Clinical effectiveness

USING CLINICAL AUDIT TO BUILD THE CASE FOR DISCHARGE SUMMARIES THAT COMMUNICATE COMPREHENSIVE GERIATRIC ASSESSMENT

M. Vettasseri, H. Wingate, Y. Ashokkumar, A. G. Blundell, A. L. Gordon
Dept of Health Care of Older People, Nottingham University Hospitals NHS Trust
Division of Rehabilitation and Ageing, University of Nottingham

Evidence-base: High-quality transfer of care documentation, reflecting all domains of comprehensive geriatric assessment (CGA), is recognised as central to good clinical practice. In January-March 2011, we audited 199 consecutive discharge summaries from Health Care of Older People (HCOP) against the Clinicians Guide to Record Standards of the Academy of Medical Royal Colleges. Several deficiencies were noted but particularly in reporting of functional status and cognition. This was despite these being routinely assessed on HCOP wards.

Change strategies: We designed a pro forma to reflect all domains of CGA – medical, psychological, social, functional and environmental. This was rejected by our trust in favour of a standardised electronic document shared across all departments based on the hypothesis that standardization would improve practice. In HCOP monthly discharge summary review and reflection sessions were organized to support good practice. We re-audited practice in 152 consecutive discharge summaries over a three month period from Sept-Dec 2012.

Change effects: There was no change for domains previously completed in >90% of patients (discharge diagnosis, reason for admission, clinical narrative and inpatient investigations). There were improvements in basic admission documentation: responsible consultant increased from 38-100% and discharge destination from 48-98%. The inclusion of a compulsory “no intentional changes to medication” box, without which the pro forma could not be authorised, saw medication change documentation increase from 81-100%.

Reporting of functional status, or cognitive performance (<50% of discharge summaries) did not improve. Advice regarding ongoing referral or management in the community following discharge was documented in <60% of patients.

Conclusion: Standardised electronic documentation supported by review and reflection sessions improved completion rates for basic admission data and medication changes but did not improve communication of comprehensive geriatric assessment to primary care teams. This evidence supports the potential benefit of a multi-domain HCOP discharge document as initially planned.