Introduction

EQUIP were commissioned by NHS Mid Essex to conduct an audit of patient discharge letters from General Medicine and Orthopaedics at MEHT between May and July 2009. Ten practices collected letters from the hospital and these were analysed against the audit criteria. A second audit was carried out in March 2010 in General Medicine alone as the quality of the orthopaedic letters was of appropriate standard in the first audit. EQUIP reviewed 75 letters from 9 of the original 10 practices.

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 wide range of people (Administration staff, Managers and Healthcare Professionals) it was agreed that it was unrealistic to expect a standard of more than 90% to be achieved, this was not the case in a number of areas where the standard has been exceeded. 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 the letters - standard met

NHS number found on 91% (94% in first audit) of letters - standard met

Date of birth on 100% (98% in the first audit) of letters - standard met

The “admitted from” and “discharged to” fields were not used at all - there were occasional notes in the free text where patients were transferred to other hospitals. The standards are not met and the fields are currently pointless.
**Admission dates** were recorded on 100% (96% in the first audit) of occasions - **standard met**

**Discharge dates** were recorded on 52 of 75 possible occasions - 69% (46% in the first audit), **Standard not met**. There has been an improvement but this is a vital field and should be completed.

**Date letter received by practice** – This was recorded on 65% (52% in the first audit) of possible occasions. For 35% of the letters, there was no way of identifying the gap between discharge date and the letter being received by the practice as insufficient information was provided. For 2 others the letters appear to be received before the patients were discharged. 24% of the letters appear to be received within 24 hours of discharge, a further 22% between 2 and 5 days after discharge. 13% of letters were received more than 1 week after discharge. **Standard not met**

**Diagnosis**

The diagnosis field was used on 75 occasions - 100% (45% in the first audit) which is **dramatically better and achieves the standard**. The change is remarkable and to be celebrated.

**Investigations**

A field is provided on the form for recording investigations. This was well used on 5 occasions out of 75 - all by ward sister or staff nurse. This is the same proportion as last time. It appears that investigations have mostly been recorded in the summary. It is important to decide whether the investigation field is required or not - if it is it should be used by all staff.

**Infections**

Infections are recorded in the right place and the **standard is met**. Of the 75 patients, one was colonised with MRSA although no episodes of bacteraemia occurred in the sample group.

**Summaries**

In general the summaries give good quality descriptions of what has happened to the patient whilst in hospital. What is frequently less clear is what the plan is following discharge - often the GP practice is left to work out what should happen next. This may reflect the changing role of the acute hospital to deal with the crisis and then pass continuing care to the GP. This appears to be a significant change and worthy of debate so that it is clear where the responsibility lies.

**Medication fields**

These are very clumsy to use and it is very hard to work out what is happening from the GP perspective. This was pointed out in the first audit but no change has been made.
The standard may be met in that the drug information is present but it is very hard to use and this area must be simplified as a matter of urgency.

Sometimes repeated letters are issued and the information is not consistent - it would be helpful to state that the latest letter supercedes it predecessor.

**Secondary care follow up arrangements**

Follow up arrangements were frequently not clear. Descriptions were given in the summary but it was usually not clear whether appointments had been made. It is important that the author of the letter makes it explicit what has been done and what needs to be done by when so that this is clear to the clerk who has to make the appointments and also to the GP. The lack of clarity at present generates significant unnecessary work in primary care.

There now appears to be a standard phrase which has a keyboard short cut ‘Your patient has been discharged and requires that you follow up the patient in your clinic at your convenience’ - this has the merit of being clear that the responsibility has been passed back to the GP but sometimes it is at odds with what is in the summary.

There were 3 patients who had been started on anticoagulants - the responsibility for monitoring was passed to the GP but with no indication of therapeutic range or duration of treatment.

One patient was a 42 year old new Type 1 Diabetes patient started on insulin, discharged 5½ hours after admission and given a follow up appointment for 3 months. It is highly likely that the patient will need additional input in the intervening period and this should have been made clear.

It may be helpful for the letter writers to reflect upon whether the information they have supplied would be adequate for the GP to continue appropriate care.

**Whom to contact at hospital if problem arises**

17% of the patients did not have the consultant in charge of the case identified so this standard is not met.

**Is narrative adequate to allow you to manage this patient?**

The following paragraph which we included in the first report is still pertinent:

*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

Last time we commented that :-

*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.*

This still applies.

Conclusions

Many of the standards have been met. There has been a dramatic improvement in the Diagnosis field which has more than doubled.

The gaps which should be filled are:-

‘Date of discharge’ this has improved but is a very important field and needs to continue to improve to above the 90% standard.

Medication fields remain poorly presented on the form and, although the data is present and the standard met, this area definitely needs revising. This is the same conclusion as last summer and it is disappointing that it has not changed despite good intentions being expressed at the meeting in the Medical Academic Unit.

There should be much greater clarity about follow up arrangements so there is no doubt in the mind of the appointment clerk or the GP as to what is to happen.

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