The 'new model' discharge summary: is it working?

Robert Butler and Maurice Greenberg

An audit was undertaken looking at the information covered and length of discharge summaries in a psychiatric day hospital. Initially data were gathered from 90 multidisciplinary summaries over 18 months. This showed that although some key headings were being covered, 20% of summaries failed to include a diagnosis and 63% were longer than two sides. The strategy devised to improve practice was the presentation of these findings to an audit meeting involving all staff which led to a general agreement to improve weaker areas. Over the following six months data were gathered on 26 discharge summaries. Headings were covered more frequently, 92% included a diagnosis and 88% were two sides or less in length.

Psychiatric discharge summaries provide general practitioners (GPs), psychiatrists and other mental health care workers with important information which may assist them in their patients' care. GPs want to receive concise discharge summaries within two weeks of their patients' discharges, which contain core information such as management, medication on discharge and follow up plans (Orrell & Greenberg, 1986). Essex & Rosenthal (1991) were clearly concerned to find "a bewildering variety of summaries in current use".

The Jules Thorn Day Hospital is a psychiatric day hospital with an inner city catchment area. Since 1989 discharge summaries have been written by the patient's key worker who may be a nurse, social worker, occupational therapist or doctor. This occurs within a framework of support from the consultant and each summary is read and counter-signed by the junior doctor. This practice followed a study at Jules Thorn Day Hospital which demonstrated that GPs prefer a multidisciplinary summary, with key heading and limited to two sides of A4 paper, to the older model which was less clearly organised and of variable length, and completed by a junior doctor (Shamash *et al*, 1989). We set out to audit the new model with a particular view to see whether it was still fulfilling its aims.

The study

Initially all discharge summaries completed during the 18 months between 1 January 1992 and 1 July 1993 were examined. The number of discharges over that period was calculated from the admissions book. Summaries were checked against a list of headings and if there was any information concerning a heading, it was recorded as 'included'. The length of each discharge summary was recorded in sides of A4 paper.

These results were presented in July 1993 to the monthly audit meeting where they where fully discussed, opinions on each heading were aired and there was a general agreement to improve on weaker areas. Six months later all discharge summaries between 15 July 1993 and 15 January 1994 were examined to complete the audit cycle and to assess whether there had been an improvement.

Findings

In the period before intervention 90 (84%) of the 107 discharges had a corresponding discharge summary. Of the 17 discharges without a discharge summary 16 patients had attended the day hospital for less than one week. Table 1 shows the information included in the discharge summaries. Following the intervention 26 (93%) of the 28 discharges had a corresponding discharge summary. All but one of the measures had improved and in four areas the improvement reached statistical significance (see Table 1).

Comment

Over the two year study period only three patients who attended the day hospital for more than one week did not have a discharge summary completed. Those who attended for less than one week had a letter written to their GPs.

The headings which GPs considered most important (management, medication on discharge and follow-up plans) were well covered before and after intervention. This demonstrates that the members of multidisciplinary teams are using the headings which were emphasised in 1989. This occurs in spite of differences in emphasis between different professionals. For

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Table 1. Comparison of information considered essential or very important by GPs* with information included in discharge summaries before and after intervention

Information	Essential or very important	% Before (n=90)	% After (n=26)
Management	98	99	96
Medication on discharge	98	94	100
Follow-up plans	95	97	100
Prognosis	81	46	85**
Patients informed of diagnosis	81	4	19*
Diagnosis	63	80	92
Investigations	61	4	26**
Length two sides or less		37	88**

χ^2 test using Yates' correction
*=P<0.05 **=P<0.01
*Orrell & Greenberg, 1986.

example, one team member may consider level of functioning more important than psychiatric diagnosis.

The four areas most poorly covered before intervention (prognosis, investigations, information given to the patient and summary length) all showed significant improvement. This shows that the audit process was an effective means of improving clinical practice.

Prognosis was initially only included in a half of the summaries. This may be because it is often so uncertain. GPs, however, are concerned about their patients' future health and one way to make prognosis more useful might be to include some of the factors upon which it is contingent; for example, whether community support needs to be in place in order to reduce the risk of relapse.

The two headings which remained poorly covered in the summaries, in spite of an improvement, were 'investigations' and 'patient informed of diagnosis'. For investigations this is likely to be because routine blood results fall out of the normal sphere of training for non-medical disciplines. Their inclusion, however, may convey important information or reduce the need for further testing. The psychiatrist should therefore ensure they are covered, and might arrange for result sheets to be included with the summary.

Although GPs are understandably interested in what their patients have been told about their diagnoses, this is an area both staff and patients can find difficult. Most staff agree that patients have a right to know their diagnosis and that it should be discussed with them in a supportive and thoughtful manner. This is an area which is not routinely covered in training despite the fact that it is probably one of the most important aspects of care.

Before intervention the majority of summaries were three sides or longer, although on some occasions the summary extended beyond three sides because the case was complicated. Restricting length to two sides is a good way of imposing the discipline of having to summarise information. This is an essential part of junior doctor training, as well as useful to GPs, by keeping their records to a manageable length. This was the best area of improvement during audit and may reflect the emphasis placed on it during the audit process.

In conclusion, this audit has demonstrated that 'new model' multidisciplinary discharge summaries in a day hospital setting are working. In particular they are being completed, they include useful information under key headings and they are a manageable length. The simple intervention of an audit meeting involving all staff has led to an improvement in the number of headings covered and the brevity of summaries. Audit is a continuous process and further efforts need to be directed towards strengthening those areas where summaries still fall short of the desired requirements.

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