

## UC TW Discharge Workflow

“DCHG” or “PDCH” milestones placed by provider

Nurse reads DC summary

Nurse changes milestone to “NDIP”

Physical DC of patient from UC

Ensure chart complete & finalized, change milestone to “Nurse Discharge”

### Summary for Completing a DCHG or PDCH milestone

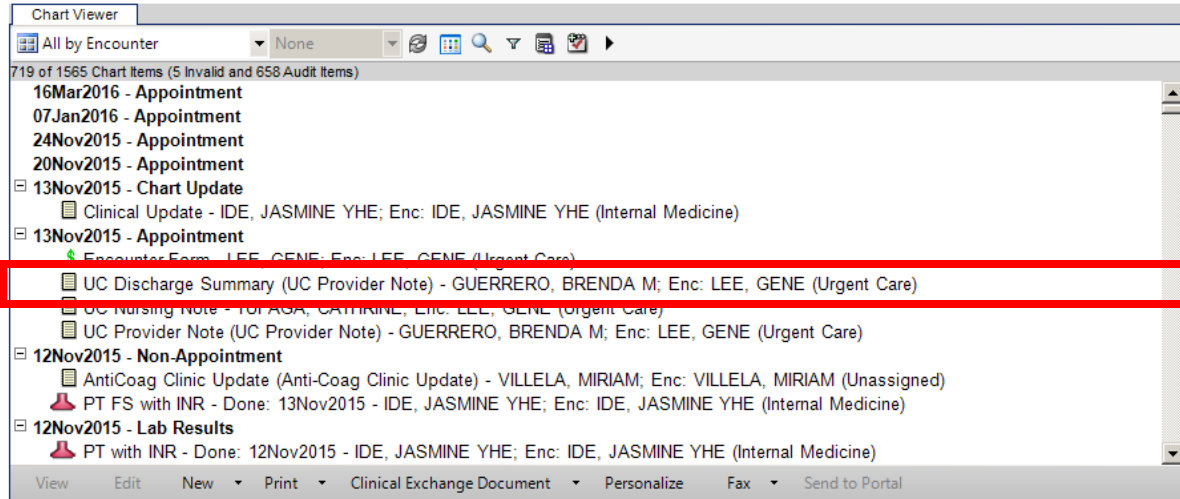
1. Provider changes status to “DCHG” or “PDCH” on tracking board. This signals that the patient is ready to be discharged (DCHG) or has already been discharged (PDCH)
2. Change Status in Tracking Board to: “NDIP” (Nurse Discharge in Progress)
3. Locate the Discharge Summary in the 3<sup>rd</sup> quadrant of the chart or “chart viewer”
4. Review Discharge summary, nurse orders, prescriptions and work note
5. Complete any outstanding orders, Print DC Summary

Status								Comments
NDCH								dc>>bh
NDCH								
XRB			C					pt in podiatry
<b>NDIP</b>			C	O		O		REQ DR. CHAN, XRB 1345
NDCH		O	C	I				
NDCH		O	C	I		C		strp neg

# Discharge Workflow

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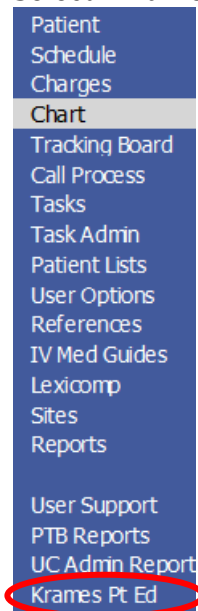
6. Print patient education material and work note if applicable.
7. Physically DC your patient.
8. Finalize nursing documentation and charges
9. Change milestone on tracking board to NDCH & change location to “HM” for home



