WASHINGTON ADVENTIST HOSPITAL
PATIENT CARE POLICY MANUAL

INTERDISCIPLINARY CARE & DISCHARGE PLANNING

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Origin: NRSG
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SCOPE

All Patient Care Areas

PURPOSE

To describe the discharge planning process and the responsibilities of the members of the patient care team in implementing the discharge planning process.

POLICY

Discharge planning is the process whereby patient needs are identified and evaluated, and assistance is given in preparation for discharge from the Hospital.

GUIDELINES

In order to provide safe and timely continuity of care, discharge planning begins before or at the time of admission. The process is multi-disciplinary and takes into account the patient's right, in collaboration with his/her physician, to make decisions regarding his/her medical care, and involves the patient's family/significant other, when appropriate. Patients having one or more of the intervention parameters undergo more intensive planning efforts.

The preadmission information and screening identifies the needs of the patients so an interdisciplinary plan of care can be implemented and the patient can be treated in the most appropriate care setting.

The interdisciplinary plan of care is continually assessed and reassessed to address specific needs, including tests or procedures, referrals, treatments and therapies, and education.

Prior to discharge, an interdisciplinary team identifies patient needs relating to home services, ancillary services, or transfer to another facility. At discharge the patient is referred to practitioners, settings, and organizations to meet his or her continuing needs.

DEFINITIONS

Intervention Parameters: Factors that might prolong the length of stay or complicate the discharge plan. These factors are established by a multi disciplinary discharge planning team, and include:

- Primary/Secondary diagnoses: Amputee, cancer with metastasis, CVA, ESRD with HTN and DM, uncontrolled DM, HIV, change in mental status, mental health diagnosis, substance abuse.
- Expected LOS greater than 48 hours
- Complexity of care: More than three (3) physicians involved
- New dialysis
- Scarce finances or inadequate insurance coverage for anticipated needs
- Repeat admission (within 30 days)
- Behavioral problems
- Non-compliance
- Lack of support systems/unclear decision-maker status
- Over 75 years of age and living alone

- Admitted from nursing home or assisted living facility
- Any suspicion of abuse/neglect
- Homeless

I. RESPONSIBILITIES:

A. ATTENDING/ADMITTING PHYSICIAN

The attending/admitting physician shall:

1. Assess and identify discharge planning needs of his/her patients and order appropriate consults to address these needs in a timely manner.
2. Collaborates with the patient, family, and members of the health-care team to determine and implement an appropriate discharge plan and to complete necessary paperwork to refer his/her patient to outside agencies and facilities.
3. Determine when the patient is ready for discharge and orders the discharge.
4. Document the discharge needs and follow-up plan of care in the patient's medical record.

B. NURSING

1. The nurse will assess the patient's physical, social, and psychological condition upon admission to the unit, recording the data on the admission assessment form. This assessment will also include the current self-care needs of the patient as well as needs that may exist at discharge. The initial discharge plan will be based on this assessment which includes:

   a. Current health status
   b. Projected level of care needed upon discharge
   c. Teaching necessary prior to discharge
   d. Patient strengths and weaknesses
   e. Resources available for post-hospital care
   f. Ability of the patient/significant other/care giver to arrange continuing care needs

2. Make referrals to appropriate disciplines for further assessment. Patients determined to require intensive planning will be reviewed and/or discussed at regularly scheduled interdisciplinary care discharge planning meetings and the discharge plan will be modified as appropriate.

3. The charge nurse will lead the unit specific interdisciplinary care planning meetings, assure that meetings start and end on time and remain focused on the patients with discharge planning needs. He/she will initiate and document updates on the Interdisciplinary Plan of Care for those patients requiring intensive planning.

4. Initiate the patient discharge process as ordered by the physician.

   a. Attending physician, or his/her designee, must issue or approve an order for patient discharge.
   b. If a consulting physician writes an order to initiate patient discharge, the nurse contacts the attending physician (or designee) and obtain approval for the discharge.
   c. The attending physician's order for discharge must be recorded on the Physician's Order Form.
   d. If the patient's condition, readiness for discharge or discharge plan is unclear to the nurse, the attending physician must be contacted for clarification.

C. REHABILITATION MEDICINE

1. All patients undergo screening for functional assessment.
2. Rehabilitation Medicine Therapist will attend the interdisciplinary care planning meetings as needed.

3. Discharge instructions given to the patient/care giver as well as equipment issued by the therapist and instructions for its use will be documented in their daily charting.

D. CASE MANAGEMENT

The Social Worker (SW) or RN Case Managers (CM) will:

1. Assess the needs of those patients on his/her unit utilizing, but not limited to, the Intervention Parameters list and the admission assessment screen. Referrals to case management may come from any source including, but not limited to: physician, nursing staff, patient, family, external agency.

