

STEPS FOR EFFECTIVE DISCHARGE PLANNING

New York State requires hospitals to provide discharge-planning services to facilitate your transition from hospital to home (or another setting such as short term rehabilitation or skilled nursing facilities).

Discharge planning provides a critical link between the treatments received when a patient is hospitalized, in rehab or at a skilled nursing facility. Ideally one designated person or team is accountable for effective discharge of patients. This may be the patient's primary nurse, a case manager, a dedicated discharge planner or an inter-disciplinary team. (i.e. physicians, social workers)

Discharge planning is not a single intervention as many issues need to be addressed including safety. There is information available for the caregivers of the patients being discharged however there is little information for the patients who live alone.

Medicare defines discharge planning this way:

A process used to define and to decide what a patient needs for a smooth move from one level of care to another.

Discharge is a short-term plan to get you out of the hospital or institution not a blueprint for the future. At the very outset of discharge planning, health care professionals, family caregivers, and the patient (if appropriate) should discuss the following:

- The patient's condition, and any changes that may have occurred as a result of treatment as the facility;
- Any likely symptoms, problems, or changes that may occur when the patient is at home;
- The patient's care plan, the caregiver's needs, and any adjustments that must be made to meet these needs;
- The potential impact of caregiving on the caregiver; warning signs of stress; techniques for reducing stress.

Planning

Prior to discharge, health care professionals should work with family caregivers - with the patient's consent, if appropriate to:

- Arrange for an assessment to determine Medicare or insurance eligibility for home care services, such as visiting nurses and home care aides;
- Set up home care services for which the patient is eligible and others for which the patient / family will pay;
- Get the home ready by arranging for equipment rental and home modifications;
- Schedule a follow up appointment.

Training

Before discharge, healthcare professional should provide family caregivers with applicable training, including:

- A written **medication** list with specific instruction on medication dosages and how long they should be taken and information about possible side effects;
- Teaching and practice of techniques such as bed to chair transfers, care procedures, use and monitoring of equipment, recognition of symptoms, and other element of patient care.
- Equipment: Who (company)?
What items?
When delivery? Phone _____

Referrals

Before discharge, healthcare professionals, caregivers, and patients should explore available support services, including:

1. Community sources of social support for caregivers and patients;
2. Community-based agencies that provide services such as transportation, equipment maintenance, respite care, home care, and volunteer services;
3. Information resources such as books, pamphlets, videos, and websites.

You may have other concerns and questions as well. Write them down as you think of them. Again, remember the first “Be realistic. Make sure you have someone else with you or to call on until you feel comfortable with the new situation. **And don’t be afraid to talk – to the doctor, the home care agency, and your family – if you feel unsure.** In most cases it takes a while to settle in, so don’t expect everything to be the same as before. But help will not be available unless you ask for it. **Be persistent.**

In hospitals or institutions many patients require post-discharge care, conveying information about specific needs to each patient who may benefit from different services will take a lot of ingenuity.

Patient Safety Program

In the environment we are now working in (with regard to safe discharge to home) certain issues need to be addressed.

1. Does the patient live alone? If the patient lives alone will the patient be able to manage medications, shopping, doctors appointments, general housekeeping, bathing and all other safety issues: (i.e. clutter – throw rugs – shower rails – stairs – toileting.
2. Is home care appropriate for the patient?
3. Does insurance cover services?
4. Can the patient pay privately?

THINGS TO KNOW WHEN YOU ARE IN THE HOSPITAL

New York State requires hospitals to provide discharge planning services to facilitate your transition from hospital to home (or another setting such as short term rehabilitation or skilled nursing facilities).

Your initial hospital stay may be a time of concern, such as -- unknown procedures, terminology etc. but ask who your discharge planner will be so you can be appropriately prepared. Please let the discharge planner know if you have any special concerns, needs, and issues regarding returning home.

The discharge planner will be a nurse and/or social worker, who is available to assist you with post hospital plans for necessary services which can include: visiting nurse, custodial care by a home health aide, therapy, medical equipment to name a few. You should receive this information in writing. The discharge planner will also help to determine your insurance eligibility for necessary services.

As a Medicare recipient if you think you are being asked to leave the hospital too soon when the hospital gives you a written notice of discharge -- you may question your hospital discharge. The notice will say **“Who you should call and how to appeal”**.

Being prepared during your hospital stay will help to avoid any last minute problems.