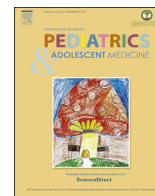


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Challenges of implementing a standardized process for discharge summaries (5 years experience)



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ABSTRACT

Introduction: Discharge summaries are essential documents to provide a long-lasting record of a patient's visit to a hospital. It provides an effective method of communication between various hospital services and primary care providers.

We conducted a study recently in KFSH&RC recommending that every admitted patient to the Pediatric Department must have a discharge summary initiated as soon as possible within the first five days of hospitalization and to be updated periodically until its completion on the patient's discharge day. Results of this study showed that most of the patients received their discharge summaries within the time limit as recommended by the JCI standard.

Objectives: The aim of this paper is to present our department's experience in regard to the difficulties, challenges, and outcomes of the adopted work flow for discharge summaries over a period of five years.

Methods: The residents have been instructed to initiate the discharge summaries as soon as possible within the first five days of hospitalization for every patient admitted under the Department of Pediatrics regardless of the expected discharge date. Afterward, it will be the responsibility of the attending junior and senior residents to update the summaries on regular basis as long as the patient under their care. They should transfer the updated summary to the coming resident that will take over the medical care until the discharge day when the most recent update will be forwarded to the attending consultant for final review and signature.

Results: Between 2011 and 2016, a significant drop in the number of delinquent records was noted. From 1131 delinquent records at the end of the fourth quarter of 2011, the number has fallen to 15 in the fourth quarter of 2016. Furthermore, compliance to JCI documentation standards showed sustained improvement since the initiation of the project. The department used to score around 50% in the discharge documentation compliance rate which has improved to be maintained around 80% in average.

Conclusions: Every new project concerning the quality of patient care provided in any institution is expected to face multiple challenges and difficulties. Proper identifications of the challenges, standardize approach for solutions, sustainability of quality monitoring for an improvement projects can maintain the success for any new project.

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1. Introduction

Discharge summaries are essential documents to provide a long-lasting record of a patient's visit to a hospital [1]. It provides an effective methods of communication between various hospital

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services and primary care providers [2].

Proper communication at the transitional process from the hospital setting back into the community is crucial for the patient's well-being in order to guarantee continuity of care [3–5]. It also provide patients and their caregivers with an adequately detailed description of their illness, management, laboratory results, medications list and needed follow up [6].

Delayed and poor quality of a patient's medical documentations, including discharge summaries, and ineffective communications with regard to the patient's conditions between healthcare providers will result in unfavorable outcomes that may have a pronounced bad impact on the continuity of care, resources used, patient and physician satisfaction and above all patient safety [7]. This highlights the importance of proper communication at the time of hospital discharges [8].

High quality discharge summaries and their availability at discharge time can adequately cut down the number of hospital readmissions, effectively increase patient's safety and satisfaction [9,10].

The frequency and severity of unwanted adverse outcomes after hospital discharge were found to be secondary to preventable causes that can be reduced by improving communication between primary health providers and community care providers [11,12]. Lacking of discharge summary's elements may negatively impact the overall discharge summary quality leading to miscommunication and mismanagement after discharge [13]. Reducing the workload on residents have showed good outcomes in improving the overall quality of discharge summaries, decreasing the number of delinquents records, improving the accuracy of documented information and better completeness of "time consuming" discharge summaries [14].

King Faisal Specialist Hospital and Research Center (KFSH&RC) is a tertiary care hospital located in Riyadh, Saudi Arabia. It is the national referral center for innumerable medical fields and is considered a modern, state-of-the-art Joint Commission International accredited (JCIA) academic medical facility.

A study was recently conducted in KFSH&RC by Almidani et al. [15] recommending that every admitted patient to the Pediatric Department must have a discharge summary initiated as soon as possible within the first five days of hospitalization and to be modified periodically until patient get discharged. Results of this study showed that most of the patients received their discharge summaries within the time limit as recommended by the JCIA standard. In addition, compliance to JCIA documentation standards has been improved as measured by the hospital Quality Management Department's audit [15].

The aim of this paper is to present our department's experience in regard to the difficulties, challenges and outcomes of adopting new work flow for discharge summaries during the last five years.

1.1. Objectives

1. To present the Department of Pediatrics data about the effect of implementing new discharge summary process on documentation compliance rates over a period of five years.
2. To discuss the challenges and difficulties encountered during the implementation period.

