Psychiatric Hospitalization Discharge Planning

Administrative Entities, Supports Coordination, Provider Organizations, Families and Individuals should be aware that Discharge Planning for a patient with an Intellectual Disability and a Mental Health Disorder should begin immediately following admission to the hospital.

Following are action steps and a checklist to serve as a guideline to aid in assuring the most appropriate support is available for a person following a psychiatric hospitalization. Discharge planning is a critical part of the person’s treatment and is typically handled by a designated staff at the hospital; this could be a social worker, nurse, case manager etc… To offer the most appropriate support upon discharge there are critical pieces of information we must ensure we have. A member of the person’s team should be responsible for communicating with the hospital on a regular basis and the team should ensure that this information is captured throughout the course of the hospital stay.

Name:_________________________ Date of Admission:____________________

Date of Discharge:________________

Debriefing-to be completed within 24 hours of admission Date Completed:____________________

What were the circumstances surrounding this person’s hospitalization? (What happened to cause the person to be hospitalized?)
______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Has the team debriefed the incident/occurrences that led to hospitalization as soon as possible following admission?______________________________________________________________

What support will be offered to staff based on debriefing?______________________________________________________________

Based on debriefing, what went well?______________________________________________________________

______________________________________________________________
______________________________________________________________
______________________________________________________________

Based on debriefing, what can we do differently to support this person in the future?______________________________________________________________

______________________________________________________________
Disposition  

Has the residential provider determined that they can no longer support the person’s needs?  
(All attempts should be made to address this within 24 hours of admission)

If the provider does discharge, attempts to locate a new provider should begin immediately

Has a residential living arrangement been identified upon discharge?

Residential contact: ______________________ Phone #/e-mail address ______________________

Medical Considerations  

Have potential medical causes for behavioral symptoms been ruled out? (75% of people with ID who present at psychiatric hospitals may actually be experiencing a medical problem):

How can we verify the cause is not medical? Who is responsible for following up with medical testing?

Hospital contact—established with 24 hours of admission  

Name of designated person responsible to contact the hospital: ______________________

Name of designated hospital contact: ______________________

Clinical Information—To be obtained from the hospital during the course of stay  

Current treatment goals and progress:

Date Completed: ______________________
Current Diagnoses:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Diagnosis</th>
<th>Date Started/ended</th>
<th>Response/Reason for D/C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medications on Admission:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Diagnosis</th>
<th>Date Started/ended</th>
<th>Response/Reason for D/C</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medications on Discharge:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Diagnosis</th>
<th>Date Started</th>
<th>Response/Reason for change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Have the person's skills/needs changed?

<table>
<thead>
<tr>
<th>Changes in Need/Future Supports-to be addressed and planned for before discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Completed: ________________________</td>
</tr>
</tbody>
</table>

How will the team address the change in skills/needs? Does treating physician have recommendations?

|                                                                                     |
|                                                                                     |
What seems to be working well in the hospital setting? (i.e. group therapy, structure, behavior planning etc...)

Can this be translated into the community setting for the person? How, and who will be responsible?

Recommended supports and outpatient services to help the person be successful in the community:

How was the person supported prior to hospitalization?

Does it make sense for the person’s supports to continue as they were prior to hospitalization? Is there a plan in place to transition the person back to the same level of support?

Are the person’s supports changing? (Is the person moving to a new setting/provider?) How will transitioning occur and what supports will be put in place to help?
How do we plan to help the person transition from the hospital? Has a transition plan been written? Have we asked treating physicians for recommendations/thoughts on what a successful transition may look like?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Emergency criteria (what do hospital physicians feel qualifies as an emergency for this person? What symptoms should staff monitor for? How should this be handled?):

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

Is there education/support needed in this person’s environment? Who is responsible for ensuring the staff/individual/family receive the appropriate training?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

**Follow up appointments/testing:**

<table>
<thead>
<tr>
<th>Physician/clinician</th>
<th>Reason</th>
<th>Date of appointment</th>
<th>Follow-up</th>
<th>Who is responsible?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date the discharged plan was developed with or reviewed with the individual:

___________________________________________________________________________

What does the person who chooses services feel we can do to be helpful?

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________