LaFleur Brooks' Health Unit Coordinating

7th edition

Chapter 20

Discharge, Transfer, and Postmortem Procedures

Lesson 20.1

Discharge Planning

1. Define the terms in the vocabulary list.
2. Write the meaning of the abbreviations in the abbreviations list.
3. Discuss the purpose of patient discharge planning and patient care conferences and identify personnel and individuals who would be involved in both.

Lesson 20.1

Discharge Planning (cont'd)

4. List five types of discharges and explain the importance of communicating pending discharge information and bed availability to the admitting department or bed placement in a timely manner.
5. List 12 tasks that may be required to complete a routine discharge when paper charts are used.
6. List six additional tasks that may be required when a patient is discharged to another facility and six additional tasks when a patient is discharged home with assistance when paper charts are used.

Lesson 20.1

Discharge Planning (cont'd)

7. Describe six tasks necessary to prepare the discharged patient's medical record for the health information management services (HIMS) department when paper charts are used.
8. Explain what the health unit coordinator (HUC) should do when a patient threatens to leave the hospital without a physician's discharge order.

Discharge Planning

- Centralized, coordinated, multidisciplinary process ensuring the patient has a plan for continuing care after leaving the hospital
- Begins upon admission to hospital
- Usually is handled by a case manager or social worker

Patient Care Conferences and Personnel Involved

- A meeting that includes:
  - Doctor/s caring for the patient
  - Primary nurses
  - Case manager or social worker
  - Other caregivers (may include family) involved in the patient's care
- Purpose:
  - To review and evaluate the goals and outcomes of the patient's recovery process
  - To modify the care plan as needed

