Hospital Admission and Discharge Planning
Mission Statement

To improve access to long-term care supports through an integrated network of partners committed to expanding the use of community-based solutions, promoting consumer directed decision-making, and enhancing efficiency and quality of service.
The information in this booklet is provided as a tool to assist anyone dealing with hospitalizations or facing extended medical care. Being a well-informed advocate will help you to receive quality services within any health care facility. It is not intended to replace medical advice. Please contact a physician as needed.

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# Table of Contents

- Introduction 2
- Hospital Admission 3
- “Getting to Know Me” 4
- While in the Hospital 5
- Medication Listing Log 6
- Team Work 7
- Roles & Responsibilities of Hospital Staff 8-9
- Discharge Planning 10
- Preparing for Home 11
- Medication Reconciliation 12
- Day of Discharge 13
- Preparing for a Transfer 14
- Roles & Responsibilities of Team Members 15
- Medical Documentation 16
- Resources 17-18
- Glossary of Terms 19-20
Introduction

“Discharge Planning begins the day of Admission”

Going to the hospital (either planned or unplanned/emergency) can be a stressful time for all involved. It can be a very confusing and alarming situation for patients and their families or support team. It is best practice to have someone support the hospitalized person in order to oversee all medical care treatment, communication and disseminate information.

According to The Centers for Medicare & Medicaid Services (CMS), hospital readmissions are seen as an important indicator of care quality and account for billions of dollars in annual Medicare spending. The Partnership for Patients and Hospitals, a national initiative, has set a goal of reducing hospital readmissions in order to improve overall outcomes for patients while in a facility and when they are discharged.


This Hospital Admission and Discharge Planning booklet will provide information to help ensure an appropriate hospital admission and safe discharge home by identifying:

- Information to have in place for planned or unplanned/emergency hospital admission
- The importance of communication to ensure continuity of care during and after hospital admission
- Strategies to ensure a safe transition to home or other facility through effective discharge planning
- The process of securing placement within a short or long term care facility when a person is not ready to be discharged home
Hospital Admission

A hospital admission can be planned or unplanned. A planned hospital admission may be scheduled because of an impending surgery. An unplanned hospital admission is usually the result of some sort of an emergency due to an unforeseen incident, illness, or complication.

Whether a hospital admission is planned or unplanned, there are some things one can have in place and ready to ensure a smooth admission process. A health history informational packet should be prepared ahead of time and updated as needs and information changes.

This packet should include the following items:

◊ Medical History Summary (if available)
  • Current Diagnoses
  • Current Medication List (see Page 6)

◊ Current Practitioner Information
  • Primary Care Physician (PCP)
  • Specialists
  • Psychiatrist

◊ ALL Medical Insurance Cards
  • Private Insurance
  • Medicare
  • Medicaid

◊ Medical Documentation
  • Healthcare Decision Making Information
  • Informed Consent Document

◊ End of Life Information
  • Advance Directives
  • Physician Order for Life Sustaining Treatment (POLST)

◊ “Getting to Know Me” Information (see Page 4)
“Getting To Know Me”

Why would this be needed?

During a hospitalization a person will come in contact with many different hospital personnel who may or may not have experience treating people with disabilities. This brief explanation lists some pertinent facts about a person and his/her capabilities. Having this document prepared in advance as part of a health history packet will help make the hospitalization experience easier for all involved.

What should it include?

- Full name
- What the person likes to be called
- What the person’s home setting is like
- Status with ADLs (activities of daily living)
- Status of one’s eyesight
- Status of one’s hearing
- Status of the person’s communication skills
- Status of the person’s ambulation
- Sensory difficulties
- Any adaptive equipment used
- Requirements for eating safely, diet modifications
- Food/fluids liked/disliked
- Something about the person’s life, activities, hobbies, pets

Other important items

- Bring personal items from home
- Preferred medical supplies (i.e., incontinence briefs) etc.
Things to Remember

- You should identify the physician in charge of a person’s treatment while hospitalized. This may not be their regular PCP. Also you must identify all of the nurses in charge of the person’s care.

- Make the nursing staff aware of personal needs that require assistance such as bathing, eating, transferring, and toileting.

- Provide any medication that have been brought to the hospital to the nurse to be reconciled by the pharmacy. Refer to Medication Reconciliation (see page 12).

- Make nursing staff aware of all personal items that may be in your possession such as money, glasses, hearing aids, canes, walker, wheelchair, CPAP machine, dentures, etc.

- Identify the social worker or discharge planner to begin asking questions about the current treatment plan and goal for discharge.

