# How to Discharge Patients at VGH

Discharging a patient safely involves meticulous planning from the moment that a patient is admitted. If you think about discharge planning during your daily rounding (integrated into your rounds notes as the "disposition" issue), the discharge process should be smooth and efficient. Before discharging a patient, you should consider the following questions:

1. Where is the patient going? Is the patient's level of function and mobility appropriate for this place? Have the OT and PT been involved, and if so, do they agree the patient is ready?
2. Are there any medications the patient came in on, but is no longer taking? Do we need to restart this before the patient can go home?
3. Are there any new and necessary medications which have been started? Who will monitor these new medications?
4. Are there any dosage adjustments to the patient's medications?
5. Does the patient require any followup investigations, such as laboratory tests, imaging, or other investigations? If so, who will follow up on these investigations and when will they occur?
6. When should the patient follow up with their family physician?
7. What are some relevant, worrisome symptoms which should prompt a patient to return to the hospital?
8. What can we do to ensure that the patient does not end up bouncing back to hospital?

**What do I need to get done for the patient to leave the building on discharge day?**

1. **Discharge medication reconciliation** done in Cerner and prescription printed
    - Done under attending's CPSBC ID
2. **Discharge medication list** (Cerner template populates what you've done above in #1)
3. **Patient Instructions box filled in Provider View** - include the following information in patient-centered language: reason for admission/diagnosis, post-discharge instructions, reasons to return to hospital, changes to routine
4. **Outpatient lab or imaging requisitions** (both likely on the ward, can be done on Cerner as well. Paper lab rec here)
    - Done under attending's MSP # (from college website)
5. **Discharge order and instructions (patient discharge handout given to patient, DC IV, prescription and med list note to be faxed to patient's pharmacy)**
    - After review with senior resident/attending
    - Can do "criteria-led" discharges, eg "pending CPAS sees to give methadone script" "first thing tomorrow morning, give script/patient discharge summary" "when mobility cleared by Allied Health"
6. Let the bedside nurse know the plan.

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**When do I have to do the discharge summary?**

- Transition to Cerner makes this step easier, but it is still very important to get these done within 24 hours of discharge. This is especially important when patients are complex/pending short-term outpatient appointments/likely to re-present to medical attention, as your summary of the patient's stay in hospital will be crucial.
- My general strategy on CTU blocks has been to physically discharge patients in the morning and complete the discharge summary in the afternoon before I leave that day, to avoid work piling up.
- My advice would be to anticipate and prepare for the upcoming discharge and periodically update "Course in Hospital" in Provider View, as this will populate the discharge summary. For any patient you are regularly assigned, you can complete the initial paragraph describing the presentation and initial events in hospital, and begin to write the issues list.

**Tips?**

- Keeping up a good "best practices" section in your rounding notes with follow-up items (appointments, investigations), home medications held, etc. can make this process a lot easier.
- Don't let unarranged follow-up items build up before discharge – eg avoid "at time of discharge, refer to Pacific Lung for PFTs and Resp follow up" – if there are things you can set up now, you will save yourself (or the person who discharges your patient for you if you're post call!!) from the discharge scramble
- Remember to CC all of the patient's actively following specialists as well as their GP on the discharge summary