



Potential Communication Failures At Hospital Discharge May Compromise SLE Care

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Disclosures

- None

Introduction

- Hospital discharges are vulnerable to communication failures, which can compromise patient safety^{1,2}
- 1 in 5 discharged patients experience an adverse event³

[1] Groene R et al. *BMJ Qual Saf* 2012; 21:i67-75

[2] Witherington EM et al. *Qual Saf Health Care* 2008; 17(1):71-5

[3] Forster A et al. *Annals of Internal Medicine* 2003; 138 (3): 161-167

Introduction

- Hospitalization in SLE is common, and 17-30% of discharged patients are re-admitted within 30 days^{4,5}
- Patients with complex rheumatic diseases require adequate handover to outpatient rheumatologists regarding the course in hospital

[4] Nangit A et al. *J Rheum* 2018; 45:6

[5] Yazdany J et al. *Arthritis Rheumatol.* 2014; 66: 2828

Components of a 'good quality' discharge summary

Consensus⁷

1. Discharge diagnosis →
2. Treatment received →
3. Results of investigations →
4. Follow-up required →

What rheumatologist wants to know

- Discharge diagnosis (and rheumatologic diagnosis)
- Medications given in hospital
- Dates, doses of infusions** (e.g. pulse steroids; cyclophosphamide; rituximab; IVIg)
- Rheumatologic medications at discharge including **future infusion dates**
- Prophylactic medications prescribed
- Test results **and pending tests/results** (e.g. biopsies, labs, imaging)
- Follow-up date at Lupus clinic & with other specialists

Objectives

1. To determine if SLE patients admitted at McGill University Health Centre (MUHC) have discharge summaries that clearly document:
 - **Relevant drugs received in hospital**
 - **Relevant drugs at discharge**
 - **Rheumatology follow-up visit date**
2. To determine, for “SLE-relevant” admissions, the timeliness of post-discharge follow-up in the Lupus Clinic

