Making hospital discharge safer for frail older patients

Hospital discharge represents one of the greatest challenges in interorganisational relationships in health care and can lay bare the potential failings of a healthcare system. The peri-discharge period is a risky time in a frail older patient's journey and clear communication is key to a safer discharge experience. Communication across the interface has been identified by the James Lind Alliance as one of the top three priorities for primary care patient safety.¹ There are three settings (angles) for the people involved in discharge: hospital staff, primary/community care staff, and patients/carers who are going home — and all parties clearly want to communicate as effectively as possible. As there are three angles, this can be conceptualised as a communication triangle.

The burden of care in our healthcare system is widely acknowledged to have been shifting towards frail older patients. These patients have the highest risk of error and harm during care transitions² because of multimorbidity, polypharmacy, and collapse of social networks. Research into discharge error and harm often focuses on this cohort though there are many other vulnerability factors, such as social deprivation, language barriers, and mental health problems. Safer discharge for an ever-increasing frail population against a background of increasing health inequality is complex, but may be addressed according to the angles of the communication triangle.

THE HOSPITAL ANGLE

Tensions are writ large in the literature related to intra- and interprofessional communication at the interface. Although GPs seldom report patient safety incidents related to discharge, when they do, communication problems are a key cause (21% of reported incidents, 27% of which are related to the interface).³ The Royal College of Physicians, the Scottish Intercollegiate Guidelines Network, and the Professional Record Standards Body have done much to improve the quality of discharge summaries.⁴⁻⁶ Electronic discharge summary formats (from NHS Digital) are

now mandatory. Despite substantial improvements to all aspects of discharge summary communication in the last 10 years, GPs continue to report issues with discharge summary communication: inappropriate delegation, unreasonable requests for investigations (both in terms of timeliness and appropriateness), unclear medication instructions, acronyms, and problems with clarity of responsibility for requested actions.⁷ Hospitals have a fast turnover of patients, even for the complex frail caseload, which is thought to be one of the reasons for the high re-admission rate in this population. There is sometimes pressure to discharge to improve hospital flow or when the home environment is considered the safer option, for example, to reduce risk of nosocomial infection or prevent deconditioning. The most junior member of the hospital team must then produce a timely discharge summary.

Few healthcare systems have managed to cross the professional and structural/organisational divide between primary and secondary care (though some, such as the Salford Integrated Record, have tried). Yet the changes to structures in primary care and organisation into networks provide an opportunity to allow primary care to communicate on a more even footing with secondary care. UK hospitals have scope to improve many elements of their pre-discharge work-up in order to reduce burden on primary care. 'Transitional care' (interventions that span the peri-discharge) is common in US hospitals. Most programmes focus on hospital-based services reaching out into the community, often reporting no difference in long-term outcomes despite high costs.⁸ One review suggests primary care-based transitional schemes might be more successful, but they have never been compared with secondary care-based interventions in head-to-head trials.⁸ Hospitals should be involved in borrowing elements of successful transition programmes that foster collaboration between primary and secondary care (such as Care Bridge,⁹ which reduced mortality within 6 months of discharge),

perhaps focusing specifically on training their staff to educate patients about their time in hospital. Improving the discharge summary requires quality training for junior doctors, but a wider secondary care provider attitudinal shift is needed in relation to delegation of workload. GPs should be involved in discussion with their discharging hospitals about this issue and in the training of junior doctors on how to write discharge summaries. GPs should use primary care placements to train Foundation Year 2 doctors to handle discharge summaries at the primary care end.

THE PRIMARY/COMMUNITY CARE ANGLE

The author's epidemiological work estimated that 8% of a vulnerable cohort of >75-year-olds experienced harm associated with primary care management of discharge summaries.¹⁰ One example of high-severity harm was the need for a patient to have dialysis after incorrect post-discharge management of furosemide. What little is known about the chain of error shows that most problems happen at the point at which the GP reviews the summary;^{7,10} in the case described above no arrangements were made for follow-up blood tests. More failures were found in relation to test ordering and instigating follow-up (~25% of requests) than in medications management (17% of requests).¹⁰ We referred to these instances as 'failures' rather than errors because we cannot be sure about their causality. GPs certainly do not always agree with the requests made of them by secondary care,⁷ highlighting again the undercurrent of tension around 'delegation' of workload to primary care. There are known issues in primary care in relation to time and workload pressure that might lead to slips and lapses, but there are clearly other latent causes of error within primary care systems, such as lack of continuity between GP and patient or loopholes in investigation management systems.

Role diversification within general practice offers numerous options for involving alternative professionals in post-discharge management. The clinical pharmacist in the general practice scheme offers scope for pharmacists to be involved, but currently no data exist on what their impact might be in reducing error/harm related to medications reconciliation after discharge.¹¹ Fragmentation of the discharge summary management process is potentially concerning, especially

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“GP clinicians and managers should take an active role in directing and engaging with this research to be sure it addresses their concerns of practicality and adaptability to GP systems.”

when considering the importance of continuity for vulnerable patients. No single practitioner is better placed to review the entire spectrum of the patient's care post-discharge than the GP. GPs need protected time and workspace to perform this complex work. Where alternative models are being offered, such as up-skilling administrative team personnel to manage clinical documents, including, potentially, discharge summaries, more evidence of their effectiveness is needed prior to accepting them into routine practice. A variety of untested solutions to reduce error were already being operated by the practices that engaged in the author's work, including: scheduling appointment book time to call discharged patients, auditing 'diary' or 'task' functions related to actions in the peri-discharge, and specific ways of recording the discharge event, for example, use of templates, free-text summaries of the discharge summary in the facing record, or even coding actions to trigger processes to complete them.⁷

THE PATIENT/CARER ANGLE

Little is known about how patients contribute to the generation of errors in the peri-discharge. Frail older patients are often 'absolved' of their responsibilities at this time by medical staff in both primary and secondary care who might see them as unable to take responsibility for their care. Hospitals must guard against this becoming an excuse not to communicate with patients/carers before they are discharged, because this is likely to lead to increased workload for GPs. The Health Foundation considered the role of patients in improving the safety of their own care in its 2012 paper,¹² and three issues dominated: the willingness of patients to be involved, where accountability for safe care lay, and the potential erosion of trust in staff. Some GP voices in the author's study⁷ were keen to point out that all primary care systems relied on the patient to complete the safety loop.

The evidence base for patient/carer-oriented solutions is lacking. Patient education-oriented transitional care research emerging from the US shows that patients with multimorbidity and polypharmacy have

the most to gain from health coaching and empowerment.¹³ There is emerging evidence that the simple step of copying patients in to their discharge summaries is welcomed by both patients and (broadly) providers.¹⁴ Our efforts should be focused on developing communication tools that empower patients and their carers to communicate with their healthcare providers to assist in closing error loops. Particular attention needs to be focused on older patients without an advocate to support this empowerment.

There is scope to make meaningful changes to patient safety at every angle of the communication triangle. The *General Practice Forward View* provides some funding for primary care-led changes.¹⁵ Secondary care clearly needs to act too, carefully considering the work they delegate to primary care and how they can best

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educate patients about follow-up needs, and more research is needed into these areas. There is also a need for further research focused on communication between patients and their GP providers after discharge. GP clinicians and managers should take an active role in directing and engaging with this research to be sure it addresses their concerns of practicality and adaptability to GP systems.

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