OREGON STATE HOSPITAL

PORTLAND – SALEM

POLICIES AND PROCEDURES

SECTION 6: Patient Care **POLICY: 6.013**

SUBJECT: **Discharge and Continuing Care Planning**

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SUPERINTENDENT

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I. POLICY

A. Planning for discharge shall begin at admission, continue until discharge occurs as part of the IDT treatment planning process and shall be recorded in the patient's IDT care plan and in supporting records.

B. The patient's treatment team, in consultation with the patient; patient's family, if indicated; and appropriate community staff, shall determine when the patient is ready for discharge. In Forensic Psychiatric Services, consultation and/or approval may be by the Forensic Risk Review Board, the Psychiatric Security Review Board (PSRB), the Department of Corrections, or the courts. The patient's physician has the final authority to issue a discharge.

C. The patient and family or significant other, if available, shall participate as much as possible in the development and implementation of the discharge plan. Oregon State Hospital (OSH) must respect and encourage the right of patients to make their own choices regarding discharge plans, given their capabilities at the time. In some cases, specific conditions may be required as part of the agreement to discharge (trial visit or conditional release).

D. The discharge plan shall consider the patient's continuing medical and psychiatric treatment needs; basic needs such as housing, finances, and employment; social needs such as family support and other needed social contact, and the safety needs of the patient and the community.

E. If a patient refuses to participate in all or part of the discharge plan or the planning process, social workers shall document the refusal and the nature of the plans offered and efforts made on behalf of the patient.

F. For Psychiatric Recovery Services – Adolescent and Geriatric patients, the responsible Community Mental Health Program (CMHP) or Mental Health Organization (MHO) shall be consulted and expected to assist in the development of the discharge plan, unless the CMHP declines to provide this service. Exceptions would be when 1) SCF is the guardian or is providing courtesy case management, and the coordination of the discharge is with them; or 2) when a patient escapes or is released by the court; and in those cases, the CMHP or MHO or SCF, as appropriate, shall be notified.

G. Psychiatric Recovery Services - Adult patients will be involved with the CMHP or MHO prior to discharge.

H. In Forensic Psychiatric Services, it is necessary to gain Forensic Risk Review Board approval on all patients to initiate discharge planning activities except when a patient is to return to a correctional setting or court, this includes Civilly Committed patients in Forensic Psychiatric Services.

I. For all Forensic Psychiatric Services discharges, the CMHP, MHO, or Corrections authorities in the location where the patient is to reside shall be contacted to arrange mental health or other supportive resources.

J. For all patients under the jurisdiction of the Psychiatric Security Review Board PSRB, it is necessary to gain the written approval of the PSRB before the conditional release or discharge takes place.

K. Treatment team members must use clinical judgment and negotiate with the patient in deciding when family members or significant others need to be notified of the patient's discharge. In general, those who have a positive interest or involvement with the patient should be notified if the patient has consented to release the information.

L. If a court unexpectedly releases a patient or a voluntary patient suddenly leaves, an effort will be made to assure adequate discharge arrangements. These efforts and outcomes are to be carefully documented in the discharge progress notes.

M. Discharge plans for patients leaving to another institutional setting (e.g., jails, corrections, medical hospitals) should include recommendations for mental health care both in that institutional setting and for discharge planning from that facility.

N. Patients being transferred to another Class 1 facility such as Eastern Oregon Psychiatric Center, or Faulkner Place, while still under civil commitment, must be managed according to OSH Policy and Procedure 1.007, Patient Transfers From Oregon State Hospital.

II. DEFINITIONS

A. "Qualified Mental Health Professional (QMHP)" means a licensed physician or psychiatrist or a person with a graduate degree in psychology, social work, psychiatric nursing, recreational therapy, another mental health related field or is a registered occupational therapist.

B. "Patient" means any patient at OSH.

III. PROCEDURES

A. Patient participation in the discharge plan shall be documented in part by the patient's signature on the Treatment Plan and the Discharge Plan Details form.

Patient participation, including comments or objections, and family or significant other participation in the discharge plan, shall also be documented in the progress notes. If a patient is unable to sign or participate, this shall be documented, with explanation, in the progress notes and noted on the treatment plan and Discharge Plan Details forms.

B. To assure that the discharge process is adequately documented, efforts to obtain outside agency consultations or services in support of a discharge plan, whether the request is honored or not, shall be documented in the patient's chart.

C. For unexpected releases, efforts to arrange discharge plans shall be documented on the Discharge Plan Details form or in the progress notes, as is appropriate, including any refusal by the patient to cooperate with the plan.

D. The social worker or designee shall document the progress of developing the discharge plan in the progress notes.

E. Notification of Family or Significant Others:

When a patient is a minor or is under guardianship, the legally responsible parties must be involved in the discharge planning process. In other circumstances, whenever there is a possibility of supportive benefit to the patient or to the family in the community, it is highly recommended that family members/significant others be involved in discharge planning, but only after gaining written consent for the release of this information from the patient.

F. Documentation of the Discharge Plan:

1. Discharge Planning Progress Notes

The Social Worker will write discharge planning progress notes throughout the course of hospitalization. Documentation will begin at the time of admission, projecting the level of care that may be needed when the patient leaves the hospital. As the Social Worker begins more specific discharge planning, progress notes will document actions taken during the process up to discharge.

2. Discharge Progress Notes

This is done by the social worker at the time of discharge and describes recent social work services provided and outcomes, gives a general description of continuing care plans, makes recommendations for continued treatment and approaches to use, states what information was provided to the community and identifies strategies, barriers, strengths and weaknesses of the plan.

3. Discharge Plan Details Form

This is initiated by the social worker and may contain recommendations from all disciplines. It provides the practical details of the discharge plan, e.g., housing, supervision, addresses, support systems, persons to contact, appointments, special care needs, recommendations, etc. The patient or legal guardian is to sign at the bottom of the form to indicate involvement in the plan. If the patient or legal guardian refuses to sign, a staff member present shall write "patient (or guardian) refuses to sign" in the open space provided for the signature and initial the statement. The physician's signature indicates

agreement with the plan and is especially important when the patient is released to foster care or group living settings to assure continuance of the patient's medications. The social worker signs to indicate the form is complete. Copies of the form go to the patient, care provider, CMHP, MHO, or other involved agencies (photocopies may be needed), and the patient's chart.

4. RN Discharge Assessment and Instructions

This form is completed by the RN prior to the patient's release and provides a physical and mental assessment of the patient, specific medication instructions, recommended medical treatments and diet instructions and other recommended nursing care needs. The patient, guardian, or responsible party signs the form, as does the nurse. Copies go to the patient or the patient's guardian and/or to the person who is responsible for the patient care.

5. Discharge Summary

This is completed by the patient's physician, and includes the course of hospitalization, continuing care plan, and recommendations for needed treatment. A copy is sent to the responsible community mental health program and other continuing care providers, as identified by the physician at the end of the report.

IV. REFERENCES

ORS 179.505 regarding Release of Information.
Health Care Financing Administration Regulations: 42 CFR 405.1037.
ORS 426.500 (2), Prepare a Written Discharge Plan for Each Chronically Mentally Ill Person...
OAR 309-31-200 through 309-31-255, Admission and Discharge of Mentally Ill Persons.
ORS 192.496(1-3), Public Records Exempt from Disclosure.
OSH Policy and Procedure 1.007, Patient Transfers from Oregon State Hospital

Replaces OSH Policy and Procedure 6.013, *Discharge and Continuing Care Planning*, dated 3/11/2003.