

GENERAL INTERNAL MEDICINE DISCHARGE SUMMARY

Patient Name: Smith, John

DOB: 25-Dec-1950, 65 years old

MRN: 1234567

Gender: Male

VISIT ENCOUNTER

Visit Number: 11186424686

Admission Date: 08-Oct-2015

Discharge Date: 14-Oct-2015

Discharge Diagnosis: Pyelonephritis

Ensure Primary Care /
Referring Provider
Information is correct

Primary Care Provider / Family Physician:

Jay, Samantha; 416-555-5555

Most Responsible Health Care Provider:

Snow, Michael; Physician; 416-123-4567

Discharge Summary Completed by:

Lee, Dan; Senior Resident; 416-321-4567 on 23-Jul-2015

Patient Encounter Type: Inpatient

Discharge Disposition: Discharged home from Toronto General Hospital (General Internal Medicine)

DIAGNOSIS (Co-Morbidities and Risks)

Conditions Impacting Hospital LOS:

Pre-Existing:

- Hypertension, Type 2 diabetes with no known complications

Developed:

- Acute kidney injury, Transaminitis

Be concise and itemize
descriptions of patient's
initial presentation

Conditions Not Impacting LOS:

- Iron deficiency anemia

Risks: None

Indicate pre-existing
conditions patient
arrived with vs.
conditions that
developed during stay

COURSE WHILE IN HOSPITAL

Relevant Complaint(s) and Concerns:

- Upon arrival: Patient presented with five days of increased urinary frequency, urgency and dysuria as well as 48 hours of fever and rigors. He was hypotensive and tachycardic upon arrival to the emergency department. The internal medicine service was consulted. The following issues were addressed during the hospitalization:

Summary Course in Hospital (Issues Addressed):

- Fever and urinary symptoms: A preliminary diagnosis of pyelonephritis was established. Other causes of fever were possible but less likely. The patient was hypotensive on initial assessment with a blood pressure of 80/40. Serum lactate was elevated at 6.1. A bolus of IV fluid was administered (1.5L) but the patient remained hypotensive. Our colleagues from ICU were consulted. An arterial line was inserted for hemodynamic monitoring. Hemodynamics were supported with levophed and crystalloids. Piptazo was started after blood and urine cultures were drawn. After 12 hours serum lactate had normalized and hemodynamics had stabilized. Blood cultures were positive for E.Coli that was sensitive to all antibiotics. The patient was stepped down to oral ciprofloxacin to complete a total 14 day course of antibiotics.

On further review it was learned that the patient has been experiencing symptoms of prostatism for the last year. An abdominal ultrasound performed for elevated liver enzymes and acute kidney injury confirmed a

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S Marginson



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Technical Association Papers Technical Association of the Pulp and Paper Industry,1928 **Paper Trade Journal** ,1928

NTIS Alert ,1997 *Core Discharge Summary* Standards Association of Australia. Technical Committee IT-014,2013

A Comparison of Two Methods of Medical Discharge Summary Generation ,1998 **Analysis of Discharge Summary**

of a Home Health Agency Jacalyn Helene Kareb,1980 **Aggregate Hospital Discharge Data Summary** ,1986

Facilitating Patient Understanding of Discharge Instructions Board On Population Health And Public He,Joe Alper,Institute of Medicine,Lyla M. Hernandez,Roundtable on Health Literacy,Board on Population Health and Public Health Practice,2014 The Roundtable on Health Literacy brings together leaders from academia industry government foundations and associations and representatives of patient and consumer interests who work to improve health literacy To achieve its mission the roundtable discusses challenges facing health literacy practice and research and identifies approaches to promote health literacy through mechanisms and partnerships in both the public and private sectors To explore the aspects of health literacy that impact the ability of patients to understand and follow discharge instructions and to learn from examples of how discharge instructions can be written to improve patient understanding of and hence compliance with discharge instructions the Roundtable on Health Literacy held a public workshop The workshop featured presentations and discussions that examined the implications of health literacy for discharge instructions for both ambulatory and inpatient facilities **Facilitating Patient Understanding of Discharge Instructions** summarizes the presentations and discussions of the workshop This report gives an overview of the impact of discharge instructions on outcomes and discusses the specifics of inpatient discharge summaries and outpatient after visit summaries The report also contains case studies illustrating different approaches to improving discharge instructions *Discharge Summary Phase 2* Professional Record Standards Body,2017 **Electronic Discharge Summary Systems** Australian Commission on Safety and Quality in Health Care,2011

