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A Quality Improvement Audit to assess the detail of ICU Admissions in Medical Discharge Summaries

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Dear Editor,

We read with interest your article: 'Prescription for Perfection: Junior Doctor's Guide to Improve Discharge Summaries'. We have performed a similar audit in our own Tertiary Institution. We looked specifically at the hospital discharge summaries for patients who had required admission to the Intensive Care Unit during their hospital admission. The current practice is for an internal discharge summary detailing the patient's ICU stay to be placed in the medical notes for access by the primary team taking over care on the ward.

As you mention, HIQA standards for discharge documentation require complete information to ensure appropriate ongoing medical care for the patient[1]. We retrospectively reviewed the electronic records for 157 patients who were discharged from ICU between January 2023 and March 2023. We reviewed their electronic medical discharge summaries to assess whether specific criteria relating to their ICU admission were present in their discharge summary to the GP. We also reviewed their discharge prescriptions to ensure that patients were not on any unnecessary medications on discharge.

157 patients' electronic discharge summaries were reviewed. Of these 66 patients (42%) did not have an electronic discharge summary completed. The reasons for this are unclear. 87 completed discharge summaries were reviewed to determine if the summary included an accurate account of the time in the Intensive Care Unit. Out of the 87 charts reviewed, 23% (20/87) did not reference an ICU admission, and 5.74% (5/87) had no clear reason for ICU admission stated. Important interventions in the intensive care unit were also omitted in 56% of the discharge summaries. These included intubation, renal replacement therapy, and culture positive infections were also omitted in 56% of the discharge summaries.

Furthermore, the discharge prescriptions of these patients were reviewed. All discharge prescriptions are electronically recorded. 143 Patients had discharge prescriptions, with 13.2%.(19/143) of patients being inappropriately discharged home on medications which had been initiated while in the intensive care unit but not subsequently discontinued prior to

hospital discharge. These medications included psychotropic medications which had been initiated for delirium or agitation management. Failure to discontinue such unnecessary medications during transition of care is a preventable prescribing error that can lead to inappropriate long-term prescription of these medications and risk of associated polypharmacy and medication interactions when the patient is discharged back to the community[2].

Our findings align with those in your institution, and it is clear that interventions to improve communication and safety at times of transition of care are imperative. The results and key points from our audit have been shared with NCHDs working in the hospital as a means of providing awareness and education. A specific focus on medication weaning and discontinuation of unnecessary medications occurred during these education sessions. The importance of completing and signing off on discharge summaries promptly as well as having discharge prescriptions reviewed by an SHO or registrar (if required) have also been highlighted during teaching sessions. Further interventions to create a separate ICU discharge summary which can be sent to the GP on discharge from the intensive care unit are also in progress. We aim to re-audit activity following these quality improvement initiatives to assess change.

Declaration of conflicts of interest:
None declared.

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