SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Discharge Summary Completion Standards
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AUTHOR	SESLHD Health Records & Medico-Legal Committee
POSITION RESPONSIBLE FOR THE DOCUMENT	Co-Chair, SESLHD Health Records & Medico-Legal Working Group Antony.Sara@health.nsw.gov.au Leonie.Patterson@health.nsw.gov.au
FUNCTIONAL GROUP(S)	Clinical Governance Records Management - Health
KEY TERMS	Discharge Summary, eDRS, Discharge Referral, Documentation, Ongoing care, Transfer, Discharge
SUMMARY	Provides guidance on the responsibilities, quality, timeliness, and distribution of a Medical Discharge Summary (MDS)

Contents

1. POLICY STATEMENT

This policy provides guidance on the responsibilities, quality, timeliness, and distribution of a patient's discharge documentation.

2 BACKGROUND

The accurate and timely completion of a discharge summary 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 discharge summary 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.

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.

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.

Admitting / attending medical officer: The senior medical clinician who has primary responsibility for the patient during the admission.

De-prescribing: The planned process of withdrawing medicines that are not required, no longer a benefit, inappropriate, or may cause harm for the patient.

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

Discharge clinician: The medical officer, nurse practitioner, midwife, or suitably authorised healthcare clinician deputed and responsible for completing the discharge documentation for the patient.

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

Discharge report: An additional document to the discharge summary/referral usually completed by Allied Health professionals to provide greater detail on discharge.

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

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.

Medication reconciliation: Formal process of verifying the intended medicines for patients, ensuring an accurate and complete list of medicines.

Multidisciplinary team (MDT): Involves a range of health professionals from different disciplines or organisations working together to deliver comprehensive patient care.

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.

Primary care provider: Discharge summary recipient including the patient's nominated General Practitioner (GP), Residential Aged Care Facility (RACF), Disability Accommodation Service, Aboriginal Medical Service (AMS), Justice Health and Forensic Mental Health Network (JH&FMHN), Nurse Practitioner, agency, or community-based clinician or other community-based service provider.

Principal diagnosis: The diagnosis established after investigation to be chiefly responsible for the patient admission at the hospital.

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).

Secure Organisation: Secure organisations are facility level locations built within eMR. These locations are secure in the fact that access will not be automatically granted to all eMR users (as occurs with all LHD hospitals). Locations will only be granted to the relevant users within the service unit. Information associated with these secure locations is not available to users without access to the organisation. For more information, refer to SESLHDPR/510 - Managing Secure Organization Access within Cerner.

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 discharge documentation as required (e.g. requested for clinical or release of information reasons)
- Complete eDRS audits and disseminate
- Complete auto-sent eMR Discharge Summary 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/Administrative staff will:

- Follow-up missing discharge summaries from the relevant staff
- Disseminate completed discharge documents by fax or post when electronic transmission is not supported
- Provide a printed copy of the discharge documentation to the patient if the service policy/procedure permits or if authorised by a Medical Officer.

4 DISCHARGE SUMMARY AND COMPLETION STANDARDS

NSW Health staff have a common law duty of care to the patients care within public hospitals and community services. Clinical staff and admitting/attending medical officers under whose care the patient has been admitted/registered, must safety transfer care to the next treating health practitioner. This includes the provision of effective discharge documentation accompanied by verbal communication.

4.1 When a discharge summary should be completed

4.1.1 Inpatients

For inpatients, a discharge summary is required for all episodes of care, 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 (see Section 4.7.1)
- Routine renal dialysis
- Day only chemotherapy/radiotherapy
- Well baby/obstetric patients (see Section 4.7.3).

4.1.2 Community Health

Community health staff must complete a discharge summary when a client is discharged from the service with the exception of:

- Services within a secure organisation
- Child and Family Health Nursing – All routine health checks for the child are documented in the My Personal Health Record “Blue Book” which is retained by the patient/carer
- Out of Home Care (Child, Youth, and Family Services) – A discharge file note and an Out of Home Care Health Pathway Program Discharge/Transfer form are to be completed and shared with relevant health care providers and Department of Communities and Justice/NGO
- Clients who are registered/admitted but have not been provided with a service/care
- Where the client has not consented to the transfer of care to be discussed with third parties
- Where the client has no general practitioner
- Where a community mental health client is registered for Triage only.

