Department of Human Services

# Effective Discharge Strategy Performance Indicators

# Discharge Database and Patient Record Audit Instruction Manual

## Part Two

**2002/2003**

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## Glossary

| | |
|---|---|
| A/LOS | Average/Length Of Stay |
| CCU | Coronary Care Unit |
| DHS | Department of Human Services |
| DRG | Diagnostic Related Group |
| EDS | Effective Discharge Strategy |
| GP | General Practitioner |
| HACC | Home and Community Care |
| HDU | High Dependency Unit |
| ICU | Intensive Care Unit |
| PAC | Post Acute Care |
| Record | A single patient record file |
| Spreadsheet | The primary document that you use in Excel to store and work with data. Also called a worksheet. A spreadsheet is always stored in a workbook. |
| SRS | Supported Residential Service |
| VAED | Victorian Admitted Episodes Dataset. This dataset is used by hospital to record information about all patients admitted to public health services. |

# Part Two

# Conducting an Audit of Patient Records: Definitions, Explanations, Inclusions and Exclusions

The purpose of this section is to provide information specific to each of the questions in the discharge audit tool, in addition to some general information. The information in this section covers what is needed to answer the questions appropriately and includes:

- a **definition** of each question;
- an **explanation** of each question; and
- the **inclusions** and **exclusions** that are specific to each particular question.

**General**

- Questions should be answered in the order they appear on the database.
- If a mistake is made, return to the previous page using the back arrow.
- To correct a mistake, click on the correct response and the error will be corrected.
- The database is set up so that any information that is not necessary for particular patient types will be blocked from use. Blocked questions will appear as a darker shade of blue.
- If you get part way through a record and for some reason cannot complete it, you can either click the 'Next Record' or the 'Exit' button depending on whether you want to exit completely from the database or want or move onto another record (maybe you need to get clarification about something in the record, so need to put it aside and come back to it later).
- Data is automatically saved as it is entered. The database can be shut down at any stage without losing any information previously entered by clicking the 'Exit' button. **Note, any information not entered will affect the final results. Ensure all records are complete before running reports.**
- Discharge activity must be documented in the patient record before it can be recorded as achieving compliance with the questions. It is not necessary (and not recommended) to seek out further information or clarification from staff, as the information should have been recorded at the time the patient was admitted.

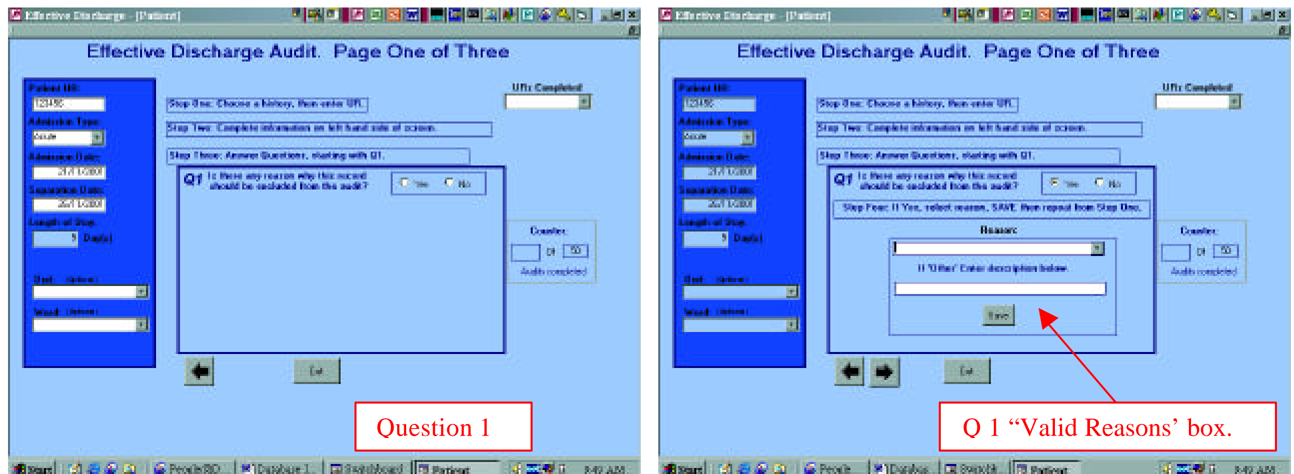
**Definition of Acute/Sub Acute Patients for the Discharge Audit**

For the purpose of the audit, patients are classified as either acute or sub acute separations. This classification will influence the questions that are asked (there are variations on certain indicators for sub acute admissions), and the two types of patients are reported separately.

The acute/sub acute classification is determined from the patient's Care Type as per the PRS/2 manual for the VAED and, in some instances, the type of facility that the patient attended. The definitions are:

- Sub Acute = Care Types 1, 2, 6, 7, 8, 9
- Acute = Care Type 4

**Question 1 - Is there any reason why this record should be excluded from the audit?**




- The purpose of this question is to exclude records that, *for any valid reason*, cannot or do not need to be audited.
- The reason for exclusion MUST be entered in the 'valid reasons' box and will be audited by DHS.
- A list of common valid reasons for exclusion is included in the drop down box.
- Tables 1 and 2 detail, those DRGs and VAED patient types who are excluded completely from the DHS audit. In general the reason for these exclusions are administrative and so exclusion from the DHS audit does not necessarily mean that they should not be excluded from adherence to the performance indicators.
- It is intended that all of these patient groups (i.e. patients with the identified DRG or VAED codes) will be filtered from the hospital population prior to the extraction of the audit data.
- Any other reasons MUST be detailed under 'other'. E.g. any additional patient groups not identified in Tables 1 or 2 and who are either frequently admitted patients regularly admitted for the same episode of care or same day investigative procedure patients, where it is felt that conducting a risk screen on every admission is unnecessary or where completing a discharge summary adhering to the KPI requirements, on every admission is unnecessary.

| **Table 2.1. VAED Codes for Exclusion from the DHS Discharge Audit** | |
|---|---|
| **Separation types for exclusion** | |
| • D | • Death |
| • Z | • Patients who leave against medical advice |
| • 1, 2, 3, 4, 5, 6, 7, 8, or 9 | • Statistical separations |
| • A | • Separation and transfer to mental health facility |
| **Accommodation types for exclusion** | |
| • 6 | • Emergency department stay only |
| • B | • Other nursery accommodation or mother's bedside |
| **Admission types for exclusion** | |
| • G | • Geriatric Respite Admission |
| • Z | • Admission to Interim Care |
| **Care types for exclusion** | |
| • 5 | • Approved Mental Health Service or Psychogeriatric Program |
| • 0 | • Alcohol and Drug Program |
| • 3 | • Family Choice: Awake Attendant care |
| • U | • Unqualified Newborn |

