MR.7.1 There is a discharge summary for all discharged patients.

MR.7.2 The discharge summary is complete and includes:

MR.7.2.1 The reason for the patient's admission.

MR.7.2.2 The patient's diagnosis.

MR.7.2.3 Brief summary of hospitalization (therapies, consultations, interventions and results of any important diagnostic testing).

MR.7.2.4 A list of medications used.

MR.7.2.5 Any surgery or procedures performed and their outcome.

MR.7.2.6 The patient's condition at discharge.

MR.7.2.7 All medications to be taken by the patient after discharge.

MR.7.2.8 Any special care the patient requires after discharge.

Standard Intent:

A discharge summary is a summary of the patient's stay in hospital written by the attending doctor. The minimum detail provided in a discharge summary is described in the standard. A discharge summary may be written on a pre-printed form or on plain paper and typed or word-processed in the Medical Record Department. The attending doctor writes a discharge summary in duplicate when the patient is discharged. The original is kept in the medical record and the copy given to the patient to take to their local doctor to enable continuing care.

MR.8 The hospital uses nationally recognized standardized diagnosis and procedure codes.

MR.8.1 The hospital uses the International Statistical Classification of Diseases and Related Health Problems, 10th Revision, Australian Modification (ICD-10-AM) for diagnosis coding.

MR.8.2 The hospital uses Australian Classification of Health Interventions (ACHI) for procedure coding.

Standard Intent:

Hospitals are expected to meet national laws and regulations including the use of standardized diagnosis and procedure codes. Clinical coding is the translation of diseases, health related problems and procedural concepts from text to alphabetic/numeric codes for storage, retrieval and analysis of health care data. Staff responsible for coding should be formally trained by attending clinical coding courses offered at a local or regional level.

Coded data are used to collect statistics on the types and incidence of diseases and injuries. This information is used at a national level for planning health care facilities, for