Publications

Yemm R, Bhattacharya D, Wright D, Poland F, *What constitutes a high quality discharge summary? A comparison between the views of secondary and primary care doctors,* International Journal of Medical Education, 2014; 5: 125-131

Conference abstracts

Yemm R, Wright D, Green D, Wood J, *Investigating medication errors on Electronic Discharge summaries: their nature, severity and predictors,* International Journal of Pharmacy Practice supp, 2012; 20: 54-55

Conference presentations

Improving continuity of care: communication of medication changes made during hospitalisation to General Practitioners in North East Essex, Essex Biomedical Sciences Institute conference (oral presentation), University of Essex, Sept 2012

Do GPs value the input made by pharmacists in the discharge process? A local service evaluation. 'Learning and Working Together to Improve Patient Safety through better Prescribing' conference (poster), Cardiff University, May 2013

Does annotation of medication changes on inpatient drug charts lead to better quality Electronic Discharge Summaries (EDS)? A 6-month Early Adopter Site project using the Royal Pharmaceutical Society's Transfer of Care guidance, Royal Pharmaceutical Society Annual conference (oral presentation), Birmingham, Sept 2013

Guidance and reports

Developing standards for health and social care records: report of the joint working group, London: Royal Pharmaceutical Society; 2010 (user group contributor)

Keeping patients safe when they transfer between care providers – getting the medicines right. London: Royal Pharmaceutical Society; 2011 (user group contributor)

Individual reports from the Early Adopter Sites, London: Royal Pharmaceutical Society; June 2012

Serving the people of north east Essex Colchester Hospital University NHS Foundation Trust

Clinical Audit Summary Document

Title: Continuity of care: the impact of an Electronic Discharge system at Colchester Hospital University NHS Foundation Trust. Part 1: An audit of the nature, severity and predictors of medication errors on electronic discharge summaries

Lead Clinician / Nurse: Rowan Yemm
Other Participants: David Green, Anne Regan

Communication Plan

Date presented at Clinical Audit Half Day:

Date reported to local clinical teams: April 2011

Staff member names of local clinical teams:

Governance Meeting(s) reported at:

Date reported:

Key Reasons for Conducting the Audit

- To form a part of ongoing work around communications at the interface and the transfer of information about medicines between care settings
- To contribute towards Rowan's PhD with the University of East Anglia
- To provide baseline data and a view of current practice relating to electronic discharge summaries and the discharge process

Methodology (In brief)

Over a two-week period in March 2011, discharge summaries for patients being discharged back under the care of their GP from 6 wards (2 medical, 2 elderly care and 2 surgical) at Colchester hospital were collected and reviewed. Patient medical notes and most recent medication charts were obtained from medical records and compared with the medicines listed on the discharge summary. A discrepancy was defined as any identified difference between medicine information on the patient's inpatient chart and those on the discharge summary, where no reason for the difference could be identified from the patient's notes. Logistic regression analysis was used to identify significant predictors of a medication discrepancy. A random sample of 30 discrepancies was individually reviewed by an independent panel of 4 senior clinical healthcare professionals for clinical significance using a validated tool. Ethical approval for the study was granted by the hospital's ethics department.

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NHS Foundation Trust

Key Findings

151 medication discrepancies were identified across 148 recruited discharge summaries. Of these, 110 discrepancies were identified and corrected by pharmacy. The remaining 41 discrepancies were identified on summaries that did not receive a pharmacy check, and were released into primary care. Information regarding time of release into primary care was available for 140 discharge summaries. Of these, 76 (54.3%) were released on the same day as patient discharge, and 44 (31.4%) the next day, therefore 120 (85.7%) were released within the 24 hour target. 20 (14.3%) summaries were released more than 2 days following patient discharge, the greatest of which being 22 days after the discharge date (mode 2, SD 4.9, range 20). Discrepancies involving dosages (29.8%) and omissions (27.8%) were most commonly observed. Patients who take 6 medicines or more were 2.5 times more likely to have a medication discrepancy at discharge than those who take 5 or less (OR 2.49; 95% CI 1.203 to 5.174; p=0.014). Patients staying in hospital for 3 days or longer were 3 times more likely to have a medication discrepancy than those who stayed for less than 3 days (OR 3.67; 95% CI 1.725 to 7.810; p=0.001), and those staying for 7 days or longer were four times more likely to have a medication discrepancy (OR 4.45; 95% CI 2.111 to 9.378; p<0.001). The mean (SD) severity score given to the discrepancies was 3.50 (3.18).

Key Learning Points

- Discharge summaries are often erroneous, with a minority of medication errors proving clinically significant.
- Most summaries are released into primary care in a timely fashion, but more work needs to be done to investigate summaries that have been delayed and that are outside of the required 24hour post-discharge window
- Omissions of medicines from the discharge summary is a common error
- This audit has identified patients at a higher risk of a discrepancy occurring at discharge, and pharmacy resources should be channelled towards such patients accordingly.

Suggested Actions

Action	Responsible Person	Time Scale	Action(s) Completed	Evidence
Circulate results among the pharmacy dept	Rowan/Anne	April 2011		

Plans for Re-audit: Re-audit to be linked into new work starting this winter on the subject of transfer of care.

Dear Sir/Madam,

Thank you very much for agreeing to participate in this audit. It is our hope that the results of the study will enable us to identify the effect the electronic system is having on the accuracy of information being given to primary care, and through identifying any areas of weakness, lead to improvement in the discharge process.

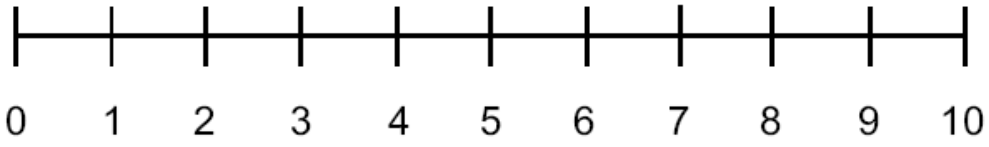
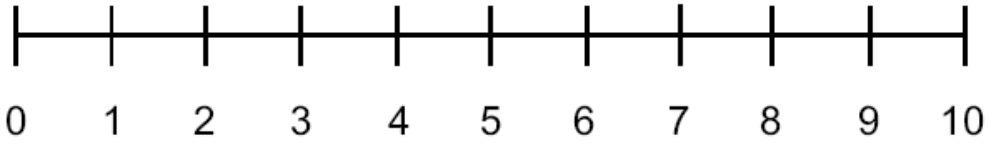
Instructions for participants

Below are 30 examples of medication errors on hospital discharge summaries. Please rate each of these in terms of their potential clinical significance. The scale runs from zero to ten, where zero should be given to an incident which would have no effect on the patient, and ten should be given to an incident that would result in death. Mark the scale clearly by either circling the appropriate number or placing a clear mark anywhere between the numbers. Assume that all patients are adults on a general medical ward. If you have any additional comments please include these in the space below.

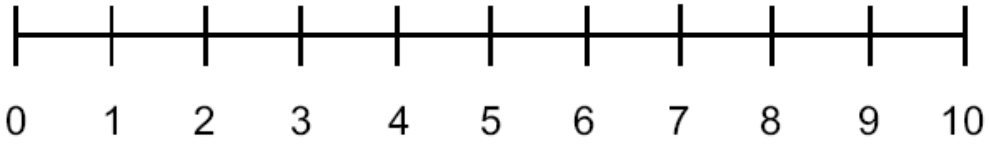
Health care professionals of different disciplines have also been asked to participate in this study. Your responses are therefore important so please rate the cases yourself. All replies will be anonymous and will be pooled with those of the other health care professionals to produce an average score for each case.

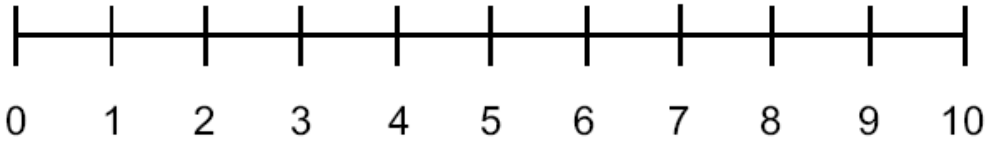
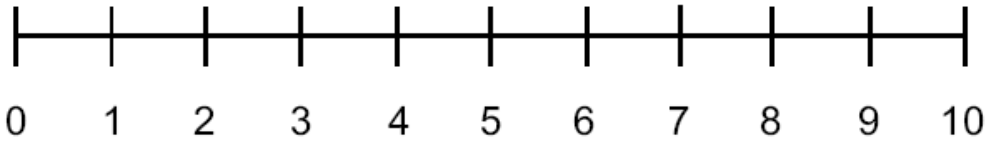
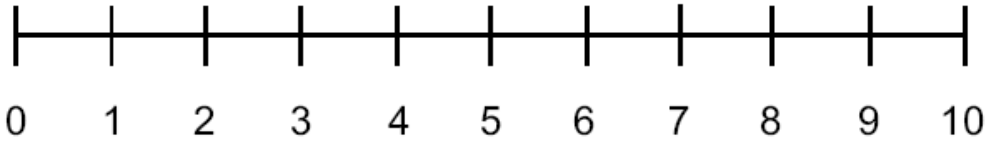
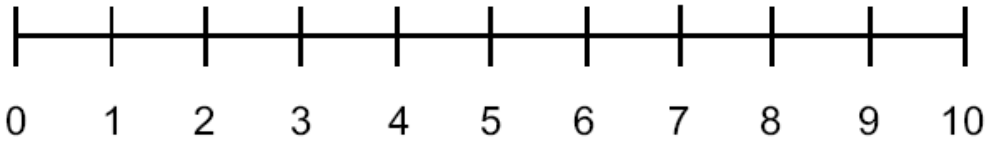
Please return the completed scoring sheets in the enclosed stamped addressed envelope at your earliest convenience. If you have any questions please do not hesitate to contact me on **r.yemm@uea.ac.uk**

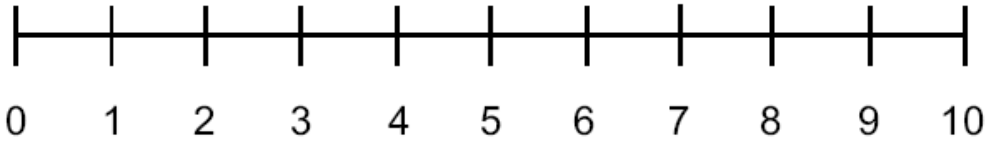
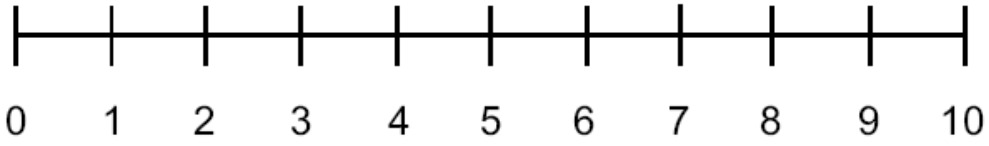
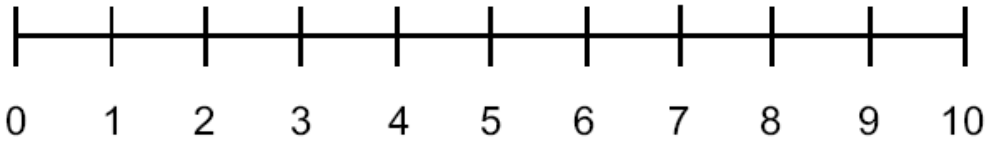
Rowan Yemm
Research Pharmacist
University of East Anglia and Colchester Hospital University NHS Foundation Trust

	0 = no effect on patient, 10 = patient death	
1	*A patient was prescribed prednisolone 30mg OD on their discharge summary. This should have been a tapering dose down to a maintenance dose of 5mg OD.*  	Please leave blank
2	*Regularly taken paracetamol was omitted from a patient's discharge summary in error*  	
3	*Calcichew® D3 forte was included on a patient's discharge summary instead of Calichew® original*  	
4	*Alfacalcidol 1 microgram capsules OD was included on a patient's discharge summary. It should have been taken three times weekly only*  	
5	*Insulin Actrapid® was included on a diabetic patient's discharge summary in error. It was for short term use during admission only.*  	

6	*A patient who was documented as being allergic to penicillin was prescribed amoxicillin on their discharge summary. On further investigation the nature of the reaction was found to be a stomach upset only.*  	Please leave blank
7	*Paracetamol normal release tablets were included on a patient's discharge summary instead of soluble tablets. The patient had swallowing difficulties*  	
8	*Amitriptyline 100mg ON was included on a patient's discharge summary. The patient usually takes 10mg ON.*  	
9	*Prednisolone 30mg OD was written on a patient's discharge summary instead of 20mg OD*  	
10	*Optive® eye drops were omitted from a patient's discharge summary*  	

11	*The dosing instructions for brinzolamide eye drops was written as being for use in both eyes instead of just the right eye on the patient's discharge summary.*  	Please leave blank
12	*Fresubin® energy was included on a patient's discharge summary instead of Fresubin® original*  	
13	*A lifelong prescription for amoxicillin for a splenectomy patient was omitted from their discharge summary in error*  	
14	*Adcal® D3 effervescent tablets were included on a patient's discharge summary instead of the original tablets*  	
15	*A patient was prescribed Senna tablets as required on their discharge summary, but had been taking them regularly during admission.*  	

16	*Trimethoprim 100mg ON for prophylaxis of a Urinary Tract Infection was omitted from the patient's discharge summary* 	
17	*Omeprazole liquid was prescribed on a patient's discharge summary instead of lansoprazole Fastabs® (effervescent tablets) for a patient with swallowing difficulties.* 	
18	*A patient with Parkinson's disease was prescribed Co-beneldopa 25/100 dispersible tablets 1 ON on their discharge summary. The dose should have been 2 ON.* 	
19	*Amantadine syrup 100mg BD for Parkinson's disease was omitted from a patient's discharge summary in error* 	
20	*'No changes' to a patient's regular medicines was recorded on the discharge summary, but Tranexamic acid had been added as a new medicine for the patient.* 	

21	*Omeprazole 40mg OD was prescribed on a patient's discharge summary in error instead of 20mg OD which they had previously taken regularly* 	Please leave blank
22	*A patient's allergy to latex and Sinemet® was documented on their drug chart and in their medical notes, but was absent from their discharge summary. 'NKDA' was recorded on the summary. Sinemet® was not prescribed.* 	
23	*Dihydrocodeine 30mg was prescribed on a patient's discharge summary instead of codeine phosphate 30mg.* 	
24	*A patient's allergy penicillin (causing rash and swelling) was documented on their drug chart and in their medical notes, but was absent from their discharge summary. 'NKDA' was recorded on the summary. No penicillins were prescribed* 	
25	*A patient was prescribed a dose of 25mg Isosorbide Mononitrate M/R OD, but the 20mg strength normal release tablets were included on their discharge summary in error.* 	

26	*A patient's allergy to non-steroidal anti-inflammatory drugs was documented on their drug chart and in their medical notes, but was absent from their discharge summary. 'NKDA' was recorded on the summary. No NSAIDs were prescribed* 	Please leave blank
27	*A patient with a documented allergy to penicillin (rash) was prescribed co-amoxiclav on their discharge summary* 	
28	*A diabetic patient was prescribed the NovoMix® 30 100units/mL vial rather than a pre-filled Flexpen on their discharge summary in error.* 	
29	*Simvastatin 40mg ON was omitted from a patient's discharge summary in error. The patient had been taking it regularly prior to and during admission.* 	
30	*A patient's allergy Lithium was documented on their drug chart and in their medical notes, but was absent from their discharge summary. 'NKDA' was recorded on the summary. Lithium was not prescribed* 	

End of discrepancy examples

Your comments and feedback would be most welcome. Please feel free to write any you should have in the space below

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Thank you very much indeed for your time and contribution to this study. If you should be interested to receive a copy of the final results, please contact r.yemm@uea.ac.uk

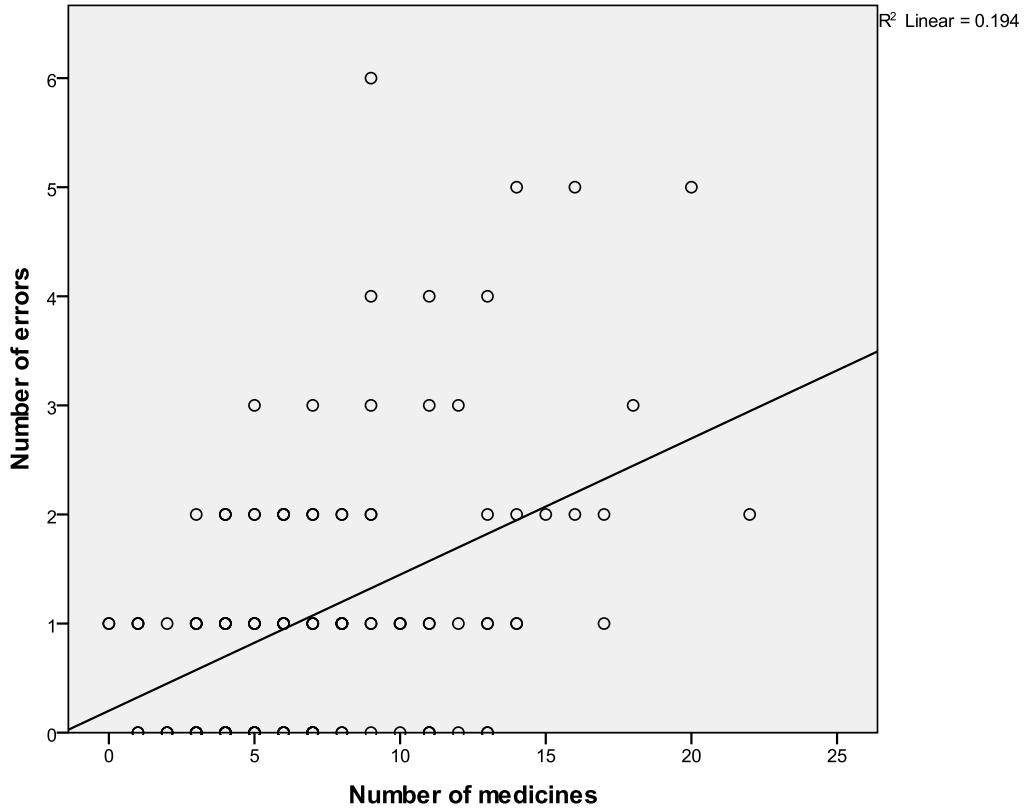

Figure 2.7: Relationship between number of medicines and number of errors observed on discharge summaries

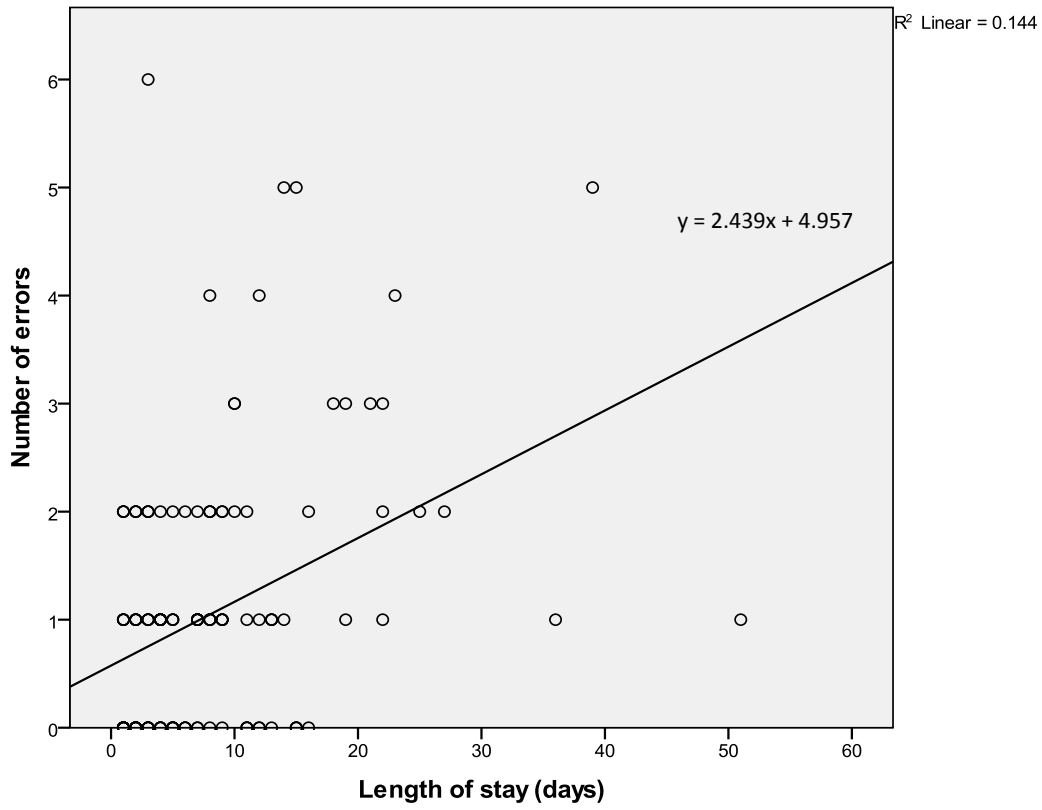

Figure 2.8: Relationship between length of stay and number of errors observed on discharge summaries

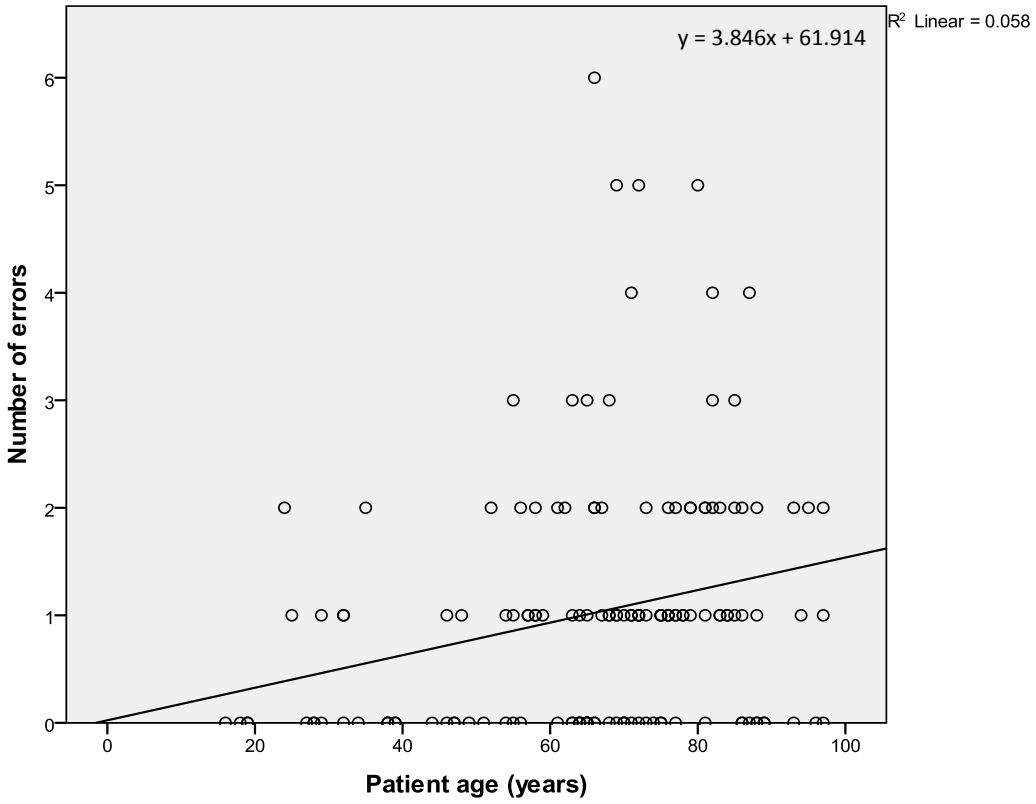

Figure 2.9: Relationship between age and number of errors observed on discharge summaries

The logistic regression analysis included the patient factors (which became the independent variables) 'length of stay' and 'number of medicines prescribed'. The variable 'age of the patient' was removed from the model due to its relationship with the number of medicines prescribed.

