Canberra Health Services Operational Procedure

Discharge Summary Completion

Contents

Purpose

The purpose of this procedure is to ensure consistency in the quality and timeliness of inpatient discharge documentation.

The accurate and timely completion of a Discharge Summary is essential for the patient's ongoing care as it forms the primary communication tool with the General Practitioner (GP) and other health professionals involved in the care of the patient. The Discharge Summary is also crucial for accurate clinical coding and Diagnosis Related Group (DRG) allocation which forms the basis for Activity Based Funding (ABF), data provision for research, statistical reporting and resource allocation.

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Scope

Medical Officers are required to complete either a discharge summary or an endorsed alternative (see Appendix A), for all Canberra Health Services inpatient episodes regardless of length of stay or discharge outcome (Note: deceased patients still require a discharge summary to finalise the clinical documentation for the episode of care) with the exception of day-only dialysis admissions.

Ultimate responsibility for completing the Discharge Summary or endorsed alternative discharge documentation lies with the discharging consultant and/or the discharging clinical unit.

Canberra Health Services has implemented the Clinical Portal EDS as the service wide solution for discharge summary completion, as this facilitates seamless electronic distribution in a standardised format for clinical handover to the GP. Discharge summaries for all multi-day inpatient episodes must be completed within the Clinical Portal EDS. Where the service/program utilises a specialised Clinical Information System as their Electronic Medical Record (EMR) this system should interface with the Clinical Portal EDS for discharge summary completion and distribution. Approval to complete inpatient discharge summaries in alternate clinical information systems will only be granted where technical difficulties prevent direct interfacing the Clinical Portal EDS application.

At present the Birth Outcome System (BOS), the Neonatal Intensive Care Units' data collection (NICUS) and the Mental Health, Alcohol and Drug and Justice Integrated Care Electronic Record (MAJICeR) are not able to interface with Clinical Portal, therefore discharge summaries from these systems will be accepted, until such time as the interfacing issues can be resolved.

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Section 1 – Responsibility for Discharge Summary completion

The Discharge Summary:

- Is a complete and accurate summary of the care and treatment provided during the patient's entire hospital stay, to finalise their inpatient clinical record documentation;
- Must be completed within 48 hours of discharge/transfer, to facilitate a smooth transition into the care of the GP or other health service.

The Junior Medical Officer (JMO) of the discharging team is generally delegated the responsibility for completing the Discharge Summary or endorsed alternative discharge documentation. Senior Medical Officers are required to monitor and oversee discharge summary completion.

There will be instances where JMOs are required to complete a Discharge Summary for a patient they did not see or were not directly involved in treating e.g. following a change of term, or for ICU patients. This does not excuse responsibility. A competent JMO should be able to complete the Discharge Summary after reviewing the patient's clinical record. A notation to the effect of: "I did not see this patient and provide this summary of care based on my review of the clinical record" should be noted on the Discharge Summary.

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Section 2 – Completion Timeframes

Discharge Summaries or endorsed alternative discharge documentation must be completed within 48 hours after discharge/transfer to adequately support ongoing clinical care and timely clinical coding.

It is preferable to complete discharge summaries or endorsed alternative discharge documentation prior to 10 am on the day of discharge to facilitate:

- Patients being discharged by 10 am
- Provision of a copy and discussion of discharge/follow up instructions with the patient (and/or carer if appropriate consent has been obtained) and
- Adequate discharge planning.

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Section 3 – Completing the Discharge Summary

The Discharge Summary must be typed/completed in the Electronic Discharge Summary (EDS) module of the Clinical Portal, to ensure legibility and facilitate electronic distribution to the GP. The discharge summary should be commenced in the EDS system on admission, to support the discharge planning process. The electronic summary should then be continually modified, updated and saved during the patient's stay in hospital to ensure that all relevant

details and complications are accurately documented, and to reduce the time required to finalise the summary when the patient is ready for discharge. Discharge summaries may be completed in other specialised Clinical Information Systems after discussion and approval by the Clinical Record Service (see Appendix A for approved alternative discharge summary documents).

