

Future leaders Communiqué

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CONTENTS

Guest Editorial	1
Editorial	2
Further Reading	2
Case: Too sick to go	3
Case: Safety netting at discharge	5
Comments from our peers	6
Listen to your patient	7
It's not always about the job	8

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Next Edition: October 2018

GUEST EDITORIAL

Dr Danielle Hume

It is my pleasure to welcome you to this issue of the Future Leaders Communiqué. We will reflect on two cases where pressured discharge planning sadly preceded tragic outcomes.

Many of us will share in the experience of a busy day in hospital, being pulled in multiple directions for competing tasks, including discharging patients. Completing an effective discharge can be time consuming and complex. Managing this process while picking up patients from a busy emergency triage, or while keeping up with a ward round, or juggling pagers, is not always easy. Despite our best multi-tasking efforts, this is a process that is often rushed and without adequate access to support.

Reflecting on my own experiences as a junior doctor, this task was often given lower priority than it deserved. I can recall chasing after my senior consultants on a ward round, taking notes, requesting investigations, and responding to nursing staff concerns as we moved from patient to patient. As was often the case, my team would instruct the patient that they were ready for discharge and we would give them a script for their new medications before moving on to the next room. Later, I would return to the ward to hurriedly complete a discharge summary and follow-up referral details, before clinic began for the afternoon.

Inadequate discharge planning has the potential to disrupt continuity of care, and increases the likelihood of adverse events. Junior doctors must fast become skilled in this process to optimise patient outcomes. A 2016 Cochrane review of 30 randomised controlled trials identified that effective discharge planning resulted in a small reduction in length of stay, and reduced the risk of readmission in older people with a medical condition. The reviewers concluded that individualised discharge planning may also increase patient and healthcare provider satisfaction (Goncalves-Bradley DC et al, 2016).

So what makes up an individualised discharge plan? A BMJ article titled 'Planning a patient's discharge from hospital' identifies good planning to involve information gathering, resolution of discharge barriers, early referral to the multidisciplinary team and collaboration with the patient and their family. This article also highlights that *"the junior doctor is often an important coordinating link in the process of discharge"* (Katikireddi, 2008).

When I first read the following two cases, I was very aware that I had been involved in the care of many patients with presentations just like Mrs JC and Mr MN. Neither of these patients suffered rare or complex illnesses, and in each of these cases small components of discharge planning, done properly, could have made all the difference. For junior doctors, these cases act as a reminder to use discharge planning to safeguard against adverse outcomes, even after patients have left our care.

EDITORIAL

We are delighted that Dr Danielle Hume was able to be our guest editor for this issue of the Future Leaders Communiqué. Danielle managed to do this while completing a busy second year as a junior medical officer at Eastern Health, as well as undertaking her first (hospital-based) year of General Practice training. Danielle is now training as a GP registrar in a medical clinic in Melbourne, and has a special interest in mental health and paediatrics.

Danielle highlights lessons from two cases involving discharge of patients from emergency departments who subsequently died. Our expert commentaries from Dr Jane Deacon and Dr Shelly Jeffcott provide insights for junior and senior doctors around these two cases, examining some of the cues that we get from patients that we should pay attention to.

The challenge with writing any discharge summary or letter is achieving some sort of balance between how comprehensive it needs to be, while keeping it succinct and pertinent for the medical practitioner who is responsible for the continuing care of the patient.

Often when we write, we write in a manner that suits our own style and how we like to take in and organise information. Writing for another reader rather than ourselves requires a conscious effort and repeated practice. The best example would be to reflect on medical school days when we would borrow each other's lecture notes and find that we had no idea what was written as our friend would use unconventional notations, draw pictures, or make random dot points! The information might all be there but no one else can see it.

So, the next time you are writing a referral letter or discharge summary, think about the reader and what is the important information that they need to act on when they first see the patient. Has the relevant background been provided? Have the priorities of care been made clear? And, will the reader know who to call if they need to clarify any information or request further assistance?