**Table 2.2. Approved DRGs for Exclusion from the DHS Discharge Audit**

| DRG | DRG DESCRIPTION | TREATMENT/PROCEDURE |
|---|---|---|
| B40Z | Plasmapheresis W Neurological Disease | THERAPEUTIC PLASMAPHERESIS |
| B62Z | Admit for Apheresis | APHERESIS |
| B67B | Degen nervous system disorders w/o Cat/Sev CC | |
| B71B | Cranial & Peripheral Nerve Disords no CC | TRANSFUSION OF GAMMA GLOBULIN |
| E63Z | Sleep Apnoea | INVESTIGATION OF SLEEP APNOEA |
| F42A | Circ Dis No AMI+Inv Card Inv Pr+Cx Dx/Pr | CORONARY ANGIOGRAPHY W LEFT HEART CATH |
| F42B | Circ Dis No AMI W Card Inv No Comp Dx/Pr | CORONARY ANGIOGRAPHY W LEFT HEART CATH |
| G40B | Cx Th Gas'py-Mj Dig Dis No C/S CC/Cmp Pr | PANENDOSCOPY WITH LASER COAGULATION |
| G41B | Complex Therapy Gastroscopy Non-Maj Dig Dis,SD | PANENDOSCOPY WITH EXCISION OF LESION |
| G42A | Other Gastroscopy - Maj Digestive Disease | PANENDOSCOPY WITH/WITHOUT BIOPSY |
| G42B | Other Gastroscopy for Maj Dig Dis, Sameday | PANENDOSCOPY WITH/WITHOUT BIOPSY |
| G43Z | Complex Therapeutic Colonoscopy | FIBREOPTIC COLONOSCOPY TO CAECUM WITH/WITHOUT BX |
| G44A | Other Colonoscopy W Cat/Sev CC or Comp Pr | FIBREOPTIC COLONOSCOPY TO CAECUM WITH/WITHOUT BX |
| G44B | Other Colonoscopy W/O Cat/Sev CC or Comp Proc | FIBREOPTIC COLONOSCOPY TO CAECUM WITH/WITHOUT BX |
| G44C | Other Colonoscopy, Sameday | FIBREOPTIC COLONOSCOPY TO CAECUM WITH/WITHOUT BX |
| G45A | Other Gastroscopy - Non-Maj Digest Disease | PANENDOSCOPY WITH/WITHOUT BIOPSY |
| G45B | Other Gas'py - Non-Maj Dig Disease, Sameday | PANENDOSCOPY WITH/WITHOUT BIOPSY |
| H41A | ERCP Complex Therapeutic Proc W Cat/Sev CC | ERCP |
| H41B | ERCP Complex Therapeutic Proc W/O Cat/SevCC | ERCP |
| H42A | ERCP Other Therapeutic Proc W Cat/Sev CC | ERCP |
| H42B | ERCP Other Therapeutic Proc W/O Cat/Sev CC | ERCP |
| H60A | Cirrhosis & Alcoholic Hepatitis W Cat CC | ABDOMINAL PARACENTESIS / PANENDOSCOPY / LIVER BIOPSY |
| H60B | Cirrhosis+Alcoholic Hepatitis+Cat/Sev CC | ABDOMINAL PARACENTESIS / PANENDOSCOPY / LIVER BIOPSY |
| H60C | Cirrhosis+Alcoh Hepatitis W/O Cat/Sev CC | ABDOMINAL PARACENTESIS / PANENDOSCOPY /LIVER BIOPSY |
| H63B | Dis Liver Exc Mal,Cirr,Al Hep No C/S CC | LIVER BIOPSY |
| I65A | Conn Tissue Malig W Pathological Frac >64 | INJECTION/INFUS OTH THRPC/PROPHYLTC SUBS |
| I65B | Conn Tissue Malig W Pathological Frac <65 | INJECTION/INFUS OTH THRPC/PROPHYLTC SUBS |
| I66B | Connective Tissue Dis <65 W/O Cat/Sev CC | THERAPEUTIC PLASM APHERESIS/GAMMA GLOBULIN |
| I69B | Bone Diseases & Spec Arthropath >74 No C/S CC | INJECTION/INFUS OTH THRPC/PROPHYLTC SUBS |
| I69C | Bone Diseases & Spec Arthropathies <75 | INJECTION/INFUS OTH THRPC/PROPHYLTC SUBS |
| I71C | Musculotendinous Disorders <70 W/O CC | INJECTION/INFUS OTH THRPC/PROPHYLTC SUBS |
| J61Z | Severe Skin Disorders | TRANSFUSION OF GAMMA GLOBULIN |
| J62B | Malig Breast Dis <70+CC or >69 No CC | INJECTION/INFUS OTH THRPC/PROPHYLTC SUBS |
| L41Z | Cystourethroscopy W/O CC | CYSTOSCOPY |
| L61Y | Admit for peritoneal Dialysis | PERITONEAL DIALYSIS |
| L61Z | Admit for Renal Dialysis | RENAL DIALYSIS |
| L07A | Transur Procs Exc Prostatectomy+C/Sev CC | CYSTOSCOPY WITH BIOPSY/TUMOUR REMOVAL |
| L07B | Transur Proc Exc Prostatectomy No C/S CC | CYSTOSCOPY WITH BIOPSY/TUMOUR REMOVAL |
| M40Z | Cystourethroscopy W/O CC | CYSTOSCOPY |
| O61Z | Postpartum & Post Abortion W/O O.R. Proc, Same Day# | |
| O64Z | False Labour | |

**Table 2.2. Approved DRGs for Exclusion from the DHS Discharge Audit (cont.)**

| DRG | DRG DESCRIPTION | TREATMENT/PROCEDURE |
|---|---|---|
| O65A | Other Antenatal Admission W Sev Comp Diag, Same Day# | |
| O65B | Other Antenatal Admission W Moderate/No Comp Diag, Same Day# | |
| Q60A | Reticuloendothelial+Immun Dis+Cat/Sev CC | TRANSFUSION OF GAMMA GLOBULIN |
| Q60B | Reticuloendothelial+Imm Dis No C/S CC | TRANSFUSION OF GAMMA GLOBULIN |
| Q61B | Red Blood Cell Disorders W Severe CC | TRANSFUSION/VENESECTION/PANENDOSCOPY |
| Q61C | Red Blood Cell Disorder no Catast/Sev CC | TRANSFUSION/VENESECTION/PANENDOSCOPY |
| Q62A | Coagulation Disorders Age>69 | TRANSFUSION OF COAGULATION FACTORS |
| Q62B | Coagulation Disorders Age<70 | TRANSFUSION OF COAGULATION FACTORS |
| R61B | Lymphoma & Non-Ac Leukaemia no Catast CC | TRANSFUSION/INFUSION/BIOPSY |
| R61C | Lymphoma & Non-Acute Leukaemia, Sameday | TRANSFUSION/INFUSION/BIOPSY |
| R63Z | Chemotherapy | CHEMOTHERAPY |
| R64Z | Radiotherapy | RADIOTHERAPY |
| S60Z | HIV, Sameday | INFUSION/PANENDOSCOPY |
| U40Z | Mental Health Treatment, Sameday W ECT | |
| U60Z | Mental Health Treatment, Sameday W/O ECT | |
| V62B | Alcohol Use Disorder & Dependence, Sameday | |
| Z01A | ORPs W Diags Oth Contacts W Cat/Sev CC | INFUSION PUMP MANAGEMENT/ENDOSCOPY |
| Z01B | ORPs W Diags Oth Contacts W/O Cat/Sev CC | INFUSION PUMP MANAGEMENT/ENDOSCOPY |
| Z40Z | F-Up After Completed Treat W Endoscopy | ENDOSCOPY |
| Z60C | Rehab, same day | |
| Z63A | Other Aftercare W Catastrophic/Severe CC | CORONARY ANGIOGRAPHY W LEFT HEART CATH |
| Z63B | Other Aftercare W/O Catastrophic/Severe CC | CORONARY ANGIOGRAPHY W LEFT HEART CATH |
| Z64B | Other Factors Influencing Health Status <80 | MANAGEMENT OF INFUSION PUMPS/STEM CELL DONATION |

## Question 2 - Is the predicted discharge date documented?

The predicted discharge date must be:

- Documented for all patients.
- An actual date. It is not acceptable to write the number of weeks (e.g. 4-6 weeks).
- If recorded as 'unknown', then this should be entered in the 'valid reasons' box as well as a description of the reason in the 'other' section.

