Manitoba Developmental Centre

Effective Date: June 14, 1989	TITLE: **DISCHARGE**	POLICY NO. I-25 ***RAD***
Review Date: May 19, 2022		PAGE 1 of 1
Revision Date:	SUBTITLE:	APPENDIX A to E

OBJECTIVE
To facilitate the coordinated transition from MDC to community living in a manner that promotes individual growth and identifies personal strengths, preferences, needs, required services and outcomes that ultimately enhance their quality of life.

POLICY
Consistent with The Vulnerable Persons Living With a Mental Disability Act, the following will be adhered to:

1. A discharge from MDC will require a resident focused discharge plan, and wherever possible, resident approval prior to obtaining consent from the SDM for Personal Care.
2. The development of a discharge plan will require the participation of the resident in collaboration with SDM for Personal Care, family/support network, interdisciplinary care team, community care providers and Community Services Worker/Agency Case Manager.
3. Community placements will be compatible with the resident's wishes and needs in relation to his/her history, personal characteristics and lifestyle as appropriate.
4. All potential risk variables (behavioural or medical), must be identified in the discharge plan. High probability risk variables must have an intervention strategy or process identified in the discharge plan.
5. The recognition of resident's medical condition (including medications) before discharge is critical. Liaison with community agencies, approved home care providers and other resources must be undertaken to ensure the availability of medical expertise to monitor and treat the condition.
6. Discharge planning is reviewed during each Individual Planning Meeting.
7. For potential suitable placement options, residential vacancy profiles will be reviewed on an ongoing basis.
8. MDC will provide contact information as a continuing resource for information, crisis management, referral and support following discharge.

PROCEDURE

1. Clinical Coordinator initiates the electronic Discharge Checklist (Appendix A)
2. Clinical Coordinator will obtain a signed consent for disclosure of personal health information, as required, from the SDM for Personal Care. Consent includes the right to share any relevant information required for the purposes of transition planning, to be given to the identified Agency, Community Service Worker/Agency Case Manager and other community professionals as deemed necessary.
3. As updated agency/vacancy profiles are received by the Community Transition Specialist, the interdisciplinary team will meet with the resident and their support network to review suitable options.
4. Once a potential suitable community living option has been identified, the support network Community Transition Specialist obtains SDM consent for transition and ensures a transition information package is sent to the identified Community Agency.
5. Clinical Coordinator/Transition Specialist will arrange for transition visits with the identified Community Agency according to Transition Guidelines for Visits (form A-223 located on the Y:Drive).
6. Clinical Coordinator will ensure the discharge checklist is complete and all documents forwarded to Health Information Services for scanning to the electronic health record thus completing the discharge process.

REFERENCES:

The Vulnerable Persons Living With A Mental Disability And Consequential Amendments Act
Council on Accreditation (COA) CA-GLS 18