# Shared Learning in Suffolk

## Type of Event:

Medication

**Event:**
Provider became aware of a systemic issue with inaccuracies around medication information contained within some of its discharge summaries. The issues related to summaries that were created and sent within an electronic patient administration system, which the Trust had recently implemented. When prescribers do not follow the designed workflow, errors can emerge in the documentation at discharge i.e. medications might not show up in the right box of the discharge summary. A combination of technical issues may result in incomplete or inaccurate information being recorded in the discharge summary that is communicated to the General Practitioner (GP) and the patient at discharge. Further issues were identified around information pulling through from future encounters into historical summary information and inability to correct an error if a historic medication is shown, as stopped by mistake.

## Notable Practice:

- Engagement and involvement with GP's throughout the project
- Evidence suggests effective collaboration and working between the integration specialists and the Trust project team
- The appearance of the discharge summary will be significantly improved

## Improvement:

- Early engagement with all affected stakeholders around the design of the workflows
- Silo working of the teams did not facilitate and end to end understanding of the design and workflows
- Ensuring that the team have the appropriate place to raise concerns

## Learning:

As a result of this incident the following improvements have been made:

- A structured Programme and Project approach model using the APM Prince 2 methodology be developed for use in all future GDE projects
- Review the current system for the central capture, recording, escalation and reporting of concerns both internally and externally
- Implement a permanent GP liaison officer or function
- Develop a suitable environment for staff to use as a safe system for practice