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| DISCHARGE PLANNING | | | | NO. 148d | |
| It is the policy of the organization to provide discharge planning for persons served. The person served will be educated on importance of developing a portable profile that addresses their medical needs and is provided assistance as needed.  A discharge plan will be formulated for residents within seven (7) days following date of admission.  “Discharge” may include transitioning from one Therapy Track to another or it may mean moving to alternative placement.  Documentation of the discharge plan will be done on a form entitled "Initial Discharge Evaluation" and will be updated quarterly and as necessary.  The Department of Social Services/Case Managers will be responsible for the coordination and documentation of the discharge plan. This person will serve as a resource person advising the resident, guardian, and / or physician of possible alternate plans of care.  The Department of Social Services/Case Managers will maintain a list of community resources for the purpose of referring residents.  The Discharge Plans/transition recommendations will be formulated by reviewing input from the persons served and/or their families/support systems, payers, providers in the continuum of care, the referral source, personal care attendants, case managers, caregivers, other relevant stakeholders, and the assessments from Dietary, Nursing, Recreational Therapy and Social Services, Speech, Occupational & Physical Therapies and / or other disciplines involved in service provision / treatment planning.. The Department of Social Services may obtain this information through review of the clinical record, personal interviews with staff members, or by interdisciplinary team conferences which can include staff members, physician, and significant others.  Discharge plans/recommendations of the patients are to be documented and shared with the persons served, families/support systems, referral sources, payers and other relevant stakeholders and re-evaluated in at least ninety (90) day periods.  Discharge / termination from medically ordered rehabilitation program(s) shall occur upon existence of the following factors:   1. Written or verbal order by the attending physician. 2. Contraindications (adverse effects to the modalities administered or potential for same). 3. Attainment of treatment goals, predicted outcomes. 4. Achievement of maintenance level benefit, unless otherwise indicated by the physician in consideration of degenerative diagnosis. 5. Death deteriorating condition of the person served (physician consultation required -for the latter). 6. A four-week lapse in the attendance and /or inconsistent, sporadic attendance at treatment sessions for an unknown reason. | | | | | |
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| DISCHARGE PLANNING | | | | NO. 148d | |
| It is the policy of the organization to provide notice regarding discharge/transition decisions to the persons served, their families, appropriate personnel, and referral sources, if applicable. Voluntary discharge / transitions involve collaboration of the aforementioned parties and time frames for discharge are reached by mutual consensus.  Time frames for involuntarily discharges are outlined in the Involuntary Discharge policy.  Also, please refer to Bed Reserve Policy for hospital stays that exceed 10 days.  When a resident is discharged from the facility, the Department of Social Services will ensure that the facility provides those responsible for the continued care of the resident (i.e. family) with the appropriate information as contained on the Discharge Summary Form. Written discharge recommendations are provided, as appropriate, to: The person served, providers in the continuum of care, primary care physicians, the referral source, the family/support system, the payer, and/or other stakeholders.  The Department of Social Services/Case Managers orients staff personnel to discharge planning and referral procedures. These persons may provide periodic in-service training sessions.  The Department of Social Services/Case Managers will see that a Discharge Summary is completed within seven (7) days after discharge.  The Department of Social Services/Case Managers will write a discharge note in the Social Service progress note section of resident’s chart.  The Department of Social Services/Case Managers will notify other appropriate departments of resident’s discharge using the form entitled "Notification of Official Patient Discharge". | | | | | |
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