Psychiatria Danubina, 2015; Vol. 27, Suppl. 1, pp 432–434 *Conference paper*
© Medicinska naklada - Zagreb, Croatia

A COMPLETED CYCLE AUDIT OF PSYCHIATRIC DISCHARGE SUMMARIES

Hellme Najim[1] & Khalid Jaffar[2]

[1]*South Essex University Foundation NHS Trust, Basildon University Hospital, Basildon, Essex, UK*
[2]*Early Intervention Services South Essex University Foundation NHS Trust, Basildon, Essex, UK*

SUMMARY

Background: *Patients discharge summaries are important as they record a vital miles stone in patients' care. Their accurate record improves patients' care and clarifies communication between different health professionals.*

Methods: *60 Discharge summaries from different consultant psychiatrists' case load were audited. The results were analysed and presented with recommendations to improve them a format was suggested. A reaudit of 62 discharge summaries was carried out by the same team after three years in the same catchment area but the practice has changed to inpatient and community.*

Results: *Improvement in most of the areas audited occur in the reaudit which indicates the usefulness of audit in improving clinical practice which a pivotal part of clinical governance.*

Discussion: *This completed audit cycle has proven that clinical practice has been reviewed and methods of improving it have been implemented. It has been noted that more items were reviewed and added to the second cycle which should be condoned.*

Conclusion: *Discharge summaries are important clinical documents in secondary and primary care communications. They are helpful for secondary care staff as they good references for people in out of hours services and Accident and Emergency. Good quality discharge summaries improve patients care and make it easy to manage clinical risk.*

Key words: *discharge summaries - communication - secondary care - primary care*

* * * * *

INTRODUCTION

Communication between primary and secondary care is the cornerstone of patient care. Discharge summaries are important not only because it records an important event in the patient's psychiatric history life, but it also forms a vital source of information to the GPs and to other mental health professionals especially out of hours services. For that reason, the summary should be comprehensive, detailed and standardised to include all important information about risks and management plans.

It has been indicated by different studies that discharge summaries lacked accuracy, timeliness and they were either too short or too long (Macauley 1996, Wilson 2001, Foster 2002). Dunn and Burton have identified five headings as their top important items i.e. admission and discharge dates, diagnosis, medication on discharge, community keyworker and date of follow up. Corssan et al. (2004) identified 10 items as the most important as follows Diagnosis, drug history, alcohol history, smoking history, forensic history, results of blood tests and follow up arrangements and completed a cycle of audit to see whether their trust has recorded these items and compared between their finding in the first audit and the reaudit. She did not find any improvement in the reaudit. Aboji et al. audited ICD10 diagnosis only in their audit (Agboji). All previous audits, up to our knowledge, concentrated on a specific number of items and checked for them in their clinical work. There was no audit which considered a comprehensive list of items to be included in the discharge summary to make it more informative for primary and secondary care.

Clinical audit is a mechanism to scrutinise and improve clinical practice. This audit took previous audits in the same area of clinical practice and tried to improve it by designing a comprehensive tool which included all relevant items of the discharge summaries.

It aimed to assess the current state of discharge summaries and tried to improve it after disseminating results and rechecking clinical practice after the first audit.

METHODS

A survey was carried out on local GPs and asked them if they consider these items as essential, can be included or irrelevant and items which were considered as essential by 50% or more of the GPs were considered essential items. They included 16 items as shown in table 1. 60 discharge summaries were included from five consultants catchment areas, 12 discharge summaries were taken from each sectors. The results were analysed and the audit was presented in the local postgraduate teaching programme in 2009. Recommendations were made to adopt this discharge summary format which included the 16 items. The importance of having a unified discharge summary format was emphasised to improve clinical practice and improve communication between primary and secondary care.

