

Procedure Title:

PRE-PLACEMENT / ADMISSION AND DISCHARGE PROCEDURES

PROCEDURE NUMBER: - -

Policy Title:

Admissions / Discharge Policy

Effective Date:

5/1/06

Revision Date:

4/1/08

**Scope:**

- All Residential settings licensed under Chapter 3800, 6400, or 6500 regulations. This department develops referral sources to secure the most appropriate services and settings for individuals. Ongoing referral sources are sought out through marketing efforts, as outlined in our agency marketing plan.
- Continued assessment and planning procedures assure that available openings match up with the applicants' needs and choice. The following guidelines facilitate this process:

PROCEDURE:

1. **Referrals for residential services received by this agency are directed to the Director of Admissions.** This is a centralized department that is responsible for intake of referrals, assessments, interviews (and/or delegation thereof), and communication with agencies. This includes individuals referred for emergency or respite placement as well.
- 2) **Once we receive a referral packet, it is reviewed for content then forwarded to the Program Director of an area that may be appropriate for the individual.** During this process, the Admissions Director will work with area Program Directors in organizing interviews and making contact with the referral agency. Director of Nursing will be included in cases where medical needs are prevalent.
- 3) **A client assessment will be completed during each interview and made part of their permanent record.** Upon return from the interview, a decision will be made regarding our ability to provide services. Formal admission or rejection letters will be sent along with a pre admission packet if applicable. The admissions department will continue to be the contact point for the agency placing the individual in our program.
- 4) **All information must be completed and returned to us prior to setting an actual admission date.** (A facsimile will be sufficient for purposes of review). Upon receipt of information, admissions department will review the file and perform a QI checklist to ensure that all necessary information has been returned. Pre admission

file material will be maintained with administrative assistant so that departments may access it on a need to know basis. Information will be copied and distributed to appropriate individuals to prepare for admission. (Emergency or respite admissions only require a physical exam that has been performed within the calendar year).

- 5) **Contact with the referral agency will be established to confirm receipt of information and to alert them of missing items.** A "Pending Admission" form will then be circulated if reasonably sure that the packet is nearing completion.
- 6) **At the time of the person's admission, all materials will be reviewed to ensure completion.** The Program Coordinator is responsible for assembling and organizing this meeting. Person conducting admission, at time of admission will circulate the Record of Admission. Person conducting admission will also initiate the Orientation checklist. Insurance process will begin immediately upon admission to ensure timely medical coverage.
- 7) **Within three days of a persons admission, another QI checklist will be completed to assess if the person's admission experience was a positive one and that all of his/her needs have been met.** The completed QI form will be sent to the Program Director for review with the Program Coordinator and residential staff. A plan of correction, if needed, should be returned to the admissions department within five business days. A copy of the final QI report will be forwarded to the QI committee.
- 8) **As a means of keeping all departments up to date regarding our census and current vacancies, discussions will take place on a regular basis to share ideas.** An updated census with pending admissions and discharges will be circulated at the beginning of each month. This department should be aware of all expansion plans, change of residence plans for individuals, larger agency development plans, etc. so as to market and fill potential vacancies.

Discharges

- 1) **All considerations for possible discharge should be followed up with an IDT meeting to discuss the proposed discharge.** The Program Coordinator will schedule the IDT meeting and will include family members and case management. If discharge is being considered due to serious behavioral or medical concerns, efforts that have been made to accommodate the individual must be discussed and documented prior to final consideration for discharge. If discharge is being requested due to progress made by the individual, then the meeting should focus on the future plans, needs and visions of the individual.
- 2) **If it is determined by those in attendance at the IDT meeting that the individual will be discharged, the Program Coordinator will request in writing, the decision to discharge the individual within 30 days.** The Program Coordinator will then work closely with case management while they seek an alternate living arrangement. If the decision to discharge is

due to behavioral or medical concerns, the team will need to implement a plan to keep the individual safe until the time of discharge.

- 3) **A discharge summary, which includes the individual's current status and recommendations for their future, should be completed prior to the actual discharge date.** The summary should also include the individual's new address, phone # and contact person. The Program Coordinator will work with nursing staff to ensure that any necessary medical information is completed as well.
- 4) **The Residential Manager will be responsible for preparing the individual for their departure.** They will be responsible for completing an inventory of all personal belongings, requesting the balance of personal funds from the fiscal office, obtaining pertinent information from the individual's social and medical files and ensuring that they accompany them. These things include original medical cards, social security card, birth certificate, etc.; however, **a copy of any original should be made and put into the file.** They will also ensure stability for the individual until the time of discharge, accessing any services the individual may require.

Internal Agency Moves

- 1) **Considerations made for an individual/by an individual to reside elsewhere in our program should be forwarded to the Director of Admissions and the area Program Director.** The referral can be made by the individual, someone who knows them well, a family member, case manager, etc. This process is inclusive to all individuals being referred to any of our residential, supported living and family living programs.
- 2) **All referrals will be followed by an IDT meeting to discuss ideas, interests and options for the individual.** This will be generated and convened by the Admissions Director (or his/her designee) and include all members of the individual's team, including family members, case management, advocates, etc. At this meeting, goals and objectives will be discussed with time frames for completing established. Funding issues will also need to be addressed, i.e.: waiver vs. non-waiver. During the planning process for an individual, it may be necessary to have additional planning meetings until objectives are met. Written correspondence should be sent to agencies and other interested parties alerting them as to a move date, location, phone #, etc.
- 3) **Similar to our discharge policy, the Residential Manager will be responsible for preparing the individual for an upcoming move.** They will be responsible for ensuring visits to the individual's new home and maintain communication with supported living coach, family living members or new home residential staff. They are also responsible for transfer of personal belongings, personal funds, social and medical files.
- 4) **The steps for general discharge/admission planning are followed in the transfer process as well.**

Respite or Pre-Placement Visit

1) Prior to a respite or pre-placement visit, the following documentation must be available to program and/or nursing staff:

- a. Copy of recent physical exam, within 12 months, including current Mantoux
- b. Immunization record
- c. Consent to provide emergency medical treatment
- d. List of current medications and prescribed treatments
- e. Current health status including drug and food allergies/sensitivities and any outstanding medical concerns
- f. Behavioral support strategies

2. The following should be brought to the assessment visit:

- a. Medications in original labeled containers
- b. Signed consent for Keystone to provide emergency medical services, as needed
- c. Emergency contact information in case applicant's visit needs to be interrupted.
- d. Spending money
- e. Hygiene supplies
- f. Health insurance information and cards confirming coverage
- g. ID, if available

3. If information listed above is not provided when the individual arrives, the Director of the residential area will be contacted to determine whether the visitor will be allowed to remain for the visit.
4. An intake meeting will occur at the beginning of the visit.
5. After the intake meeting, nursing or another identified health professional will complete and document a full body check, noting any injuries, and will weigh the individual.
6. Staff will complete and document an inventory of personal supplies and belongings at the outset and at the end of the visit.