A CLINICAL AUDIT OF DISCHARGE SUMMARIES: CONFORMITY TO SET GUIDELINES IN THE DEPARTMENT OF PSYCHIATRY AND MENTAL HEALTH AT MUHIMBILI NATIONAL HOSPITAL DAR ES SALAAM TANZANIA.

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By

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A Dissertation Submitted in Partial fulfillment of the Requirement for the Master of Science Degree in Clinical Psychology of Muhimbili University of Health and Allied Sciences

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October 2012

CERTIFICATION

The undersigned certify that they have read and hereby recommends for examination of the dissertation entitled *"A clinical audit of Discharge Summaries conformity to set guidelines in the Department of Psychiatry and Mental Health at Muhimbili National Hospital, Dar es salaam Tanzania."* in fulfillment of the requirement for the degree of Master of Science in Clinical Psychology of Muhimbili University of Health and Allied Sciences.

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DECLARATION AND COPYRIGHT

I, **Mr. Heriel H. Mfangavo**, declare that this dissertation is my own original work and that has not been presented and will not be presented to any other University for a similar or any other degree award.

Candidate's signature_____

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DEDICATIONS

To all clinicians working at the Department of Psychiatry and Mental Health at Muhimbili National Hospital

ABSTRACT

Background: Patients' records are the most basic clinical tools that are required in every consultation. Discharge summary as a document collect patient's information about inpatients care. The primary function is to support continuity of care as the patient returns to next health provider. Improvement in the care of mentally ill patients may be enhanced by improving discharge summaries writing in terms of its contents and timing. There is paucity of data that shows deficits in writing discharge summaries in the developing countries including Tanzania. Systematically reviewing and auditing care against explicit criteria and set of guidelines is a quality improvement process that seeks to improve the patient care and outcomes. Implementing best-practice guidelines for managing mental illnesses is demanding but rewarding. Identifying deficits in writing discharge summaries as done in this clinical audit is pertinent to ensure improvement of quality of patients' care and good outcome.

Objective: To determine the extent to which discharge summaries conform to the guideline for best practice of mental health service delivery in Department of Psychiatry and Mental Health at Muhimbili National Hospital (MNH)

Study site and design: A cross sectional retrospective, clinical audit of a discharge summary looking at the contents and timing of discharge summary writing was conducted in the Department of Psychiatry and Mental Health at the MNH

Methods: A chart review of all new admission discharge summaries in 2010 was done. A total of 200 planned discharge summaries were reviewed. Data was collected using a discharge check list that was extracted from guideline for best practice of mental health service delivery at MNH. The conformity level was considered at a cutoff point of ≥88% of overall contents of discharge summary as from other studies.

The results were tabulated, grouped and statistically analyzed using the descriptive statistics reported as proportions, frequencies, and comparative statistic using Pearson Chi square/fisher's exact test to detect whether there is a significant statistical difference between different categorical variables. The P value of less than or equal to 0.05 was considered statistically significant for differences examined.

Results: This study found that, of 200 systematically selected planned discharge summaries; "documented review with patient diagnosis" 100% (n=200) and "documented date of return to outpatient clinic" 90.82% (n=178) are the only two items that were in conformity with standard discharge guidelines. The other ten items studied were found not conforming to standard guidelines. Again to determine the timing of discharge summary writing, the results of this study have identified that about 93% (n=186) of the discharge summaries were written within two weeks of admission while others were before/after two weeks of admission.

Conclusion and Recommendations: Implementing good clinical practice in metal health in the department of psychiatry and mental health at MNH remains a challenge for clinicians. Discharging clinician's should follow standard guidelines for good clinical practice as agreed by the department to reduce areas of deficits in clinical practice in mental health. Interventions are needed to ensure clinicians are conforming to the standard guidelines when writing discharge summaries.

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LIST OF ABBREVIATIONS

DSM IV-TR	Diagnostic and Statistical Manual IV- Text Revised
EBPs	Evidence Based Practices
EMD	Emergency Medical Department
GP	General Practitioner
GLLAMM	General Linear Latent and Mixed Models
LOS	Length of Stay
MNH	Muhimbili National Hospital
MUHAS	Muhimbili University College of Health and Allied Sciences
NTP	National Tuberculosis Programme
SPSS	Statistical Package for Social Sciences
WHO	World Health Organisation

OPERATIONAL DEFINATIONS

New case patient files:

These are all files of the patients who have been admitted for the first time at the department of Psychiatry and Mental health of MNH.

CHAPTER ONE

1.0 INTRODUCTION AND REVIEW OF LITERATURE

1.1.1Introduction to Clinical Audit

During the 1990s, significant changes took place in the practice of mental health especially in the treatment of mental health disorders[1]. These changes were the result of a combination of factors, including deinstitutionalization, availability of new medications, and supervised care. Supervised care has prompted the need to demonstrate the efficacy and effectiveness of new medications and other evidence-based interventions to support their incorporation in clinical practice. Published guidelines for the treatment of psychiatric disorders provide a framework of reference that includes expert consensus and research evidence supporting a rational approach to disease management. Most guidelines are general, and their implementation has been left to practitioners and organizations[1].

The extent to which clinicians conform to guidelines varies, partly because of differences in financial support and the availability of other resources[2]. A clinical audit is a quality improvement process that seeks to improve the patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structures, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual team, or service level and further monitoring is used to confirm improvement in healthcare delivery[3].

The medical establishment in the Western world has paid attention to the quality and its measurement, and has incorporated audit into everyday clinical practice[4].

However, the recognition of the importance of clinical audit in developing countries is emerging only slowly. Clinical audit is a recognized part of good clinical practice with many potential benefits for improving the quality and cost-effectiveness of health care.

