Near Misses: tertiary acute care discharge summary medication list discrepancies identified on transition to a rehabilitation hospital.

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Background: The discharge summary serves as a means of communicating important clinical information from one healthcare provider to another when a patient is being transitioned between providers. An effective discharge summary is crucial in reducing hospital readmission, adverse events and advancement of the patient's healthcare needs. The aim of this study is to identify discrepancies between the inpatient medication administration record (MAR) and the discharge summary medication list for patients discharged from a tertiary care center to a geriatric rehabilitation hospital.

The aim of this study is to identify the rates and types of medication discrepancies between the MAR and the discharge summary for patients discharged from KGH to PCH, Parkside 1. These inconsistencies can lead to confusion for healthcare providers during points of transition and can have negative consequences for patient safety. Moreover, ineffective communication between healthcare providers at transition points can prevent the advancement of that patient's healthcare plan and result in increased rates of hospital readmission. This will be a quality improvement initiative and we hope to identify key areas for improvement in the discharge process to reduce discrepancy rates and readmission as well as improve communication between healthcare providers.

Methods: This will be a retrospective chart review comparing the inpatient MAR with the medication list from the discharge summary. Our study population will include patients discharged from any service at KGH to PCH Parkside 1 (geriatric rehabilitation inpatient unit) between January 1, 2018 and December 31, 2019. This will include approximately 250 patients. We will cross-reference the MAR and discharge summary medication lists to look for any medication discrepancies. A medication discrepancy will be defined as an inconsistency between the two lists. An intentional discrepancy is defined as one that the discharging physician intended to make and provided an explanation for in the discharge summary. An unintentional discrepancy is one that either the discharging physician did not intend to make or did not adequately document in the discharge summary. Unintentional discrepancies will be categorized into omission, addition, restarting held medication, changed frequency/dose etc. using the MedTax system, which has been used in prior studies. In addition, we will be comparing the rates and types of unintentional discrepancies between the various specialty services discharging to PCH Parkside 1.

Results and Discussion: This study has been submitted to HSREB for approval and we hope to have preliminary results available soon.