Clinical Communication at Discharge Procedure

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TARGET AUDIENCE and SETTING

This procedure is applicable to all clinical employees involved in facilitating a patient discharge.

PURPOSE

This procedure guides multidisciplinary ward-based care teams to plan a safe, efficient and effective discharge for all inpatients.

It applies to all inpatients being discharged from Monash Health into the community, residential care or to another health service's inpatient unit.

It also applies for transfers from Monash Health acute campuses to sub-acute.

It aims to facilitate timely and effective clinical handover to Community based clinicians including the patient's General Practitioner (GP).

EQUIPMENT

EMR Medical Discharge Summary (including deceased discharge summary if applicable) for the clinical area to be completed by the discharging doctor.

EMR Nursing Discharge Checklist (Confirmed Discharge Powerform) for the clinical area to be completed by the bedside nurse. This assists with identifying and completing outstanding tasks prior to discharge.

EMR Patient Discharge Information for the clinical area to be completed by the bedside nurse. This document collates information from the medical record, including diagnosis, procedures and advice to the patient, in plain language. It is to be printed from the EMR and forms the basis for a discussion with the patient to ensure they are leaving hospital will all the information they need.

This document is not a discharge summary and is not sent to the patient's GP.

EMR Discharge Medication list to be completed by Ward Pharmacist.

SMR eReferral to be completed by Medical Staff of discharge unit where Monash Health Specialist Consulting (non-Victorian Heart Hospital) appointments are required.

VHH (Cardiology/MonashHeart) outpatient referrals to be completed via EMR by Medical Staff of discharge unit where VHH Specialist Consulting appointments are required.

Please note in case of EMR Downtime, any documents that have been completed in EMR are able to be printed off from the Downtime Viewer. Any incomplete discharge summaries will need to be completed by medical staff once EMR is back online and then printed for the patient to receive.

STANDARD REQUIREMENTS

When undertaking any clinical interaction with a patient, staff are expected to:

- Perform routine hand hygiene. Refer to the Hand Hygiene Procedure.
- Introduce themselves to the Patient and Carer/ Family if in attendance
- Check patient identification. Refer to the Patient Identification Procedure.
- Obtain consent as per the Consent to Medical Treatment Procedure.
- Keep the patient/carer informed and involve them in decision making.
- Document interaction in the electronic medical record or health record using black pen; including date, time, signature and designation.
- Documentation of all procedures, ordering of medications and pathology, insertion of lines and devices will be done in the appropriate EMR fields where available.

PROCEDURE

Discharge planning is the responsibility of the multidisciplinary team caring for the patients and occurs throughout the episode of care.

On admission:

Plan for discharge from the day of admission in conjunction with the patient and their support person:

- Confirm Patient Identification (iPM), including GP details (name, practice address)
- Determine Estimated Date of Discharge (EDD) within 24 hours of admission
- Determine likely discharge destination and transport arrangements
- Determine the patient's and family's expectations of their care
- Assess and document any barriers to discharge that may prevent discharge once the medical reason for admission has been resolved
- Ensure plans to address social issues are implemented early
- Ensure referrals to specialist consulting teams and allied health are made early
- Ensure medications are reviewed and medication management plans developed

Individual team members' responsibilities are detailed under "Staff responsibilities at Discharge".

During inpatient stay:

On the ward round and PM huddle

- Review potential need for Advance Care Planning and document in the EMR 'Early Discharge Planning' Powerform
- Regularly review the EDD
- Review progress of management plan daily
- Ensure regular communication with consulting teams
- Keep patient and support person informed of diagnosis, treatment, medications and discharge plans
- Where available, the patient bedside communication board is to be updated to include information on patient's discharge
- Confirm patient and support person's understanding of discharge planning information using Teach - back
- Complete planning and referrals for equipment, specialist ongoing treatment/ therapy and services required after discharge
- Commence preparation for discharge prescriptions and discharge summary early
- Update Ward Clerk of any changes to patient demographic details or GP details as required (Ward Clerk to update iPM accordingly)

During last 24 hours of patient stay:

- Confirm intention to discharge by placing discharging status in iPASS
- Confirm discharge destination
- Once discharge confirmed, place 'Discharge Patient' order on the EMR, which will subsequently place a black door icon on the EMR Clinical Leader Organiser to inform the team that the patient is confirmed for discharge
- Inform patient of the time and plan of discharge
- Complete:
  - Discharge summary (medical and allied health if required)
  - Patient Discharge Information (nursing)
  - Discharge prescriptions
- Provide patient/support person with discharge documentation and discharge education using Teach- back to ensure patient/support person understands the information provided.
- Provide written information as relevant
- Provide equipment if required
- Confirm follow up services and specialist appointments and inform patient and support person about them
- Confirm patient's transport arrangements and ensure there is a plan to safely escort the patient to their form of transport
- Confirm details of GP (or GPs) nominated by patient for ongoing care (clinical handover)