However, many clinical activities take place without systematic and critical analysis of quality and yet audit is applicable at all levels of health care[4]. The overall aim of clinical audit is to improve patient outcomes by improving professional practice and the general quality of services delivered. This is achieved through a continuous process where healthcare professionals review patient care against agreed standards and make changes, where necessary, to meet those standards. The audit is then repeated to see if the changes have been made and the quality of patient care improved[5]. This study describes the experience of clinicians working at Department of Psychiatry and Mental Health of Muhimbili National Hospital (MNH) in implementing best-practice guidelines when writing discharge summaries.

1.1.2 Clinical Audit Process

The process of clinical auditing occurs in stages. Copeland[5] describe the stages as follows; **Stage one,** the researcher needs to identify the problem or issue. This stage involves the selection of a topic or issue to be audited. Selection of an audit topic is influenced by factors including: availability of standards and guidelines; conclusive evidence about effective clinical practice; problems in practice; existence of a clear potential for improving service delivery.

In stage two, the researcher need to define criteria & standards and decisions regarding the overall purpose of the audit, either as what should happen as a result of the audit, or what question you want the audit to answer, should be written as a series of statements or tasks that the audit will focus on. Collectively, these form the audit criteria.

These criteria are explicit statements that define what is being measured and represent elements of care that can be measured objectively. The standards define the aspect of care to be measured, and should always be based on the best available evidence.

A criterion is a measurable outcome of care, aspect of practice or capacity. For this study the researcher has identified issues with the compliance of clinicians to the standard guidelines when writing discharge summary". *A standard* is the threshold of the expected compliance for each criterion.

Stage three, involve data collection and to ensure that the data collected are precise, and that only essential information is collected, certain details of what is to be audited must be established from the outset. These include: The user group to be included, with any exceptions noted.

In stage four, the researcher compares performance with criteria and standards .This is the analysis stage, whereby the results of the data collection are compared with criteria and standards. The end stage of analysis is concluding how well the standards were met and, if applicable, identifying reasons why the standards weren't met in all cases. These reasons might be agreed to be acceptable, i.e. could be added to the exception criteria for the standard in future, or will suggest a focus for improvement measures.

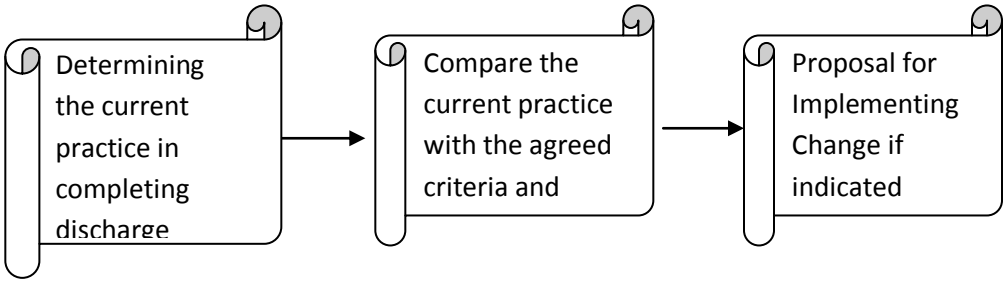
Stage five is for implementing change if indicated once the results of the audit have been published and discussed; an agreement must be reached about the recommendations for change. Using an action plan to record these recommendations is good practice; this should include who has agreed to do what and by when. Normally each point needs to be well defined, with clinicians responsible for it, and an agreed timescale for its completion. However re-auditing is necessary for sustaining improvements. After an agreed period, the audit should be repeated.

The same strategies for identifying the sample, methods and data analysis should be used to ensure comparability with the original audit.

The re-audit should demonstrate that the changes have been implemented and that improvements have been made. Further changes may then be required, leading to additional re-audits.

This stage is critical for the successful outcome of an audit process as it verifies whether the changes implemented have had an effect and to see if further improvements are required to achieve the standards of healthcare delivery identified in stage two. Figure 1 below summarizes the clinical audit process for this study

Figure 1: Clinical Audit Process for this Study:



Borrowed from Copeland[5]

1.1.3 Structure and Function of Discharge Summary

***Structure of a discharge summary*.** Discharge summary is a document containing patient information and is written during inpatient care and issued when or after a subject of care leaves the hospital. Discharge summary is expected to be written by the clinician involved in the care of the patient during admission and completed during or soon after the discharge[6].

It is expected to contain clinical content conforming to various data groups depending on the investigations, findings, assessments, interventions and planned services recorded during the healthcare event[6]. The discharge summary aims to summarize the therapeutic and other significant events during inpatient stay[6]. It provides concise details such as reasons for admission, diagnosis, investigations etc. and is also helpful as a record of responses to different therapeutic interventions.

***Functions of discharge summary*.** Discharge summary is an important and useful communication tool. It can be referred to years later to provide a quick summary of an admission. It is useful for healthcare providers to effectively implement the treatment strategies planned during admission. On the other hand, poor information transfer at discharge does appear to increase the likelihood of readmission[6].It is also important to determine as to whom the summaries are addressed to and what the stated purposes are.

The primary function is to support the continuity of care as the subject of care returns to the non-acute care or their community health care provider(s) [6]. The primary recipients of the discharge summary are health care providers for the subject of care who were providing care prior to the hospital admission and have accepted ongoing responsibility for the ongoing care. They include: the secondary service provider whether the outpatient clinic of the discharging facility, community provider, or municipal/district and the referring clinician where the subject of care usually resides or will newly reside[6].

The secondary functions of the discharge summary is to transfer information regarding an admission care to assist subsequent care which can be further admissions at the same hospital, a different hospital or outpatient follow up[6].

However, the specific content to be included in a discharge summary will depend upon the nature of the diagnoses, diagnostic tests done, assessments, medications prescribed, and interventions performed and/or planned.

Furthermore, a prompt and comprehensive discharge summary from the hospital should ensure effective continuity of care in the community.

In a survey of the views of general practitioners on psychiatric discharge summaries[7], top five headings identified in terms of importance were: admission and discharge dates, diagnosis, and medication on discharge, community key worker and date of follow-up. However, discharge summaries often have failed to meet the needs of secondary service provider.