- It is expected that this date will be reviewed during the patient's episode of care (particularly for long stay patients); however, this review will not be audited.
- If a patient is listed as waiting for a residential care facility, ideally the preferred date of discharge should be recorded (i.e. the date that the patient would be fit for discharge from the acute /subacute service).
- The average length of stay (ALOS) may be used as a default where there is no other information available.

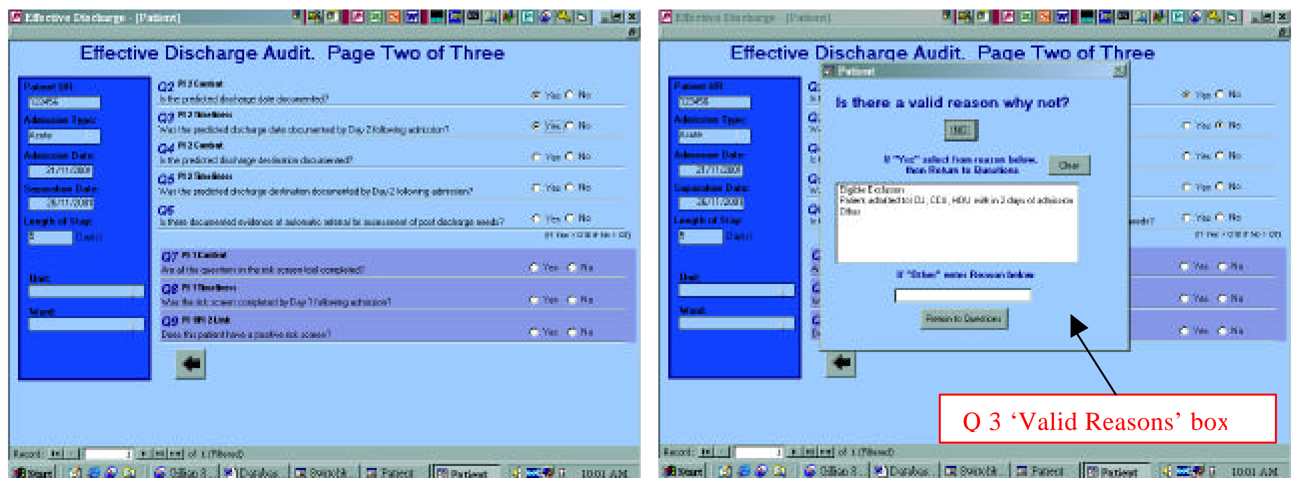
**Inclusions**

- All multi-day stay patients (elective and emergency) (VAED Accommodation Type 1 or 2)
- Transfer to non-acute psychiatric unit (rehabilitation/continuing care/other care) (VAED Separation Type A)
- Transfer to other acute hospital/extended care/rehabilitation/geriatric centre (VAED Separation Type T)
- Transfer to aged care residential facility (VAED Separation Type N)

**Exclusions**

- Admission to intensive care unit within one day of admission to hospital
- Patients unwilling to participate
- Same day stay patients (VAED Accommodation Type 3)
- Transfer to Nursing Home where prior residence

**Question 3 - Was it documented by day 2 (8 – sub acute) following admission?**




- There must be documentary evidence that the date was determined by day 2 (8 – sub acute) following admission, or the day prior to discharge for LOS = 3 days.
- Valid reasons for not adhering to the timeliness criteria should be recorded in the 'valid reasons' box.
- Where a patient is transferred to ICU, CCU, or HDU within 2 days of admission, the timeliness criteria becomes redundant.

**Question 4 - Is the predicted discharge destination documented?**

Q 4 "Valid Reasons' box.

- The predicted discharge destination must be:
  1. documented for all patients.
  2. an actual destination (e.g. home, nursing home, hostel, etc.).
- If discharge destination is to be recorded as 'unknown', then this should be entered in the 'valid reasons' box as well as a description of the reason in the 'other' section (e.g. patient too medically unstable, admitted for palliative care, awaiting ACAS review)

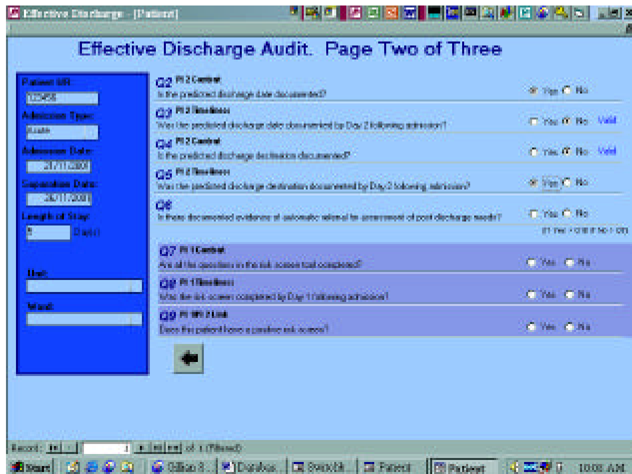
**Inclusions**

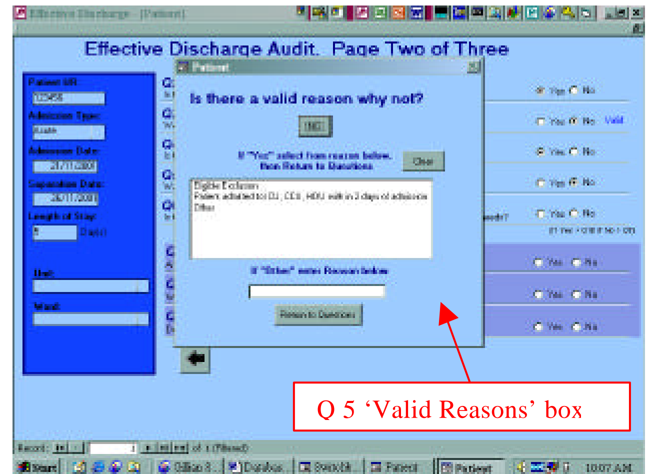
- All multi-day stay patients (elective and emergency) (VAED Accommodation Type 1 or 2)
- Transfer to non-acute psychiatric unit (rehabilitation/continuing care/other care) (VAED Separation Type A)
- Transfer to other acute hospital/extended care/rehabilitation/geriatric centre (VAED Separation Type T)
- Transfer to aged care residential facility () (VAED Separation Type N)

