Enterprise Discharge Summary

- The Enterprise Discharge Summary (EDS) is an electronic discharge summary with the ability to pull information from Queensland Health feeder systems such as HBCIS, AUSLAB, ORMIS and eLMS.
- Discharge Summaries are required to be completed within 48hrs of patient discharge.

**LOGIN**
- https://eds.health.qld.gov.au using your Novell User ID and password

**General**
- Click to view previous versions.
- Click to switch between tab or layout view.
- Mandatory tabs are denoted by *.
- Click red ‘X’ at anytime to cancel DS and exit without saving changes.
- Feeder system updates must be confirmed and the author must select the updated investigations or procedures if they wish them to be included in the DS.
- EDS does not write back to any of the feeder systems.

**Create and / or Edit DS**
- Enter UR number for patient.
- Click the  to search. The most recent stay at that facility will appear.
- Click to commence a new summary.
- Click to edit a summary.
- To commence a different summary for that patient, find the correct admission from the tabs on the left.
- Auto-save occurs when a user navigates away from a given field and a change has been detected.
- All text boxes expand as required.

**Episode Tab**
- Check Patient details, pre-populated from HBCIS.
- Enter Discharge Date if not present. NOTE: discharge date cannot be more than five days in the future. If DS Author enters a discharge date (ie not sourced from HBCIS), EDS labels the field ‘Planned Discharge Date’.

**Medical Hx Tab**
- Enter Principal Diagnosis – free text or copy from previous DS (mandatory field).
- Enter Other Active Problems – free text or copy from previous DS.
- Complete remaining fields as required.
- Clinical management data can be progressed daily.

**Procedures Tab**
- ORMIS data is automatically populated.
- Alternatively click  to enter Procedure details if required.
- Use right aligned tick boxes  to select or deselect procedure descriptions or comments.
- To delete rows click on .

**Investigations Tab**
- Admission related data will pre-populate from AUSLAB.
- Select the AUSLAB results to be sent to the GP.
- Deselect the checkbox to remove the result from DS.
- Click  to show / hide row detail.
- Click  to enter other Investigations or Radiology Results as required.

**Medications Tab**
- Admission & Discharge meds are pre-populated if an eLMS profile has been created and authorised.
- Click right aligned icons  to manually manage or add medications:
  - Tick boxes to include or exclude a medication from the printed DS.
  - Pencil  to edit medications in pop up window.
  - Trash Can  to delete row(s).
  - Plus to manually add new medications.
- If no amended script is sent to pharmacy then original eLMS will display when DS next opened.

**AR/Alerts Tab**
- Click  to indicate the patient has No Known Adverse Reactions.
- Enter any relevant Allergies / adverse Reactions / Alerts.

**Management Plan Tab**
- Enter relevant Follow Up Arrangements (incl. OPD appointments required).
- Pencil  to edit in pop up window.
- Trash can  to delete rows.
- Enter Care Plan Summary or copy from previous DS.
- Enter Recommendations for GP or copy from previous DS.
- Enter Recommendation to patient or copy from previous DS.

**Feeder Updates**
- Any new Feeder Updates must be confirmed prior to finalisation. Click on New Feeder Updates if required. Ensure updated investigations or procedures are selected for inclusion in the DS.

**Recipient Lookup**
- Click  to view or modify the Recipient/s List.
- Click Magnifying Glass icon to search address book.
- Search on GP Name or Practice.
- Click  to add Recipient to Recipient List.
- Recipient icon will be Green (confirmed) for distribution.
- If not on list, enter name and address manually.
- Recipient icon will be Blue.
- Recipient/s list cannot be modified once the discharge summary is interim or finalised.

**To Print**
- Click  to save DS PRIOR to finalising.
- Click  to Finalise and Distribute.
- Print Distribution List.
- Print number of DS as indicated.
- Sign each copy and leave in CEC with Distribution List.

For EDS queries, please contact Health Information Management Service on (07) 5433 8110 or email CabH.eHealth@health.qld.gov.au

Turn over for more detail about field entries & requirements.
Reason for Admission / Presenting Problems
• The reason(s) why a person enters the healthcare system, representing the demand for care / service. This field is used to identify symptoms, issues, problems or diagnosis requiring subject of care attendance at the healthcare facility.

Principal Diagnosis
• The principal diagnosis is defined as “…the diagnosis established after study to be chiefly responsible for occasioning the patient’s episode of care in hospital (or attendance at the health care facility)”. The final assessment or the final diagnosis of the cause of admission after information such as test results, operative and laboratory finding’s, and the course of the illness have been considered.
• Symptoms should only be recorded as a principal diagnosis if their aetiology could not be determined.
• It is unhelpful to other clinicians and clinical coders to record ‘(diagnosis)…for investigation’ (such as abdominal pain for investigation) as a principal diagnosis.
• It is also unhelpful to record ‘for …(procedure)’ as the principal diagnosis, as the name of an operation is not a principal diagnosis.