- Use the “Getting to Know Me” information to introduce the person to his or her attending physicians and nurses while in the hospital. This will help them become familiar with the person and his or her needs and abilities.
Complete this prior to any hospitalization or physician visit so that all treating physicians know what medications you are currently prescribed.

<table>
<thead>
<tr>
<th>Medication Listing Log</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Prescribing Doctor</td>
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<tr>
<td>How to Take It</td>
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<tr>
<td>Frequency</td>
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<td>Dosage</td>
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<td>Medication</td>
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</table>
Based on the concept that “Discharge Planning begins the day of admission,” it is important to recognize the key members of a person’s support team at the beginning of the hospitalization process.

A team may consist of the following people:

- The Patient
- The Family and/or Caregiver
- The Attending Physician
- Nursing Staff
- Other Support Staff (Physical, Occupational, Respiratory Therapy)
- Case Manager/Social Worker or Discharge Planner
- Healthcare Decision Maker

The team should meet as needed during the hospitalization to identify any changes of status which may result in “new” needs for the hospitalized person.

Resources should be identified for safely supporting the individual in and out of the hospital, including transportation needs, training for new equipment, and the proper management for new diagnoses and medications. The team should determine whether the needs of the individual can be met safely within the previous environment or determine where changes need to be made and implement them.

If the person cannot safely return home after discharge from the hospital, the team will have to identify other options such as a short or long term care facility.
Roles & Responsibilities

of Hospital Staff

While in the hospital, a person will encounter various hospital personnel. Each hospital staff member has a unique role and responsibility to assist you from admission to discharge. Listed below are a list of key staff that a person may encounter:

**DIETITIAN-NUTRITIONIST**—help plan specialized menus for patients and teach them how to plan a well-balanced diet.

**DISCHARGE PLANNER**—helps patients arrange for health and home care needs after they go home from the hospital or transfer to another type of care facility.

**NURSES**—there are many types of nurses in a hospital setting: registered nurses, nurse practitioners, licensed practical nurses, nursing aides, nursing students, etc. Some may check for vital signs (blood pressure, temperature, and pulse). The assigned nurse coordinates nursing care for each patient.

**OCCUPATIONAL THERAPIST**—works with patients to restore, maintain or increase their ability to perform daily tasks such as cooking, eating, bathing, dressing, etc. They can also help with safety assessments and wheelchair evaluations.

**PHARMACISTS**—responsible for dispensing prescribed medications. They prepare the medicines used at the hospital.

**PHLEBOTOMISTS**—trained to draw blood from patients for clinical or medical testing.

**PHYSICIANS-DOCTORS**—in charge of your overall care. Your treating physician at the hospital may not be your primary doctor (primary care physician or family doctor). At the hospital you could be seen by several doctors, including specialists, medical students, residents, and other hospital staff. The attending or treating physician directs them. They also see other patients.
Roles & Responsibilities of Hospital Staff (continued)

**PHYSICAL THERAPIST**—teaches patients how to build muscles, increase flexibility and improve coordination. They may use exercise, heat, cold, or water therapy to help patients whose ability to move is limited.

**RESPIRATORY THERAPIST**—prevents and treats breathing problems. For example, they teach patients exercises to help prevent lung infections after surgery.

**SOCIAL WORKER-CASE MANAGER**—offer support to patients and their families. They can help patients and families learn about transition to short or long term care facilities, home-care, social services, arrange for durable medical equipment and support groups.

**TECHNICIANS**—perform a variety of tests such as x-rays, ultrasounds, MRIs and CT scans, etc.
Discharge planning begins the day of admission and continues throughout the entire course of the hospitalization. The planning process should be person-centered, meaning decisions are made determined by the person’s needs and choices.

Discharge planning decisions should reflect changes in the person’s health status. It should include any need for follow-up treatment and monitoring, obtaining equipment or medical supply needs, and/or setting up in-home supports (i.e. visiting nurse or therapy visits).

Important Questions to Ask?

- Can the person safely return home?
- Is caregiver training needed and available before the person returns home?
- Are equipment/supplies needed?
- What kind of follow-up is needed?
- Are in-home supports needed?
- Are there any special transportation needs?
- What if the person can not return home safely?
Preparing For Home

Important Issues to Consider

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

Protocol

- Arrange for an in-hospital 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 modification
- Provide a 24-hour phone number the caregiver can call to speak with a health care professional
- Organize transportation home for the patient
- Schedule follow-up appointment(s)
- Arrange for delivery of current medications and provide new medication administration record
In an attempt to decrease medication errors during hospitalizations, the Medication Reconciliation Act (January 2006) was established. This electronic process ensures that once a person’s identifying information is entered, the correct medications are administered while a person is in the hospital.

