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Article

# Psychiatric discharge summaries: what do general practitioners want?

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## ABSTRACT

**Aims** As part of an initiative to improve and standardise our discharge summaries, we investigated the preferences of general practitioners (GPs) with regards to the information provided in summaries.

**Method** Our study methods included sending a questionnaire to all GPs in our area gathering their views on what information to include in discharge summaries on first and on subsequent inpatient episodes.

**Results** The response rate was 68%. Most GPs wanted a comprehensive first discharge summary, particularly stressing the importance of practical information. Subsequent discharge summaries could exclude case histories.

**Clinical implications** Contrary to previous studies indicating a demand for brief reports, this survey indicates that the GPs surveyed value considerable detail in adult psychiatry discharge summaries. It is important to include these views in setting standards for the auditing process and before implementing changes.

**Keywords**: adult psychiatric, communication, discharge, general practice, letter, primary healthcare, quality indicators, summary, survey

## Introduction

Discharge summaries provide the link between secondary and primary care. Their quality has been linked to the risk of readmission[1] and adverse events such as medication errors.[2] Clinical audits of discharge summaries have focused on a number of areas, including have they been done at all,[3] accuracy (errors of omission and commission),[4] conformity to a predetermined format,[3,5] conformity to medication guidelines,[6] timescales[7] and receipt by the relevant general practitioner (GP).[4] These usually involve self-evident standards.

Clinical audit is an iterative process of comparing performance against a standard; identifying any shortfall; devising and implementing a plan to abolish or reduce the shortfall; and re-auditing to reassess the performance against the standard. Many standards are readily available, such as National Institute for Health and Clinical Excellence (NICE) guidelines or the *British National Formulary*. However, in some cases, there is no clear standard, so a preliminary study is required. The current work is such a pre-audit study, which investigates the information considered useful by GPs in psychiatric discharge letters.

GPs typically receive an immediate summary (usually an A4-sized proforma) and a fuller prose letter. The focus of this study is the full letter, although it is obvious that items considered important for a brief, immediate summary, such as those arrived at by Essex *et al*[8] will be expected to be included in a full letter; in some studies it is not clear which document is referred to.[9]

The psychiatric discharge letter (or summary) typically serves two masters: an internal purpose is for future reference within secondary care, and the external purpose is to communicate with primary care. The starting point of one study[10] was guidance by psychiatrists for psychiatrists. However, there have been some studies which have sought the opinion of GPs about the content and length of the discharge summary, although none appears to be recent. Some studies have advocated separate documents for the two audiences,[10–12] although one study clearly decided against this.[13]

Psychiatrists are commonly told anecdotally by staff who are not GPs that their discharge letters are too long and will not be read by GPs. Craddock and Craddock[10] offered GPs a choice between three formats of different lengths (half A4, one side of A4, 2.25 sides of A4): 66% of GPs preferred the medium length and 25% the long length. Virtually identical rates were produced in a separate study using very similar methods, although preference for longer letters was noted for first time admissions.[14] In three separate studies, roughly 50%[13,15] to 30%[7] of letters were considered too long by GPs. Anderson and Kirby[12] found that when GPs were routinely sent a short summary with the offer of more detail on request, no GP requested more detail. Nevertheless, studies investigating the degree to which GPs read the letters give high proportions (85–98%).[7,15] A study which aimed to streamline letters found that some GPs mourned a loss of narrative.[16] When GPs were asked to suggest what could be usefully left out of letters, there was little response.[13] These findings suggest that, when offered longer letters, GPs usually read them, and although they may complain about the length, they have not been able to identify what to cut. If offered shorter letters with the option to obtain more detail, the offer is not embraced. There is scope for distinguishing between the information required at first contact and that for repeat admissions. All surveys show a heterogeneity of opinion.

Some studies have considered the content desired by GPs.[8,9,13–15] Whilst it is clear that GPs can express priorities[15] or identify a 'top 10',[9] there is no unanimous view about what is redundant. The clearest study of this is by Dunn and Burton:[13] 15 GPs rated 18 items and only one GP rated any item as 'irrelevant'; all other items were rated by all GPs as at least 'helpful at times'. The same study found that GPs did not identify what could usefully be withheld from letters.

