OTHER (DISCHARGE)

SPECIFIC QIP	QIP ACTIONS	WHAT WILL IMPROVE?	TIMELINE
Before you left hospital, were you given any written or printed information about what you should or should not do after leaving hospital?	• Development of Discharge Information Leaflet which will help patients understand the discharge planning process and what to expect while in Louth County Hospital and points of contact upon discharge. It will include information on: **Home Care Package;** The Discharge Coordinator will follow up with the local Home Supports Office to receive updates on the requested package of care. – This update is communicated to the nurses on the ward. – When a client is discharged home from the hospital, a referral is sent to the public health nurse in their area, to advise of your hospital admission and any follow-up care required. **Long term care;** If you or a family member require long term care ie, nursing home placement, the process will continue on transfer to Louth County Hospital, with the assistance of the Discharge Coordinator or Medical Social Worker. – The Discharge Coordinator will advise you, family and staff members of the date and time of discharge – Prescription and supporting discharge documentation will be completed by the hospital and sent to the nursing home.	• Communication with patients and families. • A transparent discharge from a patients perspective.	Q2 2025