

Tips for Effective and Efficient Discharge Planning

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Start discharge planning *EARLY!!* – think about it at the time of admission.

Always involve the patient's primary care provider in discharge planning

PCPs can help with transitions to home

PCPs can give you essential information about the patient's home setting, risks for returning home, etc.

PCPs can help with need for follow-up appointments

ASK: Is this patient ready/safe for discharge?

Consider social/psychiatric factors that may compromise home care, compliance, ability to take pills, substance use, cognitive impairment, baseline functional status.

Can this patient safely return to his/her prior living arrangement?

Discharge Diet

Consider:

Patient's ability to obtain/buy/prepare food

Does this patient need assistance? Visiting nurse services (VNS)?

If patient needs a special diet (diabetic, heart healthy, low sodium) – consider a Nutrition consult while patient is hospitalized

ASK: How does this patient swallow?

Does this patient need a swallow evaluation prior to discharge.

Speech therapists provide excellent evaluations about a patient's swallowing ability and teach patients safe eating practices.

Discharge Activity

ASK: Is the patient able to ambulate safely?/resume his/her prior level of activity?

Physical Therapists are able to help assess patient safety. In addition you can watch the patient ambulate yourself and assess whether additional assistance is needed. Nurses also can provide invaluable information about the patient's ability to ambulate safely.

ASK: can the patient perform ADLs or would the patient benefit from VNS?

Order durable medical equipment early.

Physical and Occupational Therapists can give you invaluable insight into what the patient might need to be safe at home and to be able to perform ADLs.

Would patient benefit from a shower bench? A bedside commode?

This information may also encourage patient's to consider need for SNF...

ASK: Does the patient need additional assistance at home?/Does the patient have skilled needs?

Does the patient need a home safety evaluation?

Wound Care/Dressing Changes

Is the patient able to do his/her own wound care/dressing changes?

How often do dressings need to be changed? Would the patient benefit from VNS? Can a family member/friend/neighbor perform wound care?

If the patient is unable to care for his/her own wound – can this patient follow-up in clinic? Urgent Care? (The Emergency Room?) Does transportation need to be arranged?

Are there changes that can be made to help a patient prevent recurrence of a wound? Does a wheelchair pad need to be revised? Would the diabetic patient benefit from education about appropriate foot wear?

Talk to a wound care specialist – they have excellent tips and creative solutions for successful wound care and dressing changes.

Discharge Medications

Does the patient need teaching about new medications added in the hospital?

For example, teaching of self-blood glucose monitoring? Subcutaneous heparin injections? Use of a spacer for inhalers?

Both (discharge) pharmacists and nurses are able to provide critical information to patient's about their medications.

Would the patient benefit from additional education about his/her chronic medications?

Would the patient benefit from a mediset?

Does this patient need an interpreter? Instructions in another language?

Is the patient informed about side effects to watch for?

(“Rash is common but seek medical attention immediately if you have problems breathing...”)

(“Rash is common but, if minor, complete the full course of antibiotic therapy anyway...”)

Does the patient need specific follow-up given their medications:

Do they need follow-up for anticoagulation

Do they need their creatinine checked if they were started on an ACE inhibitor?

Do they need liver enzymes checked if started on a statin?

Do they need a dilantin level checked?

Remember to communicate any new medications to the patient's PCP.

Give patients specific tips/parameters for taking medications:

If weight increases by more than two pounds, take an additional dose of furosemide.

Is the patient able to take / comply with prescribed discharge medications?

Would the patient benefit from discharge instructions in another language?

Are there any medications that need to be discontinued prior to discharge?

Should this patient

Discharge Follow-Up

Set up discharge appointments at the time of admission if possible.

If you know that a patient will need Cardiology follow-up within a month of discharge – this appointment can be set up upon admission so that the patient leaves with a specific appointment date/time in hand.

Discuss discharge follow-up with the patient's PCP. Often the PCP can follow-up on most medical issues and the patient may not need immediate follow-up with a Specialist.

Ask consultants about need for specific follow-up in the specialty clinics and ask re: time frame. Does the patient need any testing (laboratory/radiology) prior?

If patient has outstanding laboratory or radiology results at discharge, designate specific plan for follow-up of these results (e.g., hepatitis serologies, HIV) either with a primary care provider or in urgent care. If an outstanding result is critical (for example, final sensitivities or HIV), determine how you can contact the patient if s/he is lost to follow-up (for example - cell phone, post-office box, back-up contact (Mother in Oklahoma), and attempt to document where a patient is staying (e.g., under the Fourth Avenue Bridge)

Instructions for Follow-Up Sooner

Give the patient specific instructions for follow-up, e.g.,

Call 911 if...

Return to the ER immediately if

Return for follow-up sooner if:...

Discharge Disposition

ASK: Is the patient safe to return to his/her prior living arrangement?.

If the patient is homeless – would s/he benefit from respite, day rest? Involve the patient as well as the patient's PCP, nurses, therapists and social worker early. If ok, with the patient also consult with the patient's family/DPOA.

If the patient is going to a skilled nursing facility – consider contacting the responsible MD to determine any specifications of the SNF (e.g., can the SNF take a patient with a feeding tube)

Summary

Remember that effective and efficient discharge planning is a learned skill that improves with practice. A little bit of forethought can go a long way in preventing morbidity and mortality and avoiding future hospitalizations.

TEACHING TIPS

- Always start discharge planning *EARLY* (time of admission is not too early to start)
- Involve the patient's primary care provider. S/he can provide invaluable assistance in ensuring a safe transition from the hospital
- Effective discharge planning is best accomplished with a multidisciplinary team: involve the patient/or authorized representative, the patient's primary care provider, physical, occupational and speech therapists, nurses, social workers, nurse care coordinators, consultants and the Family/DPOA (latter if the patient permits.)