Deficits in communication and information transfer between hospital-based and primary care physicians were studied. Results showed that discharge summaries frequently did not identify the hospital physician (missing from a median of 25%), diagnostic test results (38%), and specific follow-up plans (14%). Legibility was a concern in 10-50% of the discharge summaries. Outpatient physicians estimated that their subsequent management was adversely affected in nearly one fourth of cases due to inadequate communication[8].

Improving discharge procedures and audit of discharge summaries is an important part of this study. In many hospitals, including Muhimbili the summary is used for two purposes. First, a copy is sent to the secondary service provider to provide the patient with continuation of management started during the admission and additional treatment if indicated after discharge like medication, psychotherapy. Secondly, a copy is filed in the hospital notes as a record of the admission. Therefore, it is expected that the discharging team to write more information about diagnostic work up and therapeutic interventions that will be of benefit to patient.

1.1.4 Magnitude of Discharge Summary Deficits

Currently, no documented studies that have examined the composition of psychiatric discharge summaries in East Africa including Tanzania. However, in other countries like South Africa and western countries clinical audits have been conducted in different contexts and aspects of services.

In United Kingdom a study done by Williams & Wallace[9], looking at the content of samples of psychiatric out-patient assessment letters from the sample of 92 letters and found that; most of the letters contained the five most common items. The items were: **present symptoms, treatment, history and diagnosis.**

In addition in United Kingdom, another study done by Pullen & Yellowlees[10], on the discharge summaries 10 found that diagnosis, treatment and follow up were given in over 88% of their sample of 60 recent letters. The study demonstrated poor coverage of prognosis, suicide risk and explanation of the condition, all of which were regarded as important items by general practitioners.

However, studies examining the information content of samples of discharge summaries have shown that demographic data, diagnosis, treatment and follow-up are usually well covered, but that of prognosis, advice about management and information given to patients and relatives are poorly covered, despite being regarded by general practitioners as essential[11]. Moreover, several studies indicated several important areas in which summaries could be improved to the benefit of secondary service provider and, ultimately, the patients. These included details about prognosis, personality, mental state at discharge, management advice and information given to patient and relatives[11].

In another study done by Craddock & Craddock[12] in United Kingdom, several items of information were given in over 70% of discharge summaries. Presence of an item in this study was defined as any reference to that item and did not necessarily indicate that adequate or useful information was conveyed about it. Most of these items were rated as very important or essential items of information in the study of general practitioner's requirements of communications from specialists through discharge summaries.

In Hong Kong a study was conducted in July 1999 at the Department of Surgery, Tuen Mun Hospital[13]. A total of 160 discharge summaries were collected. The results showed that area like non- classified vital information, medication on discharge, the name of clinician, and signature needed improvement. During the re-audit a total of 37 cases were audited in January 2000. The results showed good improvement in the weak areas identified in the previous clinical audit. The audit team recommended to Chief of Service to orientate each new clinician to the criteria of a good discharge summary.

The weaknesses identified in the audit were conveyed to all consultants and medical staff to assigned one senior medical officer and one medical officer to conduct orientation program to new doctors[13].

1.1.5 Extent of Clinical Audit in Clinical Practice

The medical establishment in the Western world has invested to quality and its measurement, and has incorporated audit into everyday clinical practice[14]. Although regular review of current practice with regard to communication is very useful, services provided should be tailored to the needs of those using them[14]. The primary mode of communication between the hospital care team and aftercare providers is often the discharge summary, raising the importance of successful transmission of this document in a timely fashion [15].

Most mental health services use relatively wide-ranging, detailed discharge summaries. However, information on the quality of and satisfaction with these summaries is scant[6].Further Singhal, [16] the report on an audit of discharge summaries in a 10-bed child psychiatry inpatient unit located within a children's hospital was conducted.

The tool used was questionnaires, which were sent to psychiatrist who received a discharge summary from the psychiatric unit last year.

Of those who had received a summary, 75% (9/12) were satisfied with the information provided, but two thirds 67% (8/12) felt that the summaries lacked some vital information. Ten of the respondents (83%) provided suggestions for improvement[16].

Detailed discharge summaries from an inpatient unit, are required to meet the differing needs and expectations different mental health practitioners[17]. Preparing discharge summaries raises some important training and supervision issues.

The views of junior doctors who prepared discharge summaries suggested that the subject of discharge summaries aroused strong feelings[18]. Lack of guidance given to doctors in preparing summaries' was also raised.

The recommendation for providing junior doctors with some specific training and having the completed summary checked by a senior colleague was given[18]. However, a structured format aids in the task[18]. The design and format of discharge summaries needs to account for the nature of the individual service and the expectations of it. The aim is to achieve a delicate balance of length, detail, timeliness, accuracy and relevance.

A study on the discharge summary in an acute psychiatric inpatient setting by Kader & Singh[19] to assess the standards of discharge summaries against local guidelines was done, in context of its timing and content[19]. The aim of the audit was to assess the standards of discharge summaries against local guidelines.

The results of the study showed that out of the forty-eight case notes examined, 40 (83.3%) discharge summaries were obtained. Eight (16.7%) discharge summaries were missing from the case notes. Initially time taken to type the discharge summary was looked at. Time taken was divided in to three groups; less than two weeks, two to four weeks and more than four weeks[19]. From the study[19], it was found that only 50% of discharge summaries were typed within two weeks of discharge and a quarter was done only after four weeks.

When looking at the contents[19], results showed that date typed, date of admission, date of discharge, medication on discharge and diagnoses were recorded in all (100%) discharge summaries. While date of dictation was mentioned only in 10 (25%) discharge summaries, full psychiatric history, and mental state examination on admission, physical examination on admission was recorded in 8 (20%), 30 (75%), and 8 (20%) respectively.

In 38 (95%) discharge summaries, progress on the ward was mentioned and investigations done were mentioned on 9 (22%) of discharge summaries. In only 10 (25%) of discharge summaries level of effective care co ordination was recorded. While follow up arrangements were recorded in majority (90%) of summaries, name of coordinator was recorded only in 15 (37%) of summaries.

