Forum
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EXTENDED CARE SERVICES
Improving resident care by making meds easier

Better Discharges Lead to Better Outcomes

Checklist for Successful Discharge Planning

According to a new survey report, skilled nursing facilities are managing several key components of discharge planning effectively. At the same time, these short-term residents and their families would like better education and more follow-up. To identify and bridge any gaps in communication or services, maximize medication management and treatment adherence, and prevent avoidable readmissions, consider using this checklist prior to discharge.

Tie up loose ends and conduct risk assessments

Does the patient have access to medications, and the ability to get prescriptions filled?

✓ What services and/or supports will they need when they return home?

✓ What support/help will they get from family, friends, or others in the community?

✓ What issues or risks exist in the patient's home, and how can these hurdles be addressed? Consider:

- Loose rugs
- Steep steps
- A tub that is hard to step into
- Other layout and design issues that may impede accessibility and/or safety

✓ What opportunities will the patient have for social engagement?

✓ What home care agencies or other community-based organizations will be providing support/services? Have these services been arranged?

✓ Have the patient's goals been ascertained (eg, regaining independence with ADLs or to play golf again)?

Provide education/information

✓ Did staff get consistent information about the discharge plan?

✓ Did families/patients receive information and education about diagnosis, disease management, and medication regimen?

✓ Did they have an opportunity to ask questions and voice concerns? If so, were those questions and concerns resolved?

✓ Did staff have an opportunity to discuss the discharge planning process and make any suggestions/ recommendation on how to improve it?

✓ Does your discharge planning process ensure that communication flows accurately and in real-time to everyone?

Provide follow-up

✓ Did the patient receive a follow-up call soon after discharge? When was the call placed? Where/how was this information documented? What additional action, support, or assistance was identified?

- Is the patient getting their prescriptions filled? Has someone conducted a recent medication review to ensure they aren't taking old or duplicate prescriptions?

- Does the patient have necessary follow-up appointments scheduled with their primary care provider or other practitioners? Do they need a reminder? Does the patient have transportation to get to these appointments?

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