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Best Practices for Writing Discharge Summaries in Health Link

QUIPDOC (Quality of Inpatient Provider Documentation) Task Force

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QUIPDOC Task Force Goals

1. Develop a comprehensive discharge summary that includes elements known to be important for safe transitions of care between the inpatient and outpatient/skilled nursing facility setting.
2. Develop a standard discharge summary note template used across all services at UW Health that allows recipients (referring providers, PCPs, receiving facilities) to develop a familiarity with the document, thereby making it easier to find information.
3. Develop a discharge summary note template that supports an interdisciplinary discharge model of care by incorporating the discharge recommendations made by various clinical team members.
4. Improve communication and education regarding best practices for writing discharge summaries among all providers.

Background

Many at UW Health (and nationally) believe that aspects of the quality of provider documentation have declined with implementation of the electronic health record. The QUIPDOC Task Force was commissioned to address this concern and to assist providers in defining the best practices for writing various inpatient clinical notes in Health Link.

QUIPDOC Task Force members include hospital and professional coding staff, HIM staff, residents, mid-level providers, and faculty members. The Task Force has worked over the last year to define the best practices for writing discharge summaries in Health Link. The Task Force reviewed transitions of care

literature, sought expert opinion on transitions of care and discharge documentation, surveyed skilled nursing facilities, and developed consensus opinion among the group in developing these guidelines and the accompanying note template (Discharge Summary QUIPDOC).

Defining the Ideal Discharge Summary

Optimizing transitions of care has become a clear focus of healthcare goals nationally and among clinical leaders at UW Health. The discharge summary is arguably the most important document in the transition of care for hospitalized patients. The ideal discharge summary serves two main purposes:

1. It serves as a summary of the patient's reason for hospitalization, hospital course, and discharge diagnoses.
2. It serves as a handoff to the next provider(s) of care, providing detailed recommendations about how to care for the patient in either the outpatient or skilled nursing facility settings.

The discharge summary also plays a very important administrative role. It is the source for the coded data that drives our publicly reported clinical outcomes and quality measures, populates our clinical data repository used for research, and drives (increasingly) reimbursement for both the hospital and physicians.

Creating an ideal discharge summary template represented a significant challenge to the task force, as we aimed to develop a note that was comprehensive in nature but also efficient to create. In addition, unlike H&Ps and progress notes, the discharge summary does not have a historical "best practice" or standard accepted format, nor are we taught how to write such notes as medical students. In this regard, the task force aimed to develop a note template that would not only result in a comprehensive summary of the patient's stay and subsequent recommendations, but one that would also serve as a teaching tool for more junior clinicians learning how to write a discharge summary.

The attached table outlines each note element included in the discharge summary, the best practice recommendation for that element, any suggested smart links, and the minimum requirements for professional billing/hospital coding.

There are several global elements to note about the new "Discharge Summary QUIPDOC" template:

1. The template is designed to provide placeholders/reminders to the author about certain elements that *may* be important in an individual patient's care (e.g. bowel care, bladder care, wound care, etc.). Not every element will be applicable to every patient, and the template is designed such that these elements are not required.
2. There are several elements that will be automatically pulled from other documentation sources in the chart, facilitating efficiency for the author. A *** is included after each of these elements to draw the author's attention to the inclusion of these elements so that he/she can verify the accuracy of the documentation. If accurate, the *** can simply be highlighted (F2) and deleted.

3. It is important that the note author recognize his/her responsibility in attesting to the accuracy of ALL elements included in the DC summary. By signing your name as the author of the note, you are attesting to the note IN ITS ENTIRETY.
4. The order of the discharge summary note elements was the source of much thought and deliberation by the task force. The "BRIEF OVERVIEW" section provides a quick overview of reason for hospital stay, discharge diagnoses, and active issues requiring active follow up for the next provider of care. The "DETAILS OF HOSPITAL STAY" section outlines the patient's hospital course and status at the time of discharge. The "DETAILED DISCHARGE RECOMMENDATIONS" section outlines the recommendations for follow up care and any discharge orders and instructions for the patient.