Rest of the history like past psychiatric history, past medical history, family history was recorded in 16(40%), 13(32%) and 10(25%) respectively. In 9(22%) discharge summaries, personal history and drug & alcohol history were recorded. However, forensic history and premorbid personality was recorded only in 7 (17%) and 4 (10%) of discharge summaries, respectively. Despite setting local guidelines for discharge summaries related to local needs[19], the study found that the local guidelines were not being fully met. The quality of the discharge summary also fell short of expected standards of the addresses.

Suggestions were; efforts should be made to explore possible reasons for the shortcomings and attempts made to address those, so that discharge summaries fulfill their role as an effective communication tool rather than just a routine exercise[19].

Some of the studies have looked into different aspects like medication writing in a discharge summary. For instance a retrospective audit by Kumar JA *et al*[20] of 100 discharge summaries to evaluate the accuracy of medication recording was conducted[20].

Also the recording of medication prescribed as required (PRN) prescribing, and to see whether or not general practitioners were advised on how long to continue the latter was conducted. After a formal guideline was introduced a re-audit was conducted.

The results showed that there was an improvement in summaries recording medication correctly (from 64 to 83%). The number of summaries with one or more missing medications halved and PRN sedative prescribing reduced from 18 to 3%, but provision of advice on the latter did not improve.

Kumar JA *et al*[20] conducted a re-audit in the following year looking at 100 consecutive discharges during a 6-month period from the end of last year. If any notes were missing at the time, the notes of the next patient in the list were taken.

The results suggested that, the introduction of a guideline for discharge summaries increased the accuracy of medication recording and decreased the number of medications omitted from discharge summaries, but it did not alter the frequency of the recording of wrong dosages. However, at re-audit the mistakes were mostly on physical medications, especially the errors about dosages. The clinical audit and interventions implemented helped to reduce errors in medication recording in discharge summaries. Accurate communication between primary care and hospital is essential to the continuity of patient care[20]

Moreover Wye P *et al*[21] conducted a retrospective systematic medical record audit was of all psychiatric inpatient discharges over a six-month period 1st September 2005 to 28th February 2006), at a large Australian psychiatric hospital, with approximately 2,000 patient discharges per year [21]. The purpose was to investigate the prevalence of recorded smoking status, nicotine dependence assessment, and nicotine dependence treatment provision; and to examine the patient characteristics associated with the recording of smoking status.

A one-page audit tool identifying patient characteristics and prevalence of recorded nicotine dependence treatment, and requiring ICD-10-AM diagnoses coding was used. From 1,012 identified discharges, 1,000 medical records were available for audit (99%). Documentation of smoking status most frequently occurred on the admission form (28.8%) and diagnoses summary (41.6%). Documentation of nicotine dependence was not found in any record, and recording of any nicotine dependence treatment was negligible (0-0.5%).

The rate of recorded smoking status on discharge summaries was 6%. Patients with a diagnosis of alcohol, cannabis, sedative use disorders or asthma were twice as likely to have their smoking status recorded compared to those who did not have these diagnoses[21].

Mental health services have failed to diagnose and document treatment for nicotine dependence; do not conform to current clinical practice guidelines, despite nicotine dependence being the most commonly diagnosed psychiatric disorder. Considerable system change and staff support was required to provide an environment where a primary prevention approach such as smoking care can be sustained[21]

In addition, a clinical audit done by N. Panagiotopoulou *et al* [22] to assess the quality of discharge summaries completed following acute or elective hospital review[22].

Retrospective survey with review of case notes of women who were reviewed at the hospital following an acute admission or scheduled appointment over a one month period was conducted. The Commissioning for Quality and Innovation framework, April 2009 provided the standards for this clinical audit. A total of 40 patients' case notes and relevant discharge summaries were reviewed; 10 from each clinical area. Demographic data was documented correctly for all patients. Patients' consultant and health professional completing the discharge summaries appeared in all summaries. Admission details were documented in all discharge summaries for in-patients.

The study[22] added that presenting complaint was documented in all inpatient but in only 80% of outpatient summaries. However, the clinical diagnosis, future actions, management plans and instructions for GPs were documented in all discharge summaries. For inpatients, investigations and their results during admission were documented in only 66.67% of cases, treatment during admission in only 43.3% and medications on discharge in only 20%.

No mistakes were identified in all summaries reviewed. Discharge summaries appeared to be of overall good quality but occasional omissions of vital importance such as new or altered medical treatments were identified. To resolve this problem, we produced headed discharge summaries templates and we made them available to all wards and clinics with the recommendation to be used. Moreover, training on discharge summaries has been introduced to the departmental induction[22].

In addition, another study by Gloucestershire National Health Service (NHS) Primary Care Trust[23] to gain a better understanding of the quality of the information received was conducted in January 2009 in United Kingdom. The aim of this audit was to gain evidence of the quality of information received by General Practices in order to improve patient care. A total of 14 practices took part in the audit selected to give a cross representation of size and location.

The audit took place during January 2009 and 857 questionnaires were used to provide the information for this audit. Findings showed that the vast majority (84%, 8 of 10) of discharge communication used Infoflex (electronic discharge summaries). A minority were by letter (13%) and fax or TTOs (3%).

The findings indicated that where Infoflex was used, the discharge summary was more likely to provide the necessary information to the GP and in a format that is easier to use[23]. Overall almost 75% of discharge communications were considered by primary care clinicians to provide the necessary information for adequate patient care.

The inadequate information included primary care follow-up (1 out of 3); drug related information (1 out of 6), lack of named consultant (1 out of 7) and diagnosis (1 out of 10). Infoflex was the preferred format for discharge communication. Also in order to monitor the changes/improvement of discharge communication, annual re-audits were recommended over the next three years. These recommendations through action plans and future audits will continue to be monitored[23].