4.2 Who is responsible for completing a discharge summary

The admitting/attending medical officer may delegate the responsibility to complete the discharge summary, however, ultimate responsibility for ensuring appropriate and timely completion of the discharge summary lies with the discharge consultant.

While the discharge summary may have input from any clinical staff member it must be signed off by a medical officer of rank intern or above, except for:

- Obstetrics discharge documentation which may have sign-off delegated to a qualified midwife)
- Community Health discharge documentation which will have a sign-off delegated to a nursing or allied health staff member.

There may be instances where staff 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 discharge summary 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.

4.3 Discharge summary forms and systems

4.3.1 Cerner eMR Discharge Referral template

The discharge summary must be typed into the correct "Discharge Referral template" within the eMR to ensure the correct formatting and to facilitate the electronic distribution to the NSW Health Clinical Portal.

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

eMR systems often auto-populate general fields. Information that is auto populated in the discharge summary (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.

4.3.2 Specialised clinical information systems

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

For well-baby/obstetric patients, discharge documentation may be completed in eMaternity. eMaternity is integrated with PowerChart eMR but not distributed to the NSW Health Clinical Portal. See section 4.7.2

4.3.3 Paper medical discharge summary forms

Paper forms for completing a handwritten discharge summaries should only be used where there is no eMR equivalent or in exception circumstances, such as where the eMR is unavailable for an extended period of time. If handwritten discharge documentation is completed, the ward clerk/admin officer must manually send a copy to the patient's GP either by fax or mail and file in the patient record.

4.4 Discharge documentation completion timeframes

The Discharge Summary 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 discharge summary on the day of the patient's discharge prior to their departure/last attendance. This ensures that a copy of the documentation can be given to the patient/authorised representative (if appropriate) along with discussion of discharge/follow-up instructions.

4.5 Discharge summary documentation standards

The discharge summary should provide an accurate summary of the patient's entire inpatient or community health episode with sufficient detail to allow the patient and subsequent health professionals to continue care post-discharge. It should only include relevant/appropriate information specific to the episode of care. As a minimum, the discharge summary must contain information on the following:

* Patient details	* Hospital details	* Recipient(s)
* Author(s)	Presentation details	* Presenting problem/s and diagnoses
+ Procedures	Clinical summary	* Allergies/adverse reactions
+ Medications on discharge	Ceased medicines	* Alerts/infection risks
Recommendations	Follow-up services/appointments	Information provided to patient
+ Relevant investigation results		

** Indicates items that are typically auto-populated in eMR by the Discharge Referral form – these must still be checked for accuracy*
+ indicates information that eMR PowerChart can draw in from other sections of the electronic record

For vulnerable patient groups who are increased risk of rehospitalisation, the discharge document should also include information on: early warning signs of relapse of their current illness, identification of risks and strategies to reduce each risk identified, contingency plans and relapse prevention strategies, and emergency telephone contacts to access appropriate care.

4.5.1 Patient details

- Name
- Medical Record Number (MRN)
- Age
- Sex
- Gender
- Date of birth (age in years or months/days where applicable)
- Address
- Telephone Number.

4.5.2 Hospital details

- Hospital name and Local Health District
- Hospital address and contact details (including phone numbers)
- Speciality name and nominated contact details including phone numbers.

4.5.3 Recipient(s)

e.g. GP.

4.5.4 Discharging clinician

- Discharging clinicians' designation
- Discharging clinician's supervisor (AMO)
- Contact details of AMO or delegate
- Signature or electronic credentials.

4.5.5 Presentation details

- Admission date
- Discharge date
- LOS
- Clinical Unit (from which discharged)
- Clinical specialty type (specialty responsible for discharge)
- Discharge destination (if applicable).

4.5.6 Presenting problem/s and diagnoses

Presenting problem/s and diagnose must be documented immediately after presentation including:

- Reason for presentation
- Principal diagnosis
- Additional diagnoses
- Complications
- Past medical history.

4.5.7 Procedures

Invasive clinical interventions including operations and procedures must be documented in chronological order. Operation reports completed in SurgiNet/eMR can be pulled into the eMR Discharge Summary.

If no procedures were performed, document “nil performed”.

