SESLHD PROCEDURE COVER SHEET

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KEY TERMS	Medical Discharge Summary (MDS), eDRS. Discharge Summary, Discharge Referral, Documentation, Ongoing care
SUMMARY	Provides guidance on the responsibilities, quality, timeliness, and distribution of a Medical Discharge Summary (MDS).

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

Medical Discharge Summary Completion Standards

SESLHDPR/223

1. POLICY STATEMENT

This policy provides guidance on the responsibilities, quality, timeliness, and distribution of a Medical Discharge Summary (MDS)

2. BACKGROUND

The accurate and timely completion of a MDS is essential for the patient/client's ongoing care as it forms the primary communication tool with the general practitioner (GP) and/or other healthcare professionals involved in the care of the patient. The MDS is also crucial for accurate clinical coding which forms the basis of Activity Based Funding (ABF), data provision for research, statistical reporting, and resource allocation.

A Discharge Summary is required for all inpatient episodes, regardless of outcome (such as transferred, discharged against medical advice, or deceased patients) with the exception of:

- Day only admissions
- Day only procedures, including endoscopies
- Routine renal dialysis
- Day only chemotherapy/radiotherapy

The MDS may have input from any clinical staff but the ultimate responsibility for completing it lies with the discharge consultant.

Where discharge summaries are completed in PowerChart eMR, they are automatically sent to the NSW Health Clinical Portal (with the exception of the Community Mental Health Discharge Summary). Once in the Clinical Portal, the discharge summary can be viewed by other linked NSW Health facilities. It also provides a method of secure transmission to GPs/LMOs and to the patient via My Health Record

Where a service/program utilises a specialised clinical information system for the creation of a MDS they must ensure that this system interfaces with PowerChart eMR.

2.1. DEFINITIONS

Activity Based Funding (ABF): 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.

Additional Diagnosis: Any condition/s or complaint either co-existing with the principal diagnosis, or arising during the episode of admitted patient care, episode of residential care, or attendance at a health care establishment.

Discharge: The relinquishing of patient care in whole or part by a health care provider or organisation.

Discharge referral: A referral occurring in the context of discharge.

Discharge summary: A collection of information about events during care by a provider or organisation.

Discharge consultant: Attending Medical Officer (AMO) on discharge.

Electronic Discharge Summary (eDRS): The electronic discharge summary that is created within the eMR PowerChart, and electronically dispatched to the NSW Health Clinical Portal and subsequently LMOs/GPs.

Electronic Medical Record (eMR): Most commonly used to refer to PowerChart Cerner but may also be used to refer to other electronic medical record systems in use across the District (eRIC, ObstetriX, eMaternity, MOSAIQ, etc).
Note: May also be referred to as "Electronic Health Record (eHR)"

Electronic Medication Management System (eMeds): Electronic medication management component within Cerner eMR.

Health Information:
(a) personal information that is information or an opinion about:
(i) the physical or mental health or a disability (at any time) of an individual, or
(ii) an individual's express wishes about the future provision of health services to him or her, or
(iii) a health service provided, or to be provided, to an individual, or
(b) other personal information collected to provide, or in providing, a health service, or
(c) other personal information about an individual collected in connection with the donation, or intended donation, of an individual's body parts, organs or body substances, or
(d) other personal information that is genetic information about an individual arising from a health service provided to the individual in a form that is or could be predictive of the health (at any time) of the individual or of any sibling, relative or descendant of the individual, or
(e) healthcare identifiers, but does not include health information, or a class of health information or health information contained in a class of documents, that is prescribed as exempt health information for the purposes of the HRIP Act generally or for the purposes of specified provisions of the HRIP Act

Health Record: a documented account, whether in hard copy or electronic form, of a client/patient's health, illness, and treatment during each visit or stay at a public health organisation.
Note: holds the same meaning as "health care record", "medical record", "clinical record", "clinical notes", "patient record", "patient notes", "patient file", etc.

HealtheNet Clinical Portal: eHealth NSW program that connects patient information from Local Health Districts and My Health Record systems. Accessible to NSW Health staff.

My Health Record: A personally controlled digital summary of health information that can be accessed by individuals and healthcare providers. My Health Record is an opt-out Commonwealth initiative.

Presenting Problem: symptom, disorder, or concern expressed by the patient when seeking care.

Principal Diagnosis: The diagnosis established after study to be chiefly responsible for occasioning the patient's care at the facility**.** 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.

