Nursing Service Guidelines
Inpatient Behavioral Health

Title: DISCHARGE PLANNING AND CONTINUITY OF CARE

Responsibility: Trained Inpatient Behavioral Health multi-disciplinary team

Purpose of Guidelines: To ensure that a systematic process addresses the needs for continuing care, treatment, and services after discharge. Coordination with community resources is essential in implementing the most effective service delivery. To facilitate discharge, the program assesses the patient's needs, plans for discharge, facilitates the discharge process and helps to ensure that continued care treatment and services are maintained.

Procedure:

1. 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.
    a. If the patient's condition necessitates long-term, ongoing treatment, a transfer to an appropriate facility may be arranged.
    b. If the patient's medical condition is such that the required level of nursing care is beyond that available and the patient is too physically ill to participate, transfer will be arranged to the most appropriate level of care for medical treatment.
    c. If a patient requests discharge without the treatment team's agreement and is not in need of involuntary admission as defined by the Ohio Revised Code (ORC 5122), the patient shall be discharged against medical advice.

2. Coordination with community resources is essential in implementing the most effective service delivery by the hospital:
    a. The inpatient psychiatric service provider shall make arrangements for each patient for post discharge services. Each inpatient psychiatric service provider shall provide an appropriate discharge plan for patients, or the inpatient psychiatric service provider shall arrange for each of these patients, as necessary, to receive mental health services from other mental health providers, consistent with patient choice and acceptance.
    b. The inpatient psychiatric service provider shall provide interim post discharge services for up to two weeks post discharge. The inpatient psychiatric service provider shall make all reasonable efforts prior to discharge to ensure that the patient has a specified appointment, as appropriate.
    c. Consultation and referral may occur between inpatient psychiatric service provider and community resources.
    d. A clear understanding of mutual roles and expectation among staff and community resources.
    e. Community agencies/providers may be invited to participate in treatment team and/or family meetings.

f. Identified community resources may, when appropriate to patient need and with permission of the patient, be contacted to participate in discharge planning.

3. 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.

4. Attending Physician responsibilities:
    a. Sign and date discharge order.
    b. Complete discharge form on transfers from an appropriate facility (i.e. nursing home, etc.).
    c. Complete Psychiatric discharge note (see Discharge Note Policy/Procedure).
    d. Dictate discharge summary per Medical Staff bylaws.

5. Patient Discharge:
    a. The attending physician completes an order indicating discharge date, discharge medications, and condition of patient on discharge.
    b. The social worker/therapist/nurse is responsible for the development and coordination of the discharge plan and safety plan.
    c. The social worker or therapist will coordinate family and community resources to provide optimum implementation of the discharge plan. This discharge continuing care plan is reviewed with the patient and or the family/guardian/representative.
    d. On the day of discharge, nursing staff will assist the patient with gathering his/her belongings. Nursing staff is responsible for documenting the patient's condition and ambulatory status as well as escorting the patient and family from the unit.
    e. Complete Medication Reconciliation per UTMC policy.
    f. Give patient or accompanying responsible person discharge medications/prescriptions (if applicable) with verbal instructions and printed instructions.
    g. Nurse will discharge patient and document a discharge note.
    h. A copy of the relevant portions of the post discharge plan shall be given to the patient, or as appropriate, the patient's guardian, and shall be made available, with the patient's permission, to the person or agency that will assume primary responsibility for implementation of the discharge plan.

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