2902.0 Hospital/Rehabilitation Discharge to Supported Living Arrangement

2902.1 Policy Approval Clearance Record

☐ Rural Services Policy ☐ Mental Health Policy ☒ Developmental Services Policy	This policy supersedes: n/a	Number of pages in Policy: 7
Review by Representative from the Office of the Attorney General: n/a	Date: n/a	Date Policy Effective: 09/23/2011
Rural Services Director Approval Signature: *Barbara Legier*	Date: 09/23/2011	Policy Lead: Tammy Ponder, Jessica Adams

2902.2 Statement of Purpose

2902.2.1 **Policy Statement:** Each individual residing in a supported living arrangement will be afforded the opportunity for coordinated medical care to ensure that each individual receives the support necessary to maintain a community based living arrangement unless medically contraindicated.

2902.2.2 **Purpose:** To provide clear guidelines for Rural Services staff for the coordination of medical care for individuals served by the agency to ensure appropriate placement upon discharge from a hospital setting.

2902.3 Authority

NRS 435
NRS 433.484
NAC 435.5
NAC 435.740
Division Policy 1.4
RS Policy 1905
RS Policy 2010
RS Policy 1702

2902.4 Unique Definitions and Acronyms

2902.4.1 **PRN:** means medication taken as needed.

2902.4.2 **PCP**: means primary care physician.

2902.4.3 **ADL:** means activities of daily living.

Please refer to the standard definitions policy.

2902.5 Procedures

2902.5.1 The Rural Services DS Nurse is available during regular business hours Monday-Friday to assist with discharge planning. For time management and planning purposes the Developmental Specialist III (DSIII) will submit a written referral, utilizing the Nursing Referral Form (Attachment A) requesting a Nursing Consult immediately upon knowledge of the hospitalization. Complete information on the referral form will ensure unanswered questions and/or concerns are addressed.

The DS nurse will review the hospital/rehabilitation facility documentation, interview the person served prior to discharge, and conduct an assessment to identify supports needed for the individual's safe return to the supported living arrangement (SLA). Examples of supports are home health nursing, wound care, physical therapy, dietary modifications, equipment needs, special monitoring of

signs/symptoms, oxygen use, etc. After supports are identified the DS nurse will complete the referral response section of the Nursing Referral Form prior to the individual's discharge and specify all supports needed to return the individual to the SLA, or if appropriate recommend alternative placement types. This document is returned to the DS III within 1 work day of completion of the assessment and a DAP progress note is immediately entered in DS NOW. The DSIII, ISP team and SLA provider will meet as soon as possible and determine if identified supports can be provided safely in the SLA or if alternative placement options should be considered.

A. When to submit a referral for a Nursing Consult:

1. A referral for a Nursing Consult can be made when an individual's medical condition(s) or support requirements for the condition(s) are not clearly documented or understood. A referral can also be made in the event questions or concerns arise regarding an individual's care and/or a hospital/rehabilitation progress update is needed to help identify supports required upon discharge.
2. A referral for a Nursing Consult can be made during the course of a routine hospital stay when the individual's condition changes indicating the need for new and/or additional supports.
3. When circumstances of the hospitalization or the individual's status changes, the DSIII may call on the DS Nurse to discuss the information to determine the need for a formal Nursing Consult.

B. In the event a DS Nurse is not utilized in a hospital discharge, the SLA provider must obtain the Hospital/Rehabilitation facility discharge summary and ensure the orders include:

1. All new medications are ordered with clear instructions and written prescriptions available upon discharge.
2. Review the Medication Reconciliation Form in the Hospital/Rehab chart to confirm which medications prescribed prior to hospitalization are to be continued upon discharge.
3. Medications prescribed on a PRN (as needed) basis have clear directions for administration to include symptoms/parameters (objective identifiers) indicating the need for the medication. Ex: Diastolic and Systolic Blood Pressure parameters for administration of PRN blood pressure medication. Blood sugar levels for administration of sliding scale insulin. Description of symptoms that **must be** present prior to administering psychotropic PRN. Description of pain response for administration of PRN pain medication. Pain medication must be given only for what it is intended, i.e. Loratab given for severe pain in leg must only be given for pain in leg and not for pain located anywhere else such as a headache.
4. If the individual is unable to self-identify the need for a PRN medication, the individual support plan (ISP) team needs to develop a plan to support the individual to administer PRN medications along with identification of observable symptoms/behaviors (objective identifiers) indicating the need for medication. This information needs to be included in the ISP.
5. The discharge summary must include documentation that the person served is medically and psychologically/psychiatrically stable to be discharged into the SLA without 24 hour professional clinical, medical, or psychiatric oversight.

6. If medical oversight is needed to support and/or educate the individual and the SLA staff, **an order for Home Health Nursing must be written and <u>arranged prior</u> to discharge**. Ex. Blood sugar monitoring, Blood Pressure monitoring, Wound Care, injection administrations (Luvox, Insulin), etc.
7. The hospital/rehabilitation medical record and/or information from the physician or nursing staff must include the following information to ensure adequate assessments are able to be made in determining if the individual can adequately be supported in SLA settings:
   - Is the individual functioning at his/her preadmission or baseline levels?

