Government of Western Australia
Department of Health
Chief Allied Health Office

National Disability Services
WESTERN AUSTRALIA

Collaborative Discharge Planning Meetings

Tips for health professionals

Aims of collaborative discharge planning meetings

1. Actively engage the patient and their family in the discharge planning process:
   - Identify the individual's values, capabilities, strengths and resources using person-centred communication skills.[1]
2. Support the patient to make informed decisions:
   - Some people with disabilities require additional support with decision-making.
   - Even if a patient has reduced decision making capacity, and a plenary guardian is involved, the patient can still be supported to remain at the centre of the discharge planning process.
   - For more information on supported decision making, go to: waindividualisedservices.org.au[2]
3. Balance duty of care with dignity of risk:
   - Dignity of risk is the concept that a person has the right to choose what they do and how they want to live, despite the fact those lifestyle choices may come with risk.[3]
   - Fear of risk of physical harm is a key driver of professional decision-making by health workers.[4]
   - Overestimating risk denies people's autonomy and opportunities for growth, and negatively impacts on quality of life.[1]
   - A collaborative 'risk management' approach reflects person-centred practice.[1]
4. Clarify roles and responsibilities of health workers and NDIS-funded support staff.[5]
5. Meet the health service's legal obligations under the Mental Health Act 2014 (WA) including:[6]
   - To collaboratively develop a Treatment, Support and Discharge (TSD) Plan;[7]
   - The patient's psychiatrist must ensure that the TSD Plan is prepared as soon as possible after the patient becomes involuntary (s187).[6]

Discharge Planning Principles

For patients at risk of poor outcomes and/or delays in discharge, Knox et. al[8] recommend:

1. *Early start:* within 24-48 hours of admission;
2. *Expertly coordinated* health and disability knowledge;
3. *Person-centred:* engaged in discussions and decisions;
4. *Family-focussed:* actively involved;
5. *Communication:* clear and timely information;
6. *Education* of person, family, health and support workers is key;

7. *Outcome-oriented:* finishes when person has housing and support to live an ordinary life.

Aim to conduct a family meeting early in the admission, so any potential barriers to discharge can be identified and addressed before the estimated discharge date.[9]

Trauma-Informed Care (TIC) and collaborative discharge planning

Trauma "results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being".[10]

A traumatic experience frequently produces fear, vulnerability, and helplessness.[10] People with disability experience and witness repeated trauma more often than people without disability.[11,12] Trauma-Informed Care (TIC) recognizes and addresses the prevalence and effect of trauma within healthcare.[13] The 5 key principles include:[10-14]

1. *Safety* – welcoming and non-shaming communication, to facilitate physical & emotional safety.
2. *Trustworthiness* – communicating clear expectations with patients, such as what care will be provided, when, and by whom.
3. *Choice* – maximizing patient experiences of choice and control.
4. *Collaboration* – shared power between the healthcare staff and the patient; maximizing teamwork with NDIS-funded disability service providers.
5. *Empowerment* – consider the patient's strengths, skills, and preferences; empower them to remain in the "drivers' seat" of their own life.

Why apply a trauma-informed, collaborative approach to discharge planning meetings?

1. Improved job satisfaction and reduce healthcare worker burnout.[15]
2. Reduce hospital length of stay, hospital re-admissions, and patient satisfaction.[16]
3. Provides transparency and sets expectations.[17]
4. Patients with a trauma history may mistrust authority figures and be wary of professional. helpers. Through the application of TIC, health care staff can avoid inadvertently repeating dynamics of abusive interactions and prevent retraumatization.[14]

Considerations

- In a poorly managed meeting, the least helpful voices will generally prevail – often the loudest or highest status or most negative about the options for the patient.[18]
- Considerable group-work skill is required to organize & conduct a meeting where:
  - Every participant is fully heard and has a chance to contribute substantively to decision-making;[18]
  - The meeting is completed within a reasonable time.[18]

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