Medico-Legal Opinion

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Avoiding the pitfalls that arise at referral, discharge, and follow-up

***Ms Sile O'Dowd** looks at the challenges to effective communication between healthcare providers and changes to the continuity of care obligations introduced by the Medical Council*

Unfortunately, communication breakdowns in healthcare settings are not uncommon. There is a particular danger of them occurring when there is a transfer of patients from primary to secondary care or vice versa; or between departments/wards/teams in hospital, at the point of shift changes for staff or between on-call providers. It is no surprise that these communication breakdowns can lead to patients receiving unsafe or delayed care which can have a detrimental impact on a patient's outcome as well as the doctor/patient relationship.

In Medisec's experience, claims and/or complaints often arise as a result of miscommunication or delayed communication between primary and secondary care. In an analysis of more than 19,000 claims in the US over the period 2010-2019, our underwriter MedPro found that sub-optimal communication was second only to clinical judgement as the largest contributing factor in claims.

Key risk areas at the primary/secondary care interface

Several factors contribute to these communications breakdowns, including differing ways of working, IT systems, patient expectations, current workload pressures, and unprecedented demands on healthcare services.

The main areas of risk relating to sub-optimal communication between primary and secondary care are as follows:

1. Admission to hospital

Insufficient or sub-optimal information included in a referral can result in confusion as to the reason for, or urgency of, the referral. At the more serious end, it can result in inappropriate downgrading of urgent referrals. In 2011, HIQA published a report and recommendations on patient referrals from general practice. The report recognised that the inclusion of a specified level of information in referral letters helps ensure secondary care providers are fully informed and reduces the risk of inappropriate treatment/misdiagnosis. Guidance on a standardised referral form from GPs to secondary care is included in the report and has been widely adopted.

2. Medications

When patients are admitted to hospital, their medications may be altered. In a 2014 report, Medisec undertook a study identifying key areas of risk for GPs which included exploring the main risks arising from the interaction between hospitals, GPs and pharmacists at the points of a patient's admission to, and discharge from, hospital. Medication error was found to be the biggest risk highlighted among healthcare professionals. Errors can occur due to duplication, omission, or incorrect dosage, resulting in the patient experiencing an adverse event or suboptimal clinical management. The report recommended that to decrease the risk of medication error, electronic information sharing practices be synchronised across primary and secondary care. The recent publication of the *Digital for Care – A Digital Health Framework for Ireland 2024-2030* and the plan to introduce a national shared care record are welcomed initiatives to help reduce these risks. The framework references the ability of patients to move between different healthcare settings, confident in the knowledge that their information is being shared between the healthcare professionals that are treating them in each setting. It is envisioned this will lead to safer, better care.

3. Discharge from hospital

On discharge, problems can arise when a patient is not informed or does not remember or comprehend changes to their care, what actions are outstanding, follow-up plans and who is taking responsibility for these. Communication is a key facet of effective discharge planning. Before discharge, the hospital clinician should have a meaningful conversation with the patient to discuss their illness, future treatment plan, medications (including any necessary monitoring arrangements), and any subsequent follow-up appointments. In accordance with recent changes to the ninth edition of the Medical Council's *Guide to Professional Conduct and Ethics for Registered Medical Practitioners* (the 'Guide'), this should be followed by a timely and prompt discharge summary. The Guide is discussed further below.

4. Clinical governance of test results

When the patient is discharged from secondary care and there are still test results pending, there is a danger that they will "fall between two stools", ie, between two sectors of care, each sector assuming that the other has responsibility, with the potential for the patient to suffer harm.

Changes to obligations on referral, discharge, and transfer

The Guide came into operation from 1 January 2024.

While the previous edition of the Guide had sections on continuity and transfer of care, the updated Guide includes a number of new provisions under the 'Continuity of Care' heading in chapter 4. These provisions relate to obligations and responsibilities when patients are referred, discharged or transferred including the introduction of some absolute duties. The language and detail in the Guide are much more explicit, which should provide clarity from a patient safety point of view and from the perspective of practitioners understanding their duties and responsibilities.

