Summary dismissal

GPs are often expected to pull a rabbit out of a hat for patients discharged from hospital, writes **Emily Dunn**

THIS is a time when patients are most at risk of iatrogenic illness: discharged from hospital, with changes to medications or microbiology results still pending, they remain in medical limbo until the follow-up consultation with their regular GP.

Too often, however, the hospital discharge summary, detailing drug changes or pathology, fails to arrive. And even when it does, it may be late or contain critical inaccuracies, resulting in patient harm.

According to a systematic review, only one-third of discharge summaries are available at the first post-hospital visit. Among those that do arrive, up to two-thirds will not include diagnostic results and up to 40% will not even include discharge drugs.[1]

One study of 86 people showed that half of patients discharged from hospital experienced at least one adverse event in handover of care to GPs because of incorrect information.[2]

While the advent of digital summaries and platforms such as My Health Record can assist in the delivery of discharge summaries, they do not address the quality of the clinical handover.

Dr Michael Tam, a senior lecturer in general practice at UNSW Sydney, says discharge summaries seem to be expected to have a "magical quality".

"There will be a sense that a certain number of things should be done and that if they are turned into words on the discharge summary, then they will magically be done," he says.

A 2017 pilot study of a discharge summary assessment tool found that the most valuable components for GPs included accurate lists of medications on discharge, diagnoses on discharge, reasons for any change in medications, details of treatment in hospital, and any follow-up arrangements.[3]

Lead author of the study Dr Carl Mahfouz, from the department of general practice at the University of Wollongong, adds that timeliness is key.

If discharge summaries are not written in a timely fashion, the benefit of digital delivery is lost, he says.

"I saw someone today. They had been discharged from hospital for a week but I still didn't have the discharge summary.

"I didn't know why they had been admitted, what diagnosis they had been given or if changes had been made to medications."

Succinct and relevant discharge summaries are uncommon, he notes.

"Too often, discharge summaries are extremely extensive and the information is not prioritised. Nothing beats a short, ▸

2-3 sentence, relevant medical summary," he says.

"In the hospital they are taught ISBAR [Identify, Situation, Background, Assessment and Recommendation] as a chronological logical flow of information, but that often doesn't happen in discharge summaries to GPs where there is no opportunity for correction."

Dr Tam agrees timeliness is important. He reveals he has received summaries containing instructions for interventions that should have been done two weeks prior to the summary being sent.

'It is uncommon that I would be notified that one of my patients has been admitted.'

DR MICHAEL TAM

Discharge summaries suffer from the idea that once a patient is released to community care, it is the end of their health journey, he explains.

"It is uncommon that I would be notified that one of my patients had been admitted to hospital, even more unlikely that someone would want to talk to me," he says.

"If someone called me about a patient, that 30-second conversation will probably be more useful.

"Focusing on the discharge letter can be a bit narrow and shows a lack of perspective. You can do a clinical handover with no direct paper handover at all."

Associate Professor Rowena Ivers, from the department of general practice at the University of Sydney, works primarily in Aboriginal health and says the issue of appropriate discharge summaries is even more pressing for patients from a background of social disadvantage.

"Often patients can't read, they are unwell when they have been in hospital and in a state of crisis," Professor Ivers says.

"People who have few social supports or who have low literacy, they often don't know the results of their tests or what medications they are on."

Patients who self-discharge from hospital or EDs are particularly at risk of falling through the cracks.

"Homeless patients are among the most at-risk of our clients and the most unstable. They may be cognitively impaired or critically unwell," Professor Ivers says.

"These are not necessarily the people who will present to their GP for follow-up and if they do, often the GP may not be aware they have been in hospital at all."

The chief executive of the Australian Hospitals and Healthcare Association, Alison Verhoeven, says that hospitals recognise the risk of patient harm in a clinical handover to community care.

"Often discharge summaries are the responsibility of the most junior doctors within hospital teams," Ms Verhoeven says.

"There needs to be adequate recognition of the clinical importance of discharge summaries, as well as the resources required to complete them accurately – particularly in regards to the time allocated to complete them."

