HACKETTSTOWN REGIONAL MEDICAL CENTER
NURSING POLICY MANUAL

DISCHARGE PROCESS

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Effective Date: 9/1992	**Policy No: 8620.57a**
Cross Referenced: 8620.197c and 57a	**Origin: Division of Nursing**
Reviewed Date: 5/05, 9/08	**Authority: Chief Nursing Officer**
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SCOPE
All RNs in Inpatient and Outpatient Areas

PURPOSE
To provide a guideline to assist the patient transition from hospital setting to home or other facility

POLICY
It is the policy of HRMC to assess a patient's health care needs by identifying needed resources, coordinating services prior to discharge and communicating post hospital care instructions at time of discharge.

PROCEDURE

A. Equipment
a. Wheelchair
b. Discharge documentation forms
c. Patient instruction sheets
d. Bag for belongings

B. General Guidelines
1. From time of admission, assessment of patient discharge needs is obtained using the patient history, care plan, assessments, functional status, psychosocial support system, financial resources, cultural and ethic background, level of education and barriers to care.
2. Assessment of needs are conducted throughout hospitalization by the interdisciplinary staff and reported during the daily rounds with the interdisciplinary members to assist in facilitating the discharge process
3. Teaching session with patient and family should be completed as soon as possible during hospitalization. Review and give discharge materials to patient prior to discharge date/time when possible
4. At time of admission, supply the patient with a discharge checklist which can be utilized throughout hospitalization up till day of discharge.

C. Procedure
1. Check physician's discharge order
2. Determine whether the patient has arrangements for transportation
3. Verify with Case Management arrangements for any special discharge medical equipment set up
4. Provide privacy and assistance as patient dresses and packs personal belongings.
5. Assure all valuables listed on belonging section of EMR, are presented and/or accounted for.
6. Verify the medical record to assure appropriate vaccines were given.
7. Check medication reconciliation has been completed by comparing home medication list to eMAR to discharge mediation list.
8. Provide patient with medication prescriptions and check if prescriptions were sent electronically to their pharmacy.

9.Provide information on follow up appointments
10. Review discharge instruction regarding wound care, diet and activity and clarify any questions patient may have regarding any discharge instructions.
11. Print discharge instructions and any additional education material
12. Assist patient to wheelchair; assure all hospital equipment is disconnected from patient.
13. Escort patient to entrance where transportation is waiting.

D. Documentation
1. Sign and depart document and complete appropriate nursing section. Print for patient when completed.
2. Complete discharge power form immediately when patient leaves
3. Complete plan of care to show problems have been resolved or follow up is being done at the next agency.
4. Completed discharge checklist and send home with patient.
5. The Secretary or the nurse discharges the patient from the electronic census using the PM conversion function.

RESOURCES

Care Excellence Discharge workflow
Potter, Patricia. Perry, Anne. Clinical Nursing Skills and Techniques, 7th edition. Mosby (2010) p. 21-26