

PROTOCOL FOR: Discharge Planning: Nursing Responsibilities for Preparing Inpatients for Discharge (and Referrals for Post-Hospital Support/Services)

- POLICY:**
1. All patients will be assessed prior to admission or at the time of admission to determine their discharge needs.
 2. The discharge planning process shall be integrated and coordinated by healthcare professionals and shall include the patient, family, and significant others.
 3. Discharge planning is an ongoing, interdisciplinary process involving the patient, family, and significant others, medical staff (including house officers, APRNs, PAs), nursing staff, staff of case management, social workers, dietitians, rehabilitation therapists (PT, OT, speech) and others as needed.
 4. Every hospitalized patient shall have a written discharge plan (Clinical Resume/W-10) that is given to the patient at the time of discharge. The patient and/or family signs the Clinical Resume/W-10. The top of the form includes the facility destination or home care services and the patient and/or family should sign the form indicating their awareness of the patient's destination/agency choice. If the patient is unable to sign and there is not family available, the discharge nurse may indicate on the form that the patient/family is unable or unavailable to sign.
 5. The RN is responsible for identifying the learning needs of patients, families, and significant others and for implementing the teaching plan.
 6. Each hospital department that has a direct effect on patient care shall enhance continuity of care through the appropriate utilization of hospital services, institutional facilities and community resources.
 7. Clinical Case Managers are responsible for assisting patients and families with coordination of all home care services.
 8. The social work department assists patients and families in completing and processing applications for extended care facilities, hospice placement, and evaluates financial and psychological needs.
 9. Physicians are responsible for completing discharge summaries and the sections of the Clinical Resume/W-10 related to treatments and medications. The physician writing the discharge order or on floors utilizing Computerized Physician Order Entry the physician placing the electronic discharge order signs the Clinical Resume/W-10. The house officer usually writes orders in consultation with the attending physician. The attending physician is presumed to concur with the discharge plan, even if he does not sign it.
 10. Medication reconciliation form is completed prior to discharge.
 11. At the time of discharge, all inpatients shall be escorted to the hospital entrance by a member of the transportation department, volunteer services, or by a staff member from the discharging unit.

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12. Patients with complicated discharge needs and/or circumstances that may delay discharge should be reported to the case manager and the nursing manager.
13. The hospital maintains transfer agreements for inpatient-to-inpatient referrals.

DESIRED PATIENT

- OUTCOMES:**
1. At the time of discharge, the patient, family, and/or significant other will verbalize understanding of the following: diet, medications, activities/treatment, follow-up appointments and any community referral for services or equipment.
 2. The patient will achieve an optimal level of functioning after discharge from the hospital

**CLINICAL
ASSESSMENT AND**

- CARE:**
1. The RN in conjunction with the case manager will continuously evaluate the patient for post-hospital needs. The evaluation will determine not only whether the patient will need services but also the type and frequency of those services. Therefore, the nurse should assess the patient, family, and significant other on admission and throughout the hospitalization for:
 - a. Knowledge of disease, wellness, procedures or treatment needed to maintain optimum, independent functioning.
 - b. Emotional, intellectual, sensory and physical ability to learn and carry out treatments and procedures needed for optimum independent functioning.
 - c. Cultural, language, or spiritual considerations that affect teaching and learning.
 - d. Expectation of ability to comply with and adhere to the treatment plan.
 - e. Type and frequency of services needed in the hospital.
 - f. Supplies and equipment needed for care in the hospital and after hospitalization.
 - g. Patient's independence in performing ADLs.
 - h. Availability of resources, including but not limited to caregivers, type and location of residence, financial status, and community services.
 2. Assess for need for post-hospitalization assistance or services (refer to Appendix A). Collaborate with the case manager and other members of the interdisciplinary team in determining the need for services after discharge.

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3. Instruct patients, families and significant others in needed aspects of patient care.
4. Interdisciplinary/discharge rounds may be utilized to facilitate the collaborative planning process.
5. Any patient can request referral to a community agency or placement in an extended care facility. Medical necessity must be demonstrated in order for there to be insurance reimbursement.

