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"A Prescription for Perfection": Junior Doctors' Guide to Improved Discharge Summaries

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Abstract

Aim
Assessing the quality of discharge summaries and improving communication and safety during transitions of care.

Methods
Data were collected from e-discharge summaries generated from two time periods June-December 2022 and April-July 2023 after introduction of the discharge summary flowchart and local education. 20 summaries were analysed for each time period.

Results
The number of ideal discharge summaries increased from 4 (20%) to 7 (35%). Audit 2 had 12 (60%) discharge summaries with complete clinical courses compared to 11 (55%) in Audit 1. In Audit 2, there was a 10% increase in the communication of future plans.

Discussion
Encourage Consultants/Registrars to consistently outline patient problem lists, conduct medication reviews and co-sign randomly-selected discharge summaries.
Advise NCHDs to prepare summaries in advance, recording daily patient admission progress. Prioritize the implementation of E-prescribing and electronic health records. Regular 3-montly audit. Continue to align with the ongoing Irish Medical Council plans to introduce Entrustable Professional Activities.

Introduction

Discharge summaries are integral for safe transition of patient care. In our hospital, discharge letters are electronically completed through an IT system that offers a template with mandatory fields, functioning as a prompt. The Health Information and Quality Authority

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(HIQA) National Standard for Patient Discharge Summary Information is a guide for doctors to produce documentation which are standardised and complete[1]. The aims of the two audit cycles were to assess the quality of discharge summaries in St Vincent's University Hospital (SVUH) with a view to improving communication and safety during transitions of care.

Methods

Data were collected retrospectively at two distinct time points from e-discharge summaries from June-Dec 2022 (before interventions) and April-July 2023 (after interventions) for patients admitted to the Acute Geriatric Wards. The interventions included, implementation of the Medicine for the Elderly (MFTE) Discharge Summary Flowchart (Figure 1), which was designed collectively by NCHDs (Registrars, Senior House Officers and Interns) as a guide on what information to include while completing discharge summaries. Other interventions included educational sessions delivered by NCHDs locally at SVUH and nationally.

A total of 20 samples from each time point, were selected at random and assessed against the HIQA National Standard. The electronic discharge summaries were cross-checked with the physical medical records to verify if relevant information were present or omitted. The outcomes prioritised for improvement were outlined on the SVUH electronic discharge summary proformas which are "clinical courses", "diagnoses", "complications or adverse events", "medication prescriptions" and "communication of future plans" . We also determined the number of "ideal discharge summaries" (summaries meeting all of the five named outcomes). Data were recorded and anonymised. Data from the first audit were compared to that of the second audit.

Results

The number of "ideal discharge summaries" increased from 4 (20%) to 7 (35%). Audit 2 featured 12 (60%) discharge summaries with complete clinical courses compared to Audit 1, which had 11 (55%).

All discharge summaries in Audit 2 (100%) had complete documentation of primary diagnoses, whereas Audit 1 achieved 95% in this regard. We also saw a 5% increase in the number of discharge summaries with complete documentation of additional diagnoses, from 13 (65%) in Audit 1 to 14 (70%) in Audit 2.

Both Audit 1 and Audit 2 had the same number of discharge summaries, 14 (70%), with complete documentation of complications.

In Audit 2, there was a notable 10% increase in discharge summaries (from 60% in Audit 1 to 70%) that communicated future plans effectively.

However, there was a decrease in the number of discharge summaries with a complete list of discharge medications, dropping from 12 (60%) in Audit 1 to 10 (50%) in Audit 2.