Forms for completing a handwritten discharge summary will only be made available in exceptional circumstances where the Clinical Portal is unavailable for an extended period of time. The handwritten discharge summary does not need to be transcribed into the Clinical Portal. The handwritten discharge summary is an endorsed alternative discharge summary format and will be sent by Clinical Records to the patients nominated GP instead of the Clinical Portal discharge summary.

Incomplete discharge summaries remain on the Clinical Portal for six months after the discharge date. After this point in time, please contact Clinical Records for assistance to complete discharge summaries that may be incomplete.

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Section 4 – Discharge Summary Requirements

The medical Discharge Summary should provide an accurate summary of the patient's entire inpatient episode and should provide sufficient detail to allow subsequent health professionals to continue the patient's ongoing care post-discharge. As a minimum, the Discharge Summary should contain the following data elements:

1. Patient Identification (full name, date of birth, unit record number and address)
2. Admission and Discharge dates
3. Discharging Medical Officer's name and clinical unit
4. GP name and contact details
5. Primary discharge diagnosis (see definition)
6. Additional diagnoses/complications (see definition)
7. Presenting history and symptoms, including any relevant past history
8. Operations and Procedures performed
9. Summary of management and investigations
10. Follow-up requirements and person(s) care is referred to
11. Medications at discharge (see definition)
12. Author's name, signature, designation and date completed.

Some specific types of inpatient episodes do not require a full detailed Discharge Summary and endorsed alternative discharge documentation will be accepted in these cases. See Appendix A for details of these specific episode types and the alternative documentation required.

For further advice relating to the content of discharge summaries and clinical documentation, contact Clinical Coding and Casemix Manager, on 624 42124.

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Section 5 – Care Type Changes

If a patient has had a Care Type Change or Statistical Discharge and Statistical re-admission during their hospital stay, a Notification of Care Type Change Form will be required for the initial episode(s) of care, and then a Clinical Portal discharge summary will be required at the time of formal discharge from Canberra Hospital.

Discharged To: Died
First Admitted: 17/10/2017 **Final Discharge:** 19/10/2017

Encounter History:

Episode	Admission Date	Discharge Date	Care Type	Discharge Unit	Discharge Doctor	Discharge Destination
	18/10/2017	19/10/2017	PAL	Oncology	A/Prof. Desmond Yip	Died
	17/10/2017	18/10/2017	A	Oncology	A/Prof. Desmond Yip	Statistical Pur

The discharge summary completed in the Clinical Portal should contain information regarding the entire hospital stay, i.e. in example 1, where the patient was first admitted as an acute patient on 17 October, and was then statistically discharged on 18 October to palliative care, because the clinical intent of the care provided had changed from acute care to palliative care, but the patient remained an inpatient of Canberra Hospital for the entire period, the summary should cover both the Acute and the Palliative episodes of care. Similarly in example 2 below, the summary should cover both the Acute episode and the Maintenance (Non Acute) episode of care for that patient.

Discharged To: Trans to Acute Hospital
First Admitted: 10/09/2017 **Final Discharge:** 27/09/2017

Encounter History:

Episode	Admission Date	Discharge Date	Care Type	Discharge Unit	Discharge Doctor	Discharge Destination
	22/09/2017	27/09/2017	NAC	Haematology	Dr. Michael Pidcock	Trans to Acute Hospital
	10/09/2017	22/09/2017	A	Haematology	Dr. Michael Pidcock	Statistical Pur

NOTE for Care Type:
A = Acute REH = Rehabilitation RDP = Rehabilitation in a Designated Program RDU = Rehabilitation in a Designated Unit
PAL = Palliative Care GEM = Geriatric Evaluation and Management PGC = Psychogeriatric Care NAC = Non Acute Care

For information on Care Types refer to the Canberra Health Services Admitted Patient Activity Data Standards on the Policy Register. For issues relating to the Clinical Portal please contact Digital Solutions Support.

Care Type changes can be initiated by clinicians or by the SNAP (Sub acute + Non Acute Patient) Team.

