

# EPR Core and Clinical Documentation Foundation

## Discharge Summary Note


### Reference Guide

This **Reference Guide** provides step-by-step instructions on how to complete the **Discharge Summary Note**, a structured electronic document used to summarize the discharge diagnosis, other clinical conditions, the course in hospital and interventions. It also has specific discharge instructions and provides directions to the recipients of the discharge summary. Only one **Discharge Summary Note** is available per patient visit.


Only the Attending Provider can finalize the **Discharge Summary Note**. However, Nurse Practitioners, Clinical Assistants, Physician Assistants, Residents, and their corresponding students may enter documentation in the note.

Once the **Discharge Summary Note** is saved as **Final** and the visit is discharged, the **Discharge Summary Report** is automatically faxed to the patient’s Primary Care Provider and any additional providers listed in the “Copies should be sent to” section.

### How to Complete a Discharge Summary Note

<p><b>Place the Patient into Context and Open the Document</b></p>	<ul style="list-style-type: none"> <li>Find the patient using <b>Status Board</b>, <b>Patient List</b> or the <b>Find Patient</b> functionality and place the patient visit into context.</li> <li>Click on the Enter Document icon  on the <b>Main Toolbar</b> and select the <b>Discharge Summary Note</b> document.</li> </ul>
<p><b>Discharge Date/Admission Findings</b></p>	<ul style="list-style-type: none"> <li><b>Discharge Date/Time:</b> Use the calendar to enter the planned discharge date and time</li> <li><b>NICU Admission:</b> This subsection applies to Neonatal Intensive Care Unit (NICU) admissions. It is completed by the Neonatologist when documenting newborn NICU discharge details.</li> <li><b>Disposition:</b> Utilize check boxes to indicate the patient’s disposition or type in the free-text field</li> <li><b>Admission Findings:</b> Document the patient’s admission findings in this free-text field</li> </ul>
<p><b>Summary of Diagnoses</b></p>	<ul style="list-style-type: none"> <li>Utilizing the existing <b>Health Issues</b> (or adding new <b>Health Issues</b> as needed), select the applicable issues for each category:             <ul style="list-style-type: none"> <li>Main Clinical Reason</li> <li>Other Clinical Conditions/Illnesses</li> <li>In Hospital Events</li> <li>Secondary Conditions</li> <li>Interventions</li> </ul> </li> </ul>
<p><b>Course in Hospital</b></p>	<ul style="list-style-type: none"> <li>The <b>Course in Hospital</b> field is a free-text box to document the patient’s course in hospital</li> </ul>

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<b>Labs</b>	<ul style="list-style-type: none"> <li>• <b>Lab-Content:</b> Lists the specific lab results that will automatically populate in the Lab Results section if they are available in EPR</li> <li>• <b>Lab-Results:</b> Allows you to view and select lab results to pull into your document. Only results within the selected range will be available to check off.</li> <li>• <b>Lab-Pending / Additional Information:</b> This is a free-text field for any additional lab information</li> </ul>
<b>Diagnostic Imaging</b>	<ul style="list-style-type: none"> <li>• <b>Diagnostic Imaging Reports – Pending:</b> Not in scope</li> <li>• <b>Diagnostic Imagine Reports – Comments:</b> Type in any comments you wish to add regarding any <b>Diagnostic Results</b></li> </ul>
<b>Investigation Results</b>	<ul style="list-style-type: none"> <li>• This field is a free-text box to document the patient’s investigation results</li> </ul>
<b>Consults</b>	<ul style="list-style-type: none"> <li>• <b>Consults Ordered:</b> This section is not in use as Computerized Provider Order Entry (CPOE) is not in scope</li> <li>• <b>Summary of Consultants:</b> This is a free-text area to document a summary of the consultant(s) findings</li> </ul>
<b>Vital Signs and Measurements</b>	<ul style="list-style-type: none"> <li>• Use clinical judgment to determine whether the most recent set of vital signs should be transcribed in this section</li> </ul>
<b>Allergies</b>	<ul style="list-style-type: none"> <li>• <b>Allergies and Intolerances</b> documented in the patient’s chart will appear here and will be automatically selected for inclusion in the note. Uncheck any items you do not want to include</li> <li>• If not already entered, add <b>Allergies and Intolerances</b> by clicking the <b>Allergy Summary</b> icon </li> </ul>

