Nurses Content
Downloaded from nursescontent.com



# Safe discharge after short admission Response monitoring

Nursing Foundation | Response monitoring

**For educational purposes only.**

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: During review after prescribed initial care.

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 team requests a clear account of changes after the prescribed care, rather than a statement that the patient is simply better.

## 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.



Nurses Content For educational purposes only. 1 / 7

Nurses Content
Downloaded from nursescontent.com



## 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 team requests a clear account of changes after the prescribed care, rather than a statement that the patient is simply better.

### 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

At the next scheduled reassessment, with its interval chosen for acuity: 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. Compare the current assessment with the documented baseline and identify benefit, harm or lack of response. 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.



Nurses Content For educational purposes only. 2 / 7

Nurses Content
Downloaded from nursescontent.com



# 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: Compare the current assessment with the documented baseline and identify benefit, harm or lack of response.

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: At the next scheduled reassessment, with its interval chosen for acuity: 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: At the next scheduled reassessment, with its interval chosen | 1. Explore the reason for difficulty before suggesting solutions. Rationale: Different barriers require different | Record the baseline and reassessed |



Nurses Content For educational purposes only. 3 / 7

Nurses Content
Downloaded from nursescontent.com



| 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. | for acuity: 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: At the next scheduled reassessment, with its interval chosen for acuity: 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: At the next scheduled reassessment, with its interval chosen for acuity: Identifies one immediate concern and participates in an agreed next step. Longer-term: | 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 |



Nurses Content For educational purposes only. 4 / 7

Nurses Content
Downloaded from nursescontent.com



| 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. | 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. |



Nurses Content For educational purposes only.

Nurses Content
Downloaded from nursescontent.com



## 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 observations demonstrate response, and which findings would require revising or stopping the current intervention?**

## References

Nursing Fundamentals, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2024
https://wtcs.pressbooks.pub/nursingfundamentals/

Nursing Pharmacology, 2e - Ernstmeyer & Christman (editors), Open RN / WisTech Open, 2023
https://wtcs.pressbooks.pub/pharmacology2e/

B.Sc. Nursing curriculum and regulatory notifications - Indian Nursing Council
https://www.indiannursingcouncil.org/gazette-notification

Original cases and care-plan wording by Nurses Content. Linked sources support further study; source terms and local clinical requirements apply. Prepared 23 November 2026. Not independently clinically peer reviewed.



Nurses Content For educational purposes only. 6 / 7

Nurses Content
Downloaded from nursescontent.com



## Rights and reuse

Delivered by Nurses Content. Copyright claims apply only to original material owned by its authors. Medical facts, statutory exceptions and third-party/open licence rights remain unaffected. See the website's /policies/reuse/ page for terms.



Nurses Content For educational purposes only. 7 / 7