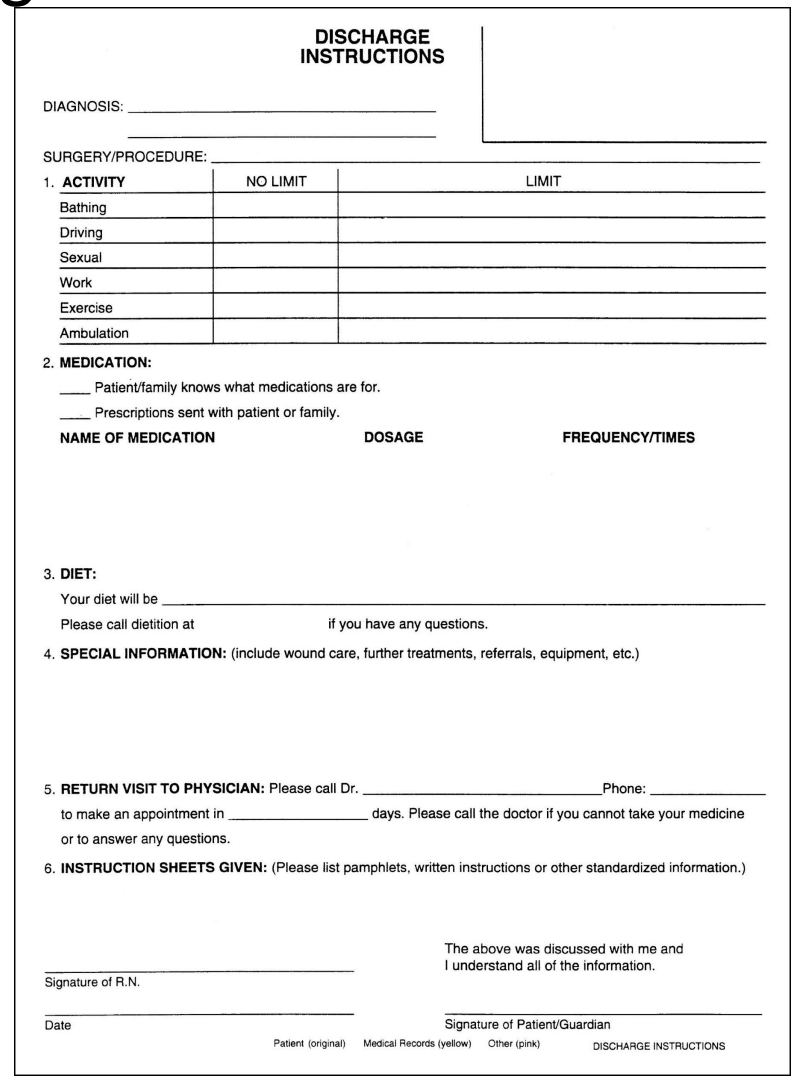
Types of Discharges

- Discharge home
- Discharge to another facility
- Discharge home with assistance
- Discharge against medical advice (AMA)
- Expiration

Pending Discharge Orders

- When transcribing a discharge order, the HUC:
  - Enters the patient’s name on the ADT sheet.
  - Notifies admitting or bed placement department by telephone or computer.
- Do not withhold notification of discharge.
  - Causes delays in patient's admission and treatment

Discharge Instruction Sheet



DISCHARGE INSTRUCTIONS

DIAGNOSIS: _____

_____

SURGERY/PROCEDURE: _____

1. **ACTIVITY**	NO LIMIT	LIMIT
Bathing		
Driving		
Sexual		
Work		
Exercise		
Ambulation		

2. **MEDICATION:**

____ Patient/family knows what medications are for.

____ Prescriptions sent with patient or family.

NAME OF MEDICATION **DOSAGE** **FREQUENCY/TIMES**

3. **DIET:**

Your diet will be _____

Please call dietition at if you have any questions.

4. **SPECIAL INFORMATION:** (include wound care, further treatments, referrals, equipment, etc.)

5. **RETURN VISIT TO PHYSICIAN:** Please call Dr. _____Phone: _____ to make an appointment in _____ days. Please call the doctor if you cannot take your medicine or to answer any questions.

6. **INSTRUCTION SHEETS GIVEN:** (Please list pamphlets, written instructions or other standardized information.)

_____
Signature of R.N.

_____
Date

The above was discussed with me and
I understand all of the information.

_____
Signature of Patient/Guardian

Patient (original) Medical Records (yellow) Other (pink) DISCHARGE INSTRUCTIONS

Admission, Discharge, and Transfer (ADT) Sheet

Admission/Discharge/Transfer Sheet

Nursing Unit _____ **Date** _____

Admissions		**Discharges**	
103	*Jackson, Henry*	*109*	*Pack, Fanny*
110	*Smith, Mary*	*102*	*Johnson, John*
105	*Packer, Penny*		

Transfers

101-1	*Jones, Thomas to 303*

Discharge to Another Facility

- Occurs when patient no longer needs expert nursing care but still requires custodial care
  - Insurance companies like the doctor to transfer the patient to an assisted living facility or nursing care home.
- The discharge to another facility is the same as a routine discharge but with additional steps.

Continuing Care Transfer Form

(Use Typewriter or Ballpoint Pen – Press Firmly) *(See Instructions on back of Page 3)*

CONTINUING CARE TRANSFER INFORMATION

TO BE COMPLETED AND SIGNED BY NURSING SERVICE (Please attach a copy of the Nursing Care Plan)

PATIENT'S NAME Last First MI	DATE OF BIRTH	SEX	RELIGION	HEALTH INSURANCE CLAIM NUMBER

PATIENT'S ADDRESS (Street number, City, State and Zip Code) | ATTENDING PHYSICIAN Name Address

RELATIVE OR GUARDIAN Name | Address | Phone Number

Name and Address of Facility Transferring FROM	Dates of Stay at Facility Transferring FROM		Facility Name and Address Transferring TO
	Admission	Discharge	

PAYMENT SOURCE FOR CHARGES TO PATIENT:

☐ Self or Family ☐ Private Insurance ID Number _____ ☐ Blue Cross/Blue Shield ID Number _____ ☐ Employer or Union

☐ Public Agency _____ ☐ Other (specify) _____

PATIENT EVALUATION:

