Patient Discharge Documentation

Summary This Guideline outlines the documentation required when discharging admitted patients from NSW public hospitals. The Guideline aims to ensure a consistent approach to the safety, usability and usefulness of discharge documentation from all NSW public hospitals.

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NSW Health

GUIDELINE

Patient Discharge Documentation

GUIDELINE SUMMARY

This Guideline outlines the documentation required when discharging admitted patients from NSW public hospitals. It aims to ensure a consistent approach to the safety, usability and usefulness of discharge documentation from all NSW public hospitals.

Discharge documentation is made up of two components, the discharge summary and the patient directed discharge letter (additional consideration). The completion of discharge documentation does not absolve the need for direct communication between treating clinical teams, patients and carers, it ensures the safe transition of care of the patient. A verbal handover of care is to be conducted whenever clinically indicated.

KEY PRINCIPLES

The inpatient discharge summary is a single integrated document which includes input from the multidisciplinary team (MDT) members where available. The discharge summary will be completed on standard electronic or paper medical record templates provided by NSW Health.

It is the responsibility of the discharging clinician to go through the discharge summary with the patient and/or family using health literacy approaches as per the National Safety and Quality Health Service Standard *Communicating for Safety Standard*. The discharging clinician must ensure that all required information is documented and provided to the patient, their carer/family, nominated general practitioner and all relevant primary care providers as soon as possible or within 48 hours of discharge as per NSW Health Information Bulletin *2020-21 KPI and Improvement Measure Data Supplement* (IB2020_040).

Each multidisciplinary team member is responsible for completing their section of the discharge summary. Information must be accurate, relevant, appropriate, avoid duplication, ensure the use of accepted terminology, and avoid the use of abbreviations.

All multidisciplinary team members contributing to the discharge summary must ensure their name, designation, and signature is provided as outlined in NSW Health Policy Directive *Health Care Records – Documentation and Management* (PD2012_069)

All members providing information must not alter the documentation of another provider in the discharge summary without prior consultation. Copying and pasting documents or statements directly from clinical notes written by other members must be avoided unless auto-population is enabled.

The discharge summary must be sent, electronically (if available), to a patient's nominated general practitioner and other relevant primary care providers unless the patient has withdrawn consent to share the discharge summary. Changes in sharing are to be documented in the clinical record.

Discharge summaries are to be shared electronically with a patient's My Health Record unless the patient withdraws consent. Changes in sharing and reasoning are to be documented in both My Health Record and the clinical record.

It must be clear within the clinical record that the discharge summary has been provided to a patient's nominated general practitioner, the patient and their carer (with consent). If there are issues with sending/receiving the discharge summary, please ensure the discharge summary is provided to the patient and/or family. All information must include who it was sent by and when.

Information in the patient directed discharge letter or a similar patient friendly format is to be written with consideration of the patient's culture, level of cognition, language and health literacy, to ensure the patient and their carer and family can understand the information. Do not use abbreviations or health jargon and write in plain English.

The primary intended recipient for the discharge summary is the patient's nominated General Practitioner (GP) or Aboriginal Medical Services (AMS). In remote locations the primary intended recipient may be the Nurse Practitioner or Registered Nurse in-charge of a remote facility.

Other recipients may include care providers such as residential aged care facilities (RACF), Royal Flying Doctor Service (RFDS), Justice Health clinicians, and community care providers.

It is the responsibility of the Local Health District or Specialty Health Network to provide organisational oversight of the discharge summary process being completed and provided to the patient and their nominated primary care provider.

Ensuring that any local guidelines reflect the requirements of this Guideline and are written in consultation with hospital executives, information technology (IT) teams, clinical staff and consumer representatives.

eHealth NSW and local IT teams are responsible for ensuring the changes required to electronic systems are coordinated and implemented. This Guideline will inform future changes required for the electronic medical record (eMR) to create a system that suits the needs of NSW Health patients and clinicians.

