DISCHARGE CHECKLIST

Name of Resident: _____

	Date Requested	Date Completed

PRE-DISCHARGE

Role of Clinical Coordinator		
a) Update the MDC Discharge/Transfer Planning Questionnaire		
b) Consult with the Residential Coordinator/designate regarding team members who should be apprised of the pending discharge.		
c) Coordinate transition meeting(s)		
d) Arrange a visit to the proposed community placement (residential and day program), if applicable.		
e) Determine whether the resident, resident's first primary contact/family and/or SDM for Personal Care are in favour of the placement.		
f) Assist in arranging for the community caregiver(s) to spend an appropriate amount of time at MDC becoming acquainted with the resident, his or her programs and identified needs. Visits are to be prearranged and will include no more than three visitors per resident at one time. The transition visits will have a purpose and outlined goal. Visits can occur on the living area if there is a specific goal (i.e. morning routine); however, the resident's privacy must be respected at all times. Transition visits to build rapport should occur off the living area to respect the privacy and dignity of the other residents.		
g) i. Facilitate transitional visits for residents to the proposed community placement (residential and day program). ii. Clinical transitional visits with community service providers will include the accompaniment of MDC care providers unless care provider is a MDC employee who currently works with the resident. iii. Determine together with the resident and the community agency/approved home care providers that once rapport with potential care providers has been established, transitional visits may be planned without the need for MDC care providers to accompany the resident. All visits on MDC grounds require a MDC staff to escort. Off-grounds visits may occur without MDC staff. The Residential Coordinator or designate may, with advance notice, arrange wheelchair transportation and a driver for agencies to take residents for an off-site visit.		
h) May assist Residential Coordinator or designate with completion of Community Discharge LOA Form (CR.43 – Appendix C) prior to any transitional visit outside the Centre without a MDC care provider. The resident's transitional visit and/or LOA to the proposed community placement must not overlap the actual discharge date. If the transitional visit is going well, the resident only needs to return to the MDC on the day of discharge for a brief visit. Exceptions to this must be approved by the respective Program Director.		
i) Ensure documentation in the electronic health record on all the transitional visits including departure information, return information and any untoward events that occurred while on the transitional visit.		
j) Ensure that when a day trip or overnight LOA is planned without the accompaniment of MDC care providers and medication is required, an LOA prescription will be ordered from the Pharmacy prior to the LOA by the Residential Coordinator or designate.		
k) Notify Residents' Trust office, support areas, Nutrition and Food Services, Employment Services and other service areas of overnight LOA, visits and proposed date of discharge through email.		

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		Date Requested	Date Completed
l)	Coordinate a discharge meeting involving all interested parties which may include the resident, the SDM for Personal Care, the resident's first primary contact, the interdisciplinary team from MDC, Community Services Worker and representatives from the prospective placement at which time: ▪ Reports from all disciplines at MDC having worked with the resident are presented. ▪ Information regarding the prospective placement (residential and day program) is shared. ▪ high probability risk variables and appropriate intervention strategies are identified. MDC must be satisfied that intervention strategies are in place at proposed community placement before discharge occurs. ▪ confirmation is given that medical and dental services have been arranged as well as psychiatry, behavioural and/or psychology services, if required. Particulars of the provision of these services is outlined in Agency Discharge Protocol (A-152 – Appendix D). ▪ the discharge process is outlined. ▪ Any other pertinent information is received and discussed. ▪ Outcome documented in the Electronic Clinical Record.		
m)	Provide information to the Chief Executive Officer or designate for approval of the proposed placement. Complete Application for Approval of Discharge Form (CR.21 – Appendix B).		
n)	Order money from Residents' Trust Account for discharge ($100 or other amount approved by Substitute Decision Maker for property).		
o)	Arrange with *Treatment Room Nurse* for a discharge physical appointment to be completed within 2 weeks prior to discharge.		
p)	Ensure that a MDC care provider, along with the resident, attends an initial appointment with a community physician/psychiatrist. A current medication list obtained from Pharmacy prior to appointment is provide to the confirmed physician for purposes of review and provision of prescription. A prescription for all medication and treatment needs must be obtained from the community physician prior to discharge date.		
q)	Arrange for staff on the residential area to prepare the resident's clothing for discharge. If the future community service provider is also an MDC employee, an alternate MDC employee should prepare belongings for discharge.		
r)	Ensure all clothing is sent to Laundry for tagging removal, accompanied by Form CR.47 Valuables & Clothing and Form N.71c Clothing and Discharge.		
s)	Arrange for the resident's files, MAR sheet, clothing sheets, medication record, ID cards and addressograph to be sent to Health Information Services and Pharmacards to be returned to Pharmacy.		
t)	Ensure that Health Information Services forwards the DNA and fingerprints to the SDM.		
u)	Ensure that the Progress Notes are approved and care planning completed in the electronic health record prior to closing the record.		

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		Date Requested	Date Completed
v)	On the day of discharge ensures that the resident has a photo ID (provided by the Systems Coordinator), immunization card (provided by the Treatment Room) and has received $100.00 (or other amount approved by SDM for Property) from Residents' Trust to meet the resident's needs until the money is transferred. Ensures a copy of the Clothing & Valuables Record has been given to the community care provider; the original is retained in the resident's clinical record.		
w)	ensure MDC retains records of discharge planning information which include: • documentation regarding the prospective discharge (e.g. prospective placement, address upon discharge, date of discharge) and; • the names (contact information) of the physician, dentist, and psychiatrist *(*if applicable*)* who will be responsible for ongoing medical, dental, and psychiatric care in the community on the MDC Discharge Information Form Questionnaire.		
x)	assist with organizing the discharge (i.e. transportation, escort, times, etc.)		
y)	on the day of discharge, ensure that, as a continuing resource for information, the resident is provided with a list of contact telephone numbers (residential area phone number, etc.).		

POST DISCHARGE

a)	work with Health Information Services to forward the following information to the community within two (2) weeks of discharge (if not previously sent): • to Community Services Worker: Discharge Planning Meeting & Reports (if applicable) or the Individual Plan if different from the previous referral package; • to Physician and/or Psychiatrist: copy of the Complete History and Physical Exam Questionnaire, Procedures/Surgical and Consultation Report, Diagnosis and Problem Report, Behaviour Support Plan, Immunization Record, Optometry Report, Audiology Report, Psychology and/or Clinical Psychology Reports, copies of pertinent consultation reports and Investigations, i.e., Specialists, EEG, CT, contracted Psychology and/or Psychiatry Reports/Progress Notes, current medications, etc.; • to Dentist: letter containing resident's personal information (i.e. birthday, health numbers) and that information is available upon request; • to SDM for Personal Care: DNA and fingerprints - acknowledgement receipt is required if other than Public Trustee's Office*;* • to Public Guardian and Trustee: Employment and Income Assistance (EIA) and Office of the Vulnerable Persons' Commissioner (VPCO) Offices (if applicable): Outgoing report.		
b)	follow up the discharge for a minimum of six (6) months with phone calls and/or visits to reinforce the positive aspects of the placement and to encourage open communication and early identification of questions/concerns with opportunity for intervention and documents in the inactive electronic health record.		
c)	Ensure the regional Community Services Worker has all relevant information for successful transfer of case responsibility.		