

On Writing Guidelines of Discharge Summary

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ABSTRACT

The discharge summary is one of the most critical documents in medical care settings. Doctors' discharge summaries (DS) are important forms of communication between the physicians in patient care, deficits in the quality of DS are common. The aim of this paper was to standardized medical staffs' writing about discharge summaries. Primary measures included physicians' preferences in discharge summary standardization, content, format, and audience. Discharge summaries should have a standardized format.

KEYWORDS

Discharge Summary; Communication; Standardized Format.

1. THE IMPORTANT OF DISCHARGE SUMMARY

Discharge summary quality was associated with re-admission risk; In theory, a discharge summary is meant to help outside physicians understand what happened to patients while they were hospitalized, but in practice, it has served as an aid for medical billing in order for a discharge summary to do the job of making the transition from hospital to home safer, it needs three key factors: It has to be timely, it has to be sent to the outside physician accurately, and it has to include useful information.

Continuing rehabilitation guidance after discharge provides a important reference for recheck. Hospitalization is the main stage of treat diseases, some diseases need consolidating treatment for a full recover. Discharge summary recorded the main situation of diagnosis and treatment outcomes in hospital, so that patients can understand clearly about their health status. Discharge instruction points out the next stage of the patient's treatment plan and living, dietary conditioning, notice, and the time of re-examination, etc., which provides the patient with rehabilitation guidance after discharge. The doctor can preliminarily understand the patient's past medical history according to the discharge summary, and provide a reliable reference and basis for the next treatment.

2. GENERAL INTRODUCTION OF DISCHARGE SUMMARY

2.1. The Definition of Discharge

Patients are officially allowed to leave, or told that they must leave. Of course, not all patients go back to their own homes. Namely, Discharge from a hospital is the point at which a patient leaves a hospital and either returns home or is transferred to another facility such as a rehabilitation centre, a nursing home, or to homes of relatives or to institutions better able to meet their needs.

2.2. Perform the Evaluations of a Patient's Health

Discharge planning is a process that requires a health care individual who is highly trained and skilled in performing accurate evaluations of a patient's health.

2.3. The Evaluation of Discharge

When considering the patient's current state, although the patient may be eligible for discharge it is important to examine factors such as the likelihood of re-injury to avoid higher health care costs. Patients' homes should also be visited and examined before they are discharged from the hospital to determine any immediate challenges and corresponding goals, adaptations and assistive devices that need to be implemented. In other words, the patient will need to be evaluated to see what services he or she requires, as well as what services he or she qualifies for (such as meals-on-wheels) or what services the patient's insurance will cover. A person may be discharged only when certain equipment, such as a hospital-style bed or oxygen, has been delivered to the home.

Follow-up appointments should also be coordinated with the patient prior to discharge to monitor the patient's progress as well as any potential complications that may have arisen.

3. THE CONSISTS OF DISCHARGE SUMMARY

Discharge summary is a text that used widely in hospital. When considering patient discharge, the doctor will prescribe a report, there are a number of factors to take into consideration, usually including patients' place of residence, the type of support available, patient name, gender/sex, age, date of birth, date of discharge, date of admission, symptoms/reason for admission/ problems/ chief complaints, vital signs/ observations/ physical examination, admission diagnoses/diagnosis, discharge diagnoses, treatment and outcomes, medication, present condition/ current state, needs/ discharge orders/doctor's advice/doctor's instruction, next of kin, prognosis, test, special examination, date of operation, name of operation, etc.

3.1. Features in Writing Language

In the discharge summary, the statement of discharge process was reviewed using the past tense. Doctors give patient's treatment programme or doctor's instruction in the future generally using the future tense; Face-to-face instructions can be in imperative sentences.

3.2. Structure Representation

3.2.1. On Expression Structure of "Reason for Admission"

Reason for admission is a clinical record made by doctor after observing symptoms and analyzing chief complaint. Admission is a process of recall, which mainly use the past passive voice.

(1) The patient was admitted to the hospital because of+(name of diseases).

Eg: A 27-year-old woman called Doris boots was admitted to the Bethune international hospital on June 1st, 2018 because of acute diarrhea and appendicitis with fever for three days.

(2) The patient was admitted with a preliminary of+(name of diseases).

Eg: The patient William, a 35-year-old male, was admitted with a preliminary diagnose of liver cancer by out-patient doctor.

(3) The patient was admitted because of /for+(name of diseases).

Eg: The patient Lily Lawson, a 40-year-old female, was admitted because of stroke on exertion for one year and exacerbation for two weeks.

3.2.2. On Expression of "Chief Complaint"

The patient complained about the symptoms or the symptoms observed by the doctor, or described the patient's physical condition, have a clear and specific subject, which use the active voice.

(1)...complained chiefly of...

Eg: The patient complain chiefly of difficulty in breathing for several days.

(2)...was admitted at/with//because of

Eg: The patient was admitted because of sub-costal pain for five days .

(3)The patient complained of/suffer from...

Eg: The patient Scott complained chiefly of cervical spondylosis for 10 years with right upper rib intermittent pain lasting for one month, which is sharpening for 3 days.

Eg: The patient suffered from pain on the chest with hard breath after hard working for a long time .

(4)The patient reported (that) ...

Eg: The patient Cristina reported chest tightness and shortness of breath.

(5)...presented ...

Eg: The patient presented a severe diarrhea for three days .

(6)... presented ...

Eg: The patient presented a severe diarrhea for three days .

(7)...was referred to ... because ...

Eg: The patient was referred to otolaryngology department because of a painless swelling in the thyroid for 14 months .

