CLINICAL ALERT

Quality and Safety

Information given to service users at discharge

2 January 2013 **Alert No: 12**

Giving service users written and verbal information at the point of discharge from inpatient care has been shown to improve knowledge and satisfaction, compared to providing verbal information alone (Cochrane Collaboration, 2008). There are also likely to be benefits in terms of self-management, medication compliance, accessing the right service at the right time and supporting carers.

An audit of case notes for 69 recently discharged patients across the Trust has shown that:

- **55**% of inspected case notes showed no evidence of a care plan signed by the service user
- there is **little** evidence recorded in clinical notes that information is given to patients at discharge

ACTION

All staff are asked to:

1) Provide all service users with written and verbal information at the point of discharge. This should include the following:

    a. CPA care plan, specifying aftercare, crisis and contingency arrangements (for individuals under CPA); OR crisis and contingency arrangements (for individuals not under CPA)

    b. Discharge notification

    c. Information on prescribed medication

2) Document in the clinical notes what information has been provided to the service user at discharge

For further information, please see the Transfer and Discharge protocol, which has recently been amended to include these actions.