Failed discharges from the psychogeriatric ward

Judy Too, Justin Gardner and Navin Savla

'Failed discharge' was used as a measure of service efficacy on a psychogeriatric unit. Thirty-eight failed discharges from hospital were compared with 38 controls. Failed discharge was associated with a diagnosis of depression and a greater number of previous admissions. Possible underlying causes are discussed.

In the current NHS climate, it is increasingly important to measure the outcome of medical care. In psychiatry, the most appropriate methodology is not clear-cut (Garden & Oyebode, 1989). 'Failed discharge', or readmission to hospital within a short period of discharge, has been advocated as a possible outcome measure (Jones, 1991). This point prevalence study, of patients under 65 years, yielded a 'failed discharge' rate of 27%. Recurrence of original symptoms, poor treatment compliance and failure of follow-up arrangements emerged as important factors.

Our study examines failed discharges in the over 65 years age group to determine which categories of patient are most at risk of readmission and the possible underlying reasons.

The study

This was a retrospective case-note study. All patients aged over 65 years who were readmitted to the psychogeriatric assessment unit at Claybury Hospital between February 1989 and June 1993 were included. The ward serves the suburban area of Chingford and parts of rural West Essex. Patients readmitted within three calendar months of discharge were identified by the hospital's computer information department (February 1989 being the earliest for which this service was available). They were compared with a random sample of patients drawn from the remainder admitted over the same time period (control group).

Data were collected on age, sex, diagnosis recorded in case-notes, length of admissions and number of previous admissions. The case-notes were examined for possible reasons for readmission, treatments received during admission and other potential contributory factors. The findings were analysed by χ^2 test with Yates correction or *t*-test as appropriate.

Findings

During the period under study 494 patients were admitted. Of these, 38 (7.7%) qualified as 'failed discharges'. The broad diagnostic categories are compared with those of the 38 randomly drawn controls with depression being the most common diagnosis among the cases, and dementia for the controls (Table 1).

The average age for patients requiring readmission was 75.9 (67–88y) compared with 79.0 (67–90y) for the controls ($P<0.025$). The number of previous admissions averaged 2.39 (0–10) for the cases and 0.91 (0–4) for the controls ($P<0.005$). The length of admission was shorter on average for the cases at 31 days (1–180 days) compared with 58 days (4–283) for the controls ($P<0.01$). The cases spent longer in hospital on readmission than during their first admission with an average length of stay of 44 days (1–117), ($P<0.05$).

For cases admitted with a diagnosis of depression, the treatments received did not differ significantly between first admission and readmission. Equal numbers (7 out of 31) received ECT while 16 out of 31 were prescribed tricyclic antidepressants in the first admission and 19 out of 31 in the second. Of these depressed patients, 23 out of 31 were referred for day hospital follow-up at initial discharge and 17 out of 31 were attending at time of readmission; 14/31 had a chronic physical illness while 10/31 had evidence of ongoing discord within their families.

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Table 1. Diagnostic groups

Diagnosis	Failed discharge	Control
Total	38	38
Dementia	5*	25*
Depression	31**	8**
Anxiety	0	2
Hypomania	1	1

*$P<0.001$
**$P<0.001$

The most frequent reason for readmission was recurrence of original symptoms (32/38). Other reasons were previous discharge against advice (1/38), non-compliance with medication (1/38) and main carer ill (1/38).

Comment

In this study, only 7.7% of patients were readmitted within three months of discharge compared with 27% in the study of patients under 65 years by Jones. While dementia was the most common diagnosis for the control group, it was the depressed patients who came back as failed discharges and then spent longer in hospital than on initial admission. It is probable that many of the patients with dementia were successfully placed in residential care on discharge and thus received the necessary support to stay out of hospital. The majority of the depressed patients were readmitted despite ongoing support from the day hospital. Chronic physical illness and family discord were noted in many cases. The contribution of physical illness and the psycho-social correlates of depression in the elderly are well recognised (Baldwin, 1991; Murphy, 1982). Early readmission to hospital also seems to be predicted by a greater number of previous admissions.

The study can be criticised for its use of a control group rather than the more protracted process of examining all 494 admissions in detail. The latter approach would have the advantage of identifying those patients with depression not requiring readmission who would provide a useful comparison group.

In this study we have demonstrated that our service, while meeting the needs of those with dementia, is not fully catering for many with depression. This finding is in keeping with earlier work (Murphy, 1983; Copeland *et al*, 1992) which highlights the poor prognosis of depression in old age. The findings relate to this particular service and require replication before conclusions may be drawn concerning psychogeriatric services in general.

For our service, at least, the study provides valuable pointers by identifying patients most at risk of early readmission and suggesting possible underlying reasons. It is clear that attention needs to be focused on the post discharge care of those with depression. The efficacy of day hospital provision and the role of ongoing family discord deserve future scrutiny in order to close the 'audit loop' and hence reduce readmissions. The study provides a further demonstration of the utility of 'failed discharge' as an outcome measure in evaluating psychiatric services.

References

BALDWIN, B (1991) The outcome of depression in old age. *International Journal of Geriatric Psychiatry*, **6**, 395–400.

COPELAND, J. R. M., DAVIDSON, I. A., DEWEY, M. E., GILMORE, C. *et al* (1992) Alzheimer's disease, other dementias, depression and pseudo-dementia: prevalence, incidence and three year outcome in Liverpool. *British Journal of Psychiatry*, **161**, 230–239.

GARDEN, G. & OYEBODE, F (1989) Audit in psychiatry. *Psychiatric Bulletin*, **13**, 278–281.

JONES, E. (1991) Audit in psychiatry: 'failed discharges'. *Psychiatric Bulletin*, **15**, 26–27.

MURPHY, E. (1983) The prognosis of depression in old age. *British Journal of Psychiatry*, **142**, 111–119.

— (1982) The prognosis of depression in old age. *British Journal of Psychiatry*, **141**, 135–142.

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