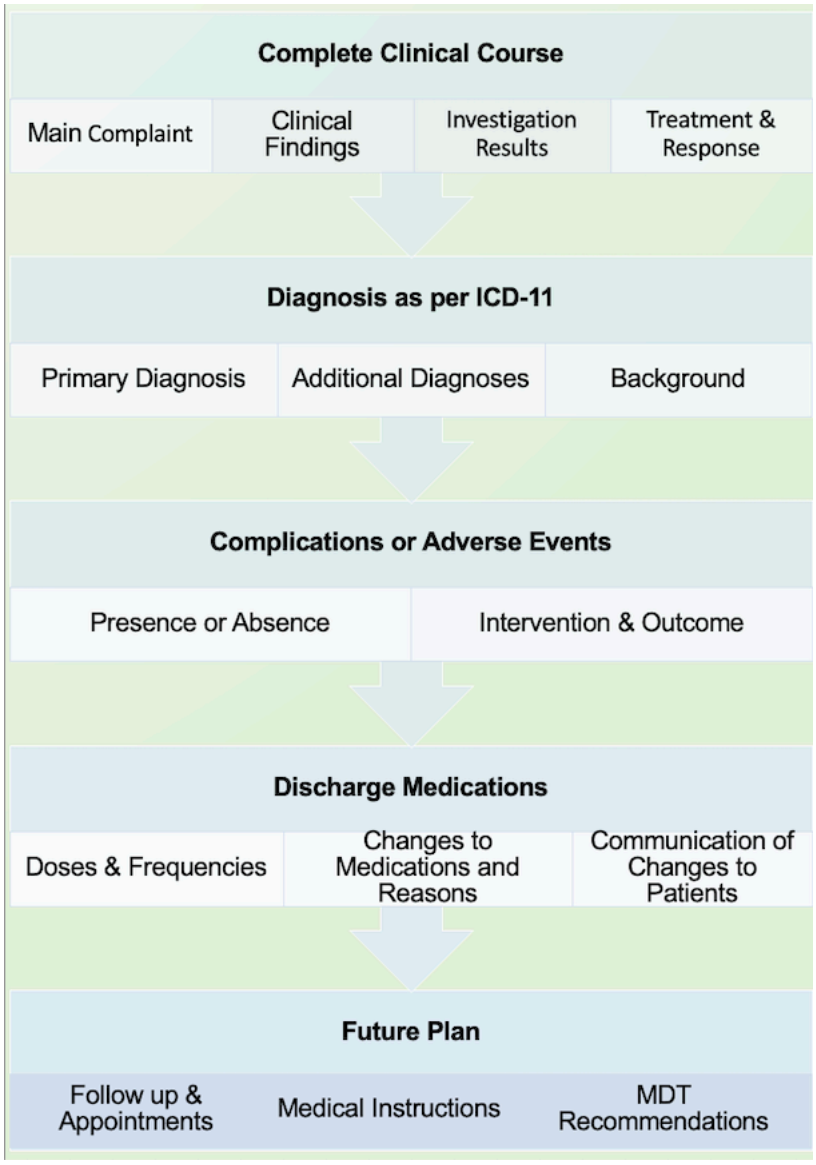

Figure 1 (Appendix) : Discharge Summary Flowchart implemented as a recommendation after Audit 1

Discussion

While comparing the findings from Audit 1 and Audit 2, there was an overall improvement in the quality of discharge summaries produced, but there are still many areas for continued development.

Educational interventions alone may rarely translate into long term quality improvements and systemic changes are often required to sustain progress. [2] Therefore, efforts have been

prioritised in SVUH to introduce E-prescribing and electronic health records to ensure clearer communication of inpatient events. A possible hypothesis for the decrease in the percentage of complete discharge prescriptions may be attributed to the more stringent recommendations applied by NCHDs while referring to the MFTE Discharge Summary Flowchart. There had been suggestions for Consultants and Registrars to regularly outline problem lists during ward rounds as well as performing medication reviews closer to the estimated date of discharge (EDD). Non Consultant Hospital Doctors (NCHDs) are advised to prepare summaries ahead of the EDD whereby the progress of patients' admissions would be recorded on discharge summaries daily. A third audit cycle will be performed in collaboration with other departments as part of a wider and regular hospital 3-monthly audit. The results from the third audit will be presented as a poster presentation at the International Forum of Quality and Safety in Healthcare, in London (April 2024), in efforts to generate more support and participation nationwide and internationally. At the national level, we will continue to align with the ongoing Irish Medical Council plans to implement Entrustable Professional Activities (EPA), which are essential tasks that a trainee can be trusted to perform without direct supervision, once sufficient competence has been demonstrated. Limitations encompass small sample sizes of 20 participants per audit cycle, constraining statistical testing; potential bias may arise when assessing discharge summaries as NCHDs would audit the work of their predecessors or current colleagues within the department, and there is limited feedback from General Practitioners (GPs). The results may not be generalizable or transferable to other departments or hospitals given the discrete nature of complex elderly patients and the differing electronic systems and resources between hospitals. Efforts will be directed toward gathering constructive feedback from the GP liaison committee meetings during the third audit cycle.

Declarations of Conflicts of Interest:
None declared.

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