Analysis was conducted for each increasing increment in the independent variables i.e. with each increasing day in the length of stay. This was in order to render them dichotomous variables so that the effect of a unit increase in that variable could be calculated. E.g. with respect to the variable 'length of stay', two (binary) possible values were, for example, less than 2 days = 0, 2 days and longer = 1.

The binary dependent variable was the presence or absence of error(s) on the EDS (error absent = 0, error(s) present = 1).

Independent variable	Level	Dependent variable		Odds ratio	95% CI		p value
		Errors absent (n)	*Errors present (n)*	*Exp(B)*	*LI*	*UI*	
Length of stay	< 2 days	14	7	3.478	1.309	9.241	0.012
	>= 2 days	46	80				
	< 3 days	26	15	3.671	1.725	7.810	0.001
	>= 3 days	34	72				
	< 4 days	32	23	3.180	1.586	6.378	0.001
	>= 4 days	28	64				
	< 5 days	36	31	2.710	1.376	5.336	0.004
	>= 5 days	24	56				
	< 6 days	43	37	3.418	1.690	6.931	0.001
	>= 6 days	17	50				
	< 7 days	47	39	4.450	2.111	9.378	<0.001
	>= 7 days	13	48				
	<10 days	50	60	2.250	0.994	5.093	0.052
	>= 10 days	10	27				
	<14 days	56	66	4.455	1.443	13.748	0.009
	>= 14 days	4	21				
Number of medicines	< 2 meds	2	5	0.687	0.128	3.685	0.661
	>= 2 meds	46	79				
	< 3 meds	5	6	1.512	0.436	5.244	0.515
	>= 3 meds	43	78				
	< 4 meds	12	11	2.212	0.890	5.497	0.087
	>= 4 meds	36	73				
	< 5 meds	21	20	2.489	1.164	5.321	0.019
	>= 5 meds	27	64				
	<6 meds	26	27	2.495	1.203	5.174	0.014
	>= 6meds	22	57				
	<10 meds	42	59	2.966	1.119	7.863	0.029
	>=10meds	6	25				

Table: Logistic regression analysis for number of medicines and length of stay with respect to number of errors. Odds ratios (Exp(B)) were calculated using SPSS version 18

The results of the Wald test show that the regression coefficient (Exp(B)) for the independent variable 'number of medicines prescribed' is significant

Variable	**Exp (B)**	**Wald**	**p value**
Length of stay	1.070	3.648	0.056
Number of medicines prescribed	1.129	4.940	0.026

It can be seen by the high p value (0.509) of the Hosmer and Lemeshow Test that the model is a good fit and accounts for 14.3% of the variance (Nagelkerke R Square).

Variable	**Hosmer and Lemeshow Test**	**Nagelkerke R Square**
Length of stay Number of medicines prescribed	0.509	0.143

Only to be completed if chart to be faxed or copied

SURNAME:

FIRST NAME:

HOSP. NO:

REGULAR PRESCRIPTIONS

Drugs for discharge, doctor initial if required

Date and month →

Ring times, enter times or enter variable dose

VTE PHARMACOLOGICAL PROPHYLAXIS REQUIRED?

Date (admission):

YES NO Sig.

Date (after 24 hrs):

YES NO Sig.

TINZAPARIN by s/c route

Dose

Dose unit

units

ml

Start date

Stop date

Prescriber's signature

Name+profession

Pharm Supply

Marked in Kardex

Drug

Clin Check

Dose

Route

Start date

Course length

Indication/additional instructions

Pharm Supply

Prescriber's signature

Print name+profession+bleep

Cease in ward

Dose changed

Marked in Kardex

8

12

14

18

22

Notes:

Faculty of Medicine and Health Sciences Research Ethics Committee

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School of Pharmacy
University of East Anglia
Norwich
NR4 7TJ

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Email: fmh.ethics@uea.ac.uk

Web: http://www.uea.ac.uk/foh/research/ethics-committee

15th November 2011

Dear Rowan

Project title – Continuity of care: Improving the transfer of care back into the community following hospital admission.

The submission of your above proposal has now been reviewed by the Chair of the Faculty Research Ethics Committee/Faculty Research Ethics Committee at their meeting on (date) and we can confirm that it is considered to be a service evaluation. There are no issues of confidentiality or harm to participants and the Chair is happy to approve the study by light touch review.

Please could you ensure that any amendments to either the protocol or documents submitted are notified to us in advance and also that any adverse events which occur during your project are reported to the Chair/Committee. Please could you also arrange to send us a report once your project is completed.

The Chair/Committee would like to wish you good luck with your project.

Yours sincerely,

Yvonne Kirkham
Project Officer

Cc David Wright

Colchester Hospital University NHS
NHS Foundation Trust

ADULT MEDICINE RECORD CARD

This is drug chart number *(in current use)* ☐ **of** ☐

Self-Administration of Medicines		
Level	**Date**	**Initials**
VTE Risk Assessment completed		
Name & Sign	**Date**	**Y/N**

Other Prescription Charts	(Tick)
Anticoagulant – Heparin/Warfarin	
Blood Transfusion	
Chemotherapy	
Diabetic	
Enteral Nutrition	
TPN	
Wound Care	

NHS/Hospital Number	
Surname	
First Names	
Date of Birth	Consultant
Weight (Kg)	Ward
Date of admission	Time of admission

NON-ADMINISTRATION CODES
1. Allergic reaction **2.** Patient fasting **3.** Omitted for clinical reasons **4.** Patient refused **5.** Patient unavailable **6.** Drug unavailable
7. Self-administration

DRUG ALLERGIES (& Nature of Allergy)
NKDA (No Known Drug Allergies) ☐ **Sign** _____ **Date** _____ (Drugs will not be administered if allergy status is not stated)

MEDICINES RECONCILIATION	Signature	Date (& Time)	Source(s)	Level
Drug history checked on admission				

Record of Patient's Own Drugs (PODs) on admission or drug history (including drugs stopped on admission)

Name of Medicine	Dose	Frequency	PODs	Comments (Reasons for changes)

ONCE ONLY PRESCRIPTION or DRUGS GIVEN IN OTHER AREAS

Date	Drug	Dose	Route	Time	Signature & GMC / GPHC / NMC No.	Time Given	Given By	Date	Pharmacy

Drug chart rewritten by Dr – name:	Date:	Old chart seen by Pharmacy – name:	Date:

Endorsed by the Medication Safety Group - October 2011

INTRAVENOUS ANTIMICROBIAL PRESCRIPTIONS

PATIENT'S NAME

NHS/HOSPITAL NUMBER

DRUG ALLERGIES (& Nature of Allergy) **NKDA** ☐

For IV Antimicrobial Prescriptions ONLY

Intravenous antimicrobial prescriptions must be reviewed after 48 hours and switched to oral as soon as clinically indicated

			TIME ↓	DATE
1. Drug				
Dose	Start date	Duration		
Frequency	Indication			
Signature		Micro approved Y / N		
GMC / GPHC / NMC No.		Pharmacy		
2. Drug				
Dose	Start date	Duration		
Frequency	Indication			
Signature		Micro approved Y / N		
GMC / GPHC / NMC No.		Pharmacy		
3. Drug				
Dose	Start date	Duration		
Frequency	Indication			
Signature		Micro approved Y / N		
GMC / GPHC / NMC No.		Pharmacy		
4. Drug				
Dose	Start date	Duration		
Frequency	Indication			
Signature		Micro approved Y / N		
GMC / GPHC / NMC No.		Pharmacy		
5. Drug				
Dose	Start date	Duration		
Frequency	Indication			
Signature		Micro approved Y / N		
GMC / GPHC / NMC No.		Pharmacy		
6. Drug				
Dose	Start date	Duration		
Frequency	Indication			
Signature		Micro approved Y / N		
GMC / GPHC / NMC No.		Pharmacy		

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ORAL ANTIMICROBIAL PRESCRIPTIONS

PATIENT'S NAME

NHS/HOSPITAL NUMBER

DRUG ALLERGIES (& Nature of Allergy) **NKDA** ☐

For ORAL Antimicrobial Prescriptions ONLY

Oral antimicrobial prescriptions must be reviewed within 7 days

			TIME ↓	DATE														
1. Drug																		Came in on it
Dose	Start date	Duration																Started in hosp.
Frequency	Indication																	
Signature		Micro approved Y / N																Dose changed
GMC / GPHC / NMC No.		Pharmacy																
2. Drug																		Came in on it
Dose	Start date	Duration																Started in hosp.
Frequency	Indication																	
Signature		Micro approved Y / N																Dose changed
GMC / GPHC / NMC No.		Pharmacy																
3. Drug																		Came in on it
Dose	Start date	Duration																Started in hosp.
Frequency	Indication																	
Signature		Micro approved Y / N																Dose changed
GMC / GPHC / NMC No.		Pharmacy																
4. Drug																		Came in on it
Dose	Start date	Duration																Started in hosp.
Frequency	Indication																	
Signature		Micro approved Y / N																Dose changed
GMC / GPHC / NMC No.		Pharmacy																
5. Drug																		Came in on it
Dose	Start date	Duration																Started in hosp.
Frequency	Indication																	
Signature		Micro approved Y / N																Dose changed
GMC / GPHC / NMC No.		Pharmacy																
6. Drug																		Came in on it
Dose	Start date	Duration																Started in hosp.
Frequency	Indication																	
Signature		Micro approved Y / N																Dose changed
GMC / GPHC / NMC No.		Pharmacy																

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SUBCUTANEOUS INSULIN

PATIENT'S NAME _____ **NHS/HOSPITAL NUMBER** _____

			TIME ↓	DATE	
1. Drug					Came in on it
Device	Dose _____ *units*	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed
2. Drug					Came in on it
Device	Dose _____ *units*	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed
3. Drug					Came in on it
Device	Dose _____ *units*	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed
4. Drug					Came in on it
Device	Dose _____ *units*	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed
5. Drug					Came in on it
Device	Dose _____ *units*	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed
6. Drug					Came in on it
Device	Dose _____ *units*	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed
7. Drug					Came in on it
Device	Dose _____ *units*	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed

medicine record card.indd 4 08/11/2011 15:19:33

REGULAR INTRAVENOUS MEDICATION FOR BOLUS OR INTERMITTENT INFUSION

PATIENT'S NAME _____ **NHS/HOSPITAL NUMBER** _____

Note: Intravenous prescriptions and access must be reviewed every THREE days. * A Prescriber must sign for treatment to continue.

		TIME ↓	DATE			* GMC / GPHC / NMC No.				* GMC / GPHC / NMC No.				* GMC / GPHC / NMC No.		
1. Drug **SODIUM CHLORIDE 0.9%**	Dose															
	Date															
Rate / Diluent / Volume **AS FLUSH**																
Signature	Pharmacy															
GMC / GPHC / NMC No.																
2. Drug	Dose															
	Date															
Rate / Diluent / Volume																
Signature	Pharmacy															
GMC / GPHC / NMC No.																
3. Drug	Dose															
	Date															
Rate / Diluent / Volume																
Signature	Pharmacy															
GMC / GPHC / NMC No.																
4. Drug	Dose															
	Date															
Rate / Diluent / Volume																
Signature	Pharmacy															
GMC / GPHC / NMC No.																
5. Drug	Dose															
	Date															
Rate / Diluent / Volume																
Signature	Pharmacy															
GMC / GPHC / NMC No.																
6. Drug	Dose															
	Date															
Rate / Diluent / Volume																
Signature	Pharmacy															
GMC / GPHC / NMC No.																
7. Drug	Dose															
	Date															
Rate / Diluent / Volume																
Signature	Pharmacy															
GMC / GPHC / NMC No.																

medicine record card.indd 5 08/11/2011 15:19:34

REGULAR PRESCRIPTIONS
EXCEPT ANTIMICROBIAL, INSULIN & INTRAVENOUS MEDICINES

PATIENT'S NAME _____ **NHS/HOSPITAL NUMBER** _____

OXYGEN	TIME ↓	DATE
Target saturation (please circle): 88-92% 94-98% Not indicated* Device (see codes): % or flow rate (L/min): PRN or continuous (please circle) Duration: *Saturation required in almost all cases except for palliative care		
Signature GMC / GPHC / NMC No. / Date	Record oxygen saturation	

Device codes:

N	Nasal cannulae	SM	Simple Mask	H	Humidified oxygen
VM	Venturi Mask	RM	Reservoir Mask	TM	Tracheostomy Mask
CP	Patient on CPAP	NIV	Patient on NIV		Other

1. Drug **ENOXAPARIN**			TIME ↓	DATE	
Route S/C	Dose	Instructions			Came in on it
Signature					Started in hosp.
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed
2. Drug					Came in on it
Route	Dose	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed
3. Drug					Came in on it
Route	Dose	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed
4. Drug					Came in on it
Route	Dose	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed
5. Drug					Came in on it
Route	Dose	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed
6. Drug					Came in on it
Route	Dose	Instructions			Started in hosp.
Signature					
GMC / GPHC / NMC No.	Date	Pharmacy			Dose changed

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REGULAR PRESCRIPTIONS
EXCEPT ANTIMICROBIAL, INSULIN & INTRAVENOUS MEDICINES

PATIENT'S NAME **NHS/HOSPITAL NUMBER**

			TIME ↓	DATE														
7. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
8. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
9. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
10. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
11. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
12. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
13. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
14. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed

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REGULAR PRESCRIPTIONS
EXCEPT ANTIMICROBIAL, INSULIN & INTRAVENOUS MEDICINES

PATIENT'S NAME _____ **NHS/HOSPITAL NUMBER** _____

			TIME ↓	DATE														
15. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
16. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
17. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
18. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
19. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
20. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
21. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed
22. Drug																		Came in on it
Route	Dose	Instructions																Started in hosp.
Signature																		
GMC / GPHC / NMC No.	Date	Pharmacy																Dose changed

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AS REQUIRED PRESCRIPTIONS

PATIENT'S NAME **NHS/HOSPITAL NUMBER**

1. Drug		Indication	Date	Came in on it
			Time	
		Frequency	Dose	Started in hosp.
Route	Dose		Nurse	
Signature		Instructions	Date	
			Time	Dose changed
GMC / GPHC / NMC No.	Date	Pharmacy	Dose	
			Nurse	
2. Drug		Indication	Date	Came in on it
			Time	
		Frequency	Dose	Started in hosp.
Route	Dose		Nurse	
Signature		Instructions	Date	
			Time	Dose changed
GMC / GPHC / NMC No.	Date	Pharmacy	Dose	
			Nurse	
3. Drug		Indication	Date	Came in on it
			Time	
		Frequency	Dose	Started in hosp.
Route	Dose		Nurse	
Signature		Instructions	Date	
			Time	Dose changed
GMC / GPHC / NMC No.	Date	Pharmacy	Dose	
			Nurse	
4. Drug		Indication	Date	Came in on it
			Time	
		Frequency	Dose	Started in hosp.
Route	Dose		Nurse	
Signature		Instructions	Date	
			Time	Dose changed
GMC / GPHC / NMC No.	Date	Pharmacy	Dose	
			Nurse	
5. Drug		Indication	Date	Came in on it
			Time	
		Frequency	Dose	Started in hosp.
Route	Dose		Nurse	
Signature		Instructions	Date	
			Time	Dose changed
GMC / GPHC / NMC No.	Date	Pharmacy	Dose	
			Nurse	
6. Drug		Indication	Date	Came in on it
			Time	
		Frequency	Dose	Started in hosp.
Route	Dose		Nurse	
Signature		Instructions	Date	
			Time	Dose changed
GMC / GPHC / NMC No.	Date	Pharmacy	Dose	
			Nurse	
7. Drug		Indication	Date	Came in on it
			Time	
		Frequency	Dose	Started in hosp.
Route	Dose		Nurse	
Signature		Instructions	Date	
			Time	Dose changed
GMC / GPHC / NMC No.	Date	Pharmacy	Dose	
			Nurse	

VARIABLE DOSE PRESCRIPTIONS

PATIENT'S NAME **NHS/HOSPITAL NUMBER**

The Prescriber must enter the dose in the upper line of each administration time for each day (e.g. for reducing dose of steroids) or give clear detailed instructions for the Nurse to determine and enter the dose when administering the treatment.

