

Owners/Group: Care Management Services HealthEast Nurse Practice Committee	Policy No. HE Administrative Policy: 100.C-6 HENSA Policy T-7
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POLICY TITLE: Discharge/Transfer/Care Planning Process and Implementation

POLICY: Care planning including (Discharge planning) for a patient will be initiated upon admission and will continue throughout the patient’s hospitalization. Every patient admitted to a HealthEast Hospital will receive individualized discharge planning with referral, as appropriate to community resources and utilizing social work services, as needed.

PURPOSE: To insure patients/surrogate decisions makers are involved in care planning and safe discharge to **any** post-facility setting and to provide continuity of care for patients and their families.

PROCESS:

Discharge or Transfer

1. Patients may be discharged from the hospital without services or discharged/transferred to another level of care, treatment, and services, to different health professionals, or to settings for continued services.
2. The hospital’s processes for transfer or discharge are based on the patients’ assessed needs.
3. To facilitate discharge or transfer, the hospital assesses the patient’s needs, plans for discharge or transfer, facilitates the discharge or transfer process, and helps to ensure that continuity of care, treatment, and services is maintained.

Interdisciplinary Care and Discharge Planning

1. On admission, the anticipated discharge needs and barriers to discharge of the patient and the ability of the patient and/or family to manage these needs will be assessed by the RN as appropriate. Reassessment of these needs will occur throughout the patient’s stay.
2. Care and discharge planning is an interdisciplinary process, with representation from caregivers such as: Medical staff, Nursing, Physical Medicine (Physical Therapy, Occupational Therapy, Speech Therapy), Nutritional Services, Pharmacy, Spiritual Care, RN Care Manager and Social Work Care Manager. The interdisciplinary team will determine desired discharge outcomes through the following:
 - a. Communication with patient and family
 - b. One to one assessment/evaluation with patient
 - c. Care management rounds
 - d. Discharge planning conferences (when requested by patient, family or team member)
 - e. Patient/family conferences (when requested by patient, family or team member)
 - f. Communication with physician
 - g. Communication with involved community providers

3. Discharge Planning/Care Management Rounds are held on a regular basis on each nursing unit in the acute care setting. At Bethesda Hospital, Discharge Planning/Care Management Rounds are held at least once a week. The care plan, progress and discharge plans of each patient are reviewed and evaluated. Care Management Rounds are held at least once per week on Hospice patients. The care plan and patient's condition are discussed; the care plan is updated as appropriate by a Care Manager or other team member.

At St. Joseph's, St. John's and Woodwinds, care planning rounds are held as often as 5 times per week on all units except Maternity Care and the Special Care Nursery. On Maternity Care and the Special Care Nursery, care planning rounds are held two times per week or on an "as needed" basis. The Clinical Director, Charge Nurse or staff nurse notes pertinent information on the Kardex, and the care plan is updated as needed.

Patient/Family Conference:

1. Patient/family conferences may be initiated by any of the interdisciplinary team members or patient/family requests. The conferences are scheduled to include pertinent members of the interdisciplinary team.
2. Attendance of patient and appropriate family members is determined by the team initiating the conference in conjunction with the patient and family members.
3. Documentation of pertinent information will be recorded in the progress notes, or on the Multidisciplinary Patient/Family Care Conference form (see HealthEast Form # MR 9783-C).

Transfer to Acute Care

See HealthEast Administrative policies # 100.C-10 through #100.C-22 or HENSA T-1a.

Transfer to Non-Acute Care (Skilled Nursing Facility, Hospice Care, Home Care, Group Home).

1. Physician Responsibilities

- a. Proactively plan with patient for discharge.
- b. Ensure all orders complete and accurate before discharge.
- c. Notify the patient of discharge.
- d. Notify the nursing staff of discharge.
- e. Write complete discharge orders, including medications according to the HealthEast Medication reconciliation process.
- f. Complete Interagency Physician Assessment and Transfer Form.
- g. Dictate discharge summary and send to accepting provider or primary care provider. Include reasons/indicators for medications and written prescriptions for narcotics.

2. Nurse Responsibilities

- a. Notify the parents of all minors about discharge. This is not necessary if the minor is legally able to consent to his/her own treatment. (**Note:** A minor who can consent for treatment is "any minor who is living separate from his parents or legal guardian, whether with or without the consent of a parent or guardian and regardless of the duration of such separate residence, and who is managing his own financial affairs, regardless of the source or extent of his income, or any minor who has been married or has borne a child." This is extracted from legislation passed by the Minnesota State Legislature, 1971.)

