

Post-discharge Communication Gap Map

Use this map when a wound-care responsibility moves from hospital discharge into a receiving care team.

Field	Use / Options
Receiving setting	Hospital to care home / Hospital to home care / Day surgery / Rehab transfer / Other
Record point	At discharge / First receiving shift / First dressing change / Before follow-up
Anonymous case ID	No name, no medical record number
Completed by	Discharge coordinator / Nurse / Care manager / Family contact / Reviewer

Is this discharge information clear?	[]	Common communication gap	[]	One communication action	[]
Wound-care instruction received	[]	Discharge note not linked to daily care	[]	Confirm daily observation owner	[]
Dressing or covering context clear	[]	Family message not entered into record	[]	Confirm follow-up contact	[]
Follow-up date clear	[]	Task written without context	[]	Add family message to handover	[]
Who to contact is clear	[]	No follow-up owner	[]	Put follow-up date in the same record	[]
Daily observation owner clear	[]	Warning concern unclear	[]	Summarize one wound question	[]
Escalation concern route clear	[]	No review question prepared	[]		

Final handover output	Use in 3 minutes	Do not record
One question the receiving team must clarify 	1. Choose the care setting. 2. Tick the main context. 3. Tick one gap or change. 4. Choose one next action.	No patient name. No medical record number. No diagnosis. No outcome claim.

Boundary: this worksheet supports workflow documentation and handover preparation. It does not diagnose, prescribe treatment, compare clinical outcomes, or replace professional assessment.
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