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Resources for Inpatient Doctors

1. Background

The national target expectations for sending discharge notifications to GPs has been reduced from 48 to 24 hours. This is essential for ensuring a smooth and coordinated transition of care for service users. By receiving their discharge notification in a timely manner, service users can obtain their medications without delay and begin their recovery in the community. ***See wider Admission, Transfer and Discharge Policy for further context and guidance.***

The information in the Hospital Discharge Form is combined with information pulled from a number of other places in RiO to create an 'editable letter' which is the document sent to the GP and uploaded to RiO as the NODF (Notification of Discharge Form – the four letter code used to upload in RiO).

We plan to gradually change how we enter information into RiO during regular clinical work. The goal is to enter most of the information needed for the discharge letter during the patient's admission, instead of waiting until the time of discharge. This will allow us to create more accurate and timely discharge letters.

Service users have expressed how the discharge process can be stressful, often sudden and lack clarity. Feedback has shown that discharge letters can act as an informative document that allows service users to understand their care and what to expect following discharge. The 'My Safety Care Plan' also acts as a useful document to better inform the service user of the care and recovery, which they should have a copy of before discharge

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2. Staff, GP and Service User Feedback

Staff and GP Feedback	
Junior Doctors/ Pharmacists	• Generally the process feels faster • The removal of the progress and treatment summary makes it harder for Junior Doctors to refer back to previous admissions if a service user is readmitted - This is now being managed through progress notes, existing records and as part of the follow-up plan
GPs	• The discharge letter can sometimes lack clarity of what's happened during the admission – the information provided can be long and unnecessary contextual information • The discharge letter should provide a short, concise summary of the reason for admission, diagnoses, and any changes in medication • If there are requests for the GP to complete specific actions, they would like to know why, if not already mentioned in the discharge letter

2.1 Why this matters: Learning from service users

Discharge Process

"Not as well as staff think I am"

"More Pre-discharge conversations"

"Lack of follow-through on agreed plans"

"No accountability"

"Poor communication"

"Better advance planning with me"

"Felt rushed"

"Had to go to A&E to get support"

"Didn't know about HTT"

"Lack of community support "

"Telephone check-in provided limited help"

"Chaotic discharge"

"Be more inclusive, language barriers"

"Staff too busy "

"Transition to community care was disjointed"

"Felt Abandoned"

"Randomly discharged on weekend"

"Felt unsafe on discharge"

"Not involving carer sufficiently"

"Plan for discharge from B&B was unclear"

"Relapsed"

"Everything feels like a battle"

"Loss in trust and faith in staff"

"Benefit from information leaflet post discharge"

"Staff not listening"

"Repeatedly fell through the cracks"

"Appointments not organised in community"

"Need more help navigating system"

Discharge Liaison Form

"Missing discharge letter delayed medications"

"Had to chase for letter"

"Did not get a discharge letter"

"Format is good"

"Content written without service user voice"

"Wording can compound feeling stigmatised"

"Less jargon"

"Staff should incorporate both professional and user perspective to reduce stigma"

"Discharge letter is very helpful tool "

"More detail about the follow-up plan so its clear who is responsible and by when"

