Appendix 2: Defining the Quality of Discharge Summaries from the Emergency Department

Important Components of Discharge Summary	Adequate	Inadequate	Unacceptable
Basic Data	Correct patient details, date, time and place of presentation and treating clinician		Wrong or no patient details, or incorrect date time or place, or incorrect treating clinician
Discharge Diagnosis	Correct Primary Diagnosis and some detail on secondary diagnoses, if relevant. If no diagnosis can be reached within the time in ED, this may be acceptable if the diagnostic uncertainty is appropriately recorded (+/- a differential diagnosis given or certain diagnoses noted as excluded)	Inaccurate Primary Diagnosis. A "symptom" is given without mention of important diagnoses excluded or an explanation of the diagnostic uncertainty. Inaccurate, irrelevant or missing detail on secondary diagnosis information	Wrong primary diagnosis or no primary diagnosis recorded, or very obvious that the wrong diagnostic details (pertaining to another patient) have been recorded
Treatment Information	Correct and concise documentation of treatments delivered in ED relevant to primary diagnosis Documentation of need for no treatment, or no documentation when no treatment given	Incomplete treatment information from ED (only some aspects of treatment documented – but not likely to be harmful)	Wrong treatment information or missing treatment information when treatment given (likely to be harmful)
Treatment Complications Information	Correct and concise documentation of most treatment complications in ED, or documentation of no complications of treatment, or no complication occurred, or no treatment given, or not recorded in patient notes if no complication of the treatment	Incomplete treatment complication information from ED (not likely to be harmful if treatment repeated)	Wrong treatment complication information or not documented when a complication happened (likely to cause harm if treatment were subsequently repeated)
Procedures Information	Correct and concise documentation of all procedures carried out in ED (does not need to include venepuncture or peripheral intravenous cannulation), or not recorded when no procedure done	Inaccurate or incomplete procedure information from ED (e.g. some but not all relevant procedures documented)	Wrong procedure information, no procedure documented when procedure occurred
Procedure Complications Information	Correct and concise documentation of most procedure complications in ED, or documentation of no complications of procedures, or no procedures carried out, or not recorded in patient notes if no complication of the procedure	Inaccurate or incomplete procedure complication information from ED (not likely to cause harm if procedure subsequently repeated)	Wrong procedure complication information or no procedure complication information documented if a complication happened (likely to cause harm if subsequently repeated)
Investigation Results Information	Correct and concise documentation of pertinent results of investigations related to the ED presentation (e.g. CT Head for minor head injury) or relevant abnormal results to flag to GP. Or documentation that no investigations were carried out as not clinically indicated (if appropriate) Discharge summaries that have been amended to include missed fractures, or initially wrongly reported scans (for example) should be regarded as adequate if the amended information is correct	Inaccurate or incomplete investigation information from ED (not likely to cause harm if investigation repeated or abnormal result not flagged)	Wrong investigation information (i.e. results from another patient) or no investigation information documented (likely to cause harm if an abnormal result was not flagged). An example would be a CT head for minor head injury not documented as being done when it was or the provisional scan result was not recorded or incorrect

G.P. Specific Ongoing Care Information • Details of hospital follow-up arrangements (service and timing) • Test results pending at discharge (and who is to review these) • Specific follow-up needs for GP to arrange (i.e. organizing further investigations)	All points recorded if applicable, or documentation that the patient does not need to be followed up, or where there is no need for ongoing care	Inaccurate or incomplete ongoing care information (i.e. missing points when relevant), unlikely to cause harm if not documented	Wrong or misleading information given to the GP regarding ongoing care or none documented when ongoing care required (likely to cause harm if not documented)
Patient Specific Ongoing Care Information • Advice on diagnosis • Detail about expectations for course of recovery • Potential Complications • Guidelines for management of the illness	All points covered on discharge summary. The information can be documented as either an instruction note in the discharge summary, as a patient information handout or as a note in the clinical information (considered as documentation of verbal information given) ***Adequate, self discharge with attempt to contact*** Patient has self-discharged without notifying healthcare professionals, and an attempt has been made to contact the patient and provide specific advice information	Inaccurate or incomplete patient-specific information (missing points above if they are relevant) ***Inadequate, self discharge with no attempt to contact*** Patient has self-discharged without notifying healthcare professionals and no attempt has been made to contact the patient and provide specific advice information	Patient-specific information wrong, not relevant to case or none documented
Patient Specific Discharge Information in Clinical Notes • Advice on diagnosis • Detail about expectations for course of recovery • Potential Complications • Guidelines for management of the illness	All points covered in clinical notes. The information is documented as either verbal instructions (but must be documented what the patient was told), an instruction note or as an information handout. All patients should have some information ***Adequate, self discharge with attempt to contact*** Patient has self-discharged without notifying healthcare professionals, and an attempt has been made to contact the patient and provide specific advice in information over the phone, then this is documented in the clinical notes	Inaccurate or incomplete (missing points above if they are applicable) patient-specific information. ***Inadequate, self discharge with no attempt to contact*** Patient has self-discharged without notifying healthcare professionals and no attempt has been made to contact the patient and provide specific advice in information	Patient-specific information wrong, not relevant to case or none documented.
Discharge Medication Information This should include all of the following • Patient Name • Dose • Frequency • Purpose – in relation to current issue (i.e. analgesia for fracture) • Potential complications or side effects • Any alteration in usual drug regimen • Relevant allergies	No medication prescribed when not indicated (minor injury and illness, mild pain only, or patient declines) All points covered on discharge summary and/or prescription record (if applicable). The last point may not always be applicable in ED. The second last may be covered verbally and is not always documented in the summary. Medication appropriate and prescribed in relation to current illness and illness severity ***Adequate, self discharge with attempt to contact*** Patient has self-discharged without notifying healthcare	Inaccurate or incomplete (missing points above if they are applicable) discharge medication information. Medication not prescribed in relation to current illness or illness severity, but unlikely to cause harm ***Inadequate, self discharge with no attempt to contact*** Patient has self-discharged without notifying healthcare professionals and no attempt has been made to contact the	Wrong medication information (wrong dose, wrong medication), not prescribed in relation to current illness or illness severity and likely to cause harm

	professionals and an attempt to provide a prescription has been made if ongoing medication required	patient and/or provide a prescription if ongoing medication required	
Review (General Follow Up) Information • Service (that will conduct the follow up visit) • Specific timeline for follow-up • Advised review with GP if needed • Advised review in ED in the event of serious complications	Any or all points covered on discharge summary and documented if relevant, or no review needed and documented	Incomplete medical review information when review indicated	Wrong or unrecorded medical review information when review indicated
Overall Adequacy	Adequate in all components (Note: If patient specific info on d/c summary is inadequate, but clinical notes adequate (and vice versa) can still be rated adequate overall for patient information	One or more section inadequate or missing	Any point rated as unacceptable (these are things that have the potential to cause harm), or no discharge summary completed for event

Key: GP=General Practitioner, ED=Emergency Department