Rancho Los Amigos National Rehabilitation Center

ADMINISTRATIVE POLICY AND PROCEDURE

SUBJECT: **THERAPEUTIC HOME PASS AND PATIENT LEAVE OF ABSENCE**

Policy No.: B827
Supersedes: October 15, 2018
Revision Date: July 28, 2022

PURPOSE OF POLICY:

A therapeutic pass is an important tool for planning the post-hospital care of the rehabilitation patient. Passes provide a trial situation for the patient and caregivers to practice rehabilitation skills and knowledge in a non-hospital setting, identifying problems, and establishing goals for the remaining rehabilitation program.

- Therapeutic Passes may be considered and granted for Rehabilitation inpatients on an individual basis.

- Therapeutic Passes for medical-surgical inpatients may be granted with the approval of the Medical/ Surgical Physician or the Surgical Area Administrator(s) or a Designee.

CONDITIONS FOR THERAPEUTIC DAY PASS:

Each pass is granted individually based on the following conditions:

- The therapeutic pass is discussed by the interdisciplinary rehab team with consideration for the status of the rehab program, discharge planning, and training.
- The physician determines that the patient is medically stable.
- There is low risk of community exposure per Infection Control.
- The interdisciplinary team identifies well-defined therapeutic pass goal(s).
- The patient/caregiver accept the conditions of pass training criteria and accepts responsibility for the pass.
- No overnight pass will be allowed. Only short-term off-site pass will be allowed to evaluate the patient home and community environment prior to discharge.
- To simulate an overnight experience, consider using Rancho's Home Practice Apartment per policy B827.1.

  Key Point: The California Department of Health Care Services (DHCS) will allow short term off site passes, but will not approve an overnight pass.

POLICY:

1. An order for the pass must be written by the patient's primary physician or physician designee.

   Key Point: Pass orders may NOT be written by the On-Call Hospitalist or Intensivist.

2. Passes are granted on a case-by-case basis, but generally are not to exceed:
   a. 2 day passes (8 hours maximum in length for each day pass) during a rehabilitation stay
   b. Exceptions are for emergency needs with prior approval from Attending Physician.

3. Passes should not conflict with other scheduled therapeutic or diagnostic activities. Unless otherwise indicated in the physician's orders:

   a. Day passes begin on Sundays and County Holidays after 10:00 a.m.
   b. A pass may begin Monday-Saturday after completion of scheduled therapy/training.
   c. The patient is to return from day pass no later than 8:00 p.m. of the day on which the pass is taken.

4. Patients and families are responsible for pass transportation.

5. Minors or persons who have a conservator will be released only to the guardian or appointed conservator. The guardian/conservator may provide written documentation with additional instructions if other individuals are authorized to be involved in the care of the minor. Required training must be completed and documented in the medical record prior to any pass.

   Key Point: If a car seat is indicated for a minor patient, it must be secured in the car before the minor is released. These patients are to be escorted to the vehicle to ensure that the car seat is utilized.

6. A patient who fails to return to the hospital before midnight of the day the pass ends will be discharged. Readmission to the hospital is at the discretion of the Attending Physician. (Program Chief, Department Chairperson, or Medical Director.)

Key Point: If the patient fails to return to the hospital, the Attending Physician shall be notified. Attending Physician is responsible for notifying the On-Call Physician regarding the patient's readmission orders.

PROCEDURE:

I. Therapeutic Pass

1. The rehab team discusses and approves passes at the Interdisciplinary Team Conference or via electronic communication (email or video conference).

   KEY POINT: The Case Manager addresses any third party payor considerations which may influence pass approval.

2. Staff complete the "Interdisciplinary Therapeutic Pass and/or Discharge Patient/Caregiver Education Record" Form R559 (Attachment A) indicating that the patient/family/caregiver has successfully met the pass criteria.

3. The patient, family and the patient's interdisciplinary team member complete and review the Goal Section of the "Therapeutic Pass Form" (Attachment B – Form R0071). Copies of this document are given to patient/family and filed in medical chart.

4. The physician writes an order for the pass indicating that the pass is contingent upon training completion.

5. On the day of a scheduled therapeutic pass, a staff physician evaluates the patient in person prior to departure and document medical clearance for the pass in the medical chart. Patients are not authorized to be released on pass unless the staff physician evaluation and documentation are completed. A change in medical status subsequent to writing the order and prior to pass departure should be communicated immediately to the physician. Passes should not be issued if there has been an interim change in medical status or change in other circumstances that may impact safety.

