Evaluation of the Completeness of Patients' Medication Reports and Discharge Summaries at Discharge from Two Wards Using Complete Medication Documentation at Discharge Measure (CMDD-M)

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Introduction

In Sweden, hospital discharge documentation must include a discharge letter directed to the patient containing a medication report, detailing changes made during the hospital stay. Incomplete documentation of medication changes has been correlated to medication errors leading to hospital readmissions. Given this correlation, it is important to be able to assess the quality and completeness of medication documentation within the Swedish healthcare system.

Aim

Evaluate the quality and completeness of discharge documentation using the checklist CMDD-M as part of ongoing quality improvement initiatives at geriatric- and internal medicine wards.

AKADEMISKA SJUKHUSET

Method

Retrospective cross-sectional study reviewing electronic medical records from two wards. Patients included were admitted in October 2021, aged 50 or older, with at least one lasting medication change during their hospital stay. CMDD-M was used to assess the completeness of discharge documentation. To achieve a maximum score of 7 points all medication changes must be mentioned including reasoning and follow-up plan.

Results

Eighty patient records were reviewed using CMDD-M where 19(23.8%) scored 7 points, and the average was 5.3. The medication report was completely missing in 8(10%) patients' discharge documentation. The most frequently missed criterion was the omission of one or more relevant medication changes from the discharge summary, 54(67.5%), and from the medication report, 48(60%), followed by reason for change not noted, 22(27.5%). There was a non-statistical correlation between number of medication changes and the completeness of documentation.

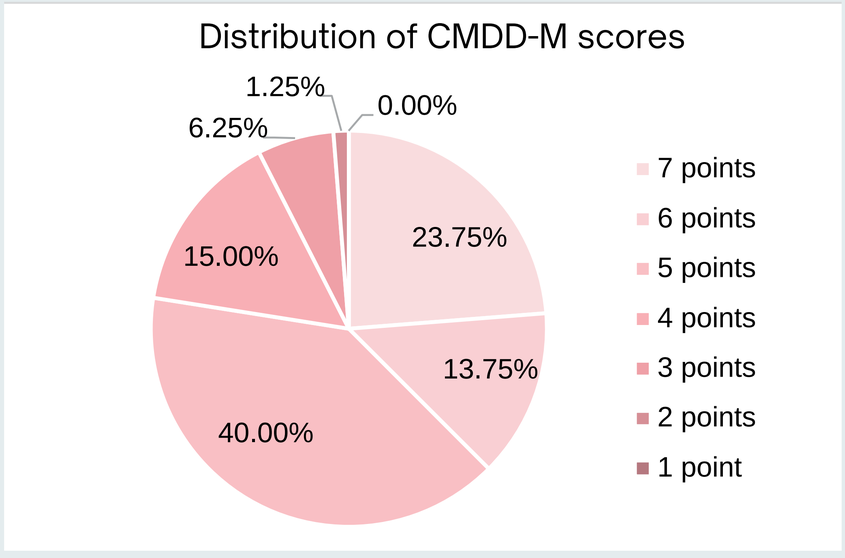

Table 1: Distribution of CMDD-M scores in the sample.

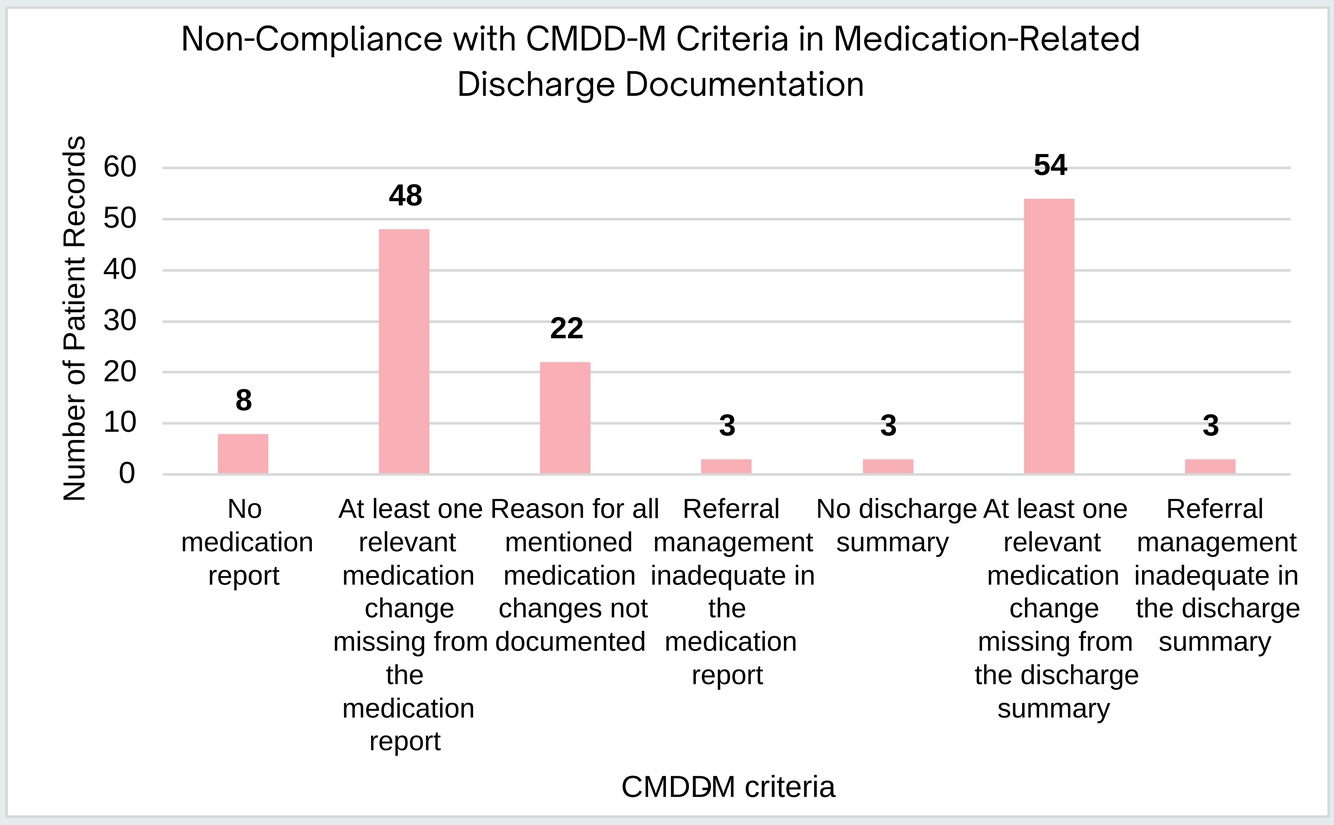

Table 2: CMDD-M criteria not met in patients' medication-related discharge documentation.

Read more about the now validated CMDD-M

Bertilsson et al. (2025) Development and Validation of an Instrument to Assess Quality and Completeness of Medication-Related Discharge Documentation. J Eval Clin Pract. doi: 10.1111/jep.70006.

Conclusion

In summary, the majority of the reviewed discharge documentation received a score lower than seven, and therefore did not meet the Swedish legal requirement. Similar findings have been reported in studies abroad. The findings in this study highlights a need for quality improvements in discharge documentation. CMDD-M may function as a comprehensive, quick, and easy-to-use tool for caregivers. Additionally, it could be used as an outcome measure in research studies aiming to enhance discharge procedures.

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