Section 9	Clinical Policies	11/01/92 -Originated
Subject 9.1	Admissions, Transfers, and Discharges	06/10/05 -Reviewed w/ changes 04/11/03 -Reviewed w/o changes
Policy 9.1.14	**Patient Discharge Planning**	Nursing Service -Author

Patient Discharge Planning

Audience

The information in this document is intended for all healthcare workers involved in discharge planning for patients and their families.

Policy

The patient's needs pertaining to post-discharge care will be assessed upon admission. A multidisciplinary team that includes the physician, registered nurse, and care manager, together with the other members of the healthcare team, will perform the assessment. A plan to meet these needs will be developed, and interventions to meet specific discharge planning goals will be designed. The plan will be monitored and revised as necessary throughout the hospital stay.

Needs Assessment Factors

Actual and potential discharge planning needs of the patient/family will be assessed on the basis of the following criteria:

- the level at which the patient and family or other caregiver understands the patient's medical condition and the reason for hospitalization
- the patient/caregiver's stated expectations
- tasks the patient can/cannot accomplish as a result of their current health problems
- socio-cultural and religious practices and beliefs
- age-related issues
- language and language barriers that impact understanding the treatment/discharge plan
- physical and/or cognitive limitations
- desire and motivation to learn
- emotional and mental status
- financial resources available to assist with discharge needs
- social support systems available to assist patient/family/other caregiver
- level of post-hospital care needs (e.g., acute, intermediate, long term)
- nature and complexity of post-hospital care needs (e.g., patient safety, infection control)
- impact of patient's illness on lifestyle of family or other caregiver and necessary interventions
- availability and accessibility of adequate housing

Needs Assessment Factors (cont'd)

- access to transportation
- readiness/availability of family or other caregiver to assist with
  care needs of patient at home.
- availability of community or other healthcare resources to assist with care
- need for special equipment, supplies, or medication
- need for monitoring agents (i.e., CPS, police hold)

Roles in Discharge Planning

At the time of discharge, the following tasks will be accomplished by the disciplines indicated, if necessary:

Physicians:

- Inform the patient/caregivers of the discharge date
- Discuss the post-discharge plan of care
- Establish time for follow-up appointment, if applicable

Nurses Assist in contacting the patient's family/caregiver to inform them of the discharge date and confirm transportation arrangements

- Ensure that all necessary patient teaching has occurred
- HUC/clerk confirms that a follow-up appointment has been made
- Provide patient and family/caregiver with the discharge instruction sheet on prescribed treatments, medications (including food/drug interactions), the nutrition plan, activity level, and scheduled follow-up appointments. (All written instructions and prescriptions should be in layman's terms
- Provide written discharge instructions for discharged TDCJ offender to their health unit providers
- Ask the patient and family/caregiver to verbalize their understanding of the discharge instructions and give a demonstration of any care procedures
- Have the patient or responsible family/caregiver sign the discharge instruction sheet attesting to the receipt of the information
- Sign and date the form, and give the original to the patient or responsible family/caregiver
- Document discharge in the medical record

Roles in Discharge Planning, continued

Care management:

- If the patient is unable, ensure the patient's family/caregiver has been contacted as necessary to inform them of the discharge date and confirm transportation
- Establish transportation home by the most appropriate means if the family is unable to provide transportation
- Establish that the patient's intended destination is safe and accessible
- Confirm arrangements for any medical supplies or equipment to be provided in the home
- Confirm transfer arrangements if the patient is being transferred to another facility, including facility acceptance, discharge prescriptions, copying pertinent parts of the medical record, completing Memorandum Of Transfer if needed
- Make any referrals necessary for assistance from community agencies or available financial assistance or advise patient to contact them. Give patient or responsible caregiver a copy of the referrals made, including address and telephone number. Have patient or family sign Care Management Referral From and give them the yellow copy. File white copy in medical record
- For patients requiring intravenous medication therapy after discharge:
  - Identify patient's financial status to determine the method/arrangements
  - If indigent patients can receive medications either once a day or twice a day at 0800 and 1500, coordinate with Infusion Services for outpatient treatment

