Discharge

The importance of discharge planning lies in its potential for reducing readmission.

According to bilingual community workers, people from diverse cultural backgrounds are still being discharged from hospital without understanding their follow-up plans.

Sometimes, even at the time of discharge, the patient is not sure why they were in hospital or what operation was done. Many patients who are not familiar with the Australian system or recent developments in patient care do not expect early discharge, and assume that they will remain in hospital until they are well. They need to understand the reasons for early discharge, and what support will be arranged.

Develop a plan for post-hospital care of the patient, centred on his or her individual problems and needs. This must involve the patient, the family, and a coordinated multidisciplinary team of health professionals with established lines of communication, which considers the patient's medical and non-medical (social etc) needs during both the hospital and post-hospital period. Multidisciplinary discharge planning is especially important for older people whose problems tend to be more complex and chronic. These issues are even more important when the patient is not proficient in English.

The discharge plan may need to be discussed with the patient and his or her family through an interpreter. Sometimes just before discharge, people are visited by a number of health staff in sequence to maximise interpreter efficiency, but it can be overwhelming for both interpreter and patient to have a single two hour session.

Discharge planning as a process must begin on admission to hospital and continue throughout the hospital stay, to ensure continuity of care in the post-hospitalisation phase. Appropriate services must be identified as early as possible by the discharge planning team to establish an ongoing working relationship with them, and to ensure that appropriate referral is

made for people from diverse cultural backgrounds. Where possible, referrals must be made well before the patient is discharged, to give service organisations sufficient time to pick up the referral.

Discharge planning teams need to be aware of intermediaries in each ethnic community with whom they can liaise, both to establish linkages with appropriate community-based services, and to be guided in a more general sense about critical cultural factors. After consultation with the person, specific ethnic organisations and other community resources can be involved (in addition to the family if the patient has family with him/her in Australia). See the Resources section for a list of selected community organisations. Volunteer visitors from their community may be available to help a recently discharged patient shop and undertake other tasks, provide company, and provide personal support etc. For those who need nursing home/hostel accommodation, a list of ethno-specific and multicultural nursing homes is given in the Resources section.

In summary, the following points should be considered essential to comprehensive discharge planning, and are particularly important for patients from diverse cultural backgrounds:

- Start planning as early as possible in the hospitalisation period, as preparations for discharge may take longer than for people without cultural and language issues.
- Consider the patient's medical and non-medical (social) needs.
- Employ a multidisciplinary approach involving a range of health professionals.
- Allow patients and their families considerable self-determination in the process of planning for their care and needs.
- Check that the patient, family and care providers fully understand the proposed care plan.
- Ensure that post-hospital care involves co-operation and collaboration between the hospital and relevant home and community care services.