	TIME ↓	DATE														
1. Drug		Dose														Came in on it
		Nurse														
Detailed Instructions		Dose														
		Nurse														
		Dose														Started in hosp.
		Nurse														
Duration		Dose														
		Nurse														
Route / Date		Dose														Dose changed
Signature		Nurse														
GMC / GPHC / NMC No. / Pharmacy		Dose														
		Nurse														
2. Drug		Dose														Came in on it
		Nurse														
Detailed Instructions		Dose														
		Nurse														
		Dose														Started in hosp.
		Nurse														
Duration		Dose														
		Nurse														
Route / Date		Dose														Dose changed
Signature		Nurse														
GMC / GPHC / NMC No. / Pharmacy		Dose														
		Nurse														

Patient Controlled Analgesia (I/V or Epidural)
Prescription and Administration Record

1. Drug(s) and concentration(s):			Route
			Pharmacy
Bolus	Lockout		Background
Signature	GMC / GPHC / NMC No.		Date
Given by	Checked by	Date	Time
2. Drug(s) and concentration(s):			Route
			Pharmacy
Bolus	Lockout		Background
Signature	GMC / GPHC / NMC No.		Date
Given by	Checked by	Date	Time

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medicine record card.indd 11

INTRAVENOUS AND SUBCUTANEOUS INFUSION THERAPY (including SYRINGE DRIVERS)

PATIENT'S NAME _____ **NHS/HOSPITAL NUMBER** _____

PRESCRIBED BY									GIVEN BY			PHARMACY
DATE	Route: Peripheral Central Subcut	Infusion Fluid Type / Strength	Volume	Drug(s) to be added (if any) Drug	Dose / Amount	Duration or Rate of Infusion	Signature	GMC / GPHC / NMC No.	Date Given	Time Given	Given by	

08/11/2011 15:19:37

INTRAVENOUS AND SUBCUTANEOUS INFUSION THERAPY including SYRINGE DRIVERS

PATIENT'S NAME _____ **NHS/HOSPITAL NUMBER** _____

PRESCRIBED BY									GIVEN BY			PHARMACY
DATE	Route: Peripheral Central Subcut	Infusion Fluid Type / Strength	Volume	Drug(s) to be added (if any) Drug	Dose / Amount	Duration or Rate of Infusion	Signature	GMC / GPHC / NMC No.	Date Given	Time Given	Given by	

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Colchester Hospital University NHS
NHS Foundation Trust

7th December 2011

Letter to
Consultants, Junior Doctors,
Matrons, Ward sisters,
Pharmacy

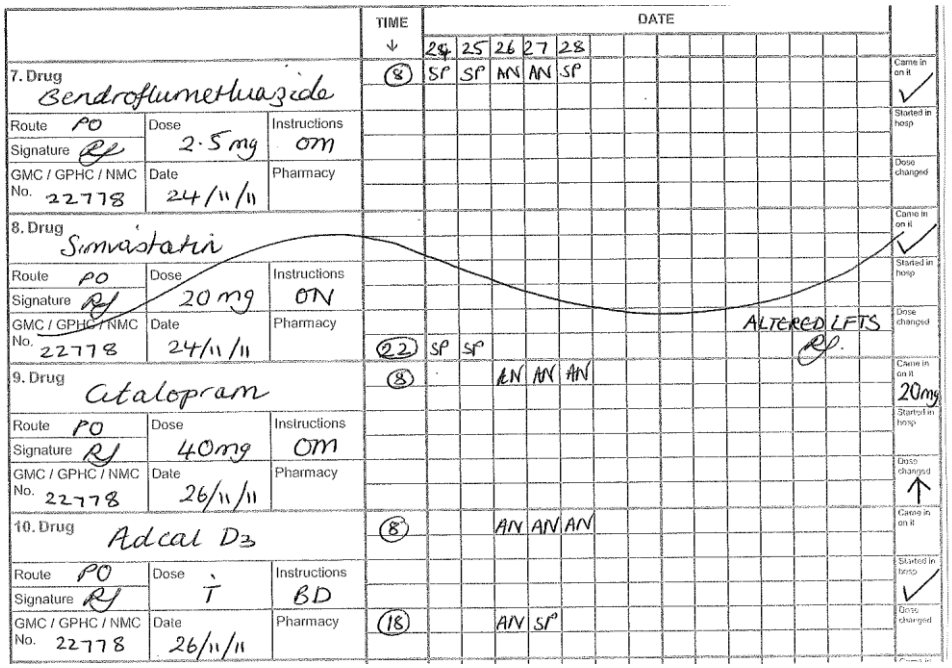
Dear Colleague,

When care is transferred to our GP colleagues they need to know what medications their patients have had started, stopped or changed, **and** why. This has been highlighted by recent guidance from the Royal Pharmaceutical Society, and endorsed by the Royal College of Physicians.

There has been a change to the hospital's drug charts to facilitate this.

The image below shows how changes to medications should be recorded on the drug chart. You need to:-

- Complete the tick boxes to indicate if the medication has been started in hospital, if the patient came in on it, or if the dose has been changed
- Write a brief explanation for any stopped medications **and** sign
- Write a brief explanation for any dose changes if appropriate



I would be grateful if **all** staff could ensure the charts are completed as described

Yours sincerely

Dr Sean MacDonnell,
Medical Director

Dr David Gannon,
Consultant

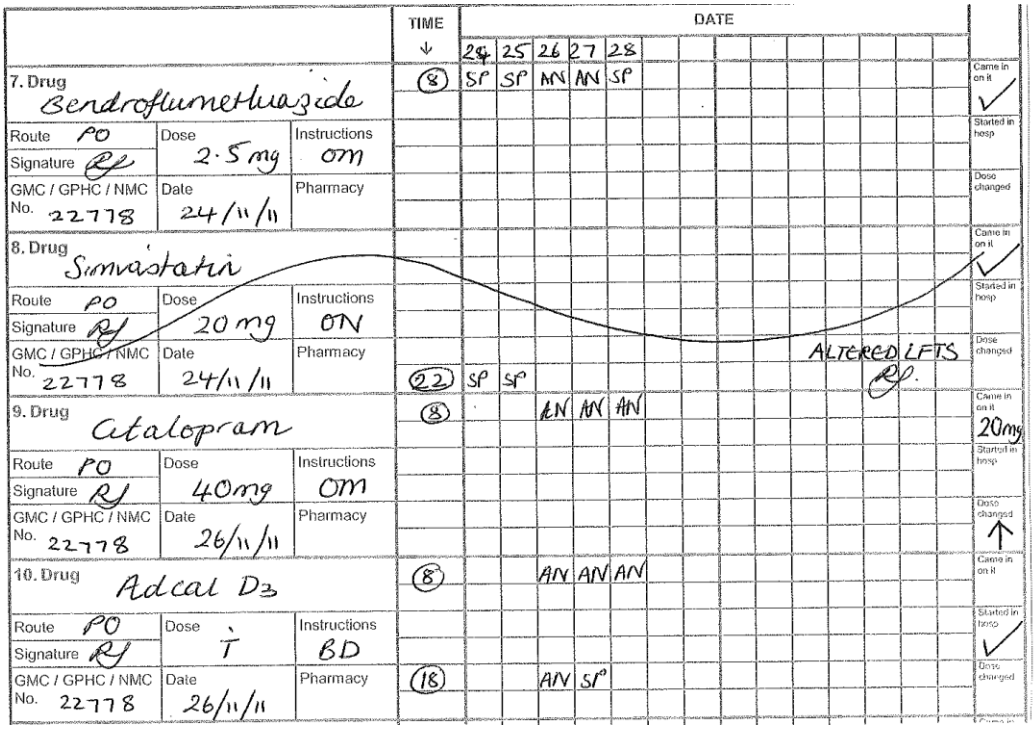
Dr Richard Needle,
Chief Pharmacist

Recording medication changes on drug charts

When care is transferred to other sites they need to know what medications patients have had started, stopped or changed, **and** why. There has been a change to the hospital's drug charts to facilitate this.

INSTRUCTIONS

- Complete the tick boxes to indicate if the medication has been started in hospital, if the patient came in on it, or if the dose has been changed
- Write a brief explanation for any stopped medications **and** sign
- Write a brief explanation for any dose changes if appropriate



If you have any questions please contact Anne Regan, senior clinical pharmacist on bleep 110 or Anne.Regan@colchesterhospital.nhs.uk

Improving the quality of information provided at discharge by Colchester Hospital University NHS Foundation Trust

The Royal Pharmaceutical Society published guidance in July 2011 to support healthcare professionals during the transfer of a patient's care between care settings. The guidance comprises a recommended minimum dataset that should accompany a patient when they make a transfer, which includes details about any medication changes that might have occurred.

Colchester hospital has volunteered to act as an early adopter site for the new RPS guidance, focussing on the communication of medication changes to GP practices at the point of discharge.

The hospital is seeking to improve the recording of medication changes on discharge summaries by introducing a newly structured inpatient drug chart on the wards. The new charts will allow for clearer and better documentation of medication changes, and highlight their importance. It is hoped that this, along with staff education, will improve the frequency and quality of how medication changes are written on discharge summaries.

Project aims

- To improve the documentation of medication changes on discharge summaries sent from 2 medical wards at Colchester hospital by February 2012 through staff education and introduction of new inpatient drug charts.

- To audit the compliance between the most recent medication list obtained from the GP surgery and the medicines list on the discharge summary at 4 weeks post-discharge.

What to expect

The project will be carried out by Rowan Yemm, a pharmacist and PhD student at the University of East Anglia. The project will be overseen by Anne Regan, senior clinical pharmacist at Colchester hospital.

Rowan will be contacting the GP surgeries of patients whose discharge summaries have been selected one month after their discharge from Colchester hospital, in order to request a faxed copy of their most recent medication list.

If you should have any queries or comments, please do not hesitate to contact Rowan Yemm on r.yemm@uea.ac.uk, or Anne Regan on 01206 742358 or Anne.Regan@colchesterhospital.nhs.uk

November 2011

Faculty of Medicine and Health Sciences Research Ethics Committee

University of East Anglia

Rowan Yemm
School of Pharmacy
University of East Anglia
Norwich
NR4 7TJ

Research & Enterprise Services
West Office (Science Building)
University of East Anglia
Norwich Research Park
Norwich, NR4 7TJ

Telephone: +44 (0) 1603 591566
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Web: www.uea.ac.uk/researchandenterprise

26th April 2013

Dear Rowan,

Project title: The attitudes, experiences and decision-making processes of junior doctors preparing discharge summaries: A multi-method ethnographic study using survey, observations and think aloud interviews. Reference: 2012/2013-07

The amendments to your above proposal have been considered by the Chair of the Faculty Research Ethics Committee and we can confirm that your proposal has been approved.

Please could you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance and also that any adverse events which occur during your project are reported to the Committee. Please could you also arrange to send us a report once your project is completed.

The Committee would like to wish you good luck with your project.

Yours sincerely,

pp P. Cole

Yvonne Kirkham
Project Officer

University of East Anglia

Colchester Hospital University NHS
NHS Foundation Trust

Participation information sheet

The attitudes, experiences and decision-making processes of junior doctors preparing discharge summaries

We would like to invite you to take part in our research study investigating the experiences of junior doctors preparing discharge summaries. In order to allow you to make an informed choice as to whether or not to take part, we would like you to understand why the research is being carried out and what it would involve for you.

What is the purpose of the study?

This study forms part of a large body of work on the subject of the transfer of care between the secondary and primary care interface, with the overall aim of understanding the discharge process from the perspective of junior doctors and GPs working with the system.

You may have already received a survey on this subject, the results of which we have used to help design and inform this study.

Why have I been invited?

You have been asked to participate because as a junior doctor at Colchester hospital, you have a working knowledge of the electronic discharge system being used, and unique expertise with respect to the discharge process.

This study aims to understand and explain the process and experience of writing a discharge summary from the perspective of junior doctors, as well as to gather your opinions and views on the important aspects of discharge, and through this to understand the pathways which might create deficits in communication at discharge.

Do I have to take part?

It is up to you to decide if you would like to participate in the study. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw your consent at any time, without giving a reason. This will not affect any of your working practices or relationships at Colchester hospital.

What will I have to do?

The observations will take place on two separate occasions in November 2012 on the ward where you usually work, and will last no more than one hour at a time, depending on how busy your workload is.

If you agree to take part in the study, a researcher will contact you on the details you have provided to arrange a convenient time and date with you to observe and interview you writing discharge summaries.

Whilst you are being observed, the researcher will ask you some informal questions about the process, and where appropriate, ask you to provide a running commentary on your thought processes and actions taken when writing the discharge summary. The researcher will help you with this by providing prompts where necessary.

The researcher will be looking at:-

- The environment you're working in
- The sources of information you use when writing a summary
- How you prioritise and make decisions relating to the content of the summary

The researcher would also like to ask you questions about your attitude towards discharge summaries and the transfer of care, your experiences preparing summaries, and to gather your views on the system used by Colchester hospital.

After the observations the researcher will spend a few minutes feeding back with you, and explore or clarify any issues or relevant points identified during the observation. The observations will be recorded using an electronic audio device, and transcripts of the dialogue will be made on completion.

Confidentiality

All information which is collected from you during the course of the research will be kept strictly confidential, and any data collected from you which leaves the hospital will have your name removed so that you cannot be recognised. Equally, any published work that results from the study will be rendered anonymous.

No data will be discussed with a supervisor, a consultant or any other person, unless it is thought that a risk to the patient or anyone else may occur otherwise.

How will I benefit from taking part?

Taking part in the study will provide you with an opportunity to influence the changes and suggest improvements that will be made to the Electronic discharge system at Colchester hospital in the future. The study also provides an opportunity for you to receive feedback on your practice when writing discharge summaries if desired.

What will happen if I don't wish to carry on with the study?

You are free to withdraw from the study at any time. If you withdraw, you can choose whether or not the information already collected from you may still be used in the study.

What if there is a problem or I wish to make a complaint?

If you have a concern about any aspect of this study, you should ask to speak to a member of the transfer of care research team at UEA on 01603 591996, who will do their best to answer your questions.

If you remain unhappy and wish to complain formally, you can do this by contacting

Rowan Yemm, lead researcher, on 01603 591996 or r.yemm@uea.ac.uk;
Prof. David Wright, project supervisor, on 01603 592042 or d.j.wright@uea.ac.uk;
or Prof. Mark Searcey, Head of School, on 01603 592026 or m.searcey@uea.ac.uk

Who is organising and funding this research?

This research is funded jointly by Colchester Hospital University NHS Foundation Trust and the University of East Anglia.

Who has reviewed this research?

This study has been reviewed and given favourable opinion by the University of East Anglia's Faculty of Medicine and Health Sciences Research Ethics Committee on ##/##/2012.

Further information and contact

If you should have any questions or would like more information about the project and your potential involvement, please contact Rowan Yemm, lead researcher in the transfer of care project team, at r.yemm@uea.ac.uk or on 01603 591996.

Date ##/##/12

University of East Anglia

Colchester Hospital University NHS
NHS Foundation Trust

Doctor Identification Number for this study: ##

CONSENT FORM

Title of Project: **The attitudes, experiences and decision-making processes of junior doctors preparing discharge summaries: A multi-method ethnographic study using survey, observations and think aloud techniques**

Name of Researcher: Rowan Yemm

Please initial box

1. I confirm that I have read and that I fully understand the information sheet dated ##/##/2012 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and that this will not affect my conditions of employment. ☐

3. I understand that the purpose of a researcher observing me is to understand the process, and not to clinically screen or identify errors on discharge summaries. ☐

4. I understand that if the researcher by chance identifies an error during the course of the observation, that they will be ethically obliged to alert me to it at the end of the observation period. It is then my duty to rectify this error in the appropriate manner. ☐

5. I agree to take part in the above study. ☐

_____	_____	_____
Name of Doctor	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

When completed: copy for participant; original for researcher site file

DATA COLLECTION FORM

DATE..... TIME..... DOCTOR REF..... WARD..... GRADE.....

OBSERVATIONS

	Dr appearance comments	Environment comments	Interruptions	Problems and how resolved
Time on summary				
Time on info access				
Info sources used				

Comments on summary content/quality	Notes

JD 1E Interview

RY: Dr ##, hi, and I'm Rowan

JD: Hi

RY: Thank you very much for letting me speak to you whilst you're writing a discharge summary. So the point of the project is to understand the process of composing a summary from your view

JD: Yep

RY: And where you gather information, how you prioritise it, and learn about the environment you're working in, and how discharges fit into your working day.

JD: OK

RY: Does that sound OK?

JD: Yes that's fine

RY: Thank you very much. So as I said I'm a pharmacist and so I know a little about the other end of discharge, but not so much about how it's all put together, so do enlighten me please

JD: So the way... often with my work I get, cos I'm an SHO, I get moved from team to team, so sometimes I'll know the patient when I'm doing a discharge and sometimes I won't . If you know the patient it's so much easier because you've seen them on their journey and you can remember everything that's happened and you produce a much safer discharge summary I think. For example I've had a patient here who's been in with us for... 32 days, and he got sent up from stroke unit, and I've just met him this week and he's going home today, and I don't really know like what's been going on and that discharge summary is pretty weak. I can't read the writing from the stoke unit, there was no medical handover from the stroke unit, there was no summary saying this is what's happened, so I've had to go through the best I can through the notes and produce a summary that I think is probably not as good as the ones I've done for patients that I actually know

RY: Thank you. That seems to be a common theme from junior doctors who I've spoken to – not knowing the patient being a challenge

JD: Yeah, yeah. I mean it's OK, it's not ideal. In EAU sometimes you do them where you don't know the patient and there's... I was told to put at the start 'I do not know this patient or unfortunately I don't know this patient' and apparently that's frowned upon but at the end of the day it's my signature going on that TTO, and I find that really unfair that consultants encourage you not to do that because it looks bad but at the end of the day you don't know that patient. But you've only not know them for a day, but on the ward they've been here for , some of them are here for 30-90 days and you're expected to write a discharge summary, but it takes so long to go through

RY: For a patient who's been in for that long, how do you prioritise the information you put in them?

JD: So there's presenting complaint, what did they actually come in with. I mean... everyone has their own style of discharge summaries and it's like not really been given a tool as to do them best. I mean, some people write down all the investigations but I don't think maybe that's necessary, I'll just say came in with shortness of breath diagnosed with infective exacerbation of COPD whereas some people will talk about what was found on examination, what the respiratory rate was, and yeah OK to document severity, if it was really severe I would keep that, but I think it's difficult to know how much information to actually put in

RY: Have you received any guidance on writing discharge summaries?

JD: No.

RY: Did you have any... Have you worked at any previous hospitals?

JD: Yeah I worked at Queen's hospital and we used exactly the same thing. The thing that they stressed was to add the co-morbidities and if you add the co-morbidities, so you go through the diagnosis and this is how I was told the trust gets

paid so it's really, they stressed at my old hospital it's how they get paid so. But if you add, no this is it here look, at the co-morbidities they're actually all there, but I don't know if you're supposed to add them there, that's what we used to do at our old hospital, but I never really use that tool. So what I do is (writes) I put the thing that they came in with, so they came in with tension headache and UTI, and this is their past medical history because this still has something to do with funding, so even if they don't come in with that (points) it is a diagnosis but not their current diagnosis

RY: So past problems as such?

JD: Yeah. And at my hospital they always, one of my consultants told me that if you put here (points) their mobility, like if they're bed bound, the trust gets an extra three thousand pounds or something. But they don't encourage that here and I haven't been told that here, and I mean I don't , so it's different information wherever you go.

RY: Have you had any practical on-the-job training, would consultants help you with writing a summary for example?

JD: No, no. It's more of a how to use the system, how to use the BedWeb system from non-clinical staff

RY: Would you feel comfortable talking to a consultant or a senior member of staff about a discharge summary?

JD: Yeah if I wasn't sure, yeah I would do that. I've spoken to a reg before. I think sometimes this bit (points), like often management plan and instructions to the GP is just left empty and I feel that, I don't know, I find that a little bit unsettling as well. I did GP and I used to get discharge summaries

RY: Ah right, so you've seen it from the other side?

JD: Yeah, and that's why I try to keep mine quite short and sweet now because it's a lot of information to go through and I just think writing down respiratory rate, temperature, is not necessarily the information that they want. They want what they came in with, possibly why they came in with it ## home etc, what they were diagnosed with, and different medications. So before, I wouldn't really worry about this bit

but now I try to be, I don't know this patient, and I don't know why that was stopped (points) but I now try and put a reason because what will happen is the patient will be discharged from the hospital and they'll go to the GP the next day saying they've stopped some of my medication. And you'll look at the discharge summary and have no idea why. And I found that really difficult, so I try and alter my practice now.

RY: That's super that you've seen it from the other side. Do you think that would perhaps be helpful to your other colleagues who perhaps haven't?

JD: Yeah. I think maybe if you've going to do this maybe speak to GPs as well, what do they find is the most important, you know, things they take from it because you can easily put GP to do this, GP to do that, and when you're in hospital and you're really busy you kind of forget GPs are actually really busy as well and sometimes it's not really fair to put the onus on them

RY: No I see. Thank you, that's great. So what stage are you at with this summary that you're doing?

JD: This is the end of it

RY: So is this the one that you didn't know?

JD: No, this is a patient that I did know but the Nicorandil was stopped in EAU and there's no reason for it, and even the consultant when he came up here was like I don't know why that's been stopped.

RY: Where would you look for information about things like that?

JD: So I would look in the notes , and it just says stop Nicorandil but there's no plan, stop Nicorandil but there's no logic that we could find from it so...

RY: And if you wanted to find out more information about that presumably it would be difficult to?

JD: There's no point

RY: If someone has been passed from team to team?

JD: Yeah, they're not going to remember the intricate details. Maybe like better documentation of why there's stopped medications but sometimes when you're on a busy post take ward round there's no way you'd ask, why are you doing this or why are you doing that, unless the consultant actively said

RY: Why is that? Tell me why

JD: Because it's so busy. It's too busy.

RY: Now you're more senior, do you feel confident challenging why things are done?

JD: Yeah, if there's something that I don't understand, if it's something that I wouldn't be able to explain on a discharge summary then I would ask.

RY: So I see there are lots of medicines on there now (points at screen). Were they put on in advance for you by anyone or have you written them all out yourself?

JD: I have written these up. But I don't recognise me writing that so I think that's what the pharmacist added

RY: Pharmacist (looks) oh yes, I can see at the bottom it says pharmacy checked

JD: Yeah

RY: How do you find the system to use? You said you used to use it at your old hospital

JD: As an F1 I used to hate it, I used to absolutely hate it! I have to say it's better here than it was at Queen's for example if I wanted to do a Seretide inhaler I'd have to know the medications in them, you can't just type Seretide and you always forget and it just takes so long. We used to complain about that at Queen's and oh we can't change the system but quite obviously you can. So even though it's the same system it's a lot easier to use

RY: More user friendly?

JD: I think it's fine, I think it's great. My old consultant told me about this system and how cheap it is to use and that's the

reason they're doing it, it's not the best one but it's the cheapest one.

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RY: So are you entirely on care of the elderly now?

JD: Yes I am

RY: And would you say you enjoy writing discharge summaries?

JD: If I know the patient it's not a worry, but if I've got like this patient (points) I've got no idea

RY: And when's he going home?

