IMPLEMENTATION OF DECOMPENSATED CIRRHOSIS DISCHARGE BUNDLE: A UNIVERSITY HOSPITAL EXPERIENCE

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Background Decompensated liver cirrhosis is a frequent reason for admission to acute medical and gastroenterology units. Over the last two decades, a significant rise in the prevalence of liver cirrhosis in the UK has been noted, with the major culprits being alcohol related liver diseases, hepatitis B & C, and non-alcoholic obesity related disease. It has been observed that re-admissions to the hospital are common following discharge of the patients with decompensated liver cirrhosis. In order to improve the quality of discharge and reduce the re-admissions a decompensated discharge bundle has been developed by BSG and BASL. We aimed to assess the practice in our hospital against BSG/BASL guidelines and the impact by the implementation of the said discharge bundle.

Methods All those patients who were admitted with decompensated cirrhosis were included for data collection. Standard Quality Improvement model was adopted using two PDCA cycles. In cycle 1, discharge letters of 40 patients were assessed retrospectively against the decompensated cirrhosis discharge bundle tool kit during the months of January, February and March 2021. In cycle 2, there was re-assessment of discharge letters for 40 patients during the months of April, May and June to look for any change or improvement.

Results In cycle 1, it was noted that only 20% of the decompensated cirrhotic patients had weight, urea and electrolytes, diuretic dose adjustment and communication with the patients regarding future plans recorded on the discharge letters. Hence, the bundle was introduced by displaying the awareness posters in the Gastro ward and discussed with the junior doctors in the board round. Additionally, emails were sent to doctors of gastro unit regarding the discharge bundle introduction.

There was a significant improvement of results in cycle 2, where 60% of the patients with decompensated cirrhosis had the above mentioned parameters documented in the discharge letters respectively.

Conclusion There were inconsistencies in the discharge letters when assessed during cycle 1 and the documentation was sub-optimal. However, with the introduction of discharge bundle in the hospital has led to a significant improvement in the discharge letter documentations when compared against the decompensated cirrhosis discharge bundle in cycle 2. In order to get much better results and to continue the improvement, we would consider the incorporation of the bundle in the Trust E-Library and include in the junior doctor inductions.