options should be written on the discharge planning sheet.

Follow-up Physical Health Care - Despite the fact that they see doctors more frequently, psychiatric patients are more likely than the general public to have physical illnesses. Psychiatric symptoms can cause patients to neglect physical health problems, so follow-up care in the community is important to help them look after their health and prevent illness. This should include dental care and eye care.

Education, Financial Assistance, and Other Needs -

Before leaving hospital, patients must have good basic education to help them recognize symptoms of their illness, as well as birth control options, and prevention of AIDS and other sexually transmitted diseases.

Many people will require help getting transportation to and from aftercare appointments. Some will need help applying for financial assistance and/or GAIN handicap benefits. Necessary arrangements should be called to the attention of appropriate team members, case managers, or community liaison workers.

Hospital Discharge Checklist

1. MEDICATION

- Medication supply/prescription _____
- Number of days medication supplied for _____
- Medication education-drug dosage, time, how to take _____
- Special instructions _____

2. RESIDENCE

- Boarding home _____ Group home _____
- Hotel _____ Nursing home _____
- Family residence _____ Residential care facility _____

Own home/lives alone _____ Other _____

3. FOLLOW-UP MENTAL HEALTH CARE

Mental health team _____

Psychiatrist/therapist _____

Nurse specialist/visiting nurse _____

Psychiatric social worker _____

Community support group _____

Day care program referral _____

4. ACTIVITIES OF DAILY LIVING

Hygiene instructions _____

Activity, rest _____

Activities requiring assistance _____

Safety instructions _____

Work, school, skills training _____

5. FOLLOW-UP MEDICAL CARE

Appointment with GP or specialist _____

Visiting nurse/practitioner _____

Medical clinic appointment _____

Diet/fluid instructions _____

Dental care _____

Special instructions _____

6. SPECIAL NEEDS

STD and AIDS prevention education _____

Symptom recognition education _____

Transportation needs _____

Financial assistance _____

7. ADDITIONAL COMMENTS

- Adapted from A Discharge Checklist, *Journal of Psychosocial Nursing*, 1995

- British Columbia Schizophrenia Society
