SHANTI HOSPICE

501 W. RAY ROAD, SUITE 6
CHANDLER, AZ 85225

Discharge / Transfer Process

SECTION 5: PROVISION OF CARE AND RECORD MANAGEMENT

POLICY #: 5.10

POLICY

1. All patients being discharged will have required documentation to ensure appropriate communication is provided to the physician, as requested.

2. A hospice discharge is defined as:
   - The patient moves out of the hospice's service area or **transfers** to another hospice
   - A patient is determined by the hospice to be no longer terminally ill
   - Shanti Hospice determines, under hospice policy, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. Shanti Hospice will do the following before it seeks to discharge a patient for cause
     - Advise the patient that a discharge for cause is being considered;
     - Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation;
     - Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and
     - Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

3. Prior to discharging a patient for any reason listed above, Shanti Hospice will obtain a written physician's discharge order from the hospice medical director.

4. If a patient has an attending physician involved in his or her care, this physician will be consulted before discharge and his or her review and decision included in the discharge note.
5. A discharge summary will be completed, the original maintained in the medical record, and a copy will be provided to the attending physician in a HIPAA-compliant manner, even if the attending physician is also the medical director of Shanti Hospice.

6. The discharge summary will contain at least the following information:
    - The date and reason for discharge
    - Any instructions or referral information given to the patient or family
    - Patient identifying information
    - Patient's physician
    - Hospice diagnosis
    - Significant health history
    - Discharge orders, instructions, medication profile and allergies, if discharge is other than patient death
    - A brief description of services provided and ongoing needs that cannot be met
    - Status of patient at the time of discharge
    - Presence of Advance Directives
    - End of life decisions
    - Any third party revocation or termination
    - A summary of the patient's stay, including treatments, symptoms and pain management
    - The patient's current plan of care
    - The patient's latest physician orders
    - Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility