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'DISCHARGE LETTER QUALITY; HOW TO HELP BOTH JUNIOR DOCTORS AND GPS?'

Editor,

Discharge letters are an important communication enabling the safe transfer of a patient from secondary to primary care. Research has shown that many junior doctors feel inadequately trained in the process of writing discharge letters[1]. The authors of this work noted a wide variation in how long it took junior doctors to complete letters. A survey of UK GPs noted that they too are unhappy with the standard of letters they receive. They highlight accuracy, clarity and timeliness of receiving letters as causes for concern [2]. This team has completed a quality improvement project aiming to reduce time spent writing discharge letters and improve their clarity.

METHODS

Baseline data was collected on how long it took 4 junior doctors to complete 1 weeks-worth of discharge letters working across 4 medical wards of the Ulster Hospital, Northern Ireland in January 2017. Two complete Deming 'plan-do-study-act' (PDSA) cycles were then performed. In cycle 1 (March 2017) an educational intervention was introduced to the 4 junior doctors. This consisted of a 1-hour teaching session by medical consultants, with GP input on how to write an efficient and effective discharge letter. In cycle 2 (August-October 2017), an educational intervention was delivered by one of the original junior doctors to all incoming junior doctors to Northern Ireland at their regional induction day.

RESULTS

Baseline data showed that the mean time taken to complete 31 discharge letters was 25.9 minutes, with a range of 58 minutes (*Table 1*). After cycle 1, mean time spent completing 43 discharge letters fell by 43.2% ($p<0.001$) to 14.7 minutes, with a range of 25 minutes. GP and consultant feedback indicated that letters written after education had increased clarity. After cycle 2, mean time completing 34 letters was 21 minutes, with a range of 31 minutes. This is a 19% reduction relative to baseline ($p<0.05$).

TABLE 1.

Time taken to complete discharge letters over a one-week period by four junior doctors at baseline and after PDSA cycle one and two educational interventions.

	Baseline Data	PDSA 1	PDSA 2
Mean Time (min)	25.9	14.7	21
Median Time (min)	24	15	21
Range (min)	58	25	31

DISCUSSION

Over the course of a typical week, the change brought about through PDSA cycle 1 could save a junior doctor 2 hours and 45 minutes. This could free doctors to increase exposure to other facets of healthcare provision and training opportunities. Despite our findings and evidence showing that small group based teaching sessions provided to junior doctors can improve the speed of completion and quality of discharge letters, many medical schools do not incorporate extensive teaching[3]. Cycle 2, which increases the scale and sustainability of our project reduced time spent completing discharge letters, but was not as effective as cycle 1.

Discussion with local GPs revealed that they receive large volumes of letters and examination results from secondary and tertiary care centres each day. This team proposes the introduction of educational sessions to junior doctors focussing on how to complete efficient and effective discharge letters to improve clarity of communication and decrease time spent on letter composition.

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POINT OF DECISION PROMPTS AND SIGNPOSTING FOOTPRINTS IMPROVE STAIR USE IN A UK CITY CENTRE OFFICE

Editor,

Physical inactivity is a public health priority, with sedentary behaviour and lack of physical movement major contributory factors to serious illness, including coronary heart disease (CHD), stroke, Type 2 diabetes and breast and bowel cancer

(1). Small bouts of physical activity may be an effective way to reach recommended physical activity levels (2). Stair use is easily integrated into daily activities and associated with health benefits (3). We compared upward and downward stair and elevator journeys before and after the introduction of a multicomponent intervention consisting of point-of-decision prompts (PODPs) and signposting footprints at a city centre office in Northern Ireland.

Fig 1. Example of Point of Decision Prompt (PODP) used above elevator call buttons.

Using a before-and-after study design, measurement of people using the elevator and stairs originating or terminating on the ground floor were made for a period of a working day (9 hours 10 minutes) over three days (Monday 8am-1pm, Thursday 1pm-3pm and Tuesday 3pm-5.10pm) during a typical working week prior to the intervention. Measurements were repeated under identical circumstances four weeks and six months after introduction of the intervention. The setting was a six-story office building in the city centre of Belfast, Northern Ireland. Seven PODPs with simple messages, bright colours and bold text were designed and placed 10cm above the two elevator call buttons on each floor (Figure 1). Green footprints with a "Take the Stairs" message were stuck to the floor and stairwell entry door to increase visibility of the stairs and direct staff to take the stairs (Figure 2). Absolute and relative differences between pre-and post-intervention elevator and stair use were determined and chi-squared tests used to test for significant differences.