**Exclusions**

- Admission to intensive care unit within one day of admission to hospital
- Patients unwilling to participate
- Same day stay patients (VAED Accommodation Type 3)
- Transfer to Nursing Home where prior residence

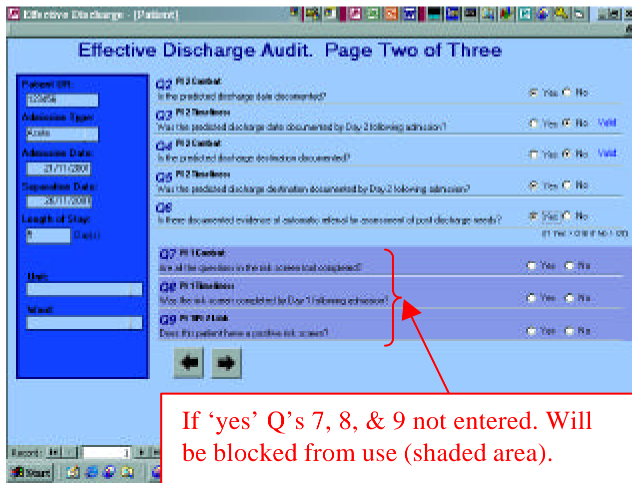
**Question 5 - Was it documented by day 2 (8 – sub acute) following admission?**

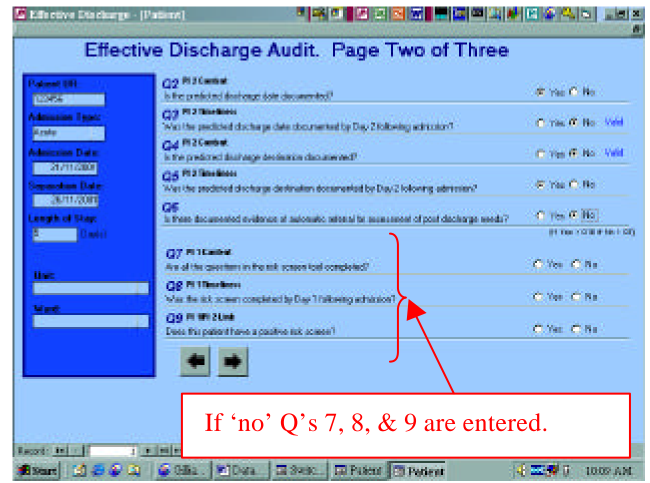



- There must be documentary evidence that the destination was determined by day 2 (8 – sub acute) following admission, or by the day prior to discharge for LOS = 3 days.
- Valid reasons for not adhering to the timeliness criteria should be recorded in the 'valid reasons' box.
- Where a patient is transferred to ICU, CCU, or HDU within 2 days of admission, the timeliness criteria becomes redundant.

**Question 6 - Did this patient have a documented automatic referral for assessment for post-discharge needs?**




- The purpose of the risk screen is to flag those patients who require further assessment for the determination of their post-discharge needs. In some health services all admitted patients receive an automatic referral for assessment of post-discharge needs by an allied health worker. In these circumstances the risk screen becomes redundant.
- An automatic referral for assessment is expected to be a broad policy that would apply to ALL admitted patients of a particular health service or Unit within a health service. For example, many sub acute services have a policy that all admitted patients are assessed by nominated allied health staff for the purpose of the determination a patient's post-discharge needs.

- Where there is an automatic referral for assessment the risk screen will not apply and questions 7 to 9 will be blocked.
- An automatic referral for assessment must be clearly documented as such in the patient record.
- Although sub acute services are more likely to have automatic referral systems, this would equally apply to any other services where this is standard policy.
- Risk screen timelines will apply where a patient is admitted with an automatic referral for assessment.

**An automatic referral for assessment ONLY applies to an assessment that is specifically targeted at determining post-discharge needs (i.e. the need for community services). It does not include medical and nursing assessments (i.e. diagnostic assessments).**

**Question 7 - Are all the questions in the risk screen tool completed?**

A 'no' response will get 'valid reasons' box as per next screen.

Q. 7 'Valid Reasons' Box

Q.7. If 'no' to risk screen (with no valid reason), Qs 8 to 11 are recorded as 'not valid'.

- To achieve compliance to this question there must be documentary evidence that the four mandatory risk screen questions have been adhered to. The questions are:
    i. Patient likely to have self care problems
    ii. Patient lives alone
    iii. Caring responsibilities for others
    iv. Patient used services before admission
- Different healthcare facilities with their specialities may benefit from enhancing the tool to suit their particular patient demographic. It is acceptable for health services to alter the wording of the tool providing all components of the risk screen criteria and the full intent of each of the questions are addressed in the revised tool. For example, hospitals with large numbers of paediatric separations should have developed a risk screening tool specific to this patient population.
- Compliance with this performance indicator will be confined to the stipulated minimum content criteria. Therefore, a health service that uses a risk screen with ten items (i.e. the four minimum criteria and six additional items) will only need to report against the four minimum criteria.
- Where a patient record does not achieve compliance to this question, it will deemed that questions 8 (timeliness) and 9 (outcome of risk screen) will also not achieve compliance. This will be automatically recorded as such by the database.

**Pre Admission Clinics**

- Assessments carried out at pre admission clinics are valid. The timeliness component for risk screening specifies that it must be done by *Day One* following the admission date.

**Patients Living Alone**

- All patients who live alone AND who are 70 years and over should be referred for further assessment of post-discharge needs. It is acceptable for the question to be expressed in the risk screen with the inclusion of the age criteria – e.g. Patient lives alone and is 70 years or over.

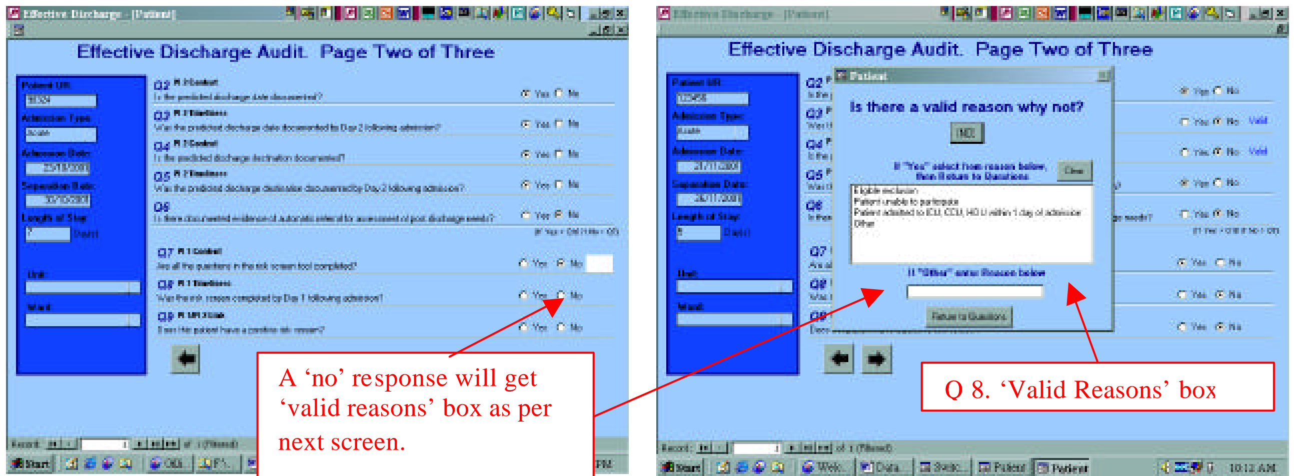
**Inclusions**

- Same day stay patients (VAED Accommodation Type 3)
- All multi-day stay patients (elective and emergency) (VAED Accommodation Type 1 or 2)
- Transfer to non-acute psychiatric unit (rehabilitation/continuing care/other care) (VAED Separation Type A)
- Transfer to other acute hospital/extended care/rehabilitation/geriatric centre (VAED Separation Type T)
- Transfer to aged care residential facility (VAED Separation Type N)

