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Heywood Hospital
Member of the Heywood Healthcare Family

Social Service Department

DISCHARGE PLANNING ~**HIGH RISK SCREENING CRITERIA Inpatient Units**
POLICY:
The Department shall have a High Risk Screening Procedure as a component of Discharge Planning

OBJECTIVE:
The purpose of High Risk Screening is to assure individuals and their families that, within twenty four hours of a patients admission into the hospital or have been placed under the INo/Observation Bed Status, every effort is directed toward helping them to develop an adequate plan in preparation for discharge/release from the hospital to home or an extended care facility.

The Department is one member of the multidisciplinary team that shall implement a High Risk Screening system to identify patients who may require assistance or be in need of discharge planning services specific to the scope of service provided by the department upon initial hospitalization and continue to monitor patient's status during hospitalization assessing for potential needs for discharge planning and/or additional intervention.

PROCEDURE:

Patient's determined to need assistance with arrangements for post-hospital care shall have a comprehensive, individualized discharge plan which is in writing and is consistent with medical and/or psychiatric discharge orders and identified patient needs.

All patients are screened against the **High Risk Screening Criteria** within 24 hours of admission by Nursing and assessed for a referral to the department.

In the event of an emergency, staff are available for consultation by contacting the assigned social worker /or designee initially in the event they are not available follow up with the department director.

The staff will assess all new hospitalizations against the initial High Risk Screening Criteria. Those meeting HRS Criteria will have an Assessment Completed within 48 working hours.

Cases identified as not meeting High Risk Screening Criteria, staff will complete the HRS Monitor Assessment form in the EMR at that time demonstrating patients have been screened against the HRS criteria. Staff will continue to monitor patient's status through Multidisciplinary Rounds.
Should it appear patient may benefit from a referral after that time, staff will open case and complete an assessment.

HRS: Acute Areas covering Telemetry, Intensive Care, Med/Surg
Watkins I/ICU and Watkin 2

All Patients are screened to determine the need for discharge planning services.

The premise:

Patients who present with clinically complex illnesses are at risk for longer lengths of stay thereby requiring more intense care coordination while in the hospital and upon discharge

- The initial screening is conducted by the primary care nurse completing the initial patient care assessment. This assessment is completed 7 days a week 365 days per year.

- Patients are screened by staff for actual and potential discharge needs and by the clinical reason necessitating acute hospitalization.

The following areas are to be automatically opened by staff for potential High Risk:

- All patients age 80 and over
- Diagnosis of
  a. Fractured Hip
  b. Hip/Knee replacements
  c. New CVA
- Patient from SNF –ECF Monitoring {confirming bed hold& return back to SNF}
- Patients with involvement with Home Care/Home Health Care agencies prior to admission who need reinstatement and/or reassessment for services at time of discharge.
- Alleged Victims/Survivors of recent Abuse, Neglect and Mistreatment
- Any other patient whom you feel may be in need of a discharge planning assessment and/or other intervention.

Other issues/characteristic represent patients with potential High Risk may be indicated:

- Patients in observation status > than 48 hours
- Length of stay 5 or more days
- High cost patients such as multiple trauma
- Diagnoses associated with long lengths of stay, (multisystem failure, ventilator dependent)
- Co morbidities such as: CHF, COPD, CVA, Diabetes, AMI, Addiction Disorder, Behavioral Health etc.
- Multiple system issues suggesting the need for home care services or post acute placement {SNF or Acute Rehab, Addiction placement etc}
- Patients readmitted within 30 days
- Frail, particularly the elderly
- Cognitively impaired
- Payer issues / Uninsured / Undocumented
- Language barriers

- Cultural Issues Identified
- Lack of social support
- Significant functional decline anticipated to be long term or permanent
- Skin and/or wound care problems
- Problematic nutritional status
- All terminally ill patients
- Homeless

High Risk Screening for other Inpatient Units:

HRS for Maternal Child Health OBS & Pedi

- Alleged Abuse, Neglect and Mistreatment
- Adoption Services
- Teen Pregnancy
- Addiction Identified
- May benefit from an Assessment/Consultation

Behavioral Health Units include GPU, MH and PHP Units

All patients on these units are automatically opened.

Resources: Mass DPH regulatory standards;
Mass DMH regulatory standards:
Joint Commission standards