REVISION HISTORY

Version	Approved By	Amendment Notes
GL2022_005 April 2022	Deputy Secretary, Patient Experience and System Performance	New Guideline

CONTENTS

1. BACKGROUND

1.1. About this document

This Guideline outlines the documentation required when discharging admitted patients from an NSW Health public hospital. It includes approaches from the National Guidelines for On-Screen Presentation of Discharge Summaries 2017, NSW Health Policy Directive *Care Coordination: Planning from Admission to Transfer of Care in NSW Public Hospitals* (PD2011_015) and supports a consistent approach to safety and usefulness of discharge documentation from all NSW public hospitals.

The decision to discharge is based on the patient being suitably fit to leave a NSW public hospital into a safe environment. This decision subsequently determines administrative processes including discharge documentation, billing, data collection and reporting.

The completion of discharge documentation does not absolve the need for effective communication between treating clinical teams, which is needed to ensure the safe transition in care of the patient. Wherever clinically indicated and required, a verbal handover of care and management plans must be conducted in line with the NSW Health Policy Directive *Clinical Handover* (PD2019_020).

This Guideline applies to all admitted patients being discharged from a NSW public hospital, with the exception of:

- Patients being discharged from a mental health inpatient unit. For these patients, please refer to NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Health Mental Health Services* (PD2019_045)
- Patients discharged home from an emergency department. For these patients, please refer to NSW Health Policy Directive *Departure of Emergency Department patients* (PD2014_025)
- Patients attending outpatient clinic appointments

Patients who discharge against medical advice are included in the scope of this Guideline as defined by NSW Health Policy Directive *NSW Health Admission Policy* (PD2017_015). At a minimum provide a completed discharge summary as outlined in this Guideline to ensure safe continuation of care for the patient in the future. If a patient leaves the hospital prior to receiving the discharge summary, a copy must be sent to the nominated general practitioner.

This Guideline does not cover an exhaustive list of situations and there may be special circumstances that are beyond its cover. For those scenarios, please consider where the Guideline is applicable, and ensure appropriate clinical judgement and optimal transition of care is provided to the patient.

1.2. Key definitions

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

Allied health profession	Refers to any of the 23 professions employed by NSW Health which may be involved in the patient care. Professions can be found on the NSW Health website.
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.
Discharging clinician	The medical officer, nurse practitioner, midwife or suitably authorised healthcare clinician deputed and responsible for completing the discharge documentation for the patient.
Discharge report	An additional document to the discharge summary usually completed by Allied Health professionals to provide greater detail on discharge.
Multidisciplinary team (MDT)	Involves a range of health professionals from different disciplines or organisations working together to deliver comprehensive patient care.
Medication reconciliation	Formal process of verifying the intended medicines for patients, ensuring an accurate and complete list of medicines.
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, 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 patient admission at the hospital.
Referral	The effective communication, with the intention of initiating quality and safe care transfers, 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 transitions care responsibility on the recipient.

Additional diagnosis	A condition or complaint either coexisting with the principal diagnosis and/or arising during the admission or visit at the hospital, requiring any of the following: commencement, alteration or adjustment of therapeutic treatment; diagnostic procedures; enhanced clinical activity and care.

1.3. Legal and legislative framework

NSW Health staff have a common law duty of care to the patients cared for within NSW public hospitals. Clinical staff and admitting/attending medical officers under whose care the patient was admitted, must safely transfer care to the next treating health practitioner. This includes the patient's general practitioner, other medical specialists, and community services.

In NSW public hospitals an evidence-based approach to suitably transition care is through the provision of effective discharge documentation, accompanied by verbal communication (e.g. teach-back). Discharge documentation written in 'plain English' informs the patient, their carer/family, and their usual treating health practitioner of the reason for admission, relevant details of their inpatient stay including investigations and treatment and recommendations for ongoing care and follow up.

2. DISCHARGING CLINICIAN

2.1. Medical documentation in the discharge summary

The admitting/attending medical officers may delegate the responsibility to complete the discharge summary. Where completion of a discharge summary is delegated, the admitting/attending medical officers will have mechanisms to ensure that accurate and quality, 'plain English' discharge summaries are completed. (*reviewing discharge summaries completed by the delegate, ensuring the delegate has a clear understanding of key aspects of the patient history for inclusion in the discharge summary*).