SPEECH: ☐ Normal ☐ Impaired ☐ Unable to speak

HEARING: ☐ Normal ☐ Impaired ☐ Deaf

SIGHT: ☐ Normal ☐ Impaired ☐ Blind

MENTAL STATUS: ☐ Always Alert ☐ Occasionally Confused ☐ Always Confused

FEEDING: ☐ Independent ☐ Help with Feeding ☐ Cannot Feed Self

DRESSING: ☐ Independent ☐ Help with Dressing ☐ Cannot Dress Self

ELIMINATION: ☐ Independent ☐ Help to Bathroom ☐ Bedpan or Urinal ☐ Incontinent

BATHING: ☐ Independent ☐ Bathing with Help ☐ Bed Bath with Help ☐ Bed Bath

AMBULATORY STATUS: ☐ Independent ☐ Walks with Help ☐ Help from Bed to Chair ☐ Bed Bound

NURSING ASSESSMENT AND RECOMMENDATIONS:

APPLIANCES OR SUPPORTS: or check none ☐

TREATMENTS:

Last Medication: _____ /Dose: _____

Date: _____ Time: _____

Signature Title Date

TO BE COMPLETED AND SIGNED BY THE ATTENDING PHYSICIAN

ECF Admitting Diagnosis:

Patient knows diagnosis: ☐ Yes ☐ No

Surgical Procedures: (current admission)

Orders: Diet, medication and special therapy *(To be renewed in 48 hours)*

If necessary, attach order sheet – The above constitutes valid temporary orders only if signed by a physician.

Please send a copy of the following records with patient:

☐ Summary Sheet (face sheet)
☐ Discharge Summary
☐ Physical Examination and History
☐ Consultation
☐ Other (specify) _____

Transfer by: ☐ Ambulance ☐ Car ☐ Other (specify) _____

Allergies: ☐ No ☐ Yes (specify) _____

VDRL: ☐ Positive ☐ Negative

Anticoagulant: ☐ Taking now ☐ Previously

Chest X-Ray Diagnosis: _____

I will care for this patient after admission to new facility: ☐ Yes ☐ No

Medication Regimen is stabilized: ☐ Yes ☐ No

Anticipated length of stay for extended care _____ days

Physician's Signature Date

Address Telephone Number

Discharge Home with Assistance

- Some patients require care be provided at home as part of their recovery process.
- Additional steps are required when a patient needs home health care.
- The HUC should notify the patient's case manager.
  - The case manager arranges home health care and home health equipment.

Preparation of Discharged Patient's Paper Chart for HIMS Department

- Check the summary/DRG worksheet for the doctor's summation and the patient's final diagnosis.
- Check for the correct patient identification labels on chart forms.
- Shred all chart forms that have been labeled and have no documentation on them.
- Check for old records or split records and send with the chart to HIMS.

Preparation of Discharged Patient’s Paper Chart for HIMS Department, cont'd

- Arrange chart forms in discharge sequence according to hospital policy.
- Send the discharged patient’s chart to HIMS, along with any old records of the patient (must be sent the same day of discharge).

Discharge Checklist

DISCHARGE CHECKLIST

(To be completed and sent with chart to the Medical Records Department by end of shift on which the patient is discharged. Check Yes or No box.)

Date of Admission 12/4/XX

Check List

HISTORY & PHYSICAL

Yes	No	
☒	☐	1. History and Physical on chart within 48 hours. Due 12/6/XX (IF NO, ANSWER NUMBER TWO.)
☐	☐	2. History and Physical Notification Form # 00-0531 sent to Medical Records. Date sent _____

Health Unit Coordinator Signature Ima Clerke

Check List

FINAL DISPOSITION OF CHART

Yes	No	
☐	☐	1. All sheets embossed with correct patient master card and legible, and all reports are for this patient.
☐	☐	2. Portions of chart that have been removed are replaced in proper order, with chart dividers removed.
☐	☐	3. Reports are correctly inserted or attached.
		4. FRONT SHEET:
☐	☐	a. Discharge diagnosis written on Front Sheet by Doctor. If No, answer 4b.
☐	☐	b. Final diagnosis noted on Telephone Tentative or Final Discharge Diagnosis Form #00-0523 attached to chart and send to Medical Records with check list. If unable to complete, state reason on form.
☐	☐	5. Previous Medical Records returned to Medical Record Department.
☐	☐	6. Accordion folders used for sending records to Medical Record Department.
☐	☐	7. Discharge entered in Unit Transit Book.

