Australian Commission on **Safety and Quality** in Health Care

National guidelines for presentation of electronic discharge summaries

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Executive summary

Discharge from hospital is a high-risk event. Poorly written or incomplete discharge summaries can lead to medication errors, inadequate follow-up care, unnecessary hospital readmissions, and possibly, patient deaths. High-quality and timely discharge summaries enhance patient safety.

Recognising this critical patient safety risk, the *National Guidelines for Presentation of Electronic Discharge Summaries* (the Guidelines) have been revised and updated from the previous 2017 edition. Initially developed following a clinical safety review of the My Health Record system – which revealed inconsistencies in discharge summaries across hospitals, general practice, and the national electronic health record – the Guidelines aim to ensure a nationally consistent approach to accurate, concise, and well-designed electronic discharge summaries (EDS).

Extensive literature findings demonstrate that discharge summaries are an essential component of effective clinical handover at transitions of care, which can reduce errors and improve outcomes. The Guidelines provide evidence-based recommendations on the structure, format, and content of EDS, which must be supported by robust clinical governance, training, and evaluation processes.

The Guidelines build upon technical specifications and document architecture for EDSs, that were first published in 2010 by the former National e-Health Transition Authority (NEHTA). These remain current under the stewardship of the Australian Digital Health Agency (the Agency).

Extensive stakeholder consultation with clinicians, across the acute and primary care sectors, informed the updated Guidelines. Other activities that informed the revision process included:

- A literature review and environmental scan of international best practice
- Facilitated workshops with representatives from Australian states and territories to determine the current implementation of the Guidelines
- Online surveys to explore clinician perspectives and experiences with EDSs
- Targeted consultation to align recommendations with national digital health initiatives.

These Guidelines are intended for clinicians and health service organisations using EDSs in their clinical information systems. The Guidelines are not intended to be a comprehensive guide for all clinical specialties and scenarios. Rather, they provide general recommendations that are applicable to most circumstances. Ultimately, implementing these Guidelines means fewer avoidable errors, fewer readmissions, and safer patient care.

Introduction

Transitions of care are a period that increases risk of harm for patients.[1] A discharge summary consists of curated health information to support safer transition and follow-up care after a patient's discharge from hospital.

The main purpose of a discharge summary is to inform clinicians what has happened to a patient in hospital and what is required when the patient leaves hospital for continuity of care. The primary recipient of a discharge summary is a patient's nominated healthcare provider (usually a general practitioner). Discharge summaries also serve important secondary functions such as providing health information for use by:

- Patients and/or their carers
- Community-based healthcare providers (for example, medical specialists)
- Clinicians in a hospital setting (for example, following subsequent hospital presentations, or clinicians who may be providing ongoing specialist care both inhospial and in an outpatient setting)
- Clinical coding specialists.

High-quality and timely discharge summaries support clinicians to make appropriate clinical decisions and ensure continuity of care as patients leave the hospital. Discharge summaries may be prepared in a paper-based format or increasingly, as an electronic discharge summary (EDS).

Despite advancements in digital health technology, there is significant variability in the quality of EDSs. Improving safety at transitions of care is a national healthcare priority and standardisation in discharge summary content can reduce variability to support better patient outcomes. Attempts to standardise EDS content have presented significant challenges due to the diverse and complex needs of multiple stakeholders. This is amplified by the variability in digital maturity across the health system[2]. A system-wide approach is necessary to address these complex challenges and drive the necessary standardisation.[3]

Background

The Guidelines were first published in 2017 as the *National Guidelines for On-Screen Presentation of Discharge Summaries*. They were submitted to the Australian Health Minister's Advisory Council for endorsement and subsequent implementation across the country.

The Guidelines were developed to address recommendations that emerged from the Commission's Clinical Safety Program. As part of this program a series of eight clinical safety reviews of the My Health Record system were completed. The fourth clinical safety review, conducted in 2014, involved an end-to-end investigation of the accuracy and data quality of EDSs. It recommended that the Commission work with relevant Australian Government agencies, jurisdictions and clinical peak bodies to develop a common presentation format for EDSs.

The 2017 edition of the Guidelines were developed based on the technical specifications available at the time of publication, which were first published in 2010 by the former National e-Health Transition Authority (NEHTA). The technical documents are currently under the stewardship of the Australian Digital Health Agency (the Agency) and published as the 'eDischarge Summary' document collection on the Agency's developer portal.

Objective and purpose

The Guidelines aim to enhance the overall quality and usability of the EDS and contribute to better patient outcomes at transitions of care. They complement a range of efforts for continuous improvement, including those achieved through technology standards, software development requirements and other planned work under the National Digital Health Strategy.

The Guidelines provide recommendations to ensure that the necessary information about a patient's hospital encounter, are provided in a structured and consistent manner. This helps EDS recipients to rapidly identify any risk areas, and important follow up actions that may be required.

The Guidelines provide recommendations regarding:

- The content within each section of the EDS
- The relative position of sections within the EDS
- Formatting and presentation (for example, tables, bullet points)
- Functionality considerations to support delivery of an accurate and concise document.

These Guidelines provide a baseline from which clinicians and health services can assess the quality of their EDS and implement targeted interventions for ongoing quality improvement.[4] They also reflect valuable feedback from clinicians that could inform future updates to technical infrastructure to enable changes that will drive more nationally consistent EDSs.