She points to the same-day discharge summary project at the Sunshine Coast Hospital and Health Service in south-east Queensland that succeeded in improving timely completion of discharge summaries from 19% to 74% over a two-year period. This was achieved through implementing both a minimum data set and education programs for medical staff.[4]

Failures in clinical handover, however, can go both ways, for example, when hospitals receive an out-of-date medication list in a GP referral letter.

Dr Michael Rice, a GP based in Beaudesert in the Gold Coast hinterland, Queensland, and a past president of the Rural Doctors Association of Queensland, says that he often receives inadequate communication from GPs when working in metropolitan hospitals.

"GPs can forget that the hospital is judging their reputation, capability and qualifications on the information they provide," Dr Rice says.

"Many referrals from GPs to secondary care include irrelevant medications, such as medications ceased long ago, or may miss important information such as diagnoses under active treatment."

Dr Tam says that a senior clinician in the ED available to take phone calls from a GP is often more valuable than a GP referral letter.

"If I knew what I needed to send them to the ED for, I wouldn't be sending them to ED. I would be getting them a direct admission. That doesn't come across so well in a letter," he says. "The more junior a medical officer, the less the care is handled as a question of risk management and the more it is framed as a diagnosis."

Whereas most GPs have an understanding of hospital systems, junior doctors writing discharge summaries often have limited experience of general practice, Dr Tam says.

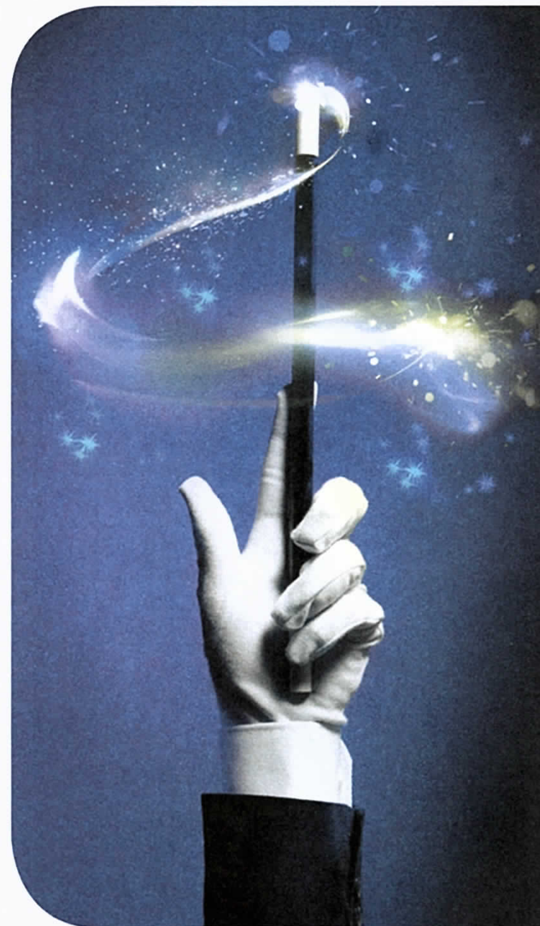
"It is seen as an administrative task rather than an important part of the handover," he says.

He welcomes growing awareness of the idea that "it is probably better not to think of patients being discharged from hospital but of transfer of care, or handover".

When it comes to solutions, some believe that measures to address poor quality handovers, either from hospital doctors or GPs, should begin in medical school.

"We stress to our medical students [at Wollongong university] how to summarise things," Dr Mahfouz says.

"It does require training and practice, and I am not sure if all junior doctors get that part of the training."



Furthermore, hospitals should make the handover summary the responsibility of the registrar, rather than the intern or resident.

"In my day, the consultant would get a copy and amend or add to it. Today it is too often the job of the most junior doctor," Dr Mahfouz says..

"I don't believe they should be the ones responsible. Often they will change rotation to a new ward and they will have five discharge summaries to write for patients for whom they know very little about. This is where the registrar needs to take some ownership."

Professor Ivers believes that secure electronic platforms are one option for efficient and accurate communication between hospitals and general practices.

