Guidelines for discharging patients

These guidelines are for patients, practitioners (medical specialists) and nursing staff.

Purpose

The purpose of this information is to outline Southern Cross Healthcare (SCH) standard process for patient discharge (this includes inpatients and day-stay patients).

This process meets the requirements of the Health and Disability Sector Standards (2008) and ensures patients experience a planned and coordinated discharge or exit from our facilities and are informed about what to do after leaving hospital in terms of:

- The home environment, support needed, dietary needs and activities to complete or avoid.
- Addressing any issues of concern or uncertainty in particular identification of early warning signs of complications and what action to take.
- Reviewing medications using a reconciled medication list to discuss the purpose of each medicine, how much to take, how to take it and potential side effects.
- Explaining any test results to the patient/whānau. If test results are not available at discharge, inform patient of how to obtain results and follow-up.
- Ensuring follow-up appointments are clearly documented for patients prior to discharge

Point of Note

- The national SCH discharge form (electronic or paper version) is suitable for both day-stay patients and inpatients. This is the minimum information required for any patient discharge.
- Any phone call or other communication received post-discharge from the patient or regarding the patient must be documented in the patient's clinical record either on paper or electronically in CWS.

Process

Step	Process/task
Prior to admission	• Reviews the information provided on the patient admission forms and seeks further information or clarification as appropriate to identify discharge needs and goals

Step	Process/task

	• Ensures needs for discharge are anticipated and planned and recorded in the patient's clinical record
	• Documents that:
	  ○ Responses provided by the patient in the patient health questionnaire (PHQ) have been reviewed by an RN and appropriate information entered into CWS or on appropriate patient records.
	  ○ Confirms General Practitioner (GP).

At time of admission	• Completes actions relevant to discharge if these have not been completed prior to admission. • Confirms the accuracy of discharge information with the patient – documenting concerns or alerts in the patient clinical record – either on paper or within CWS (consider Conditions and Alerts section). • Reviews and discusses the individualised information on the Blood Clots and You brochure (as completed by the patient) making any alterations that may be necessary in conjunction with and the understanding of the patient. • Undertakes medication review as per Medication Reconciliation Guideline.

During hospitialisation	• Ensures needs for discharge (including patient education requirements and medication prescriptions) are anticipated, planned and actioned at the most appropriate time within the duration of the hospital stay, and that these are:
	  ○ Recorded in the patient's clinical record;
	  ○ Clearly communicated at handover between staff and with the practitioners as appropriate; and
	  ○ Communicated to the patient in plain language: patient's condition,

Step	Process/task
	discharge process, and next steps at every opportunity throughout the hospital stay.

At time of discharge	• Discusses the discharge process with the patient
	• Receives and actions instructions:
	  ○ From the admitting practitioner
	  ○ According to written care plan/pathway
	  ○ On any standing orders
	  ○ From other members of the multi-disciplinary team involved in patient's care eg physiotherapist, dietician
	  ○ Completes patient **discharge assessment** including pain score and vital signs, ability to void and any other assessments specific to the patient's procedure / individual needs such as drain and dressings removal/review, bowel activity.
	  ○ A set of **vital signs** is required as close to discharge as practicable, but at a minimum, within four hours of discharge. If these vital signs are outside accepted parameters for that patient, eg patient has been febrile, a further set of vital signs must be performed immediately prior discharge (and the discharge decision reviewed if necessary).
	
	Note: Where there are any signs, symptoms, issues or concerns prior to the patient leaving the hospital, these are immediately communicated to the patient's medical specialist for any further instructions and to the on-duty nurse in charge. These are to be recorded in the patient clinical record and on the discharge form.
	
	• Completes any district nurse / home help or other community referrals (eg ostomy care, breast care, service

Step	Process/task

	consumer support groups) and ensures the details are recorded on the Discharge Form (with a copy filed in the patient's record).
	• Confirms the surgeon's follow up appointment arrangements (including whether these are to be made by the surgeon or the patient).
	
	• Completes medications management processes:
	  ○ Removes intravenous cannula.
	  ○ Completes medicine reconciliation processes as per SCH guideline.
	  ○ Lists medications that vary in administration times on the discharge form (including the time last taken), ensuring the patient understands their specific medication regime including what medications to take (and why), what medications to withhold and when/if to recommence.
	  ○ Returns patient's own medications, discussing any medications that have since been discontinued by a prescriber.
	  ○ Gives patient their discharge prescription, any 'take-home packs' that have been prescribed (if applicable) or provides instructions to purchase general sale medicines if required, eg paracetamol.
	  ○ Provides information pamphlets for discharge medications as available (eg from MIMS Gateway or clinical pharmacist)
	  ○ Ensures a copy of the discharge prescription remains in clinical notes in case needed for clarification/follow-up.
	
	• Provides the patient with the following information checking their understanding via "teach-back" process and facilitates opportunity for questions:

Step	Process/task
	○ General discharge information, including knowledge of the 'Your Discharge' form (with specific focus on signs and symptoms requiring contact with their surgeon or GP). ○ Ensures patient/whānau are aware of who to contact for questions or in an emergency. ○ Specific discharge instructions as required by the Medical Specialist. ○ Relevant patient education/teaching. ○ Information sheets regarding after-care including wound management and hand hygiene. ○ Information regarding the return to activities of daily living, treatments, return of equipment, return of human tissue/explanted devices arrangements (as applicable). • Reviews and, if required, updates the information on the "Blood Clots and You" brochure with the patient ensuring clear understanding of actions required after discharge. • Completes the electronic discharge summary (EDS), giving one copy to the patient. This is sent to the patient's GP electronically if the patient has provided their GP information (unless otherwise requested by the patient). • Completes scanning of sundries. • Notifies administration staff of impending discharge. • Escorts or offers to escort the patient to their car, or has another staff member assist with this.
Leaving hospital against medical advice	In the uncommon situation where a patient leaves hospital against medical advice: • Attempt to provide discharge information and the completed discharge form.

Step	Process/task
	• Inform the admitting Medical Specialist immediately/as soon as practically possible. • As appropriate, contact the patient's 'next of kin/contact person'. • Document all actions in the patient's clinical record including completing any locally required forms. If a patient insists on driving themselves home within 24 hours of having a general anaesthetic or is still under the influence of sedative medication, the nurse will: 1. Tell the patient that the doctor's instructions are that they are not safe to drive (if that instruction has already been given) and document that instruction. 2. If the patient is not compliant (or no specific direction was given by the doctor) a. Inform the admitting doctor and request them to intervene. b. If the doctor cannot be contacted or their instruction is to do nothing, however there is significant concern, inform senior staff member/ General Manager/ on call nurse manager for further advice. 3. If the patient still intends to drive inform them of the decision to call the police - document this within the clinical notes.

References

- NZ transport authority - Medical aspects of fitness to drive – A guide for health practitioners
- Air New Zealand Medical Information Form for Air Travel (MEDA)
- Health and Disability Sector Standards (2008)
- Code of Health and Disability Services Consumers' Rights (1996)
- Southern Cross 'Your Discharge' form

Local documents

- Careplan / Pathway / Standing Orders and medical specialist preferences
- Medical Specialists' surgery/procedure specific patient information sheets
- Southern Cross Discharge Form (when paper process required)

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