2. Further assess patients who trigger a screen through the nursing assessment process, and initiate discharge planning on those patients identified as meeting any of the intervention parameters within two (2) working days. On weekends, the SW or CM may be contacted for facilitating the discharge of patients with complex needs.

3. Contact the attending physician to coordinate plans and to keep him/her informed of progress and changes.

4. Review the patient chart and interview the patient/care giver to gather pertinent information about resources, previous level of care, and willingness to engage in discharge planning.

5. Coordinates the interdisciplinary care planning process through discharge, including:
- Determine availability of services to meet the patient's identified needs at discharge, including education about options and patient/family (SO)agreement with plan, and final discharge plan in the patient's medical record.
- Track patient progress to discharge, identifying potential obstacles and team member responsibilities for follow through
- Make appropriate internal and external referrals, including arrangements for Home Health, DMEs, home IVs or oxygen.
- Refer patients to ancillary services and community resources as appropriate.
- Facilitate discharge to continuum of care facility.

6. Participate in the unit specific interdisciplinary care planning meetings.

7. Case management will document pertinent assessment information (Assessment Form) and continuing interventions (Patient Progress Notes).

8. Perform case management on a case-by-case basis to assure continuity of care and prevent discharge delays.

E. NUTRITIONAL SERVICES

1. Patients will be screened upon admission to the hospital for a length of stay of greater than 24 hours to identify nutritional problems and to evaluate the need for further nutritional intervention.

2. Referrals will be sent for the dieticians to conduct nutritional assessments. A follow-up screening and assessment will be performed by Nutrition Services, as appropriate.

3. Prior to discharge, any patient needing nutrition education will receive instructions, which is documented on the Patient Progress note.

4. Attendance at the interdisciplinary care planning meetings will be determined by the dietician covering the individual unit in consultation with the other interdisciplinary team members.

F. PASTORAL CARE

1. A chaplain or student intern will attend the interdisciplinary care planning meetings whenever possible.
2. Emergency needs will be seen to as soon as possible.
3. Requests for services may be made by any discipline by calling Pastoral Care.
4. Interventions are documented on the Patient Progress note.

G. RESPIRATORY CARE

1. Education required by the patient/care giver in the use of equipment and/or home treatments will be provided by the respiratory care practitioner prior to discharge and documented in their daily charting.
2. Attendance at the interdisciplinary care planning meetings is a must in Critical Care and will be on an as needed basis outside of Critical Care.

H. PHARMACY

1. Instruction concerning medications will be provided by the RN with additional support from the pharmacist when needed. Patient/care giver instruction will be documented on the discharge record.
2. The pharmacist will attend interdisciplinary care planning meetings in Critical Care and as needed outside of Critical Care..

I. SOCIAL WORKER

1. The Social Worker initiates psychosocial assessment for all referred patients.

2. The Social Worker counsels patient and family for emotional adjustment to illness and discharge plan.

V. PATIENT, PATIENT'S FAMILY, GUARDIAN

The patient, if competent, makes the ultimate decision regarding the final discharge plan after taking into account the recommendation of the physician and other members of the health-care team and involved family members. He/she needs to participate in learning about discharge planning needs and available options, weigh the risks and benefits of these options and communicate his/her decision to the health-care team. If the patient is judged incompetent by a court of law or by two physicians who certify that the patient is disabled ("lacks sufficient understanding or capacity to make or communicate a responsible decision on health care"), or if the patient is a minor, the decision-making responsibility falls to the patient's guardian, legally-authorized representative or next-of-kin as detailed by Maryland State Law. (See Policy WAH.5852).

II. INTERDISCIPLINARY CARE PLANNING MEETINGS

A. Interdisciplinary Care Planning meetings are held daily (Monday – Friday) all in-patient nursing units to facilitate inter-disciplinary collaboration for discharge planning. Meetings are attended by Nursing and Case Management staff (case manager and/or Social Work) to review all patients on the unit, to identify patients who have discharge planning needs, to track care planning progress, and to facilitate meeting identified needs. Other members of the care team may attend the meetings on an "as needed" basis. Included in the discussion will be patient's diagnosis, overall plan of care, reason for continued acute admission, plan for the day, anticipated discharge date, and anticipated discharge needs. While all patients are reviewed for discharge planning needs, there is focused effort on those patients requiring intensive planning and or those in observation/extended recovery status..

B. Interdisciplinary Treatment Team meetings are held daily on the Behavorial Health Unit. They are attended by Psychiatrists, Nursing, Social Work, Utilization Management and Day Treatment. Other members of the health care team attend as needed.

C. Designated team members are responsible to contact physician and/or ancillary for follow-up and concerns.

D. Each discipline to document relevant information obtained from the meetings in their daily charting.

Reference:

Dept. of Health. (2008). Information for a healthy New York: Suggested model for transitional care planning.