Typical Failures in Discharge Planning

Comprehensive Discharge Planning

- Failure to actively include the patient and family caregivers in identifying needs and resources and planning for the discharge.
- Lack of understanding of the patient's physical and cognitive functional health status that may result in a transfer to a care setting that does not meet the patient's needs.
- Not addressing the whole patient (underlying depression, etc.).
- No advance directive or planning beyond do-not-resuscitate status.
- Assuming the patient is the key learner and not including the family or a caregiver.
- Not reinforcing the need to make and keep a follow-up appointment and/or not scheduling a follow- up appointment for the patient.
- Written discharge instructions that are confusing, contradictory to other instructions, or not tailored to a patient's level of health literacy or current health status.
- Poor understanding by providers that the patient's social support is lacking.
- Lack of an emergency plan, including telephone number the patient should call first.
- Patient returns home without essential equipment (e.g., scale, supplemental oxygen).
- Lack of referral to community resources that can address social determinants of health.

Medication Management

- Medication errors and adverse drug events as a result of incomplete or inaccurate medication history.
- Multiple medications are exceeding the patient's ability to manage them all.
- Medication reconciliation does not align with medications patient is taking when patient arrives home.
- New medications not available on discharge; patient may have difficulty filling prescriptions in a timely manner (e.g., financial limitations or lack of transportation).

Patient and Family Engagement

- Failure to actively include the patient and family caregivers in identifying needs and resources and planning for the discharge.
- Unrealistic optimism of patient and family to manage at home.
- Lack of understanding of the patient's physical and cognitive functional health status that may result in a transfer to a care setting that does not meet the patient's needs.
- Multiple medications that exceed the patient's ability to manage them all.
- Patient/family failure to ask clarifying questions on instructions and plan of care, and teach-back not utilized to validate understanding.
- The care provided by the facility unravels as the patient leaves the hospital (i.e., poorly understood cognition issues emerge).
- Multiple care providers; patient believes someone is in charge.
- Patient lack of adherence to self-care (e.g., medications, therapies, daily weights, or wound care) because of poor understanding or confusion about needed care, transportation, how to schedule appointments, or how to obtain or pay for medications.

Transition Care Support

- No follow-up appointment scheduled or not knowing who to follow up with when there are multiple providers.
- No follow-up phone call from the discharging organization within the first few days after discharge (reinforce follow-up appointment, ensure medications are filled, answer questions about discharge instructions).
- Follow up is seen as solely the responsibility of the patient.
- Patient's inability to keep follow-up appointments because of illness, financial limitations, or transportation issues.
- Lack of an emergency plan, including the telephone number the patient should call first.
- Lack of referral to community resources that can address social determinants of health.
- Social risk factors that further influence discharge failures, include lack of insurance, homelessness, low income, lack of primary care, lack of transportation, and lack of access to nutritional foods.

Transition Communications

- Failure to use standard transition tools, with critical information missing.
- Medication discrepancies and lack of one current medication list.
- Discharge plan not communicated in a timely fashion or does not adequately convey important anticipated next steps.
- Poor communication of the care plan to the hospital team, nursing home team, home healthcare team, primary care physician, or family caregiver.
- Current and baseline functional status of patient rarely described, making it difficult to assess progress and prognosis.
- Discharge instructions missing, inadequate, incomplete, or illegible.
- Patient returning home without essential equipment (e.g., scale, supplemental oxygen).

Sources

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