Discharge Summary TEHS Hospitals Procedure

<table>
<thead>
<tr>
<th>Target Audience</th>
<th>All Clinical Employees; Clinical Coders; Ward Clerks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jurisdiction</td>
<td>Gove District Hospital; Katherine Hospital; Royal Darwin Hospital</td>
</tr>
<tr>
<td>Jurisdiction Exclusions</td>
<td>N/A</td>
</tr>
<tr>
<td>Document Owner</td>
<td>N/A</td>
</tr>
<tr>
<td>Executive Director of Medical Services TEHS</td>
<td></td>
</tr>
<tr>
<td>Approval Authority</td>
<td>Chairs</td>
</tr>
<tr>
<td>KH Clinical Quality Council; RDH Clinical Quality Council; GDH Safety and Quality Committee</td>
<td></td>
</tr>
<tr>
<td>Author</td>
<td>N/A</td>
</tr>
</tbody>
</table>

The attributes in the above table will be auto-filled from the PGC System. Do not update in this document.

**Purpose**

To ensure compliance with the National Safety and Quality Health Service Standard 6: Clinical Handover for discharge documentation through:
- Clearly defining the roles and responsibilities that support the creation and dispatch of a discharge summary
- Providing guidance to authors to facilitate the completion of a high quality discharge summary
- Ensure the patient’s treating clinic receive a discharge summary in a timely manner.

To improve the capacity of the discharge summary to provide information required for the coding of diagnosis related groups (DRG) and therefore hospital casemix funding.

**Procedure**

**Responsibilities**

| Heads of Department | Approve discharge summary document templates/profiles for their Department  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assign relevant User Groups to documents used by their Department</td>
</tr>
<tr>
<td></td>
<td>Develop and manage a process to inform the Clinical Applications Training &amp; Support (CATS) of User Group membership rules</td>
</tr>
<tr>
<td></td>
<td>Monitor their Department’s compliance with discharge summary policy</td>
</tr>
</tbody>
</table>

<p>| Medical Services    | Inform the Clinical Applications Training &amp; Support (CATS) of changes to User Groups two weeks prior to roster rotation |</p>
<table>
<thead>
<tr>
<th>Role</th>
<th>Tasks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Treating Specialists</td>
<td>Ensure the Estimated Date of Discharge (EDD) is allocated, documented, and reviewed for each patient. Determine change of care type, as required. Ensure the quality and timeliness of documents dispatched under their bed card. Document the process for discharge documentation if it varies from the general processes outlined below. All variances are documented in Appendix 2: Specialist- and unit-specific variances. Ensure incidents of harm or potential harm resulting from any deficiency in the discharge processes are recorded in RiskMan.</td>
</tr>
<tr>
<td>Medical Officers</td>
<td>Creation of patient’s discharge summary at admission. Progressive documentation of medication changes within the discharge summary profile. Completion of discharge summary content for all patient admissions including: change of care, hospital transfer, take own leave, deceased patients. Discharge summary validation. Discharge summary dispatch to the patient’s treating clinic within 48 hours of discharge. Discharge summary dispatch to the patient’s personal electronic health record, for registered patients. Discuss all referrals, appointments, and follow-up information including medication advice with the patient, carer or appropriate service prior to discharge, in plain language. Prior to Term changeover: Complete outstanding discharge summaries, Discharge preparations including discharge scripts, letters to GPs, appointments and any other arrangements and consultations. OR Ensure that each patient has a clearly documented management plan to ensure seamless transfer of care to the incoming team. Documentation of Estimated Date of Discharge (EDD), revisions and final ready for discharge date in patient’s medical record. Completion of discharge summaries placed in individual medical officer’s allocated box within Medical Records. Record incidents of harm or potential harm resulting from any deficiency in the discharge processes in RiskMan.</td>
</tr>
<tr>
<td>Nursing and Midwifery staff (as per unit delegations)</td>
<td>Creation and completion of discharge summary for patient admissions as per Unit delegations. Discharge summary validation. Discharge summary dispatch to the patient’s treating clinic within 48 hours of discharge. Discharge summary dispatch to the patient’s personal electronic health record, for registered patients. Discuss all referrals, appointments, and follow-up information including medication advice with the patient, carer or appropriate service prior to discharge, in plain language. Record incidents of harm or potential harm resulting from any deficiency in the discharge processes in RiskMan.</td>
</tr>
<tr>
<td>Role</td>
<td>Responsibilities</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Ward/Admission Clerks/ED reception</td>
<td>Enter and update information on CareSys, i.e., admission information, referrer details, clinic/general practice/GP details. Change of Care type, patient transfer and/or discharge information. Confirm the Medicare number, financial category and correct POSTA details prior to discharge to ensure that the patient is not incorrectly billed. Assemble the medical record within 24 hours of discharge (on a week day and as soon as possible following a weekend) and prior to the record being moved to the doctors discharge room/area for completion of the discharge summary. Discharge administration processes including assigning the Unit/professional to complete the Discharge Summary on CARESYS WORKC screen and tracking the medical record on the MRTSI screen once the medical record is moved to the area designated for medical officers to complete the discharge summary. Assist with booking of outpatient and other appointments as required. Assist with mailing documents to discharge summary addressess as requested.</td>
</tr>
<tr>
<td>Team Leader</td>
<td>Enter and update information on CareSys, i.e., Alerts and Allergies, expected date of discharge. Ensure Change of Care Type and/or patient transfer information is correct. Ensure allocated EDD is displayed on electronic patient management system. Record incidents of harm or potential harm resulting from any deficiency in the discharge processes in RiskMan.</td>
</tr>
<tr>
<td>Discharge Care Coordinators</td>
<td>Identification of clear discharge plans for patients with complex post-discharge care needs. Record incidents of harm or potential harm resulting from any deficiency in the discharge processes in RiskMan.</td>
</tr>
<tr>
<td>Medical Records</td>
<td>Collect on a daily basis, the medical records of discharged patients with a completed discharge summary or any record 4 working days after patient discharge for return to the Medical Records Department for processing and coding. Place coded medical records without a completed discharge summary in the assigned medical officer's allocated box within the Medical Records Department. Assist medical officers to locate medical records requiring discharge summaries to be completed. Compile and disseminate reports to enable performance monitoring of discharge summary completion to: Heads of Department, Heads of Unit, Individual medical officers (currently not available), Governing Committee responsible for performance management, as required.</td>
</tr>
</tbody>
</table>