Referral: The communication, with the intention of initiating care transfer, from the provider making the referral to the receiver. Referral can take several forms most notably:
- Request for management of a problem or provision of a service (e.g. a request for an investigation, intervention or treatment)
- Notification of a problem with hope, expectation, or imposition of its management (e.g. a discharge summary in a setting which imposes care responsibility on the recipient).

Sub-Acute + Non Acute Patient (SNAP): Inpatient classification care type of one of the following:
- Palliative care
- Rehabilitation care
- Psychogeriatric care
- Geriatric care
- Management/Maintenance care
- Mental Health Care

Treating team: 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:
- if the consumer named another health service provider as his or her current treating practitioner—that other health service provider; and
- if another health service provider referred the consumer to the treating team for that episode of care—that other health service provider.

3. RESPONSIBILITIES

3.1 District Managers/ Service Managers will:

Ensure that:

- The principles and requirements of this procedure are applied, achieved, and sustained
- All relevant staff understand and comply with the requirements of this procedure
- All relevant staff receive education and training to enable them to carry out their roles and responsibilities in relation to this procedure
- All staff have timely access to systems and equipment required
- Compliance reports/audits are reviewed and actioned appropriately.

3.2 Discharge consultant will:

Ensure that:

- The principles and requirements of this procedure are applied, achieved, and sustained
- All relevant staff understand and comply with the requirements of this procedure
- All relevant staff receive education and training to enable them to carry out their roles and responsibilities in relation to this procedure
- All staff have timely access to systems and equipment required
- Compliance reports/audits are reviewed and actioned appropriately.

3.3 Medical/Midwifery staff will:

- Read, understand, and comply with the requirements of this procedure.

3.4 Health Records staff will:

- Follow-up on outstanding MDS as required (e.g. requested for clinical or release of information reasons)
- Complete eDRS audits and disseminate
- Complete auto-sent eMR MDS audit and re-transmit where required
- Provide information on eDRS completeness where required.

3.5 IT will:

- Support processes by supporting technology such as electronic health record systems and the interfaces between electronic health records and the HealtheNet Clinical Portal
- Ensure efficient processing of new and revised GP information within health systems.

3.6 Ward clerks will:

- Follow-up missing MDS from the relevant staff
- Disseminate completed MDS by fax or post when electronic transmission is not supported

- Provide a printed copy of the MDS to the patient if the service policy/procedure permits or if authorised by a Medical Officer.

4. PROCEDURE

4.1 Responsibility for MDS completion

While MDS may have input from any clinical staff member it must be signed off by a medical officer of rank intern or above (with the exception of the Obstetrics MDS which must be signed off by a qualified midwife).

Ultimate responsibility for ensuring appropriate and timely completion of the MDS lies with the discharge consultant.

There may be instances where medical officers are required to complete a discharge summary for a patient they did not see or were not directly involved in treatment. This does not excuse the requirement or responsibility for a MDS to be completed. A notation of to the effect of "I did not see this patient and provide this summary based on my review of the clinical record" may be added.

If a patient has had a Care Type Change during their hospital stay a MDS will be required at the time of formal discharge. The MDS should contain information regarding the entire hospital stay.

4.2 Completion timeframes

MDSs must be completed within 48 hours of discharge/transfer to adequately support ongoing clinical care and timely clinical coding.

It is preferable to complete the MDS on the day of the patient's discharge prior to their departure. This ensures that a copy of the MDS can be given to the patient/authorised representative (if appropriate) along with discussion of discharge/follow-up instructions.

4.3 Completing the discharge summary

The MDS must be typed in the correct Discharge Referral template within the eMR to ensure the legibility and facilitation of electronic distribution to the clinical portal.

The MDS may be commenced in eMR on admission and kept as a "provisional" document until completion to support the discharge planning process. The discharge summary should not be completed/sign-off too far in advance of patient discharge to ensure it adequately reflects treatment and follow-up instructions.

Forms for completing a handwritten MDS will only be made available in exceptional circumstances, such as where the eMR is unavailable for an extended period of time. If a handwritten MDS is completed, the ward clerk must manually send a copy to the patient's GP either by fax or mail and file in the patient record.

4.4 Discharge summary requirements

The MDS should provide an accurate summary of the patient's entire inpatient episode with sufficient detail to allow subsequent health professionals to continue care post-discharge. As a minimum, the MDS should contain the following:

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 if known
5. Principle 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. Summary of any Advance Care discussions, plans and documents
11. Follow-up requirements and person(s) care is referred to including time frames where relevant
12. Medications at discharge (see definition)
13. Author's name, signature, designation and date completed.

Only include relevant/appropriate information specific to the episode of care.

