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SPECIALIST SUBSTANCE MISUSE INPATIENT UNIT: AN EXAMINATION OF COMMUNICATION BETWEEN INPATIENT AND PRIMARY CARE PHYSICIANS.

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Background

The discharge letter is the principal means of communication between the inpatient and the primary care physicians in the UK health care system. Good-quality correspondence between specialist services and general practitioners (GPs) is fundamental to patient care and makes transition from secondary to primary care as smooth as possible for patients

Aim

The aim of this study was to assess and improve the quality of discharge communication from the specialist substance misuse inpatient unit to general practitioners

Method:

This study was carried out in North Staffordshire Combined Healthcare NHS Trust in July 2013, UK. Fifty three Patients who were admitted to the inpatient unit between March & May 2013 were randomly selected from the Health Informatics Service. A proforma was designed based on approved mental health discharge summary headings from the Royal College of Psychiatrists UK and the results were compared against a previous audit done in 2012 which only looked into some of the component included in the present study

Results

The study showed that most components of GP details, Patient Demographics, Admission Details, Clinical Details and discharge recommendations were well documented in the discharge letters analysed. The sub components where documentation were not adequate included Gender (0% documented), discharge destination (34% documented), mental capacity (1% documented), allergies (0% documented), Risk assessment (68% documented). However the findings were significant better than the previous audit in most areas.

Conclusion

This re-audit revealed that the quality and standards achieved for most aspects of discharge summaries were high. However not all aspects met the standards, some very important aspects including risk assessment, drug allergy, details of care coordinator and discharge destinations recordings were poor. There may be reasons for failure to meet the standards; Gender was never recorded in the discharge letters but one could easily assume the gender of the patients from the narrative of the discharge letters. It was noted that discharge destinations were more likely to be recorded if patients were not discharged home. Mental Capacity was not recorded in 98% of cases, as most admissions to the Inpatient unit are planned and patients come on a voluntary basis and have capacity regarding the admission and treatment

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