



Improving e-discharge summaries: guidance for supervisors of the learning resource

Introduction:

By October 2018, NHS organisations are required by the NHS England Standard Contract to be sending discharge summaries by direct electronic transmission as structured messages using coded data and standardised clinical headings, so that data can be automatically extracted into GP records ([NHS Standard Contract 2017/18 and 2018/19 Technical Guidance](#), section 39.22). Discharge summaries have historically been found to be poorly written and contain inaccurate and ineffective information^{1,2,3,4}. Given that the safety and effectiveness of care is largely dependent upon accurate and appropriate communication, this is clearly an important issue that requires attention.

The Royal College of Physicians' (RCP) Health Informatics Unit (HIU), with the Professional Record Standards Body (PRSB), has been instrumental in developing a standard for the content and structure of discharge summaries: <https://www.rcplondon.ac.uk/projects/healthcare-record-standards>.

The junior doctors authoring discharge summaries have little, if any, training on how to write good discharge summaries and do not usually receive feedback or supervision for the task⁴; the methodology and resources available for writing discharge summaries may vary both between and within Trusts. Discharge summary completion is a commonplace activity for doctors, but also for other allied medical professionals including physician associates, advanced clinical practitioners and pharmacists.

To achieve accuracy and consistency in discharge summaries, the HIU has now created an education resource which aims to improve the understanding of the importance of comprehensive, accurate summaries, and explain how this can be achieved. This guidance document has been written to accompany the resource.

The education resource was piloted in six NHS Trusts across England, targeting predominantly Foundation doctors. The results and recommendations from evaluating the pilot were used to update the learning resource materials and have been incorporated into the guidance within this document.

¹ Care Quality Commission. Managing patients' medicines after discharge from hospital. London: Care Quality Commission; 2009. http://webarchive.nationalarchives.gov.uk/20101122140156/http://www.cqc.org.uk/_db/_documents/Managing_patients_medicines_after_discharge_from_hospital.pdf [Accessed 21.08.18]

² Moore C, Wisnivesky J, Williams S, McGinn T. Medical errors related to discontinuity of care from an inpatient to an outpatient setting. *Journal of General Internal Medicine*. 2003;18(8):646-51.

³ May-Miller H, Hayter J, Loewenthal L, Hall L, Hilbert R, Quinn M, Pearson N, Patel A, Law R. Improving the quality of discharge summaries: implementing updated Academy of Medical Royal Colleges standards at a district general hospital. *BMJ Open Quality*. 2015;4(1):u207268.w2918

⁴ Care Quality Commission. Beyond barriers: how older people move between health and care in England. London: Care Quality Commission; 2018. <https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england> [Accessed 21.08.18]

Learning activity details:

Duration	1-2 hours (excluding pre-training and post-training audits)
Audience	Any healthcare professional that authors discharge summaries to primary healthcare teams from a secondary care setting
Timings	<p>Deliver to trainee doctors as close to the start of their F1 year as possible, preferably before they begin authoring discharge summaries, or as part of classroom teaching and/or a workplace-based assessment (WPBA).</p> <p>Deliver to other healthcare professionals, including pharmacists, advanced clinical practitioners and physician associates before they begin writing the summaries, wherever possible.</p>
Group size	<p>The learning activity could be done by either individuals or groups of trainees, supervised by an educational supervisor or a relevant senior clinician who understands and champions the discharge summary as a communication tool between primary and secondary care.</p> <p>The recommended group size would be 8-10 trainees, to enable participation by all in discussions, but it could be delivered to larger groups if the equipment and space available could cater for this.</p> <p>If it is not possible for the trainees to be supervised directly during the activity, it could be carried out independently by trainees using the 'Guidance for trainees', as individuals or small groups, but this is far less preferable. One of the highest scoring benefits of this learning resource has been the opportunity to discuss e-discharge summaries with peers and senior colleagues.</p>
Equipment required	<p>For training provided to a supervised group, it would ideally be delivered in an IT suite facility with enough computers for each trainee or each pair. The supervisor would also need access to a computer and a projector, so that all trainees could see the supervisor's screen at one time for the purposes of discussion. Training materials could be provided in paper format where computers are not available.</p> <p>Trainees working independently would need to be directed to the toolkit in advance of their training and would need a computer.</p> <p>When completing the audit of their discharge summaries, trainees would need to have access (in digital or paper form) to discharge summaries they had written and internet access for the audit tool.</p>

Resource toolkit contents:

