WA Health Statewide Discharge Summary Policy
Title: WA Health Statewide Discharge Summary Policy

1. Background

A single statewide discharge summary policy for WA Health’s hospitals is to help standardise policy and practice to ensure a consistent system across the whole of WA Health.

A discharge summary is timely and accurate documentation and communication which completes the patient discharge process.

Discharge summaries are essential to formally communicate information about a patient’s admission to their general practitioner (GP) and/or other health care provider. They contribute to the continuity of care and safe transition between the hospital and the community.

They are an important step towards improving the care pathway and enable the delivery of safe patient-centred care.

Discharge summaries assist the GP in the ongoing effective management of their patients by clearly communicating relevant information. The continued involvement of the patient’s GP or primary healthcare provider ensures the best outcomes for patients.

As well as clinician to clinician communication, the discharge summary provides the basis for assignment of codes by clinical coders, which are classified into Diagnosis Related Groups (DRG) and are used for Activity Based Funding (ABF) to individual health services.

It is essential that all relevant conditions, procedures, complications of treatment or surgery are documented in the discharge summary to ensure the health service is correctly funded.

The coded data is also used for a range of local and national reporting requirements and other purposes including; clinical research, financial and performance management; identifying epidemiological patterns and disease trends; reviewing resource use; workforce and facilities planning; monitoring safety and quality of care and for making comparisons between facilities, local areas and other jurisdictions.

2. Scope

This policy includes discharge summaries for patients discharged from inpatient same-day or multi-day beds. It does not include discharge of patients from emergency departments (EDs).
This policy does not include patients who Discharge Against Medical Advice (see appropriate hospital/health service policies for specific guidance); however the intent in reference to these patients is that the policy can be used similarly.

This policy applies to all persons employed in WA Health, which incorporates the following entities:

- Department of Health
- Metropolitan Health Services
- Peel Health Service
- WA Country Health Service

3. Policy statement

**Inpatients**

Discharge summaries are to be completed at the time of discharge for all inpatients including:

- patients who are being discharged home
- patients transferred to another external health care facility
- patients who died in hospital.

A progress discharge summary is required for:

- patients who are transferred to Hospital in the Home (HITH)
- patients with an internal episode of care type change (i.e. from acute to rehabilitation). Medical officers should refer to the Admission, Readmission, Discharge and Transfer (ARDT) Policy for WA Health Services (2014) for specific guidelines in these cases.

There are some exceptions identified in this policy. Patients who do not require a discharge summary are:

- patients transferred (on leave) to another health care facility with an expected return
- same day procedures where the operation report provides the necessary clinical details (e.g. endoscopy)
- day only patients admitted for haemodialysis, where no complications arise, where no other treatment is provided and where the record creation is automated
- day only chemotherapy patients where no complications arise and where the record creation is automated
- radiotherapy and intravenous therapy, where no complications arise and no other treatment is required
- recurring same day care episodes (e.g. same day infusions, transfusions, dialysis for treatment of the same conditions over weeks or months) – a single global discharge summary covering all episodes is sufficient
- healthy (unqualified) newborns (babies in their birth episode, with no peri-natal morbidity)
- statistical discharges for an episode of care change require a progress (not final) discharge summary.

Staff will need to refer to local hospital sites for particular procedures required for documentation in the relevant patient’s health record of the care/treatment of the exceptions outlined above. When a discharge summary is not required, the minimum information recorded on the patient’s health/medical record should include the diagnosis/procedure, care or treatment provided and any proposed recurrent care. In addition, hospitals should develop mechanisms to provide timely information to GPs for exception-type patients to inform of procedures, findings, aftercare and follow-up; especially for investigative procedures such as endoscopy and angiography.

Note: This policy should be read in conjunction with existing health service or hospital policies. Specific sites may require the completion of other documentation in addition to the requirements outlined in this policy.

**Discharge Planning**

Planning for discharge should commence before admission for elective and planned admissions and at the time of admission for emergency patients.

Staff need to review specific hospital site/health service policies for required procedures on discharge planning and activities that focus on coordinating services effectively so that there are no unnecessary delays for the patient at discharge.

**Completion of Discharge Summaries**

The medical team that discharges the patient is responsible for completion of the final discharge summary. The consultant in charge is responsible for ensuring compliance with this. If a medical officer is not available to complete the discharge summary on time, the next senior clinician in the team will be responsible for completing it.

An exception is where postnatal patients meet the criteria for midwife discharge, in which case the midwife is responsible for signing the appropriate discharge summary.

Senior medical clinicians and registrars are to provide oversight of junior medical officers to ensure that discharge summaries are completed correctly prior to discharge or transfer to another facility. They are to ensure that the appropriate training, education and support are provided so that the responsible medical officer is able to produce a correct, concise, high quality discharge summary.

The following guidelines are recommended for the content of discharge summaries.

Minimum mandatory information should include:

- patient details and identification information
• admission and discharge date  
• presenting history  
• principal diagnosis (and any relevant secondary diagnoses/comorbidities)  
• complications, adverse reactions/allergies or alerts  
• current medications on discharge  
• plan for patient, nominated GP and/or health care provider on future management  
• patient destination.

Information required when relevant includes:

• clinical intervention summary  
• summary of relevant investigation results  
• brief summary of treatment and progress  
• any results pending (copy of results to be arranged to be sent directly to GP if follow up by the GP is requested)  
• other services arranged.