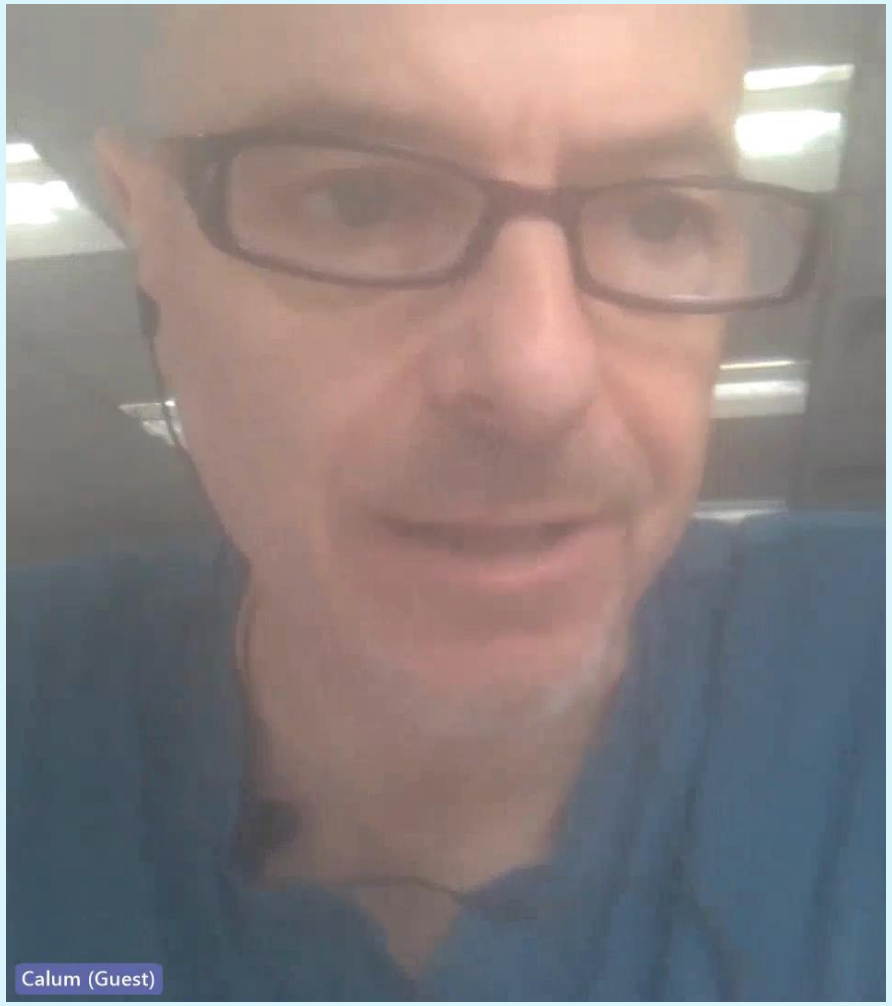
"Letters don't always get to GP electronically "

"More opportunities to discuss this before discharge "

2.3 Why this matters: Service user experience

Video: 2 minutes watch time

Please see the video here: https://www.elft.nhs.uk/intranet/teams-support-me/corporate-performance/discharge-liaison-form-dlf-project



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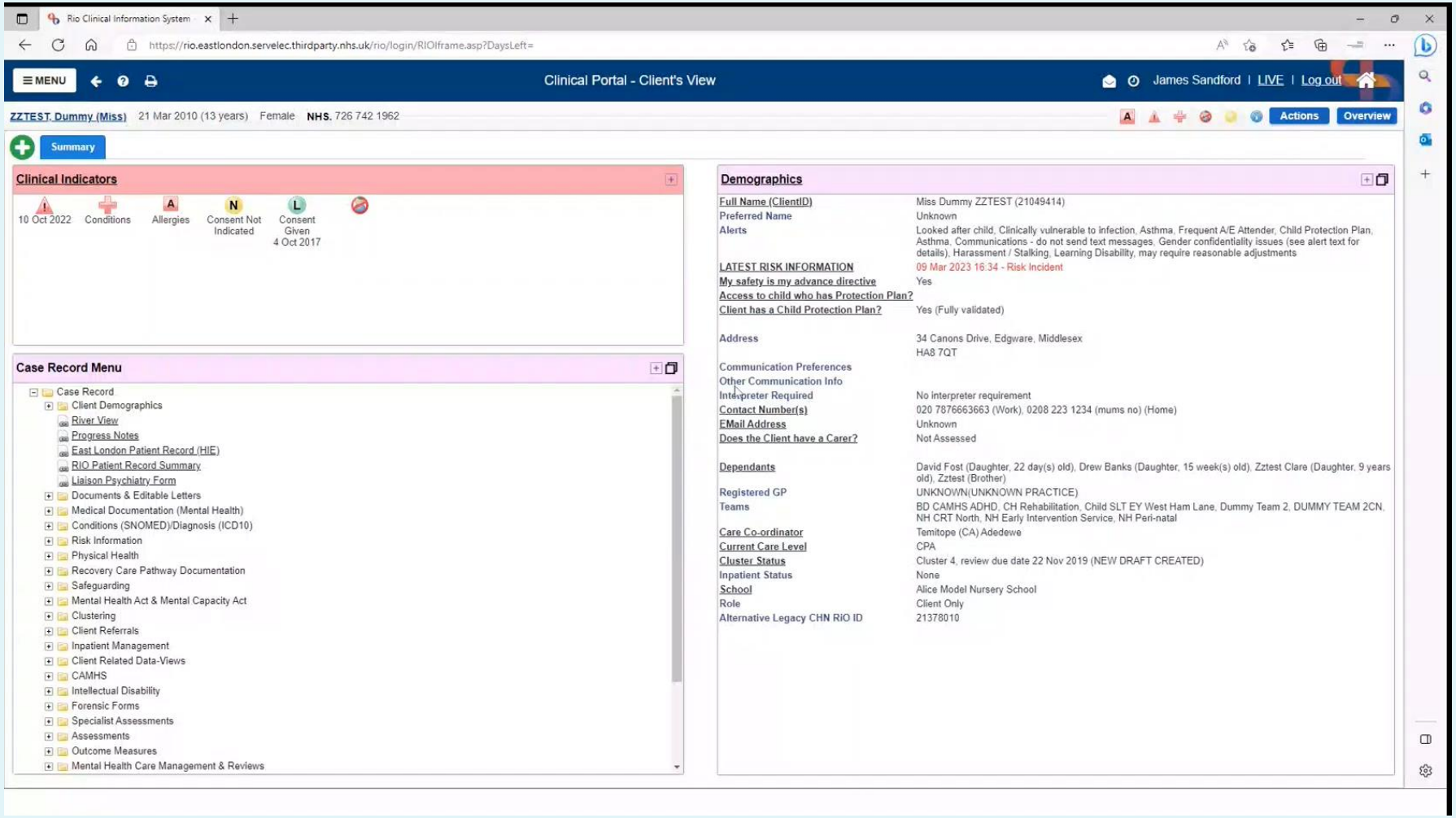
3. RiO

