THE UNIVERSITY OF TOLEDO MEDICAL CENTER

Nursing Service Guidelines
General

Title: **DISCHARGE PLANNING FOR THE HEART FAILURE PATIENT**

Responsibility: Outcome Management (Social Worker)

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

Procedure:

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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