Royal United Hospital Bath NHS
NHS Trust

Doctors

Discharge Summary

1. **MDT staff to contribute to the discharge summary as appropriate**
2. **The discharge summary must be Finalised by the discharging clinician and handed to the patient.**
3. **Only New Medications that have been verified by Pharmacy should be included in the Discharge Summary**
4. **The following fields if known should be recorded and included in the discharge summary: Principal Diagnosis; Primary Procedures (if appropriate) and Co-Morbidities.**

Support available:

Please contact your local Champion User

Service Desk:

Tel: 01225 82 5444

Email: ruh-tr.ITServiceDesk@nhs.net

RUH

CERNER

BT
Bringing it all together

Complete a Discharge Summary

Complete a Discharge Summary

NOTE: First check in **Documentation** for an existing Discharge Summary for the current encounter. If yes, open and add to it

Step 1. Open the relevant patient record and select **Documentation** from the Side Bar menu

Step 2. Click **Add** 

Step 3. Select **Discharge Summary** from the **Type** drop down

Step 4. Type **ruh** and click the **Binoculars**  icon

Step 5. Double click on **RUH Discharge Summary** – the Discharge Summary opens.

Header

Step 6. Click on **Click to add Header** – Header window opens. Check **Lead Clinician** – if not correct then update (see Consultant Transfer mini-manual).

Step 7. If Header contains correct Consultant click **OK**

Discharge Date (mandatory field)

Step 8. Click **Discharge Date** – date box opens

Step 9. Enter the **discharge date** or the best estimate

Last Ward

Step 10. Free text field to add **Last Ward**

Discharge Destination

Step 11. Select the appropriate **Destination**

Principal Diagnosis

Step 12. Click **Include Principal Diagnosis** – Problems and Diagnoses pane opens

Step 13. Select appropriate Diagnosis and click **Include**

NOTE: If the Diagnosis has not yet been recorded, click **Add** and add the Diagnosis by the usual method.

Complete a Discharge Summary

Then select and click **Include**

Other Diagnosis

Step 14. Repeat as above

Principal Procedures

Step 15. Click **Include Principal Procedures** – select appropriate procedure and click **Include**

Other Procedures

Step 16. Repeat as above

Clinical Narrative

Step 17. Click Clinical narrative === and enter all relevant information into the free text box

Co-Morbidities

Step 18. Click **Include Co-Morbidities** – Problems and Diagnoses pane opens

Step 19. Make appropriate selections from the Problems section (use **Ctrl** key for multiple selections) and click **Include**

NOTE: If Co-Morbidities have not been yet been recorded, click **Add** and record them in the usual way. Then select and click **Include**

Allergies

Step 20. Click **Include Allergies** – make appropriate selections (use **Ctrl** for multiple selections) and click **Include Selected**

Past Medical History

Step 21. Click **Include Past Medical History** – Past Medical History pane opens

Step 22. Make appropriate selections (use **Ctrl** key for multiple selections) and click **Include**

Results and Investigations

Step 23. Click **Additional Information** and enter appropriate information into the free text box (e.g.

abnormal results)

Review / Management

Step 24. Include all specific further actions for Hospital / GP

Medications

Step 25. **Medications Unchanged** – Select **only** if patient's medications are unaltered

Step 26. **No TTAs Required** – Select **only** if patient is given no drugs to take home, including additional supplies of patient's current medications

Step 27. **New Medications – DO NOT USE**

Step 28. **New Medications – Additional Information**. Free text box to record New Medications

Step 29. **Usual Medications at Discharge** – **DO NOT USE**

Step 30. **Usual Medications at Discharge – Additional Information.** Record any medications the patient was taking on admission

Step 31. **Changes to Usual Medications at Discharge –** free text box to record changes to patients' usual medications

Discharging Clinician

Step 32. Click on the blue chevrons and input the name of the Discharging Clinician.

Finalise Now?

Step 33. Click **Yes** to finalise the Discharge Summary once all information has been inputted

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NOTE: If **Yes** is not selected to finalise the Discharge Summary then it will **NOT** be sent electronically to the GP. Only the discharging clinician can finalise the Discharge Summary and they must ensure all the relevant information has been inputted including any by Nurses / AHPs

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Step 34. Click **Sign**

NOTE: The Discharge Summary must only ever be Signed – **Never** Save or Save and Close

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Step 35. Notify the Nurse to print the Discharge Summary

Result: The Discharge Summary will sent by email to the GP as soon as the patient has been discharged via Millennium

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NOTE: The Discharge Summary will **NOT** be sent unless it has been finalised by the discharging clinician

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Updating an incomplete Discharge Summary

Step 1. Open the patient record from the appropriate patient list and select **Documentation** from the Side Bar menu

Step 2. Select the correct Discharge Summary and double-click

Step 3. Select **Correct** and click **OK**

NOTE: Always Correct the Discharge Summary – **Never** Modify

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Step 4. Add any further information as relevant.

Step 5. Ensure the Nursing / AHP Information has been inputted before **Finalising** the Discharge Summary and **Signing** it