

**Human
Services**



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Department of Human Services

Supplementary Information for the Effective Discharge Strategy Performance Indicators Audit

September 2001

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Introduction

The Effective Discharge Strategy Performance Indicators were to be implemented in all Victorian acute hospitals, sub-acute services, and multi-purpose services (MPS) on 1st July 2001 with the aim of further enhancing discharge policies and practices within these organisations. It is a requirement that the indicators are implemented and complied with for all eligible admitted patients. All hospitals will be required to undertake an audit of their patient records in June 2002 to monitor compliance against the indicators.

A Definitions and Reporting Guide has been developed to assist with compliance to the indicators and the audit process. An information session was held on 30th July to answer questions around the implementation and to explain how compliance to the indicators will be audited.

A number of questions and issues around the implementation and auditing have been raised. The purpose of this paper is to address the issues that have been raised to date. This document should be used in conjunction with the *Definitions and Reporting Guide 2001/2002*.

1. General Issues

Clinical Pathways

A clinical pathway is sufficient evidence of a discharge plan and discharge date if it is documented, dated and signed.

Hospital in the Home / Rehabilitation in the Home

Hospital in the Home and Rehabilitation in the Home are both inpatient services. As such they are included in the performance indicators.

Other Nursery Accommodation or Mother's Bedside

Other nursery accommodation or mother's bedside (VAED Accommodation Type B) is an exclusion for all indicators. (NB This exclusion replaces the exclusion of 'unqualified neonates', and the VAED code was incorrectly reported as 'N' in the Definitions Guide).

Excluding Patients Who Present Frequently

There are a number of patients who are frequently admitted to hospital, for example, chemotherapy, renal dialysis and radiotherapy patients. It is not necessary to keep re-screening frequently admitted patients at each admission. It is expected that the patient would only need to be risk screened the one time and a discharge summary would only be sent at the completion of the course of treatment. This should be documented in the patient's history. It is acceptable to exclude other groups if ongoing treatment is part of the same episode of care. These patients would be completely excluded from the PIs.

The following DRGs will be eligible for exclusion.

Z60C	Rehab, same day
U40Z	Mental health treatment, sameday with ECT
O65A	Oth Antenatal Admission W Sev Comp Diag, Same Day#
O65B	Oth Antenatal Admission W Moderate/No Comp Diag, Same Day#
O61Z	Postpartum & Post Abortion W/O O.R. Proc, Same Day#
O64Z	False Labour

It is strongly recommended that hospitals contact the patient's GP either by phone or letter for patient's admitted under these DRGs.

Same Day Procedures and Tests for Exclusion

There are a number of procedures or tests where the patient is admitted, but the performance indicators are difficult to implement and are not necessarily relevant. These have been excluded from the having to comply with the performance indicators. The following DRGs will be eligible for complete exclusion from the PIs.

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 Disorders 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	Cplx Ther Gastroscopy Non-Maj Dig Dis ,SD	PANENDOSCOPY WITH EXCISION OF LESION
G42A	Oth Gastroscopy - Maj Digestive Disease	PANENDOSCOPY WITH/WITHOUT BIOPSY BIOPSY
G42B	Oth Gastroscopy for Maj Dig Dis ,Sameday	PANENDOSCOPY WITH/WITHOUT BIOPSY BIOPSY
G43Z	Complex Therapeutic Colonoscopy	FIBROPTIC COLONOSCOPY TO CAECUM WITH/WITHOUT BX
G44A	Oth Colonoscopy W Cat/Sev CC or Comp Pr	FIBROPTIC COLONOSCOPY TO CAECUM WITH/WITHOUT BX
G44B	Oth Colonosc W/O Cat/Sev CC or Comp Proc	FIBROPTIC COLONOSCOPY TO CAECUM WITH/WITHOUT BX
G44C	Other Colonoscopy, Sameday	FIBROPTIC COLONOSCOPY TO CAECUM WITH/WITHOUT BX
G45A	Oth Gastroscopy - Non-Maj Digest Disease	PANENDOSCOPY WITH/WITHOUT BIOPSY
G45B	Oth Gas'py - Non-Maj Dig Disease,Sameday	PANENDOSCOPY WITH/WITHOUT BIOPSY
H41A	ERCP Compx Therapeutic Proc W Cat/Sev CC	ERCP
H41B	ERCP Compx Therapeut Proc W/O Cat/Sev CC	ERCP
H42A	ERCP Other Therapeutic Proc W Cat/Sev CC	ERCP
H42B	ERCP Oth 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 Tiss Malig W Pathological Frac >64	INJECTION/INFUS OTH THRPC/PROPHYLTC SUBS

