Effective Date: June 14, 1989	TITLE: **DISCHARGE**	POLICY NO. I-25
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OBJECTIVE

To facilitate the coordinated transition from MDC to community living in a manner that promotes individual growth and identifies personal strengths, preferences, needs, required services and outcomes that ultimately enhance their quality of life. The decision to develop a plan for moving to the community is based on the individual's preparedness and individual's/SDM's wishes and the available community placement which meets the individual's needs. Specific transitions may be developed in keeping with the Department of Families.

POLICY

Consistent with The Vulnerable Persons Living With a Mental Disability Act, the following policies for discharge from MDC will be followed:

1. A discharge from MDC will require a comprehensive pre-discharge plan and must include consent of the SDM for Personal Care.
2. The development of a comprehensive discharge plan will require the participation of the resident in collaboration with SDM for Personal Care, family/support network, interdisciplinary care team, community care providers and Community Services Worker.
3. Community placements must be compatible with the resident's wishes and needs in relation to his/her history, personal characteristics and lifestyle.
4. All potential risk variables (behavioural or medical), must be identified in the Community Discharge plan. High probability risk variables must have an intervention strategy or process identified in the discharge plan.
5. The recognition of the need to ensure stability in the resident's medical condition (including medications) before discharge is critical. Liaison with community agencies, approved home care providers and other resources must be undertaken to ensure the ready availability of medical expertise to monitor and treat the condition.
6. Discharge planning begins prior to admission and reviewed during each Individual Planning Meeting.
7. For potential suitable placement options, residential vacancy profiles will be reviewed on an ongoing basis.

PROCEDURE

1. Residents living at the MDC will have a Discharge/Transfer questionnaire completed.
2. Individuals are identified as candidates for community placement by self-identification, family preference, by direction of their SDM for Personal Care or they reside at the MDC under court order placement.
   a) If a MDC resident's name has been previously on the transition list, the Clinical Coordinator will annually obtain a signed consent from the SDM for Personal Care. Consent includes the right to share any relevant information required for the purposes of transition planning, to be given to the identified Agency, Community Service Worker and other community professionals as deemed necessary.
   b) If a MDC resident's name is newly identified to be added to the transition list, the Clinical Coordinator will obtain written approval/consent from the SDM for Personal Care for that individual's name to be added to the transition list. Subsequently, a signed consent form from the SDM for Personal Care will be obtained to share information required for the purposes of transition planning, to be given to the identified Agency, Community Service Worker and other community professionals as deemed necessary.
   c) If an individual is admitted to the MDC on a court order placement, not a respite placement, this individual's name will be added to the transition list. After a period of stability, as decided by the care team in consultation with the contracted psychologist, the Clinical Coordinator will obtain signed consent from the SDM for Personal Care to share information required for the purposes of transition planning, to be given to the identified Agency, Community Service Worker and other community professionals as deemed necessary.
3. As updated vacancy profile lists are received by the Clinical Coordinator, the list will be provided to the Residential Coordinators (RCs) to determine if there is a suitable fit for any of the residents identified on the MDC Transition List.

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4. Once a potential suitable placement option has been identified, the Clinical Coordinator obtains SDM consent and ensures a referral information package is sent to A/Program Manager, Community Living disABILITY Services. The package will include:
    a) reason for admission and social history, if applicable.
    b) copies of the most recent Individual Plan including Individual Profile Face Sheet, Individual Planning Meeting Summary, Care Guide, list of current medications and Behaviour Support Plan, if applicable and any other pertinent reports required to maintain present quality of life.
    c) copies of psychological and/or clinical psychological report and psychiatry report, if applicable.
    d) copies of SDM appointment documents.
    e) other reports as requested.
5. If it is agreed that discharge planning can proceed, the Clinical Coordinator will complete Discharge Checklist – Appendix A, Section 1:
6. The Residential Coordinator or designate will complete Discharge Checklist – Appendix A, Section 2:

REFERENCES:

The Vulnerable Persons Living With A Mental Disability And Consequential Amendments Act
Council on Accreditation (COA) CA-GLS 15
Diagnostic and Statistical Manual of Mental Disorders 5 (DSM 5)
MDC Policy and Procedure VI-95 Consent for Health and Medical Treatment
individual to reach his/her potential.

