The psychiatric discharge summary: a tool for management and audit

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SUMMARY. The aims of this study were to review the information needs of general practitioners in relation to the discharge of mentally ill patients; to design a discharge summary that would meet these needs and evaluate its use by junior hospital staff; and to assess the usefulness of this summary for audit. The information needs of general practitioners were identified from a review of the literature and from discussions with local general practitioners. A prototype discharge summary was designed and reviewed by a panel of general practitioners, regional advisors and course organizers from the south east Thames region. It was used for all patients discharged from the acute psychiatric ward in Hither Green Hospital over a 10 month period. One copy was given to the patient to take to the general practitioner, one was posted to the general practitioner and a final copy was kept in the patient's hospital records.

The senior house officers found the summary easy to complete. It reduced uncertainty about what data to provide, and helped to focus on the most critical information needed by general practitioners for continuity of care. Using a pre-coded data collection sheet, analysis of the information on the summaries was easily done. It provided a rapid audit of caseload, diagnoses, therapy, methods of admission and discharge, length of stay, risk factors and roles of all involved in future management. This information can be of use to the psychiatric team, general practitioners and hospital managers and could be the first step towards the development of shared care.

Introduction

OF all people discharged from hospital, the mentally ill are among the most vulnerable. A critical time for such patients is the first two weeks after discharge. This is when problems arise, support is most needed, drugs run out, and default from follow up is most likely. The initial discharge summary (as distinct from the final report) could provide the basic information needed to ensure effective continuity of care during this most vulnerable period.

Not all acute psychiatric units send an early discharge summary. Even when this is done, there is little agreement about what information is of most value to the general practitioner. Previous studies have shown that vital information about management, follow-up plans and responsibilities is often omitted.[1] Junior hospital staff are rarely taught how to write discharge summaries that are relevant to the needs of general practitioners. Another important factor is that few psychiatric discharge summaries are designed to meet the specific information needs of those responsible for follow-up care in the community.[2]

The aims of this study were to review the information needs of general practitioners in relation to the discharge of mentally ill patients, to design an early psychiatric discharge summary to meet these needs, to assess its use by the junior hospital staff, to analyse the data provided by the summary and to evaluate the usefulness of the summary for audit.

Method

Design of discharge summary

There is extensive literature on the information needs of general practitioners when their patients are discharged from hospital. Surveys have shown that this information should include the differential diagnosis, management, treatment on discharge, prognosis, what the patient and relatives were told, future management plans including details of the responsibilities of all involved as well as the date of any follow-up appointment.[3,4] Moreover, general practitioners have indicated that this information is needed within two weeks of discharge.[5] Meetings were held with 30 interested local general practitioners in the Lewisham postgraduate centre to obtain a consensus on the specific items of information that were considered most relevant. These included: dates of admission and discharge; how the patient came to be admitted; type of admission; diagnosis and management; type of discharge; disabilities on discharge; what patient and relatives were told; prospects for returning to work (work prognosis); accommodation on discharge; medication, drugs, dosage, frequency and quantity; risk factors that increase the need for follow up; follow-up plans and responsibilities; services, and facilities organized; and whether or not a shared care record was given.

There is evidence that using a structured summary helps to focus on the most appropriate information, facilitates retrieval, has educational value and promotes brevity.[6-8] A first draft was produced and reviewed by the group of 30 general practitioners, as well as the regional advisors and 20 course organizers from the south east Thames region. It was then redrafted. The final design tried to ensure that information could be recorded accurately and was easy to analyse (Figure 1).

Staff training

Completion of the discharge summary is not self evident and hospital staff need to know what its objectives are and how it is to be used. This training must be done as soon as a new doctor starts the job. If the general practitioner is responsible for follow up the hospital staff must ensure that a surgery appointment is made prior to discharge. The date of this appointment should be given to the patient and put on the summary. This enables the general practitioner to take appropriate action if the patient defaults from the follow-up appointment. Regular supervision is necessary to ensure that this summary is being filled in correctly and that it becomes part of the normal discharge routine.