I65B	Conn Tiss Malig W Pathological Frac <65	INJECTION/INFUS OTH THRPC/PROPHYLTC SUBS
I66B	Connective Tissue Dis <65 W/O Cat/Sev CC	THERAPEUTIC PLASMAPHERESIS/GAMMA GLOBULIN
I69B	Bone Dis & 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
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
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
Z63A	Other Aftercare W Catastrophic/Severe CC	CORONARY ANGIOGRAPHY W LEFT HEART CATH
Z63B	Oth Aftercare W/O Catastrophic/Severe CC	CORONARY ANGIOGRAPHY W LEFT HEART CATH
Z64B	Other Factors Influenc Health Status <80	MANAGEMENT OF INFUSION PUMPS/STEM CELL DONATION

Documenting the Performance Indicators

In some hospitals, aspects of the PIs are recorded in areas other than the Medical Record, e.g. estimated discharge date on the ward whiteboard etc. Staff are reluctant to duplicate recording of information and hence do not write the EDD in the medical record as well.

Although this may be the case, the medical record is ultimately the only place where a long term record of information pertaining to a patient's care is documented. Hence, it is important that information is documented in the medical records as well, both for communicating with other colleagues who may not be familiar with the ward's processes and for medico-legal purposes.

In the case of the example of an electronic discharge summary, where the date of discharge is saved on an electronic record that can be accessed, but is not printed on the discharge summary hard copy, this date can be used in the audit.

Patients Unable to Participate.

Some patients are unable to participate in the performance indicators, for example those with dementia, psychosis, not fully conscious, etc. Typically these patients would have a next of

kin / carer who would respond on their behalf. If this person isn't available, then the situation should be documented. Hospitals would not be penalised in these instances providing the record contains documentation of the difficulties or reasons for not following the indicators in accordance to normal guidelines.

2. Performance Indicator 1 – Risk Screening

Documenting a Risk Screen Response.

In most circumstances a 'Yes' or 'No' response to the risk screen questions will be adequate and the 'not applicable' is generally unnecessary. It may be appropriate, however, to include a 'not applicable' for some categories of patients such as those admitted for terminal care or where there is an automatic referral for assessment.

Negative Risk Screen

In circumstances where there is a negative risk screen (i.e. there is a 'no' response to each of the four mandatory risk screen questions), it is:

- 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).
- a requirement that, for all eligible separations, hospitals comply with Performance Indicator 2 – *commencement of the preparation of a discharge plan* – as it is still necessary to document a predicted discharge date and destination. As there is no need to respond to the risk screen, the component of KPI 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 KPI 2 would be recorded.

Paediatric Risk Screen

Hospitals with large numbers of paediatric separations should have developed a risk screening tool. This should be submitted to the Department for consideration prior to the 1st October (when the data collection period begins).

Same Day Rehabilitation Patients

Same day rehabilitation patients do not need to be risk screened at each admission. In any situation such as this (e.g. same day chemotherapy, radiotherapy, dialysis, etc.) it is expected that the patient would only be risk screened the one time. This should be documented in the patient's history.

Risk Screening Maternity Patients

The application of the risk screening questions is relevant to maternity patients and, as such, they should be included in the suite of risk screen questions for those patients. It is likely that

hospitals would include additional questions specific to their particular patient demographic in addition to the four compulsory questions.

For all patients (maternity or not), this question would assume some level of ‘common-sense’ judgment as to whether the caring responsibilities are likely to be more than what the patient can reasonably cope with post discharge.

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

The risk screen identifies patients living alone and over 70 as requiring referral for further assessment. The reason for attaching an age criteria to the question was to filter the large numbers of younger patients for whom living alone would not be an issue. Evidence shows that persons over 70 years are more likely to require additional support services post discharge, and it is suggested that further assessment of these patients should be undertaken to ensure that they are not at risk. However, it may be that formal assessment is not required and this should be noted in the file.

It should be noted that for all patients, irrespective of age, this question is a judgment call on the part of the person doing the risk screen and it is appropriate that the question be considered for all patients, irrespective of age. 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.

