



## Good practices, project and research of Support for Informal Carers

<b>Name</b>	Quality Information for Patients on discharge from hospital/safe transfer of care
<b>Type of practice</b>	A tool which identifies the patient's ongoing care needs
<b>Summary</b>	Discharge summary is important in maintaining continuity of patient care from hospital to primary health-care setting, particularly for elderly patients with complex co-morbidities. Caring for Carers Ireland discharge summary project set out to improve the communication of discharge information between primary health care facilities and general practitioners through the design and implementation of a new discharge summary template and its subsequent evaluation over the next three years. The discharge summary form was paper-based. Post-implementation surveys of health providers and Carers revealed high satisfaction rate.
<b>City/country:</b>	Co. Clare, Ireland
<b>Aims:</b>	This project aims to provide patients with information on their ongoing care and treatment needs at the time of discharge from Hospital. It aims to enhance the safe transfer of care, improve communication, support equity of access and promote the integration of service provision. The provision of appropriate, comprehensive, high quality, accessible and timely information is one of the key elements of The Strategy, Quality and Fairness - A Health System for You <sup>1</sup> . The Discharge Summary promotes: <ul style="list-style-type: none"> <li>▪ Patient involvement in their own care</li> <li>▪ Enable shared family care</li> <li>▪ Promote patients understanding of own health status</li> <li>▪ Enhance understanding and compliance with care and treatment programme</li> <li>▪ Support Communication and Integration of hospital and community services.</li> </ul>
<b>Approach / method, activities, phasing:</b>	Literature review / review of documentation in use Collaboration with key stakeholders including patients and their family carers Plan, Design and Pilot Patient Discharge Summary in four Community Hospitals
<b>Additional information:</b>	The patient Discharge summary/safe transfer of care documentation includes the following patient: Nurse- Functional assessment, available supports, recommended paramedical support, signature & date; Physician- General Practitioner's details, completed drug allergies, physical examination, significant laboratory tests and results, social history, discharge diagnosis, discharge medications, signature & date. (see attached)
<b>Distinguishing characteristics:</b>	The Discharge summary remains the property of the patient, which may be shared with the Family Carer. Provision of written information to patient, Community Nurse, General Practitioner & retention of copy by hospital at point of discharge from hospital. The same information is provided to each stakeholder.
<b>Factor(s) of success</b>	The advantages of providing written information to the patient means that a patient can read and re-read the details away from the distraction and anxiety of the hospital. Acceptance by all stakeholders of this involvement in extended care / safe transfer of care may act as a catalyst for further change. Ownership of the project by all stakeholders developed over time.
<b>Bottle neck(s)</b>	In principal endorsement, rather than strong active endorsement from Executive members of the Health Service Executive, In principal support rather than strong, active support from senior medical staff, As a paper-based system is time consuming & not the most appropriate for data storage or updating, the delay in implementation of a user friendly fully

	integrated hospital information system that allows a hard copy to be given to the patient as well as an e-document to be transmitted securely to the GP's surgery has limited the scope of this pilot project.
<b>Results</b>	Strong endorsement of this service by patients & Family Carers. Carers value direct contact with hospital staff to discuss both admission & discharge of care recipient, Consistently positive response from GP's to the introduction of a system which facilitates prompt notification of discharge & a succinct, comprehensive discharge summary of patients with complex needs. Staff responded positively regarding the importance of good communication with Carers involved in patient care at discharge, It is acknowledged that improving the quality of discharge procedure is time intensive, Staff training and support is required to improve and maintain the improvements in standards in the quality of discharge process.
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<b>Internet address of good practice (if available):</b>	bbarron@caringforcarers.org
<b>Target groups:</b>	Family Carers and those for whom they care. Recipients of long term care in the community
<b>Products:</b>	Patient Discharge Summary/Safe Transfer of Care document
<b>Financier / sponsor:</b>	Caring for Carers; Health Service Executive, Mid-Western Region, Ireland.
<b>Good practice is organised in cooperation with these other organisations:</b>	Consultant Geriatricians / Hospital Consultants Hospital Management Committee Nurse Managers Director of Services for Older People Public Health Nurses General Practitioners Patients and Family Carers Representatives of Caring for Carers Ireland
<b>Range (locally, regionally, nationally):</b>	Locally/regionally Presented at National Conference of Irish Society for Quality & Service in Health Care 2005 (ISQHA)
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<b>Key words:</b>	Patient discharge summary; continuity of care; family carer; Caring for Carers Ireland; safe transfer of care; integration of service provision; HSE