If the Care Type change is initiated by a clinician, the SNAP team member for your area needs to be notified as there are assessments required to be completed for different Care Types.

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Section 6 – Discharge Medications

The Discharge Prescription must be completed by the Medical Officer with reference to the current medication chart. The discharge medications section of the Electronic Discharge Summary (EDS) should be used for this process with the prescription being printed and then forwarded to the Canberra Hospital Pharmacy.

The EDS Discharge Prescription, or the Discharge Medication form, must be forwarded to Pharmacy at least **1 hour prior (or 3 hours for complicated discharges)** to the patient being discharged from hospital.

If amendments or corrections are made after sending the EDS Discharge Prescription to Pharmacy, it is the responsibility of the Medical Officer who completed the EDS Discharge Prescription to make the amendments to the Discharge Summary within the EDS as soon as possible to ensure the GP receives accurate information regarding their patient's medications on discharge.

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Section 7 – Distribution of Discharge Summaries

Once finalised, the Discharge Summary should be printed and given to the patient (and/or carer as appropriate) so they understand and can remember their follow-up instructions.

For patients referred to Outpatient Clinics at Canberra Hospital for follow up, include the Clinic name and fax number in the CC section using the predetermined list contained within the EDS module of the Clinical Portal, and the referring doctor (if different to GP).

Electronic distribution of the Discharge Summary to the patient's nominated GP, any additional recipients noted in the CC section, and the Clinical Record Information System (CRIS), will occur automatically after "Finalisation" within the EDS module. The method of distribution of electronic discharge summaries is determined by the details listed for each GP/ Practice in ACTPAS, and the consent (to share information with the GP) recorded for the patient in ACTPAS at the time of discharge summary finalisation.

If the patient has consented to participate in the Commonwealth Government *My Health Record* system, a copy of their Electronic Discharge Summary will also be distributed to their *My Health Record* at this time.

Handwritten Discharge Summaries received in the Clinical Record Service with the inpatient notes are manually faxed to the GP.

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Section 8 – Delayed completion

The hardcopy (paper) inpatient notes may be retained on the wards for up to 48 hours after discharge, to facilitate prompt Discharge Summary completion, and then sent to the Clinical Record Service for scanning into CRIS. After scanning occurs, the hard copy notes will not be available to members of the clinical team, so any Discharge Summaries still not completed at this time will have to be completed by viewing the patient's record in CRIS.

Records are scanned urgently if a discharge summary has not been completed, to facilitate prompt completion of the Discharge Summary and continuity of care.

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Section 9 – Monitoring Discharge Summary completion rates

The Discharge Summary Liaison Officer distributes weekly reports by email to JMOs, Registrars, Clinical Unit Directors and the Medical Officer Support Credentialing Education & Training Unit (MOSCETU) detailing all discharged patients that still require a Discharge Summary. JMOs are expected to work through their lists and complete their discharge summaries each week. Additional lists can be provided on an ad-hoc basis by the Clinical Record Service if requested.

The Clinical Portal also provides JMOs with tools to monitor and manage their Discharge Summary Completion responsibilities by way of configurable "Worklists" and the "Review EDS" feature. These tools provide real-time status reporting of EDS completion which allows individual JMOs to constantly monitor and manage their discharge summary workload. These features are not specifically covered in the initial Clinical Portal training sessions but can be easily configured with assistance from Digital Solutions Support if desired, once the JMO is more familiar with the Clinical Portal application or through the help sheets available on the Intranet.

Note:
The Clinical Record Service is limited in their ability to sign the Discharge Summary section of the Medical Officer Staff Clearance form if there are *any* patients on any Clinical Unit the Medical Officer was rostered to cover during their period of service at Canberra Hospital that still don't have a completed Discharge Summary. Refer to section: Responsibility for Discharge Summary completion.

The Medical Officer Support Credentialing Education & Training Unit will be notified of any JMOs who have not completed their required Discharge Summaries.

