

DECISION MAKING TOOL FOR ACCEPTING AN INDIVIDUAL WHEN DISCHARGED FROM A HOSPITAL OR EMERGENCY ROOM

This checklist is intended to be used by mental retardation residential staff as a decision making tool regarding accepting the discharge of an individual with mental retardation and also taking an individual back to their residence after an emergency room visit.

Patient Name: _____ Facility: _____

Diagnosis: _____ Proposed Date/Time of Discharge: _____

ACTIVITY

- ☐ Individual's mobility level has not changed from pre-hospitalization
If changed:

- ☐ Provisions can be established to accommodate individual's mobility level
(e.g., walker, wheelchair, bedside commode, ramp, or relocation to first floor of home)

EQUIPMENT

- ☐ Individual's equipment can be available and staff can be trained
(e.g., braces or splints, feeding tube equipment, Oxygen, or walker)

MEDICATIONS

- ☐ Individual's medications are clearly understood and can be made available

PAIN MANAGEMENT

- ☐ Individual is verbal and can communicate pain
- ☐ Individual is nonverbal and a non-verbal pain assessment tool is available
- ☐ Individual's pain medications are clearly understood and can be made available

DIETARY

- ☐ Individual's diet will change from pre-hospitalization
If changed:

- ☐ Provisions can be made for diet instructions

SPECIAL INSTRUCTIONS

- ☐ Individual's special instructions such as warning signs of relapse, what to do, and who to contact, are clearly identified
Comments:

SAFETY

- ☐ Individual's safety considerations are identified and can be secured

HOME HEALTH

- ☐ Individual does not need home health services

If yes:

- ☐ Individual's home health agency/service has been contacted and a visit is scheduled

FOLLOW-UP

- ☐ Individual's Primary Care Physician's name, phone number, and instructions for follow-up are documented
- ☐ Individual's follow-up lab work, x-rays, and/or specialized tests are documented and understood

HEALTH CARE QUALITY UNIT (HCQU)

HCQU contacted for Technical Assistance at (610) 435-2700 or (610) 435-9050.

- ☐ Prior to discharge
- ☐ After discharge
- ☐ No need to contact

Completed by: _____ Provider Agency: _____

Date: _____