Improving the quality of documentation in discharge summaries of patients attending RespOPAT clinics

Dr Megan Offer and Dr Sonia Sharma, (CT2), Addenbrookes Hospital

Background

There is a once weekly SHO-led clinic within the respiratory department where patients on outpatient IV antibiotics are reviewed. This is known as the RespOPAT (respiratory outpatient antibiotic therapy) clinic.
The clinic was started in conjunction with the 'Healthcare at Home' nursing team to reduce the number of days patients required to stay in hospital when being treated with long term IV antibiotics for respiratory conditions such as infective exacerbations of bronchiectasis or empyema.

Aims

S Evaluating the information on discharge summaries for patients attending RespOPAT clinics

M Use of the e-hospital system to accurately check discharge summaries and the information written

A Dedicated SHO clinic, motivation from OPAT nurses to run an efficient clinic

R OPAT clinic is aiming to expand and include more patients from clinic as well as ward

T Repeated QIP cycles in 8 week blocks from Aug 2016 – Jan 2017

PDSA Cycle

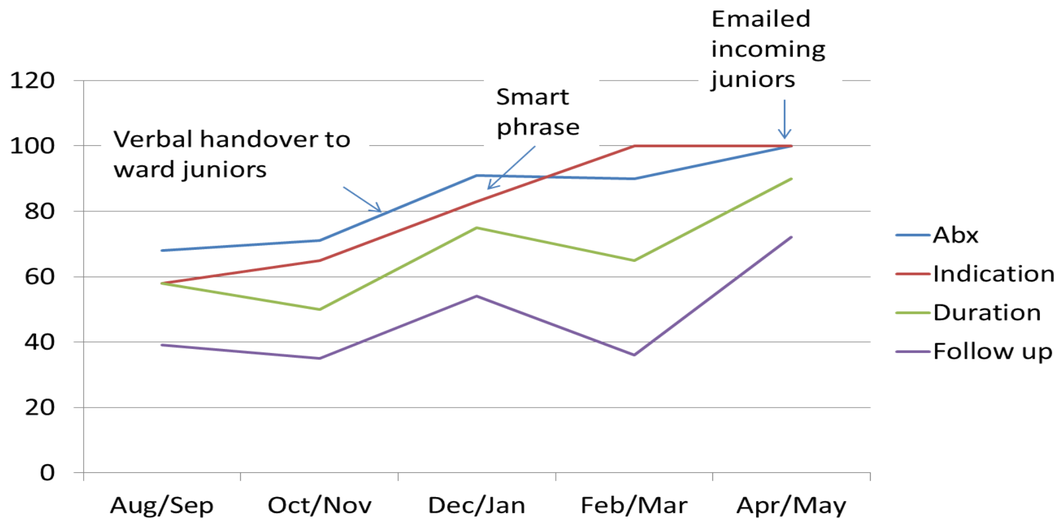
Plan
Record the specific information documented in discharge summaries:
Indication, Type of Antibiotic, Duration, Long term follow up

Do
Use of the e-hospital system to record information in 8 week blocks

Study
Generally good documentation re antibiotic and indication, but improvement required with regards to long term follow up and duration

Act
Introduction of electronic smart phrase to aid discharge summaries

Results: Run Chart



Conclusions

- Good documentation ensures continuity of care and minimises risk to patient safety
- Use of the e-hospital system has improved documentation within discharge summaries

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