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 Enduring Power of Attorney (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 & Addiction Services (adult or older adult) for an assessment regarding 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

Appendix 1: Flowchart – Management of complex discharge/placements