TIMELY DISCHARGE SUMMARY COMPLETION IS CRUCIAL FOR ALL INPATIENTS. THIS ENSURES CONTINUITY OF CARE, DECREASES HOSPITAL RE-ADMISSION RATES AND PREVENTS ADVERSE EVENTS POST-DISCHARGE.

THE APPLICATION WAS DEVELOPED IN COLLABORATION WITH UHN CLINICIANS, PATIENT PARTNERS, PRIMARY CARE, AND THE TORONTO CENTRAL LOCAL HEALTH INTEGRATION NETWORK. IT SUPPORTS COLLABORATIVE PRACTICE AND IMPROVED VALUE FOR PRIMARY CARE.

THIS GUIDE PROVIDES A GENERAL OVERVIEW OF KEY FEATURES AND FUNCTIONALITIES AVAILABLE WITHIN THE DISCHARGE SUMMARY APPLICATION.
APPLICATION ACCESS

1. Log in to EPR using your EPR ID and password and search for the patient.

2. Click on the patient's electronic record and then select their active inpatient visit.
Navigate to the **Patient Care** tab and then click on the **Discharge Summary** button.

The note will launch in a separate web browser and default to the **Visit (Encounter)** tab.
GENERAL LAYOUT

PREVIEW BUTTONS can be used to preview the note in full-screen or split-screen mode, or to hide the preview note.

PATIENT DEMOGRAPHIC INFORMATION is always indicated at the top of the screen.

The DISCHARGE SUMMARY consists of six tabs — Visit (Encounter), Diagnosis, Course While in Hospital, Alert Indicators, Medications and Discharge Plan.

COLOURED MESSAGES indicate downtime reminders and other important notifications.

PRINT can be used to print the Discharge Summary or a medication-related document within the Medications sub-tabs.

MEDICATIONS tab consists of seven sub-tabs; users are defaulted to the BPMH sub-tab.

ALLERGIES section displayed within each sub-tab can be collapsed (hidden).

The MAIN SCREEN area allows for documentation of medication details.

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COLOURED BANNER indicates downtime reminders and other important notifications.

UNDO allows the user to remove the most recent changes saved to the note.

opens Help and Support information; including eModules, guides and Help Desk contact information.

USER EDITING indicates other users working concurrently.

NAME indicates the user logged into the application.

CLOSE allows the user to save and log out of the application.

SAVE allows the user to save all work and exit the application; the application also auto-saves each time a field is completed.

COMPLETION/SIGN-OFF allows the user to indicate completion or cancel completion in each Medication sub-tab.

AUDIT TRAIL indicates sign-off history of a note.

PREVIEW area displays the note being updated and how it appears when printed.
FEATURES & FUNCTIONALITIES

Enhanced inter-professional collaboration through:

The ability to **concurrently contribute** to the same note, with an **indicator** in the upper-right corner showing the **number of users editing**.

**User notifications** when another clinician has edited a part of the Discharge Summary.

**Fields that lock** if another clinician is updating them, to prevent accidental overwriting of information.

**Completion/Sign-Off buttons** allow the user to indicate completion or cancel completion in **Medication** sub-tabs; the **Review** button allows Pharmacists to indicate review of the section; sign-off/review is only possible when no one else is editing the same table.

**Copies to be sent to** Providers/Specialists/Clinicians within the Patient’s Circle of Care who should be notified

**Hovering** over a heading/button displays its definition and/or explains its functionality.

**Hyperlinks** to important information or supplementary forms are available, including the **EPR Provider List Change Request Form, LU Codes, and EAP Forms**.

The medication route can be selected from a list of drop-down options and edited if needed; the route for added medication rows will auto-populate to “orally.”
Samples of good Discharge Summaries specific to Medicine, Rehabilitation, and Surgery, can be viewed to ensure quality documentation that supports timely and appropriate follow-up care.

In the event that there is no information to be documented in a section, the No relevant information to note checkbox can be selected so the section will not appear in the final note.