## Details for Completing a DCHG or PDCH milestone

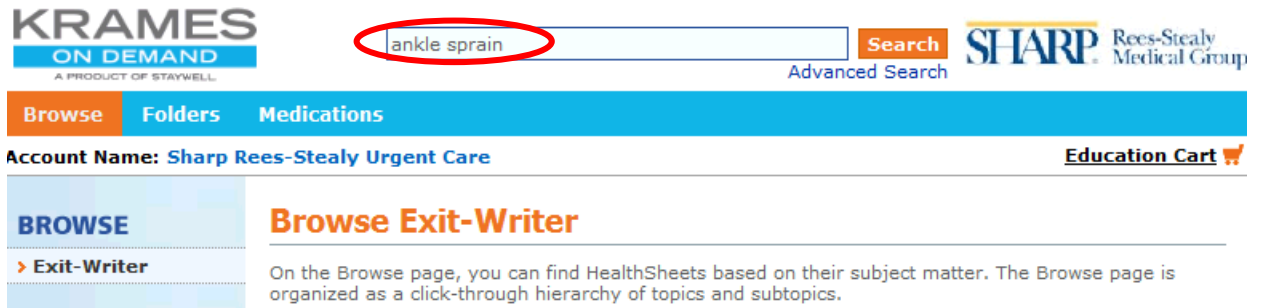
### Creating Patient Education Material

- 1) Select “Krames Pt Ed” from the VTB



- 2) In the search box, enter the provider’s DC diagnosis OR instructions that provider wants you to give patient (i.e. – ankle sprain)

# Discharge Workflow



**KRAMES**  
ON DEMAND  
A PRODUCT OF STAYWELL

ankle sprain Search  
Advanced Search

**SHARP** Rees-Stealy Medical Group

Browse Folders Medications

Account Name: Sharp Rees-Stealy Urgent Care Education Cart

**BROWSE**

> Exit-Writer

**Browse Exit-Writer**

On the Browse page, you can find HealthSheets based on their subject matter. The Browse page is organized as a click-through hierarchy of topics and subtopics.

- 3) Click the “Search” button
- 4) From the “Search Results” screen, simply select the instructions from the list, click on the drop downs under the “Action” section then click “Go”.

## Search Results



**Action**

Print Larger Spanish English Exclude Go

Actions Text Size Language Print Duplicate Transcripts

Results Returned: Showing 77 of 77 documents for search term 'ankle sprain'

Exit-Writer (77)

<input type="checkbox"/>	Document Name	Languages
<input type="checkbox"/>	Sprain, Ankle, No X-Ray	EN, SP
<input type="checkbox"/>	Sprain, Ankle, No X-Ray (Child)	EN, SP
<input checked="" type="checkbox"/>	Sprain, Ankle, with X-Ray	EN, SP, AA, CH, FR, PL, RU, TA, VI

