

Sample Home Health Discharge Summary

Moving from Paper Based to Electronic Hospital Discharge Summaries Facilitating Patient Understanding of Discharge Instructions Electronic Discharge Summary Systems Documentation Standards for Discharge Summary to GP for Mental Health Adults Patients A Comparison of Two Methods of Medical Discharge Summary Generation Health Information Analysis of Discharge Summary of a Home Health Agency The Proceedings of the ... Annual Health Care Information & Management Systems Conference An Evaluation of the Deinstitutionalization Process in the U.S. Department of Health, Education, and Welfare Region X: Appendices Best Practices for Hospital & Health-system Pharmacy Problem-oriented Nursing Assessment Guidelines and Documentation Requirements for Social Workers in Home Health Care Public health reports Being a Medical Records/Health Information Clerk Discharge Planning for Continuity of Care Medical Risk Management Reports of Cases Argued and Determined in the Supreme Court of the State of Kansas. Published Under Authority of Law by Direction of the Supreme Court of Kansas AAMSI Congress Medical Journal of Australia Minnesota Rules Kusnadi Kusnadi Institute of Medicine Australian Commission on Safety and Quality in Health Care Tony Adams Mervat Abdelhak Jacalyn Helene Kareb Washington (State). Department of Social and Health Services. Planning and Research Division. Office of Research American Society of Health-System Pharmacists Patricia Dubbert Larkin Leah Blanchard Kathryn McMiller Evelyn G. Hartigan Edward P. Richards Kansas. Supreme Court

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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

the roundtable on health literacy brings together leaders from academia industry government foundations and associations and representatives of patient and consumer interests who work to improve health literacy to achieve its mission the roundtable discusses challenges facing health literacy practice and research and identifies approaches to promote health literacy through mechanisms and partnerships in both the public and private sectors to explore the aspects of health literacy that impact the ability of patients to understand and follow discharge instructions and to learn from examples of how discharge instructions can be written to improve patient understanding of and hence compliance with discharge instructions the roundtable on health literacy held a public workshop the workshop featured presentations and discussions that examined the implications of health literacy for discharge instructions for both ambulatory and inpatient facilities facilitating patient understanding of discharge instructions summarizes the presentations and discussions of the workshop this report gives an overview of the impact of discharge instructions on outcomes and discusses the specifics of inpatient discharge summaries and outpatient after visit summaries the report also contains case studies illustrating different approaches to improving discharge instructions

successful joined up care depends on gps community and acute mental health care

teams and social care professionals all having access to timely information about a persons care and treatment the prsb has developed the mental health discharge summary standard to ensure that relevant information is shared so professionals can provide continuity of care when an adult is discharged from mental health services source professional record standards body

this book has been thoroughly revised and updated to reflect the vast technological changes in the field for 2 year or 4 year health management programs this text focuses on health data its collection and use it emphasizes the deployment of information technology and the role of the him professional in the development of the electronic health record

unlike other available books on medical records which focus on management of him departments this one is especially designed for entry level health information medical record clerks it orients learners to the essential step by step procedures for being a medical records clerk from the importance of confidentiality to filing key topics specific chapter topics cover the health information management department number and filing methods processing medical records assembly and analysis of the medical record physician incomplete area confidentiality and release of information and other medical record clerk functions for directors managers supervisors of him departments in hospitals physicians offices and outpatient clinics and also for use in hospitals and for anyone maintaining medical records

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