

Transitions of Care – How to Write a “Good” Discharge Summary

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Imagine the scenario... It's 12:30 P.M. and you have clinic scheduled in 45 minutes. The case manager informs you that Mrs. Jones just got a bed at Goddard House and the ambulance is booked for 1:30 PM. You opened the discharge summary when she came in but it is far from complete. How can you finish the paperwork, grab lunch and still make it to clinic on time?

The discharge summary is often seen as the bane of any intern's existence. You have spent days, sometimes weeks, providing care for a patient and now it all needs to be summarized in a brief document. Ideally, this document should take no more than a few minutes for the receiving practitioner to review and ascertain the salient details of the hospitalization. In conveying this information, it can be helpful to think of the discharge summary as an admission H & P. If you were admitting the patient, what would you want to know?

- Diagnosis – This should be as accurate as possible. For example, cough is a symptom. Was the patient ultimately diagnosed with pneumonia, bronchitis, or a COPD exacerbation? The diagnosis will immediately guide the practitioners care plan.
- Past Medical History (a.k.a. Secondary Diagnoses) – What is pertinent in providing comprehensive care for this patient? It is more important that the new provider knows the most recent ejection fraction for a patient discharged after a CHF exacerbation than know that the patient has a history of onychomycosis. When admitting a diabetic patient, one would take a different approach for an individual with a glycosylated hemoglobin of 14.1 than person with a glycosylated hemoglobin of 6.9.
- Medications (and allergies) – The list you provide in the discharge summary will be used as a guide for the admission orders at the nursing home. If the patient is admitted over the weekend, the patient may not be seen for several days by a doctor or nurse practitioner. It is important to list all the medications that the patient is currently taking and note those which were held (i.e. poor oral intake so glipizide held or dose reduced). Cutting and pasting the outpatient medication list without review can result in medication errors and adverse outcomes.
- Procedures and Significant Tests – It is not necessary to list every test which was performed during hospitalization. As mentioned in this section's title, only significant test **results** should be reported. For example, it is not necessary to report the daily chest x-ray of a patient was intubated in the ICU with a multilobar pneumonia. Mention test results which were important in patient outcomes and medical management decisions.

- Reason for admission and hospital course – This section is dedicated to communicating the “story” associated with the patient’s hospitalization. How did the patient present? What was the key history that provided clues to the diagnosis and severity of presentation? Were there any events that affected management during the course of hospitalization? This section is generally the most time consuming to write. Conveying the relevant details in a **succinct, cohesive** manner is truly an acquired skill.
- Outstanding Issues - Use this section to convey what is needed to provide continued care. This can be as mundane as “check potassium in one week” to “needs CT chest in three months to follow up lung nodule.”
- Follow-up appointments – Where, when and with whom? If known, provide phone numbers in case appointments need to be rescheduled.

One final point to remember is that perhaps some time in the future, you will be on the receiving end and will appreciate a document well done.