

SUBJECT: Discharge Planning and Referral		
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REVIEWED BY: Hospital Nurse Directors, Social Worker		SUPERSEDES: VIII-D-59

Purpose

Discharge planning services are readily available to the patient and his/ her family. If there is no family available, the healthcare team works with persons significant to the patient. Services are based on individual patient need, the availability of community resources, and the patient's social support network. The discharge planning process provides continuing care based on the patient's need at the time of discharge. Discharge plans are initiated, updated, and reassessed throughout the patient's hospitalization. For some patients, discharge planning consists of a clear understanding of how to access services in the future if the need arises.

Policy

Prior to discharge from the hospital, each patient receives appropriate discharge planning and referral assistance in an effort to ensure a safe living environment. The discharge plan for each patient is individual and is to be kept confidential. Discharge planning begins at the time of admission during the completion of the Multi-Disciplinary Assessment and Referral Form. Discharge planning is the joint effort of the patient, family, clinician, and hospital care team on Med/Surg or personnel involved in the patient's plan of care. The patient's clinician may request a social work consult to assist with discharge planning needs and concerns. In the absence of the social worker, the charge nurse is responsible for discharge planning and psychosocial referrals. The patient and his/her primary family member or interested person is counseled to prepare for post-hospital care. Discharge plans throughout the hospitalization are reassessed to ensure appropriateness of continuing care needs and resources/services. The encouraged hospital discharge time is 1:00 PM, pending clinician orders and medical needs. Each patient has care or treatment instructions to follow at home or at the referring agency. If the patient is discharging to home, the patient signs a copy of the instructions, verifying that the patient understands the instructions. The signed copy remains in the patient's medical record. If the patient is a minor, the patient's parent or legal guardian must sign the form. Members of the multi-disciplinary care team are empowered to institute a "hard stop" when the transition of care communication is incomplete or if inconsistencies are present amongst the care team or the care team and the patient and/or the patient's family.

Definition

High Risk: Patients likely to suffer adverse health consequences upon discharge without adequate assessment and plans for discharge ensuring that continuity of care, treatment, and services are maintained.

Hard Stop: The discharge plan is halted until further assessment and/or communication can occur, to ensure patient safety.

Procedure

1. The nursing staff is responsible for:
 - a. Identifying patients considered "high risk" and referring those patients to the charge nurse/social worker.
 - b. Collecting patient information and documenting on the Multi-Disciplinary Assessment and Referral Form. This information includes a description of the patient's home living situation, functional status, cognitive abilities, and social support.
2. If patient is considered "high risk", the social worker/charge nurse is responsible for:
 - a. Reviewing the patient's medical record, focusing on the patient's personal goals for discharge, providing consultation, and initiating the referral process for area resources.