GAIN

GUIDELINES AND AUDIT
IMPLEMENTATION NETWORK

GUIDELINES ON REGIONAL IMMEDIATE DISCHARGE DOCUMENTATION FOR PATIENTS BEING DISCHARGED FROM SECONDARY INTO PRIMARY CARE

June 2011

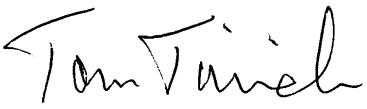
FOREWORD

Guidelines on Regional Immediate Discharge Documentation for patients Being Discharged from Secondary into Primary Care

These guidelines have been published by the Guidelines & Audit Implementation Network (GAIN), which is a team of health care professionals established under the auspices of the Department of Health, Social Services & Public Safety (DHSSPS) in 2008. The aim of GAIN is to promote quality in the Health Service in Northern Ireland, through audit and guidelines, while ensuring the highest possible standard of clinical practice is maintained.

This guideline was produced by a sub-group of health care professionals involved in health care across Northern Ireland and was chaired by Dr David Stewart Medical Director, RQIA

GAIN wishes to thank all those who contributed in any way to the development of these guidelines.



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CONTENTS

INTRODUCTION

NEED FOR A GUIDELINE FOR IMMEDIATE DISCHARGE INFORMATION

Clear and complete documentation in a patient's health record is directly linked to the quality of care they receive. Detailed and accurate documentation helps reduce negative outcomes, by ensuring that all clinical staff caring for patients have access to the information they need to deliver a good standard of care.

Current hospital practice seeks to reduce in-patient stay to a minimum length of time and so the need for effective discharge planning and post-discharge information is paramount.

Effective communication between secondary and primary care is vital to ensure a smooth and seamless transition of care for all patients when they leave hospital. The information conveyed at the time of discharge from hospital has always been an important element of communication between secondary and primary care. The immediate discharge summary is therefore among the most crucial pieces of documentation in the health record, as it is the basis of communication between secondary and primary care and essential for ensuring quality and continuity of care.

The immediate discharge summary captures a variety of data intended to inform the GP of the highlights of the patient's stay in hospital. It can only be effective if it is complete, accurate and made available in a timely manner. An incomplete or delayed discharge summary leaves both doctor and patient at a disadvantage. A GP needs access to this useful and potentially life-saving information quickly and it is critical to their ability to continue care uninterrupted when they resume responsibility for a patient's care.

Immediate discharge summaries have in the past been found to be deficient in content, with illegible information, incomplete patient details, lack of diagnosis and treatment provided and also missing details of follow up needed. A major issue with discharge documentation has been the provision of accurate medication information.

An audit of the quality of medication information in 2009 in Northern Ireland showed that:

- there was limited access to computers resulting in a large number of handwritten prescriptions
- illegible prescriptions
- lack of dosing details on warfarin prescriptions
- lack of information to explain changes in medication during in-patient stay or monitoring requirements

An audit of the quality of medication information provided on discharge summaries to GP's from secondary care were carried out by the prescribing teams of the then Health and Social Care Boards (HSCB) in Northern Ireland and showed the following results

- 21% of GPs received information within 2 days
- 30% of GPs received information within 4 days
- 75% of GPs received information within 7 days
- 38% of discharge prescriptions audited had a discrepancy

Other HSCB audits have been less favourable and showed that:

- Discharge information (discharge slip and discharge summary) had not arrived for 67% of patients within 5 days
- One month post discharge, no information had arrived for 50% of patients discharged from a medical ward.

One study that looked specifically at medication information showed that 38% of discharge prescriptions audited had a discrepancy.

Once a discharge summary is received by a GP practice, the information on changes to medication needs to be critically reviewed and incorporated into the GP's patient record, so that appropriate changes made to medicines during a patient's stay in hospital are continued as intended by the hospital prescriber.

A 2008 national survey by the NHS Alliance reported that patients in England are regularly put at risk because some hospitals delay sending essential information to GPs when patients are discharged.

In 2002 the Royal College of Physicians audited 149 case notes in five hospitals in England and Wales. Of 87 printed discharge summaries present in the notes, 17% had no diagnosis, 19% no procedure, 21% had no follow up arrangements and 75% provided the GP with no information on what the patient had been told.

The Scottish Intercollegiate Guidelines Network (SIGN) reported that there was continuing evidence that the quality of immediate discharge documents used in NHS Scotland fell far short of the ideal. A working group was established and a minimum dataset and format for a discharge document was produced.

An original discharge document was produced in 1996 and this was reviewed and updated in 2003.

There are no specific Northern Ireland standards for communication of discharge information to GPs; currently each Trust manages this process within its own governance arrangements.

