

DISCHARGE SUMMARIES – START, SAVE, EDIT AND COMPLETE A DISCHARGE SUMMARY

Once you have the ward displayed from either **View Patients by Ward** or **Inpatient Whiteboard**:

Select your patient so their name appears in the **Patient Banner**

Right-click the patient's row then select **Add Discharge Summary** – you may need to scroll down the menu

The screenshot shows a patient banner for JENKINS, June Training (Mrs) with address 13 Wilson Avenue, BRIGHTON, BN2 5PA. Below the banner is a table titled 'Patients by ward (RSCH Egre...' with columns for Bed, NHS Nu..., and Patient Name. A context menu is open over the row for JENKINS, June Training, listing options: Add Clinical Notes, View Clinical Notes, View Charts, Record Patient Observations, View All Observations, Add Discharge Summary, and Send Casenotes.

Bed	NHS Nu...	Patient Name
Waiting Area		
Bay Name: Female Bay 1		
Bed 01		
Bed 08		
Bed 03	JENKINS, June Traini	
Bed 06	PTESTELEVEN, Robert...	4400436 06... Male 05-Nov-2019 1... 07-Feb-2020 21:00
Bed 05	PTFRITWELVE, Bob (Mr)	4400442 04... Male 07-Nov-2019 1... 07-Feb-2020 12:52

The **Discharge Summary** window opens on top of the Careflow window.

The first screen displays showing the **Clinical date / time** as now. Change this to a date/time in the past as required:

Template Start screen

The screenshot shows the 'Discharge Summary (IP)' template start screen. The title bar indicates 'Discharge Summary (IP)' and '29-Mar-2022 14:37'. Below the title bar is a 'Clinical Date *' field with a calendar icon, showing '29-Mar-2022' and '14:37'. A text box below the field explains: 'The 'clinical date' is intended to represent as closely as possible the date and time the clinical information was actually captured. Only amend this date if the clinical information you are about to record has not been captured in real-time i.e. it was captured in the past.'

Click the **Next** button - More tabs now display down the left-hand side.

DISCHARGE SUMMARIES – START, SAVE, EDIT AND COMPLETE A DISCHARGE SUMMARY

Diagnoses/Relevant Investigations/Procedures/Treatment *:

The screenshot shows a web form for entering discharge summary data. On the left is a navigation menu with tabs: 'Diagnoses / Relevant Investigations / Procedures / Treatment' (with a red asterisk), 'Medication & Allergies' (with a red asterisk), 'Future Management' (with a red asterisk), 'Legal Information', 'Person Completing Record' (with a red asterisk), and 'Discharge Details' (with a red asterisk). The main form area contains several sections: 'Diagnosis *' (with a tooltip 'Please enter a Diagnosis.'), 'Clinical summary *', 'Procedure / treatment given *', 'Relevant past medical history' (containing 'Asthma, Type 2 Diabetes'), and 'Social History' (with sub-sections for 'Health Status Factors', 'Household composition *', 'Occupational history *', and 'Lifestyle factors *', each with a 'Select values...' dropdown). At the bottom right are 'Back' and 'Next' buttons. Annotations include: a box stating '* Fields with a red asterisk are mandatory' pointing to the asterisks; a box stating 'Blue text has come from the last discharge summary' pointing to the blue text in the 'Relevant past medical history' field; and a larger box stating 'Blue text does NOT appear on the summary to the GP. Either click in the box and edit or add to the text, or press Enter on the keyboard to confirm the data as is. The text then turns black.' pointing to the same blue text.

* Tabs with a red asterisk indicate there are outstanding mandatory fields in that tab.

You cannot **Complete / Print** the summary if mandatory fields are outstanding.

Click each tab that you need to complete and enter the relevant data. **Medications & Allergies** tab is completed in EPMA (eLearning available) or see the **Add, Edit and Delete Medications** guide for a non-EPMA ward, if you want more detail than that shown on the next page.

You can also use the **Next** and **Back** buttons (bottom-right of the screen) to move through the tabs

Medication / Allergies / Adverse Reactions * :

Allergy

Reactions will automatically be printed in the document.
Click the red Alerts ribbon on the top left to view them.

Allergy

Allergy status unknown

You can't update allergy details here. If any allergies are missing, ensure EPMA. They will then show in all discharge documents and will show summary is opened.

