Quality Rating for Discharge Summary Components

Component item	Omitted 0	Less than optimal 1	Optimal 2	Excessive 1
Admission diagnosis:	No information	Less than optimal e.g. only chief **complaint** or presenting **symptoms**	Preliminary or working diagnosis given at the time of admission	
List of discharge diagnoses:	No information	Less than optimal e.g. only signs, symptoms or unknown abbreviations	**Principle** discharge diagnosis or main reason for admission AND **All additional** pertinent diagnoses where applicable	
Discharge diagnosis responsible for the greatest part of the LOS:	No information	Diagnosis accountable for the largest portion of the patient's stay		
History of present illness:	No information	Some information missing	A brief summary of initial presentation and diagnostic evaluation	Excessive description
Pertinent physical findings:	No information	Some information missing	Findings relevant to diagnoses	All findings or substantial number of irrelevant findings
Goals of care:	No information	Some information missing	Level of treatment, code status (e.g curative, life prolonging palliative, symptomatic palliative).	
Course in hospital:	No information	Incomplete description with missing links	Synoptic, problem based description of sequential events and respective evaluations, treatments and prognoses	Excessive information
Hospital consults:	No information OR "no consults" not ticked in absence of consults.	Some information missing	Description of specialty and/or allied health consults **OR** a statement "no consults"	
Procedures in hospital:	No information	Unknown abbreviations used	A list of procedures with key findings and date OR statement "not applicable"	
Discharge medication:	No information	Some information missing	A listing of all discharge medications with specific description of new, altered and discontinued medications and rationale for changes. **OR** specific statement: "see DMR" **OR** a specific statement "no medications"	

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Pertinent lab tests and investigation results:	No information	Some information missing	**Relevant** (key) tests and investigations	**all** tests and investigations, or substantial number of irrelevant results
Test results pending at discharge:	No information	Some information missing	Tests ordered during the hospitalization that are pending at the time of discharge.	
Outcome of care/Condition at discharge-functional ability:	No information	Some information missing	A documentation that gives a **sense** of patient's functional and/or cognitive health status at discharge when applicable e.g. stable at baseline Where applicable, includes residual comorbid illnesses and risk factors	
Follow up issues identified:	No information		Description of outstanding issues that will require follow up along with recommendations for recipient healthcare provider **OR** statement that "no outstanding issues exist" or "no recommendations exist"	
Appointments after discharge:	No information	Some information missing	Person responsible for scheduling, date, time/timeframe, care provider name and specialty where applicable	
Discharge instructions:	No information	Some information missing e.g. a mention about discharge instructions given without specifying what they were	List of verbal/written information/education provided to patient/surrogate decision maker (SDM) clearly stated Where applicable, symptoms and signs to seek care for (e.g. unresolved or recurring chest pain, signs of infection) OR statement "No special education/instruction required"	
Identified attending clinician to be called by PCP if there are questions:	No information	Some information missing	Main author of the discharge summary clearly stated.	