*Since all systems may encounter errors, one should never assume that the medication list is correct!*

It is essential to be proactive and complete the following steps to avoid medication errors while a person is hospitalized and at discharge:

- Bring a copy of the current medication list to the hospital (see Page 6)
- Upon admission, make sure that all medications are continued as prescribed, unless the attending physician says the current medications are contraindicated with necessary treatment
- Upon discharge, review list noting any changes (new medications, discontinued medications, increased or decreased dosages)
- Review the updated medication list with current pharmacist
- Use the Medication Listing Log form on Page 6 to record current medications
Be Prepared!

As previously stated, “Discharge planning begins the day of admission.” This is a good idea in theory but is not always standard practice, so a person’s support team must think ahead.

Have questions prepared to ask the doctor. Hopefully, many of these questions were asked before admission and during the hospitalization. Make sure that the questions are simple and easy to understand for the individual and caregivers.

- Will the person return home?
- Will the person’s healthcare needs be greater or change?
- Will the person need rehabilitation services or therapy?
- Will he/she need assistance with daily care, toileting, bathing, eating, etc.?
- Will the person require caregiver hours?
- Will family members or caregivers need training?

Do not forget to ask for any new prescription orders, documentation with instructions for care, follow-up appointment(s), and who to contact if a need occurs.
Preparing For A Transfer

What if the person can’t go home yet?

In some cases, a person may not be able to be discharged directly home. He or she may have a medical condition requiring further acute or long-term care. In this instance, it is important to remember that the hospital has a responsibility to check and make sure that proper arrangements are in place before the person is discharged. This is possible by providing the treating physician and social worker/discharge planner with a clear picture of the supports that are available at the person’s home.

Short-Term Care

A person may be eligible for a short-term care stay at a skilled nursing facility (also referred to as a SNF) or other facility. The time frame is 180 days or less and usually involves a rehabilitation component. This type of placement is typically preceded by a hospitalization.

Examples requiring short-term or acute nursing services may include, but are not limited to, the following:

- Surgery for joint replacement (i.e. hip or knee)
- Post surgery care requiring intensive therapy (i.e. physical, occupational or respiratory)
- Change in status (i.e., decreased mobility, ventilator dependent), requiring home adaptations (i.e., lifts, ramps), or alternative residential placement

Long-Term Care

Keep in mind that the person’s health may decline or change so much that their needs can no longer be met or addressed at their home. If this is the case, alternative placement in a Long-Term Care Facility (also known as a nursing home) may need to be considered.

It is important to talk with the social worker and/or discharge planner to initiate the process. He or she will assist the team in locating placement options and contact the Area Agency on Aging (AAA). See Resources on Pages 17-18 for how to check on a nursing home.
Roles & Responsibilities of Team Members During A Transfer to a Short or Long Term Care Facility

Team members will have different roles and responsibilities as they plan to transfer a person to either a short or long-term care facility. It is imperative that all involved team members are proactive and prepared advocates for the person being supported.

The “Attending Physician” will need to evaluate the person’s current status, needs and recommend him/her for:

1. Rehabilitation
2. Short-Term Care
3. Long-Term Care

This physician will complete the MA-51 form needed for transfer and write the discharge order/summary from the hospital.

The person’s “Support Team” should be headed by a lead person who is available for all medical updates. This person will communicate closely with the team regarding potential placement options through insurance coverage and hold team meetings as necessary.

The lead person should check the status of each possible transfer facility to make sure it will adequately support and meet the physical, mental and emotional needs of the person. The team’s greatest role in this case is Advocacy!

Following placement in either a short-term or long-term residential setting, it is important to support the individual the same as if they were in the hospital. The social worker for the alternate residential setting will ensure proper completion of all paperwork required for placement and start planning for discharge on the day of admission.
During the course of a hospitalization, there will be numerous times when documentation will be needed. Listed below are some of the forms that may be presented.

- **Health Care Decision Making Information**
  - This documentation may be needed if the person is unable to make health care decisions on their own.

- **Informed Consent Documentation**
  - This documentation gives consent to a specific treatment or procedure. The person would need to understand the proposed treatment or procedure; understand the benefits of having it; understand the risks of having it or not having it; and be able to communicate their decision.

- **Advance Directive**
  - This document provides information about a person’s choices at the end of life. Advance Directives do not go into effect unless the person has a terminal condition and cannot speak for themselves or is permanently unconscious.