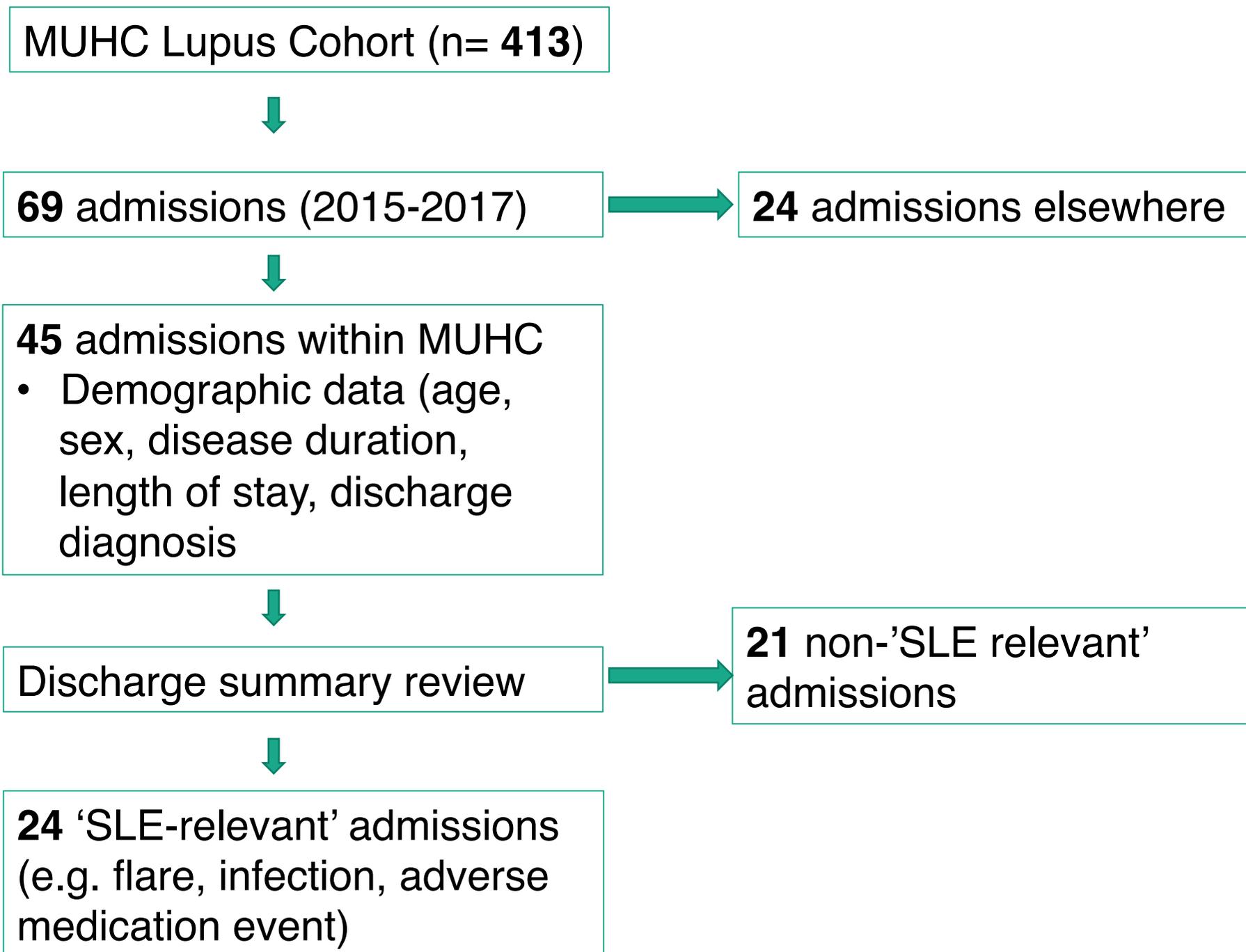
Methods

- Retrospective review of the MUHC SLE clinic database
 - Annual assessments document hospitalizations since the last study visit
- Reviewed MUHC hospitalizations between 2015-2017

Methods

- For all “SLE-relevant” admissions (eg. flare, infection, adverse drug event), reviewed the discharge summary to determine if:
 - Discharge diagnosis mentioned
 - Rheumatology follow-up date mentioned
 - Details of immunosuppression given in-hospital complete
 - Details of immunosuppressive medications at discharge
 - Pneumocystis and osteoporosis prophylaxis mentioned
- Determined time between discharge and next lupus clinic follow-up

Results



Results

Characteristics of all MUHC-admitted SLE patients (n=45)

Age – mean (SD)	38.9 (14.1)
Sex – female, n (%)	42 (93)
Mean SLE duration, years (SD)	12.6 (10.0)
Mean hospitalization days (SD)	6 (7.4)
Race/ethnicity – n (%)	
Caucasian	23 (51)
Black	5 (11)
Asian	9 (20)
Hispanic	2 (4)
Indigenous	3 (7)
Other	3 (7)

Results

- SLE-relevant admissions (24)
 - 2 SLE new diagnoses
 - 9 SLE flares
 - 7 infections
 - 5 adverse drug events
 - 1 postpartum hypertension
 - 1 pulmonary embolism

Results

Discharge summary content	N present / N relevant (%)
SLE diagnosis mentioned	24/24 (100)
Discharge diagnosis mentioned	24/24 (100)
Details of immunosuppression given in hospital complete	9/18 (50)
Infusions* - mentioned	2/3
Infusions - doses	0/3
Infusions - dates	1/3
Details of immunosuppression prescribed at discharge complete	10/17 (59)
PJP prophylaxis mentioned when prescribed	6/9 (67)
OP prophylaxis mentioned when prescribed	1/12 (8)
Rheumatology follow-up date given	11/24 (46)

* 1 cyclophosphamide, 1 IVIg, 1 belimumab

Results

Follow-up interval	All 'SLE-relevant' admissions (n=24)	SLE new dx/ flares (n=11)
≤ 2 weeks – n (%)	11 (46)	8 (72)
≤ 1 month – n (%)	17 (71)	11 (100)

