Audit Ref: 110/97-8

PORTSMOUTH HealthCare NHS TRUST

Re-audit of Use of Benzodiazepines & Night Sedation in Elderly Mental Health

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April - September 1997

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AUDIT SUMMARY

Aims and objectives of audit

This was a re-audit (cycle 3) of an initial audit carried out in 1995-6. As with the original two audits, this re-audit sought to examine the processes surrounding the prescribing of benzodiazepines and of night sedation in Elderly Mental Health (EMH). The re-audit examined whether use of these medications was reviewed on admission, whether the reason for prescribing them was documented if commenced during the admission, whether prescriptions of these medications were reviewed prior to discharge, and whether all changes in drug type or dose were clearly communicated to the patient's GP. Standards were taken by direct reference to current and previous medical literature.

Methodology

Data was gathered by examining 50 sets of case notes of patients discharged since April 1997, from either Mulberry A ward (functional problems) or Mulberry C ward (organic problems).

Results

Completion of the audit revealed the following:

1) Medical staff are generally failing to document the review of benzodiazepine/night sedation prescriptions at the first ward round (audit finding 25%).

2) Medical staff are frequently failing to record in the medical notes any new prescriptions of benzodiazepines/night sedation, or the reason for these prescriptions (audit finding 53%).

3) At the patient's last ward round before discharge, medical staff are not consistently documenting whether to continue or discontinue prescriptions of benzodiazepines/night sedation, neither are they recording who has responsibility to review the prescriptions following discharge (audit finding 14%).

4) Medical staff are not recording in the discharge summary the required information about benzodiazepines/night sedation, i.e. whether patient is taking them, whether this is expected to be short or long-term, or who is responsible for monitoring this (audit finding 21%).

Recommended action

Recommended action includes the following:

1) Following the realisation that standard 1 is inappropriate, the time scale of the standard was adjusted from "at the first ward round" to "at some time during the admission."
2) Duty doctors to be requested to only prescribe between one and two doses of night sedation when requested out of hours.
3) Nursing staff at night requesting night sedation for a patient to be asked to hand this over to colleagues on day shift to be discussed with ward doctor during working hours. Decision to then be made and recorded in medical and nursing notes as to appropriateness of regular or PRN night sedation.
4) Consideration to be given to a system that ensures accurate recording of essential information without having to duplicate information for both final ward round and discharge summary. This may involve the adoption of a district-wide, standardised discharge summary to be completed at each patient's last ward round prior to discharge.

1) ACKNOWLEDGEMENTS

Gosport War Memorial Hospital
EMH secretaries.
Ward staff of Mulberry Ward and Phoenix Day Hospital.
CPNs at Phoenix Day Hospital.

St Christopher's Hospital, Fareham
EMH secretaries.
CPNs at Ashwood.
Staff of Cedarwood Day Hospital.

2) INTRODUCTION

i) Objectives

The audit objectives were to ensure that:

1) On admission, use of benzodiazepines/night sedation is reviewed.
2) If commenced during admission, reasons why appropriate are clearly documented.
3) All above prescriptions are reviewed prior to discharge.
4) All changes are clearly communicated to GP.

Rationale

In view of the wide ranging effects of benzodiazepines and the frequency of night sedation in the elderly, often as a repeat prescription, admission to hospital is an ideal time to review this. It is also essential for the service to monitor their own prescriptions of these medications and to ensure that they do not become regular prescriptions by default.