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LEWISHAM AND NORTH SOUTHWARK HEALTH AUTHORITY
DISCHARGE LETTER

HITHER GREEN HOSPITAL **DEPARTMENT OF PSYCHIATRY**
CONSULTANT _____

Dear Dr,
I have pleasure in sending you the following details of your patient who has just been discharged from this hospital.

	Name	Address	Phone
Patient			
Next of kin			
GP			

Hosp No Date of birth

Admission date Discharge date

REFERRED BY
1. self 2. GP 3. CPN
4. social worker. 5. psychiatrist
6. police 7. other _____

ADMISSION
1. voluntary 2. section number __

DIAGNOSIS _____

MANAGEMENT _____

PRESENT PROBLEMS
1. thought disorder
2. withdrawn
3. depression
4. anxiety
5. other comments _____
6. work prognosis _____

DISCHARGE
by 1. self 2. Dr
to 1. home 2. hostel 3. part III
4. sheltered 5. other _____

MEDICATION drug	dose, frequency	quantity

ADVICE _____

Patient given shared care record
yes no

RISK FACTORS
1. lives alone
2. single parent
3. little family support
4. young children
5. divorced
6. recent bereavement
7. housing problems
8. social neglect
9. no fixed abode
10. multiple admissions
11. history of self injury
12. drug/alcohol problems
13. poor compliance
Other _____

Occupation _____

FOLLOW-UP PLANS
1. GP follow-up Apt date __
2. CPN _____
3. outpatient clinic appointment date _____
4. occupational therapy ____
5. day centre _____
6. retraining _____
7. rehabilitation _____
8. social worker involved __
9. GP responsible for injections
yes no
10. other _____

SIGNED _____

Figure 1. *Early discharge summary.*

Use of the summary form

The A4 summary form was used for all patients discharged from the acute psychiatric ward in Hither Green Hospital over a 10 month period. One copy was posted to the general practitioner, one was given to the patient to take to their doctor as soon as possible, and one copy kept for the hospital record.

Evaluation of the summary form

The summaries were analysed by one of us (B E), to assess their value for audit. Information was recorded on method of referral to the hospital, type of admission and discharge, length of stay, diagnosis, risk factors and follow-up plans. A precoded data collection sheet was used to make this analysis as straightforward as possible.

Results

Between 1 April 1989 and 31 January 1990 a total of 115 patients were discharged from the acute psychiatric unit at Hither Green Hospital. Discharge summaries were completed by senior house officers for 112 patients and these were analysed. Three summaries were not completed because the patients had discharged themselves and the notes were returned to the hospital medical records department. The diagnoses were omitted in two summaries. Of the 12% of patients not given psychiatric follow-up appointments, none had general practice appointments arranged prior to discharge. Three patients were to return to their general practitioner for injections but were not given an appointment for this. Where drug/alcohol problems coexisted with mental illness these were rarely mentioned in the diagnosis. All other categories of data on the summaries were fully completed.

Ease of use

After training in the aims and use of these summaries, the hospital staff found that they were easy to complete. The senior house officers reported that the summaries reduced uncertainty about what data to provide, and helped to focus on the most critical information needed for continuity of care.

Evaluation

In February 1990 the 112 summaries were analysed. The following information was obtained.

Referrals. Twenty three patients had referred themselves, 23 patients were referred by general practitioners and 23 by the psychiatrist, while 14 people had had admission arranged by the police. Seventeen patients were admitted from the local accident and emergency department, two came directly from hospital outpatient clinics and one patient was admitted at the request of his wife. Only nine patients were admitted solely at the instigation of the community psychiatric nurse or social worker.

Admissions. There were 83 voluntary admissions and 29 patients were sectioned — 20 were admitted under section 2, five under section 3, two under section 4, one under section 5 and one under section 136.

Discharges. Of the 112 patients only seven discharged themselves. Eighty six patients returned home while 22 went to hostels, part III accommodation or other residential accommodation. Four patients had no fixed abode.

Length of stay. Seventy seven per cent of the patients were discharged within four weeks. A further 13% had a stay of between five and eight weeks. Only 10% stayed for longer than eight weeks. This latter group included patients who were extremely violent, who failed to respond to treatment, who were detained for six months under section 3 or who refused to leave.