Ensure the required patient information is entered into Caresys.

Primary Responsibility – Ward Clerk

It is the ward clerk's responsibility to interview all patients upon transfer or direct admission to the ward to:

- Ensure the patient's contact and demographic information remains accurate.
• Update the details of the patient's current preferred clinic/general practice (and/or their preferred GP provider) in Caresys
  o Note: GPs may work at more than one location so Clerks must ensure the clinic name/location is correct
  o Several practices have similar names so ensure you select the correct option.

Procedure
Ward Clerks should adhere to the question format detailed in their Caresys manuals.

Create Discharge Summary Document

Primary Responsibility – Intern/RMO (See Exceptions Below)
In general, the creation of a discharge document is the responsibility of Unit/Division intern/RMO attached to the Specialist that the patient is admitted under.

Exceptions to this include:
• Same Day procedures – the registrar/specialist takes responsibility for the creation, validation and dispatching of discharge documents resulting from day procedures they perform and where the intern/RMO has little involvement
• Admissions primarily under Nursing care, for example Maternity. In these cases, Nursing/Midwifery staff take responsible for the creation, validation and dispatching (sending) of those Discharge Summary Documents.

Inpatient discharge summary documents should be created at the beginning of an admission episode. This will allow medication changes to be progressively documented. Discharge medications for the patient need to be created in eMMa prior to discharge of the patient from the CareSys system. Failure to create discharge medications prior to patient discharge will prevent eMMa auto-filling medications into the document profile.
Procedure

For creation of discharge document by responsible MO/nursing staff:

a. Check the Patient's 'Documents' form – this ensures a summary has not already been created for the patient's current episode.

b. Choose the correct discharge summary template and profile – this ensures all required information is able to be documented for that admission.

c. Add your name as "Author". (Note: the author who creates the document is called the "Primary Owner" of the document.) Check your name appears as Primary Owner when creating new documents. Check (and change if needed) when editing documents started by others.

d. User Groups – some templates have multiple User Groups attached. These User Groups defined the persons with approved access to read/edit/ dispatch that document that have already been added as owners of the document. Do not remove any of these User Groups.

e. Add any other Owners. Only Owners can contribute to or dispatch the document.

   i. The Specialist whom the patient is admitted under (as per bed card) must be included as an Owner on all Discharge Summaries. It is the author's responsibility to add the treating Specialist. Check they may already be included as part of a User Group.

   ii. Consider adding other JMOs, e.g., if you will need to handover the patient.

f. Setting User Preferences – the User Preferences screen can be used to set the default document type and profile. This is useful if you are mostly creating one document type on regular basis.