1.2. Inclusion criteria

- All pediatric patients admitted under the care of Pediatric Department

1.3. Exclusion criteria

- Pediatric patients who are not under the care of Pediatric Departments

2. Methods

2.1. Implementation of discharge summaries' improvement project

In reference to the previously mentioned publication [15], a discharge summary improvement project was launched with main objective to improve the quality of discharge summaries as well as minimizing the number of delinquent records. To achieve this, the residents have been instructed to initiate the discharge summaries as soon as possible within the first five days of hospitalization for every patient under the Department of Pediatrics care regardless of the expected discharge date. Afterward, it will be the responsibility of the attending junior and senior resident to update the summary on a regular basis as long as the patient under their care. They should transfer the updated summary to the coming resident that will take over the medical care until the discharge day when the most recent update will be forwarded to the attending consultant for final approval and signature. The detailed process has been published before [15].

2.2. Challenges and difficulties

Changing a culture of practice in a big department that has multiple sections with wide variety of working process is a challenging step. Moreover, there is a huge dynamic in the flow of the residents covering the same patient as mandated by the residency training program structure. These issues have created multiple challenges during the implementation process of the new discharge summary project.

2.2.1. Challenges include but not limited to the following

According to the training structure set by the Saudi commission for health specialties, every resident should rotate across the in-patient's areas following certain block schedule. This may include a rotating resident from outside the department/hospital in frequent occasions. This dynamic created a huge challenge in regard to standardizing the level of awareness between all residents covering the service. To overcome this problem, we created orientation sessions conducted by a designated resident to be given at the beginning of each block rotation for the existing residents. These sessions include a summary of the project with algorithm, templates and dictation instruction cards distributed to all new trainees. In addition, all rotating residents from outside the department are required to complete a dictation course run by medical records department and to attend the above-mentioned session.

For the newly starting residents, a structured orientation program that includes special session about the discharge summaries dictation process, templates and regulations is provided for all at the beginning of their residency training programs.

When questioned, the residents claim that the workload was the most important compliance barrier, in addition to the overlap between the pediatrics medical team's rounding times in the patient area because of lacking a standardized rounding schedule for the pediatrics teams. This makes it very difficult for the residents to plan their day especially if the round time in some situation can't be predicted and may interrupt the working process of the residents including the completion of the discharge summaries. Therefore, we have implemented a new regulation that organizes the

rounding time between pediatrics medical teams that helped in preserving a free time for the residents to complete their work.

Another challenge was lacking the close monitoring of the process on a daily basis. Previously, the overall compliance was monitored based on quarterly compliance report issued by the hospital administration. Therefore, we assigned a designated resident based on a nomination from the residency program director, to follow up the daily report received from medical records department that demonstrate the number of discharged patients on a daily basis. This report includes as well the presence or absence of the dictated discharge summaries. Accordingly, the assigned resident will communicate with each concerned resident as needed to finalize the pending summaries. This process is running under observation of the departmental administration and corrective actions were applied once identified.

Compliance with the approved templates for the discharge summaries (that was built up in the department in collaboration with the Quality Management Department and incorporated in the electronic health system) is another challenge. The deviation from the approved templates was observed in frequent reports. Therefore, a designated resident was requested to ensure that all dictated summaries are compliant with the approved template. This was achieved by reviewing the daily report from medical records department and approaching the non-compliant resident accordingly.

Another challenge is the noncompliance with forwarding the final discharge summary to the attending consultant for final review and signature. This led to increased number of delinquent records for the consultants. The reason was identified as a gap in the system that allows the resident to sign and save the document without forwarding it to the responsible consultant. We asked medical record department to solve this problem. Moreover, we managed to forward the daily discharge report to each responsible consultant. This helped in bringing their attentions to the pending summaries of their patients on a daily basis.

Also, medical record departments have enhanced their support to this project by identifying a unified phone extension for record clearance to handle all queries and concerns.

One of the special challenges is the part time staff in regard to their delinquent's records as they are not available routinely in the department to be notified about the deficiencies with a lacking of a proper notification process for part timer. This was addressed with the department administration and corrective actions implemented with direct support from the section heads.

In an order to motivate the good practice among our residents in regards to the compliance with discharge summary project, it was considered as a criteria in selecting the resident of the month and resident of the year awards. In addition, it was linked to the clearance process required before applying for leaves.

In order to increase the awareness and encouraging all stakeholders to support and comply with the project, the overall department performance in regard to discharge summaries was maintained as a standing item in the regular departmental collaborative meetings, since the individualized performance metrics in this regards are not yet adopted in the hospital system.

