

QIP Incomplete Discharge Summary

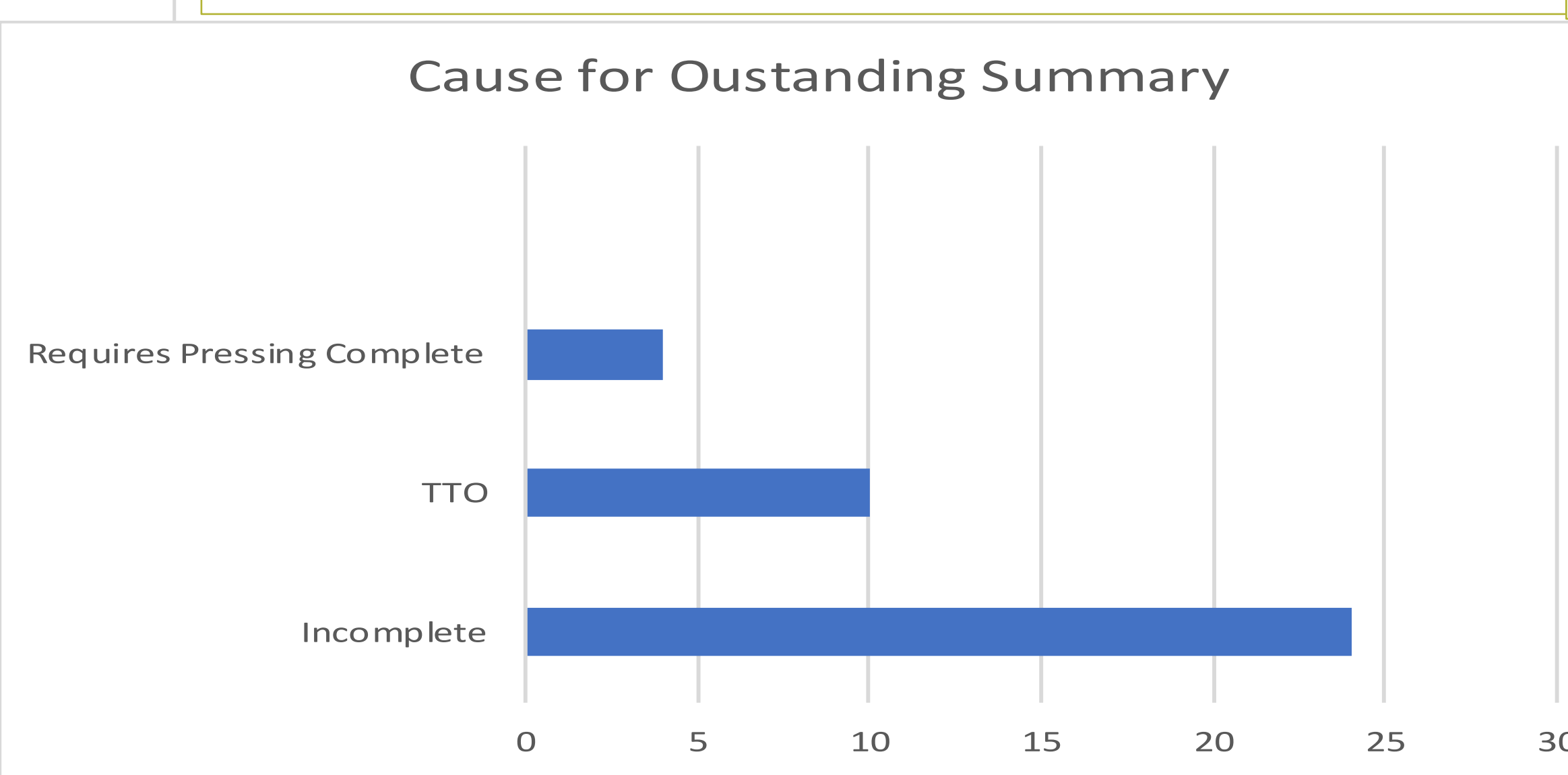
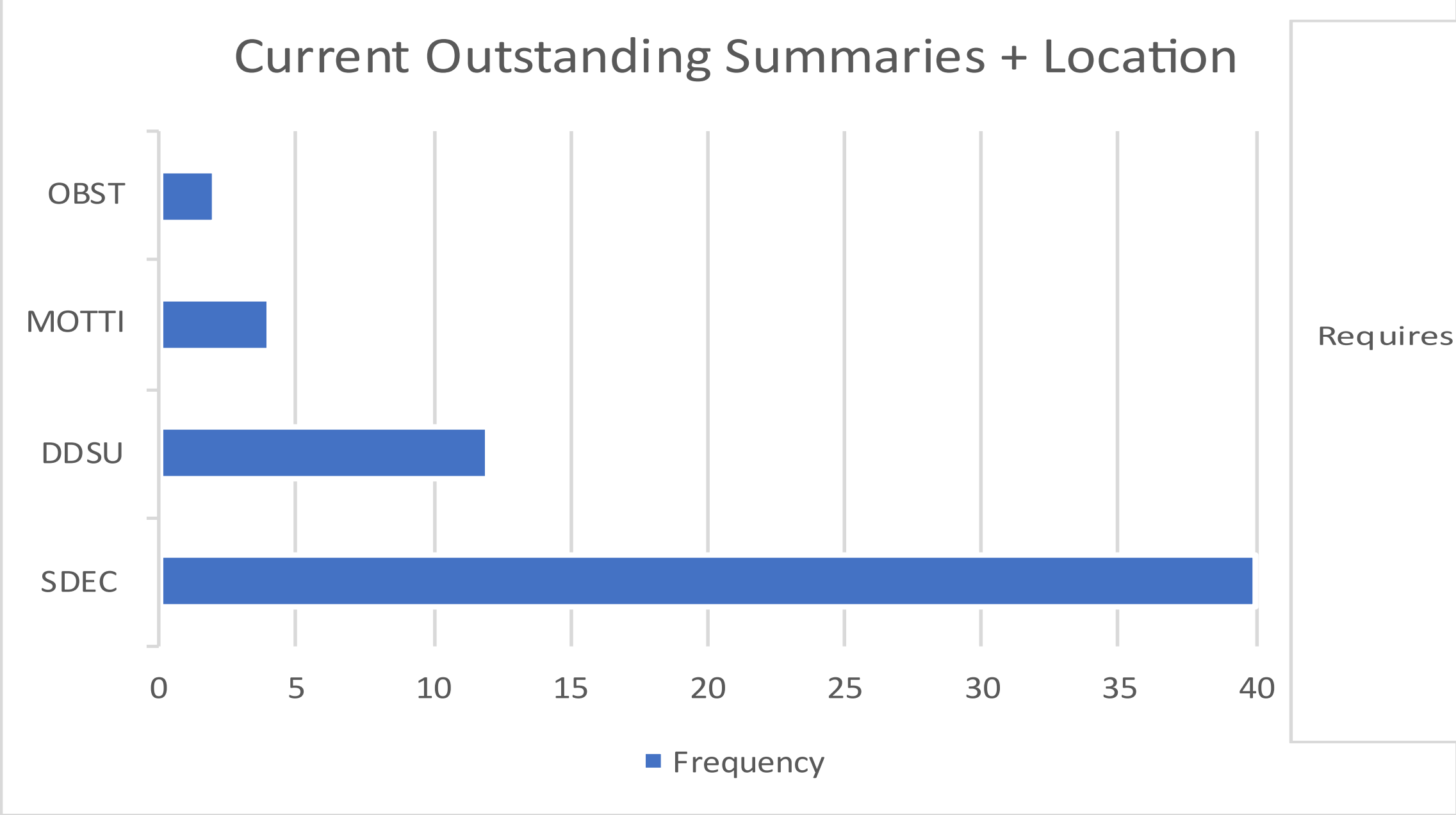
Aim: For all discharge summaries to be comprehensively and robustly completed within 24hours of discharge