FURTHER READING

'Discharge from hospital to a community or care home setting for adults with identified social care needs', National Institute for Health and Care Excellence (NICE), 2017. Available from: <https://goo.gl/8SA55k>.

'Quality Standards for Emergency Departments and Other Hospital Based Emergency Care Services', Australian College of Emergency Medicine (ACEM), 2015. Available from: <https://acem.org.au/getmedia/cbe80f1c-a64e-40ab-998f-ad57325a206f/Quality-Standards-1st-Edition-2015.aspx>

'Guidelines for the Victorian Emergency Department Care Coordination Program', 2009. Department of Health and Human Services, Victorian Government. Available from: <https://goo.gl/Td6tFp>.

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ACKNOWLEDGEMENTS

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DISCLAIMER

All cases that are discussed in the Future Leaders Communiqué are public documents. A document becomes public once the coronial investigation process has been completed and the case is closed. We have made every attempt to ensure that individuals and organizations are de-identified. The views and conclusions are those of the authors and do not necessarily represent those of, the individual Coroner, the Coroners Court, Department of Health, Department of Forensic Medicine, Victorian Institute of Forensic Medicine or Monash University. If you would like to examine the case in greater detail, please contact us and we will provide the relevant website for the Coroners Court jurisdiction.

FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in clinical practice. Please email your comments, questions and suggestions to: flc@vifmcommuniqués.org

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Case Number:
COR 2012 4544 Vic

Case Précis Author:
Dr. Danielle Hume MD, BBiomed Sc
(General Practice Registrar)

CLINICAL SUMMARY

Mr MN was a previously healthy 36-year-old man who presented to a metropolitan emergency department with a two-day history of diarrhoea, fevers, nausea and vomiting.

Mr MN was accompanied by his concerned partner at the time of his presentation, arriving at the hospital at approximately 10:15pm. The only doctor working in the department at that time examined Mr MN, and found him to be tachycardic, febrile and clinically dehydrated. Mr MN was provisionally diagnosed with gastroenteritis and was managed with antiemetics, intravenous and oral rehydration, and placed in isolation. Stool and urine samples were ordered for Mr MN, however were not collected prior to his discharge. The doctor reviewed his blood results, noting his creatinine to be raised, consistent with severe dehydration.

Mr MN was transferred to ICU on broad-spectrum intravenous antibiotics and later diagnosed with Streptococcus pyogenes septicaemia of unknown source.

It was also noted that Mr MN's platelet count was low. Some hours after presentation, Mr MN was discharged home, despite his partner raising concerns regarding his ongoing diarrhoea. At the time of discharge Mr MN was persistently tachycardic, however afebrile and normotensive. He had received a total of four litres of normal saline over four hours.

Two days later, Mr MN represented to the same emergency department in septic shock. He had continued to experience fevers, nausea, vomiting, and bloody diarrhoea in the intervening period.

Mr MN was transferred to ICU on broad-spectrum intravenous antibiotics and later diagnosed with Streptococcus pyogenes septicaemia of unknown source. Despite aggressive resuscitation and life support Mr MN continued to deteriorate, and in discussion with his family was palliated.

Five days after his initial presentation to the emergency department, Mr MN developed asystole and died.

Mr MN's partner raised several issues surrounding his death; most notably that Mr MN was discharged from hospital despite their voiced concerns regarding his ongoing diarrhoea.

PATHOLOGY

An autopsy was conducted which concluded that the cause of death was multi-organ failure secondary to sepsis, for which a source was unable to be identified.

INVESTIGATION

The focus of the coronial investigation into Mr MN's death was the decision-making by the doctor in the emergency department (ED) on Mr MN's first presentation to hospital.

Mr MN's partner raised several issues surrounding his death; most notably that Mr MN was discharged from hospital despite their voiced concerns regarding his ongoing diarrhoea.

Mr MN's partner also reported that a senior member of nursing staff had that night, expressed the belief to them that Mr MN was 'too sick to go home'.

