

Abstraction of Discharge Instructions

Updated June 2007

(Effective 4/1/07+ Discharges - Specifications Manual for National Hospital Quality Measures Version 2.2)

- Question 4:** Is it considered conflicting information between the specific list of discharge medications and the general reference to discharge medications when the MD's discharge summary states "Resume home meds" but then also lists two or three new meds which the patient was not on prior to admission but which were started during the hospitalization?
- Answer:** No. In cases where a general reference such as "resume home meds" is documented along with a list of discharge medications that essentially supplement the general reference, the abstractor should consider both the meds included in the general reference plus the additional medications listed as the discharge medications.
- Question 5:** If the physician lists medications in the discharge summary, and the nurse lists those medications **plus** more on the patient's discharge instruction form, is that acceptable?
- Answer:** Yes. The Discharge Instructions measure requires that all medications prescribed at discharge be listed out in the written discharge instructions given to the patient. If there are additional medications in the written instructions, this is acceptable, for the purposes of our measure.
- Question 6:** When discharge medications listed in the discharge summary match the medications listed by the nurse on the patient's discharge instruction sheet, but the MD stated "continue home meds" in the discharge orders and some of the home meds are not addressed on the patient's instruction sheet, do you count this as a "Yes" or "No" for 'Discharge Instructions Address Medications'?
- Answer:** Mark "Yes". In cases such as this, where there is conflicting information between a specific list of discharge medications (on discharge summary, in this case) and a general reference to discharge medications ("continue home meds"), the abstractor should **consider the specific list of discharge meds most accurate and use only that list.** See the General Abstraction Guidelines for more information.
- Question 7*:** What mistakes does the CDAC see hospitals make when it comes to validating discharge instructions?
- Answer*:** The most common hospital errors the CDAC finds in validation of discharge instruction data elements include:
1. The hospital does not include the names of ALL medications prescribed at discharge in the written instructions.
 2. The hospital gives only verbal instruction about diet, activity, etc. Instructions must be given to the patient in WRITTEN format.
 3. Follow-up instructions given to patient include only the direction to "Follow up as needed." Follow-up prescribed on a PRN or as needed basis is excluded per the guidelines.
 4. In the case of CHF booklets (brochures, teaching sheets), documentation does not convey that the booklet was given to the patient/caregiver. It is not enough to just include a copy of the booklet in the medical record. There must be documentation that the patient/caregiver was actually **given** a copy of the booklet OR the booklet must have the patient's name or medical record number AND hospital staff or the patient/caregiver signature on it. Additionally, too often documentation does not communicate the content contained in the booklet.

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Question 8*: Our hospital hands out brochures in teaching HF patients. Will this count for the Discharge Instructions measure?

Answer*: Documentation that a brochure on Heart Failure was given to a patient does not automatically constitute adequate discharge instruction on the six areas included in the HF-1 Discharge Instructions measure: discharge medications, diet, activity level, follow-up, weight monitoring, and what to do if heart failure symptoms worsen. If a copy of the brochure is included in the medical record, the hospital abstractor should examine its contents, determine which of the discharge instruction areas it covers, and answer the discharge instruction data elements accordingly. **ONLY THE DOCUMENTATION PROVIDED IN THE MEDICAL RECORD ITSELF SHOULD BE USED IN ABSTRACTION - ABSTRACTORS SHOULD NOT REVIEW OUTSIDE LITERATURE.** Please note that brochures frequently do not suffice for Discharge Medications instructions, as the written instructions given to the patient need to be specific to that patient's discharge medication regimen.

Question 9: MD writes in the d/c summary that the patient is to "hold off on his Naprosyn until at least Monday or Tuesday". The Naprosyn was not listed on the patient's discharge instruction sheet along with the other d/c meds. Would the correct answer to 'Discharge Instructions Address Medications' be "Yes" or "No"?