Under the Co-morbidities, History, and Risks section of the Diagnosis tab, selecting the appropriate option buttons can group conditions to indicate Pre-existing or Developed status, and/or Impacts to the Length of Stay. The Discharge Summary note is populated accordingly.

Co-morbidities, History, and Risks can be auto-populated from a previous Discharge Summary (completed within the past 6 months). This information can then be edited within the form as needed.
Type-ahead cells narrow down long lists to show only matching options. Three characters must be entered into these cells before a list of matching options appears. Type-ahead cells in the Course While in Hospital, Interventions, Follow-Up instructions section display pre-built templates for optional use.

Under the Investigations section of the Course While in Hospital tab, Lab, Microbiology, Radiology and other results can be filtered by type, by clicking on the appropriate rounded button.

Radiology result details can be displayed by selecting View Report; Users may copy and paste pertinent information into the edited by clicking in the Details field.

Select the Include in Note checkbox for results to appear in the note.

When documenting Lab and Radiology results only include those items pertinent to follow-up care; do not copy and paste entire radiology results.

Under the Interventions section of the Course While in Hospital tab, a View OR Note button will be displayed (if any OR Notes were completed during the visit); selecting this button will display available OR Notes from which the User can copy and paste pertinent information into the Details field.
# TABLE/GRID USABILITY FEATURES

<table>
<thead>
<tr>
<th>ICON/BUTTON</th>
<th>FUNCTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Dotted edges along the left-side of a cell indicates that a row can be moved up or down." /></td>
<td>Dotted edges along the left-side of a cell indicates that a <strong>row can be moved up or down</strong>.</td>
</tr>
<tr>
<td><img src="image" alt="A garbage can icon on the left-side of a row can be clicked to delete the row." /></td>
<td>A garbage can icon on the left-side of a row can be <strong>clicked to delete the row</strong>.</td>
</tr>
<tr>
<td><img src="image" alt="A lock icon on the left-side of a row indicates that the row cannot be moved or deleted." /></td>
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</tr>
<tr>
<td><img src="image" alt="A greyed-out cell in a table indicates that a value cannot be entered." /></td>
<td>A greyed-out cell in a table indicates that a <strong>value cannot be entered</strong>.</td>
</tr>
<tr>
<td><img src="image" alt="Add Row" /></td>
<td>Clicking this button <strong>adds an additional row</strong> to a table in order to enter additional medications.</td>
</tr>
<tr>
<td><img src="image" alt="Add Column" /></td>
<td>Clicking this button <strong>adds an additional column</strong> to a table.</td>
</tr>
<tr>
<td><img src="image" alt="Update from EPR" /></td>
<td>Clicking this button <strong>pulls the most recent information documented in EPR</strong> and overwrites data in the table.</td>
</tr>
<tr>
<td><img src="image" alt="Pull from Previous Visit" /></td>
<td>Clicking this button <strong>pulls information from the most recent visit</strong> where a Discharge Summary was signed-off (within the past 6 months).</td>
</tr>
<tr>
<td><img src="image" alt="Pull History from Sign-out Tool" /></td>
<td>Clicking these buttons <strong>pulls information from integrated systems actively being updated</strong> during the current visit (e.g. PHS appointments, OR Notes, Sign-out Tool); information in the table will not be overwritten.</td>
</tr>
<tr>
<td><img src="image" alt="Align BPMH Medications" /></td>
<td>Clicking this button <strong>pulls signed-off BPMH medications into the table</strong> being edited, aligns to matching medications (if exists), and adds to data in the table.</td>
</tr>
<tr>
<td><img src="image" alt="Clear Medications" /></td>
<td>Clicking this button <strong>clears the entire medication table above</strong>; this change can be reversed using the Undo button.</td>
</tr>
</tbody>
</table>

To move more easily within tables click **Tab to move ahead by one cell** and **Shift+Tab to move back by one cell**.
The six tabs of the UHN Discharge Summary are Visit (Encounter), Diagnosis, Course While in Hospital, Alert Indicators, Medications and Discharge Plan. These tabs align with the Discharge Summary template mandated by the Toronto Central Local Health Integration Network (TC LHIN), and used by all hospitals within it.