The family of Mr MN obtained an independent expert opinion from an emergency physician. The emergency physician concluded that Mr MN's initial clinical presentation and pathology results (namely the presence of band forms and metamyelocytes), warranted admission for further investigation and management with intravenous antibiotics. Further, the emergency physician opined that had this treatment been initiated at the time of first presentation, Mr MN may have survived.

In addition to the coronial investigation, internal hospital and external Medical Board of Australia reviews were conducted. These reviews included a review of clinical practice and processes that may have contributed to Mr MN's death. It was concluded that Mr MN's initial discharge was a result of an error in clinical judgement. A meeting with senior staff representing the hospital was held with Mr MN's partner subsequent to his death. The hospital discussed the partner's concerns and acknowledged the error that had been made in discharging Mr MN home.

The treating doctor willingly participated in the hospital review process, and accepted the findings of that review, undergoing a period of training and supervision as a result. A caution was issued to the doctor by the Australian Health Practitioner Regulation Agency.

Several recommendations regarding processes within the ED were made. These included the development of an "Emergency Department Safe Patient Discharge Process" to support clinical decision-making.



This new program included vital observation checks prior to discharge, as well as clear avenues for escalation of concerns surrounding discharge. A follow-up phonecall service was also implemented by the ED.

Further to the above reviews, the hospital medical workforce made changes to staffing in the ED following Mr MN's death. On initial presentation, Mr MN was attended by the only doctor working in the ED for the night. It was also noted to be an unusually busy night, with a higher number of presentations than average. The medical workforce unit made several changes including increasing the overlap of medical staff to facilitate better review and handover of patients, and increasing access to on-call support in busy periods.

This case highlights the importance of clinically safe discharge processes as well as recognising and responding to concerns, all while working within the pressures of a busy hospital department.

CORONER'S FINDINGS

The coroner stated that Mr MN died of multiorgan failure secondary to sepsis of unknown source, which may have been prevented had Mr MN been admitted to hospital at the time of his initial presentation.

The coroner commented that the hospital had both acknowledged and thoroughly addressed the error, and as such, the preventative role of the coroner had been addressed by their internal review. Therefore, the case did not proceed to inquest and no further recommendations were made.

AUTHOR'S COMMENTS

On reading Mr MN's case I was struck by the tragic outcome in such a young patient, with a presentation often attended to by junior doctors. This case highlights the importance of clinically safe discharge processes as well as recognising and responding to concerns, all while working within the pressures of a busy hospital department.

Mr MN's discharge from initial presentation was found to be clinically inappropriate in the context of severe illness with ongoing symptoms, and incomplete investigation given the stool and urine samples requested were not collected. The coroner found this to be the result of an error in clinical judgement by the treating doctor. It is however acknowledged in the coroner's findings that Mr MN presented on an unusually busy evening, and his attending doctor was the only doctor staffing the emergency department. So, this begs the question, when our workload is near unmanageable how can we safeguard against error?

The Australasian College for Emergency Medicine (ACEM) details quality standards for safe discharges including consistent screening processes and consultation with an emergency physician or doctor-in-charge of the emergency department. In accordance with this, many hospitals have clear protocols related to patient safety and suitability for discharge. Understanding and adhering to these protocols will benefit junior doctors by identifying 'at risk' patients who may otherwise be overlooked.

In any case, where serious concerns are raised regarding a patient's care, it is important to reflect and reassess by asking, "should I be concerned too?"

In Mr MN's case, reconsideration of his discharge may have been prompted by a vital observation check, possibly identifying his persistent tachycardia as cause for concern.

These guidelines also stipulate that the ED team ensures results of investigations requested are followed up within a clinically suitable timeframe. Although stool and urine samples would not have yielded immediate results, they may have proven useful in identifying potential pathogens or prompting follow up with Mr MN's progress in days to come.

Another way in which safe discharge planning can be supported is by acknowledgement and consideration of patient, family and other staff member concerns. In Mr MN's case, his discharge went ahead despite concerns voiced by the partner, and more subtly expressed by nursing staff.