A discharge summary must be completed in line with the requirements of this Guideline, for all discharges, including deceased patients with the following exceptions:

- Patients out of scope
- Day Only patients
- Well-baby and obstetric patients.

2.1.1. Requirements for minimum information

A 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
Medicines on discharge	Ceased medicines	Alerts/infection risks

A discharge summary must contain information on the following:		
Recommendations	Follow-up services/appointments	Information provided to patient
Relevant investigation results		

For vulnerable patient groups who are at increased risk of rehospitalisation, the discharge document must 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.

For patients returning to Justice Health or Correctional Services, follow these key steps:

- 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.
- Do not advise the patient of any follow-up appointments. This poses a security risk and if disclosed the appointment will need to be re-scheduled.

2.1.2. Description and display of discharge summary information

Each of the required minimum standards (section 2.1.1) must follow the description and display principles in order of which they appear below:

Patient details

The patient's full name must be documented on a single line, in a larger, bold font. Patient details are to appear in the following order:

1. Name
2. Medical Record Number (MRN)
3. Age
4. Sex
5. Gender
6. Date of birth (age in years or months/days where applicable)
7. Address
8. Telephone number

Hospital details

Printouts and electronic communications are to be display the hospital details including:

- Hospital name and Local Health District (districts)/Specialty Health Network (networks)
- Hospital address and contact details including phone numbers
- Speciality name and nominated contact details including phone numbers.

Recipient (s)

A discharge summary is to display the intended audience(s) so appropriate transfer of care occurs.

Discharging clinician

The name and details of the discharging clinician must be documented in an area adjacent to the recipients' names. This must include:

- Discharging clinician's designation (role in organisation)
- Discharging clinician's supervisor (admitting/attending medical officer)
- Contact details of admitting/attending medical officer or delegate (if not previously stated)
- Signature or electronic credentials.

Presentation details

Key details of the presentation are to be documented, including:

1. Admission date
2. Discharge date
3. Length of stay at hospital
4. Clinical unit (the location from which the patient was discharged)
5. Clinical specialty type (the specialty responsible for discharge)
6. Discharge destination. This is to be included for all patients including those who discharge against medical advice and deceased patients.

Presenting problem/s and diagnoses

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

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

Consider aligning problem/s with attributed diagnoses/conditions where appropriate (e.g., abdominal pain – appendicitis).

Procedures

Invasive clinical interventions including operations and procedures must be documented in chronological order. If no procedures were performed, document 'nil performed'.

Procedures with medical devices

Where a medical device has been implanted or explanted during the inpatient visit, the discharging clinician must include the product name, type, model and batch number for all devices. Refer to NSW Health Information Bulletin *Strengthening practice -Implantable Medical Devices* (IB2019_035), for the definition of implantable medical devices and information on exempt devices.

Clinical summary

The clinical summary section allows the discharging clinician to communicate, in free text, a concise summary of the patient's hospital stay. The clinician is to focus on quality rather than the quantity of information documented.

The discharging clinician must 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. Ensure information provided is succinct and appropriate for continuity of care.

Allergies / adverse reactions

Relevant information to be documented including:

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

Where there is no known allergy or adverse reaction 'nil known' must be documented. Every attempt must be made to ensure this information is current and updated.

Medicines on discharge

Medicines must be documented, grouped according to their status (i.e., new medicines at the top, followed by changed, then unchanged), and ordered alphabetically within each group. It is to be based on the medication reconciliation completed at the start of a patient's admission.

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, form, and route

- *Directions:* dose, frequency (including 'as required'), and any special instructions e.g., in relation to food; when the next dose is due for intermittent medicines, or when the last dose was administered
- *Duration/end date*
- *Status:* new, changed or unchanged
- *Change reason/clinical indication.*

NSW public hospitals must have appropriate systems in place for continuity of medicine management for patients after discharge. For more detailed information refer to NSW Health Policy Directive *Medication Handling in NSW Public Health Facilities* (PD2013_043).

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, form and route
- *Reason*: Explain why a medicine has been ceased or suspended
- *Duration:* Identifying temporary versus permanent cessation.

