

Mental Health – Discharge Process and Documentation for Nurses

This document details the Mental Health Discharge process and documentation for Nurses. It begins when the Provider assesses the patient to be appropriate for transfer or discharge.

Discharge Process for Nurses

1. Review patient orders in Care Compass (your patient list).



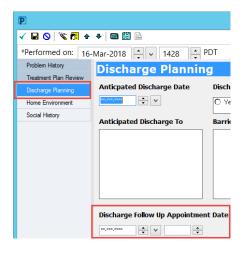
- Check for a Discharge Patient order
- If a patient is being discharged on Extended leave, check for a MHA Form 20 order
- 2. Ensure that the Discharge Medication reconciliation is completed by the Provider
- 3. Click the down arrow z to display 3 discharge documents from the Workflow **Discharge** tab of the Mental Health Summary page.

Select and update discharge documents.

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4. Document the **Discharge Follow Up Appointment Date** and any other relevant discharge in the **Discharge Planning** section of the **MH Treatment and Discharge Planning** PowerForm



5. Document pertinent discharge information in the **Discharge Needs Comments**.

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If required by your unit, complete the **Admission Discharge Outcomes Assessment** PowerForm accessed through **AdHoc** folder in the Organizer toolbar.

- 6. Update the Valuables and Belongings PowerForm as necessary.
- 7. Document on the Nursing Discharge Checklist tasks to be completed.



- 8. Document any additional patient information in a **Nursing Narrative Note** if needed. Ensure to re-name your note with the word "Discharge".
- 9. Complete additional discharge documents on paper as required by your site-specific workflow.
- 10. Review discharge documentation completed by the Provider and print a copy of the **Patient Discharge Summary** as required.
- 11. Upon leaving the unit, discharge the patient encounter via the **Discharge Encounter PM Conversation**. This may be completed by the Unit Clerk as well.

Related Topics

Inpatient and Mental Health - Transfer

Related Positions

Mental Health Nurse

Mental Health Nurse Supervisor

Unit Clerk

Key Words

Discharge