Respiratory Therapists:

- Determine home respiratory medical equipment needs
- Provide patient/family teaching on medications, medical equipment, and therapy procedures to be performed at home
- Perform oxygen assessments to determine necessity of home oxygen
- Participate in interdisciplinary discharge planning rounds and conferences

Roles in Discharge Planning (cont'd)

- Advise patient and family of available community resources, if needed
- Communicate and coordinate care with other respiratory care practitioners and healthcare providers across the continuum (e.g., Skilled Nursing Facilities, Home Health agencies, nursing homes, and TDCJ)

Physical Therapists:

- Make appropriate recommendations for equipment needs, such as ambulation devices, wheelchairs, and bedside commodes.
- Instruct patient/family/caregiver on a written home exercise program
- Instruct family/caregiver in proper transfer/guarding and positioning techniques. Have them verbalize and demonstrate each technique
- Make necessary recommendations for follow-up physical therapy, e.g., outpatient, home health, rehabilitation, skilled nursing facility, early intervention, or school-based therapy programs

Occupational Therapists:

- Make appropriate recommendations for equipment needed for self-care and independence in activities of daily living
  Instruct patient/family/caregiver in appropriate techniques to facilitate optimal safety and independence
- Instruct patient/family/caregiver on a written home exercise/activity program
- Instruct patient/family/caregiver in use and appropriate maintenance of splints and other orthotics. Instruction may occur verbally, by demonstration, and/or in writing.
- Make necessary recommendations for follow-up Occupational Therapy (e.g., outpatient, home health, rehabilitation, skilled nursing facility, early intervention, or school-based therapy programs).

Roles in Discharge Planning (cont'd)

Therapeutic Recreations:

- Instruct patient/family/caregiver about leisure resources available in the community.
- Make necessary recommendations for follow-up Therapeutic Recreation (e.g., skilled nursing, rehabilitation, school-based therapy, or community recreation programs).

Nutritionists:

- Participate in interdisciplinary discharge planning rounds and conferences.
- Instruct patient/family/caregiver regarding nutrition and any dietary modifications as indicated.
- Advise patient and family of available community resources, if needed.
- Make necessary recommendations for follow-up Nutrition Services (e.g., skilled nursing facility, dialysis center, or other points in the continuum of care).

Pharmacists:

- Assist medical staff with drug regimens.
- Provide patient/family/caregiver with medication information.

Guidelines for TDCJ Offender Patients

Because of security-related issues, communication regarding the discharge of TDCJ offender patients is coordinated through the TDCJ Care Management. Information of this nature will only be released to authorized security and medical staff on a need-to-know basis.

Non-Pharmaceutical Patient Supply Needs

Registered Nurses will instruct patients prior to discharge on supply use and needs.

- Based on the supply need assessment by the healthcare team, the patient will be given a Home Supply Formulary list completed and signed by the physician before discharge.
- The supply list will be for up to three days worth of supplies.

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Non-Pharmaceutical Patient Supply Needs, continued

- Patients are encouraged to obtain their supplies from an outside provider. If the patient is unable to obtain their supplies from another provider, he may obtain them from the Materials Management Hospital Supply Room. The patient is responsible for the cost of the supplies or the applicable co-pay
- Ostomy patients may be referred to the Ostomy Nurse for temporary supply arrangements through Industry Patient Programs

Required Documentation

The following information must be documented in the patient's discharge note or on appropriate approved forms in the medical record:

- Provision of all discharge-related patient/responsible caregiver education.
- Appropriateness of housing.
- Availability of transportation.
- Assessment of availability of family/other caregiver and their readiness to assist with the care of the patient at home.
- Availability of assistance from community resources, including referrals to other healthcare agencies, as appropriate.
- Availability of medical equipment, supplies, and medication as indicated.
- Follow-up plan.