Standardising Patient Discharge Summary Information: a Draft National Data Set for consultation

Consultation Feedback Form

November 2012

Your views are very important to us. We would like to hear what you think about the draft guidelines.

Your comments will be considered and will inform the development of the national data set for clinical discharge summaries. When commenting on a specific aspect of the draft dataset, it would help us if you tell us which element you are commenting on or the table number that you are commenting on.

The closing date for consultation is 5pm on Friday 11 January 2013

You can email or post a completed form to us. You can also complete and submit your feedback online on www.hiqa.ie.

About you

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Organisation* *Please indicate if you are making your submission in a personal capacity only or on behalf of your organisation	On behalf of the Irish Medical Organisation
Date	11 January 2013

General feedback questions

You may provide us with feedback on the specific questions asked within the consultation document and repeated here (see questions that follow), or alternatively you can provide us with general comments.

Consultation Question 1

Question 1: Are there benefits in having a standardised data set for clinical discharge summaries, and, if so, what are the main benefits?

Please comment

Increased patient safety and quality of care are the main benefits of having a standardised data set for clinical discharge summaries, reducing repetition and errors in diagnostics and assuring that General Practitioners have all the relevant information on discharge of a patient from hospital.

Standardised data is also easier to import into electronic record systems.

A standardised data set for clinical discharge summaries can also lead to administrative efficiencies, however it is always necessary to verify patient details as they move between healthcare settings. Patient safety must be the driving motivator for change.

In terms of the description of a good discharge summary, we would propose that this definition should also include high quality clinical information which should be as concise as possible.

Consultation Question 2

Question 2: Have the appropriate groupings of data items been included in the data set?

No
6.2 - It is unacceptable that a 'patient discharge summary information' form would not contain a dedicated space to specify "general practitioner" details - in the same way as consultant details are specified as distinct from 'hospital professional'. If, in addition, the form wants to specify "primary care healthcare professional" details a second box should be added to the form under "other primary care healthcare professionals".

Other references throughout the draft form to "primary healthcare professionals" should be changed to "general practitioners and/or other primary healthcare professionals". General practitioners are distinct from all other primary healthcare professionals both functionally and contractually. As indicated in 6.6.2 of the form, general practitioners clearly have a central role in the ongoing care of patients and this must be recognised in the discharge summary.

Consultation Question 3

Question 3: Have all of the appropriate data items have been included in the data set? Would you leave out any of the data items listed? Would you suggest additional data items?

6.1.6 – To ensure patient safety, a unique patient identifier is of critical importance. Ideally a unique health identifier should be developed for use on a national basis.

6.3.4 / 5 - one entry may be sufficient for both hospital site and ward, however there is a need to include an item for subsequent transfers

6.3.8 - In the case of patient death, the discharge summary should also include whether the death was reported to the Coroner, the person responsible for completing the medical Certification of Cause of Death and the cause of death as it appears on the certificate.

6.3.10 – the consultant under whose care the patient was admitted should be included as an additional item

6.5.1/ 2 - In order to avoid duplication of information the section on medications should be divided into three items:

- medications that have been discontinued during this admission
- new medications that have been added to the prescription (and it is crucial that the duration of therapy be made clear)
- medications where the dosage/frequency/administration have been changed

There is frequently a problem with discharge medications - sometimes the hospital is unaware of medications taken by the patient - especially when the patient is admitted through A&E as an emergency and without a GP referral letter. In order to limit any changes to medication need to be clear and rationalised.

Consultation Question 4

Question 4: Do the definitions provided in Tables 1 – 7 of the consultation document adequately explain each of the data items? If not, please suggest improvements?

6.2.4 – It may be impractical to have the MCN of the doctor to whom the patient is being discharged.

6.3.2 – The source of referral should be required, although the name of the doctor may not be necessary – a tic box should be adequate - ie GP/ self / A & E etc

6.3.6 – an approximate time of discharge should be all that is necessary

6.3.9 – Date of death should be a required item. GPs would also wish to be notified of death of a patient immediately and separately from the discharge summary.

6.4.1 - The suggested follow up by the GP has to be separate , clear and agreed. It is not sufficient to indicate that the following investigations , blood tests , follow up procedures are to be undertaken by the GP. This equates with additional work - work transfer from secondary to primary care and cannot be accepted without discussion. This also exposes GPs to potential litigation. To prevent possible adverse outcomes the GP must have accepted the request and this be accurately documented.

6.4.3 – Operations and Procedures should be a required item.

6.4.8 – Relevant Investigations and Results should be a required item to prevent duplication.

