DISCHARGE PLANNING

DEFINITION

Discharge planning is the plan evolved before a patient is transferred from one environment to another. This process involves the patient, family, friends, and the hospital and community health care teams. Discharge planning is an integral part of the continuity of nursing care for patients throughout their hospital stay.

PURPOSE

١. To ensure continuity of care by providing instructions, information, and guidelines.
٢. To promote continuity of coordination and communication within the health care environment on discharge from hospital.
3. To prepare patient physically and psychologically for transfer to a changed environment.
4. Prepare the family emotionally and psychologically for a changing environment.

PROCEDURE

SN	Action	Rationale
1.	Assess the patient for home care needs and formulate a plan of care to meet the individual, physiological, psychological,and social needs. **This must begin on admission and is an ongoing process.**	To enable planning to start well in advance of discharge home.
2.	Document all relevant information (social, communication, home address, telephone number, etc...) Ensure that the next of kin / or sponsor is the person who is willing to accept the responsibility for legal and financial affairs.	To facilitate planning, coordination, and communication. Personal information may not have been entered or updated in nursing and medical records.
3.	Establish whether hospital / health centre will be involved following the patient's discharge. Document names and telephone numbers.	To enable contact for exchange of information to assist in assessing potential needs on discharge.
4.	Review patient's activities of Living's form. (refer to Activity Livings and nursing care plans).	To establish the actual and potential activities that the patient can perform
5.	Plan discharge with patient's care givers and other members of health care team.	To collate information and coordinate planning.

SN	Action	Rationale
6.	Ensure that any essential aids or equipment have been obtained, adaptations made, and orientation given to patient and care givers before discharge.	Some equipment may not be available or may take a long time to be obtained. The patient may be at risk at home and suffer unnecessary discomfort and stress.
7.	Teach patient / family any necessary skills required for rehabilitation, allowing sufficient time to practice before discharge.	To enable patient to be as independent as possible and promote an understanding of self-care techniques.
8.	Reinforce any special instructions with written information e.g. health education sheet.	To enhance the patient's understanding and knowledge of disease process, prescribed treatment, and precautions.
9.	Review the physician's progress notes, physician's order notes , nursing progress notes, and nursing care plan.	To obtain specific instructions / information regarding discharge planning.
10.	Consult and finalize the arrangement for discharge. e.g. physiotherapist, social worker, dietary therapist, public relations officer etc...	To enhance holistic approach.
11.	Coordinate with the relevant departments and ensure that : • Medication, dressings, equipment, and supplies are ordered for the patient. • Out-Patient clinic appointment and referral note are booked.	
12.	• Ensure that patient handover the hospital belongings. • Enter in the discharge book • Complete records and send to the MRD	

Note

Assessment and planning for weekend leave is as important as for final discharge.