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Safe discharge after short admission Initial assessment

Nursing Foundation | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

56-year-old man recovering from a minor medical illness. Care stage: At the first supervised assessment.

Medical history: The acute medical problem has been clinically reviewed for discharge. The patient has an updated medicine list but is unsure which previous products were stopped. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The patient wants to regain the usual level of independence. Review available support, daily activities, treatment access and preferred language rather than assuming these are the same for every person.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Unsure which medicines to continue and how to arrange follow-up.

Objective findings and required checks: Clinically reviewed for discharge; medicine list and home support need verification.

Physical examination and investigations: Check readiness, medicine reconciliation, function, transport, access and understanding.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Safe discharge after short admission: Transitions between services can create information gaps and medication errors.

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Medical / surgical management

Coordinate an accessible written plan, teach-back, follow-up and communication with the next service.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Reconciled discharge medicines	Continue only the authorized plan	Confirm indication, schedule, changes and access
pharmacist review	Resolve discrepancies	Document clarified instructions.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Unsure which medicines to continue and how to arrange follow-up. Clinically reviewed for discharge; medicine list and home support need verification. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize learning needs about the condition and care plan; difficulty sustaining the agreed treatment plan; daily self-care needs exceed current ability; emotional distress affecting participation in care. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Coordinate an accessible written plan, teach-back, follow-up and communication with the next service. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. Coordinate an accessible written plan, teach-back, follow-up and communication with the next service. Rationale: Transitions between services can create information gaps and medication errors. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about missed treatment, side effects, cost and	Difficulty sustaining the agreed treatment	Short-term: After the first indicated intervention, at the	1. Explore the reason for difficulty before suggesting solutions. Rationale: Different barriers require different	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
beliefs without blame. Assess: Review the medication list, refill access and ability to follow instructions.	plan. Possible factors: treatment burden, access barriers or uncertainty. Validate against the patient's assessment.	documented review time: Identifies one practical barrier and agrees on a feasible solution. Longer-term: Before the clinically approved transition or agreed follow-up: Has an affordable treatment and follow-up plan verified with the team.	responses. 2. Reconcile medicines and involve pharmacy or community services when needed. Rationale: A simpler, accurate plan can reduce avoidable errors. 3. Agree reminders, support and follow-up using shared decision-making. Rationale: Plans are more sustainable when they fit the person's circumstances.	finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask which activities the person can do and where help is wanted. Assess: Assess personal-care tasks, cognition, mobility and available support.	Daily self-care needs exceed current ability. Possible factors: weakness, symptoms or reduced confidence. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Completes a chosen self-care activity with the agreed level of assistance. Longer-term: Before the clinically approved transition or agreed follow-up: Patient or caregiver demonstrates essential care skills and knows support options.	1. Assess ability task by task and respect preferences and privacy. Rationale: Specific assessment prevents unnecessary dependence. 2. Provide only the assistance required and use suitable aids. Rationale: Supported participation protects dignity and builds independence. 3. Teach caregivers with consent and confirm realistic support at home. Rationale: Continuity depends on available skills and resources.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage	Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or	Short-term: After the first indicated intervention, at the documented review time: Identifies one immediate concern and participates in an agreed next step.	1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
without making assumptions.	unfamiliar treatment. Validate against the patient's assessment.	Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care.	checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance.	met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

Have the patient explain medicines, warning signs, contact arrangements and next appointment.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

New symptoms or failure to meet discharge criteria requires reassessment before leaving.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Transitions between services can create information gaps and medication errors.

- Priority concerns: Learning needs about the condition and care plan; Difficulty sustaining the agreed treatment plan; Daily self-care needs exceed current ability; Emotional distress affecting participation in care.

- New symptoms or failure to meet discharge criteria requires reassessment before leaving.

- Have the patient explain medicines, warning signs, contact arrangements and next appointment.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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