Discharge Planning & Transition Plan

Supporting a participant's safe transition from rehabilitation back to their home community

A sample of the coordination documents Savora Collective prepares. All names, contact details and identifying information have been removed for illustration.

PURPOSE

This plan provides guidance to the rehabilitation team regarding a participant's discharge from rehabilitation, including planned and unplanned or early discharge. The objective is to ensure the participant has a safe, coordinated and supported transition back to their home community, with their community support network involved before discharge occurs.

PLEASE CONTACT THE SUPPORT COORDINATOR BEFORE FINALISING DISCHARGE

Once the Support Coordinator has confirmed that the discharge and transition arrangements are appropriate, the community support provider can coordinate the participant's collection, transport home and the support workers required for their return. This process prevents the participant leaving rehabilitation without appropriate transport, community supports and continuity of care in place.

1. DISCHARGE PLANNING

Discharge planning should commence as early as possible and involve the participant and their existing support network. Prior to discharge, please ensure:

- The participant is involved in discussions and decisions regarding their discharge.
- Information is communicated in an accessible way, considering the participant's communication and accessibility needs.
- The participant's discharge destination is confirmed.
- Transport back to their home community is confirmed.
- Community supports are arranged and ready for the participant's return.
- Required medications and prescriptions are available.
- Medication changes are clearly documented and communicated.
- Relevant discharge summaries and clinical information are provided.
- Follow-up appointments, referrals and treatment recommendations are documented.
- Required equipment, belongings and essential items are returned with the participant.
- Any identified risks or changes in the participant's presentation are communicated to their community support network.

2. COMMUNICATION WITH THE PARTICIPANT

The participant should remain actively involved in their discharge planning. Staff should:

- Communicate clearly and directly with the participant.
- Ensure communication is accessible given their communication and accessibility needs.

- Allow additional processing time where required.
- Check that the participant has understood important information.
- Avoid multiple staff communicating conflicting information.
- Provide important information in writing where possible.
- Clearly explain medication changes, appointments and ongoing treatment recommendations.

3. DISCHARGE CONTACT & COORDINATION ORDER

For all planned, early or unplanned discharges, please follow the contact pathway below.

1

Savora Support Coordinator

SUPPORT COORDINATOR / BEHAVIOUR SUPPORT PRACTITIONER

Contact the Support Coordinator before discharge arrangements are finalised.

Phone [direct contact provided on engagement]

The Support Coordinator will assist with:

- Reviewing the proposed discharge arrangements.
- Identifying any immediate risks or support requirements.
- Confirming what community supports need to be in place.
- Coordinating with the participant, family and providers.
- Determining whether the proposed transition arrangements are appropriate.
- Confirming when the community support provider and support workers can proceed with collection and support arrangements.

IMPORTANT

Please do not arrange the participant's collection or discharge transport until the Support Coordinator has been contacted and the discharge arrangements have been discussed.

2

Community Support Provider

COMMUNITY SUPPORT TEAM

Once the Support Coordinator has confirmed the arrangements are appropriate, the community support provider can coordinate the participant's practical supports.

Phone [provided on engagement]
Email [provided on engagement]

The community support team is located near the rehabilitation facility and can assist with collecting the participant from rehabilitation, transporting them safely back to their home community, organising support workers for their return, ensuring appropriate supports are available following discharge, and coordinating practical transition arrangements. The provider should be given as much notice as possible to allow appropriate transport and staffing arrangements to be made.

3

Family / Nominated Contact

FAMILY REPRESENTATIVE

Keep the family or nominated contact informed of discharge and transition arrangements where appropriate.

Phone [provided on engagement]

The family or nominated contact should be kept informed of the participant's discharge and transition arrangements where appropriate, including any significant changes to their presentation, treatment, medication or ongoing support needs.

4. EARLY OR UNPLANNED DISCHARGE

IF THE PARTICIPANT REQUESTS TO LEAVE, OR AN EARLY DISCHARGE IS BEING CONSIDERED, CONTACT THE SUPPORT COORDINATOR IMMEDIATELY

Do not wait until the participant has physically left the service before contacting their community team. Where clinically and legally appropriate, the participant should be supported to remain in a safe location while their discharge arrangements are coordinated.

The same contact pathway applies: first the Support Coordinator (discuss discharge, risks and transition requirements and confirm arrangements), then the community support provider (once arrangements are confirmed, organise collection, transport and required support workers), then the family or nominated contact (keep them informed where appropriate).

5. TRANSPORT HOME

The participant should have confirmed transport arrangements before leaving rehabilitation. Once the Support Coordinator has agreed to the discharge arrangements, the community support provider can coordinate collection and transport back to the participant's home community. Before collection, please confirm:

- Discharge date and time
- Collection location
- Who will be collecting the participant
- Destination in the home community
- Supports arranged for the participant's arrival
- Medications and prescriptions
- Equipment and personal belongings
- Relevant discharge documentation
- Any immediate risks or support considerations for the journey

6. MEDICATION & CLINICAL HANDOVER

Prior to discharge, please provide:

- Current medication list
- Details of medications commenced, ceased or changed during admission
- Required prescriptions
- Relevant clinical and discharge summary
- Follow-up recommendations
- Upcoming appointments
- Identified warning signs or concerns
- Recommendations for ongoing rehabilitation or community treatment
- Any changes in the participant's functional or support needs

7. SAFE TRANSITION CHECKLIST

Before the participant leaves rehabilitation, please confirm:

- ☐ The Support Coordinator has been contacted
- ☐ Discharge and transition arrangements have been discussed with the Support Coordinator
- ☐ The community support provider and support workers have been contacted following confirmation
- ☐ Collection and transport home are confirmed
- ☐ Supports are arranged for the participant's return
- ☐ The family or nominated contact has been informed where appropriate
- ☐ Safe destination confirmed
- ☐ Medications and prescriptions supplied
- ☐ Discharge documentation supplied
- ☐ Follow-up appointments and referrals identified
- ☐ Equipment and belongings returned
- ☐ Relevant risks and support recommendations handed over

DISCHARGE CONTACT PATHWAY

1. Savora Support Coordinator
Discharge coordination and confirmation

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2. Community Support Provider
Collection, transport home and organisation of supports

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3. Family / Nominated Contact

Family communication and involvement