Medication

Does the patient have prescribed medication? *

Yes

The discharge letter does not need hand signing unless it requires a supply of controlled medication

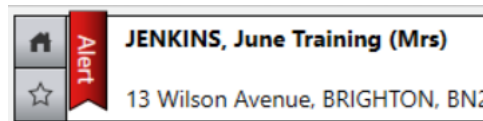
Medication started, stopped or adjusted *

Weight

 KG

Care: Not all allergies are visible here but they will display in the Discharge Summary document.

Always check the allergy details by clicking on the **Alert ribbon** on the **Patient Banner**



Note: All allergies are added and edited in ePMA

Manually added medications

Table ordered by row created date in **Ascending** order.

Medication	Dose/Frequency/ Duration/NFD	Drug Status	Comments	Indication	Dispensing Status
Click 'New' to create a new item					

New

Record medications with complex instructions, such as reducing doses here.

Would you like to add medications with complex instructions ?

Yes No

Click the **New** button to add a medication.

You must enter at least 3 characters in your search criteria.

Begin with the **% symbol** as a wild card to make it easier to find medications.

Type **non** to record Non-Formulary Drugs – although always use the actual drug name if possible.

Refer to the **Discharge Summaries > Add Edit and Delete Medications** guide for more details.

Future Management *:

Secondary Care follow up plan
 Secondary Care follow up plan *
 Select values...
 Additional information for secondary care
 Advice for Primary Care follow-up *
 Information given to patient/carer *
 Select values...
 CQUIN – Dementia & VTE
 Documented VTE risk assessment carried out
 Yes No
 Reset

Select values...

- Diagnostics test
- Follow up required in
- Follow up already booked
- Other
- No follow up required
- Referral to another team

Time in Hospital since Admiss
 24h 12min
 Additional **Dementia questions** display for patients who are 75 or older

If this patient has been an inpatient for >72hrs has the dementia/delirium assessment been completed?
 Yes No Not applicable
 Reset

If you suspect delirium/dementia or other cognitive problems have you arranged appropriate follow up & documented this above?
 Yes No Not applicable
 Reset

Legal Information:

Mental Capacity Assessment
 Mental Capacity Assessment completed?
 Yes No

Advance decision to refuse treatment (ADRT) including DNACPR
 Details of any refused treatments
 Refused date

Lasting power of attorney for personal welfare or court-appointed deputy (or equivalent)
 Power of Attorney - name

Second Power of Attorney exists?
 Yes No
 Reset

Safeguarding issues

Additional **Mental Capacity fields** display if you select **Yes** to the first question

Mental Capacity Assessment
 Mental Capacity Assessment completed?
 Yes No

Mental Capacity Assessment details

Mental Capacity Assessment completed by
 Search
 Advanced Search

Person Completing Record: *

Current allocated consultant

Dr Sean O'NUNAIN

This Consultant is auto-populated from the PAS

Discharging consultant specialty

Cardiology

Clinician completing the discharge summary *

BLACKWELL, Steve (Mr)

Grade *

Role

Clinician

Team contact details *

Discharge Details:

Discharge to location / destination *

Discharging ward

PRH Albourne Ward (1st Floor)

Date/time of discharge

Discharge method

Not set

Additional discharge comment

Additional multi-disciplinary notes

Additional fields display depending on what you select from these values in the **Discharge to location / destination** field

NON-HOSPITAL IN UK (HOME, CARE HOME, TEMPORARY RESIDENCE) - 04
PATIENT DIED IN UNIT - 06
INDEPENDENT HOSPITAL PROVIDER IN UK - 03
OTHER NHS TRUST SITE - 02
NON UK DESTINATION (E.G. REPATRIATION) - 05

If you have filled in as much as you can for now, but have not finished, click the **Save** button to save your progress.

The **Complete** button will not become available until all the mandatory fields have been recorded and therefore all the asterisks have disappeared from the tabs on the left-hand side.

NOTE: The **Complete** function is for printing the Discharge Summary which you must sign and send to Pharmacy if there are TTOs.

This is covered below...

