Team Name: Critical Care and Medicine Team Lead: Regional Director -Acute Care Approved by: Executive Director-Mid	Reference Number: CLI.5110.PR.012 Program Area: Critical Care (ER, Observation, SCU) Policy Section: General
Issue Date: January 9, 2017 Review Date: Revision Date: August 13, 2018	Subject: Discharge Instructions: Emergency Department

PROCEDURE SUBJECT:

Discharge Instructions: Emergency Department

PURPOSE:

Effective communication is a critical element in providing safe patient care, including at end-of-service and/or with transition to community-based services. The *Discharge Instructions Record*: *Emergency Department* (CLI.5110.PR.012.FORM.01) captures relevant and comprehensive information to be provided to patients being discharged from the emergency department. Comprehensive information enhances continuity of care.

IMPORTANT POINTS TO CONSIDER:

It is recognized that there will be situations where exceptions to this procedure occur. Indicate the rationale for the exception in the patient's health record.

Providing discharge instructions to patient/designate is a shared responsibility between physician and nurse or other providers involved in the patient's discharge.

PROCEDURE:

1. When a patient is assessed as safe for discharge back to community from the emergency department, complete and review with the patient/designate the *Discharge Instructions Record: Emergency Department* or the printed *Emergency Department Information System (EDIS) Discharge* form.
2. The information includes but is not limited to:
   2.1. Summary of care provided;
   2.2. Recommendations for interventions addressing outstanding issues and to promote health;
   2.3. Follow-up appointments and referrals.

3. When documentation of care of the emergency patients is done with *EDIS,* generate the patient's copy of the discharge instructions using that system.
4. Provide patient/designate with the original *Discharge Instructions Record*: *Emergency Department* or a print-out from *EDIS*.
5. If a hard copy is used, place a copy of the *Discharge Instructions Record: Emergency Department* in the patient's hospital health record.
6. Indicate in the patient's health record if the patient was seen, assessed and discharged without nurse involvement.

Evaluation

Complete retrospective audits biannually on 10 charts at regional sites and 5 charts at the non-regional sites, using the *Discharge Instructions Record: Emergency Department Chart Audit* (CLI.5110.PR.012.FORM.02).

SUPPORTING DOCUMENTS:

CLI.5110.PR.012.FORM.01	Discharge Instructions Record: Emergency Department
CLI.5110.PR.012.FORM.02	Discharge Instructions Record: Emergency Department Chart Audit

REFERENCES:

Accreditation Canada. (2014). *Qmentum program: Standards, emergency departments.* Ottawa, ON: Author.