Westmead Hospital

A Guide to Medical Discharge Summaries

1. Introduction

This document provides guidance for Medical Officers on the preparation of Medical Discharge Summaries for inpatients at Westmead Hospital.

The medical team that discharges the patient is responsible for completion of the Discharge Summary. This is usually done by the team junior medical officers (JMOs), an Intern or Resident Medical Officer. The admitting Consultant is responsible for ensuring this occurs. The admitting Consultant and team Registrars and/or Fellows are to provide oversight of JMOs to ensure that Discharge Summaries are completed prior to discharge or transfer to another facility. They are to ensure that the JMOs are informed about specific requirements for their team and supported to enable preparation of high quality and timely Discharge Summaries. If the medical officer who usually prepares the Summary is not available to complete it on time, the next most senior clinician (e.g. Registrar or Fellow) in the team is responsible for this.

It is important to remember that the summary is a legal document and may be read by patients and their carers.

This guide:

- Describes the use and importance of the clinical information contained within the Discharge Summary
- Lists the sections of a Discharge Summary
- Provides practical direction on the preparation and distribution of a Discharge Summary

The aim of this guide is to:

- Standardise Discharge Summary structure and content
- Enable the production of accurate, complete, timely, high quality Discharge Summaries
- Promote a consistent approach to preparing and distributing Discharge Summaries
- Facilitate the safe and effective transfer of patient care back to community based health care providers
- Support clinical coders to accurately code discharges for funding and administrative purposes

2. Use and Importance of Medical Discharge Summaries

The Medical Discharge Summary is a **clinical handover document communicating a patient's continued care plan to their post-hospital care team** such as General Practitioners, residential care providers, allied health professionals, medical specialists and other community based health care providers.

The Discharge Summary should accurately communicate:

- Why the patient was admitted to hospital
- How they were managed during the admission and
- Plans for ongoing management and follow-up

Although the primary function of the Discharge Summary is to support the transfer of patient care from the acute hospital setting, it is also important to **facilitate coding for funding purposes** by clinical coders. The Discharge Summary and clinical notes are used for assignment of codes which are aggregated into Diagnosis Related Groups (DRGs). DRGs are used for Activity Based Funding.

Any patient activity that involves the use of resources including extra care requirements or increased monitoring, should be documented in the Discharge Summary.

It is essential that all diagnoses and interventions including operations, procedures, investigations and complications of treatment are documented in the Discharge Summary. An accurate, specific and comprehensive summary of the complete clinical picture of the patient's admission enables the clinical coders to assign the correct DRG, ensuring the hospital receives the appropriate resourcing under the Activity Based Funding Model. If there are inconsistencies between the patient's medical record and Discharge Summary, the clinical coder may contact the responsible clinician or medical team member for review.

Information contained within the Discharge Summary is also used for a range of local and national reporting requirements and other purposes including:

- Monitoring safety and quality of care
- Identifying epidemiological and disease trends
- Financial and performance management
- Reviewing resource use
- Measuring, analysing and reporting hospital and ward activity
- Making comparisons between facilities, local areas and other jurisdictions
- Clinical research and
- Workforce and facility planning

The Discharge Summary is also helpful when a patient attends the Emergency Department or is readmitted to the hospital by presenting a summary of the earlier admission.

The consequences of delayed or incomplete Discharge Summaries include:

- Unnecessary duplication of tests
- Delays or errors in patients receiving appropriate treatment
- Avoidable re-admission to hospital
- Inadequate information for coding and other administrative purposes

3. Sections of a Medical Discharge Summary

The core components of a Medical Discharge Summary were identified from review of the following documents:

- The NSW Health Guideline on Medical Discharge Referral Reporting Standard (GL2006_015)
- The NSW Casemix Classifications Handbook 2016/17
- The National Safety and Quality Health Service Standards (2012) and
- The Australian Digital Health Agency Discharge Summary Documents (v1.5.1)

These core components have been categorised into 8 broad sections within the Discharge Summary:

1. **Patient Details** (Name, Age, DOB, Facility MRN, Sex, Home address)
2. **Intended Recipient Details** (Nominated General Practitioner and/or other community based health care provider name and address)
3. **Admission and Discharge Details** (Facility name, address, phone number, attending clinicians, admission and discharge date, admission type i.e. elective or emergency admission)
4. **Alerts, Allergies and Adverse Reactions**
5. **Clinical Narrative** (the bulk of the Discharge Summary is contained within this section)
6. **Medication Information and Medication Reconciliation**
7. **Follow Up and Future Management**
8. **Details of Person(s) Completing the Discharge Summary** (Name, Position, Finalised Date)

Speciality specific information may also be added to suit departmental needs.

