GENERAL OPHTHALMOLOGY

Audit of Ophthalmology Discharge Summaries in a Nigerian Teaching Hospital

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Introduction: Discharge summaries are important components of hospital care which ensure continuity, especially in hospital transitions.[1] A discharge summary eases out readmission to the hospital and extraction of data for research and as a summary for other purposes.[1] It is generally accepted that provision of a discharge summary is part of good clinical practice.[2] In the United States of America, the Joint Commission International (JCI) acknowledges its importance and mandates that certain essential elements be included[3].

Methods: This was a retrospective review of all discharge summaries written by house officers and residents in ophthalmology from 1st January to 31st December, 2012 in University of Nigeria Teaching Hospital, Enugu. The summaries were checked for presence, completeness and accuracy of domains considered essential.

The following items/domains were assessed:

1. Biodata
2. Date admitted and date discharged
3. Consultant in charge of case
4. Referral doctors address (where applicable)
5. Principal diagnosis
6. Complications and associated conditions
7. Operations/surgeries
8. Summary of clinical course
9. Condition at discharge
10. Discharge/follow up instructions, especially discharge medications (i.e. dosage, duration)
11. Next clinic appointment date
12. Name, signature, and rank of discharging resident doctor.

Exclusion criteria were case files with missing discharge summaries, illegible discharge summaries, and case files of any patient who died while on admission.

Data analysis was performed with the use of Statistical Package for Social Sciences (SPSS) version 17.

Results: A total of 420 discharge summaries were studied. Fourteen case files were excluded; 11 had missing discharge summaries, while one was for a patient who died in the ward.

Table 1: Frequency of completeness and accuracy of key information provided for some of the content items checked in the 420 discharge summaries

Content Item	Accurate/Complete (%)	Inaccurate/Incomplete (%)	Absent (%)
Biodata	267 (63.3)	153 (36.4)	Nil
Admission/discharge dates	412 (98.1)	8 (1.9)	Nil
Consultant in charge of the patient	418 (99.5)	2 (0.5)	Nil
Principal diagnosis	386 (91.9)	30 (7.1)	4 (1)
Complications/associated conditions	139 (33.1)	165 (39.3)	116 (27.6)
Surgical procedures (n=197)	371 (88.3)	43 (10.2)	6 (1.4)
Condition on discharge	398 (94.8)	10 (2.4)	12 (2.8)
Follow up notes/discharge medications	322 (76.7)	44 (10.5)	54 (12.8)
Next clinic appointment date	296 (70.5)	7 (1.7)	117 (27.8)
Name/signature of doctor	144 (34.3)	273 (65)	3 (0.7)

Most items assessed had some contents in their respective fields, the exception being the field for referral doctor's address (Table 1). Five discharge summaries were found to have no entries made for referral doctors' address.

The most problematic field was the summary of clinical course during admission with varying proportions of incomplete and absent information (Table 2).

Table 2: Frequency of completeness and accuracy of key information provided in the 420 discharge summaries concerning the clinical course ("summary") portion of the discharge summary template currently being used at the Teaching Hospital.

Content item checked	Complete/ accurate(%)	Incomplete/ inaccurate(%)	Absent(%)
History of presenting illness	376(89.5)	38(9.1)	6(1.4)
Significant examination findings	293(69.8)	21(5)	106(25.2)
Results of relevant investigations	79(18.8)	7(1.7)	334(79.5)
Changes in medications	52(12.4)	Nil	368(87.6)
Main treatment given	281(66.9)	15(3.6)	124(29.5)

Notable errors/observations included widespread use of the abbreviation 'ad' for adult in the field for age; use of several other abbreviations without first writing the words in full; and mixing up the laterality of the affected eye or the eye being treated, i.e. writing "right eye" instead of "left eye". In addition, there was widespread use of only terms such as "satisfactory," "not satisfactory," "stable," and "not stable," when providing information in the field for "patient's condition on discharge".

Another error noted was writing only the full name of the discharging doctor without a signature.

Other errors also noted were mixing up of eye ointments with eye drops during documentation and thepractice of writing only an original copy of the discharge summary instead of the stipulated duplicate or triplicate copies.

Conclusion: For a good discharge summary to be written, proper training and guidance is needed and it is erroneous to assume that every doctor can write a good /correct summary. Lack of proper guidance from supervising consultants may result in discharge summaries being given low priority.

In this study, the most problematic portion was the area on "summary" which contains pertinent information on clinical course during hospital stay and demonstrated need for improvement.

Against this backdrop, one can infer that the under reporting of results from relevant investigations and changes in medications (as noted in our study) is a worrisome trend for the promotion of continuing care.

Based on the above, although no universal consensus exists on the ideal format for discharge summaries, we propose that several of these deficiencies can be mitigated if appropriate sub-headings are provided in the summary to serve as a guide.

To improve our discharge summary system, interventions which may be required include the following measures:

1. Intensive and regular physician education on the importance and process of writing discharge summary;
2. The supervising consultants should oversee the preparation of these summaries on a regular basis;
3. Development of validated standardized discharge summary templates which will recognize the peculiarities of specialized patient groups;
4. The transition to computer based electronic discharge summary system as most Nigerian public institutions are still using paper-based electronic records.

Finally, health policy makers should make and implement recommendations on the provision of an appropriate format for writing hospital discharge reports.

References

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