NHS
Ashford and St. Peter's Hospitals
NHS Foundation Trust

IMPROVING DISCHARGE INFORMATION FROM THE EMERGENCY DEPARTMENT

BACKGROUND
The Francis Report emphasised the need for better information to be made available to patients and other healthcare professionals, and specifically that clinical information should be shared from the hospital to primary care in a manner that ensures that patient care is safe, accurate and timely.

For patients attending the Emergency Department (ED) there is a need to ensure a safe transfer of care back to their GP and ensure all relevant information is provided to support this. The discharge summary documents produced for patients attending the ASPH ED were found to be incomplete and not providing sufficient information for GPs so a small team of professionals from both Primary and Secondary care was formed to make some improvements.

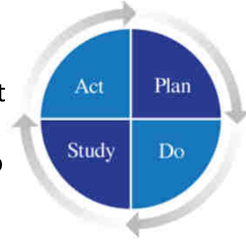
AIM
To ensure the safe transfer of care to primary care for all patients who have attended urgent care by improving the completion and quality of information in ED discharge summaries by March 2017.

MEASURES
The team came together to carry out an audit of 100 patient records and their discharge summaries (50 adults and 50 paediatrics). This provided a really helpful baseline from which the team could aim to improve.

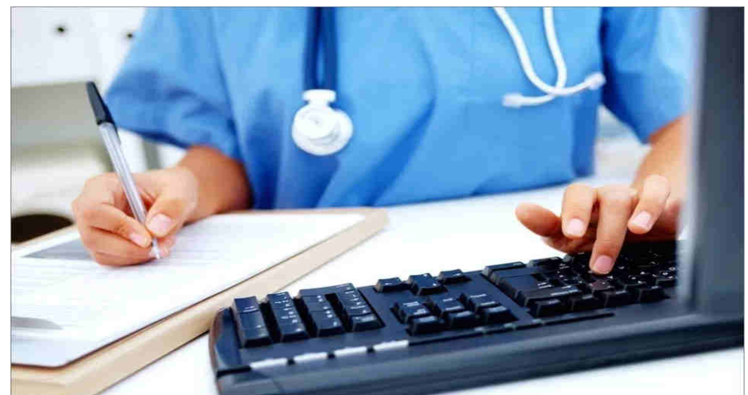
The team agreed to measure their success based on:
i) The percentage of patients discharged from ED with discharge summary completed and sent to a GP.

ii) The percentage of core information completed in discharge summaries from ED.

THE CHANGES
In the baseline audit the team found that essential information such as investigations carried out and changes to medication were being recorded in less than 50% of cases. The team came together and agreed a minimum data set for ED discharges which would form the basis of the improvements.



Changes to the ED IT system supported some improvements, but on-going audits showed that further improvements were required. The team led teaching for clinical staff in ED; as well as feedback on good practice and further minor changes to the discharge letter.



OUTCOMES
By the end of the March 2017, the team had made a number of improvements and the latest audit showed over 97% compliance with the minimum dataset.

- Recording of investigations carried out increased form 48% to 98%
- Recording of patient diagnosis increased from 76% to 94%

The team will continue to monitor and make improvements based on feedback from patients and GPs.

THE TEAM
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