An audit on the quality of immediate discharge letters (IDLs) written for patients discharged from old age psychiatry wards 4 and 5 at Forth Valley Royal Hospital.

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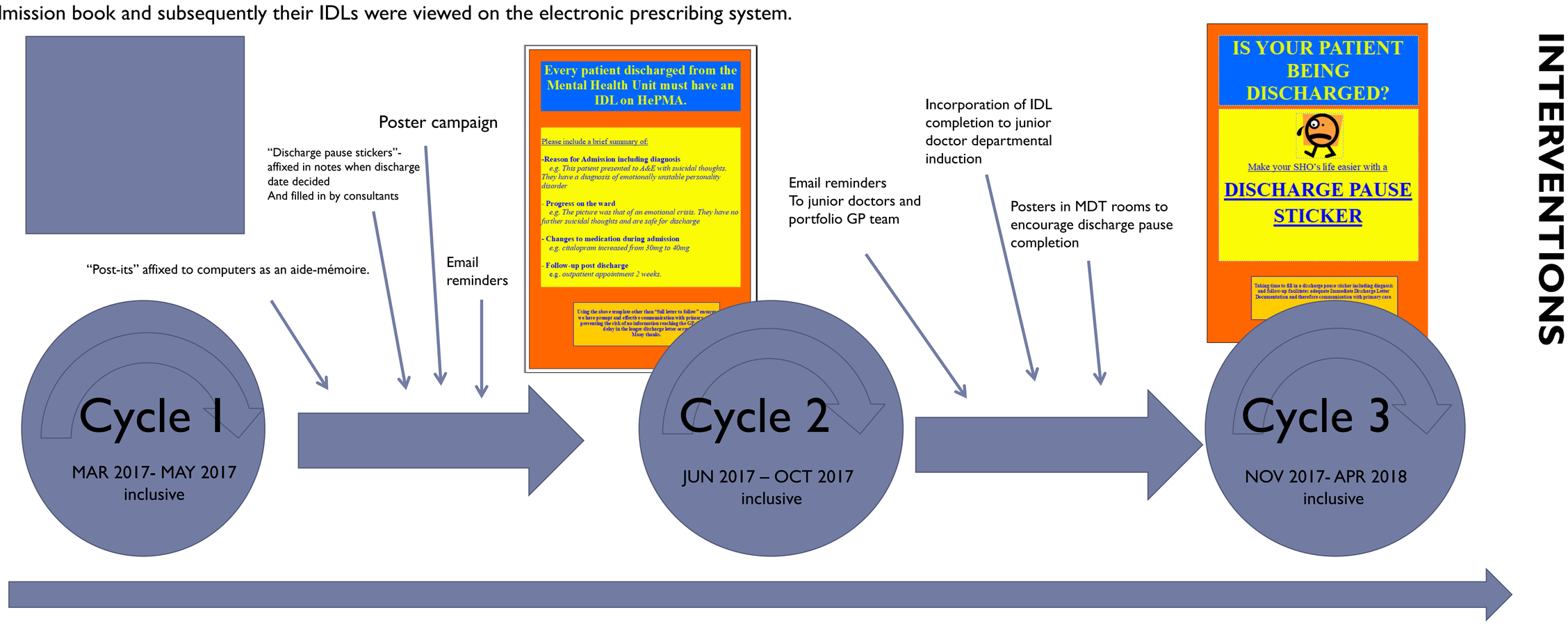
Aim: To assess the quality of immediate discharge letters (IDLs) for patients discharged from elderly inpatient psychiatric wards 4&5, Forth Valley Royal Hospital, by examining whether the following data were recorded: ***Reason for admission including diagnosis (RFA); Clinical progress (CP); Changes to medication (M) and Follow-up (FU).***