Scope

These Guidelines are intended for clinicians and health service organisations implementing an EDS through their clinical information system. These Guidelines are based on the *eDischarge Summary Core Information Components* technical document, which defines the minimum set of data elements that are recommended for any system that creates and transfers discharge summary information electronically within Australia.[5] Like the *Core Information Components* document, the Guidelines are not intended to be a comprehensive guide, but to provide general recommendations that are likely to apply to most circumstances.

It is recognised that additional information may be required in a discharge summary based on several factors including:

- Patient group (for example, paediatrics, aged care, disability)
- Discharge destination (for example, transitional or residential care)
- Clinical specialty (for example, mental health, oncology, cardiology)
- Unique workflow requirements (for example, emergency departments, maternity).

Key findings

Table 1 Key findings related to electronic discharge summaries (EDSs) from stakeholder consultation with relevant recommendations

Priority problem statement	Recommendations
EDS recipients often need to scroll through several pages on screen to locate important information.	The most important information should be located towards the top of the EDS. This ensures recipients can rapidly access and view this information.
Discharge summaries contain irrelevant or repetitive information making it difficult to find information quickly.	The EDSs should have a consistent structure with content that is curated to ensure relevance and enhanced data quality for greater use.
The discharge summary is not well designed or fit-for-purpose.	General practitioners and other stakeholders in primary care should be engaged by health service organisations during development, implementation and ongoing quality improvement of an EDS.
Information provided about medicines on discharge are incorrect or inadequate for continuity of care.	EDS authoring and rendering systems should adopt nationally agreed medicines terminology codes wherever possible to enhance interoperability and data integrity. The preferred terminology set for medicines in Australia is the latest version of the Australian Medicines Terminology (AMT).
Discharge summaries often do not include sufficient information to support patient-centred continuity of care.	Additional curated and patient-centred information should be included in the EDS, where it is relevant and necessary for enhanced continuity of care. For example, functional status, advance care planning documents, social context and cultural or communication needs.
Data fields left blank, or incomplete are open to misinterpretation.	Electronic systems may be configured to include system-level interventions such as forcing functions to prevent the omission of important information. If applied, forcing functions should be limited to critical data fields. Clinical judgement should be applied by the discharging clinician to include other relevant information.
Significant errors in EDSs may result from suboptimal integration with clinical workflow.	Clinical workflow should be considered before implementation of an EDS and supported by customised periodic training for clinicians.
The discharge summary is perceived as a time-consuming administrative task by clinicians.	There are several advantages of EDSs over the paper-based discharge workflow, which could be leveraged and supported by appropriate clinical governance. For example, auto-population of data fields to minimise manual entries. Health services could also consider workflows that support multidisciplinary (nursing, allied health, pharmacy) input into the EDS.

Stakeholder perspectives

The following are illustrative quotes from survey participants obtained during stakeholder consultation highlighting perspectives on implementation of electronic discharge summaries (EDSs). Findings from the surveys have been considered as part of the development of these Guidelines.[3]

'... there is a lack of accountability for incomplete or incorrect medication lists'

Survey participant – Hospital

'The role of EMRs +/– AI assistance to build a living document / dynamic discharge summary needs to be explored further'

Survey participant – Hospital

'Remind people not to use abbreviations… It is not always common knowledge outside the specialty'

Survey participant – Primary care

'Being able to know where information should be located and what should be included in a discharge summary is beneficial to all health professionals dealing with transition of care'

Survey participant – Primary care

'This [documenting medicines information in the EDS] is onerous if not automated to some extent and supported by pharmacy workforce in addition to medical staff'

