



# An audit of discharge summaries from secondary to primary care

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Received: 12 January 2018 / Accepted: 5 July 2018 / Published online: 17 July 2018  
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## Abstract

**Background** Health is information-intensive. Reliable health care depends on access to this information in a timely and accurate manner. A standardised data set for clinical discharge summaries is essential to optimise the care the patient receives, particularly at discharge. The Irish Health Information and Quality Authority (HIQA) have recently developed a national standard for patient discharge summaries.

**Aims** Our aim was to assess the current quality of discharge summaries being received, determine the main areas of concern and establish the areas to improve patient safety.

**Methods** We studied 60 discharge summaries received at 3 general practices in the Mid-West of Ireland. We used HIQA “National Standard for Patient Discharge Summary” 2013 as our audit standard.

**Results** Mandatory fields including Surname, Forename and date of birth were present in 100%, missing in 0%. The patient's address was missing in 7% ( $n = 4$ ). Gender was missing in 82% ( $n = 50$ ). Source of referral was missing in 52% ( $n = 32$ ). No method of admission was documented in 70% ( $n = 43$ ). Whilst principal diagnosis was documented in 100% ( $n = 60$ ), no co-morbidities were documented in 28% ( $n = 17$ ). No medication was documented in 30% ( $n = 18$ ), and there was no documentation of medication changed in 39% ( $n = 24$ ). Details of the person completing the discharge summary were incomplete as follows: 85% ( $n = 52$ ) had no specialty documentation, 36% ( $n = 22$ ) had no registration number and 38% ( $n = 23$ ) had no contact number.

**Conclusions** This audit shows deficits in adhering to HIQA standards. These must be addressed as a matter of urgency.

**Keywords** Content · Discharge summary · Hospital · Patient · Secondary care

## Introduction

It is generally accepted that timeliness and quality of hospital discharge summaries are crucial for patient safety and efficient health service provision after discharge [1]. Systematic reviews have concluded that what was needed most in a discharge summary were reason for admission,

treatment, outstanding results on discharge, the main diagnosis and subsequent management, with a standardised and structured form being preferred [2, 3]. These echo the findings of earlier research [4].

In July 2013, the Irish Health Information and Quality Authority (HIQA) issued a national standard for patient summary information [5]. Whilst acknowledging that some clinical specialties have specific requirements regarding information they need to share with general practitioners on discharge, the HIQA standard aimed to be a generic data set fulfilling the needs of the majority of clinical specialities [5]. Elements of the patient discharge summary were classified as being either mandatory, optional or mandatory where applicable.

The aim of this study was to assess the current quality of discharge summaries being received from secondary care hospitals in the Mid-West of Ireland. Using the HIQA report as our standard, we aimed to determine the main areas of concern and thus establish the areas to improve patient safety and optimise quality of service.

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**Electronic supplementary material** The online version of this article (<https://doi.org/10.1007/s11845-018-1862-6>) contains supplementary material, which is available to authorized users.

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## Methods

An audit template was developed based on 12 mandatory parameters as recommended by the 2013 HIQA report. This is shown in Appendix 1. The discharge summaries of 60 patients received by 3 GP training practices were retrospectively studied over a 6-month period from June to November 2017.

Discharge letters that were included came from University Hospital Limerick, St John's University Hospital Limerick, University Orthopaedic Hospital, Croom, Co Limerick, University Hospital Nenagh, University Hospital Ennis and Galway University Hospital.

Details of the practices are given in Table 1. Inclusion criteria were discharge reports received from any hospital or secondary care institution. Results were tabulated in "MS Excel". Descriptive statistics were used.

## Results

These are summarised in Table 2. Patients' baseline parameters were present in all cases and the address was present in 56 (93%) of cases. However, gender was only indicated in 10 (17%) of cases.

Less than half of cases (28 or 47%) indicated the source of referral and method of admission was documented in 17 (28%). Whilst the admission diagnosis was documented in all cases, co-morbidities were documented in 43 (72%). A full list of medication was documented in 42 (70%), but only 36 (60%) had a list of medications which had been stopped or withheld.

The speciality of the person completing the discharge summary were complete in eight (13%) cases.

## Discussion

This study shows that there are deficits in the standard of discharge summaries emanating from secondary care hospitals in the Mid-West. Whilst the reasons for this are understandable in terms of the undoubted pressure on the hospital

system, the current situation is clearly not ideal and is at odds with the HIQA standards.