In any case, where serious concerns are raised regarding a patient's care, it is important to reflect and reassess by asking, "should I be concerned too?" Personally, this is a practice that has been invaluable to me in a range of clinical situations by assisting me in making decisions collaboratively with colleagues, patients, and family members. Had the concerns raised by Mr MN's partner been acknowledged and explored by the treating doctor, Mr MN's outcome may have been very different.

KEYWORDS

Diarrhoea, dehydration, tachycardia, sepsis, emergency department, decision-making, discharge

CASE SAFETY NETTING AT DISCHARGE

Case Number:
COR 2009 002381 Vic

Case Précis Author:
Dr. Danielle Hume MD, BBiomed Sc
(General Practice Registrar)

CLINICAL SUMMARY

Mrs JC was a socially isolated 72-year-old woman whose family resided interstate. Mrs JC had a significant past medical history of chronic obstructive pulmonary disease (COPD), recurrent falls, hypertension, and insulin dependent type 2 diabetes mellitus with recent hypoglycaemic episodes and subsequent blackouts. Due to her history of falls and blackouts, Mrs JC wore a personal alarm at home.

Mrs JC presented to her local general practice on a public holiday, complaining of right-sided chest pain following a fall at home two days prior. Her doctor noted Mrs JC to be in significant distress and pain, and referred her to the nearest emergency department.

On arrival to the emergency department Mrs JC was noted to be short of breath and complaining of severe ('nine out of ten') pain. She received analgesia and was investigated with a chest x-ray, which revealed multiple right-sided rib fractures. Mrs JC was then discharged home with a prescription for paracetamol, codeine, oxycodone and diclofenac, with instructions to follow up with her local doctor in the following days.

On arrival, Mrs JC was found to be acutely delirious, with evidence of pneumonia and exacerbation of her COPD.

Four days later, Mrs JC telephoned her daughter in a distressed state, relaying that she had fallen at home while not wearing her personal alarm. Mrs JC had been unable to ambulate after the fall, and after several hours had managed to crawl to the phone. Mrs JC's daughter phoned an ambulance that proceeded to bring her to the emergency department once again.

On arrival, Mrs JC was found to be acutely delirious, with evidence of pneumonia and exacerbation of her COPD. She was transferred to the Intensive Care Unit (ICU) where she continued to deteriorate. In discussion with Mrs JC's family, the decision was made to withdraw active treatment and she died eight days later with family present.

PATHOLOGY

Mrs JC's death was not reported to the coroner in the first instance, and was subsequently identified as requiring reporting due to a 'fall' being listed in the death certificate. As a result of the delay in reporting, there was no opportunity for an autopsy to be performed.

The emergency physician highlighted that it is not only the responsibility of emergency department doctors to treat acute illness, but to anticipate complications and minimise the risk of these occurring.

In place of an autopsy, the coroner, a forensic pathologist, and a medical clinician reviewed Mrs JC's medical records, and determined that it would be reasonable to attribute Mrs JC's death to pneumonia in the setting of multiple rib fractures and known COPD.

