PeaceHealth
Springfield Rehabilitation Hospital

Next Review: *06/2027*
Area:

PC 575 Discharge Planning

POLICY

Discharge planning begins at the time of admission and includes the interdisciplinary team, patient and patient's support person(s), in order to assure the patient's needs at the time of discharge are met.

PURPOSE

A. The Rehabilitation Hospital provides a coordinated discharge planning process for all patients as an integral part of their rehabilitation program. This process is ongoing from the time of admission to the Hospital, is interdisciplinary in nature, and includes a range of activities that include patient and/or family education. Discharge planning needs are identified during the preadmission process, incorporated into a plan specific to each patient and provided under the direction of the patient's physician. It involves constant communication among patients, patient's support person(s), staff, and community agencies.

B. The responsibility for the discharge planning process is shared by the patient, patient's support person(s), and all members of the Rehabilitation Interdisciplinary Team. The Medical Staff, Nurses, Case Manager, Physical Therapist, Occupational Therapist, Speech Language Pathologist, Respiratory Therapist and Dietitian provide the nucleus of the team and contribute as they professionally relate to the patient. Goals for the discharge plan include:

   1. A progressive program of physical rehabilitation if possible;
   2. Re-entry into family, social, community and vocational settings at the highest level of capability; and
   3. Plan for adequate medical and therapy follow-up (to include Palliative Care Services when applicable)

C. The responsibility for team coordination and for intervention with respect to discharge planning is provided by the Case Manager under the direction of the patients Rehabilitation Physician. The primary goals are to ensure that patient and patient's support person(s) are prepared for discharge and have obtained the basic knowledge and skills necessary to achieve the greatest level of functional independence.

PROCEDURE

Discharge planning includes a comprehensive consideration of all medical, physical, psychological, social and vocational aspects of the patient's impairments and needs. Each member of the interdisciplinary team plays an integral role in the discharge planning process. There is an ongoing re-assessment of the discharge plan based on changes through team and family conferences, morning operations review, and ongoing 1:1

conversations with patients/families/providers as needed.

A. PHYSICIAN ROLE

The Rehabilitation Physician is responsible for assuring that the patient's post-rehabilitation needs have been identified and a plan of care formulated to assure continuity of care to the patient. She/he:

1. Contributes information relative to the patient, which is utilized by the Rehabilitation Team in the assessment and discharge planning process;
2. Initiates an order at time of admission to the Social Worker/Case Manager or Psychologist for assistance with psychological support, and patient/family education during the rehabilitation program;
3. Contributes to and approves the post- inpatient rehabilitation plan of care;
4. Attends team conferences and care conferences,
5. Establishes follow-up appointments/referrals with community physicians for patients and determines rehabilitation follow-up as indicated; and
6. Completes the transfer forms with orders and instructions for post rehabilitation care, including Outpatient rehabilitation services, Home Care nursing/therapists, medical equipment and prescriptions and other care/equipment as needed.
7. When a discharge date is established Physician will write a discharge order.

B. NURSING ROLE

1. Assesses patient discharge planning needs upon admission. Care plans and patient/family education and training should reflect patients' anticipated needs at discharge.
2. Attends interdisciplinary patient team conferences, reviews Social Worker/Case Manager's notes, and makes verbal or written recommendations for follow-up and post rehabilitation needs.
3. Initiates appropriate referrals to other departments as necessary to meet identified patient needs.
4. Documents a patient discharge care plan addressing the patient's residual impairments/needs and provides supportive instructions and reference materials to ensure successful home and community re-integration.
5. Ensures that patients are discharged in a safe and appropriate manner with prescriptions/adaptive equipment, instructions for medications/equipment utilization and care.

C. CASE MANAGER ROLE

1. The Case Manager (CM) works in conjunction with the entire rehabilitation interdisciplinary team to assure comprehensive assessment of the needs of all patients and to develop and implement an interdisciplinary plan of care for the patient's rehabilitation program. The CM is responsible for addressing the medical, financial, environmental, psycho-social, cultural, adjustment and social issues as they influence the continuity of patient's rehabilitation process and the plan of discharge.
    a. Assesses psychosocial needs of patients/families
    b. Evaluates, educates and counsels patients and patient’s support person(s) with respect to discharge planning to maximize the post-rehabilitation support network.
    c. Acute and sub acute psychiatric and substance abuse treatment referral/s, if needed.