REMIT OF THE IMMEDIATE DISCHARGE DOCUMENT

Currently, when a patient leaves hospital a summary (often handwritten) is produced by medical staff, detailing relevant information considered necessary for the General Practitioner to continue patient care. This is the current "Immediate Discharge Document". This is followed by a more detailed, usually typewritten letter "The Final Discharge Summary". There is evidence to suggest that there is a wide variance in the quality and quantity of information supplied in the immediate discharge document, in addition to possible delays in receipt of the final discharge summary.

This guideline will provide a dataset and template for an immediate discharge document that should be available at the time of patient discharge. In many instances if used properly it can facilitate accuracy of information and it may be that a single discharge communication is all that is necessary, but in those cases where it is felt necessary to produce two separate documents the immediate discharge dataset will provide a template for any further communications. There is also evidence to suggest that a structured format for discharge information, as provided by the immediate discharge dataset is preferred to narrative style letters.

FORMAT AND CONTENT OF THE IMMEDIATE DISCHARGE DOCUMENT

The two main issues identified in relation to immediate discharge documentation relate to the quality of information and its timeliness. Regarding structure, evidence suggests that most GPs prefer a structured format as opposed to a narrative style. The structured format is perceived to be more complete, easy to read and legible and allows for important information to be located more easily. A structured format in the future will also allow the discharge summary to be produced electronically.

Studies have shown that the main items of information that GPs feel should be included in the immediate discharge summary are

- reason for hospitalisation
- treatment received while in hospital
- discharge diagnosis
- comprehensive and reconciled medication list
- active problems at discharge
- prognosis
- follow up arrangements
- carer information
- dates of admission and discharge
- details of doctors involved with the patient's care
- Information on drugs stopped and started in hospital with reasons for this.

These items are seen as a minimum requirement and potentially much more information may be included in a discharge document.

Information technology can facilitate the discharge summary process, as well as the seamless sharing of information between hospitals and GPs. Electronic preparation and transfer of discharge summaries has been suggested as a way of solving both timeliness of receipt, and also improving the legibility and content. Other benefits include

- more information included
- do not need to later type or dictate a formal letter
- permanent electronic record
- available immediately
- always legible
- full details with GP at time of discharge
- allows more accurate clinical coding
- ability to import to GP record

An electronic discharge summary can also be commenced early in a patients' admission, and added to by the treating doctor as required. Details of tests such as pathology and diagnostic results can also be pulled across from the clinical hospital administration system. Any further information such as medication changes can be added or modified prior to completing and signing off the document.

TRANSMISSION OF THE IMMEDIATE DISCHARGE DOCUMENT

At present the means of communication from hospital to general practitioner will still be manual, but where available the electronic summary is posted or emailed to the practitioner. It is realised that many organisations will not in the first instance be able to transmit the summary electronically, though electronic transmission of the immediate discharge document will be the ultimate aim. Electronic generation of the immediate discharge documentation will support and guide content and legibility of information. In the first instance however ceasing the production of handwritten immediate discharge documents in favour of computer generation will be seen as a major step forwards.

It is not considered to be good practice to send the discharge summary home with the patient as there is no guarantee that the information will be passed on to the general practitioner.

PRODUCTION OF THE IMMEDIATE DISCHARGE DOCUMENT

The Immediate Discharge Document is a "live document" which should be started as soon as a patient is admitted to hospital. Completion of the document is often delegated to junior staff who may have had little contact with the patient, and because of workload may have difficulty in completing immediate discharge summaries in a timely manner.

A key component in production of a timely, accurate immediate discharge summary is education for all doctors, but especially for junior doctors regarding the importance of documenting clear information for GPs in order to assist with the ongoing management of a patient following discharge form hospital.

Although most discharge summaries will be completed by junior staff all summaries should be approved by a senior member of staff.

The overall aim of this guideline is to develop a dataset of essential information to be included in an immediate discharge summary, which will facilitate the timely communication of accurate discharge information to general practitioners.

Headings/sub-headings	**Definition/illustrative description of the type of clinical information to be recorded under each heading**
GP Details	
GP Practice	GP Practice where patient is registered
GP Practice Address & Postcode	The name and address and postcode of the patient's registered GP practice
GP Practice Code	Code which defines the practice of the patient's registered GP
Patient Details	
Patient Surname, Forename	
Date of birth	
Gender	Male / Female
Health & Care No	
Patient address and postcode	Patient's usual address and postcode
Patient telephone number(s)	Contact telephone number
Communication needs	Does the patient have any specific communication needs (for example interpreter required)
Carer Details	
Carer Surname, Forename	
Carer address and postcode	Carer's usual address and postcode

Carer telephone number(s)	Carer's contact telephone number
Admission Details	
Method of admission	How the patient was admitted to hospital, e.g. emergency, elective, transfer, mental health
Hospital site / ward	Physical site to which the patient was admitted / ward
Responsible Trust	The NHS Hospital Trust to which the patient was admitted (this may not be the same as the name of the hospital).
Date of admission	Day patient was admitted to the hospital
Time of admission	Electronic environment only.
Discharge details	
Date of discharge	
Time of discharge	Electronic environment only
Discharge method	E.g. Patient discharged on clinical advice or with clinical consent; patient discharged him/herself or was discharged by a relative or advocate.
Patient died (national code)	
Discharge destination	
Destination Address	Not required if patient's own home
Discharging consultant	The consultant responsible for the patient at time of discharge (include contact details)

Discharging speciality/ department	The speciality/department responsible for the patient at the time of discharge.
Clinical Information	
Diagnosis at discharge	Primary diagnosis, secondary diagnoses and relevant previous diagnosis, including complications and co-morbidities (e.g. for coding purposes)
Operations and procedures	New and relevant previous operations and procedures, including complications and adverse events.
Risks and warnings	Significant risk of an unfavourable event occurring, patient is Hepatitis C +ve, MRSA+ve, HIV +ve C.diff etc. Any clinical alerts, risk of self neglect / aggression/ exploitation by others.
Clinical narrative	Very brief narrative description of the in-patient episode. **Should include complications and nutritional status.**
Relevant investigations and results	The relevant investigations performed and their respective results, where present, e.g. endoscope, CT Scan etc. It is important to highlight investigations and test results which relate to a GP action.
Relevant treatments and changes made to treatments	The relevant treatments which the patient received during the inpatient stay. Can include medications given whilst an inpatient.

Medication Details at Discharge	
Name of medicine (prescribe generically where appropriate)	Accurate and complete discharge information is reliant on medicines reconciliation being performed at admission and on discharge. *(Whilst the minimum dataset is not a discharge prescription, it is recommended that a full prescription history is included in the dataset unless the IDD follows an episode that has not resulted in any changes to the patient's medication. Under these circumstances, it should be made clear in the IDD that there have been no changes).*
Route of administration	
Frequency	
Dose (approved units)	
Length of treatment with an agreed wording for 'long-term' i.e. treatment is on-going Start and stop dates (where relevant)	Start and stop dates for short or defined courses of treatment should be detailed
Drug started & (brief) reason	
Dose changed & (brief) reason	
Drug stopped & (brief) reason	
Supply given to patient	
Use of patients' own drugs (PODs)	

Reason for not complying with product standardisation / NI formulary / PCE choices (if appropriate)	
Compliance aids	Details of whether compliance aids are required or already given to the patient should be provided. If already provided detail whether being used or not. It may be appropriate to highlight that patients should not be commenced on compliance aids in hospital without an appropriate assessment and arrangements being made for continued supply in primary care. In some cases it will be appropriate to refer the patient to their community pharmacist.
Repeat Dispensing	Include a recommendation for patient to be commenced on this if appropriate.
Allergies/medicine sensitivities	Allergies, drug allergies and adverse reactions Record if there are no known drug allergies The layout of allergy status documentation from the regional kardex template should be used.
Monitoring	A section for monitoring or follow-up of medication should be included
Patient reason for Medication	
Required from hospital pharmacy	
Quantity dispensed	

Pharmacy dispensed	
Suitable for 28 day supply Yes / No	
FUTURE MANAGEMENT	
Hospital	Actions required/that will be carried out by the hospital department. To include: • action (e.g. outpatient, pending investigations and results, outstanding issues) • follow up of any red list drugs / clinical trials • person responsible • appropriate date and time • venue (location)
Secondary care information	Actions hospital has arranged for patient Requested / planned / agreed with carer, community services (palliative care, specialist nurse practitioner, rehab team, social services). To include: • action • person responsible • appropriate date and time • care plan (if established) made available on request
GP	Actions required by the GP. To include: • action (e.g. specific actions, pending investigations and results, outstanding issues, HRT and cervical screening) • person responsible • appropriate date a time • suggested strategies for potential problems, e.g. telephone contact for advice

Information given to patient, carer, or authorised representative	This can include: • Carers • Relatives • Specific verbal advice and details of any discussions • Written information including leaflets, • Letters and any other documentation. Differentiation required between information given to patients, carers and any other authorised representatives.
PERSON COMPLETING SUMMARY	
Doctor's name	
Grade	
Speciality	
Doctor's signature	Acknowledged that if this is electronic this may not appear as a separate signature.
Doctor's contact/bleep number	
Date of completion of discharge record	

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ISBN Number: 978-1-906805-15-9