Discharge summaries

Remember that what you write will be read by future people admitting the patient. It is very useful if you write a full, thorough, concise history. People reading your summary should know what happened to the patient during the admission as if they were there (without being a blow-by-blow account!). Think about what info you had to chase – if you had to request old operating notes to find out what blood vessels were fixed in a CABG, consider adding this to the discharge summary (*under PMHx) so others don't have to do the same thing. You'll be grateful for people who save you the time by doing this!

Principal diagnosis – reason for admission, not symptom. Eg if patient admitted for PR bleeding and cause was colon cancer, then principal diagnosis is colon cancer and complication is PR bleeding.

Complications

Any major complications the patient had, eg aspiration, new onset AF, deconditioning due to long illness, bowel perforation, etc. The complication must be directly due to the admission reason/admission itself rather than pre-existing problems. So a pt with known AF who has an episode of AF post-op doesn't need this in complications unless it involved intervention. A pt with no history of AF who develops it during admission should have it listed as a complication. Things like pain are not complications (they are expected!).

Secondary diagnoses – other medical problems the patient has, eg AF, IHD, DM type 2…

Procedures

Select the operation they had from drop down list, then manually select date. Also click the check box on the bottom box.

Clinical synopsis

Patients admitted electively

Age Gender admitted for elective *Operation* after (*CT, colonoscopy, investigation*) found (*diagnosis*).

Under GA, (*brief Op summary*).

Post operatively, patient (*recovered well, was slow to recover, died, etc*).

Patient was discharged home with planned follow up in:

- OPD in *x weeks*
- GP *as required – note if GP to do anything, eg bloods, review aspirin*
- *Med Onc or other appts, and when*

Patients admitted through ED

Age Gender BIBA/referred by GP to ED with (*symptom*) on a background of (*history*). On examination, was (*diaphoretic, tender where, febrile, stable/unstable*). Bloods showed (*WCC, CRP, LFTs*).

Patient was admitted under (*protocol*) and (*treatment initiated, eg Abx, fasting, NGT*). (*Scans ordered*) showed (*results*). Taken to theatre where (*brief op summary*).

If not stated previously, state diagnosis (*SBO secondary to adhesions, mesenteric adenitis, etc*).

Brief summary of admission story (recovered well, slow to recover, abdominal pain persisted/resolved/vanished completely).

Patient was discharged home with

- OPD in *x weeks*
- GP *as required – note if GP to do anything, eg bloods, review aspirin*
- *Med Onc or other appts, and when*

Medications
Include all medications the patient is on, as well as the ones you have added. This helps with future admissions. For the analgesia, make it for one week, so people reading the summary later realise it is not long-term.

Examples of synopsis

Emergency admission
66 year old male admitted for PR bleeding on a background of AF (on warfarin). He had had a previous admission for PR bleeding Feb 2009, at which time his INR was 6. This episode of PR bleeding had been managed conservatively. A subsequent colonoscopy in March 2009 had shown polyps of the sigmoid and caecum, which had both been removed. There was also evidence of extensive diverticular disease of the whole colon.

On this admission, his INR was 2.5 and he had suffered several episodes of painless bright red/dark red PR blood loss. His BP and Hb had both dropped and he required transfusion of 5 units PRBC. His warfarin was reversed with Vit K and FFP. A RBC scan showed active bleeding into the caecum, and he proceeded to theatre for a laparotomy and right hemicolectomy.

Under GA, old blood was found in the colon, as well as multiple diverticuli throughout the colon. An actively bleeding diverticulum was found in the caecum and a formal right hemicolectomy was performed. The ileum and ascending colon were brought together with a side-side stapled anastomosis. A large defect in the mesentery was found, and not closed.

Post operatively, he recovered well and remained stable on the wards. He was restarted on his warfarin day 10 post-op and discharged when his INR was therapeutic. He is to visit Colorectal OPD in 6 weeks for review. We politely request that his GP monitor his INR regularly.

Elective admission
48 year old male from MINDA admitted for elective reversal of Hartmanns due to failure to adequately manage his stoma. The Hartmanns was successfully reversed in theatre. On day 2 post-op, he aspirated on thickened fluids and was MET called for hypoxia and hypotension. He was transferred to ICU for management and a tracheostomy inserted. This was converted to a minitracheostomy before he was successfully extubated on the 29th December and transferred to HDU. Two days later, her again aspirated, and a MET call lead to a further ICU admission for aspiration pneumonia.

On the 5th Jan 2010, an AXR suggested small bowel obstruction and he returned to theatre for division of adhesions. An internal hernia with proximal jejunum incarcerated under the mesentery of the descending colon was found.

He recovered well from the second procedure and the small bowel obstruction resolved. A gastrograffin follow through was ordered and showed no obstruction.

He was discharged home stable, with planned follow up in Colorectal OPD in 6 weeks. He is to see his GP in one week for review of his electrolytes, as his potassium level was borderline elevated during admission (K+ 4.5), although no evidence of arrhythmia was found.