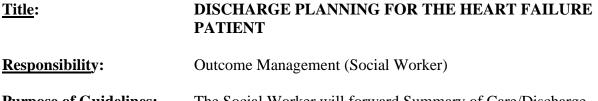
Nursing Service Guidelines General



<u>Purpose of Guidelines</u>: The Social Worker will forward Summary of Care/Discharge Instructions to the accepting agency to communicate transitions in care.

Procedure:

THE UNIVERSITY OF TOLEDO

- 1. The Social Worker will do a discharge planning assessment on each heart failure patient.
- 2. The Social Worker will discuss discharge planning with each patient and/or patient representative and will determine if the patient will have a need upon discharge.
- 3. The patient and/or patient representative will be given a list to provide the patient with a choice of the agency that they will choose for follow up care.
- 4. The Social Worker will provide all appropriate paperwork, Summary of Care and Discharge Instructions to the agency that the patient has chosen for post-acute care services.
- 5. The Social Worker will document the post-acute provider information on the discharge instructions.
- 6. The Social Worker will communicate the discharge plan regarding the patient in the morning multidisciplinary meeting and document this information in the patient chart.
- 7. The Social Worker will communicate the acceptance of referral and arrangements to the patient and/or patient representative, the physician, the bedside RN, and all other multidisciplinary staff involved in patient care.
- 8. Follow up/discharge appointments will be made by clinic staff. The appointment will be placed on the discharge instructions.
- 9. All follow up appointments will be made within seven days of discharge.
- 10. After discharge, the secretary of Outcome Management will fax the discharge paperwork to the patient's primary care physician.
- 11. The Outcome Management phone number is listed on the discharge paperwork for the patient and/or patient representative for any questions or concerns regarding post-acute care arrangements.

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