St Elsewhere and Somewhere Hospitals NHS NHS Trust

Discharge Summary USE BLACK INK ONLY

Patient Details	**Admission and GP Details**
Surname	Discharging Consultant
Forename M / F/ ……	Discharging Speciality/ Department
Date of Birth	Method of Admission
NHS/ Hosp No.	Date of Discharge
Address	Date of Discharge
	G.P. Details
Tel No.	
Diagnosis at Discharge	**Operations and Procedures**

Reason for Admission and Presenting Complaint(s)
Clinical Narrative
Relevant Investigations and Results
Discharge Destination
Relevant legal Information (e.g. was an independent Mental Capacity Act Advocate required)
Information given to patient and/or authorised representative (including e.g. see GP in 2 weeks)

Physical Ability & Cognitive Function :	**On Admission**	**At Discharge**
Physical		
Cognitive		
Other		

Advice, recommendations and future plans (including results awaited and outstanding investigations)
G.P. Actions (Date)
Strategies for potential problems

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Discharge Summary USE BLACK INK ONLY

Name	**D.O.B**	**NHS/ Hosp No.**

Actions and Outstanding Investigations

	Action	Person Responsible	Date
Hospital (e.g. OP Appt) /Investigations			
Community & Specialist Services (e.g. nursing, therapy)			

Medications Stopped/ Changed **Yes/ No**

If yes please give details:

Allergies/ Risks & Warnings

Discharge Medications	**Dose**	**Frequency**	**Route**	**Duration**	**Quantity Supplied (Pharmacy used)**

Compliance aid? Dossette/ Nomad/ Other Supplying Pharmacy

Pharmacy dispensed by Checked by Date

Details of Discharging Doctor

Print Name_ _ _ _ _ _ _ _ _ _ _ _ _ _ _ Doctors Signature _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _ _

Date _ _ _ _ _ _ _ _ _ _ _ _ _ Grade FY/ ST< 3/ ST> 3/ SpR/ Con Bleep No. _ _ _ _ _ _ _ _ _ _ _ _ _

Information for use of example templates

Standards for the structure and content of admission, handover and discharge documentation for hospital inpatients were developed in a project co-ordinated by the Royal College of Physicians, in partnership with NHS Connecting for Health, and agreed by the Academy of Medical Royal Colleges**.**

These standards represent a consensus view of the medical profession. They will improve patient safety by standardising the information held on patients throughout their stay in hospital, reducing the likelihood of mistakes and missing information at admission, handover and discharge.

The benefits of the structure and content standards are set out in 'Standardising the structure and content of medical records' published by the Digital & Health Information Policy Directorate of NHS Connecting for Health and Department of Health and are available on-line at [http://www.rcplondon.ac.uk/hiu]

The standards are structured as a series of headings with a description of what the heading refers to. The wording of the headings should be used to structure both paper and electronic patient records. **The wording of the headings should not be changed.**

In electronic records, information that has been entered once can be represented in different documents without requiring additional data input. Paper based documents however are fixed in presentation, and therefore not all of these headings would be appropriate for use in all cases.

The example templates for admission, handover and discharge have been developed to show how they may be used in paper documents. They can be downloaded as Microsoft Word documents and used 'as is' with the addition of relevant logos or used as the basis for hospitals and clinical services to develop their own paper records.

Where the templates are modified for local use and particular headings are not used, then there should be explicit justification for why this is the case. For example where patients have been admitted to hospital for routine uncomplicated surgical procedures, it would not be necessary to supply information for all the headings, and they need not be included in the paper documents.

Admission clerking proforma

The admission clerking proforma provided is an example of an implementation of the structure and content standards. The standards are the 'high level headings' and are highlighted. Additional sub-headings have been added so that the proforma can be easily used. The subheadings can be freely modified to suit local practice, specialised services and particular clinical settings.

Handover documents

Handover between clinical teams is one of the high risk transactions in clinical practice. There are two principal types of handover document suggested: handover to hospital at night or weekend teams and handover where on going care will be with a different consultant team. The handover documents can be used 'as is' and are unlikely to require significant amendments.

Not all handovers justify completion of paper documentation in busy clinical practice. However it is strongly recommended that formal handover documents are used when handing over patients who will require attention or who are at clinical risk.

The hospital at night and weekend handover example templates record information on several patients per page and will normally be discarded when no longer required. As they hold personal clinical information, care should be taken to ensure that they are not left lying around public areas, and should be disposed of for shredding.

The consultant team example template holds the information for a single patient and should be filed in the medical notes of the patient handed over.

Discharge Summary

The discharge summary template can be downloaded and used as is for the majority of hospital in-patients. It may be that patients admitted for routine minor procedures will not require the depth of information in the full discharge summary.