Introduction

EQUIP were commissioned by MEHT and NHS Mid Essex to conduct an audit of patient discharge letters from general medicine and orthopaedics. Ten practices collected letters from the hospital and these were analysed against the audit criteria. We are grateful for their input. 162 letters were analysed in total. The discharges were between May and July 2009.

Criteria

The criteria were agreed in discussion between Dr Blainey, Medical Director of MEHT and John Guy, clinical lead, EQUIP. They were subsequently shared with the participating practices who were happy with the content.

Standards

In any situation involving a lot of human beings it is unrealistic to expect a standard of more than 90% to be achieved. It was agreed that all the criteria below were important and this standard should be applied across all of them.

Findings

Patient demographics

The patient’s name was found on all the letters - standard met!

Referring GP found on all but one of the letters - standard met

NHS number found on 94% of letters - standard met

Date of birth on 98% of letters - standard met

Patients address was found on only 2 letters - these were occasions on which the old style handwritten discharge form was used. This is not a field in the new electronic discharge letter.

Admission dates were recorded on 96% of occasions - standard met
**Discharge dates** were recorded on 75 of 162 possible occasions - 46%, **Standard not met.** This makes it very difficult to assess delay in sending letters.

**Date letter received by practice** – This was recorded on 52% of possible occasions - this probably reflects the electronic communication and the more widespread use of scanning. Whilst there is a strong suspicion that letters are not received promptly we probably do not have the definite information to prove this and this should be addressed if we are to repeat the audit.

The ‘admitted from’ and ‘discharged to’ fields are not used. Only 2 patients had discharge locations other than home recorded and these both went to other wards. **The standards are not met.**

It could be more useful for the medical admissions to identify in ‘admitted from’ fields whether referred by GP, referred by self, referred by out of hours or ambulance service as this might give useful information to help manage the increase in medical admissions.

The discharging team should be aware of where the patient is being discharged to and recording “home” should only require one mouse click.

**Diagnosis**

The diagnosis field was used on 73 occasions (45%) which is **below the standard.** The diagnosis was discernible from 141 letters (87%) It would be helpful to coders as well as to practices if the diagnosis was recorded in the appropriate place on the letter. As part of the learning experience of junior doctors they should be able to identify the diagnoses of patients in whose care they have been involved - is this a requirement for satisfactory completion of a F1/F2 post.

That said, there were some excellent, concise descriptions of complex medical problems.

A field is provided on the form for recording Investigations. This was used on 11 occasions, mostly to record blood test results. 107 other investigations were recorded within the summary field - it is likely that most investigations are being recorded but it seems a shame not to use the relevant field in the letter. The system is not user friendly and it may be that this field is difficult to use. **Standard may be met** in the text of the letter but as the field is provided in the format it would be better if the information was recorded there.

Infections are recorded in the right place and the **standard is met.** 6 of the 162 patients were colonised with MRSA although no episodes of bacteraemia occurred in the sample group.
The medication fields seem very clumsy to use and it is hard to work out what is happening from the GP perspective. There appears to be duplication with medication TTO and medication on discharge which would appear to record similar if not the same data. It is certainly helpful to know when medication the patient was taking on admission has been stopped and the reasons for this and also the intended duration of the discharge therapy.

The standard may be met in that the drug information is present but it is very hard to use and this area should be simplified.

Secondary care follow up arrangements

- Who with: 64% of patients were to be followed up
- When: 83% of these had a clear indication of when
- Arranged or not: 47% of these had been arranged prior to discharge

The percentage of patients followed up appears quite high - the numbers are influenced by the orthopaedic patients, most of whom need to be reviewed post discharge. Standard is met

Whom to contact at hospital if problem arises

Almost all the patients had the consultant in charge of the case identified and the name of the doctor who signed the letter so this standard is met.

Is narrative adequate to allow you to manage this patient?

The orthopaedic patients generally have clear discharge and follow up arrangements.

The medical discharges are often without follow up and the patients often have complex medical problems. There are very few clear instructions to or advice for the GP as to the follow up that is needed. It may be that re-admissions could be reduced if some thought was given to this aspect of care. The GPs in Mid Essex are generally enthusiastic but not telepathic - it is unusual to receive a phone call about a patient coming home so some careful attention to advice about follow up in the community would be helpful.

Other comments

Sometimes duplicate discharge summaries are received and some of these have been updated - it would be helpful to know that these have been revised.

Several practices identified specifically problems with the discharge medication as it was very hard to identify what was intended.
Conclusions

Many of the standards have been met. The gaps which should be filled are:-

Date of discharge - less than half are recorded and this is important

Admitted from and discharged to fields are not used - this needs discussion as to whether it is important or not to include.

The diagnosis field is used on less than half the occasions and this is important to remedy.

Medication fields are poorly presented on the form and, although the data is present and the standard met, this area definitely needs revising.

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