Automatic Referral for Assessment and PI 1

In some sub-acute services the majority of admitted patients receive an automatic referral for assessment by an Occupational Therapists, Physiotherapists, and Social Worker within 7 days of their admission, and all patients who are admitted to a rehabilitation ward are assessed by an Occupational Therapist and a Physiotherapist within 48 hours of admission. The assessment process usually incorporates an evaluation of functional capacity and potential for recovery.

Where there is an automatic referral for assessment it will not be necessary to undertake a separate risk screen, however timelines for risk screening still apply. Although Sub-Acute services are more likely to have automatic referral systems, this would equally apply to any other services where this is also the standard procedure.

3. Performance Indicator 2 - Commencement of the Preparation of a Discharge Plan

Automatic Referral for Assessment and PI 2.

Referral for assessment must be recorded in the patient record (see also PI 1 above). An example of how this could be recorded in the patient record is:

Referral for Assessment

Social Worker

Physiotherapist

Other 1. _____
2. _____
3. _____

This clearly identifies the 'automatic' referrals and allows space for any additional referrals.

Predicted Discharge Date and Destination

As much information needs to be recorded as is available in regards to the discharge destination and predicted discharge date. If the discharge destination is unknown or awaiting ACAS review, then it is acceptable to document this as a legitimate response to the PI. If the name of the nursing home is known, then this should be recorded.

An actual discharge date must be nominated. 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 nursing home bed or Residential Care facility, the preferred date of discharge should be recorded.

It is suggested that the average length of stay (ALOS) be used as a default where there is no other information available. Concerns have been raised by the field, that by using an ALOS, staff may not necessarily 'think' about the predicted discharge date as they write it down, which is not the intent of the KPIs. The date should still provide a prompt to encourage staff to 'think' about what needs to be done before the patient is discharged. A date whether it be simply an ALOS is always more preferable to no date at all.

Same Day Patients

Same Day Patients are excluded from Performance Indicators 2 and 3. For the purpose of the audit, data will not need to be recorded against these indicators. Same day patients should be risk screened (PI 1) and a discharge summary should be sent to the patient's GP (PI 4).

It would be expected however, that hospitals would assess and follow-up on all patients with a positive risk screen and arrange appropriate assistance post-discharge.

Two Day Admissions

In the case of 2 day admissions, in order to adhere to KPI 2, the discharge plan would need to be commenced on the day of admission. This is potentially difficult, particularly if the admission is late on day 1.

Where there is a length of stay 3 days or less, the requirement is that the discharge plan is commenced the day prior to discharge. A predicted discharge date and destination should be documented, even for 2 day admissions. If a hospital is able to undertake a referral for assessment (and then potentially conduct the assessment), and still discharge on day 2, then this should be recorded this in the patient record.

4. Performance Indicator 3 – Timely Notification of Community Providers

Defining a Community Provider

A community provider is defined as a service that is deemed necessary for the patient's ongoing needs post-discharge. A General Practitioner is not a community provider for the purposes of the performance indicators.

Notifying a Community Provider

All community providers should be notified at least two days prior to discharge. It would be expected that most providers would prefer early notification of a new client. Where a service provider requests a same-day 'referral', it is still necessary to 'notify' them at least 2 days prior to the expected date of discharge.

If a patient is referred to more than one community provider, all notifications have to comply with the Performance Indicator and it is expected that all notifications should conform to the both timeliness and content criteria.

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.

Notification of Existing Community Providers

Notification of existing community providers on patient admission is not an indicator that will be audited. Existing community providers would need to be notified that services need to be resumed. If the hospital is not aware of current community providers (i.e. answers no to 'Pt used services before admission' in the risk screen), then hospitals will not be penalised for not notifying the provider of the patient's discharge. However, if the hospital becomes aware of a pre-existing provider then this should be noted in the patient record, and then requirements are as per the indicator.

Sometimes it is difficult to elicit information such as the names of existing community providers from patients (particularly if they are aged or have dementia), or from their next of kin/carers, as they may not be aware of services being used. The hospital's ability to inform the provider is dependant on being able to elicit appropriate information on what services are being used prior to admission. It is expected that a hospital would take all reasonable steps to determine the existing community providers and that these actions be documented in the patient record. Hospitals will not be penalised for not having information that they are unable to obtain.

Contact Details

Indicator 3 calls for names of people contacted to be recorded. This includes both the contact details of an appropriate hospital staff member (to be given to the community provider), and the details of the community provider contact. It is desirable that both the name and title are recorded, as it is often easier to locate a contact by name. Where that person is unavailable, then the hospital / community provider can direct the call to an alternative staff member. It is not good practice to record just a job title as a contact point.

