

An Audit of Discharge Summaries from Acute Psychiatric Settings - Content and Timing

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Abstract

Discharge summary is an important and useful communication tool, which summarize the therapeutic events and planned intervention during inpatient stay. A clinical audit was undertaken in an acute psychiatric inpatient setting in order to assess the standards of discharge summaries against local guidelines, in context of its timing and content. Discharge summaries of 48 patients who were discharged from acute psychiatric wards were examined. It was found that only 50% of the summaries were typed within 2 weeks. Date typed, date of admission, date of discharge, medication on discharge and diagnoses were recorded in all (100%) discharge summaries. However majority of the summaries, fell short of standards in the parameters like date typed, full psychiatric history, mental state and physical examination on admission, investigations done while on the ward, risk involved and level of effective care coordination. It is apparent that the present study has identified deficiencies in the content and timing of discharge summaries. Attempts should be made to explore possible reasons for the shortcomings and address them (German J Psychiatry 2006;9:94-96).

Keywords: discharge summaries, content, timing

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Introduction

The discharge summary aims to summarize the therapeutic and other significant events during inpatient stay. It provides concise details of reasons leading to admission, diagnosis, investigations etc and is also helpful as a record of responses to different therapeutic interventions. It is an important and useful communication tool. It can be referred to years later to provide a quick summary of an admission. It is useful for healthcare providers to effectively implement the treatment strategies planned during admission. A prompt and comprehensive discharge summary from the hospital should ensure effective continuity of care in the community. On the other hand, poor information transfer at discharge does appear to increase the likelihood of readmission (Olfson & Walkup, 1997).

The purpose of the discharge summary is particularly important in context of content and timing. It is also important to

determine as to whom the summaries are addressed to and what the stated purposes are. In a survey of the views of general practitioners on psychiatric discharge summaries (Dunn & Burton, 1999), top five headings identified in terms of importance were: admission and discharge dates, diagnosis, medication on discharge, community key worker and date of follow-up. This is understandable since general practitioners are mainly concerned about implementing the post discharge care plans. On the other hand, one would expect admitting team to ask for more information about diagnostic work up and therapeutic interventions.

A clinical audit was undertaken in an acute adult psychiatric setting in order to examine contents of discharge summaries in Liverpool, and also to look at the time taken for the letters to be typed.

Method

The audit was undertaken in Mersey Care NHS Trust, Liverpool where acute and community psychiatric services are divided in to four catchment areas or patches. Patch based multidisciplinary teams are located in four different mental health resource centres. Inpatient beds are based at two different hospitals. Discharge summaries are prepared by the senior house officers, typed by secretaries and sent to patient's general practitioner; with copies filed to the respective case notes.

The aim of the audit was to assess the standards of discharge summaries against local guidelines. These state that following information should be included; date of dictation and date typed, date of admission and discharge, full psychiatric history (unless referred back to a well documented previous discharge letter), mental state and physical examination on admission, progress and treatment given, results of investigations, any referrals made or pending, the risk assessment, diagnosis, effective care coordination level (standard or enhanced), care coordinator, medication on discharge, follow up arrangements. It also stated that letters should be typed within two weeks of discharge and should be filed in the respective patient's case notes.

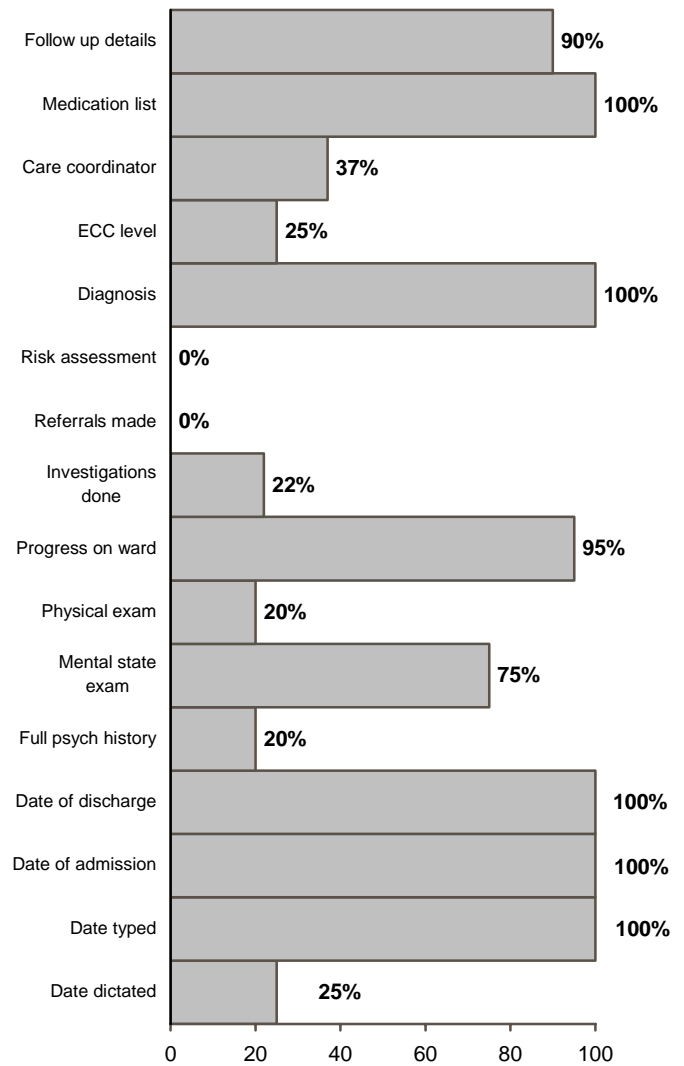
Discharge summaries from case notes of forty-eight patients aged 18- 65 years who were discharged from the acute adult psychiatric wards, in the month of April 2005 were obtained. Data was collected in July 2005 in order to leave enough time for the discharge summaries to be filed in the respective case notes. All the discharge summaries were evaluated with respect to above-mentioned standards. Data was analyzed in terms of descriptive analysis using frequency and percentages.

