

DISCHARGE SUMMARY

Name of Patient:			
Tel No.		Mobile No.	
IPD No.		Admission No.	
Treating Consultant/s Name, contact numbers and Department/Specialty			
Date of Admission		Time of Admission	
Date of Discharge		Time of Discharge	
MLC No. / FIR No.			
Provisional Diagnosis at the time of Admission			
Final Diagnosis at the time of Discharge			
ICD-10 code(s) or any other codes, as recommended by the Authority, for Final diagnosis			
Presenting Complaints with Duration and Reason for Admission			
Summary of Presenting Illness			
Key findings, on physical examination at the time of admission			
History of alcoholism, tobacco or substance abuse, if any			
Significant Past Medical and Surgical History, if any			
Family History if significant/relevant to diagnosis or treatment			
Summary of key investigations during Hospitalization			
Course in the Hospital including complications, if any			
Advice on Discharge			
Name of treating Consultant/ Authorized Team Doctor		Signature of treating Consultant/ Authorized Team Doctor	
Name of Patient / Attendant		Signature of Patient / Attendant	

Sample Discharge Summary Home Health

**Michael L. Malone, Marie Boltz, Jonny
Macias Tejada, Heidi White**



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Handbook of Home Health Care Administration Marilyn D. Harris, 1997 Table of Contents Foreword Introduction Ch 1 Home health administration an overview 3 Ch 2 The home health agency 16 Ch 3 Medicare conditions of participation 27 Ch 4 The joint commission s home care accreditation program 63 Ch 5 CHAP accreditation standards of excellence for home care and community health organizations 71 Ch 6 Accreditation for home care aide and private duty services 81 Ch 7 ACHC accreditation for home care and alternate site health care services 86 Ch 8 Certificate of need and licensure 92 Ch 9 Credentialing organizational and personnel options for home care 101 Ch 10 The relationship of the home health agency to the state trade association 111 Ch 11 The national association for home care and hospice 115 Ch 12 The visiting nurse association of America 124 Ch 13 Self care systems in home health care nursing 131 Ch 14 Home health care documentation and record keeping 135 App 14 A COP standards pertaining to HHA clinical record policy 147 App 14 B Abington Memorial Hospital home care clinical records 150 Ch 15 Computerized clinical documentation 161 Ch 16 Home telehealth improving care and decreasing costs 176 Ch 17 Implementing a competency system in home care 185 Ch 18 Meeting the need for culturally and linguistically appropriate services 211 Ch 19 Classification an underutilized tool for prospective payment 224 Ch 20 Analysis and management of home health nursing caseloads and workloads 236 Ch 21 Home health care classification HHCC system an overview 247 Ch 22 Nursing diagnoses in home health nursing 261 Ch 23 Perinatal high risk home care 274 Ch 24 High technology home care services 279 Ch 25 Discharge of a ventilator assisted child from the hospital to home 291 Ch 26 Performance improvement 301 Ch 27 Evidence based practice basic strategies for success 310 Ch 28 Quality planning for quality patient care 315 Ch 29 Program Evaluation 320 App 29 A Formats for presenting program evaluation tools Ch 30 Effectiveness of a clinical feedback approach to improving patient outcomes 341 Ch 31 Implementing outcome based quality improvement into the home health agency 352 Ch 32 Benchmarking and home health care 383 Ch 33 Administrative policy and procedure manual 395 Ch 34 Discharge planning 399 Ch 35 Strategies to retain and attract quality staff 421 Ch 36 Evaluating productivity 436 Ch 37 Labor management relations 448 Ch 38 Human resource management 459 Ch 39 Staff development in a home health agency 474 Ch 40 Transitioning nurses to home care 484 Ch 41 Case management 495 Ch 42 Managed care 499 Ch 43 Community based long term care preparing for a new role 507 Ch 44 Understanding the exposures of home health care an insurance primer 519 Ch 45 Budgeting for home health agencies 527 Ch 46 Reimbursement 535 Ch 47 How to read interpret and understand financial statements 549 Ch 48 Management information systems 558 Ch 49 Legal issues of concern to home care providers 571 Ch 50 Understanding the basics of home health compliance 590 Ch 51 The HIPAA standards for privacy of individually identifiable health information 616 Ch 52 Ethical practice in the daily service to home care client their families and the community 666 Ch 53 Participating in the political process 675 Ch 54 Strategic planning 693 Ch 55 Marketing an overview 708 Ch 56 The internet in home health and hospice

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Evaluation Handbook for Home Health Agencies Dorothy Kleffel,Elizabeth Wilson,1980 Health Facility Surveyor Training United States. Health Standards and Quality Bureau,1990 **Geriatrics Models of Care**

Michael L. Malone, Marie Boltz, Jonny Macias Tejada, Heidi White, 2024-05-30 Following the success of the previous edition the second edition of *Geriatrics Models of Care* is the definitive resource for systems based practice improvement for the care of older adults. Several new models of care have been published in the last eight years; new outcomes have emerged to better understand the impact of existing models and with the rise of the Age Friendly Health Systems movement promoting organized efforts to prepare our health care settings for older individuals is of more importance than ever. The second edition is organized based on the practice setting along a continuum of care: hospital, transitions from hospital to home, outpatient settings, and the emergency department. This book also highlights long term care models which is an important part of the continuum of care for older Americans. Further, this edition features models that address the needs of vulnerable populations. This new section will describe a spectrum of programs for older adults who have Alzheimer's disease or Parkinson's disease. Other models describe best practices for older adults undergoing surgery or those who want to remain functioning independently in their home. A defining feature of this book is that each chapter follows a standard template: 1 the challenge which led to the model, 2 the patient population served, 3 core components of the intervention, 4 the role of interdisciplinary health professionals, 5 evidence to support the intervention, 6 lessons learned in the implementation and dissemination of the model, 7 implications for family caregivers and communities, particularly underserved and diverse communities, and 8 how each model will provide care across the continuum during an entire episode of care. In addition, each chapter features a call out box with practical tips for implementing the model.

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