SOP	Discharge of Patient from a Nursing Department				
All staff and Directors		Effective Date	Jan 2024	Compiled by	Anneline van Dyk
		Revision Date	Dec 2029	Approved by	Thuli Dlungwana
Reference	CH-SOP-NUR-002	Version	1.0	Approver's signature & designation	 Chief Operations Officer
		Page	1 of 2		

DISCHARGE OF PATIENT FROM A NURSING DEPARTMENT

1. SCOPE

The scope of this procedure covers the process to be followed and requirements to be met by the nursing department for the discharge of a patient from a nursing department as requested by the treating doctor. The patient will be discharged from the nursing department and the patient administration department will be informed of the patient's discharge and all relevant documentation will be send to the patient administration prior (if a private patient) or after discharge from the nursing department. This standard operating procedure applies to all Crestcare Hospitals.

2. PURPOSE

- To ensure the complete and safe discharge of a patient to home/rehabilitation or "step down" facility
- To ensure the patient/family have the relevant information regarding the patient 's illness/diagnosis, medication (if prescribed) and exercise or restrictions
- To ensure the patient has a follow-up appointment if indicated by the doctor and the arrangements are known to the patient/family

3. DEFINITIONS

- Registered Nurse is a person who is registered with SANC as a Registered Nurse (RN)
- Enrolled Nurse is a person who is registered with SANC as an Enrolled Nurse (EN)

4. METHODOLOGY AND PROCEDURES

- Ensure the patient has been discharged by the treating doctor, check with the registered nurse
- Inform the patient /relatives/place of care of the discharge of patient
- Arrange for the necessary follow up appointment (Personal assistant) as requested by the treating doctor prior to discharge
- Arrange with the family /relative/place of care with regards to the appropriate time for discharge and arrange transport accordingly
- Ensure patient's TTO (to take out medication) are sent for to the pharmacy if appropriate. Registered or Enrolled nurse needs to explain indications and dosage of medication to the patient/family
- Wound dressings and/or removal of stitches/clips/drains are done as per doctor's orders prior to discharge and documented in nursing notes
- Assess IV infusion site and remove IV cannula prior to discharge
- Assess skin integrity if indicated (high risk patients) and documentation done
- Return patient's valuables (if appropriate) and document
- Inform the patient/relatives on medication, diet, wound care, follow up appointment etc. on discharge
- Assist patient/family in collecting and packing the patient's personal belongings
- X-ray's and other relevant documentation to be handed to the patient/family

- If the patient is discharged to another health care facility, ensure transfer letter is done and a copy is handed to the person transporting the patient
- Ensure patient signs the discharge document
- Assist patient to leave ward e.g. by wheelchair
- Document discharge with relevant details i.e. how the patient left the department, condition on discharge, medication/prescription, wound and intravenous site.
- Discharge the patient from the SAP system, monitor (if indicated - ICU and high care) and from the patient register. Compile the complete documentation in the patient file and send to the patient administration department
- All bed linen must be removed after the patient left the department and arrange for terminal cleaning of the patient area

5. CAUTIONS AND EMERGENCY STANDARD CARE

None

6. RESPONSIBILITY AND AUTHORITY

- The doctor requesting the discharge of the patient
- The Registered Nurse in charge/team leader
- The nurse discharging the patient

7. DOCUMENTATION

- Patient's hospital file
- Nursing and medical documents generated during the hospitalization period
- Admission and discharge document (as per system)

8. REFERENCES

None

9. APPENDICES

None