An initial audit carried out by the clinical leader from December 1995 to March 1996 revealed mixed results for Mulberry A Ward and very poor results for Mulberry C Ward. The clinical leader then carried a re-audit 2 months later (May to June 1996). Results showed some improvement in Mulberry C ward, but results were still poor overall for both wards. A second re-audit was therefore considered appropriate 10-12 months later.

ii) Standards source

Standards were formulated and agreed by local consensus among the Consultants in Old Age Psychiatry for Portsmouth HealthCare NHS Trust, taking account of current research literature. The literature search carried out revealed several research articles that influenced the nature of the standards devised. In particular, Hallstrom (1981) commented on the risk of a withdrawal syndrome following discontinuation of benzodiazepines, whilst Spencer (1991) has noted the presence of psychotic symptoms in some elderly people taking benzodiazepines. Closser (1991) has stated that: "review of the literature leads to the conclusion that benzodiazepine prescribing for the elderly should be undertaken with the greatest caution and only with the recognition of all potentially disastrous effects" (Closser, 1991, p. 35). These include dependence, withdrawal, and cognitive and psychomotor impairment, all of

which are proportionally greater in the elderly. There are also studies suggesting that the cognitive deficits may persist after withdrawal of long term benzodiazepines (Tata et al, 1994).

iii) Relevance to the service

It is clearly important for elderly people to have regular reviews of any medications they may be taking in order to ensure that:

a) the medications are still appropriate;
b) any potential side effects can be monitored and treated.

iv) Participating services

None.

3) METHODOLOGY

a) Sample type and size

It was intended that the sample comprise 50 consecutive discharges from Mulberry A and C Wards from April 1997. Some sets of case notes, however, were not available at the time of audit. It was therefore decided to audit chronologically from April 1997 until 50 sets of notes had been examined. The final time period covered was of discharges occurring from April to August 1997.

b) Data collection method

Data collection involved the retrieval and examination of case notes by the clinical auditor from their various locations in Trust premises at Fareham and Gosport. The required information was recorded on a data collection sheet (see Appendix 2).

c) Accessibility of case notes

13 sets of case notes were consistently unavailable for examination, in spite of several visits by the clinical auditor to the relevant Trust premises concerned.

BACKGROUND INFORMATION

DIAGNOSES

Dementia:	23
Depression:	19
Alcohol abuse:	2
Chronic schizophrenia:	2
Wernicke Korsakoff:	1
Deliberate self harm:	1
Delusional disorder:	1
Acute psychotic episode:	1

Patients taking benzodiazepines and/or night sedation on admission:	13
Patients not taking benzodiazepines and/or night sedation on admission:	37

Breakdown of benzodiazepines/night sedation taken on admission

Temazepam:	6
Welldorm:	2
Nitrazepam:	1
Triclofos:	1
Lorazepam:	1
Zolpidem:	1
Sleeping pills from GP (not known which type):	1

Patients taking benzodiazepines and/or night sedation on discharge:	16
Patients not taking benzodiazepines and/or night sedation on discharge:	34

Breakdown of benzodiazepines/night sedation taken on discharge

Temazepam:	5
Chloral Hydrate:	3
Triclofos:	3
Temazepam + Librium:	1
Chloral Betaine:	1
Nitrazepam:	1
Welldorm:	1
Not known (discharged to Haslar):	1

4) RESULTS AND ACTION PLAN

As with the two previous audits on this topic, the results for all four standards have been split to show the audit findings for Mulberry A and for Mulberry C separately.

Mulberry A caters for elderly patients with functional problems (e.g. depression).
Mulberry C caters for elderly patients with organic problems (e.g. dementia).

Standard 1

Aspect
At the first ward round, all benzodiazepines/night sedation prescriptions will be reviewed. The decision to continue or discontinue will be clearly documented in the medical notes.

Expected standard: *100%.*

Exceptions: *None.*

Audit findings
11 patients were taking an overall total of 12 regular or PRN benzodiazepine or night sedation prescriptions on admission (one patient was taking both a benzodiazepine and a night sedation). Sample size therefore 12.

i) benzodiazepines/night sedation reviewed

Mulberry A		Mulberry C	
Standard met:	2/8 (25%)	Standard met:	1/4 (25%)
Standard not met:	6/8 (75%)	Standard not met:	3/4 (75%)

Overall result	
Standard met:	3/12 (25%)
Standard not met:	9/12 (75%)

ii) decision to continue or discontinue documented in medical notes

Mulberry A		Mulberry C	
Standard met:	2/8 (25%)	Standard met:	1/4 (25%)
Standard not met:	6/8 (75%)	Standard not met:	3/4 (75%)