Other Active Problems
• This field should incorporate any problems, additional diagnosis or co-morbidities actively treated / monitored within this admission.
• A Problem is defined as a “condition for which a specific diagnosis has not yet been identified”.
• An additional diagnosis is defined as “a condition or complaint coexisting with the principal diagnosis”.
• Co-morbidities are defined as “pre-existing additional conditions that affect the patient during the episode of care in terms of requiring any of the following; therapeutic treatment, diagnostic procedures / interventions, increased nursing care and / or monitoring”.

Previous Medical History
• Previous Medical History relates to diagnoses’ that has no bearing on the current hospital stay, that provides an accurate, brief and concise outline of a patient’s previous medical conditions
• Requires no therapeutic treatment, diagnostic procedures / interventions or increased nursing care and / or monitoring.

Inpatient Clinical Management
• This is the main body of the summary providing an accurate, brief and concise account of the episode including admission type and/or care and/or treatment provided during admission.
• N.B. The clinical significance of abnormal investigation results (laboratory, x-ray and other diagnostic tests) should be documented here as the pathology field is pre-populating. Document the condition relating to the test results, for example ‘anaemia’ rather than ‘Hb 6’. Record any treatment or effect on the care plan and/or length of stay, for example transfusion for anaemia.

Complications
• Complications arise during the episode of care or attendance at a health care facility and are defined as condition / s that result from surgical or medical care.
• Examples include MRSA septicaemia, E. coli UTI, urinary retention, acute blood loss anaemia, pneumonia, haemorrhage or wound infection due to the intervention.
• The cause and effect between a condition and an intervention must be documented to enable the condition to be coded as a procedural complication. The causal link requires documentation such as due to … complication of … resulting from … or secondary to …
• ‘Postoperative…’ or a variation of this wording is not sufficient as this may simply indicate a condition arising in the post-operative period and not a complication.

Procedures
• This information is pre-populated into EDS from the ORMIS system however a manual entry can be created to describe an additional procedure.
• Procedure is defined as a clinical intervention that; is surgical in nature and / or, carries a procedural risk and / or, carries an anaesthetic risk and / or, requires specialised training and / or, requires special facilities or equipment only available in an acute care setting.

Pathology
• This information is pre-populated into EDS from Auslab.
• IMPORTANT - When selecting pathology results in EDS to be included in the finalised discharge summary they are displayed in the finalised PDF version (printed hard copy) of the summary, however are not displayed in the EDS if electronically distributed to the General Practitioner. The General Practitioner will only see the investigation, order date, order number, specimen type, when it was collected and the status.

Medical Imaging
• This information is not pre-populated into EDS from the radiology system.
• Enter medical imaging results by adding a manual entry to the significant other investigations fields. This can be copied directly from the radiology report.

Medications at Admission/Discharge/Seased
• If an eLMS profile has been generated for the patient this will pre-populate into EDS from the eLMS system. Contact the ward pharmacist to discuss eLMS profile creation.
• Where an eLMS profile is not available a manual entry can be created.

Adverse Reactions/Alerts
• Refer to the Alerts and Adverse Reactions form in the front of the clinical record for documented adverse reactions.
• If there are no known adverse reaction please select the ‘add an acknowledgement confirming that the patient has no known adverse reactions’ icon.

Follow Up Arrangements
• Include arrangements you would like to have organised for the patient from internal hospital service or external health services i.e. outpatient clinic, third party healthcare provider follow up appointments.

Recommendations to GP
• Include any follow up required by the General Practitioner.

Recommendations to Patient
• Include information that has been communicated to patient whilst admitted eg. Cease smoking etc.
• Please ensure that the summary is distributed to the patient in a timely manner when including recommendations to the patient.

Care Plan Summary
• Outline any ongoing care arrangements required by the patient and health care providers for any plans of action relating to continuum of care eg. Heart Failure Clinic Review, GP in 2 weeks, continue medication as prescribed and diet plan.

Summary Distribution
• On completion of the discharge summary by the treating medical officer, the ward receptionist from the discharging ward is responsible for:
  □ Forwarding the discharge summary to the GP/referring doctor/other care provider as advised by the medical officer and/or identified on the EDS distribution report.
  □ Completing the ‘dispatched by’ section of the distribution report to identify the person who has dispatched the summary.
  □ Filing the original in the clinical record.