In reviewing the clinical audit in developing countries, the example of audit undertaken in the medical department of Queen Elizabeth Central Hospital, Blantyre, Malawi, illustrates the feasibility and benefits of local audits[24]. The review reports that a successful example of a national level audit is the model NTP of Malawi developed by the International Union against Tuberculosis and Lung Disease[25] and implemented in numerous developing countries throughout the world, with technical support of the WHO Global Tuberculosis Programme.

There are different ways of measuring quality. One common model for considering the elements of health care delivery is to look at structure, process and outcome[26].

Measuring quality in health care raises the standard of care through decreased uncertainty in health care provision, rationalized choice, appropriate direction of limited resources, increased job satisfaction and improved ethical standards and appropriateness of medical interventions and variability in medical judgments [27]. In addition, large and unacceptable variations in clinical practice are usually due to a lack of evaluation combined with inadequate data and can be reduced by measuring quality: clinical practice is thus directed appropriately so that health care workers do not waste time or expose patients to unnecessary risk by providing ineffective treatment[28]

In South Africa, Janse van ABR [29] conducted a study to review and describe the clinical profile and acute in-patient treatment of patients diagnosed with schizophrenia over a four-year period.

The aim of the study was to review and describe the documented evidence for the diagnosis of schizophrenia; and to identify possible associated or predictive factors in the acute in-patient treatment outcome of patients at an acute ward within a general hospital, Helen Joseph Hospital. Routine discharge summaries were used in a retrospective clinical review of patients with schizophrenia. The study contributed by identifying these predictive indicators for the acute in-patient treatment outcome of patients with schizophrenia.

Future standard operational procedures for diagnostic and treatment processes in acute wards were proposed and may have to include structured interviews in order to enhance the quality of the routine process of diagnosis and treatment of patients with schizophrenia[29].

Again in reviewing the outcome of the care a study on the Clinical profile of acutely ill psychiatric patients admitted to a general hospital psychiatric unit with the objective of providing the baseline information on psychiatric morbidity and treatment outcome was conducted by Janse van ABR [30]. The study was a retrospective clinical audit which was undertaken at the mental health service delivery, teaching and research at Helen Joseph Hospital in South Africa over a one-year period from September 2003 to August 2004.

The study focused on the two service delivery datasets; the inpatient Discharge Summary Report and the Consultation/Liaison Report. A total number of 438 service users were recruited and monthly averages of 80 consultation/liaison assessments were conducted during the study period. Non-compliance and substance abuse contributed significantly to the admission of service users. Schizophrenia was indicated as the most likely diagnosis in almost a quarter of cases. The emphasize was that; morbidity and treatment outcome at Helen Joseph Hospital in South Africa will only be contextualized after the implementation of a regular clinical audit process in all the facilities of its referral network[30].

A clinical audit now forms an integral part of clinical practice in developed countries, at least partly in response to legal and professional pressures. Again, there is less motivation for audit in developing countries where these pressures are less[26]. However in the face of resource constraints, those who make decisions about health care expenditure may not consider audit a priority.

Professional accountability may be less rigorous in developing than in developed countries. Some health care workers may find audit threatening and resist its introduction so as not to upset a comfortable status quo[26].

1.1.6 Process to Effective Documentation

Many health care tasks are boring, repetitive and performed without feedback. Providing feedback on quality of performance is one way to improve health care worker motivation, job satisfaction and performance[26]. A wider perspective on health care embraces not only the quality of interventions but also ethical considerations of the moral rights of patients [31], such as patient privacy and confidentiality and treatment of patients without prejudice, bias or favour., Furthermore, objective assessment of these considerations may at least in part mitigate the extent to which they have been ignored on the grounds of political or cultural expediency. Again, socioeconomic conditions have exposed weaknesses in the health care delivery systems in many countries in sub-Saharan Africa and elsewhere. Faced with two factors there is a heightened need to focus on the issues of quality and cost effectiveness of health care[26].

However planning helps, discharge planning ensure that patients are discharged from the hospital at an appropriate time in their care and that, with adequate notice, with other services will be organized. The aim of discharge planning is to reduce hospital length of stay and unplanned readmission to hospital, and improve coordination of services following discharge from hospital[32].

All patients should have a treatment plan within 24 hours of arrival. The expected date of discharge should be proactively managed against the treatment plan on a daily basis and changes communicated to the patient. Ward rounds should be scheduled in a way that allows at least daily, a senior clinical review of all patients[33].

Again, effective and timely discharge requires the availability of alternative, and appropriate, care options to ensure that any rehabilitation, recuperation and continuing health and social care needs are identified and met[34]. Approaches that ensure closer adherence to evidence-based guidelines and meet patient self-management needs may improve clinical outcomes and reduce health care expenditures[35].

Discharge summary is the primary mode of communication between the hospital care team and aftercare providers is often the discharge summary. It raises the importance of successful transmission of this discharge summary in a timely fashion. Unfortunately, the discharge summary reaches the primary care provider by the time of the first follow-up visit in only 12 to 34 percent of such visits, and even then often lacks key information[36]. Changes to service delivery principles and frameworks have influenced trends to more comprehensive and modular documentation forms. Documentation of quality improvement processes will help ensure that mental health-specific needs for information are met during the transition to a more integrated health system[37].

Although clinical audit is a recognized part of good clinical practice with many potential benefits for improving the quality and cost-effectiveness of health and continuing care, many clinical activities take place without systematic and critical analysis of quality and yet clinical audit is applicable at all levels of health care[26]. Routine clinical audit programmes should be essential components of good professional practice[38]. Therefore it is important to consider more than clinical audit to improve the quality of service of a particular facility.

A study by Crossan *et al*[39]was done to examine and attempt to improve the recording of information within psychiatric discharge summaries in an adult psychiatry department, by means of audit and feedback. Psychiatric discharge summaries from an acute adult psychiatric department were examined to determine the recording of ten selected items. Following feedback and discussion, the audit was repeated after 6 months.

Findings showed that 51 discharge summaries were examined on the first occasion and 53 on the second. There was considerable variability in the standard of recording across the selected items, but the patterns of recording were similar at both stages. No improvement was found in the recording of information at the second audit.