JD: Today

RY: (To other doctor) I'm so sorry I've been sitting in your seat, do you need to use it?

JD: He's going home today

RY: And how long will it usually take you to do a discharge summary?

JD: If I know the patient five minutes, if I don't know the patient, half an hour

RY: Do you get interrupted when you're doing a summary?

JD: Yes, all the time, all the time. I mean, we sit here (looks around) and people come up to you all the time about this patient that patient this patient that patient, and if it is busy it will take you more than five minutes

RY: Is there somewhere more quiet where you can work?

JD: You can go into the office, but if you're the only person on your team then no not really

RY: Because people will need to find you?

JD: Yes

RY: Well that's super, thank you very much it's been really interesting speaking to you, thank you so much.

JD 2S Interview transcript

RY: So you're on your surgical rotation at the moment?

JD: I am yeah surgical rotation

RY: How long have you been in your position?

JD: Uhhh, since February I would say

RY: OK, and are you based solely on this ward or do you move about?

JD: No, so Brightlingsea, Wivenhoe and this ward.

RY: So if you'd be kind enough to perhaps give me a little bit of a running commentary, not enough to distract you, and if there's anything of interest perhaps we could have a quick chat about it when you're doing it

JD: Fine, yeah absolutely. Uhh so this gentleman has come in as an elective case so it's a fairly straightforward summary very different to say a medical summary or someone who's come in via EAU because they tend to whether or not they have complications they'll be in for a couple of days maximum and we know exactly what's going on with them so there won't be much to write with regards to..

RY: Do you know this patient yourself?

JD: I don't

RY: How does writing discharge summaries for patients you know compare to those that you don't?

JD: I think it's a lot easier, obviously if you know them it's a lot easier. Plus you can go into more detail rather than being vague. So for this gentleman I would say ## just by looking at his obs and having a quick two minute chat with him that he's stable, his obs are stable, he's comfortable, pain-free, able to go home, whereas if there was more specific things in the patient ## that you need to. For example this morning, and umm because I was looking after her I knew that she had resolved AF and that's not always documented on the notes and so I wouldn't have known unless I had been told when looking after the patient. Right... (looks in patient notes) so

with surgical, surgical elective ones this is the piece of paper that you want. Basically the surgical procedure and it's got everything on here so you can't really deviate much from it

RY: Would you have any of the previous notes when discharging a surgical patient?

JD: There are previous notes, generally don't tend to look through them very often

RY: Ok, sure

JD: (looks on screen) so I have to check that even if ###. Uhh procedures, he's had ## done (types)

RY: Are notes generally well documented for surgical patients?

JD: Uhh, yes and no. During the actual procedure itself yeah very good but then afterwards I think the medics are a lot better at writing down exactly what's wrong with the patient, cos with surgery they'll be like patient's comfortable, you know, review again tomorrow, so they won't ask specifics (looks on screen and types) but the follow-up is generally, I think it depends on the surgeon in charge, the follow-up is generally quite good so you know what's going to happen to the patient and when they need to be sent home.

RY: So a good plan?

JD: Yes

RY: Have you done your medical rotation?

JD: Yes

RY: And how does it compare to this in terms of the discharging?

JD: It's a lot longer to do discharge summaries, but you know your patients so you're more comfortable doing it

RY: OK. Do you feel comfortable doing discharge summaries now?

JD: On surgery I think it's something you get used to. This is my last rotation, but if I started and I didn't know the patient and I had to do a discharge summary I'd be more worried because

I'd be, well I wouldn't have had this experience and I (types) I've forgotten what I was going to say there

RY: Sorry if I'm distracting you

JD: It would take me a lot longer, if I'd just started, because I'd want to know everything about the patient, but now you realise actually that's, you realise what's important to put in a discharge summary. I'm not saying they're going to be the best discharge summaries because they should be comprehensive, but with this you tend to try to put in the bare minimum, yeah what you think the GP might want to know or what the following doctor might want to know if this patient was readmitted. And I think as well when you get patients admitted especially on medical take, if you want to know what's wrong with them you have, then you look through the previous discharge summaries, and it's easier to look through the ones that are more concise and to the point rather than ones that waffle on and on

RY: That's really interesting. So how do you go about prioritising which information goes in? Is that something that comes with experience?

JD: Yeah I think from experience. I used to put in everything until I realised what was important, what needs to be put in, and just kind of go down that route.

RY: Did you have any training for writing discharge summaries?

JD: No, no

RY: Do you ever confer with your peers about discharge summary writing?

JD: Not really no, I haven't really spoken to anyone about it really. Everyone just kind of does their own thing. I know a lot of people who will spend a lot of time like doing the proper coding, instead of writing the diagnosis they will look for the code like this, but it's not really a priority for me especially I started to feel like that when I was working on EAU on medicine and actually EAU medicine is very different from ward medicine because you don't know the patients and

everyone just gets pulled from ward rounds to see a discharge summary and then you got a hundred different jobs to do so there literally is no time

(Continues typing)

RY: Please let me know if I'm distracting you

JD: No it's fine

RY: I noticed that you were looking at the drug chart here for recent medicines

JD: Yeah

RY: Do you consult the notes for information about medicines?

JD: I try to, see this gentleman here has got a recent letter with all the meds he was on from the GP so makes it more handy, but a lot of people don't have that, and I personally wouldn't go sifting through old notes to see what meds he was on (looks through drug chart and types medicines)

RY: Will you get this summary checked by a pharmacist before you send it?

JD: Uhh, no. We would on medicine, and we would if there was a specific, like on this one it says must be seen by a pharmacist before, so for this one we would. I just tell nurses before they print it out to make sure a pharmacist sees it. And then the pharmacists will release it yeah. Whereas if, (looking at drug chart and screen) I've missed out one haven't I. On medicine actually up on Langham ward the nurses wouldn't give out a discharge summary without it being checked by a pharmacist so, I find cos I started on obs and gynae so I'm used to doing my discharge summaries, print them off and give it to the patient, but then when I started on medicine so printed my first one off and they said oh you haven't got this checked and I was like so? And err so, does it depend on ward, or speciality? I'm not really too sure

RY: Do you consult a pharmacist if you're ever unsure about medicines on a discharge summary?

JD: Yeah

RY: Would they be your first port of call, or..?

JD: The pharmacist? Yeah

RY: So how is it communicated to you that a patient is going home?

JD: Uhh, it all depends, usually we will do a ward round and obviously each, there will be a senior during a ward round, so you go around, each has their own team and if your senior says this patient is for home then you already know they're going to go home. When you're on call obviously it's different cos the nurses will be like this patient is for home, and you have to go and check the notes, read through what the plan was, are they actually for home, and then you just do the discharge summary

RY: Would you ask that information at the time from your consultant or senior?

JD: No cos there wouldn't be a consultant available at the time. Generally if I'm on call, I'm talking about weekends or something, if you're on call on the weekend and there's you, and SHO, there's probably two F1s, an SHO, a reg and a consultant, but he's not there a lot of the time. So if a patient does need to be discharged and if it's clearly noted patient will go home on a weekend if LFTs are resolved, for example, if they are resolving then you know they can go home. Whereas if it just kind of says, if it's vague like, review and home on weekend then I'll ask either an SHO or a reg to come and review them to see if they can go home

RY: Thank you

(typing)

RY: A lot of the discharge summaries I see from surgery often have no changes written instead of the medicines listed. Why does that happen?

JD: Yeah, urrr I think it depends. I think if the discharge summary is done by one of the seniors, so if they've just operated a minor procedure on a patient, say for example excision of a sebaceous cyst and the patient's going to be out within two hours and all they really need is a bit of

paracetamol then they'll write no changes and they'll then write paracetamol here (points to additional information box on screen) but I think it's more to do with the seniors not wanting to waste their time

RY: And is this patient more complicated?

JD: Well this patient, yeah he's had a, not a major procedure I wouldn't say, but he's at risk and plus it says because it's meant to be checked by pharmacy as well so you take it a bit more seriously.

RY: Ok sure. Because of warfarin?

JD: Well he's not going home on warfarin, moving to therapeutic clexane I think

(typing)

RY: Is medicines the most time consuming part of the discharge summary?

JD: Yeah, but the thing is medicines are fairly straightforward – you write what you see. It's the other discharge information parts sometimes because sometimes you've got no notes to work on.

RY: Really? So what would you use instead?

JD: No, no, as in speaking in a very vague sort of manner as in it will just, sometimes this (points to notes) might not be legible so you're guessing at what's on there so you're like what shall I write? If they haven't written follow up does this person need a follow up? That's when it gets difficult

RY: How do you rate your handwriting?

JD: I think it's fairly... (laughs), fairly legible

RY: I know that mine's got worse since qualifying!

JD: Yes, mine's definitely got worse but I think you can still read it! (laughs)

RY: That's probably the dawn of email, we don't have to write very often...

JD: Definitely! (Continues typing) I think there's clexane actually on here, so that needs a therapeutic dose. That they're going to be on roughly, just over one hundred and ten units (looks at weight on chart and performs calculation on phone)

(typing)

RY: Do you use the medication changes fields on the drug charts for information?

JD: Where's that?

RY: (Shows on chart)

JD: No I don't, to be honest I've never heard of that before. I'm surprised to even see a tick there, we don't normally get to see that

RY: You don't? Perhaps they're better on medical wards where someone has been in for a bit longer?

JD: Yeah I suppose if people are in and out within a couple of days here. We don't even get to see green writing here on most of these notes! (laughs)

RY: Well you picked a good one here then!

(typing in free text about management plan for GP and review of case from patient notes)

JD: Right, good, that's it I think.

RY: With something like a follow up in a clinic how do you know what the plans for a patient are?

JD: How do I know? So it says it here (points in notes) patient to go home today, follow up in clinic

RY: Oh ok, sure

JD: And with experience you get a feel for what kind of stuff needs to be followed up and what doesn't like someone that comes in with appendicitis they'll just have the surgery and go home, someone comes in with obviously big procedures like hemi-colectomies or diverticulitis, any sort of infections...

RY: (looking in notes) There's an awful lot of note form, it's quite concise. How do you find that to understand?

JD: Yeah...

(nurse interrupts)

N: Have you got room nine's there? Ah this young man, I just need to write his obs down

JD: (to nurse) Is he passing wind do you know? I did ask him but he wasn't too sure but I need to ask him again before I finalise.

N: Oh ok, I'll ask him

JD: The bowels are not open yet are they?

N: No Sylvia is meant to be... I think they have been. I will, I'll definitely find out for you, but I think the ## says yes

JD: Thank you. So most of that's done...

(nurse interrupts)

N: He was asking about, is it Fybogel he's going home with? He says what happens when he finishes what you're going to, what he's going to go home with, does he need to keep asking his GP for more?

JD: The clexane?

N: Er, Fybogel

JD: The Fybogel? Yeah, well he's seeing his GP on Tuesday...

N: Yes so I said if you're writing up on his prescription and his GP will get a copy of that with that on it, so I said then all he's got to do is ask for more of it...

JD: Yeah yeah this is all emailed automatically to the GP

N: Yeah that's what I said, I said as long as... he just said would that be on there, so he hasn't got to worry, and he's also asking about pads cos of his back, could I give him a couple to take home and I said his GP can supply those to him...

JD: Well as long as we give him enough til Tuesday

N: That's fine

JD: Good, ok that's done.

RY: Thank you, lovely. So you're all done now, what happens now?

JD: What happens now is I'll go and make sure one more time that everything's correct, speak to the patient and make sure they're happy to go home and they understand and then that's it, and tell the nurses it's done and then once I've obviously finalise my bit on it then they can print it off whenever the patient goes home

RY: Would you normally write the summaries in this area, this particular part of the ward?

JD: There's a computer down the other side so whichever one is free, I mean there's always someone on a computer somewhere so you've got to...

RY: How often do you get interrupted when writing a summary?

JD: Ahh, all the time. It depends where you sit.

RY: How does that affect you?

JD: How does? Ahh it just makes you slower. I don't think it increases your, personally I don't think it increases my chances of making a mistake. It just obviously takes longer cos you're sorting out two things at once

RY: You certainly were concentrating very well even though I was chatting to you, so very well done I'm sorry to distract you there (both laugh). So thank you very much for speaking to me.

JD 3E interview transcript

RY: Thank you very much for speaking to me. So you're in the process of writing a discharge summary now?

JD: Yeah just finishing

RY: Was this for a patient who you knew?

JD: Er, yes. He's only been in for one day so as much as you can know a patient in a day

RY: Only one day?

JD: Yes, he's possibly going to go at the weekend but because doctors at the weekend don't have time to do them if they're predicted to go at the weekend we try to do them on the Friday, so they can go at the weekend with discharge summaries already done but it does mean that if things change over the weekend there may or may not be changes to the summary which is not great but...

RY: So putting some work in advance for them

JD: Yes

RY: Brill, thank you. So how long have you been at Colchester?

JD: I've been here four months

RY: And have you worked on any other wards or specialities?

JD: I've just worked on this ward.

RY: OK, and were you at any previous hospitals before Colchester?

JD: Yeah I was at Zereford for F1 in Plymouth.

RY: How does the discharge summary writing process compare to here?

JD: Uhh, I don't know. I don't think it's as good here – the diagnosis, I don't know, I think it would be nicer if there was a part for diagnosis and a part for past medical history, see there's nowhere I can put in past medical history so you end up putting all the things they've had before in their diagnosis.

Because otherwise it gets missed and you need to have a past medical history in there for coding reasons I think

RY: You're not the first doctor to tell me that. I'm interested to hear that, thank you. Where do you look for information when you're composing a discharge summary?

JD: I usually go through the notes, check all the bloods and check all the imaging they've had on this admission and then if there's something I'm not sure sometimes I'll go through old notes just to check

RY: Do you find that information is normally readily available to you?

JD: Yeah, sometimes you have to search a bit but it depends, I think it depends who's written in the notes. If someone on a ward round has made good notes then it's quite easy so I like to try and when I write notes anyway I try and write the all diagnosis and so it's easy when I go to write the summary.

RY: How do you find translating what other people have written in notes?

JD: Some people's writing is not great! (whispers) Bruno's (laughs)

RY: You mentioned before this is quite a lazy Friday for you (laughs) but how often do you normally spend on summaries? Are you under any time pressure to complete them?

JD: Sometimes, it depends. Sometimes you'll have no one going in a day and sometimes you'll have like five discharges in a day. I try to be prepared and write them early but you've got

RY: Who makes the decision as to when a patient gets discharged here?

JD: Uhh, it's sort of joint between doctors and therapists and once someone's medically fit we have to make sure they are physically equipped from a OT and physio point of view.

RY: And who's responsibility is it to do the discharge summary? Is that decided on the ward?

JD: It always falls to a junior doctor. We kind of split the ward into different areas and it's just if it comes in the area you're doing then you do the discharge.

RY: Great, thank you very much. How important do you think of discharge summaries compared to your other roles?

JD: I think it's important, um,

(other doctor interrupts)

JD2: Can I take this?

RY: Um, can I keep it? I would rather

(laughing)

JD: Yeah I think it's important so the GP has the information, I don't know, I think probably communication between GPs and hospitals isn't always great and so I think it's important to do a good summary. But, if there's acutely sick people that obviously comes first because that's something that needs doing then and there

RY: Have you had any training on writing summaries?

JD: Yeah as part of my induction I got training on this system

RY: What about what constitutes a good discharge summary?

JD: Probably! (laughs) I can't remember what they told me but they would have told me something!

RY: Do you feel confident in your abilities to write good summaries? If that's not too personal a question

JD: Yeah I think I'm ok!

RY: Back yourself?

(laughing)

RY: So do you feel personally responsible for the information you're writing on a summary? How does it compare to, say, prescribing?

JD: I think I feel responsible for both. I guess I'm just that kind of person. But yeah I feel responsible for what I've written, make sure the information is there.

RY: Thanks very much. May I ask about medication changes on summaries? Do you fill in the boxes for medication changes on stroke?

JD: Sometimes. In the beginning I didn't even know the box was there! And now I try to, it depends. If people have been in for months and months and months they've been on so many medications and unless you have their first drug chart and last drug chart you don't really know what's changed, but for patients who have been in for a shorter length of time it's quite easy to see what you've stopped on this admission, umm, so then I'd usually put it in. But yeah for patients who end up being here for six months and things, it's quite hard to know what's happened with their meds sometimes.

RY: Within your team here on stroke ward, how would you describe the communication?

JD: Yeah, well we have a handover each morning with doctors, therapists, nurses and that's quite good so you usually you get an idea of which patients might be going home, try and predict who's going to go home on what days, um, yeah and generally talk about their progress kind of medically and with therapy so that's quite good.

RY: How do you feel about talking to other members of your team...

JD: Yes!

RY: That's good! What about if there are any issues with the discharge? Who would you normally consult?

JD: Well usually because with stroke patients there's lots of, I guess discharge can be quite complex because there's lots of mobility problems, swallowing problems, all that sort of stuff so usually the therapist like OTs and physios and things are really involved in their discharge and usually they are quite well from the medical point of view but we're not as involved in you know care packages and different mobility aids they're

going to need. So we usually, once they're medically fit, we're not as involved and so usually any problems with the discharge will go through the therapist

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JD: (with reference to on call) And you're just given the notes and this person is going in half an hour, do the summary. And so you've just got a set of notes and that's quite hard to do summaries you know no one really knows the patient because staffing is always changing and so then it's difficult but once you're on, if you're in a ward based environment, you know most of the nurses you know the team and everything runs a bit smoother.

RY: Well it's been lovely to speak to you, thank you very much indeed for your help.

JD 4E interview transcript

JD: Well the thing is, while we're taught to do it the way the experts do it, the coding for illnesses sicknesses sometimes you don't see the exact illness word for word ## wouldn't specify what the person is suffering from like for example on stroke ward we have ### partial, total immobile ## it's true ## type of stroke ## at a specific time, things like that. So we don't use that coding, so it mixes up everything

RY: In stroke do you have more time to plan for your discharges?

JD: That's not true, it keeps changing every day. Sometimes a person is planned to go home next time it's always changing. But sometimes it's straightforward

RY: And do you personally write discharge summaries?

JD: We don't we type them

RY: Sorry, do you personally type them?

JD: of course we do that's why we are here, boxes have got to be ticked

RY: How often do you write summaries for patients whose care you have been involved in?

JD: No, hardly

RY: How does that vary from a patient who you do know?

JD: For a patient I know, I'm more at peace for those I know, and it's faster. But it's mechanical when I'm writing for someone I don't know. Takes longer too.

RY: How do you know which information to prioritise on a discharge summary?

JD: Everything's important on there

RY: Everything?

JD: Yes

RY: Do you have any experience of working in general practice?

JD: I have worked there for 6 months – I am a GP trainee.

RY: Ah so you have lots of experience

JD: No it's not a lot, only 6 months

RY: Did you have any experience of using the summaries when they were received in GP world?

JD: Oh my god they were very beautiful I was impressed

RY: Really?

JD: Yes I wish I'd got the person's name – a good summary. The patient was sent down, got the discharge summary, it was good

RY: Ok, do you find writing discharge summaries an enjoyable task?

JD: I find everything enjoyable, it's my work. You have to enjoy it

RY: You have to enjoy your work?

JD: Yes

RY: Ok... how much of your time is spent on writing summaries in your day?

JD: I must say if I had my way I wouldn't write any

RY: You wouldn't?

JD: I'd tell Louise to do it – she loves doing it!

RY: (to Louise) do you Louise?

(laughing)

JD: It's not that I don't like them but the typing, I don't like typing, I take longer to type than writing

RY: How do you find the system to use? McKesson, is it relatively user friendly?

JD: Everything depends on your training, so if you're trained to use it yeah... it's easy to use

RY: Have you had training on this system?

JD: Yes, the only thing they taught me in Colchester. The first day I came to this trust, that was the only thing I was taught and I was sent onto the wards, there was no induction

RY: The only thing? What about the content of the summary? For example, what constitutes a good discharge summary?

JD: A good discharge summary is a patient summary. That's what it is. Everything is important. Well not the weight and height and the minor details, but the investigations, results of investigations

RY: What if for example the patient had been in for a long admission. How would you prioritise say information about medication changes?

JD: No I wouldn't go into that. I would just get the final medication list and go through a list of those that they came with and use, so I won't give details of, if it's a long admission. We don't have much space to write and in that sense it's limited.

RY: How easy do you find it to locate information in patient notes? Medicines for example

JD: The easiest to locate is medicines. That's what, I do that first because I feel happier when I do that because it's quick ## choose## but sometimes you choose based on what's in the patient notes like when they say, this is just an example, Ramipril and you choose ten milligrams but actually it's five milligram two tablets

RY: Yes, I understand

JD: So when the discharge summary is completed and you will see the green pen saying five milligrams two tablets

RY: Like having your homework marked?

JD: No it's not that, it's just that the drug chart sometimes doesn't say the exact thing the patient is receiving, and another one I've seen if it's forty milligrams of Atorvastatin for example and it's eighty, it might not be the right example, and

you click eighty milligrams, it may actually be forty milligrams times two, as an example

RY: How reliable is the drug chart to use for information? Do you ever use the notes for information about medicines?

JD: The drug chart is always better than the notes.

RY: Why is that?

