Potential Improvements for the Generation and Processing of Discharge Summaries

This table is not intended to be prescriptive but a collection of ideas for collaborative approach shared by primary and secondary care to improve the information recorded and shared for patients being discharged from hospital recognising the impact on the discharge process itself.

<table>
<tr><th>Functional Ideas i.e. what could be implemented</th><th>Ideas for how to operate the functions</th></tr>
<tr><td colspan="2">1. Generate the Discharge Summary</td></tr>
<tr><td>The Discharge Summary must collate and contain these items specified by the eDischarge Standard.
Prepopulated with data recorded prior to discharge.
All new Diagnoses and Procedures
All procedures, diagnoses should be SNOMED coded.
Onward Management Plan
Any community care packages in place / commissioned
Inpatient care received
Referrals
Planned outpatient appointments.
Specific advice and actions stating who is responsible for each.
Patient advice for after care.</td><td>EPR conformance with PRSB e-discharge standard
Ensuring that the EPR maps to SNOMED within the Trust so diagnoses and procedures are transferred to the summary rather than having to be created de novo.
Ensuring Planned outpatient investigations/ follow-up/ Any community care packages are clearly articulated and displayed.
Ensure specific advice and all actions including the person or organisation responsible are clearly stated and displayed. (See Implementation guidelines about what is appropriate and what isn’t)
Specific actions/ follow-up/ advice for patients for after-care is recorded and clearly displayed.
Ensure medications are clearly marked as Continued, New, Stopped
Ensure medications are listed in alphabetical order
Ensure medications are mapped to dm+d</td></tr>
<tr><td colspan="2">2. Reviewing the discharge summary</td></tr>
<tr><td>Responsible consultant to clinically approve the content of the discharge summary.

Discharge coordinator to expand their role from completing the traditional discharge checklist to reviewing the discharge</td><td>Discharge summary completed by team.

Sent to consultant for clinical approval.

ADT Board. (EDD available Live)</td></tr>
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summary alongside Primary care coordinator. Quality review: ensuring information in (1) is captured in right form. • Any diagnoses/ procedures not mapped to SNOMED are amended in consultation with the responsible consultant. • Check any planned follow-up is recorded in the discharge and organised. Check community teams – step-down/ matrons/ DNs are aware of patient and when first review/ visit is due. Any follow-up/ GP requests are reviewed for appropriateness. • GPs not responsible for "chasing" investigation results • If tests need to be done following discharge, timelines, rationale, what to do if result is abnormal (send back to which team, etc) all clearly recorded. (check if in e-discharge)	Discharge coordinator has a list of discharges to discuss with Primary Care Coordinators – this is done virtually using Teams/ similar. Primary Care Coordinators reviews summary via screenshare focussing on (1) new diagnoses/ procedures mapped to SNOMED, (2) recording of planned follow-up (3) reviewing appropriateness of GP actions.
3. Sending the discharge summary	
Practice should be sent the summary electronically (*test acknowledgements communicated with discharge coordinator?)* Copy should be given to patient. Primary care coordinator to check practice receives the discharge summary.	All patients are linked to GP practice via ODS which has corresponding method of electronic communication e.g.MESH/ docman email inbox specified Discharge summary is sent via method. Process required for checking discharges have been received e.g. via discharge coordinator/ Network coordinator interface in the absence of a technical solution. This avoids duplicates.
4. Receiving/ Processing the discharge summary	
In the absence of structured receive capability: • Administrative team at the practice records diagnoses/ procedures in the GP EPR (SNOMED) • Admin team checks if there are any GP actions in the agreed part of the discharge summary and	Receive capability built to consume structured data and auto-populate new diagnoses/ codes, medication (with clinical approval), etc

<table>
<tr><td>workflows to pharmacists +/- GP (if actions)
• Pharmacy technician/ Pharmacists review and reconcile medication as well as additional check (if not sent to GP) to ensure no specific actions are required from GP</td><td></td></tr>
<tr><td colspan="2">5. Recording any quality issues with discharge summary</td></tr>
<tr><td>Primary care coordinator (s) to audit and record any issues encountered by admin/ pharmacists/ GPs processing the summary.

Distinct coordinator from the care coordinator liaising with the trust?</td><td>Audit proforma/ log which is completed for every discharge summary received detailing issues encountered in real-time by the person involved.

Primary Care coordinator to own the log and ensure issues recorded clearly.

Log has dual purpose [for (6) and (7)]</td></tr>
<tr><td colspan="2">6. Clarification of data received</td></tr>
<tr><td>Pharmacist/ Primary Care staff to clarify information with the hospital teams (with discharge coordinator?) e.g. medication errors/ omissions/ follow-up plans.</td><td>Most appropriate/ relevant practice/network staff member to clarify issues identified using the log with the hospital discharge coordinator (who may have to go and liaise with the most appropriate person to resolve issues)

Response received within specified time as per locally developed SLA.

Updated discharge summary should be sent.

Summary received by coordinator/ amendments made to EPR.

Communicated to GP/ person raising original issue</td></tr>
<tr><td colspan="2">7. Ongoing System Audit & Continuous Improvement</td></tr>
<tr><td>Metrics such as quality of discharge, timeliness of receipt captured and reviewed regularly with the trust.

Multi organisational Team incl senders and receivers of DS.

Learning and actions</td><td>System wide partnership quality meeting focusing on discharge metrics and learning. A review team that represents the producers and consumers of discharge summaries.

Spot checks of discharge summaries, perhaps for particularly complex patient cohorts.

Who: Designated Quality Lead, Trust quality lead, Borough/ Place based quality lead (s), to discuss by exception/ or thematic analysis of issues raised.</td></tr>
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	Reporting to the Health and Care System Quality Lead happens as BAU by each primary care organisation network on an agreed weekly/ monthly basis.