**Canberra Health Services**

**Procedure**

**Discharge Summary Completion – Inpatients**

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| Purpose |

The purpose of this procedure is to provide guidance for clinicians to complete inpatient Discharge Summaries and to ensure that they are accurate, timely and high-quality.

The Discharge Summary is a clinical handover document that ensures continuity of care, safe transition between the hospital and the community, and improved patient communication and education.

The Discharge Summary forms part of the patient’s clinical record and may be read by the patient and their carers. It also facilitates clinical coding and Diagnosis Related Group (DRG) assignment for accurate reporting, benchmarking, research applications, measuring hospital activity, resource allocation and funding.

This procedure:

* emphasises the importance of accurate and timely completion of the Discharge Summary
* outlines the roles and responsibilities of clinicians completing Discharge Summaries
* provides direction in the preparation and distribution of the Discharge Summary.

The timely completion of a succinct and comprehensive 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. It also provides the patient with a record of their admission, post-discharge instructions and follow-up arrangements. The Discharge Summary is also crucial for accurate clinical coding and DRG allocation which forms the basis for Activity Based Funding (ABF), data provision for research, statistical reporting and resource allocation.

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| Alerts |

Canberra Health Services (CHS) has implemented the Clinical Portal Electronic Discharge Summary (Clinical Portal EDS) as an organisation-wide solution for inpatient Discharge Summary completion. This facilitates seamless electronic distribution of Discharge Summaries in a standardised format for clinical handover to the GP and uploading to the national My Health Record.

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 by HIS where technical difficulties prevent direct interfacing the Clinical Portal EDS application.

As data collection for the Birth Outcome System (BOS) and the Neonatal Intensive Care Unit Systems (NICUS) are not able to interface with Clinical Portal, Discharge Summaries from these systems are accepted.

Appendix A outlines the current **endorsed alternative Discharge Summary documentation** templates.

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| Scope |

This document applies to:

* Medical Officers
* Registered Nurse and Midwives working within their scope of practice.

An inpatient Discharge Summary is required for all:

* admitted patients
* deceased patients
* admitted patients who leave against medical advice.

Exclusions:

* Day only dialysis admissions.

While this procedure refers to Medical Officer inpatient Discharge Summaries, input from Allied Health clinicians should be included where appropriate.

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| Section 1 – Responsibility for Discharge Summary Completion |

The discharging consultant has ultimate responsibility for ensuring the Discharge Summary is completed accurately by the day of the patient’s discharge or transfer. The Consultant, Registrars, and/or Fellows are to ensure the Junior Medical Officers (JMOs) within their teams are informed about specific requirements of their team and supported in the preparation of timely and high-quality Discharge Summaries.

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 Intensive Care Unit (ICU) patients. Where this is the case, notation should be made on the Discharge Summary e.g. “I did not examine this patient and provide this summary of care based on my review of the clinical record”.

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| Section 2 – Completion Timeframes |

Completion of Discharge Summaries, or endorsed alternative discharge documentation, should be completed by the day of discharge or within 48 hours after discharge/transfer, to adequately support ongoing clinical care and timely clinical coding.

Clinicians should aim for completion of inpatient Discharge Summaries before 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)
* adequate discharge planning, and
* timely clinical handover to the patient’s GP and and/or community treating team.

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| Section 3 – Completing the Discharge Summary |

The Discharge Summary must be completed in the Electronic Discharge Summary (EDS) module of the Clinical Portal, to ensure legibility and facilitate electronic distribution to the GP and uploading to the patient’s national My Health Record.

The Discharge Summary should be a concise but comprehensive summary of the patient’s inpatient journey. It should be commenced in the EDS system as soon as possible after admission, to support the discharge planning process. The electronic summary can then be 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.

Forms for completing a handwritten discharge summary will only be made available by HIS in exceptional circumstances for business continuity planning where the Clinical Portal is unavailable for an extended period. In these scenarios the handwritten Discharge Summary does not need to be transcribed into the Clinical Portal and will be manually faxed to the patient’s nominated GP by the Health Information Service (HIS).

Incomplete Discharge Summaries will remain on the Clinical Portal for six months after the discharge date to allow for delayed completion. For assistance in completing overdue Discharge Summaries, please contact the HIS at [CHS.HIS@act.gov.au](mailto:CHS.HIS@act.gov.au).

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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 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 of Terms)
6. Additional diagnoses/complications (see Definition of Terms)
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 including any referrals and details of any follow-up appointments
11. Medications at discharge (see Definition of Terms) including new medications, dose changes, ceased medication and instructions.
12. Author’s name, signature, designation, and date completed.