     (Example: If ambulatory prior to admission is he/she currently ambulatory? If continent prior to admission, is he/she currently continent? If not, why not? Does the individual require rehabilitative supports/services?)
   - Is the individual eating and drinking adequately without nausea/vomiting?

     (Review the hospital Intake Flow Sheet documentation.)
   - Is the individual eliminating (urine/stool) adequately?

     Example: Is he/she reported to be suffering with constipation/diarrhea?

     (Review the hospital Output Flow Sheet.)
   - Is the individual able to complete activities of daily living (ADL's) at his/her preadmission ability level?
   - Has the individual reported or indicated other complaints/concerns that were not addressed in the discharge instructions? What are the complaints? Were they addressed? Is the problem still active?
8. If an order for rehabilitation is written, a scheduled start date, the facility name and contact person is recommended instead of a referral.
9. Hospital follow up appointments should be ordered and scheduled if possible prior to discharge.
10. Discharge orders should include the anticipated return to work/day program date and any special precautions or restrictions to activity. This may include referral to their primary care physician (PCP) or specialist to determine the return to work/day program date.

2902.5.2 Timelines

Table 2902.1: Timelines for "Hospital/Rehabilitation Discharge to Supported Living Arrangement" Policy

Requirement	Deadline	Starting Date	Responsible Party	Actions to be Taken
DS III completes Nursing Consult	Immediately	Upon knowledge of the hospitalization	DS III	Ensure appropriate placement upon discharge
Nursing Consult	Immediately	Upon receipt of the Nursing Referral Form	DS Nurse	Assess
Referral Response	Prior to discharge & within 1 work day of completion of assessment	Upon completion of assessment	DS Nurse	Supports identified

Review of support needs	As soon as possible	Upon receipt of assessment	DS III	Determine placement options

2902.5.3 Documentation

A. Case File Documentation (paper):

Table RS2902: Case File Documentation for Hospital/Rehabilitation Discharge to Supported Living Arrangement Policy

File Location	Data Required
Medical Section of Individual's file	Nursing Referral Form

B. Electronic Documentation (electronic):

Table RS2902: Case File Documentation for Hospital/Rehabilitation Discharge to Supported Living Arrangement

File Location	Data Required
DS NOW Progress Note	Results of Nursing Assessment

2902.5.4 **Supervisory Responsibilities:** Supervisors will provide in-service training to ensure all staff understands the requirements of this policy and its procedures. Supervisors will revisit this policy periodically, but no less than annually for recommendations for improvement or additions.

2902.6 Policy Cross Reference

2902.6.1 Policies:

Division Policy 1.4
RS 1905
RS 2010

2902.7 Attachments

2902.7.1 2902A Nursing Referral Form

Attachment 2902A
Nursing Referral Form

Rural Services
Developmental Services
NURSING REFERRAL FORM

Date of Referral:_____ **Referring Developmental Specialist III:**_____ **Extension Number:**_____

Please fill out the following demographic information about the person you are referring for nursing services:

Name:_____ Record Number:_____ DOB:_____

Address:_____ Phone No:_____

Living Arrangement (check):

- ☐ **Family Home**
- ☐ **Supported Living Arrangement (Intermittent Support)**
- ☐ **Supported Living Arrangement (24 hour Support)**
- ☐ **Other**:_____

Medicaid Benefits Y ☐ N ☐

Current Diagnoses

Axis I: _____

Axis II: _____

Axis III: _____

List All Medications:

_____

_____

_____

_____

Reason for Referral *(check)*:

- ☐ **Nursing Assessment**
- ☐ **Nursing Consult**
- ☐ **Medication Review**
- ☐ **Hospital Discharge Planning**
- ☐ **Dietary Consult/Support**
- ☐ **Medication Administration Certification Consult**
- ☐ **Staff Training**
- ☐ **Individual Training**
- ☐ **Family Training**
- ☐ **Change in Health Status**
- ☐ **Change in Ability to Manage Health Needs**
- ☐ **Needed for Waiver Packet. Date Due:** _____
- ☐ **Assess for PASARR Screening**
- ☐ **Other**:_____

NURSING REFERRAL

Priority Level (Low 1 – High 5): 1 ☐ 2 ☐ 3☐ 4 ☐ 5 ☐

Please specify why the referral is being made at this time and if considered high priority why?

_____

_____

_____

_____

IF THIS PERSON IS SERVED BY A PROVIDER, PLEASE INDICATE THE PROVIDER NAME AND TYPE OF SERVICE RECEIVED (e.g., JDT, ISLA, etc.):

_____

_____

Please provide contact information. Also provide names of those who know the referred individual well and would be willing to provide additional information:

Name	***Relationship***	***Phone Number***

Result of Consult and Nursing Recommendations:

_____ _____

Developmental Services RN Date

Approved:

Distribution: Electronic Nursing Folder
DS III