All patients requiring a discharge summary will have it completed correctly before their discharge or transfer to another external health care facility. Copies of the discharge summary are to be provided as follows:

• one copy to the patient  
• one copy for the patient’s health record  
• one copy is sent to the patient’s usual GP  
• one copy to the referring doctor if this is different from the usual GP  
• additional copies may be required for ongoing care management (e.g. private specialist, another hospital, aged care facility, Silver Chain, nursing post; and where relevant include organisations involved in transporting the patient (e.g. St John Ambulance Australia, Royal Flying Doctor Service)  
• one copy to the parent of children/adolescents, at the discretion of medical staff.

A discharge summary for a deceased patient should be completed, ideally by the treating staff/team, within 24 hours.

Discharge summaries should be completed in accordance with the WA Health Clinical Casemix Handbook 2012-2014.

The principal diagnosis, other relevant conditions, complications and interventions recorded on the discharge summary should be accurate and specifically describe the complete clinical picture of the patient.

Note: Hospital sites/health services will have particular/authorised systems used to create discharge summaries. Staff will need to check the appropriate application to use at each site.

Communication
The hospital discharge summary is the primary document communicating a patient’s care plan to GPs and other health care professionals taking over the care of the patient following hospital discharge. It should be a clear, concise and fully completed with the patient’s diagnoses, symptoms, treatment and plans for follow up care/management.

The diagnoses and procedures documented on the discharge summary should accurately communicate why the patient was admitted to hospital and how they were treated.

The discharge summary should be faxed/emailed to the relevant GP within 24 hours of discharge as a minimum standard for WA Health hospitals.

Handwritten discharge summaries will only be accepted if an electronic discharge summary is not operational.

The medical officer should consider phoning the GP if the patient requires significant follow up or for significant events such as death and major diagnosis. This is especially important for GPs and/or health care providers with rural patients.

Hospitals will need to establish systems and processes to monitor and ensure the timely completion of discharge summaries.

Coding

Clinical coders are not able to accurately code admissions without a discharge summary, except for day cases where adequate information is provided within the record. Detailed information from the discharge summary is needed for the clinical coders to be able to assign the correct DRG; ensuring the hospital/health service receives the appropriate resourcing under the Activity Based Funding model.

If the patient’s health record and discharge summary have inconsistencies, the clinical coder will communicate a query to the responsible clinician or medical team member for review.

Data generated by clinical coding can be used for many purposes including; clinical management; monitoring quality; research; financial management; identifying disease trends; reviewing resource use; workforce and facility planning; setting benchmarks and for comparative studies.

4. Definitions

| Discharge Summary | A discharge summary is currently defined as “A collection of information about events during care by a provider or organisation” [AS4700.6 (Int) 2007]. It is a document produced during a patient’s stay in hospital, as either an admitted or non-admitted patient, and issued when or after a patient leaves the care of the hospital. |
5. Roles and responsibilities

Heads of Department

Heads of Department are responsible for:
Implementation and managing compliance with this policy in their areas.

All medical, nursing and allied health staff involved in patient care

All medical, nursing and allied health staff involved in patient care are responsible for:
The completion and dissemination of discharge summaries in compliance with this policy.

6. Compliance

100 per cent of discharge summaries will be completed on the day of discharge or transfer to another health care facility.

The hospital Head of Department has responsibility for implementation and managing compliance with this policy in their areas.

Hospital sites/health services will develop methods to:

- establish governance processes and monitoring systems to ensure compliance with this policy
- manage the operational requirements necessary to enact this policy
- provide and maintain local procedures to facilitate correct recording and reporting of activity
- maintain adequate documentation to validate admitted care
- provide education and direction to staff in the application of this policy
- report results to relevant staff for analysis
- undertake regular audits of the completion rates for finalised discharge summaries
- medical officers identified as having ongoing low compliance will be counselled/educated by senior clinical directors
- completion of discharge summaries can be raised with staff in clinical performance management meetings
- annually audit health records to ensure:
  - health records contain a summarised coding sheet or discharge summary signed by a medical officer
  - documentation in the health record substantiates the diagnosis and procedure descriptions that result in the DRG assignment.

WA Health will use this policy when auditing hospital admitted activity and through the annual clinical information audit. This audit reviews clinical coding, quality of clinical
documentation, completion of discharge summaries and ARDT policy compliance. Patient records flagged as potential errors will be advised to the hospital for correction.

7. Evaluation

WA Health will use this policy when auditing hospital admitted activity and through the annual clinical information audit. This audit reviews clinical coding, quality of clinical documentation, completion of discharge summaries and ARDT policy compliance. Patient records flagged as potential errors will be advised to the hospital for correction.

8. References

[WA Health Clinical Casemix Handbook 2012-2014.]

Department of Health Operational Directive OD0540/14 Admission, Readmission, Discharge and Transfer Policy for WA Health Services

Department of Health Operational Directive 0201/09 Clinical Information Audit Program Hospital Activity Reporting

9. Relevant legislation (optional)
State Records Act 2000 Sections 3, 31, 78

State Records Principles and Standards 2002 Standard 1, Principle 1, Standard 2, Principle 5

Public Sector Management Act 1994 Section 29 (n)

10. Related documents

This policy should be read in conjunction with existing health service or hospital policies. Specific sites may require the completion of other documentation in addition to the requirements outlined in this policy.

11. Authority

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<tr>
<td>Contact:</td>
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<td>Directorate:</td>
<td>Systems Policy and Planning</td>
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