- **Physician Orders for Life Sustaining Treatment (POLST)**
  - This document is completed by the medical practitioner with the person. It outlines the person’s choices for care when they have serious medical conditions. The POLST form can transfer from hospital to other facilities such as a nursing home.
Resources

How to check on a nursing home:

- Schedule a visit prior to transfer
- Go to www.medicare.gov and click the link for Nursing Home Compare
- Go to www.health.state.pa.us
- Go to www.carepathways.com
- Go to www.skillednursingfacilities.com
- Contact Long-Term-Care Ombudsman at (717-783-8975)
- Contact Pennsylvania nursing care complaint line at (800) 254-5164

Administration on Aging
www.aoa.gov
(202) 619-0724
Caregiver resources from the Administration on Aging

Caregiving.com
www.caregiving.com
Online support, information and resources for caring for an aged relative

Care Planner
www.careplanners.org
(800) 989-3588
Online decision support tool for seniors, individuals with physical disabilities, and their caregivers
Resources (continued)

**Eldercare Locator**
800-677-1116
www.eldercare.gov
Help with locating aging services in every community throughout the United States

**End of Life Planning Resources and Guidance**
www.pchc.org/end-of-life-planning
Free website guide to multiple links, resources, documents and information for end of life planning

**Healthfinder**
www.healthfinder.gov
Free internet guide to consumer health information from the US Department of Health and Human Services

**Pennsylvania Department of Aging**
1-717 787-7313
www.aging.state.pa.us
Aging Policies and Services

**Pennsylvania Senior Law Project**
1-877-727-7529 or 1-877-PA SR LAW
www.seniorlawcenter.org
Free, confidential hotline staffed by attorneys, available to give Pennsylvania residents (60 and older) legal information and advice

**Philadelphia Corporation For Aging**
215-765-9040
www.pcecares.org

**POLST Form**
Physician Orders for Life-Sustaining Treatment
Information about use of the form and how to obtain it
Area Agencies on Aging (AAA)
A source of information for issues and concerns affecting older people and their caregivers. Specific services at each agency vary throughout the state, depending on the county of support.

Advance Directive
A signed and witnessed document that is a valid declaration under the Advance Directive for Health Care Act. This document allows a person to make their end of life treatment wishes known. Advance Directives only become effective when the person has a terminal condition and cannot speak for themselves.

Discharge Planner (Social Worker)
A person trained to identify medically related social and emotional needs of patients and provide aid in obtaining/setting up services necessary for an appropriate discharge.

Do Not Resuscitate Order (DNR)
An order in the individual’s medical record that Cardiopulmonary Resuscitation (CPR) or other specified life-sustaining measures or treatments should not be provided to the individual. Can only be issued by a physician.

Emergency Admission
An unplanned visit to an emergency room with an admission for hospital stay to treat an unexpected illness or injury.

Health Care Decision Maker
The person responsible and designated to make health care decisions for an individual.

HIPAA (Health Insurance Portability and Accountability Act of 1996)
National standards for electronic health care transactions and national identifiers for providers, health plans, and employers. Permits the use and disclosure of Personal Health Information (PHI) for the purposes of treatment, payment and operations (TPO) without the patient’s prior written consent or authorization.
Glossary of Terms

Informed Consent
The granting of permission to health care providers to treat specific conditions. Consent must be based on full disclosure of the facts needed to make the decision, including knowledge of the risks, benefits, and alternatives.

Long-Term Care
A range of services addressing health, social and personal care needs of persons who lack some capacity for self-care, usually based on needed skilled care, which takes place in a facility for over 180 days.

MA-51
A form completed by the prescribing physician to enter short or long term care facilities. It provides medical evaluation of current diagnoses.

Planned Admission
Any hospitalization scheduled in advance to undergo treatment or medical procedure (i.e., surgery).

POLST
Physician Orders for Life-Sustaining Treatment (POLST) Form is used to communicate decisions about life-sustaining treatment. It is used by the treating physician to indicate what types of life-sustaining treatment a person may or may not want. The POLST is a voluntary form and can accompany a person from one setting to another (i.e. hospital to nursing home).

Short-Term Care
Required regular nursing assistance and help with activities of daily living due to a physical or mental condition taking place in a facility for under 180 days.

Skilled Nursing Facility (SNF)
A facility providing 24-hour-per-day skilled nursing services and rehabilitative care with an emphasis on medical supervision, including restorative nursing care, physical, occupational, and other therapies, dietary and pharmaceutical services, and an activities program.