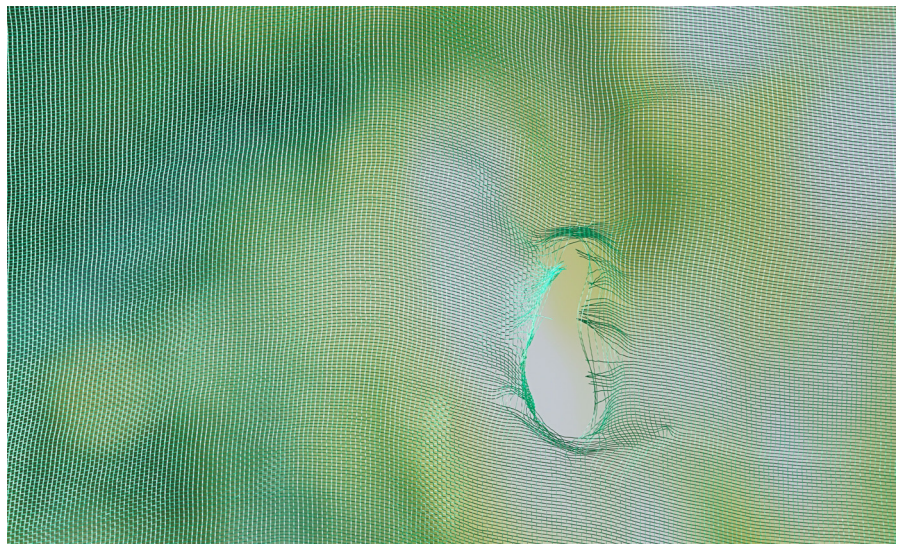
INVESTIGATION

The focus of the coroner's inquest was to explore the adequacy of clinical management at Mrs JC's initial presentation to hospital. The key issues identified by the coroner were a paucity of clinical documentation by the emergency department medical staff, and suboptimal discharge planning in the first instance.

An emergency physician provided an expert opinion on Mrs JC's case. This physician did not identify any issues with Mrs JC's initial assessment and management with analgesia, however noted her presentation was high risk for complications due to her medical comorbidities.

Additionally, the clinical documentation of Mrs JC's initial presentation did not include any record of an assessment of her social circumstances, raising significant concerns surrounding the adequacy of discharge planning.

The emergency physician highlighted that it is not only the responsibility of emergency department doctors to treat acute illness, but to anticipate complications and minimise the risk of these occurring. In Mrs JC's case, a number of options may have achieved this. These included multidisciplinary assessment and discharge planning, discharging her into the care of a responsible person, or performing a follow up welfare check on Mrs JC in the days following discharge.



CORONER'S FINDINGS

The coroner found that Mrs JC's clinical management on initial presentation was in keeping with professional standards, however acknowledged that her discharge planning was suboptimal. Due to a lack of clinical documentation, the coroner was unable to conclude whether Mrs JC's social circumstances were adequately assessed prior to discharge. The coroner recommended that the hospital "consider allocating specific responsibility for the completion of the Discharge Tool within the emergency department, to ensure that adequate discharge planning occurs, and that the rationale for discharge decisions is apparent".

Mrs JC was clearly at risk of developing further complications due to her social isolation and significant medical comorbidities.

The emergency department involved in this case responded by stating that ordinarily a 'Care Coordinator' addresses patients' discharge circumstances, however as Mrs JC presented on a public holiday, this service was not available. As a result of the inquest, the hospital has now improved coverage by the Care Coordinator role to seven days per week, and has implemented processes to ensure patients reviewed after hours are followed up post discharge.

AUTHOR'S COMMENTS

Mrs JC's case is yet another clinical scenario commonly encountered by junior medical staff. In this case, the doctor responsible for Mrs JC's discharge conducted an appropriate assessment and instigated reasonable management, however it is unclear if her social circumstances were considered when formulating a discharge plan. Mrs JC was clearly at risk of developing further complications due to her social isolation and significant medical comorbidities.

In this situation, it is important for junior doctors to take measures to manage risk and uncertainty when discharging a patient. An article by the Australian Family Physician, aimed at doctors-in-training transitioning to General Practice, describes this technique as 'safety netting'.

This technique includes communication of an explicit follow up plan, including red flags that indicate the need to represent, and an explanation of how to seek further help.

As junior doctors, it is important to actively seek out support from all available sources to safety net our patients and ourselves, as well as improve our quality of care.

The coroner, in her finding, referred to a resource that is available at many hospitals, aimed at supporting 'at risk' patients on discharge. The 'Emergency Department Care Coordination Model' facilitates multidisciplinary discharge planning, including access to additional community-based supports and follow up. This model has been shown to significantly reduce representation as compared to patients who are not reviewed by a Care Coordination team.

In Mrs JC's case, the use of 'safety netting' by developing an appropriate follow up plan, including review by the Care Coordinator team, may have resulted in earlier detection of potential complications, which may have significantly improved her prognosis. As junior doctors, it is important to actively seek out support from all available sources to safety net our patients and ourselves, as well as improve our quality of care.

