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Lessons from the TAPS study

Communication failures between hospitals and general practices

The Threats to Australian Patient Safety (TAPS) study collected 648 anonymous reports about threats to patient safety from a representative random sample of Australian general practitioners. These contained any events the GPs felt should not have happened and would not want to happen again, regardless of who was at fault or the outcome of the event. This series of articles presents clinical lessons resulting from the TAPS study.

Clinical lesson

There is nothing new about GPs expressing concerns about inadequate access to patient information related to episodes of hospital care. General practice must continue to advocate for access to adequate, accurate, legible and timely patient discharge reports, accurate medication lists, results of investigations, and reports on attendances to hospital emergency departments. General practitioners should be involved in management and discharge planning during their patients' hospital admissions. Shared electronic health summaries may improve information sharing between hospitals, GPs and patients.

Case study

A woman, 61 years of age, was transferred from a teaching hospital to a nursing home where she was to be under the care of her local GP. The patient had suffered a cardiac arrest and subsequent hypoxic brain injury, and now was in a semiconscious state with a Glasgow Coma Scale (GCS) of five, and with a tracheostomy and peg tube in place. She had been in the teaching hospital for 4 months. On discharge, the hospital staff had sent the nursing home a medication list and a seven word discharge summary of the patient's 4 month admission: 'anoxic brain injury secondary to VF arrest'.

The manager of the nursing home had been asked to see the patient before discharge to assess if the nursing home could manage her care. The manager recalled that the patient had been on insulin when seen in hospital. The patient had not been known to have diabetes before admission, there was no mention of diabetes in the discharge summary, and insulin was not included on the list of medications. The registrar who had been responsible for the patient's care in the teaching hospital was contacted and confirmed that the patient had been commenced on insulin while an inpatient at the teaching hospital.

A revised medication list was faxed to the nursing home with insulin added.

Comment

This report illustrates the need for hospital discharge information to be accurate and comprehensive enough to allow the safe, continuing care of individual patients when they are discharged to the care of their GP or other health care provider.

Fifteen percent of all error reports in the TAPS study related to hospital care.[1] Problems with hospital discharge information and communication problems between emergency departments and general practitioners were major features of these error reports. These reports illustrate the risks to our patients when they cross 'boundaries' in our health care systems. It is not acceptable that such risks to patient safety continue in an era of improved communication and information technology.

Errors in communication between hospitals and general practice

Communication failures were a feature of 19% of the TAPS reports relating to errors in the processes of health care.[2] Close to half of these reports related to hospital discharge and other hospital based communication errors (*Table 1*).

Recent studies in Canada, Germany and the United Kingdom have consistently reported that hospital-GP communication is a significant safety problem.[3–5] The Australian Critical Incidents study provided a case report that highlighted an incident in GP communication with a hospital emergency department and called for better integration of communication between hospitals and general practices.[6] Failure to provide appropriate and timely discharge information to GPs is a longstanding and fundamental flaw in our health care system.[7]

Table 1. Major errors in communication between hospitals and general practices reported by GPs

- Lack of discharge summaries
- Poorly written or illegible discharge summaries
- Incorrect information contained in discharge summaries
- Lack of notification of the GP after an emergency department attendance by a patient
- Lack of a medication list following patient discharge from hospital
- Difficulties related to communication between GPs and emergency departments about requests to assess critically ill patients
- Difficulties obtaining important clinical information from a patient's GP
- Difficulties in GPs accessing information about investigations or procedures
- Problems with hospital staff expectations of postdischarge care, such as unrealistic instructions about pathology follow up (eg. hospital staff expecting INR testing to be available in the community on a Sunday)

The TAPS data is based on reports by GPs, not hospital staff. While the TAPS reports may not reflect problems that hospital staff experience when trying to communicate with GPs, they do provide a rich perspective on many of the communication difficulties encountered with hospital staff from the perspective of GPs.

An individual GP may feel powerless to overcome the process errors that are associated with the workings of large hospitals. Technology now exists to minimise threats to patient safety through the use of information technology and improved communication between hospitals and general practices. However, use of this technology is not yet a consistent feature of much of our health care system.

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