**\* DOUBLE CHECK ORDERS & MEDS TO ENSURE COMPLETION BEFORE DISCHARGING PATIENT \***

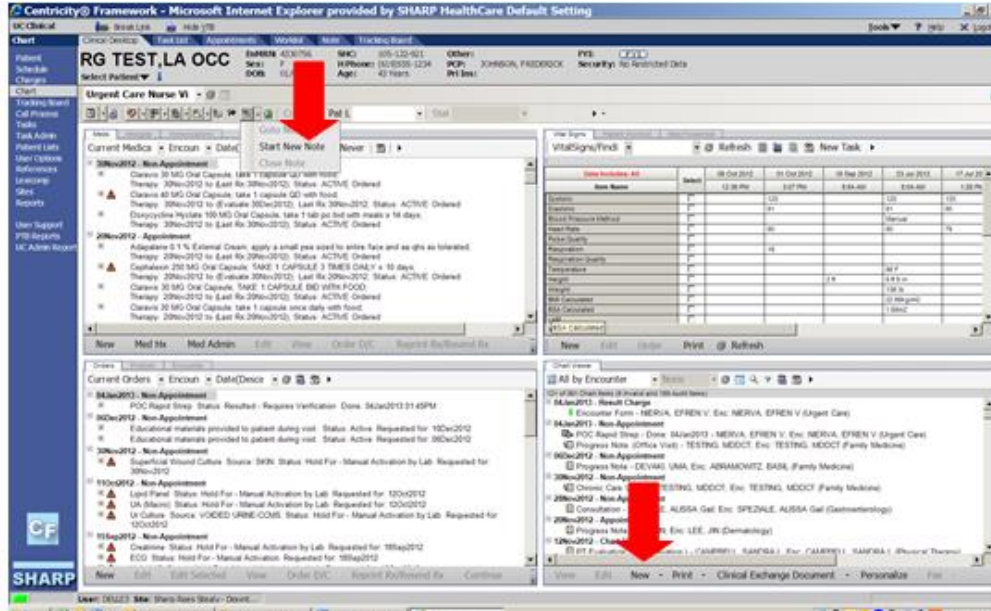
## Other Patient Education Resources

- 1) Click on “Lexicomp” from the vertical toolbar in TW

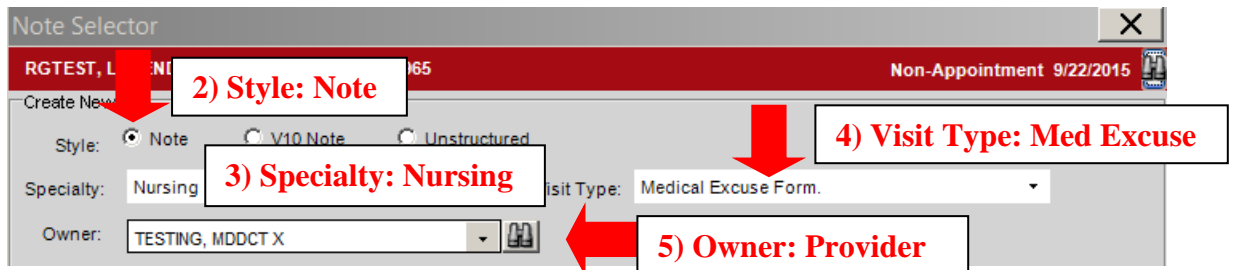
## Creating a Medical Excuse Form

- 1) Click New Note (2 different ways shown below)

# Discharge Workflow



- 2) Style: Note
- 3) Specialty: Nursing
- 4) Visit Type: Medical Excuse Form
- 5) Owner: Provider Seeing Patient
- 6) Click OK



- 7) The “Note Authoring” Window will pop up.
- 8) Choose appropriate in the “Work Note” section. Example provided below:

# Discharge Workflow

The screenshot shows a medical software window titled 'Medical Excuse Form'. The patient information at the top reads 'RGTEST, LAVENDER 50 YO M DOB: 10Dec1965' and the date is '9/22/2015'. The form is divided into several sections: 'Medical Release Form' with radio buttons for 'Patient Seen Today' and 'Patient Seen Other Date'; 'Work/School Excuse' with checkboxes for 'Medically Excused from Work/School', 'May Return to Work/School w/Limits', and 'May Return to Work/School', each with an 'Eff Date (Today)' field and an 'OI' checkbox; and 'PE/Sports Excuse' with similar checkboxes and fields. A 'Status: Needs Input' indicator is visible in the top right corner of the form area.

9) Sign → Change Sig Type to “Co-Author” (so provider will sign) → Click OK

The 'Note Signature' dialog box contains the following fields and options:

- User Name:
- Password:
- Sig Type:
- Make Final

Carbon Copy Recipients:

Recipient Name	Role	Note Output
There are n		

Buttons: OK, Cancel

10) If document does not auto print, in Chart Viewer, Click on “Medical Excuse Form” under today’s date.

11) Right Click → Print → Selected

# Discharge Workflow

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Work note will look like this:



## Medical Excuse Form.

**Name:** RGTEST, LAVONNE  
**MRN#:** 4553246

**DOB:** 02/05/1968  
**Gender:** F

**Date of Encounter:** 10/28/2015

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### Medical Excuse Form

LAVONNE RGTEST was evaluated and treated on 02/12/2016.  
She is medically excused from work/school effective 02/12/2016 .  
Expected return to work/school 02/15/2016.