Ensure Correct Recipient Address List

Primary Responsibility – Document Owner

Clinical Work Station (CWS) will not let you dispatch a document unless you select at least one Addressee.

A treating Clinic for follow up care is to be identified for all patients.

A treating Clinic addressee may be added into the body of the document without a complete address being known, e.g. in the case of an interstate provider.

Information must not be sent to a treating clinic/practice/practitioner where the patient states that they do not want this to occur.

Procedure

Include:

- Patient

- Patient's treating clinic/practice (as preferred for follow up care)

  o Will automatically be displayed (on the left) where the information has been nominated in Caresys through the ADMIT screen (collected by the admission/ward clerk)

  o For remote patients the community clinic should be included, Add the Rural Health Practitioner/RMP/DMO if known or include the option "DMO for XXX region"

  o Choose the GP within the Clinic/Practice only if known otherwise choose the option "practice doctor/nurse". Patients may see more than one GP at a clinic and GPs may work at more than one location. It is therefore more reliable to select the Clinic rather than treating doctor/GP.

  o Unlisted Clinic/Practice details may be added within the body of the document.

- Referrer – especially if different to the patient's preferred clinic/practice
• Other addressees, e.g. private specialist can be selected from Organisations or Person list.

Do not include:
• DoH hospitals or clinics that have access to discharge documents
• Medical Records
• Urban Aboriginal Medical Services unless the patient has indicated that they attend/will be attending this service for follow up care.

Patients without a treating clinic/General Practice listed in CareSys should be encouraged to identify their preferred clinic for follow up care. Where a patient identifies a clinic but is not registered with that clinic the discharge summary should clearly state that the patient has identified their intent to attend that clinic as a new patient.

Note: GPs may work at more than one practice and rotate/change practice location so ensure you choose the correct practice location. Note also that some services have several independent clinics that operate under their logo, e.g., Miwatj Health, so ensure you choose the correct clinic.

Content – Completing the Discharge Summary

Primary Responsibility – Document Owner

A completed discharge summary is required at the time of discharge/death for all patients.

This includes patients who discharge themselves against medical advice or take own leave.

Exclusions:
• Same day renal dialysis patients, Same day chemotherapy, Same day endoscopic procedures
• Non-admitted patients which includes patients who attend an outpatient clinic and patients treated in the Emergency Department (ED) who do not meet any of the criteria for admission.
• Dead on arrival (no active resuscitation)
• Babies who are stillborn, or show no sign of life at birth
• Boarders
• Posthumous organ donor.

The responsibility for recording accurate diagnoses and procedures, especially the principal diagnosis, lies with the Document Owner.

There must be supporting documentation evidenced in the medical record for all diagnoses and procedures recorded on the discharge summary.

Procedure

Authors should accurately document all aspects of a patient's episode of care, particularly procedures and complications, in a clear and precise way. Diagnoses should be clearly sequenced according to importance and causal relationships, where known, should be specified. This is vital to the coding process. The presenting symptoms do not need to be recorded if the underlying cause has been established.

To reduce the risk of error authors must avoid the use of abbreviations that may cause confusion or have more than one meaning in a clinical setting.

Medications changes and the rationale must be documented. Discharge medications for the patient need to be created in eMMa prior to discharge of the patient from the CareSys system. Failure to create discharge medications prior to patient discharge will prevent eMMa auto-filling medications into the document profile.
At times it may be necessary to prioritise the completion of discharge summaries. Prioritisation should be based on clinical assessment. Factors to be considered in this prioritisation would include: medication changes, surgical procedures, the need for follow up care or appointments, pending test results.