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.		

DISCHARGE CHECKLIST

Name of Resident: _____

		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.		

DISCHARGE CHECKLIST

Name of Resident: _____

		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.		

MANITOBA DEVELOPMENTAL CENTRE
APPLICATION FOR APPROVAL OF DISCHARGE

Approval is requested for the following community placement:

Name: _____

Date of Birth: _____

Placement Location: _____

Type of Residential Placement: _____

Regional Worker: _____

Day Program: _____

Family Involvement: _____

Proposed Placement Date: _____

Detailed resident information is available from the most recent Individual Plan date: _____.

Date _____ Clinical Coordinator Signature _____

Date _____ Residential Coordinator Signature _____ Supported: ☐ Yes ☐ No

Comments _____

Date _____ Program Director Signature _____ Supported: ☐ Yes ☐ No

Comments _____

Decision related to this proposed move approved: ☐ YES ☐ NO

Date _____ Chief Executive Officer Signature _____

IMPORTANT: Forward signed form to Health Information Services for scanning

Reminder: MDC remains responsible for the care of residents until the official discharge to the community agency

Department of Families
Manitoba Developmental Centre
Box 1190, Portage la Prairie, Manitoba R1N 3C6
T (204) 856-4200 **F** 204 856-4258

COMMUNITY TRANSITION
DAYPASS/LEAVE OF ABSENCE (LOA) FORM

PART I

Date: _____ Destination (be specific) _____

This is to acknowledge that _____ is being placed on Leave
Resident's Name
of Absence from _____ until _____ in the care
Date LOA begins *Date LOA ends*
of _____.
Community Home/Agency Name

During this time, it is understood and agreed that _____
Community Home/Agency Name
has had sufficient information shared with them and feel confident that they are able to provide care in a manner that ensures _____'s safety and well being
Resident's Name
during the Leave of Absence.

Should the Agency have any questions or concerns with respect to _____,
Resident's Name
the MDC strongly encourages them to contact the MDC.

Signed: _____ _____
Community Home/Agency Representative *Clinical Coordinator or Residential Coordinator/Designate MDC Care Provider*

Print: _____ _____
Community Home/Agency Representative *Clinical Coordinator or Residential Coordinator/Designate MDC Care Provider*

Dated: _____

IMPORTANT: *Signed Copy to Agency, Original to Health Information Services for scanning*

The Substitute Decision Maker has been advised and has approved of the Discharge Planning Process and is aware of the provision of transitional visits.

Reminder: MDC remains responsible for the care of residents until the official discharge to the community agency

DAYPASS/LEAVE OF ABSENCE (LOA) MEDICATION ADMINISTRATION

1) All medication that the resident is to receive throughout the duration of the daypass/LOA will be provided by the MDC pharmacy in bubble packs for the Community Agency staff to administer. Liquids and creams etc will be dispensed separately but will contain an MDC label with administration instructions provided.
2) The medication will be accompanied by a Manrex Administration Record (MAR) sheet for the Community Agency staff to sign off that they have administered the medication and visually witnessed the resident swallow the medication. Upon resident return to the MDC following the transitional visit, the Community Agency staff will provide the MDC MAR sheet and a copy of the Community Agency's MAR sheet.
3) Prn medication will also be provided on bubble packs as indicated above.
4) If the resident requires the administration of a prn medication, the Agency staff **MUST** consult by telephone with the Nurse In Charge on the resident's home area before administering the medication to the resident. The Nurse In Charge may determine that the resident requires to be returned to the Manitoba Developmental Centre for assessment.

