Joe's Story

The hospital has discharged Joe and told him to see his GP that day. The GP is unable to get any written records from the hospital—or even any details over the phone.

Joe had made an appointment at a busy general practice on a Friday afternoon.

Joe had been admitted to hospital four days prior with a transient ischaemic attack (TIA), and though he had no residual effects, he had been put on twice daily (anticoagulant) clexane injections. He had been given a box of ten to take home and told to continue with them until he received notification of his outpatient appointment. He had been discharged from hospital in the morning and told to see his GP that day to ensure he was given his injections.

The GP saw Joe. There had been no notification of admission or discharge from the hospital. Luckily Joe had brought the box of clexane with him, and the GP was able to identify which "injections" Joe was referring to. The practice nurse contacted the hospital in order to obtain Joe's file notes and treatment plan. She was advised by the ward that these had been sent to medical records, yet medical records had no record of them. The acute care nurse (that the practice nurse spoke to) was unable to assist because she "had not looked after Joe during his stay".

The decision was made to ensure Joe received his twice-daily clexane and to follow up with more information on Monday. The GP realised that due to Joe's arthritic hands he would not be able to administer his own injections, and his partner was unwilling. The practice nurse was called and charged with the task of ensuring Joe was referred to community nursing. The referral documentation was completed and sent urgently and the practice nurse also followed up with a phone call that afternoon. The referral agency advised that they would send the referral to community nursing but couldn't guarantee service over the weekend due to the lateness of the referral.

The practice nurse, concerned about the importance of this treatment, contacted the community nursing service, who were not aware of the referral (it was found near the fax machine). The community nurse appreciated the urgency of the referral and assured the practice nurse that the clexane injections would be given over the weekend.

On Monday, after the morning rush, the practice nurse contacted the outpatient clinic on Joe's behalf to chase up his appointment and to find out how long he required the clexane injections. They advised that he had failed to turn up at an appointment that morning at 9 a.m. His file had been returned to medical records, and it would be up to Joe to make another appointment.

When the practice nurse rang Joe, neither he nor his partner knew about the appointment. No discharge summary had been received by the GP. Joe had to wait another week for an appointment and had to return to the GP for another script for clexane. The practice nurse had to call medical records and obtain the latest pathology results.

A discharge summary arrived later that week, stating that Joe had been admitted with TIA, and "discharged to his home residence". There was no mention of medications or the intention to follow up in the outpatient clinic.

Can we do better?

A less diligent—or more overworked—practice nurse might not have checked that the community nurse had received the referral. How can we ensure that communication to health providers has been received?

How can we improve the sharing of hospital records with those who need this information?