

## PURPOSE

To provide a formal process for escalation and collaborative management of complex discharge planning and funding decisions for BOPDHB Provider Arm, Support Net and Planning and Funding services.

## STANDARDS TO BE MET

- 1. Identification of patient who will have complex discharge planning requirements or projected long stay**
  - 1.1. Multidisciplinary Team (MDT) review.** All patients with potential complex discharge requirements should be identified as soon as possible following admission and then followed through at subsequent MDT meetings. This may be identified over a series of MDT reviews which identify features in [Appendix 1](#); or involve multi-service providers.
  - 1.2. Risk of complex discharge requirements identified.** Patients who present as complex discharge planning have two or more of features in [Appendix 1](#).
- 2. Escalation of concern – patient identified as complex**
  - 2.1 Identify lead contact for liaison and facilitation of meetings to support process. This may be a social worker, Clinical Nurse Manager (CNM) / Clinical Nurse Specialist (CNS), Doctor or service manager.
  - 2.2 \*This person takes responsibility for liaison with identified service provider and co-ordination of transition to discharge.
  - 2.3 Social Work service – prepare a preliminary report outlining:
    - a) Past history – physical, mental health, social and behavioural
    - b) Current presentation – reasons for admission, current health status
    - c) Social needs assessment
    - d) Requirements for discharge consideration, e.g. InteRAI assessment for people >65 year in age.
    - e) Legal status, e.g. is there EPOA in place; any other legal requirements which will inform placement decisions.
  - 2.4 Medical, Occupational Therapy or other allied health service reports as required for individual client’s needs.
  - 2.5 Referral to appropriate Mental Health service (adult or older adult) for an assessment re capacity / placement options as required.
  - 2.6 Nursing assessment provided of care requirements, e.g. complexity of medication management or behaviour.
  - 2.7 Contact made with Support Net for assessment for discharge plan of care. Preliminary review by Support Net identifies that care requirement beyond the capacity of existing contracted providers.
  - 2.8 Notify service business leader. Contact made with identified Planning and Funding Portfolio Manager requesting assistance and setting up “Placement / Transition management meeting” as per appendix 1.

## ASSOCIATED DOCUMENTS

- Bay of Plenty District Health Board policy 6.5.1 Discharge Planning – Inpatient and associated controlled documents

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**Appendix 1: Flowchart – Management of complex discharge/placements**