Answer: The correct answer would be "No". If the discharge summary documents the Naprosyn as a discharge medication, it should be interpreted as a discharge medication (i.e., required in the written discharge instructions) unless documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge – regardless of the noted plan to delay initiation/restarting of the Naprosyn for a time period after discharge.

Question 10*: How should hospitals be abstracting 'Discharge Instructions Address Medications'?

Answer*: Abstraction requires a two-step process:

1. Review all discharge medication documentation available in the chart (e.g., physician orders, discharge summary, progress notes) and determine **all** of the medications being prescribed at discharge. Remember to use discharge medication information included in a discharge summary dated after discharge as long as it was added during the hospital's normal course of completing a medical record per organization policy, or within 30 days after discharge, whichever is sooner. Compile one discharge medication list to compare against the patient's discharge instruction sheet.
2. Check this list against the written discharge instructions given to the patient, to ensure that these instructions addressed the names of **all** of the discharge medications. If a list of discharge medications is not documented elsewhere in the record, and the completeness of the medication list in the written discharge instructions cannot be confirmed as complete, select "No". EXCEPTION: If a comparison list is not available, and the discharge list in the written discharge instructions cannot be determined to be complete or incomplete, but the written discharge instructions given to the patient have the name or initials of the physician/APN/PA signed, stamped, or typed on the form, presume the list of discharge medications in those instructions is complete.

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Question 11: If discharge instruction sheets are filled out or signed by an MD should we automatically consider the discharge medication list on the instruction sheet complete ("Yes" to 'Discharge Instructions Address Medications')?

Answer: No. In cases where one or more comparison lists for the discharge medication list in the written discharge instructions is available (e.g., a list noted in discharge summary), the comparison between those lists and the list on the written instructions should still be done, regardless of the physician/APN/PA signature. Only when a comparison list for the discharge medication list given to the patient is NOT available can the abstractor assume the discharge medication list on the patient's instruction sheet is complete because the physician/APN/PA signed or initialed the instruction sheet. Credit for medication instructions can NOT be taken if the discharge summary (or any other source) suggests the discharge medication list in the written discharge instructions is missing a medication, regardless of whether the physician/APN/PA signed the discharge instruction sheet or not.

Question 12: When two or more physicians list different discharge medications for the same patient how do I decide which list to use for determining 'Discharge Instructions Address Medications'?

Answer: One physician's discharge medication list does not take priority over another physician's list. All discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor. In cases where there is a medication in one source that is not mentioned in other sources, it should be interpreted as a discharge medication (i.e., required in the written discharge instructions) unless discharge medication documentation elsewhere in the medical record suggests that it was NOT prescribed at discharge – i.e., Consider it a discharge medication in the absence of contradictory documentation. If documentation is contradictory (e.g., MD noted discontinuation of a particular medication in the discharge medication orders, but this medication is listed in the discharge summary's discharge medication list), or after careful examination of circumstances, context, timing, etc, documentation raises enough question about what medications are being prescribed at discharge, the case should be deemed "unable to determine" (select "No"), regardless of whether the medication in question is included in the discharge medication list in the written discharge instructions.

Question 13: Can we answer "Yes" to Symptoms Worsening instruction if documentation in the chart states the patient was given any one of the following instructions in written format?

1. "Contact office with any problems"
2. "Return to ER with any acute changes in condition"
3. "Call doctor if symptoms recur"

Answer: Yes. If written instructions address what to do if unspecified "symptoms," "problems," or "condition" changes recur, worsen, etc., infer they are referring to heart failure symptoms, unless documentation suggests otherwise.

Question 14*: How should I abstract the notation "Lose weight" on a discharge instruction sheet?

Answer*: Answer 'No' to 'Discharge Instructions Address Weight Monitoring'. Instructions directed toward weight loss only do not meet the intent of this measure and are specifically listed in the Exclusion list.

Question 15: Are vitamins required to be listed on the patient's discharge instruction sheet?