Some medicines may require additional instructions in addition to the above and should follow the 'ceased medicines' section within the discharge summary. The contents and requirements for this are in section 3.4 of the Guideline.

- 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 (CMIs) or patient education that has been provided or if they are required.

Alerts

Clinically relevant alerts are to be identified by the discharging clinician and included in discharge documentation (e.g., falls risks). Non-clinical alerts must be excluded unless relevant for the receiving general practitioner. Bullet points are to be used to ensure the summary can be easily read.

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.

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 discharge follow-up appointments are initiated or confirmed prior to discharge by the discharging clinician. If this is not possible, ensure actions and persons responsible are noted clearly in the 'Recommendation' section of the discharge summary.

It is the responsibility of the admitting/attending medical officer to ensure appropriate clinical follow up and ongoing care of the patient has been arranged prior to their discharge from a hospital.

To facilitate discharge, this does not have to be completed on the ward, patients can be transferred to the transit/discharge lounge as required. The following appointment information must be provided:

- Description
- Date and time
- Booking status
- Name of primary care provider being visited
- Location
- Contact details
- Specific instructions e.g., Nil By Mouth (NBM) or preparation pre-visit, payments if required
- Arranged/to be arranged by hospital/patient.

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

Information provided to patient

The discharge summary must outline the complete list of recommended actions that were provided to the patient and/or carer. This informs primary care providers of follow-up care information that the patient and/or carer was provided. Written material should be supported with appropriate verbal communication using health literate approaches.

A Patient Friendly Medication List (PFML) must be provided to all patients where possible. Patients will be prioritised according to clinical needs, with a focus on minimising the risk of medication-related problems after discharge from hospital and reducing the risk of hospital readmission.

The information must be consistent with that of the discharge summary, and any changes made must be reflected in both documents. Patient friendly medication list is to be presented in a landscape view table and include columns for:

- Morning
- Midday
- Evening
- Night.

Where applicable, adjust the font size to cater for patients with vision impairment. Refer to the National Guidelines for On-Screen Presentation of Discharge Summaries 2017 for further information.

Selected investigations results

Only relevant and important investigations performed while the patient was in hospital are included in the discharge documentation. The decision is made by the discharging clinician and is determined on a case-by-case basis. The discharging clinician are to consider the delivery of all copies of the investigation results to the patient's nominated general practitioner where appropriate and clinically indicated. This must be provided with the discharge summary where appropriate.

If there are several results within the same category, it is recommended that the discharging clinician group them together, such as: pathology, imaging, and others. Display using the following headings and highlight critical investigation results where relevant:

- Test name
- Date
- Result.

2.2. Allied health documentation

It is the responsibility of the 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. Allied health documentation is usually required where the 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, the allied health clinician involved in the patient's care is to document this in the 'clinical summary' section. Only one entry per allied health discipline is to be included in the discharge summary.

Minimum requirements for the allied health section in the clinical summary of the inpatient discharge summary are:

- The allied health profession e.g., Social Work
- Name of primary treating allied health clinician and contact details
- Name of person completing the discharge summary (if different to the primary treating allied health clinician)
- Reason for intervention/reason for referral

- Clinical findings (relevant to reason for intervention), including any relevant patient goals
- Brief summary of the intervention(s) provided
- Reference to detailed discharge report if one is being provided

The recommendation section is to 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 this patient belongs to a vulnerable/high risk cohort e.g., cognitively impaired.

Any outpatient or community follow-up information provided by the allied health clinician, including referrals which have been made to other agencies must be documented in the follow-up appointments section.

When an allied health 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.

2.2.1. Allied health discharge report

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 inpatient discharge summary and is at the discretion of the allied health clinician, based on the patient's complexity and discharge requirements.

The allied health discharge report may be completed by individual allied health professionals or a combined multidisciplinary team report.

Allied health clinicians may choose to provide a detailed discharge report, in addition to the discharge summary when:

- More detail is required on a patient's treatment or follow-up care to safely transfer care between providers
- Where there has been significant input from multiple allied health professions, an allied health discharge report may be provided in lieu of each profession documenting in the discharge summary.

