Discharge plans: a case study

It may come as a shock to caretakers of the patient that discharge planning may commence as soon as a patient has been admitted. This does not necessarily mean that the patient is being released for home, but rather it means that plans are being put in place for a successful discharge plan to take place. Information is gathered about the patient, how they live, for example, do they live with others, are they dependent or independent (Birjandi & Bragg 2009). Caretakers are actively involved in a discharge plan provided the patient gives consent. Once the patient shows improvement, it is clear that further recovery in a hospital set-up is not likely to take place and thus they are sent to an environment they may adopt to their needs; their home.

Birjandi, A & Bragg, (2009) say that discharge planning is essential and should be done right, whether the discharge is to a rehabilitation center, a nursing home or the client's home. Medical practitioners should have an ideal discharge plan as studies have shown that improvement in hospital discharges with great outcomes when appropriate discharge plans are made.

Healthcare givers, family members and patients themselves have a great role to play after discharge in maintaining good health. Even though discharge planning is essential in patients' health there is inconsistence in both the discharge process and the quality of discharge planning in most of the health care system.

In this paper, we shall look at a discharge plan for a client with the cerebral vascular accident from hospital to their home. We shall look at initial assessment of the client at the time of admission; determine the possible

discharge needs, family involvement in decision making and how to transport the client to their destination.

Birjandi, A & Bragg, L. (2009) describe discharge planning as a method used to decide the requirements of a patient as they shift from one level of care to another, only doctors may approve patients release from a health facility, but the actual discharge plan may be done by a nurse, case manager, case manager. Complicated conditions such as cerebral vascular accident may have a team approach. Well organized discharge planning may reduce the chances of re-hospitalization and aid in recovery; ensure medications are well prescribed and administered correctly. In general a discharge plan should involve the following; evaluation of the client by qualified practitioner, discussion with both the client and the caregiver, planning of the transfer process and homecoming of the client, determining whether the caretaker needs more training or any other kind of support, referral to support an organization or care agency and finally arranging for follow up activities.

In our case we shall look at Ms. Kate a 76 year-old female who was admitted from the emergency department with a diagnosis of Right Cerebra Vascular Accident. Her Past Medical History includes: hyperlipidemia, hypertension, osteoarthritis, and osteoporosis.

Neurological: left-sided weakness for the past 2 days, awake, alert, and oriented to person, place, and time. Denied swallowing difficulties, no visual defects and denied pain.

Medications: Aspirin 81mg per oral daily; Tylenol 650mg per oral when necessary for pain;

Cerebral vascular and pulmonary: Placed on a cardiac monitor, findings indicated normal sinus rhythm. Vital signs taken every 4 hours, pulse 82; blood pressure 168/64; respirations 20. Lung sounds were clear to auscultation bilaterally. Oxygen Saturation on room air 97%.

Gastrointestinal: Abdomen soft, non-tender, not distended, positive bowel sounds. Bowel movement present

Genitourinary: Voids freely, requiring assistance to the bathroom. Output approximately 1000ml/day. Brief episode of dysuria on admission.

Integumentary: skin intact, no lesions noticed

Musculoskeletal: Active range of motion right side; limited range of motion on the left side; required assistant to get into a wheelchair. History of recent balance problems.

Psychosocial: lives with daughter in a two story home; occupation: retired teacher

Discharge needs were discussed with the caretaker, these included the physical condition of the family before and after hospitalization, the details of the kind of care required by the client were discussed, included information of the patients prognosis, what activities she might need to help with; information about the clients medication and diet should be given, any extra equipment that was deemed necessary such as wheelchair, oxygen and who will be in charge of the clients meal preparation, transport to referrals and support groups.

The daughter who lives with Mr. Kate was involved in the discharge process, her ability and willingness to provide care to her mother was assessed, and the results were as follows; she felt it was too early for her discharge, as she did not have time to spare to take care of her mother as her work was demanding. She also had concerns about she would go about transporting her mother from the bed to her chair and taking her to the bathroom. She was referred to help agencies that assist in taking care of patients at their homes at a paid fee. Several agency information was availed to her, with instructions to come up with a decision on which one to use. She was also given a choice to hire an individual at a fee or hire nurses or case managers or other persons familiar with the condition.

Ambulance services were given as an option to transport the patient to their home at a small fee at the time of discharge or the client may use assisted transport to their homes, wheelchair or stretchers were suggested be used for our client as she could walk with assistance. This was done in advance and the patient was fully responsible for this kind of transport arrangement.

Discharge planning varies according to the hospital set up and the person who initiates it, and what kind of follow-up is needed, and whether the care takers are assessed for their ability to cater for the client’s needs. The transition of care and discharge planning all centered on improving the quality of care administered to a client, for example, education the care givers and training them on the conditions of their patients, encouraging preventive care and including caretakers to be part of the health care team. Simple steps such as exchanging patient’s progress regularly with the doctors or the health team increase the chances of effective follow up care.

