

# Comparing the Quality of Discharge Documentation between Specialist Elderly Care Wards and Acute Medical or Surgical Wards

Anthony P Howe  
Salford Royal NHS Foundation Trust, Salford  
United Kingdom



Howe A; Akbar S, Ashrafi H, Chmiel W, Choonara H, Kent L, Yip K, Gaillemine O & Vilches-Moraga A

# CONFLICT OF INTEREST DISCLOSURE

I have no conflicts of interest to declare

# Background

Forms part of ongoing audit cycle started in July 2016 to assess quality of discharge summaries

Broader scope to assess quality of those documents across all directorates; Ageing and Complex Medicine, Ortho-geriatrics, General Surgery and Acute Medicine  
- Further analysis comparing between these directorates

Salford Royal:

- 850+ bed teaching hospital in the north west of England, UK
- It serves the needs of a local population as well as acting as a tertiary centre for neurosciences, dermatology, renal medicine, general surgery and intestinal failure

# Rationale

Good quality documentation is essential to the safe transition of care for elderly patients at the point of discharge.

High quality discharge documentation is used to:

- Safely facilitate transfer of care from hospital to the community
- Serve as a record of the events of an admission for health care providers
- Communicate with patients, relatives and carers:
  - This may be single source of information regarding the events of an admission
  - Some experience lengthy hospital admissions or develop an acute confusional state or have established underlying cognitive impairment.
    - This may affect the ability to recall events and follow up plans after discharge.
  - Some have care provided by relatives or health care professionals who may not be fully aware of the events of the admission

# Methodology

Utilising electronic patient record (EPR) – Sunrise Allscripts

Established national (Academy of Medical Royal Colleges 2013) and local (Salford Royal NHS FT) guidance on discharge summaries

Inclusion criteria: all patients aged  $\geq 74$  years

Inpatient admission and discharge to community (home or care facility) from Ageing and Complex Medicine (ACM); Orthogeriatric, General Surgical and Acute Medical wards

Two cycles of data collection Jan – Feb 2017 and April 2017

# Methodology

Data Collected: 32 data points including:

|                       |   |
|-----------------------|---|
| Basic information:    | Length of admission, location   |
| Demographics:         | Age and sex   |
| Authorship:           | Role, whether involved, weekday vs. weekend   |
| Acute kidney injury:  | If diagnosed; whether this is recorded, appropriate follow up                                 |
| Clinical information: | Past medical history, new diagnoses, summary of admission, relevant investigations/procedures |
| Social/functional:    | Assessment documented, community care provision   |
| Medicines:            | Whether started, stopped or amended + rationale   |
| Communicating care:   | Follow up details, action for GP  |
| Patient information:  | Summary in lay terms, contact information   |
| Dementia/delirium:    | Diagnoses and interventions recorded  |

Comparisons between ACM and non-ACM wards

# Results

## Demographics & authorship

321 records reviewed

Average age: 83.2 years

Male 120    Female 201

Author Role:

| Role                    | ACM   |       |
|-------------------------|-------|-------|
| Foundation (1 – 2)      | 37.3% | 70.5% |
| Core Trainees (3 – 4)   | 33.2% |       |
| Specialty Trainees (5+) | 15.2% |       |
| Consultant              | 7.1%  |       |
| ANP/Pharmacist          | 3.7%  |       |
| Medical Students        | 3.4%  |       |

  

| Data                            | ACM | Non-ACM |
|---------------------------------|-----|---------|
| Author involved in patient care | 95% | 84%     |
| Weekday                         | 98% | 93%     |

Authorship:

# Results

## Clinical information and AKI

### Clinical information:

|                              | ACM | Non-ACM |
|------------------------------|-----|---------|
| Summary of visit             | 98% | 93%     |
| Investigations or procedures | 96% | 93%     |
| Clear list of new diagnoses  | 69% | 57%     |
| Updated past medical history | 65% | 38%     |

### Acute kidney injury:

|                       |       |       |
|-----------------------|-------|-------|
| Incidence             | 25.8% | 17.4% |
| Documented            | 93.1% | 95.8% |
| Appropriate follow up | 73.6% | 80.0% |



# Results

## Social and functional information

### Care facility

|                                  | ACM   | Non-ACM |
|----------------------------------|-------|---------|
| % of patients from care facility | 34.1% | 16.4%   |
|                                  | ↓     | ↓       |
| documentation                    | 81.8% | 46.7%   |

### Functional assessment

|               | ACM   | Non-ACM |
|---------------|-------|---------|
| documentation | 25.8% | 19.9%   |

# Results

## Medication changes

|                                     | ACM | Non-ACM |
|-------------------------------------|-----|---------|
| Medication regime change documented | 79% | 84%     |
| Rationale for change documented     | 67% | 77%     |

# Conclusions

- Discharge summaries are authored primarily by junior members of the team
  - Summaries with involvement from pharmacists, physiotherapists etc. were of higher quality
  - ACM discharge summaries authored more frequently by members of patients own team
- Clinical information is more accurately documented by ACM teams
- Medication regime changes more accurately documented by non-ACM teams
  - Does not take into account perhaps more complex medication regime changes in ACM wards
- Social and functional assessment very poorly documented across all wards

# Issues identified

- Junior members of the team (particularly new graduates) have little training in comprehensive discharge documentation for the elderly
- Variable provision of feedback for teams about completed discharge summaries
- Service pressures often mean that documentation is done at the last moment – at the point of discharge
- Electronic patient record has risk of copy and pasting of potentially inaccurate or excessive medical information (i.e. entire radiological reports/operation notes etc.)

# Further work...

- Community involvement
  - Survey and/or focus groups with general practitioners and community health care professionals
- Establish consensus on minimum standards
  - Survey Consultants in Ageing and Complex Medicine in addition to Surgical and Medical colleagues
- Patient involvement
  - Survey access to and use/understanding of discharge documentation
- Training for authors and regular feedback
  - Rolling monthly data collection and feedback for teams
- Assess impact of in-reach services to general surgery and acute medicine on quality of discharge summaries

# Merci de votre attention

....see you next year in