There were 6383 total observations, 2205 prior to intervention and 2179 four weeks post-intervention and 1999 six months post-intervention. Total stair journeys increased significantly from 16.6% to 30.2% (82% relative, 14% absolute increase, $p<0.0001$) four weeks post-intervention and remained significantly higher at 29.2% six months post intervention (77% relative, 13% absolute increase, $p<0.0001$). There was no significant reduction in total stair journeys between four weeks (30.2%) and six months post intervention (29.2%) ($p = 0.49$). Staff were over twice as likely to use the stairs four weeks after the intervention (Odds Ratio total journeys 2.2 [1.9 -2.5]) and six months after the intervention (Odds Ratio total journeys 2.1 [1.8 - 2.4]) compared to pre-intervention.

Fig 2. Signposting footprints used on the floor and stairwell door.

Most previous studies on interventions to increase stair use in workplaces involve PODPs alone with stair climbing increasing between 0.3% and 10.6% following introduction

(4). There are few studies of multicomponent interventions involving motivational POPDs and directional signs (e.g. footprints) in UK workplaces. We found a simple, inexpensive multicomponent intervention comprising motivational PODPs and floor-based directional footprints produced significant increases in stair use in a UK office building. The relative increase (82%) was much greater, and the absolute increase similar (11.8%), to previous studies (2). Journeys were over twice as likely to be taken using the stairs post-intervention. This simple effective intervention has potential for use in other buildings.

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Competing interests: None.

Ethical Approval: This study did not require Research Ethics Committee approval as it was an evaluation of a service change. We reached this decision using the Health Research Authority decision aid (http://www.hra-decisiontools.org.uk/research/). We assessed that we did not need to obtain informed consent because we did not collect any identifiable information about individuals. The study was approved by the Public Health Agency Staff Health and Wellbeing Group and the Public Health Agency Management Team, which provided corporate oversight and governance.

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PATIENT SAFETY INCIDENTS AMONG FOUNDATION DOCTORS

Editor,

Unfortunately, patient safety incidents (PSI) occur in our complex health care systems. These can have a negative effect both on the patient and the doctor involved. [1,2] Apart from the usual feeling of guilt, doctors also experience problems with job satisfaction, their relationship with colleagues, depression, inability to sleep, fear of going to work and low self-esteem. [3,4] There is limited data on the extent of this problem, especially among junior doctors. Getting support after errors may be difficult for senior physicians, let alone for junior ones. There is data to suggest that discussing such events with supervisors giving constructive criticism leads to better doctor outcomes. [5]

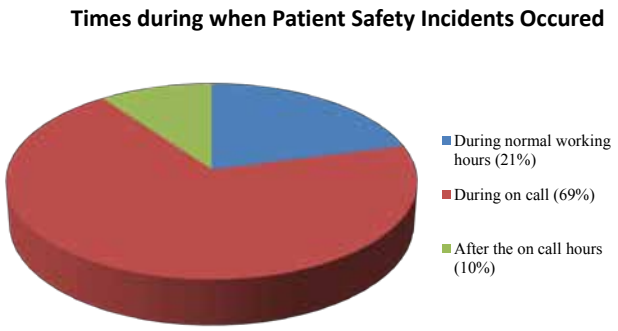

Fig 1. Time of PSI occurrence

The aims of our study were to determine how often foundation doctors are involved in PSIs and which are the most common incidents. An anonymous online questionnaire was distributed amongst Foundation Doctors working within the Malta and Severn (UK) Foundation schools, and 140 doctors completed the survey. There were no differences in the results between the 2 schools. Involvement in at least 1 PSI occurred in 58.5% of doctors. The remainder, (41.5%) claimed that they were never involved in such an event.

In most cases (48.9%), the PSI was identified by the doctor performing it. Doctors expressed different reactions after such events including; concern about the patient's health (25.6%), need for self-improvement (24.2%), disappointment (17%), shame (13.5%), guilt (12.5%) and desire to quit (4.9%). Only 1.35% did not demonstrate any apparent concern. The time of occurrence (Figure 1) and the type of PSI`s (Figure 1) are demonstrated below.

In terms of learning events, 31.2% noted the importance of good communication between doctors and patients, re-confirming patient identity prior to any intervention (27.7%), the need to give more attention to clinical practice guidelines (22%), re-check drug allergies (9.9%) and check blood results thoroughly (9.2%).

In 80.8% of PSI`s, doctors claimed there were no patient consequences. The rest did not give any answer. They considered fatigue (57.7%), time restriction (49%), doctor