

Discharge Summary

Summary	Details
Patient Identification	Name: John Rivers Date of Birth: January 1, 1980 Medical Record Number: 123456
Date of Admission	April 1, 2023
Date of Discharge	May 25, 2023
Reason for Admission	Patient presented to the emergency department with severe chest pain radiating to the left arm, accompanied by shortness of breath and sweating. Initial EKG findings and elevated cardiac enzymes confirmed the diagnosis of Acute Myocardial Infarction (heart attack).
Procedures Performed	Coronary Angiogram revealed a 90% stenosis in the left anterior descending (LAD) artery. Coronary Angioplasty and placement of a drug-eluting stent were successfully performed to reestablish blood flow.
Medications Prescribed	<ul style="list-style-type: none">- Aspirin, 81 mg daily (antiplatelet agent for heart health)- Atorvastatin, 40 mg daily (to manage cholesterol levels)- Metoprolol, 50 mg twice daily (beta-blocker to control heart rate and blood pressure)- Nitroglycerin, as needed (for chest pain relief)
Patient's Condition at Discharge	At discharge, the patient's condition was stable. Mild, intermittent chest discomfort was reported but significantly improved compared to admission. The patient was ambulatory and independent in performing activities of daily living. Vital signs were within normal range. Cardiac rhythm was sinus rhythm with no significant ectopy.
Follow-up Care Instructions	Medications: Continue all prescribed medications without interruption unless advised by a doctor. Diet: Follow a heart-healthy diet low in sodium, saturated fats, and simple carbohydrates. Exercise: Start with light walking, gradually increasing to moderate-intensity exercise for at least 30 minutes a day as tolerated. Lifestyle: Smoking cessation advised (if applicable), and stress management techniques recommended. Follow-up: Schedule an appointment with a cardiologist in 2 weeks and with the primary care physician within one week.

Aoda Discharge Summary Sample

United States. Indian Health Service

A red circular graphic with a gradient, appearing as a partial circle or a stylized arrow pointing to the right, located to the right of the text 'United States. Indian Health Service'.

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The move to electronic discharge summary systems was anticipated to solve the longstanding problems associated with poor data quality and reduce delay in the production and transmission of discharge summaries between secondary and primary care health care providers in the UK National Health Service A consequence of investment in a national IT infrastructure for electronic health records has focused attention on template design and the IT system requirements The routine practices of doctors involved in discharge summary construction and other factors that contribute to the problems of delay and data quality have been less well explored This study aimed to gain an understanding of paper based discharge summary construction in a secondary care context in order to identify and analyse the implications for improving electronic discharge summary systems and potentially avoid inadvertent transfer of inherent problems A mixed method case study design was used to examine the patient discharge process and the construction of discharge summaries in one NHS Hospital Trust Data was collected through semi structured interviews with hospital doctors n 10 and simulated discharge summary production n 10 A syntactic analysis was also performed on discharge summaries n 11 and proformas n 3 The data was analysed thematically and inductively in order to identify the factors that contribute to the twin problems of data quality and delay associated with discharge summaries The pragmatic semantic syntactic conceptual framework Morris 1938 and Speech Act Austin 1962 and Mental Frame Minsky 1981 theories were used to analyse how information contained in discharge summaries was represented interpreted and used This study

found that moving from a paper based to an electronic discharge summary system will not necessarily resolve the problems of poor data quality and delayed production of discharge summaries More comprehensive solutions are required in order to facilitate more effective discharge summary communication between secondary and primary care health professionals and to address entrenched custom and practice in current hospital practice These include uni professional medical orientation of discharge summaries attitude of senior doctors inadequate preparation of junior doctors inconsistent data entry including absence of common usage of short forms and abbreviations and little accountability for quality control Recommendations include training for junior doctors regulating the use of shortened forms improving the features of data entry systems structuring the clinical coding data and introducing systems to ensure greater organizational accountability for effective discharge communication More comprehensive change related to the introduction of multidisciplinary contribution discharge summary construction and integration of discharge summary standards in care pathways may improve overall discharge summary quality

ENSURING THE MESSAGE IS RECEIVED: ADOPTING A PATIENT ORIENTED DISCHARGE SUMMARY APPROACH TO DISCHARGE Linda Butler,2017 Background Patients and families report being overwhelmed by information at discharge and finding the process very stressful This results in information misinterpreted and recalled inaccurately which can pose significant risks to the patient The current discharge tool being utilized with stroke patients at the Chatham Kent Health Alliance CKHA was not meeting the needs of patients and their families hence the need to adopt a new approach Purpose To develop a discharge tool using the Patient Oriented Discharge Summary PODS parameters to enhance patient experience at discharge and empower patients and their families to successfully manage their care in the community Methods An interdisciplinary team including patient and family advisors modified an existing discharge tool using PODS parameters to trial with patients admitted to the Integrated Stroke Unit and Inpatient Rehabilitation Units Feedback from patients families and staff were collected and common themes identified The tool was modified to reflect the feedback received and then introduced to the rest of the organization for utilization with patients with a stroke diagnosis Findings Data is still being collected at this time but preliminary results show enhanced satisfaction on behalf of both patients and staff and increased ability of patients caregivers to recall medications and follow up appointments post discharge Implications An effective discharge tool will ensure that patients and caregivers consistently leave the hospital with the information needed to successfully manage their care Proven to be a success within the stroke population ongoing work is taking place to adapt this discharge tool to other diagnoses

Design and Implementation of Discharge Summary System □□□,2009

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