Date of Discharge _____

Health Unit Coordinator Signature _____

☐	☐	8. Nurses notes are complete.

R.N. or L.P.N. Signature: _____

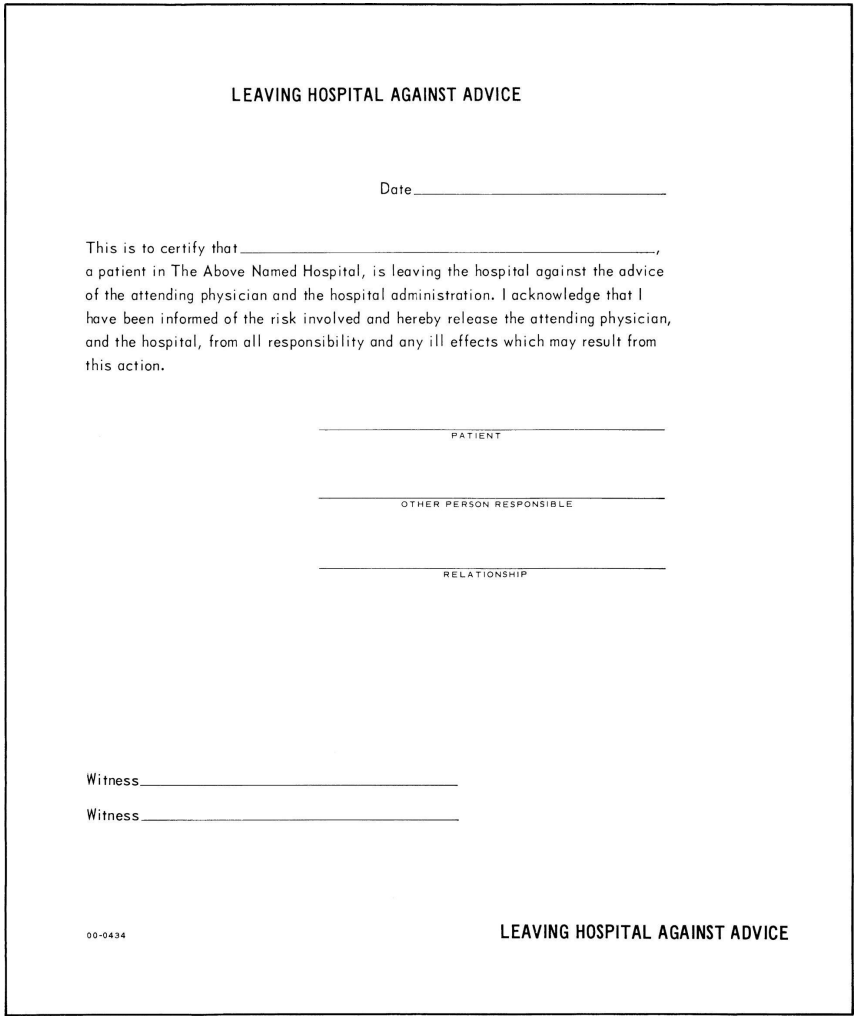
Discharge Against Medical Advice (AMA)

- A patient may decide to leave the hospital without the doctor's approval.
- When a patient announces his/her attention to leave the hospital:
  - HUC should ask the patient to be seated until the nurse is advised.
  - The hospitalist, resident, and/or admitting doctor may be called to speak with the patient.
  - The patient may be advised that insurance may not cover the hospital bill if he/she leaves AMA.