- DOCUMENTATION:**
1. Refer to the Clinical Manual Procedure for: Documentation: Discharge (Inpatient).
 2. Complete Nursing Database (Core and/or Inpatient).
 3. Progress notes addressing Discharge Planning will be written within 24 hours of admission and whenever there is a change in status or plan. Daily notes may be required for complicated cases or short-term hospitalizations.
 - a. If there are no discharge issues identified at the time of initial assessment, patient goals and a preliminary discharge plan should be established and documented in the progress notes.
 - b. The discharge goals and plan are reviewed and updated periodically as the patient's condition warrants.
 4. Document any referrals that have been made.
 - a. If at the time of initial assessment it is determined that the patient cannot return home or will be unable to care for himself/herself independently in the home setting, the nursing staff in conjunction with the departments of case management and social work will assist in planning for continuity of care.
 - b. Patients who seem to be unable to return home or who were admitted from another facility are referred to the social work department.
 5. Document patient teaching on the Patient and Family Teaching Record.
 6. On the day of discharge, the following will be completed: (Refer to Procedure for Documentation: Discharge (Inpatient)).
 - a. Patient going home without services:
 - 1) Clinical Resume/W-10 (Fill out according to instructions on back of form and distribute copies as designated on bottom of each sheet).
 - 2) Discharge Note
 - 3) Prescriptions
 - b. Patient going home with services:

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- 1) Clinical Resume/W-10 (Fill out copies according to instructions on back of form and distribute copies as designated on bottom of each sheet). Fax to appropriate homecare provider.
 - 2) Physical/Occupational Therapy Summary (if appropriate)
 - 3) Prescriptions
 - 4) Discharge Note
- c. Patient going to an extended care/inpatient facility:
- 1) MI/MR Screen and screening result (completed by Social Work)
 - 2) Clinical Resume/W-10 (Fill out according to instructions on back of form and distribute copies as designated on bottom of each sheet)
 - 3) Medical Discharge Summary - required for any transfer to rehabilitative unit, hospice, or ECF.
 - 4) Physical/Occupational Therapy/Speech Therapy Summary
 - 5) Any additional requirements such as lab studies, X-rays, etc.
 - 6) Nurse calls ECF with updated nursing report.
 - 7) If transferring by ambulance, an ambulance authorization form must be signed by a physician.
 - 8) DNR transfer if applicable

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 9/90

REVISION DATES: 9/91, 5/93, 1/95, 5/95, 10/97, 2/00, 2/03, 4/03, 4/05, 7/08, 8/08

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APPENDIX A

High Risk Categories with a Reasonable Expectation of Need for Post-Hospital Support or Services

1. Age:
 - a. 65 or older, living alone or with an incapable caregiver.
 - b. Under age 18 - suspected abuse, neglect, substance abuse, accidental drug ingestion.
 - c. Pregnant and postpartum minors with limited parental support.
2. Residence/Other Services:
 - a. Transfers from other facilities, including nursing homes, group homes, other hospitals.
 - b. Patients that are currently being serviced by other agencies.
 - c. Unclear, or no known place of residence.
 - d. Unsafe home environment (e.g., fall risk).
3. Behavioral Factors:
 - a. All psychiatric patients.
 - b. All patients with developmental/intellectual disabilities.
 - c. History of noncompliance with health care plan.
 - d. Readmissions within 15, 30, 60 days - except in cases of readmission per chemotherapy protocol.
 - e. Attempted suicide.
 - f. Possible/active substance abuse.
 - g. Family conflict.
4. Social/Familial/Cultural:
 - a. No identification.
 - b. No next of kin and/or guardianship need.
 - c. Cultural and/or language barriers.
 - d. Inadequate financial resources.

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5. Diagnostic:

- a. Handicapped - paralysis and other progressive, degenerative, or debilitating conditions.
- b. Organic brain disorders.
- c. Abuse - physical, emotional, or failure to thrive.
- d. History of multiple hospitalizations within a short period of time.
- e. Obstetrics: early discharge (within 24 hours after vaginal delivery or within 48 hours after cesarean delivery), first time breastfeeding, minor parent, adoption, multiple gestations, infant loss.
- f. Patients who require special equipment in the home, e.g. oxygen glucose testing equipment, specialty beds, intravenous therapy (hydration, TPN, antibiotics), parenteral or enteral feedings, apnea monitors, ventilators.
- g. Patients with changes in body image (stomas, tracheostomies, plastic surgery repair, burns).