Freudenthal HOME HEALTH

Discharge Planning

Policy No. 4-009.1

PURPOSE

To promote patient independence, safety, and use of community resources prior to patient discharge from the organization.

POLICY

Discharge planning will be initiated for every patient upon admission to the organization. Patients will not be discharged without appropriate preparation. The patient's continuing care needs will be assessed on an ongoing basis, as well as at discharge. information will be provided to assist the patient in planning his/her discharge, including referral and transfer.

PROCEDURE

I. During the initial assessment, the clinician will:

   A. Assess the following and identify:

      1. Anticipated date of discharge
      2. Resources available, including persons and finances
      3. Anticipated changes in living situation
      4. Areas that might require assistance

   B. Document the patient discharge potential on the plan of care.

   C. Provide information regarding the patient discharge potential at case conferences with other team members, as appropriate.

II. Clinicians will assist patients regarding their discharge by:

   A. Consulting with the patient and family/caregiver regarding the need for discharge from the organization

   B. Serving as a referral source for patient and family/caregiver in obtaining follow-up support services

   C. Consulting with the patient and family/caregiver regarding the provision of discharge information

   D. Participating in a conference with the patient and family/caregiver regarding the patient discharge plans, if requested

   E. Sending a post discharge letter to the patient's physician

III. Clinicians will inform the appropriate Clinical Supervisor in the event that problems arise in discharge planning and obtain appropriate assistance.

IV. All communication and information regarding discharge planning will be documented in the clinical record. *(See "Discharge Criteria and Process" Policy No. 4-045.)*