

NURSING SERVICE GUIDELINES INPATIENT BEHAVIORAL HEALTH

Guideline: Discharge planning and continuity of care



Policy Number Superseded:

Responsibility: All trained inpatient behavioral health staff

Effective Date:
November 2025

Purpose of Guideline: To ensure that a systematic process addresses the needs for continuing care, treatment, and services after discharge.

Initial Effective Date:
February 2020

Procedure:

- (A) Discharge planning begins upon admission and is the joint responsibility of the attending psychiatrist, clinical social worker or therapist, and the registered nurse. Patients shall be discharged from the inpatient setting when deemed clinically suitable by the attending physician.
 - (1) If the patient's condition necessitates long-term, ongoing treatment, a transfer to an appropriate facility may be arranged.
 - (2) If the patient requires a higher level of medical/nursing care than what is currently offered on the inpatient psychiatry unit, transfer will be arranged to the most appropriate level of care for medical treatment.
 - (3) If a patient/guardian/representative requests discharge without the treatment team's agreement and patient does not meet criteria for involuntary admission as defined by the Ohio Revised Code (ORC 5122.10), the patient may be discharged against medical advice.
- (B) Coordination with community resources is essential in implementing the most effective service delivery by the hospital.

Guideline:

Discharge planning and continuity of care

2

- (1) Each inpatient psychiatric service provider shall make arrangements for post-discharge treatment services and provide an appropriate discharge plan for patients.
 - (2) The inpatient psychiatric service provider shall provide post discharge services for up to two weeks post-discharge when needed.
 - (3) Consultation and referral may occur between inpatient psychiatric service provider and community resources.
 - (4) Community agencies/providers may be invited to participate in treatment team and/or family meetings.
 - (5) Identified community provider may, when appropriate to patient need and with permission of the patient/guardian, be contacted to participate in discharge planning.
 - (6) For children/adolescents, each inpatient psychiatric service provider shall make provision for coordination of psycho-educational treatment and recommended aftercare with the patient's local school and any existing individualized education plan from the patient's local school.
- (C) Patient discharge process
- (1) The attending physician completes a discharge order in the electronic medical record indicating discharge date, discharge medications, and condition of patient on discharge.
 - (2) The treatment team is responsible for the development and coordination of the discharge plan and safety plan.
 - (3) The discharge continuing care plan and after visit summary are reviewed with and provided to the patient and/or the family/guardian/representative.
 - (4) Nursing staff is responsible for documenting the patient's condition and ambulatory status, as well as escorting the patient and family from the unit. Give patient, or accompanying responsible person, discharge medications/prescriptions (if applicable) with verbal instructions and printed instructions.

Guideline:
Discharge planning and continuity of care

3

Approved by:

*Kurt Kless, MSN, MBA, RN, NE-BC
Chief Nursing Officer*

Initial effective date:

February 2020

Review/Revision Completed by:

*Stephanie Calmes, Ph.D., LPCC-S,
LICDC-CS, Administrative Director,
Psychiatry*

Review/Revision Date:

January 2023
November 2025

Next review date:

November 2028