A document may on occasion become corrupted. There can be several reasons for this, such as importing text using 'cut & paste' instead of 'copy & paste,' or typing too much text into tables. The ACIS HelpDesk may be able to help retrieve/reconstruct a document or isolate which part of the document has been corrupted.

See Appendix 1: Completing the perfect discharge summary.

Dispatch – Validation and Sending of the Document

Primary Responsibility – Document Owner

The Document Owner is responsible for both the validation (checking) of the document and its dispatch (send). The Document Owner should be listed as the author in the author field in CWS.

Any Owner of an incomplete discharge document can open, edit, validate and dispatch the document, e.g., primary owner on leave or rotated to another unit.

Multi-disciplinary User groups should check the Unit’s rules to determine who can validated and dispatch the document.

Prior to document dispatch, CWS will prompt to confirm that the patient has consented for the document to be sent to the SEHR/MEHR/PceHR. If the patient has declined transfer of information to their registered eHealth Record, the ‘Send to SEHR’ should be un-ticked prior to dispatch of the document.

The method for dispatch of the discharge summary to the addressess will be according to the addressess’ preference as set within CWS. This may include fax, post or encrypted electronic mail.

After the discharge summary has been dispatched, the printer will automatically print at least one (1) paper copy – this is for the patient. The copy should be handed to the patient, where possible, or mailed to the patient’s designated postal address. Additional copies will be printed for each addressee who has requested to receive their copy by post. The ward administration officer/ward clerk should assist with the mailing of discharge documents.

Once the discharge summary has been dispatched, all clinical staff Territory wide with access to CWS can now view/read this document.

Error in Dispatched Document, and Document Dispatched in Error

Once a document has been dispatched it cannot be edited or deleted.

Where information needs to be added, corrected or removed from a dispatched document, a new document will need to be created. The original document can be copied and edited or addressess amended, as required.

When a replacement document is created, the status of the original document needs to be updated within CWS.

Old/superseded versions need to be recovered/removed from the patient, from all addressess and from the SEHR/MEHR/PceHR. Documents dispatched in error and containing significant errors that may impact on safe patient care require telephone follow up to all addressess.

Procedure for Wrong Patient

Create a new discharge summary document. Remove original document (see box below).

Procedure for Wrong Content

Copy or Supersede the original document to edit and dispatch. Remove original document (see box below).
Remove original document

Change the status of the document within CWS to reflect that the document was dispatched in error. (Go to My Documents and double click on the document. The Document Detail form will appear. Click the box with "Dispatched in Error")

Contact all addressees (including patient) to request removal of the document from their records

Contact the MeHR administrators to request the incorrect document be removed from SEHR/MEHR and PCeHR via email - [redacted] - or help desk on 1800 [redacted]. Include the patient name, HRN, date and details of the documents to be removed, your name and the reason for the amendment/removal. This information is required for auditing and tracking purposes.

Procedure for Missed Addressee

Re-send original document (NOT New Copy button). Remove previous addressees, including SEHR/MEHR/PCeHR, otherwise they will receive duplicate copies.

Documents created and not dispatched within 90 days of admission may be administratively dispatched within CWS as an “Incomplete Summary” under the Discharge Audit process. Should this occur in error, e.g., for a long stay patient, a new document will need to be created.

Change of Care Type

Patients who meet the criteria for admission are admitted on CareSys with an appropriate ‘Care Type’. Determining the ‘Care Type’ is a medical responsibility and represents the clinical intent or acuity of care. A patient may have one or more Care Type during their hospital admission, at which time the patient is statistically discharged from the current episode and statistically readmitted to the new episode of care via the Change of Clinical Intent (CHCII) screen on the CareSys. This hospital activity is reported to the NT Admitted Data Activity Collection (ADAC) and impacts on the Activity Based Funding (ABF).

Change of Care Type occurs when the clinical intent of care changes. For example the patient is no longer receiving acute care and is administratively discharged and readmitted to a subacute, non-acute care or mental health care type.

Subacute care includes: Rehabilitation, Palliative Care, Geriatric Evaluation and Management
Nonacute care includes: Maintenance
Mental Health care includes: Acute Psychiatric Care

The treating team is required to complete and dispatch a summary document for the episode they are providing care for before handing over to the new team following a change in Care Type. This supports the effective clinical handover and referral of the patient and ensures the community clinic/GP providers remain informed.

