

Discharge - Discharge Summary



Digital Health
CONNECTING BEST CARE

Digital Health
Quick Reference Guide

This Quick Reference Guide will explain how to:

- Complete Discharge Summary



Important

All discharge summaries require:

- A documented principal diagnosis
- Discharge medication reconciliation and script

Discharge Process Quick Summary

1. Select **Medical Officer View** and select the Discharge tab

- Medication Reconciliation, Problems/Alerts and Follow up must be completed for every discharge

The screenshot shows the 'Medical Officer View' interface. The top navigation bar includes tabs for 'Summary', 'Admit', 'Manage', and 'Discharge' (highlighted with a red box and callout 1). The left sidebar contains various menu items, with 'Discharge Summary' highlighted by a red box and callout 3. The main content area displays 'Problems/Alerts' and 'Medication Reconciliation (0)'. A red arrow with callout 2 points to the 'Discharge Summary' option in the sidebar.

2. Select Medication Reconciliation and complete

- Refer to the QRG "*Medications – Discharge Prescriptions – Creating and Printing*" on the Digital Health Quick Reference Guide website.

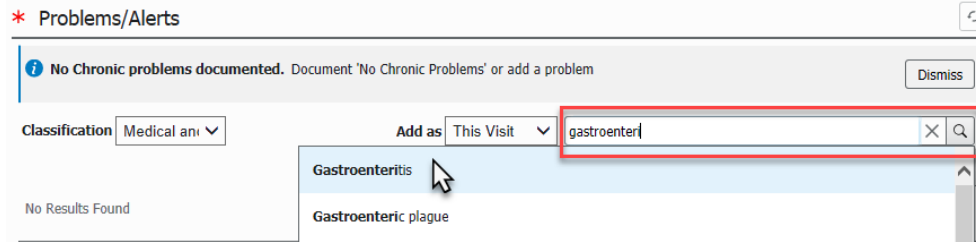
3. Continue to review and complete each component within the discharge tab page

- Review Documents, Outstanding orders, Observations, Laboratory, Microbiology, Medical Imaging results, Document the Hospital Course and Patient Instructions and hit save
- Select any results to tag to add to the discharge summary document

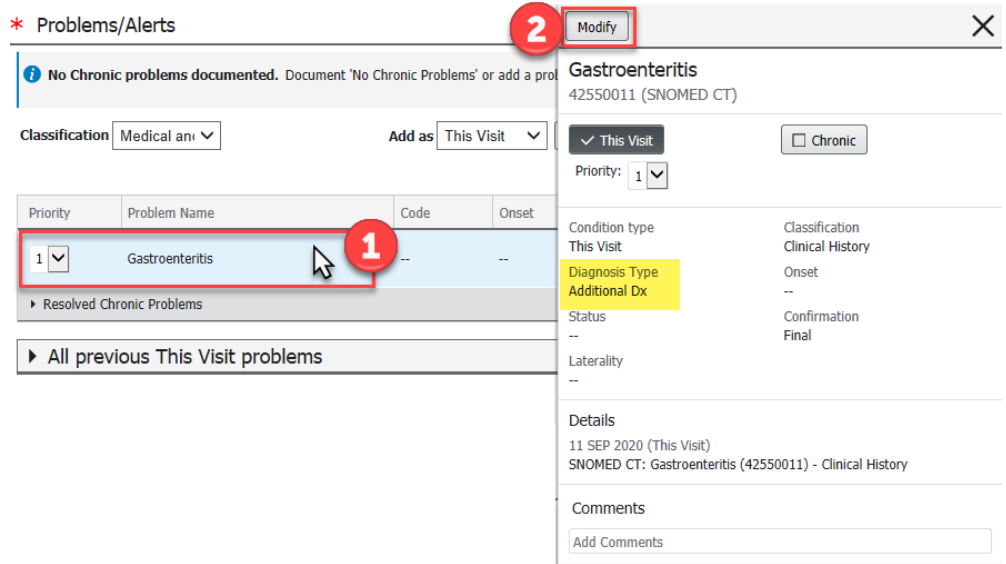


Documenting a Principal Diagnosis

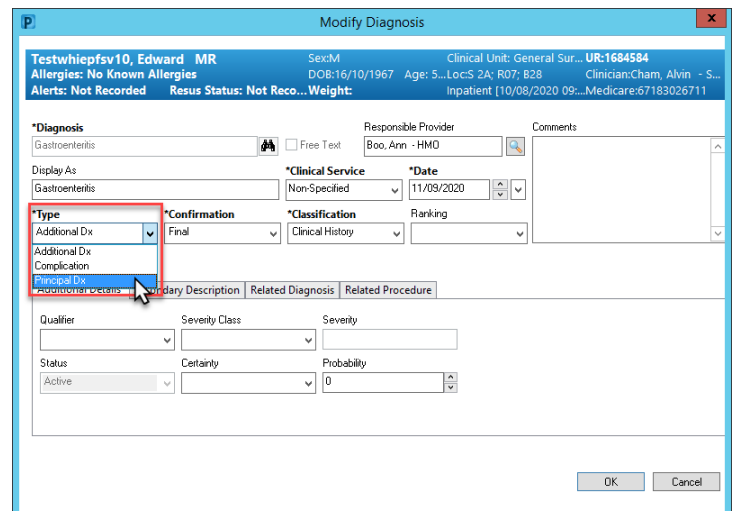
- Once at the Problems/Alerts component, Use the search box to search for your patient's diagnosis and select from the drop down the most appropriate for your patient to add it as part of their clinical record
 - At this point, enter in any other past medical history that may have not been entered before



- Select the added problem (e.g. Gastroenteritis).
 - Details of the problem will appear on the right side of the window. Note here it says "Additional Dx" for diagnosis type.