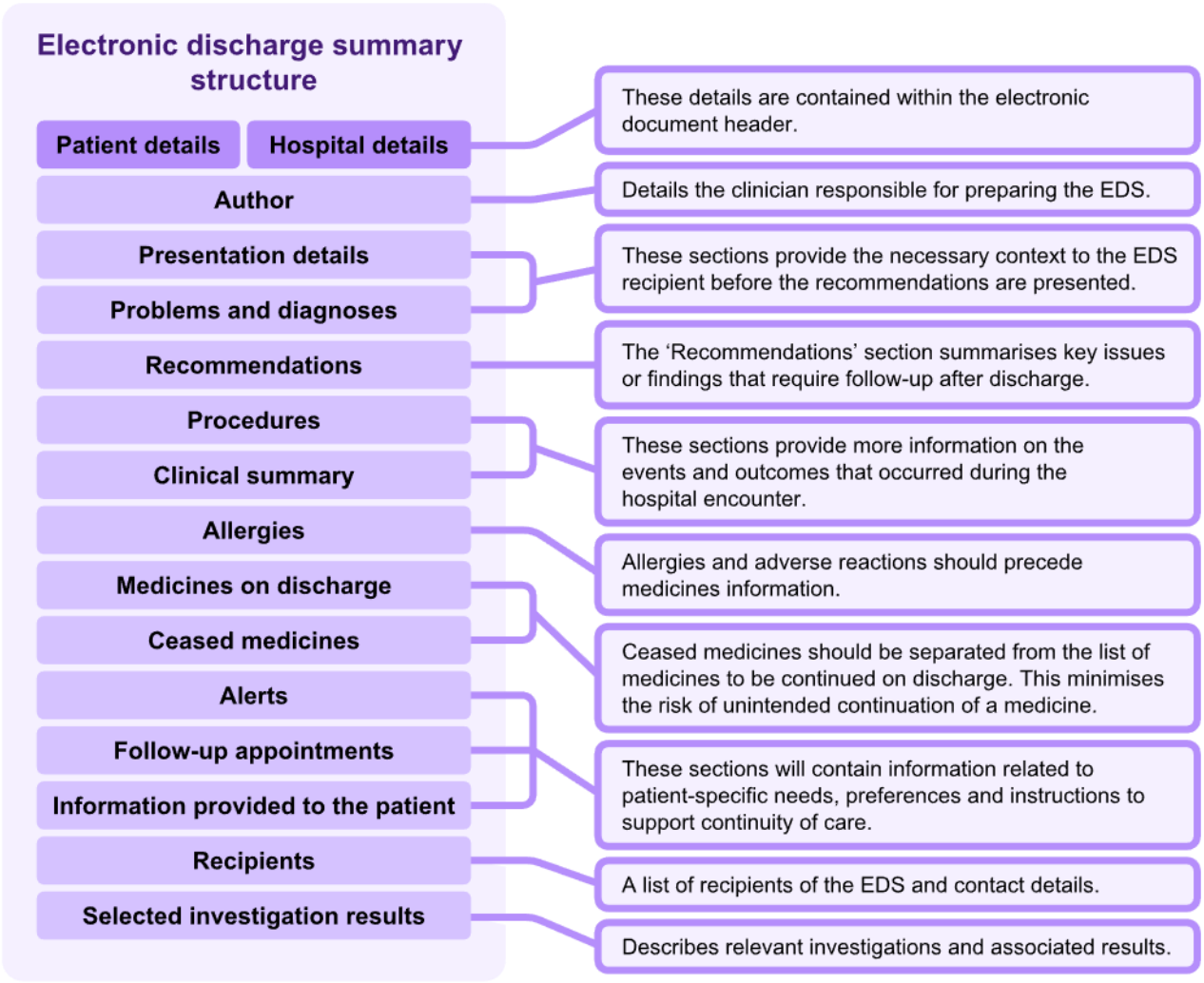
Survey participant – Hospital

Changes made to the Guidelines

Based on findings from the literature and stakeholder consultation, the Guidelines include the following updates:

1. Revised the position of the 'Recommendations' section in the overall structure of an EDS to reflect the views of stakeholders in both hospital and primary care settings.
2. Alignment with other national initiatives to improve health information exchange such as the Australian Core Data for Interoperability (AUCDI).[6]
3. Addition of general principles and considerations that align with the Commission's work to enhance safety and quality at transitions of care. This change recognises the variability in digital maturity across Australian health service settings, and provides practical guidance for improving discharge summary quality, which is technology agnostic.
4. Removal of information that duplicates content that exists within technical documents.
5. Other minor changes to provide clarity based on stakeholder feedback.

Figure 1 Illustrates the order and position of section headings within the electronic discharge summary (EDS), based on feedback from stakeholder consultation



Principles for safe, high-quality transitions of care

Transitions of care encompass all scenarios where a person moves within or between health services and settings. This includes discharge of a patient into the community following an acute hospital admission. Poor transitions of care are associated with adverse events such as higher rates of readmission to hospital and medication errors. More than 50% of all medication errors occur when people move from one healthcare setting to another.[7] Effective communication between clinicians and the person receiving health care ensures that continuity of safe and high-quality care is maintained at care transitions and beyond.

The overarching principles for safe, high-quality transitions of care (Table 2) should be adopted by all health services accredited to the National Safety and Quality Health Service (NSQHS) Standards.

Table 2 The Principles for safe, high-quality transitions of care mapped to their application in discharge summaries

Principles	Application in discharge summaries
 **Transitions of care are person-centred.**	Discharge summaries should reflect the needs, preferences, and goals of care of the person.
 **There is multidisciplinary collaboration to support the transition of care.**	• The discharge planning process starts from the time of admission. • Key members of the person's care team are identified and engaged early for discharge planning. • The person's general practitioner or other primary healthcare provider are included in discharge planning, particularly for complex cases.
 **There is an enduring, comprehensive, and secure record system to document share and securely access information about the person's current and ongoing care.**	• A copy of the electronic discharge summary (EDS) is provided to the person receiving care, at the time of discharge. • The EDS is transmitted electronically at the time of discharge through a secure messaging service to a person's nominated primary care provider. • The EDS and other relevant clinical information should be uploaded into the My Health Record system. • The information communicated in the EDS is complete, accurate, relevant, and provided in a timely manner.
 **There is ongoing continuity of care.**	Discharge documentation is communicated in an agreed standardised format (for example, terminologies and identifiers) and includes all information requirements to enable safe and high-quality ongoing care.