Answer: If the doctor prescribes a vitamin at discharge, and he identifies it by name (e.g., Vitamin C, Calcium), then this name IS required in the written discharge instructions given to the patient. In contrast, if he does not identify it by name but rather uses a more general reference (e.g., "multivitamin"), then the name is NOT required in the written instructions - and, to further clarify, the general reference (e.g., "multivitamin") is NOT required in the patient's discharge instructions either.

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Question 16: There is a discharge instruction guideline which states “Instructions must address at least the NAMES of all discharge medications.” Do ALL discharge medications need to be listed out in the patient's written instructions? Are there some exceptions?

Answer: Exceptions are extremely rare - They include the following:

1. Cases where a discharge medication outside of the discharge instruction sheet is documented only in more general terms - not name-specific (e.g., "insulin", "antacid of choice", "ACEI"). The discharging nurse can't possibly be expected to cite the medication by name if this is never specified by the physician.
2. Oxygen (should not be considered a medication)
3. Medications to be administered in the physician office or clinic (those that won't be taken by the patient or given by the caregiver/HH at home)
4. Medications clearly listed as “PRN” on the Medication Administration Record (MAR) from the last day of hospitalization when discharge medication documentation outside of the written discharge instructions **ONLY** uses a reference such as “continue current medications” or “continue present meds”, rather than lists of the names of the discharge medications.

Question 17: Our physicians use the medication reconciliation process. At discharge they use the medication reconciliation form to document whether a medication is prescribed at discharge or is to be discontinued. If this signed medication reconciliation form matches the patient discharge instruction sheet, is this okay to answer “Yes” for the Discharge Instruction Meds?

Answer: No, automatic credit cannot be taken in cases where all discharge medications on the signed reconciliation form are included on the discharge instruction sheet given to the patient. ALL discharge medication documentation available in the chart should be reviewed and taken into account by the abstractor in compiling a list of medications prescribed at discharge to compare against the written instructions given to the patient - e.g., physician orders, discharge summary, progress notes, etc.

Question 18*: I've got a preprinted discharge instruction sheet with checkboxes in front of specific “Activity” instructions but they are all left blank. Can I still take credit for activity instructions?

Answer*: No. In cases where a document provides a checkbox for discharge instruction information and the checkbox is left unchecked, credit for giving that instruction to the patient/caregiver should not be taken.

Question 19*: For discharge instructions - Is a physician signature required, or will a RN signature suffice??

Answer*: Credit for discharge instructions does not necessarily require a physician/APN/PA or nurse signature. Signatures play into abstraction two different ways:

1. Physician/APN/PA signature or initialing is necessary to get credit for medication instructions in a case where a comparison list for the discharge medication list given to the patient is NOT available (and the abstractor cannot determine whether that list is complete or incomplete).
2. Hospital staff OR patient/caregiver signature/initialing on a teaching sheet, brochure, or booklet is necessary to potentially get credit for discharge instructions in cases where a teaching sheet, brochure, or booklet is present in the record but there is no explicit documentation that a copy was given to the patient/caregiver.

**FAQ that has significantly changed due to revisions in abstraction guidelines for 7/1/06+, 10/1/06+, and/or 4/1/07+ discharges.*

II. Summary of Forthcoming Changes in Abstraction Guidelines

(Specifications Manual for National Hospital Quality Measures 2.3; EFFECTIVE 10/1/07+ DISCHARGES)

Clarification added to assist abstractor in determining how to count “matches” between the compiled discharge medication list and the discharge medication list included in the written discharge instructions given to the patient:

Consider two medications that are **brand/trade name vs. generic name** in nature or that have the **same generic equivalent** as matches (e.g., Vasotec vs. enalapril, Toprol vs. Toprol XL, ASA vs. EC ASA, Prinivil vs. Zestril, Lopressor vs. metoprolol, Metoprolol vs. metoprolol succinate).