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 ***Date Completed:_____***

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 ***Date Completed:_____***

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 ***Date Completed:_____***

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

Date Completed:_____

Current treatment goals and progress:_____

_____

_____

_____

_____

_____

Current Diagnoses:

Medications on Admission:

Medication	Dosage	Diagnosis	Date Started/ended	Response/Reason for D/C

Medications on Discharge:

Medication	Dosage	Diagnosis	Date Started	Response/Reason for change

Have the person's skills/needs changed?

Changes in Need/Future Supports-to be addressed and planned for before discharge

Date Completed:

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:

Physician/clinician	Reason	Date of appointment	Follow-up	Who is responsible?

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?