Willapa Harbor Hospital Policy/Procedure

Admission, Discharge or Transfer

Discharge Planning 10140 **Official** (Rev: 5)

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 faclity 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 within 12 hours of arrival:
    a. Review of History
    b. Physical assessment, including vital signs and oximetry.
    c. Pain assessment
    d. Medication Reconciliation- using the program in the electronic record, reconcile all home medications. If patient is unable or an unreliable historian, attempt to get a list of last filled medications from the patient's pharmacy.
    e. Nutrition screening
        i. The screening tool can be found in the electronic record as part of the admission forms.
        ii. When completed, the screening tool will identify the nutritional triggers requiring a dietician referral.
        iii. If needed, a referral will be made to the Hospital Dietitian via electronic record mail.
        iv. The dietitian will determine when the patient can be evaluated, and how, i.e. as an inpatient, observation patient, or outpatient, depending on severity of condition and patient length of stay.
        v. 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.
    f. Skin assessment.
    g. Screening for Venous Thromboembolism (VTE), Pneumonia vaccine and when appropriate, Influenza vaccine administration.

h. Falls assessment- if patient has fallen at home or history of falls, they are automatically considered high risk.
i. Assessment of self-care ability, caregiver assistance and patients' level of support at home.

2. A plan of care will be initiated within 12 hours of arrival to the inpatient unit.
3. Patients with valuables have the option of having valuables locked in the safe in admitting.
    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. Patients refusing to place valuables in safe must sign a release of responsibility form, relieving WHH of responsibility for lost, stolen or damaged items.
5. 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.
6. Willapa Harbor Hospital is not responsible for lost, stolen or damaged items left at the bedside.
7. Patient and family are oriented to the patient's room including meals and menus, television, general hospital routines, call light and information folder.
8. Physician rounds are conducted each morning. Families are encouraged to participate if they desire.
9. Discharge planning will meet with each patient/family to assist with planning for needs after discharge.

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 given the Medicare Outpatient Observation Notice (MOON) to sign. The patient will be given a copy of the signed MOON form for their records and the original stays with the patients' chart.
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 initiated by the HUC/CNA, with direction from the attending physician or nurse.
5. Appropriate documents will be copied or duplicated, including, but not limited to, diagnostic tests, labs, physician H & P, Medication records, EKG's/Telemetry strips, Summary of Care document, transfer flow chart and nurses notes.
6. an Emergency Medical Treatment and Active Labor Act (EMTALA) form must be completed and a copy left in the patients chart.
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, resolve 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.
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.
3. Discharge planning or primary nurse to notify the attending physician if home care is requested or desired.
4. Review the written discharge instructions with the patient and family/caregiver on the day of discharge. Discharge planning to arrange for transportation if needed.
5. 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)	

Signed by

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Revised [01/26/2007 Rev. 1], [11/30/2015 Rev. 2], [11/21/2016 Rev. 3], [06/22/2018 Rev. 4], [02/14/2020 Rev. 5]

Reviewed [04/21/2009 Rev. 1], [05/05/2009 Rev. 1], [04/16/2019 Rev. 4], [11/22/2021 Rev. 5]

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