4.5.8 Procedures with medical devices

Where a medical device has been implanted/explanted during the inpatient episode the details must be included in the discharge summary. This includes product name, type, model, and batch number for all medical devices.

Refer to the NSW Health Information Bulletin IB2022_009 - Implantable Medical Device for more information.

4.5.9 Clinical summary

Provide a concise summary of the patient’s hospital/community attendance. The author should keep sentences short and highlight critical information, including time critical follow-up. Key health literacy principles such as bullet points are to be used to ensure the summary can be easily read.

Where the patient has had a stay in an intensive care unit (ICU) or high-dependency unit (HDU) a brief clinical summary outline of their ICU/HDU stay is to be provided following the same principles in the discharge summary.

If a patient has had a Care Type Change during their hospital stay, the discharge summary should contain information regarding the entire hospital stay.

4.5.10 Allergies/adverse reactions

Relevant information to be documented including:

- Medicine/substance name and brant (where relevant)
- Reaction type (e.g. allergy, intolerance, adverse effect)
- Clinical manifestation (e.g. rash, urticarial reaction)
- If a reaction occurred during admission – date/time and duration.

Where there is no known allergy or adverse reaction “nil known” must be documented.

4.5.11 Medicines on discharge

Medicines must be documented as follows:

- Grouped by status in the following order
  - New
  - Changed

- Unchanged
- Ordered alphabetically within each group
- If significant changes in medicines have occurred, clearly group "medicines on admission" and "medicines on discharge".

Any changes to the patient's medicine regimen are to be identified and communicated in the discharge summary, together with a reason for each change:

- Medicine name: generic first, then brand specific to the patient if known; strength, and route
- Directions: dose, frequency (including "as required"), and any special instructions (e.g. in relation to food; when the next dose is due to intermittent medicines, or when the last dose as administered)
- Duration/end date
- Status: new, changed, or unchanged
- Change reason/clinical indication.

4.5.12 Ceased and temporarily suspended medicines

It is recommended that ceased or temporarily suspended medicines are documented in a separate section in the discharge summary with details including:

- Medicine name: generic first, then brand specific to the patient if known; strength, and route
- Reason: Explain why a medicine has been ceased of suspended
- Duration: Identify temporary versus permanent cessation.

Some medicines may require additional instructions and should follow the 'ceased medicines" section within the discharge summary. Such as:

- Ongoing monitoring requirements (e.g. therapeutic drug monitoring, metabolic monitoring in patients on long term anti-psychotics, International Normalised Ratio (INR) testing and targets for warfarin
- De-prescribing plans or dose adjustment requirements
- Use or recommendation of dose administration aids
- Consumer Medicines Information (CMI) or patient education that has been provided or if they are required.

4.5.13 Alerts

Clinically relevant alerts are to be identified and included in the discharge documentation. Non-clinical alerts must be excluded unless relevant for the receiving general practitioner/facility. Bullet points are to be used to ensure the summary can be easily read.

4.5.14 Recommendations

Instructions for ongoing patient management must be documented, including required actions and who is responsible for them with:

- Specific recommendations for treatment
- Specific recommendations for follow-up care
- Relevant timeframes for action
- Pending investigations, results, and actions required.

4.5.15 Follow-up appointments

It is important to document appointments that have been scheduled, are in the process of, or need to be, organised. It is recommended that most follow-up appointments are initiated or confirmed prior to discharge. If this is not possible, ensure actions and persons responsible are noted clearly in the "Recommendation" section of the discharge summary.

The following appointment information must be provided:

- Description
- Date/Time
- Booking status
- Name of primary care provider being visited
- Location
- Contact details
- Special instructions (i.e. Nil by mouth, payments)
- Arranged/to be arranged by hospital/patient.

Note: If the patient is returning to Justice Health and Forensic Mental Health Network or Corrective *Services NSW, do not advise the patient of any follow-up appointments. This poses a security risk and if disclosed the appointment will need to be rescheduled.*

4.5.16 Information provided to patient

The discharge summary must outline the complete list of recommended actions that were provided to the patient and/or carer.

A Patient Friendly Medication List (PFML) should be provided to all patients/clients where possible. This should be presented in a landscape view table and include columns for morning, midday, evening, and night.

The information provided to the patient must be consistent with the discharge summary, and any changes made must be reflected in both documents.