1. **'Discharge summary template overview' (PDF)**
A generic discharge summary template aligned with the PRSB e-discharge summary standard⁵. This is not intended to be a definitive template but includes the main clinical headings for educational purposes to help people to write a quality discharge summary.
2. **'Discharge summary template crib sheet' (PDF)**
Notes to guide writing a discharge summary.
3. **'Discharge summary template and annotated example' (Excel)**
An example patient discharge summary annotated to explain points of importance.
4. **'Activity-Clinical notes example' (PDF)**
Example clinical notes to accompany the discharge summary writing task, in PDF format for ease of printing, if desired.
5. **'Activity-practice discharge summary writing task' (Excel)**
Example clinical notes with accompanying blank discharge summary, with relevant fields pre-populated.
6. **'Activity-practice discharge summary example completion'**
Example completion of a discharge summary for the example clinical notes provided.
7. **'E-discharge summary self-assessment checklist'**
Self-assessment checklist to enable self- or peer-review and guided reflection of the completed practice discharge summary (4-6 above).
8. **'Guidance for supervisor - e-discharge summary learning resource'**
Guidance notes for supervisors of the e-discharge summary learning resource (this document).
9. **'Guidance for trainees -discharge summary learning resource'**
Instructions for trainees completing the e-discharge summary learning activity independently (without supervision).
10. **Audit tool** to assess the quality of an e-discharge summary. Available online:
<https://www.rcpworkforce.com/se/253122AC0ECA952>

Learning activity methodology:

Before the learning activity

We suggest that, prior to running the learning activity with the trainees, you familiarise yourself with the contents of the resource pack.

You may find it helpful to review the most recent PRSB guidance on e-discharge summaries:

<https://theprsb.org/standards/edischargesummary/>

⁵ Professional Record Standards Body. E-discharge summary. London: Professional Record Standards Body ; 2018.

<https://theprsb.org/standards/edischargesummary/> [Accessed 21.08.18]

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You should familiarise yourself with the generic discharge summary template that has been created for the purpose of this learning activity. It is not intended to be a definitive template. It has been created as a “best practice” example from the PRSB standard and through discussions with a variety of stakeholders including hospital doctors, GPs, pharmacists, and patients. The template is unlikely to be identical to the system used in your organisation; as well as not looking the same, some of the contents or fields may differ.

We suggest you compare and contrast your own Trust’s discharge summary template with the generic discharge summary template in the learning resources and, if there is a large discrepancy, the PRSB standards (see Figures 1 and 2). This exercise is useful in highlighting any fields that are not specifically included in your Trust’s template, such that, following the learning activity, the trainees can be signposted to the Trust document and where they may include best-practice elements if specific fields for them are absent.

Adaptations may be required to meet trust or professional body requirements eg medication prescribing; mandatory senior review and sign off; multiple author input.

E-discharge summary example template overview

<p>A Patient Demographics: Patient name Date of birth Address NHS number Safety alerts</p>	<p>B GP Practice: GP name GP practice details</p>		
<p>C Social context</p>			
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-right: 1px solid black; padding: 5px;"> <p>D Admission details</p> <p>Reason for admission Date/time of admission Admission method Relevant past medical, surgical and mental health history</p> </td> <td style="width: 50%; padding: 5px;"> <p>Diagnoses</p> <p>Primary diagnosis Secondary diagnoses</p> </td> </tr> </table>		<p>D Admission details</p> <p>Reason for admission Date/time of admission Admission method Relevant past medical, surgical and mental health history</p>	<p>Diagnoses</p> <p>Primary diagnosis Secondary diagnoses</p>
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<p>E Clinical Summary:</p> <p>Clinical summary Procedures Investigation results</p>			
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-right: 1px solid green; padding: 5px;"> <p>F Discharge details and plan:</p> <p>Date/time of discharge Discharge destination Next appointment details Plan and requested actions Information and advice given Patient and carer concerns, expectations and wishes</p> </td> <td style="width: 50%; padding: 5px;"> <p>Medication: Added/amended; continued; discontinued Medication name, Form, Route Dose duration description Dose directions description Indication/description of amendment Additional information/patient advice Quantity supplied Pharmacy check</p> </td> </tr> </table>		<p>F Discharge details and plan:</p> <p>Date/time of discharge Discharge destination Next appointment details Plan and requested actions Information and advice given Patient and carer concerns, expectations and wishes</p>	<p>Medication: Added/amended; continued; discontinued Medication name, Form, Route Dose duration description Dose directions description Indication/description of amendment Additional information/patient advice Quantity supplied Pharmacy check</p>
<p>F Discharge details and plan:</p> <p>Date/time of discharge Discharge destination Next appointment details Plan and requested actions Information and advice given Patient and carer concerns, expectations and wishes</p>	<p>Medication: Added/amended; continued; discontinued Medication name, Form, Route Dose duration description Dose directions description Indication/description of amendment Additional information/patient advice Quantity supplied Pharmacy check</p>		
<p>G Adverse Drug Reactions: Causative agent Description of reaction</p>			
<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; border-right: 1px solid blue; padding: 5px;"> <p>H Person(s) completing record: Name, role, organisation, date and time</p> </td> <td style="width: 50%; padding: 5px;"> <p>Distribution list: Name, role, organisation</p> </td> </tr> </table>		<p>H Person(s) completing record: Name, role, organisation, date and time</p>	<p>Distribution list: Name, role, organisation</p>
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Figure 1: HIU e-discharge summary template overview

