Willapa Harbor Hospital

Admission, Discharge or Transfer

Disclaimer

Approvals

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Revision Insight

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Owner:	Beth Erfourth, Med/Surg Manager
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Revision Note:
Added qualified personnel for transportation

POLICY:

1. Patients admitted to Willapa Harbor Hospital (WHH) will be admitted to one of three statuses;
    a. Inpatient- Patient meets acute care criteria.
    b. Observation- Patient does not meet Inpatient care criteria, but needs observation to determine next steps in plan of care.
    c. Respite Care- Patient does not meet either status, but family need time to coordinate care at home or require a respite from care for a defined period. This is a private pay status.
2. On admission and discharge/transfer from the facility, the following conditions must be met:
    a. Admission meets one of the criteria above and care needs can be met at WHH.
    b. The transfer is necessary for the patient's welfare and the patient's care needs cannot be met at WHH.
    c. The transfer or discharge is appropriate because the patient's condition has improved sufficiently, no longer requiring the services provided.
3. Willapa Harbor Hospital does not admit or observe pediatric patients (birth to 12 years old). After stabilization, they will be transferred to an accepting pediatric facility if further care is required.
4. When a patient is transferred or discharged there must be documentation in the clinical record from the patient's physician identifying the reason for the transfer or discharge.
5. Willapa Harbor Hospital will provide sufficient preparation and discharge education to patients/caregivers to ensure safe and orderly transfer or discharge from the facility.

PURPOSE:

To clarify the process of admission, observation, transfer and discharge for licensed practitioners, WHH staff and patients/families and community members.

PROCEDURE:

ADMISSION:

1. All patients admitted to Willapa Harbor Hospital will have the following completed by admitting nurse prior to the end of you shift:
    a. Admission navigator
        1. Travel screening, Vital signs, Interpreter Services, Allergies, Home medication verification and reconciliation, (If patient is unable or an unreliable historian, attempt to get a list of last filled medications from the patient's pharmacy.) History, Patient disability, Gender Identity/Sexual orientation, Immunizations (review and confirm), Pnumovax and influenza vaccine assessment (influenza is seasonal), LDA's, Directives, Healthcare Agents, Belongings, Nutrition assessment with referral if needed, ADL's, Psychosocial, Suicide, Fall, and Skin risk assessments, Patient goals, Discharge planning, SDOH.
            1. If a dietitian consult is needed, the provider must be notified and a referral order must be placed.
                i. If the Registered Dietitian is unable to assess the patient before discharge, the physician will be notified regarding the need for dietary consultation upon discharge. The physician can then add a prescription or order for dietary evaluation after discharge if s/he chooses.
    b. Basic assessment
    c. Secondary skin assessment to be completed by 2nd RN per policy "Skin Assessment for Inpatients, Observation Patients, & Swing Bed Patients"
    d. Pain assessment
    e. Screening for Venous Thromboembolism (VTE) with results communicated to provider.
2. An individualized plan of care will be initiated.
3. Patients with valuables have the option of having them locked in the safe in admitting. In order to do this:
    a. Complete belongings envelope in front of patient and another WHH staff member.
    b. Count all cash and document amount on envelope.
    c. Document all credit cards, ID, etc.
    d. Seal envelope and place receipt in patients chart.
    e. Take envelope to admitting and request that it be placed in the safe.
    f. Complete log for items entered into the safe.
4. Willapa Harbor Hospital staff will document all belongings arriving with the patient in the medical record. These include but are not limited to clothing, jewelry, glasses, hearing aides, false teeth, wallet/purse, cell phones/electronic equipment, etc.
5. Patient to be informed that Willapa Harbor Hospital is not responsible for lost, stolen or damaged items left at the bedside.
6. Patient and family are oriented to the patient's room including meals and menus, television, general hospital routines, call light, information folder, notified of daily physician rounds and encouraged to participate.
7. Discharge planning will meet with each patient/family to assist with planning for needs after discharge.

If, for some reason, admission documentation cannot be completed during the shift of admission, a detailed report MUST be communicated to the oncoming shift so that it can be completed within 12 hours of admission.

OBSERVATION:

1. All patients admitted to observation status will be notified on admission that they are in Observation status. They are given a pamphlet explaining observation status.
2. All procedures noted above under "ADMISSION" are followed for patients under observation status.
3. For most insurances including Medicare, Observation status is an outpatient level of care. Diagnostic exams such as CT scans, MRI, Nuclear Medicine studies may require prior authorization before scheduling. Please discuss the order and patient information with discharge planning before scheduling any exams.
4. If a Medicare insured patient is in observation status longer than 24 hours, they will be provided the Medicare Outpatient Observation Notice (MOON) to

sign. The patient must be provided a copy of this form.
5. If a patient in observation status is changed to inpatient status, the MOON form must be signed regardless of number of hours in observation.

TRANSFER:

1. Patients requiring transfer to a higher level of care will be informed of need and choice of tertiary facility will be taken into account whenever possible.
2. Attending physician will contact appropriate physician at tertiary facility. Once an accepting physician has agreed to transfer of care, physician to physician report is completed.
3. Accepting facility must determine bed availability and placement before initiating transportation. All STEMI and Stroke patients are an acception. They are transferred as quickly as possible to Providence St. Peter's without confirming bed availability.
4. Transportation will be provided by appropriate qualified transport personnel per EMTALA requirements. The WHH staff (Unit HUC or RN), will obtain the qualified personnel BLS, ALS, ground or Air with our partnerned EMS providers, with direction from the attending physician.
5. Appropriate documents will be printed and sent with the patient, this may include, but not be limited to the "Interfacility Transfer Report".
6. An Emergency Medical Treatment and Active Labor Act (EMTALA) form must be completed and signed.
7. Document the transfer of care and give report to receiving nursing staff, including an estimated time of arrival.
8. For transfers from the inpatient unit, address the plan of care.

DISCHARGE:

The discharge process begins on admission as we assess the patients ability to provide self-care, amount of caregiver support, understanding of health needs and medications. Discharge from WHH includes:

1. Review discharge plan and process with patient and family/caregiver at least 24 hours in advance if able.
2. Discuss any complicated treatments/procedures (dressing changes, wound care, etc.) that may be required after discharge. Assess patient's/caregivers abilities and understanding to meet these needs. Address any questions or teaching needs the patient and family/caregiver may have. Discharge medication teaching must also be discussed.
3. Discharge planning or primary nurse to notify the attending physician if home care is requested or desired.
4. Discharge Navigator to be completed.
    1. Patient belongings, LDA's removal/resolution (if applicable), medication detail, instructions in regards to provider notification, activity, diet and/or any miscellaneous instructions, follow up appointment information, any specific instructions/patient education.
5. Review the discharge instructions (AVS) with the patient and family/caregiver on the day of discharge and ensure that teaching has been successful. Obtain all signatures and provide a copy to the patient.
    1. Discharge planning can arrange for transportation if needed.
6. Post discharge followup phone call to be made by discharge planning 24-48 hours after discharge. Document phone call and any concerns in the EMR.

References

Reference Type	Title	Notes
	Documents referenced by this document	
Related Documents	Clincial Documentation Improvement	Associated document
Related Documents	Hospital Issued Notice of Noncoverage (HINN)	Associated document
Referenced Documents	Emergency Transfer Policy (EMTALA)	
Referenced Documents	Skin Assessment for Inpatients, Observation Patients, & Swing Bed Patients	

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