A major enforcement tool that helped in sustaining the success of this project is including the discharge summaries in the patient discharge checklist. This checklist is monitored by the caregivers for each patient before his/her discharge. Other enforcement tools as part of patient centered care, is involving the patients in requesting the discharge summaries before leaving the hospital.

3. Statistical statement

The data in this study are the official departmental data received

from the Quality Management Department and was presented as it is without modification.

4. Results

Between the fourth quarter of 2011 and the fourth quarter of 2016, a significant drop in the number of delinquent records was noted. From 1131 delinquent records at the end of the fourth quarter of 2011, the number has fallen to 15 in the fourth quarter of 2016. The numbers of delinquent records per year are shown in [Table 1](#). This finding shows that most of the patients received their discharge summaries within the time limit as described in the hospital policy. Furthermore, compliance to JCIA documentation standards, as measured by the hospital Quality Management Department's audit of 20 randomly selected charts in a quarterly basis, showed sustained improvement since the initiation of the project. The department used to score around 50% compliance rate between Q1 2011 to Q3 2013. This has improved dramatically until reached and maintained around 80% in average between Q2 2014 to Q4 2016 ([Fig. 1](#)).

In more than one occasion, the department was recognized as one of the top departments across the hospital in regard to the compliance with hospital policy for discharge summary's documentations.

5. Discussion

High quality discharge summaries is an essential tool for better patient outcome in all healthcare institutions. It is considered as one of the important methods for communication between healthcare providers in regard to the patient's medical information. On the other hand, inaccurate and deficient discharge summaries is a contributing factor for inappropriate continuity of patient care [15].

Multiple efforts put in place to have a standardized framework across different institution to improve the quality of discharge summaries [15].

In our study, we demonstrated an overview of an ongoing process for improvement with its challenges and tools to overcome them. Most of these difficulties were mainly around monitoring process; staff buy in, technical issues, communications and orientations for new employees.

Maintaining the culture of success and sustaining the achievements is more important and challenging than initiating a project. The measures that we implemented to correct all of the previously mentioned challenges played a role in supporting the success of our project.

6. Conclusions

Every new project concerning the quality of patient care provided in any institution is expected to face multiple challenges and difficulties. Proper identifications of the challenges, standardize approach for solutions, sustainability of the monitoring for any improvement projects can help to maintain the success for any project.

Table 1
Number of delinquent records.

Q4 (2011)	1131
Q4 (2012)	1321
Q4 (2013)	481
Q4 (2014)	51
Q4 (2015)	47
Q4 (2016)	15

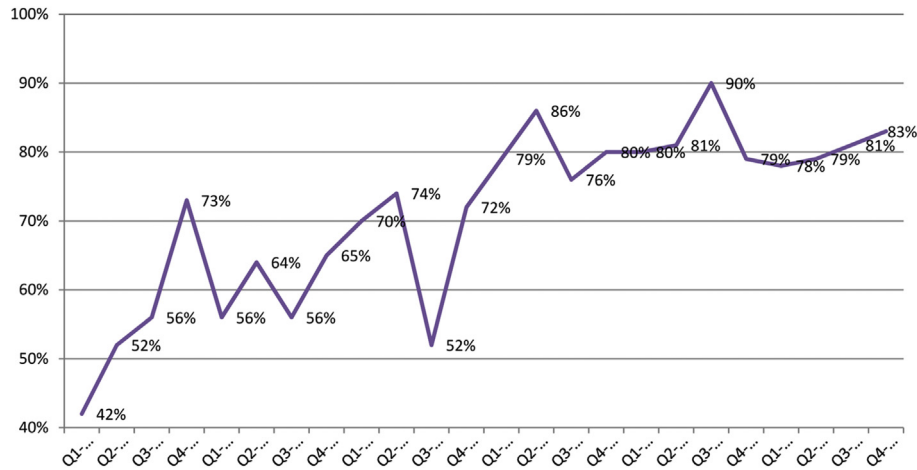


Fig. 1. Discharge documentation compliance rate.

Ethical considerations

This paper demonstrating the Department of Pediatric's work experience and the data are based on the official reports received from the hospital Quality Management Department and the permission for publishing these data was taken from the department administration.

Conflict of interests

This paper is to present our department's experience in regard to the difficulties, challenges and outcomes of the adopted workflow for discharge summaries over a period of five years and will not promote any specific business interest. The authors have declared that there is no conflict of interest.

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