Southern Discharge Summary (Transfer of Care)- Summary of Key Changes

General Changes

Document Name
There is an agreed terminology change for these documents throughout the Te Waipounamu region to "Transfer of Care" instead of "Discharge Summary".

Mandatory Fields/Sections
In the old Discharge Summary only the Diagnosis, Allergies/Adverse Drug Reactions and Smoking Cessation fields were mandatory. In the new template a number of additional fields/sections have been made mandatory in order to improve the quality and consistency of documents. Mandatory fields/sections in the new template are:

- Advice to Patient/Whānau
- Information and Requests to GP
- Medications on Discharge and Changes to Medications
- Alerts / Adverse Drug Reactions
- Active Diagnoses
- Plan

Recognising that there is no particular value in completing most of those fields for a patient who has died during their admission, alongside of this a "Patient deceased" flag has been added, which will leave the last three as the only mandatory fields (ideally we would like this to just be Active Diagnoses, but there are technical limitations that stop us from changing the status of the Alerts / Adverse Drug Reactions and Plan fields using this flag). Note that there is also a specific Deceased Discharge Summary template available which should be used in preference for deceased patients if a Transfer of Care has not already been started.

Ordering of Fields
The order of fields has been changed to place the key information for Patient/Whānau and GP at the beginning of the document (previously these were towards the end of the document).

Changes to Fields

Diagnoses (changed)

- The current template provides options to look up and apply standard codes or enter free text descriptions. Free text descriptions are preferred in many cases as the code options typically do not provide sufficient clinical detail. In the new template we are proposing to use free text descriptions exclusively.
- The "primary" and "secondary" classifications for diagnoses have been removed and replaced with a single field to record all active diagnoses based on feedback that "primary" and "secondary" is often an artificial construct. An option to add inactive diagnoses if desired has been added. Inactive diagnoses are treated, controlled inactive ongoing problem (not the reason for admission). Note that the first diagnosis recorded in the Active diagnoses field will be the one reported as the Primary diagnosis by the clinical coders.

Medications (changed)

- Streamlining of medications fields to:
  - Medications on Admission
  - Medications on Discharge
  - Changes to Medications
- Incorporation of an alternate option for recording and reconciling medications, including ability to create scripts (printable) for discharge medications, using the Meds Management functionality. This is primarily to replace functionality for Dunstan, who don't use MedChart, and will also support any other case where MedChart is not use (e.g. ED).

Presenting History, Exam, and Clinical Management Summary (changed)

- The Presenting History and Clinical Management fields in the current template have been combined into the new Presenting History, Exam, and Clinical Management Summary.

Procedures (changed)

- The Procedures field has historically had very little use, with most people preferring to capture summary details of procedures within the Clinical Management Summary instead.
- In the new template we have introduced an option to pull summary details from any Operation Notes completed in HCS in relation to this encounter. Because use of the HCS Operation Note is not yet universal, we have made this an optional field that can be activated where it is relevant.

Referrals Follow Up (changed)

- Auto population of details of upcoming appointments is removed due to concerns that this can be confusing as often as it is helpful. In the majority of cases the appointments displayed have no relationship to the current encounter. Appointment details can change after the discharge summary is printed, creating potential for confusion. A field is provided within the Summary for Patient/Whānau section for relevant details related to this admission to be entered manually.

Smoking Cessation (removed)

- This field is removed as the discharge summary is not the best place to capture this, and often the person completing the discharge summary won't have been involved in these conversations. Is included a the new HCS Comprehensive Admission Assessment document. Removal from the discharge summary has been discussed with the Clinical Coding Team and Smokefree Co-ordinator.

Relevant Results (changed)

- Replaced with Interpretation of Relevant Investigations
- Generally in the past this has just been a copy and paste of results from Eclair, lacking the context of clinical review/interpretation of those results.
- The intent is that the content provided here will include context and interpretation, not just 'raw' results to reduce the risk of misinterpretation or misunderstanding associated with inclusion of results without clinical interpretation.

Plan (new)

- New field added to give additional prominence to this information (historically captured at the bottom of the Clinical Management Summary).