Government of **Western Australia**
Department of **Health**
Chief Allied Health Office

NDS
National Disability Services
WESTERN AUSTRALIA

Collaborative Discharge Planning Meeting Procedure

Before the meeting

☐ Identify the most appropriately skilled person from the MDT to facilitate the meeting.
Note: The facilitator requires appropriate skills in group work and therapeutic communication[1,2]

☐ The meeting facilitator (or delegate) to take responsibility for meeting scheduling, invitations, and coordination.
Ideally, this person should act as the primary contact point for the family.[1]

☐ When inviting the patient and family members, the meeting facilitator should spend time with them to complete the **Family Meeting Planning Outline (Appendix A)** to:

- Outline the purpose and objectives of the family meeting;
- Establish what is expected of the patient and their family (e.g. to give or receive information, to hear a decision or help make it);[3]
- Identify how the patient and their family can be supported to actively engage in the meeting (e.g. any individual considerations for communication, availability of communication aids);
- Ensure the patient is aware of relevant disability advocacy services, mental health advocacy services, interpreter services, Aboriginal Liaison Officer services.

Note: Use the patient's interpretation of family, i.e., those who are closest to the patient in terms of affection[1]

☐ Identify the most relevant participants; potential attendees include:[1,4]

- The patient
- Family members, informal support person/s and/or legal guardian
- Hospital social worker
- NDIS support coordinator
- Allied health team members (e.g. physiotherapists, occupational therapists, speech pathologists, dieticians)
    - Consider inpatient and NDIS-funded community therapists
- Delegate from the patient's medical team
- Nursing staff (e.g. Nurse Unit Manager or community-based nurse)
- A representative from the NDIA (for a NDIS planning meeting)[5]
- Behaviour Support Practitioner.

Note: only key professionals should be invited, based on the identified needs of the patient and the family, so they do not feel overwhelmed.[1]

☐ Logistical arrangements:

- Select a time & date that allows ample notice to maximise attendance.[1]
- If possible, book a meeting room; the ideal setting is private and quiet, with chairs arranged in a circle or around a table.
  This promotes collaboration rather than opposition[6]*, and encourages emotional safety.*

☐ If a member of the MDT is unable to attend, they are to write a brief recommendation and appoint a proxy to present this at the meeting.
This can be documented on the Collaborative Discharge Planning Meeting Summary (Appendix B).

☐ Meeting facilitator to:

- Bring the completed **Collaborative Discharge Planning Meeting Outline (Appendix A)**; along with **the Collaborative Discharge Planning Meeting Summary (Appendix B)**, and **Collaborative Discharge Meeting Action Plan (Appendix C)**.
- Be prepared to respond if attendees become distressed during the meeting, and plan ways to manage their emotional responses.[1]

During the meeting

☐ Introduction

Meeting facilitator to:[1]

- Thank everyone for attending, introduce him/herself, invite others to introduce themselves and state their role.
- Establish ground rules in a non-patronising way (e.g. each person will have a chance to ask questions and express views; however, could one person please speak at a time; request no interruptions such as phones).
- Indicate the duration of the meeting (recommended maximum time of 60 minutes).
- Introduce the documentation forms **(Appendix B and C)** and identify a note-taker, to document outcomes and actions allocated to all involved.

Note: Meeting notes can partially compensate for non-attendance.

☐ Clarify the purpose of the meeting

Meeting facilitator to:[1]

- Briefly outline the purpose of the meeting.
- Confirm with the patient and their family members that they understand the purpose of the meeting.
- Ask the patient and their family if they have any other concerns, and prioritise what will be addressed during this meeting.
    - *Note: other concerns can be addressed on a one-on-one basis or future meeting.*
- Clarify if specific decisions need to be made (e.g. discharge destination) and who is involved in decision making i.e. establish whether there are any concerns about the patient's decision-making capacity, and whether they have a guardianship order in place.
- Reframe questions and topics throughout the meeting to ensure the patient and family members understand.

☐ Progress report

Meeting facilitator to:[1]

- Facilitate a 'round robin' where clinicians provide an overview of their professional role, a progress report, and recommendations for discharge, such as support needs and referrals (e.g., outpatient medical follow-up, ongoing rehabilitation, wound care)
- Invite same from patient and/or family member.
- Ask the patient and each family member if they have any questions about the patient's health status, plan and prognosis.
- When the family are discussing a patient that lacks decision-making capacity, each family member can be invited to offer their opinion/ideas about the patients wishes (be prepared for differing opinions and conflict).
  E.g. What do you think your relative/friend would choose if they could speak for themselves? Considering that knowledge, what do you think should be done?

☐ Future planning

Meeting facilitator to:[1]

- Introduce the goal setting section of the **Collaborative Discharge Planning Meeting Action Plan (Appendix C).**
- Summarise any areas of consensus, disagreements, decisions, and the ongoing plan (i.e., clarify next steps), and seek endorsement from attendees *e.g. Are we all clear on the next steps?*
- Emphasize positive outcomes arising from the meeting.
- Offer final opportunity for questions, concerns, or comments *e.g. Are there any questions you have that haven't been answered yet?".*
- Identify one family spokesperson for ongoing communication.
- Thank everyone for attending.

☐	Designated note taker to: • Record on the **Collaborative Discharge Planning Meeting Summary (Appendix B)** and **Collaborative Discharge Planning Meeting Action Plan (Appendix C)**; ensure these are completed by the end of the meeting. • These documents are to include: ▪ Who was present. ▪ What decisions were made (confirmed or pending). ▪ Tasks to be completed. ▪ Name of people allocated to tasks & their contact details. ▪ Timeframes for each task. ▪ Any follow-up communication required, timeframe for this, process of how this will occur (e.g. telephone calls, future meeting). • Provide 2 x copies for the patient and their family members (one to take home, one to keep with the patient at their bedside). • Place original in the patient's medical record for all staff to access.
After the meeting	
☐	Meeting facilitator to check in with patient and/or family within 48 hours to determine if the meeting was helpful.[1] *E.g. Did you feel you were able to voice your preferences and concerns? Do you have any follow up questions?*
☐	Meeting facilitator to maintain contact with the key family spokesperson, including organizing any follow-up meetings or telephone calls as required.

References

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2. Gursansky D, Kennedy R, Camilleri P. *The Practice of Case Management: Effective Strategies for Positive Outcomes.* Routledge; 2012. Accessed May 10, 2022. doi: 10.4324/9781003118183. pp. 111-113.
3. Schoeb V, Staffoni L, Keel S. Influence of interactional structure on patient's participation during interprofessional discharge planning meetings in rehabilitation centers. *J Interprof Care*. 2019;33(5):536-545. doi:10.1080/13561820.2018.1538112
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6. Durocher E, Gibson B, Rappolt S. Mediators of marginalisation in discharge planning with older adults. *Ageing Soc.* 2017;37(9):1747–1769. doi:10.1017/S0144686X16000593