Preparing for Discharge

BQIS Fact Sheets provide a general overview on topics important to supporting an individual's health and safety and to improving their quality of life. This is the second of three Fact Sheets regarding Hospitalization.

Intended Outcomes

Reader will understand actions necessary to help with successful discharge planning in cooperation with hospital personnel.

Definitions

Discharge Planning: Medicare defines discharge planning as "a process used to decide what a patient needs for a smooth move from one level of care to another."

Facts

- Spending time with an individual during their hospitalization will increase communication, build rapport with facility staff, and minimize errors in following the person's plan of care.
- It is best practice for an assigned person (health care coordinator, nurse, Qualified Intellectual/ Developmental Disabilities Professional (QIDP)) to maintain routine contact with the hospital.
- For planned admissions, discharge planning begins during admission.
- For unplanned admissions, the discharge planning process begins as soon as the individual's outcome becomes clearer.
- Most hospitals now have staff specifically assigned to discharge planning or case management.
- Discharge planners can be nurses, case managers, social workers, or others.
- Discharge planning is a process—not a single event.
- Discharge from a hospital does not mean that the individual is fully recovered. It simply means that a physician has determined that their condition is stable and that he/she does not need hospital-level care.

Recommended Actions and Prevention Strategies

1. During admission, establish a contact person who can give an update on the individual's status while at the hospital. This contact person may be a nurse, case manager, or social worker.

2. Discuss who the discharge planner will be and set up a contact or meeting time.
3. Inform the provider contact person/health care coordinator (HCC) and guardian/health care representative of the hospital contact person and discharge planner's information.
4. Designate a provider contact person/ health care coordinator (HCC) to:
    - Discuss with the contact person the best time of day to call for information and visit the individual. Explain that someone from the provider organization will be calling or visiting periodically to follow the individual's progress and treatment course. Encourage the hospital staff to call for any problems, questions, or concerns.
    - Share with the discharge planner the individual's current living situation and supports such as nursing presence, direct support staff or family caregiver presence, housemates, and available transportation.
    - Discuss the need for a verbal report to be provided to the HCC prior to formal discharge.
    - Share information with the discharge planner as needed regarding the person's home physical environment such as shared bedroom, no shower, presence of stairs, bathroom set up and location etc.
    - Alert the discharge planner of the need for the HCC to be informed in a timely manner of any new orders or treatments that may continue after discharge.
    - Discuss the need to receive detailed written instructions on the discharge instructions for any new medications or treatments.
    - Discuss the need to receive detailed written instructions on the discharge instructions regarding what to watch for, what to expect, any restrictions, and any other recommendations for the management of the health issue.
    - Discuss the need for prescriptions for new medication and/or treatment orders.
    - Discuss the reason for any new medications and whether there are any special instructions related to the use of the medication, including times to administer, methods of administration, and anticipated side effects.
    - Discuss when any new medications should begin.

- Make sure any medications that are to be discontinued have specific orders for the discontinuation.
- Discuss whether any monitoring/observation is necessary and what would prompt a call or follow-up appointment to the health care provider.
- Discuss who to call for problems and what numbers to call.
- Discuss whether any specific training and/or equipment are necessary.
- Discuss the need for any new equipment (oxygen, adaptive equipment, etc.) or transportation (ambulance) to be arranged/obtained prior to the day of discharge.
- Discuss whether any follow-up procedures or appointments are necessary.
- Ask how the results of any tests and any physician orders will be obtained and/or communicated. Encourage hospital staff to provide copies of anything available at time of discharge.

5. The person taking the individual home should:
   - Read all discharge orders and recommendations back to the health care provider to make sure they are legible and understood.
   - Prior to leaving, discuss when last food and fluid intake, urine void, and bowel movement occurred, and if any medications or treatments were given that day including, time of administration. Make sure this information is written on the discharge instruction.

6. **If there are concerns regarding the status of the person and you are uncomfortable taking the person home, tell the hospital personnel your concerns and explain the reasons why.** Contact the guardian/health care representative and/or provider contact person if you have concerns. *Do not take the person home until concerns are resolved.*

Learning Assessment

The following questions can be used to verify a person's competency regarding the material contained in this Fact Sheet:

1. The following information may useful to a discharge planner:

   A. Whether the person's home has stairs

   B. If the person has a nurse to follow his care

   C. If the person likes television

   D. A & B

   E. B & C

2. If the person is discharged from the hospital but does not look OK to you:

   A. Just bring them home and call your supervisor.

   B. Try and perk them up before you go

   C. Alert the hospital personnel and your supervisor/nurse and voice your concerns

   D. Alert the nurse's supervisor and complain about the care

3. True or False: Most hospitals have someone that is responsible for discharge planning.

References

A family caregiver's guide to hospital discharge planning. National Alliance for Caregiving and the United Hospital Fund of New York. Retrieved 07/20/2015 from http://www.caregiving.org/pdf/resources/familydischargeplanning.pdf.

Hospital discharge planning: A guide for families and caregivers. Family Caregiver Alliance: National Center on Caregiving. Retrieved 07/20/2015 from https://caregiver.org/hospital-discharge-planning-guide-families-and-caregivers.

Hospital-to-home discharge guide. Next Step in Care. Retrieved 07/20/2015 from http://www.nextstepincare.org/uploads/File/Guides/Hospital/Hospital_to_Home_Guide/Hospital_to_Home.pdf.

Related Resources

Hospitalization Series Fact Sheets: *Preparing for Discharge* and *After Discharge*

Learning Assessment Answers

1. D
2. C
3. True