JD: Sometimes, if the pharmacists have done their work which they usually do you have the corrected version, you have the green, see everything is there but sometimes you make little errors based on wrong names. An example I saw a nicotine patch fifteen milligrams and there was no such thing in our drug formulary. We had Nicorette and Nicotinel, so I put Nicotinel because that was nicotine but they didn't have fifteen they have fourteen milligrams. And then next day there was a big fuss about it do I adjust it as if I made a mistake but then it was in the notes, fifteen milligrams of nicotine, not Nicorette or not Nicotinel. The Nicotinel I suppose that's the same as the nicotine so the computer put Nicotinel

RY; I see, so product choice can sometimes be a challenge?

JD: Define the products in the notes better. But ## we do a good job, we don't have any problems with medications. The problem I have is with lab investigations some may have had twenty CT scans. We want to do it a second time ## to do it. Lot of typing in CT and the date and the next one ## so it's likely you would have done this ten times on this patient not just once.

RY: Thank you very much it's been really helpful speaking to you. Thanks very much indeed

JD 5M Interview transcript

RY: Thank you, go ahead

JD: At the weekends you often get asked to do discharge summaries for people that you don't even know and you're doing them from drug charts that you can't really read properly

RY: Are you normally based on this ward?

JD: No I'm normally based on Tiptree

RY: Oh right, so a real difference to the patient you see here then?

JD: Yep, yep. So this, for example (shows drug chart) I couldn't read what that says and this patient, there was no discharge summary written from the day team at all. It wasn't just that I had to review it and things like that, I had to write the whole thing myself and often I write at the beginning of the discharge summary that if there's any questions, don't direct them towards me from the GP because I won't be able to answer them and for the medical team who usually looked after the patient to do that. And also written in the notes some medications I don't know whether, there's nothing written here or in the notes as to whether they need to be continued lifelong or whether they are just for kind of short periods and things like that. So usually you just have to kind of make the best judgment as to what you do really.

RY: So where do you look for information to fill in discharge summaries for someone who you don't know?

JD: So there... one, ask the nurses if they know anything about where that is, look through the drug card, see whether there's any information about their instructions as to what's to be continued first, and in their medical notes.

(nurse interrupts)

RY: So do you find that information is well provided to you?

JD: Um, sometimes. It depends I think how long they've been on the ward and things like that. Sometimes you might get asked questions about whether drugs have been changed and

going home on them now, and what dose they're going home on, and usually you just have to prescribe what they're currently having on the drug card and maybe ask the GP to review if needs be. But um, sometimes it's, if they've been on the ward for a long time and the pharmacist has seen them then it's usually quite clear what they came in on and things like that, cos of all the green writing, but if they've been coming from EAU and a certain amount of drugs have been started and we don't really know, some people don't come in with a full list of what they've had ##

RY: How often do you do discharges at a weekend?

JD: A lot! (laughs) Probably seventy percent of what I do over a weekend in discharge summaries.

RY: Oh wow, that's a lot. And how much time do you have to do the summaries?

JD: Not really, they wouldn't be... if I knew this patient better and if I had more time I'd be able to go through the notes thoroughly and find out all the information so definitely not as good a discharge summary as if the day team had been able to do it in the week

RY: In general do you feel confident writing discharge summaries?

JD: Not for people I don't know. If I have never met the patient before. If I've # with them been down in EAU or I've been involved in their treatment then it's a lot easier because you know the patient but if you've been asked to do a discharge summary for somebody you don't then no.

RY: Have you had any training for writing discharges?

JD: Yes, yeah

RY: How would you rate the training?

JD: Err, it wasn't too bad. I was quite lucky because I was able, I did three weeks shadowing here before I started so it was part of while I was at medical school at the end of my year we did three weeks shadowing the doctor we were taking over

from and so I got a lot of advice from them and we had kind of formal training in our induction week as well.

RY: Which university was that with?

JD: Barts and the London

RY: Oh right, brilliant. That sounds really good

JD: Yes it's really good, all the other medical schools they've literally just go their induction week and that's it, your kind of lectures on fire safety and that sort of thing which

RY: Do you think you learnt what constitutes a good discharge summary from that or is that something that comes personally?

JD: Hmm, yeah but I think it depends who teaches you and where you are. When I was, I did respiratory first and then we did quite good discharge summaries which were quite important because they would have a lot of care in the community, but then when I was doing surgery the discharge summaries turned into very much this patient came in for an elective this, they're well and they've gone home, that kind of thing. Um, but we did also have a lecture which we thought was a little bit pointless a couple of weeks ago. We have teaching every month, FY1s, and we got our teaching on discharge summaries a couple of weeks ago, at the end of the rotation and found out we've been doing it wrong all along (laughs) but we did have some in induction as well.

RY: Ok brilliant, thank you. Going back to what we spoke about earlier where you find information from, how well are things to go in the discharge summary provided in the patient notes?

JD: Um, I think usually if there are any changes or new things that have been added usually like patient to go home with this or things like that... um, but if they've been seen in an emergency like the EAU and things like that it's usually just written to start this and there's not very much information about what they need to be on...

RY: If you weren't confident with the information provided, who would you speak to about that?

JD: Either the nurses on the ward to see if they have been handed over any information on that, or the doctor that prescribed it if it's been written in the medical notes, because if it's written in the notes that they'd done it then they usually sign it with their name and bleep number. If someone's just prescribed it on here (points to charts) there's no way of contacting them cos you've got a signature but you don't know what the name is.

RY: How do you feel about escalating things to more senior doctors if you're unsure of something?

JD: Yeah if it was a kind of, if it was a drug such as they'd increased their dose of a hypertension drug cos they were hypertensive while they were here then I'd often maybe not escalate that but just get their GP to review their blood pressure in the community and adjust the medication accordingly, but if it was a new drug that one I didn't know very much about the drug or I didn't know why they were on it then yeah I'd happily find out from someone more senior what it is

RY: Lastly about the environment you're in now, obviously you're on a busy ward now, where do you normally do your discharge summary writing?

JD: Normally on a busy ward! (laughs) especially on the weekends when you're at the AMU and you're standing at a computer that's surrounded by lots of people and yeah it's not exactly an ideal situation, we don't often have like an office or anywhere that we can go into or anything like that

RY: And how often do you get interrupted when doing summaries?

JD: Quite often, yeah! (laughs)

RY: Does it put you off?

JD: I think so, especially when you're doing the medications because it's easy to, you could easily miss one out or something like that if you were interrupted half way through or got called to go and see a patient. Um, I mean it's more annoying when you're interrupted for things that can wait

until you've finished it but obviously there are some things that can't wait if you're interrupted by nurses for a poorly patient or something so

RY: How easy do you find this particular software to use?

JD: Not great! (laughs). It's very annoying, crashes quite a lot and you lose your information if you haven't submitted every two minutes, skip from one page to the other everything gets deleted, if someone else has got a screen open with something on you can't, if their computer had the same patient on it then you wouldn't be able to use it together. Yeah it's not, I mean especially the kind of problems and investigations you have to code it all and it's just very complicated there's fifty different options for a fall (laughs) like a fall while in bed, a fall in a public place, but certain public places...

RY: I understand that's got something to do with how you get paid, or the hospital gets paid?

JD: Yes, but obviously depending on how much time you've got to do the discharge summary you can free hand it and if you haven't got much time you can just write fall and it gets sent to coding and they do it

RY: And this discharge summary you're writing at the moment, will you get it checked by a pharmacist at a weekend or will it go without?

JD: It depends, when I was doing surgery um you only get discharge summaries checked if they've got certain medications on them so controlled drugs, warfarin, insulin, things like that. In the week you always get every single discharge summary checked um it's usually the nurses responsibility really. We finalise it at the end and finalise the clinical information and then I leave it and I would never produce it because the nurses can print it out whatever, but the medication and things I think it usually depends on whether, what kind of medicines are on it. If someone's on Oramorph or oxynorm, things like that, I think they would usually get checked.

RY: That's brilliant, thank you very much indeed for speaking to me.

JD 6M Interview transcript

JD: Some of the interruptions when you're doing a TTO # and you end up getting up to do something else. The other thing is I'm really worried about this patient can you come and see them #

(background noise)

RY: So we've come out of sight now, is this your quiet zone?

JD: Yeah, yeah. If you go to certain places in EAU they're busier

RY: So when you're on EAU on a Saturday what are your main jobs?

JD: OK so post take, post take with the consultants, like you saw me with Dr Gannon today um and then you have jobs to do # inpatients need a cannula, request bloods, request x-rays, do the TTOs.

RY: How high on that list would TTOs be?

JD: TTOs is quite high for a number of reasons. Number one, the patients are keen to go home so you have to sort of respect their wishes and they want to go home, and some, if some of the post take jobs aren't too, put a blood form in for tomorrow, er alter request from x-ray and make sure it gets done by the end of the day, then they can sort of come back a bit because you know, say bloods are due tomorrow that you can hand them in by the end of your shift it's fine. So TTOs are quite high up there. When patients are sick, for me, I deal with the sick patients first and sometimes patients argue when they want to go home, we get taught clinical priorities and TTOs tend to go right down, and then there's a fine line if nurses want to discharge a patient, they want to clear a bed space # so you have to find a balance.

RY: So who are you writing a TTO for today?

JD: So this is Mark O'Brian, patient came in after a collapse

RY: Is the patient known to you? Did you treat him?

JD: No. Well, I've just been on the post take ward round so I didn't clerk him, he came in this morning at five am so I just

saw him very briefly for about five minutes with Dr Gannon, probably less than that, and so I'll basically do the TTO from the clerking doctors' notes and Dr Gannon's notes and from there I'll write up the details of what happened.

RY: With EAU TTOs I see the notes are quite concise, quite clear. How do these compare to notes you see on others wards?

JD: Any patient on the ward has come from EAU so they will all have this clerking sheet with them, and then they will have continuation sheets like this depending on how long they have been in on the wards. So when you have continuation sheets, say some are ten, fifteen pages long because they've been in for a week or two, and they can be, you have to try and find out the important points from that. Um, some of them, some you might say are just # patient, they just had one episode of vomiting or not feeling too well. So whether that needs to be relayed to a GP, you have to see it in the clinical context. A lot of the time it doesn't. Um, but we always find that the more important things happen on EAU. Although something obviously significant might happen on the ward, but the bulk of what happens or at least the beginning of a TTO comes in here, and we always try to tell the GP what they came in with. The past medical history which we try to add on to the TTO it comes in here (points) from EAU mainly, so yeah. (pause) So the way I start off I always with age so he is 43 year old 44 year old and then I will always do past medical history but it looks like he has no past medical history, and again this varies between doctors. One would say, Oh you can go up and ask the patient does he have a past medical history, or it all depends on how much time you have, some might say I'm so busy today shall I go and ask his past medical history? How much of a benefit would it be to the patient? And to the GP? Or you can go to the old medical history and have a look. So here (looks in notes) this doesn't give us much information on past medical history, he's just had a previous biopsy

RY: So you're looking at a previous discharge summary

JD: Yes you can do that, or sometimes I go and ask a patient, but then again this patient is fit and well, and requiring no follow up, just had a slight collapse. He's not on any

medication, I did ask him that. Um, yeah that's another thing, they've got in here no medication, but I ask the patient if he's on any medication deliberately for the TTO because I want to know if he's on regular meds. So yeah anyway, so that's just...

RY: Super, thank you

(typing)

JD: I always try and put on a TTO via A and E or via the GP and I think that definitely plays some role because if it's via the GP when the GP has looked at you can see what the last consultation was with the GP that made them come in

RY: Ok

(typing)

RY: These are very detailed notes, is that helpful?

JD: Yeah. Well see some doctors are very good and write a lot of detail which is important, some are not so detailed and so your discharge summaries aren't too long sometimes. So it's hard to see, yeah it's variable between doctors

RY: Do you see a difference between ones referred by GP and A and E?

JD: Oh in terms of the detail? Um, no not really. I think it more depends on the clerking doctor, whoever sort of bothers to take all the detail and history, whether it's through A and E or the GP I think it depends what doctor as opposed to the mode of transition.

(typing in clinical text)

JD: I'm just trying to read this first, very quickly, so as...

(reads notes, mutters to self)

RY: What are you thinking?

JD: Ok so I just try to think logically, how am I going to write this out. What happens sometimes if you start off here in the history, so patient came in with this this this, and then you try to follow it logically, so you write as they've written. You'll find that something here could have been mentioned at the start,

cos it's just, would have fitted in better at the start, so that's why I just have a uhh quick glaze, and also you know as well like this patient is really keen to go home, so nurses may say 'hurry up and do a TTO' so you quickly just want to say blah blah blah, and then you look and you're like oh everything's fine OK and you miss, so he had a CT head so that's quite important to put that in, the CT head scan. So again I'll just try to have a brief look down

(typing, nurses talking in background)

RY: (reading the summary) you're really telling a story here

JD: Yeah, I mean yeah. The thing is, the only thing, if you don't, what you don't want to write is, I didn't mention the restaurant, you know what I just said he felt really hot, and the GP may question where, sort of what he was doing at the time, so the reason I put the restaurant which is obviously true was, he was obviously just sitting there wasn't doing anything vigorous. Yeah, umm, basically, the more detail you give the more apparent it becomes to the GP.

RY: Have you had any training as to how to write discharge summaries?

JD: yeah we have, I would say, we had training when we first started on how you do discharge summaries. What would be helpful if what we had, if we had, if training was also focussed on things that could potentially go wrong, because what you often find is if you don't click the submit button then sometimes it comes back or disappears, and sometimes the medication aren't found here so you just write it under additional drug information, and things like that. And as you go along and you do more TTOs you realise some things that are important, like recently I've been told it's very important to add medications stopped since admission, cos it's important for the GP cos someone may have low blood pressure and they're on a blood pressure medication and the GP has no idea that the blood pressure's low so might restart it in the community. If they restart it, they go home, they have a fall due to low blood pressure, and then they're just back with us

RY: Is that information normally readily available to you, from the information sources that you have here?

JD: Well we, in terms of this is why we stopped the medication? No. The only time I know about it is if I'm doing the ward round myself with the consultant and the consultant specifically says oh look the blood pressure's a hundred, doesn't need to be on this medicine. But sometimes someone doesn't have to tell me, sometimes it's obvious. When they've come up from EAU and ## drug chart ## drugs normally on so, I've seen before on a ward the consultant will look at whether they're on amlodipine and it's obvious from looking at their observations that blood pressure is ninety something then they should have their blood pressure medication stopped. So yeah, with that, if I was doing a TTO for this patient who's been here for two weeks and they've crossed off, I don't know, Adcal D3 or omeprazole then I wouldn't know why unless I saw it documented. If they'd come in with a fall, and they'd had a bleed and someone crossed off Aspirin and Clopidogrel then I would use my medical knowledge that they've caused bleeding so they've stopped the drug because of that, or Diclofenac for example. And like I said, blood pressure medications I'd probably have a look at their obs and say yeah OK I can see why they've stopped them.

RY: What's your opinion on the level of detail provided in the notes? You mentioned about things being obvious or making assumptions...

JD: Yeah, umm... sometimes, yeah. If the detail is not there that we need for the TTO, but I think the reason being, what will happen is the nurse will just see a doctor and say look does he need to be on this medication and no, the blood pressure has been low for a couple of days so just take it off altogether, and so the doctor just crosses it off, he doesn't document it in the notes, which I don't think you can blame them for because they are very busy but obviously for the patient's TTO it's quite useful to know that, and as I said with the Clopidogrel if someone's bleeding then they just cross them off straight away, um, without documenting because I think it's obvious between doctors why they stopped it.. yeah why they don't write it. Ideally, in an ideal world they should

but there's different factors like time, things like that, which means you can't do it. One other thing as well, TTOs are very important in terms of time constraints. Some patients are very keen to go sort of within the next five minutes while they've got transport waiting and that means when you do a TTO sometimes you are rushed to do the TTO because there's an ambulance waiting, they're threatening to leave in the next two-three minutes if it's not done, so...

RY: How's that for you?

JD: Yeah I mean obviously that does lead to a less accurate, less detailed TTO, um, and obviously that's not always our fault. And I think nurses as well could give us more of an idea of when transport would come, because I've been in situations where nurses will say transport's booked for half an hour this patient needs a TTO and if they'd liaise with us and say look, doctor, when's a good time for us to book transport for this patient so that you have enough time to do the TTO and we could say look 12 o'clock would suit us, 1 o'clock would suit us as opposed to, sort of in a way, blackmailing, saying look we need this TTO by 11'oclock because transport's booked, and that's a little unfair.

RY: Thank you, that's interesting.

JD: One other thing as well which is important– some patients get upset over discharge summaries which are slightly inaccurate or don't reflect what happened in the story, so I try and make them detailed in that sense as well, because they ## and I've seen some patients as well that see a discharge summary and go to the doctors and say that's not true, that never happened, which is not always your fault, because it's probably the clerking doctor's fault for not documenting it correctly.

RY: So when writing a summary you've got not only the patient reading it in mind but the GP as well...

JD: Yeah the GP as well. Because I do think it is important to the patient because when they go home they don't just get this piece of paper and chuck it in the bin, they do look at it and say OK this is what happened and they keep it for future

reference. If they go to an outpatient clinic, even though it's something completely unrelated, say for a clinic for pain, the patient sometimes feels it's important that that doctor knows what's happened to them so sometimes they take a copy and give it to the doctor, although it's really of no or little relevance. I think it's important in that sense as well.

RY: Do you write jargon when you're writing a TTO?

JD: Do you know I tend not to, but..

RY: Abbreviations?

JD: Abbreviations, yes I do. I'm quite, I should write it in full. Abbreviations I tend to write AMTS or AMT, CT head or CXR. Again actually that's quite bad for the patient, again I understand. For a GP they will know, but if it's important you probably shouldn't write abbreviations. But, we do... which is...

RY: In the interest of time, or..?

JD: Yeah it's purely in the interest of time, always. And pressure...

(typing)

JD: In terms of, you said writing a story, I'm not going to put things like knelt against a wall or knelt down, they're not really clinically relevant.

RY: What helps you to decide what goes in to a summary?

JD: Just from your own medical knowledge. So things like no chest pain or shortness of breath, these are precipitative factors that can cause, well these are things that might happen prior to epilepsy, or prior to a faint. Sometimes with chest pain if someone has had a heart attack and then collapsed, heart attack can obviously cause a collapse, then the chest pain is important to write chest pain, palpitations as well, irregular heartbeats, again it can always be a cause.. of the collapse. Or missed heartbeats, so a bit of ## I just use my clinical knowledge to establish what's important.

RY: Do you feel confident in your abilities to source out what's important, and how has that changed with months of experience?

JD: As time's progressed I've got more and more confident with using my clinical knowledge to rule out what's important, what's not. It just all comes with experience really. I think for someone who started on day one, yeah they'll probably look at this and think what shall I write, what not to write, but I guess after months and months it just comes, yeah.

(nurse interruption, new recording starts)

RY: Can you tell me a little about the interruptions you have when writing a TTO?

JD: Interruptions, yeah, I mean there's one. But it happens. If you can't disturb a doctor when they're doing a TTO then nurses can't get their message across, and I think interruptions have to happen. I don't think we should be ## TTO ## we should be able to talk to a nurse then come back to a TTO. I don't think any huge, huge mistakes would happen if a nurse asked you to see a patient and you had to get up and then come back to the TTO. I don't think anything like that should really distract you. The only thing is it takes longer, you could easily, you know, someone might say, see with this patient I could go and document that stool sample's been taken but then I just get up, go do it and come back. In the interests of time..

RY: Do you think you're a good multi-tasker? Is that part of the job?

JD: Yeah I think you have to be. You have to be. If you can't multi-task as a doctor then you're not going to do very well because you get ## all the time. The nurses will see you and your fellow doctors will want you to do something and ask you to put a cannula in, take bloods, or give some advice, so you've got to multi-task. You've just got to remember what the nurse told you, and OK I'll come back to that, once you've got the TTO and you've got to try to remember. I just tend to jot it down on a piece of paper so I don't forget. Another thing

about EDS, once the nurses find out you're doing an EDS they'll ask you to do this one as well (laughs)

RY: Whilst they've got you sitting down?

JD: Yeah

(typing)

RY: Who makes the decision as to whether the patient should be discharged?

JD: Umm, normally the consultant in EAU, but yeah EAU consultant, but on the ward you've got the powers to decide. Most doctors tend to check with a senior ## medically fit for discharge, so as soon as their social situation is sorted out then they're good to go from there. ## inclined to go as long as there's been no recent problems. But, you know, if they've come in with acute medical problems and you've treated them and they're now stable then if you were a FY1, 2, registrar then you can send them home, there's nothing stopping you.

RY: Sorry, I'm distracting you now

JD: No, no it's fine

(typing)

JD: What I'll do here as well, so the patient's got query loss of consciousness for 5 minutes so I'm just going to ask the patient did they actually lose consciousness because that would be useful if they did put it in because it would be useful for the TTO, for collapse anyway loss of consciousness is something so I'm just going to quickly ask

RY: Of course

(new recording starts)

(typing)

(nurses talking in background)

JD: The other thing is, one could always argue that ## he come into hospital, but obviously there's no documentation whether you have to keep going up and down and asking the patient and how important it is ## in relevant history there's only so

many times ## that wouldn't change any management in the future – how he came into hospital, and what made him decide to come. So I wouldn't... it's all, what's the word, it's all ## the benefit of whether to ask the patient that question and how useful it would be to a GP, do you know what I mean? Versus the need to ## basically

RY: Do you feel that you have to be concise with discharge summaries?

