

Discharge summaries: a guide for foundation doctors

Introduction

Junior doctors have many responsibilities, including attending ward rounds, organizing investigations, assessing patients and creating discharge summaries. Many of the skills needed are learnt during final year medical school placements. However, discharge summary technique is not always well demonstrated to students, and this can lead to confusion and inefficient use of time when faced with multiple patients to discharge for the first time. This article outlines key areas which need to be addressed.

Importance of discharge summaries

A discharge summary is a clinical report prepared by a physician or other health professional at the conclusion of a patient's hospital stay or series of treatments (Mosby, 2009). It outlines the patient's chief complaint, the diagnostic findings, the therapy administered (and the response to it), and gives recommendations and follow-up advice on discharge. All doctors need to be able to share patient information accurately and concisely with colleagues and other health-care professionals across all disciplines, in line with *Good Medical Practice* (General Medical Council, 2006). To this end, discharge summaries are a crucial part of ensuring patient safety and continuity of care.

Acute hospitals now have a contractual obligation to provide discharge summaries to GPs within 24 hours. With many thousands of patients registered it is extremely difficult for a GP to know the outcome and plan for each and every patient. All members of the hospital team have a shared responsibility to ensure that a timely and accurate summary of a patient's hospital stay is produced. It is therefore important to prioritize discharge summa-

ries early on, because of the quality and quantity of information which needs to be included. This will also avoid potential delays, which can lead to patient distress and have serious resource implications for the hospital. Scottish Intercollegiate Guidelines Network (2003) guidance on discharge summaries emphasizes the importance of producing a structured discharge document in helping GPs and other health professionals to continue a patient's care. It is therefore important that all doctors are proficient in writing these.

Discharge summaries are typically produced in electronic or hard copy form. Electronic discharge summaries allow instant transmission of discharge summary information via e-mail to GP surgeries. It is worth bearing in mind that with handwritten or typed hard copy discharge summaries, the vagaries of the postal system mean that sometimes they may not be received, and fax numbers can be incorrect or faulty. Other means of communication, such as the telephone, can be used in addition to the handwritten letter, and can be extremely effective for patients with particularly complex or specific needs, e.g. palliative care. Not only will you have direct confirmation that the GP is clear about what needs to be done, but a lot of useful information can be given, particularly if the GP will need to follow up a patient urgently. This may take extra time, but it will be appreciated by the GP and could avoid an unnecessary re-admission. This also applies to electronic discharge summaries which are e-mailed to the GP practice; nothing is better than speaking directly to the person involved when a patient's needs are complex.

Patients are not always able to give a full and accurate account of their stay in hospital, nor can they be expected to remember all the investigations, treatments and medications which they had. In emergency situations, when patients present at other hospitals or out-of-hours primary care facilities, a discharge summary kept by the patient could potentially be the only source of vital medical information available to the health professional. It is therefore important to have a good understanding of the elements which need to be included in the discharge summary.

Producing a reliable discharge summary

Take the time to read through the patient's notes to ensure that important details are not missed. If there are any doubts regarding a particular finding, investigation, treatment or incident, then contact the health-care professional or team involved. If you are trying to convey information to someone outside the hospital you have a duty to ensure it is the right information. Always remember that what might seem to be a minor detail on the ward can turn out to be of crucial importance to the GP, who might not have immediate access to results of lab tests and radiology reports.

In many hospitals, discharge summaries are electronically created and e-mailed, or printed and sent by post. If your hospital uses handwritten summaries, make sure that you write legibly and clearly with enough pressure to mark all carbon copies.

Pre-emptive discharge

If your hospital has electronic discharge summaries, it is worth considering starting the discharge summary at the time of admission (e.g. for elective day surgery). As these admissions are planned and the patient (usually) well there is often very little change to the patient's overall condition. If any information needs to be added then you can make the necessary changes at the time of discharge. This forward planning will set you apart from others, and will be appreciated by nursing staff and your seniors.

Section-specific tips

Diagnosis

The reason for admission should be included, in addition to other conditions identified during the hospital stay, in order of importance. If no cause for a particular symptom or clinical finding could be identified, this should be clearly stated.

Past medical history

Although the GP will have access to records of the patient's medical and social conditions, out-of-hours primary care facilities and emergency departments rely on the medical history given by the patient. A discharge summary detailing an accurate past medical history is therefore

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very useful for the initial management by the health professional.

Medications and allergies

All medications brought in by the patient that have been modified or stopped must be included, alongside any new medications started during the hospital stay. This includes any controlled drugs administered to the patient which need to be continued on discharge, written in figures and words with details of duration of administration and total quantity to be supplied. It is also important to record a patient's regular medications before admission as this tells the GP whether the patient's drug history matches the hospital prescription. Any allergies identified during the stay in hospital and their nature must also be documented.

