The inside scoop...How to write a discharge summary

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Editor: Catherine George

It's your first day of internship and you step onto the ward. You've seen *Grey's Anatomy, House MD, Scrubs* so you have some idea what you're in for...or at least you thought you did. A few hours in it doesn't take long before you realise that you are underprepared for one of the most important responsibilities of your job. No, I am not talking about emergency tracheostomies, end of life discussions, inotropes ... I'm talking about discharge summaries.

As part of our local redesign group at our hospital, we were tasked with regularly surveying junior medical officers to identify key issues within the hospital system that can be improved. A recurrent issue raised year after year was a resounding dissatisfaction of interns with discharge summaries. It wasn't just that they were cumbersome (though this was undoubtedly a contributor), but rather that there was a lack of formal guidelines or education about what was required for discharge summaries. This was made worse as they moved through different rotations under different consultants and registrars with different expectations. Inevitably, this resulted in significant variability in the quality and length of discharge summaries. I personally have seen some discharge letters ranging from a single sentence to dissertations of Iliadic proportions (I recall my own magnum opus was 10 pages long!). The former situation can indicate loss of vital information, whilst the latter likely implies time that could have been better spent.

In response to this, and backed by the executive of our hospital who saw this as a priority, we set up a subcommittee of over 12 interns, residents and registrars to address the issue of what makes a good discharge summary in the hope of trying to establish some formal guidelines. In this blog, I'll share some of the key learning points from our efforts.

But firstly, it's worth revisiting the purpose of discharge summaries. Traditionally, we think of discharge summaries as a letter to the general practitioner (GP) detailing the

events of a patient’s admission to hospital. But discharge summaries also serve other functions and there are several components of the healthcare system that rely on them. Emergency physicians are increasingly relying on previous discharge letters as reliable documentation of a patient’s medical history where this is otherwise not available. Consultants and inpatient teams from various hospitals likewise use it as a record of investigations and treatment a patient may have received at their own or other institutions. Even hospital administrators rely on discharge summaries to keep track of hospital activity and codes to ensure appropriate allocation of funding.

With this in mind, we decided that we needed to approach all the above stakeholders for our own project. So together with an enthusiastic group of interns and residents, we surveyed general practitioners, medical and surgical consultants, coding officers and emergency physicians on what they thought were essential components of discharge letters, what’s *not* important and what can be improved. These are summarized below.

TMI (Too Much Information)

The overwhelming consensus amongst all the groups was that the more concise a discharge summary – the better. After all, most GPs working in a typically busy practice will not have time to rifle through all ten pages of your discharge document. Indeed, as most senior consultants would tell you, discharge summaries used to be a hand-written single-page form filled in just as the patient was about to leave. Overall, the feedback was that a discharge summary should be treated as a handover document – a synthesized narrative with only the relevant facts rather than several disparate details.

The *Sine qua non* (What not to miss)

When asked what were the most relevant aspects of a discharge summary that **should** be included there was some slight variation between the stakeholders, but invariably the feedback was a focus on the **discharge plan** – in particular for relevant pathology, appointments and actions that GPs and other specialists are required to follow through. This is a handover summary distilled to its essence, so the take home message was that if you only had a few precious minutes to write a discharge letter – focus on the plan. But there were other essential items that recurred in the surveys that many thought were absolute requirements and they include:

- **Changes in medications and rationale**
- **Main and secondary diagnoses and issues during the admission (being as a b a ondasesan ds**

- A comprehensive but brief opening summary was th

Similarly, most stakeholders felt that investigation results (pathology, imaging etc) should only be included if they were significant and/or needed to be followed up.

Surgical consultants specifically felt that routine inclusion of social history is not necessary and should only be included if relevant (i.e. risk factors for illness or if there were barriers to discharge p