Results

Out of the forty-eight case notes examined, 40 (83.3%) discharge summaries were obtained. Eight (16.7%) discharge summaries were missing from the case notes. Initially time taken to type the letter was looked at. Time taken was divided in to three groups; less than two weeks, two to four weeks and more than four weeks. It was found that only 50% of discharge summaries were typed with in two weeks of discharge and a quarter was done only after four weeks.

Date typed, date of admission, date of discharge, medication on discharge and diagnoses were recorded in all (100%) discharge summaries. While date of dictation was mentioned only in 10 (25%) discharge summaries, full psychiatric history, and mental state examination on admission, physical examination on admission was recorded in 8 (20%), 30 (75%), and 8 (20%) respectively. In 38 (95%) discharge summaries, progress on the ward was mentioned and investigations done were mentioned on 9 (22%) of discharge letters. In only 10 (25%) of discharge letters level of effective care co ordination was recorded. While follow up arrangements were recorded in majority (90%) of summaries, name of coordinator was recorded only in 15 (37%) of letters.

Figure 1. Components of Discharge Summaries



Information on risk involved and whether any referrals made or pending was not mentioned in any of the letters.

Psychiatric history provided in the discharge summary also was analyzed separately. The presenting complaint or circumstances leading to admission were recorded in the majority (80%) of discharge summaries. Rest of the history like past psychiatric history, past medical history, family history was recorded in 16(40%), 13(32%) and 10(25%) respectively. In 9(22%) discharge summaries, personal history and drug & alcohol history were recorded. However forensic history and premorbid personality was recorded only in 7 (17%) and 4 (10%) of discharge summaries, respectively.

Discussion

In the present study, an attempt was made to examine the timing and content of discharge letters in an acute psychiat-

ric inpatient setting. Although the results of this audit are not up to the standards, review of previously published work showed that they were not altogether surprising. Orrel and Greenberg (1986) found that only 26% of GPs had received a brief communication about an in-patient stay within 2 weeks of discharge. In this study 50% of letters were typed within 2 weeks of discharge. One could only assume that General Practitioners received summaries later than two weeks.

One could speculate why it has not been possible to meet the local audit standards. Senior House Officers usually dictate the letters in the mental health resource centres. As the inpatient wards and the secretaries are based at different locations, it is possible that it took time for the case notes to reach the secretaries. In most of the letters, date dictated was not recorded. So it is not possible to determine the reasons for the time lag for getting the letters typed. It can be pointed out that, in the letters where, the dictated date is recorded, the discharge summaries have been typed within two weeks.

As most of the hospitals provide only two weeks worth of medication following discharge, it is also important for the letters to reach GPs within two weeks of discharge, so that they have clear information regarding the management plan. This is particularly important since Cochrane et al. (1992) found that, after discharge, an alarming 90% of elderly patients were receiving different medication regimes at home from those they had been prescribed in hospital.

Several studies have identified deficiencies in the quality of discharge summaries. These mainly concern timeliness, accuracy and length (Macauley et al., 1996; Wilson et al., 2001; Foster et al., 2002). Similar deficiencies were reported in the present study. Since the summaries in the present study were mainly aimed at the General Practitioners, it is good to note that the majority of the summaries contained the items thought to be important to them (date of admission and discharge, diagnosis, medication). However a vast majority did not provide other information like key worker and date of follow up.

Since at a local level discharge summaries are also used for reference purposes, deficiencies in areas such as detailed content of full psychiatric history, investigations done and risk assessment are equally important and has to be addressed clearly.

Despite setting local guidelines for discharge summaries related to local needs, the present study found that the local guidelines were not being fully met. The quality of the discharge summary also fell short of expected standards of the addresses. Efforts should be made to explore possible reasons for the shortcomings and attempts made to address those, so that discharge summaries fulfil their role as an effective communication tool rather than just a routine exercise.

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