Guidance for health service organisations

Considerations	Rationale
Health services implementing an EDS should refer to the latest release of nationally agreed technical and informatics standards for EDSs.	EDSs that do not comply with technical standards may not be uploaded to the My Health Record.
Consider the use of auto-population or forcing functions for input of data in the EDS, ensuring clinicians are aware of data provenance.	System-level configuration following a risk assessment should enable functionality that improves data quality and to reduces the administrative burden on clinicians authoring an EDS.
Coded data should be used wherever possible and should be consistent with nationally agreed standards to support interoperability.	Wherever data components are codable, this should be enabled. The use of coded data is critical for data quality and interoperability. A digital health standards catalogue has been published by the Australian Digital Health Agency to consolidate all the relevant national and international standards for digital health in Australia.
A high-level summary of recommendations should be provided to support continuity of care. These recommendations should be in a prominent position towards the top of an EDS.	Feedback from stakeholder consultation indicated that there is a strong preference for the 'Recommendations' section to be presented in a prominent position towards the top to the EDS. This would ensure that important recommendations or follow-up actions are highlighted and quickly accessible to the EDS recipient.
Health service organisations should have processes in place to ensure contact details for a patient's nominated primary healthcare provider are updated in the patient administration system before discharge from the hospital.	Contact details of the patient's nominated primary healthcare provider are usually documented by clerical staff on admission and should be confirmed again by the discharging clinician.
Health services should have policies and procedures in place to support high-quality and timely discharge planning and communication.	Safer transitions of care following discharge from hospital are enabled by effective and timely communication. This is achieved through a well-planned and executed discharge process and a high-quality discharge summary. Importantly, the EDS should be finalised and shared with the nominated primary healthcare provider, the patient or carer, and shared to the My Health Record, at the time of discharge.
Health services should establish a mechanism for EDS recipients in primary care to provide feedback that informs local quality improvement activities. For example, a hyperlink or QR code within the discharge summary.	Poor collaboration with recipients in primary care is a significant barrier to producing high-quality discharge summaries. Stakeholder feedback highlighted the importance of engagement with the primary care sector to implement EDSs that are fit-for-purpose and responsive to evolving needs.

Guidance for clinicians

The considerations outlined below refer to sections of the EDS that are uncoded free text as these represent the greatest variability in structure and quality. Free text data fields give the EDS author flexibility and control over data input. This means EDS authors also have a responsibility to ensure that free text content is of high quality and utility.

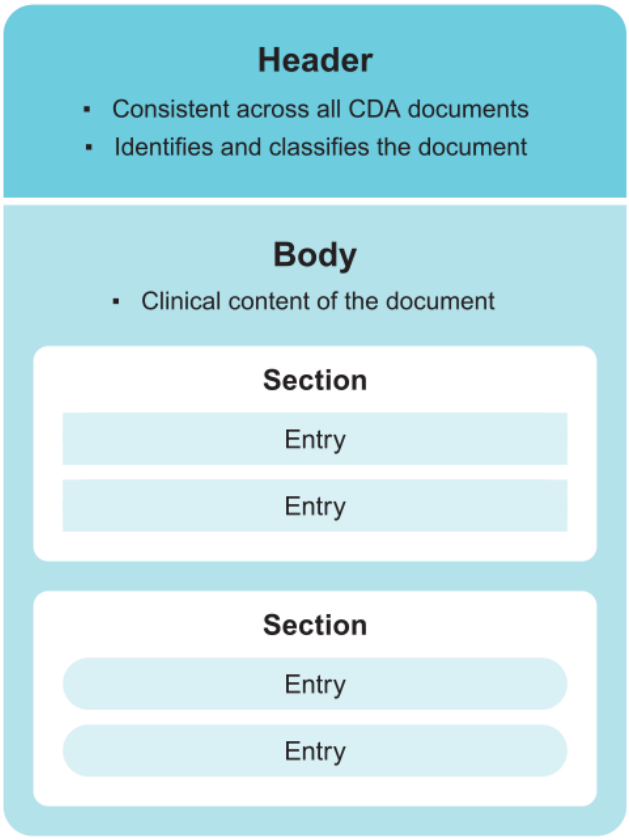
Considerations	Rationale
Content should be curated to ensure information is patient-centred, concise and relevant.	The EDS is a critical part of clinical handover. It is the responsibility of the discharging clinician to use their clinical judgement to prepare a high-quality EDS.
Avoid abbreviations and jargon in accordance with the Recommendations for Safe Use of Medicines Terminology.	Some acronyms and abbreviations are highly specialised and do not have a commonly understood meaning. To reduce the risk of misinterpretation, abbreviations should be avoided.[8] If abbreviations must be used, they should be spelled out in full at the first use. Although an EDS is intended for use by clinicians and healthcare providers, patients and/or carers also receive a copy. The EDS should be written in a manner that can be interpreted by patients.
Avoid 'copy and paste' of information from the electronic medical record (EMR) into the EDS.	This has been identified in the literature as a consistently reported barrier to the effective use of an EDS due to the potential for errors and duplicate or irrelevant information.
Confirm the details of the intended EDS recipient with the patient.	The discharging clinician should confirm the details of the person's nominated primary healthcare provider prior to discharge to facilitate delivery to the intended recipient.
An EDS should be used in combination with other handover methods (for example, phone call or case conference) for patients with complex needs or require timely follow-up.	There is no mechanism for the recipient of an EDS to acknowledge in real-time that an EDS has been received. Therefore, in complex or time-critical scenarios, a safe clinical handover may require additional communication between the discharging and the receiving healthcare provider, to supplement the EDS.

Structure of an electronic discharge summary

Electronic transmission of clinical information requires both human-readable and machine-readable formats. To fully appreciate the Guidelines, it is necessary to understand the technical structure of an electronic discharge summary (EDS) based on the current technical document architecture.

