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| Subject: Discharge Summary & Documentation | Effective Date:  Revised Date:  Revised Date:  Revised Date: |
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POLICY:

When the program anticipates a discharge, there must be a discharge summary that includes:

## A recapitulation of the patient’s stay.

## A final summary of the patient’s status to include items below at the time of the discharge that is available for release to authorized persons and agencies.

## A post-discharge plan of care that is developed with the participation of the patient and his or her family, which will assist the patient to adjust to his or her new living environment.

INTENT:

The intent of this regulation is to ensure appropriate discharge planning and communication of necessary information to the continuing care provider.

“**Post discharge plan of care**” means the discharge planning process that includes assessing continuing care needs and developing a plan designed to ensure that the individual’s needs will be met after discharge from the program into the community.

When the program “anticipates discharge” the discharge is not an emergency discharge (e.g., hospitalization for an acute condition) and is not due to the patient’s death.

“**Adjust to his or her living environment**” means that the post discharge plan should describe the patient ’s and family’s preferences for care, how the patient and family will access these services, and how care should be coordinated if continuing treatment involves multiple care givers. It should identify specific needs after discharge such as personal care, sterile dressings, and physical therapy, as well as describe /care giver education needs to ensure the patient care giver is able to meet care needs after discharge.

PROCEDURE:

# Care Management is responsible to communicate discharge plan with the MD/DO.

# All discharge planning activities including aiding the patient and his/her family in locating and coordinating post discharge services will be documented in the Care Management section of the chart.

# Documentation of education provided by nursing, therapists and pharmacists to patient and family to teach them how to care for their diagnosis/condition for continuity of care, safety, and prevent the need for rehospitalizations will be documented.

# Medication reconciliation will be documented on admission and for all discharges.

# The discharge summary from each discipline will be documented in their section of the chart [or on an ITD status summary form].

# The physician discharge summary is to include:

## The patients discharge status compared to the admission status.

## Information pertinent to continuing care for the patient addressing post-discharge care including referrals and follow-ups.

## Discharge disposition.

# The discharge summary or at least a recapitulation of the stay with orders will be available at the time of transfer/discharge to another facility such as a SNF or LTC etc.

# A conference call by care management and/or nursing staff will be made to the Nursing Home, Assisted Living, or any other level of care when a patient is discharged to discuss patient’s preferences, present status and on-going needs before the transfer occurs.

# A follow-up call will be made by care management or nursing to the Nursing Home or Assisted Living Facility later the day of transfer/discharge or early the next day to ensure that all orders were understood, and no questions has arisen from them.

# Above calls are to be documented in the care management section of the medical record and issues are to be addressed.