SUBJECT: DISCHARGE PLANNING - ALL DISCIPLINES	REFERENCE #8401
DEPARTMENT: ORGANIZATIONWIDE	PAGE: 1 OF: 7
	EFFECTIVE:
APPROVED BY:	REVISED:

POLICY:

- Discharge planning is a process and service where patient needs are identified and evaluated. Assistance is given in preparing the patient to move from one level of care to another.

- Continuity of care requires thoughtful preparation by the entire healthcare team. Each patient's needs for continuing care are assessed in an ongoing fashion by all members of the healthcare team. This assessment may begin prior to admission, but in no event later than at the time of the admission nursing assessment. All disciplines are involved in the assessment/evaluation, reassessment and planning for after discharge healthcare needs of the patient and/or family including, but not limited to:

  - Members of the medical staff
  - Nursing staff members
  - Rehabilitation Services professionals
  - Social Workers
  - Respiratory Care Practitioners
  - Pharmacists
  - Case Managers

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- The discharge planning function focuses on meeting the patient's continuing healthcare needs after discharge. These needs may have necessitated the admission to the facility or may occur as an expected outcome to medical or surgical intervention, such as cast care following open reduction of a fracture, postoperative wound care, etc. The purpose of discharge planning is to identify the patient's continuing physical, emotional, social, housekeeping, transportation and safety needs and to arrange services to meet those identified needs. Needed discharge services may include:

  - Long term care

    - A list of participating medical skilled nursing facilities that are available and in the geographic area requested by the patient shall be included in the discharge plan.

  - Home health services

    - A list of participating medical home health agencies that are available and serve the patient's geographic area shall be included in the discharge plan.

  - Hospice services
  - Ambulatory care services
  - Rehabilitation services
  - Support groups
  - Community agency services
  - Community mental health
  - Adult foster care

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- Patients will be discharged based upon attainment of patient care goals as evident in the interdisciplinary plan of patient care, clinical pathways and/or other stipulated guidelines.

- Patient education is a major focus of discharge planning activities for all patients. Many patients' after care needs are met through education provided by each member of the healthcare team. As a result, documentation for patients with less complex discharge planning needs is often found within documentation associated with patient education. Patient education includes, but is not limited to, information about:

  - Acceptance of illness, disability and needed treatment
  - Coping with illness complicated by social and emotional problems
  - The conditions that may result in transfer to another organization or level of care
  - Alternatives to transfer, if any
  - The clinical basis for discharge and/or termination of treatment
  - The anticipated need for continued care following discharge
  - Self-care and nursing measures in the home situation

- Written discharge instructions shall be given to the patient/family in a manner that the patient/family can understand.

- If it is determined that a patient does not need a discharge plan, the patient's physician may request one.

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PROCEDURE:

- The initial assessment/evaluation for discharge planning needs is conducted during the nursing admission assessment or prior to the admission for patients within a designated critical path.

- Each discipline assesses and reassesses needs for after care as part of their ongoing assessment and reassessment processes. Discharge planning needs will be based on the plan of patient care. It is the responsibility of each discipline assessing discharge planning needs to document associated assessment findings within the medical record.

- Based on this assessment/evaluation, patients that demonstrate more complex discharge planning needs are referred to the Discharge Planner who will arrange services/care to meet those needs. An RN, social worker or other qualified staff oversees the development of the discharge plan.

- Examples of patient needs that would require more complex discharge planning include, but are not limited to:

    - Need for long term care placement
    - Need for home health services
    - Need for community agency referral
    - Need for community mental health services
    - Need for hospice services
    - Need for medical equipment not provided by the associated hospital department for use after discharge
    - Need for transfer to another acute care hospital (for services not provided at ____________________ Hospital)

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- Additionally, an automatic referral to the Discharge Planner for focused discharged planning is made for all “high-risk” patients:
  - Adult high-risk patient include:
    - Those admitted through the Emergency Department
    - Those with immunosuppressive disease
    - Those who are homeless
    - Those that live alone
    - Those with potential for IV therapy in the home
    - Suspected cases of abuse
  - Pediatric high-risk patients include:
    - Those with fractures of the femur that may eventually require spica cast application
    - Anticipated long term absence from school
    - Those with potential for IV therapy in the home
    - Suspected cases of abuse
  - Excluded from automatic referral are admissions with an anticipated length of stay of less than 48 hours.

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- Patients referred to the Discharge Planner receive the initial discharge planning interview within 48 hours of admission. The Discharge Planner will coordinate discharge planning efforts by all disciplines for those patients identified as high-risk or patients that demonstrate more complex discharge planning needs.

- All pertinent information shall be documented on the patient's plan of care and placed within the medical record.

  - ___________________ shall document in the patient's medical record that the list of home health agencies or skilled nursing facilities was given to the patient or family member.

  - The discharge plan shall also identify disclosable financial interests between the hospital and any home health agency or skilled nursing facility on the list.

- The patient is provided with discharge instructions, written in a manner that the patient and/or the patient's family or other caregiver can easily understand.

- The patient (or family, as needed) shall be given written information on all medications prescribed for after discharge.

- Medication information/reconciliation provided at discharge shall include medication name, dose, route, frequency and purpose.

  Note: When the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications.

- Patient medication discharge instructions shall include:

  - How to take the medications prescribed, the time for the next dose and how long to take any new medications that may be prescribed.

  - The importance of carrying a list of medications at all times.

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- The importance of providing a current and accurate medication list to all healthcare providers who are providing care to the patient, i.e., pharmacist, primary care physician, follow-up care physician.

- Patients and families shall be reminded to throw away old lists of medications, and to give all their physicians and pharmacies the updated list of medications.

- Any specific psychosocial concerns or crisis intervention needs will be referred to the medical Social Worker for assessment and care planning/discharge planning needs.

- As appropriate, discharge planning activities, including education related to these activities, are integrated into the patient's plan of care.

- All discharge plans shall be reviewed before the patient is discharged from the hospital to ensure that the discharge plan meets the needs of the patient.

- The patient and family, as appropriate, shall receive information regarding the patient's discharge or transfer needs, including continuing care, treatment and services needed by the patient.

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