The suggestion was audit and feedback alone may have little effect in changing clinical practice[39]. Instead considering the experience of undertaking clinical audit from a trainee's perspective, illustrates barriers to change and highlights the possible limitations of audit as a clinical tool[39].

1.2 PROBLEM STATEMENT

Documentation has been very important from legal, professional perspectives and continuum of patient care. Documentations for a long time have not been an area of focus in the resource limited countries. The patients' records are among the most basic of clinical tools and are involved in almost every consultation. Patients' records help to give clear and accurate picture of the care and treatment of patients and to assist in making sure they receive the best possible clinical care. They help clinicians to communicate with each other, with other healthcare professionals and with themselves, and are essential to ensure that an individual's assessed needs are met comprehensively and timely. Aggregated, they form a permanent account of individual considerations and the reasons for decisions. Essential for effective communication and good clinical care, they are often accorded low priority, are poorly maintained and not readily available.

Again clinical handover from hospital to community is a high-risk scenario particularly for patients who suffer mental illness. For this group of patients with a mental illness are at greater risk than the general patient population of unplanned readmissions during this same time.

In the mental health care setting, stigma, confidentiality and issues relating to competency for decision-making increase the complexity of discharge communication. In both acute and community settings deficits in communication and information transfer is increasingly being identified as a factor in adverse health events and diminished safety and quality of care.

However, information about mental health patients at the point of transfer from one service to another tends to be confined to their psychiatric status. People with a mental illness may have poorer physical health and issues with relationships and lifestyle. Information about the person's social and physical health therefore is required for a holistic treatment plan.

Moreover, the quality, type and depth of the information is often dependent upon factors such as the interpersonal relationship between the discharging psychiatrist and individual inpatient personnel, and time available by both parties to spend on the handover process at any given time.

Due to lack of documented studies on the subject, the sensitivity of the subject in implementing best practice in mental health, researcher came up with the proposal to assess the current situation at the department. Also the availability of the standard guidelines for a good mental health practice for discharge summary has made the researcher to propose for the study.

The long term goal is to have regular and continuous improvement process for continuing care that will lead to the development and implementation of a best-practice model for patients with mental health disorders attending at the Department of psychiatry and mental health of MNH as per standard guidelines.

1.3RATIONALE AND JUSTIFICATION

Implementing best-practice guidelines for psychiatric illness is demanded but rewarding process. It requires the joint effort and commitment of all the practitioners involved in the care and treatment. The team agrees this effort and discharging clinician will be responsible in documentation as per team agreement. It also requires the drive, creativity, and perseverance of discharging clinicians to communicate the team effort in managing the patient as per standard guidelines.

Working with mentally ill inpatient is a multi professional collaboration and involves communication of what has been done and what is preferred for a patient to get better. This communication is transferred to a secondary service provider being the outpatient clinic of the respective firms or other facilities through a discharge summary. This communication is integrated into daily practice through standardized guidelines and simplifies work for discharging clinicians in doing their best in implementing best practices. However, implementation of the best-practice guidelines in mental health is an ongoing process that requires ability to decide and adapt to the ever-changing realities of health care and the frequent revision of priorities by involved mental health practitioners in which clinical psychologists are also involved.

Therefore understanding the current practice in implementing best clinical practice through standardized guidelines in discharge summary writing in terms of its contents, timing and identifying areas of deficits is pertinent to the enhancement, communication and improvement in the quality of patients' care and good outcome.

1.4. CONCEPTUAL FRAMEWORK OF THE STUDY:

A theoretical framework facilitates the research process. In choosing a theoretical framework I adopted the image theory which has been used in other evaluation studies Falzer *et al*[40]. However the environmental context in which it was used by Falzer *et al*[40] is very different in this environmental context. However it has helped the researcher of this study in describing conformity process to the standard guideline of the department by clinicians.

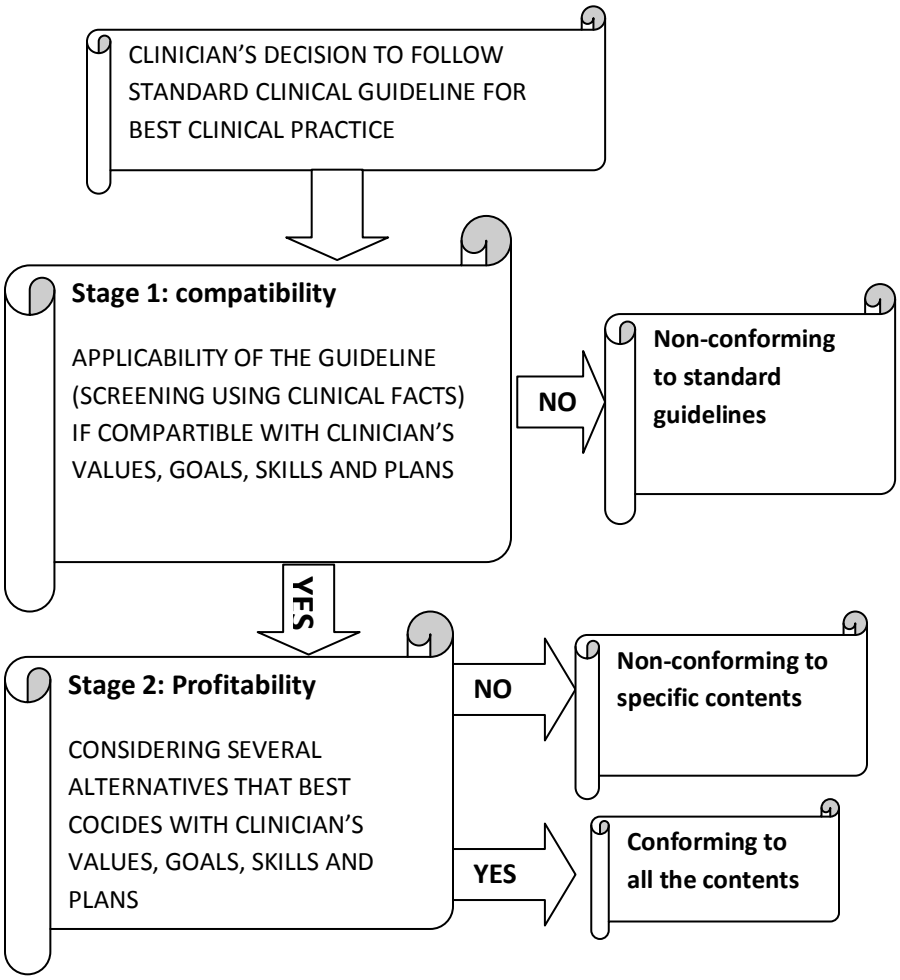
Falzer *et al*[40] reported that the two stage image theory of decision making describes decision making as a cognitive process and point out that decision processes begin with filtering out unacceptable alternatives, and only if necessary proceeding to a second stage of choosing a preferred alternative[40].

