ED Practice Guideline: Discharge Plan of Care & Education for Non-Behavioral Health Patients

Practice Guideline

Note: This practice guideline describes essential components of assessment and intervention at discharge. Divergence from the guideline is acceptable based on provider judgment, and should be reflected in documentation.

Goal

Patients are discharged according to individualized need, which includes consideration of diagnosis, self-care, follow-up plan and referrals to community resources, specialty care and collaboration with patient's lay caregiver and/or support person when/if available. The hospital may incorporate evidence based practices. The hospital must not delay a patient's discharge or transfer to another hospital. The hospital must not require the disclosure of protected health information without obtaining a patient's consent.

Provider Discharge Process

Determine the patient disposition and follow-up plan, this includes:

A. Determine plan for ongoing care, including follow-up and physician referral as needed.
B. Write the order for patient discharge.
C. Determine the patient's ability to return to work or school, if applicable.
D. Write prescription(s) and reconcile the home medication list, if applicable.
E. Explain to the patient the suspected diagnosis, results of any studies, the treatment and the follow-up, as applicable.
F. Record the patient's condition on discharge.
G. Ensure the discharge plan is appropriate to the needs and acuity of the patient and the abilities of the support person or lay caregiver.
For patients who present with a Behavioral Health Crisis:

A. Refer to GOP: Releasing A Patient Following a Behavioral Health Crisis

RN Discharge Process

Complete the discharge process, including but not limited to the following:

A. Review the medical record for completeness of nursing care/reassessments and any noted areas of concern.

B. Identify and resolve incomplete orders.

C. Complete and document discharge nursing assessment, including the patients' condition and identification of education and training needs of the patient and/or their support person or lay caregiver, specific to their care and treatment.

D. Prepare discharge teaching plan, incorporating readiness to learn and learning needs assessment.

E. Consider special education needs such as interpreter services, non-English written material, large print, family or care giver teaching and supplemental educational materials (e.g., fever pamphlets or packets for managing fever at home).

F. Complete discharge teaching addressing ongoing care needs, which may include:
   1. General safety concerns (e.g., medication safety in a pediatric patient with accidental ingestion; water safety; fall prevention strategies; seat belt use; tobacco use by family members of pediatric patients with reactive airways disease; bicycle helmets; use of sunscreen, etc). Information about diagnosis to support continuation of care at home.
   2. Pain management.
   4. Warning signs and symptoms that would indicate the need to return.
   5. Follow-up plan.

G. Consider the safety needs for those patients who are unable to carry out their usual activities and/or who are unable to protect themselves, such as but not limited to:
   1. Patients whose ability to drive may be impacted i.e. those who have received narcotics or sedation in the ED, under the influence of ETOH or elicit drugs, new seizures, mental health crisis, altered mobility and/or with eye patches, should not drive and may need assistance arranging transportation.
   2. Patients who are identified as fall risk may need referrals or education to reduce fall risk and prevent injury form falls. Patients who have had sedation and others at risk should be accompanied by a designated responsible adult.

H. Prepare the patient for discharge; e.g., discontinue: oxygen, monitoring equipment, vascular access, etc., as appropriate.

I. Coordinate discharge, including involvement of interdisciplinary services and support person and/or lay caregiver as needed.

J. Assess transportation needs for safety and provide coordination as needed.
K. Coordinate follow-up, as needed:
   1. Patients established with their own provider, may be referred to their provider if appropriate. If specialty care is needed, they may be referred to a specialist.
   2. Patients without a provider may be referred for an initial follow-up visit with the on-call physician in the appropriate specialty, if needed. Patient will be provided the name, address and phone number of an appropriate provider for follow-up care.

L. Assess patient and/or family or lay caregiver, when designated, understanding and ability to follow discharge plan and readdress if needed.

M. If a patient is returning to a care facility, discharge nurse should communicate with receiving facility and document that patient's current care needs can be met.

N. Give the patient or care giver or support person a copy of written instruction.

O. Repeat discharge assessment (including vital signs) as appropriate for condition. A recheck should occur of any abnormal vital signs prior to discharge. Any vital sign that remains abnormal should be reported to the provider to verify appropriateness of patient discharge status.

References

2008 Hospital Accreditation Standards: Oak Terrace, IL (2008)

Approval

OR Regional Emergency Department Clinical Collaborative

All revision dates: 08/2020, 09/2019, 05/2019, 12/2015, 12/2015, 10/2008

Attachments

No Attachments

Approval Signatures

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Applicability

OR - Clinical Support Staff (CSS), OR - Connections, OR - Credena Health (CH), OR - Home Health (HH), OR - Home Medical Equipment (HME), OR - Home Services, OR - Home Services Pharmacy (HSRx), OR - Hospice (HO), OR - Providence Ctr for Medically Fragile Children, OR - Providence Hood River Memorial Hospital, OR - Providence Medford MC, OR - Providence Medical Group, OR - Providence Milwaukie Hospital, OR - Providence Newberg MC, OR - Providence Portland MC, OR - Providence Seaside Hospital, OR - Providence St. Vincent MC, OR - Providence Willamette Falls MC