



Patient Safety Alert

Stage One: Warning

Risks arising from breakdown and failure to act on communication during handover at the time of discharge from secondary care

29 August 2014

Alert reference number: NHS/PSAW/2014/014

Alert stage: One - Warning

Between October 2012 and September 2013 there were around 10,000 reports to the National Reporting and Learning System (NRLS) of patient safety incidents related to discharge. The handover of patients when discharged from secondary to primary, community and social care is a complicated and multifactorial process.

Communication at handover is identified as a particular area of risk and accounted for approximately 33% of the 10,000 incidents reported to the NRLS. Review of these incidents identified that patients are sometimes discharged without adequate and timely communication of essential information at point of handover to all relevant staff and teams in primary and social care, including out of hours, and that information is not always acted on in a timely manner. This can result in avoidable death and serious harm to patients due to a failure in continuity of care as well as avoidable readmission to secondary care. An example incident states:

'Continuing Care Team (CCT) received hospital discharge fax to provide daily wound care for a patient who was being discharged after a long inpatient stay with a right groin biopsy wound. Patient [was however being] discharged after long inpatient stay with end stage fibrocystic lung disease. There was no mention on the fax that the patient was for end of life care. There was very poor communication from the ward and medical team to the GP and CCT at time of discharge and no end of life drugs, DNRCPR or referral for community end of life care.'

NHS England is leading a national programme of work to support organisations in improving the communication and management of information at handover by building on successful local and national initiatives already in place. This Stage 1 Alert is asking organisations to help form a national picture by informing us of their current practice and challenges and by sharing examples of what they have done to improve the quality and timeliness of communication with primary and social care on discharge. This includes GPs, community nurses, social care, voluntary sector and medicines reconciliation; and initiatives may include system design, policy, strategy and handover tools. To collect the required information local sector specific questionnaires and a best practice template have been developed.

Information received through the questionnaires and best practice template will be used to inform a subsequent Stage 2 Alert (Resource), which will provide a range of resources and recommendations to support organisations in improving safety of handover at discharge at a local level.

NHS England will also build a web-based best practice resource and are collaborating with local and national experts and enthusiasts in the field to provide series of webinars to facilitate system wide learning on this subject. Staff can sign up for these webinars at the [Patient Safety First website](#).

Actions

Who: All NHS organisations, other providers of NHS funded care and social care sector

When: To commence immediately and be completed by 13 October 2014



1 Identify any work that your organisation is undertaking or has undertaken to ensure that communication during handover at time of discharge is safe and timely, including medicine reconciliation, which could benefit other organisations and share via the [online template](#).



2 Identify a person within your organisation to be the link with NHS England on this programme of work and email their contact details to patientsafety.enquiries@nhs.net. They will be contacted about forthcoming discharge webinars



3 Complete the anonymous online questionnaire(s) relevant to your sector to inform the identification of national priorities for safety improvement relating to communication during handover at time of discharge [here](#).



4 Share this alert with the main voluntary sector organisations that you work in partnership with on discharge and invite them to access the resources accessible on the [Patient Safety First website](#).

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Technical notes

Search strategies for similar incidents

The NRLS was searched for all incidents reported as death and severe harm, themed as transfer/discharge incidents. All moderate, low harm and no harm incidents coded as transfer/discharge and/or discharge delay/failure, discharge inappropriate and discharge planning failure were also identified.

Two separate reviews of data were subsequently undertaken for:

- all care settings other than mental health; and
- mental health.

You can see the review of National Reporting and Learning System (NRLS) incident data relating to discharge from acute and mental health trusts by clicking [here](#).

Stakeholder engagement

The Patient Safety Alert was developed with advice from the the NHS England Primary Care Patient Safety Expert Group (see www.england.nhs.uk/patientsafety for membership details) and support from other patient safety expert groups, as well as the NHS England Patient Safety Steering Group.