FACT SHEET

Abstraction of Discharge Instructions - Reminders[1]

Effective April 1, 2010 through March 31, 2011 Discharges

Discharge Instructions Address Medications

2-step process

1. **Compile comparison list:** Determine the final list of discharge medications using ALL sources of discharge medication documentation.
2. **Do comparison:** Check the compiled list against the written discharge instructions for completeness.

STEP 1 - Compile comparison list

- Completely disregard the following medications:
  - Antacids
  - Food supplements
  - Herbs
  - Laxatives
  - Minerals EXCEPT potassium (includes saline/sodium chloride products)
  - Vitamins
  - Any medication referred to only by class (e.g., “Angiotensin-Converting Enzyme Inhibitor” listed in discharge summary)
- Include discharge medications included in a discharge summary (or other source) dated after discharge as long as it was documented within 30 days after discharge. Whether or not this information was available to the discharging nurse is irrelevant in abstraction.
- In a case where there are two discharge summaries or two discharge medication reconciliation forms in the chart, use the latest dated/timed version - e.g., Two discharge summaries, one dated 5/22 (day of discharge) and one dated 5/27 - Use the 5/27 discharge summary. If one or both are not dated or timed and the abstractor cannot determine which was done last, both should be used to compile the comparison list of discharge medications. Note: An addendum to a discharge summary should not be considered a second discharge summary. In such cases, both the original discharge summary and its addendum should be used.

[1] See *Discharge Instructions Address Medications* abstraction guidelines in Specifications Manual for National Hospital Inpatient Quality Measures for complete abstraction instructions.

- Include over-the-counter and prn medications (unless they fall into one of the medication categories bulleted above).
- A general reference to discharge medications such as “continue home medications” should be ignored if the discharge medication names are listed out in any source outside of the instructions given to the patient (e.g., medication reconciliation form). In this type of case, only that specified list should be used to compile the comparison list of discharge medications.
- When the **only** reference to discharge medications (outside of the instructions given to the patient) is “Continue home meds” or the like, ALL sources of home medications should be used to compile the list (history and physical, medication reconciliation forms, Emergency Department record, nursing admission assessment, etc.).
- If there is a discharge medication noted in one source that is not mentioned in other sources, take it as a discharge medication - It is required on the discharge instructions.
- **Credit for medication instructions cannot be taken when there is contradictory documentation**. In general, contradictory documentation is documentation in one place that says the patient is being discharged on medication X and a different place says the patient is NOT being discharged on medication X (e.g., “Aspirin” listed in discharge orders and noted as “Do not continue” after discharge on medication reconciliation form would be considered contradictory). Exceptions include cases where documentation is clear there is a stopping of one particular dosage of a medication and the starting of a different dosage of that medication, or a discharge medication reconciliation form that lists “Continue” to a medication in the Home medications section and a “Do not continue” to that same medication in the In-hospital medications section – These should not be considered contradictory.

STEP 2 - Do comparison

- Consider differences which are **brand/trade name vs. generic name** or have the **same generic equivalent** as matches (e.g., Vasotec vs. enalapril, Advil vs. Motrin).
- Whether two different medications have the same action or fall under the same medication class is irrelevant (e.g., Prevacid vs. Protonix is not a match).
- If the patient is being discharged on insulin of any kind, ANY reference to insulin as a discharge med in the written instructions is sufficient (e.g., “Humulin N” vs. “Novolin 70/30,” “insulin” vs. “Humalog”). Note that contradictory documentation regarding an insulin will still count as a mismatch.
- The listing of a medication class on the written instructions, without additional notation of the specific medication name, is NOT acceptable (e.g., Written instructions merely list “Continue inhaler,” instead of "Continue Albuterol inhaler"). This is true regardless of whether or not documentation outside of the written instructions provides the specific medication name in question (e.g., discharge summary notes "inhaler", dc instruction sheet notes "inhaler" - NOT acceptable). Note that this would not apply if the medication class fell into one of the medication categories bulleted above (antacids, laxatives, vitamins, etc.).
- Physician signature on the discharge medication list given to the patient does not ensure credit! His/her signature only plays a role in abstraction if a comparison list is not

available, and the discharge medication list in the written instructions cannot be determined to be complete or incomplete. In such cases, presume the list is complete if a physician/APN (advanced practicing nurse)/PA (physician's assistant) signed the form. Note that this approach would apply in cases where the physician notes only "For discharge meds see Patient Discharge Instruction Sheet" - The physician/APN/PA signature would be required because there is no comparison list.