The mechanism of discarding unacceptable alternatives is called screening. Image theory studies have shown that the most common screening strategy involves unit-weighting. Commonly, screening eliminates all choices except one and therefore becomes determinative[38]. For instance, if the decision is to follow a treatment guideline unless there are specific reasons not to follow, then screening is the definitive decision strategy.

Therefore, it is suggested that clinicians incorporate evidence based practices (EBPs) into their decisional processes through the mechanism of screening. Instead of, or at least prior to, their using a guideline to assist in making a choice, they assess the guideline's applicability by using pertinent clinical facts as screening criteria.

Thus, clinicians will follow the guideline unless there is sufficient reason not to follow and it may determine that the guideline is not appropriate for a clinical practice[40] .Figure 2 below summarizes the conceptual framework of this study.

Figure 2: Conceptual framework



Source: Adopted from Beach LR, Strom E[41]

1.5. OBJECTIVES OF THE STUDY

Broad Objective

The main purpose was to determine the extent to which discharge summaries did conform to the Muhimbili National Hospital guidelines for good mental health practice in the Department of Psychiatry and Mental Health at Muhimbili National Hospital

Specific objectives

1) To determine proportion of conformity to discharge summary writing as per agreed department standard guidelines in terms of its contents
2) To identify the specific areas of deficits in the discharge summaries as per department's guidelines
3) To determine the timing of discharge summaries writing
4) To publish the findings of the this study

1.6. RESEARCH QUESTIONS:

1) What proportions of discharge summaries at the Department of Psychiatry and Mental health at MHN are conforming to the standard guidelines?
2) To what extent are the specific content areas of a discharge summary having deficits?
3) Knowing time to have a discharge plan in place, when do most clinicians write discharge summaries in the Department of Psychiatry and mental health?

CHAPTER TWO

2.0 RESEARCH METHODOLOGY

2.1Design of the Study

This study is a cross sectional, retrospective clinical audit of a discharge summary looking at the contents and timing conformity as per set standard guidelines of MNH.

2.2 Study Area

The study was done at the Department of Psychiatry and Mental Health of Muhimbili National Hospital. The facility has ability to accommodate up to 12 patients in acute ward for both male and females. Also in the general ward there are about 23 beds for females and 24 beds for males. However all patients admitted in the facility are considered acute because the facility accepts only acute cases. The provision of the services has been divided into four groups of firm's namely Temeke, Kinondoni, Ilala and Magomeni as per catchment area.

Then clinicians of the same firm will continue with outpatient care for their patients. Each firm has clinicians of different discipline in mental health and includes psychiatrists, clinical psychologists, occupational therapists, clinical social workers, residents and interns. Each of these has a different role as per standard guidelines and they are able to communicate to each other effectively in helping the mentally ill patient together as a team.

2.3 Study Population

A chart review was done and researcher reviewed all the new admission discharge summaries in the year 2010.

2.4 Sample Selection

The aim of sampling is to get a sample that will be representative of a target population. For this study the first thing was to get the total number of files of patients seen in 2010 as new cases and were admitted. The reason for choosing new cases is that some of the old cases have more than one file and it is hard to find the lost files. From computer data of medical records, the total of 2956 patients' files number had admission status in 2010. Among these files a total of 1957 were new cases and only 1807 patient's files were found with a copy of discharge summary.

