OREGON STATE HOSPITAL

POLICIES AND PROCEDURES

SECTION 6:	Patient Care	**POLICY: 6.013**
Subject:	**Discharge and Conditional Release Planning**	
POINT PERSON:	**SOCIAL WORK DIRECTOR**	
APPROVED:	**DOLORES MATTEUCCI** **SUPERINTENDENT**	**DATE: AUGUST 6, 2018**

I. POLICY

A. Oregon State Hospital (OSH) will assist patients with discharge planning. Discharge planning must be initiated at admission and considered throughout a patient's hospital stay as a continuing and critical aspect of quality patient care.

1. When a patient is under guardianship, the legally responsible parties must be involved in the discharge planning process, which may include community re-integration and transitional activities.
2. The patient's interdisciplinary treatment team (IDT) must verify that the responsible party, guardian, lay caregiver, family, significant other, if available and with patient consent in accordance with OSH Policy 6.021, "Release of Information and Communication with Patient Families, Guardians, and Significant Others", participate in the development and implementation of the patient's discharge plan.
3. Discharge planning must be documented in social work progress notes, the patient's treatment care plan (TCP), and in other applicable medical record documents.

B. OSH must periodically assess a patient's continued need for hospital-level of care and readiness for discharge.

1. The determination regarding readiness for discharge is the responsibility of the patient's IDT, and, when the patient is under their jurisdiction, the applicable legal review entity.
2. The patient's IDT must follow Procedures A and applicable department-level protocols to complete the discharge process.

C. Conditional release approval must be obtained from Risk Review or the applicable legal review entity before a patient's conditional release.

D. Health care personnel (HCP) must document discharge planning activities. Social workers must document discharge planning in accordance with established Social Work Department protocols.

E. A patient's risk for suicide will be assessed in accordance with OSH Policy and Procedure 6.056, "Suicide Risk Screening and Assessment".

F. OSH will reassess its discharge planning process as indicated in the Quality Assurance Performance Improvement plan. Reassessment will include a review of discharge plans to verify the plans are responsive to discharge needs.

G. A HCP who fails to comply with this policy or related procedures may be subject to disciplinary action, up to and including dismissal.

II. DEFINITIONS

A. "Discharge" means the movement of a patient from OSH to either a community setting or other institutional setting including but not limited to jail or Department of Corrections (DOC) custody.

B. "Discharge plan" means a written plan describing the patient's needs upon release from OSH. The discharge plan includes identification of the patient's continuing: medical, psychiatric, and other recovery service or support needs; basic needs such as housing, finances, and employment; social needs such as natural supports, peer supports, and other needed social contact; and the safety needs of the patient and the community.

C. "Discharge planning" means a process that begins upon admission and that is based on the presumption that with sufficient supports and services, all individuals can live in an integrated community setting. Discharge planning is developed and implemented through a person-centered planning process in which the patient has a primary role.

D. "Discharge readiness" means a determination by the patient's IDT that the patient could be successfully treated at a community level of care. This determination is based on reasonable professional assessment, and applies to a patient under civil commitment, voluntary admission, or commitment under Oregon Revised Statutes (ORS) 161.325, 161.327, 161.370, or 161.365. Discharge readiness terms include:

1. "Conditional release" means the movement of a patient who will remain or be under the jurisdiction of the PSRB from a psychiatric hospital setting to a community setting.

2. "Community restoration ready" means a patient committed under ORS 161.370 or ORS 161.365 is found ready to transition to the community.

3. "Ready to transition" means that, consistent with the patient's civil commitment order, the patient's IDT has determined that placement in the community is appropriate for the patient.

E. "Health care personnel (HCP)" for the purposes of this policy means the population of health care workers working in the OSH healthcare setting. HCP might include, but is not limited to: physicians, nurses, nursing assistants, therapists, technicians, dental personnel, pharmacists, laboratory personnel, students and volunteers, trainees, contractual staff not employed by the facility, and persons not directly involved in patient care (*e.g.,* clerical, dietary, housekeeping, maintenance).

F. "Lay caregiver" for the purposes of this policy and in accordance with Oregon Administrative Rule 333-505-0050 means a person who, at the request of the patient, agrees to provide aftercare to the patient at the patient's residence.

G. "Responsible party" means designated representatives of the local mental health authority, mental health program, or other parties identified by the as community case managers or liaisons.

III. PROCEDURES

Procedures A Discharge Readiness

IV. REFERENCES

42 CFR § 405.1037.

42 CFR § 482.13(b).

42 CFR § 482.23(b).

42 CFR § 482.24(b).

42 CFR § 482.43.

42 CFR § 482.61.

42 CFR § 482.62.

Discharge assessment and instructions, STK-00108 [Medical record form].

Discharge plan details, 59-06-0403-00 [Medical record form].

Disclosure of protected health information, DHS-2097 [Medical record form].

Joint Commission Resources, Inc. (2018). *The joint commission comprehensive accreditation manual for behavioral healthcare*. CTS.06.01.02 – 06.02.05. Oakbrook Terrace, IL: Author.

Joint Commission Resources, Inc. (2018). *The joint commission comprehensive accreditation manual for hospitals*. PC.04.01.03 – 04.02.01. Oakbrook Terrace, IL: Author.

Joint Commission Resources, Inc. (2018). *The joint commission comprehensive accreditation manual for hospitals*. RC.01.03.01. Oakbrook Terrace, IL: Author.

Joint Commission Resources, Inc. (2018). *The joint commission comprehensive accreditation manual for hospitals*. RC. 02.04.01. Oakbrook Terrace, IL: Author.