The exchange of clinical documents between systems in Australia is organised based on Clinical Document Architecture (CDA) determined by Health Level 7 (HL7), an international standards development organisation. The basic structure of a CDA document (Figure 3) includes a header and a body. The header remains the same for all CDA document types, while the body contains the clinical information. The body of a CDA document contains individual data elements (entries) grouped within individual sections. If the EDS implementation at a health service level does not conform to the CDA structure, it is likely that the receiving (rendering) system will be limited in what information is stored and/or processed. This may impact the completeness, accuracy and/or usability of the information being displayed to the end-user.

Figure 2 Logical structure of the CDA document with corresponding data components in the electronic discharge summary



Data components of an electronic discharge summary

The recommendations in this part of the Guidelines should be considered alongside technical standards and requirements published on the Australian Digital Health Agency's Developer Portal.

Header

Patient details

This component should contain all the relevant information to accurately identify the individual that has received care in a health service.

Recommendation	Rationale
Display the patient details on the upper left corner of the EDS, within the 'Header' component.	• Patient identification details should be displayed in a consistent manner so users can efficiently and accurately identify the patient. • Eye-tracking sessions revealed that the upper left corner of the summary received a significant number of fixations.
Display the patient's name on a single line, in a larger, bold font.	Presenting the patient's name in bold and using a larger font improves contrast and visibility of critical information.
Display other patient's details in the following order: • Date of birth (age) • Sex assigned at birth • Gender identity • Indigenous status • Address • Telephone • Medical Record Number (MRN) • Individual Healthcare Identifier (IHI).	• Inclusion of an Individual Healthcare Identifier (IHI) aligns with objectives of the national Healthcare Identifiers Service. • Displaying patient details consistently can help minimise clinical safety risks through accurate identification and matching. • Inclusion of Indigenous status improves data quality and outcome measures of First Nations people and aligns with the national 'Closing the Gap' initiative.
Ensure the patient's details are always visible, regardless of whether the user scrolls up or down.	Displaying hospital information in a static position allows this information to be readily available regardless of the section of the EDS that is being reviewed.
If a patient is deceased, display 'DECEASED' next to the patient's name in bold, upper-case letters.	Healthcare providers should be able to immediately identify whether the patient for whom the EDS has been written is deceased.

Hospital details

Recommendation	Rationale
Include the facility's unique national identifier known as the Healthcare Provider Identifier – Organisation (HPI-O).	Aligns with the objectives of the national Healthcare Identifiers Service and is a foundational element to enable interoperability.
Display the hospital details in the upper right corner of the EDS, within the document 'Header' component.	Stakeholder consultation revealed that details of the treating hospital are critical pieces of information. They allow the healthcare provider to seek additional information on the patient's episode of care, if required.
Display the hospital name on a single line, in bold, with a larger font.	Presenting the hospital name in bold and using a larger font improves contrast and visibility of critical information.
Display the hospital details in the following order: • Local health district, or equivalent • Address • Phone number (where possible, include ward phone number in addition to main hospital number).	Hospital phone numbers are included in case the primary healthcare provider needs to contact the author or senior clinician for clarification.
Ensure the hospital details are always visible, regardless of whether the user scrolls up or down.	Displaying hospital information in a static position allows this information to be readily available regardless of the section of the EDS that is being reviewed.

Body

The following sub-headings represent the sections within the body of a CDA structured electronic discharge summary (EDS).

Author

This component should include information for the EDS recipient to be able to identify the author of the document should any follow up contact be required. If there are multiple contributors to the EDS, the author details should correspond to the clinician with delegated authority to finalise and attest (or electronically signs) the EDS prior to transmission.

Recommendation	Rationale
Display the name of the document's author close to the hospital details.	Stakeholder consultation highlighted that primary healthcare providers would like the author's name displayed close to the hospital details. This allows healthcare providers to readily determine who they need to contact and how they can be contacted if further discussion is required.
Include additional information about the author including: • Author's name • Designation or job title • Phone number or pager number if available.	Stakeholder consultation revealed challenges with contacting the author following discharge. Displaying the author's designation or job title in an EDS may facilitate efficient identification and contact (particularly if calling a hospital switchboard). To minimise duplication, a phone number should only be included if it is different to the numbers provided under hospital details.

Presentation details

This section includes administrative information, which provides context about the healthcare encounter.

Recommendation	Rationale
Display the presentation details in a horizontal table immediately following author details.	Key details about the presentation or hospital encounter, presents contextual information concisely.
The following data elements should be included: • Presentation date • Discharge date • Length of stay (at hospital) • Ward/unit (the location from which the patient was discharged) • Episode type (for example, emergency, medical, surgical, mental health) • Senior clinician (the healthcare professional responsible for the patient's care at the time of discharge) • Discharge destination.	These data elements are recommended based on consultation with healthcare providers and provide a more context for the hospital encounter.

Problems and diagnoses

This component of the EDS should succinctly outline the reasons for the hospital encounter, diagnoses, and co-morbidities.

