Practice Pointer: Discharge Documentation

Category: Clinical Documentation of discharge planning and discharge

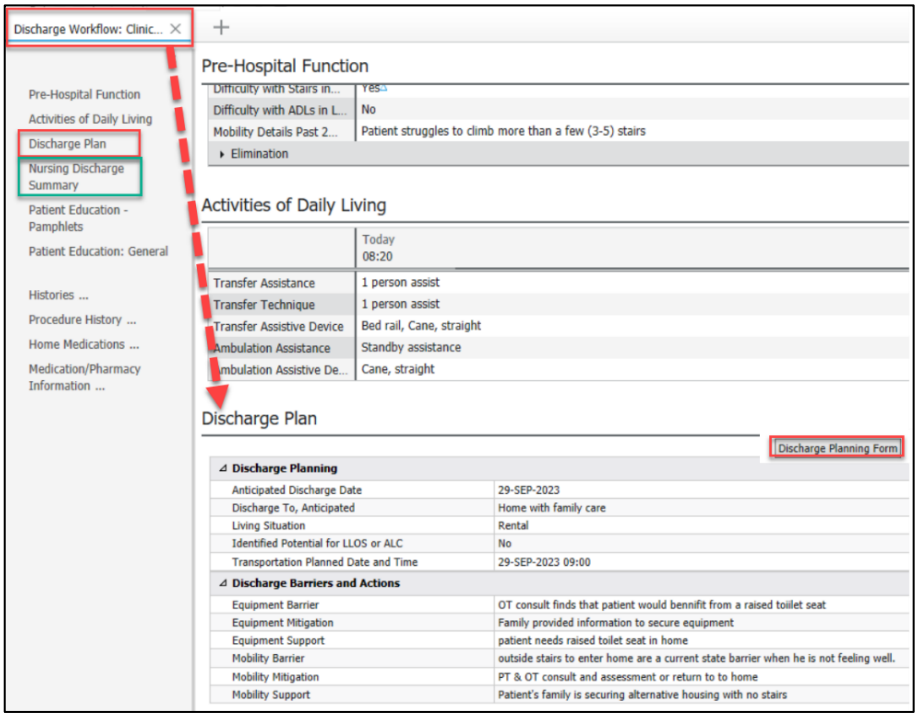
Impacts: All Health Care Professionals (HCPs) who contribute to acute care discharge readiness (e.g. Nursing and Allied Health)

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



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- 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