



MONTANA STATE HOSPITAL POLICY AND PROCEDURE

DISCHARGE SUMMARY

Effective Date: June 23, 2020

Policy: HI-04

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- I. PURPOSE:** To provide guidelines for the completion of discharge summaries.
- II. POLICY:**
 - A. The discharge summary provides a synopsis of the patient's clinical history while in the hospital. The basis for the discharge summary is the patient's clinical assessments, treatment plan, progress notes, and treatment plan reviews.
 - B. A discharge summary is to be entered into the patient record within fifteen (15) days following discharge.
- III. DEFINITIONS:** None.
- IV. RESPONSIBILITIES:**
 - A. The attending Licensed Independent Practitioner or a designee is responsible for completing the discharge summary.
- V. PROCEDURE:**
 - A. The discharge summary will be written by a member of the hospital's professional staff who is well acquainted with the patient's clinical course during the hospitalization. The summary must be signed off by the attending Licensed Independent Practitioner.
 - B. The discharge summary will contain the following information:
 - 1. **Identifying Data:** Patient's name, hospital number, date of admission, and discharge date.
 - 2. **History of Present Illness:** Includes reason for admission and pertinent history, which may include psychiatric, drug and alcohol, family, medical, social, work, marital/children, military service, and criminal histories, and living situation.
 - 3. **Significant medical and/or physical findings:** From review of the physical evaluation done by the medical clinic.

4. **Laboratory, X-ray and other consultation findings:** Results of any significant diagnostic tests or procedures should be listed here along with any pertinent consultation findings.
5. **Course in the hospital:** Include mental status upon admission, target symptoms, address treatment modalities utilized, response to treatment, adverse or unexpected results of treatment (such as medication side effects), special treatment procedures used (such as seclusion and restraint), and patient's role in the treatment process.
6. **Condition at discharge:** Includes mental status upon discharge, justification for discharge (typically no longer in need of inpatient level of care, no longer a danger to self or others, can be safely and effectively treated within the community, etc.)
7. **Level of risk at discharge:** Includes risk assessment of danger to self or others.
8. **Informed consent:** Assessment of the patient's ability to understand relevant medications/medical information. Communication between the patient and licensed independent practitioner about the patient's medications/medical treatment. The patient's agreement or response.
9. **Disposition and treatment recommendations:** Significant components of the discharge planning process, difference of opinion with community providers, any significant communications with providers, families, Tarasoff concerns (if used, specify who was contacted, list phone numbers/addresses, indicate what was said, or else indicate where in the record such information can be found; details are VERY IMPORTANT).
10. **Legal status at discharge:** Voluntary, conditional release, and other details regarding commitment or other legal matters which may be important.
11. **Discharge Instructions**
 - a. Restriction to physical activities.
 - b. Dietary restrictions.
 - c. Follow-up instructions to patient.
 - d. Conditions of release (if not mentioned in legal section).
12. **Discharge Medications:** Including days of medications provided.
13. **Diagnosis:** Using DSM V criteria/terminology.
14. Other Conditions which may be a focus of clinical attention.

15. **Signature and Date and Time.**

- VI. REFERENCES:** Hospital Licensure Standard 482.61(e).
- VII. COLLABORATED WITH:** Medical Staff, Director of Health Information, Director of Clinical Services.
- VIII. RESCISSIONS:** HI-04, *Discharge Summary* dated May 20, 2014; HI-04, *Discharge Summary* dated July 13, 2009; HI-04, *Discharge Summary* dated October 30, 2006; HI-04, *Discharge Summary* dated September 1, 2002; HI-04, *Discharge Summary* dated May 20, 2002; Policy HI-04 *Discharge Summary* dated February 14, 2000; HOPP HI-08-97-R, *Discharge Summary*, dated April 9, 1997.
- IX. DISTRIBUTION:** All hospital policy manuals.
- X. ANNUAL REVIEW AND AUTHORIZATION:** This policy is subject to annual review and authorization for use by either the Administrator or the Medical Director with written documentation of the review per ARM § 37-106-330.
- XI. FOLLOW-UP RESPONSIBILITY:** Medical Director.
- XII. ATTACHMENTS:** For internal use.
A. Discharge Summary Template

Signatures:

Kyle Fouts
Hospital Administrator

Thomas Gray, MD
Medical Director