Recommendation	Rationale
The following information should be included in a table format: • **Reason for presentation**: the symptom(s) or injury that was reported as the reason for initial presentation to the health service. • **Principal diagnosis**: The diagnosis established following medical assessment and determined to be the primary cause for admission to the health service. • **Secondary diagnoses**: Other health conditions that were identified or diagnosed during the hospital encounter. • **Complications:** Conditions that arise because of a procedure or treatment and other care-related incidents (for example, Infection, pressure injury). • **Past medical history**: Previous surgery, previous diagnoses and chronic conditions.	• The sub-headings selected for the various types of problems and diagnoses follow the recommendations of healthcare providers during stakeholder consultation. • Presentation of this information in a table format facilitates readability.
This section should be coded to standard terminologies.[6] Free text entries should only be used if no coded value is available.	Use of standard terminology improves data quality and interoperability.

Recommendations

This section of the EDS presents the most critical information for the continuity of patient care following discharge. The recommendations are not intended to duplicate details from other parts of the EDS, but rather to provide a high-level summary of important findings or changes that require action or ongoing monitoring. This section should also include recommended actions made by the broader multidisciplinary team (for example, Aboriginal Liaison Officer, allied health, nursing, pharmacy, aged care liaison) to facilitate person-centred and culturally appropriate ongoing care.

Recommendation	Rationale
As one of the most critical components for continuity of care following discharge, the 'Recommendations' section should be prominently visible to the receiving clinician and located near the top of the EDS.	• Evaluation of the recommendations from the 2017 edition of the Guidelines determined that a completed EDS may extend for several pages. This pushed the 'Recommendations' section further down requiring clinicians to scroll through many pages to find this important information. • Eye-tracking data also supports the inclusion of the most important information at the top of the document.
Display this in a table format and include the following information: • Recommendation (and approximate timeframe for action if relevant) • Name of the person to whom the recommendation is directed (see Practice points).	This component should be synthesised accurately and concisely by the discharging clinician.

Figure 3 Examples of the content that may be included in the 'Recommendations' section

Recommendations	For action by
Changes have been made to medicines on discharge – please see relevant section below for details – prescription required for continued supply (two weeks supply provided by hospital).	GP
Pathology test results pending (liver function tests) – hospital team to follow up with patient.	Dr Smith
Penicillin allergy challenge conducted under immunology (details in clinical summary) – consider removing this allergy from the electronic health records.	GP

Practice points

- Defining accountability and responsibility at discharge is critical to a safe and effective clinical handover.[1] The EDS alone is not a sufficient form of clinical handover because there is no mechanism for the recipient to acknowledge receipt or accept responsibility.[1]
- For clinical issues that require timely follow up, or for patients with complex problems, the EDS should be supplemented with another form of direct communication with the responsible primary care provider should be made (for example, a phone call).
- Ensuring a safe and effective clinical handover at discharge requires appropriate processes that are person-centred and align with community-based models of care. For discharge to services such as Aboriginal Community Controlled Health Organisations (ACCHO) or residential care, tailored communication is essential to support continuity of care, particularly where a discharge summary is not available in a timely manner or accessible electronically.

Procedures

This section should list any relevant procedures or clinical interventions that were undertaken during the hospital encounter. A procedure or clinical intervention is defined as an intentional intervention to diagnose, treat or manage a health condition, often involving invasive or potentially harmful techniques requiring skin or mucosal penetration or tissue manipulation.[6]

Recommendation	Rationale
Display the list of procedures and interventions performed in hospital as a bullet list in chronological order	Presenting procedures as a bullet list aligns with the heuristic principle that reading entire paragraphs and unstructured information is a cognitively demanding task.
If no procedures were performed during the hospital stay, this section should be omitted from the EDS.	Removing blank section headings ensures the EDS remains concise and limited to relevant information.
Include the results or outcomes of any procedures undertaken during admission. If required, procedure reports may also be hyperlinked or attached to the EDS.	Outcomes of a diagnostic procedure (including where no abnormalities are detected) are important and may reduce the need for unnecessary repeated testing.

Clinical Summary

This component describes the clinical management of the patient during the hospital encounter, and other relevant information that is not adequately captured in other parts of the EDS. For example, the *Antimicrobial Stewardship Clinical Care Standard* recommends that comprehensive documentation is provided in a patient's healthcare record following a new allergy or adverse reaction. The required detail may not be captured in the 'Allergies and Adverse Reactions' component therefore additional information could be included in the 'Clinical Summary'.

The clinical summary is often the longest and least consistent section due to its unstructured (free text) composition. It is also highly variable based on case complexity, patient needs, and preferences of the authoring clinician. Despite the lack of consensus during consultation with clinicians regarding the ideal structure of this section, improved consistency in the presentation of this section could be achieved by:

- Following an agreed logical structure to documentation at the local health service level (for example, problem-based clinical notes)
- Using clinical judgment to ensure content is relevant, concise and curated.

Recommendation	Rationale
The clinical summary should be a curated and concise overview of the clinical problems, their treatment and their outcomes. Avoid 'copy and paste' of information from the progress notes in the electronic medical record.	This section should give the healthcare provider receiving the EDS, a concise overview of the key clinical issues.
Formatting with bullet points, short sentences, and bold text to highlight key issues is preferred over paragraphs of text in a narrative form.	• This section is often one of the largest and least consistent in the EDS, appropriate formatting should be used to facilitate readability. • The use of bullet points aligns with heuristics principles to improve readability of the text.

