Freudenthal HOME HEALTH

Discharge Criteria & Process

Policy No. 4-045

PURPOSE

To outline the process for discharging a patient from service.

POLICY

When the patient's plan of care changes and this change results in discharge or reduction of services, the patient or his/her representative, as well as his/her primary physician, will be notified and involved in planning decisions.

A discharge summary will be completed and filed in the clinical record. *(See "Discharge Summary" Policy No. 4-046.)*

Definitions:

1. **Termination/Discharge:** Discontinuance of all organization services by the organization.
2. **Reduction of Services:** A change in the patient's service plan in which one (1) or more existing services are discontinued.

Discharge/Reduction of Services Criteria:

1. Services will be terminated when the patient meets one (1) or more of the discharge criteria:
    a. A change in the patient's medical or treatment program that requires a change-to a different level of care.
    b. A change in the patient's condition requires care or services other than that provided by the organization.
    c. If appropriate, the goals of home care have been attained or are no longer attainable.
    d. There is no longer anyone to provide supportive/custodial care.
    e. The patient or family/caregiver refuses or discontinues care.
    f. The patient or family/caregiver refuses to cooperate in attaining the objectives of home care.
    g. Conditions in the home are no longer safe for the patient or organization personnel.
    h. Family/caregiver has been prepared and is capable of assuming responsibility for care.
    i. The patient moves from the geographic area served by the organization.
    j. The patient's physician (or other authorized independent practitioner) has failed to renew orders, or the patient has changed physicians and orders cannot be obtained from the new physician to support the patient's needs.

k. The physician gives orders that are not consistent with the stated diagnosis as required by law and fails to give the needed orders when requested by the organization.

l. If the physician face-to-face encounter was not completed prior to the initial certification, the patient or family/caregiver refuses to obtain a physician face-to-face visit within 30 days of start of care.

m. The organization is closing out a particular service or all of its services.

n. The patient expires.

PROCEDURE

1. The organization will verbally notify the patient of the decision to terminate or reduce services within one (1) visit prior to the time the change in service is to occur (i.e., prior to the last scheduled visit).
2. Prior notice will not be necessary when services are discontinued by the patient or physician; however, action taken must be documented in the clinical record and a discharge summary completed. A copy of the discharge instructions will be mailed to the patient.
3. An update to the comprehensive assessment, including required OASIS data elements, will be completed, as required by regulation.
4. For a patient requiring continuing care, assistance will be given to the patient and family/caregiver in order to manage continuing care needs after the organization services are discontinued. Discharge instructions will be provided.
    a. Discharge planning will identify needs the patient may have.
    b. Arrangements for such services will be coordinated by the organization when applicable.
5. The decision to terminate or reduce services must be documented in the clinical record citing the circumstances and notification to the patient, the responsible family/caregiver or representative, and the patient's physician. The Clinical Supervisor or designee is accountable for the decision and the required documentation.
6. Each clinician making the final visit for his/her discipline will complete the sections of the discharge notice for discontinuing a discipline. (See "Discharge Summary" Policy No. 4-046.)
7. If more than one (1) discipline is providing care, the discipline being discontinued will be specified on the interim order.

8. **ORGANIZATION DISCHARGE:** A discharge summary will be completed for all discharged patients. A copy may be mailed to the primary physician. (See "Discharge Summary" Policy No. 4-046.)

9. The clinician will update the comprehensive assessment, including required OASIS data elements, as required by regulation.

10. All discharge paperwork will be due in the office within 72 hours of the discharge date. This will include the discharge order, discharge summary, plan of care, medication profile, and OASIS.

11. The discharge record will be organized according to the organization policy regarding clinical record contents. Documentation will be reviewed by the Clinical Supervisor or designee and completed within 30 days of the discharge, at which time it will be removed from the active files.