Powerchart does not currently align with the core components and 8 sections identified by the review.

This document links Powerchart with the identified core components and sections.

This document provides screenshots of the current Powerchart Generic eDischarge Summary fields with **practical guidance on what information should be entered into each field. See pages 4–12.**

General rules for completion of Discharge Summaries are listed on **page 13**.

4. Preparing the Discharge Summary

A Discharge Summary is required for all admitted patients on discharge, including deceased patients.

The Discharge Summary should be commenced at the start of the admission. It is a live document to be updated regularly throughout the patient's inpatient stay and completed by the day of discharge.

Ensure that the Discharge Summary is available for transmission / distribution to community health care providers **on the day of the patient's discharge.**

5. Who should receive a copy of the discharge summary?

Copies of the Discharge Summary should be provided to:

- The patient unless otherwise specified (see below)
- A patient's nominated GP or General Practice
- The referring doctor, if this is different from the usual GP
- Any other nominated community based health care providers such as:
  - medical specialists
  - allied health professionals
  - aged care facility providers
  - organisations involved in patient transport

There may be departmental exceptions to the provision of Discharge Summaries for some patients such as those admitted under the Adolescent and Young Adult Medicine and Psychiatry teams.

A hardcopy of the discharge summary should also be filed in the patient's medical record.
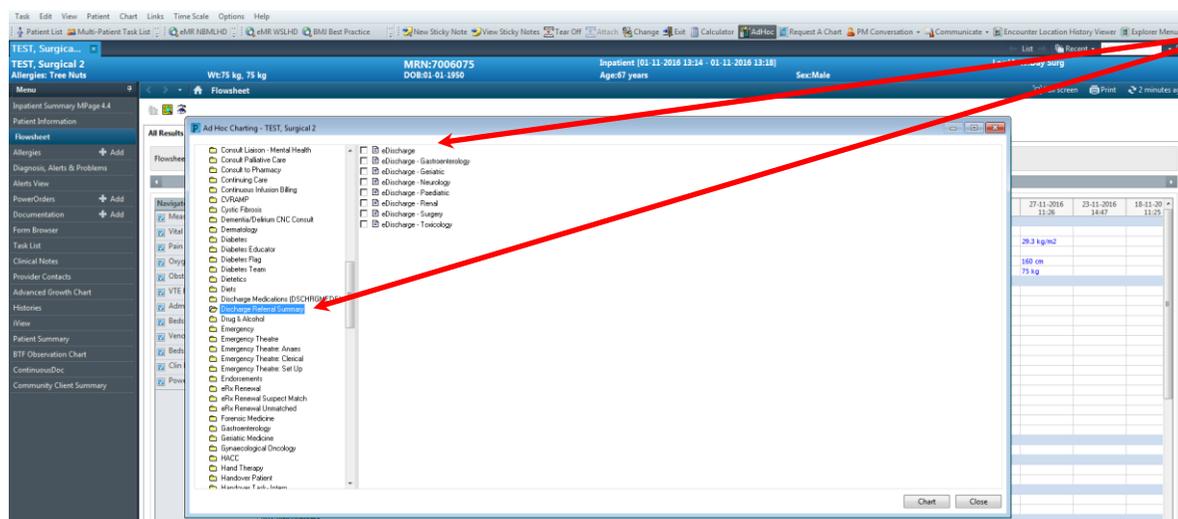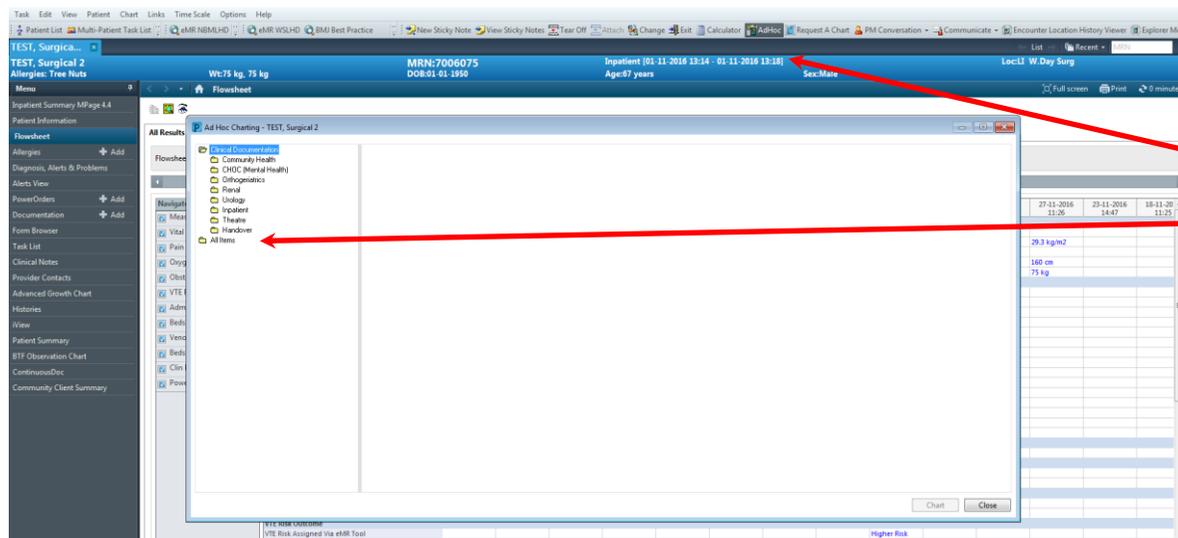
6. Disseminating the Discharge Summary