Implementation of Best Practice Recommendations

1. Effective Tuesday, June 12th, the "Discharge Summary QUIPDOC" note template (smart text) will be available when searching "QUIPDOC Discharge Summary" in a smart text search window in Health Link. Services who have developed a service specific Discharge Summary based on the "Discharge Summary QUIPDOC" template will also have those templates available in the search field.
2. The Best Practices should be used as the guiding principles in the development of any NEW discharge summary note templates. Services who wish to customize the new "Discharge Summary QUIPDOC" template to meet their individual service needs, may submit a HEAT ticket with this request. Please note that services will be allowed to customize content and ADD any additional information to their templates, but elements will not be removed from the template during the initial phase of this rollout. In addition, because consistency in the order of note elements is essential for our referring providers and receiving facilities in easily finding information, we will not make changes to the order of note elements during the initial phase of the rollout.
3. Requests to remove elements or change the order of note elements should be forwarded to the QUIPDOC task force for consideration of downstream implications. You may email requests to Dr. Shannon Dean at sdean@uwhealth.org.
4. Attendings are encouraged to familiarize themselves with the best practices and use them as a basis for providing feedback to residents and students on the quality and content of their written discharge summaries.
5. Incoming residents and fellows will be taught to write DC summaries using the new Discharge Summary QUIPDOC template (or a service specific DC summary template based on the QUIPDOC version) during their Health Link training on June 22nd or June 29th.
6. Resident superusers from each of the core residency programs will be reviewing the new "Discharge Summary QUIPDOC" template with their colleagues and will continue to seek input/feedback on individual service needs.

7. After implementation, we will be seeking feedback from referring providers, our internal PCPs, and skilled nursing facilities on the newly designed discharge summary template. With ongoing learning, we expect periodic improvements/changes will be made in the DC summary template in a continual effort to improve communications at transitions of care.

Discharge Summary - Note Elements	**QUIPDOC Best Practice Recommendations**	**Smart Link Suggestions**	**Minimum requirement for professional billing/hospital coding**
Note Type	When selecting "D/C Summary" as the note type in Health Link, the discharge summary note template will be automatically displayed in the body of the note.The author should confirm the correct note type when initiating a note.		All patients (inlcuding observation status) require a DC summary after leaving the hospital.
Header	The note type and name of the service under whom the patient is currently listed will be automatically inserted into the default discharge summary template.		Not required.
Salutation	The name of the PCP and referring provider listed in Health Link will be automatically inserted into the "Dear ..." greeting. A *** exists to ensure that the author validates the correct PCP and referring provider are listed. If the incorrect PCP/referring is listed, you may enter a "Change PCP" order in Health Link. This order will alert admissions staff to update the listing in Health Link to the correct PCP/referring provider.	.PCP (name of PCP on file for patient in Health Link) .REFERRINPROV (name of the referring provider on file for patient in Health Link)	Not required
Brief summary of reason for hospitalization and hospital course	A one sentence summary of the reason for hospitalization and hospital course to provide a brief orientation for the reader (e.g. Briefly, Mr X was admitted for RLQ pain, underwent appendectomy, and had an uneventful postoperative course).		Not required
Admitting Provider	The name of the attending physician at the time of admission will be automatically inserted into the default discharge summary template.	.ADMPROV (name of attending physician at time of admission)	Not required
Discharging Provider	The name of the attending physician currently listed in Health Link will be automatically inserted into the default discharge summary template. If the attending listed is incorrect, you may enter a "Change Attending" order and the attending will be automatically updated in Health Link. You will need to refresh the smart link to see the correct name appear.	.ATTPROV (name of attending physician currently listed in Health Link)	Required element

