Communication of medication changes to primary care on discharge from the RVI Cardiology Department.

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Background

Clear and effective communication between hospitals and primary care is essential to ensure continuity of care for patients after discharge from hospital. Failure to communicate medication changes in a timely and effective manner risks causing harm to our patients. We aimed to quantify the percentage of medication changes communicated to primary care upon discharge.

Methods

Retrospective review of electronic records for patients admitted to Cardiology (RVI) between 12/01/20 and 20/01/20 (n = 36). Medication changes were identified by comparing *admission medications* and *discharge medications*. Percentage of medication changes communicated to primary care was quantified by reviewing discharge letters.

Results

In total there were 303 admission medications (avg. 8.4 per patient) and 371 discharge medications (avg. 10.3 per patient). We identified 183 medication changes (avg. 5.1 medication changes per patient). This included 112 new medications, 45 discontinued and 26 changes to dose/route/form.

53% of medication changes were documented in the discharge letter. 36% of medication changes had a documented indication or explanation for the change.

Discussion

This audit demonstrates poor communication of medication changes to primary care upon discharge from hospital, with inadequate documentation of indication or reason for change.

In response to these findings we implemented changes to junior doctor teaching, with updated guidance and additional pharmacy teaching for new and current foundation doctors. Furthermore we have initiated changes to the electronic patient record system to improve documentation of medication changes, and facilitate communication to primary care on discharge.