Trust discharge summary review example

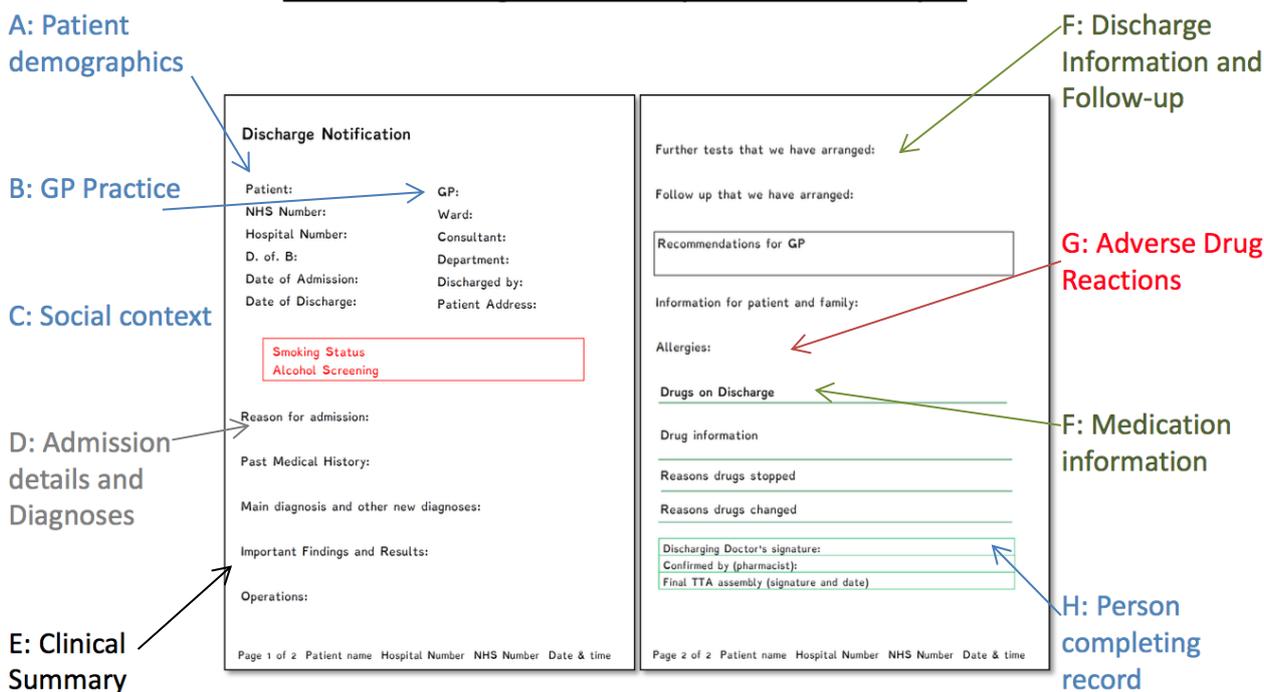


Figure 2: This demonstrates the exercise described in the *'Before the learning activity'* section above: identifying the sections on the Trust discharge summary for comparison with the HIU template. The diagram shows an example discharge summary from an organisation, and the sections within it have been linked to the relevant sections of the generic discharge summary template provided in the resource pack.

Pre-activity audit

We suggest reviewing the standard of discharge summaries in the Trust prior to delivering the learning activity. This should be an audit of discharge summaries written by individuals who will be taking part in the training. Audit materials have been prepared as part of this resource pack to enable an audit both before and after the learning activity to assess the impact of the learning activity on the quality of discharge summaries in your organisation, as well as the helpfulness of the learning activity for the trainees.