   A Nurse from _____ is available from 0700 hours until 2300 hours at: 204 856- _____
   Resident's Home Area *Area Phone #*

   Between 2300 hours and 0700 hours contact the Night Supervisor at 204-856-6014.
5) Community Agency staff must not administer, apply or provide any medication to the resident unless the medication has been provided by the MDC pharmacy as per statement # 1 above. This includes all over the counter medications (e.g. oral medication such as tablets and capsules), creams, drops, liquids, lozenges etc.).
6) **Agency staff must contact MDC staff prior to seeking medical/psychiatric intervention except in life threatening situations.**
7) **Any medication errors must be reported to MDC immediately.**

Signed: _____ _____
Community Home/Agency Representative *Clinical Coordinator or Residential Coordinator/Designate MDC Care Provider*

Print: _____ _____
Community Home/Agency Representative *Clinical Coordinator or Residential Coordinator/Designate MDC Care Provider*

Dated: _____

IMPORTANT: *Signed Copy to Agency, Original to Health Information Services for scanning*

PART III

CHECKLIST FOR COMPLETION UPON RETURN FROM COMMUNITY VISIT:

- ☐ *Bubble Packs/Medications Returned*
- ☐ *MDC MAR Sheet Returned*
- ☐ *Copy of Community MAR Sheet Provided*
- ☐ *Medication Administration by Community Agency Staff Not Required During Transitional Visit*

Signed: _____ _____
Community Home/Agency Representative *Clinical Coordinator or Residential Coordinator/Designate MDC Care Provider*

Print: _____ _____
Community Home/Agency Representative *Clinical Coordinator or Residential Coordinator/Designate MDC Care Provider*

Dated: _____

The Substitute Decision Maker has been advised and has approved of the Discharge Planning Process and is aware of the provision of transitional visits.

Manitoba Developmental Centre (MDC)
AGENCY DISCHARGE PROTOCOL

Name: _____

MDC requires that the following has been completed by agency or community care provider.

Please complete and return to Clinical Coordinator*:*

☐ The resident's Care Guide, Individual Plan, Behaviour Support Plan (if applicable), and the Resident Profile have been communicated to and understood by agency staff/caregivers.

☐ Staffing is in place prior to any visits by the resident (including overnight staff if applicable).

☐ Home Address: _____

Home Phone Number: _____

☐ Community **physician** confirmed**. Initial appointment must occur prior to or on discharge date.**

Name of physician: _____

Contact information: _____

_____

☐ Community **psychiatrist** confirmed (if applicable).

Name of psychiatrist: _____

Contact information: _____

_____

☐ Community **dentist** confirmed.

Name of dentist: _____

Contact information: _____

_____

Date: _____ Signature: _____

Printed Name: _____

Agency & Title: _____

POTENTIAL SERVICE PROVIDER LIST FOR PRE-DISCHARGE

RESIDENT NAME: _____ **DATE:** _____

Type of Service Provider	Name of Contact (if applicable)	☑ if Notified
CEO		
Program Director		
Residential Coordinator		
Nursing Outreach		
Psychiatry		
Pharmacy		
Physician		
Dental		
Public Trustee/SDM		
Contracted Psychologist(s)		
Personal Development Counsellor(s)		
Recreation Services/Canteen		
Resident Employment Services		
Communication Services		
Music Therapy		
Rehabilitation Services		
Dysphagia Team		
Nutrition Services		
Health Information Services		
Residents' Trust		
Systems Admin. & Support		

Note: Changes to personnel should be reported to Clinical Coordinator *who will be responsible for maintaining an updated list.*

Completed by _____ Date _____

Approved by RC or Designate_____ Date _____

ARTICLE & DESCRIPTION (include serial numbers, etc.)	RT	Gift	Date purchased/ Received	Initial	Date discarded/ Reason

Discharge date:_____

Signature of receiver:_____

Notification of any discrepancies must be reported to:
Manitoba Developmental Centre
Social Services Department
P.O. Box 1190
Portage la Prairie MB R1N 3C6
within 48 hours