Overall result	
Standard met:	3/12 (25%)
Standard not met:	9/12 (75%)

Discussion

There have now been 3 cycles completed in this audit. Cycle 1 provided a baseline of the current clinical practice at that time and indicated that standard 1 was not being met (looking at Mulberry A and C together it was met in 60%). Discussion was held with all medical staff in the relevant teams, where there was agreement that this was an important standard. This was because a significant proportion of our patients on admission were already receiving benzodiazepines and this was therefore an important opportunity to review them. All medical staff therefore agreed to work towards meeting the standard.

Cycle 2 was undertaken 6 months later to determine whether the raising of medical staff awareness had produced the improvement in this. The results were, however, disappointing in that they showed a deterioration with the standard being met in only 50% of cases.

Clearly the raising of staff awareness was not sufficient. It was therefore agreed that the responsibility for this review should be with the consultant at the first ward round, and to facilitate this the above requirement would be included in the "Guidelines for documentation in the medical notes at the first and last ward round." These guidelines are communicated to all new medical staff and are posted on the walls of the rooms where reviews take place. Therefore this standard was modified and re-audited in the current cycle.

The results show a further deterioration to 18%. This was discussed at length among the consultant body, who felt that given the importance of reviewing these prescriptions there must be a system in place that is both practical and reliable. Overall it was felt that the review must take place at some time during the admission, but there was no clear clinical reason why this must be at the first ward round - and may indeed be more appropriate prior to discharge when plans for future management are being formulated. Given that we were expecting all prescriptions of benzodiazepines/night sedation to be reviewed prior to discharge in standards 3 and 4, this would include those commenced prior to admission. As a consequence the wording of this standard was modified and efforts directed at introducing a system that guarantees, as far as possible, that standards 3 and 4 are met.

ACTION PLAN

Action to be implemented

The wording of this standard will be changed to read:

"All benzodiazepine/night sedation prescriptions will be reviewed either 3 months after admission or prior to discharge (whichever is the sooner). The decision to continue or discontinue will be clearly documented in the medical notes."

Person(s) responsible: EMH consultants.

Implementation date: February 1998.

STANDARD 2

Aspect
If benzodiazepines/night sedation are commenced during the admission, this will be documented in the medical notes with reasons.

Expected standard: *100%*

Exceptions: *None.*

Audit findings

15 patients were prescribed benzodiazepines and/or night sedation during their admission.
2 of these 15 patients were prescribed benzodiazepines and night sedation.

Sample size therefore 17 (one for every prescription).

i) Documentation of prescription in medical notes

Mulberry A		Mulberry C	
Standard met:	9/15 (60%)	Standard met:	0/2 (0%)
Standard not met:	6/15 (40%)	Standard not met:	2/2 (100%)

Overall result	
Standard met:	9/17 (53%)
Standard not met:	8/17 (47%)

ii) Reason given for prescription in medical notes

Mulberry A		Mulberry C	
Standard met:	9/15 (60%)	Standard met:	0/2 (0%)
Standard not met:	6/15 (40%)	Standard not met:	2/2 (100%)

Overall result	
Standard met:	9/17 (53%)
Standard not met:	8/17 (47%).

Overall findings (i.e. where prescription both recorded and reason for it documented)

Standard met:	9/17 (53%)
Standard not met:	8/17 (47%)

Discussion

N.B. these 8 failures were all regarding the prescription of night sedation. Many requests for night sedation occur out of hours and are made to duty doctors. It would be unreasonable to expect the junior doctor to review each of these patients in depth to decide on the appropriateness or otherwise of longer term night sedation. However, a system needs to be in place to bring the issues to the attention of the ward doctor who would be the most appropriate person to make these decisions.

(N.B. for a comparison of these results with the two previous audits, see table on page 14).

ACTION PLAN

Action to be implemented:

1. Duty doctors to be requested to only prescribe between one and two doses of night sedation when requested out of hours. This information will be included on the induction course.