Primary Care Physician (PCP) at Discharge & Contact	The name of the PCP currently recorded in Health Link and his/her phone number will be automatically inserted into the default discharge summary template. A *** exists to ensure that the author validates the correct PCP and referring provider are listed. If the incorrect PCP/referring is listed, you may enter a "Change PCP" order in Health Link. This order will alert admissions staff to update the listing in Health Link to the correct PCP/referring provider.	.PCP (name of PCP on file for patient in Health Link) .PCPPH (phone number listed in Health Link for the PCP)	Required element
Admission Date	The admission date should be included. The date will be automatically inserted into the default discharge summary template. This is the facility admit date—the date the patient arrived on the admitting unit.	.ADMITDT	Not required.
Discharge Date	The discharge date should be manually entered on the day of discharge.	.DISCHDT may be used as a smart link if the patient has already been discharged from the hospital. This should not be used if the patient is still admitted.	Required element
Primary Discharge Diagnoses	Recommend a free text list of the principal diagnoses most relevant to the reason the patient was hospitalized. (e.g. For a patient with cerebral palsy, epilepsy, and reflux admitted for aspiration pneumonia, the primary discharge diagnosis is "aspiration pneumonia". For purposes of clinical clarity, all diagnoses must be recorded in full without the use of abbreviations.	Smart links using the problem list should not be used in this section as the provider should include problems selectively.	Required element
Secondary Discharge Diagnoses	Recommend a list of the patient's comorbid conditions afffecting care that either predated the hospitalization or were secondary complications of the hospitalization/ primary diagnosis. For a patient with cerebral palsy, epilepsy, and reflux admitted for aspiration pneumonia, the secondary diagnoses are cerebral palsy, epilepsy, and GERD. If the patient had developed a catheter associated UTI while hospitalized that has since resolved, this would also be listed as a secondary diagnosis. For purposes of clinical clarity, all diagnoses must be recorded in full without the use of abbreviations.	Smart links using the problem list should not be used in this section as the provider should include problems selectively.	Not required
Discharge Disposition	The note should clearly state where the patient was discharged to (e.g. home, skilled nursing facility, rehab unit, etc.). The patient's disposition is captured by Case Management in their documentation and this will be automatically pulled into the note template. Providers should verify that this information is accurate.	Flowsheet row number 330539 is used in this section @FLOWREFRESH (330539)@	Required element

Name of legal guardian and/or Healthcare POA & contact information	The name of the patient's legal guardian and/or POA along with contact information should be immediately visible in the discharge summary. This is especially important for patients being discharged to a SNF. This information is captured by Case Management and will be automatically pulled into the note template if it has been documented.	Flowsheet row numbers 316305 and 330622 are used in this section @FLOWREFRESH (316305,330622)@	Required element
Code status at discharge	The code status for the patient at the time of discharge should be manually entered by the discharging provider.	THIS SHOULD NOT BE A SMART LINK	Required element
Active Issues requiring FU	Active issues requiring FU should be explicitly stated in the discharge summary (e.g. labs needed as outpatient, labs still pending at discharge that require follow up, titration of pain medications, etc.). A template for filling out this information is included in the default discharge summary template with sections for WHAT the issue is, WHO is managing the issue, WHAT is needed for follow up, and what associated follow up appointments have been made to address the issue. **IF YOU ASSIGN SOMEONE OTHER THAN YOURSELF AS THE MANAGING PROVIDER FOR A PARTICULAR ISSUE, YOU ARE REQUIRED TO COMMUNICATE DIRECTLY WITH THAT PERSON SO THAT HE/SHE IS EXPLICITY AWARE.**		Not required
Medication Monitoring	Recommendations for medications requiring ongoing monitoring/adjustment should be included in this section. Discharge medication monitoring orders recommended by pharmacy and signed by the provider will be automatically pulled into the note. Pharmacy is currently writing recommended orders for warfarin and any antimicrobials requiring monitoring.	.DCMEDMONITORING	Not required
Outpatient Follow Up	Any scheduled future appointments will be automatically inserted into the default discharge summary template. Providers should verify accuracy and add any appointments that still need to be scheduled.	.AFUTAPPT will pull all appointments that are scheduled prior to the time of discharge.	Required element
Lab Orders	Any outpatient lab orders for the patient that have been entered in Health Link will be automatically pulled into the default discharge summary template.	.DCLABORDERS will pull any outpatient lab orders that have entered.	Not required