It is imperative to ensure that the Discharge Summary is sent to the correct community based health care providers.

It is important to ask the patient or their family/carers the names of their nominated community based health care provider, and to ensure that this is accurately recorded in Cerner. If the nominated providers have not been recorded in Cerner, seek the Ward Clerk's assistance to rectify this.

The Discharge Summary is to be disseminated by two means to the required community based health care providers either via the patient, by fax, by post or electronically.

Screenshots of Powerchart Generic eDischarge Summary fields - Practical guidance on completion

Powerchart offers a number of Discharge Summary templates through the 'Ad Hoc' charting function. This is the starting point of the Discharge Summary.

Select 'Ad Hoc'. This opens the Ad Hoc charting window.

Click on 'All items'

Scroll down and select 'Discharge Referral Summary' and then select the 'eDischarge' option and 'Chart'. This opens the Generic eDischarge Summary template.

Use the Generic eDischarge Summary template **UNLESS DIRECTED OTHERWISE BY YOUR DEPARTMENT.**

The Generic eDischarge Summary template contains 5 parts, each of which requires data input.

Generic eDischarge Summary
Part 1

Presenting Complaint

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Background History

History of Presenting Illness

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Diagnoses For This Admission

Mark all as Reviewed

To add a detailed Clinical Diagnosis

1. Click on the + Add icon or right click and select Add ....
2. Enter Diagnosis in the Search field
3. Select filter: Starts with, Contains or Exact match
4. Select appropriate Finding
5. Enter additional detail

Use Folders to access Specialty Diagnoses

Diagnosis (Problem) being Addressed this Visit

+ Add   Modify   Convert   Display: All

Annotated Display | Clinical Dx | Dx Type | Responsible Provider | Ranking

Diagnoses For This Admission

To add a detailed Clinical Diagnosis

1. Click on the + Add icon or right click and select Add ....
2. Enter Diagnosis in the Search field
3. Select filter: Starts with, Contains or Exact match
4. Select appropriate Finding
5. Enter additional detail

Use Folders to access Specialty Diagnoses

Diagnosis (Problem) being Addressed this Visit

Annotated Display | Clinical Dx | Dx Type | Responsible Provider | Ranking

*Diagnosis   Free Text   Responsible Provider   Comments

Display As   *Clinical Service   *Date
                  Non-Specified   01/11/2016

*Type   *Confirmation   *Classification   Ranking
Principal   Confirmed   Medical

Use the **'Presenting Complaint'** field to state the symptom, disorder or concern which led the patient to seek treatment (e.g. shortness of breath, dizziness, chest pain, pyrexia). Note that this is different to the diagnoses field below. Use this field to state whether this was an **elective** or **emergency** admission.

Use this field to document the **history of the presenting complaint**. Also use this field to document the patient's **social and living circumstances** (such as whether they live alone at home, or at a residential care facility). Document the patient's functional mobility and any other social factors that influence their health status and reasons for contact with health services e.g. occupational exposure to risk factors or a family history of specific disorders.