The only consistent view is that some items frequently considered important by GPs are relatively rarely recorded by psychiatrist, particularly the management plans after discharge[7,9,13,16] and what information has been given to the patient and carers.[7,9,11,13] Silence on this last point may simply be apposite: Butler and Greenberg[3] reported that only 4–19% of day hospital patients were informed of their diagnosis by the time of discharge.

It follows that there is currently no clear consensus to form a standard against which an audit can take place. Although the current study was conceived of within an audit context and approved by the audit mechanisms, it is a pre-audit survey to establish a standard, not part of an extant audit cycle.

## Method

We designed a questionnaire to assess the value which GPs attach to the pieces of information reported in a discharge summary. We included the standard discharge summary sections and the information identified as important by Dunn and Burton.[13] We did not include information reported as standard in the heading of a discharge summary and considered essential (e.g. identifying information, consultant's name, dates of admission and discharge, Mental Health Act status and CPA level). GPs were asked to state their attitude to the inclusion of a specific item in the discharge summary using the ratings 'information I do not want in a discharge summary', 'information I feel neutral about', 'information I would like in a discharge summary' and 'information I consider essential in a discharge summary'. Information included in discharge summaries for first admissions and for subsequent admissions were rated separately. A final section in the questionnaire asked GPs for additional comments and recommendations on how discharge summaries could be improved.

At the time of the survey, secondary adult mental health services in Peterborough were provided by four community mental health teams. These teams kept up-to-date lists of the GP practices and GPs in their area, and we identified the GPs used in this survey from these lists. If a surname appeared more than once, or in more than one practice, the practice was contacted to determine whether it was the same practitioner working in two practices or two different practitioners. GPs working in more than one practice received only one questionnaire. A total of 122 questionnaires were posted to 39 practices. Questionnaires were anonymous and included an addressed prepaid return envelope and a cover letter explaining the questionnaire. Questionnaires were designed to fit onto a single page, to be quick to complete and to be easy to understand, in order to improve the return rate.

Because of the origins of the study as a pre-audit standard-setting exercise, approval was obtained from the clinical audit and clinical effectiveness team according to the Trust's clinical governance procedures and national guidance.[17]

## Results

Five questionnaires were returned by practices because the practitioner did not work there any more, resulting in a survey number of 117. Eighty questionnaires were returned (68%). The GPs' attitudes to the inclusion of the various sections in a discharge summary for a first admission are summarised in Table 1.

All the information, apart from past medical history and physical examination, was considered 'wanted' or 'essential'. The majority of GPs were neutral about the inclusion of past medical history and physical examination. Table 2 summarises the GPs' responses to the inclusion of the same sections in subsequent admissions. Their attitude to the inclusion of past medical history and physical examination remains unchanged. However, the majority of GPs were 'neutral' regarding the inclusion of past psychiatric history, family history, personal history and premorbid personality in subsequent discharge summaries. The rest of the items of information were considered 'essential' or 'wanted'.

Twenty-one respondents added free-text suggestions. The majority of these reaffirmed the importance of items of information included in the questionnaire. Practical information (such as medication at discharge, follow-up plans including risk management, keyworker, support arranged for patient, and who to contact in emergency) was stressed as particularly important. Only a few respondents commented directly or indirectly on the length of discharge summaries: one respondent considered all items mentioned in the questionnaire to be standard information which should be included in all discharge summaries, whether first or subsequent admissions; another stressed the importance of a 'good psychiatric history'; while another expressed their preference for a 'good old-style discharge summary'. Suggestions for brevity included a preference for concise and pertinent information, for management on the ward to be brief and for the inclusion of only positive results in investigations. One respondent asked for the inclusion of information regarding carers – whether they have been sufficiently informed and will contact services when concerned.

