

# Content of a discharge summary from a medical ward: views of general practitioners and hospital doctors

**ABSTRACT**—The objective of this study was to seek the views of general practitioners (GPs), hospital physicians and junior hospital doctors about the relative value of different items of *clinical* information in discharge summaries from medical wards, and so form a minimum and recommended data set for the purposes of clinical audit. GPs were selected randomly from five family health services authorities in England, and hospital consultants and junior hospital doctors were randomly selected from all 14 former health regions. Postal questionnaires were then sent to a sample of 400 GPs, 400 hospital consultants and 400 junior hospital doctors. The results have been tabulated. 'Details of drugs at discharge' (including frequency, dosage and proposed length of treatment), 'significant results of investigations, both positive and negative', 'suggested or made arrangements for follow up', and 'information given to patient about diagnosis' were ranked particularly high by all three groups of respondents.

Discharge summaries should provide general practitioners (GPs) with core information about their patients' recent admission to hospital and plans for further treatment. They also serve a useful function for junior hospital doctors and consultants at any subsequent outpatient visit or readmission, and may be used for coding and analysing the outcomes of the clinical work of a firm or directorate. Many commissioners of health care audit the timeliness of receipt of discharge summaries. A principal focus of our work was to develop a protocol by which the quality of the content of the discharge summary could be audited.

The study was concerned with the formal discharge summary which is normally sent to the GP as opposed to the brief handwritten note usually given to the patient on discharge. The structure of the brief immediate note has already been considered by Clements [1], and Zoltie and de Dombal have considered communication between accident and emergency departments and GPs [2].

The Körner data set was the standard set for operational management (the admitted patient care contract minimum data set, now forms the standard set

for operational management). It includes patient data such as age, sex and ethnic origin; administrative information such as postcode and dates of admission and discharge; and clinical information such as diagnosis and procedures performed. Most of these items can and should be collected by administrative staff but diagnoses require medical input. A good discharge summary must also include those items deemed by all concerned to be relevant and necessary for continuing patient care. The purpose of this study was to establish a minimum set of items which would meet these criteria and allow audit of the content of discharge summaries.

## Method

A preliminary 'brainstorming' workshop was held in which GPs and hospital doctors identified a list of clinical items thought to be relevant. After this, a questionnaire was developed and reviewed by 30 hospital consultants and 30 GPs. Having incorporated their suggestions, we produced a considered list of 20 data set items, the items being listed in random order (Table 1). The questionnaire was then circulated to 400 GPs randomly selected from the medical lists of five family health services authorities (FHSA): Avon, Birmingham, Camden & Islington, Leicester and Norfolk (80 from each FHSA). These locations were selected in order to obtain the views of GPs working in both rural and urban areas. Respondents were asked whether or not they were fundholding practitioners and to state their length of service as a principal in general practice.

The questionnaire was also sent to 400 consultants randomly selected from a list held by the Royal College of Physicians of consultants in 11 medical specialties: cardiology, endocrinology and diabetes, gastroenterology, general (internal) medicine, geriatrics, haematology, infectious diseases, nephrology, oncology, rheumatology and thoracic medicine. These consultants were asked to hand a further copy of the questionnaire to the member of their team responsible for dictating discharge summaries.

In addition to the list of clinical items shown in Table 1, subjects received an introductory letter explaining the purposes of the study and the Körner data set items. The letter stressed that, since the survey was concerned only with clinical data, information which ought to be collected by a hospital patient management system (Körner data set including primary and secondary diagnoses and procedures) was *not* the

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subject of the enquiry. Those surveyed were asked to reply within two weeks of receipt of the questionnaire. A second questionnaire was sent to non-responders after one month.