Use this field to document the '**Principal Diagnosis**'. This is the diagnosis established to be chiefly responsible for requiring the patient to be admitted and cared for. The principal diagnosis is the final assessment of the condition that was primarily responsible for the episode of care.

Click 'Add' and then use the 'Type' drop-down menu to select 'Principal'. Diagnoses can be entered via free text or searched for using the search function. **Note: only one Principal Diagnosis should be selected.** However, if more than one medical condition meets the definition for a principal diagnosis, list the conditions in order of clinical significance for the admission (this can also be documented using free text in the 'Clinical Summary – Progress and Management' field below).

Procedures should NOT be recorded as a diagnosis e.g. tonsillectomy, total hip replacement, caesarean section are NOT acceptable diagnoses – instead the reason the patient underwent the procedure should be recorded as the diagnosis e.g. recurring chronic tonsillitis.

Events causing the illness should NOT be recorded as the diagnosis e.g. 'fall' or 'motor vehicle accident' are NOT acceptable diagnoses – instead the injury caused by the fall or accident should be recorded as the diagnosis e.g. hip fracture

This field is also used to document '**Additional Diagnoses**'.

Multiple additional diagnoses may be listed.

An additional diagnosis is a condition or complaint that either co-exists with the principal diagnosis or arises during the patient's admission.

The additional diagnosis can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint or other factor affecting the patient's health status.

Use the 'Type' drop-down menu to select 'Other' and then use the 'Ranking' drop-down menu to select 'Additional'.

Additional diagnoses may be sub-categorised as complications and comorbidities.

Complications are conditions that were not present on admission but developed during admission or resulted from surgical or medical care and affected the patient's treatment/management and/or length of stay (e.g. methicillin resistant Staphylococcus aureus, urinary tract infection, pneumonia, post-operative haemorrhage or infection or an adverse medication reaction). Complications can be related to the disease process, result from lack of an intervention (e.g. failure to treat a condition) or be directly related to an intervention (e.g. related to a procedure, surgery, anaesthesia or medication).

Hospital Acquired Complications are conditions or injuries related to a medical intervention rather than to a patient's disease process. Hospital acquired complications should be documented in the Discharge Summary. Where a condition is caused by a procedure, **clearly document the cause and effect** using terms such as: due to…; complication of…; resulting from…; secondary to…; Writing 'post-op' is NOT sufficient – as it may indicate that the condition arose in the post-operative period, but is not due to that procedure.

Cause and effect documentation can be typed into the 'Clinical Summary' field below.

Comorbidities are conditions that existed at the time of admission and which affected patient care in terms of requiring treatment, diagnostic procedures and interventions, and increased clinical care / monitoring (e.g. hypertension, diabetes, dementia, chronic obstructive airways disease).

This section can also be used to document the patient's **smoking status and drug and alcohol history**. Specifically state the level / severity of substance use. Use the specific terms: intoxication / harmful use / dependence / withdrawal, as appropriate.

Document ANY additional diagnoses likely to result in resource consumption during an admission.

Ongoing Problems And Alerts

Past Medical History and Alerts

To add an Alert

1. Right click to Add New Problem
2. Under the Classification field, select Alerts
3. Enter the Alert in the Problems field
4. Select the appropriate Alert under Terminology

NOTE: Problems and Alerts display across subsequent presentations unless removed

Problems

[+ Add] [Modify] [Convert] [No Chronic Problems] Display: [All ▼] [...]

Name of Problem	Annotated Display ▲	Onset Date	Confirmation	Classification	Last Reviewed	Last Updated	Last Updated B

Use this field to document known **alerts** (e.g. MRSA, resuscitation plan in place, behavioural or communication issues).

Alerts from previous admissions will auto-populate unless removed.

This field should also be used to document a patient's past medical history. This may include the additional diagnoses listed in the previous field. Entries made here from previous admissions will auto-populate unless removed.

Generic eDischarge Summary
Part 2

Clinical Summary

Progress and Management

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PART 2

Use the 'Clinical Summary – Progress and Management' field to **describe in detail the patient's treatment and progress during the admission**.

This may be in the form of a problem list.

Itemize each diagnosis and state any clinically significant laboratory, histopathology or other investigation results.

State what treatment or management was provided for each problem.

Physical examination findings may be recorded here. Include Consults or advice requested from other medical or surgical teams.

