Discharge Planning

Purpose

This document establishes the Department of Rehabilitation Services guidelines for discharge planning.

Audience

This information in intended for all Rehabilitation Services staff and students completing clinical affiliations.

Policy

The Department of Rehabilitation Services will actively participate in discharge planning from the onset of treatment until final discharge plans are implemented. The ultimate objective for all therapeutic interventions is to prepare the patient for return to the highest level of independent functional performance. Therapeutic interventions include: assessment, treatments to maximize functional performance, and the provision of patient and family education relevant to home programs and aftercare instructions.

Documen-tation

- The results of assessments, planned treatment interventions, and discharge recommendations will be shared with the physician and medical staff through documentation in Epic medical record and via verbal reports during rounds/meeting times.
- Documentation by Rehabilitation Services staff will record all patient and family education, including the provision of patient-specific home programs, on the Patient-Family Teaching form and within the content of a treatment note.
- Discharge planning goals will be revised as needed dependent upon the individual patient's medical status, personal objectives, and progression in therapy.
- The therapist will document discharge plans according to the guidelines for the patient's particular medical service or unit.
- All clinicians will participate in discharge planning activities and will document therapeutic recommendations in EPIC.
- A comprehensive discharge summary should be either documented in Epic or written and submitted for inclusion in patient medical record at the termination of services.