**Exclusions**

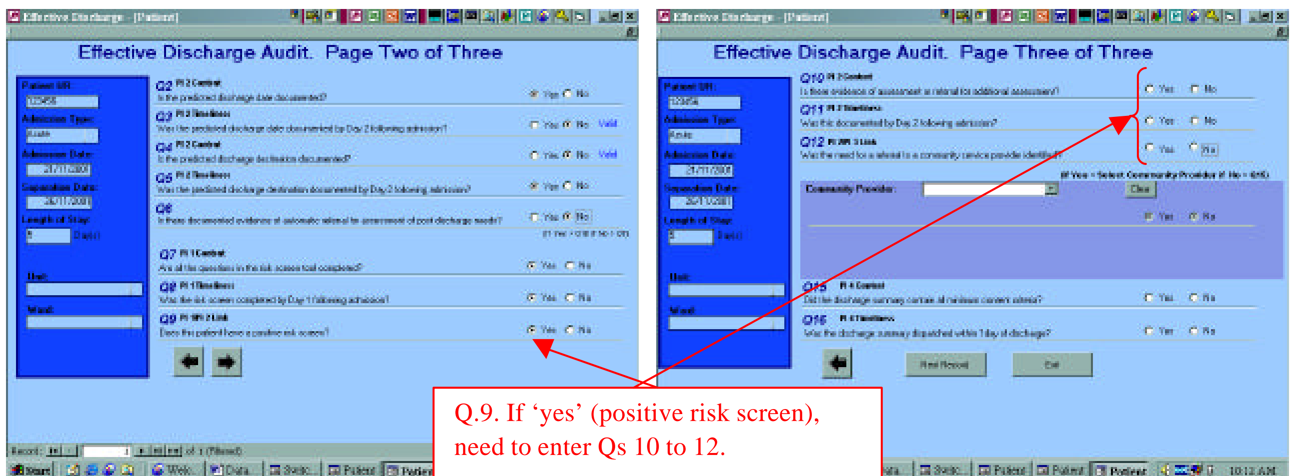
- Admission to intensive care unit within one day of admission to hospital
- Patients unwilling to participate
- Transfer to Nursing Home where prior residence

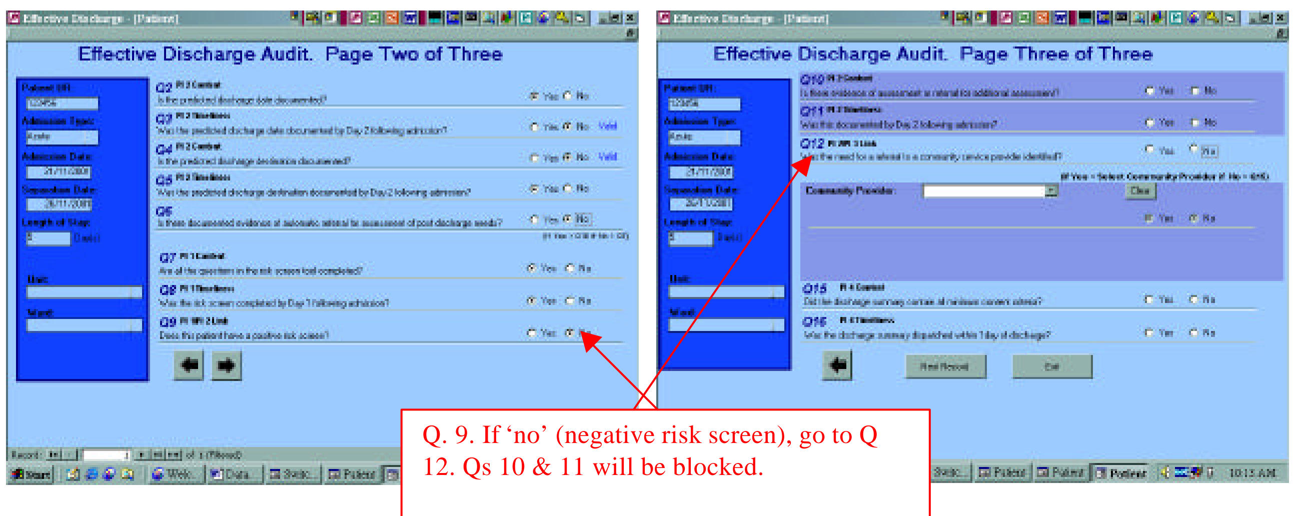
**Question 8 - Was the risk screen completed by day 1 (7 – sub acute) following admission?**




- There must be documentary evidence that the risk screen was completed by day 1 (7 - sub acute) following admission.
- Where the response to question 7 (Were all the questions in the risk screen completed?) was 'no' (did not achieve compliance), then this question will be automatically recorded as a non-compliance.

**Question 9 - Did this patient have a positive risk screen?**



**Definition of a Positive Risk Screen**

- The risk screen questions are:
  - i. Patient likely to have self care problems.
  - ii. Patient lives alone.
  - iii. Caring responsibilities for others.
  - iv. Patient used services before admission.
- A positive risk screen is defined as follows:
  1. A positive response to any *one or more* of the risk screen questions (i), (iii) or (iv); or
  2. A positive response to risk screen question (ii) (Patient lives alone) *and* is over 70 years.
- There are two possible outcomes in regards to a positive risk screen.
  1. Patient *has* been risk screened, but *has not* been referred for further assessment (where this action should have been taken) - *does not* achieve compliance to PI2.
  2. Patient *has* been risk screened and *has* been referred for further assessment or further assessment is deemed not required (and this decision is documented in the patient record) - *achieves* compliance to PI2.