Discharge Against Medical Advice (AMA), cont'd

- Admitting doctor, resident, or hospitalist will write a discharge order.
  - Will document that the patient is leaving against medical advice
- HUC prepares release form.
  - Signed by the patient or their representative
  - Patient is then permitted to leave the hospital.
- Discharge procedure is the same as for a routine discharge.

Discharge Against Medical Advice (AMA) Form



LEAVING HOSPITAL AGAINST ADVICE

Date_____

This is to certify that_____,
a patient in The Above Named Hospital, is leaving the hospital against the advice of the attending physician and the hospital administration. I acknowledge that I have been informed of the risk involved and hereby release the attending physician, and the hospital, from all responsibility and any ill effects which may result from this action.

_____
PATIENT

_____
OTHER PERSON RESPONSIBLE

_____
RELATIONSHIP

Witness_____

Witness_____

00-0434

LEAVING HOSPITAL AGAINST ADVICE

Postmortem Procedures and Transfers

9. Explain the HUC tasks that may be required and/or requested when a patient dies and discuss the need for the patient's death to be verified and the time documented by a doctor or resident.
10. Discuss how the deceased patient is transferred to the morgue and explain the possible HUC tasks related to the release of remains and organ donation.
11. Explain the usual circumstances regarding a patient's death that must be met for the patient to be accepted as an organ donor.
12. Explain why an autopsy would be performed and list the circumstances that would define a "coroner's case."

Postmortem Procedures and Transfers (cont'd)

13. List eight tasks performed by the HUC when a patient dies (postmortem) when paper charts are used.
14. List the two primary reasons a doctor would write an order for a patient to be transferred to another room or nursing unit.
15. List nine tasks that are performed when a patient is transferred from one unit to another when paper charts are used.
16. List seven tasks performed by the HUC when a patient is transferred from one room to another room on the same unit when paper charts are used.

Postmortem Procedures and Transfers (cont'd)

17. List seven tasks that are performed by the HUC when a transferred patient is received on the unit when paper charts are used.
18. Discuss the importance of reading the entire set of discharge or transfer orders prior to the patient being discharged or transferred.
19. Describe additional tasks that the HUC may need to carry out to complete a routine discharge procedure when the electronic medical record with computer physician order entry is used.

Discharge of the Deceased Patient

- Some patients who enter the hospital are well advanced in age.
- Other patients, in any age group, may have a terminal illness that results in expected death.
- Occasionally, death is unexpected (complications from surgery, traumatic injuries, or sudden onset of a life-threatening condition, such as a heart attack).
- In other instances, the patient's death is prolonged, and health care staff members have the opportunity to offer additional support to family members.

HUC Tasks When a Patient's Death is Expected

- May be asked to call a member of the clergy from a specific religion to speak with the patient or to perform final rites.
  - Most facilities have a list of representatives from various denominations and nondenominational groups who can assist patients and families, and many hospitals employ a chaplain to address the religious needs of patients.
- A notation should be made on the patient’s Kardex form of any final rites that have been performed.

Certification of Death

- The hospitalist, resident, or doctor must be notified to pronounce the patient dead and record the time of death.
- The patient is examined for any signs of life.
  - If none can be detected, the patient is pronounced dead, and the official time of death is recorded on the doctor's progress note.

Release of Remains and Possible Related HUC Responsibilities

- The patient's family or guardian must indicate the funeral home to which the body will be released.
- Usually the family must sign a form before the patient can be released to the funeral home.
- The HUC would notify the funeral home of the expiration (when and if requested to do so).

Release of Remains

- Most hospitals have a stretcher with a lower compartment that may be covered with a sheet to transport a deceased patient.
- Funeral home personnel may pick up the patient from the unit or the hospital morgue.