- b. Verify that the discharge order has been entered into the patient's medical record.
- c. Discuss new medications ordered with the patient/family and obtain necessary written prescriptions.
- d. Collaborate with physician to complete the Interagency Physician Assessment and Transfer Form and/or the Discharge Instructions Form, as appropriate.
- e. The original of the Interagency Physician Assessment and Transfer Form:
 - i. Is to be sent with the patient as part of the referral information for those patients not going home.
 - ii. Can be given to patients that are discharged home.
 - iii. A copy will be kept in the patient's chart and is a permanent part of the medical record.
- f. Complete any required teaching for continued treatments and medication at home and document on the Discharge Instructions form.
- g. For patients being discharged to another facility (Nursing Home, Transitional Care Unit, etc.), send both pages of the original copy of the Nursing Home Pre-Admission Screening (Nursing assessment form) to the facility and place one copy of the form in the chart. Give verbal report to receiving facility upon their request.
- h. Assure medication reconciliation is complete

3. RN Care Manager and/or Social Worker

- a. Inform health care team of GLOS related to diagnosis.
- b. Assure timely care progression.
- c. Communicate with payor about plan and progress on as needed basis.
- d. Clarify patient's status (observation vs. inpatient).
- e. Identify primary decision maker
- f. Identify appropriate level of care/resources needed after discharge through discussions with the interdisciplinary team, the patient and family.
- g. Coordinate the arrangements for appropriate Home Care, Hospice Care or Transitional Care Unit/Skilled Nursing Facility placements.
- h. Serve as communication link between hospital staff, community, patient and family.
- i. Discuss with the patient or the patient's decision maker transportation options and coordinate arrangements if necessary.
- j. Clarify with the receiving facility and patient/family how discharge prescriptions will be filled (particularly Assisted Living, Board and Care, and Group Homes).
- k. Discuss with primary decision maker financial obligations related to next level of care.
- l. Document ongoing activity in the Physician Progress Notes section of the medical record.

5. HUC/IC Responsibilities

- a. Compile and facilitate the information needed for the Discharge Envelope, as appropriate.
- b. Assure completion of discharge checklist and after signed, retain copy in the medical record
- c. If discharge checklist is incomplete, contact RN Care Manager or Social Work Care Manager.
- d. Arrange follow-up services as needed (including follow up appointments).
- e. Complete assigned delegated tasks.

Discharge protocol of a patient to Transitional Care Unit/Skilled Nursing Facility:

- 1. Patients are provided information about Transitional Care Units/Skilled Nursing Facilities. A referral will be made to the Transitional Care Unit/Skilled Nursing Facility selected by the patient/family. Documentation regarding the offer of choice of Transitional Care Unit/Skilled Nursing Facility will be documented in the Progress Notes.

2. The Social Worker will make the referral and fax the following information to the Transitional Care Unit/Skilled Nursing Facility: face sheet, history and physical and the nursing assessment form. The Transitional Care Unit/Skilled Nursing Facility will call the hospital unit nurse for further information if needed. Infection control issues need to be communicated to the receiving facility.
3. Once the screen has been reviewed, the Transitional Care Unit/Skilled Nursing Facility will notify the Social Worker to report if placement is appropriate.
4. The hospital health care team and receiving facility identifies the physician who will follow the patient in the nursing home.
5. The Social Worker completes County Pre-admission Screening forms, if needed.
6. Paper work to accompany the patient:
 - a. Patient's Face Sheet
 - b. History and Physical & Recent Consults
 - c. Laboratory results- last 3 days
 - d. Interagency Physician Assessment and Transfer Form
 - e. Original Medication Reconciliation form (POR)
 - f. Nursing Assessment form original copy pages 1 and 2
 - g. Level 1 preadmission screening if anticipated LOS and SNF is greater than 30 days
 - h. Physician Progress Notes- Last 3 Days
 - i. Physician Discharge Summary-If available
 - j. Health Care Directive-if one exists
 - k. Other documents as needed to provide a complete summary
 - l. Pertinent test of X-ray results
 - m. Physical Therapy/Occupational Therapy/Speech notes- initial note and last 3 days
 - n. IV Flow Sheets
 - o. Medications given within 24 hours

Discharge of a patient to a Home Health Agency or Hospice Care:

1. Patients are provided information about Home Health Agencies or Hospice Care. A referral will be made to the Home Health Agency or Hospice Care selected by the patient/family. Documentation regarding the offer of choice of Home Care/Hospice Care will be documented in the Progress Notes.
2. A Social Worker or a nurse will coordinate Home Care/Hospice Care services with the selected Home Care/Hospice Care provider.
3. Information that must be faxed on all Home Care and Hospice Care referrals are copies of:
 - a. Face sheet
 - b. History and physical
 - c. Interagency Physician Assessment and Transfer Form
 - d. Other pertinent information

Other HealthEast Policy References:

- HE Admin. # 100.B-29 "Medication Reconciliation"
- HE Admin. # 100.B-31 (HENSA H-4) "Hand Off Communication"
- HE Admin. # 100.C-10 "Emergency Medical Treatment and Active Labor Act (EMTALA)"
- HEPN M-9 "Medication Reconciliation"
- HENSA T-1a "Transfer of Emotionally Ill and/or Chemically Dependent Persons"
- HE Admin # 100.B-32 "Social Work Indicators"
- HENSA S-3" Standards of Care and Standards of Practice"

References:

- HealthEast Form # MR 8724-S “Discharge Instructions”
- HealthEast Form # MR 9753-C “Nursing Home Pre-Admission Screening (Nursing assessment form)”
- HealthEast Form # MR 9754-C “Interagency Physician Assessment and Transfer Form”
- HealthEast Form # MR 9783-C “Multidisciplinary Patient/Family Care Conference”
- TJC Hospital Accreditation Standards

Unit and Department Communication:

- All Nursing Units
- Nursing Service Office
- Care Management Services

Policy Revisions:

Initial Approval: June 11th, 1990

Debra J. Reines RN, CNS
Co-Chair
Linda [Signature]
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	04/94	Social Work Services	03/06
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