The same authors used the same template to reaudit discharge summaries in 2014. 62 discharge summaries were identified from three consultants as new ways of

Table 1. Re-audit of information provided on discharge summaries sent out to GP's

	Present parameters in 2007		Present parameters in 2012	
	N=60	%	N=62	%
Date of admission	60	100	62	100
Date of discharge	60	100	62	100
Diagnosis	58	97	62	100
ICD10-coding	57	95	52	83
Illicit drug misuse history	34	57	52	83
Alcohol history	35	58	51	80
Smoking history	3	5	17	28
Forensic history	28	47	53	85
Past psychiatric history	17	28	62	100
Past medical history	49	82	62	100
Mental state examination	58	97	62	100
Phisical examination	49	83	61	98
Medication on discharge	59	98	62	100
CPA-discharge planning	37	57	62	100
Risk assessment/Level of risk	-	-	23	37
Follow arrangements	60	100	62	100

working into inpatients and community consultants have reduced the number of inpatient consultants. The results were analysed and presented at the local teaching postgraduate teaching programme.

RESULTS

The results are summarised in Table 1. There was improvement in recording of all items included in the 16 item template apart from one, i.e. ICD10 Code as there was a slight decline, 95%, to 83%. Risk assessment was not included in 2009 as forensic history was considered as representative of risk for that reason it was not checked in 2009. It was recorded only in 37% of discharge summaries in 2014 which considered as an improvement but not to a satisfactory level as it should be 100%.

DISCUSSION

Clinical audit is an important mechanism by which NHS organisations make sure that clinical work gets checked and standards are met in all aspects of clinical work. Unfortunately, some audits have proven that despite efforts to improve clinical work by audit, the reaudit did not demonstrate improvement in clinical practice as results stayed as before the first. This was true with Crossan et al. as discharge summaries did not improve after their audit. In our audit, only three items achieved 100% in the first audit, compared to eight in the reaudit. Forensic history improved by 67% which is good but it has not reached 100%. It is our opinion that this area combined with the risk assessment should be 100% always as it is very important to manage risk and communicate risk assessment and way of managing this risk between different health professionals especially in communication between primary and secondary care. Past medical history was good in the first audit as it reached 82% but improved to reach 100% which was important as a highlighted area in the CPA document of 2007 (Agboji). Psychiatric history was only 28% in the first audit but reached 100% in the second audit which is an important improvement. Medication on discharge is an area of paramount important for GPs as highlighted in another survey (Najim 2012), was good as 98% in the first audit but reached 100% in the second audit. CPA-discharge planning was 57% in the first audit but it reached to 100% which was an outcome for which we should commend psychiatric trainees in our trust.

CONCLUSION

Discharge summaries are vital in the care of patients as they record a major life event of these patients, they are not only important in communicating relevant clinical information to GPs, they also provide a reference for other professionals in secondary care as community teams, crisis intervention and home treatment teams and after hour services and the more comprehensive and concise they become the more efficient the team gets in providing care for such patients. It is recommended to generalise this experience in other trusts and repeat it periodically to make sure that the standard is reached and maintained in order to make sure that patient care is not compromised.

Acknowledgements: None.

Conflict of interest: None to declare.

References

1. *Agboji H, Moore A: Audit of ICD 10 diagnosis use at admission assessments and in discharge summaries by Psycxhiatric Trainees.*
2. *Crossan I, Curtis D & Ong Y: Audit of psychiatric discharge summaries: completing the cycle. Psychiatric Bulletin 2004: 28:329-331*
3. *Foster DS, Paterson C, Fairfield G: Evaluation of immediate discharge documents - room for improvement? Scottish Medical Journal 2002; 47:77-79.*
4. *Macauley EM, Cooper GC, Engeset J, et al: Prospective audit of discharge summary errors. British Journal of Surgery 1996; 83:788-790.*
5. *Najim HA & Loughran M: Analysis of GPs' Opinion IN Psychiatrists' New Patients Letter. Progress in Neurology and Psychiatry 2012; 16:6.*
6. *Wilson S, Ruscoe W, Chapman M, et al: General practitioner-hospital communications: a review of discharge summaries. Journal of Quality in Clinical Practice 2001; 21:104-108.*

Correspondence:
Hellme Najim, MB Ch B FRCPsych, Consultant Psychiatrist
South Essex University Foundation NHS Trust, Basildon University Hospital
Basildon, Essex SS16 5NL, UK
E-mail: hellme.najim@sept.nhs.uk