**Table 1** GP responses to information desired in a first admission psychiatric discharge summary

| | Median | Range |
|---|---|---|
| Presenting complaint | 4 | 3–4 |
| Past psychiatric history | 4 | 1–4 |
| Past medical history | 2 | 1–4 |
| Family history | 3 | 1–4 |
| Personal history | 3 | 1–4 |
| Premorbid personality | 4 | 1–4 |
| Mental state examination | 4 | 2–4 |
| Physical examination | 2 | 1–4 |
| Investigations | 4 | 2–4 |
| ICD-10 diagnosis | 4 | 1–4 |
| Management on the ward | 3 | 1–4 |
| Place discharged to | 4 | 2–4 |
| Medication | 4 | 3–4 |
| Risk factors | 4 | 2–4 |
| Care coordinator | 4 | 2–4 |
| Follow-up plan | 4 | 3–4 |
| Responsibility of GP | 4 | 2–4 |

Note: 1, Information I do not want in a discharge summary; 2, Information I feel neutral about; 3, Information I want in a discharge summary; 4, Information I consider essential in a discharge summary.

## Discussion

Our aim was to solicit the requirements of GPs as part of our process of standard-setting for our discharge summaries. A response rate of 68% is within the range of previously published studies, ranging from less than 50%[14] to 89%,[10] the majority being 71–75%.[7,9,13]

Word of mouth had given us the impression that our discharge summaries were too long. It was evident from our results that, at least for the discharge summaries of first admissions, GPs in our area require the inclusion of all the items of information, apart from physical examination and medical history – the reporting of these could be limited to abnormal findings. Suggestions from GPs stressed the importance of including practical information

**Table 2** GP responses to information desired in discharge summaries of subsequent admissions

| | Median | Range |
|---|---|---|
| Presenting complaint | 4 | 1–4 |
| Past psychiatric history | 2 | 1–4 |
| Past medical history | 2 | 1–4 |
| Family history | 2 | 1–4 |
| Personal history | 2 | 1–4 |
| Premorbid personality | 2 | 1–4 |
| Mental state examination | 4 | 1–4 |
| Physical examination | 2 | 1–4 |
| Investigations | 4 | 1–4 |
| ICD-10 diagnosis | 4 | 1–4 |
| Management on the ward | 3 | 1–4 |
| Place discharged to | 4 | 2–4 |
| Medication | 4 | 3–4 |
| Risk factors | 4 | 1–4 |
| Care coordinator | 4 | 1–4 |
| Follow-up plan | 4 | 2–4 |
| Responsibility of GP | 4 | 2–4 |

Note: 1, Information I do not want in a discharge summary; 2, Information I feel neutral about; 3, Information I would like in a discharge summary; 4, Information I consider essential in a discharge summary.

and no suggestions criticised current summaries for being too long. This is in contrast to the reports of some earlier studies[10,18] and in accord with the findings of Dunn and Burton[13] of the GP requirements for discharge summaries. However, in our study, GPs found the case history more important than that reported by Dunn and Burton.[13] This difference might be explained by our study being based on general adult discharge summaries rather than old age psychiatry summaries, where case histories are more lengthy and could be perceived as less relevant in cases of dementia. Furthermore, our questionnaire distinguished between first admission and subsequent discharge summaries, which might further influence the relative importance of case histories in either section. It was evident from our results that GPs considered the inclusion of personal history, family history, premorbid personality and psychiatric history as less important in subsequent discharge summaries. An annotation added by one GP stated that only *changes* to any of this information should be included. It is evident from the questionnaires, and reiterated by the comments added by the GPs, that practical information (medication at discharge, follow-up plan and risk management, keyworker, support given to patient, who to contact in case of emergency) ensuring continuity of care is of utmost importance to GPs.

The suggestion of writing two separate discharge summaries (one a comprehensive summary for the notes, and one a brief summary for GPs[10–12]) would not satisfy the requirements of the GPs in our area. One possibility is a two-tier system:[14] a comprehensive summary for first admissions and a summary that does not include the case history, except for any changes, for subsequent admissions. However, access to the first discharge summary might not always be practically possible and it is our opinion that copying these mostly static sections into the current discharge summary is prudent. A discharge summary that includes all the necessary information could still be easy to navigate. This could be achieved by standardising the format, using clear headings and judicious editing to ensure concise and relevant information.

Our results study differ from those of some previous studies, whose summaries may have failed to capture the heterogeneity inherent in general practice and the tensions between wishing to be well-informed and awareness of time pressures. We strongly advocate the involvement of primary care colleagues in secondary care documentation, and in their involvement in audit cycles. This should result in improved continuity of care after discharge from hospital, the time considered most difficult for our patients and a vulnerable time for suicide.[19]

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