

Practice Pointer: Discharge Documentation



Category: Clinical Documentation of discharge planning and discharge



Impacts: All Health Care Professionals (HCPs) who contribute to acute care discharge readiness (e.g. Nursing and Allied Health)

What is the Practice?

- HCPs review and contribute to discharge readiness and discharge planning from the time of admission, up to and including day of discharge based upon the patient's specific needs
- HCPs include and refer to departmental or program specific standards during discharge planning and documentation
- HCPs document discharge activities in a timely and comprehensive manner to support a safe and seamless discharge
- An organizational policy supporting discharge planning and documentation is in progress; keep up to date with announcements on policy instrument updates

What do I need to know:

- The Discharge Plan component of the **Discharge Workflow Clinician Summary Page** displays interdisciplinary discharge documentation that informs and supports ongoing discharge planning
- The **Discharge Planning Form** can be accessed from this page

The screenshot displays a web interface for a Discharge Workflow Clinician Summary. The left sidebar contains a navigation menu with items like 'Pre-Hospital Function', 'Activities of Daily Living', 'Discharge Plan', 'Nursing Discharge Summary', 'Patient Education - Pamphlets', 'Patient Education: General', 'Histories ...', 'Procedure History ...', 'Home Medications ...', and 'Medication/Pharmacy Information ...'. The 'Discharge Plan' item is highlighted. The main content area is divided into sections: 'Pre-Hospital Function', 'Activities of Daily Living', and 'Discharge Plan'. The 'Discharge Plan' section is expanded to show a 'Discharge Planning Form' with the following data:

Discharge Planning	
Anticipated Discharge Date	29-SEP-2023
Discharge To, Anticipated	Home with family care
Living Situation	Rental
Identified Potential for LLOS or ALC	No
Transportation Planned Date and Time	29-SEP-2023 09:00

Discharge Barriers and Actions	
Equipment Barrier	OT consult finds that patient would benefit from a raised toilet seat
Equipment Mitigation	Family provided information to secure equipment
Equipment Support	patient needs raised toilet seat in home
Mobility Barrier	outside stairs to enter home are a current state barrier when he is not feeling well.
Mobility Mitigation	PT & OT consult and assessment or return to home
Mobility Support	Patient's family is securing alternative housing with no stairs

- Nurses must complete a Nursing Discharge Summary at time of patient discharge, which can be accessed from the Discharge Workflow Clinician summary page

What do I need to do:

- Update clinical documentation to inform discharge planning whenever there is a change in patient condition or a change in the plan of care
- Document discharge planning activities (e.g. assessments, needs, barriers and actions) at each patient interaction as appropriate in your discipline specific locations (e.g. Powerforms)
- If appropriate for your role, use the Discharge Planning Form to document discharge barriers, and actions taken to alleviate them
- Use the Discharge Workflow Clinician summary page to review and contribute to the discharge plan
- Document all patient education, and patient education handouts provided to the patient