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Implementation

Dissemination of this procedure occurs at JMO Orientation, Registrar Orientation, and will be available on the Canberra Hospital Policy Register, the Clinical Record Service Intranet page, and via Tool Links, in the Electronic Discharge Summary module, of the Clinical Portal.

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Related Policies, Procedures, Guidelines and Legislation

Legislation

- *ACT Health Record (Privacy and Access) Act* 1997

Policies

- Clinical Handover Procedure
- Clinical Record Management Policy

Operating Procedures

- Clinical Record Management Procedures

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References

[1] *ACT Health Record (Privacy and Access) Act* 1997
www.legislation.act.gov.au
[2] Australian Consortium for Classification Development. (2017). *Australian Coding Standards* (Tenth Edition).Sydney: Independent Hospital Pricing Authority

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Definition of Terms

ABF - Activity Based Funding[1]

Activity Based Funding is the process of reimbursing a health care service for the cost of patient care based on the casemix or activity of the hospital. Hospitals are paid a set amount for each patient treated, based on the DRG to which the episode is allocated.

ACTPAS
ACT Patient Administration System

Additional Diagnosis[2]
A condition either coexisting with the principal diagnosis or arising during the admission that affects patient management in terms of requiring any of the following:

- commencement, alteration or adjustment of therapeutic treatment
- diagnostic procedures
- increased clinical care and/or monitoring.

BOS
Birth Outcome System

CC
Carbon copy

Clinical Record
In this document the terms “clinical record” and “health record” are synonymous and refer to the main centralised Canberra Health Services record of care for a patient.

CRIS – Clinical Record Information System
The acronym for the Clinical Record Information System which is the current scanned clinical record solution in use by Canberra Health Services for the management and storage of the centralised clinical record.

Discharge Summary
Is a summary of the care and treatment provided by Canberra Health Services for the entire inpatient episode of care (from admission to formal discharge/separation). The presence of a summary of care for part of the episode or from a particular discipline or ward such as the Metavision ICU summary (which is not distributed to GPs) does not remove the need for a full Discharge Summary to be completed and sent to the GP. The Discharge Summary has been previously referred to as a Casemix Summary or Discharge Referral.

DRG - Diagnosis Related Groups
Are an internationally recognised casemix classification system designed to provide a method of categorising and characterising acute episodes of care, related to the resources required by the hospital to care for the patient.

EDS – Electronic Discharge Summary
The electronic discharge summary is created within the Clinical Portal, and electronically dispatched to the centralised CRIS record and GP’s and other recipients as necessary.

EMR
Electronic Medical Record

ICU
Intensive Care Unit

JMO
Junior Medical Officer

MAJICeR
Mental Health, Alcohol and Drug and Justice Integrated Care Electronic Record

Medications at Discharge
Minimum requirements include:

- Details of all medication the patient is prescribed at the time of discharge including:
  - Medication name (generic)
  - Current dose (strength, form and frequency)
  - Expected duration of treatment.
- Details of any medication changes made during the episode, and the reasons
- Information on any adverse drug reactions the patient has a history of or has experienced during the episode.

MOSCETU
Medical Officer Support Credentialing Education & Training Unit

My Health Record
My Health Record is a secure, online service which enables participating consumers to access personal health information, including Canberra Health Services Electronic Discharge Summaries.

NICUS
Neonatal Intensive Care Unit System

Patient Identification
Minimum requirements for patient identification include; patient's full name, date of birth and Unit Record Number (URN). Barcoded patient identification labels from the Patient Administration System should be used where possible.

Primary Discharge Diagnosis[2]
The **diagnosis** established *after study* to be chiefly responsible for occasioning an episode of admitted patient care. The phrase *after study* should be interpreted as the evaluation of findings to establish the condition that was chiefly responsible for occasioning the episode of care. The condition established after study may or may not confirm the admitting diagnosis.

Record[1]
Means a record in documentary or electronic form that consists of or includes personal health information in relation to a consumer (other than research material that does not disclose the identity of the consumer), and includes:

a. a photograph or other pictorial or digital representation of any part of the consumer; and
b. test results, medical imaging materials and reports, and clinical notes, relating to the consumer; and
c. any part of a record; and
d. a copy of a record or any part of a record.

