## Definitions of quality assessment items

| ITEM | DEFINITION |
|---|---|
| **Admission diagnosis** | Preliminary or working diagnosis given at the time of admission |
| **List of discharge diagnoses** | Principle discharge diagnosis or main reason for admission AND All additional pertinent diagnoses where applicable |
| **Discharge diagnosis responsible for the greatest part of the length of stay** | Diagnosis mostly accountable for the largest portion of the patient's stay |
| **History of presenting illness** | A brief summary of initial presentation and diagnostic evaluation |
| **Pertinent physical findings** | Physical findings relevant to diagnoses |
| **Goals of care** | Level of treatment, code status (e.g curative, life prolonging palliative, symptomatic palliative) |
| **Course in hospital** | Synoptic, problem based description of sequential events and respective evaluations, treatments and prognoses |
| **Hospital consults** | Description of specialty and/or allied health consults |
| **Procedures in hospital** | A list of procedures with key findings and date |
| **Discharge medication** | A listing of all discharge medications with specific description of new, altered and discontinued medications and rationale for changes. |
| **Pertinent lab tests and investigation results** | Relevant (key) tests and investigations |
| **Test results pending at discharge** | Tests ordered during the hospitalization that are pending at the time of discharge |
| **Outcome of care/Condition at discharge-functional ability** | Documentation that gives a sense of the patient's health status at discharge. When applicable, includes functional status (e.g. if they can perform their activities of daily living), cognitive status (e.g memory, attention and executive functioning) |
| **Follow up issues identified** | Clearly described outstanding issues for follow up AND Set out recommendations to a recipient healthcare provider |
| **Appointments after discharge** | person responsible for scheduling, date, time/timeframe, care provider name and specialty where applicable |
| **Discharge instructions** | List of verbal/written information/education provided to patient/surrogate decision maker (SDM) clearly stated. Where applicable, symptoms and signs to seek care for (e.g. unresolved or recurring chest pain, signs of infection) |
| **Identified attending clinician to be called by PCP if there are questions** | Main author of the discharge summary clearly stated |

## Appendix B -Discharge summary scoring tool

| Component item | Omitted<br>0 | Less than optimal<br>1 | Optimal<br>2 | Excessive<br>1 |
|---|---|---|---|---|
| **Admission diagnosis:** | No information | Less than optimal e.g. only chief **complaint** or presenting **symptoms** | Preliminary or working diagnosis given at the time of admission | |
| **List of discharge diagnoses:** | No information | Less than optimal e.g. only signs, symptoms or unknown abbreviations | **Principle** discharge diagnosis or main reason for admission AND **All additional** pertinent diagnoses where applicable | |
| **Discharge diagnosis responsible for the greatest part of the LOS:** | No information | **Maximum 1**<br>Diagnosis accountable for the largest portion of the patient's stay | | |
| **History of present illness:** | No information | Some information missing | A brief summary of initial presentation and diagnostic evaluation | Excessive description |
| **Pertinent physical findings:** | No information | Some information missing | Findings relevant to diagnoses | All findings or substantial number of irrelevant findings |
| **Goals of care:** | No information | Some information missing | Level of treatment, code status (e.g curative, life prolonging palliative, symptomatic palliative). | |
| **Course in hospital:** | No information | Incomplete description with missing links | Synoptic, problem based description of sequential events and respective evaluations, treatments and prognoses | Excessive information |
| **Hospital consults:** | No information<br><br>OR "no consults" not | Some information missing | Description of specialty and/or allied health consults<br><br>**OR** a statement "no consults" | |

| Component item | Omitted<br>0 | Less than optimal<br>1 | Optimal<br>2 | Excessive<br>1 |
|---|---|---|---|---|
| | ticked in absence of consults. | | | |
| | | | | |
| **Procedures in hospital:** | No information | Unknown abbreviations used | A list of procedures with key findings and date<br><br>OR statement "not applicable" | |
| | | | | |
| **Discharge medication:** | No information | Some information missing | A listing of all discharge medications with specific description of new, altered and discontinued medications and rationale for changes.<br><br>OR specific statement: "see DMR"<br><br>**OR** a specific statement "no medications" | |
| | | | | |
| **Pertinent lab tests and investigation results:** | No information | Some information missing | **Relevant** (key) tests and investigations | **all** tests and investigations, or substantial number of irrelevant results |
| | | | | |
| **Test results pending at discharge:** | No information | Some information missing | Tests ordered during the hospitalization that are pending at the time of discharge. | |
| | | | | |
| **Outcome of care/Condition at discharge-functional ability:** | No information | Some information missing | A documentation that gives a **sense** of patient's functional and/or cognitive health status at discharge when applicable e.g. stable at baseline<br><br>Where applicable, includes residual comorbid illnesses and risk factors | |
| | | | | |
| **Follow up issues identified:** | No information | | Description of outstanding issues that will require follow up along with recommendations for | |

| Component item | Omitted<br>0 | Less than optimal<br>1 | Optimal<br>2 | Excessive<br>1 |
|---|---|---|---|---|
| | | | recipient healthcare provider<br><br>**OR** statement that "no outstanding issues exist" or "no recommendations exist" | |
| | | | | |
| **Appointments after discharge:** | No information | Some information missing | Person responsible for scheduling, date, time/timeframe, care provider name and specialty where applicable | |
| | | | | |
| **Discharge instructions:** | No information | Some information missing e.g. a mention about discharge instructions given without specifying what they were | List of verbal/written information/education provided to patient/surrogate decision maker (SDM) clearly stated<br><br>Where applicable, symptoms and signs to seek care for (e.g. unresolved or recurring chest pain, signs of infection)<br><br>OR statement "No special education/instruction required" | |
| | | | | |
| **Identified attending clinician to be called by PCP if there are questions:** | No information | Some information missing | Main author of the discharge summary clearly stated. | |
| | | | | |