"When we are not sent automatic discharge summaries, it is quite time-consuming to chase results. This can be dangerous for the patient. A secure email conversation between clinicians at discharge would be more helpful."

Dr Rice says some of the best clinical handovers he has received have come from colleagues in rural hospitals.

"Many of the doctors working in rural hospitals also work as GPs – either in their local community or another community – so they are familiar with the issues and appreciate the importance of timeliness and relevance."

By comparison, Dr Rice says, clinical handovers from a metropolitan ED are often anonymous.

"In metro practice it is common to see the dreaded words 'GP to chase'. The GP is not the community intern or the labrador for the hospital. Where systems exist to direct results to a known GP, they should be used."

Dr Rice says that simple steps, such as ensuring that pathology results are copied to the GP, are often not utilised by hospital-based doctors.

"On the other hand, doctors in rural ED who have experienced patient care from the other side seem to be more willing and able to copy investigations to the GP."

Ms Verhoeven says it is important that hospitals "measure what we value".

"Our hospitals need to monitor the rates of discharge summaries that are completed within a clinically appropriate time, while also monitoring the quality. "

For improving GP communication to hospitals, Dr Rice believes there is scope for accreditation surveyors to examine the quality of referrals and for those not meeting basic requirements to be sent back.

He admits, however, that it may be more difficult to achieve when it comes to communications from hospitals to GPs.

"I dream of a world where the GP could refuse to accept a patient transferred out of hospital until reasonable information could be provided," he says.

Note: Both the Australasian College for Emergency Medicine and the Royal Australasian College of Physicians declined interview requests for this story.

References on request.

MEDICATION 'INVISIBILITY'

Dr Michael Tam remembers a patient who had been started on medication for Parkinson's disease between hospital admissions.

"When he went back into hospital, the team looked at his medication list from his previous admission rather than gaining information from his provider," Dr Tam recalls.

This meant that not only was the patient not receiving medication for Parkinson's but also that he was restarted on an antidepressant medication that had been ceased by his GP. He developed serotonin syndrome.

"He was quite unwell and in the context of this particular admission, the team assumed the delirium was related to sepsis," Dr Tam says.

"After a week, the serotonin syndrome settled down but that context had been invisible to the team.

"When he was discharged, a new medication list was not sent home with him, so he was back home taking the SSRI again and taking his Parkinson's medication – and he went back into serotonin syndrome.

"That was a pretty bad error that was curiously invisible."

WHAT DISCHARGE LETTER?

Among the GP gripes about discharge summaries is that they are often not done at all.

Dr Michael Rice remembers a patient who returned to him after admission to a metropolitan hospital. The patient had initially attended as a day case, but experienced a serious complication resulting in an unplanned readmission.

The patient then returned to Dr Rice for follow-up of his hospital-ordered investigations. But Dr Rice only received a discharge letter from the initial, uncomplicated admission.

"The investigations showed that something serious had happened to this patient, but the clinical handover in front of me said all was well. There was no mention of the bit that they wanted me to follow-up."

In remote areas of Australia, communication between hospitals and local health services can be even more pressing.

Associate Professor Rowena Ivers previously worked in remote communities in the NT and remembers a well-publicised case in which an elderly Aboriginal man was discharged from hospital and retrieved by air to return to his community.

"The airstrip was 10km from town," Professor Ivers recounts. However, the hospital didn't inform the clinic he was coming home.

"He was stranded at the airstrip and died of dehydration."

'GP TO CHASE RESULTS ...'

While hospital-ordered pathology is invaluable information for patients returning to GP care, measures to ensure results are shared with the GP vary between states and area health services.

Dr Rice says that the discharge letters from one Queensland hospital he regularly deals with includes three separate fax numbers for GPs to obtain results for haematology, biochemistry and radiology.

"These are the results that are processed most quickly and are most likely to be available before the patient leaves the department," Dr Rice says.

"However, for microbiology results that often taken several days and may require the GP to change antibiotics, there is no fax number provided."

Irrespective of that, the use of fax numbers to seek results is an anachronism, he says.

Queensland Health has other mechanisms that are far more efficient for transmitting results, but they are usually not used, he says.