The discharge report must be included in the patient's medical record under the correct inpatient encounter and referred to in the discharge summary.

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

2.3. Nursing and midwifery discharge report

Where nursing and midwifery discharge information is required, beyond what is documented by medical and allied health professionals, the required information must be included in the clinical summary section of the discharge summary. Where needed, a supplementary document may be included.

This must be completed before discharge, communicated to the MDT, and finalised by the discharging clinician as per section 2.1.

3. SPECIALITY SPECIFIC CONSIDERATIONS

3.1. Day only and extended day only admissions for interventional procedures

3.1.1. Required documentation for discharge

Ensure that patients are provided health literate information about the 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 e.g. teach-back.

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.

3.1.2. Information requirements

This document must include the following information at a minimum:	
Patient identification	
Presenting Problem/Reason for procedure	
Planned procedure	
Summary of procedure	Date of procedure AMO and / or procedural list Primary procedure performed Outcomes / complications
Continued care recommendations	Post-operative precautions Post-operative instructions e.g Medicine instructions Follow up arrangements

3.1.3. Workforce considerations for preparation of discharge documentation

The discharge documentation provided to extended day only and day only patients is not intended to contain all information in a discharge summary for an inpatient admission. It is intended that the document serves to provide a minimum set of information to inform the patient's primary care team.

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.

NSW Health staff must have an awareness of evidence-based health literacy approaches for written and verbal communication. It is recommended that all frontline clinical staff as a minimum undertake health literacy training and utilise recommended health literacy tools to increase the effectiveness of communication.

3.2. Well mothers and babies

For well mothers and babies, discharge can be initiated and coordinated by midwifery staff as per local Postnatal Clinical Pathways, and under the framework of the National Midwifery Guidelines for Consultation and Referral. Discharge summaries must be complemented by the My Personal Health Record and provided to the mother.

3.3. Mental health consumers discharge from non-mental health facility

Where a patient being discharged from a general hospital bed and has received treatment/consultation with mental health services during their stay, the discharging 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.

Please refer to NSW Health Policy Directive *Discharge Planning and Transfer of Care for Consumers of NSW Mental Health Services* (PD2019_045) for further information.

3.4. Additional medicine instructions post-discharge

Where additional instructions are required for ongoing medicine management, the discharging clinician, in consultation with the pharmacist (where available), will document these instructions in a section following the 'ceased medicines' section of the discharge summary. Information to be documented in this section may include:

- 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
- Medicine dose adjustment requirements, including recommendations for future cessation of medicines e.g., weaning dose plan of corticosteroids
- Recommendation for commencement of a dose administration aid
- Recommendations for pain management for post-operative patients, including information on dose reduction and/or cessation of opioids.

Refer to NSW Health Policy Directive *High-Risk Medicines Management* (PD2020_045) and NSW Health Policy Directive *Medication Handling in NSW Public Health Facilities* (PD2013_043) for further information.

If a separate patient friendly medication list is provided, the information must be consistent with that of the discharge summary, and any changes made must be reflected in both documents.

Patient friendly medication lists must state the date they were authorised on both the electronic and printed copy.

4. PATIENT DIRECTED DISCHARGE LETTER FOR PATIENTS AND CARERS

4.1. Patient directed discharge letter requirements

The patient directed discharge letter is not a mandatory requirement of the patient discharge documentation. It is an example of what can be adapted within districts/networks. It is at the discretion of the districts/networks to:

- Determine responsibility for completing a patient discharge letter i.e., medical officer, nurse practitioner, clinical nurse consultant, allied health representative.
- Tailor health literate solutions for non-English speaking patients and carers
- Identify appropriate recipients i.e., Aboriginal liaison officer
- Adjust it appropriately using health literacy principles depending on patient cohort and what information is required.

The amount of information provided must be proportional to the medical treatment and patient information needs. The discharging clinician are to consider the sections of the discharge summary that need to be included in the patient directed discharge letter, based on the needs of the individual.