Documentation of Patient Demographic Details

It will not be necessary to document that patient demographic details have been given to the community provider.

Timely Notification of Community Providers

Many community services are only provided on a Monday to Friday basis, compared to the 7 day hospital system. It is argued that it is often difficult, to refer patients to community providers over the weekend. However, adherence to the KPI requires that notification is sent – not that notification has been received. Thus, provided there is evidence that a referral was attempted, the KPI is achieved. A message (including all the content requirements) on an answering machine, or a fax receipt is considered providing notification.

There are occasions where it is not possible to achieve the timeliness component of the PI, despite all reasonable attempts to do so. The following case studies provide two such examples.

Case Study 1 - Notification of community provider when a community provider is unable to accept the referral.

A patient is estimated to be discharged on the 07/08. A referral is made to a Community Service Provider such as RDNS on 05/08, but on the 06/08, it transpires that RDNS will be unable to provide the service, hence on the 06/08, a referral is made to PAC. The patient is discharged on the 07/08 as planned.

Compliance to PI 3 requires that all notifications to community providers should be completed within the time specifications. Obviously, in this case, all reasonable attempts were made to plan for discharge and therefore it is reasonable to consider that the timeliness component of the indicator was achieved, providing the circumstances were clearly documented in the patient record. Similarly, this would apply if a patient changed their mind in the 24 hours prior to discharge or a new issue arose requiring referral to an additional community services.

Case Study 2 – Notification of community provider if a patient is discharged earlier than estimated.

The estimated date of discharge is determined and the community service is notified 2 days prior to the expected discharge date as required. However the patient is subsequently deemed medically ready to go a day earlier than expected.

Providing appropriate carer / community services can be arranged so that the patient will be discharged with all necessary care arrangements in order, it is reasonable to consider that the timeliness component of the indicator was achieved. The circumstances surrounding the discharge should be clearly documented in the patient record. It is not appropriate though, to discharge a patient who needs carer / community services if these have not been suitably arranged.

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”. For that patient record, only performance indicators 1, 2 and 4 would be applicable. Providing all three achieved both the timeliness and content criteria components, then that record would achieve the requirements for the Total Discharge Compliance Score.

Performance Indicator 3 – Exclusions and Inclusions

Transfer to other acute hospital/extended care/rehabilitation/geriatric centre (VAED separation type T) is duplicated in the inclusion and exclusion criteria (refer page 11 Effective Discharge Strategy, Performance Indicators, Definitions and Reporting Guide 2001/2002). It should be deleted from inclusions (i.e. it is considered an exclusion).

Transfer to nursing home (VAED separation type N) is listed as both an inclusion and exclusion. It should be deleted from exclusions (i.e. it is considered an inclusion).

Transfer to non-acute psychiatric unit (rehabilitation/continuing care/other care) (VAED Separation Type A) is listed as an inclusion. It should be listed as an exclusion.

Denominator for Performance Indicator 3 Score

The denominator should read – ‘Total number of eligible separations with referral to community providers’.

5. Performance Indicator 4 – Provision of a Timely and Informative Discharge Summary

Where the Visiting Medical Officer is the Patient’s General Practitioner.

For many rural hospitals the VMO is the local GP and the relevance of the discharge summary has been questioned. A discharge summary still needs to be sent to the GP’s surgery. It is important that a record of the patient’s post discharge needs is on file at the

GP's surgery. Circumstances may arise where, for example, the GP needs to refer to the patient's medication or follow-up details and it is not practicable to get this information from hospital records, or the GP is unavailable and a locum is providing relief.

Signing the Discharge Summary

The discharge summary provides essential information for the ongoing management of patient care. For the discharge summary to be of value the timeliness of the transfer of information to the GP is essential. Through extensive consultation with the field during the development of the performance indicators, it was determined that it was necessary for the discharge summary to be dispatched within one day of separation. Whilst it is preferable that a clinician signs the discharge summary, in order to achieve compliance to the indicator this is not mandatory and it has been suggested that, where individual hospital protocols permit, it is acceptable for another nominated person to sign the summary. The Department of Human Services would recommend however, that it is preferable for the discharge summary to be signed by the hospital medical officer.