### Signatures

Electronically signed by : LESLIE DELACRUZ, RN; Feb 12 2016 5:35PM PST (Co-author)

## Some Clarifications Regarding DC Summary:

- 1) **Patient is verbal discharge:** The DC summary may show up in the clinical note section. The provider has to activate the summary in order for it to populate in Follow My Health. No action required for the nurse.
- 2) **DCHG in status column of tracking board & summary present in notes section at time of DC:** This is the only time the nurse needs to print DC summary. Print both summary & patient education instructions if indicated on the summary.
- 3) **DCHG in status column of tracking board & no summary:** Look for an order that needs to be implemented or a prescription which needs to be given to the patient.

**Now that you've given all the information to your patient,  
physically walk / push wheelchair out of the department.**

## Now, you can complete your nurse's note:

1. In the note section, click on "UC RN Disposition"

## Discharge Workflow

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The screenshot shows a mobile application interface for a 'Note'. At the top, there is a 'Note' tab, a dropdown menu set to 'UC Nursing Note', a refresh icon, and an 'INACTIV' button. Below this is a list of categories, each with a square icon to its left. The categories are: Travel Screening (with sub-item 'UC RN Travel Screening'), Reason For Visit (with sub-item 'Reason for Visit'), Contraception (with sub-item 'Contraception SRS UC'), Allergies (with sub-item 'Current Meds'), Med/Allergy History (with sub-item 'Med Allergy History SRS'), Vitals, Nursing Documentation (with sub-item 'UC RN Nursing Document'), Communicable Disease (with sub-item 'Communicable Disease S'), Education (with sub-item 'Patient Education SRS UC'), Disposition (with sub-item 'UC RN Disposition' highlighted in blue), Plan (with sub-item 'UC Plan (Clinical Summar'), Results/Data (with sub-item 'UC Results'), Audit Details, and Signatures.

2. Select how the patient was discharge by clicking on one of the radio buttons (in this example, we will choose “Nurse Discharge”.)

The screenshot shows the 'Disposition' details window. At the top, there is a header 'Disposition' with a chevron icon. Below the header, there is a sub-header 'UC RN Disposition'. Underneath, there is a section titled 'Disposition' with four radio buttons: 'Nurse Discharge', 'Provider Discharge', 'Transport to Higher Level of Care', and 'Miscellaneous'. The 'Nurse Discharge' radio button is selected.

3. This will open the “Details” window; complete as applicable.

# Discharge Workflow

**Nurse Discharge**

Late Entry \_\_\_

First contact with patient

Patient home care instructions provided to  patient  parent  family

Prescription given to  patient  parent  family

Prescription sent electronically via Surescripts

Work note given to  patient  parent  family

School note given to  patient  parent  family

Verbalizes understanding  In no apparent distress

**Patient left**

ambulatory  via wheelchair  via ambulance

with family  family member to drive

SL flushed with 10mL of NS and intact

Comment: \_\_\_\_\_

Signature Stamp

Clear Spell Check OK Cancel

4. Click “OK” button when complete.
5. “Sign” the note. You will be the “Author” under Signature Type and check “Make Final”. Then click “OK”.

**Disposition**

Nurse Discharge

Communicable Disease

**Note Signature**

User Name:

Password:

Sig Type:

Make Final

Carbon Copy Recipients:

Recipient Name	Role	Note Output
There are n		

OK Cancel

**Output Template**

Output Template	CC
<input checked="" type="checkbox"/> UC Nursing Note	

Patient home care instructions provided to patient

Prescription given to patient

School note given to patient

Verbalizes understanding

Patient left ambulatory

**Plan**

Recompile  Spell Check Copy Forward Show Uncopied Form Data Security Codes Save & Close Save Close



## Discharge Workflow

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6. Finally, change the milestone on the tracking board to NDCH and change location to “HM” for home.