

Beth Israel Deaconess Medical Center Perioperative Services Manual	
<b>Title:</b>	<b>Outpatient Surgery Discharge Instructions</b>
<b>Policy #</b>	<b>PSM 300-303</b>
<b>Purpose</b>	The goal of the Outpatient Surgery General Discharge Form is to provide instruction for patients and <b>family member or designee</b> with complete and concise postoperative information pertaining to their <b>surgical/procedural and anesthesia</b> experience.
<p><b>Policy Statement:</b> A General Discharge Instruction and Medication Reconciliation <b>forms</b> will be completed by the surgeon or his designee for each patient discharged after an outpatient surgical procedure.</p> <p><b>I. Guidelines for Implementation:</b></p> <ol style="list-style-type: none"> <li>1) The patient's name and Medical Record Number will be placed on the discharge instruction sheet and medication reconciliation <b>form</b>.</li> <li>2) The primary nurse assigned to the patient is responsible for reviewing the completed discharge instruction and medication reconciliation forms with the patient and/or family member or designee before discharge.</li> <li>3) A copy is given to the patient and the originals are placed in the patient's chart.</li> </ol> <p><b>II. Completion of form:</b></p> <ol style="list-style-type: none"> <li>1. Instructions following anesthesia or sedation are reviewed with the patient and/or family member or designee.</li> <li>2. <b>Pain and Prescription</b> Medications <ol style="list-style-type: none"> <li>a) Indicate when patient received prescription by checking the appropriate box</li> <li>b) Document the time the last dose of narcotic medication was given and what time another dose may be taken.</li> <li>c) <b>Review any adjunctive</b> medication that may be taken in addition to the prescription medication for pain.</li> <li>d) Review the patient's medication list and any changes made to their current medication regimen. Attach a copy of the patient's updated medication list (printed from PIMS) to the patient's copy of the General Discharge Instruction Form.</li> <li>e) Review all medication side effects and relevant restrictions.</li> </ol> </li> <li>3. Urination <ol style="list-style-type: none"> <li>a) If applicable, indicate time patient should expect to void. The nurse will review the following information: <ol style="list-style-type: none"> <li>i. The patient is instructed to call the MD with any problems voiding</li> <li>ii. The patient is instructed to go the nearest Emergency Room if unable to void within an 8 hour period after their last void.</li> </ol> </li> <li>b) <b>Instructions are provided if being discharged with a catheter, including written instructions with diagrams.</b></li> </ol> </li> </ol>	

4. Surgical Dressing
  - a) Review care of surgical incision, describing normal and typical appearances.
  - b) **Explain the** purpose and care of drains that will be left in place, including written instructions with diagrams, if applicable.
  - c) Provide patient with enough supplies for one dressing change, if applicable.
5. Bathing
  - a) As directed by surgeon or designee
6. Activity
  - a) As directed by surgeon or designee. If no surgical restrictions to activity are indicated, encourage progressive movement and ambulation during recuperation.
  - b) Instructions related to resuming usual activities, climbing stairs, and lifting
  - c) Review instructions for returning to work if indicated by surgeon or designee.
7. Diet
  - a) Review diet instructions. Make recommendations for progressive diet if patient has experienced nausea and/or vomiting.
8. How you may feel
  - a) Review normal expectations and symptoms during recovery from surgery.
9. Call your doctor if...
  - a) Review atypical symptoms, whom to call and when
  - b) Provide physician contact number
10. Additional instructions
  - a) Many surgeons have surgery specific printed instructions. Review any additional instructions with the patient and/or family member or designee, and provide a written copy for them to take home.
11. Return Visit
  - a) Physicians will provide patients with a postoperative follow-up appointment, **if applicable**, or instructions to call their office to make an appointment within a specific time frame.
12. Signature
  - a) The patient or responsible adult transporting patient will sign, date and time the instructions, indicating that they have received verbal instructions and a written copy of the same.

## References

American Society of PeriAnesthesia Nurses. *Standards of PeriAnesthesia Nursing Practice*. 2017-2018. Cherry Hill, NJ: ASPAN: 2017.

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