Organ Donation

- A patient may designate specific organs or may indicate that any needed organs or tissues may be donated.
- Because of state laws, the nursing staff may be required to ask the family about organ donation.
- Additional consent forms are necessary for the harvesting of an organ (organ procurement).
- The HUC would notify the morgue of the patient's death when and if requested to do so and prepare all required forms for the patient's family to sign.

Usual Criteria to be Accepted as an Organ Donor

- In most cases, the patient must be declared brain dead and be connected to a ventilator.
- Most individuals who have died due to cardiac arrest and have no cardiac or respiratory activity are potential donors for tissue but are unable to donate organs.
  - There are some circumstances in which a patient can donate organs after cardiac death, termed *donation after cardiac death.*

Autopsy or Postmortem Examination

- Performed to determine the cause of death or for medical research purposes
- The family may ask that an autopsy be done, or the doctor may request it.
- Before an autopsy can be performed, the family must grant permission unless the death is declared a coroner’s case.

Coroner’s Case

- Death due to sudden, violent, or unexplained circumstances, such as an accident, a poisoning, or a gunshot wound
- Deaths that occur less than 24 hours after hospitalization is begun may also be called coroner’s cases.
- The law gives the coroner permission to study the body by dissection to determine whether evidence of foul play is present.

Postmortem Procedure

- Contact attending doctor, hospitalist, or resident to verify patient's death.
- Notify the hospital operator of the patient's death.
- Prepare forms; check chart for signed autopsy consent.
- Notify mortuary.

Postmortem Procedure, cont'd

- Check chart or ask patient's nurse whether to take body to morgue or wait there until mortuary arrives.
- Nurse or CNA gathers clothes and labels belongings bag.
- Obtain mortuary book; have mortuary form prepared.
- Perform routine discharge steps.

Transfer of Patient

- A variety of circumstances may necessitate a patient transfer including:
  - Condition may change.
  - Need of a particular type of care offered on a specialty unit
  - Isolation purposes
  - Room they originally requested becomes available.
  - Roommate incompatibilities

Transfer of Patient, cont'd

- Primary reasons for a doctors' order for patient transfer to another room or nursing unit:
  - A change in status of acuity
    - May be for more intensive nursing care (regular unit to intensive care unit [ICU]) or less intensive nursing care (ICU to regular unit)
  - Need for an isolation room
    - May include the requirement for airborne isolation in the case of a new diagnosis of tuberculosis or a need for reverse isolation (to protect the patient) in the case of organ transplantation or the diagnosis of an immunosuppressive disease

Transfer to Another Room on Same Unit

- Transcribe transfer order.
- Notify patient's nurse.
- Correct/replace labels and place patient's chart and Kardex forms in correct spots.
- Move patient's name to correct bed on census screen; send any changes to nutritional care department.
- Record transfer on ADT log sheet.
- Notify environmental services to clean room.
- Notify switchboard and information center.

Receiving a Transferred Patient

- Notify patient's nurse of expected arrival.
- Introduce yourself to patient; notify nurse of arrival.
- Correct/replace labels and place patient's chart and Kardex forms in correct spots.
- Record transfer on ADT log sheet.
- Notify nutritional care of transfer.
- Move patient's name to correct bed on census screen.
- Transcribe any new doctors' orders.

Reading Entire Order when Transcribing a Transfer or Discharge Order

- Additional orders included in a discharge or transfer order are often missed, to be discovered after the patient has left the hospital.
- Examples:
  - discharge after a PA, LAT chest x-ray
  - mother to have CPR training prior to discharge
  - copy patients last three days of labs and diagnostic studies and send with patient to XXX Rehab Center
  - discharge with Rx (the prescription may be left in the patient's chart)

Changes in HUC Responsibilities with the Use of EMR with CPOE

- The discharge, transfer, and postmortem procedures differ with the implementation of EMR with CPOE.
- Many of the tasks involving paper charts are eliminated, but the admission, discharge, and transfer (ADT) documentation and the label book are used when EMR and paper charts are used.
- Additional tasks include monitoring the patient's EMRs, printing forms from the computer and scanning documents into the patient's EMR.