**VISIT (ENCOUNTER)**

This tab includes the patient’s visit information, primary care and most responsible provider information, and contact information for Discharge Summary recipients from EPR.

Recipients documented in the patient’s EPR face-sheet are auto-populated into the Copies to be sent to section.

Double-check contact information for recipient(s) to ensure they are the intended recipient(s); recipients listed multiple times will receive multiple copies of the Discharge Summary.

**DIAGNOSIS**

This tab includes the diagnosis most responsible for the patient’s course while in hospital, co-morbidities or conditions that exist at the time of admission or develop post-admission, and their effect on the patient's Length of Stay.

**COURSE WHILE IN HOSPITAL**

This tab includes the patient’s chief complaints and concerns, a summary of their course while in hospital, laboratory and radiology results, and any other interventions, procedures, or treatments; only items pertinent to follow-up care should be included.

**ALERT INDICATORS**

This tab includes the patient’s allergens and their reactions.

EPR is the source of truth for allergies and all updates must be made in EPR; allergy information is auto-updated each time a tab is launched.
5 MEDICATIONS

This tab includes seven medication and pharmacy-related sub-tabs that are further discussed in the Medication Reconciliation section (page 14).

6 DISCHARGE PLAN

Instructions for the patient after discharge can be documented in the Follow-Up Instructions for Patient section.

Pre-populated follow-up instructions can be selected and modified further if needed.

The recommended plan to ensure timely and appropriate follow-up care for the patient can be clearly articulated in the Follow-Up Plan Recommended for Receiving Provider(s) section.

All appointments and referrals to ensure timely follow-up care must be documented in the Appointments and Referrals section, with clear indication of the status—Booked, Patient to be called, or Patient to call. Appointments are grouped by status. Appointments that have been scheduled in PHS can be pulled into this section.
The **Best Possible Discharge Medication List** is the information source that will flow into the **Medication Letter** and **Patient Medication Grid**.

Signed-off Best Possible Medication History (BPMH) must be aligned and reconciled in the Discharge Medication List in order to sign-off. Signed-off Discharge Reconciliation can also be a source of BPMH if the patient is readmitted.

The **Update Discharge Medications from EPR** button will pull active medications from EPR and overwrite all data currently within the table.

Select **Exclude “Hospital Only” medications from Discharge Summary** to omit medications reconciled as “Hospital Only” from the Discharge Summary output.

Select **Exclude Discharge Medication List from Discharge Summary note** to sign-off on the Discharge Summary without completing medication reconciliation; only the **Discharge Medication Comments** will appear in the **Discharge Summary printout** (if a patient’s Discharge Disposition is set to Deceased, this checkbox is auto-selected).
Within the medications table, **Reconciliation Options** include **New: Started in Hospital, New: Start on Discharge, Same as Home, Adjusted, On Hold: Reassess, Discontinued, and Hospital Only.**

When **Same as Home** is selected, details in the BPMH column (if available) are auto-populated into subsequent fields; when **New: Start on Discharge** and **New: Started in Hospital** are selected, medication name is populated into subsequent fields and Rx? is auto-selected.

**Rx all Medications** allows Users to prescribe **New, Adjusted and Same as Home** medications with one click.

Up to **two** separate **Prescriptions** can be generated to support Prescribers with limited sign-off authority on medications (e.g. scope of practice does not include sign-off on narcotics or Patients that have multiple dispensaries).

Prescribers with limited sign-off authority can print both prescriptions, but have the other prescriber sign-off the second prescription if needed.

Prescribed medications are marked in the Medication List in the Discharge Summary note with Mitte & Repeat information.

