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Audit On Quality of Clinical Information Sent From Secondary Care to General Practitioner in Merseyside-UK

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Introduction:

Home treatment Team deals with high turnover of patients with significant risks on daily basis. There have been complaints by General Practitioner's that discharge letters have inconsistent information regarding medications, risks and diagnosis.

Aims & Objectives:

To standardise the content of discharge letter, improve the communication between primary and secondary care and to reduce medication errors eventually maintaining remission.

Methodology:

It is a retrospective audit done in May 2014 looking at the discharge letters to primary care in the month of October 2013. As there were no standards to compare, internal standards were set up for the purpose of audit based on the discussions with various General Practitioners.

Discharge letters were scrutinised based on the Primary and Secondary diagnosis with ICD 10 category, clear documentation of risk and details of medication including name, dose, frequency and duration. Audit tool was devised looking into this and 54 out of 108 patients were selected randomly and audited.

Results:

Although majority had diagnosis stated quality of discharge summaries were variable with lot of psychiatric jargons. Risks were documented in an unstructured manner with inconsistent management plans. Most of the letters had medications with some had no dosage or frequency documented clearly.

Outcome:

Results were discussed and presented in academic programme in the trust. New template was devised with all the relevant information and implemented successfully. Re audit to done after 6 months with the view of replicating trustwide.