Procedure

Each Divisional Team will create and dispatch a summary document (as part of the referral process) and before transferring the patient to the new Division’s treating Team. The treating team may elect to use the standard discharge summary document profile (for more complex cases) or the intra-hospital transfer summary profile (where a brief summary is sufficient)

The ‘discharge destination’, if required, should clearly state the patient is being transferred within the hospital - this is to ensure patient’s treating clinic/GP does not think the patient is discharged for follow up under their care.
Discharge medications are not required, therefore do not enter discharge medications in eMMa or manually enter on the CWS document.

The new Team will start a new discharge document using their own template for their episode and care.

**Transfer of Care**

The treating team is required to complete and dispatch a summary document for the episode they are providing care for before transfer of the patient. This supports effective clinical handover and referral processes and ensures the community clinic/GP providers remain informed. When a patient is transferred it is the responsibility of the transferring hospital to include information identifying the referring primary health service and preferred clinic for follow up care (if different) to ensure they receive discharge information.

**Transfer to another Division**

Each Division has its own set of discharge summary templates which are not transferable between the Divisions due to variation in content and layout. Example: patient transfers from DSaCC to DoM or vice versa. The treating team may elect to use the standard discharge summary document profile (for more complex cases) or the intra-hospital transfer summary profile (where a brief summary is sufficient).

The 'discharge destination', if required, should clearly state the patient is being transferred within the hospital – this is to ensure patient’s treating clinic/GP does not think the patient is discharged for follow up under their care. Discharge medications are not required, therefore do not enter discharge medications in eMMa or manually enter on the CWS document.

**Transfer to another Team within a Division**

There are a range of discharge summary profiles/templates within each Division.

Sometimes the discharge document commenced for the patient will not be suitable for completion by a different Team within the same Division. A possible example is transfer from Orthopaedics to General Surgery.

In these circumstances the treating Team will create and dispatch a summary document before transferring the patient to the new Division’s treating Team unless alternative procedures are in place.

The 'discharge destination' should clearly state the patient is being transferred within the hospital – this is to ensure patient’s treating clinic/GP does not think the patient is discharged for follow up under their care. Discharge medications are not required, therefore do not enter discharge medications in eMMa or manually enter on the CWS document.

**Transfer to Hospital In the Home (HITH)**

As per HITH Policy, the treating team is required to complete and dispatch the discharge summary for the episode they are providing care for prior to the HITH team accepting the patient. The discharge summary must contain information from the treating Unit’s involvement and must include discharge medications.

The HITH team will dispatch a further discharge summary at the end of their episode of care containing information only about the HITH care provision.

Information about the patient’s preferred treating clinic/practice for follow up care should be included in the transfer information.

**Transfer to Another hospital**

The treating team is required to complete and dispatch the discharge summary for the episode. The ‘discharge destination’ should clearly state Transfer - Other Hospital – this is to ensure patient’s treating clinic/GP does not think the patient is discharged for follow up under their care. Discharge medications are not required, therefore do not enter discharge medications in eMMa or manually enter on the CWS document.
The contact and discussion about a patient for transfer should be made by the most senior medical officer to the consultant accepting care of the patient at the receiving hospital.

Information about the patient’s identified preferred treating clinic/practice for follow up care should be included in the transfer information.

Transfer to Residential Aged Care Facility (RACF)

Note: Transfer to a RACF means that the patient is discharged/transferred to a RACF as a new admission. Where the patient has been admitted from and discharged back to a RACF (i.e., the RACF is their usual place of residence) the discharge destination should be “HOME”.

RACFs require that all patients have an identified GP prior to admission and the patients GP should be made aware of discharge and any requirements of the discharge care plan. The treating team is required to complete and dispatch the discharge summary as for a discharge to the community setting. The ‘discharge destination’ should clearly state Transfer – Residential Aged Care – this is to ensure patient’s treating clinic/GP is aware the patient is discharged to the RACF and that for follow up care will be required. Discharge medications are required, therefore enter discharge medications in eMMa or manually enter on the CWS document. The RMO may also be required to complete RACF admission paperwork and medication chart. Please ensure medication lists are complete on discharge summary and RACF medication chart.

Medical Records Movement/Tracking

The medical record is to be assembled by the Ward Clerk within 24 hours of discharge (on a week day and as soon as possible following a weekend).

