INTERNAL ONLY

SESLHD PROCEDURE COVER SHEET

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KEY TERMS	Medical Discharge Summary (MDS), eDRS. Discharge Summary, Discharge Referral
SUMMARY	Provides guidance on the completion of discharge summaries including when they must be completed, who is responsible and the associated timeframes for completion and distribution of the medical discharge summary.

COMPLIANCE WITH THIS DOCUMENT IS MANDATORY

Feedback about this document can be sent to seslhdexecutiveservices@sesiahs.health.nsw.gov.au

Medical Discharge Summary PR 223

1. POLICY STATEMENT

This policy provides guidance on the completion of discharge summaries including when they must be completed, who is responsible and the associated timeframes for completion and distribution of the medical discharge summary.

2. BACKGROUND

The nature of Medical Discharge Summaries is evolving due to the implementation of electronic medical records systems, principally eMR. This policy guides staff on the correct processes to follow when a discharge summary is required.

A **Medical Discharge Summary (MDS)** is a collection of information about events during care in hospital. It is completed by a Medical Officer/Midwife and forwarded to all/any appropriate person(s) responsible for the continuing care of the patient. This includes all patient transfers to NSW Health facilities and external health agencies. An MDS is a legal document that can be used for a number of purposes including but not limited to ongoing patient care, referrals and legal matters. For example, subpoenaed or copies provided to the patient / Solicitor.

Definitions – sourced from AS 4700.6 Part 6
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.
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:
a) Request for management of a problem or provision of a service, e.g. a request for an investigation, intervention or treatment.
b) 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.

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

Additional Diagnosis: Conditions or complaints either coexisting with the principal diagnosis or arising during the admission or visit at the facility. This may be used for the primary diagnosis for a procedure that is carried out.

3. RESPONSIBILITIES

3.1 Medical / Midwifery staff will:

- Complete a MDS for **ALL** discharges and **ALL** deceased patients, with the following exceptions –
  - Day only admissions

    - Day only procedures, including endoscopies
    - Routine renal dialysis
    - Day only chemotherapy/radiotherapy
- Complete a MDS on the day of discharge.
- Ensure that a summary is not prematurely signed off (i.e. prior to the patient actually leaving the facility).
- Ensure the preparation of MDS by rank of medical student or above (excluding Obstetric MDS).
- Ensure sign off of MDS by Intern or above (excluding Obstetric MDS).
- Ensure preparation and sign off of all Obstetric discharge summaries by qualified midwife.
- Ensure the MDS contains the following **minimum** information (based on NSW Health GL2006_015):
    - minimum patient identification – MRN, Name, DOB
    - alerts, allergies and adverse reactions (including 'Nil' where relevant)
    - presenting problem
    - principal diagnosis
    - additional diagnoses (including 'Nil' where relevant)
    - procedure(s) / investigations
    - significant incidents e.g. falls, hospital-acquired infections.
    - medications on admission, those on discharge and the reasons for any changes.
    - continued care recommendations (follow-up appointments/services referred to)
    - name, designation, and signature of the author
    - date finalised.
- Do not include irrelevant or non-appropriate information such as large images from Medical Imaging, domestic violence alerts, previous drug use

3.2 Line Managers will:

- Ensure clinical staff have timely access to any electronic discharge summary systems.
- Ensure clinical staff receive adequate training in the completion of discharge summaries (both electronic and manual).

3.3 Network Managers/ Service Managers will:

- Audit compliance with completion of MDS on a regular basis.
- Ensure security of information with electronic dissemination to email accounts only where applicable and authorised.

3.4 Ward Clerks (or other ward staff) will:

- Obtain missing MDS from the relevant Medical Staff / Midwives prior to returning record to the Medical Record Department.
- Disseminate completed and signed MDS to the nominated AMO, LMO or other health care provider or organisation, either electronically or via fax / mail within 24 hours of the summary being completed.
- Provide a printed and signed copy of the MDS to the patient if the Health Service policy permits or if authorised by the Medical Officer.

3.5 Medical Record staff will:

- Follow up on outstanding MDS as required (e.g. clinical need, medico-legal purposes).
- Follow-up on all rejected MDSs and re-send.
- Provide information to Site / Sector / District Patient Safety and Quality Committee regarding compliance and other identified issues associated with the completion of discharge summaries (e.g. clinical content and quality).

4. DOCUMENTATION

Health Care Record
electronic Medical Record (eMR) – Electronic Discharge Referral System (eDRS)
Manual (hand written) discharge summary - SMR010.001
ObstetriX Discharge Summary

6. AUDIT

Medical Administration will audit the quality of discharge summaries on an as-required basis. Regular MDS completion statistics / audits to be maintained by Medical Records / Clinical Information Services.
Relevant issues to be reported to the SESLHD Health Records Steering Committee.

7. REFERENCES

PD2012_069 Health Care Record – Documentation and Management
GL2006_015 Medical Discharge Referral Reporting Standard MDRRS)
PD2007_092 Discharge Planning: Responsive Standards (Revised November 2007)
PD2005_314 Electronic Information Security Policy – NSW Health
PD2005_593 NSW Health Privacy Manual Patient Matters Manual
SESIAHS PD 057 Documentation in the Health Care Record
AS 4700 Implementation of Health Level Standard (HL7) Version 2.3.1 (Standards Australia)
AS 4700.6 – 2004 Part 6: Referral and Discharge Summary
International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Australian Modification (ICD-10-AM)

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