2. Nursing staff at night requesting night sedation for a patient to be asked to hand this over to colleagues on day shift to be discussed with ward doctor during working hours. Decision to then be made and recorded in medical and nursing notes as to appropriateness of regular or PRN night sedation.

Persons responsible: EMH consultants.

Implementation date: February 1998.

STANDARD 3

Aspect
At the last ward round prior to discharge all benzodiazepines/night sedation prescriptions will be reviewed. It will be documented in the medical notes: -
i) to continue or discontinue, with reasons;
ii) who will be responsible to review this.

Expected standard: *100%.*

Exceptions: ***None.***

Audit findings

Sample size
25 prescriptions of benzodiazepines/night sedation were being administered in total during th ospi stay of the 50 sampled patients.

However, only 17 prescriptions were still being given just prior to the final ward round.

Sample size therefore: 17.

It will be documented in the medical notes: -
i) to continue or discontinue, with reasons;

Mulberry A		Mulberry C	
Standard met:	1/14 (7%)	Standard met:	0/3 (0%)
Standard not met:	13/14 (93%)	Standard not met:	3/3 (100%)

Overall result	
Standard met:	1/17 (6%)
Standard not met:	16/17 (94%)

It will be documented in the medical notes: -
ii) who will be responsible to review this.

Sample size
Sample size 14, because 3 of the original 17 prescriptions included in part i) of standard 3 were discontinued at the final ward round.

Mulberry A		Mulberry C	
Standard met:	2/11 (20%)	Standard met:	0/3 (0%)
Standard not met:	9/11 (80%)	Standard not met:	3/3 (100%)

Overall result	
Standard met:	2/14 (14%)
Standard not met:	12/14 (86%)

Discussion

In cycle 1 to establish baseline levels this standard was met overall in 63% of cases. In cycle 2, after raising staff awareness, it was met overall in 67%. Given the importance of these prescriptions being reviewed prior to discharge and the lack of improvement in cycle 2 it was decided to change the standard to state that the review would occur at the last ward round - thereby becoming consultant led - and would be included in the *"Guidelines for documentation in medical notes at the first and last ward rounds."*

On re-audit, standard 3 was met overall in only 14% of cases. This poor result highlighted the fact that the *"Guidelines for documentation in medical notes at the first and last ward rounds"* were not fulfilling their hoped for function, and that an alternative system needed to be considered. There has been ongoing discussions about adopting a district wide discharge summary that would be completed at the last ward round and then filed in the medical notes. This includes a section that lists each medication, its indication, and the person responsible to monitor it. Using this modified discharge summary would therefore ensure that all medications (including benzodiazepines) were reviewed and discussed at the last ward round. If this is adopted it would render this standard obsolete and effectively combine it with standard 4.

ACTION PLAN

Action to be implemented:

1. This standard is to be discussed further and a decision made as to whether the reason for continuing the medication should be recorded or not. Prescriptions of night sedation are to be regarded as self-explanatory.

2. Consideration will be given to the adoption of a system that ensures these points are listed in the discharge summary and that this is filled in at the last ward round. As long as copies are filed in the medical notes this information would not need to be duplicated.

Person responsible: EMH consultant body.

Implementation date: February 1998.

STANDARD 4

Aspect
In the discharge summary, it will be documented: -
i) whether patient is taking benzodiazepines/night sedation;
ii) whether this is expected to be long term or short term only;
iii) who is responsible for monitoring this.