Once assembled the Ward Clerk will place the medical record in the area allocated for the medical officers’ to complete the discharge summary and track the medical record on the MRTSI screen.

Medical Record Department (MRD) staff will routinely collect the medical records from the wards within several days (usually 4 days) of discharge. This is to enable the record to be coded and to ensure its availability for subsequent outpatient follow up etc.

Following coding, records without a completed discharge summary will be placed in the assigned medical officer’s allocated box located in the MRD.

Records in the assigned medical officer’s allocated box located in the MRD are available 24 hours 7 days per week, (provided the record is not needed for ED/OPD appointments, readmission, etc). MRD has a number of work stations available for medical officers to complete summaries.

Medical Officers can provide a list of incomplete documents /medical records requiring discharge summaries to be completed to the Clinical Coding Support Clerk within MRD who can assist medical officers locate the records within standard office hours:

- On the day, (maximum <10 and records located with MRD), or
- Over the weekend (>10 and/or the records within the MRD). List to be submitted before Friday 10am.

Records will be located over the weekend and available to the medical officer on the following Monday.

Audit/Quality

Specialists are responsible for the accuracy and timing of discharge summaries dispatched under their bedcard and therefore for ensuring that adequate standards of documentation are met.

Specialists should monitor compliance with discharge summary policy including the audit of discharge summary quality and act on audit results, as required.

Medical Records will provide Specialists with reports to enable the monitoring of Discharge summaries including:

- Discharge summaries not completed within 48 hours, by unit division
• Discharge summaries not completed within 7 days, by unit division
• Outstanding discharge summary report for “Patients discharged without a discharge summary” by specialist.

Medical Officers can generate a list of incomplete documents or non-dispatched documents through the My Incomplete Documents tab. The from date and document type can be selected to refine the search.

Staff notified of incidents of harm or potential harm resulting from any deficiency in the discharge processes must ensure this information is recorded in the RiskMan system.

### Document Quality Assurance

<table>
<thead>
<tr>
<th>Method</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implementation</td>
<td>Document will be available for all staff via PGC</td>
</tr>
<tr>
<td>Review</td>
<td>Document will be reviewed within four years, or when a change in practice occurs</td>
</tr>
<tr>
<td>Evaluation</td>
<td>Incidents will be recorded in the patient’s notes and RiskMan, and managed by the appropriate Unit Manager</td>
</tr>
</tbody>
</table>

### Key Associated Documents

**Key Legislation, By-Laws, Standards, Delegations, Aligned & Supporting Documents**


- [11am Discharge RDH Procedure](#)
- [Admissions KH CareSys Data Entry Manual](#)
- [Admissions TEHS CareSys Data Entry Manual](#)
- [Basic Wards – Ward Clerks and RN Team Leaders CareSys Data Entry Manual](#)
- [Discharge Summary NT Hospitals Policy](#)
- [Emergency CareSys Data Entry User Manual](#)
- [Hospital Administrative Admission NT Policy](#)
- [Hospital Discharge NT Hospitals Policy](#)
- [Manual 8 Clinical Work Station (CWS) Creating and Dispatching Documents](#)
- [Subacute and Non-Acute Patient Data Collection Guidelines](#)
### References