This may take the form of a separate letter or section of the discharge paperwork, with attached information where appropriate. A copy of an optional template for this letter is attached in Appendix A. Please ensure that on completion of an electronic patient directed discharge letter a spellcheck is completed, and in the case of a handwritten letter, that it is legible.

A patient directed discharge letter may include the details of:

- Hospital admission
- Treatment and investigations
- Discharge management plan and instructions
- Current list of active medicines and any short-term discharge medicines with relevant instructions
- Follow-up appointments or referrals to other care providers
- What the patient should expect in terms of timing/level of recovery
- Short-term and long-term impacts of the condition for which they have been treated

- Culturally, linguistically and cognitively appropriate resources, especially for patients identified as requiring an interpreter. References or attachments can include information sheets, pamphlets, videos specific to the patient's needs
- The possibility of deterioration and symptoms and/or signs to watch out for, including specific instructions to return to the hospital or primary care provider when specific concerns arise
- Contact details of the admitting/attending medical officers and/or nominated discharging clinician to clarify information
- The contact details of other relevant services who will be providing follow-up care or advice such as community nursing or allied health services.
- Medicines and medication management plan.

The patient directed discharge letter does not replace the need for patients to be supplied with copies of comprehensive medical records (including investigation results) upon request under Section 12 of the Privacy Manual for Health Information.

5. APPENDIX LIST

1. Patient directed discharge letter template
2. Implementation checklist

5.1. Patient directed discharge letter template (example only)

Dear XXX,

We hope this letter helps you understand what happened following your admission to XXXX Hospital and what we recommend for the future. We encourage you to show it to your family or carer, so they also understand. You will also be given the usual discharge summary to give your doctor that explains medical issues in more detail.

You came into hospital on XX/XX/2018 and are going home on XX/XX/2018.

The reason you came into hospital (symptoms, diagnosis)
You woke in the early morning with your heart racing and feeling short of breath.
The diagnosis was a heart rhythm problem called Atrial Fibrillation.

The important tests and results
An electrocardiogram (ECG) confirmed Example 1 [Atrial Fibrillation (a fast irregular heart rhythm)].
Your chest X-ray was unremarkable.
Blood tests were unremarkable. There was no evidence of heart muscle damage, kidney problem or anaemia. A heart ultrasound showed that your heart was pumping well.

The treatment(s) you received while you were in hospital
You were given a tablet called XXXXX and your heart rhythm returned to normal / slowed to a normal rate. You should continue to take it XXXXX times a day to keep the rhythm regular. Because of a slight risk that blood clots could form in your heart with Atrial Fibrillation, you have begun taking XXXXXX.

Recommendations for you when you go home (follow-up care)
The XXXXXX medicine might make you bruise more easily, so try to be careful about not bruising yourself. You might feel a little fatigued with the XXXXXX, but this is usually not an issue.

Your current medicines
When you go home, you may be on a combination of tablets that is different from before you came to hospital – some tablets may have been stopped or doses changed, and new ones begun. You will need to follow the instructions on the medicines section of your discharge summary or Patient Medicines List if you have received that. It is important to consult your GP within 3 days for a review and to get your prescriptions renewed. Sometimes medicines will be listed as their generic (active ingredient) name, or sometimes as trade brand names, which may differ. If you are uncertain, seek advice from your doctor, pharmacist or nurse.

Your discharge summary for your GP will contain a full list of your medicines.

Your follow up appointments that you need to go to:
GP within 3 days for review and further prescriptions.
Cardiologist Dr X within 4-6 weeks
Add other appointments if applicable.

If you have any questions/concerns after discharge, please speak to your GP.

Kind regards
Dr (Resident Medical Officer)

for Dr (Cardiologist)

5.2. Implementation checklist

Organisation / Facility:	

Assessed by:	Date of Assessment:		
Key Requirements	**Not commenced**	**Partial compliance**	**Full compliance**
	❑	❑	❑
	Notes:		
	❑	❑	❑
	Notes:		
	❑	❑	❑
	Notes:		
	❑	❑	❑
	Notes:		
	❑	❑	❑
	Notes:		
	❑	❑	❑
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