6. The patient checks out equipment and supplies needed for the pass.

7. Nurse provides medications and a medication schedule.

8. Medications needed for pass will be prepared and dispensed by Pharmacy based upon the physician orders. Pass medications will not be taken from the PYXIS automated dispensing system. Licensed nursing staff will provide the patient and caregivers with the pass medications and necessary education.

9. Following the pass, unused supplies/medications are returned to the Nursing Staff and will be subject to Infection Control and Pharmacy practices.

DOCUMENTATION:

A. **"Interdisciplinary Therapeutic Pass and/or Discharge patient/Caregiver Education Record" (Attachment A)**

1. This document provides an overview of the major areas of functional education and identifies when patient/caregiver is trained for a functional skill.

2. Each team member identifies skills that the patient/caregiver need to demonstrate before going on pass. Staff schedules training sessions, assesses completion of instruction, and determines that the patient/caregiver adequately performs return demonstration of skills safely and effectively.

3. When the criterion in a category is met, the clinician checks the skill on the checklist, identifies person(s) trained, and dates and initials that training and return demonstration. If a specific skill within a category does not apply, the "NA" box is checked.

4. Patient/caregiver signs the bottom of the Therapeutic Pass Training Criteria Form upon completion of all the applicable training.

5. One Interdisciplinary Therapeutic Pass and/or Discharge patient/Caregiver Education Record is used for all passes. It is filed in the medical record. Additional training will be indicated on the same form as the patient/caregiver training progress to include additional elements..

B. **"Therapeutic Pass Form" (Attachment B – Form R0071)**

1. This form documents pass goals developed by staff and patient/caregivers.

2. The level at which the patient is projected to be able to perform the activity is completed on the form according to the following rating scale:

I	Independent
S	Supervised or set up only
Min	Minimum assistance (pt performs 75%; caregiver performs 25% of activity)
Mod	Moderate assistance (pt performs 50%; caregiver performs 50% of activity)
Max	Maximum assistance (pt performs 25%; caregiver performs 75% of activity)
T	Total assistance (pt performs <25% of activity)

3. The patient/caregiver is instructed to provide feedback about the activities. The form is used to indicate "Tried", "Did it", or "Help Needed" for each activity.

4. The "Comment" Section may be used to record information regarding barriers, problems encountered, and/or level of success in accomplishing goals.

5. The lower portion of the form is completed by the nurse before the patient leaves on pass and is signed by the patient or the responsible party. Pass destination and contact information is recorded.

6. Upon return to the hospital, the patient and caregiver will provide feedback about accomplishment of goals, including barriers to meeting expected pass goals. The nurse checks for completion of the Therapeutic Pass Form. If comments have not been completed by the patient or caregiver, the nurse may elicit and document feedback.

7. The Case Manager reviews pass outcome with patient and family, documents in medical record, and communicates with rehab team.

8. Rehab team shall discuss outcome of therapeutic pass at the next team conference or earliest appropriate team discussion.

    a. If a patient abuses pass privileges by returning unreasonably late or under the influence of alcohol or other substances, further passes will be denied.

    b. Team may discuss options to address problems encountered during pass, additional patient/family training, need for program extension, revision of goals, anticipated length of rehab program, etc.

C. **"Discharge / Therapeutic Pass Equipment and Supplies Control (Attachment C – Form R559)**

1. This form documents equipment/supplies issued to patient/family for pass or discharge.

2. Rancho staff determines appropriateness of issuing supplies/equipment. Education will be provided for the patient/caregiver to safely use the items issued for the pass.

II. Patient Leave of Absence (LOA)

A. Patients are placed on Leave of Absence (LOA) when patients are scheduled to leave their assigned unit. This applies to any of the following scenarios:

- Patient is being seen at an outside facility
- Rehabilitation patient is going to RLA Operating Room (OR) for surgical procedure
- Rehabilitation patient becomes ill and needs to be moved to medical-surgical care or higher level of care within Rancho or outside Rancho.
- Patient goes on overnight pass
- Other as determined by hospital administrators.

B. Nursing communicates patient's LOA status to Bed Control and Bed Control inputs the information into the electronic health record (EHR).

C. Nursing Resource Office maintains a log of patients on LOA.

D. If the patient returns within three midnights, nursing will notify bed control the patient has returned.

E. If the patient does not return within three midnights, nursing will discharge the patient. The patient's physician may also order to discharge the patient within the three midnights.

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