

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.

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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.

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Area	Topics	Assessment focus
Cardiovascular	Hypertension, heart failure, angina, myocardial infarction, hyperlipidaemia and arrhythmias.	Indication, vital-sign trend, volume status where relevant, ECG/laboratory context, adverse effects and monitoring.
Respiratory	Pulmonary-function interpretation, asthma, COPD and drug-induced pulmonary disease.	Symptoms, exacerbations, device technique, adherence and response/adverse-effect monitoring.
Endocrine	Diabetes, thyroid disease, contraception, hormone replacement and osteoporosis.	Relevant laboratory trend, comorbidities, patient-specific risks and correct medicine/device use.
Special populations	Paediatrics, geriatrics, pregnancy and breastfeeding.	Age/weight where required, organ function, pregnancy/lactation context and authorised patient-specific information.
Ophthalmology	Glaucoma and viral/bacterial conjunctivitis.	Diagnosis, correct eye-product technique, contamination prevention and specialist follow-up.

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