JD: I think it all depends on the individual case. If someone had come in with simply some musco-skeletal shoulder pain after doing heavy exercise or at the gym, you know nice and concise, but if someone who had, you know, complicated lung cancer diagnosed with the cancer in hospital when they came in, then you want to be a bit more... So it all depends, I think even with collapses, I think it should be concise, because with collapse it's important to know what happened before the collapse, during the collapse and after the collapse, so with collapses yes, but it just all depends on the individual condition, what they've come in with.

RY: Ok sure

JD: People who come in with simple UTIs don't really need much

(typing)

JD: What I do as well myself just to be on the safe side, if someone has mentioned something about a small bleed, if the doctor in the middle of the night is very tired, if it's 5am in the morning, they might miss something relatively important on there, so I always just double check that.

RY: Ok great. Do the discharges you do at weekends vary from ones you do midweek? Obviously you're in a position to take a bit more time with me here this morning

JD: Umm, yeah. So in EAU, I don't think they vary that much, just for some reasons it seems as though the patients who are admitted on Friday night, on Saturday night, on the weekend it just seems the patients go home sometimes slightly quicker, hence your TTOs are shorter, and as soon as you've done post

take ward round they can go home, whereas on the weekdays it seems patients just stay longer in, and I'm not sure why that is.

(background noise – trolley?)

(typing)

RY: What's that? (points to screen)

JD: Oh so this is the diagnosis, yeah so um once I've done the discharge summary just detailing what happened, I will always, well, you have to do that - you can't submit the TTO unless the diagnosis is there.

RY: (looks on screen) and in the case of this patient is there no action for the GP?

JD: No, yeah so we always write nil here. The TTO system is quite good in the sense that if you leave it blank it flags it up, you can't just leave it so you write nil or any instructions planned. Then again, actually I'm just realised it's a good job you mentioned that because on here there is removal of stitches. See that's the other thing with writing TTOs. Because on here I've got removal of stitches by GP but it's not written here, so for my own benefit before I started the TTO I said to myself I'll remember to write there. And then by the time you come to the end of it ten minutes later you can forget. The patient knows about this anyway, so it's just a reminder. So these are just things that happen on TTOs, you can just miss out unfortunately

RY: Have you worked at any other hospitals?

JD: No, but I think other hospitals have different TTO systems. Some people have spoken positively to me about other hospital systems working where their TTO systems may be more efficient. See if they included a past medical history section here instead of diagnosis, past medical history that would help a lot.

RY: A lot of your colleagues have said that too. It seems to be a common theme...

JD: Yeah I think they are working on something in the near future I've heard. So we'll see

RY: For the discharge summary you just finished, will that be checked by a pharmacist, being a weekend?

JD: No in EAU they tend not to be. On the wards on the weekend I don't believe they do, unless the patient's on warfarin. But on the ward I believe normally they are checked by pharmacy but I think sometimes the patients going home without warfarin, and if they're rushed for time, then pharmacy don't check them. But I think pharmacy should check them personally, but again it's in the interests of time, availability of the pharmacist to come up to the ward quickly, etc so...

RY: Can I ask you a little about responsibility? In discharge summaries you produce, even though you perhaps might not know the patient, how do you feel about your responsibility for writing it?

JD: Yeah I think in terms of what's being written, you are responsible for what's been written, but what you write has been dictated by what the clerking doctor's written. In an ideal world, someone may say OK you should go and maybe ask a patient questions that aren't on here, but again in the interests of time you can't always do that. So I think the responsibility lies with you and the clerking doctor, but at the end of the day your name goes on to who's writing it, so whatever's on there is really um, lies with yourself, the responsibility unfortunately. Then again, how good it is depends on the clerking doctor ## as to how much detail is on there

RY: Well it's been really helpful speaking to you, thank you very much indeed.

JD 7E Interview transcript

RY: Thank you for speaking with me. So have you done any discharges this morning?

JD: No I haven't, not yet.

RY: When do they normally fit into your working day?

JD: So usually you come into work, you have the board round where you identify who's potentially going, who's definitely going home today and who's potentially going, you plan discharges for the week. So they are highlighted on our morning board round but we tend to do the ward round first, see all the patients first, um prioritise the jobs and then if there's like emergency TTOs when they've got transport booked for like ten o'clock, eleven o'clock, this afternoon then we work around that and then we plan it towards the time. There's occasions that you come in and then they're going straight away and they haven't had a discharge and you have to just either one of you will step out of the ward round or you just have to do that first. So we haven't had any this morning just yet

RY: How important do you see discharges compared to your other working jobs?

JD: I think it's difficult in terms of workload especially on a Monday morning when you've got new patients and you've got patients that have sort of been highlighted by the weekend on call doctors as unwell and stuff, you would prioritise seeing those patients rather than writing a discharge, and then go to the discharge planning. Usually it's OK if you're fully staffed and there's enough, you're with a junior as well who can do the discharge while you do the more, the other jobs really.

RY: So who is it within your team who writes the majority of discharges?

JD: Um, we do share them out but the house officer, the FY1 will do the majority, and then I will, I'm F2, so I will do them as well so we do share them but generally they take the role of just doing as many as they can.

RY: How do you feel about doing discharges now compared to when you were an F1?

JD: Fine, I think the thing is you work as a team and everybody should have to do it and I don't believe it should be an F1 job, I think at the end of the day you just all muck in and you do it. I don't think the registrar should have to do it because they're busy with other things but I do believe you just share them out and some discharges I like doing because if they're a complex patient I feel better when I've done it then I myself know that it's on the discharge summary if that makes sense so...

RY: Do you write summaries for patients you don't know?

JD: Um, I think that happens when you're on call. That happened a lot when I was a house officer here so that does happen and I'm more than happy to do it, it doesn't bother me at all as long as I understand what's written and it's clearly documented in the notes then I will do that, but then, like on this ward you can switch between teams, like today I'm covering which, for another consultant which I've never met any of these patients before so there will be discharges that I write this afternoon that I've never met them but as long as I understand...

RY: If you don't understand what's there, or if there is a problem, who would you consult with?

JD: If I don't understand I'd just, the consultants here are very approachable, um there's... I would never write something if I was unsure on the discharge summary anyway. So I'd contact Dr Schauz in the case of say today

RY: And you say they're friendly, do you feel happy contacting senior members of staff for

JD: ...yeah they are friendly as long as they're around – it's tracking them down which is the hard thing! So you know on this ward I have no problems. On call I don't tend to...

(nurse interrupts)

N: Sorry, the lady is C5, Mrs Pinder, the cannula just issued

JD: Fine, just get one of the clinical attaches to do it if you need it just now

N: OK

JD: They're taking blood, in fact they're taking blood now so it's worth doing it when she's having blood cultures as well.

N: No they're done and gone

JD: Oh, just ask them to do a cannula

N: Who, the phlebotomist?

JD: No, no the clinical attachee. They're going to do blood cultures now

N: I don't know I haven't seen any. OK if I see them I will ask

RY: Do nurses help you with discharge summaries?

JD: I've never had a nurse ever help me with a discharge summary. I've heard this rumour that sometimes they might help you write them then you have to go and sign them but I've never had that and I'd rather write them myself to be honest

RY: What do you think about pharmacists writing summaries?

JD: I think the thing is it's not their role to write the discharge summary, they're not involved, yes they're involved in the medication but we're involved in the whole patient path I don't see how they, a) why they should and I don't think it would be, not correct information but they would just be reading the notes and summarising all the notes, and it's fine, maybe it's fine to do that, but at the end of the day it's us that needs to check them and it's our name at the bottom of it so we're responsible. So I think what they do for the medication is the best, and that's their role I don't think they should have to summarize.

RY: How often do you get summaries checked by a pharmacist on your ward?

JD: Yeah all of them here seem to be checked by pharmacy unless it's out of hours or you know I think they have a, I don't

know if they have a rule or something where a couple of nurses who check medications, I'm not sure how that happens but it tends to be here that they always seem to get checked by pharmacy, can't say that that's the mode on emergency assessment unit or other places

RY: When you're writing a summary, you mentioned looking in the notes. What sources of information do you tend to consult when you're writing one?

JD: Um, either my own knowledge, and then the notes, and then the drug card. Depending if they've got something like a complicated bed sore I will look at the nursing notes if they're available, correct, I generally just use the notes to be honest, the drug card and my own knowledge of the patient.

RY: Does relevant information for discharges tend to be well documented in the notes? Do you find them easy to use?

JD: That's dependent on who's either done the notes. That's variable that's, most of it is, when the new patients come up generally you'll have a summary page of what they've come in with, what's been done, what their investigations are, and that's very useful to start the discharge summary with. Some don't, and then you have to do your own summary. I think the thing is it's a fine balance between putting in too much information and not enough for the GPs to read them so if you over, if you write paragraphs and paragraphs then it doesn't get read and things will get missed because they don't have the time to read them

RY: Have you had any training as to what should go into a summary?

JD: No. I think we got, when I first started at the trust we got shown how to use Bedweb and that's it.

RY: Not in terms of the content?

JD: No, I haven't. Maybe I missed that session I'm not sure.

RY: So how do you decide what does and doesn't go into the summary?

JD: I always just put, it's generally like a summarised version of the history of investigations and what we want done now. # I don't think it needs to be anything more # but all the investigations really are, ought to be copied to the GP anyway, for what happens in hospital, or at least summarising in the discharge summary.

RY: Can I ask you a bit about the environment you work in as well?

JD: yeah

RY: You mentioned you've got a nice friendly team up here. Whereabouts do you normally write the summaries?

JD: On the ward, so any of the free computers. We don't have an office on this ward. Other places that I have worked at this hospital have an office where you can go and write them which is a lot better

RY: Do you get interrupted when you're on the ward?

JD: Yeah, as soon as they see you. That was a prime example, as soon as they see you they'll ask you to do something even if it's not you know, urgent

RY: And how does affect you?

JD: Um I think the thing is, my attitude is that I can only do one thing at a time and I will put it on my list of things to do. Unless it's really urgent you know I just carry on with what I'm doing and some of them are quite understanding and some of them are quite rude and that's just the nature of the job!

RY: Well thank you very much it's been really interesting to speak to you. Thank you.

Faculty of Medicine and Health Sciences Research Ethics Committee

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Dear Rowan

Project title: Which characteristics and components of a discharge summary do GPs consider most important at discharge? A qualitative study to inform a Discrete Choice Experiment
Reference: 2012/2013-20

The amendments to your above proposal have been considered by the Chair of the Faculty Research Ethics Committee and we can confirm that your proposal has been approved.

Please could you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance and also that any adverse events which occur during your project are reported to the Committee. Please could you also arrange to send us a report once your project is completed.

The Committee would like to wish you good luck with your project

Yours sincerely

Yvonne Kirkham
Project Officer

Improving continuity of care following a hospital admission

University of East Anglia

Colchester Hospital University NHS
NHS Foundation Trust

Colchester General Hospital
Pharmacy Department
Turner Road
Colchester, Essex
CO4 5JL
Tel: 01206 742100
Fax: 01206 742319

7th November 2012

How can medicines information provided by Colchester hospital at discharge be improved?

Dear ,

Colchester hospital is aiming to improve its discharge communications and is conducting exploratory work to investigate your views on the current discharge system, and how it could be improved.

We would be grateful if you would complete the enclosed questionnaire, which is a short, tick-box exercise that should take you **no more than 10 minutes** to complete. All responses will be anonymous. A separate participation card is enclosed, completion of which will prevent you being sent a follow-up questionnaire.

We may at a later stage like to invite you to take part in further research, in the form of a short interview to discuss some of the important issues raised in this questionnaire. If you would be willing to be approached to take part, please indicate so on the enclosed participation card.

Should you have any queries or comments on the questionnaire, please contact Rowan Yemm, lead researcher, at **r.yemm@uea.ac.uk**.

Thank you very much for your co-operation

Yours sincerely,

Rowan Yemm
Transfer of Care Project team lead

Colchester Hospital University NHS
NHS Foundation Trust

Colchester General Hospital, Pharmacy Dept
Turner Road
Colchester
CO4 5JL
Tel: 01206 742100
Fax: 01206 742319

January 2013

How can medicines information provided by Colchester hospital at discharge be improved?

Dear Dr ##,

Colchester hospital is aiming to improve its discharge communications and is conducting exploratory work to investigate your views and experiences working with the current discharge system, and how it could be improved. We have conducted similar work with local GPs, and would now like to understand the process from the perspective of junior doctors working with the system.

We would be grateful if you would complete the enclosed questionnaire, which is a short, tick-box exercise that should take you **no more than 10 minutes** to complete. All responses will be anonymous. A separate participation card is enclosed, completion of which will prevent you being sent a follow-up questionnaire.

We may at a later stage like to invite you to take part in further research, where you would be interviewed by a researcher and observed on the wards composing discharge summaries. If you would be willing to be approached to take part, please indicate so on the enclosed participation card.

Should you have any queries or comments on the questionnaire, please contact Rowan Yemm, lead researcher, at **r.yemm@uea.ac.uk**.

Thank you very much for your co-operation

Yours sincerely,

Rowan Yemm
Transfer of Care Project team lead

Discharge questionnaire participation card

❍ I have completed and returned the questionnaire

❍ I would like to receive a copy of the results of this study

We may at a later stage like to invite you to take part in further research, in the form of a short interview discussing any issues raised from the results of this questionnaire

❍ I would be willing to be approached to take part in further research on this topic.

Thank you very much for your participation

Reference _____

University of East Anglia

Colchester Hospital University NHS
NHS Foundation Trust

How can medicines information provided by Colchester Hospital at discharge be improved?

Instructions for completion

1. The questionnaire is designed to take less than 10 minutes to complete
2. Return the questionnaire in the enclosed stamped addressed envelope
3. Complete and return the enclosed stamped addressed participation card

Discharge Summary Process

1. Approximately what proportion of discharge summaries are received from Colchester hospital within 24 hours of a patient being discharged? _____ %

2. Approximately what proportion of discharge summaries are received prior to the patient's first GP appointment after discharge? _____ %

3. Approximately what proportion of patient records are updated prior to their first appointment following discharge? _____ %

4. Please state below the timeframes within which you would consider the arrival of discharge summaries to be ideal, acceptable and unacceptable

   Ideal _____ hours

   Acceptable _____ hours

   Unacceptable _____ hours

At present, discharge summaries are required to be sent by Colchester hospital within 24 hours of discharge. This requirement often results in discharge summaries **not** being checked for accuracy by a pharmacist before sending.

5. How frequently do you look whether the discharge summary has been checked for accuracy?

   Always ❍ Often ❍ Sometimes ❍ Rarely ❍ Never ❍

6. Do you feel comfortable using information on a discharge summary to update your records if it has **not** been checked for accuracy?

   Yes ❍ No ❍

It is likely that accuracy checking could be achieved without additional resources in the majority of cases if discharge summaries were able to be sent within 72 hours of discharge.

7. Would you consider waiting longer than 24 hours to receive a discharge summary in order to guarantee that it had been checked for accuracy?

   Yes ❍ No ❍

8. Which **ONE** of the two pieces of medicines information sent from Colchester hospital do you believe to be most important when updating your records? **Please only tick ONE box**

   Details of medicines prescribed at discharge ❍

   Details of medicine changes which occurred during hospitalisation ❍

Discharge Summary Content

9. Please rank the following information relating to medicines provided on a discharge summary in order of importance to you, where 1 = most important and 4 = least important. **Please indicate your choice by drawing a line between the shapes to the ranks listed opposite, as in the example shown below.**

Example	Please draw only ONE line to each rank	Ranking
Example A	♦ ♦	1
Example B	♦ ♦	2
Example C	♦ ♦	3

	Please draw only ONE line to each rank	Ranking
Details of medicines prescribed at discharge	♦ ♦	1
Details of medication changes made during hospitalisation	♦ ♦	2
Continuation plans for medicines prescribed at discharge	♦ ♦	3
Rationale for medication changes made during hospitalisation	♦ ♦	4

10. Is there any other information relating to medicines that you consider to be important on a discharge summary?

11. Please rank the following characteristics of a discharge summary in order of importance to you, where 1 = most important and 4 = least important. **Please indicate your choice by drawing a line between shapes to the ranks listed opposite, as in the example above.**

	Please draw only ONE line to each rank	Ranking
Timeliness of receipt following discharge	♦ ♦	1
Accuracy of the discharge information provided	♦ ♦	2
Grammar and legibility of the text	♦ ♦	3
Completeness of the discharge information provided	♦ ♦	4

12. Are there any other characteristics of a discharge summary that you consider to be important?

Discharge Summary Quality

13. Approximately what proportion of discharge summaries from Colchester hospital contain inaccuracies that require practice time to address? _____ %

14. Approximately how much time per day on average is spent addressing these inaccuracies?
_____ hours

15. How would you rate the quality of the following sections within the discharge summaries provided by Colchester hospital?

	Excellent	Good	Fair	Poor	Very poor
Details of medicines prescribed at discharge	❍	❍	❍	❍	❍
Details of medicine changes which occurred during hospitalisation	❍	❍	❍	❍	❍
Clinical information in the free text	❍	❍	❍	❍	❍
Continuation plans and action required by the GP after discharge	❍	❍	❍	❍	❍

Demographics

16. What is your gender? Male ❍ Female ❍

17. For how many years have you been qualified as a GP? _____ years

Please use the space below to provide any further comments or recommendations you may have for the discharge system provided by Colchester hospital

Thank you for completing this questionnaire

University of East Anglia

Colchester Hospital University NHS
NHS Foundation Trust

How can medicines information provided by Colchester Hospital at discharge be improved?

Instructions for completion

1. The questionnaire is designed to take less than 10 minutes to complete
2. Return the questionnaire at the end of the session, or to the pharmacy department by hand

Discharge Summary Process

1. Approximately what proportion of your working day is spent on discharge summaries?

   _____ %

2. Are you familiar with the medication changes fields on the inpatient charts? (If no please skip to question 4)

   ❍ Yes ❍ No

3. How often do you use the medication changes field on inpatient charts for information when composing discharge summaries?

   ❍ Always ❍ Often ❍ Sometimes ❍ Rarely ❍ Never

At present, discharge summaries are required to be sent by Colchester hospital within 24 hours of a patient's discharge. This requirement often results in discharge summaries **not** being checked for accuracy by a pharmacist before sending.

4. How frequently do you send discharge summaries that have **not** been checked for accuracy?

   ❍ Always ❍ Often ❍ Sometimes ❍ Rarely ❍ Never

5. Do you feel comfortable sending discharge summaries that have **not** been checked for accuracy?

   ❍ Yes ❍ No

Discharge Summary Quality

6. Have you received formal training on how to write discharge summaries? (If no please skip to question 8)

   ❍ Yes ❍ No

7. From where did you receive your training on how to write discharge summaries? (Please tick all that apply)

   ❍ Medical school ❍ Formal trust induction

   ❍ On-the-job training ❍ Other (Please state _____)

8. How would you describe the amount of training that you have received on how to write discharge summaries?

   ❍ Too much ❍ Right amount ❍ Too little

9. Is there anything that you believe could help you to improve the quality of the summaries you write?

Discharge Summary Content

10. Please rank the following information relating to medicines provided on a discharge summary in order of importance to you, where 1 = most important and 4 = least important. **Please indicate your choice by drawing a line between the shapes to the ranks listed opposite, as in the example shown below.**

Example	Please draw only ONE line to each rank	Ranking
Example A	♦ ♦	1
Example B	♦ ♦	2
Example C	♦ ♦	3

	Please draw only ONE line to each rank	Ranking
Details of medicines prescribed at discharge	♦ ♦	1
Details of medication changes made during hospitalisation	♦ ♦	2
Continuation plans for medicines prescribed at discharge	♦ ♦	3
Rationale for medication changes made during hospitalisation	♦ ♦	4

11. Is there any other information relating to medicines that you consider to be important on a discharge summary?

12. Please rank the following characteristics of a discharge summary in order of importance to you, where 1 = most important and 4 = least important. **Please indicate your choice by drawing a line between shapes to the ranks listed opposite, as in the example above.**

	Please draw only ONE line to each rank	Ranking
Timeliness of receipt following discharge	♦ ♦	1
Accuracy of the discharge information provided	♦ ♦	2
Grammar and spelling in the text	♦ ♦	3
Completeness of the discharge information provided	♦ ♦	4

13. Are there any other characteristics of a discharge summary that you consider to be important?

14. Which **one** of the two pieces of medicines information sent from Colchester hospital do you believe to be most important? **Please only tick one box**

- ❍ Details of medicines prescribed at discharge
- ❍ Details of medicine changes which occurred during hospitalisation

15. If you could make one change to the electronic discharge system at Colchester hospital what would it be?

Demographics

16. What is your gender?
    ❍ Male ❍ Female

17. What is your current role at Colchester hospital?
    ❍ FY1 ❍ FY2

18. Which medical school did you attend? _____

Please use the space below to provide any further comments or recommendations you have for the electronic discharge system and discharge processes used by Colchester hospital

Thank you for completing this questionnaire

Transfer of Care Project
School of Chemistry and Pharmacy
University of East Anglia
Norwich Research Park
Norfolk, NR4 7TJ
Tel: 01603 591996

January 2013

What are GPs' expectations at discharge, and what characteristics and components of a discharge summary do they consider most important?

