

PROTOCOL FOR: Discharge Planning: Hospital Based Clinics - Outpatient Nursing Responsibilities for Making Home Care Referrals

- POLICY:**
1. All patients will be assessed for home care referrals.
  2. All patients/significant others will be included in the referral planning process.
  3. Patients and, if appropriate, family/significant others will receive necessary teaching to ensure optimal level of functioning at home.
  4. This policy applies to hospital base clinics (i.e., UCC, AACU).

**DESIRED PATIENT  
OUTCOME:**

At time of discharge, patient, guardian and/or significant other will verbalize understanding of the following: diet, medications, activities/treatment, follow-up appointments and any community referral for services/equipment.

**ELIGIBILITY  
REFERRAL  
CRITERIA:**

Any patient can request referral to a community agency or placement in an extended care facility. However, for a patient to have a reasonable expectation of insurance covered service in the community, he must:

1. Be essentially homebound.
2. Require a skilled service such as nursing, physical therapy, or speech therapy on an intermittent basis.

**ASSESSMENT:**

The nurse will continue to evaluate the patient at home 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 evaluate:

1. The patient's knowledge of disease, wellness, procedures or treatment needed to maintain optimum, independent functioning.
2. The caregiver's knowledge of above if the patient is unable to function independently.
3. The patient's and family's emotional, intellectual and physical ability to learn and carry out treatments and procedures needed for optimum independent functioning.
4. Both patient and caregiver as to a reasonable expectation of compliance and adherence to the treatment plan.
5. The type and frequency of services needed in the hospital.
6. Supplies and equipment needed.
7. Patient's independence in ADL activities.
8. If the patient's home environment, family relationships and other resources are equal to meet the patient's needs with the support of a community agency.

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**ASSESSMENT  
FOR HIGH RISK  
CATEGORIES:**

- The nurse should assess all patients for services or assistance. Patients who fall into any of the following high-risk categories have a reasonable expectation of a need for support/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. Mentally retarded, regardless of age
    - d. Pregnant minors
  2. Residence:
    - a. Patient living in other facilities, including nursing homes, group homes, other hospitals.
    - b. Unclear, or no known place of residence.
  3. Behavioral Factors:
    - a. History of noncompliance with health care plan.
    - b. Attempted suicide.
    - c. Possible/active substance abuse.
  4. Social/Familial/Cultural:
    - a. No identification.
    - b. No next of kin and/or guardianship need.
    - c. Cultural/language barriers.
  5. Medical:
    - a. Handicapped - paralysis and other progressive, degenerative, or debilitating conditions.
    - b. Abuse - physical, failure to thrive.
    - c. All psychiatric patients.
    - d. History of multiple hospitalizations within a short period of time.
    - e. AIDS.
    - f. Pregnancy.
    - g. Bone Marrow Transplants.
    - h. Newly diagnosed IDDM.
    - i. Orthopedic trauma.
  6. Nursing Care/Social Work:
    - a. Patients with teaching needs.
    - b. Patients with inadequate financial resources.
    - c. Patients being currently serviced by other agencies.
    - d. Patients who may require special equipment in their homes: e.g. oxygen, ventilator, apnea monitors, parenteral or enteral feedings.
    - d. Patients with changes in body image (stomas, plastic repair, burn).
    - e. Patients requiring placement to a facility outside the home (nursing home, skilled nursing facility, hospice).

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**COLLABORATION:** The nurse should include the consultation with following persons in preparing the patient for discharge:

1. The patient
2. The patient's family or significant other
3. Attending Physician
4. Advanced Practice Nurse
5. Clinical Nurse Specialist
6. Case Manager
7. Dietitians
8. Social Worker
9. Rehabilitation Therapists
10. Pharmacists

Multidisciplinary planning meetings may be utilized to facilitate the collaborative process.

**PATIENT TEACHING:** The nurse is responsible for identifying the learning needs of patients and their significant others. Every opportunity should be utilized to:

1. Assess patient's and significant other's knowledge of the patient's current disease process and care needs.
2. Teach patients/significant others needed aspects of patient care.

**DOCUMENTATION:**

1. Complete Nursing Data Base.
2. Document any referrals that have been made.
3. Document any patient teaching.
4. W10 if requested by the agency.

**APPROVAL:** Nursing Standards Committee

**EFFECTIVE DATE:** 5/01

**REVISION DATES:** 3/02