Allergies and adverse reactions

This component should list all documented allergies and adverse reactions including those that are pre-existing and newly identified. This section should not be used for extensive documentation but rather to capture the key discrete data for each allergy or adverse reaction. For more information on documentation of allergies and adverse reactions refer to the 'Clinical Summary' component of the EDS.

Recommendation	Rationale
Ensure this section precedes the 'Medicines on discharge' section.	Allergies and adverse reactions are presented before medicines on discharge because of the relationship between these two sections.
Display allergies and adverse reactions in a table format	Presenting this information in a table format facilitates readability.
The following minimum information should be included: • Substance name • Clinical manifestation(s) (for example, urticaria, vomiting, angioedema) • Severity of reaction.	Consistent with Australian Core Data for Interoperability[6] available at the time of publication.
Use standard terminology value sets published by the National Clinical Terminology Service (NCTS) for coding of this data group.	The use of standard terminology sets aligns with national efforts to support interoperability and data quality.[6]
The allergies section should always be included in an EDS. If no allergies are recorded, include a statement to indicate that there are no known allergies.	A qualifying statement confirms that the absence of recorded allergies is not an omission error.

Medicines on discharge

This section should include a complete list of medicines (including any complementary or non-prescription medicines) and their status at the point of discharge. It should also contain all other relevant medicines-specific instructions for continuity of care on discharge from hospital.

Recommendation	Rationale
Medicines on discharge should be displayed in a table format	Presenting this information in a table format facilitates readability.
Display 'Medicines on discharge' immediately after allergies/adverse reactions.	Allergies are presented before medicines on discharge because of the relationship between these two sections.
Display information relating to medicines after the clinical summary.	Eye-tracking sessions confirmed that displaying the medicines before describing the treatment provided to the patient could negatively affect readability, causing healthcare providers to scroll up and down to understand why certain medicines were introduced, ceased or changed.
Medicines information should be displayed according to principles in the *National guidelines for on-screen display of medicines information*.	Medicines information should be presented consistently and in line with evidence-based practice to ensure medication safety.
The minimum information recommended for inclusion in this section include: • Medicine details (name, form strength, route of administration) • Directions (dose amount, frequency and intended duration) • Indication • Status (for example, changed dose or directions, new, unchanged) • Additional information.	Aligns with Australian Core Data for Interoperability.[6]
Include a column in the table for additional instructions or information necessary for continuity of care. Refer to Practice points for more information.	• This recommendation is based on findings from the literature review and stakeholder consultation indicating that the EDS should include more medicines information. • An additional column is proposed for clinicians to clearly document any specific information associated with each medicine.
A reconciled medicines list should be included in a discharge summary. If a medicines list is not available or incomplete, it must be documented clearly in this section.	A qualifying statement provides clarity and reduces the risk of medication errors.

Table 3 Example of a 'Medicines on discharge' section in the EDS

Medicine	Directions	Indication	Status	Additional information
prednisolone 25 mg – tablets – oral	Take ONE tablet in the morning with food for 7 days then reduce the dose as directed.	Inflammation	New	See your doctor for continued supply and monitoring. Dose tapering plan: • 20 mg (4 x 5 mg tablets) daily for 7 days, then • 15 mg (3 x 5 mg tablets) daily for 7 days, then • 10 mg (2 x 5 mg tablets) daily for 7 days, then • 5 mg daily for 7 days, then STOP.
perindopril arginine 5 mg + amlodipine 10 mg – tablets – oral	Take ONE tablet daily	High blood pressure	Dose reduced	Dose reduced due to low blood pressure in hospital. See your doctor to review.
escitalopram 50 mg – tablets – oral	Take ONE tablet daily	Anxiety	Unchanged	Patient has supply at home.
metformin 500 mg – tablets – oral	Take ONE tablet THREE times a day with food.	Diabetes	Withheld	Metformin has been temporarily withheld due to illness. See your doctor to review.

Accurate medicines information at discharge can be improved through:

- Early discharge planning and engagement with the patient and their primary healthcare provider to ensure potential risks and patient needs or preferences are identified well before discharge.
- Documentation of a best possible medication history as early as possible on admission.
- Electronic medication reconciliation conducted on admission, at each transfer of care (between wards or facilities during the same encounter), and at the time of discharge.
- Early involvement of a hospital pharmacist to coordinate medication management in the community and provide patient-friendly verbal and written information.

Practice points

Medicines information that should be included in the EDS, where applicable:

- Complete list of medicines on discharge (including any complementary or non-prescription medicines)
- Rationale for any medication changes
- Dose administration aids such as blister packs
- Supply arrangements
- Therapeutic drug monitoring
- Tapering or dose-reduction plans
- Additional information relating to any prescribed high-risk medicines.

Ceased medicines

This component should list details about medicines that have been permanently ceased at the time of discharge. Medicines that have been withheld temporarily should not appear as ceased medicines.

