

to improve our decision-making and documentation of DNR orders. We used a standardised order form (SOF), which addressed all-important areas of this decision.

DNR decisions in medical case notes were audited before and after the introduction of a SOF. All aspects of the decision were scrutinised against recommended guidelines³.

In the initial 9-month audit period, 94 case notes with DNR decisions were retrospectively identified. Having noted shortcomings in documenting and recording the decision, we introduced a SOF to complement case note entries. We then prospectively re-audited our performance. Results between both audits were examined and compared using the Chi² test.

In the initial audit, 81/94 (86.2 per cent) of DNR indications were in keeping with accepted guidelines (relating to patient wishes, likely futile outcome, the presence of an advance directive or poor quality of life). In the re-audit period this improved to 61/92 (98.4 per cent) ($p < 0.01$). The patient was actively involved and consulted about the decision in 1/94 (1.1 per cent) when case notes alone were used, versus 9/62 (14.5 per cent) when combined case notes and SOF were used ($p < 0.001$). In both audit periods, 60/94 (63.8 per cent) and 44/62 (71 per cent) respectively, the patient was too ill or too confused to be consulted about the decision. More decisions were authorised by the consultant in charge of the patient when an order form was used, 56/62 (90.3 per cent) versus 35/94 (37.2 per cent) ($p < 0.001$). In addition DNR decisions were more likely to be reviewed during the re-audit period when the SOF was used 50/62 (80.6 per cent) versus 36/94 (38.3 per cent) ($p < 0.001$).

Since our audit was completed, further updated guidelines have been issued⁴. The General Medical Council have also issued a draft policy relating to good practice in this area of medicine⁵. This makes it quite clear that doctors 'must be prepared to explain and justify your actions and decisions, to patients and their families, your colleagues and, where necessary, the courts and the GMC'. We recommend using a standardised order form to complement case note entries to facilitate better decision-making and documentation of the DNR decision.

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Delayed hospital discharge

A proportion of hospital inpatients stay longer than expected or required for their medical diagnosis. These patients are elderly, often with poor social support or requiring long-term care due to disability of dis-

ease, including hospital acquired infection. These patients put a considerable strain on both resources and staff morale^{1,2}.

The reasons for the 1405 extra days spent in hospital by a total of 317 patients over a four month period are summarised in Table 1. A 'seasonal' ward, opened for the winter, admitted 22 patients under the medical team, 8 (2 per cent of total) of whom stayed an extra 180 days (13 per cent of total extra days). In comparison, 30 patients admitted to non-medical 'outlier' beds incurred only 3 extra days from a total of 223. While patients over 65 years represented half of the total admissions, they accounted for over two-thirds of extra days (Table 2). The longest inpatient stays were incurred by patients with cerebrovascular events, urinary tract infections and falls. The major reason for the delay was the unavailability of appropriate long-term care facilities. Delay in requesting arrangement of facilities was not a major contributor.

Other studies have confirmed this indirectly³, but there are few data on delayed discharge in the UK. Immediate transfer of appropriate patients to an Acute Elderly Care service is only viable if levels of staffing and ancillary support are comparable to the general medical service. Intermediate care wards merely shift the problem and their costs are often greater because patients in these wards may not be

Table 1: Reasons for delayed discharge.

Reason for delay	n	Mean age (years)	Total days	Extra days
Medical team	206	57.7	1288	8
Social Services	37	72.2	1477	1030
Occupational therapy	8	71.4	240	157
Tertiary transfer	17	60.5	212	87
Other	49	65.7	436	195

Table 2: Relation between age and inpatient stay.

Age (years)	n	Average stay {range in days}	Total days	Extra days
60–64	24	15 {1–103}	327	134
65–69	36	10 {1–61}	376	77
70–74	51	18 {1–106}	846	396
75–79	27	18 {1–88}	446	232
80–84	17	10 {1–41}	177	60
>85	28	13 {1–82}	350	167

given priority for placement. Others have introduced the concept of a specialist social worker, working within a regional framework to place patient impartially¹. A radical (and effective) model is that of the Swedish reforms which placed financial responsibility for long-stay 'bed-blocking' patients on municipalities rather than hospital Trusts⁴.

The problem of delayed discharge is an everpresent concern in most hospitals. Steps to reduce these delays must have audit as their basis if they are reasonably expected to identify areas of concern and restructure them. We hope our findings will encourage similar study and perhaps a change in practice.

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Journal of the Royal College of Physicians of London

Volume 1 January–December 2001

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