**Negative Risk Screen**

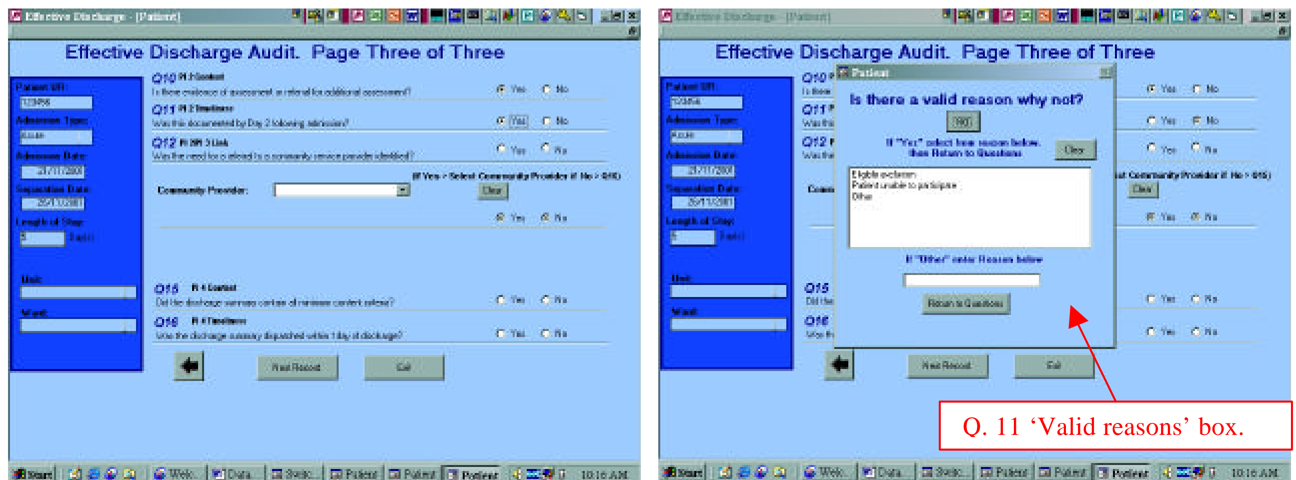
- In circumstances where there is a negative risk screen (i.e. there is a 'no' response to all four mandatory risk screen questions), it is:
  1. acceptable to assume that if all questions are ticked "no" (i.e. a negative risk screen) that no further assessment is required, and so it is not necessary to explicitly document that this is the case (i.e. by specifically writing "no further assessment required" in the patient record).
  2. required that, for all eligible separations, hospitals comply with PI2 by documenting a predicted discharge date and destination. As there is no need to respond to the risk screen, the component of PI 2 "response to risk screen minimum criteria" is not applicable, therefore when conducting the audit, if predicted discharge date and destination are completed within the time specified, full compliance to PI 2 would be achieved.
- Where the response to question 7 was a 'no' (did not achieve compliance), then this question will be automatically recorded as a non-compliance'.

**Question 10 - Is there documented evidence of assessment or referral for additional assessment?**

Q. 10 'Valid Reasons' box

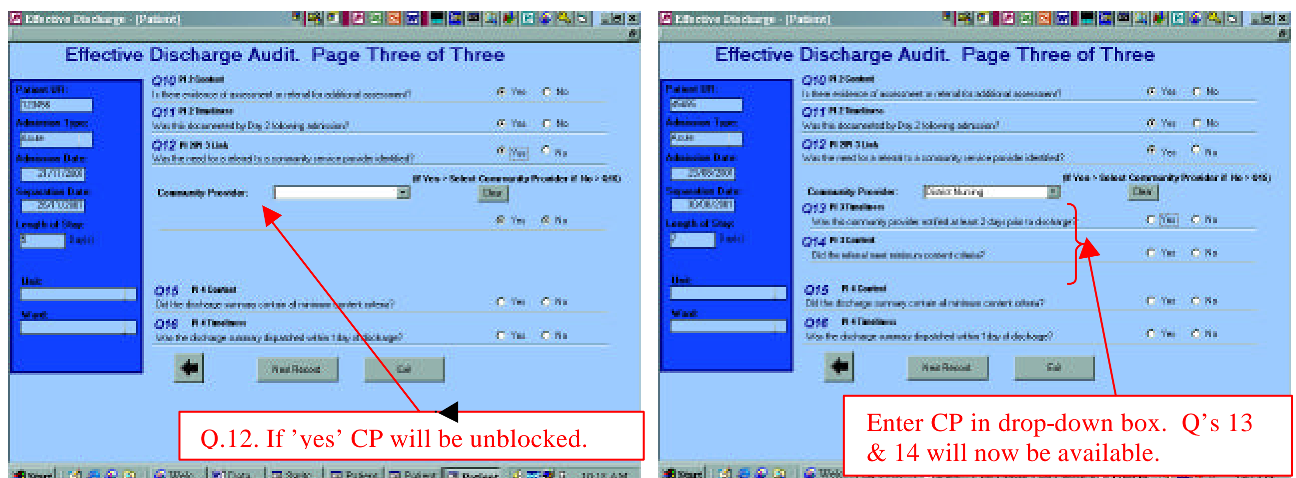
- Where a patient has been identified as needing further assessment of post-discharge needs, the patient record must contain documentary evidence that either the referral for the assessment or the actual assessment has occurred.
- Where there is an automatic referral for assessment, there must be evidence of this assessment having occurred within the specified timeliness criteria as for the risk screen (i.e. within 1 day for acute admissions and 7 days for sub acute admissions).
- Some patients may have a positive risk screen but do not need a referral to a community provider. In these instances, a 'no' response and a valid reason why there was no evidence of further assessment or referral for further assessment (e.g. patient's family may indicate that they will provide adequate care, patient does not want community services, etc.) should be entered.

**Question 11 - Was this documented by day 2 (8 – sub acute) following admission?**




- There must be documentary evidence that the referral for assessment or the actual assessment was completed by day 2 (8 – sub acute) following admission, or by the day prior to discharge for LOS = 3 days.

**Question 12 - Was the need for a referral to a community service provider identified?**



This question must be completed for:

- All Community Services involved in the patient's post discharge care, both pre-existing services and new referrals.
- All new referrals to Residential Care – i.e. notification of the residential care provider, where ACAS assessment and paperwork has not been required.
- Where a referral is to a coordinating service such as PAC, it is acceptable to simply document this, as this service will refer on as applicable to the patient's needs.

It should also be noted that:

- KPI3 does not include the GP
- KPI3 does not include outpatient appointments attended at the hospital.
- Variation for LOS = 3 days – notification by day prior to discharge is acceptable.

**Defining a Community Provider**

- Community providers are any services deemed by the hospital to be necessary to a patient post-discharge. They may include: district nursing services, community nursing services, community health, home and community care providers (e.g. Community Health Centres, district nursing, HACC), or post acute care (PAC), cardiac rehabilitation, allied health appointments at community health centres, or any other relevant and appropriate service. Residential care is NOT deemed to be a community provider where the patient was a prior resident of the facility, or where it is a new referral requiring an ACAS assessment and referral. However, residential care where neither of these conditions are met (e.g. most supported residential services), are regarded as a community provider and referral must adhere to the performance indicator mandatory criteria. A general practitioner is not classified as a community provider for the purposes of the performance indicators.

**Notification of Existing Community Providers**

- Existing community providers need to be notified that services need to be resumed. It is expected that these referrals would comply with the mandatory timeliness and content criteria components for PI 3.

**Patients With a Negative Risk Screen**

- Where a patient has a negative risk screen and does not require the services of a community provider, PI 3 is automatically not applicable and you would answer 'no' to Question 12.
- Where a patient is not risk screened (i.e. a 'no' response to Question 7), it may be that this patient has been identified by some other means of the need for a community provider. In this instance you should answer 'yes' to Question 12. (Note. This record would 'fail' KPIs 1 and 2, but may still comply with KPI 3 if the mandatory requirements for timeliness and content criteria are met).

