

PROTOCOL FOR: Discharge From Emergency Department

PURPOSE: To outline a standard by which Emergency Department staff will facilitate patient discharge from Emergency Department.

POLICY: All Emergency Department patients will receive written discharge instructions signed by the Emergency Department Attending. The nurse will have the patient sign or initial the bottom of the abbreviated discharge sheet under "patient signature" to show that the instructions have been received and understood. The RN/LPN sign as witness. The patient receives a detailed copy. The signed form will be scanned into the computer.

DESIRED OUTCOME: ED patients will receive and comprehend their written discharge instructions upon discharge from the ED.

IMPLEMENTATION

- PROCESS:
1. All patients will receive an Emergency Department Discharge Instruction Sheet informing the patient of the nature of the illness or injury and the treatment given signed by the Emergency Department attending. Precise instructions on medications, procedure to be followed at home, and problems which may occur should be given. Elicit from the patient an understanding of the written discharge instructions given.
 2. The patient should be informed as to whether or not further care is necessary and how to obtain that care. Follow-up care includes private physicians, hospital facilities and specialty clinics. Whenever possible, an appropriate follow-up appointment is made for the patient.
 3. The nurse will ascertain any problem the patient may have in implementing his/her instructions. Frequent problems encountered are transportation, social factors and supplies.
 4. The nurse will facilitate the resolution of problems by contacting the appropriate departments. Frequent consults include referral to: 1) Case Manager, 2) Social Services and 3) Physical Therapy. These departments can be very helpful in arranging referrals to the many agencies that offer varied services in the community.
 5. Patients are responsible for having their own prescriptions filled.
 6. The nurse will ensure that no patient leaves the Emergency Department by him/herself unless it is safe to travel unaccompanied. This is especially important when a patient has received medications which may effect mental or physical status. Transfer home with family or friend is the usual method of transport in this case.

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7. The patient will be provided with a follow-up contact phone number. The nurse will encourage the patient to feel free to call the Emergency Department if any problems arise.
8. Upon discharge, Call Back Status will be initiated by MD/APRN/PA/RNs for follow up with patient.
9. Teaching and educational information will be given as appropriate.

- DOCUMENTATION:
1. Instructions on medications, treatments at home with restrictions, problems which may occur and follow-up care are documented and signed by the ED Attending on the Emergency Department Discharge Instruction Sheet.
 2. The patient's signature and witness signature are documented on the discharge sheet.
 3. Patient's response to discharge instructions is documented in the Emergency Department Record.
 4. Physicians must document all medications administered and prescriptions given on the Emergency Department Record.

APPROVAL: Nursing Standards Committee
Emergency Department Standards Committee

CREDENTIALS: RN, MD

EFFECTIVE DATE: 12/88

REVISION DATES: 1/95, 9/96, 10/97, 1/06, 9/08