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What happened to my patient? Automated patient follow-up

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What problem was addressed?

Reflection is the process where 'an individual thinks analytically about…… their professional practice with the intention of gaining insight and using the lessons learned to maintain good practice or make improvements when possible'(1).

It can be challenging and time consuming to access the information required to reflect upon your clinical practice by reviewing the outcomes of individual patients (referred to as patient follow-up). This is particularly the case in acute specialties such as Emergency Medicine (EM) where the patient is either discharged or moves on to be cared for by another specialty; or specialties where (perhaps due to shift patterns) there is disjointed continuity of care.

Information regarding individual patient's ongoing care is commonly recorded in electronic health records (EHR), providing valuable information on their ongoing management, treatment, final diagnosis and outcome.

What was tried?

This study aimed to automate the process of patient follow up, so rather than individual EM clinician's keeping patient details and manually searching files to find out what happened next/the final diagnosis, this process was automated.

A novel automated system was developed that that provided EM clinicians working at the Northern General Hospital (NGH), Sheffield with patient follow-up information. This collected information from two EHRs in use: "Lorenzo" and "ICE" to generate a list of patients reviewed by each individual clinician and relevant patient outcome data.

This information was sent by weekly email to EM clinicians of all grades.

Detailed patient information was presented in separate tables ("Admissions", "Re-attendances", "Deaths", "Handovers" and "Senior Reviews").

For each patient information collected included "ED diagnosis", "Destination" (admitting specialty), "Inpatient final diagnosis" and "Length of admission" (nights).

This process was implemented in December 2020 and is ongoing. Clinicians experience and opinions on this system was collected via surveys in February 2021 and February 2023. Surveys were opt-in, anonymous, carried out online using Google Forms, available for a two-week period, and distributed by email. They contained single-answer, multiple-choice, and open free text questions.

What lessons were learnt?

The surveys identified that:

- The majority of clinicians regularly read their emails (100% in 2021, 75% in 2023)
- Most found them useful (95% in 2021, 92% in 2023)
- A minority felt that they generated anxiety (10% in 2021, 12% in 2023)

Clinicians used the information for workplace-based assessments, supervisor meetings, discussion with peers and to facilitate collection of patient feedback.

The qualitative feedback was also positive 'It's brilliant, informative and helpful for me as an established consultant to reflect on the cases I see and advise on.'

This information was used to:

- Develop an option for individual clinicians to chose to opt-out of receiving this communication.
- Expand the system to include Emergency Nurse Practitioners and ED Triage Nurses

Routine Electronic Health Care record data can be used innovatively to provide feedback on individual patients to healthcare staff to support their reflection, learning and improve patient care.

Reference:

Academy of Medical Royal Colleges/COPMeD. Reflective practice toolkit, 2018. Accessed at: https://www.aomrc.org.uk/wp-content/uploads/2018/09/Reflective_Practice_Toolkit_AoMRC_CoPMED_0818.pdf