Recommendation	Rationale
Ceased medicines should immediately follow the 'Medicines on discharge' section.	Ceased medicines should be separated from the list of medicines to be continued on discharge. This minimises the risk of unintended continuation of a medicine.
Medicines information should be displayed to align with *National Guidelines for on-screen display of medicines information*.	Medicines information should be presented consistently and in line with evidence-based practice to minimise the risk of error.
Display ceased medicines in a table, including all relevant information (for example, active ingredient, strength and dose form).	Presenting this information in a table format facilitates readability.
Include a reason to describe why a medicine was ceased. For example, sub-optimal clinical response, suspected or confirmed allergies or adverse reactions.	Provides context and minimises ambiguity. This information is critical to informing future clinical decisions. Where an allergic or adverse reaction is the reason for discontinuation, the relevant details should also be documented in the 'Allergies' section.
If no medicines have been ceased during the admission, include a statement to indicate this.	If this section is blank, it creates ambiguity about the completeness of the medicines list.

Alerts

Alerts are any special considerations that should be communicated to support the delivery and continuity of patient-centred care. Alerts may include the following examples:

- Safety alerts
- Infection control needs or status of infection (for example, sepsis)
- Functional status (for example, mobility aid)
- Cognitive and/or sensory impairment (for example, behaviour support plans)
- Legal information
- Preferences (for example, goals of care, interpreters, religious or cultural needs)
- Advance care planning documents.

Recommendation	Rationale
Display alerts as a bullet list, using short sentences.	Bullet lists facilitate faster review of the discharge summary.
The 'Alerts' section should not be automatically populated.	• Information in this section may be sensitive and should be included at the discretion of the author. • While some information may not be appropriate for inclusion in a discharge summary, it should still be provided to the receiving clinician through other mechanisms if it is important for continuity of care.

Follow-up appointments

This component of the EDS should include details about any appointments that have been made by the health service on behalf of the patient to facilitate follow up or review.

Recommendation	Rationale
Present follow-up appointments in a table.	Presenting this information in a table facilitates readability and allows healthcare providers to readily identify what appointments have already been booked.
Describe the follow-up appointment and: • Include the date and time of the appointment if it has already been booked, or the recommended timing. • Indicate the booking status. • Name the healthcare provider who will provide the services. • State the location of the appointment. • Include the contact details of the healthcare provider who will provide the follow-up services.	Including the relevant details provides the patient or other EDS recipient a point of contact to ensure follow up after discharge.

Information provided to the patient

This section should summarise details of any information or instructions provided to the patient. If a separate patient-directed letter is provided, it may be cross-referenced within this section of the EDS. Any patient information or education provided at discharge should also be noted in this section (for example, diabetes educator, pharmacy, wound care). Information provided to a patient should tailored to ensure it is accessible and appropriate within the specific patient context (for example, Easy English, using interpreters).

Recommendation	Rationale
Display this section as a bullet list, using short sentences.	Within the current digital health infrastructure this section is an uncoded free text format. Presenting information in a bullet list facilitates readability of the discharge summary.

Recipients

This component should list the details of the nominated primary healthcare provider and any additional recipients of the EDS.

Recommendation	Rationale
Name the recipient and indicate whether they are the primary recipient or other primary healthcare provider.	This minimises ambiguity about the intended primary care recipient.
Include contact details such as telephone number, address and organisation.	Inclusion of contact details facilitates communication to support ongoing care.

Selected investigation results

This component of the EDS should include only results that are considered important for continuity of care, particularly where a hospital admission is long or complex.

Recommendation	Rationale
Include selected investigations and associated results at the end of the discharge summary.	Investigation results can be several pages long. Displaying this component last means allows important information in earlier sections of the EDS to be readily available.
Only relevant results should be included as determined by clinical judgement of the discharging clinician.	Stakeholders indicated that the amount of information in this section may vary based on the complexity and condition of the patient, or the length of stay.
Provide relevant commentary regarding abnormal investigation results.	This information could reduce ambiguity and unnecessary repeated tests. Inclusion of additional information about abnormal investigation results should be determined by the discharging clinician based on latest clinical recommendations.
Indicate where an important result is still pending at the time of discharge. This should be reiterated in the ‘Recommendations’ section of the EDS.	This information enables timely follow up and reduces unnecessary duplication of tests.

Next steps

High-quality discharge communication is critical for safe transitions of care. These Guidelines will be considered in the development of the third edition of the NSQHS standards, which serve as an important driver of standardisation across health services.

These Guidelines highlight that value of a clinician-led approach to national standardisation of electronic discharge summaries (EDSs). Strategic engagement between several Australian Government entities is required to address implementation barriers and progress actions against the National Digital Health Strategy, which will enable standardisation. The Commission will work with the Australian Digital Health Agency and state and territory governments to promote the use of these Guidelines, as part of the planned upgrades of national digital health infrastructure (for example, My Health Record) to enhance health information exchange.

The Australian Government Department of Health and Aged Care has funded a program of work led by the CSIRO's Australian eHealth Research Centre to accelerate the development of standardised data sets to support interoperability and health information exchange across all health settings. This program has published the Australian Core Data for Interoperability (AUCDI) Release 1 in June 2024. The AUCDI Release 1 are considered the minimum data elements required to support standardised clinical information capture at the point of care, and to enable safe and meaningful health information exchange between care providers.[6] These Guidelines have considered the data groups published in AUCDI Release 1, recognising that future releases will build upon these foundational data sets.

The Commission also recognises the rapidly evolving potential for use of artificial intelligence (AI) in the healthcare environment, however in these early stages of application, the risks of harm are likely to outweigh the perceived benefits. At the time of publication of these Guidelines, evidence to support the broad use of AI technology for the authoring of an EDS is lacking and further research is required.

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