Immediate Discharge Document: Improving Discharge Letter Accuracy at the Mater Hospital Belfast

Dr Abigail Nelson, Dr Cathal Harkin, Dr Kathryn Mitchell, Dr Sabina Conway

Introduction

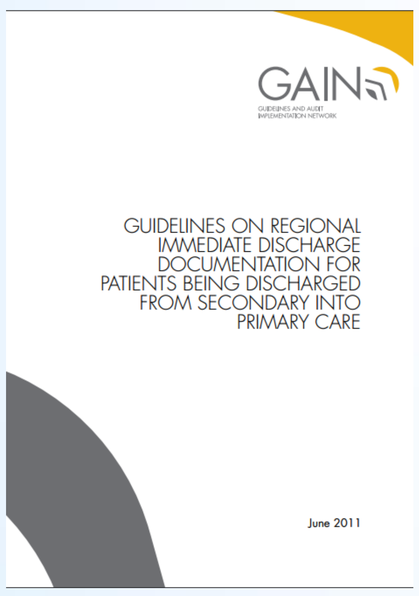
When a patient is discharged, the accurate transfer of information between secondary to primary care is extremely important for a patient's ongoing treatment in the community. This can be hindered and patients lost to follow up if information such as review plans, diagnosis, requests for GP action are missing from discharge letters.

Standards

GAIN Guidelines on Regional Immediate Discharge Documentation for patients being discharged from secondary into primary care 2011.

We looked especially at the table of minimal discharge requirements, focusing on:

- Discharge diagnosis
- Follow up arrangements



RQIA Review of Discharge Arrangements from Acute Hospitals 2014.

These guidelines recommend using an immediate discharge summary such as the one this project was centered on.

Aims/Objectives

Within the Mater there was a pre-existing 1 page discharge summary sheet for consultants to fill in when patients are medically fit for discharge.

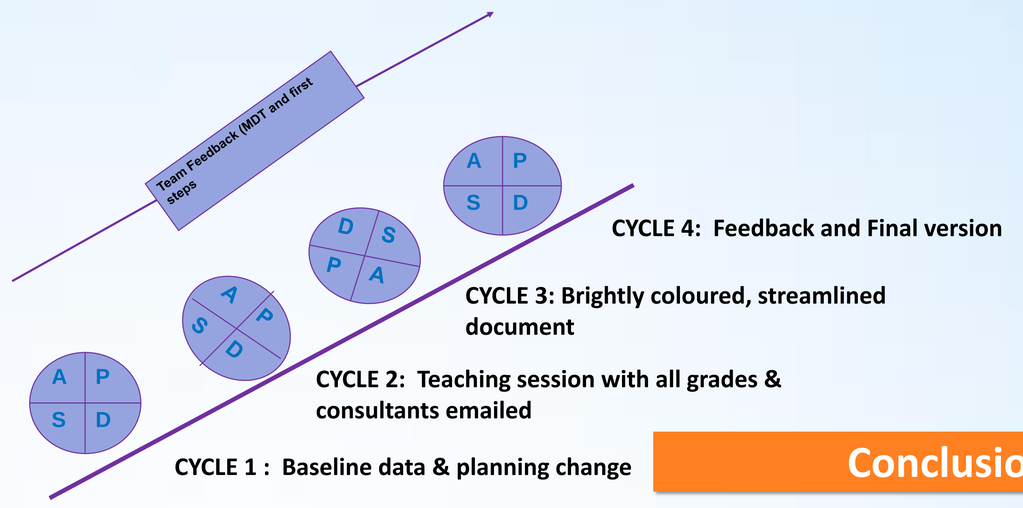
Our aim was to increase the use of the IDD by all medical consultants to 90% by May 2016 over a 4 month period.

We also wanted to carry out a satisfaction survey among F1s and Consultants to assess impact.

Methods

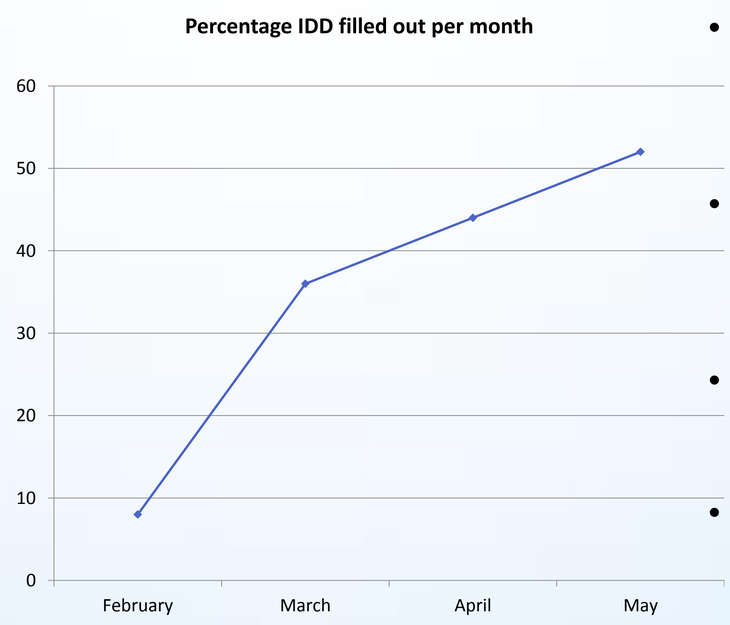
4 PDSA cycles carried out:

1. Gathering baseline data and planning – speaking to consultants and administrative staff regarding amending document/placing in admission packs etc
2. Formal information session for all grades of medical staff informing of changes and taking feedback.
3. Introduction of new document: bright yellow, streamlined, in the front of every admission pack
4. Gathering feedback from F1s and consultants and ensuring new system was sustainable for changeover.



Results

Before any changes implemented 8% of IDD documents were filled out from a random sample of 5 per ward. This improved to 36% on second audit, 44% on third and 52% on the fourth.



Survey results:

66% F1s felt that not enough crucial information was included in the last medical note from the ward round to complete discharge summaries.
100% felt that the IDD makes discharges safer.

100% consultants found layout user friendly but 100% also felt document was time consuming. 66% felt the document would make a positive impact on patient follow up. 1 person found some duplication from PTWR notes
1 person thought F1s should take a lead on completing forms on the ward round

Conclusions

This project centred on patient safety and ease of information transfer by making sure discharge letters aligned more closely with GAIN recommendations.

Our results show a large increase in use of the document, although our original target has not yet been met. The implications of the documents use by consultants are obvious:

- precise follow up instructions ensure correct review appointments impacting positively on waiting lists.
- Outstanding investigations are highlighted prompting those completing the letter to ensure they have been arranged.
- GPs clearly informed of diagnosis and exactly what action, if any is being requested of them.
- Correct diagnoses has implications for epidemiological studies and future service provision.

Future prospects:
With frequent staff changeover an issue for continuity, the importance of completion was highlighted at staff induction with new F1s, encouraging prompting of senior staff to fill out these forms so completion rates could be improved further.

References

RQIA, November 2014. Review of Discharge Arrangements from Acute Hospitals

Gain Guidelines, June 2011. GUIDELINES ON REGIONAL IMMEDIATE DISCHARGE DOCUMENTATION FOR PATIENTS BEING DISCHARGED FROM SECONDARY INTO PRIMARY CARE

DOH 2010: Ready to Go – Planning the discharge and transfer of patients from hospital and intermediate care