Inpatient Discharge Risk Interception Protocol

A Rapid Triage Decision Matrix, Clinical Scripting, and Safety Gate Scorecard

Target Workflow: Inpatient Care Transitions and 72-Hour Bounceback Prevention
Designed for: Inpatient Clinical Social Workers, Hospital Case Managers, and Care Transition Leads

Rapid Implementation Brief

Deploy this protocol within the initial 24 hours of hospital admission and execute the final safety gates 12 to 24 hours before planned departure. This tool provides defensible documentation syntax, immediate escalation triggers, and hard-stop clinical criteria to halt unsafe patient transitions before transport is arranged.

Section 1: 24-Hour Admission Risk Triage & Escalation Matrix

Evaluate newly admitted patients across the four primary vulnerability domains below. If a patient meets two or more conditions, initiate proactive transition coordination immediately.

Vulnerability Domain	Presenting Clinical Indicator	Immediate Social Work Action	Defensible Charting Syntax
Utilization & Chronicity	2+ admissions or 3+ ED presentations in trailing 90 days.	Pull regional health information exchange records. Identify past breakdown points and assign complex case designation.	"Patient historical utilization indicates recurring post-discharge decompensation secondary to outpatient coordination gaps. Intensive care transition plan initiated on Day 1."

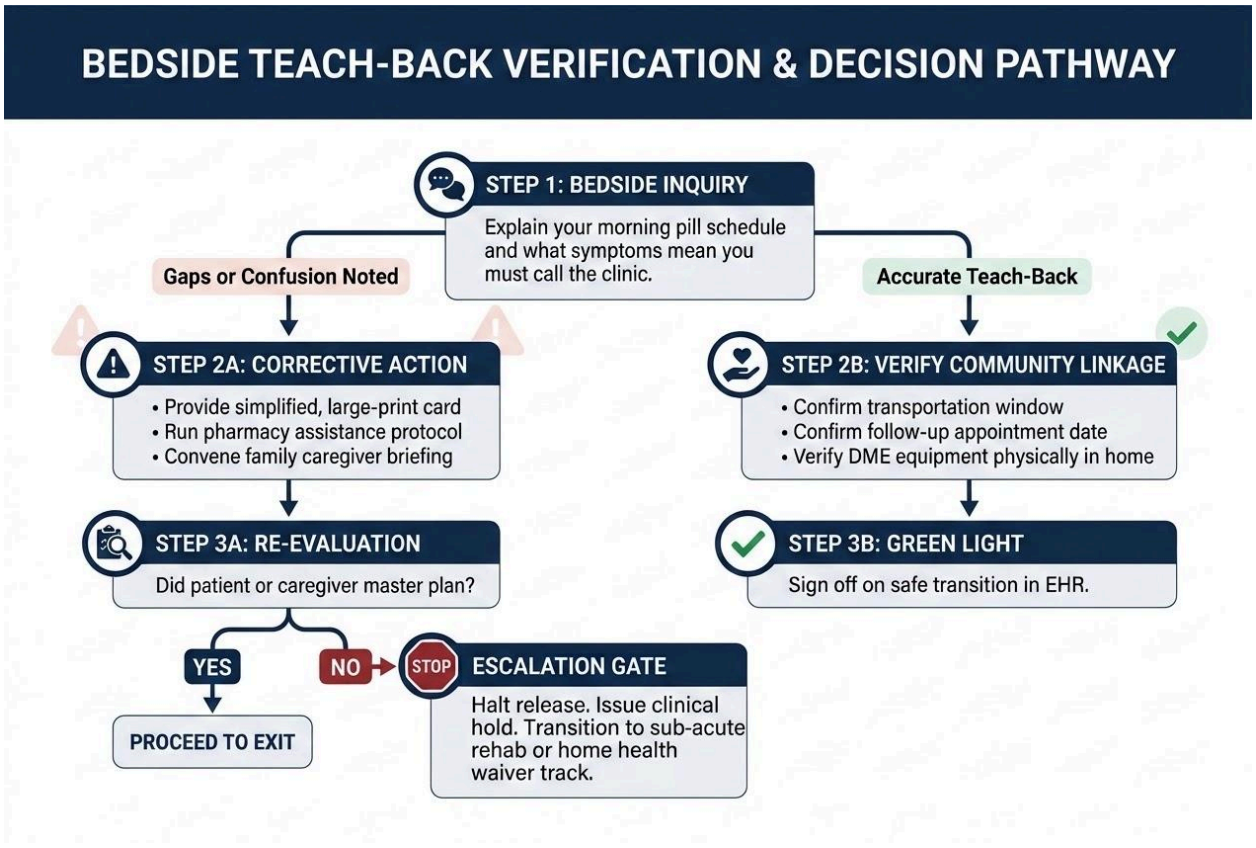
Vulnerability Domain	Presenting Clinical Indicator	Immediate Social Work Action	Defensible Charting Syntax
Pharmacotherapy Complexity	5+ daily maintenance drugs, anticoagulants, insulin, or new high-cost biologics.	Order bedside meds-to-beds delivery. Verify pharmacy stock, copay tier, and prior authorization clearance 48 hours prior to anticipated exit.	"Social work consulted for pharmacotherapy reconciliation barriers. Potential financial toxicity identified. Bedside medication delivery requested to ensure zero lapse in therapy."
Functional & Home Safety	Physical therapy notes max or moderate assist; patient reports living alone with home stairs.	Conduct home structural assessment with family. Initiate DME equipment orders (walker, commode, transfer bench) immediately.	"Discrepancy identified between charted mobility scores and domestic architectural barriers. Discharge home deferred pending DME delivery and verified caregiver assist schedule."
Caregiver Stability	Primary caregiver demonstrates acute fatigue, cognitive impairment, or hesitance.	Convene formal family conference. Assess caregiver capacity and introduce community-based respite or transitional waiver services.	"Family consultation conducted. Primary support person expresses acute burnout and inability to manage wound care independently. Post-acute placement evaluation initiated."

