



HEALTH HOLDING

HAFER ALBATIN HEALTH
CLUSTER
MATERNITY AND
CHILDREN HOSPITAL

Department:	Provision of Care		
Document:	Multidisciplinary Policy and Procedure		
Title:	Discharge and Transfer Summary		
Applies To:	All Healthcare Provider		
Preparation Date:	January 05, 2025	Index No:	PC-MPP-010
Approval Date:	January 19, 2025	Version :	2
Effective Date:	February 19, 2025	Replacement No.:	PC-MPP-010 (1)
Review Date:	February 19, 2028	No. of Pages:	5

1. PURPOSE:

- 1.1 Ensure the continuity of patient care after discharge or referral.
- 1.2 Ensure that information related to the patient's care is given to him/ her upon discharge and to other healthcare providers after discharge/ transfer.

2. DEFINITONS:

- 2.1 **Discharge Summary** – is a comprehensive report of the entire patient's stay within the hospital for current admission.
- 2.2 **Transfer summary** – is a type of discharge summary but is targeted towards an organization/ practitioner from the same or different organization that will assume the care of patient for the same need episode.

3. POLICY:

- 3.1 Complete discharge summary is prepared for all inpatients:
 - 3.1.1 A copy is given to the patient at discharge.
 - 3.1.2 A copy must be kept in the patient's medical record.
 - 3.1.3 As appropriate, a copy of the discharge summary is provided to the healthcare provider responsible for the patient's continuing or follow up care.
- 3.2 At the time of discharge, the assigned consultant or his/ her designee will write the discharge summary and authenticate it by name and signature of the consultant.
- 3.3 Physician can write a medical report for long stayed cases as required.
 - 3.4.1 The patient will receive the discharge summary with required follow up appointments with date and time.
 - 3.4.2 Receives information on how and when to re-access health and supportive services when required.
- 3.5 A transfer summary will be prepared by the attending physician/ his/her designee and authenticated by the attending physician to the receiving organization if the patient is transferred to another hospital.
- 3.6 The attending physician/ his/her designee will prepare a death summary for all deceased patients.
- 3.7 Death reports, copies of discharge and transfer summary are kept in the patient's medical record.
- 3.8 The hospital uses the International Statistical Classification of Diseases and related Health Problems, 10th Revision (**ICD-10**) and Australian Classification of Health Interventions (**ACHI**) for diagnosis and coding. Physician enters the code for final diagnosis while writing the discharge summary.

4. PROCEDURE:

- 4.1 The attending physician/ his/her designee will write the discharge summary on the day of discharge or 1 – 2 days earlier for long stayed cases. Give it to the patient before discharge.
- 4.2 The summary should include:
 - 4.2.1 Patient identification: four names for Saudi/ complete name for non-Saudi, medical record number, sex, date of birth and nationality.

- 4.2.2 Date of admission.
- 4.2.3 Date of discharge.
- 4.2.4 Reason for admission.
- 4.2.5 Provisional and final diagnoses, comorbidities.
- 4.2.6 Significant history and physical examination findings.
- 4.2.7 Diagnostic and therapeutic procedures performed.
- 4.2.8 Course in the hospital.
- 4.2.9 Medications administered during hospitalization.
- 4.2.10 Discharge medications: type, dose, frequency, duration and plan of medications with education to the patient and family and explanations of any possible side effects that they should observe.
- 4.2.11 Nutrition e.g. for diabetes, inborn errors of metabolism
- 4.2.12 Instructions for rehabilitation (for patients who require it according to assessment of their needs) and giving post discharge appointment.
- 4.2.13 Patient condition at time of discharge.
- 4.2.14 Required follow up investigations
- 4.2.15 Follow up appointments with all required services
- 4.2.16 No abbreviations should be used in the discharge summary.
- 4.3 The assigned physician will:
 - 4.3.1 Discuss the post discharge plan of care and instructions with the patient/ patient guardian.
 - 4.3.2 Advise family of available community resources, including other suitable health care agencies those close to the patient's home and informs the patient how and when to re-access health and supportive services.
 - 4.3.3 A copy of discharge summary will be placed in the patient's medical record.
- 4.4 The assigned nurse at the time of discharge will:
 - 4.4.1 Arrange follow up appointments
 - 4.4.2 Give the discharge summary to the patient/ patient guardian and keep a copy in the patient's medical record.
- 4.5 Leaving against medical advice:
 - 4.5.1 Refer the policy on Refusal of Admission or Treatment or Request Discharge Against Medical Advice
 - 4.5.2 Document discharge summary
- 4.6 Death statement and report:
 - 4.6.1 The physician pronouncing the death will:
 - 4.6.1.1 Write progress note indicating death date and time and all events before death and during resuscitation as soon as possible after the death is pronounced.
 - 4.6.1.2 Complete death notification form at the time of death.
 - 4.6.1.3 Write the death medical report:
 - 4.6.1.3.1 It includes essentially the same information as the discharge summary with the addition of summary of the events immediately prior to death and/ or leading to the death, cause of death and date and time of pronouncing the death.
 - 4.6.1.3.2 If not written by the responsible consultant, it should be signed by the physician who wrote it and countersigned by the responsible consultant.
 - 4.6.1.3.3 Keep the death report in the medical record.
- 4.7 Transfer summary:
 - 4.7.1 If the patient is transferred to another hospital, the summary should include the following:
 - 4.7.1.1 Patient's demographics and medical record number
 - 4.7.1.2 Date and reason for the patient's admission
 - 4.7.1.3 Patient diagnosis
 - 4.7.1.4 Brief summary of hospital course and services provided (therapies, consultations, procedures up to date)
 - 4.7.1.5 Medication list and time of last dose given.

- 4.7.1.6 Patient condition and physical status at the time of transfer
- 4.7.1.7 Rationale for transfer
- 4.7.1.8 Results of the patient's diagnostic investigations (e.g. laboratory and radiology)
- 4.7.1.9 Resuscitation status and infection control e.g. MRSA
- 4.7.1.10 Name and signature of the referring MRP and hospital administrator/ designee
- 4.7.1.11 Name of the receiving institution (and receiving physician if possible)

5. MATERIALS AND EQUIPMENT:

- 5.1 Discharge Summary Form
- 5.2 ICU Physician Transfer/Discharge Form
- 5.3 Multidisciplinary Progress Notes

6. RESPONSIBILITIES:

- 6.1 Physicians
- 6.2 Nurses
- 6.3 Medical Records Personnel

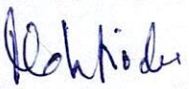


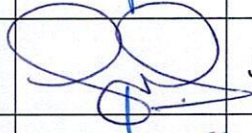


7. APPENDICES:

- 7.1 Discharge Summary Form

8. REFERENCES:

- 8.1 MCH, Directorate Of Health Affairs Holy Capital.

9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Rhodora Natividad	Document Management Control Coordinator		January 05, 2025
Reviewed by:	Dr. Shaimaa Bayoumi Emara	Assistant Medical Director for Medical Quality		January 05, 2025
Reviewed by:	Mr. Sabah Turayhib Al Harbi	Director of Nursing		January 07, 2025
Reviewed by:	Mr. Abdullellah Ayed Al Mutairi	QM&PS Director		January 08, 2025
Reviewed by:	Dr. Tamer Mohamed Naguib	Medical Director		January 12, 2025
Approved by:	Mr. Fahad Hazam AlShammari	Hospital Director		January 19, 2025