Dear Dr ##,

I am writing to you because you expressed an interest in being approached to take part in further research in a recent postal survey regarding how Colchester hospital could improve their discharge summaries.

I would like to invite you to take part in an interview on this subject to explore and explain the findings of the survey, and to provide insight into the value that GPs place on the different components and characteristics of a discharge summary. I am carrying out this research as part of my PhD investigating issues with transfer of care at discharge, which is funded by University of East Anglia and Colchester hospital.

Colchester hospital is aiming to improve its discharge communications, and would like to hear your views and experiences of working with the current discharge system in order to understand the process and how it could be improved from the perspective of GPs. We will also be conducting similar work with junior doctors employed at the trust

Please find enclosed a participation information sheet and a consent form for this study. Please read the information carefully and consider whether you would like to take part. A researcher will contact you by telephone at your practice in the next few days in order to confirm whether or not you would like to take part, and to answer any questions you might have.

In the meantime, should you have any queries or if you require any further information, please do not hesitate to contact me at **r.yemm@uea.ac.uk**.

Thank you very much for your co-operation and interest in our research.

Yours sincerely,

Rowan Yemm
Transfer of Care Project team lead

University of East Anglia

Colchester Hospital University NHS
NHS Foundation Trust

Participation information sheet

What are GPs' expectations at discharge, and what characteristics and components of a discharge summary do they consider most important?

We would like to invite you to take part in our research study investigating the expectations and preferences of GPs for the information they receive at discharge. In order to allow you to make an informed choice as to whether or not to take part, we would like you to understand why the research is being carried out and what it would involve for you.

What is the purpose of the study?

This study forms part of a large body of work on the subject of the transfer of care between the secondary and primary care interface, which is being carried out as part of a PhD.

You will have already received a survey on this subject. The aim of this study is to build on the results of the survey to inform a Discrete Choice Experiment, which is a type of stated preference questionnaire in which you are asked to choose between two alternative services that are described according to their properties. This will investigate the relative value that GPs place on the different properties of a discharge summary, which will help Colchester hospital to ensure you receive the information you consider most important for effective patient care after discharge.

In order to do this, we first need to identify the key properties of discharge summaries, which are of significance to GPs.

Why have I been invited?

You have been asked to participate because you have expressed an interest in further research within the recent postal survey on this subject.

As a GP based in North East Essex, you have a working knowledge of the electronic discharge system being used by Colchester hospital

Do I have to take part?

It is up to you to decide if you would like to participate in the study. If you agree to take part, we will then ask you to sign a consent form (a copy of which is enclosed). You are free to withdraw your consent at any time, without giving a reason. This will not affect any of your working practices, conditions of employment or relations with the hospital.

What will I have to do?

A researcher will contact you at your practice by telephone 4 days after sending this information to enquire whether you are willing to participate, and to answer any questions that you may have about the study.

If you agree to take part, the researcher will arrange a convenient time and date with you for the interview to take place. This will be at the practice where you usually work, and the interview will last no more than 1 hour.

The researcher will be seeking for information about:-

- Your expectations with regards to discharge communications
- The properties of discharge summaries you consider most important
- The content of discharge summaries you consider most important

The interviews will be recorded using an electronic audio device, and transcripts of the dialogue will be made on completion.

Confidentiality & Data Storage

All information which is collected from you during the course of the research will be kept strictly confidential, and any published work that results from the study will be rendered anonymous. Audio recordings will be destroyed after being checked against the transcripts. Transcripts will have your name removed so that you cannot be recognised, and will be stored securely at the University. Completed consent forms will also be stored securely at the University, with access only available to the researcher.

How will I benefit from taking part?

Taking part in the study will provide you with an opportunity to suggest improvements and influence the changes that will be made to the electronic discharge system used by Colchester hospital in the future.

What will happen if I don't wish to carry on with the study?

You are free to withdraw from the study at any time. If you withdraw, you can choose whether or not the information already collected from you may still be used in the study.

What if there is a problem or I wish to make a complaint?

If you have a concern about any aspect of this study, you should contact Rowan Yemm, PhD student and lead researcher in the transfer of care project team at UEA, at r.yemm@uea.ac.uk or on 01603 591996, who will do their best to answer your questions.

If you remain unhappy and wish to complain formally, you can do this by contacting David Wright, project supervisor, on d.j.wright@uea.ac.uk or 01603 592042 or Mark Searcey, Head of School, on m.searcey@uea.ac.uk or 01603 592026.

Who is organising and funding this research?

This research is being carried out as part of a PhD which is funded jointly by Colchester Hospital University NHS Foundation Trust and the University of East Anglia.

This study has been reviewed and given favourable opinion by the University of East Anglia's Faculty of Medicine and Health Sciences Research Ethics Committee on 21/12/2012.

Further information and contact

If you should have any questions or would like more information about the project and your potential involvement, please contact Rowan Yemm at r.yemm@uea.ac.uk or on 01603 591996.

University of East Anglia

Colchester Hospital University NHS
NHS Foundation Trust

GP Identification Number for this study: ##

CONSENT FORM

Title of Project: **What are GPs' expectations at discharge, and what characteristics and components of a discharge summary do they consider most important? A qualitative study to inform a Discrete Choice Experiment**

Name of Researcher: Rowan Yemm

Please initial box

1. I confirm that I have read and that I fully understand the information sheet dated ##/##/2012 for the above study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, and that this will not affect my conditions of employment. ☐
3. I give my permission for the researcher to interview me, and for the interview to be recorded using an audio recording device. ☐
4. I agree to take part in the above study. ☐

_____	_____	_____
Name of GP	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

When completed: copy for participant; original for researcher site file

GP 01 interview

RY: Dr **##**, can I start off by saying or asking you... what are your expectations of the discharge summaries that you receive?

GP: To be an accurate reflection of the patient's journey from point of speciality admission through their journey in hospital including investigations and test results to their point of discharge with an up to date list of medications

RY: Thank you...you mentioned accuracy at the start there... what would you perceive as being an accurate discharge summary?

GP: In encompassing an accurate discharge summary, so, date of admission, time of admission, diagnosis, primary diagnosis, test results, treatments, and investigations

RY: In terms of number of errors or any inaccuracies could you give me an idea of what would be an acceptable level in your view, or unacceptable...

GP: What the type of acceptable error?

RY: Yes, yes please.

GP: So, what would be a type of acceptable error? ... I mean ideally you don't have any, spelling mistakes and grammar I can live with [*laughs*] that doesn't affect the diagnosis... drug errors you can often see micrograms for milligrams but it's not ideal... investigation reports which are wrong that's unacceptable...and a... I guess a sort of fluffy diagnosis such as a chest infection versus a specific pneumonia or specific pneumonia would be acceptable ... but I think they should be accurate that's the point

RY: When you're describing the quality of the discharge summary, is accuracy something you consider as being a measure of quality?

GP: Yes

RY: Can you think of any other indicators of quality that you consider to be important?

GP: Evidence based treatment

RY: Ok...

GP: So investigations that were appropriate for the diagnosis ... a management plan given to the GP with timescale, follow up management plan

RY: That was something that came up as being a big issue in the survey results, that GPs felt that they weren't given adequate management plans or details of follow up, why do you think that might be the case?

GP: I suspect the level of doctor writing the discharge summary, probably going off on ward round notes where they will be looking for the immediate management problem and will most likely say I'll see them in clinic in 6 weeks but there won't be a plan between discharge and 6 weeks... it's kind of assumed that the GP will pick up with it and again it's assumed that patients have access to their GP which they do whereas they don't have it to the secondary care specialist they were admitted under so they come back to us with questions and often we can answer them but sometimes if you don't have all the information or it's not accurate we have to end up phoning secretaries to get missing scans or tests and then put the picture together which takes time for us

RY: ... Who would normally perform that role in the GP surgery? Would it be yourself as the doctor chasing up inaccuracies, or...

GP: ...so it will either be us, so you'll either if it's urgent phone up the lab for results or you could ask your secretary if it's a bit more time or write to the specialist asking for... further clarification on the management plan if there is insufficient advice

RY: Just going back to the point about accuracy ... as I was talking about with the discrete choice experiment earlier trying to put levels on accuracy *[shows example]* in terms of the numbers here ... what we're looking for is a way of describing accuracy could you think of a way to quantify the level of accuracy?

GP: In a discharge summary? It's a very subjective statement isn't it, but I guess you can you could have a variety of categories which include diagnosis, appropriate medication, medication changes ... text that you're given about the journey... the investigations the management ... and then follow up plans I think all add to the.. you know.. how you would categorise how I would look at a discharge summary and categorise the accuracy... and timeliness, I mean you look at some of the not necessarily the discharge summaries but some of the A and E letters that we get... and they will come after we will get the A and E letter after the patient has been admitted and discharged.

RY: Oh crikey! Ok...

GP: So they've kind of missed the boat

RY: What would you perceive as being a timely discharge summary then? What would be your ideal levels *[shows example]?*

GP: ...So it depends again on the nature of the admission, so I would say and elective hernia repair a few days but if someone's been admitted with a myocardial infarction and will need follow up such as blood tests within a week at the surgery we would like to have it within 24, 36 hours.

RY: 24, 36...

GP: For acute ... admissions, elective admissions like hip replacements again or often surgical procedures I think ... we could wait longer

RY: Ok brilliant... so you've just given me an example there of where say timeliness would be unacceptable if it was an... like you said it was an acute condition. You also mentioned medication changes earlier. Can you tell me a bit about the quality of information about medication changes that you currently receive from Colchester?

GP: ... Very variable, so I think the physicians are probably very good at putting all the medicines down there and putting down what they've stopped and why they've stopped it. The orthopaedic surgeons will put down the painkillers they have

given and you'll have no idea what other medicines you are because when we we have a two system check here with all the discharge summaries where two doctors will review the notes ...sorry review the discharge letter.. we will compare it against their notes particularly for medicines so we can see what they have on the discharge summary and what we have been prescribing and then we will amend our records accordingly. And often with surgical discharge summaries there is nothing to amend other than they've been put on painkillers acutely.

RY: Quite, and how do you feel about receiving discharge summaries that do just say 'no changes' rather than a complete list of medicines?

GP: Well if that's appropriate, it depends how many co-morbidities they have, you've got someone who's on an antihypertensive then you know where it is.. yeah, I mean, it keeps it simple then takes time for us to double check every medicine and if there is no change and that's a fair thing to say but how do they know what the patient's told them is what is really being prescribed

RY: Yes quite, you have to have a lot of trust to your patient and also to you your discharging doctor I imagine as well then

GP: Yes

RY: What implications might a lack of medication changes on a discharge summary have and the information about those changes?

GP: Well it leads to again the patient when they ask for repeat medicines if we haven't changed it on their repeats that we give then they won't get what they want and they will query that then and this then creates a problem for our dispensary who will then ask to bring it to the doctor's attention and if it's not on the discharge summary then we don't know what is the correct information so we then have to liaise with the specialist. So it just has a knock on effect, mainly in terms of time. It's not really good management either I think it's a...GMC good practice guideline that the GP should be the centre of care and be kept informed of changes etc.

RY: You mentioned your two system check approach here at the surgery, do you mind telling me a bit more about that?

GP: So all post that comes in gets assigned to a duty doctor, we have two sites at the university here at Rowhedge. The doctor who is on call for that session, so it will be, we do a half day each, they will annotate anything that needs re-coding and they will review the drugs on the discharge summaries and other clinical letters that come back and then they will review that against what we are currently prescribing and change them accordingly, and we usually write on the clinic letter that the meds have been updated and usually the letters are addressed to a named doctor err the duty doctor is often not that doctor and we will forward it on to the named doctor who will double check everything

RY: Ok, and who would then be responsible for updating the records?

GP: The duty doctor does that so they mainly just there to they shouldn't have any work to do except from double check things, but the actual admin stuff is done by the first doctor.

RY: And do you receive electronic summaries directly into your email?

GP: Yes

RY: And is that the receptionist who manages that?

GP: Yes so they get them, scan them, and assign them to the duty doctor.

RY: Ah Ok, and then they're assigned from there I understand now, thanks

GP: Yes

RY: Um well thank you very much I've gone through the key points that I had here on my list. Are there any other... relevant aspects of discharge that you feel would be of interest or any areas of importance?

GP: I think discharge summaries from Colchester general have got a lot better in my time here I've been here 3 years and

generally very happy with them, it's the A and E discharges, that needs to be your next project!

RY: OK *[laughs]*

GP: Their coding is appalling! We never code anything off their letters and there's no free text so, what is coded as the same condition for one patient could be very different to what is coded as the same for another patient. So that could be your...

RY: OK, I'll feed back then shall I? *[laughs]*

GP: *[laughs]* Yes next PhD Project

RY: Brilliant, thank you very much.

GP 02 interview

RY: Dr #, thank you for meeting with me today... Can I start by asking you, what are your expectations of a discharge summary please?

GP: I want a discharge summary to actually come in a reasonable time from patient's discharge. Recently, we've been having quality control which is expecting them to be arrived within 24 hours of discharge but this actually usually at the expense of useful information and it's a bit of a waste of time really... I would expect to know why the patient went into hospital, when they went to hospital, when they came home and whether they've come home or to a care home for example for an elderly patient. I'd like to know what the diagnosis was [##] when they were in hospital, what plans for future treatment are, whether they are the responsibility of the GP or the consultant looking after them... what tests were done in hospital including blood tests and what the results of these were... what medication that the patient has been put on, whether there has been changes to medication... plans for follow up did I mention that?

RY: You did, yes

GP: ... I think that covers most things really so it's really diagnosis, plans for the future, if a diagnosis hasn't been made what's actually going to happen to that... I think that's most of the things really

RY: OK, thank you. What would you describe as being a key indicator of quality of a discharge summary?

GP: Key indicator, that's quite difficult ... actually containing the information that I've actually said that I'd like to be in there...

RY: OK

GP: ... accuracy! Actually accuracy is probably a key indicator because I have experienced a lot of inaccuracies in discharge summaries over the last year or two when there's been this emphasis on speed rather than accuracy

RY: How are inaccurate discharge summaries processed within your practice?

GP: How are they processed? Well, sometimes... I mean it depends on the individual doctor really because we all have our own ways of working. Personally, I've got various things I do. One of them is I'll discuss with our managers what to do about it and sometimes these go back to our commissioning group for action. Sometimes I will actually write to the clinician named on the discharge summary as having been the consultant involved. I don't usually address it with the junior doctor who sent the report because quite often they're actually not that involved with the care of the patient but the consultant has overall responsibility whether or not they had contact with the patient and they are often in a good position to deal with it. Sometimes just occasionally I have actually telephoned the junior doctor who has completed the summary if there's been something that I think the junior doctor can address like an inaccuracy in prescribing or something so it does vary really. But quite often it involves writing back to the consultant involved [##]

RY: Thank you. Can you give me an example of a summary for which you'd say the level of accuracy was unacceptable?

GP: Well I have actually recently had a summary of a patient who was admitted for a medical problem, an elderly patient, and the discharge summary mentioned that they'd actually been involved in a road traffic accident. We did actually express some surprise at this because when the one of our nurses saw the patient for follow up treatment they mentioned that they were sorry the patient had been involved in an accident and the patient was a bit surprised to hear this! So that sort of inaccuracy is fairly major

RY: Quite, yes

GP: I've actually had patients where there is one patient's name up the top of the letter and it's a completely different patient... That's happened more than once

RY: Crikey. You mentioned timeliness earlier, I understand there is an increasing push for summaries to be sent within 24 hours...

GP: Yes this has been... this has happened because commissioners are trying to address GPs' concerns about things like discharge summaries and one of the problems previously has been that they take too long to arrive. You might have had a patient admitted to hospital with something wrong with them and it's maybe a month before you get a discharge summary. That's a bit of an exaggeration or an exception but it does happen and that's unacceptable but it's gone to the opposite extreme where they are now actually expected in hospitals to send us a discharge summary its either 24 or 48 hours after discharge, and whilst that's helpful and does inform you it doesn't inform you of everything and quite often you'll get a very short discharge summary that doesn't have... it may not be inaccurate but doesn't have adequate information for ongoing care

RY: Right. What would you say would be a reasonable time post discharge to receive a summary?

GP: If there's no immediate changes to patient's treatment that we have to action right away I would say probably two or three days is reasonable but certainly within a week.

RY: Within a week...

GP: I wouldn't accept beyond a week as being acceptable. Apart from anything else if there has been any change whatsoever to patients' treatment or there are outstanding investigations or else, patients will very frequently turn up at my surgery within a week asking for information that I don't always have

RY: You mentioned also earlier about medication changes being present on discharge summaries. Can you tell me about the quality of information on medication changes you currently receive on summaries?

GP: Very variable. Quite often it's very difficult to work out whether there have been complete changes to the medication or whether it's just a few things. One thing that seems to

happen frequently now is that in discharge summary the patient's original medication that went into hospital is not actually mentioned only what they're on or what they've been changed to. And it can be very difficult to work out whether the hospital has actually stopped a whole lot of medication or just continued the medication and added new medication. The other thing that can happen is that the dosage a patient was on of a medication when they went into hospital is listed as different when they come out and you're not sure whether that's been changed deliberately for clinical reasons because it's not mentioned or whether it is just an inaccuracy on the discharge summary.

RY: Do you feel that the information about medication changes could be presented in a different way in order to make it more clear to you?

GP: It could be clearer, because sometimes as I say there's only a list of medication it says medications which have been changed but it doesn't mention all the other medication so you're not sure whether they're still continued or not.

RY: What implications might a lack of medication changes on a summary have in practice?

GP: Well a patient may have been started on an important new medication for example diabetes that if they don't continue it might mean that their diabetes goes out of control, or blood pressure for example, if they've been started on a new blood pressure medication then if they don't continue it then their blood pressure might go out of control and if you don't know their supposed to be taking it... patients don't always know what they're supposed to be taking particularly with an increasingly elderly population they get confused over what they're taking anyway

RY: Thank you very much Dr #, that's all I have to ask, so thanks very much for your time

GP 03 interview

RY: When a patient is discharged from hospital what are your expectations for the content of a discharge summary?

GP: I would ideally like it to be concise, so that there's not going to be a large amount of information but I appreciate that sometimes that's not... a possibility junior doctor loads of things done but in terms of the actual content itself I would like to know what's changed so what's changed from when they were admitted to when they were discharged... so if there was a potential diagnosis what this diagnoses would mean for me, what investigations have been performed and what they've come to a conclusion about... and yeah any changes to any medications what's been started and what's been stopped and for that to be really really clear on the discharge letter 'cause I'd say predominantly when we're checking these letters when they come in it really is to look at medications you know to see whether or not the patient has had something changed, whether we in fact need to be issuing them, checking that they're getting any particular issues with it, that sort of thing, and blood monitoring, that sort of thing

RY: Brilliant, thank you... Can you describe for me what you believe constitutes a really good discharge summary?

GP: OK... Accurate *[laughs]*

RY: *[laughs]* OK

GP: So a discharge summary I would often say is more accurate when it has been done by a person who has had some form of clinical exposure to the patient, I would say invariably there are...a lot of discharges that come out with the first statement saying 'I have not seen this patient'...and that is [##] not their fault and I feel... almost a bit sorry for the doctor who's been lumbered doing it because they're trying to scrabble together some information probably in a really hurried fashion... and that leads to inaccuracy and ... you know you get glaring holes in the information that comes through so there is a... distinct lack of... you know what lead from A to B you know in terms of the diagnostics, urgency that sort of thing, so yeah I would say inaccuracy.

RY: So what do you perceive as being an accurate discharge summary then?

GP: OK so an accurate discharge summary I would say...is something that does not contain any drug errors in it so dosaging... inaccuracies... also with the hospital when they discharge people there's obviously going to be a limited supply of medication that they are going to supply to that patient but often it is quite unclear as to how much exactly has been given to that patient and therefore how quickly we are going to need to intervene in terms of getting and sorting medication, it should be a ... up to a 28 day supply... sometimes patients have only been issued 7 days supply and... you know often if they've been unwell they don't have the social support to be able to get into us or something like that then it may lead to a situation when they ring you up needing their medication, can't get to us easily and there's a bit of a scrabble around trying to get that sorted yeah so I would say...accuracy over... drug doses you know what drugs have been prescribed and also any... you know mishaps that happened with drugs in hospital so any adverse reactions and what exactly what the adverse reaction was sort of characterising that as to whether it was a serious allergy or whether it was in fact just an intolerance.

RY: Can you give me an example of a summary for which you'd say the level of inaccuracy is unacceptable?

GP: Absolutely, and I think it is the example that I have shown you, obviously within the realms of confidentiality and covering up everything else I can see that the diagnosis here is 'NAD'... procedures and investigations it says 'NAD'... review of cases 'admission only' and management plan instructions to GP it says 'nil', and that is just one example that came through this week... of a very poor discharge summary but often you know you get sometimes crazy diagnoses put down as well and you think well how on earth did you come up with that diagnoses from what you've written down... so yeah that's an example for you.

