Discharge Planning and Discharge Overview

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While admitted, a patient receives care until they are Ready for Discharge. A patient may require support and communication with their extended health network, this process is generally referred to as *Discharge Planning*.

Recording a planned discharge

Main article: Admission.

During the pre-admission/admission process, the **Planned Date of Discharge** or **Length of Stay** can be entered.

For Day Surgery locations, the system calculates the planned date as the **same day.**

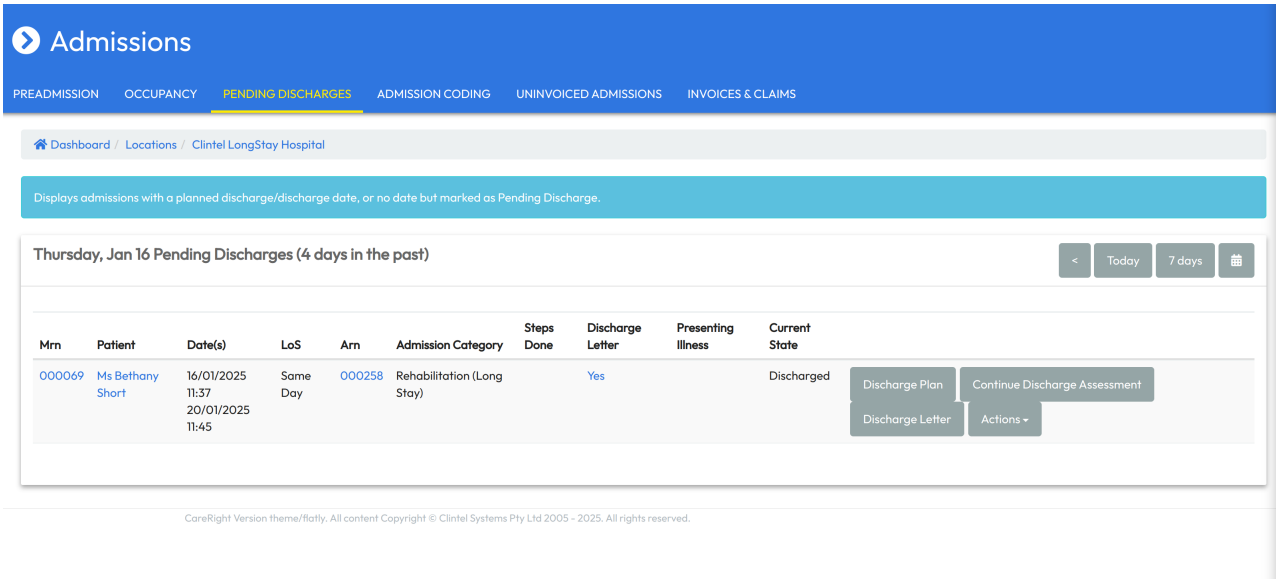
For General Hospital locations, the system assumes and prompts for a **length of stay**.

See planned discharges at this location

Discharge planners can access the **Pending Discharges** screen for their location.

This screen displays:

- Any admission with a planned discharge date matching your search criteria, that is not discharged, cancelled, etc.
- Or any admission marked as pending discharge, with no planned discharge date or discharge date set.



This requires at a minimum *admission viewer* rights.

Start the discharge process for an individual patient

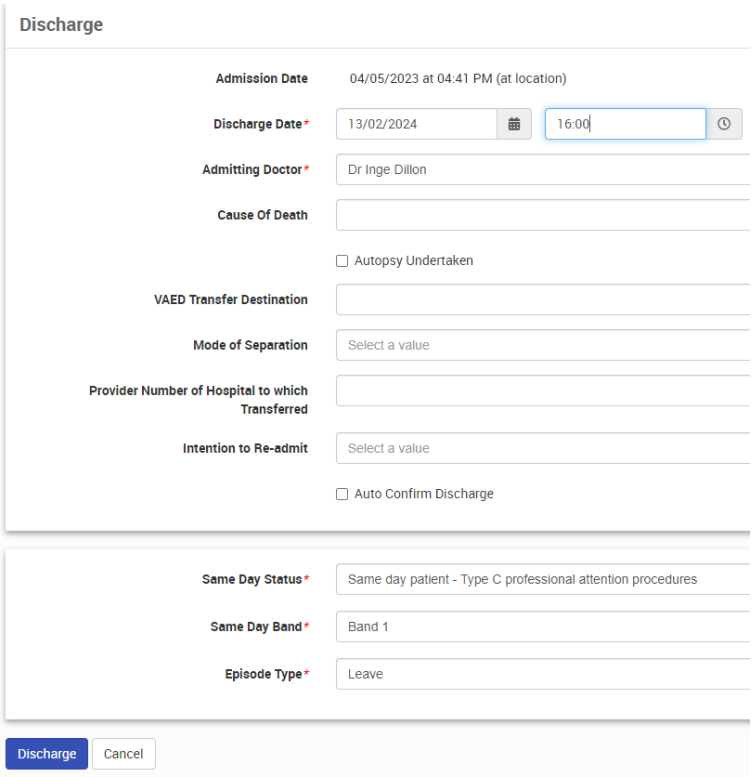
How to Discharge a Patient

Discharge refers to patients who have completed their admission. Discharge may also be referred to as “separation”. Discharge are administrative and mainly used for statutory reporting purposes.

