How to Discharge a Patient Safely

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Discharging a patient safely involves meticulous planning from the moment that a patient is admitted. If you think about discharge planning during your daily rounding (integrated into your rounds notes as the "disposition" issue), the discharge process should be smooth and efficient. Before discharging a patient, you should consider the following questions:

1. Where is the patient going? Is the patient's level of function and mobility appropriate for this place? Have the OT and PT been involved, and if so, do they agree the patient is ready?
2. Are there any medications the patient came in on, but is no longer taking? Do we need to restart this before the patient can go home?
3. Are there any new and necessary medications which have been started? Who will monitor these new medications?
4. Are there any dosage adjustments to the patient's medications?
5. Does the patient require any follow-up investigations, such as laboratory tests, imaging, or other investigations? If so, who will follow-up on these investigations and when will they occur?
6. When should the patient follow-up with their family physician?
7. What are some relevant, worrisome symptoms which should prompt a patient to return to the hospital?
8. *What can we do to ensure that the patient does not end up bouncing back to hospital?*

When you are ready to discharge a patient, you will need the following orders in the chart:

1. Discharge home (or other place)
2. d/c IV
3. d/c Foley catheter
4. Prescription in chart (or prescription given to patient)
5. Patient to follow-up with GP in 2 weeks (patient to call) OR include the appointment details if available
6. Other follow-up appointments
7. Patient to return to the hospital if … (see below for a description of what to include here)

Below is the structure of a discharge summary. It may be easier for you to type up the discharge summary so that your senior can provide you with some feedback before you dictate it.

For any dictation, be sure to identify your name, level of training, whom you are dictating on behalf of (i.e., the attending staff), what the document is (i.e., discharge summary), who the patient is, the patient's date of birth, and the medical record number. More details on dictation tips can be found in the documents provided from transcription services.

Make sure you carefully consider who needs to receive a copy of the discharge summary. You should mention at the very least to send a copy to the patient's family doctor and the attending. If your patient is following up with any relevant specialists, include these people as well.

<u>Discharge Summary</u>

(format adapted for St. Paul's Hospital)

Most Responsible Diagnosis
self-explanatory

Pre-Admit Diagnoses
List their past medical history with brief details on important aspects, just as you would in a consult.

Post-Admit Diagnoses
Self-explanatory; detail this in a list as above

Secondary Diagnoses
This section is supposed to contain any diagnoses in the lists above that did not significantly affect the length of stay. This does require some degree of interpretation but in many cases I simply list all of the past medical history in the pre-admit diagnoses.

Code Status
Please make sure that you establish the code status at the beginning of the admission! If you are a medical student, you should have a resident or your staff confirm the code status before it is entered in the hospital system

Operative Interventions
These are formal procedures that take place in the operating or procedure room. There would typically be a procedure note on the system dictated by the performing physician. Common interventions that might be occur for CTU patients include upper or lower endoscopy, bronchoscopy, and interventional radiology procedures.

Other Interventions
These are any interventions which did not take place in an operating or procedure room. Examples could include PICC insertion, central line insertion, bedside paracentesis, bedside lumbar puncture, etc.

Flagged Interventions
This is a very important section in which you must include whether the patient had any of the interventions in the list below for the purposes of hospital statistics and funding:

Cardioversion
Endoscopic/Percutaneous Biopsy
Per-orifice Endoscopy
Cell Saver
Feeding Tube
Pleurocentesis
Central Lines, PICC/Portacath
Heart Resuscitation
Tracheostomy
Chemotherapy
Mechanical Ventilation
Radiotherapy
Dialysis
Paracentesis
Total Parenteral Nutrition

Names of Relevant Specialists
List all consulting specialists as well as the attending physician. Some people include the family physician in this list although this is not absolutely necessary.

Allergies
Self-explanatory

Medications

Please structure this section as follows (leave out any sections that are not applicable):

The following medications were discontinued:
1.
2.

The following medications were adjusted:
1.
2.

The following medications were left unchanged:
1.
2.

The following medications were started:
1.
2.

Post-Discharge Follow-Up

List any follow-up appointments ideally with the date, time and location if you know this information. One of the follow-up appointments should be with the family physician, and this will typically be in a week or 2 weeks. It is appropriate to ask the patient to call their family physician to make this appointment if you feel the patient is reliable. Just include an order in the chart stating when the patient is to follow-up with family physician. If the patient requires their family physician to follow-up with INR, be sure to call the family physician.

It is good practice to include as your last follow-up suggestion to have the patient return to the hospital immediately if there are any potentially dangerous signs (choose 2 or 3 which would be clinically relevant). These signs could include fainting, worsening chest pain, fever, etc. as appropriate. Make sure that if you are including this suggestion, that you actually educate the patient about it before discharge. You can even write an order "Patient is to return to the hospital if … " so the nurses can reiterate the message.

Discharge Disposition

e.g., "The patient was discharged home in stable condition"
e.g., "The patient was transferred to nursing home in stable condition"

Treatment/Course in Hospital

Include a *brief* paragraph with the patient's identification (age, sex), 2-3 relevant points on past medical history, what they were admitted to the hospital for, and what date they presented. Briefly discuss the HPI in 2-3 sentences *maximum*. Include *one* sentence on any relevant findings (physical exam or labs or other investigations) at the time of admission. The last sentence should be "The patient was admitted to the CTU for management of the following issues:"

Then, list the patient's issues as you have listed them in your daily notes. Include all major issues, including those that were present in the beginning but may have resolved. Include what the presumed cause was (and if appropriate, briefly explain the supporting evidence), what we did to manage the problem, and what the outcome was. If the problem is not resolved and there is plan for follow-up, you can describe the plan briefly. Mention if any other services were consulted for assistance.

This section should ideally not be dictated in a narrative format as this becomes very long and difficult to read for someone who wants to get to the point and know what was done for each relevant issue.