Many other studies have shown deficits in the timeliness of and information contained within hospital discharge summaries that may adversely affect patient care [1, 6–8]. In particular, medication errors have been shown to occur in discharge summaries with potentially harmful consequences. Thirty-three percent of paediatric discharge letters in one UK study contained medication errors, and 10% of these had the potential for patient harm [9]. A study of discharge letters of frail elderly patients found a medication error rate of 15%, and 13% of these errors were considered serious [10].

Reasons for such deficits include systems insufficiencies (e.g. medication reconciliation process, staffing challenges), lack of understanding others' roles (e.g. unclear which provider should be completing the discharge summary), information-communication breakdowns (e.g. inaccurate information communicated to the primary medical team), patient issues (e.g. patient preferences misaligned with recommendations) and poor collaboration processes (e.g. lack of structured interprofessional rounds) [11]. Also, that over a third of junior doctors felt inadequately prepared for writing discharge summaries [12].

However, high-quality discharge summaries have been developed successfully in different areas of the USA in electronic format [13, 14]. A brief, low-intensity educational intervention can improve quality of discharge communication and be incorporated into residency training [15].

## Strengths and weaknesses of the study

Strengths were that the data was collected directly from hospital discharge letters received at the practices using a standard template by three experienced doctors in their final year of specialist general practice training. This data was compared directly with a "gold standard" in the form of the 2013 HIQA report. The discharge summaries were produced in the second half of 2017 and are therefore time-relevant and reflect current practice in the Mid-West area. The data was collected from three geographically separate practices in the Mid-West,

**Table 1** Practice characteristics

Practice ID	GP Reg	Urban/rural	GP FTE	Nurse FTE	Admin FTE	Computerised
1.C	1	Rural	2	1	2	Full
2.L	1	Rural	1	1	2	Full
3.E	1	Urban	2.5	1	1	Full

*Practice ID* practice identification code, *GP Reg* General Practice Registrar (this is a senior GP trainee), *urban/rural* whether the practice studied is located in an urban or rural setting, *GP FTE* the number of full-time equivalent general practitioners employed in the practice, *nurse FTE* the number of full-time equivalent practice nurses employed in the practice, *admin FTE* the number of full-time equivalent administrative staff employed in the practice, *computerised* the degree of computerisation of the practice

**Table 2** Results

Mandatory field	Present <i>N</i> (%)	Absent <i>N</i> (%)
Surname	60 (100)	0 (0)
Forename	60 (100)	0 (0)
Date of birth	60 (100)	0 (0)
Address	56 (93)	4 (7)
Gender	10 (17)	50 (83)
Source of referral	28 (47)	32 (53)
Method of admission	17 (28)	43 (72)
Documented diagnosis for admission	60 (100)	0 (0)
List of co-morbidities	43 (72)	17 (28)
List of medication documented	42 (70)	18 (30)
Medication stopped or withheld documented	36 (60)	24 (40)
Specialty of person completing discharge summary documented	8 (13)	52 (87)
Person completing discharge summary registration number	38 (63)	22 (37)
Person completing discharge summary contact telephone number	37 (62)	23 (38)

which allowed for inclusion of a diversity of source hospitals of the discharge summaries.

Weaknesses were that the data was collected for a 6-month period. Whilst it is possible that discharge summaries released at other times of the year might have been different to the sample analysed, this is unlikely. Also, the data was collected on only 60 discharge summaries from hospitals in the Mid-West and Western regions of Ireland only. Some hospitals may have better or worse standards of discharge summary preparation, through training their nonconsultant hospital doctors (NCHDs) differently. However, there is no reason to believe that any other hospitals in Ireland differ significantly from those studied.

The audit did not review all of the standards set out by HIQA. The group headings were defined as “mandatory” and “mandatory as applicable”. Given the volume of data, it was decided that confining the audit to the mandatory areas was most relevant. However, in doing so, critical elements such as whether the discharge letter clarified actions expected of the GP and whether it laid out a management plan for the patient were not assessed. Finally, only three practices were studied. However, all three were well established with a good urban rural mix. Thus, we believe that the results of the study are applicable nationally (Table 2).

## Conclusion

The current standard of discharge summary from secondary care falls short of accepted standards.

Interventions which have been shown to be successful at improving such standards should be employed to address this issue as a matter of urgency.

**Funding** There was no external source of funding for this study.

## Compliance with ethical standards

**Ethical approval** This was a clinical audit and therefore did not require ethical approval.

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