1. From a Patient Admission, select the **Discharge** button.
2. Check details and edit discharge date/time as required.

3. Select a Discharge Diagnosis - Mandatory field.
4. Select a Discharge Status – Mandatory field.
5. Select a Discharged to – Mandatory field.
6. Discharge letter will be ticked if you have created a discharge letter on the Discharge Planning page.
7. Check the Confirm discharge box if the discharge is definite or has already occurred.
8. Select **Discharge** button.
    a. **Note**: On discharge, the QHAPDC Standard Unit Code will display the admitting doctor's details.

Upon discharge a Patient Snapshot is taken - see section Patient Snapshot for more information.



Cancel Confirmed Discharge

See Cancel Patient Discharge.

Confirm Pending Discharge

See Confirm a Pending Discharge

Creating a Discharge Plan

Discharge planning is used to manage the client's discharge from the facility. This includes documentation summarising the care received, services required after discharge and transport from the facility to the discharge location. Discharge letters for clients can be based on pre-defined templates.

Edit the Discharge Plan

Clicking **Edit** allows you to edit the following fields:

Field	Description
Admission Date	Displays the current admission date
Planned Discharge Date	Use the date picker to enter the planned discharge date.
Discharge To	Select the proposed destination from the drop-down list.
Discharge Transportation	Select the transport required from the drop-down list
Discharge Plan	The text field provides a place to enter the specific discharge notes. This field is not visible when the client is NOT admitted.
Copy Discharge Plan To Clinical Notes	Ticking means that the plan will be copied to Clinical Notes upon saving.

When writing your Discharge Plan Using the Text Editor, under the Insert Menu you have some useful tools:

- Insert image
- Replacement Variable: Insert values from fields in the Patient record
- Insert Template: Commonly used blocks of text, letters, templates can be added
- Insert Date / time
- Attachment: insert any file (PDF, image, zip) into the clinical note.

See Using the Text Editor for more details.

Discharge Letters

You can write a discharge letter for a patient using the **Discharge Letter** button.

If an admission is cancelled, any Discharge Letters that are in draft format will be deleted. See Correspondence → Letters for details on creating letters.

If enabled, the My Health Record & Health Identifiers Service Integration will allow you to upload this to a Patient's My Health Record.

Support Services Required

Provides a simple check list to record the client's discharge requirements for Support Services.

Fields available:

Field	Description
Service Required	Code of the service required
Description	Description of the service required
Notified	Check box to denote a service has been notified
Links	
Edit	Click to edit and check or uncheck "Notified"
Delete	If a service is not required use the delete link to remove

Add a Support Service

1. Click **Create New.**
2. Select the service required from the drop down list.
3. Add a Description.
4. If service has been notified click the notified box.
5. Click C**reate Requirement.**

Other Requirements

Provides a simple check list to record the client's other discharge requirements e.g. equipment (Note: only visible if a client

has been admitted).

Fields available:

Field	Description
Other requirement	Code of the other requirements
Description	Description of the other requirements
Notified	Check box to denote a service has been notified
Links	
Edit	Click to edit and check or uncheck “Notified”
Delete	If a service is not required use the delete link to remove

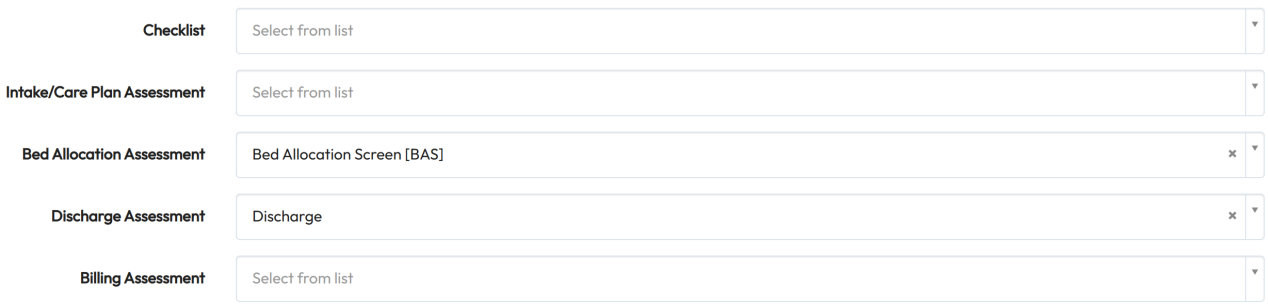
Add Other Requirements

1. Click **Create New.**
2. Select the service required from the drop down list.
3. Add a Description.
4. If service has been notified click the notified box.
5. Click **Create Requirement.**

Discharge Assessments

CareRight supports extending the core Discharge Plan functionality with a Discharge Assessment.

This can be configured by system administrators by Configuring Admission Categories.



When configured, various CareRight screens will present *Discharge Assessment* controls, allowing you to start or continue your discharge processes.

Discharge Letters

A Discharge Letter is similar to standard Correspondence, but can be initiated from the Discharge Plan or your customised Discharge Assessment.

These may be:

- Sent via Secure Messaging or other means
- Uploaded to My Health Record

Administrative discharges

Where you have performed an Administrative Admission, a corresponding Administrative Discharge is possible.