Telephone conversions, post discharge with doctors also helps to anticipate problems and improve care at home.

Corey, G., Corey, M., & Callanan, P. (2003) suggest that relative to discharge planning with some patient, there may be underlying issues that contribute to ethical dilemmas. As case managers, we should take reasonable steps to safeguard the interests and rights of those clients. Ethical dilemma occurs when an individual has to choose between two or more conflicting ethical standards. There is no one right answer and there is no easy answer! Codes of ethics provide guidelines, but don't necessarily tell us what to do. Using a hierarchical ethical decision-making approach can help you achieve an acceptable resolution. Mattison, (2000) reminds us that utilizing an ethical decision-making model doesn't result in bias-free decisions. Our values still come into play utilizing an ethical decision-making model and we may not be aware of it! First of all, it is important to remember clients' rights to self determination and autonomy – clients have the right to make poor decisions. However, the role of the case manager is different in this situation depending on the client's cognitive capacity for decision making. If the client has capacity, the focus is on ensuring the client is making an informed decision and reassuring the care team, which includes the family, about resources to maximize safety. If the client does not have capacity, the focus is identifying someone who can act on the client's behalf and exploring alternatives for creating a safe discharge in respect of the client's wishes. For the client

When the care team perceives discharge unsafe; Promote informed consent – this involves educating the client about the team's concerns related to his

or her safety and potential consequences associated with an unsafe discharge. Review and encourage the use of resources to maximize safety, this involves identifying the services the client will need in a lesser care environment for the discharge to be successful. For the care team May not be aware of resources available to enable older adults to live safely in their own homes; reviewing these resources can eliminate concerns. May be worried about remote dangers that should not trump client autonomy and self determination, i. e. " If there was a fire, he would have difficulty escaping."

When the care giver does not appear able to provide care. Sometimes family members or other caregivers wish to care for a client in a lesser care environment, but there are concerns about their ability to do so. In this situation, family/caregiver education is an important intervention.

When the caregiver does not seem able to provide care; Approaches to family/caregiver education: Convene a team conference with them to review the client's level of care and specific care needs. Have the individual assume full responsibility for care for a period of time while in a safe environment (i. e. Work a 4-hour shift as his/her loved one's caregiver in the nursing home so he/she is fully informed of what to expect in terms of career. Often this will result in the family member realizing for themselves that the care is too much and they will either not be able to do it or will need to have outside support. Alternatively, sometimes family members will actually do well, relieving the team's fears about their ability. Try a short trial visit in the lesser care environment, say 24-48 hours, with a planned return to the higher care setting to debrief re: problems encountered.

When a client or caretaker refuses necessary service; again, it is important to remember clients' rights to self determination and autonomy – clients have the right to make poor decisions. However, sometimes what seems to be a " poor" decision is based on misinformation or other concerns; it is important for case managers to explore factors contributing to the refusal of services deemed necessary by the care team. Potential factors contributing to service refusal; Cost; sometimes clients and their families don't feel recommended services are (or will be) affordable. Have referred agency review associated costs with them; sometimes services are not as much as anticipated. Assist client/family to access sources of financial support such as Medicaid. Reframe costs as in terms of future savings, i. e. Paying a little for care now will prevent costly hospitalizations in the future. Discomfort with the thought of strangers in the home. Validate this concern; it is uncomfortable having unfamiliar people help with intimate tasks in one's private domain. Arrange for client/family to meet potential service providers ahead of time to minimize anxiety.

Additional factors potentially contributing to service refusal; misunderstandings regarding the purpose of recommended services. Feelings of guilt or shame related to not being able to provide all care independently. Recommended services don't fit client/family's cultural belief system. Past negative experiences with similar services

Caretaker unwilling to have client return home; this is one of the most heart-wrenching ethical dilemmas to deal with and can bring up many issues of counter-transference; good self-care and supervision is important. Things to keep in mind; Client has a right to return to his or her own home, caretaker

has a right not to provide care if this is something he or she is uncomfortable with, There may be a history of domestic violence or other traumatic relationship issues contributing to spouse/partner's reluctance, Spouse/partner may be unaware of support services available to assist with care management and that the Client may be at risk for elder abuse.

For clients with capacity, living environments deemed " unsafe" may simply represent differences in lifestyle choices between client and the care team. For example, client's home is cluttered, smells like cats, and there are dirty dishes and dust everywhere, but is not actually hazardous in any way. Case manager's role: advocate for clients and educate them, offer services to assist client with home management. If home is in disrepair, infested with rats, covered with mold and rotting garbage hazardous situation indicative of deeper problems. Case manager's role: further assessment regarding client's capacity and whether interventions can make home livable; recognize that sometimes it is just not possible for clients to return home

We may conclude by stating that effective discharge planning and transitional care have real benefit in improving the out-come of a patient and bringing down the rate of re-hospitalization of the same patients.

Reference

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