### Definitions and Search Terms

<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Activity based funding</strong></td>
<td>A system for funding public hospital services provided to individual patients using national classifications, cost weights and nationally efficient prices developed by the Independent Hospital Pricing Authority. The Council of Australian Governments (COAG) agreed to the introduction and phased implementation of ABF as part of the 2011 National Health Reform Agreement.</td>
</tr>
<tr>
<td><strong>AN-DRG</strong></td>
<td>See Australian National Diagnosis Related Groups.</td>
</tr>
<tr>
<td><strong>AR-DRG</strong></td>
<td>See Australian Refined Diagnosis Related Group.</td>
</tr>
<tr>
<td><strong>Australian National Diagnosis Related Groups</strong></td>
<td>See Diagnosis Related Groups.</td>
</tr>
<tr>
<td><strong>Australian Refined Diagnosis Related Group</strong></td>
<td>See Diagnosis Related Groups.</td>
</tr>
<tr>
<td><strong>Casemix, case mix</strong></td>
<td>The mix of patients treated by a hospital or unit.</td>
</tr>
<tr>
<td><strong>CATS</strong></td>
<td>Clinical Application Training and Support Unit. Contact details are available on the Acute Care Information Systems Helpdesk and Contacts intranet page.</td>
</tr>
<tr>
<td><strong>Coding</strong></td>
<td>The translation of documented conditions, treatment and procedures the patient undergoes during an admission into ICD-10-AM codes that accurately reflect the complete clinical picture of the patient and resources utilised. Assignment of codes is governed by protocols known as the Australian Coding Standards. Medical staff are to accurately document all aspects of a patient’s episode of care, particularly procedures and complications, in a clear and precise way. This is vital to the coding process to ensure the episode is classified in a way which truly reflects the resource consumption for that episode of care.</td>
</tr>
<tr>
<td><strong>CWS</strong></td>
<td>Clinical Work Station. Previously called JadeCare.</td>
</tr>
<tr>
<td>Preferred Term</td>
<td>Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Diagnosis Related Groups</td>
<td>Australian Refined Diagnosis Related Groups (AR-DRGs) is a patient classification system that provides a clinically meaningful way of relating the number and types of patients treated in a hospital to the resources required by the hospital. The Australian National Diagnosis Related Groups (AN-DRG) was the first national DRG classification (1992–1997) developed to classify acute admitted patient episodes in public and private hospitals. It was subjected to a major overhaul after it was decided that Australia should adopt the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), and also a new procedure classification. The end result was the release of the Australian Refined DRG Classification in December 1998. Since 1998 the Australian Refined Diagnosis Related Groups (AR-DRGs) Classification has been revised every two years. (DHA, 2009, p. 11)</td>
</tr>
</tbody>
</table>
| Discharge Summary Documents Profile/Template | Each Document type has a selection of 'Profiles' or templates available from the drop-down box menu. Discharge Summaries Document Profile type:  
• Determines the template layout, information required and instructions  
• Governs what information auto-fills  
• Are included in reports on compliance with hospital discharge policy  
• Are automatically posted to the MeHR/PCEHR site for registered clients |
<p>| Dispatch | Dispatch refers to the sending of a discharge document and includes the sending to the patient's practice/Clinic/GP and the sending to the MEHR. |
| DRG | See Diagnosis Related Groups. |
| Electronic Health Record | These terms all refer to the patient's personally controlled Electronic Health Record (EHR). My eHealth Record (MeHR) was formerly known as the Shared Electronic Health Record (SEHR) and was used in all public hospitals, Aboriginal Community Controlled Health Services, remote health centres in the NT. MeHR and is being transitioned to the National eHealth Record System (PCEHR) but the icon in CWS still lists the original SEHR. |
| MEHR | See Electronic Health Record. |
| Owners | Staff, other than the Primary Owner, who have been given access to read and edit the discharge document before it is dispatched (sent). Only Owners can edit/contribute to the document. Owners can include an individual person or defined user group. Owners may also be referred to as Co-Owners. |
| PCEHR | See Electronic Health Record. |
| Primary Owner | The person who creates the discharge document is called the &quot;Primary Owner&quot; of the document in Clinical Work Station (CWS). The Author tab displays Primary Owner, and Owners. |
| SEHR | See Electronic Health Record. |
| User Group | A defined group of persons with approved access to read/edit and dispatch a specific discharge template. Some templates have multiple User Groups attached which enable the editing of multidisciplinary documents. Clinical Applications Training and Support (CATS) is included for assistance with problems. |</p>
<table>
<thead>
<tr>
<th>Preferred Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Validation</td>
<td>Validation is the process whereby the information is checked as being correct and complete, and should occur before the document is dispatched (sent).</td>
</tr>
</tbody>
</table>
Appendix 1: Completing the Perfect Discharge Summary

[Adapted from Royal Children's Hospital Melbourne document "Completing the perfect discharge summary" available at http://www.rch.org.au/rchhis/coding_casemix/Completing_the_perfect_discharge_summary/]

Add Principal Diagnosis

This is the diagnosis established to be chiefly responsible for the patient's episode of care in hospital.

More than one condition may be recorded as principal diagnosis if equally responsible for the episode of care. Because there can only be one principal diagnosis, the condition first listed on the discharge summary will be coded as the Principal Diagnosis, therefore please list in order of significance.