Individual Staff responsibilities at discharge

Medical staff responsibilities:

1.1 Confirm Estimated Date of Discharge (EDD) with the consultant and/or senior medical staff on day of admission.

1.2 Review EDD every day. Communicate EDD to Nurse in charge and/or bedside nurse. Ensure patient and support person are involved in decisions about their discharge and understand their diagnosis, treatment, medication and discharge plans.

1.3 All patients are to have a consultant input or review 24-48 hours prior to discharge or transfer.

1.4 Prepare a discharge prescription for the patient using the 'Discharge Medication Reconciliation' function in the EMR. Refer to Discharge Medication Reconciliation (including Discharge Prescriptions) EMR Quick Reference Guide.

1.5 Ensure the appropriate EMR Medical Discharge Summary is completed prior to discharge and includes the following information:

- Patient name, UR number, date of birth and home address;
- Hospital name, campus, unit, treating clinician name and contact information;
- Admission and discharge/death date and time, discharge destination;
- Brief note on patient's progress, complications and morbidity during admission;
- Surgical or other procedures undertaken;
- Co-morbidities/Pre-existing conditions including relevant past history, in particular conditions, which affected the management or length of stay of the patient;
- Relevant investigations and results – unreported results (e.g. pathology, radiology) must be indicated with appropriate phone numbers for follow up;
- Medications including discharge medications, changes to regime and rationale, and any suspected adverse drug reaction;
- Pharmacy discharge planning information component completed
- Relevant clinical risks including risk of falls, pressure injuries, infection and adverse medication reactions;
- Any Patient Clinical Alerts, ensuring that any alerts that may be of a sensitive nature are edited appropriately (e.g. remove Family Violence alerts as appropriate).
- Confirm that the GP listed on EMR (iPM) is the correct GP, nominated by the patient, responsible for ongoing patient care.
- Where patients are discharged to a RACF (Residential Aged Care Facility), a copy of the discharge summary will be sent to the RACF nominated GP (if known) as well as the patient's usual GP.

1.6 If Medical Discharge Summary is completed by an intern, ensure that it is reviewed and electronically countersigned by the Registrar.

1.7 Upon signing in the EMR, the Medical Discharge Summary will automatically be sent to the patient's GP (if the patient has a GP nominated in iPM) via HealthLink or InterFax. A copy of the Discharge Summary can be printed for the patient (if requested) or for Specialists/Specialist clinics/private rooms/community services as required. Relevant Specialists or additional GPs would also be added to the Discharge Additional Recipients on the Discharge Summary.
See EMR Discharge Workflow Quick Reference Guide for EMR workflow.

1.8 It is vital that an E Referral is completed on SMR for all non-VHH Specialist Consulting follow up appointments and via EMR for all VHH Specialist Consulting referrals . Other non - E Referral follow up appointment requests to be made as determined (i.e. Pathology requests).

Bedside Nurse / Midwife / Associate Nurse Manager Responsibilities

2.1 Enter EDD into the EMR 'Early Discharge Planning' Powerform within 24 hours of admission and subsequently with any change. This will automatically feed into Patient Flow Manager.

2.2 Document relevant post discharge care recommendations within the 'Advice to Patient' section of the EMR nursing workflow (Discharge page). This will feed into the EMR 'Patient Discharge Information' form.

2.3 Complete the Nursing Discharge Checklist in the EMR 'Confirmed Discharge Details' Powerform to coordinate the discharge plan. Identify and complete outstanding tasks.

2.4 Ensure appropriate equipment, transport and services as per patient's needs have been arranged. Provide patient with a comprehensive explanation of care and follow-up at discharge.

2.5 Provide patient/support person with a copy of the completed 'Patient Discharge Information' form. Use Teach-back to ensure patient understands the post discharge information provided.

2.6 For patients being discharged to a Residential Care facility, ensure clinician to clinician handover has occurred and confirm that the RACF is ready and able to admit the new resident or accept the return of their current resident. A hard copy of the discharge summary needs to be provided in the discharge pack that accompanies the patient to the RACF, as residential services are not on EMR. Where possible a copy of the discharge summary must be sent to the RACF nominated GP as well as the patient's usual GP.