KEYWORDS

Falls, rib fracture, COPD, discharge planning, follow up, care coordination

COMMENTS FROM OUR PEERS

"As junior doctors working in hospitals, we also have little knowledge of the types of services that are available in the community. I find the input of allied health (occupational therapist, physiotherapist, social worker) invaluable in preparing and facilitating smooth and successful discharge, and try and refer early on during admission."

"When concerns are raised by the patient, their family or colleagues, it is worthwhile taking a moment to really reflect and ask oneself whether there is cause for greater clinical concern."

"It is difficult to provide adequate attention to patients sometimes, particularly on busy units or in the emergency department. However, no matter how busy the working environment is, patient safety and safe discharging is paramount. Even though this may take some extra, precious time, it is worthwhile to prevent error."

"Be sensitive to patient needs and circumstances outside of the hospital. For a junior doctor, it is easy to get caught up in the medical side of the patient's presentation that you forget their psychosocial circumstances. Take collateral histories from family, friends, neighbours, and community health staff to get a better picture of this."

LISTEN TO YOUR PATIENT

Dr Jane Deacon
Grad Dip Health Law, MBBS

Jane has been working as a medico-legal advisor with MDA National for the last 11 years, a role which involves assisting medical practitioners with claims and complaints and general medico-legal advice. Jane continues to work part-time in general practice.

These two tragic cases illustrate the difficulties in discharge planning, and cause us all to pause and think “how could that have been managed better?”

Sir William Osler said “listen to your patient, he is telling you the diagnosis”, and to that I would add that the patient, his support person, and experienced nursing staff are giving you useful information about not only the diagnosis, but also the management. Beware of the patient who “looks sick”, and if nursing staff express concern about a discharge, review your patient again. Trust your gut feeling if you have concerns about a patient, but can't quite work out what is going on.

I well remember a patient I saw in the emergency department many years ago. His opening words to me were: “I'm so sick I need to be in the hospital”. My assessment of his physical complaints was that they were not serious at all, and I discharged him home. Two days later he committed suicide. In retrospect, he was right, he did need admission, but not for his physical problems. His physical symptoms were his entry ticket to the emergency department, but his subtext was his mental health. The patient's agenda was admission.

I think it's important to address the agenda of the patient, and also their family.

Ascertain what the patient and family's expectations are of the diagnosis and management of their symptoms.

Consider how that fits with your assessment and, if there is a mismatch, take a step back and re-consider. Communication with your patient is the key to understanding whether you need to reconsider your management – have you missed something? – or perhaps the patient requires more information, and some “safety netting”.

Think of your patient as a person, in their social setting, not just their presenting complaint of broken ribs, or diarrhoea. Imagine that person after they leave the emergency department. What do they understand of their illness? What sort of home will they return to? Will they have support at home?

Safety netting is a term used in General Practice to describe a consultation technique that helps manage diagnostic uncertainty. Safety netting is also of benefit where the diagnosis is known but carries a significant risk of serious complications.

It has been my experience that patients are sometimes reluctant to re-present, and may have the impression that once they have been discharged from the emergency department they should not return.

This may be due to the clinical condition or because of individual characteristics of the patient which may put them at a particularly high risk of complications.

Rather than instructing patients to “come back if you're not better”, it may be more helpful to provide patients (and family members) with clear advice about the likely course of the illness or injury recovery, and what specific clinical features to look out for that would indicate that the patient should re-present.

It has been my experience that patients are sometimes reluctant to re-present, and may have the impression that once they have been discharged from the emergency department they should not return. Patients don't have the same understanding as doctors that the clinical picture may change, and another medical review may be indicated, where the diagnosis may be clearer.

As always, communication is the key. This requires communication with your patient, their family members, and at times, a phone call to the patient's GP to facilitate discharge arrangements. Listening to their concerns, addressing their questions, and sharing your knowledge in the discharge planning will keep patients safer.

EDITOR'S COMMENTS

Please note this commentary, like all others published in the Future Leaders Communiqué, is the author's reflection on the topic and should not be construed as advice representative of their organisation.