Radiology Orders	Any orders for imaging that have been entered into Health Link will be automatically pulled into the default discharge summary template.	.DCRADORDERS will pull any orders for imaging that have been entered.	Not required
Other Procedure Orders	Any orders for other procedures (e.g. cardiac cath, colonoscopy) that have been entered into Health Link will be automatically pulled into the default discharge summary template.	.DCOTHERPROCS will pull any orders for other procedures that have been entered.	Not required
Test Results Pending at Discharge	A list of all labs/test results that are still pending at the time of discharge should be included in the discharge summary. This also serves as a reminder to the discharging provider about tests that may need to be listed in the Active Issues requiring follow up section to alert the next providers of care of things that are still outstanding.	.INPROCESSTESTS will pull any lab/diagnostic study that does not have a final result in Health Link at the time of discharge.	Required element
Presenting Problem/History of Present Illness	An admission problem or diagnosis (if known) should be clearly stated in the patient's chart. A separate heading of "admit diagnosis" is not required, as long as the HPI/narrative captures the reason for the hospitalization. This section should serve as an orientation section for the next provider about what initially brought the patient to the hospital. Do NOT solely refer to the patient's H&P, as the recipient of the discharge summary may not have access to the initial H&P.		Reason for hospitalization is required but can be included in HPI
Hospital Course	The hospital course should be a description of the events that occurred during the hospitalization and how a given problem/diagnosis was managed. The author should carefully reflect on inclusion of only that level of detail that will be helpful to the patient's next set of care providers or that would be helpful if the patient were readmitted for a similar problem.	If problem-oriented charting is being actively used, .HPROBOVERAPALL may be used to show all active and resolved hospital problems with their overview sections. Providers may also choose to pull in the Hospital Management Note if teams are using this to document the hospital course throughout the patient's stay. If neither of these tools are used, the author may use free text (***). A smart list with these options is available in the default discharge summary template.	Required element

Operative Procedures Performed	A list of all procedures performed in the OR or those requiring anesthesia during the current encounter will be automatically included in the default discharge summary template. A *** exists to ensure that the author validates the accuracy of the information and its relevance for inclusion in the discharge summary.	.ORALLSURGDATE will provide list of all operative procedures and the date on which it was performed	Required element
Other Procedures Performed	Recommend including a list of all procedures performed for the patient that are particularly relevant to his/her hospitalization (e.g. line placement, intubation, angiography, important imaging). Include dates of all procedures.	A smart list containing a list of potentially important procedure types is included in the default discharge summary template. {OtherProcedures: 4001084}	Required element
Consults	Recommend including a list of all consulting services involved in the patient's care during hospitalization (e.g. PT, OT, speech, cardiology, social work, etc.).	A smart list containing a list of all consulting services is included in the default discharge summary template. {Consults: 3000675}	Not required
Pertinent Lab Results	Any lab results listed in this section should have associated narrative history in the hospital course section. This section is listed to especially call out labs that may require ongoing follow up to provide easy reference to the next care provider about previous values in the hospital (e.g. INR,TSH, digoxin).	A smart list containing labs frequently requiring ongoing follow up is available in the default discharge summary template.	Not required
Pathology	Pathology results must be clearly stated by the provider writing the DC summary; if path is still pending enter a statement to that effect.		Required element
Last vitals and patient weight	The patient's last recorded set of vital signs and last recorded weight will be automatically inserted into the default discharge summary template.	Flowsheet row numbers 8, 235013, 9, 5, 6, and 14 are used in this section.	Not required
Physical Exam at Discharge	A physical exam, including detailed information pertinent to the patient's reason for hospitalization, should be included in the discharge summary. (e.g. detailed neuro exam should be included for patients discharged after stroke; detailed wound exam should be included for patients discharged after surgery). Appearance of pressure ulcers should be included as appropriate.	A smart list containing placeholders for portions of the physical exam is included in the default discharge summary template. {PHYSICAL EXAM:3001975}	Required element

