(A) Policy Statement
Discharge planning will be initiated on admission and integrated into the nursing care of all patients.

(B) Purpose of Policy
To prepare patients for discharge and promote the earliest possible discharge.

(C) Procedure
1. Discharge planning should include: assessment and identification of current and anticipated needs, medical planning for care needs post discharge, and preparing and/or referring the patient for admission to another health facility or return to home. A discharge planning screen is completed on admission by the admitting Registered Nurse (RN).

2. Discharge planning should be conducted in a supportive manner and include principles of the teaching/learning process.

3. Discharge planning assessment for the patient and/or family should include: biological-psychosocial-physiological health care needs, home health care treatments, activity restrictions, dietary and medication regimens, mental and physical adjustments, self-care requisites, and preventative health care practices.

4. Discharge planning should encourage collaboration and cooperation between all members of the health care team including patients and families on an ongoing basis.

5. Collaboration with Outcomes Management Staff for special or complex needs is encouraged.

6. Discharge planning and documentation of related activities for all patients must be completed routinely in Electronic Medical Record (EMR).

7. All Discharge Instructions will be completed by an RN.
### policies superseded by this policy:

*It is the responsibility of the reader to verify with the responsible agent that this is the most current version of the policy.*