4.5 eDRS auto-population and copy/paste

eMR systems often auto-populate general fields. Information that is auto populated in the discharge summary in the electronic medical record (e.g. phone numbers, GP details, medication, diagnosis) should be routinely checked for accuracy.

Some eMR systems allow staff to pull in information from other parts of the record, such as imaging, pathology, operation reports, or medication. These should be reviewed for accuracy and relevance to the summary.

As a general rule, clinicians should avoid copying and pasting in the electronic medical records. The use of copy and paste has been associated with a higher incidence of errors such as copying and pasting incorrect/inaccurate information or of the wrong patient's information. If copy and paste is necessary, to avoid formatting issues the clinician should first copy the text into notepad and then into the eMR document. Clinicians must review the final document it to ensure it is accurate and appropriate.

4.6 Discharge Medications

The Discharge Prescription must be completed by the Medical Officer with reference to the current medication chart.

In eMR, this process starts with eMeds discharge reconciliation where a doctor determines what medications the patient will continue taking at home and what will not be continued on discharge. Discharge prescriptions are also identified at this stage.

Once the discharge reconciliation process is completed, the information can be automatically pulled in to the eMeds version of discharge referral documents.

The eDRS is to be used for medications supplied by the hospital pharmacy or a handwritten script is to be given to the patient.

4.7 Distribution of Discharge Summaries

Once finalised, the MDS should be printed and provided to the patient and/or their authorised representative as appropriate so that they can understand and reference any follow-up instructions/appointments. If the MDS is not ready upon discharge, a copy of the discharge summary should be posted to the patient/client/authorised representative where appropriate.

If an inpatient or community health MDS is completed in PowerChart Cerner, the eDRS will automatically be transmitted to the NSW Health Clinical Portal and then on to the patient's nominated GP as entered in the system. The MDS will not send to the NSW Clinical Portal until it is signed in eMR and the encounter is discharged in iPM / eMR. If the patient has not opted out of the Commonwealth Government's *My Health Record* system, a copy of the eDRS will also be transmitted to their *My Health Record* at this time.

If a Discharge Summary is competed in eMaternity, the discharge summary will be automatically transmitted to PowerChart eMR where it can be viewed in PDF format. It will not be uploaded to the Clinical Portal or automatically distributed and therefore must be distributed by the ward clerk.

5. DOCUMENTATION

Discharge Summary (Paper Form) – SMR010.001 (for use during downtime only)
PowerChart eMR electronic Discharge Referrals (eDRSs) (includes Emergency, Inpatient, and ED)
ObstetriX/eMaternity Discharge Summary

eMR QRGs
eMeds QRGs

6. AUDIT

6.1. PowerChart eMR eDRS Compliance Rates

Health Information/Medical Record Managers regularly distribute reports outlining completion compliance to service/unit/program managers indicating both completion rates and timeliness. Service/unit/program managers are expected to review the lists and follow-up on outstanding discharge summaries.

Ongoing issues are escalated where appropriate.

Results reported to the SESLHD Health Records & Medico-Legal Committee

6.2. Failed/in-error eDRS notifications

Failed or in-error eDRS notifications received from HealtheNet are audited by HealthICT to ensure all required medical discharge summaries are distributed to the nominated GP and the patient's My Health Record (where applicable).

7. REFERENCES

NSW Ministry of Health Guideline GL2006_015 – Medical Discharge Referral Reporting Standard (MDRRS)

NSW Ministry of Health Privacy Manual for Health Information

NSW Ministry of Health Policy Directive PD2012_069 - Health Care Records – Documentation and Management

SESLHDPR/605 - eMR – Copy and Pasting within Electronic Documentation

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
01/12/10	0	Endorsed – Area Patient Safety & Clinical Quality Committee Noted – Area Clinical Council
12/11/2012	1	Health Information Managers – SESLHD in consultation with eMR Team
15/11/2012	2	SESLHD website – draft policies for comment. Feedback received and updated January 2013.
26/03/2013	3	SESLHD Health Record and Medico-Legal Working Party
20/05/2013	4	SESLHD Health Records and Information Steering Committee
21/08/2017	5	SESLHD Health Record and Medico-Legal Working Group
13/12/2017	6	Endorsed - SESLHD Clinical Informatics Steering Committee
April 2020	6	Executive Sponsor updated
April 2021	7	Major review commenced by SESLHD Health Records & Medico-Legal Committee
June 2021	8	Draft for comment period. Feedback received and incorporated.
July 2021	8	Final version approved by Executive Sponsor. To be tabled at Clinical and Quality Council for approval.
August 2021	8	Approved at Clinical and Quality Council.