Section 9 Subject 9.1 **Policy 9.1.14**	Clinical Policies Admissions, Transfers, and Discharges **Patient Discharge**	11/01/92 - Originated 08/14/14 - Reviewed w/changes 04/11/03 - Reviewed w/o changes 08/14/14 - Effective Nursing Service -Author

Patient Discharge

Policy

To optimize compliance with a patient's post-hospital plan of care, an assessment of the patient's actual and potential discharge planning needs shall be initiated upon admission. A multidisciplinary team that may include the physician, registered nurse, care manager, and social worker, together with the other members of the health care team, shall perform the assessment. A plan to meet these needs shall be developed, and interventions to meet specific discharge planning goals shall be designed. The plan shall be monitored and revised as necessary throughout the patient's hospital stay.

Verbal communications concerning discharge or the discharge planning process shall be conducted in layman's terms using the patient's preferred language. Written discharge instructions shall also be provided, using materials that have been translated into the patient's preferred language whenever possible. If the patient is a minor, the preferred language of the responsible parent or guardian shall be used. **Note**: For security reasons, communication regarding the discharge of TDCJ offender patients is coordinated through TDCJ Care Management. Information of this nature shall only be released to authorized security and medical staff on a need-to-know basis.

When patients are being discharged to hospice, home health, or skilled nursing facilities (SNF), the care management team or Social Worker (Angleton Danbury campus) will work with the patient and/or their family to determine which service they will retain, taking into consideration such things as the patient's funding source, physical location of the patient and support personnel in relation to the service, patient/family preference based upon past experience, and other relevant factors based upon the patient's needs. UTMB providers will not recommend or show preference for one service over another and shall leave the choice of the service provider to the patient and/or his or her family.

UTMB respects the diverse cultural needs, preferences, and expectations of the patients and families it serves to the extent reasonably possible while appropriately managing available resources and without compromising the quality of health care delivered.

Roles in

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

Discharge Planning

Care management or Social Worker (Angleton Danbury campus):

1. Complete a Case Management Social Functional Assessment and reassessment of the discharge planning process.
2. Identify payor to determine resource options for patient care needs, and refer unfunded patients and patients with limited resources for government program eligibility or other community resource options.
3. Verify and confirm the patient/family discharge plan is safe, smooth, and sustainable. Provide education regarding continuing care, treatment, and services that the patient will need. Confirm transportation, DME, supplies, and medications.
4. Confirm understanding of discharge plan with patient/family.
5. Document discharge plan/disposition in the EMR.
6. At discharge or transfer, the hospital informs other service providers who will provide care, treatment, or services to the patient about the following:
   a. The reason for the patient's discharge or transfer
   b. The patient's physical and psychosocial status
   c. A summary of care, treatment, and services it provided to the patient
   d. The patient's progress towards goals
   e. A list of community resources or referrals made or provided to the patient.

Roles in Discharge Planning, continued

Physicians:

1. Inform the patient and family/caregiver(s) of the discharge date (except for TDCJ offender patients)
2. Discuss the post-discharge plan of care
3. Establish time for follow-up appointment(s), if applicable

Nurses:

1. Assist in contacting the patient's family/caregiver(s) to inform them of the discharge date and confirm transportation arrangements.
2. The nurse caring for the patient must complete the discharge instructions.
3. Provide patient and family/caregiver(s) with the discharge instruction sheet on prescribed treatments, medications, diet, activity level, and scheduled follow-up appointments, if any. Provide written discharge instructions to discharged TDCJ offender patients and their health unit providers using Patient

Discharge Instructions Medical Record Form .

4. Ask the patient and family/caregiver(s) to verbalize their understanding of the discharge instructions and give a demonstration of any care procedures.

Roles in Discharge Planning (cont'd)

5. Ensure that all necessary patient teaching has occurred.
6. For follow-up appointments at UTMB clinics, verify that a follow-up appointment has been made.
7. Document discharge in the medical record.
8. Confirm correct discharge status completed in the medical record.

Respiratory Therapists:

1. Determine home respiratory medical equipment needs.
2. Provide patient/family education on medications, medical equipment, and therapy procedures to be performed at home.
3. Participate in interdisciplinary assessments to help determine necessity of home oxygen.

Participate in interdisciplinary discharge planning rounds and conferences.

Physical and Occupational Therapists:

1. Share discharge recommendations for equipment needs and follow-up physical and/or occupational therapy (e.g., outpatient, home health, Skilled Nursing Facility (SNF), inpatient rehab, long-term care, early intervention or school-based programs) with the physician and medical staff through documentation in the medical record and verbal reports during rounds or team meeting times.
2. Provide all patient/family/caregiver education and training in a written format and document all education and training services in the medical record.

Dietitians:

1. Participate in interdisciplinary discharge planning rounds and conferences.
2. Assist medical staff with nutrition regimens.
3. Instruct patient/family/caregiver regarding nutrition regimens and any dietary modifications as indicated.
4. Inform patient and family of available community resources, if needed.
5. Document recommendations for follow-up nutrition services as indicated. (e.g., SNF, dialysis center, or other points in the

continuum of care).

Roles in Discharge Planning (cont'd)

Pharmacists:

1. Assist medical staff with drug regimens.
2. May provide patient/family/caregiver with medication information.

Required Documentation

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

1. Provision of all discharge-related patient/family/caregiver education.
2. Availability of transportation.
3. Assessment of availability and readiness of family or other caregiver(s) to assist with the care of the patient at home.
4. Availability of assistance from community resources, including referrals to other health care agencies, as appropriate.
5. Availability of medical equipment, supplies, and medication as indicated.
6. Follow-up plan.

Reassessment of the overall discharge planning process

The overall effectiveness of the multidisciplinary discharge planning process shall be reassessed through a periodic review using actual patient discharge plans to determine if the discharge needs of those patients were met. This review shall occur at least every three years.

Against Medical Advice (AMA)/Away Without Leave (AWOL)

Patients leaving the hospital against medical advice (AMA) should be asked to sign the AMA release form. A patient's refusal to sign the AMA release form should be documented in the nurse's discharge note. Documentation shall be made in the Nurse's Notes regarding the status of the patient upon AMA discharge or prior to being absent without leave (AWOL) from the unit, as well as notification of physician and nursing administrator.

Patients who have been issued a pass but fail to return at the designated time will be placed on AWOL status by physician's order and discharged.

References

IHOP Policy 9.1.2 Management of Patient Belongings
IHOP Policy 9.1.8 Passes for Inpatients
IHOP Policy 9.1.9 Delayed Discharge of Newborns

IHOP Policy 9.1.15 Adoption from the Neonatal Nurseries
IHOP Policy 9.13.9 Interdisciplinary Admission Assessment and Reassessment
IHOP Policy 9.13.30 Medication Reconciliation
TDCJ 03.01.006 The TDCJ Discharge Planning Process