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AUDIT ON THE DOCUMENTATION OF PATIENTS MEDICATION IN THE LETTERS FROM PSYCHIATRISTS TO THE GENERALPRACTITIONERS

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Introduction: Clinical correspondence between general practitioners and specialists remains fundamental to the process of referral from primary care and transmission of management advice from consultants.

Discrepancies over medication records for patients with mental illness living in community were highlighted by a previous audit and recommendation for improvement were accepted and implemented by the trust.

Aims: An audit of the documentation of patient's medications in the Psychiatric clinic letters compared to the general practitioners records was done two years back and several recommendations were made to improve the communication.

The aim of this study was to examine if the recommendations from the previous audit was implemented and if the quality of communication about medication conveyed by the Psychiatrist to the General Practitioner improved.

Methods: Latest Psychiatric clinic letter of 50 patients were randomly selected from the computer database and they were checked against the latest GP records.The expectation is that the Psychiatric and GP records would correspond 100%.

Results: This re-audit revealed most of the recommendations from the previous audit were implemented and as a result of that, the numbers of errors were reduced. However there were still significant errors detected including wrong medication, omission and incorrect dosage, schedule and frequency.

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