3.1 How to access the Hospital Discharge Form

Video: 3 minute watch time

Click here: How to access the Hospital Discharge Form



3.2 What RiO forms populate the discharge letter?

Clinical information entered into dedicated forms on RiO is automatically incorporated into the discharge letter. The following list of forms outlined which ones must be completed prior to discharge.

1	Information entered into the **Clinical Assessment Form** in the Medical Documentation Folder will be automatically pulled to populate the 'circumstances of admission' and 'mental state examination' sections on the discharge letter. It is expected that the admitting doctor will complete this form on admission. ***During early deployment, this loop may not have been closed, and these two fields may need to be completed before the editable letter can be generated.***
2	**Blood and ECG results** in the Investigations form in the Physical Health folder. Completed by Junior Doctor
3	**Blood pressure and BMI data** in the Observations and Measurements form in the Physical Health folder. Completed by Ward Nurse
4	**Smoking, diet, exercise and alcohol intervention information** in the Lifestyle form in the Physical Health folder. Completed by Ward Nurse
5	**The new Hospital Discharge form** found in the Medical Documentation folder which gathers information on treatment during admission, discharge medication and discharge plan. It is anticipated that this be completed during the discharge ward round. Completed by Junior Doctor

3.3 Editable letter template

Contents derived from the following forms:

Clinical Assessment form

Investigations form

Observations and Measurements form

Lifestyle form

DISCHARGE LIAISON FORM

RIO Number:	NHS Number:
Admission Date:	Discharge Date and Time:
CONSULTANT:	CARE COORDINATOR:
ON CPA? CPA	Subject to 117?

ADMISSION AND TREATMENT SUMMARY

Circumstances of admission
presenting complaint

Mental State Examination on Admissio
appearance and behaviour

PHYSICAL HEALTH INFORMATION

Blood tests carried out
HbA1c (mmol/mol): 40.44

Blood test comments

ECG tests carried out

ECG comments

Blood pressure
Last BP date: 27 Jun 2022
BP: 112/72

BP intervention, BMI, BMI related lifestyle interventions **Smoking status, Smoking interventions**

PRIMARY DIAGNOSES

ALLERGIES

MEDICATION ON DISCHARGE
Hospital only drugs will need to be added to the patients GP record for information, these include CLOZAPINE and any long-acting depots that are prescribed and administered in secondary care

Drug Name	Route	Dose	Direction	No of days supplied	Hospital to continue	GP to continue prescribing
test med	None	None	None	None	None	None