4.5.17 Selected investigations results

Only relevant and important investigations performed while the patient was being treated should be included in the discharge summary. If there are several results within the same category, it is recommended that they are grouped together, such as: pathology, imaging, and others.

Display by listing the test name, date, and result. Highlight critical investigation results where relevant.

4.6 Multi-disciplinary discharge documentation

4.6.1 Documentation in the discharge summary/supplement

It is the responsibility of the nurse or allied health clinician involved in the patient's care to determine if documentation in the discharge summary is required and communicate this to the discharging clinician. Areas where this is common may need to develop a specialised workflow (i.e. rehabilitation, aged care).

Documentation is usually required where the nurse or allied health clinician has assessed the patient as:

- Requiring follow-up in the community/outpatient setting or receiving facility
- Having changes to their health and/or functional status.

If contribution to the discharge summary is required, this should be documented either in the 'clinical summary section' or in the discharge summary supplement available in eMR (this must then be pulled into the eDRS). Only one entry per discipline should be included in the discharge summary and/or supplement.

When included, the following must be documented:

- The profession (e.g. nurse, social work, psychology)
- Name of the primary treating clinician and contact details
- Name of the person completing the discharge documentation (if different to the primary treating clinician)
- Reason for intervention/reason for referral
- Clinical findings relevant to reason for intervention, including relevant patient goals
- Brief summary of the intervention(s) provided
- Reference to detailed nursing or allied health "Discharge/Transfer Report" if one is being provided.

The recommendation section should include:

- Follow-up treatment or care instructions including any equipment which has been provided or needs to be sourced by the nominated general practitioner, patient, or usual primary care provider.
- Any follow-up appointments which need to be made by the nominated general practitioner, patient, or usual primary care provider
- Whether the patient belongs to a vulnerable/high risk cohort.

Any follow-up information provided, including referrals which have been made to other agencies, must be documented in the follow-up appointments section.

When a clinician makes a diagnosis relevant to their discipline as part of their assessment (e.g. Post Traumatic Amnesia (PTA), dysphagia, malnutrition, etc), this must be documented in the diagnosis section of the discharge summary.

4.6.2 Supplemental "Discharge/Transfer of Care Report"

A "Discharge/Transfer of Care" template is available in eMR for allied health clinicians.

An allied health discharge report provides a clinical handover to the primary care provider or other relevant services who will be providing follow-up care or advice. This is to be separate to the discharge summary and it is at the discretion of the allied health clinician, based on the patient's complexity and discharge requirements.

Allied health clinicians may choose to provide a detailed "Discharge/Transfer of Care Report" in addition to the discharge summary when:

- More detail is required on the patient's treatment or follow-up care to safely transfer care between providers
- Where there has been significant input from allied health professionals, a "Discharge/Transfer of Care Report" may be provided in lieu of each profession documenting in the discharge summary.

If the patient is discharged and allied health clinicians have not documented in the discharge summary, it is the responsibility of the treating clinician to provide a discharge report to the patient's nominated general practitioner and other relevant primary care providers on the next working day.

4.7 Specialty Specific Considerations

4.7.1 Day only and extended day only hospital admissions for interventional procedures

Ensure that patients are provided health literate information about surgical procedures that have been completed, including adequate information about post-operative precautions and continued care recommendations. Wherever possible, this information is to be provided in writing and supported by appropriate verbal communication.

A discharge document must be provided to the patient's primary care provider or other relevant services who will be providing follow-up care or advice. The discharge documentation provided is not intended to contain all information normally held in a general inpatient admission discharge summary. It is intended that the document serves to provide a minimum set of information to inform the patient's primary care team.

At a minimum, the document must include:

* Patient identification	
* Presenting problem/Reason for procedure	
* Planned procedure	
Summary of procedure	Date of procedure
	AMO and/or proceduralist
	Primary procedure performed
	Outcomes/complications
Continued care recommendations	Post-operative precautions
	Post- operative instructions
	Follow-up arrangements.

** indicates items that are typically auto-populated in eMR*

The responsibility to prepare a discharge document for day only and extended day only patients may be delegated to nursing staff in the post-operative care unit, under the supervision of a medical officer. If delegated, nursing staff must utilise the paper "Day Only Admission – Nursing" form.