This field should also be used to document **Clinical Incidents**.

A clinical incident is any unplanned event which causes, or has the potential to cause, harm to a patient. Clinical incidents include near misses (incidents that did not cause harm, but had the potential to do so), and adverse events (an incident in which harm resulted to a person receiving healthcare) e.g. **falls, hospital-acquired infections, medication side-effects, wrong patient receiving treatment** (e.g. wrong patient receiving an x-ray), **correct patient receiving wrong care** (e.g. a surgical procedure performed on the wrong side of the body or the provision of the incorrect meal) resulting in an adverse event. These events may result in the disability or death of a patient, or prolonged hospital stay by the patient.

ALS and PACE calls should also be documented within this section of the Discharge Summary. All clinical incidents should be documented in both the patient's medical record and Discharge Summary to ensure accurate coding.

Generic eDischarge Summary

Part 3

Pathology Results

Enter only relevant and important results, limited to conclusions/summary.

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Medical Imaging Results

Enter only relevant and important results, limited to conclusions/summary.

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Clinical Interventions

Describe clinical interventions (including operations, procedures and relevant nursing and allied health interventions) performed on the patient during the healthcare encounter.

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Use the 'Pathology Results' and 'Medical Imaging Results' fields to document results of investigations that are considered to have had an impact on the management of the patient during the admission.

The most recent investigation results or those of greatest clinical significance may also be included.

The condition relating to the test results should be clearly documented using **medical terminology**, e.g. 'anaemia' rather than 'Hb 6'.
Where possible **be specific about the diagnosis** e.g. 'iron deficiency anaemia' is preferable to 'anaemia'. Document what treatment was provided in response to the investigation results (this may already have been done in the 'Clinical Summary' field above.

Do NOT include provisional imaging reports in the Discharge Summary. These reports have not been finalized and should not be distributed. Note any pathology results or medical imaging reports that are outstanding at the time of discharge and document the plan to ensure that these results are followed up (this may also be recorded in the 'Follow-Up Plan and Appointments' field below).

Use the **'Clinical Interventions'** field to document all procedures undertaken from the time of admission to the time of discharge. This includes diagnostic, therapeutic and allied health procedures.

Medical procedures / interventions may be surgical or non-surgical. Examples of surgical interventions are: hip replacement, appendectomy and cataract extraction. Examples of non-surgical interventions are allied health interventions, blood transfusions, biopsies, dialysis and mechanical ventilation.

Record ONLY ONE procedure as the 'Principal Procedure'. The principal procedure is the most significant procedure that was performed in treating the principal diagnosis. It is also important to document any **additional procedures** performed for treatment of the principal or additional diagnoses e.g. the principal procedure is a right open hemicolectomy for adenocarcinoma of the right colon, while the additional procedure is the insertion of a percutaneous drain for management of an abdominal collection. **Multiple additional procedures may be documented.**

Generic eDischarge Summary

Part 4

Allergies

Mark All as Reviewed

+ Add | Modify | ○ No Known Allergies | ○ No Known Medication Allergies | Reverse Allergy Check | Display [All ▼]

D/A	Comments	Substance	Category	Reactions	Seve...	Type	Est. Onset	Reaction S...	Updated By	Source	Revi...	Interac

State the medication name / allergen and nature of the reaction.

Allergies from previous admissions will auto-populate unless removed.

If no allergies are known, document this.

This column supports **medication reconciliation**. Accurate recording of the patient's medication in the Discharge Summary is critical. Medication reconciliation is the accurate recording and comparison of all medications a patient was taking on admission to hospital with those they are taking at the time of discharge, documenting all changes that have taken place. This reconciliation is done to avoid medication errors such as omissions, duplications, dosing errors, or medication interactions.

Select one option from the drop-down menu:

- New
- Changed
- Pre-existing
- Ceased

If changes have been made to the formulation, strength, dose, frequency or route of administration of medications that the patient was taking at the time of admission, **record the reasons why these changes were made.**

State the **indication** for the medication i.e. **What was the medication prescribed for?** as this may not be clear from the name of the medication alone

Medications On Discharge

Use Generic Names and add Brand Names if necessary

For Combination Drugs please use the example format below

e.g. Augmentin Duo (R) : Enter Amoxycillin 500mg + Clavulanic Acid 125mg in 'Medication' column

