Discharge Planning

Discharge is a handoff, not an event · plan it from day one, and assume nothing you said was heard

Start on day 1
not the morning of

THE CORE CHECKLIST *the items that actually prevent readmission*

Item	What good looks like
⚠ **Medication reconciliation** the highest-risk step	**Compare the discharge list against the pre-admission list, drug by drug**, and account for every difference: started, stopped, dose changed, or unchanged. **State the reason for each change in the summary.** The classic harms are a home medication silently omitted, a temporary inpatient drug continued forever (proton pump inhibitors and antipsychotics are the usual offenders), and a **duplicate under a different brand name**
Follow-up that exists	**Make the appointment before the patient leaves**, with a date, time and place on the paperwork, rather than telling them to call. Aim for **within 7 days for high-risk patients** and sooner after heart failure or a complex medication change. **An instruction to arrange follow-up is not follow-up**
Pending results have an owner	**List every test still pending and name who will act on it.** Results returning after discharge are a well-documented source of missed diagnoses, because everyone assumes someone else is watching. Include cultures, histology and imaging not yet reported
The summary reaches the next clinician	**Complete it at discharge, not days later**, and make sure the primary care physician actually receives it. It must contain the diagnosis, what changed, the medication list with reasons, pending results, follow-up, and **what to do if things go wrong**
Red flags in plain language	**Specific, written, and in the patient's own language:** what symptoms mean call the clinic, what means come back immediately, and the phone number for each. "Come back if you feel worse" is not usable instruction

CONFIRM IT LANDED *understanding is the part that is assumed and rarely checked*

USE TEACH-BACK

"So I know I explained it clearly, can you tell me how you will take the new blood thinner?" Ask them to say it back **in their own words**, and re-teach whatever comes back wrong. **Framing it as checking your explanation rather than testing them** is what makes it acceptable to patients.

USE A PROFESSIONAL INTERPRETER

Never a family member for discharge instructions or consent. Provide written material in the patient's language and at an appropriate reading level, and check they can actually read it.

INCLUDE THE CAREGIVER

Whoever will actually manage the medications should be in the conversation, and often is not present on the ward round. Phone them if necessary. A perfect plan explained only to a delirious or exhausted patient will fail.

THE PRACTICAL BARRIERS *ask about these early, because they take days to solve*

Barrier	What to do
Can they afford it?	**Ask directly about cost and insurance coverage before choosing the drug.** A prescription that is never filled is the commonest silent failure of a discharge plan. Check formulary, consider a cheaper equivalent, and involve the pharmacist
Can they get it?	Transport home and to follow-up, a pharmacy that is open and reachable, and whether they can physically collect it. **Consider discharge with medications in hand where available**
Can they manage it?	Dexterity, vision, cognition and health literacy. Consider a **pill organizer, blister packaging or simplified regimen**. **Every additional daily dose reduces adherence**, so consolidate where clinically reasonable
Is home safe and adequate?	Stairs, bathroom access, who is there, and whether care needs exceed what is available. **Involve case management and physical or occupational therapy on the day of admission** if the answer is uncertain, since placement and home services take days to arrange and are the usual reason a medically ready patient stays
High-risk medications	**Anticoagulants, insulin, opioids and steroids** cause a disproportionate share of post-discharge harm. Confirm the patient can demonstrate injection technique, knows the monitoring plan, has the follow-up blood test booked, and **has naloxone where indicated**

WHO NEEDS EXTRA *target the effort where readmission risk is concentrated*

HIGHER-RISK PATIENTS

Prior admission in the past 6 to 12 months, which is the strongest single predictor, plus polypharmacy, heart failure, COPD, cirrhosis, cognitive impairment, frailty, limited social support, substance use and homelessness.

WHAT TO ADD FOR THEM

A follow-up phone call within 48 to 72 hours, pharmacist-led medication review, earlier clinic follow-up, home health, and a named point of contact. **Bundled interventions work better than any single element**.

BE HONEST ABOUT LIMITS

Not all readmissions are preventable, and some reflect disease progression rather than a failed discharge. **For a patient with advanced illness, the right plan may be a goals-of-care conversation and hospice referral** rather than a tighter follow-up schedule.

What the patient should physically leave with: a written medication list with the changes marked and the reasons given, the **date, time and place** of each follow-up appointment, prescriptions that can actually be filled, written red-flag instructions with the phone numbers to call, any equipment or supplies already arranged, and **the name of the condition they were treated for**. **Hand it over and walk through it rather than leaving it in a folder**, since paperwork given without explanation is rarely read.

PEARLS & PITFALLS

- **Start discharge planning on day one.** Ask on admission where the patient came from, who helps at home, and what would need to be true for them to go back. **The barriers that delay discharge are almost never medical**, and they take days to solve.
- **Do not discharge on a normal-looking morning without checking the trajectory.** A patient improving, eating, mobilizing and off oxygen is ready; a single reassuring set of vital signs is not the same thing. **Discharges late in the day and on Fridays carry more risk**, because follow-up and pharmacy access thin out.
- **Deprescribe deliberately at discharge.** Admission is the best opportunity to stop drugs that no longer help. **Document the reason for stopping**, or the next clinician will helpfully restart it.
- **Tell the patient the diagnosis in words they will repeat.** Patients frequently leave unable to say what they were treated for, which makes every later encounter harder. **Write it down, plainly, at the top of the paperwork.**

References: Project RED (Re-Engineered Discharge) and Project BOOST transition-of-care toolkits · Agency for Healthcare Research and Quality guidance on medication reconciliation and teach-back · published evidence on post-discharge follow-up and readmission reduction bundles.

Educational aid; verify against current guidance and local policy.