Expected standard: *100%.*

Exceptions: *None.*

Audit findings

i) Recorded whether patient is taking benzodiazepines/night sedation;

Sample size: 14

Mulberry A		Mulberry C	
Standard met:	11/11 (100%)	Standard met:	3/3 (100%)

Overall result	
Standard met:	14/14 (100%)

ii) Recorded whether this is expected to be long term or short term only;

Mulberry A		Mulberry C	
Standard met:	2/11 (18%)	Standard met:	2/3 (67%)
Standard not met:	9/11 (82%)	Standard not met:	1/3 (33%)

Overall result	
Standard met:	4/14 (29%)
Standard not met:	10/14 (71%)

iii) Recorded who is responsible for monitoring this;

Mulberry A		Mulberry C	
Standard met:	3/11 (27%)	Standard met:	0/3 (0%)
Standard not met:	8/11 (73%)	Standard not met:	3/3 (100%)

Overall result	
Standard met:	3/14 (21%)
Standard not met:	11/14 (79%)

Discussion

Several of the discharge summaries that failed the standard contained a written record that the patient concerned would be followed up by a particular health professional (e.g. Geriatrician, CPN) or at a particular location (e.g. Day Hospital, Rest Home). However, in none of the cases was there a mention of who would have specific responsibility for monitoring the benzodiazepine or night sedation prescription.

One discharge summary that failed the standard stated that the patient "had been abusing her night sedation (before admission) e.g. taking up to 8 Zolpidem tablets nocte." This issue of abuse of night sedation reinforces the importance of identifying a specific person to be responsible for monitoring medication.

In cycle 1 and 2 this audit finding was consistently poor for the "giving reasons for the continuation of the prescription" (the standard was met in only one case in cycle 1, and one case in cycle 2). In no cases was it indicated who was the person responsible for monitoring the prescription or whether it should be short term or long term. It was expected that with the introduction of the "Guidelines" it would ensure this documentation at the last ward round and facilitate its transfer at the time the discharge summary was typed.

In cycle 3 the standard was met in 29% of cases (documentation of whether the prescription should be long or short term) and in 21% of cases (documentation who would be responsible for monitoring this). Although this is showing a very small improvement it is neither acceptable nor (given the poor results on standard 3) is it surprising.

The consultant body felt that the adoption of the new format of discharge summary would help to ensure that this standard is being met.

ACTION PLAN

Action to be implemented:

Review of current discharge summary and consideration given to the adoption of a (district-wide) standardised discharge summary. This new discharge summary will be completed at the last ward round, and will include both a list of medications, and also for each individual medication the following will be recorded:

i) the reason for prescription
ii) who will be reviewing it.

Persons responsible: EMH consultant body.

Implementation date: February 1998.

N.B. Fareham and Gosport are to get a new discharge policy which will be reviewed in a year's time.

COMPARISON OF AUDIT RESULTS FROM THE 3 AUDITS (Dec 95 - June 97)

	MULBERRY A		MULBERRY C	
STANDARDS	CYCLE 1 (Dec 95)	CYCLE 2 (June 96)	CYCLE 1 (Dec 95)	CYCLE 2 (June 96)
1. On admission, bz/ns should be reviewed & this should be documented in the notes	100%	60%	50%	N/A
2. If bz/ns is commenced during the admission, this should be documented in the notes, giving reasons.	0%	33%	0%	100%
3. Prior to discharge any bz/ns prescriptions should be reviewed & either discontinued or, if continued, documented with reasons why appropriate in the notes.	100%	66%	40%	50%
4. If a bz/ns is continued, this should be: i) documented in discharge summary with a reason why this was appropriate.	N/A	0%	33%	100%
ii) This should also include recommendations on how long the prescription should continue.	N/A	0%	0%	0%
iii) This should also include the review date.	N/A	0%	0%	0%

N.B. A separate table is required for Cycle 3 (June 97) because the wording of some of the standards for Cycle 3 varied slightly from that for Cycles 1 and 2.

	MULBERRY A	MULBERRY C
STANDARDS	CYCLE 3 (June 97)	CYCLE 3 (June 97)
1. On admission, bz/ns should be reviewed & this should be documented in the notes (whether to cont/discont)	25%	25%
2. If bz/ns are commenced during the admission, this will: i) be documented in the medical notes ii) With reasons.	60%	0%
3. At final ward round prior to discharge all bz/ns prescriptions should be reviewed. It will be documented in medical notes: i) to cont/discont, with reasons	7%	0%
ii) Who will be responsible to review this	20%	0%
4. In the discharge summary it will be documented: i) whether pt is taking bz/ns	100%	100%
ii) Whether this is expected to be long term or short term only	18%	67%
iii) Who is responsible for monitoring this.	27%	0%

CONCLUSION

1. There was a high expectation that the "Guidelines" would ensure that an improvement in practice would occur. This was not, however, the case. This highlights the importance of the re-audit to check that changes in practice are occurring as predicted by the new system and, as in this case when it is failing to do so, to look urgently at other measures that can be implemented to ensure the desired change. In this situation a modified discharge summary is to be introduced.