3.2.3. The Expression of "Present Illness History"

Present illness history belongs to the chief complaint past history, and should be used in the active voice.

(1)The patient began(started)to...

Eg: His stomach began to bleed four days ago.

Eg: Callie started to sneeze a week ago.

(2)The patient felt...

Eg: The patient felt dizzy with nausea and fatigue.

Eg: The patient felt nasal itching, belch and gastric distention after taking some antibiotics orally for her abdominal pain about two hours ago.

(3)The patient developed/noted/noticed/had...

Eg: The patient had a visceral(including heart, brain, lung, liver, kidney) function failure.

Eg: The patient developed heart colic, spasm and incontinence several times a day.

3.2.4. The Expression of "Past Medical History"

Past medical history also belongs to the content of the main complaint, which needs to be used in the simple past tense and often in the active voice:

(1)She had a/no history of...

Eg: She had a history of bronchial pneumonia, acute appendicitis, insomnia.

Eg:She reported a remote history of hypotension.

Eg:Plotkin had no history of allergy;however,allergic to pineapple was present.

(2)There was no history of...

Eg There was no history of tobacco or irritant use.

(3)The patient's medical history consisted of ...

Eg:The patient's medical history consisted of diabetes.

(4)The patient was quite well until...

Eg:The patient was quite well until she had a feeling of nausea and desire of vomiting two months before during hard work,brisk walking ,or vigorous running.

(5)The patient suffered from...

Eg:William suffered from tuberculosis and inject insulin for more than five years.

3.2.5. The Expression of "Family Medical History"

(1)He had/admitted (no) a family history of...

Eg:The patient admitted a family history of tuberculosis.

(2)There was a history of...

Eg:There is a history of heart disease on his mother's side.

(3)His father/mother died of...

His father died of lung cancer.

3.2.6. The expression of " Vital signs and Related Auxiliary Tests"

Vital signs of the patient include: Her/His respiratory rate was+(Res.Rate) +per minute and pulse rate was +(Pulse.Rate)+ beat per minute. Her/His temperature was recorded as+(Temp)degrees centigrade + and blood pressure revealed +(BP)+ mmHg. CT scan(ultrasound) showed...

Eg:CT examination of the head showed brain tumor.

3.2.7. The Expression of " Medication History"

(1)The patient had received +medication/operation therapy, including...

Eg:In The Queen Elizabeth Hospital,the patient had received surgical therapy, including cardiac catheterization and cystectomy.

(2)The patient's medications were...

Eg:The patient's medications at the time of discharge were roxithromycin two capsules daily,penicillin 30mg daily.

(3)the patient's medications was changed to...

Eg:The patient's medication was changed to aspirin and loratadine.

3.2.8. The Expression of "Diagnostic Results"

(1)The patient was diagnosed with...

Eg:Leo was diagnosed with acute gastroenteritis and was treated with antibiotics.

(2)A diagnosis of...was confirmed

Eg:A diagnosis of bronchial pneumonia was confirmed on the basis of a CT scan and a MRI.

(3)The patient was diagnosed of having...

Eg: The patient was diagnosed of having recurrent foul smelling pus from her right ear for 20 days.

(4)...was diagnosed

Eg: Chronic suppurative otitis media was diagnosed.

(5) The patient was admitted with a diagnosis of ...

Eg: The patient was admitted with a diagnosis of measles.

3.2.9. The Expression of "Treatment"

(1) the patient's treatment consisted of...

(2) The patient was treated with...

(3) A treatment protocol...was started.

(4)...was treated.

3.2.10. The Expression of "Doctor's Instruction"

Discharge orders generally use imperative sentences:

(1) Take medicines on time.

(2) Avoid Vigorous running and hard work.

(3) Stay away from both alcohol and smoking.

(4) Take medications following the doctor's advice.

(5) it is important to build up a positive attitude towards life.

(6) It is a must to have regular exercise, at least three times a week.

(7) it is important to have a healthy diet, with more vegetables and fruit and less meat.

(8) No medications are needed after discharge.

(9) The Synonyms of Discharge order: discharge orders/nursing instructions/needs/doctor's instruction/note.

4. EXAMPLE OF DISCHARGE NOTE.

The patient+ (patient name), a (Age)-year-old+ (Gender), was hospitalized/admitted on +(Date of Admission), and discharged on +(Date of Discharge). He/she complained of +(Reason for Admission)+ for nearly+(one/two/three+day/week/month).

Examination of the +(body part)+ showed that there were +(Examination). He/She was diagnosed with+(Diagnosis).

The patient improved, showing gradual resolution of +(Reason for Admission)+ after taking +(Medication) and (Treatment). The results of the treatment are very good, and the patient showed swift improvement. (...Prognosis and Needs...) No medications are needed after discharge. Major prognosis and needs for him/her are as follows:

(a) First of all, No medications are needed after discharge....

(b) What's more (secondly), it is a must to/the patient should +....

(c) Last but not least (lastly): it is important to +....

5. CONCLUSION

This paper briefly analyzes the importance of discharge summary, expounds the key components of discharge summary, and gives the commonly used expression structure in the field of medical English, providing a systematic template framework for medical professionals. Hospital discharge summaries enable communication between inpatient and outpatient physicians. Efforts are necessary to build consensus toward the ideal discharge summary. When used effectively, discharge summaries reduce hospital re-admissions.

The quality of discharge summaries was insufficient in terms of timeliness, transmission, and content. Discharge summary quality was indeed associated with readmission risk; patients whose summaries included useful content or were sent to outside clinicians had lower readmission rates. There may therefore be both a need and professional support for further training in discharge summary writing, requiring confirmatory research.

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