Handover and Discharge Checklist

Includes:

- ✔ Handing over responsibility for patient care
- ✔ Having discharge discussions with patients
- ✔ Completing discharge summaries
- ✔ Distributing discharge summaries

About this Checklist

The OMA has developed a series of checklists to help you understand and implement the CPSO's *Continuity of Care* policies.

This checklist organizes the expectations related to handover and discharge from across all four *Continuity of Care* policies into common tasks. It lists key action items followed by the exact wording from the source policies. It also includes optional guidance from the CPSO's *Continuity of Care: Advice to the Profession* document.

This checklist is not intended as a substitute for reading the CPSO *Continuity of Care* policies in full.

Handing Over Responsibility for Patient Care

☐ Give comprehensive information to the receiving physician and allow for timely discussion when handing over care

- When handing over primary responsibility for patients to another health-care provider, physicians **must** facilitate a comprehensive and up to date exchange of information and allow for discussion to occur or questions to be asked by the health-care provider assuming responsibility. (*Transitions in Care*, 4)
- Physicians **must** respond in a timely manner when contacted by other physicians or health-care providers who want to communicate or request information about a patient. What is timely will depend on, for example, the impact to patient safety that may be caused by a delay in responding. (*Availability and Coverage*, 4)

☐ Work with other health care providers to inform the patient about who will be responsible for their care

- Within hospitals or health-care institutions where care is provided by a team of changing individuals, physicians **must** coordinate with others on the team to keep patients informed about who has primary responsibility for managing their care (i.e., their most responsible provider). (*Transitions in Care*, 1)

Having Discharge Discussions with Patients

☐ Engage the patient in a discharge discussion and provide written reference materials if needed

- Prior to discharging an inpatient from hospital to home, physicians **must** ensure that they or a member of the health-care team has a discussion with the patient and/or substitute decision-maker about:
    a) Post treatment or hospitalization risks or potential complications;
    b) Signs and symptoms that need monitoring and when action is required;
    c) Whom to contact and where to go if complications arise;
    d) Instructions for managing post-discharge care, including medications (e.g., frequency, dosage, duration); and
    e) Information about any follow-up appointments or outpatient investigations that have been or are being scheduled or that they are responsible for arranging and a timeline for doing so. (*Transitions in Care*, 5)

- Physicians **must** use their professional judgment to determine whether to support this discussion with written reference materials, and if so, the specific nature of the materials. In making these determinations, physicians must consider a variety of factors including:
    a) the health status and needs of the patient;
    b) post treatment or hospitalization risks or potential complications;
    c) the need to monitor signs or symptoms;
    d) whether follow-up care is required;
    e) language and/or communication issues that may impact comprehension;
    f) whether those involved in the discussion are experiencing stress or anxiety which may impair their ability to recall and act on the information shared; and
    g) where the patient is being discharged to. (*Transitions in Care*, 7)

☐ Involve the patient's family and/or caregiver if the patient or substitute decision-maker i) wants you to, and ii) gives consent

- Physicians **must** take reasonable steps to facilitate the involvement of the patient's family and/or caregivers in the discharge discussion where the patient or substitute decision-maker indicates an interest in having them involved and provides consent to share personal health information. (*Transitions in Care*, 6)

Additional Advice to the Profession from the CPSO

It can be helpful to have discharge discussions with patients and/or substitute decision-makers in advance of discharge rather than immediately before discharge. The more time patients and caregivers have, the more likely they are to process the information, ask questions, and adequately prepare.

Completing Discharge Summaries

☐ Complete a discharge summary within 48 hours of discharging the patient

- The most responsible physician must complete a discharge summary for all inpatients within 48 hours of discharge. (*Transitions in Care*, 8)

Additional Advice to the Profession from the CPSO

The *Transitions in Care* policy requires that physicians complete (not distribute) the discharge summary within 48 hours of discharge. It's generally good practice to complete dictation at the time of discharge. Depending on the process at your practice location, "complete" could mean that the dictation is complete but pending transcription.

☐ Include the necessary information for post-discharge care in the discharge summary and use language that is understandable to the receiving health-care provider

- The most responsible physician **must** include in the discharge summary the information necessary for the health-care provider(s) responsible for post-discharge care to understand the admission, the care provided, and the patient's post discharge health care needs. While physicians must use their professional judgment to determine what information to include in the discharge summary, it will typically include:
    a) Relevant patient and physician identifying information;
    b) Reason(s) for admission;
    c) Any diagnoses or differential diagnoses at discharge;
    d) A summary of how active medical problems were managed (including major investigations, treatments, or outcomes);
    e) Medication information, including any changes to ongoing medication and the rationale for these changes;
    f) Follow-up care needs or recommendations; and
    g) Appointments that have or need to be scheduled, any relevant and outstanding outpatient investigations, tests, or consultation reports. (*Transitions in Care*, 9)
- The most responsible physician **must** use language that is understandable to the health-care providers who will receive the discharge summary. (*Transitions in Care*, 10)

Distributing Discharge Summaries

☐ Distribute discharge summaries to the appropriate health-care provider(s) in a timely manner

- The most responsible physician **must** direct that the discharge summary be distributed to the patient's primary care provider, if there is one, and/or another health-care provider who will be primarily responsible for post-discharge follow-up care. (*Transitions in Care*, 11)
- If a delay in the completion or distribution of the discharge summary is anticipated, the most responsible physician **must** provide a brief summary of the hospitalization directly to the health-care provider responsible for follow-up care in a timely manner. (*Transitions in Care*, 12)

☐ Communicate directly with the post-discharge health-care provider when necessary

- Where follow-up care is time-sensitive or the patient's condition requires close monitoring, the most responsible physician **must** also consider whether direct communication with the health-care provider assuming responsibility for follow-up care is warranted. (*Transitions in Care*, 13)

Handover and Discharge Checklist Summary

About this Checklist

This checklist contains a summary of the expectations related to handover and discharge set out across the CPSO's four *Continuity of Care* policies. It is not intended as a substitute for reading the policies in full.

Handing Over Responsibility for Patient Care

- ☐ **Give comprehensive information to the receiving physician and allow for timely discussion when handing over care**
- ☐ **Work with other health care providers to inform the patient about who will be responsible for their care**

Having Discharge Discussions with Patients

- ☐ **Engage the patient in a discharge discussion and provide written reference materials if needed**
- ☐ **Involve the patient's family and/or caregiver if the patient or substitute decision-maker i) wants you to, and ii) gives consent**

Completing Discharge Summaries

- ☐ **Complete a discharge summary within 48 hours of discharging the patient**
- ☐ **Include the necessary information for post-discharge care in the discharge summary and use language that is understandable to the receiving health-care provider**

Distributing Discharge Summaries

- ☐ **Distribute discharge summaries to the appropriate health-care provider(s) in a timely manner**
- ☐ **Communicate directly with the post-discharge health-care provider when necessary**