Discharge Case Presentation and Counselling

Experiment 5 - Practical Notes

Name: _____ Roll no.: _____ Date: _____

Aim

To present an allocated completed case and review the discharge medicine plan.

Principle

A discharge presentation explains the clinical course and pharmacy contribution. A reconciled plan and patient understanding support continuity of care.

Requirements

- Allocated clinical notes or fictional case, current approved medicine information and local clinical policy.
- Case-record form, calculator where needed and supervising pharmacist.

Procedure

1. Prepare the case

Use the allocated clinical record or a fictional teaching case. Record a case code, setting and date; exclude names and personal identifiers.

2. Assess the required information

Confirm admission-to-discharge medicine changes; discharge orders and intended durations; follow-up appointment/monitoring; patient understanding and practical barriers. Note missing information explicitly.

3. Develop the pharmacy assessment

Present the initial problem, major findings, treatment course, pharmacy issues and outcome. Compare pre-admission, inpatient and discharge lists. Explain the authorised discharge medicines in plain language and ask the patient to explain the plan back. Document unresolved discrepancies and the follow-up owner.

4. Discuss and document

Present the assessment to the supervising pharmacist or treating team. Record the accepted action, responsible person and intended follow-up.

5. Evaluate the outcome

Review the agreed clinical or process endpoint. Record what changed, what remained unresolved and the next step.

Observations and Record

Record component	Student entry
Coded case and date	_____
Presenting problem and diagnosis	_____
Allergies / previous medicines	_____
Relevant clinical and laboratory findings	_____
Pharmacy problem and priority	_____
Proposed plan and monitoring	_____
Supervisor decision and follow-up	_____

Result

Assessment: ____. Proposed action: ____. Supervisor decision: ____. Follow-up outcome: ____.

Precautions

- Use the treating team and current patient-specific information for all actual medicine decisions.
- Maintain confidentiality and confirm allergy, medicine and timing information.
- Do not invent patient observations, acceptance of an intervention or follow-up outcomes.

Viva Questions and Answers

1. Why reconcile at discharge?

Intentional changes must be distinguished from unintended omissions or duplications.

2. What is teach-back?

Asking the patient to explain the plan in their own words so the explanation can be improved if needed.

Disease-area Checklist

Area	Topics	Assessment focus
Gastrointestinal / liver	Peptic ulcer, reflux, inflammatory bowel disease, alcoholic/viral liver disease, jaundice and drug-induced liver disorders.	Symptoms, liver-function context, bleeding risk, interacting medicines and monitoring.
Haematology	Anaemia, venous thromboembolism and drug-induced blood disorders.	Blood-count trend, bleeding/thrombosis context and medicine-related risks.
Neurology	Epilepsy, Parkinsonism, stroke and Alzheimer disease.	Functional status, adherence, adverse effects, swallowing/device needs and relevant monitoring.
Psychiatry	Schizophrenia, affective/anxiety/sleep disorders and obsessive-compulsive disorder.	Treatment goal, mental/functional status, adverse effects, interactions and safe follow-up.
Pain / evidence	Pain pathways, neuralgias and headaches; evidence-based medicine.	Pain and function goals, cause, medicine exposure, patient preferences and quality of evidence.

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