SNAP
Sub acute + Non Acute Patient Team

Treating team[1]
In relation to a consumer, means health service providers involved in diagnosis, care or treatment for the purpose of improving or maintaining the consumer's health for a particular episode of care, and includes:
a. if the consumer named another health service provider as his or her current treating practitioner—that other health service provider; and
b. if another health service provider referred the consumer to the treating team for that episode of care—that other health service provider.

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Search Terms

Discharge summary, Timeliness, Completion, Documentation, Junior Medical Officer, JMO, Treating team, Intern, Clinical Record, Handover, Clinical Handover, GP, Ongoing care, Standard 6, Discharge Referral, Clinical Portal, Discharge Summaries, Electronic discharge summary, EDS, BOS, MAJIC, NICUS

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Attachments

Appendix A – Endorsed Alternative Discharge Documentation

Policy Team ONLY to complete the following:

Date Amended	*Section Amended*	*Divisional Approval*	*Final Approval*
24/02/2018	*Complete Review*	*ED CSS*	*CHHS Policy Committee*
16/04/2020	*Template and document updated to reflect current organisational structure*	*Policy Team Leader*	*Co-chair CHS Policy Committee*

This document supersedes the following:

Document Number	*Document Name*
DGD13-017	*Discharge Summary Completion SOP*

Appendix A – Endorsed Alternative Discharge Documentation

Type of Inpatient Episode	Accepted Form
Cardiology 1. Ward CPE 2. Ward CCU 3. Ward CLD	1. Chest Pain Assessment and Discharge Form 2. Elective Short Stay Cardiac Procedures Admission and Discharge 3. Admission, Assessment and Discharge Form or 4. Cardiology Unit Investigations – typed final procedure report All documents must be signed by Clinician and include Diagnoses and Procedures
Elective Day-only Surgery Wards DSU or EDSU	Day Surgery Operation Report/Discharge Summary or Operation Record (Must include Follow-up information)
Emergency Department Ward EMU	ED Discharge Letter
Gastroenterology Day-only procedures Ward GAS	Typed reports including: • Lower GI endoscopy report • Upper GI endoscopy Report • Endoscopy Report • Bronchoscopy report • ERCP report
Hospital-in-the-home HITH Day-only	HITH Day-only Medical Admission or completed Identification sheet (Must be signed by Clinician and include Diagnoses and Procedures)
Mental Health *	MAJICeR discharge summary
Obstetric Delivery episodes Without any medical intervention	BOS Discharge Summary (by Midwife) accepted for Mother's delivery episode & Newborn episode (Excludes babies admitted to Neonatology who require an alternative as per below)
Qualified Newborn - SCN or NICU ward All other wards	Typed Centre for Newborn Care Discharge summary Clinical Portal discharge summary or Neonatal Assessment -GP Discharge Letter
Short stay episodes (<12 hours) Paediatric short stay, Rehabilitation Independent Living Unit (RILU), Cancelled surgery	Identification Sheet completed (Must be signed by Clinician and include Diagnoses and Procedures)
Statistical Discharges Where patient remains in hospital in a new episode of care with different Care Type	Notification of Care Type Change (Must be signed by Clinician and include Diagnoses and Procedures)

*Alcohol and Drug Program (ADP) complete their discharge summaries in Clinical Portal/ EDS

Abbreviations

BOS – Birth Outcome System
CCU – Coronary Care Unit
CLD – Cardiac Catheter Laboratory Day Unit
CPE – Chest Pain Evaluation
DSU – Day Surgery Unit
ED – Emergency Department
EDSU – Extended Day Surgery Unit
EMU – Emergency Medical Unit
ERCP – Endoscopic Retrograde Cholangio-Pancreatogram
GAS – Gastroenterology
HITH- Hospital In the Home
MDU - Medical Day Unit
MAJICeR - Mental Health, Alcohol and Drug and Justice Integrated Care electronic Record
NICU – Neonatal Intensive Care Unit
SCN - Special Care Nursery