**PURPOSE:**

To provide guidelines for the use of the Patient Discharge (Home Care) Instruction Form *when needed for Downtime*.

**KNOWLEDGE BASE:**

1. Patients who are discharged from the hospital requiring nursing care, will receive instructions and individualized teaching prior to discharge. Evidence of the instructions and the patient's and/or significant other's understanding of these instructions should be noted on the Patient Discharge Instruction Form. NOTE: Discharge instructions may also be addressed on a Nursing Reassessment Flowsheet (including a Nursing Free Text Note), Education Record, or Plan of Care. Individualized teaching and written instructions must be consistent with the responsible medical practitioner's instructions.

2. The Patient Discharge (Home Care) Instruction Form is printed on three-part NCR.

3. When the physician completes any section of the Patient Discharge (Home Care) Instruction Form, a physician's signature is required on the physician signature line. The nurse responsible for the patient's care will ensure completion of the entire Patient Discharge (Home Care) Instruction Form. The form will be signed by the nurse who completed the patient Discharge Instruction Form. The patient and/or support person will sign on the appropriate signature line to indicate their understanding of the Patient Discharge Instructions.

4. When the allocated space on the original form has been used completely, an identical form will be used and labeled "page 2."

**PROCEDURE:**

1. Label all three copies of the Patient Discharge (Home Care) Instruction Form with the Easy ID patient label in the lower right-hand corner.

2. Complete admission date, discharge date and room number.
3. Medications: Document “As per Medication Reconciliation Report” instead of transcribing the medications onto the Patient Discharge (Home Care) Instruction Form. Provide and review the Medication Reconciliation Report with patient as per Medication Reconciliation Policy (# 01.PAT.81).

*If the Medication Reconciliation function is not available, transcribe prescriptions including dosage and schedule. Document which of these prescriptions the patient has already taken that day including medication, dosage, and time last taken. Under instruction/frequency/education column, document the verbal and/or written information that has been provided to patient/significant other. Also, list any medications that the MD specifically instructed the patient to continue after discharge (that might not have been administered while hospitalized. Indicate if written information has been provided regarding medication(s) by placing an “X” in the Micromedex handout column.

4. Diet: If not completed by the dietitian, check appropriate box to indicate if there are any diet restrictions. Also note any special instructions (e.g., no added salt, drink 6-8 glasses of water daily, etc.).

5. Activity: Indicate any restrictions of activity. Describe limitations if applicable (e.g., when to resume activities of daily living).

6. Special Instructions/Equipment: Use this space to describe any additional home instructions not previously covered if applicable (e.g., signs and symptoms patient should watch for and report to the physician). Include necessary information about wound care, drainage tubes, etc. List equipment needed for home care and any instructions regarding its use. Check the “refer to handout” box if applicable.

7. Handouts: Document what handouts were given to patient and/or support person.

8. Follow-up appointment: Complete physician’s name, appointment data and time (if this information is known) and physician’s phone number.

9. Referral to Home Care Services/Community Resources: If referral is made to home care services/community agency, indicate name, phone number of agency and any comments needed.
10. **Signatures:** Physician signature is required on physician signature line if physician completes any section of the Patient Discharge Instruction Form. The patient or significant other will sign indicating an understanding of patient discharge instructions. The nurses completing the instructions will also sign.

11. The back side of the Patient Discharge Instruction form has information about smoking cessation and symptoms to watch for with congestive heart failure. In addition, there is information regarding Cardiac Rehabilitation.

12. **Distribution of forms:**
   1. Discharge Instructions:
      a. White (original): to the patient after signatures are obtained.
      b. Yellow: to be placed on the chart to go to Medical Records.
      c. Pink: to be placed on the chart to go to Medical Records Department (Medical Records will forward it on to the physician office).

   2. Medication Reconciliation Report:
      a. Signed copy to be placed on the chart to go to Medical Records.
      b. Signed copy to patient (per “Medication Reconciliation” Policy # 01.PAT.81).

12. If a patient is going to the Comprehensive Rehab Unit (CRU) or to HealthSouth, these Discharge Instructions should be completed as they are being discharged from acute care.

**REFERENCES:**

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**APPROVAL:**
CDIT Council 11/14/12