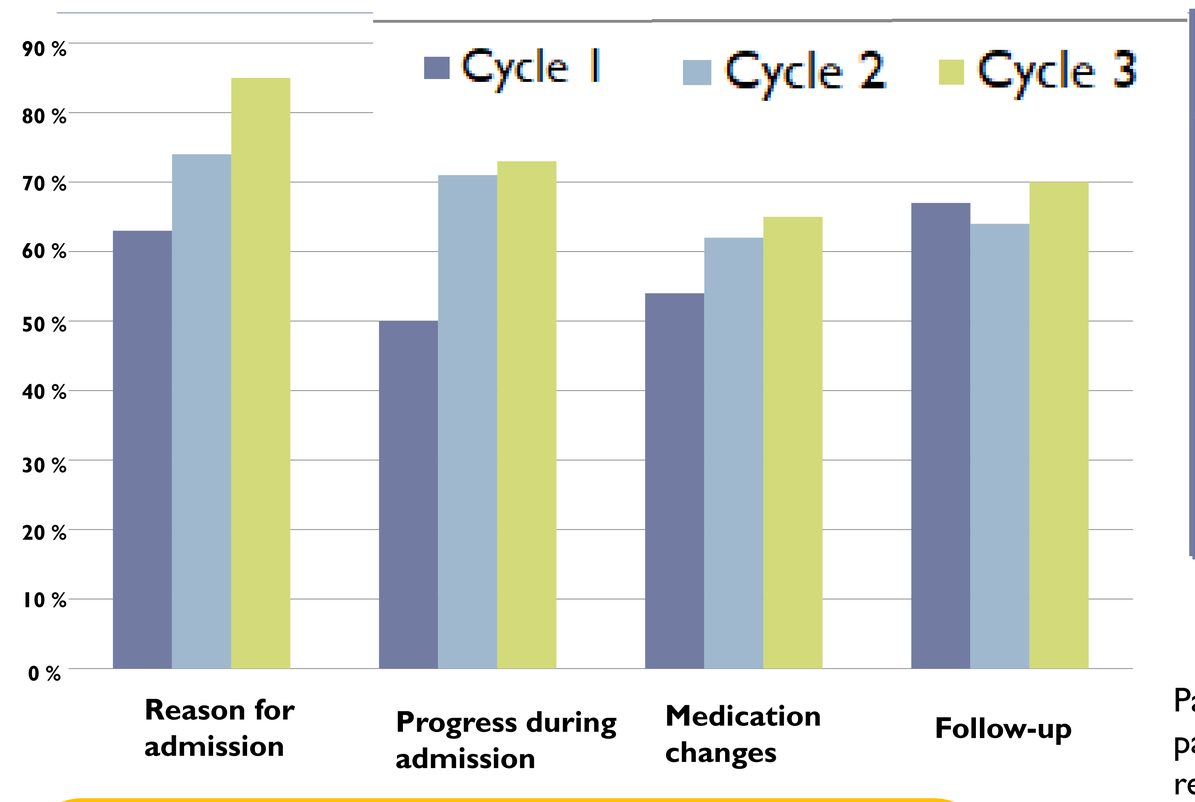
We hypothesised that simple measures could significantly improve standards.

Background

- The sharing of accurate and timely records of patients' care and treatment in hospital with general practice is vital for patient safety and good care.
- This is true for psychiatric patients, particularly older adults who often have complex comorbidities and polypharmacy.
- Comprehensive final psychiatric discharge letters can often take days to weeks to be completed.
- An IDL sent on the day of discharge can enable GPs to receive vital information in the interim and **should be completed to a high standard.**

Method: A minimum dataset for the IDL based on current SIGN guidance ("The SIGN Discharge Document." 2013. URL: http://www.sign.ac.uk/assets/sign128.pdf) was decided on by a working group (see aims). This dataset was audited for three cycles over the course of a year. CHI numbers and dates of admission of all patients were obtained from the ward admission book and subsequently their IDLs were viewed on the electronic prescribing system.





Results

On ward 5 there was an improvement of adequate completion of the first 3 criteria over the three cycles: RFA (63%, 71%, 85%), CP (50%, 71%, 73%), M (54%, 62%, 65%). FU arrangements documentation showed minimal change (67%, 64%, 70%).

In ward 4 all but two IDLs had information complete in all 4 fields across the three cycles, but this was for a very low number of patients (12).

The percentage of IDLs with no information in any fields and the percentage with information complete in all four fields showed little change.

loopholes in current system requiring addressed

- Patients being discharged whilst on pass- no letters as medications not required
- Follow-up plans not adequately documented by discharging team
- Patients with short admissions who don't require medications dispensed- discharge letters aren't being done.
- portfolio GPs writing IDLs do not tend to comment on the mental health side of the patients admission.

Next Step:
Move over to electronic documentation and new Trakcare electronic system for writing discharges will allow further opportunities for quality improvement

Conclusion: Implementation of simple and low cost interventions improved standard of IDLs generated from our old age wards for the majority of patients. This audit highlighted "loop-holes" which require addressed going forward in order to continue to improve standards.