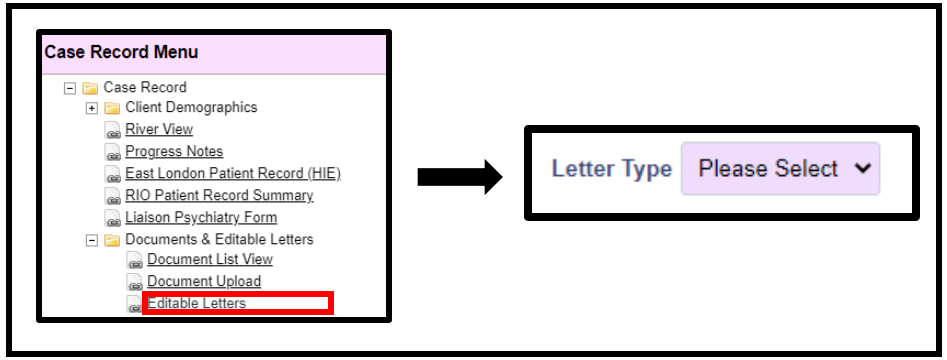
MEDICATIONS CHANGED DURING THIS ADMISSION

Validating pharmacist: **Date/time of validation:**

FOLLOW UP PLAN

Discharge Care Plan
GP Follow-up Plan

DOCTOR COMPLETING FORM	NAME AND POSITION	DATE



The editable letter can then be generated and sent to the GP. The editable letter is titled "**Discharge Liaison Form" and should be found close to the top of the list as shown below.

Note: access to the editable letter is assigned on an individual basis. We hope we have assigned this letter to everyone who needs it but if you don't see it then please contact the RiO Helpdesk via the Service Now portal and we can get this swiftly corrected.

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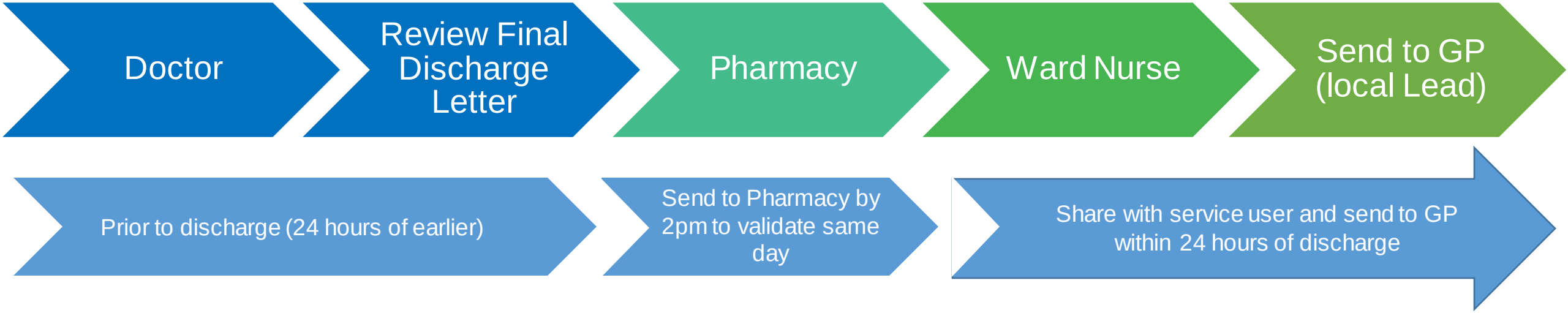
4. Process

4.1 Recommended process flow



- The Junior doctor will complete the "Hospital Discharge" form.
- Junior Doctor to ensure that all the information on the form is correct including admission and discharge date.

- Establish or follow existing governance process for reviewing final discharge letter. Use 'DLF Data Report' to view contents of complete form.
- Doctors are responsible for the quality and accuracy of the discharge letter prior to pharmacy sign off and/or admin sending to GP
- Junior Doctor or the Consultant will email Pharmacy to notify pharmacy that their form is ready for validation

- Ward pharmacist will validate the form and digitally sign. **Please note that the pharmacist will just be reviewing medication and allergies.**
- Pharmacy will validate medication on the same day if received **before 2pm.**
- Ward pharmacist will use editable letters to create the discharge liaison letter (see email below for guide on how to complete this)

- **Gold standard is a copy of discharge letter printed and given to patient**
- Patient to be given medication, which has been sense checked by Ward Nurse
- Patient discharged

- Depending on the borough the ward administrator, Pharmacist, or Doctor will send the discharge letter to the GP.
- **Please note, it is the Junior Doctors responsibility to check the final letter before it is sent to the GP and ensure all quality checks have been completed**

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5. Good Practice

5.1 Learning from discharge letter audits

Good Practice	Areas for further training
Quality of written information • Evidence of clear & concise summary related to circumstances of admission and key relevant information pertaining to the admission itself within in the 'circumstances of admission' section • Clear and concise follow up plan section for community teams and GPs **Completeness of information** • Physical health information and interventions completed within dedicated forms rather than progress notes • Key medication changes highlighted where appropriate	**Quality of written information** • clarity of written information in relation to the circumstances of admission section is variable. **33%** had the full assessment automatically inserted from the MSE and admission summary included without any further review to check its relevance, quality, grammar and format before being submitted to GP. **Automation issues** • **18%** of discharge letters checked in the audit had information from previous admissions (out of date). In some cases it was been 5 years old. Emphasises the need for robust governance structures to check the editable letter before it is uploaded or review whether information should not be automated going forward. **Governance** • Variability in review process of discharge notifications. Where doctors are involved in submitting discharge notifications directly to the GP, the information included has been clearer and more concise.

