

CONFERENCE ABSTRACT

Improving Communication with General Practitioners post ST elevation Myocardial Infarction

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Introduction: Coronary artery disease remains one of the leading causes of death worldwide. NICE guidelines recommend all patients post ST elevation myocardial infarction (STEMI) should be discharged on specific classes of medication and with clear information for their general practitioner.

Short description of practice change implemented: We delivered a teaching session on discharge communication guidelines post STEMI to junior staff rotating through our unit.

Aim and theory of change: To assess and improve the compliance with guidelines on communication with general practitioners through education of our junior staff.

Targeted population and stakeholders:

Patient Group: Patients diagnosed with ST elevation Myocardial Infarction.

Target for Intervention: Junior Doctors working in Cardiology Service.

Stakeholders: Cardiology Service. General Practitioners. Patients.

Timeline:

March 2016: Audit performed on all STEMI discharges for 2015.

April 2016: Teaching Session delivered comprising of initial audit results and guidelines on communication.

July 2016: Re-Audit performed of STEMI discharges for June 2016.

Highlights: We show the importance of continuing education of junior staff rotating through specialist services in order to improve communications and continuity of care between primary and tertiary services. Improving this communication may improve our patients long term outcomes, by ensuring they are on the optimum secondary prevention regimen post STEMI.

Comments on sustainability: Due to staff turnover, a brief overview (<10 minutes) of guidelines on communication post STEMI would need to be delivered on a 3 monthly basis.

Comments on transferability: This intervention is a simple, cost neutral way to ensure increased standardisation of discharge summaries through education despite high rates of staff turnover.

Conclusions: We achieved a significant improvement in rates of communication with general practitioners with regard to duration of antiplatelet therapy (51.2% vs 88.2%, $p < 0.05$) and up titration of medications (19.87% vs 61.76%, $p < 0.05$) but not of repeat testing of fasting lipid profiles (36.8% vs 26.4%, $p = 0.1936$). It was felt the lack of improvement in relation to repeat lipid testing was due to ambiguous wording used in the teaching session as there was an improvement in documentation of fasting lipid profile results, but not in instructions to re-test.

Discussions: Given many medications cannot be uptitrated to maximally tolerated doses during brief inpatient stays, the GP plays a key role in ensuring this is done as an outpatient. Clear instructions on discharge are essential as GPs may be reluctant to make changes to medications prescribed by specialists. Junior staff may also be uncomfortable dictating plans for patient in a specialist service unless they themselves are explicitly informed of the same by their senior colleagues.

If the medication is not titrated up to the maximally tolerated dose, the patient may not derive maximum benefit and may suffer an increased risk of major adverse cardiac events (MACEs).

Lessons learned: Education of junior staff on guidelines is an essential component of ensuring a high standard of continuity of care between tertiary and primary care services.

Keywords: communication; myocardial infarction; continuity of care