Investigations

Details of investigations should be recorded in the summary, e.g. key blood tests, microbiology and radiological investigation reports. Other specialized investigations such as echocardiograms and lung function tests should be summarized.

Treatment and follow up

All interventions that the patient received should be concisely recorded, as well as the response to the treatment. This also includes details of the resuscitation status of the patient and ongoing care for terminal illnesses, e.g. end of life pathways. Important details that are frequently missed include catheterization history and invasive monitoring, e.g. central lines. These are relevant to the GPs as well as having financial implications for the hospital department via clinical coding.

Surgical operations carried out should be accurately detailed, in addition to postoperative events. The outcome of referrals to other specialties during the stay should also be recorded. Outpatient appointments should be detailed, as well as contact details and names of personnel to seek help or advice from as appropriate. Outreach and district nursing arrangements should be explained when necessary. Arranging proper follow up is very helpful in situations where regular wound checks, dressings, removal of sutures or administration of medications are needed. Nurses are extremely important in arranging the fol-

low-up care of the patient, so it is vital to convey appropriate information to the nursing staff regarding required follow up.

The ward pharmacist has an important role in ensuring that patients get the right medication at the right dose when they get home. If patients are discharged on medications which need regular pharmacist support then the pharmacist needs to be involved from the beginning.

Guidance issued by the Royal College of Physicians (2008) acknowledges that not all sections of the discharge summary are necessarily relevant in every situation and foundations doctors should familiarize themselves with this guidance to aid their overall record keeping.

Examples of poor discharge summaries leading to problems

Mr RB is 60 years old and was discharged home after being diagnosed with atrial fibrillation. He had been started on warfarin before discharge, and was due to have the dose adjusted accordingly by his GP over the next few days because the anticoagulation clinic had been cancelled because of staff sickness. Mr RB visited his GP a week later complaining of persistent bruising, and was admitted to hospital when his international normalized ratio was found to be 9.

Proper documentation in the summary would have made it clear to both the patient and the GP of the need for close international normalized ratio monitoring.

Mrs Y is 20 years old and was discharged following emergency appendicectomy. While in hospital she had a reaction to cefuroxime, which was previously not known. She was discharged at the weekend, and the busy on-call foundation year 1 doctor who had not met the patient before was asked to complete the discharge summary. Annoyed that the discharge letter had not even been started during the week by the ward doctors, the foundation year 1 doctor decided to save time and asked a nurse about the operation and the patient's previous medical history, without looking through the notes or medications record. The nurse, in the middle of a drug round, confirmed the patient was otherwise fit and well, and required only simple analgesia to go home with. The summary was quickly written, and the allergies box was left blank.

Three weeks later Mrs Y became unwell, and was seen by an out-of-hours GP, who noted the recent discharge letter. He prescribed amoxicillin for a chest infection, after confirming with Mrs Y that she is not allergic to penicillin. Mrs Y had another, more serious reaction and was admitted to hospital via ambulance.

Had the discharge summary mentioned the allergy to cefuroxime, the out-of-hours GP would have considered the potential cross-reactivity with amoxicillin, and prescribed a different antibiotic.

Conclusions

The discharge summary is an important form of communication between hospitals and primary care. It is of great value in emergency situations as it provides relevant information regarding a patient's health. Having a clear understanding about what constitutes a good discharge summary is essential for junior doctors in their early days of training. In addition, the ability of a junior doctor to produce a timely, prompt and quality discharge summary will be highly appreciated by seniors, ward staff, pharmacists and, most importantly, patients. This can easily be highlighted in the doctor's portfolio and during appraisals. **BJHM**

Conflict of interest: none.

General Medical Council (2006) *Good Medical Practice*. General Medical Council, London (www.gmc-uk.org/guidance/good_medical_practice/working_with_colleagues_sharing_information.asp accessed 1 August 2010)

Mosby (2009) *Mosby's Medical Dictionary*. 8th edn. Mosby Elsevier, St Louis

Royal College of Physicians (2008) *A Clinicians Guide to Record Standards - Part 2 : Standards for the structure and content of medical records and communications when patients are admitted to hospital*. Royal College of Physicians, London
Scottish Intercollegiate Guidelines Network (2003) *65 The Immediate Discharge Document*. Scottish Intercollegiate Guidelines Network, Edinburgh

KEY POINTS

- Discharge summaries are essential for continuity of care of patients and are a means of good communication between hospital and community health workers.
- Discharge summaries are a valuable sources of information in emergencies.
- Ensuring that they are completed accurately and promptly is part of Good Medical Practice.