Some specific types of inpatient episodes (see Appendix A) do not require a fully detailed Discharge Summary and endorsed alternative discharge documentation will be accepted in these cases.

For further advice relating to the content of discharge summaries and clinical documentation, contact the HIS Clinical Coding Manager, on 5124 2124 or email [CHS.HIS@act.gov.au](mailto:CHS.HIS@act.gov.au)

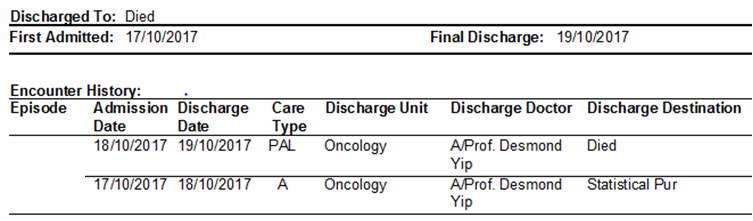
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| Section 5 – Care Type Changes |

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 a full Clinical Portal Discharge Summary will be required at the time of formal/physical discharge from Canberra Health Services.

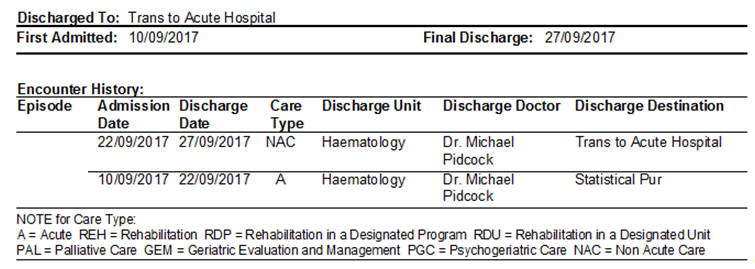
The Discharge Summary completed in the Clinical Portal should contain information regarding the entire hospital stay. In Example 1 below, the patient was first admitted as an Acute Care patient on 17 October, and was then statistically discharged on 18 October to Palliative care, because the clinical intent had changed from Acute care to Palliative care. However the patient remained an inpatient of Canberra Health Services for the entire period, hence the summary should cover both the Acute and the Palliative episodes of care.

Example 1



Similarly, in Example 2 below, the summary should cover both the Acute episode and the Maintenance (Non-Acute) episode of care for the patient during that hospital stay.

Example 2



Care Type changes can be initiated by clinicians or by the Sub acute + Non Acute Patient (SNAP) Team. If the Care Type change is initiated by a clinician, the SNAP team member for your area needs to be notified as there additional assessments are required for different Care Types. For more information on Care Types contact [CHS.SNAP@act.gov.au](mailto:CHS.SNAP@act.gov.au). For issues relating to the Clinical Portal please contact Digital Solutions Support [Digital.Support@act.gov.au](mailto:Digital.Support@act.gov.au)

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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 as per the CHS Medication Handling Policy. The Discharge Medications section of the Clinical Portal EDS should be used for this process with the prescription being printed and then forwarded to the Canberra Hospital Pharmacy. Only medications to be continued after discharge should be included in the Discharge Medications section.

The Discharge Medicine Plan section should detail all changes to pre-admission medication made during the admission, and the reason for the change. For example, dosage changes or medications ceased during the episode.

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 log into the Clinical Portal and make the amendments to the EDS Discharge Summary 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) to support their understanding and to help them 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 Patient Folder (CPF), 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 ACT Patient Admission System (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 uploaded to their *My Health Record* on finalisation.

Handwritten Discharge Summaries received by HIS will be manually scanned into CPF and faxed to the GP but cannot be uploaded to the *My Health Record* system by CHS.

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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, before being sent to HIS for scanning into CPF. 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 CPF.

Records are scanned urgently if aDischarge 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 HIS 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 with overdue Discharge Summaries. JMOs are expected to work through their lists and complete their Discharge Summaries each week. Executive Directors also receive regular updates at mid-term and end of term. Additional lists can be provided on an ad-hoc basis if required.

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](http://acthealth/c/HealthIntranet?a=da&did=5438874&pid=0).

**Note:**

The HIS 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 who still don’t have a completed Discharge Summary. Refer to Section 1: Responsibility for Discharge Summary Completion for further information.

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| Evaluation |

**Outcome**

* To ensure the completion of high quality inpatient Discharge Summaries, to support ongoing care and the safe transition of the patient from the hospital into the community.
* To provide an accurate and comprehensive summary of the patient’s inpatient journey and to facilitate accurate clinical coding and DRG assignment for funding, management and quality purposes.