DISCHARGE SUMMARIES – EDIT and/or COMPLETE A DISCHARGE SUMMARY

Once you have the ward displayed from either **View Patients by Ward** or **Inpatient Whiteboard**:

Select your patient so their name appears in the **Patient Banner**

Right-click the patient's row then select **Edit Discharge Summary** as the summary has already been started - you may need to scroll down the menu

The screenshot shows a patient banner for JENKINS, June Training (Mrs) with address 13 Wilson Avenue, BRIGHTON, BN2 5PA. Below the banner is a table of patients by ward (RSCH Egremont Ward - Barry). The patient JENKINS, June Training is highlighted in the table. A context menu is open over the patient's row, listing various actions such as 'Add Clinical Notes', 'View Clinical Notes', 'View Charts', 'Record Patient Observations', 'View All Observations', 'Edit Discharge Summary', 'Send Casenotes', 'Receive Casenotes', and 'Favourite Ward'. The 'Edit Discharge Summary' option is selected.

Bed	NHS Nu...	Patient Name
Waiting Area		
Bay Name: Female Bay 1		
Bed 01		
Bed 08		
Bed 03		JENKINS, June Training
Bed 06	PTESTELEVEN, Robert...	4400436 06-... Male 05-Nov-2019 1... 07-Feb-2020 21:00
Bed 05	PTFRITWELVE, Bob (Mr)	4400442 04-... Male 07-Nov-2019 1... 07-Feb-2020 12:52

Check and update all the relevant fields.

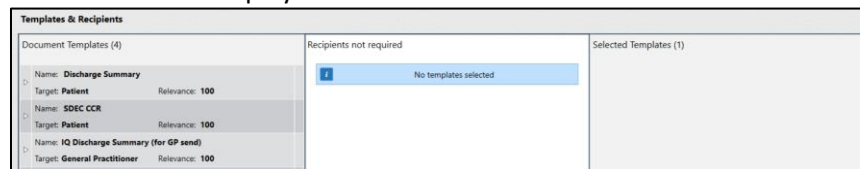
If you are not finished, select the **Save** button again to save your changes

The screenshot shows four buttons: Save, Complete, Authorise, and Cancel.

DISCHARGE SUMMARIES – EDIT and/or COMPLETE A DISCHARGE SUMMARY

If the summary is finished, click the **Complete** button

The **Print** screen displays – this consists of 3 columns:

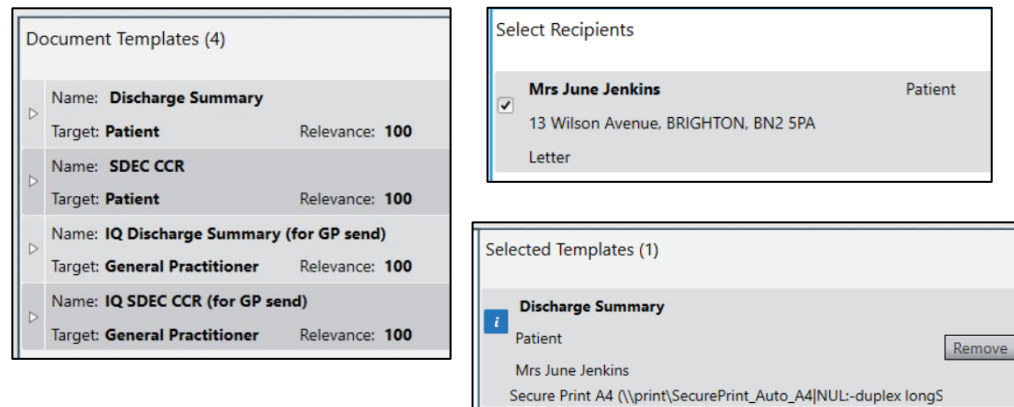


Select the correct patient Discharge Summary in the **Document Template** column (1st column)

Note: SDEC CCR (Same Day Emergency Care, Clinical Care Record) is used in certain wards only, e.g. EACU, RAMU

The patient is shown, already ticked, in the **Recipients** column (2nd column).

Click the **Select** button in the **Recipients** column – the template moves into the **Selected Templates** column (3rd column)



Click the **Submit** button.

The summary displays as a Word document – check the Taskbar

Care: Do not make changes here as they will not display if somebody later views the summary rather than re-prints the Word document

Close Word to send the document to the **SecurePrint** queue

Note: You cannot print from within the Word document.

Say **No** to the Save message as you will not have made changes

A confirmation message displays in the bottom-right corner of the screen.

