Top 5 Discharge Summary Tips

By: Dr. Amit Shah, University of Texas Southwestern Medical Center at Dallas

1) JUST DO IT!

Get it done, at the moment of discharge—while you are writing the scripts, arranging follow up, etc. Not only will it be much quicker, but you are much less likely to make mistakes (medications, follow-up, etc). A discharge summary written 30 days after discharge is of no use to anyone as they've already had their follow-up or their readmission, etc. The rule in most hospitals is dictation within 24 hours of discharge. Vow to never spend a moment of your days off/vacation dictating old charts!!

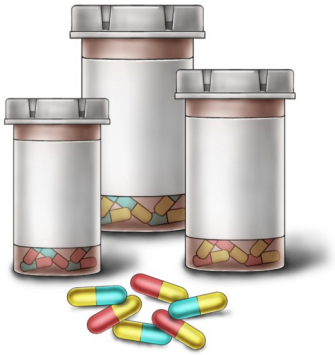
2) Beware of Verbal Diarrhea

"I am sorry I have had to write you such a long letter, but I did not have time to write you a short one"-- Blaise Pascal
Just because you spent 3 weeks taking care of a patient does not mean the discharge summary needs to be 20 pages long. It must be readable, concise, and in a problem-based format (not a blow-by-blow account). DO NOT cut and paste or read into the telephone the full admission H&P. This is a **SUMMARY**. If someone wants the whole chart, they can get it!

3) Remember your 7th grade English Teacher: Before writing, think about who your audience is

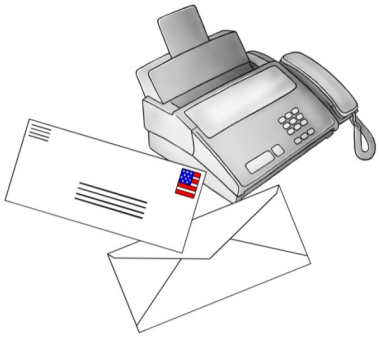
A PCP, a NH or rehab physician, or a specialist the patient will see for the first time are all going to want different information. Think about who the primary audience is for your discharge summary and highlight the information that will be most relevant. Put yourself in the shoes of the recipient—"What would I need/want to know if I was the next doctor taking care of this patient?"

4) Be compulsive about the medication list



Medication errors at discharge are a leading cause of readmission to hospitals and adverse drug reactions. Never write "resume home medications"—you have no idea what the patient is really taking at home. Clearly identify new meds, changed meds, stopped meds, and continued/unchanged meds. Beware of EMRs—**garbage in, garbage out:** If the person who took the medication list at admit was incorrect, your medication reconciliation will be wrong. Always confirm the final list with your patients!

5) Make sure your discharge summary gets there



This one is obvious, but most often forgotten. Your hard work is wasted if the person you wrote for never gets the summary in a timely fashion. If the follow-up is within the same system, then they can often look in the EMR. But, many patients have providers outside—for these providers you have two options: 1) The Low Tech Option: Complete and print out 2 copies and give to the patients; tell them to give one to their PCP. Or, 2) The High Tech Option: fax/e-mail it yourself. Either way, make sure it gets there!