IT'S NOT ALWAYS ABOUT THE JOB

Dr Shelly Jeffcott
BSc Hons. (York, Psych.),
PhD (Glasgow, Comp Sci.)

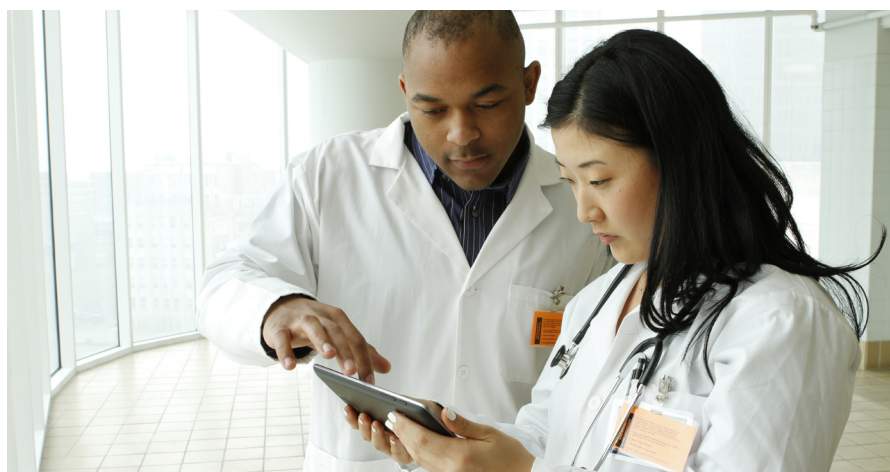
Strategy Implementation & Quality
Improvement Manager Scottish
Ambulance Service NHS Scotland

In a keynote presentation at the Institute of Healthcare Improvement's (IHI) Forum in December 2016, President Emeritus Don Berwick, described the need for us to move into what he called a moral era of healthcare. He recommended that the way we approach our day-to-day roles in the safe, effective and person-centred delivery of care to our patients shifts from "what do I do?" to "what am I part of?" and, when interacting with our patients, from "what is the matter?" to "what matters to you?" (Berwick, 2016).

The first question can remind those, particularly our newest doctors and managers in a system, to look beyond the scope of the setting that they work in toward the wider patient journey. Then we should be considering interdependencies between boundaries of care. What do the people taking over care for your discharged patient need to know and/or what do the family need to understand about potential deterioration of their symptoms and when and how they need to seek medical help again.

*Junior doctors
have a key patient
safety role as custodians
to these discharge
summaries.*

Discharge summary letters are notoriously devoid of important information. It is often the responsibility of junior doctors who have limited time, training and little understanding of the importance of the document. In an audit of 149 case notes in five UK hospitals, only 87 contained printed discharge summaries and 17% of those did not contain a diagnosis, 19% had no procedure, 21% had no follow-up arrangements and 75% provided the GP with no information on changes to medicines (Mann and Williams, 2003).



Junior doctors have a key patient safety role as custodians to these discharge summaries. Whether discharge summaries are done manually or are part of an electronic system, which would auto-populate from other hospital data systems and could be electronically transferred to help improve the timeliness of information transfer between care settings, there will always be the opportunity for free text to allow you to add in some narrative.

*It's not always
about the job you do then
and there, but what you are
part of across the wider
system of care.*

Could you ask what matters to your patient? Or ask their family member or someone who accompanied them? What is to stop you from adding a line to this effect or a verbatim patient comment like "I'm so sick I need to be in the hospital".

Informal comments from another professional may not be appropriate to record but this extra insight about how the patient was feeling in their own words could be a lifeline to another health care professional picking up the baton of care before it is too late. You may not be able to have your concerns addressed with senior clinicians or to influence discharge decisions determined by other pressures, but you still have the power to ensure that what goes in the discharge summary back to those caring for that patient in the community is as comprehensive as possible.

It's not always about the job you do then and there, but what you are part of across the wider system of care. And what matters to your patients should be something that matters to you when transferring their care and could be that extra safety net that makes the difference between life and death.

FURTHER READING

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