Response to: an audit of discharge summaries from secondary to primary care

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We read with interest the article by O'Connor et al. [1]. Their group assessed the quality of discharge summaries from secondary to primary care using the Irish Health Information and Quality Authority's *National Standard for Patient Discharge summary (2013)*. Their group identified areas of concern in discharge summary documentation and how patient safety can be improved. In support of previous studies on discharge summary quality, they concluded that standards for discharge summary documentation are not consistently achieved [2–4].

With the aims of improving discharge summary quality and the consistency of information transfer, our group have analysed and compared patient discharge summary documentation against operation notes. We randomly selected 3 months of consecutive operative cases (from within the last 12 months) from a tertiary paediatric orthopaedic centre in London, England. Of the 91 patients we studied, (age 8 ± 4.7 SD; 49 M) 20 (22.4%) had discharge summaries of an unacceptable quality, either due to information being absent or inconsistent with operation note documentation. Sixty-six (77.6%) patients had discharge summaries with a procedure description that matched the procedure description on their operation note. Seventy-eight (91.8%) patients had a follow-up management plan documented in their discharge summary, with 73 (85.9%) patients having their discharge summary and operation note documenting the same follow-up management plan.

Our findings further demonstrate the occurrence of documentation inconsistencies within this method of communicating health information. Ultimately, our group has analysed different data parameters to O'Connor et al., and have still

identified similar flaws of incomplete documentation and incorrect data entries, within discharge summaries.

Possible reasons that we have identified for the poor quality of discharge summary documentation included temporary members of the medical team writing discharge summaries (who are unfamiliar with documentation expectations) and outdated discharge summary coding systems. To address these issues, we suggest implementing data recording checklists, training for the use of coding in a discharge summary and developing a prepopulated data base of agreed procedures. Overall, it is hoped that analysis of discrepancies and absences of data will enable changes that improve the short and the long-term management of these patients and improve patient safety [4].

References

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