2. It was also necessary to continue to critically examine the standards so that they reflect good clinical practice but do not duplicate paperwork unnecessarily for already pressurised junior doctors. For instance, the introduction of the modified discharge summary makes the need for standard 3 obsolete as discussed earlier.

3. It should be noted that one of the consultants was on maternity leave for the duration of this audit. It is possible that the covering locum consultant was unaware of the guidelines (although all locum medical staff are supposed to be informed of current guidelines pertaining to the prescribing of drugs).

4. In view of the failure to see the hoped-for improvement in practice, and because of the changes proposed in the action plans, re-audit of these standards is recommended within 12 months (subject to the introduction of a new common discharge policy).

Audit Title: Re-audit of benzodiazepines & night sedation

Audit Ref: 110/97-8

PORTSMOUTH HealthCare NHS TRUST

RESULTS SYNOPSIS

No	STANDARD	Target	Result	ACTIONS	Responsibility	Completion Date	Risk /GP
1.	At the first ward round, all benzodiazepines/night sedation (BZ/NS) prescriptions will be reviewed. The decision to continue or discontinue will be clearly documented in the medical notes.	100%	25%	Change standard to: "All bz/ns prescriptions will be reviewed either 3/12 after admission or prior to discharge. Decision to cont or discont will be clearly recorded in medical notes."	EMH consultant body	Feb 1998	
2.	If BZ/NS are commenced during the admission, this will i) be documented in the medical notes ii) with reasons.	100%	i) 53% ii) 53%	1. Duty drs to be requested to only prescribe 1-2 doses of n/s when requested out of hrs. 2. Night nurses requesting n/s for a pt to hand this over to day nurses to discuss with ward Dr in working hrs. Decision to be recorded in medical & nursing notes.	EMH consultant body	Feb 1998	
3.	At the last ward round prior to discharge all BZ/NS prescriptions will be reviewed. It will be documented in the medical notes:- i) To continue or discontinue, with reasons. ii) Who will be responsible to review this.	100%	i) 6% ii) 14%	1. Discuss std further, then decide whether reason for continuing the medication should be recorded (n/s prescriptions excluded). 2. Consultants to discuss whether to set up a Trustwide discharge policy that records vital information in discharge summary (filled in at last ward round).	EMH consultant body	Feb 1998	
4.	In the discharge summary, it will be documented:- i) Whether patient is taking BZ/NS. ii) Whether this is expected to be long term or short term only. iii) Who is responsible for monitoring this.	100%	i) 100% ii) 29% iii) 21%	Consider using a new, Trustwide, standardised discharge policy (see previous Action Plan).	EMH consultant body	Feb 1998	

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APPENDIX 1 AUDIT TOOL

ASPECT	EXPECTED STANDARD	EXCEPT-IONS	DEFINITION/ INSTRUCTIONS
1. At the first ward round, all benzodiazepines/night sedation (BZ/NS) prescriptions will be reviewed. The decision to continue or discontinue will be clearly documented in the medical notes.	100%	None	Record: 1. Taking BZ or NS on admission. 2. If reviewed, check whether reason given at 1st ward round & documented in medical notes.
2. If BZ/NS are commenced during the admission, this will be documented in the medical notes with reasons.	100%	None	Record: 1. If commenced during admission - check prescription charts; 2. If documented with reasons in medical notes.
3. At the last ward round prior to discharge all BZ/NS prescriptions will be reviewed. It will be documented in the medical notes:- i) To continue or discontinue, with reasons. ii) Who will be responsible to review this.	100%	None	Check entry of last ward round and prescription charts. N.B. it is as important to [pick up those cases where medications were discontinued with no reasons given, as those cases where it was continued.
4. In the discharge summary, it will be documented:- i) Whether patient is taking BZ/NS. ii) Whether this is expected to be long term or short term only. iii) Who is responsible for monitoring this.	100%	None	Check discharge summary & TTOs.

