

DISCHARGE ALGORITHM

UNIVERSITY HOSPITAL

Patient is admitted

Day 1/Stage 1: Admission

- Discharge needs assessed as part of initial nursing assessment
- Anticipated Discharge Date identified by Case Manager, discussed with physician and documented in Progress Notes. Care Coordination pamphlet given to patient/family.

Day 2/Stage 2: Diagnosis

- Discussion with physician and patient re discharge options. (CM/SW)
- Projected Discharge Plan established and documented in Multidisciplinary Care Plan (CM/SW).
- Patient choice in facilities and services documented in chart.
- Education needs assessed, plan established & documented on Patient Profile. (RN)
- All education documented on "Multidisciplinary Education Record". (Team)
- Referrals needed (nutrition, PM&R Wound Care, etc) identified and requested
- Benefits confirmed (CM/SW)
- Initial communication with family/friend (CM/SW)



Day 3/Stage 3: Treatment

- Reassess/revise discharge plan (Team)
- Changes/revisions documented. (CM/SW)
- Contact facilities/agencies as required. (CM/SW)
- Education: reassessment and return demonstration (RN)

Day Prior to Discharge

- Confirm Discharge plan, ensure transport arranged.(CM/SW)
- Inform patient/family of potential discharge reinforce 11am discharge (CM/SW/RN)
- Potential discharge order written (Physician). Include diagnostic tests, etc that need to be done prior to discharge as well as discharge orders.
- Potential Discharge List created by Case Mangers & sent to Ancillaries and Nursing

Day of Discharge

- Potential discharge list reviewed by Ancillaries and Nursing. Discharged patients prioritized for services
- Physician confirms discharge and completes orders by 9 a.m.
- Discharge disposition documented in medical record. (CM/SW)

Patient is Discharged