**Patients with a Positive Risk Screen**

- All patients with a positive risk screen should be referred for further assessment.
- In some instances a patient may have a positive risk screen and a referral further assessment but it is deemed that post-discharge community services are not required. The reason for this decision must be detailed in the 'valid reasons' box.

**Inclusions**

- All multi-day stay patients (elective and emergency) (VAED Accommodation Type 1 or 2)
- Transfer to aged care residential facility (VAED Separation Type N)

**Exclusions**

- Admission to intensive care unit within one day of admission to hospital
- Patients unwilling to participate– i.e. does not provide consent
- Same day stay patients (VAED Accommodation Type 3)
- Transfer to other acute hospital/extended care/rehabilitation/geriatric centre (VAED Separation Type T)
- Transfer to non-acute psychiatric unit
- Transfer to Nursing Home where prior residence

**Question 13 - Were all community providers notified at least 2 days prior to discharge?**

Q. 10 'Valid Reasons' box.

**Notifying a Community Provider**

- All community providers should be notified at least two days prior to discharge (unless LOS is 3 days, then is must occur by the day prior to discharge).
- If a patient is referred to more than one community provider, all notifications must comply with the timeliness and content criteria.

**Length of stay 3 days or less.**

- Where the length of stay is three days or less, notification of community providers of the need for services must be completed by the day prior to discharge.

**Inclusions**

- All multi-day stay patients (elective and emergency) (VAED Accommodation Type 1 or 2).
- Transfer to aged care residential facility (VAED Separation Type N).

**Exclusions**

All patients are potentially eligible except for the following groups:

- Admission to intensive care unit within one day of admission to hospital.
- Patients unwilling to participate– i.e. does not provide consent.
- Same day stay patients (VAED Accommodation Type 3).
- Transfer to other acute hospital/extended care/rehabilitation/geriatric centre (VAED Separation Type T).
- Transfer to non-acute psychiatric unit.
- Transfer to Nursing Home where prior residence

**Question 14 - Did all referrals meet minimum content criteria?**

If 'yes' will ask if any further CPs

Q.14 'Valid Reasons' box.

- There must be documentary evidence that all referrals to community providers contained the following details:
  - *(i)* the community provider (e.g. district nursing).
  - *(ii)* the method of notification (e.g. telephone call, face-to-face).
  - *(iii)* the details of a nominated health professional hospital or delegate responsible for any further information to the community provider (this should include a name and a position title).
  - *(iv)* the predicted discharge date that has been given.
  - *(v)* *for phone or face-to-face contact*, there should be documentary evidence that notification has been received by the community provider, including contact name, position title, and name of service provider (e.g. RN Mary Smith from RDNS accepted referral from RN Jane Smythe from the HCO).
- At the completion of Question 14, you will be asked whether there are other community service providers. Questions 13 and 14 must be answered for all community providers the patient is referred to.
- For referrals to *internal* hospital Community Service Provider liaison persons eg RDNS or PAC liaison staff, where there is access to the patient's Medical Record, it is sufficient that a simple referral is documented or that the liaison has documented initial contact with the patient in the Medical Record within the timeliness criteria, rather than fulfilling the explicit content criteria for KPI 3.

**Inclusions**

- All multi-day stay patients (elective and emergency) (VAED Accommodation Type 1 or 2)
- Transfer to aged care residential facility (VAED Separation Type N)

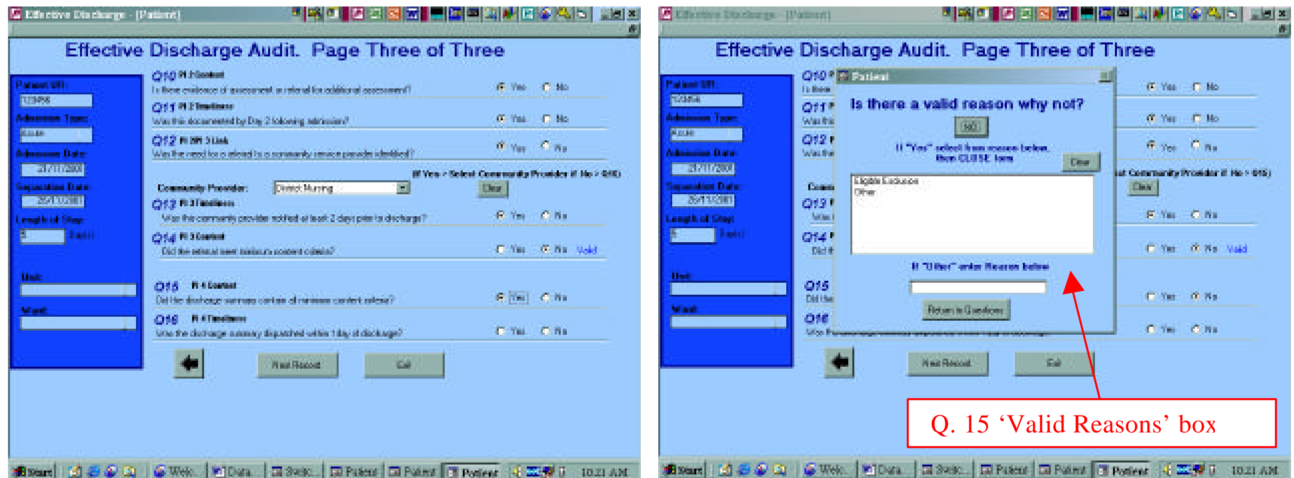
**Exclusions**

All patients are potentially eligible except for the following groups:

- Admission to intensive care unit within one day of admission to hospital
- Patients unwilling to participate– i.e. does not provide consent
- Same day stay patients (VAED Accommodation Type 3)
- Transfer to other acute hospital/extended care/rehabilitation/geriatric centre (VAED Separation Type T)

- Transfer to non-acute psychiatric unit (rehabilitation/continuing care/other care) (VAED Separation Type A)
- Transfer to Nursing Home where prior residence

**Question 15 - Did the discharge summary contain all minimum content criteria?**




Compliance to PI4 requires that the discharge summary contain documentary evidence relating to each of the elements listed.

- Basic demographic information. This includes: (i) the patient's name, hospital identifier and date of birth (ii) the hospital name, unit and the contact details (i.e. name, title & phone number) of doctor for further information (iii) the general practitioner's details.
- Relevant clinical information (the discharge diagnosis, admission and discharge dates, discharge destination, and relevant list of investigations).
- Medication (i.e. complete list of current medication).
- Follow-up (i.e. unreported pathology results, scheduled outpatient appointments, specific instructions or requests for the general practitioner to action).

**Compliance with "Follow up" Information on the Discharge Summary**

- Compliance with 'Follow up' only requires documentation of any relevant information. If no follow up is required, "Not Applicable" (N/A) or "no specific follow up required" should be documented.

