Psychiatric Bulletin (1990), **14**, 618–620

Audit in practice

Audit of psychiatric discharge summaries

NICK CRADDOCK, Sheldon Research Fellow, Department of Psychiatry, University of Birmingham, Queen Elizabeth Hospital, Birmingham B15 2TH (correspondence); and BRIDGET CRADDOCK, Senior Registrar in Psychiatry, Worcester Royal Infirmary, Worcester

Improving discharge procedures is a topical subject and audit of discharge summaries is an important part of this procedure. In many hospitals the summary compiled following a patient's discharge is used for two purposes: a copy is sent to the general practitioner to provide details of the patient's illness and management, and a copy is filed in the hospital notes as a record of the admission. Discharge summaries often fail to meet the needs of either psychiatrist or GP. Using a questionnaire study, we have recently demonstrated that GPs and psychiatrists have different requirements from discharge summaries (Craddock & Craddock, 1989). The present study, which examines the content of a sample of discharge summaries from a large psychiatric hospital, was conducted to identify potentially important items of information which are consistently poorly covered in psychiatric summaries.

We know of no previous study examining the composition of psychiatric discharge summaries. Two studies have examined the content of samples of psychiatric out-patient assessment letters: Williams & Wallace (1974) found the five most common items recorded in their sample of 92 letters were: present symptoms, treatment advised, follow-up, personal history and diagnosis. Pullen & Yellowlees (1985) found that diagnosis, treatment advised and follow-up were given in over 88% of their sample of 60 recent letters. Both studies demonstrated poor coverage of prognosis, suicide risk and explanation of the condition, all of which were regarded as important items by general practitioners.

Studies examining the information content of samples of non-psychiatric discharge summaries have shown that demographic data and details of diagnosis, treatment and follow-up are usually well covered, but that prognosis, advice about management and information given to patients and relatives are poorly covered, despite being regarded by general practitioners as essential (Bado & Williams, 1984; Tulloch *et al*, 1975).

The study

The study was based at Highcroft Hospital, Birmingham, which is a large psychiatric hospital serving a population of 466,000 and with a staff of 10 consultant and 13 junior psychiatrists (all posts are approved for psychiatric training by the Royal College of Psychiatrists). One of us (BC) photocopied each discharge summary for 100 consecutive discharges commencing 1 March 1986; on the photocopy neither the patient's name and address nor the name of the doctor writing the summary appeared. The other author (NJC) scrutinised each photocopied summary and recorded its length and the presence or absence of 23 items of information deemed by the authors to be of potential importance in psychiatric discharge summaries (see Table I). Presence of an item was defined as *any* reference to that item and did not necessarily indicate that adequate or useful information was conveyed about it.

Findings

Of 100 sets of case notes examined, 43 were first admissions and 57 subsequent admissions. The distribution of lengths of the summaries, expressed in sides of A4 typescript, was: first admissions: median $1\frac{1}{4}$ (interquartile range $\frac{3}{4}$–2, full range $\frac{1}{4}$–$3\frac{1}{2}$); subsequent admissions: median $\frac{3}{4}$ (interquartile range $\frac{1}{2}$–$1\frac{1}{2}$, full range $\frac{1}{4}$–3). Table I shows the proportion of summaries in which each of 23 items of information was present.

Comment

Any study of the content of discharge summaries is fraught with methodological problems, including (a) subjective factors when deciding on presence or absence of an item of information, and (b) heterogeneity of the admissions with respect to duration, course of illness and information previously known to general practitioner and hospital. We have

https://doi.org/10.1192/pb.14.10.618 Published online by Cambridge University Press

TABLE I
Proportion of discharge summaries containing various items of information

Item	*Number (%) of summaries in which item is present*					
	First admissions (n=43)		*Subsequent admissions* (n=57)		*Total admissions* (n=100)	
Completed summary	43	(100%)	53	(93%)	96	(96%)
Date of admission	41	(95%)	52	(91%)	93	(93%)
Date of discharge	40	(93%)	47	(82%)	87	(87%)
In-patient treatment and progress	33	(77%)	50	(88%)	83	(83%)
Follow-up arrangements	34	(79%)	49	(86%)	83	(83%)
Diagnosis	35	(81%)	45	(79%)	80	(80%)
Discharge treatment	28	(65%)	48	(84%)	76	(76%)
Admission mental state	32	(74%)	39	(68%)	71	(71%)
History of presenting complaint	32	(74%)	34	(60%)	66	(66%)
Legal status (formal/informal)	25	(58%)	30	(53%)	55	(55%)
Past psychiatric history	23	(53%)	19	(33%)	42	(42%)
Reason for admission	18	(42%)	22	(39%)	40	(40%)
Investigations	18	(42%)	16	(28%)	34	(34%)
Personal history	23	(53%)	8	(14%)	31	(31%)
Physical examination	15	(35%)	11	(19%)	26	(26%)
Discharge mental state	10	(23%)	16	(28%)	26	(26%)
Past medical history	18	(42%)	7	(12%)	25	(25%)
Family history	21	(49%)	3	(5%)	24	(24%)
Medication on admission	12	(28%)	7	(12%)	19	(19%)
Advice about management	5	(12%)	12	(21%)	17	(17%)
Smoking/alcohol/drug abuse	12	(28%)	3	(5%)	15	(15%)
Premorbid personality	10	(23%)	2	(4%)	12	(12%)
Prognosis	7	(16%)	1	(2%)	8	(8%)
Information given to patient	1	(2%)	4	(7%)	5	(5%)

attempted to minimise problem (a) by using a simple operational definition that scores an item as present if *any* mention is made of that item (thus, our results show the *maximum* possible proportion of our sample of summaries in which adequate data may be provided). Our approach to problem (b) has been to examine an unselected, representative, consecutive sample of discharge summaries.

