Northern Territory Government
DEPARTMENT OF HEALTH
Controlled Document
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Discharge Summary NT Hospitals Policy

Target Audience	All Employees
Jurisdiction **Jurisdiction Exclusions**	Royal Darwin Hospital; Alice Springs Hospital; Katherine Hospital; Gove District Hospital; Tennant Creek Hospital N/A
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Approval Authority	Chairs CAHS Executive; TEHS Executive Committee
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Policy Statement

A hospital discharge summary must be provided where there is an identified need to ensure safe, ethical and efficient ongoing management or at completion of the episode of care.

A discharge summary must be provided at the time of the hospital discharge, or disseminated within 48 hours of discharge.

Policy Purpose

Hospital clinicians have a professional responsibility to provide an effective discharge summary for all patient separations from the NT hospitals.

Policy Details

Consent for Transfer of Health Information

Express consent to the use or transfer of health information from the hospital to the patient's referring practitioner is not required. Use or disclosure of information from continuing care is considered to be a directly related secondary purpose within the reasonable expectations of the patient, or to be with the implied consent of the patient.

Hospitals must obtain information about the patient's current clinic/general practice and/or intended general practitioner GP and other primary health care provider's contact details from the patient at each episode of care. This should be done in a manner that is least disruptive to the patient and according to hospital procedures.

Hospitals should explain to the patient, in general terms, what kind of information will be sent on discharge to the practitioners listed by the patient. Hospitals should respond to any concerns the patient expresses about this occurring.

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

The method for transfer of the discharge summary must be agreed by the GP/community clinic/other health care provider according to the recipient's capacity and according to the urgency of the patient's needs. This may include fax, post or encrypted electronic mail.

Patient information transfer from Hospital to GP/community clinic/other health care provider must comply with HB 304:2007 *Guide to Australian electronic communication in health care*.

Record Management

Discharge summaries must be documented in Clinical Workstation wherever possible. The discharge summary must be retained in the patient's electronic medical record and a copy provided to the patient, carer, general practitioner and other relevant health professionals.

Note: A discharge summary does not negate the need for additional communication, e.g., telephone.

Minimum data set for discharge summaries – non-inpatient and inpatient separations

Refer to Appendix: "Minimum data set for discharge summaries – non-inpatient and inpatient separations".

Exclusions

- Same day renal dialysis patients, Same day chemotherapy, Same day endoscopic procedures
- Same day eye procedures [CAHS-only]
- 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.

Responsibilities

Unit head

Monitor the content of discharge summaries.

Ensure policy compliance.

Report compliance with the policy and strategies to resolve identified barriers to compliance to Heads of Department meetings monthly.

Implementation, Review and Evaluation Responsibilities

	Method	Responsibility
Implementation	Document will be available for all staff via PGC	Health Policy Guidelines System Administrator
Review	Document will be reviewed in four years, or earlier as required	Executive Director of Medical Services TEHS
Evaluation	Incidents will be reported via RiskMan and managed by the appropriate Unit Manager	Relevant Unit Managers

	Method	Responsibility
	Report discharge summary performance quarterly, as a quality indicator, to the Top End Health Service Safety and Quality Committee and Central Australia Health Service Safety and Quality Committee	Hospital Quality Units

Key Associated Documents

Key Legislation, By-Laws, Standards, Delegations, Aligned & Supporting Documents	Hospital Discharge NT Hospitals Policy Australian Commission on Safety and Quality in Health Care (ACSQHC). (2011). "Standard 6: Clinical Handover." In *National Safety and Quality Health Service Standards Guide for Use in Hospitals*. Sydney: ACSQHC. Retrieved from http://www.safetyandquality.gov.au/wp-content/uploads/2011/09/NSQHS-Standards-Sept-2012.pdf Australian Privacy Principles. In *Privacy Act 1988* (Cth.), Schedule 1. Retrieved from http://www.austlii.edu.au/au/legis/cth/consol_act/pa1988108/ (Northern Territory) Information Privacy Principles. (2002). In *Information Act 2002* (NT), Schedule 2. Retrieved from http://www.austlii.edu.au/au/legis/nt/consol_act/ia144/sch2.html Standards Australia. (2007). *Guide to Australian electronic communication in health care* (HB 304:2007). Homebush, NSW: Standards Australia. Discharge Summary RDH Procedure [under development]
References	N/A

Definitions and Search Terms

Preferred Term	Description
Discharge	Action taken at the completion of an episode of care, whether short or long term.

Alternative Search Terms

N/A.

Appendix: Minimum Data Set for Discharge Summaries – Non-Inpatient and Inpatient Separations

Hospital details

Patients details including name, date of birth, sex, address, hospital record number

General Practitioner (GP) practice/clinic contact details, including GP details if known

Community care centre (where applicable)

Admission date (inpatient separations) or episode of care date(s) (non-inpatient separations)

Discharge/transfer date

Date of death (when applicable)

Principal diagnosis

Other diagnoses/co-morbidities

Procedures performed

Patient informed of diagnosis/prognosis (when applicable)

Adverse events during hospitalisation

Medications on discharge (rationale for change)

Results key investigations performed (including pending results)

Treatment plan/follow up on discharge

Referral to specialist arranged

Referral to allied health or community care

Patient referred back to GP for follow up

Suggested action by GP

Name of medical officer to contact

Signature and name of the author printed legibly.