Cognitive Status at Discharge	A cognitive status exam should be included for ALL older, developmentally delayed, TBI, or stroke patients. At UWHC, RNs document various aspects of cognitive status every 24 hours. RN documentation regarding level of consciousness, orientation level, cognition, and speech (including date and time documented) will be automatically inserted into the default discharge summary template. **Providers should verify the accuracy of this information before signing the note. This information can be modified by R clicking on the text in blue and selecting "Make Text Editable".**	Flowsheet row numbers 200008, 200009, 200010, and 200011 are used in this section. @FLOWDATETIMEREFRESH(200008,200009,200010,200011)@	Not required
Diet Orders	A diet order is required for all patients. The currently active discharge diet order AND any signed orders as recommended by speech/swallow therapy will be automatically inserted into the default discharge summary template. For patients with prescriptive diet recommendations and/or dysphagia, detailed recommendations regarding dietary restrictions, caloric intake, tube feeding schedule, dietary consistency and prevention of aspiration should be included if not already recommended by speech therapy/nutritional services.	.DCDIET will pull the discharge diet order. .DCSPEECHREC will pull the speech/swallow therapists recommended discharge orders.	Required
Fall Risk status	Fall Risk status is especially important for patients being transferred to another facility. The Fall Risk status documented by nursing staff will be automatically inserted into the default discharge summary template. **Providers should review this information for accuracy prior to signing the note. This information can be modified by R clicking on the text in blue and selecting "Make Text Editable".**	Flowsheet row numbers 401911,200618,316957 are used in this section. @FLOWDATETIMEREFRESH(401911,200618,316957)@ ???	Required for SNF
Activity orders	An activity order is required for all patients. The currently active discharge activity order AND any signed orders as recommended by physical and occupational therapy will be automatically inserted into the default discharge summary template. Orders should include information regarding transfer methods and mobility aids as applicable. **Providers are responsible for ensuring that there are no conflicting instructions/orders regarding activity in each of these sections.**	.DCACTIVITY will pull the discharge activity order. .DCPTREC and .DCOTREC will pull recommended orders from PT and OT respectively.	Required

Wound care instructions	A smart list allowing the user to pull the currently active discharge wound care order will be available in the default discharge summary template. Recommend including anticipatory guidance about type of wound and location, care instructions, dressing changes, and when to call as part of this order. As a reminder, a current description of the wound should be included in the PE.	.DCWOUNDCARE will pull the wound care discharge orders entered by a provider or wound care nurse if that service is involved and has made recommendations.	Required
Bladder care	Recommend including information regarding bladder care protocols as applicable. A smart list allowing the user to pull the currently active bladder care discharge order will be available in the default discharge summary template.	.DCBLADDERCARE will pull recommended bladder care discharge orders written by the provider or other responsible individual.	Required if applicable
Bowel care	Recommend including information regarding bowel management protocols as applicable. A smart list allowing the user to pull the currently active bowel care discharge order will be available in the default discharge summary template.	.DCBOWELCARE will pull recommended bowel care discharge orders written by the provider or other responsible individual.	Required if applicable
Other patient care instructions	Recommend including other patient care recommendations/instructions as appropriate for patient and disposition. A smart list allowing the user to pull the currently active "Other Discharge Patient Care Instructions" order will be available in the default discharge summary template.	.DCOTHERPTCARE will pull the currently active "Other Patient Care Instructions" order.	Required if applicable
Patient's goals/preferences	Include information regarding patient's care preferences (e.g. do not hospitalize, comfort care, discussions that have occurred with palliative care, etc.). This information is particularly relevant for patients discharged to a SNF.		Not required
Discharge Medications	A list of the patient's medications at the time of discharge should be checked for accuracy. The note written by the pharmacist after medication reconciliation has been completed will be automatically inserted into the default discharge summary template. This note will not be available for inclusion until med rec is complete.	.DCSUMMEDLIST will pull the same discharge medication note that is provided to the patient at the time of discharge.	Required element
Post Discharge Contacts	Recommend including information regarding who to contact for immediate questions regarding the patient's care. All DC summaries should include the number to the UW Access Center for urgent questions that arise requiring physician to physician communication.		Required element

Discharge Summary Prepared By	Recommend including names of all providers who contributed to the authorship of the discharge summary. As DC summaries are becoming shared documents on many services, recommend including the names of all involved in writing the document.	.ME will pull the name of the current writer of the note.	Required element
Attending Physician Documentation of Time Spent on Discharge	Recommend including attending's time spent on discharge if greater than 30 minutes. This may be documented on a discharge summary OR previous progress note. Time includes final examination of the patient, discussion of the hospital stay (even if the time spent by the physician on that date is not continuous), instructions for continuing care to all relevant caregivers, and preparation of discharge records, prescriptions and referral forms.	.ATTENDINGCOSIGNDISCHARGE	Not required. If no time is documented, the lesser code is billed (less than 30 minutes).