6.4.12 – A patient's immunisation history should be part of the patient's health record. Additional immunisation given during admission only is required in the discharge summary.

6.6.1 – Hospital Actions should be conditional. If investigations or referrals are pending they must be included, again to prevent duplication.

6.6.2 – As per 6.4.1 above, GP actions must be separate, clear and agreed. The definition should be changed to "actions that are agreed with the general practitioner".

It may be necessary to adapt some definitions to ensure that the form is appropriate to patients discharged from psychiatric care.

Consultation Question 5

Question 5: Does the usage information provided in Tables 1 - 7 of the consultation document clearly explain the proposed use of each of the data items? If not, please suggest improvements.

6.4.1 See Question 4 above

6.4.2 / 3 - Acronyms and abbreviations should not be allowed – as there is a potential for legal problems where mishaps occur. Precise words must be used. ICD 10 codes as used in the Hospital In-Patient System should not be acceptable – as this is specialised work not undertaken by doctors.

6.6.2 – As per 6.4.1 above, GP actions must be separate, clear and agreed. The usage should be changed to "Any actions that the general practitioner has agreed to organise should be documented".

It may be necessary to adapt some usage to ensure that the form is appropriate to patients discharged from psychiatric care.

General Comments

Please provide any general feedback you wish to give below.

General Comments on the standardised discharge summary information
The IMO welcomes the development of standardised discharge summary information. The form as proposed is comprehensive but lengthy. Hospital IT systems should be able to populate much of the data allowing healthcare professionals to concentrate on the relevant clinical information. The standardised discharge form should be piloted to ensure practicality as far as possible.

The proposed letter requires input from a number of professionals - NCHD, Consultant, Dietician, Physiotherapist, Occupational Therapist etc. These professionals may not always be available at the time of discharge thus potentially delaying the discharge or resulting in an incomplete discharge letter. It may be more practical to issue an initial short version on the day of discharge with agreed vital data necessary for the continual care by the receiving doctor - GP or hospital. The more comprehensive discharge letter could then follow in a timely manner - ideally within 48 hours. It may also be appropriate for the discharge plan co-ordinator to take on the task of ensuring that each professional completes the form.

Discharge letters generate a significant source of work for doctors in Irish hospitals, especially for teams with a high turnover of patients. These draft proposals, whilst welcomed, will significantly increase the workload on those doctors completing discharge letters. Often the most inexperienced NCHDs can end up writing most of the discharge letters. They can spend most of their working day writing these documents. Sometimes they have never managed the patient being discharged, are often unaware of the patient details and have to analyse the patient chart retrospectively to see what happened over the duration of the admission. Where this practice takes place, there should be a rebalancing of the task of writing discharge letters, with a reminder to all doctors, that everyone has a duty to write discharge letters to the standard decreed. When an excess burden on writing these letters falls on the most inexperienced NCHDs, this balance will need realignment.

If junior NCHDs are spending most of their day writing discharge letters, the resultant effect on their training must be considered by the wider clinical team. The HSE and HIQA needs to acknowledge this increased workload and will need to audit and monitor how NCHDs are spending their clinical time.

As national healthcare policy develops it may be necessary to review the standardised discharge summary information to ensure that it is fit for purpose.

General comments on the effective use of information and communication technology
While standardised patient discharge information can help ensure that a patient's primary physician has all the necessary information relevant to the patient's hospital diagnosis and care, it is essential that systems are in place to ensure that the data is transferred in a secure and timely manner. The IMO is calling for a secure, confidential and monitored on-line communication system to allow health professionals to communicate more effectively.

In the absence of a national system of electronic health care records, ICT systems in health care in Ireland are developing in an *ad hoc* fashion. It is important that the patient summary discharge data can easily be embedded into hospital ICT and GP Practice Management Systems. Urgent attention is needed to the development of interoperability standards and the IMO welcomes progress in this area with the recent publication of the HIQA *Guidance on Messaging Standards for Ireland*.

The IMO are also calling for the urgent publication of the Health Information Bill to clarify issues in relation to patient safety and patient confidentiality including the secondary use of patient data.

Thank you for taking the time to give us your views.

Please return your form to us either by email or post:

ehealth@hiqa.ie

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If you have any questions on the draft data set, you can contact the consultation team by calling (01) 8147685.

Please return your form to us either by email or post before 5pm on Friday 11 January 2013

Please note that the Authority is subject to the Freedom of Information Acts and the statutory Code of Practice regarding FOI.

For that reason, it would be helpful if you could explain to us if you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances.