Audit of communication between primary and secondary care

Introduction

Discharge planning has always been an important element of communications between secondary and primary care. In the past the standard of such communication has, at best, been reasonable but, at worst, non-existent. Many patient complaints about the NHS involve failures of communications; other complaints involve perceived misinformation.

Current hospital practice seeks to reduce in-patient stay to a minimum length of time. This, along with the increase in the number of day cases, means that the need for effective discharge planning and post-operative instructions is paramount.

The discharge summary is used as a form of communication to disseminate information to others involved with the patient's care. The quality of this communication can be measured using audit.

Benefits of Audit

Benefits for the patient

- patients benefit from a smooth discharge procedure with less stress: this, in turn, helps facilitate a successful recovery
- fewer misunderstandings mean fewer unnecessary changes or duplication in care
- no unnecessary breaks in treatment owing to medicines not being available

Benefits for healthcare professionals

- confidence in continuity of care
- healthcare professionals have up-to-date information about the details of secondary care
- pharmacists able to obtain further supplies of unusual or complex medications before the patient's supply runs out.

Criteria and standards

Criteria

The designated/nominated community pharmacist should be noted on admission form/documentation. On discharge the same pharmacist should be informed of all relevant information pertaining to that discharge, which might include:

- patient's full identification, including any temporary address
- all details of drug treatment, including prior to admission and discharge medication. Any medical sundries required
- any unusual extemporaneous preparations or medicines that will continue to be supplied from the hospital (such as clinical trial material; non-Drug Tariff items)
- whether the patient is at risk and requires particular attention (such as elderly/confused; admitted with drug-related problems; at home with no carer/support)
- any relevant information relating to ability of patient to take drugs (such as literacy, language, dexterity) any necessity for a domiciliary visit

Standards

Standards for the above criteria should be set reasonably high as discharge is an integral part of *The patients' charter*. This may be 100% for patients at high risk or with unusual medications or 80% for lower risk patients. The precise levels would need to be negotiated locally involving all the local stakeholders, for example, hospital pharmacists, community pharmacists and health authority pharmaceutical adviser.

All the above mentioned criteria would need collaboration between those involved and a pilot audit could be performed to help eliminate any problems.

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Data collection

A simple tick form could be used to see whether or not the relevant information is set out on the discharge summary. A similar form or the same form extended could be used by the pharmacist to see whether action required is taken.

Length of time for the audit could be between one week and one month depending on numbers involved. An alternative would be to take the first 25-50 patients discharged from a particular clinical area and follow them through the audit process. A later audit might include a patient satisfaction questionnaire.

If the standard-setting becomes difficult then a pilot audit would be useful to establish what the situation is at present. The pilot audit can also locate any unforeseen problems.

Analysing the data

One of the objectives of any multi-professional clinical audit is to get professionals discussing the treatment of their patients: until professionals talk together, few changes are likely to occur unless constrained by outside influences. An audit of communication needs professionals to come together to decide what they need know and who needs to know it. The outcome might be a monitoring system that includes some form of checklist for all professionals (including social services) to be included on the discharge summary.

Making changes and re-audit

Any changes made to original criteria should be re-audited

not more than twelve months after any changes have been made.

Patient discharge communication audit

Patient	DOB	Sex M	Sex F	Date disch	Info rec	Dom visit	Action	Result	Outcome
TOTALS									

The following instructions can help you make use of the above form.

Patient identification , date of birth and sex to be completed.

Date disch Date patient was discharged. Actual date to be inserted.

Info rec All relevant information received by pharmacist. Tick only if Yes.

Dom visit Domiciliary visit requested. Tick only if Yes.

Action If Yes to above question then date of visit arranged. Actual date to be inserted.

Result Was the visit deemed necessary? Tick only if community pharmacist agrees visit was warranted.

Outcome This column to be completed as necessary. For example, a code can be used to identify

- what the was the outcome of the visit?
- were medical appliances required?
- was more explanation needed about the patients' medication?
- was a district nurse required to make a visit?

This form could be adapted to provide whatever information is required by both the secondary and primary care teams.

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