In our study, several items of information were given in over 70% of summaries (see Table I). Most of these have been rated as very important or essential items of information in studies of general practitioners' requirements of communications from specialists. Prognosis, advice about management and information given to the patient were recorded in only a few cases, a deficiency also noted in previous studies (Bado & Williams, 1984; Williams & Wallace, 1974; Pullen & Yellowlees, 1985). A further interesting finding in our study was the paucity of information about premorbid personality and mental state of the patient at discharge: these data are very important, both for GP and psychiatrist, in monitoring a patient's progress and assessing changes in mental state.

The comparison of summaries from first admissions with those for subsequent admissions shows that, for most items, there is fuller coverage in the first admission summaries (see Table I). This is in agreement with the preferences of both GPs and psychiatrists (Craddock & Craddock, 1989).

Concluding remarks

We believe this is the first study of the content of a sample of psychiatric discharge summaries. Despite methodological shortfalls, the study indicates several important areas in which summaries could be improved to the benefit of GPs, psychiatrists and, ultimately, the patients. These include details about prognosis, personality, mental state at discharge, management advice and information given to patient and relatives. Our research methodology could be usefully extended to allow effective clinical audit of psychiatric discharge summaries.

Acknowledgements

We gratefully acknowledge the assistance of the medical and administrative staff of Highcroft

https://doi.org/10.1192/pb.14.10.618 Published online by Cambridge University Press

Hospital and thank Dr Christine Dean for help with the manuscript.

References

BADO, W. & WILLIAMS, C. J. (1984) Usefulness of letters from hospitals to general practitioners. *British Medical Journal*, **288**, 1813–1814.

CRADDOCK, N. & CRADDOCK, B. (1989) Psychiatric discharge summaries: differing requirements of psychiatrists and general practitioners. *British Medical Journal*, **299**, 1382.

PULLEN, I. M. & YELLOWLEES, A. J. (1985) Is communication improving between general practitioners and psychiatrists? *British Medical Journal*, **290**, 31–33.

TULLOCH, A. J. FOWLER, G. H., MCMULLAN, J. J. & SPENCE, J. M. (1975) Hospital discharge reports: content and design. *British Medical Journal*, **4**, 443–446.

WILLIAMS, P. & WALLACE, B. B. (1974) General practitioners and psychiatrists – do they communicate? *British Medical Journal*, **1**, 505–507.

Psychiatric Bulletin (1990), **14**, 620–622

Sketches from the history of psychiatry

Useful or useless architecture? A dimension of the relationship between the Georgian schizophrenic James Tilly Matthews and his doctor, John Haslam

ROBERT HOWARD, Registrar, The Maudsley Hospital, Denmark Hill, London SE5 8AF

James Tilly Matthews, a paranoid schizophrenic admitted to Bethlem on 28 January 1797, was to become the most colourful and controversial inmate of the hospital in the years up to his death in 1815. Influential relatives and friends campaigned for his release and attempted to demonstrate his sanity, on two occasions, in 1797 and 1809, having him examined before high court judges. The hospital medical staff, in particular John Haslam, the apothecary (in post 1795–1816), were obliged to demonstrate repeatedly Matthews' continued insanity, and to this end his case was published (Haslam, 1810). Bethlem was under political pressure to continue Matthews' detention. His admission followed an attempt to disrupt a sitting of the House of Commons in December 1796, which occurred as the climax of a campaign of deluded lobbying during which he had made threats against the safety of senior politicians, including Lord Liverpool, the Home Secretary (Matthews, 1796). Under in-patient care, Matthews continued to express threats against the lives of the Royal Family, politicians, and the staff of Bethlem (Matthews, 1804). Transferred to the incurable ward in 1798, his continued detention was at the specific request of the Home Secretary, a fact revealed by Haslam at the 1809 hearing (Haslam, 1809). In May 1813, Matthews, having developed a spinal abscess, was transferred to a private madhouse in Hoxton, where it was felt country air might improve his medical condition. He died there in January 1815.

During Matthews' time as a patient, and even after his death, it was repeatedly alleged that Haslam had developed a personal animosity towards him, and that this had led to harsh treatment and unnecessarily prolonged detention. The testimony of relatives and friends at the 1809 hearing (Dunbar, 1809), and the House of Commons inquiry of 1815, show clearly that they held this opinion. More damning are the allegations made at the Commons Inquiry by the head keeper, James Simmonds, who reported that Matthews had been unnecessarily handcuffed and leglocked for two to three years because "he would not submit to the apothecary" (Simmonds, 1815). Whatever the nature of Haslam's treatment of Matthews, the evidence suggests that he held a low opinion of madmen in general, as when expressing his understandable concern that the House of Commons Inquiry which had led to his professional disgrace had based its questioning of him, and other hospital staff members, on a manuscript written by

https://doi.org/10.1192/pb.14.10.618 Published online by Cambridge University Press