Title:
Community Doctor Preferences for Hospital Discharge Medication Information

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Theme: Quality and Safety in Hospital Medicine

Disclosures: None

Application: Please consider this project for **Oral Presentation** at the Quality Improvement Preconference workshop on September 24, 2015 and as a **Poster Presentation**.

a. Background: Transition from hospital to home represents a vulnerable time for patient safety, particularly surrounding medication changes. As part of the hand-off to primary care, medication changed in hospital is disseminated to patients' receiving family doctors in the discharge summary, a one-way communication varying by author.

b. Aim: As the Calgary Health Region works to implement a Required Organizational Practice to improve safety, we bring community doctors' insight into the process. Until now, hospitalists have never asked their audience for feedback on the usefulness of the medication information they relay. Learners will review how family doctors interpret the clarity, organization and usefulness of medication information found in hospitalists' discharge summaries and the improvements they would like to see.

c. Improvement/Innovation: Hospitalists who commonly author discharge summaries were presented with the findings of the telephone interviews and invited to implement the recommendations community family doctors requested.

d. Measures (QI Methods): We invited community family doctors who commonly receive discharged patients from the Peter Lougheed Centre Hospital (PLC) in Northeast Calgary to walk through the discharge summaries they received within the prior 3 months. 6 doctors participated and 23 discharge summaries were evaluated. Participants were asked to rate and comment on the clarity, organization, and completeness of the medication information. We asked how they determine what home medications a patient should take from the discharge summary and what improvements could be made.

e. Project Impact: We presented the results to PLC hospitalists who had authored the discharge summaries and generated 2 recommendations they were enthusiastic to implement. Further steps for this project will be completed at a later time including an invitation for feedback on each discharge summary sent to community offices to increase sample size and assessment of community family doctors' impressions of the discharge summaries after hospitalist implemented their recommendations.

Results: All community doctors found if there were no home meds listed, the overall use of the discharge summary was reduced. 41% of the time, some home medications were not represented. Only 55% of the time, community doctors were confident they knew what changes to home medications were made in hospital. Why a dose or schedule of a

home medication changed was clear 55% of the time and 83% of interviewed doctors wanted the reasoning behind changes. Perceived medication errors totalled a whopping 54. 69% of medication information evaluated was considered "organized" but there was no consensus how the medications should be organized. One doctor found that changes/additions were well communicated, hospital admission of her patients could be seen as an opportunity to access scores of resources including investigations and consults not available in the community.

f. Lessons learned: In addition to technological builds suggested, hospitalists were recommended to include 1) a full list of home medications 2) rationale behind medication changes to ensure it is clear what was known and what was intended.

Thank you for considering this abstract.

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