Trainee doctors are required to undertake quality improvement projects, including audits, and may be able to use this review as evidence for part of this requirement.

The audit tool is available here: <https://www.rcpworkforce.com/se/253122AC0ECA952>

Learning activity method

1. The trainee(s) are initially asked to review and critique an example discharge summary (see ***'3. Discharge summary template and annotated example'***). The supervisor leads the discussion

around the purpose of discharge summaries, their audience, problems and pitfalls, best practice aided by the annotated points and the crib sheet notes to guide writing a discharge summary (Figures 3a and 3b – see **'2. Discharge summary template crib sheet'**). This exercise also introduces the generic example template to the trainee(s), as well as highlighting the importance of good written documentation.

2. The trainee(s) then completes a discharge summary for an example patient (see **'4. Activity-Clinical notes example'** and **'5. Activity-practice discharge summary writing task'**). They may choose to use the guidance material (see **'2. Discharge summary template crib sheet'**) to help write the summary.
3. The completed discharge summary is either peer- or self-assessed using the checklist (see **'7. E-discharge summary self-assessment checklist'**), supported by their education supervisor or senior clinician. A completed discharge summary is included to aid the discussion, if required (see **'6. Activity-practice discharge summary example completion'**).
4. Specific training may then be required, incorporating the learning into the relevant Trust's discharge proforma.

Variations: note that trainers may wish to adapt the material, as required. Different methodologies, eg "flipped classroom" (pre-reading), team-based learning and large group methods could all be employed.

After the learning activity

We suggest all participants review at least one real discharge summary using the audit tool (access using the link: <https://www.rcpworkforce.com/se/253122AC0ECAF952>) for their own benefit.

F1(s) undertaking the training could complete a case-based discussion (WPBA) by writing a real discharge summary for one of their patients on the Trust's system in their Foundation portfolio, with the focus on written communication. They could be encouraged to reflect on the elements they have included, based on the learning activity, that they may have otherwise neglected.

Post-activity audit

We suggest that, as a minimum, learning activity participants review one of their discharge summaries utilising the training materials soon after the activity to reinforce their learning. A re-audit is suggested two to four weeks after the workshop, on a minimum of 10 real discharge summaries (in total per group), written by the learning activity participants. It is suggested that this is carried out by the participants, as an additional activity to benefit their reflection on the process of writing e-discharge summaries and to share learning.

5.

Section	Headings and elements	Notes
A	Patient demographics	Check the correct patient record is being completed, especially where autopopulated by the electronic patient record
	Patient name	Autopopulated
	Date of birth	Autopopulated
	Patient address	Autopopulated
	NHS number	Autopopulated (unique identifier)
B	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).
	GP practice	Name of a patient's general practitioner, if offered by the patient or their representative
C	GP name	Autopopulated – Name and address of the patient's registered GP practice
	GP practice details	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	Social context	
	Admission details	The main reason why the patient was admitted to hospital, eg chest pain, breathlessness, collapse, etc.
	Reason for admission*	Autopopulated
	Date/time of admission	May be autopopulated, eg elective/emergency
	Admission method	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 anaesthetic issues, etc
E	Diagnoses	List 7 bullet points/ brief factual information
	Primary diagnosis*	'Currents', primary diagnosis (or symptoms), active diagnosis 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.
F	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.
	Investigation results	The details of any therapeutic or diagnostic procedures performed. This should be the name of the procedure, with additional comments if needed. It is important to include results of investigations which the GP is likely to monitor either of the health condition or associated 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;
	Discharge details and Plan	It is really important the GP understands the next steps for the patient and what they are responsible for organising
G	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)
	Next appointment details	Follow-up appointment booked, eg outpatient department – include contact details.

Figure 3a: Crib sheet – part 1

Plan and requested actions:								
Information and advice given	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							
Patient and carer concerns, expectations and wishes	Note of information and advice given and patient/carer comprehension 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.							
Medication								
Medication name*	Form*	Route*	Dose duration description*	Dose directions description	Indication†/ description of any	Additional information/ patient	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"; "20mg at 10pm"	Description of the entire medication dosage and administration directions, including dose quantity and medication frequency, eg "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)								
Allergies and adverse reactions								
Causative agent*	"No known drug allergies or adverse reactions" should be recorded where a specific agent is not mentioned							
Description of reaction*	The agent such as food, drug or substances that has caused or may cause an allergy/intolerance or adverse reaction in this patient. A description of the manifestation of the allergic reaction experienced by the patient. Eg skin rash.							
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						

Figure 3b- Crib sheet – part 2