⚠️ **Regulatory Guardrail (CMS CoP § 482.43):** Hospitals must evaluate a patient's post-discharge needs and the availability of needed services. Never document a patient as

> "ready for discharge" if prescribed post-acute support services remain unverified or unfunded.

Section 2: Bedside Teach-Back Verification & Decision Pathway

Execute this structured four-point verification loop during the pre-discharge window (12 to 24 hours before planned release). Do not rely on passive patient agreement.



> 💡 **Clinical Efficiency Pro-Tip:** If a patient cannot successfully repeat the emergency escalation protocol (who to call before dialing 911), their 72-hour bounceback probability increases significantly. Document this as an unaddressed cognitive or health-literacy transition barrier.

Section 3: Clinical Documentation Phrase Bank

Use these defensible, objective phrasing templates in your electronic health record progress notes, interdisciplinary huddles, and physician communications.

A. Documenting Social Determinants of Health Barriers

- **Housing/Utility Instability:** "Psychosocial assessment reveals unstable domestic infrastructure (lack of reliable refrigeration for temperature-sensitive medication). Patient

lacks a safe recovery environment. Discharge to unhoused shelter contraindicated pending medical respite bed placement."

- **Health Literacy and Executive Function:** "Patient demonstrates receptive communication deficits regarding titration protocols. Patient is unable to verbally teach back dosage schedules. High risk for adverse drug event in home setting without daily supervised administration."
- **Financial and Coverage Barriers:** "Prescription coverage check demonstrates a tier-four copay barrier exceeding patient monthly disposable income. Discontinuing discharge pathway until manufacturer co-pay assistance or generic therapeutic substitution is approved."

B. Defensibly Delaying an Unsafe Medical Discharge Order

- **Medical Team Alignment Note:** "Social work team discussed case with attending physician [Name, MD]. While patient is hemodynamically stable, necessary post-acute skilled nursing facility acceptance is pending authorization. Discharging patient prior to secured placement creates immediate safety risks. Transition deferred 24 hours to finalize authorization."
- **Documenting Patient Right of Refusal with Harm Reduction:** "Patient exercises informed refusal regarding recommended sub-acute rehabilitation placement. Capacity assessment completed; patient understands risks of home recovery without 24-hour supervision. Harm-reduction protocol deployed: physical therapy home safety instructions provided, emergency pendant ordered, and daily family check-in schedule verified."

Section 4: Pre-Discharge Safety Gate Scorecard

Complete this mandatory compliance checklist before signing the final social work discharge clearance. All non-negotiable gates must pass.

Status	Safety Check Item	Verification Standard	Reviewer Initials
[ ] Pass	**Gate 1: Medication in Hand**	Bedside "meds-to-beds" delivery complete or pharmacy confirmation of filled, funded prescriptions.	_____
[ ] Pass	**Gate 2: Equipment Delivery**	DME (oxygen, walker, hospital bed)	_____

Status	Safety Check Item	Verification Standard	Reviewer Initials
		physically confirmed delivered and assembled in residence.	
[ ] Pass	**Gate 3: Caregiver Readiness**	Designated support person completed in-person return demonstration for complex care tasks.	_____
[ ] Pass	**Gate 4: Funded Transportation**	Wheelchair van or family ride confirmed with direct phone contact and arrival window.	_____
[ ] Pass	**Gate 5: Locked Outpatient Appt**	Follow-up appointment scheduled within 7 calendar days with provider name and location documented.	_____
[ ] Pass	**Gate 6: Teach-Back Mastery**	Patient accurately explains red-flag clinical symptoms and the exact non-emergency contact number.	_____

Remediable Vs. Non-Remediable Stop Criteria

- **Remediable Delay (Hold 2 to 4 Hours):** Missing standard mobility DME, pharmacy delivery delays, or pending transportation dispatch. Resolve via floor stock or discharge lounge transfer.
- **Non-Remediable Stop (Hold 24+ Hours):** Primary caregiver sudden refusal/abandonment, complete lack of heat/electricity in home, insurance denial of home

oxygen, or acute delirium relapse. Escalate to attending physician and departmental leadership immediately.

Clinical Social Work Sign-Off Block

I confirm that a comprehensive psychosocial transition assessment has been completed. The patient and their primary care support network have participated in discharge planning, understand the transition orders, and have verified access to essential post-acute clinical and social resources.

Clinician Signature: _____ **Date/Time:** _____
Printed Name & Credentials: _____ **License #:** _____
Attending Physician Notification Completed: [ ] Yes [ ] N/A (Physician Co-Signed)