- **The discharge summary should be brief, containing only pertinent information on the hospital episode, rather than duplicating information which GPs already have access**
- **Below describes a template for a generic discharge summary, created for the purposes of this learning activity and will not be identical to the form used within your organisation, where you may find slightly different content or other terms being used.**
- **The template is based on the standard for e-discharge summaries, published by the Professional Record Standards Body and available online: https://theprsb.org/standards/edischargesummary/**
- *** Several of the elements will contain information which aligns with clinical coding. This will be done by using drop-down lists in your organisation's system or by software identifying terminology which can be coded in the background - this means it is very important to use terms accurately and appropriately. Marked ***

Section	Headings and elements	Notes
A	**Patient demographics**	**Check the correct patient record is being completed, especially where autopoulated by the electronic patient record**
	Patient name	Autopopulated
	Date of birth	Autopopulated
	Patient address	Autopopulated
	NHS number	Autopopulated (unique identifier)
	Safety alerts:	Any alerts could be documented here eg treatment limitation decisions, multi-resistant organisms, refusal of specific managements eg blood products; safeguarding concerns. This includes risks to self (eg suicide, overdose, self-harm, neglect), to others (to carers, professionals or others) and risks from others (risk from an identified person eg family member).
B	**GP practice**	
	GP name	Name of a patient's general practitioner, if offered by the patient or their representative
	GP practice details	Autopopulated - Name and address of the patient's registered GP practice
C	**Social context**	Includes elements such as lifestyle factors eg smoking status, alcohol, and social context, eg whether the person lives alone. This is particularly important if the admission and discharge locations differ. Consider what information a new carer would need to know. More detailed information would be recorded in forms, such as "This is me" form for dementia patients. Also includes educational history.
D	**Admission details**	
	Reason for admission*	The main reason why the patient was admitted to hospital, eg chest pain, breathlessness, collapse, etc.
	Date/time of admission	Autopopulated
	Admission method	May be autopopulated, eg elective/emergency
	Relevant past medical, surgical and mental health history	Whilst the GP is likely to hold this information it is useful for documents to stand-alone and provides an insight into the basis for clinical decisions. Includes relevant previous diagnoses, problems and issues, procedures, investigations, specific anaesthesia issues, etc
	Diagnoses	**List / bullet points/ brief factual information**
	Primary diagnosis*	***Confirmed*** primary diagnosis (**or symptoms**); active dianosis being treated. Record to highest level of certainty, eg do not record a diagnosis if it is not certain, record a symptom instead.
	Secondary diagnoses*	Record any other diagnoses relevant to admission, such as: other conditions which impact on the treatment eg dementia, diabetes, COPD; complications during admission eg venous thromboembolism, hospital acquired pneumonia; or incidental new diagnoses.
E	**Clinical summary**	
	Clinical summary	Details of the patient's journey can be written in this section, including details about the patient's admission and response to treatments, recorded as a summary narrative. Very concise, where possible.
	Procedures*	The details of any therapeutic or diagnostic procedures performed. This should be the name of the procedure, with additional comments if needed.
	Investigation results	It is important to include results of investigations which the GP is likely to monitor either of the health condition or assocaiated with medication use eg renal function in patients with diabetes or prescribed an ACE inhibitor. This is also an opportunity to provide more detail on medical problems not related to the main admission eg current lung function tests in patient with COPD admission for elective procedure; cardiac echogram, etc
F	**Discharge details and Plan**	**It is really important the GP understands the next steps for the patient and what they are responsible for organising**
	Date/time of discharge	Autopopulated
	Discharge destination	Highlight when different to patient's usual address and if permanent or interim arrangement eg residential care, rehabilitation facility, local hospital (from tertiary centre)
	Plan and requested actions:	Make clear where the responsibility for actions lies (eg with the GP practice or hospital). eg Health or test monitoring, specialist services eg Macmillan, Diabetes, Optometry
	Information and advice given	Note of information and advice given and patient/carer comprehension

	Patient and carer concerns, expectations and wishes	Description of the concerns, wishes or goals of the person in relation to their care, as expressed by the person, their representative or carer. Also record who has expressed these. Where the person lacks capacity this may include their representative's concerns, expectations or wishes.
	Next appointment details	Follow-up appointment booked, eg outpatient department - include contact details.

Medication

All information required to prescribe medication, quantity supplied, pharmacy check

Medication name*	Form*	Route*	Dose duration description*	Dose directions description	Indication*/ description of any amendment	Additional information/ patient advice	Quantity supplied	Pharmacy check
May be generic name or brand name	Form of the medicinal substance eg capsules, tablets, liquid	Medication administration description (eg oral, intravenous, etc). May include method (eg inhaler).	Recommendation of time period for which the medication should be continued. "Continue indefinitely"; "Do not discontinue" (never discontinue); "Stop when course complete".	Description of the entire medication dosage and administration directions, including dose quantity and medication frequency, eg "1 tablet at night" or "20mg at 10pm"	Reason for medication being prescribed, where known. Description of any amendment, where relevant	May include guidance to prescriber, patient or person administering the medication eg rinse mouth with water after use	The quantity of the medication (eg tablets, inhalers, etc.) provided to the patient on discharge. This may be dispensed by the pharmacy or on the ward. Or "Patient's own medication".	Initials of pharmacist

Status: Added/amended

Status: Continued

Status: Discontinued (also to include date of discontinuation)

G Allergies and adverse reactions

"No known drug allergies or adverse reactions" should be recorded where a specific agent is not mentioned

Causative agent*	The agent such as food, drug or substances that has caused or may cause an allergy intolerance or adverse reaction in this patient.
Descripton of reaction*	A description of the manifestation of the allergic reaction experienced by the patient. Eg skin rash.

H Person completing record

Autopopulated; multiple authors could contribute to discharge summary eg ward doctor, pharmacy, therapists, nursing staff, but this is the individual clinician who is responsible for completing the discharge summary.

Name	Role	Organisation	Date and time completed	Additional information

Distribution list
(cc and to include patient)

May be automated depending on electronic record used; print copy for patient and go through it with them to check for accuracy and ensure understanding. A copy of the discharge summary should be sent to the admission referrer where relevant, in addition to the GP.

Name	Role	Organisation