Improving the Discharge Summary Farrant Hiroshi Sakaguchi,2014 The Completeness of a Discharge Summary Ali Bin Saleh,2003 *A Comparison of an Automated Discharge Summary with the Traditionally Transcribed Discharge Summary* James A. Menke,1997 Quality, Accuracy, and Potential Impact of the Hospital Discharge Summary for Patients Discharged to Sub-acute Care Facilities Amy Jo Haavisto Kind,2011 **Moving from Paper Based to Electronic Hospital Discharge Summaries** Kusnadi Kusnadi,2012 The move to electronic discharge summary systems was anticipated to solve the longstanding problems associated with poor data quality and reduce delay in the production and transmission of discharge summaries between secondary and primary care health care providers in the UK National Health Service A consequence of investment in a national IT infrastructure for electronic health records has focused attention on template design and the IT system requirements The routine practices of doctors involved in discharge summary construction and other factors that contribute to the problems of delay and data quality have been less well explored This study aimed to gain

an understanding of paper based discharge summary construction in a secondary care context in order to identify and analyse the implications for improving electronic discharge summary systems and potentially avoid inadvertent transfer of inherent problems A mixed method case study design was used to examine the patient discharge process and the construction of discharge summaries in one NHS Hospital Trust Data was collected through semi structured interviews with hospital doctors n 10 and simulated discharge summary production n 10 A syntactic analysis was also performed on discharge summaries n 11 and proformas n 3 The data was analysed thematically and inductively in order to identify the factors that contribute to the twin problems of data quality and delay associated with discharge summaries The pragmatic semantic syntactic conceptual framework Morris 1938 and Speech Act Austin 1962 and Mental Frame Minsky 1981 theories were used to analyse how information contained in discharge summaries was represented interpreted and used This study found that moving from a paper based to an electronic discharge summary system will not necessarily resolve the problems of poor data quality and delayed production of discharge summaries More comprehensive solutions are required in order to facilitate more effective discharge summary communication between secondary and primary care health professionals and to address entrenched custom and practice in current hospital practice These include uni professional medical orientation of discharge summaries attitude of senior doctors inadequate preparation of junior doctors inconsistent data entry including absence of common usage of short forms and abbreviations and little accountability for quality control Recommendations include training for junior doctors regulating the use of shortened forms improving the features of data entry systems structuring the clinical coding data and introducing systems to ensure greater organizational accountability for effective discharge communication More comprehensive change related to the introduction of multidisciplinary contribution discharge summary construction and integration of discharge summary standards in care pathways may improve overall discharge summary quality

Effect of a Computer Based Discharge Summary on Administrative Data from a Newborn Special Care Unit Thomas Lyon Dobrov,2000 Documentation Standards for Discharge Summary to GP for Mental Health Adults Patients Tony Adams,2017 Successful joined up care depends on GPs community and acute mental health care teams and social care professionals all having access to timely information about a persons care and treatment The PRSB has developed the mental health discharge summary standard to ensure that relevant information is shared so professionals can provide continuity of care when an adult is discharged from mental health services Source Professional Record Standards Body **Annual Discharge Summary** United States. Indian Health Service,1900 *Discharge Summary Communication from Secondary to Primary Care* Haya Saud Zedan,2012 **A Pilot Study of the Systems Flow of Hospital Discharge Summary Reports** Karen K. Lorimor,1994

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