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<p><b>Advanced Care Plan</b></p>	<ul style="list-style-type: none"> <li>• <b>Advance Care Plan:</b> Review the current Advance Care Plan (ACP) status and update as applicable via Health Issues</li> <li>• <b>Advance Care Plan Additional Information:</b> This is a free-text field to document additional information about the patient's ACP Goals of Care</li> </ul> <div style="border: 1px solid green; padding: 5px; margin-top: 10px;"> <p><b>Note:</b> Refer to your site or regional policies for guidance on who is responsible for adding the <i>Advance Care Plan Health Issue</i> to the EPR. Responsibilities may vary by site and must follow established workflows. Also review procedures for any additional Advance Care Plan documentation requirements, including related orders and forms.</p> <p>The paper based Advance Care Planning/Goals of Care form remains the source of truth. When entering the Advance Care Plan Health Issue into the EPR, clinicians must ensure the status designation is transcribed exactly as documented on the paper form.</p> </div>
<p><b>Health Care Directive</b></p>	<ul style="list-style-type: none"> <li>• Review this section to indicate if the patient has a <b>Health Care Directive</b> within their paper chart. If required, utilize the <b>Health Issue Manager</b> to update this</li> </ul>
<p><b>Discharge Instructions</b></p>	<ul style="list-style-type: none"> <li>• <b>Medications:</b> Enter the details of immunizations and medications ordered or modified or any prescriptions given.</li> <li>• <b>Patient Instructions:</b> This section is completed by the nursing using the <b>Discharge Summary Note - Supplemental</b></li> </ul>
<p><b>Recommendations</b></p>	<ul style="list-style-type: none"> <li>• Use this section to record a recommendation for the patient to follow up with their primary care provider and to document any additional recommendations for the patient</li> </ul>
<p><b>Follow Up Appointments</b></p>	<ul style="list-style-type: none"> <li>• This section is completed by the nursing and support staff using the <b>Discharge Summary Note - Supplemental</b></li> </ul>
<p><b>Health Care Team</b></p>	<ul style="list-style-type: none"> <li>• This section allows other health care team members such as medical consultants to document their findings and recommendations.</li> </ul> <div style="border: 1px solid green; padding: 5px; margin-top: 10px;"> <p><b>Note:</b> All Health Issues that have been previously documented will be automatically populated in this section.</p> </div>

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<p><b>Completion of Discharge Summary Note</b></p>	<ul style="list-style-type: none"> <li>• <b>Copies to be sent to:</b> Select all the patient’s care providers that you want to send the <b>Discharge Summary Report</b> to             <ul style="list-style-type: none"> <li>○ If a provider is not already added, add them</li> </ul> </li> </ul> <div style="border: 1px solid green; padding: 5px; margin: 10px 0;"> <p><b>Note:</b> The patients Primary Care Provider (PCP) will be selected by default. If the patient has requested their PCP not receive a copy, the PCP must be deselected.</p> </div> <ul style="list-style-type: none"> <li>• <b>Copies to Additional Provider:</b> For use <u>only</u> when a provider name is not available within EPR. Ensure that the providers full name, clinic name and stress address or city and fax number (if known) are included. This will not be auto fax rather; <b>Health Information Services</b> will have to manually print and fax the report.</li> <li>• <b>Completion:</b> mandatory field required to save this document as <b>Final</b></li> </ul> <div style="border: 1px solid green; padding: 5px; margin: 10px 0;"> <p><b>Note:</b> The <b>Discharge Summary Note</b> <u>must be saved</u> as <b>Final</b> for the <b>Discharge Summary Report</b> to auto fax to the patient’s PCP and any other providers indicated in the “Copies should be sent to” field.</p> </div>
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