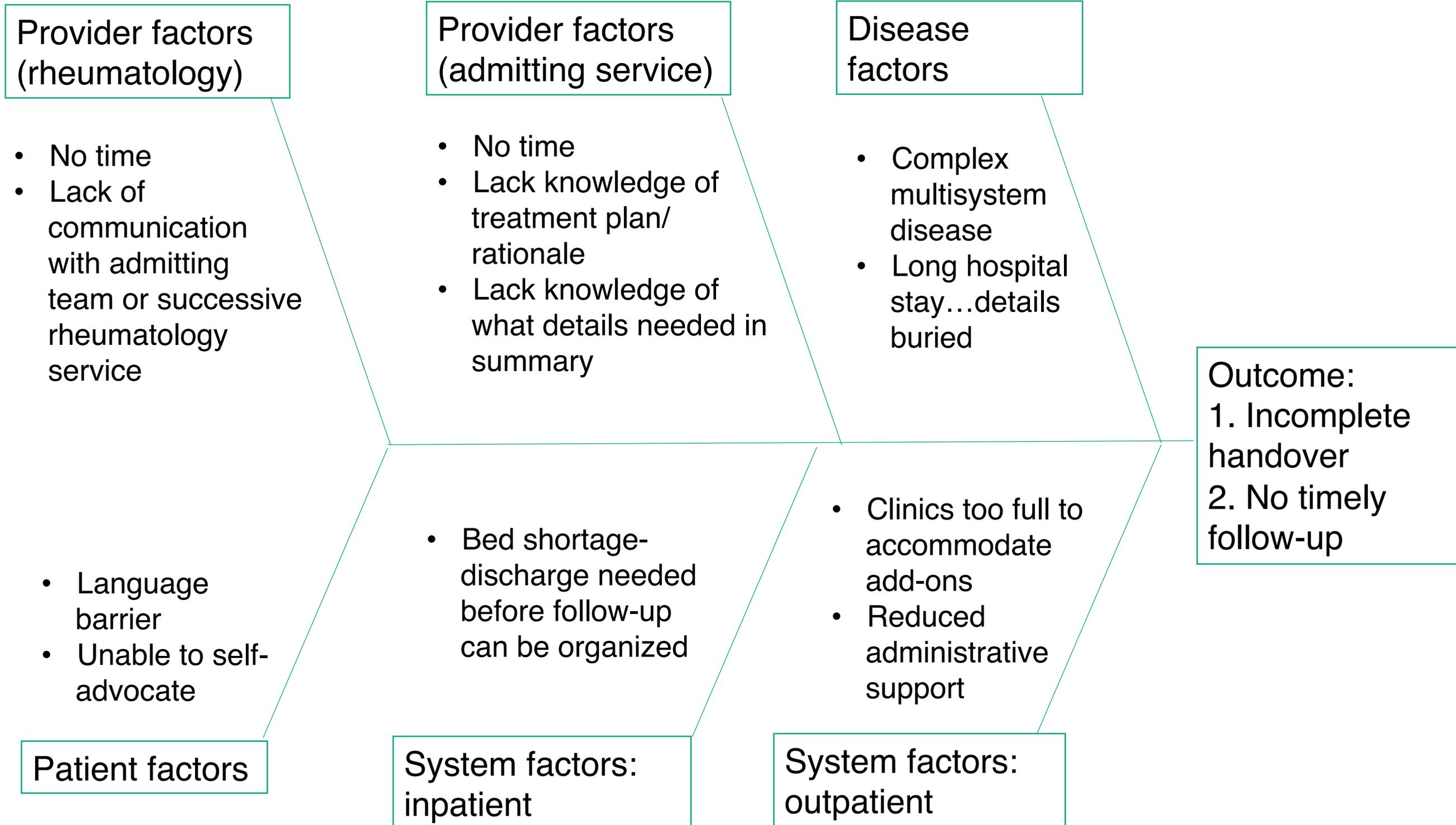
Potential limitations

- Audit limited to SLE patients only
 - Question relevant to other systemic rheumatic diseases
- Hospitalization outside MUHC not included
- Patient and inpatient provider (i.e. internal medicine) perspective would be useful
- Limited number of events, thus could not examine whether certain features (e.g. length of stay, diagnosis) correlate with quality of discharge summaries

