SITE-SPECIFIC DISCHARGE SUMMARY INSTRUCTIONS

EUH/EUHM

To dictate:

1. 2-8255 (EUH); 6-2222(EUHM)
2. Press '2' for d/c summary
3. Enter NPI and #
4. Enter patient MRN
5. Begin dictating
   Pause: 4 Rewind: 3
   Resume dictation: 2
   End dictation: 5
6. After transcription (< 24 hrs), you will find the summary in your PowerChart "documents to sign" box. Edit and sign.

To use the template:

1. Go to "Document viewing" in PowerChart
2. Click "Add"
3. Click on "Encounter pathway" tab
4. Type in "Discharge", change filter to "contains", hit "search"
5. Highlight "Emory Discharge Summary" and click "Add to Favorites"
6. Make sure all discharge communication elements are included (see list on the other side of the card)!
7. This is an official document that is sent to PCPs, so be professional and coherent.

GRADY

1. In the patient's EPIC chart, click on the **Discharge** tab (far left).
2. Click on **Discharge Summary** to the right.
3. Navigate through the d/c summary using the yellow arrows at the top of the note.
4. Click **Accept** when finished.
5. Make sure all discharge communication elements are included (see list in this card).

VA

1. Click on "discharge summary" tab at the bottom of CPRS.
2. Make sure all discharge communication elements are included (see list on the other side of this card).
3. ALL required fields must be completed prior to verification.

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Transitions of Care

OVERNIGHT COMMUNICATION

The WRITTEN Sign-out

1. UPDATE ALL ELEMENTS DAILY – your handover is only as good as the effort you put in!!
2. Although all hospitals have a template, the following elements should be included:
   - Brief hospital course
   - Problem list (include active AND chronic problems)
   - Code status
   - Family or NOK contact information (note if there are unusual circumstances)
   - "To-Do" Items (follow-up activities) – be as specific as possible
   - If-Then Contingency planning / anticipatory guidance (see below)
   - Team /Attending / Resident / Intern (with contact numbers for each)

The VERBAL Sign-out

"SSAIF-IR" (based on Chu et al., JHM 2010; 5: 344-348)

S: Sickest First
S: Summary Statement
1-3 sentences- why is this patient here and what do you think is going on?
A: Active Issues
What happened to this patient today?
What are the ongoing issues that might need to be handled overnight?
I: If-Then Contingency Planning
What anticipatory guidance can you provide to help the cross-covering resident? "If you get called for"X", then do "Y"."
F: Follow-up Activities
What does the cross-cover resident need to follow-up on?
Provide specifics – "Please check "X" at 9:00, if it comes back as "Y", then do "Z".
I: Interactive Questioning by the "receiving" provider
Opportunity for the "receiving" provider to clarify information.
R: Readback by the "receiving" provider
"Receiving" provider should confirm follow up activity and contingency plans

When the night is DONE:

CLOSE THE LOOP!
Communicate with the team about overnight events.

DISCHARGE COMMUNICATION

***Dictate or write on the day of discharge (no later than 24 hours of discharge); notify PCP by phone or email of any important new diagnoses / testing follow-up.**

- Attending of record
- Outpatient PCP
- Principal Diagnosis (or Reason for Admission)
- Problem List
- Imaging / Procedures with results
- Relevant history, physical exam, studies at presentation (3-5 sentences)
- Hospital Course by Problem List
- Discharge Medications
  - → Highlight changes (NEW, CHANGES in doses/frequency, or STOPPED)
  - → You can "refer to discharge medication list".
- Discharge disposition w/ Advanced Directives & Code Status
- Test results pending at discharge
- Follow-up appointment(s) date(s)/time(s) and outpatient studies planned

***Note**: Additional requirements may vary by hospital

Discharge Checklist:

Start early and work with your interdisciplinary care team!!

1. **Discharge setting**:
   - ✓ If the patient is forgetful or has dementia, is there a caregiver responsible for the patient's care?
   - ✓ Is there need of additional support (therapy, social services, nursing) after discharge?
2. **Medications**:
   - ✓ Has the medication list been reconciled, simplified, and provided to the patient?
   - ✓ Have YOU verbally explained new/changed/stopped medications to the patient?
   - ✓ Is there a timely plan, such as lab tests or provider appointments, to monitor for adverse effects of new or changed medications?
3. **Discharge Instructions**:
   - ✓ Has the patient been provided disease-specific education?
   - ✓ Is there a 24/7 number that the patient can call with any questions?
   - ✓ **Have YOU taken the time to meet with the patient to answer any questions about discharge instructions?**
4. **Follow-Up**:
   - ✓ Is there a written plan for testing and/or provider appointments?
   - ✓ Have you ensured that the PCP will have a discharge summary when they first see the patient?
   - ✓ Is there follow-up with the PCP within 7-21 days of discharge?

For more information:
http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/PDFs/TARGET.pdf