HARDIN COUNTY GENERAL HOSPITAL
HOSPITAL-WIDE POLICY

Title: Discharge Planning **Effective Date: 9/30/2004**
Policy Number: HW142 **Med Staff:**
Regulation: **Admin:**

I. POLICY

Continuity of care requires thoughtful preparation by the entire healthcare team. Each patient's needs for continuing care are assessed in an ongoing fashion by all members of the healthcare team. This assessment may begin prior to admission, but in no event later than at the time of the admission nursing assessment. All disciplines are involved in the assessment and planning for after discharge healthcare needs of the patient and/or family including, but not limited to:

Members of the medical staff; Nursing staff members; Rehabilitation services professionals; Social workers; Respiratory care practitioners; Pharmacists; Case Managers.

The discharge planning function focuses on meeting the patient's continuing healthcare needs after discharge. These needs may have necessitated the admission to the facility or may occur as an expected outcome to medical or surgical intervention, such as cast care following open reduction of a fracture. The purpose of discharge planning is to identify a patient's unique needs for continuing physical, emotional, housekeeping, transportation, social and other needs and to arrange services to meet those needs. Needed discharge services may include:

Long-term care; Home Health services; Hospice services; Ambulatory care services; Rehabilitation service; Support groups; Community agency services; Community mental health.

Patient education is a major focus of discharge planning activities for all patients. Many patients' after care needs are met through education provided by each member of the healthcare team. As a result, documentation for patients with less complex discharge planning needs is often found within documentation associated with patient education.

II. DEFINITIONS
NA

III. RESPONSIBILITY
All Staff

IV. EQUIPMENT
NA

V. PROCEDURES
INFECTION CONTROL: N/A

The initial assessment for discharge planning needs is conducted during the nursing administration assessment or prior to the admission for patients within a designated critical path.

Each discipline assesses needs for after care as part of their ongoing assessment and reassessment process. It is the responsibility of each discipline assessing discharge planning needs to document associated assessment findings within the medical record.

Based on this assessment, patients that demonstrate more complex discharge planning needs are referred to the discharge planner who will arrange services/care to meet those needs. Examples of patient needs that would require more complex discharge planning include, but are not limited to:

- Need for long-term care placement;
- Need for home health services;
- Need for community agency referral;
- Need for community mental health services;
- Need for medical equipment not provided by the associated hospital department for use after discharge;
- Need for transfer to another acute care hospital (for services no provided at Hardin County General Hospital)

Additionally, an automatic referral to the discharge planner for focused discharge planning is made for all "high-risk" patients. Adult high-risk patients include:

- Those admitted through the Emergency Department;
- Those with immunosuppressive disease;
- Those who are homeless;
- Those that live alone;
- Those with potential for IV therapy in the home;
- Suspected cases of abuse

Pediatric high-risk patients include:

- Suspected cases of abuse;

Patients referred to the discharge planner receive the initial discharge planning interview within 72 hours of admission. The discharge planner will coordinate discharge planning efforts by all disciplines for those patients identified as high-risk or patients that demonstrate more complex discharge planning needs.

All pertinent information shall be documented within the patient's medical record.

Any specific psychosocial concerns or crisis intervention needs will be referred to the medical social worker for assessment and care planning/discharge planning needs.

As appropriate, discharge planning activities are integrated into the patient's Plan of Care.

VI. DOCUMENTATION

NA