- An extra medication is acceptable on the written discharge instructions UNLESS there is contradictory documentation specifically saying the patient is NOT being discharged on that medication (e.g., "Lasix" on the written instructions and "Dc Lasix" in the discharge orders would be considered contradictory).

- If there is a plan to start a medication after discharge or a hold on a medication for a **defined timeframe** after discharge (e.g., "Start Plavix as outpatient," "Hold Lasix x 2 days," "Hold Plavix until after endoscopy"):
  - If it is **NOT listed** as a discharge medication elsewhere (e.g., "Plavix," "Lasix"), it is **not required** in the discharge instructions (but if it is listed on the instructions, this is acceptable).
  - If it **IS listed** as a discharge medication elsewhere (e.g., "Plavix," "Lasix"), do not regard this as contradictory documentation, and **require** the medication in the discharge instructions.

- If there is a documented hold on a medication at discharge **without a defined timeframe** (e.g., "Hold aspirin" on discharge medication reconciliation form):
  - It is not required on the discharge instructions.
  - If it is listed as a discharge medication anywhere (e.g., "Aspirin" in the discharge summary's discharge medication list, the discharge instruction sheet, etc.), consider this contradictory documentation (case fails).

- In sum, credit cannot be taken if:
  - Instructions do not include the names of all medications listed out from final compiled list, OR
  - There is contradictory documentation re a discharge medication (either between 2 sources used to compile the final list or between the compiled list and the discharge medication list given to the patient), OR
  - There is no comparison list AND the physician/APN/PA did not sign the discharge medication list/instructions given to patient, OR
  - Documentation is not clear that the patient received a copy of the discharge medication list/instructions.

Discharge Instructions Address Symptoms Worsening

REMINDER: Instructions must be specific to **heart failure** symptoms – e.g., "Call the office if weight gain greater than 2 pounds," "congestive heart failure booklet given: Addresses what to do if symptoms worsen." Instructions stating what to do if "symptoms worsen," "problems occur," "the patient's condition changes or worsens," etc., with no heart failure context, do NOT count.

All Instruction Elements

- Documentation must be clear that a copy of the written instructions (or discharge medication list) was given to the patient/caregiver.
  - A notation such as “Pink copy – Patient” on a form suffices.
  - When a copy of **discharge instruction material** is present in the medical record (such as congestive heart failure handouts, brochures, and forms labeled as Discharge Instructions). but there is no documentation which clearly indicates a copy was given, the inference should be made that it was given IF the patient's name or the medical record number appears on the material AND hospital staff or the patient/caregiver has signed the material. This inference can be made for **discharge instruction material** only. It does **NOT** apply to other medical record documents such as medication reconciliation sheets, physician discharge summaries, nursing care plans, etc. - Explicit documentation that a copy of these forms was given to the patient is required in order to count them as written discharge instructions.
- All instructions should be given to the patient/caregiver in writing by the time of discharge. Instructions mailed to the patient after discharge cannot be used in abstraction.
- Written instructions given to the “caregiver” includes instructions provided to family, instructions sent to home health agency or receiving facility before the patient is discharged, and instructions given to transferring prison official or Emergency Medical Systems personnel.
- Materials outside the medical record CANNOT be used in abstraction. Documentation in the individual record must outline what discharge instruction areas were covered in a congestive heart failure booklet given to the patient, exactly which discharge medications were included on the list sent home with the patient, etc.

Important change in abstraction of *Discharge Instructions Address Follow-up*, *Discharge Instructions Address Symptoms Worsening*, and *Discharge Instructions Address Weight Monitoring*, effective October 1, 2010 discharges

Exclusions have been added which will no longer allow credit in cases where follow-up/symptoms worsening/weight monitoring instruction is in the form of a pre-printed appointment statement with fields left blank, unless next to a checked checkbox.

Examples:

- “Make an appointment with your physician in [blank line] for follow up”
- “If you gain more than [blank line] pounds in [blank line] days, you need to call your doctor”

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