

UCONN HEALTH

UCONN JOHN DEMPSEY
HOSPITAL

SECTION: PATIENT CARE

NUMBER: 08-029

SUBJECT: DISCHARGE PLANNING PROCESS

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PURPOSE: To ensure quality coordinated continuity of care within available resources as an integral part of total patient care.

POLICY:

1. Discharge planning is an ongoing, interdisciplinary process.
2. The discharge planning process shall be integrated and coordinated by healthcare professionals and include the patient and/or family and significant other.
3. Each hospital department that has a direct effect on patient care shall enhance continuity of care through the appropriate utilization of hospital services, institutional facilities and community resources.
4. Every hospitalized patient shall have a written discharge plan.
5. The Hospital maintains transfer agreements in the Chief Executive Officer's Office.

PROCEDURE:

1. Patients are assessed to determine their discharge needs at the time of, or prior to admission.
 - a. The participants in the initial assessment include the physician, staff of Case Management, Nursing, Social Work (as appropriate), the patient and/or the patient's family.
 - b. The assessment includes but is not limited to the patient's resources in terms of care givers, residence, and finances as well as functional status, and available community services.
2. If there are no potential issues related to discharge identified at the time of the initial assessment, patient goals and a preliminary discharge plan should be established. The goals and plan are reviewed and updated periodically as the patient's condition warrants.
3. If at the time of the initial assessment, a determination is made that the patient has issues (i.e., the patient cannot return home or will be unable to care for himself/herself independently in the home setting), the nursing staff and/or the Departments of Care Coordination will provide assistance in planning for continuity of care, as appropriate.

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4. Assessment of the patient during hospitalization is ongoing. Referral to the Care Coordination Department can be made any time.

DOCUMENTATION:

1. The After Visit Summary (AVS) - discharge plan will be completed for every hospitalized patient and given to the patient at the time of discharge. If the patient requires post discharge care at a skilled nursing facilities or in-home services a W-10 will also be provided.
 - a. The form is completed by those professionals involved in the patient's discharge plan formulation. It is to be signed by the nurse discharging the patient and the prescriber writing the discharge order. (Note: At John Dempsey Hospital, the house officer/LIP, not the attending physician usually writes orders, in consultation with the attending. The attending physician is presumed to concur with the discharge plan, even if he/she does not sign it).
 - b. The patient and/or their family sign the AVS. The form includes facility destination or home care services and the patient and/or family should sign the form indicating their awareness of the patient's destination/agency choice. If the patient is unable to sign and there is no family available, the discharge nurse may indicate on the form that patient/family unable or not available to sign.
 - c. At Discharge the completed and signed AVS is sent to the in-basket of the primary care physician if they are within the HealthONE system. If they are external primary care physician the AVS will be auto faxed as identified in the electronic health record.
 - d. The AVS is to be completed for all patients upon discharge. An AVS and W-10 will be completed for those patients who are being referred for community services or referral for admission to an extended care facility (nursing home, rehabilitation hospital, hospice or acute care hospital). The physician completes the sections related to treatments and medications.
2. Discharge Summaries/Summary of Care are being sent via Care Everywhere for providers that are in the Care Everywhere network. If the provider is not in the Care Everywhere network and fails the auto fax feature, the Discharge Summary/Summary of Care will be sent by manual fax. If no fax number is available, the Discharge Summary/SOC will be mailed by the US postal service.

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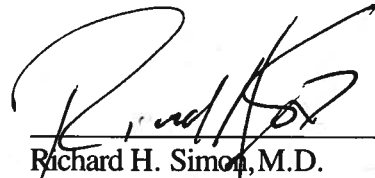
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3. In the event of a failed fax, an in basket message is sent to the Health Information Management Department (HIM). The HIM department will then mail the Discharge Summary/Summary of Care to the provider in the failed fax message.



Andrew Agwunobi, MD, MBA
Chief Executive Officer



Richard H. Simon, M.D.
Chief of Medical Staff

Date Issued: 2/91,

Date Revised: 12/91, 12/94, 10/97, 5/00, 12/02, 3/09, 10/15, 12/18, 3/21

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