Diagnoses. Psychoses, schizophrenia, bipolar affective disorders and depression were the diagnoses for 85% of the patients.

Risk factors. The risk factors identified in the 112 patients are shown in Table 1. The 'other' category includes pregnancy, child in prison, partner left, recently evicted, lost job, sibling a schizophrenic, history of sexual abuse, temporary resident from abroad and financial problems. Forty four per cent of the patients lived alone and most of these patients had two or more of the following risk factors: multiple admissions, drug/alcohol problems, little family support and social neglect. Nineteen per cent of patients had young children and 11% were single parents. Poor compliance was only considered a risk factor for 11% of patients. Twenty nine patients (26%) had problems with alcohol or drugs, yet this was only mentioned in the diagnoses of eight patients and in only one patient was drug psychosis recorded.

Table 1. Risk factors identified among the 112 patients.

Risk factor	Number (%) of patients
Lives alone	49 *(44)*
Multiple admissions	42 *(37)*
Drug/alcohol problems	29 *(26)*
Young children	21 *(19)*
Little family support	19 *(17)*
Divorced	17 *(15)*
Social neglect	17 *(15)*
Single parent	12 *(11)*
Poor compliance	12 *(11)*
Housing problems	11 *(10)*
History of self injury	9 *(8)*
Recent bereavement	5 *(4)*
No fixed abode	4 *(4)*
Other	4 *(4)*

Follow-up plans. The follow-up management plans given on the forms are shown in Table 2. Eighty eight per cent of all patients were given outpatient appointments on discharge. None had general practice appointments arranged prior to discharge. Only three patients were to be given injections by their general practitioner. A third of patients were to be followed up by the community psychiatric nurse, and 17% were given day centre placements. The social worker was only involved in follow-up management plans for nine patients and five patients were referred for occupational therapy.

Table 2. Follow-up plans for the 112 patients.

Follow-up plans	Number (%) of patients
Outpatient clinic	99 *(88)*
Community psychiatric nurse	38 *(34)*
Day centre	19 *(17)*
Social worker involved	9 *(8)*
Occupational therapy	5 *(4)*
GP responsible for injections	3 *(3)*
Retraining	1 *(1)*
GP follow up	0 *(0)*
Rehabilitation	0 *(0)*
Other	6 *(5)*

Discussion

The discharge summaries provided valuable audit data which was easy to retrieve, code and analyse. Much of this information was not routinely collected by the hospital. The audit data can be used to help answer the following questions related to follow-up management: Are high risk patients being given follow-up appointments to see a psychiatrist? What group of patients are being seen by the community psychiatric nurses? Should more patients be given follow-up appointments to see their general practitioner on discharge from hospital? What sort of patients receive occupational therapy, rehabilitation and day centre placements? How many patients received a shared care record? These questions relate to the appropriateness of follow-up plans on discharge. When roles and responsibilities are clearly defined in a discharge summary it then becomes possible to audit outcomes, and discover what actually happened to the patients who are discharged. Effective continuity of care is difficult to achieve if hospital communication with general practitioners is poor. In a recent survey of all psychiatrists in the south east Thames region (72% response), 22% said they did not send out any early discharge summaries to general practitioners,[9] yet the consultants in these units estimated that it would take between two and six weeks for the final reports to be sent.

This study has shown that a comprehensive early discharge summary can provide essential information that meets the needs for those involved in follow-up care. This summary is acceptable to junior hospital staff who found it easy to use and of educational value. However, systematic training of each new senior house officer is necessary to ensure that summaries are completed and this should be seen as an integral part of the task relating to hospital discharge and follow-up care.

There is now an obligation to ensure that patients and relatives have been informed about treatment and future management before discharge from hospital.[10] This is easier to do when plans are clearly outlined in the discharge summary.

There is an urgent need for each psychiatric unit to formulate its own policy about discharge summaries, which should be seen as an essential management tool to ensure effective transfer and continuity of care. The following questions should be discussed by the psychiatric team together with local general practitioners: Do we accept the need for discharge summaries? What are their objectives? Should they also be used for audit? Who will train the staff and supervise their use? How does the present procedure compare with the one described in this paper? This could be the first step towards the development of shared care.

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