4.7.2 Well mothers and babies

For well mothers and babies, discharge can be initiated and coordinated by delegated midwifery staff as per local Postnatal Clinical Pathways and under the framework of the National Midwifery Guidelines for Consultation and Referral.

Discharge documentation may be completed in eMaternity and should be provided to the mother.

4.7.3 Mental health consumers discharged from non-mental health facility

Where a patient being discharged from a general hospital bed has received treatment/consultation with mental health services during their stay, the discharged team are to collaborate with the responsible mental health clinician on discharge planning. This will ensure discharge documentation provides clear advice on post-discharge mental health care, including referral to community-based services where appropriate.

Refer to NSW Health Policy Directive PD2019_045 - Discharge Planning and Transfer of Care for Consumers of NSW Mental Health Services for further information.

4.8 Discharge Prescriptions

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.

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

4.9 Distribution of Discharge Summaries

4.9.1 Patient/Carer

Once finalised, all discharge summary documentation 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 discharge documentation is not ready upon discharge, a copy of it should be posted to the patient/client/authorised representative where appropriate.

For patients returning to Justice Health and Forensic Mental Health Network or Corrective Services NSW :

- Place the prepared discharge documentation in a sealed envelope marked “Confidential” and for the attention of the Justice Health and Forensic Mental Health Network
- Give the sealed envelope to the escorting corrections officers who will deliver it to a Justice Health and Forensic Mental Health Network clinician at the receiving facility.

Note: Do not advise the patient of any follow-up appointments – this poses a security risk and if disclosed the appointment will need to be rescheduled.

4.9.2 eMR, NSW Health Clinical Portal, and My Health Record

Where an inpatient or community health discharge summary is completed in PowerChart Cerner, the eDRS will automatically be transmitted to the NSW Health Clinical Portal only when it has been signed/verified in eMR and 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 or another specialized electronic health record, it should be automatically transmitted to PowerChart eMR where it can be viewed in PDF format.

4.9.3 General Practitioners

For inpatients, discharge summary will be sent to the patient/client’s nominated GP through the NSW Health Clinical Portal. For community health clients, the discharge summary will be sent to the encounter GP, which may be different from the GP documented in iPM.
Exceptions for this are when:

- The GP is not set-up to receive documents electronically.
  The discharge summary will be distributed to the NSW Health Clinical Portal but will need to be posted or faxed to the GP by the ward clerk/administrative staff.

- The patient/client has advised that they do not want their documentation shared with their GP and the correct iPM/eMR flag has been updated to reflect this.
  The discharge summary will be distributed to the NSW Health Clinical Portal but not to the patient's GP. The discharge summary should not be posted or faxed to the GP.

- A discharge summary is completed for a patient/client's attendance within a secure organisation.
  The discharge summary will not be distributed to the NSW Health Clinical Portal and will need to be posted or faxed to the patient's GP if appropriate.

- Documentation has been completed within a separate specialized electronic health record other than Cerner eMR.
  The discharge summary will not be distributed to the NSW Health Clinical Portal and will need to be posted or faxed to the patient's GP if appropriate.

5. DOCUMENTATION

- Discharge Summary (Paper Form) – SMR010.001 (for use during downtime only)
- PowerChart eMR electronic Discharge Referrals (eDRSs) (includes Emergency, Inpatient, and ED)
- eMaternity Discharge Summary
- Day Only Admission (SSEH) – SES060.007
- Day Only Admission – Nursing – SES060.111
- eMR Guides
- eMeds QRGs
- iPM 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 Health

- 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
- NSW Ministry of Health Guideline GL2022_005 - Patient Discharge Summation

SESLHD

- SESLHDPR/605 - eMR – Copy and Pasting within Electronic Documentation
- SESLHDPR/510 - Managing Secure Organisation Access within Cerner eMR

8. VERSION AND APPROVAL HISTORY

Date	Version No.	Version and approval notes
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	Review by SESLHD Health Records & Medico-Legal Committee
June 2021	8	SESLHD website – draft policies for comment. Feedback received and updated June 2021.
March 2023	9	Major review by SESLHD Health Records & Medico-Legal Committee in response to published *MoH Guideline GL2022_002 - Patient Discharge Documentation* and implementation of eMR POV2. Listed on Draft for Comments page.
28 August 2023	9	Approved by SESLHD Clinical and Quality Council.