Improving electronic discharge summaries in elderly care medicine: a quality improvement project

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Aims

To improve the comprehensiveness of electronic discharge summaries in a teaching hospital elderly care department using quality improvement methods and repeated audit cycles.

Methods

We performed a snapshot audit at 4-monthly intervals towards the end of each junior doctor rotation in elderly care. 30 electronic discharge summaries were selected randomly from the elderly care base wards over a 1-week period. Their quality was assessed against the recommendations of NICE and our hospital trust's policy on discharge summaries.

After each audit cycle, we presented our findings at departmental meetings and promoted discussion to assist our junior trainees in writing comprehensive discharge summaries. We showed cases where incomplete information had led to subsequent problems for patients, such as when omitted service information had led to confusion for GPs, patients and relatives. Between audit cycles, we advertised the importance of discharge summaries in poster format, encouraged a review of electronic discharge summaries by educational supervisors as part of a case-based discussion for national e-portfolios, asked local GPs what information they considered important in discharge summaries, and adjusted the template to allow easier input of multidisciplinary data.

Results

The predominately medical domains of presenting complaint, past medical history, investigations, treatment and medications were consistently well documented, with over a 95% documentation rate. AMTS score, changes to medications, and discharge destination were documented far less frequently, at 25%, 18% and 13% respectively. After educational interventions highlighting the importance of this information, there was significant improvement; 53%, 79% and 77% respectively. Re-audit showed sustainability of these changes despite new junior trainees each 4 months. Multidisciplinary information, with respect to functional goals, was lacking, with only 16% of discharge summaries including occupational therapy assessments, and only 40% including details on physiotherapy information and which community services patients were being discharged with.

Conclusions

This rolling snapshot audit shows that the quality of information in electronic discharge summaries in elderly care medicine can be improved and sustained by repeated education of new junior trainees using quality improvement methods. We are aiming to develop electronic discharge summaries that better reflect comprehensive geriatric assessment and the importance of input from our multidisciplinary colleagues in elderly care.

The next audit cycle will review the impact of changes to the electronic discharge summary template to include multidisciplinary functional goals and key discharge destination and services information. We believe this process will lead to safer and better quality information for our elderly patients discharged from hospital.

Conflict of interest statement

We have read and understood the policy on declaration of interests and declare that we have no competing interests. ■

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