Legal advice has been sought on this issue, and the advice was that providing the information was restricted to the transfer of information from the patient record to the discharge summary (i.e. not prescribing any particular course of treatment), then the person signing the summary is only signing against the accuracy of the transfer of information. Where, for example, there might be a misdiagnosis or medications have been incorrectly prescribed this would still be the responsibility of the diagnosing or prescribing doctor.

The issue of having a clinician sign the discharge summary in a timely manner seems to be most problematic for small rural hospitals where a doctor may not be available at the time of discharge. In most of these hospitals, the VMO is often the patient's own GP. In these instances the doctor would be the one to receive the summary and would therefore have the opportunity to review the summary in the surgery.

Where the patient is discharged and the summary sent to a non-VMO GP it is important that the doctor has access to the patient's discharge information. A delay in providing this information because the VMO is not available to sign the discharge summary could compromise patient care if the patient seeks medical advice with no discharge information available.

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, documentation of "Not Applicable" (N/A) or "no specific follow up required".

Doctor Contact Details

It is a requirement of the content component of this indicator that the contact details of an appropriate doctor who can provide further information if required be detailed. It is preferable to record both the name and position of the doctor. If someone was to phone and ask for that doctor and they were scheduled off, then it would be a matter of the hospital suggesting that the caller speak to an alternative person as appropriate. It may be that if the contact person (who has one job title), is being relieved by another person with a different

title. However, colleagues may be more aware of which doctor is most likely to be looking after a particular group of patients.

Notification of General Practitioners

It is a requirement of this indicator that a discharge summary be dispatched within one day of discharge to the patient's GP. This is most often facilitated by faxing the details to the GP surgery. When a patient is discharged on the weekend, the GP clinic may be closed and in some instances the fax is turned off. If the fax is sent but cannot be received by the GP because their fax machine is turned off, a 'failure to transmit' notice should print out from the fax machine. However, in many cases the fax machine would be left on and the summary would be dispatched as required. For those GPs that turn their fax machine off, provided there is evidence that the hospital attempted to send the discharge summary, they will not be penalised. Where the summary was successfully sent, it means that the GP will have access to the discharge summary should there be an unexpected problem. If there are concerns that a patient may require services over the weekend and it is not possible to send the discharge summary to the doctor, a copy of the summary can be given to the patient.

Performance Indicator 4 – Exclusions and Inclusions

Transfer to nursing home (VAED separation type N) is listed as both an inclusion and exclusion. It should be deleted from exclusions (i.e. it is considered an inclusion).

6. Patients Admitted for Terminal Care

Patients who are separated as a death (VAED Separation Type D), are excluded from the audit. However, it is not necessarily clear at admission whether a patient will die or if their medical circumstances will change and they will be discharged prior to death. In a number of cases a patient may be admitted for terminal care, but for a range of reasons, they are discharged home or to another care arrangement (e.g. nursing home). Clearly, it will not be certain on admission how the patient will be separated.

Patients Admitted for Terminal Care and Subsequently Die as an In-patient

PI 1 Risk Screening: It is appropriate to record a 'not applicable' response and document the reason as 'admitted for terminal care'.

PIs 2 and 3: Excluded from these two indicators.

PI 4 – Discharge Summary: As per guidelines (i.e. should be sent to GP within one day of separation with all relevant content criteria).

Patient Admitted for Terminal Care and Subsequently Discharged to Other Accommodation.

PI 1 Risk Screening: It is appropriate to record a 'not applicable' response and document the reason as 'admitted for terminal care'.

Where the patient's condition improves and a decision is made to send them home or to some other accommodation, it will be necessary to ensure appropriate discharge procedures are followed.

PI 2 Commencement of the preparation of a discharge plan.

Timeliness 'not applicable'

Content Criteria Discharge Date: either the predicted date or 'unknown'

Discharge Destination: either the predicted destination or 'unknown'

Response to positive risk screen: a referral for assessment should be done

PI 3 Notification of community providers: As per guidelines (i.e at least 2 days prior to discharge with all relevant content criteria).

PI 4 – Discharge Summary: As per guidelines (i.e. should be sent to GP within one day of separation with all relevant content criteria).

7. Medication Summary

Provision of a Medication Summary

For all admissions it is desirable that a complete list of medications be obtained. However, it is understood that this is not always practicable, particularly for day procedures. The following guidelines will apply:

- For all eligible multi day stay patients a complete list of medications should be obtained and listed on the discharge summary.
- Day patients will be exempted from the requirement to list a complete medication list. However, where the information is available, the Department would encourage its inclusion.

