

<p>Name of Policy: <u>Discharge Assessment of Acute Care Inpatients</u></p> <p>Policy Number: 3364-131-28</p> <p>Department: Outcome Management</p> <p>Approving Officer: Director of Nursing/Chief Nursing Officer</p> <p>Responsible Agent: Director of Outcome Management</p> <p>Scope: The University of Toledo Medical Center</p>	 <p>Effective Date: March 1, 2022</p> <p>Initial Effective Date: January 10, 2007</p>
<p> <input type="checkbox"/> New policy proposal <input checked="" type="checkbox"/> Minor/technical revision of existing policy <input type="checkbox"/> Major revision of existing policy <input type="checkbox"/> Reaffirmation of existing policy </p>	

(A) Policy Statement

High risk patients will be screened prior to discharge to determine potential discharge planning needs.

(B) Purpose of Policy

To identify cases in need of discharge planning services prior to the actual discharge dates. Early discharge planning will promote reasonable planning time, will be positive for customer service, and will reduce avoidable in patient hospital days.

(C) Procedure

1. High risk screening guidelines for patients admitted into the hospital is as follows:
 - ✓ 80 years and older
 - ✓ Readmissions
 - ✓ 10 day stay or more
 - ✓ Self Pay Patients
 - ✓ Non USA citizens
 - ✓ Change in disease process/patient condition
 - ✓ Diagnosis (examples, not mutually exclusive) CHF, AMI, PN, Oncology, COPD, CVA, Complex Wounds, Hospice, Diabetes, Trauma, Assault/Abuse, Hip/Knee Replacement, Sickle Cell, Pancreatitis

2. Each unit multidisciplinary team (social work, resource utilization coordinator and lead nurse) will review the daily unit census, admitting RN history assessment and the Outcome Management Report to identify patients that meet the high risk screening assessment guidelines. Clinical judgment and prioritization of individual unit needs will guide high risk screening.

3. The Outcome Management Team will assess cases and document needs using the standardized Initial Assessment/Readmission Assessment online format under the Discharge Planning tab in the Care Organizer system.

4. The Outcome Management Team will continue to evaluate the high risk patient population and address changes in needs throughout their hospital stay.

