DISCHARGE PROCESS: STEP BY STEP

1. □ A day or so ahead of anticipated discharge date, resolve any problems still in the Care Plan. A patient mu not leave here with unaddressed problems still in the Care Plan
2. □-Ensure that MD completes the Discharge Medication Reconciliation.
   □-Find out if the patient has a supply at home. □ If not, get a prescription.
   □-If MD writes a prescription, add it to the MEDICATION BY HISTORY section.
   □–If MD has written a discharge order, check the Activities/Interventions & the PAL. Tasks will flow to these areas when discharge order is entered.
4. □ Print out the Discharge Orders (So that you can view them while in Depart Process)
5. □ Click DEPART tab

□-DIAGNOSIS: Add diagnosis if MD has not done so already.

□-Skip MEDICATION RECONCILIATION. Do MEDICATION BY HISTORY (above) instead.

□-FOLLOW UP: Click -Free-text Follow Up- and just type in the appointment information. Click ADD.

□-Change date of appointment at the top and then click OK.

-Skip ORDERS

□-PATIENT EDUCATION HANDOUTS: -type "Burn" in search area.

-double click on -Burn Care Instructions-

-erase everything displayed there and then just free text the instructions

-**IMPORTANT**- Click OK then PRINT it *before* you SAVE !!!

-*OR* you can use the Preprinted Discharge Instructions in the filing cabinet and document that you gave this to the patient.

□-MEDICATION EDUCATION HANDOUTS: This is where you add any medications that are *new* to the patient. In other words, medications they were never taking at home before. Just type medications in the search area and double click medication. Repeat this until you have all new meds in the Selected Leaflets section at the bottom of screen.

- Click OK. Do not print. This will print later when you print the whole Depart Form.

□-INTERDISCIPLINARY EDUCATION:-complete this page.

□-CORE MEASURES REVIEW: Is there an orange sheet on chart? -Document on appropriate Core Measure Review Form at top.

□-Rescreen for Influenza and Pneumococcal vaccinations.

-Skip INTERDISCIPLINARY READINESS FOR DISCHARGE.

□-VALUABLES AND BELONGINGS:- Add any that were not captured during hospital stay.

□ -print 2 copies. Place signed copy in chart. Give unsigned copy to patient.

□-DISCHARGE NOTE: complete this when patient is finally discharged.

□**Important- At the bottom of the first page that pops up when DEPART Icon is pushed, there is a box that needs to be checked. (Patient/family/caregiver verbalizes understanding of instructions given)

□-Print DEPART FORM using PRINT button at the bottom of the same page as above.
**Important- Do not forget to click SAVE after printing. If you do not, your work will not be saved!!

□**Important- If MRSA Surveillance was NEGATIVE on admission the patient MUST be re-swabbed.

□-Only thing that goes into the paper chart is the Signature Page of Depart Form & signed copy of the Valuables and Belongings Form.

□ - Ensure patient has all belongings. □Check the bedside table. □Check the closet.

MASTER COPY

Updated Sept 2017 PW