Further information can be obtain by referring to:

Australian Pharmaceutical Advisory Council, *National Guidelines to Achieve the Continuum of Quality Use of Medicines Between Hospital and Community*, January 1998.

8. Audit

Recording Performance Indicator Data

It is expected that hospitals will collect the performance indicators for all eligible patients, however, only the sample provided by the Department will be included in the Department's review of hospital performance.

Performance Indicator Database

It will not be necessary (or possible) to collect the data for the purposes of the audit until June 2002 when each hospital is given the list of patient records to be audited. Some hospitals are choosing to collect their own data throughout the year to monitor their performance. It is not necessary to have the DHS specific database to do this, although it is intended that the database will be made available as soon as possible.

It should be emphasised that the databases are only a repository for the results. What is more important is that hospitals ensure that the patient record contains the necessary information against each of the indicators. The results will be entirely dependent on the quality of the information contained in the patient record.

The Audit Sample

The patient records for inclusion in the audit will be identified by UR and a specific discharge date. Most of the ineligible patients (eg. deaths, same day chemotherapy, renal dialysis, etc.) will be filtered from the sample. Where a patient has had multiple admissions in the data collection period (but they are not for conditions eligible for exclusion), only the episode of care relevant to the discharge date specified will be audited. It should be noted though, where a patient was admitted on multiple occasions throughout the audit period, the patient record may be audited against different separation dates. Where this occurs each occasion should be counted as a different sample and the PIs assessed against the nominated episode of care.

It is the hospital's decision as to who conducts the audit. This can be decided individually by each organisation.

Exclusions from the Audit

Discharge planning is important for all patients, however, for practical reasons, there are some patient categories that will be excluded from the performance indicators and the 2001/02 audit.

For each of the four performance indicators the specific inclusions and exclusions are detailed in the *Definitions and Reporting Guide 2001/2002* and apply to the audit.

Where possible, exclusions will be filtered from the VAED records prior to the sample being drawn. There will, however, be exclusions that cannot be filtered, and the auditors will be expected to exclude them. An over sample of patient records will be made available to hospitals for this.

The Data Collection Period

The data collection period is a six month period which commences on 1st October 2001 and concludes on 31st March 2002. It is not possible to start the data collection period any later as it is necessary to have this six month period from which to draw the sample as many of the smaller hospitals do not have enough separations to be statistically significant if the time period is any less.

Calculating the Performance Indicator Scores

The total discharge compliance score is based on the number of medical records for which all four key performance indicators are complied with. For some patients, eg same day patients, they will only be able to comply with a maximum of 2 PI's. Where an indicator is determined to be 'not applicable' then, for the purposes of the audit, it will be deemed to having achieved compliance. In all cases, if compliance were achieved to all relevant indicators, then that would mean that the Total Discharge Compliance Score is achieved.

Because of the situation that not all patients will be eligible for all 4 indicators, the sample number of the denominator for each of the performance indicator scores will be different. The following case study provides an example of how to determine the denominator for a hospital that is auditing 100 patient records. For the sake of clarity, the example is limited to exclusions based on length of stay and response to the risk screen.

Case Study 5 – Determining the sample size (N)

For hospital X, the total number of records to be audited is 100.

Performance Indicator 1

All patients should be risk screened. For PI 1, the sample size is: $N = 100$

Performance Indicator 2

At this hospital, 40 of the records pertained to day patients and are therefore excluded from this indicator. 60 patients are therefore eligible for PI 2. For PI 2 the sample size is: $N = 60$

Performance Indicator 3

Of these 60 patients 40 were assessed via the risk screen as needing referral for assessment and from these assessments, only 25 were identified as needing community services post discharge. The denominator for this PI is the 'number of eligible separations with referral to community providers', so for PI 3, $N = 25$.

Performance Indicator 4

All patients required a discharge summary to be sent to their nominated GP, so for PI 4 $N = 100$.

Reporting the Data

The results of the audit will be collected and reported publicly by the Department of Human Services. Results will be compared across like hospitals. The Department requires that hospitals report compliance to both the timeliness and content criteria for each PI in addition to overall performance against the indicators. This will enable hospitals to receive feedback on which criteria they are performing well on and which they are not. The data must be reported back to the Department in the prescribed format as detailed in the *Definitions and Reporting Guide 2001*.

Auditing 2002/03 and Beyond

For next year and in the future, the intention is to include the performance indicators on the VAED. Hospital will be informed of the final details of the information to be collected.

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