Are our discharge summaries fit for purpose as a method of communication between healthcare professionals?

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Background

- Discharge letters are a key document in transferring information and maintaining patient safety
- Given the complex needs of palliative patients, accurate discharge summaries are vital
- At Severn, discharge summaries are currently dictated letters with no standardisation of layout

Standard

- Using the Royal College of Physicians guidelines:
  - *Standards for the structure and content of medical records and communications when patients are admitted to hospital 2008*
- This document provides a checklist of information to be communicated on discharge
- We then amended the checklist with palliative patients in mind

Method

- All 58 patients who were admitted between January and June 2012 and then discharged were included
- Discharge summaries were reviewed and compared with the amended RCP checklist:

Modified RCP guidelines

Demographic data

Patient Name	Patient Number	Date of Birth
Gender	Patient address	Patient telephone no
GP name + address		

Admission/discharge data

Date of admission	Source	Date of discharge
Destination	Consultant	

Clinical data

Diagnosis	Reason for admission	Procedures/investigations
Clinical narrative	Allergies	Changes to medications
Information given to carers	Medications	

Recommendations

DNAR/advanced care planning	Follow up	Requests for GP

Who completed the letter

Name	Designation	Signature
Date letter completed		

Results

Admission data

- Date of admission/discharge: 100%
- Source of admission: 62%
- Destination on discharge: 82%
- Consultant:15%

Advanced Care Planning

- DNAR decision: 6%
- Follow up: 22%
- Requested for GP: 36%

Demographic data and letter completed by

- 100% except gender [10%] and telephone number [1.6%]

Clinical information

- Diagnosis: 96%
- Investigations: 72%
- Reason for admission: 86%
- Clinical Narrative: 98%
- Medications on discharge: 91%
- Medication allergies: 0%
- Changes to medications: 72%
- Information given to carer/relative: 13%

Discussion

Areas consistently well documented were down to the clerical team
Medications allergies were NEVER documented
Advanced Care Planning information very poorly documented

Recommendations

Present the findings to the clinical team
Create a standardised discharge summary template
Re-audit after full implementation of the template

New Discharge Template

Following discussion with GPs, found the structured approach much easier to follow

Also prompting the clinical team writing the discharge letter

Has been implemented, and is currently being re-audited

Patient name and address	
Patient Tel No	

Date of birth		Hospice ID	
Gender		NHS number	
GP name & address		Hospital number	

Reason for admission	
Diagnosis	
Allergies and sensitivities	

Date of admission		Date of discharge	
Admitted from		Discharged to	

Significant events during admission	
Significant results	
ACP/DNAR discussion	
Information given to family	
Current medication	
Alterations made to medications	
Requested GP action	
Follow up	

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