Discharge Assessment
Preparation for Discharge to Home from CCTC

Before a patient is discharged from CCTC, the following areas should be assessed to determine suitability and requirements for discharge.

1. **What is the original reason for the patient's admission?**

    a. Is the problem resolved?
    b. Does the admitting service agree to the discharge?
    c. Does the problem require any follow-up?

    Examples:
    - Follow-up appointment with surgeon, cardiologist, MRP
    - Appointment for rehabilitation (e.g., following amputation, patients may go home to recover but need a follow-up appointment for admission to rehabilitation and for prosthesis clinic).
    - Is there any patient information available to send home with the patient?

2. **What complications did the patient have while in hospital?**

    a. What other services were consulted during the patients stay?
    b. Do any of these consulting services need to see the patient as part of follow-up; services should be notified prior to discharge to determine whether follow-up appointments are needed?
    c. Is there any patient information available to send home with the patient (See back of binder).

    Examples of some of the issues requiring follow-up appointment:
    - Follow-up appointment with consulting medical services:
        - cardiology (e.g., patient who had MI during admission)
        - medicine or nephrology (e.g., resolving renal failure, newly diagnosed hypertension or other medical condition)
        - vascular surgeon (e.g., incidental aneurysm finding during admission)
        - neurology (e.g., patient with seizure or neurological consult)
    - Does the patient need any continued treatment (e.g., coumadin for cardiac arrhythmias or treatment for DVT or PE).
    - Did the patient have a GI bleed that requires continued therapy with H2 antagonists or PPIs?
    - Do the patients need any other referrals or ongoing teaching for new or existing problems?

      Example:
        - Newly diagnosed diabetics require referral to diabetic teaching.

3. **Is the patient able to ambulate safely and climb stairs if necessary?**
    a. Observe patient walking, assess stair climbing if necessary. If you have concerns re safety or ability to manage ADLS, consult with the physiotherapist.
    b. Check with physiotherapist to determine whether physiotherapy has been involved and has any recommendations for discharge.
        i. The physiotherapist may make recommendations such as walker, brace etc.
        ii. If necessary, the physiotherapist should assess to determine whether home Physiotherapy or OT referral is indicated (ordered through South

West LHIN Community Care Access). This might include stair climbing support or provision of assist devices such as walkers or bathtub rails.

c. If South West LHIN Community Care Access is required, the physiotherapist will write a note and make recommendations for the South West LHIN Community Care Access physiotherapist and/or OT referral.

4. Has the medication profile been reviewed by the pharmacist before discharge? The pharmacist may wish to provide medication instruction, particularly for new medications.

a. If preadmission medications are to be continued, the family physician will order any refills
b. Scripts will be required for any new medications that the patient may required
c. ***Remember to include a script for pain medication if required.***
d. Our pharmacist may be able to contact the community pharmacy to facilitate filling of the prescription.
e. Ensure prescription forms are completed an placed in the chart.

5. Does the dietitian have any nutritional recommendations before discharge?

a. All patients who are discharged home with enteral feeding require a South West LHIN Community Care Access dietitian referral.
b. The dietitian may request home referral for other reasons.
c. The dietitian may wish to meet with the patient and/or family to provide written or verbal information.
d. The CCTC dietitian will document instructions for the South West LHIN Community Care Access dietitian.

Example:

- A patient going home on coumadin for the first time should have instruction regarding dietary intake of vitamin K containing foods.

6. Is the patient on dialysis? A number of factors must be considered before a dialysis patient is discharged home.

a. Previous IHD patients who are normally dialyzed at a satellite out-patient program must have 3 stable runs in a dialysis chair before they can return to their home program (this includes centres such as Chatham, Owen Sound, Sarnia, Tillsonburg, Woodstock and any self-care dialysis).
b. Most ICU patients will require some treatment modification before being ready to return home.

7. What support is available to the patient at home?

a. Will the patient have someone with them at home?
b. Who is picking the patient up? How will they get home? Is this appropriate?

8. Have you checked with the social worker to identify any outstanding issues?

a. Are there any forms or referrals that need to be completed?

9. **Is a South West LHIN Community Care Access referral required?**

a. Referral for nursing care should be made if patient has wound care or IV access (e.g., PICC).

b. If patient is receiving antimicrobials via PICC line and the PICC line has a known date of removal (e.g. after 5 more days of antibiotics), a South West LHIN Community Care Access order must be written for the removal that includes the length of the PICC line. Fax a copy of the PICC line insertion checklist to South West LHIN Community Care Access with the order to avoid delays.
c. If a dressing is required for wound assessment by a nurse. A light dressing applied to the wound will ensure assessment.
d. If the patient should be assessed once a day by a nurse but does not have a wound, the referral can request "vital sign assessment" or "blood pressure check".

10. Identify the name of the family physician.

a. Fax a copy of the discharge summary and instruction sheet to the family physician.
b. Instruct the patient to make an appointment with their family physician (determine recommended timeframe through discussion with CCTC physician) for follow-up and communicate this in the discharge summary provided to the family physician.

11. **Double Check**

a. Be sure that all referrals and orders that are sent to South West LHIN Community Care Access have the physicians signature (in addition to printed name and CPSO number). Without a signature the referral will be rejected.
b. Give patient a copy of all instructions and place a copy in the clinical record.