Discharge Expectations

General

- The discharge is one of the most important, and potentially hazardous tasks you will do on inpatient medicine. Doing it conscientiously can help to keep your patients safe and keep them from returning to the hospital.
- Start thinking about discharge from the day of admission. You should think about what needs to change prior to the patient being safe for discharge (discharge criteria such as off oxygen, etc). You should also think about where they will go and roughly when they might be ready. If you do not know, ask your senior or attending.
- If the patient will possibly need a nursing home after discharge, order PT and OT on admission.
- Residents should contact social workers (for nursing home discharges) 2 days prior to the estimated day of discharge as it may take 48 hours to get insurance company approval.
- Residents should contact case managers (for home health discharges) early on the day of discharge to be sure this can get arranged.
- Patients should not be formally discharged until seen by the attending physician for the day.
- PCPs should be called and notified of their patient's discharge; they should be advised of any important and/or urgent follow-up information at that time.

The Discharge Process

- The discharge process can be initiated under the "Discharge" tab on the left hand column of the main Epic patient screen.
- Use the "Order Reconciliation" tab to thoroughly review patient medications prior to leaving the hospital. Please pay very close attention to the dosages, frequencies, and durations that appear on the medication reconciliation as these often change during the admission (or were wrong to begin with).
- All interns and medical students should have their medication reconciliations reviewed by a senior resident or attending prior to the patient leaving the hospital.
- Prescriptions being given to patients at discharge should be printed from the Epic system, signed, and placed in the patient's chart.
- Patients should be discharged with less than 7 days of narcotics or other schedule 2 medications. If more is required, an OARRS report and additional documentation by the attending is required under state law so please notify the attending if an exception occurs.
- Important follow-up details should be relayed to the patient on the "Discharge Instructions" tab within Epic. The nurse will print this out and give to the patient upon leaving the hospital. These instructions should be simple and easy to understand. Use the .ucfmdcinstructions dot phrase and adjust as needed.

- All follow up appointments with any medical provider (PCP, specialist, wound care center, etc.) should be added to the “Discharge Instructions” sheet.

SNF and Home health discharges

- Any patient going to a nursing home (SNF, ECF) or those who will be receiving some sort of home service (home health nursing, home PT/OT, etc) will need a Continuity of Care (COC) form completed prior to discharge.
- COC forms can be found by typing “COC” at the New Orders for Discharge section of the Order Reconciliation in the Discharge tab.
- When doing a COC, assume that the patient you discharge to a nursing home will not get seen by a doctor for 48 hours. You are writing admission orders for the patient at the SNF.
- COC forms should include all aspects of the patient’s care that you wish the nursing home or home health nurse to provide (O2 orders, dressing changes, wound care, lab draws, important vitals, weights, etc) after discharge from the hospital.
- Be explicit about what you want to have happen; do not assume that the staff will take initiative to alert the facility MD of problems.
- Please include a miscellaneous order to call TCH and request a d/c summary if there is not a discharge summary on the patient’s chart within 24 hours of admission.
- All interns and medical students should have their COCs reviewed by a senior resident or attending prior to the patient leaving the hospital.

Discharge Summaries

- Discharge summaries are to be completed within 48 hours of patient discharge or 24 hours for those not discharged to home.
- All discharge summaries should be “routed” from Epic to the patient’s PCP upon completion of the summary.
- Patients being discharged to Rehab facilities, skilled nursing facilities (SNF) or extended care facilities (ECF) ideally should have their discharge summaries completed prior to the patient leaving the hospital. If this is not possible, then writing on the COC form to “call medical records for discharge summary within 24 hours” is acceptable.
- Always remember, the discharge summary is meant for your medical colleagues (not the patient) to review and be able to quickly ascertain any important details related to the hospital admission or important follow up after discharge. It should be pertinent and succinct. If you are not sure of what to include in a discharge summary, always try to think about what you would want to know if you were the patient’s PCP and were receiving the summary in your office (in 1-2 minutes) about his/ her hospitalization.

- Once you have reconciled a patient’s medications, the shortphrase “.dischargemedslist” can be used to place the reconciled meds into the discharge summary.