2. The CM is responsible for coordinating the discharge planning process for all patients. The CM also works to develop and implement a plan of care to improve or maintain the patient's health and rehabilitation status following discharge from the Hospital. This may include coordination of the following:
    a. Outpatient Rehab, Community and Home Program or Post-Acute Rehab Program;
    b. Skilled home care follow-up services (e.g., RN, Home Health Aide, PT/OT/ST/SW);
    c. Skilled nursing, residential care or other alternate care facility;
    d. Attendant care and transportation, as needed;
    e. Palliative care/Hospice services as applicable
    f. Referrals to a broad range of community resources with the goal of supporting independence and optimal functioning after discharge;
    g. Housing and supportive follow-up care (e.g., board and care referrals, attendant care, homemaking and meal preparation services, transportation); and
    h. Equipment needs, including home oxygen and wound vacs as needed.
3. Throughout the patient's rehabilitation program, the CM communicates with third party payers, verbally and/or in writing, to obtain continued authorized coverage for stay and approval for recommended services/equipment prior to discharge.

D. REHABILITATION SERVICES ROLE (Physical Therapy, Occupational Therapy, and Speech Language Pathology Services)

Rehabilitation Services staff participate in the discharge planning process.

1. In conjunction with the patient and family, therapists make recommendations for discharge placement, equipment needs and follow-up care required.
2. In cases where purchase or rental is required, individual therapists will make recommendations for model and vendors. The individual therapists, in conjunction with Case Manager, initiate contact with patient's insurance carrier and family regarding purchase and delivery of equipment.
3. Therapists identify, coordinate and provide the patient, patient’s support person(s) education and training as it relates to patient's functioning in his/her discharge environment.
4. If clinically indicated and geographically reasonable, a home evaluation may be completed with therapist, patient and family. Appropriate recommendations, modifications or interactions are made.

E. NUTRITION SERVICES ROLE

Nutrition Services participates in the discharge planning process by providing appropriate and timely nutritional care as a component of interdisciplinary discharge planning.

Nutrition Services:

1. Provides nutritional care information to the Rehabilitation team;
2. Develops an individualized nutrition care plan upon physician order; and
3. Provides instruction, evaluates progress and assesses compliance of patients on the therapeutic dietary

regimen; and

4. Provides discharge diet instructions upon physician's order.

F. PHARMACY ROLE

Pharmacy is responsible for participating in the discharge planning process. The Pharmacy provides education to the patient and/or patient’s support person(s) on the identification, purpose and proper administration of the prescribed medications as appropriate

G. RESPIRATORY THERAPY ROLE

1. Assesses patient's respiratory status and pulmonary function;
2. Instructs patient, patient’s support person(s) regarding patient's respiratory needs, makes recommendations for home treatment, oxygen and equipment needs;
3. Informs interdisciplinary team of recommendations and instructions given;
4. Obtains prescriptions for oxygen and respiratory equipment for home use ; and
5. Coordinates home respiratory program with Case Manager to ensure expedient delivery of equipment and therapy.

H. AVAILABILITY OF COMMUNITY RESOURCES

Patients will be given choices regarding their preferences for community services post discharge. A list of community resources available will be kept in the Case Manager's office for easy access to:

1. Short-Term Acute Care Facilities
2. Long-Term Acute Care Facilities
3. Outpatient Rehabilitation Services
4. Skilled Nursing Facilities
5. Housing Options
6. Medical and Non-Medical Home Health Care Services
7. Palliative Care/Hospice services
8. Department on Aging and Disability Resource Center
9. Medical DME/Oxygen and Nursing Suppliers
10. Home Delivered Meal programs

I. DOCUMENTATION

Ongoing documentation occurs throughout patients rehabilitation stay. The discharge planning instructions are documented in the medical record by members of the Rehabilitation Program Team. In addition, discipline specific discharge plans are completed by members of the Rehabilitation Team and contribute to the development of a discharge plan of care for each patient which identifies ongoing goals, problems and needs, recommended future interventions, patient and patient’s support person(s) education and other recommendations at the time of discharge. A final Discharge Summary is recorded by the physician in the medical record.

REFERENCES

This policy and procedure contains content that ensures compliance with the OregonAdministrative Rules (OARs) for Special Inpatient Care Facilities, Rehabilitation Hospitals,found under OAR 333-505-0055 – Discharge Planning Requirements and OAR 333-071-0400 – Organization Policies.

Attachments

No Attachments

Approval Signatures

Approver	Date