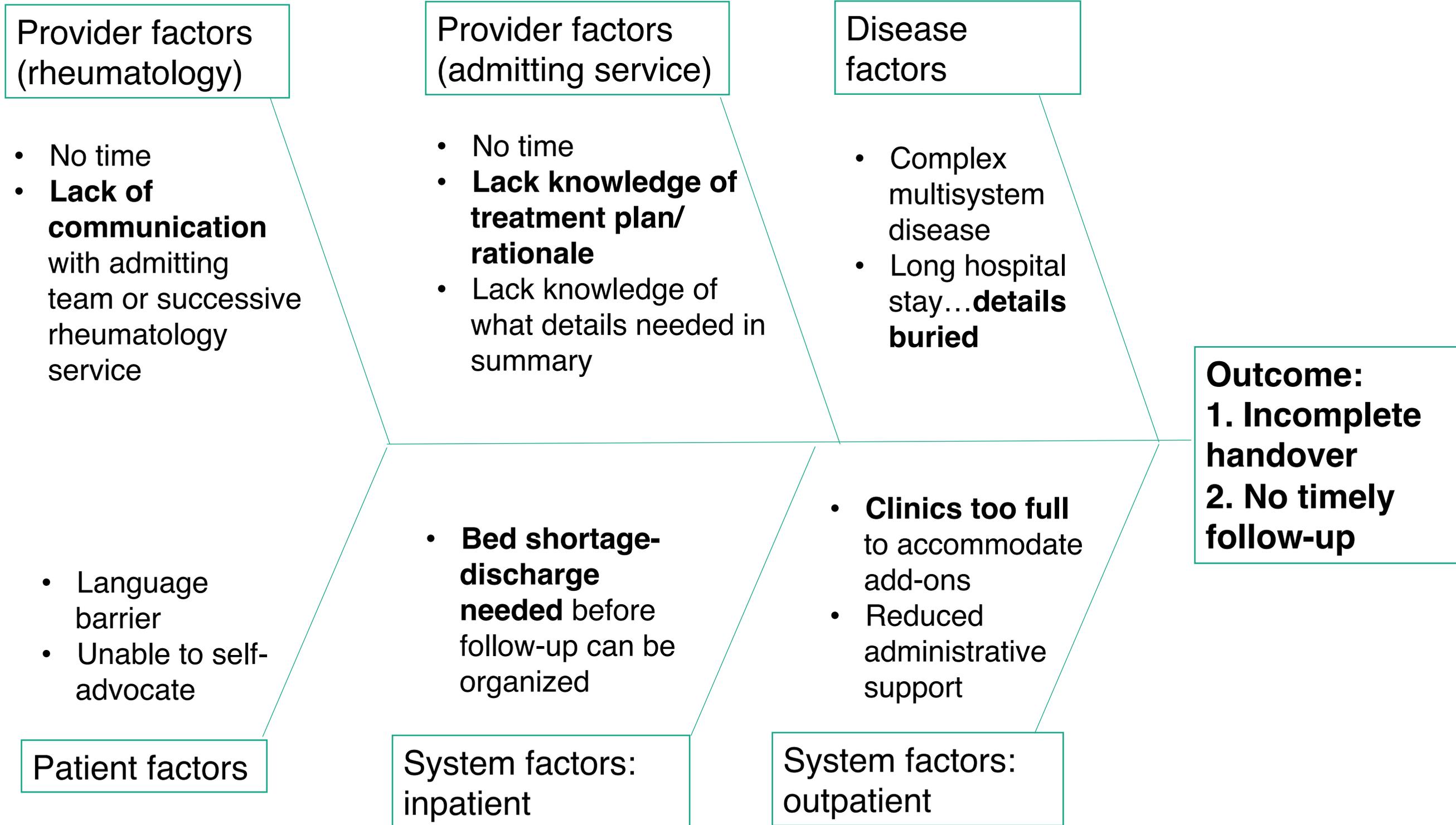
Conclusions

- We have identified potential communication failures at hospital discharge that may compromise SLE care
- The discharge transition may be improved through:
 1. Ensuring all patients have prompt follow-up after admissions for lupus flares or complications
 2. Ensuring discharge summaries:
 - include accurate details of medications given in hospital and prescribed at discharge
 - include the follow-up date

Is it that simple?



Is it that simple?



Future directions

- Gather additional information (focus groups, surveys) to determine barriers (related to patients, care providers)
- Establish target follow-up interval
 - e.g. within 2 weeks for all SLE flares/new diagnoses?
- ?Rheumatology-driven electronic summary of hospitalization for patients
 - With complex hospital stays
 - Who received infusions of cyclophosphamide, rituximab, pulse steroids, etc

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Singer Family Fund For Lupus Research
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