Medication (Include Strength for Combination Drugs)	Modified Release	Dose	Unit	Frequency	Route	Duration	Dispensed on Discharge	Reason For Change/Indication	*Item Status
	<Alpha>		<Alpha>				<Alpha>		<Alpha>
	<Alpha>		<Alpha>				<Alpha>		<Alpha>
	<Alpha>		<Alpha>				<Alpha>		<Alpha>
	<Alpha>		<Alpha>				<Alpha>		<Alpha>
	<Alpha>		<Alpha>				<Alpha>		<Alpha>
	<Alpha>		<Alpha>				<Alpha>		<Alpha>

Use the generic medication name (include the brand name if applicable)

State the dose, unit and whether it is a modified release medication using the drop-down menu. Select either YES or NO

State the frequency of administration (including if it is PRN), the route and duration.
State the stop date for all medications prescribed for a short term or defined course of treatment. State 'Repeat' if the patient is to continue taking the medication after discharge and no specific stop date has been agreed

Indicate whether the medication was dispensed on discharge using the drop-down menu. Select either YES or NO

Variable and Complex Medications / Drug Monitoring

Enter any additional comments relating to medication in the box below

For variable dose instructions please write medication and instruction

e.g. Prednisolone 5mg tablets 10mg mane for 3 days then decrease to 7.5mg mane for 7 days then 5mg mane until reviewed.

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Use this section to communicate **variable medications**, **medication monitoring**, and other **medication follow up requirements**.

For example, state whether:

- A medication has been withheld on discharge (i.e. temporarily suspended, either for one dose or for a few days but will be restarted or reviewed in the future. State when the medication should be restarted or reviewed and by whom e.g. hospital clinician or GP)
- A medication requires dose adjustment (e.g. warfarin, short course of steroids, immunosuppressants)
- A medication requires therapeutic drug monitoring (e.g. warfarin, anti-epileptic medication, digoxin)
- A medication requires adverse effect monitoring (e.g. anticoagulants, anti-epileptic medication, steroids, opioids)
- A medication requires specialist follow-up
- The patient requires a medication compliance aid (e.g. a dosette, Webster-pak, spacer, a medication management service)
- Any other medication follow up is required

Generic eDischarge Summary

Part 5

Follow-Up Plan And Appointments

Describes services that have been provided for, requested for or arranged for the patient.

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Service Booking Status

☐ Appointment ☐ Event ☐ Promise ☐ Request
☐ Appointment Request ☐ Intent ☐ Proposal

Advice To Patient

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Discharge To

○ Other (home/discharge to usual residence/own accommodation/welfare institutions including prisons, hostels and group homes)
○ Discharge/transfer to (an)other acute hospital
○ Discharge/transfer to a residential aged care service, unless this is the usual place of residence
○ Discharge/transfer to (an)other psychiatric hospital
○ Discharge/transfer to other health care accommodation (includes mothercraft hospitals)
○ Statistical discharge - type change
○ Left against medical advice/discharge at own risk
○ Died

Comments

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Tick either of the Appointment or Appointment Request boxes as appropriate.

In the 'Advice To Patient' field state what information was provided to the patient such as the recommended activity level, falls prevention advice, wound care, referrals to smoking cessation programs or any other advice or recommendations.

Click to select the appropriate discharge destination.

Any other comments can be entered here

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PART 5

Use the 'Follow-Up Plan And Appointments' field to document:
- Hospital clinician actions
- GP actions
- Falls prevention actions
- Social care actions

Hospital clinician actions are tasks or services that will be carried out by the treating team or any other hospital staff member.
Any pending or future appointments or actions that the hospital has responsibility to organise should be documented. Include information on any pending investigations results or reports, and who will follow this up.

GP actions are services requested of the General Practitioner.

Falls prevention actions: Patients are screened by nurses for their falls risk on admission. If any falls risk factors are identified, a Falls Risk Assessment Management Plan (FRAMP) will be documented. Patients who have had a fall, or are at risk of a fall post-discharge (due to medical conditions or high risk medications) should be reviewed and their risk managed prior to discharge.

The patient's **falls risk and falls history should be documented in the Discharge Summary**. The Discharge Summary should also **include referral to appropriate falls prevention services** where appropriate.

To reduce the incidence of patient falls and minimize harm from falls post-discharge, consider referral to or request the patient's GP refer the patient to the appropriate service on discharge. Referrals may be made to: community health services, Home Medicines Review, specialist medical practitioners such as geriatricians or ophthalmologists, continence nurses, and allied health professionals such as physiotherapists, occupational therapists, podiatrists, dieticians, optometrists and exercise physiologists.

