Title: DISCHARGE PLANNING AND CONTINUING CARE OVERVIEW

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

Procedure:
Discharge Planning:

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 Program when deemed clinically suitable by the attending physician. When specific therapeutic placement is ordered by the Attending Physician, the clinical social worker or family therapist arranges the placement involving the family as appropriate. The Unit's clinical social worker, therapist, and nurses are familiar with facilities that provide long-term skilled nursing, nursing home care, residential care, day treatment, outpatient psychotherapy, and partial hospitalization.

1. 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 but not to exceed 30 days.

2. Patient Discharge:

The attending physician writes an order indicating discharge date, discharge medications, and condition of patient on discharge. The social worker or therapist is responsible for the development and coordination of the discharge plan and safety plan. 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/Power of Attorney. 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. Complete Medication Reconciliation per UTMC policy.

Give patient or accompanying responsible person discharge medications (if applicable) with verbal instructions and printed instructions. All medications will have medication fact sheets or document that patient is not appropriate to receive the information. Nurse will discharge patient and document a discharge note.
3. **Continuing Care:**

When a patient is referred to Senior Behavioral Health by an outpatient agency or mental health professional, the patient is referred back to that agency or professional unless it is not clinically appropriate. The referral source will be updated regardless of the disposition. Other patients may be followed in individual and/or family psychotherapy by the attending psychiatrist or other qualified person recommended by the attending psychiatrist. Patients may be referred to an appropriate outpatient provider within their geographic home area. A copy of the discharge continuing care plan will be sent to referral source and/or outpatient provider. The family therapist/social worker will make certain that all necessary release of information have been signed and fax discharge plan/documentation to the appropriate agencies for continuity of care. Family therapist/social work will write a discharge progress note addressing each problem in the treatment plan and status at discharge and summarize disposition and follow-up plan.

4. **Discharge Referrals:**

Patients not returning home and being referred to other treatment facilities will be provided with ongoing treatment by that facility. The patient and the family participate in the decision-making process. Patient and family/guardian/Power of Attorney involvement is coordinated by the social worker or family therapist. a) Review Continuing Care/Discharge Plan and Safety Plan with the patient and family.

Reviewed by: Lindsay Watson, Program Director & Monecca Smith 7/2017