APPENDIX 2 DATA COLLECTION FORM

Pt code no. ☐☐ MULBERRY area: A C

Consultant.....

ADMISSION date: ..... DISCHARGE date: .....

DIAGNOSIS: (from discharge summary) .....
.....

MEDICATION on admission: ....
....
....

MEDICATION on discharge: ....
....
....

At first ward round
(check notes and drug charts)

Taking BZ/night sedation on admission?REG yes ☐ no ☐ PRN yes ☐ no ☐

If taking BZ/NS on admission, were they reviewed at first ward round after admission? YES NO N/A

If no, when were they reviewed?.....

Was the reason to continue/discontinue documented in notes? YES ☐ NO ☐ N/A ☐

Were BZ/NS commenced **during** the admission? YES ☐ NO ☐
(check drug chart)

If YES, is this documented in notes? YES ☐ NO ☐ N/A ☐

Do notes record the **reason** for commencing BZ/NS? YES ☐ NO ☐ N/A ☐

At final ward round
(check notes and drug charts)

Is it documented whether to continue/discontinue BZ/NS?	YES ☐	NO ☐	N/A ☐
Reason why documented in notes?	YES ☐	NO ☐	N/A ☐
Do notes state who is responsible for reviewing BZ/NS?	YES ☐	NO ☐	N/A ☐

Discharge Summary
(check discharge summary and TTOs)

Is it recorded:

Whether patient is taking BZ/NS?	YES ☐	NO ☐	N/A ☐
Whether this is expected to be long term or short term only?	YES ☐	NO ☐	N/A ☐
Who is responsible for monitoring this?	YES ☐	NO ☐	N/A ☐

APPENDIX III

PORTSMOUTH
HealthCare
NHS
TRUST

CARE PROGRAMME/DISCHARGE SUMMARY

ELDERLY MENTAL HEATLH - ST. JAMES' HOSPITAL

LOCKSWAY ROAD, PORTSMOUTH, PO4 8LD
TEL: (01705) 822444 FAX: (01705) 872708

Name: Address: Post Code:	d.o.b:	Hos. No:
	Legal Status:	Consultant:
	Ward:	

Admission Date:	**Discharge Date:**
Admitted From:	**Discharged to:**
Post Code:	**Post Code:**
Admitting G.P:	**Discharge G.P:**

REASONS FOR ADMISSION:

DIAGNOSIS: 1) 2) 3)	**ICD.10 Code:**

PROGNOSIS:

PROGRESS AND TREATMENT (Physical, Psychological, Social):

Medication on Discharge:

Medication	Indication	Review Period	Person Respor

INFORMATION GIVEN (Concerning Diagnosis, Prognosis, Treatment, Follow-up):

To Patient:

To Carers:

IN CASE OF ENQUIRY PLEASE CONTACT KEY WORKER NAME:
Tel No:

THIS SUMMARY HAS BEEN SENT TO:

G.P: C.P.N: Social Ser:

Previous G.P: S.W (SJH): Other:

ANY OTHER INFORMATION: (including review of Benzodiazepine/night sedation on admission appropriate)

NEEDS NOT MET:

CPA Status MIN/FULL KEYWORKER REVIEW DATE

FOLLOW-UP:

Day Hospital: Home Care:

Out Patient: M.O.W:

C.P.N: Other:

S.W. (SJH): Social Ser:

Day Centre: Case Manager:

Signed: Dictated:
Date: Typed:

Name and Status:

HEALTH AUTHORITY RESPONSE

DISTRIBUTION LIST

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