COHESIVE HEALTHCARE MANAGEMENT & CONSULTING

MANGUM REGIONAL MEDICAL CENTER

Patient Discharge Safety Checklist

PURPOSE: The transition out of the hospital is crucial for a good recovery and can reduce chances of future hospital stays. When planning for patient discharge, there are some key questions to address to clear up any confusion about care and to ensure a safe, successful transition to home.

INSTRUCTIONS:

1) The Case Manager assigned to the patient will initiate this form upon the patient's admission to the hospital.
2) The Case Manager shall include the patient and/or family/patient representative in the discharge planning process to assist in a safe and successful transition to home.
3) A review of the Patient's Discharge to Home Plan shall be done at each IDT meeting or more frequently as indicated by the patient's hospital course to discuss barriers/challenges to home discharge and the need for appropriate interventions to prevent a failed home discharge or hospital readmission.
4) The Case Manager will provide routine updates of the review to the patient and/or family/patient representative to assist in mitigating any barriers or impediments to a safe and successful transition to home.
5) Patient and/or family/patient representative understanding should be confirmed by using a technique known as "teach-back." A "yes" answer far too often does not guarantee understanding by the patient and/or family/patient representative. Ask the patient and/or family/patient representative to explain back the information that has been communicated to them. Repetition and reinforcement should be utilized as often as necessary to ensure the information is understood.
6) Use the attached Patient Discharge Safety Checklist to consider when preparing for a discharge to home. The Patient Discharge Safety Checklist shall be retained as part of the patient's medical record.

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Patient Discharge Safety Checklist

Patient Name: _____ Date of Admission: _____/_____/_____

Admission Diagnosis: _____

Patient/Family Representative: _____ Relationship: _____ Contact Number: _____

Patient/Family Representative: _____ Relationship: _____ Contact Number: _____

Name of PCP: _____ City/State: _____

(Check each item as applicable to the patient's status at time of discharge)

Discharge Date: _____/_____/_____

□ Discharge to Home □ Family/Patient Representative Support (Describe): _____

□ Discharge Instructions Ordered & Copy Provided to Patient □ Yes □ No

□ Discharge Condition: □ Stable □ VS WNL □ Independent Ambulation □ Ambulatory with assistive device (circle): W/C Walker Cane □ Bedbound

□ Home Health (HH) Set-Up: □ Yes □ No □ N/A Name of HH: _____ Frequency of Visits: _____

□ Medical Equipment Set-Up: □ Yes □ No □ N/A (Describe): _____ Name of Company: _____

□ Medications/Prescriptions Set-Up: □ Yes □ No □ N/A (Describe): _____ Name of Pharmacy: _____

□ F/U Appointments Set-Up: □ Yes □ No □ N/A (Describe): _____

□ *Assistive Services Set-Up: □ Yes □ No □ N/A (Describe): _____

(*Includes assistance with meals, household chores, transportation, personal care, etc.)

□ Education, Teaching, & Training Completed as Applicable: □ Yes □ No □ N/A (Describe): _____

_____

□ **Discharge Call Completed Within 48 hours of Discharge (excluding holidays & weekends): Date: _____/_____/_____ Time: _____:_____**

Comments: _____ Case Manager Signature: _____

Case Manager Discharge Summary:

_____

_____

_____

Case Manager: _____ Date: _____/_____/_____