***Audit included 30 Discharge letters. 5 from each borough after launch of the new form**

5.2 Good Discharge Letter Example

Clear and concise summary related to the circumstances leading to the admission and key information during the admission. It should make for clear reading, written in past tense. The clinician has taken time to reorganise the section as sometimes the automation of this section can result in unnecessary content being added. It is the responsibility of the doctor to view the completed discharge letter before it goes to the service user and GP, to ensure high quality

Physical health information and interventions completed within dedicated forms and **not** in progress notes

DISCHARGE LIAISON FORM

RIO Number:	NHS Number:
Admission Date:	Discharge Date and Time:
CONSULTANT:	CARE COORDINATOR:
ON CPA?	Subject to 117?

ADMISSION SUMMARY

Circumstances of admission

was brought by the police into A&E because she was feeling suicidal. She was diagnosed of PTSD. She was discharged from the ward in February 2023 but did not engage further with CIMHS when she was referred. She was prescribed Olanzapine 5mg and Mirtazapine 15mg both at night. She is not currently taking any medication. She presented to be stressed with her accommodation situation which is her main stressor. She is hearing voice but telling her positive things to do. She felt disappointed that there was no follow up by the mental health team when she was discharged from the hospital. She said her room is not lighten up and she lives like a prisoner. She stated that due to everything going on at the moment for her she has missed her exams which is really painful and struggle to come to term with that news.

Mental State Examination on Admission

She maintained eye contact throughout the conversation.
She was fluent and coherent in her speech, there was no delay in speech.
She was low in mood and angry with the feeling of committing suicide
She had the understanding of her current situation and agreed to start her medication after picking it up today from her GP.

Risk:
She is a risk to self
risk to others is low

PHYSICAL HEALTH INFORMATION

Blood tests carried out
Discharged prior to completion

ECG tests carried out
Last ECG done: 23 May 2023
ECG Result: Normal

ECG comments
Sinus Rhythm
Rate- 72
QT- 411
QTc- 450

Blood pressure
Last BP date: 23 May 2023
BP: 116/61

BMI
BMI: 24.03
Height: 179
Weight: 77

BMI related lifestyle interventions
Diet Intervention: Intervention not required
Exercise Intervention: Intervention not required

Smoking status
Smoking status: No

DIAGNOSES
F61X - Mixed and other personality disorders
History of F431 - Post-traumatic stress disorder

ALLERGIES
NKDA

MEDICATION ON DISCHARGE
Hospital only drugs will need to be added to the patients GP record for information, these include CLOZAPINE and any long-acting depots that are prescribed and administered in secondary care

Drug Name	Route	Dose	Direction	No of days supplied	Hospital to continue	GP to continue prescribing
mirtazapine tablet	po	15mg	night	7	No	Yes, weekly
olanzapine tablet	po	5mg	night	7	No	Yes, weekly

MEDICATIONS CHANGED DURING THIS ADMISSION
Nil - recommenced medication from last admission

Validating pharmacist: **Date/time of validation:**

FOLLOW UP PLAN

Discharge care plan
Discharge to CIMHs
- consider psychology management
Crisis Plan aware

GP follow-up plan
please continue with above medications
please provide weekly prescriptions