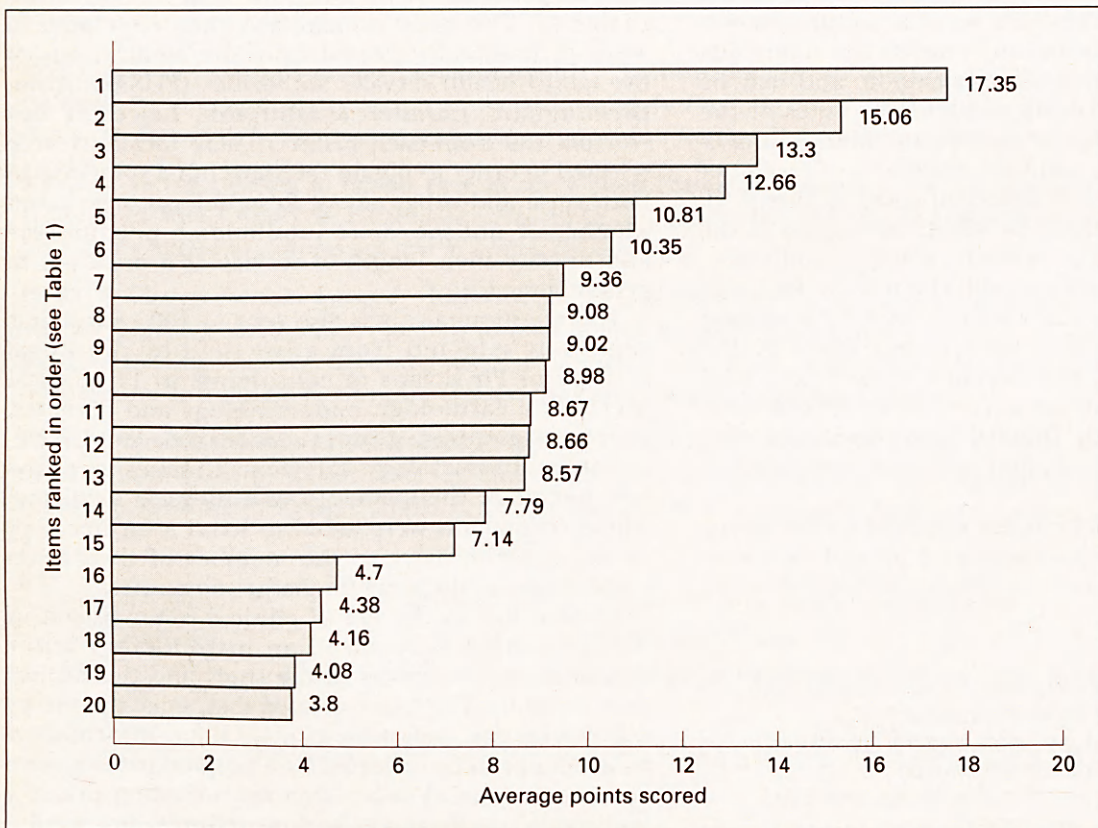
Respondents were asked to choose the 12 clinical items they thought most important—it was thought that this number would form a check list of reasonable length for the purposes of clinical audit. Respondents were asked to rank their chosen items in order of importance (1: most important; 2: the next most important, etc). Joint rankings were permitted. They were given the opportunity to add and rank any items which they felt should be included in their first 12 choices but which had not been listed, and space was provided for comments regarding the study design and content of the questionnaire. Points were assigned to each ranked item on a score of 1 to 20: the item ranked first was given 20 points, the second 19 points, the third 18 points—and so on. A bar chart (Fig 1) was constructed by dividing the total points scored for each item by the number of completed questionnaires for each group of doctors separately to obtain a weighted average.

**Results**

Overall, 639 (53.2%) doctors replied to the questionnaire. Of these, 49.6% were GPs, 34.3% hospital

**Table 1. List of 20 data set items that respondents were asked to rank**

- Information given to carer/relative
- Significant results of investigations, both positive and negative
- History of drug reactions or allergies
- Recommended lifestyle changes
- Details of drugs at discharge (including frequency, dosage and proposed length of treatment)
- Degree of certainty of diagnosis
- Suggested or made arrangements for follow up
- Relevant social factors
- Information given to patient about diagnosis
- Information given to patient about prognosis
- History of presenting problem or complaint
- Adverse inpatient events such as cardiopulmonary arrest
- Prognosis
- Drugs given in hospital *other* than drugs at discharge
- Hospital extension/bleep number for clinician contact
- Name of hospital clinician whom GP can contact for advice
- Relevant examination findings
- Clinical management (other than coded procedures)
- Functional ability (activities of daily living)
- Community services arranged (for the purposes of this survey, health and social services are considered as one)



**Fig 1.** Average points scored by each item for a discharge summary (data set item weighted by numbers of doctors responding in each group).



