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Discharge Planning

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Sec. 19a-504c-1. Discharge planning

(a) Every hospitalized patient shall have a written discharge plan, which shall be given to the patient or family or representative prior to discharge.

(b) The discharge plan shall include but not necessarily be limited to identification of the patient's needs for continued skill care or support services, and the specific resources to be utilized to meet these needs.

(c) The discharge plan must be completed on a timely basis so that appropriate arrangements for post hospital care management are made before discharge.

(d) The discharge plan is to be developed in collaboration with the patient, or appropriate family or representative and other care givers.

(e) The discharge plan shall be approved by the physician of record.

(f) The written discharge plan must be signed by the patient and/or family member or representative indicating their understanding of the discharge plan of care.

(g) The documentation of the written discharge plan shall be retained as a permanent part of the patient's medical record.

(h) Information necessary to ensure the continuity of care will be sent to participating providers, as appropriate, a copy of which will be retained as a permanent part of the patient's medical record.

(Effective September 25, 1989)