

PROTOCOL FOR: Discharge Planning

- POLICY:**
1. Discharge planning will be initiated on the day of admission and will involve the patient's active participation in the treatment plan.
 2. A discharge planning note will be completed on admission and at least every 72 hours.

DESIRED PATIENT

- OUTCOMES:**
1. Patient will actively participate and be able to verbalize discharge plan.
 2. Patient will verbalize agreement with and willingness to follow through with discharge plan.
 3. Patient will acknowledge that discharge plan adequately meets on-going care needs.

**CLINICAL
ASSESSMENT AND**

- CARE:**
1. Refer to Nursing Practice Manual protocol for Discharge Planning: Inpatients.
 2. Collaborate with interdisciplinary team in developing the discharge plan and provide the patient with follow-up care options (i.e., Partial Hospital Program, outpatient clinics, other structured/supervised housing).
 3. Provide support and encouragement in exploring follow up options.
 4. Assist patient with making needed appointments for follow up care.

- PATIENT TEACHING:**
1. Educate patient to importance of identifying treatment goals and establishing plans for follow up care.
 2. Educate patient regarding the importance of follow through with established plan for medications and therapy.
 3. Educate patient about the need to participate in daily structured activity.
 4. Educate patient about importance of utilizing appropriate resources/ supports after discharge.
 5. Educate patient/significant other to recognize those target symptoms which indicate relapse/readmission.

- DOCUMENTATION:**
1. On the day of discharge, document assessment of current clinical status, understanding of discharge plan, and willingness to follow-up with recommended care.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 5/90

REVISION DATES: 5/91, 4/92, 11/94, 10/96, 6/99, 10/00, 10/03, 6/06, 3/07, 8/08