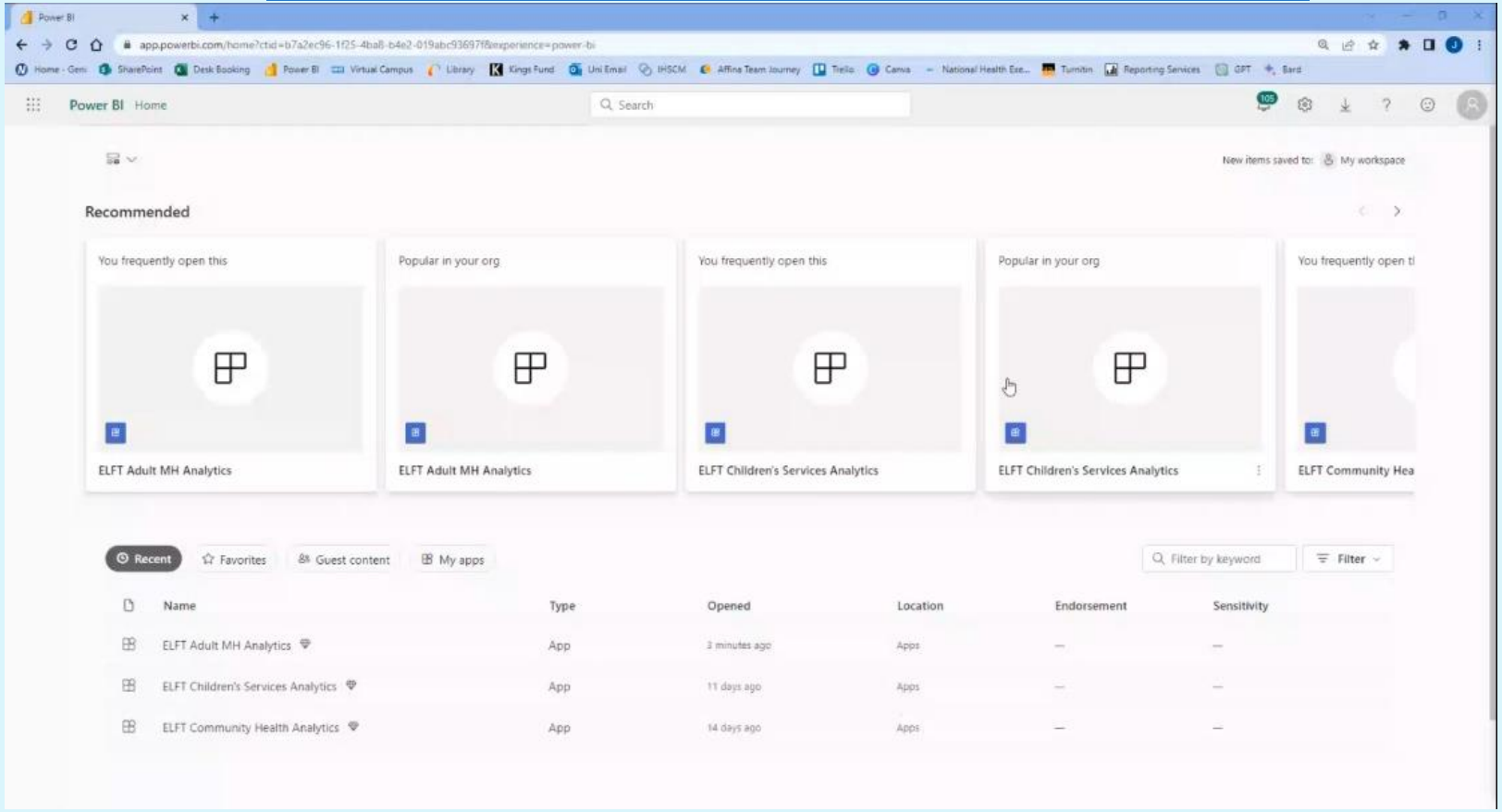
Key medication changes and any important high-risk medications highlighted

Clear and concise follow up plan section for community teams and GPs. This box should also be used to detail any pertinent information related to the admission that might provide useful context for the plan and recommendations to the GP

5.3 How to understand & monitor your wards performance using Power BI Reports

Video: 1:40 minute watch time

Click here: How to monitor performance through PowerBI



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6. Recommendations

6.1 Recommendations for directorate teams

Establish a way for doctors to view the completed discharge letter before it goes to the service user and GP, to ensure high quality

Develop the discharge plan during the ward round or pre-discharge meeting, so that all information is captured in advance

Coproduce the discharge plan with the service user, prior to discharge, and use this opportunity to ensure contact information is up-to-date for the 72-hour follow-up

Use the data in PowerBI at ward level to view performance

Provide the “My Recovery Plan” to the service user at the point of discharge, together with the discharge letter as per the guidance in the ‘Admission, Transfer and Discharge Policy’

Consider creating an information leaflet or ward poster that helps explain the support available from community services following discharge

Explore expanding the peer support offer on wards to help the transition from hospital to community care settings