

**PROTOCOL FOR:** Discharge Planning

- POLICY:**
1. Discharge planning begins the day the patient is admitted. Early, anticipatory discharge planning is essential for a smooth transition from treatment to other services. It is the clinician's responsibility to coordinate the discharge plan with the patient.
  2. A Change of Service Note including who gave report and to whom will be documented in the progress note section of the patient's chart. When the patient is being transferred to or from the PHP and the IOP, in addition to the brief Change of Service Note, the transferring clinician will also do a dictation. When the patient is discharged from PHP/IOP service and will be going to the outpatient level of care in addition to the aforementioned, the discharging clinician and program APRN will also complete a W10 form.

**DESIRED PATIENT**

- OUTCOMES:**
1. All patients will be assessed in an ongoing manner for post discharge needs.
  2. All patients and significant supports will be included in the discharge planning process.
  3. Patients will be informed of resources available in the community for care after PHP.
  4. Patients will be appropriately referred to outpatient services as indicated, following discharge from the hospital.

**PATIENT**

**TEACHING:** Patients will be informed of available community resources while with PHP/IOP to support continuity of care while attending program services.

**DOCUMENTATION:** The following documentation will be completed at the time of discharge:

1. Discharge notes from treating clinicians
2. Discharge Summary
3. Clinical Resume
4. Medication Reconciliation Form

**APPROVAL:** Nursing Standards Committee

**EFFECTIVE DATE:** 12/91

**REVISION DATES:** 12/92, 12/93, 7/94, 11/97, 3/99, 2/00, 9/02, 5/03, 6/07, 8/08, 10/08