DC Planning Process to Ensure all needs met/ Initiatives

I. OPN

Utilize patient-centered goal setting and treatment planning to ensure we are taking into consideration the patient's needs and expectations in a comprehensive manner and incorporating them into the documentation.

Therapist to ask patient:

1) At eval: What concerns do you have regarding returning home and functioning safely and independently? Attempt to elicit at least 3. If less than three, give multiple choice options to prod thinking and ensure the patient has thought of everything.

2) Do you have any concerns regarding safety, balance, mobility or activities of daily living?

3) Document weekly in PR any updated / revised concerns and goals, use the exact words of patient and put them in quotes so we know it is coming from the patient.

4) All concerns about a safe home discharge should be resolved prior to discharge and documented in DC Summary or near DC

II. FATs

Utilize a variety of appropriate FATs to uncover specific deficits impacting patient's ability to return home safely and incorporate them into the documentation. FATs should be documented at eval and weekly in Progress Report

How to Incorporate FATs in clinical documentation:

1. Complete an evidence based functional assessment test (e.g. Berg, DGI, PPT etc. something with a higher ceiling than the Tinetti)

2. Score the test (quantify fall risk)

3. Identify areas of the test that the patient did not score well in

4. Hypothesize as to what is causing the deficit(s)

a. Your clinical reasoning to determine the underlying impairments causing the functional deficit

b. The patient's concerns, observations, thoughts, goals

5. Write goals (who, what, when, where, and to what degree)

a. Develop specific goals related to the deficit areas in the FAT: Choose any of the next higher levels in each category (based on the appropriate level for the pt) and use that exact wording to write the goals.

6. Decide on treatment interventions.

III. Pre-Discharge Checklist
Utilize the pre-discharge checklist to insure all areas have been addressed prior to setting dc date, especially **caregiver education** on all functional areas with full readiness demonstrated by CG. If CG not able to safely manage patient, an alternate DC plan should be discussed with the supervisor who can address that with the facility team.

IV. Home Pass
Offer a therapeutic "home pass." After any necessary caregiver training is completed, therapy team will suggest a home pass to trial home setting to assess ability to negotiate home setting with the caregiver that will be assisting. (involve IDT- example: nursing to ensure patient is able to manage any wound care, medications, treatments without assistance). Home pass should be offered day before NOMNC; that way if home trial identifies any areas that need to be addressed, d/c date can be modified if necessary. (ex: height of bed, walking on carpet, tub transfers, etc…..). If patient or family decline a home pass offer, please document that the benefits were explained, however the patient declined the offer. If they do participate, issue the home pass form

The supervisors must review and approve all potential discharges with the staff at the time discharge planning is initially being considered. The therapists must come prepared with their **documented evidence of appropriate FATs** & **documented pts concerns and goals** for safe discharge **and pre-DC checklist**. If a disagreement occurs on discharge readiness, further treatment strategies will be discussed and decided upon.

Once consensus on discharge readiness is reached between the Supervisor and staff, the DC date should be presented to IDT for further discussion prior to final DC Date being set.