Documentation tips for clinicians

Tips to support ✓Patient care ✓Clinical handover ✓Quality data

The Discharge Summary

ACT Government | Canberra Health Services

A d/c summary is required even if a patient dies, has a procedure cancelled or leaves against medical advice.

Problems and diagnoses

The problems and diagnoses field is one of the most critical components of a discharge summary. It provides a succinct overview of the conditions treated, as well as the reason for admission. The problems and diagnoses field automatically populates from the problem list and will populate across visits.

! Update and review the problem list to ensure the accuracy of this field on discharge.

Principal diagnosis (aka the principal problem)

The principal diagnosis is the reason the patient was admitted to hospital, determined after all relevant investigations have been carried out. It can be active or resolved.

- **It is not a procedure** → if the patient was admitted for a procedure, list the condition requiring the procedure.
- **It should not be a symptom** → in the absence of a definitive diagnosis, consider using the words 'suspected', 'possible' or 'treated as'. Alternatively, list the most specific symptom (e.g., right iliac fossa pain vs abdo pain).
- **It should be a condition that was present on admission** → it should not be a condition that arose in hospital.
- **It should be the primary reason for the admission** → when two or more conditions may have influenced the admission, consider the diagnosis that could not be managed in the community.

! All patients require a principal diagnosis (condition) documented

Additional diagnoses (aka problems managed this admission, active problems)

These are conditions (active or resolved) that were managed during the admission and may have influenced:

- **Treatment** → e.g., hypotension requiring IV fluids or adjustment of medication
- **Diagnostics** → e.g., AKI requiring daily pathology (creatinine/eGFR levels)
- **Clinical care** → e.g., rheumatoid arthritis reviewed by rheumatology team

Complications

Complications are conditions that were not expected during treatment or recovery. For instance, those due to:

- **Procedures** → e.g., post op bleed resulting in acute blood loss anaemia.
- **Health care errors** → e.g., anaphylaxis following administration of a known allergen.
- **Patient factors** → e.g., DVT despite adequate prophylaxis.

Relevant details should be provided in the clinical summary (link the condition with the cause and treatment required).

Other ongoing medical problems (aka non-hospital problems, not actively managed this admission).

These are conditions that did not require treatment, diagnostics or clinical care during the admission and may encompass patient history.

Operating theatre procedures

Operating theatre procedures will list here. Other procedures (e.g., biopsies) should be detailed under clinical summary.

Clinical summary

A comprehensive but brief opening summary is essential to contextualise the admission. This should include the principal diagnosis and a brief synopsis of the major complications. Think of it as the opening title for an essay – but keep it brief and:

1. Provide a brief history of presentation
2. List all diagnoses (condition or symptom) and the management and treatment provided (including procedures).
3. Use bold text to highlight important information
4. Be free of abbreviations.

Provided by HIS, GPLU, and MOSCETU.

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Recommendations

The recommendations section should include suggested actions required for ongoing management. These may include:

- Medications
- Dressing, drain and wound care
- Follow up on pending bloods
- Lifestyle management (e.g., smoking cessation)
- Other important information (e.g., driving restrictions)

Medications on discharge

Medications are automatically populated from the medications list. Review discharge orders to enable you to maintain a complete and accurate list of medications including:

- **New medications** → these will populate the discharge summary as "**START** taking"
- **Changes to existing medications**→ these will populate the discharge summary as "**CHANGE** how you take"
- **Ceased medications** → these will populate the discharge summary as "**STOP** taking"
- **Continued medications** → these will populate the discharge summary as "**CONTINUE** taking"

! It is important to provide information on why medications were ceased, changed, or started. This should include information on how long a medication needs to be taken and any titration required (e.g., prednisone 15mg daily for 3 days, then 10mg daily for 3 days, then 5 mg daily for 3 days, then cease).

This information can be included in the clinical summary. You can also "add comment" (✚ Add comment) during your discharge medication reconciliation. This will populate as a "note to patient" in the medication list.

Allergies

Review any allergies, adverse reactions, and contraindications. These will automatically populate from the 'allergies' tab in DHR.

Alerts

Alerts other than goals of care are not automatically populated. List any alerts that may affect follow up including:

- Goals of care and resuscitation status
- Infection status
- Blood products refusal

! Be aware of the sensitivity of information that could be captured as an alert.

Booked Follow Up Appointments

Booked appointments (e.g., outpatient appointments) will populate this section

Information Provided to the Patient

Use this space to list any information provided to your patient. This may include:

- New medications
- Safety nets (e.g., present to ED if…)
- GP follow up, specialist appointments
- Care of wounds, lines, drains etc.

Ensure the discharge summary is sent via the communications tab, within 48hrs of the patients discharge

Selected Investigation Results

Provide only relevant investigation results that are useful for primary healthcare providers to take over care. Think about what information you would need to take over care for your patient, or if the patient were to represent to hospital.

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