A procedure cannot be recorded as a principal diagnosis, e.g., tonsillectomy, appendicectomy, otoplasty and reduction of fracture are not acceptable diagnoses.

Symptoms should never be recorded as a principal diagnosis when a related definitive diagnosis has been established.

Add Any Additional Diagnoses

An additional diagnosis is one that affects patient management in terms of requiring any of the following: therapeutic treatment, diagnostic procedures, clinical evaluation or increased nursing care and/or monitoring.

It is important to document how the condition was actively treated or assessed during the admission.

Examples of conditions that meet these criteria are: diabetes requiring a monitoring/change of medication, and incontinence requiring an increase of nursing care/monitoring.

Complications

A complication can be described as a condition not present at the time of admission that arises during the admission affecting the patient's management and/or length of stay.

The cause and effect between a condition and a procedure must be documented to enable the condition to be coded as a procedural complication.

Examples of complications include MRSA septicaemia, E. coli UTI, urinary retention, acute blood loss anaemia, pneumonia, haemorrhage or wound infection due to a procedure.

Any Procedure Carried Out During the Episode of Care

List all diagnostic and therapeutic procedures undertaken from the time of admission to the time of discharge.

List non-operative procedures, e.g., CT scans, nuclear medicine, lumbar puncture.

Procedures that could not be completed should be described to the extent carried out with a notation of the unsuccessful or abandoned procedure.

Any Significant Findings on either Pathology or Imaging Reports

List all significant findings.

Identify the organism responsible for infection, if known, as this can impact upon DRG assignment, e.g., E. coli UTI.

If investigations were undertaken and the results indicated a probable diagnosis, yet no specific treatment was initiated during the episode of care, the suspected condition can be coded.

Infectious status where applicable (as per action 3.13.2 of the National Safety and Quality Health Service Standards).
Medications
List all current medications.
Document (progressively) all medication changes and rationale for the medication change.
Medication changes may reflect the management of an additional diagnosis.
Pharmacy can print a medication list for the patient.

Discharge care plan
The discharge care plan provides information to both the patient and to after hospital care providers.
The patient’s understanding of and commitment to the discharge care plans can have a significant bearing on their outcomes. It therefore should be easy for the patient to read, use plain language and be appropriate for patient/carer/family’s health literacy.
Include patient self-care activities such as diet, activity level or limitations, weight monitoring, driving, etc.
Include symptom recognition and management where relevant, include and emergency plan if required.
Detail the plan for follow-up appointments – where possible appointments should be made prior to discharge.
If not arranged detail who is responsible for arranging.
Detail the plan for follow up of tests/studies for which confirmed results are not available at the time of discharge.
List any community resources the patient will utilise, such as home health care, Meals on Wheels, physio, OT, etc.
List any certificates provided, e.g., Centrelink, work-related, etc.
Consider phoning relevant after-hospital providers – GP, nursing and/or allied health – if the patient’s care has been complex or requires significant follow-up.

DOs and DON'Ts
Do
• Be specific, include qualifying descriptors for diseases
• Clearly sequence multiple principal diagnoses according to importance
• Clearly identify causal relationships with terms such as ‘caused by,’ ‘due to’ or ‘as a consequence of’
• Indicate whether the patient was treated for the suspected condition if terms such as ‘likely,’ ‘probable,’ ‘?’ and ‘query’ are used
• Ensure consistency between the admission notes, progress notes and the discharge summary
• Sequence multiple injuries with the most severe first
• Record conditions as ‘caused by a procedure’ or as ‘following a procedure’ if they were directly due to the procedure
• Ensure diagnoses written on the discharge summary are supported by documentation within the progress notes refer to a site as ‘infected’ if an organism is cultured and record the organism (linking it to the infected site)

Don’t
• Record the presenting symptoms if the underlying cause has been established
• Use uncommon abbreviations
• Record a procedure as the Principal Diagnosis
• Record a measurement or figure without documenting the interpreted diagnosis, e.g., Hb 64 without documentation of anaemia or K+ without documenting hyperkalaemia
• Record a condition seen on imaging without documenting its significance or treatment required, e.g., atelectasis
Appendix 2: Specialist- and Unit-Specific Variances
Nil.