**Measures**

* Regular monitoring by the HIS Discharge Summary Liaison Officer (DSLO) with weekly reporting to JMOs, Registrars, Clinical Unit Directors and MOSCETU
* Mid term and end of term reporting by the DSLO to Executive Directors
* Regular monitoring by QSII on Quality dashboards
* Discussion at monthly Discharge Summary meetings between HIS, GP Liaison Unit (GPLU) and MOSCETU.

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| Related Policies, Procedures, Guidelines and Legislation |

**Policies**

* Medication Handling Policy
* Nursing and Midwifery Continuing Competence
* Informed Consent (Clinical)
* Clinical Records Management
* Australian Commission on Safety and Quality in Healthcare, Australian Charter of Healthcare Rights

**Procedures**

* Clinical Records Management
* Infection Prevention and Control Healthcare Associated Infections Clinical
* Patient Identification and Procedure Matching
* Same Day Discharge for Elective Percutaneous Coronary Intervention Adult Patients
* Admission to Discharge
* HITH Referral Admission and Discharge (Adults and Children)
* Transfer from Inpatient Ward to Discharge Lounge

**Guidelines**

* Fasting Guidelines – Elective and Emergency Surgery
* Discharge Liaison Nurse Guidelines

**Legislation**

* *Health Records (Privacy and Access) Act* 1997
* *Human Rights Act* 2004
* *Work Health and Safety Act* 2011

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| References |

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

[*www.legislation.act.gov.au*](http://www.legislation.act.gov.au)

2Australian 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 Funding1**

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 Diagnosis2**

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

**Care Type**

Care Type refers to the nature of the clinical service provided to an admitted patient during an episode of admitted patient care. The care type must reflect the primary clinical purpose or treatment goal of the care provided. The Care Type is assigned by the clinician responsible for the management of the care based on their clinical judgement, and for mental health and subacute care types, the specialised expertise of the clinician who will be responsible for the management of the care. During a hospital stay, the primary clinical purpose or treatment goal of care may change, necessitating a care type change.

**Care Type Change**

A care type changes occurs when there is a change in the clinical intent or primary clinical purpose or treatment goal of the care provided for the patient. For Example, a patient who is admitted following a stroke will initially be admitted under an acute care type, and will have a care type change to rehabilitation when the main focus of care changes from acute management to functional improvement and rehabilitation.

**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.

**CPF – Clinical Patient Folder**

The acronym for Clinical Patient Folder 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**

The 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.

**DRG - Diagnosis Related Groups**

Are elements of 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 CPF record and GPs 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 ACTPAS should be used where possible.

**Primary Discharge Diagnosis2**

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.

**Record1**

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:

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

**SNAP**

Sub-acute + Non-Acute Patient Team

**Statistical Admission**

A statistical admission is an administrative process that occurs within an inpatient stay when changing the type of care. When the Care Type changes, the patient is statistically discharged from one care type and then statistically readmitted under the new care type. This can only occur when there is an authorised change in Care Type by the appropriate responsible clinician.

**Statistical Discharge**

A statistical discharge is an administrative process that occurs within an inpatient stay when changing the type of care. When the Care Type changes, the patient is statistically discharged from one care type and then statistically readmitted under the new care type. This can only occur when there is an authorised change in Care Type by the appropriate responsible clinician.

**Treating team1**

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:

1. if the consumer named another health service provider as his or her current treating practitioner—that other health service provider; and
2. 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, MAJICeR, NICUS.

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| Attachments |

Appendix A – Endorsed Alternative Discharge Documentation

**Disclaimer**: *This document has been developed by Canberra Health Services specifically for its own use. Use of this document and any reliance on the information contained therein by any third party is at his or her own risk and Canberra Health Services assumes no responsibility whatsoever.*

*Policy Team ONLY to complete the following:*

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| --- | --- | --- | --- |
| *Date Amended* | *Section Amended* | *Divisional Approval* | *Final Approval* |
| *06 July 2021* | *Complete Review* | *Paul Ogden, EGM, FBI* | *CHS Policy Committee* |
|  |  |  |  |

*This document supersedes the following:*

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| --- | --- |
| *Document Number* | *Document Name* |
| *CHHS18/040* | *Discharge Summary Completion* |
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## Appendix A – Endorsed Alternative Discharge Documentation

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| **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 THE or EDS | 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) |
| 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 |
| 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) |

Abbreviations

BOS – Birth Outcome System NICU – Neonatal Intensive Care Unit

CCU – Coronary Care Unit SCN - Special Care Nursery

CLD – Cardiac Catheter Laboratory Day Unit THE – Theatre Ward

CPE – Chest Pain Evaluation

ED – Emergency Department

EDS – Extended Day Surgery

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