**Inclusions**

- Same day stay patients (VAED Accommodation Type 3)
- All multi-day stay patients (elective and emergency) (VAED Accommodation Type 1, or 2)
- Transfer to aged care residential facility (VAED Separation Type N)

**Exclusions**

- Admission to intensive care unit within one day of admission to hospital
- Patients unwilling to participate– i.e. does not provide consent
- Transfer to other acute hospital/extended care/rehabilitation/geriatric centre (VAED Separation Type T)
- Transfer to non-acute psychiatric unit (rehabilitation/continuing care/other care) (VAED Separation Type A)

**Question 16 - Was the discharge summary dispatched within 1 day of discharge?**

Q. 16. 'Valid Reasons' box.

**Definition of dispatch**

- Dispatch is the release of the discharge summary to the nominated general practitioner by the health service within the stipulated timeliness component. The dispatch mechanism can be by facsimile, email, or post (either internal or external). Dispatch includes the date and the mechanism by which the discharge summary was forwarded.
- Where a patient does not have a nominated GP or does not consent to the discharge summary being sent to their GP, the discharge summary is deemed to be dispatched if the record was given to the patient.

**Inclusions**

- Same day stay patients (VAED Accommodation Type 3)
- All multi-day stay patients (elective and emergency) (VAED Accommodation Type 1, or 2)
- Transfer to aged care residential facility (VAED Separation Type N)

**Exclusions**

- Admission to intensive care unit within one day of admission to hospital
- Patients unwilling to participate– i.e. does not provide consent
- Transfer to other acute hospital/extended care/rehabilitation/geriatric centre (VAED Separation Type T)
- Transfer to non-acute psychiatric unit (rehabilitation/continuing care/other care) (VAED Separation Type A)

## Calculating Performance Indicator Scores

- The database will automatically calculate the scores for each of the indicators as well as the Total Discharge Compliance Score and the Total Hospital Effective Discharge Performance Score. Further details of how to produce reports using the database functions are detailed in Part One. Although it is not necessary to know how to calculate the compliance scores for the audit, the following information is included for those interested.
- Where certain patient types are excluded from particular PIs (e.g. PIs 2 and 3 are not applicable for same day stay patients, or where patients with a positive risk screen but do not need to be referred to a community service provider, etc.), these will be taken into account in the calculations. In these circumstances the 'score' for an excluded indicator for a particular patient will be deemed to have achieved compliance to the indicator.
- The screen below shows the way the database signifies which results will be included in the calculation of the compliance scores. In most instances where 'yes' has been entered in response to a question (indicating compliance to the question), then the 'yes' box will be marked with no further information shown. In those instances where a 'no' response was entered, but there was a valid reason for not complying with the indicator, the word 'valid' will appear next to the 'no' box. Where compliance was not achieved and there were no valid reasons for not complying with the question, 'not valid' will appear next to the 'no' box.

**Calculating Compliance**

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Achieves compliance.

Does not achieve compliance.

Certain key questions (or a combination of questions) are used to calculate the various performance indicator scores. Table 2.3 below shows which questions are used to calculate the scores.

**Table 2.3. Calculating Compliance Scores**

| Indicator | Numerator (m) | Denominator (d) |
|---|---|---|
| PI 1 - Timeliness | Question 8 | Q.1 ('No' responses only) |
| PI 1 – Content Criteria | Question 7 | Q.1 ('No' responses only) |
| PI 1 Score | Questions 7 + 8 | Q.1 ('No' responses only) |
| PI 2 - Timeliness | Questions 3 + 5 + 11 | Q.1 ('No' responses only) |
| PI 2 – Content Criteria | Questions 2 + 4 + 10 | Q.1 ('No' responses only) |
| PI 2 Score | Questions 2 + 3 + 4 + 5 + 10 + 11 | Q.1 ('No' responses only) |
| PI 3 - Timeliness | Question 13 | Q.12 ('Yes" responses only) |
| PI 3 – Content Criteria | Question 14 | Q.12 ('Yes" responses only) |
| PI 3 Score | Questions 13 + 14 | Q.12 ('Yes" responses only) |
| PI 4 - Timeliness | Question 16 | Q.1 ('No' responses only) |
| PI 4 – Content Criteria | Question 15 | Q.1 ('No' responses only) |
| PI 4 Score | Questions 15 + 16 | Q.1 ('No' responses only) |
| Total Discharge Compliance Score | Q's 2 + 3 +4 + 5 + 7 + 8 + 10 + 11 + 13 + 14 + 15 + 16** | Q.1 ('No' responses only) |
| Total Hospital Effective Discharge Performance Indicator Score | PI 1 m/d + PI 2 m/d + PI 3 m/d + PI 4 m/d* | 4 |

* m = numerator, d = denominator

** For the purposes of the calculation, where a question is not applicable (e.g. a community provider is not required, patient record is excluded from an indicator, etc.), the score for that indicator will be deemed to have complied with the indicator.

## Troubleshooting

At times there may be difficulties with setting up the database and audits or entering the data. Table 2.4 below details some of the more common problems. Please read this section first before contacting DHS for assistance.

| **Table 2.4. Trouble Shooting** | |
|---|---|
| I cannot import the DHS audit data. | The file must be saved to a new spreadsheet. You cannot save the whole workbook as it includes the data from other hospitals. Each hospital must have a separate Excel file. |
| I can't enter data into one of the questions in the database. | Depending on how you answer some questions, or the patient type, some questions do not need to be answered. These will be blocked and are highlighted in the darker blue colour. If you think that you need to enter the information and it is blocked, check the related questions. It may be that you have entered an incorrect response to a prior question. |
| I entered a response to a question and other questions were automatically completed as well. | For some questions (e.g. Q 7) if you have not complied with the performance indicator criteria, it will not be possible to comply with the related questions for that indicator (i.e. if you haven't answered the risk screen questions, then it is not possible to have completed the risk screen within the prescribed time frame and it is not possible to have determined whether the risk screen is positive or negative). These questions will automatically be completed and you should go to the next available question and continue the audit. |
| I incorrectly entered a response that was tied to other questions (e.g. the risk screen questions), and when I changed my original response, the other questions didn't change. | You will need to enter the correct response for the associated questions. By entering a new response, the previous information will be changed and updated for the calculations. |
| The results of the audit don't appear to be correct. | The database will use the information entered against certain key questions to calculate the results. Ensure that all your responses are entered correctly and that there are no incomplete records in the audit. |
| I want to delete a community provider from my list. | Community providers can only be deleted through the 'Update Community Providers' function located on the main menu page of the database. |

| Table 2.4. Trouble Shooting | |
|---|---|
| A 'debug' error message has appeared. | If you get a message to 'debug' it means your program is not working as it should. Attempting to 'debug' will generally not fix the problem so best to enter 'end' this question, then close and re-open the database. If the problem still persists, you should contact DHS. |
| When I go to save the report it asks me what type of program I should open it in. | The reports should be opened as a 'Rich Text File' (rtf). Once you have done this you can save it on your computer. When you open the file for the first time it should be converted from an rtf file to a Word file. |
| My Access files are opening in the incorrect version. | See Appendix A |
| I updated information in the hospital and audit information section but it didn't update the database. | Shut down the database and re-open. |
| I am unable to download and install the database. | Ensure that you are using the correct version of the database. If unsure you should check with your IT administration. The run-time versions of the database are loaded on as programs. Many organisations require authorisation to load new programs. |

If all else fails contact discharge.strategy@dhs.vic.gov.au Please provide a detailed description of the problem and all your contact details including a telephone number. Please do not telephone with problems.