

## Discharge Summary Re-Audit – 2025

### Objective:

To reaudit Inpatient Unit discharge summaries

### Methods:

All discharges from the inpatient unit from March 1<sup>st</sup> to April 25<sup>th</sup> 2025 were included. Data was collected from EMIS.

Standards were based on the SIGN discharge document template and recommendations from previous discharge summary audits (2019 and 2021)

### Results:

Nine discharges were audited. Eight of these had discharge summaries.

Standard	Patient ID	GP ID	Consultant ID	Ward/dept	Date of Admission	Date of Discharge	Diagnosis	Reason for admission	PMH	Clinical progress	Allergies	Medication stop/start/review	FU	Action for GP	ACP
<b>N=8</b>	8	8	1	7	7	6	8	8	7	8	8	7	8	6	8

The majority of summaries were well written and included all relevant sections including actions for GP when appropriate.

One discharge did not have a summary. This was a complex admission who was transferred to hospital twice but not readmitted to the hospice on the final transfer, however there was apparently no written communication with the GP.

One summary included an incorrect date of admission and discharge. Three summaries had less well written clinical progress sections which did not fully address all aspects of the admission.

Some of the summaries had reordered the structure of the template which made the letter less easy to read. One letter had the date of admission and discharge moved to below the main body of text, and four summaries had included actions for GP in the main text rather than within the designated “Actions for GP section”.

**Recommendations:**

- Clarification is needed of the process for completing discharge summaries when patients are transferred to hospital and not subsequently readmitted to the hospice. We should consider sending the GP a copy of the transfer letter as well as a discharge summary to ensure accurate information sharing.
- All patients should receive a copy of their discharge summary. In practice, a hard copy may be provided to the patient on discharge but this information is not currently captured– this was also highlighted in the 2021 audit.
- The team should consider writing the discharge summary directly to the patient with copies to the GP and other relevant clinical teams. This was also recommended in the 2021 audit. This approach is considered to improve accessibility for patients and is widely endorsed within the NHS.
- Consider senior clinical review of discharge summaries to ensure quality and accuracy. Senior oversight and inclusion of the responsible consultant name is recommended in the SIGN discharge summary template.
- Ensure the template structure is followed so that the discharge summary is quick and easy to read.