Improving Discharge Instructions for Follow-Up Care

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BACKGROUND

Preliminary chart audits revealed variability in discharge instructions across providers.
Several patient experience comments noted confusion over when and why to return.
Staff feedback indicated a need for standardized templates and workflow support.

PURPOSE

Clear and comprehensive discharge instructions are essential for safe and effective patient transitions from clinic to home. Inconsistent or vague instructions can lead to missed follow-up care, misunderstandings of return precautions, and preventable readmissions. This quality improvement initiative aims to enhance the clarity and usability of discharge instructions with a focus on four key elements: follow-up care, return precautions, next steps, and referrals. Through staff education, standardized templates, and patient-centered communication strategies, the goal is to ensure that patients leave their appointments with a clear understanding of what to do, when to do it, and why it matters. This initiative supports better outcomes, patient satisfaction, and care continuity.

METHODS

1. Follow-Up Care Instructions
Clear identification of follow-up appointments (who, when, and where)
Documentation of any needed tests/labs to be done prior
2. Return Precautions
Specific symptoms or signs that warrant urgent return to care or ER
Plain language use to improve patient comprehension
3. Next Steps
Step-by-step instructions for managing their care at home (e.g., wound care, medication reminders)
Checklist format for ease of use
4. Referrals
Clear referral instructions, including specialty, location, and scheduling process
Reinforcement of why the referral is important.

RESULTS

Patient were understanding of discharge instructions and where aware what treatment plan was given.

Staff has a well-organized templates in EPIC with follow up instructions to provide at end of visit.

CONCLUSIONS

Develop or revise standardized discharge instruction templates in the EMR.

Educate clinical staff on scripting and plain language best practices.

REFERENCES

1. Internal Tools:
EMR template builder (e.g., SmartPhrases or dot phrases)
Patient education materials from Healthwise or Krames
Teach-back training modules (e.g., AHRQ Health Literacy Toolkit)

2. External Guidelines & Evidence:
Agency for Healthcare Research and Quality (AHRQ) – Tools for safe discharge and patient education
Institute for Healthcare Improvement (IHI) – Care transitions and follow-up practices
Joint Commission – National Patient Safety Goals on communication

3. Measurement Plan:
Pre/post audit of discharge instruction completeness
Patient understanding surveys (e.g., "Do you understand your follow-up plan?")

PATHWAY DESIGNATED