Social care actions are services relating to the patient's social care that have been requested to be undertaken.

Once the fields in the template have been populated, the Discharge Summary can be 'signed' by clicking the green tick button in the top left hand corner.

It can then be converted into a Clinical Note.

Select Clinical Notes from the left hand menu bar and select 'Add' to bring up the 'Add Document' window.

Select 'eDischarge' in the 'Type' drop-down menu. This converts the Ad Hoc chart to a Clinical Note (though without the original formatting).

This step has to be undertaken for the document to be displayed in Clinical Notes in the Flowsheet.

The document needs to be electronically signed once finalized.

General rules for completion of Discharge Summaries

- **Use medical terminology** (e.g. do NOT write '↓ K' or 'Na+' instead use medical terms such as hypokalemia, hypernatremia) Diagnostic results such as laboratory or histopathology results cannot be coded unless the clinician has **interpreted** the result and indicated the **clinical significance** (in terms of requiring monitoring or treatment)
- **Document the relationship between the condition and the treatment / management** i.e. link the diagnosis with the corresponding treatment
- **Avoid the use of abbreviations or acronyms** when there is the possibility of ambiguity (e.g. 'MI' may refer to myocardial infarction or mitral insufficiency, 'CRF' may refer to cardiac risk factors, chronic renal failure or chronic respiratory failure, 'PE' may refer to either pulmonary embolus or pericardial effusion)
- **Avoid the use of medical eponyms** where possible. An eponym is a medical term named after a person that pioneered the procedure or technique. The use of medical eponyms can cause confusion (e.g. Halsted's operation can refer to either a repair of inguinal hernia, or mastectomy for the treatment of breast cancer)
- **Avoid non-standardised terminology** (e.g. do NOT use the term 'acopia')
- **Be as specific as possible** – adding specificity to your Discharge Summary enables a more detailed code to be assigned which may result in increased funding. State the:
    - **Exact site** of fracture
    - **Microorganism** responsible for infection if known (e.g. E coli urinary tract infection AND include the **antibiotic sensitivity AND resistance of the organism**)
    - **Stage** of pressure (decubitus) ulcer
    - **Cause** and **place of occurrence** of injury, poisoning or adverse event
    - Whether a condition is **acute** or **chronic** or both
    - **Type** of anaemia (e.g. 'anaemia secondary to acute blood loss', or 'iron deficiency anaemia' NOT '↓ Hb')
    - **Diagnosis behind the symptom** if the underlying cause has been established (e.g. headache due to hypertension, syncope due to atrial fibrillation, angina instead of chest pain)
- **Specify how injuries and accidents occurred and where** (e.g. slipped on driveway at home)
- **Specify the approximate duration of any loss of consciousness associated with head injury**
- Ensure that the information contained in the Discharge Summary is a **complete** and **accurate** reflection of the patient's admission and is **consistent with the patient's medical record**
- **Clearly designate** the **single diagnosis** that best meets the definition of the **principal diagnosis** and **list this first**
- If there are multiple injuries, list the **single injury that poses the most severe threat to life** as the **principal diagnosis**
- List all other diagnoses as **additional**
- If the diagnosis is uncertain or queried at the end of the episode of care, document the probable cause and/or what the patient was treated for – otherwise it will not be coded
- **Make reference to results pending** – this flags to the clinical coder that coding may require updating once all results are finally reviewed

The most important requirements of a Discharge Summary are that it be: **Complete, Accurate** and **Timely**

A **complete** Discharge Summary provides a clear description of **all diagnoses and interventions** including operations, procedures, investigations conditions that arose during the admission and complications of treatment. It is essential that **any patient care activity involving the use of resources including increased care requirements (nurse specials) or monitoring (e.g. telemetry, blood glucose), behavioural management or patient communication challenges be documented in the Discharge Summary.**

An **accurate** Discharge Summary is a precise, specific, detailed, factual account of the patient's admission.

A **timely** Discharge Summary is prepared prior to discharge and available for transmission / distribution to community health care providers **on the day of the patient's discharge**

REMEMBER**: Incomplete, inaccurate, conflicting or non-specific documentation leads to incorrectly coded records which impacts funding. If it is not documented, it did not happen. Be specific - close enough is not good enough!**