START AND ENTER DETAILS INTO A DISCHARGE SUMMARY

This process is for **Chichester, Worthing & Shoreham**.

*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	**(SRH Aldwick Ward) Last Refreshed 24-Oct-2022 10:28:23** NHS Number · Patient Name · Hospital N... · DoB · Gender · Ad SMITHSON, Jake (Mr) View All Observations Add Discharge Summary Send Casenotes

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

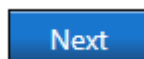| Discharge Summary WEST 24-Oct-2022 10:35	Clinical Date * 24-Oct-2022 10:35 The 'clinical date' is intended to represent as closely as possible the date and time the clinical information was actually captured. Only amend this date if the clinical information you are about to record has not been captured in real-time i.e. it was captured in the past.

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

Diagnoses/Relevant Investigations/Procedures/ Treatment *: * Tabs with a red asterisk indicate there are outstanding mandatory fields in that tab.	Discharge Summary WEST 24-Oct-2022 10:35 Diagnoses / Relevant * Investigations / Procedures / Treatment

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

* Fields with a red asterisk are mandatory

Complete:

Diagnosis *

Clinical summary *

Procedure / treatment given *

Relevant past medical history (not mandatory but can be filled out if required)

Blue text will come from the last discharge summary

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.

Diagnoses & Procedures

Diagnosis *

[   ] ⓘ Please enter a Diagnosis.

Clinical summary *

[   ]

Procedure / treatment given *

[   ]

Relevant past medical history

Asthma, Type 2 Diabetes

Please only enter details about relevant investigations in the clinical narrative. Avoid detailed reports in this section as these are available to GP's via ICE

Social History:

Select from the drop-down menu:

Household composition *

Occupational history *

Complete:

Lifestyle factors *

Blue text will come from the last discharge summary

Blue text does NOT appear on the summary to the GP

Select **Clinical frailty score** * from the drop-down menu

Social History
_____

Health status factors
Household composition *

Select values...   ▼

Occupational history *

Select values...   ▼

Lifestyle factors *

Smoker, Not very mobile.

Clinical frailty score *

                                    ▼

Click each tab that you need to complete and enter the relevant data. **Medications & Allergies** are completed in **EPMA** (eLearning available).

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

---

Click the **Next** button to move to the **Medications & Allergies** tab

Next

Allergies should be prepopulated from information bought across from EPMA

Allergy
_____

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

Allergy

PENICILLINS

Always check the allergy details by clicking on the **Alert** ribbon on the Patient Banner	**JENKINS, June Training (Mrs)** 13 Wilson Avenue, BRIGHTON, BN2
Select **Yes/No** to confirm information is correct *	Confirm that the allergy information is correct * ● Yes ○ No Confirm that the allergy information is correct * ○ Yes ● No You can't update allergy details here. If any allergies are missing, ensure they are added to EPMA. They will then show in all discharge documents and will show here the next time the summary is opened.
For the **Medication**, select **Yes** from the drop-down menu to bring TTO's across from EPMA (if written). If not, select **No** for now and add later.	Medication Does the patient have prescribed medication? * Yes ✕ ▼ ⓘ Please enter a Does the patient have prescribed medication?. EPMA auto populated medication during this stay | Medication	Dose
aspirin 75 mg Dispersible Tablets	75 mg at BREAKFAST time; 08:00
glyceryl trinitrate 400 micrograms per dose Spray	2 spray PRN Relief of chest pain
isosorbide mononitrate 60 mg Sustained Release Tablets	60 mg at BREAKFAST time; 08:00
paracetamol 500 mg Tablets	1000 mg at 06:00 and 12:00 and 18:00 and 22:00 PRN relief of pain max four times daily
senna 7.5 mg Tablets	7.5 mg at BED time; 22:00 PRN for constipation	

Click the **Next** button to move to the **Future Management** tab	Next
Select **Secondary Care Follow up plan** from the drop-down menu * Enter **Secondary Care Follow up** details Enter any **Pending investigations** * Enter **Advice for Primary Care follow-up** * Enter any **Information given to patient/carer** *	Secondary Care follow up plan Secondary Care follow up plan * Select values... ▼ Secondary Care follow-up details Pending investigations * Advice for Primary Care follow-up * Information given to patient/carer *
Have you issued a MED 3 & period signed off * is mandatory The other 2 options aren't mandatory but can be completed if required.	Multi-disciplinary notes Have you issued a MED 3 & period signed off? * Special requirements
Click the **Next** button to move to the **Legal Information** tab	Next

None of this information is mandatory but can be filled in if relevant	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 Safeguarding issues
Click the **Next** button to move to the **Discharge Details** tab	Next
Select **Discharge to location / destination** from the drop-down menu * Select **Discharge address** * as either **Usual place of residence** or **Other location** Add **Additional discharge comment** if required	Click 'Save' or 'Close' to save the summary during the patient stay Click 'Complete' when patient is being discharged, and the summary is ready to be sent to the patient's GP. The summary will be locked for all future edits. Discharge to location / destination * NON-HOSPITAL IN UK (HOME, CARE HOME, TEMPOR ✕ ▼ Discharge address * ⦿ Usual place of residence ○ Other location Actual discharge address * 117 Mill Lane, PORTSLADE, BRIGHTON, EAST SUSSEX, BN41 2FH Additional discharge comment
Click the **Next** button to move to the **Completion** tab	Next
Current allocated consultant and **Current specialty** is pre-populated Select **CLINICAL INFO COMPLETE** from the **Summary status***drop down menu	Current allocated consultant Dr Michael Bacon Current specialty General Internal Medicine Summary status * CLINICAL INFO COMPLETE ✕ ▼ Select 'CLINICAL INFO COMPLETE' when the summary is ready for print. You will be prompted to complete your details.

Date completed* will pre-populate **Clinician completing the discharge summary*** will pre-populate if it's a clinician but not for admin Select **Grade*** from the drop down menu **Role** will pre-populate Enter **Team contact details*** e.g. bleep number	Date completed * 05-May-2023 Clinician completing the discharge summary * JONES, Liam (Dr) Grade * SPR Role Admin & Clerical Team contact details * Bleep 1234

If you have filled in as much as you can for now, but have not finished, click the **Save** button to save your progress. This will leave the discharge in **draft** with the ability to go back in and edit. Then click on **Close.** If you haven't saved and click on **Close** then you will get a prompt to save the summary.

The **Complete & Authorise** buttons 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.

[Save] [Close] [**Complete**] [**Authorise**] [Cancel]

Click 'Complete' to print patient or paper copies. This is covered in the guide 'Edit & Complete a Discharge Summary'.

Only click 'Authorise' after discharging patient to send GP copy electronically. This will lock the summary and no changes can be made.

On the ward, the **Discharge Summary Status** will show as **In Progress** for the patient	Discharge Summary Status In Progress