The Guide defines continuity of care as *"the provision of healthcare in a coordinated manner with the involvement of different practitioners in different healthcare settings"*. It specifically identifies the movement of patients within and between primary, secondary, and tertiary care as having the potential to be high-risk for their safety if continuity of care is disrupted.

▶ Transfer of information

The Guide restates the position that it is in the best interests of patients to have the overall management of their care under the supervision of their GP. To that end, the Guide specifies that GPs should be informed, in a timely and prompt manner, of any treatment, referrals, and plans for care provision.

With inclusion of the words "you must", paragraph 33.2 now places an absolute duty to share all relevant information with colleagues in a prompt and timely manner when referring, delegating, or transferring the care of a patient, or discharging a patient.

▶ Obligations on discharge

Of particular note to hospital-based teams, there are new, clear obligations relating to discharging patients set out at paragraph 33.7 of the Guide as follows:

"Discharge of a patient from care must be accompanied by a timely and prompt discharge summary which includes at least the minimum basic information, including:

- *A summary of relevant medical and treatment history.*
- *Medication and medication changes.*
- *Any planned follow-up by the discharging service.*
- *Action required by primary care/community services (if involved).*
- *Action required by the receiving GP clearly documented."*

▶ Tests and investigations

In addition, paragraph 33.8 of the Guide now places a mandatory obligation on the doctor who orders diagnostic tests or investigations to follow up on the results to ensure these investigations have taken place, results are followed up and appropriate action taken, including communication to the patient's GP. This change confirms that responsibility to review any test results and take appropriate action lies with the requesting doctor or clinical team and removes any ambiguity about where responsibility lies.

Risk management tips

With the shifting focus toward collaborative and team-based care, coupled with pressures from unprecedented waiting lists and staff shortages, the need for consistent, accurate, and effective communication between healthcare providers is becoming even more challenging. The Medical Council has recognised these challenges with the clarifications provided in the Guide. Some risk management tips that can be adopted to assist optimal communication between teams and sectors include the following:

1. Standardise the communication between primary and secondary care at both referral and discharge, including as a minimum:

a. At referral

- Indication for referral.
- Past medical history.
- Current clinical status.
- Current medications and allergies.
- Results of any relevant investigations.
- Family history if relevant.

b. At discharge

- Diagnosis and treatment.
- Discharge medications, especially if changes have been made to a prior medication regime or if medication monitoring is required.
- Recommended follow-up and required monitoring.
- Engagement of other primary care services/community services, eg, public health nurse, physiotherapist, etc.
- Action required by the receiving GP clearly documented.
- Known and pending tests results.

In line with the obligations under the Guide, the discharge summary should be promptly sent to the GP, ideally via Healthlink or Healthmail, to ensure the information is transferred securely and in a timely manner. It is hoped that the introduction of a national shared care record in due course will allow this information to be readily accessible by all healthcare providers and alleviate the pressures of transmission.

2. Standardise communication with patient

At both referral and discharge, engage with the patient and discuss, using plain English, the nature of their illness, medication prescribed including any monitoring required, and follow-up including subsequent appointments to ensure they fully understand. It is important to make a note of these discussions in the patient's medical records.

3. Medication review

It is strongly advised that both primary and secondary care providers undertake a medication review for high-risk patients, eg, polypharmacy, at or following discharge to avoid medication errors such as omissions, duplication, dosing errors, or drug interactions.

4. Follow-up

Ensure all tests requested are followed up appropriately by the clinician who ordered the tests and the results communicated to the patient. With a large volume of referrals, discharges and follow-ups occurring between primary and secondary care, patient safety is dependent on healthcare organisations ensuring they have effective communication processes in place. While the burdens and pressures on healthcare setting can provide obstacles to good communication, the implementation of standardised referral and discharge forms, clarification on obligations and responsibilities on healthcare practitioners and the future introduction of a national shared care record are steps in the right direction.

References available on request