Oregon Administrative Rules §§ 309-091-000—309-091-0050.

Oregon Administrative Rules §§ 333-505-0030 – 333-505-0055.

Oregon Administrative Rule § 333-520-0020.

Oregon Administrative Rule § 333-525-0000.

Oregon Administrative Rule § 309-033-0300 – 309-033-0330.

Oregon Administrative Rule § 309-035-0125.

Oregon Administrative Rule § 309-035-0170.

Oregon Revised Statutes §§ 161.290 – 161.400.

Oregon Revised Statute § 179.505.

Oregon Revised Statute § 426.

Oregon Revised Statutes §§ 441.196 — 441.198.

Oregon State Hospital Policy and Procedure Manual. *Authorized person passes*, 6.002. Author. Oregon State Hospital Policy and Procedure Manual. *Clinical documentation*, 6.045. Author.

Oregon State Hospital Policy and Procedure Manual. *Forensic risk review and privileges*, 6.029. Author.

Oregon State Hospital Policy and Procedure Manual. *Guardianship and conservatorship*, 6.044. Author.

Oregon State Hospital Policy and Procedure Manual. *Interdisciplinary treatment team*, 6.011. Author.

Oregon State Hospital Policy and Procedure Manual. *Release of information and communication with patient families, guardians, significant others*, 6.021. Author.

Oregon State Hospital Policy and Procedure Manual. *Risk review for civil patients*, 6.043. Author.

Responsible Person/Group	Procedures
Interdisciplinary Treatment Team (IDT)	1. Encourage patient involvement whenever possible in decisions regarding community placement when planning discharge or conditional release. 2. Identify barriers that could impede or delay discharge, and: a. develop TCP goals and interventions specific to the identified discharge barrier with identified completion dates; b. assign IDT resources to mitigate identified barriers; and c. verify that continuity of services and recommended supports are coordinated with community service providers. 3. When the IDT, Risk Review Panel, or Program Executive Team (PET) (as applicable) determines the patient is "ready to transition" or "conditional release ready", finalize immediate discharge planning and coordination to a lesser level of care. 4. Document discharge readiness status in the patient's medical record at the time the IDT determines the patient's discharge readiness per department protocols. 5. After determining that a patient under the PSRB can be safely supervised in the community, request the Risk Review Panel review and approve or deny a conditional release readiness request. 6. If a patient must be unexpectedly discharged, (*e.g.,* due to court action or a voluntary admit patient request), attempt to connect with community-based services and supports for continuing care. Document such efforts. 7. Provide the patient's guardian with opportunity to participate in discharge planning. 8. If a patient refuses to participate in all or part of the discharge planning process, document the refusal, the reasons for refusal, the nature of the plans offered, and efforts made on behalf of the patient. 9. Use clinical judgment and include the patient to identify whom the patient wants to be notified of their discharge. a. Identify who is legally required to be notified of the patient's discharge. b. Notify the identified persons. 10. Assess the patient's risk for suicide in accordance with OSH Policy and Procedure 6.056, "Suicide Risk Screening and Assessment".

	Include input from the patient's lay caregiver, when applicable, and other supports.
Psychiatrist/PMHNP	1. When the patient is ready for discharge, identify the patient's readiness for discharge in a progress note. 2. Collaborate with the social worker and patient on the continuing care discharge plan (CCDP). 3. Complete the medical record and discharge order, including destination of patient's discharge. Sign the discharge order. 4. Complete the Discharge Summary within 30 days of patient discharge and include the course of hospitalization, continuing care plan, and recommendations for needed treatment.
Registered Nurse (RN)	1. Complete a "Discharge Assessment and Instructions" form prior to the patient's release, including a physical and mental assessment of the patient, specific medication instructions, recommended medical treatments, diet instructions and other recommended nursing care needs. 2. Review the information on the completed form, including medication instructions, with the patient. 3. Complete suicide risk screening immediately before the patient's discharge. 4. Facilitate treatment and medical equipment to send with the patient.
Social worker	1. Document community integration and discharge planning progress throughout the patient's hospitalization in progress notes in accordance with applicable protocols. 2. Complete a CCDP in collaboration with the psychiatrist/PMHNP and patient, including information such as housing, supervision, addresses, support systems, persons to contact, medical needs, appointments, special care needs, an evaluation of the likelihood the patient needs post-hospital services and the availability of the services, and recommendations in accordance with Oregon Revised Statute (ORS) 441.196. 3. Schedule follow-up appointments for no later than seven days after discharge. 4. If follow-up appointments cannot be scheduled within seven days after discharge, document why the seven-day goal could not be met. 5. Include recommendations for mental health care in the CCDP for a patient going to another institutional setting (*e.g.,* jail, correctional facility, medical hospital) both for that institutional

	setting and for discharge planning to the community from that setting. 6. If the patient or legal guardian refuses to sign the CCDP, write, "patient (or guardian) refuses to sign" in the open space provided for the signature, and initial the statement. 7. Attach lists of resources specific for the patient's needs which could include skilled nursing facilities (SNF), intermediate care facilities (ICF), local housing, shelters, food banks, etc. 8. When complete, sign the CCDP.
Health Information	1. Send a copy of the Discharge Summary to the responsible community mental health program and other continuing care providers, as identified by the psychiatrist/PMHNP at the end of the document. 2. File the original in the patient's medical record after completion. 3. File the original Discharge Assessment and Instructions form in the medical record. 4. Send copies of the Discharge Assessment and Instructions form to the patient or the patient's guardian and/or to the person responsible for the patient's care. 5. Make copies of the CCDP form available to the patient, care provider, community mental health plan representative, or other involved agencies at discharge.