Retrospective audit
Time period 1st March to 31st May 2024 data collection after implication
Data collected from 10th June to 10th September 2024
Location St Mary Hospital Isle of Wight

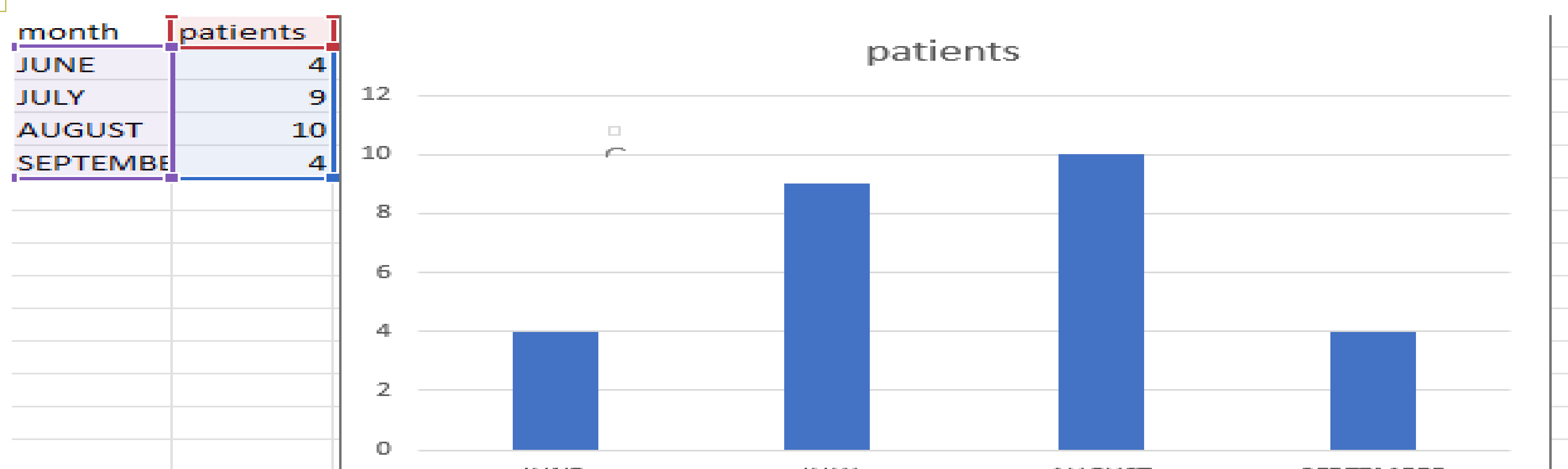
Pre-Implementation:
1: We had form team and define the responsibilities for each team members.
2: collect baseline data to check current status of discharge summaries including accuracy and completeness.

Idea generation
Formulate Discharge summary booklet.
-Establish a regular training schedule for new and existing staff.
Continuous Monitoring: Implement continuous monitoring and feedback mechanism to maintain high standard.

Steps for Implementation
Discharge summary booklet sent by email mentioning how to write a discharge summary on e-care logic mentioning about regular monitoring of discharge summaries and help was offered
By regular monitoring found the areas which needed improvement so sent the emails and feedback
Discussed with IT department and pharmacy to sort out issues



Post Implementation Results:
There were 67 incomplete Discharge summaries at the start of the project and this has now reduced to only 27 incomplete discharges within 12 weeks



LOCATION	NUMBER OF PATIENTS
SDEC	20
DSU	4
MOTTISTONE	3

Causes of pending discharge summary post implementation:
5 was need to click to complete.
6 was seen by consultant in SDEC but discharge summaries was not completed.
3 was cancelled on OT list.
3 was medication was prescribed but not completed on discharge slip.
4 was on call registrar was given on phone advice but proper communication was not given as patient has been admitted in SDEC.
2 was documentation was done in paper but not updated in e-care logic.
2 was no information available
1 was twice admission by SDEC by mistake
1 was patient was discharge next day but not updated in system in next day

Feedback
Click medically fit to discharge and complete discharge summaries
All need to complete discharge summaries /even paper notes if seeing patient in sdec
If patient canceled on OT list the gynae theatre team that day needs to complete discharge summaries
If medications prescribed , choose correct option on medication page to complete it.
Phone consultations regarding patient in SDEC needs discharge summaries
Update the discharge summary if patients not being discharged same day by the on call team

Recommendations: Circulate the discharge booklet to every new member of team (consultants. registrars and sho's)
Every Monday of the week sho's can review the discharge summaries of previous week and give feedback
Reaudit in 3 months to see the progress
Individual feedback so as to continue and maintain the good work

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