YOUR PATHWAY HOME: DISCHARGE PLANNING GUIDE

A Guide for Residents & Families

At the Brenda Strafford Foundation, we are committed to supporting residents and their families through every step of their care journey—including the transition to a new home or community setting. Our discharge planning process is designed to ensure that all care needs are met, and transitions are as smooth, safe, and comfortable as possible.

What is Discharge Planning?

Discharge planning is a collaborative process that prepares you or your loved one to safely leave our care and continue the journey toward recovery, independence, or ongoing support in another setting.

Why does it matter?

- Ensures continuity of care
- Minimizes risks of hospital readmission
- Provides tools and education for success at home or in a new environment

When does planning begin?

Planning starts early during your stay—ideally upon admission. Our interdisciplinary team works together to ensure you're well-supported every step of the way.

What can you expect before discharge?

- A discharge meeting may be arranged with your care team.
- Your health history, medications, and care needs will be reviewed.
- A discharge summary will be provided for your new care providers.

What is your role in the process?

- Let us know your preferences and any concerns you may have.
- Talk with your family about plans and support after discharge.
- Ask questions—we're here to help.

Types of Discharges We Support

From Long-Term Care (LTC) to Another LTC Site

- We work with you to ensure your medical and personal information is shared accurately with the new facility.
- Transportation plans and all necessary documentation are arranged.
- Your physician, care team, and family are involved every step of the way.

From Supportive Living (SL) to Long-Term Care

- When health needs change, your AHS Case Manager and Program Manager will assess your care requirements.
- If more support is needed, we help facilitate a transition to an appropriate LTC site.
- Families are included in care conferences, and additional care may be provided while waiting for placement.

Discharge to the Community

- A care team, including AHS Home Care, Transition Services, and family, will help plan your return to the community.
- We'll assess your home support, ensure needed equipment is arranged, and provide education about ongoing care and medications.
- Follow-up services are coordinated to support your continued wellness.

Upon Leaving the Site

We will help ensure:

- Your belongings are returned or prepared for pickup.
- Medications and prescriptions are ready (for community discharges).
- Final paperwork is completed.
- Your departure is supported with care, dignity, and compassion.

For more information, please contact the Program Manager or Director of Care.