Table 2. Items that ought to be in a discharge summary ranked in order of importance

Item	Weighted average (see text)	GPs	Hospital consultants	Junior hospital doctors
Details of drugs at discharge (including frequency, dosage and proposed length of treatment)	1	1	1	1
Significant results of investigations, both positive and negative	2	2	2	2
Suggested or made arrangements for follow up	3	4	3	3
Information given to patient about diagnosis	4	3	5	4
Relevant examination findings	5	9	4	5
Adverse inpatient events such as cardiopulmonary arrest	6	6	7	6
History of presenting problem or complaint	7	15	6	7
Information given to patient about prognosis	8	7	9	11
Prognosis	9	5	10	13
Clinical management (other than coded procedures)	10	12	8	9
History of drug reactions or allergies	11	13	11	8
Community services arranged	12	8	14	10
Degree of certainty of diagnosis	13	10	12	12
Name of hospital clinician whom GP can contact for advice	14	11	13	14
Information given to carer/relative	15	14	15	15
Functional ability (activities of daily living)	16	17	16	19
Recommended lifestyle changes	17	18	17	16
Drugs given in hospital, <i>other</i> than drugs at discharge	18	16	19	20
Relevant social factors	19	20	18	18
Hospital extension/bleep number for clinician contact	20	19	20	17

consultants and 16.1% junior hospital doctors. Table 2 shows a breakdown of how each separate group of doctors ranked the items. There were no significant differences in the responders in terms of age, funding status or the different hospital specialties surveyed.

### Discussion

There was agreement that the following should all feature prominently in a discharge summary

- medication being taken by the patient on discharge
- significant results of investigations, both positive and negative
- arrangements for follow up
- information given to patients about their diagnosis

Although the other rankings varied between the professional groups, the remaining items were considered of more or less equal value until the last five (see Fig 1). 'Relevant social factors' and 'functional ability' (activities of daily living) were ranked surprisingly low. GPs ranked 'prognosis' higher than consultants or junior hospital doctors. Junior hospital doctors ranked both 'information given to patient about prognosis'

and 'prognosis' lower than the other two groups. GPs are often asked by their patients about their prognosis; hospital doctors should consider this and make available information that GPs would find useful, even if they themselves are familiar with the facts. This highlights the need for consultants to impress upon their junior staff the relevance of providing such information where available. Conversely, GPs regard 'community services arranged' of greater importance than do hospital doctors, but did not rank 'the history of presenting problem or complaint' in their top 12—perhaps because they have often referred the patient to the hospital and are already aware of the patient's earlier history.

Few respondents listed additional clinical items they considered important. Suggested items included 'referral diagnosis' and 'relevant previous medical history' (both suggested by two respondents) and 'blood pressure and smoking habits' (one respondent). Considering the current emphasis on outcome measurement, it was surprising that data on the outcome of an admission were not mentioned either by the working group or by any subsequent respondent. Perhaps this reflects reality—that techniques of measuring outcomes in other than a research environment are still in their infancy.

Parallel with this project, the Information Working



Group of the Conference of Medical Royal Colleges and their Faculties in the UK has been considering the definitions of some of the data items ranked in this study [3]. This report contains a useful bibliography about discharge summaries. It also stresses that variations in data collection, in language and in criteria for documenting clinical information need to be addressed as we move towards electronic patient records.

### Conclusion

It has been suggested that one of the reasons for poor quality discharge summaries is a mutual lack of understanding between hospital doctors and GPs [4]. It is hoped that a better understanding of each other's need will emerge by identifying what both groups would like to see included in a discharge summary. The current emphasis on providing more care in the community requires better communication than ever before between different health professionals. Until recently the audit of discharge summaries has been restricted to timeliness of their delivery. We can now progress to assessing their content.

### Acknowledgements

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# Treatment of adult patients with renal failure

## RECOMMENDED STANDARDS AND AUDIT MEASURES

This report is produced by the Renal Association in collaboration with the Royal College of Physicians. Its aim is to set standards that will improve the quality of care for patients with renal failure and protect them from the effects of substandard treatment.

The report provides a consensus statement on recommended standards for haemodialysis, peritoneal dialysis and transplantation. Initiatives for comparative audit to determine outcome are also recommended. Special arrangements for children with renal disease are described in an appendix.

The report contains essential guidance for purchasers and providers of health care who are drawing up contracts for renal services within the NHS.

### Contents

Remit and purpose of the document ♦ End-stage renal failure ♦ Specific practical aspects of comparative audit ♦ Recommended standards and targets for haemodialysis ♦ Recommended standards and targets for peritoneal dialysis ♦ Audit of the treatment of patients with ESRF on dialysis ♦ Transplantation ♦ Acute renal failure ♦ Chronic renal failure (pre-dialysis) ♦ General nephrology ♦ Appendix 1: Incidence, nature and treatment of renal disease — a guide for the non-specialist ♦ Appendix 2: Special arrangements for children with renal disease.



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