Responsibilities of Nurse / Midwife Manager

3.1 Ensure all relevant documents are completed and staff have communicated the post discharge care recommendations with the patient and support person, that the patient and support person understand the instructions and a copy of the Patient Discharge Information has been provided to the patient/support person. Rounding on a sample of patients ready for discharge may assist in this.

3.2 Escalate to Consultant/Department Head if the EMR Medical Discharge Summary has not been completed despite attempts by the Ward Clerk/Bedside Nurse/Midwife.

3.3 Ensure appropriate processes exist for **out of hours** discharges.

Responsibilities of Unit Heads

4.1 Ensure Junior Medical Staff routinely communicate the care/discharge plan with the patient and support person and the EMR Medical Discharge Summary is accurately completed prior to discharge.

4.2 Monitor quality and timeliness of EMR Medical Discharge Summaries.

Allied Health Responsibilities

5.1 Complete MPTL (Multi Patient Task List) documentation to indicate care is complete on CLO (Clinical Leader Organiser).

5.2 Communicate specific discharge information to patient and support person and document within the 'Advice to Patient' section within their EMR workflow page, which will flow into the 'Patient Discharge Information' form.

5.3 Ensure specific discharge information for health care providers taking over care is communicated to medical staff to document in the EMR Medical Discharge Summary.

5.4 Arrange appropriate equipment and follow up services/ ongoing treatment as required for patient and inform patient about these. For comprehensive services and discharge pathways please refer to the Discharge Planning Tool and Flowchart.
http://intranet.southernhealth.org.au/alliedhealth/ourservices.html

Pharmacist Responsibilities

6.1 Profile prescription once received to ensure accuracy. Refer to the Medication Reconciliation Procedure.

6.2 Complete the 'Discharge Medication Management Plan' freetext component of the Pharmacy View Pharmacist Discharge page, and the 'Pharmacy Discharge Medication Management Plan' PowerForm.

6.3 Select the 'Prescription received' in the 'Prescription Status' field and 'Prescription profiled and Medication Management Plan for discharge field complete' radio buttons in the 'Discharge Checklist' section and sign the form.

6.4 Provide any discharge medications and medication list to the patient/support person.

6.5 Provide medication counselling to the patient/support person using Teach-back to ensure understanding. Communicate and explain any medication changes and medication management follow up required. Refer to the Medication Counselling Procedure.

6.6 Provide a full medication list and communicate any changes to patient's local pharmacy provider and GP if required.

6.7 Select the 'Patient Ready for Discharge (Pharmacist discharge complete)' radio button in the 'Prescription Status' field of the 'Pharmacy Discharge Medication Management Plan' PowerForm, to indicate the patient is ready for discharge from a pharmacy perspective. Complete the 'Medication Counselling Provided', 'Medication List Provided' and 'CMI Provided' status in the 'Discharge Checklist' section of the PowerForm. Refer to Documenting A Pharmacy Discharge Medication Management Form QRG.

Responsibilities of Ward Clerks

7.1 Confirm Patient Identification (iPM), including GP details (name, practice address) on day of discharge (prior to completion of discharge summary).

7.2 If available, ensure a copy of final EMR Medical Discharge Summary is provided to the patient.

7.3 Where the patient cannot nominate a General Practitioner (GP) or GP Clinic, a copy of the EMR Medical Discharge Summary must be handed to the patient to give to the relevant treating clinician at their next visit.

7.4 Incomplete (i.e. saved but not signed) EMR Medical Discharge Summaries must be referred to the Nurse Unit Manager to follow up with medical staff.

7.5 Review completion of outpatient specialist referrals as required/relevant in the BI Ward clerk report.

7.6 Forward EMR Medical Discharge Summary onto any specialist/external care provider included in the discharge summary (associate) but not available in iPM i.e. external Cardiologist or Bolton Clarke.

KEY STANDARDS, GUIDELINES OR LEGISLATION

Standard 6: Communicating for Safety

KEYWORDS

Clinical Communication, Discharge, Multidisciplinary Team

RELATED DOCUMENTS

Discharge Planning Support Information, Discharge Outcomes flow chart, Neonatal Discharge Care Planning, Obstetric Discharge Summaries, Pharmacist Discharge Prescription Planning Workflow, Comprehensive Care- Assessment and Care Planning, Assessment Care Planning and Discharge (Operational), Patient Discharge (Operational),

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