RY: Are there any sorts of errors you might be prepared to accept on discharge summaries?

GP: Prepared to accept, as in...?

RY: ...For example, something to do with a minor error that you would consider...?

GP: Well I don't think there is any scope for error where medications or reference to the patient's safety is concerned. I think absolutely the patient safety has to be paramount and there's no scope for any... you know slacking off, I'd say... you know if they got the wrong consultant they'd been admitted under or something like that or stated the wrong ward or something like that, that wouldn't particularly worry me because I can still find that information out and get the inaccuracy solved, but anything related to patient safety no there's no negotiation there that has to be completely accurate.

RY: Thank you. You mentioned medication changes earlier when speaking about the content of discharge summaries, how would you describe the quality of information about medication changes on discharge summaries you currently receive?

GP: ...Well I think it's variable... and I think that... often if a pharmacist has been involved there is going to be more accuracy over the amount and the medications that have been prescribed. But I would say the downside to that is, and I think the hospital have been trying to look at that, they've put the addendums on that's just...although we need to know these addendums, they're not helpful really because we get a duplication of work in the Colchester community for us in terms of we're looking at the same letter twice, and in our case with double checking - we have two doctors look at each item of post that comes through the post – that quadruples the work load, so from that point of view I think that's not helpful, but yeah I would say that having a pharmacist involved is helpful

RY: How do you use the information about medication changes in practice?

GP: Well I mean as soon as we get a discharge summary through we relate it to the patient's record swhat records we

have so it's a double checking procedure what we are actually looking at is what's changed and what's new and what's been removed that sort of thing, and we just compare that to the records we have. If there's obvious discrepancies, there are certain medications we can just add on but if there's a limited repeat, so the patient can access the medication that they need but only over a certain period of time before they would need to discuss it with a doctor... yeah I think that's it really

RY: How would you describe the timeliness of discharge summaries?

GP: Ok well I mean there is variation there as well, I think that... you know recently we had a lot of discharge letters that came through and they were several months out of date but that was sort of all as one batch... but from that point of view obviously the hospital has a target, it is a very narrow target in terms of, I think it's about within 24 hours if they can get it out... I would say that that's not necessarily a target that I... would want to push, but what I would say is that it depends on the patient, so it depends what they are being discharged into the community with and how quickly we are going to need to act on that information. One thing I've found particularly helpful as a GP is that if the patient has been discharged into the community and there's not a chance of that discharge letter coming through to us quickly, actually the patient having a copy of that discharge letter is invaluable if I'm going out on a home visit I go see that patient and I then have an account of what happened at the hospital and it's there for me to see so that I can actually try to incorporate what the patient is telling me and try to work out what needs to happen next. Cos sometimes it can be very difficult to do that when there's a lack of information and you're in a patient's home environment, you've just been called out for you know a problem post discharge which is very very common and yeah having a lack of information makes a GP's work yeah difficult, but we're not... unused to that.

RY: I'm sure. So, you mentioned different patients having different discharge needs, what would you consider to be an acceptable timeframe in which to receive summaries?

GP: I would say... I think a week is too long, I would say an ideal for me would be 72 hours, I think within 3 days, so that actually that gives the patient some time to get into the community, it gives time for anything that's going to happen to happen, and it also [##] up within that period of time, if a GP's got a letter on the system and they are being called out to visit then actually they will have that information they need, so I would say... Although depending on the case, I mean obviously there are those issues that appear sooner especially with weekend discharges where people have been discharged into the community and within 72 hours there are problems, you know, that would lead to some difficulties in us accessing that information, but yeah I'd say 72 hours would be the maximum amount of time that I'd wait.

RY: So over 72 hours, is it fair to say that you'd think that was unacceptable for summaries?

GP: Well... in terms of... there's obvious... you've got to be realistic about things, the hospital has its own issues and... and obviously with the way the system is set up for junior doctors to provide this element of the service there obviously is... it's different depending on the different doctor, as to sort of how much pressure they're under and whether or not they're going to get the information out. But no, I would say that... yes *[laughs].* After 72 hours I wouldn't be too chuffed if I'm getting called out and a patient has a complication but I do understand... I'm trying to be realistic in the fact that actually [##] the junior staff who haven't seen the patient and then doing lots of other unfamiliar activities in the hospital and learning, they might not be able to get on with those things churned out in time, but I guess they could be another way of looking for facilitating people who are actually caring for these patients on a day by day basis, sometimes be able to provide the discharge summaries at a timely fashion, because when you're doing ward rounds and things like that you know that is a very busy time for a junior doctor – they're scrabbling around getting this bit of paper, that bit of paper, trying to get blood results up, trying to do this and that - at the end of the day it's junior doctors - you're doing all the bloods and there's a lot of admin involved. I think there's no clear answer to how exactly how a junior doctor would get more time to sort the

discharge side of things but I guess if there was something, you know, maybe on a ward by ward basis as to how it could work for that ward for the person who needs to do the discharge summary for that patient and who could provide the most accurate discharge for that patient doing it.

RY: Thank you. In terms of follow up plans or action for you on discharge summaries, can you tell me about how well they are provided for?

GP: I think sometimes... sometimes the information comes through and it is inaccurate and it says 'GP to, you know, this that and the other'and this is obviously something that is going to be needing to be checked in secondary care or by whoever ordered the investigation and so I guess that there is some inappropriate use of that column as to what the GP is expected to do. That is very variable and I think it often highlights the junior status of the doctor when they are putting something like that down, but I think it's very important the main message to the GP has to be in that statement to say, you know, this is what needs to happen for this patient if it's a plan, if something needs to happen that the GP needs to action, now if they make a reference to what the GP needs to do in the sort of cloak and dagger way and it's not specific then it can get missed, so I'd say if something... if they want the GP to do something then that really is the slot to say, 'look, GP, please can you make sure this gets done', then I would say it always does get done, if you know it's put in. But it's often around checking results and doing this that and the other, but the thing that really annoys me if when 'GP to arrange this appointment, GP to arrange that appointment, GP to arrange this follow up', I mean, that's inappropriate, you know, we haven't been involved in that admission and actually if there's a decision that another speciality that needs to see that patient then really there has to be some discussion with that speciality as to how that's going to be facilitated for that patient. So the patient's not dumped back into the community, then has to speak to another doctor who hasn't been involved in the decision making process and then gets referred on from there because that's just time wasting, and I think a little bit of shirking responsibility in terms of actually if you need to make a referral then it needs to be done in

secondary care, unless this is obviously something that GPs would do.

RY: Is follow up plans the right expression to use there? How else as a GP would you express that term?

GP: Follow-up plans... sort of on-going plan, I mean follow-up plan does what it says on the tin and obviously...yes it's the on-going plan of action isn't it, so to speak. I can't think of a more... snappy way of saying it at the moment *[laughs]*

RY: That's absolutely fine, thank you very much. Well thank you very much Dr #, that's all I have to ask, are there any other points of interest you'd like to raise?

GP: No I think I... I probably sound like I'm whingeing, you know, all the sort of main bug bears really came up in the questions you asked. But yeah, I think that at the end of the day the patient safety is going to be in the hospital's heart, and it's at our heart as well, we want to work with the hospital to have as accurate discharge and as smooth a process as possible. There's obviously a massive workload in terms of discharges back and forth but, you know, I'd definitely be keen to be involved in, you know, improving things – definitely.

Using Ngene software, the DCE design and constraints were applied and inputted to the system as follows:-

```
design
;alts = A*, B*, C*
;rows = 12
;eff = (mnl,d)
; cond:
if (a.format = 0, a.times = [2,3,4]) ,
if (a.format = 1, a.times = [1,2,3]) ,
if (b.format = 0, b.times = [2,3,4]) ,
if (b.format = 1, b.times = [1,2,3])
;model:
u(A) = times * times [1,2,3,4] + format * format [0, 1] + timein * timein
[1,2,3] + change * change [1,2,3] + plan * plan [1,2,3] /
u(B) = times * times [1,2,3,4] + format * format [0, 1] + timein * timein
[1,2,3] + change * change [1,2,3] + plan * plan [1,2,3] /
u(C) = times * times3 [2] + format * format3 [1] + timein * timein3 [2] +
change * change3 [2] + plan * plan3 [2] $
```

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27th September 2013

Dear Rowan,

Title: Estimation of the relative value of aspects of a discharge summary using Discrete Choice questions: A pilot survey of GPs in North East Essex. Reference: 2012/2013 - 68

The amendments to your above proposal have been considered by the Chair of the Faculty Research Ethics Committee and we can confirm that your proposal has been approved.

Please could you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance and also that any adverse events which occur during your project are reported to the Committee. Please could you also arrange to send us a report once your project is completed.

The Committee would like to wish you good luck with your project.

Yours sincerely,

Mark Wilkinson
Chair
FMH Ethics Committee

CC Supervisor

University of East Anglia

What do GPs want from a discharge summary? The Discharge Summary Preference (DSP) survey

##/##/2013

Dear Doctor,

UEA is conducting exploratory work to investigate your priorities and preferences for the information that is provided to you when a patient is discharged from hospital.

Researchers at UEA have constructed a **short, online survey** for GPs in East of England. Its objectives are to:-

- Investigate GPs' preferences for the content and characteristics of discharge summaries
- Gather information on the current properties of discharge summaries that are received.

Taking part
We would be grateful if you follow the link to complete our online survey, which is a short, anonymous, tick-box exercise that should take you **no more than 15 minutes** to complete. Completion of the survey will be seen as consent to take part.

https://www.surveymonkey.com/s/YBS98DK

Collaborating institutions
This survey involves researchers from the University of East Anglia (UEA) and Colchester Hospital NHS Foundation Trust, and forms part of a PhD research project. This survey is part of a large project examining the issues in communication between the secondary and primary care interface. This project has been approved by UEA Faculty of Medicine and Health Ethics Committee.

Contacts
For more information on this project, please do not hesitate to contact me on r.yemm@uea.ac.uk.

If you have any concerns or complaints relating to this project, please contact Prof. Mark Searcey, Head of School, on m.searcey@uea.ac.uk

Yours sincerely,

Rowan Yemm
Lead researcher – DSP project team
Research pharmacist and PhD student

What do GPs want from a discharge summary? The Discharge Summary Preference (DSP) survey

This online survey is part of a project which is examining the issues in communication between t secondary and primary care interface, when a patient is discharged from hospital.

This survey is investigating the preferences of GPs in East of England for key properties of dischar communications. Its objectives are to:-

- Investigate GPs' preferences for the content and characteristics of discharge summaries
- Gather information on the content and characteristics of discharge summaries currently received GPs in the East of England

This survey is open to all GPs working in East of England, and data collection will run until November 201

This survey is designed to take less than 15 minutes to complete

Collaborating institutions

This survey involves researchers from the University of East Anglia and Colchester Hospital NHS Foundati Trust, and forms part of a PhD research project.

Contacts

For more information on this project, please contact Rowan Yemm, research pharmacist and PhD studer on r.yemm@uea.ac.uk

Last discharge summary you received

Please consider the last discharge summary that you received. Please select from the options below the characteristics which best describe this summary

*How soon after the patient's discharge was the summary received?

- ◯ Within 1 day
- ◯ Within 3 days
- ◯ Within 7 days
- ◯ Within 14 days

*Were details of medication changes and their rationale provided on the summary?

- ◯ No details of medication changes provided
- ◯ Details of changes only provided
- ◯ Details of changes and their rationale provided

*Were details of follow-up plans, and who is responsible for implementing them, provided?

- ◯ No details of follow-up plans provided
- ◯ Details of plans only provided
- ◯ Details of plans and responsible implementer provided

*How long was spent resolving any inaccuracies that were present on the summary?

- ◯ 20 minutes or longer
- ◯ Up to 20 minutes
- ◯ 0 minutes (no inaccuracies present)

*What was the format of the summary?

- ◯ Paper-based
- ◯ Electronic

YOUR PREFERENCES FOR DISCHARGE SUMMARIES - About the questions

Imagine that one of your regular patients is discharged back into your care after a short medical admission at your lo general hospital. You have the choice of receiving either **discharge summary A, discharge summary B,** or a summa which is like the **last summary you received** (see previous section)

The discharge summaries could vary according to the following aspects:-

Time taken to receive — This is the **time it takes for the discharge summary to be received in your practice**, in da after the patient's discharge date. This could be after **1, 3, 7 or 14 days** of discharge.

Medication changes — This describes the **provision of details of any medication changes** on the dischar summary, and their rationale, which may have occurred during the patient's admissi These could either be **fully, partially or not provided** on the summary.

Follow-up plans — This describes the **provision of details of any follow-up plans** for the patient on t discharge summary, and who is responsible for arranging and implementing them. The could either be **fully, partially or not provided** on the summary.

Time to resolve inaccuracies — This is the **time that it takes you and members of staff in your practice to any reso errors or inconsistencies** that might be present on discharge summaries. This could ta **20 minutes or longer, up to 20 minutes, or no time,** if no inaccuracies are present on t summary.

Summary format — This describes the **format and method of delivery** of the discharge summary to yo practice. This could be either **paper-based or electronic.**

In this survey you will be presented with different scenarios and asked to make a choice between whic summary you would prefer to receive.

When you make your choice, please base your decision only on the aspects listed above. Please imag other aspects of the discharge summaries not listed here are the same.

YOUR PREFERENCES FOR DISCHARGE SUMMARIES - Example question

The question below shows a **completed EXAMPLE question**. Please read the information provided al **discharge summaries A and B** shown, and consider **the last summary you received (see page 2)**, a information make a choice as to which summary you would prefer to receive.

	Discharge summary A	Discharge summary B	Last discharge summary received
Time taken to receive it	Within 3 days	**Within 1 day**	
Medication changes	Not provided	**Changes and rationale provided**	
Follow-up plans	Plans and responsible implementer provided	**Not provided**	
Time taken to resolve inaccuracies	0 mins (No inaccuracies present)	**20 mins or longer**	
Summary format	Paper-based	**Electronic**	
Your choice (please tick ONE only)	❑	✓	❑

Please note that if you select **discharge summary A,** you prefer a discharge summary which:-

- is received within **3 days** of discharge
- provides **no medication changes**
- provides **follow-up plans and who is responsible for implementing** them
- contains **no inaccuracies**
- is **paper-based**

If you select **discharge summary B** you prefer a discharge summary which:-

- is received within **1 day** of discharge
- provides **medication changes and rationale**
- provides **no follow-up plans**
- contains inaccuracies which take **20 minutes or longer** to resolve
- is **electronic**

Or, if you select the **last summary you received** you prefer a discharge summary which is like the last one you received.

YOUR PREFERENCES FOR DISCHARGE SUMMARIES

Please consider the information provided in each of the 14 following scenarios and choose which of t summaries described you would prefer to receive in each case. **Please choose one option only, and i choice by ticking the appropriate box at the bottom.**

When you make your choice, please base your decision only on the aspects listed. Please imagine that al aspects of the discharge summaries not listed here are the same.

Scenario 1 of 14

1.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 7 days	Within 3 days	
Medication changes	Changes and rationale provided	Changes only; no rationale provided	
Follow-up plans	Plans and responsible implementer provided	No plans provided	
Time taken to resolve inaccuracies	0 mins (no inaccuracies present)	20 mins or longer	
Summary format	Electronic	Paper-based	

*Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

YOUR PREFERENCES (II)

Scenario 2 of 14

2.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 7 days	Within 3 days	
Medication changes	No changes provided	Changes and rationale provided	
Follow-up plans	No plans provided	Plans and responsible implementer provided	
Time taken to resolve inaccuracies	0 mins (no inaccuracies present)	20 mins or longer	
Summary format	Paper-based	Electronic	

*Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

Scenario 3 of 14

3.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 1 day	Within 14 days	
Medication changes	No changes provided	Changes and rationale provided	
Follow-up plans	Plans and responsible implementer provided	No plans provided	
Time taken to resolve inaccuracies	0 mins (no inaccuracies present)	20 mins or longer	
Summary format	Electronic	Paper-based	

*Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

YOUR PREFERENCES (III)

Scenario 4 of 14

4.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 7 days	Within 3 days	
Medication changes	No changes provided	Changes only; no rationale provided	
Follow-up plans	No plans provided	Plans and responsible implementer provided	
Time taken to resolve inaccuracies	Up to 20 mins	Up to 20 mins	
Summary format	Electronic	Paper-based	

Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

Scenario 5 of 14

5.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 3 days	Within 7 days	
Medication changes	Changes and rationale provided	No changes provided	
Follow-up plans	Plans only; no responsible implementer named	Plans only; no responsible implementer named	
Time taken to resolve inaccuracies	0 mins (no inaccuracies present)	20 mins or longer	
Summary format	Paper-based	Electronic	

Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

YOUR PREFERENCES (IV)

Scenario 6 of 14

6.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 1 day	Within 14 days	
Medication changes	Changes and rationale provided	No changes provided	
Follow-up plans	No plans provided	Plans only; no responsible implementer named	
Time taken to resolve inaccuracies	20 mins or longer	0 mins (no inaccuracies present)	
Summary format	Electronic	Paper-based	

Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

Scenario 7 of 14

7.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 14 days	Within 1 day	
Medication changes	Changes only; no rationale provided	Changes only; no rationale provided	
Follow-up plans	No plans provided	Plans and responsible implementer provided	
Time taken to resolve inaccuracies	Up to 20 mins	Up to 20 mins	
Summary format	Paper-based	Electronic	

Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

YOUR PREFERENCES (V)

Scenario 8 of 14

8.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 14 days	Within 1 day	
Medication changes	Changes only; no rationale provided	No changes provided	
Follow-up plans	Plans and responsible implementer provided	No plans provided	
Time taken to resolve inaccuracies	Up to 20 mins	0 mins (no inaccuracies present)	
Summary format	Paper-based	Electronic	

Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

Scenario 9 of 14

9.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 3 days	Within 7 days	
Medication changes	Changes and rationale provided	No changes provided	
Follow-up plans	Plans only; no responsible implementer named	Plans only; no responsible implementer named	
Time taken to resolve inaccuracies	Up to 20 mins	Up to 20 mins	
Summary format	Electronic	Paper-based	

Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

YOUR PREFERENCES (VI)

Scenario 10 of 14

10.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 3 days	Within 7 days	
Medication changes	Changes only; no rationale provided	Changes only; no rationale provided	
Follow-up plans	Plans and responsible implementer provided	No plans provided	
Time taken to resolve inaccuracies	20 mins or longer	Up to 20 mins	
Summary format	Paper-based	Electronic	

Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

Scenario 11 of 14

11.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 7 days	Within 3 days	
Medication changes	Changes only; no rationale provided	Changes and rationale provided	
Follow-up plans	Plans only; no responsible implementer named	Plans only; no responsible implementer named	
Time taken to resolve inaccuracies	20 mins or longer	0 mins (no inaccuracies present)	
Summary format	Paper-based	Electronic	

Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

YOUR PREFERENCES (VII)

Scenario 12 of 14

12.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 3 days	Within 7 days	
Medication changes	No changes provided	Changes and rationale provided	
Follow-up plans	Plans only; no responsible implementer named	Plans and responsible implementer provided	
Time taken to resolve inaccuracies	20 mins or longer	0 mins (no inaccuracies present)	
Summary format	Electronic	Paper-based	

Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

Scenario 13 of 14

13.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 7 days	Within 1 day	
Medication changes	No changes provided	Changes and rationale provided	
Follow-up plans	No plans provided	Plans and responsible implementer provided	
Time taken to resolve inaccuracies	20 mins or longer	0 mins (no inaccuracies present)	
Summary format	Paper-based	Electronic	

Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

YOUR PREFERENCES (VIII)

Scenario 14 of 14

14.	Discharge summary A	Discharge summary B	Last summary you received
Time taken to receive it	Within 7 days	Within 3 days	
Medication changes	No changes provided	Changes only; no rationale provided	
Follow-up plans	No plans provided	Plans and responsible implementer provided	
Time taken to resolve inaccuracies	Up to 20 mins	Up to 20 mins	
Summary format	Electronic	Paper-based	

Which discharge summary would you rather receive?

	Discharge summary A	Discharge summary B	Last summary you received
Your choice (please choose ONE summary only)	◯	◯	◯

Demographic questions

What is your gender?

- ◯ Male
- ◯ Female
- ◯ Prefer not to say

For how many years have you been practicing as a GP?

Please use the space below to provide any further comments or recommendations you have on the subject of discharge summary content and characteristics

Thank you very much for completing this survey

Survey evaluation form

Please could you complete the questions below to provide feedback on this questionnaire

How easy did you find the questionnaire to complete?

- ◯ Very easy
- ◯ Easy
- ◯ OK
- ◯ Difficult
- ◯ Very difficult

How would you describe the number of questions?

- ◯ Too few
- ◯ Right amount
- ◯ Too many

Are the attributes listed appropriate for describing a discharge summary?

- ◯ Yes
- ◯ No
- ◯ Unsure

If no, please provide details below

Are the levels of attributes listed appropriate?

- ◯ Yes
- ◯ No
- ◯ Unsure

If no, please provide details below

Are there any attributes or levels that are missing?

- ◯ Yes
- ◯ No
- ◯ Unsure

If yes, please provide details below

Please use the space below to provide any further comments you may have on this questionnaire

Thank you very much for completing this survey and evaluation form