- Select Modify to change the diagnosis type to "Principal Dx" and click OK





- Use the “This Visit” and “Chronic” buttons to allocate problems as an active problem during this visit only or a chronic issue.
If your patient has no chronic problems, select the “No Chronic Problems” button to confirm.

This Visit |
 Chronic

Follow-Up documentation in EMR

Referrals and follow up need to be documented so that it is part of the patient’s medical record and discharge summary.

- Once you reach the “Follow-Up” component on the Discharge page
Select “Follow up with Primary Care Provider” and click Modify to enter more information and Save

Follow Up

Add Follow Up	
Quick Picks	PCP - No Gp, No Gp
Saved Templates	Cernertest, Medical Officer P2 2
	Follow up with primary care provider

Save as Template

Follow up with primary care provider

Time Frame

None
 Only if needed

Phone

Address

City **State**

Postal Code

Comments

- If an outpatient referral is required, either search for the site via “Location” or enter clinic information as free text and click “Save”.



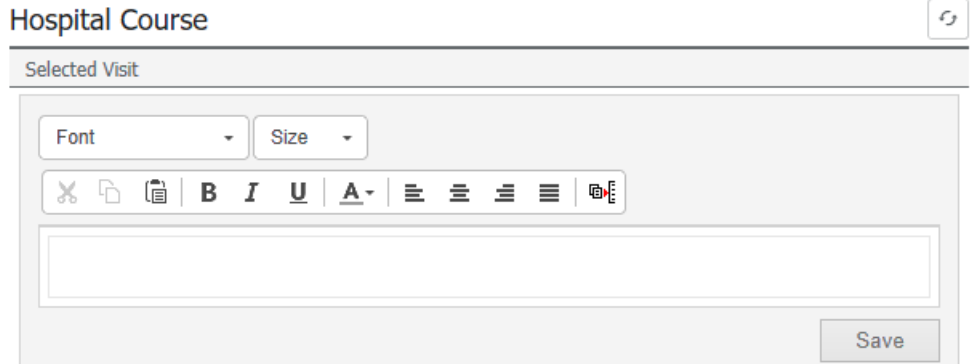
Important

- Step 9 does **NOT** send a referral order
- An outpatient referral order will still need to be completed. Refer to “Scheduling and Referrals – Placing an outpatient referral or review order” QRG

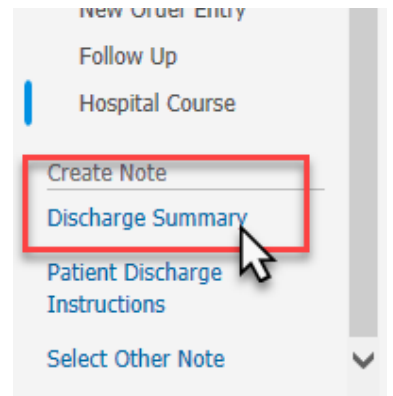


Completing and Creating the Discharge Summary

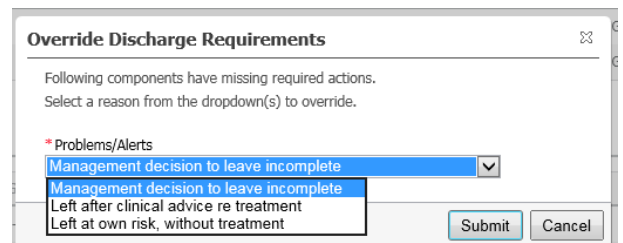
1. Enter the patient’s hospital course summary in to the “Hospital Course” Section and save.
 - This box allows for multiple users to collaborate and save notes without adding to the patient’s official medical record until the final discharge summary is completed.
 - This is the recommended way to start and prepare your discharge summaries
 - It allows for a colleague to edit, review and then submit the discharge summary.



2. After saving, Select “Discharge Summary” under ‘Create Note’ to generate the Discharge Summary document



At this stage, if you have forgotten to complete steps to enter a Principal and Final diagnosis, you will receive this prompt. Please click Cancel and navigate to Problems/Alerts





- At this point, the pathology results you tagged earlier will auto populate whilst microbiology and radiology reports will be available on the left-hand side of the window for you to drag it to insert into the appropriate section.

The screenshot shows a 'Discharge Summary' window with a 'List' tab. On the left, a 'Tagged Text' window is open, containing the text 'XRAY Chest 27/08/2018 12:23...' and 'THIS IS A TEST REPORT'. On the right, the main document is displayed with various sections: 'Admission Information' for Turp, Surgical Uat2 MR; 'General Practitioner' details; 'Hospital Course' (FYI); 'Results Review' with a 'Pathology Results' table; and 'Radiology Reports' which contains 'THIS IS A TEST REP...' and 'Other Investigations' with a date of 27/08/2018 12:23 AEST.

Test Name	Test Result	Date/Time
INR	1.6 (High)	22/08/2018 09:59 AEST

- Review your document and make any final edits in this window.
- Click on "Sign/Submit" then "Sign & Print" or "Sign" to finalise the Discharge Summary



Important

- A copy will be sent to the patient's GP (if registered on the PulseNet network) as documented in iPM and a copy will also be automatically uploaded to myHR if the patient has consented to myHR.
- Further revisions/addendums to the discharge summary will automatically send to myHR