**Discharge Medication Comments** documented in this sub-section will appear in the **Discharge Summary** and the **Pharmacy Note**.
Up to two Prescriptions, a Pharmacy Note, and the Discharge Summary can be generated from the Discharge Reconciliation sub-tab.
BEST POSSIBLE MEDICATION HISTORY (BPMH)

BPMH can be populated from a signed-off Discharge Reconciliation or BPMH from a patient’s previous inpatient visit (within the last 6 months).

BPMH completed while a patient is an emergency patient is preserved when the visit is converted and the patient is admitted as an inpatient.

The General Communications field is for internal Pharmacist communications and does not print onto any notes.

Prescription and non-prescription medications are documented in separate tables.

Signed-off BPMH prescription medications auto-populate and align within the admission, transfer and discharge reconciliation tables.

Smoking and ETOH History information is printed in the comments area of the BPMH.

Any Sources of BPMH and Drug Plan checkboxes selected, along with information entered in the accompanying field, will be printed into Pharmacy Notes.

Press the Enter key to format Community Pharmacist information to separate lines.
ADMISSION RECONCILIATION

Improved Reconciliation options are available in the Admission Medications table, including New, Same As Home, Same as Acute Care (for rehab), Adjusted, Patient not taking at home, On Hold: Reassess, and Discontinued. When the reconciliation option Same as Home is selected for a medication, BPMH details are auto-populated into subsequent fields.

By clicking the Discrepancy? checkbox, “Discrepancy found” will appear in the Comments field; the Comments field will print onto the Pharmacy Note.

TRANSFER RECONCILIATION

Transfer Date and Time must be entered for all transfers in order to pull medications from EPR for the specified period of time.

By clicking the Work List checkbox beside each medication (if appropriate), users can generate and print a list of medications requiring follow-up.
PATIENT MEDICATION GRID

In order to sign-off on the Patient Medication Grid, the Discharge Reconciliation must be ‘Marked as Reviewed’ and/or ‘Signed-off.’ Within the Patient Medication Grid, the Instructions field must be filled out and checkboxes in that row need to be selected to appear in the grid.

Columns in the grid can be renamed by clicking on their title and editing the field.

An extra column can be added to the grid to accommodate an additional medication time by using the blue Add Column drop-down button above the grid.

Columns can be rearranged by clicking the column header and dragging it to the desired slot, and removed by dragging the column out of the grid.

Users will be prompted to update the Patient Medication Grid if any changes have been made to the Discharge Reconciliation; only medications modified in the Discharge Reconciliation will be updated in the grid. Customizations made to medication name, instructions, schedule checkboxes and purpose for all other medications will be preserved.

Most patients prefer the vertical grid over the horizontal grid.

MEDICATION LETTER

Medications in this sub-tab are populated from the Discharge Reconciliation sub-tab and are categorized based on their reconciliation status.

Fields under the Notes heading are not mandatory; only fields containing information will appear in the Medication Letter.

Drug coverage can be pulled from BPMH if available.
Printing Wallet Cards for patient medications can be printed for some Medication sub-tab outputs by checking the Wallet Card checkbox. Wallet Cards print on a separate page.

Users also have the option to include allergies and/or provide a space for patient notes.

Clicking Split in a Medications sub-tab allows Users to select a note output to preview or print.

Clicking Print allows Users to view print options specific to the sub-tab, and generate a PDF to be printed; sub-tabs with multiple output options will default to printing what is currently being viewed.

Patient/Chart/Both copies of the Discharge Summary and Medication tab outputs can be printed, with the copy type indicated in the header of each printout.

Printouts can be generated in small, normal or large-text format based on the patient/user preference; medication outputs default to print in small text.

Wallet Cards for patient medications can be printed for some Medication sub-tab outputs by checking the Wallet Card checkbox. Wallet Cards print on a separate page.
The Patient Medication Grid can be printed in **horizontal** or **vertical** versions, with additional options of printing on **letter** or **legal-sized** paper.

### PRINT OPTIONS

<table>
<thead>
<tr>
<th>SECTION</th>
<th>PRINTOUTS</th>
<th>FORMATS</th>
</tr>
</thead>
<tbody>
<tr>
<td>BPMH</td>
<td>BPMH Summary</td>
<td></td>
</tr>
<tr>
<td>Admission Rec</td>
<td>Admission Rec Summary</td>
<td></td>
</tr>
<tr>
<td>Discharge Rec</td>
<td>Pharmacy Note</td>
<td>Patient or Chart copy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Up to two Prescriptions</td>
</tr>
<tr>
<td>Med Letter</td>
<td>Medication Letter</td>
<td>Patient or Chart copy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(With) Wallet Card</td>
</tr>
<tr>
<td>Patient Medication Grid</td>
<td>Patient Medication Schedule</td>
<td>Legal or Letter-size</td>
</tr>
<tr>
<td></td>
<td>(Vertical &amp; Horizontal)</td>
<td>With Allergies</td>
</tr>
<tr>
<td></td>
<td>Wallet Card</td>
<td>With Space for Patient Notes</td>
</tr>
<tr>
<td>Transfer Rec</td>
<td>Transfer Rec Summary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Work List</td>
<td></td>
</tr>
<tr>
<td>All Tabs</td>
<td>Discharge Summary</td>
<td>Patient or Chart copy</td>
</tr>
<tr>
<td></td>
<td>Prescription</td>
<td></td>
</tr>
</tbody>
</table>
SIGN-OFF & REVISIONS

All note outputs can be previewed as a PDF and printed directly from the application, for both the patient and their paper chart. The image below depicts the View Only mode.

After sign-off, notes can be revised, re-signed off, and re-sent to the intended recipients. Notes are auto-faxed to Primary Care and Referring Providers each time they are signed-off and a new note/revision is uploaded to EPR.

A DRAFT COPY watermark appears on outputs printed prior to sign-off/review.

FINAL NOTES can be viewed and printed using the drop-down at the top-left of the screen.

REVISED COPY appears in the header of a Discharge Summary note if it has been revised and re-signed-off, to inform intended recipients.

FINAL NOTE OUTPUTS:
- Discharge Summary
- Prescription(s)
- Medication Letter
- Best Possible Medication History
- Admission, Transfer & Discharge Reconciliation
- Patient Medication Grid(s) (Horizontal, Vertical, Wallet Card)
- Other Documentation
Once **Sign-off** is selected, a **page count and note preview** will be displayed for Users to review and send the note; **Return to Edit** (revise) gives Users the option to return to the form and continue editing the note (best practice recommends not to exceed three pages to maintain a succinct note for the recipient).

**REVISE** allows edits to be made to an already signed-off Discharge Summary note; the note must be re-signed-off to save into EPR and be re-sent to the recipients.

**SIGN-OFF DETAILS** appear at the top of the screen, documenting if/when the note has been signed-off and submitted.
DOWNTIME

GENERAL INFORMATION

- If EPR is down, the application will also not be available
- If a source system (labs, radiology, or medications) is down, the application will function, but source data will be unavailable

PLANNED DOWNTIME

- Scheduled outside core business hours (2 - 6 hours)
- Email communication sent in advance and a banner message in the application to indicate downtime

UNPLANNED DOWNTIME

- May involve the entire application or a source system
- Email communication sent and an overhead pager announcement made
- Users may wait until the application is restored
- If documentation is needed urgently:
  - Admission Medication Reconciliation can be documented in the patient chart (TG/TW/PM) or using the form B-0011 (TR)
  - Discharge Prescriptions can be issued using Prescription form 2113
  - Medication Grid can be completed using form D6979 (TG/TW/PM) or D6979T (TR)

RECOVERY PROCESS

- No additional reconciliation required
- Copies of paper Prescriptions and Medication Grids must be placed in the patient’s paper chart
SUPPORT

Technical
Ext. 4357
help@uhn.ca

Education
https://www.uhnmodules.ca/DischargeSummary

Change Requests
Medical.Informatics@uhn.ca