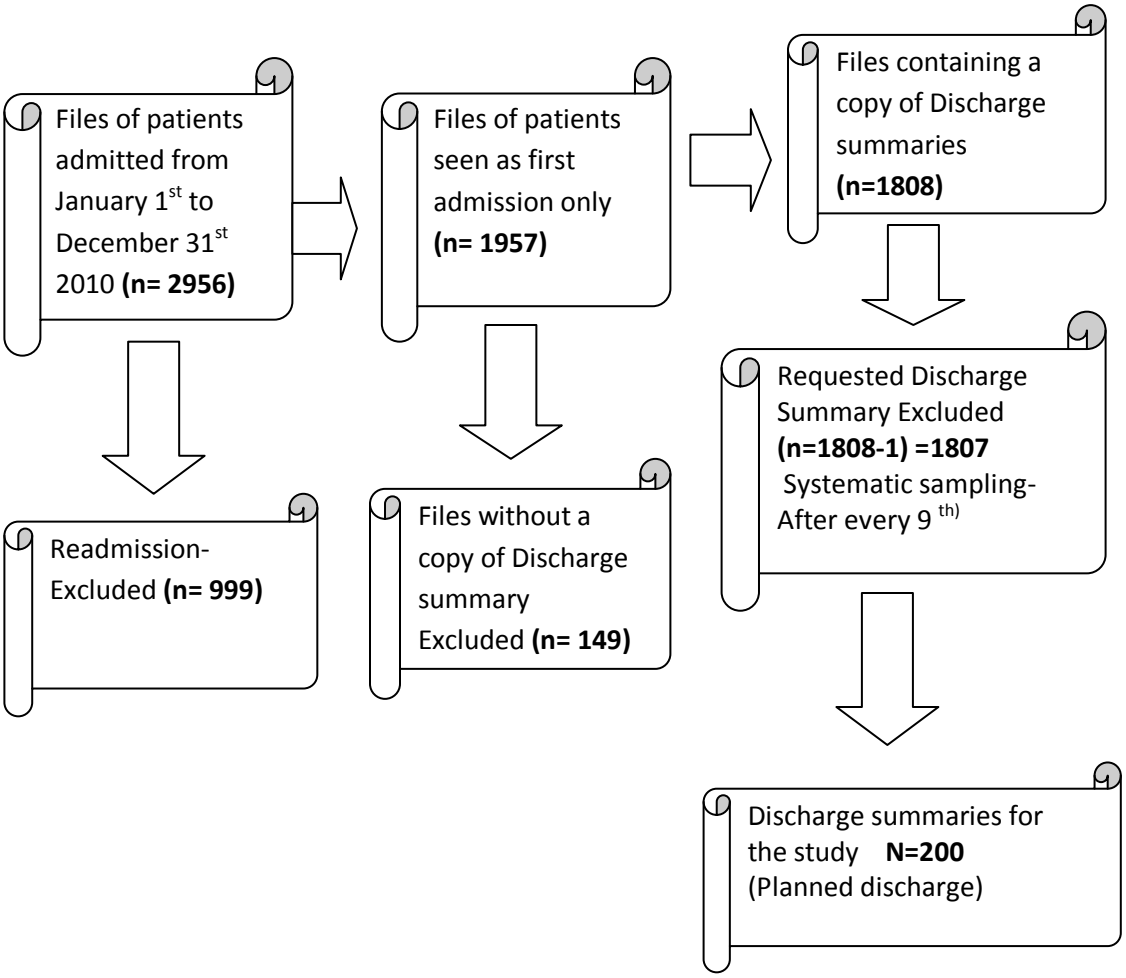
2.5 Sampling Procedure/Technique

The list of 2956 patients admitted in 2010 in which 1957 were new cases. Only 1807 patient's files were found with a copy of discharge summary, these files were systematically selected in which every ninth patient's file from the list was selected by assigning the files number 1 up to 1807 so as to get the required sample size of 200. See figure 3.

2.6 Inclusion and Exclusion Criteria

The study included all files with discharge summaries written in 2010 as planned discharges. Exclusion criteria were all the files without a copy of discharge summary, discharge summaries which are difficult to read, discharge summaries written on piece of paper, readmission in the same year, requested discharges and discharge against medical advice (DAMA).

Figure 3: Sampling Procedure



2.7 Sample Size Estimation

The estimated sample size N was computed using the formula; $N = \frac{z^2pq}{d^2}$

Where; N = Estimated Sample Size, Z = is the standard normal deviate, which turns out to be 1.96 on using the 95% confidence interval,

P = 88%. This was the cutoff point of the proportion for conformity in discharge summary writing in one of the study in United Kingdom[10].Other studies had a higher/lower proportion than this and others could not give overall proportion.

q = (1-P) = proportion, d= margin of error will be 0.05%,

Therefore; $N = 1.96^2 \times 0.88 \times 0.12 / 0.05^2$ N=163

When adjusting for missing discharge summaries in the file 10%=17

N= 163+17=180

Therefore estimated Sample Size was 180. However, I collected 200 discharge summaries to increase the power of the study

2.8 Data Collection

Data were collected from the new case patient files looking at the discharge summary for planned discharge. The files that were involved were those of 2010 only.

2.8.1 Data Collection Tool

Researcher created a checklist(See Appendix I- Data collection tool) which was drawn from a standard discharge checklist as a standard guideline of the department (See Appendix II-Discharge checklist guideline of the Department of Psychiatry and Mental health at MNH) to collect data from the discharge summary written in a discharge form of MNH No. A. 005. From the checklist, information included were those identifying the following variables;

i) Timing of discharge summary writing. This is the range between the date of admission and discharge. According to the standard guideline, discharge plan should be ready at the end of the second week of admission (See Appendix III-Matrix of Standard of the Department of Psychiatry and Mental Health at MNH). Therefore researcher wanted to determine the timing of discharge summaries at the department.

ii) The discharging clinician title whether a resident or intern by looking at their signed names and comparing it with the list of clinicians available during the discharge summary written at the head of Department Psychiatry and Mental Health MNH

iii) The firm where the patient/clinician belongs by checking the address of residence of the patient and list of the clinicians of a particular firm during the time of discharge summary writing available at the head of Department Psychiatry and Mental Health MNH.

iv) The 12 contents areas of discharge summaries derived from the discharge checklist. A total of 17 questions were extracted from discharge checklist and used to collect data for this study. Data were scored using Yes/No response.

2.8.2 Recruiting and training of research assistants

Two research assistants, trainees in medical field were recruited to assist in data collection. They were trained for 3 days prior to conduction of the study. The purpose of the training was to familiarize them with the tool and the necessary procedures for data collection.

2.8.3 Data Management

Soon after data collection, all questionnaires were checked for completeness. The responses to all the questions were checked and any inconsistencies were noted and corrected. All data were recorded and transferred on Statistical Package for Social Sciences (SPSS) Version 15.

The conformity level was considered to be ≥88% taken from other studies[10]. Non conformity was considered to be ≤88% and areas of deficits were identified. The results were tabulated; grouped and statistically analyzed using the descriptive and comparative statistics Pearson Chi square test/Fisher's exact test was used to detect whether there was a significant statistical difference between different categorical variables. The $P < 0.05$ was used as a level of statistical significance in this study.

2.8.4 Ethical considerations

Ethical clearance to conduct the study was sought from Muhimbili University and Allied Sciences Ethical Review Board. In addition, the Muhimbili National Hospital and the department of psychiatry gave permission to access the patients discharge summaries. Files were collected from medical record office, coded in a questionnaire and data collection was done in a room at the department where only the people who are involved in the study was. This was done to protect the biographic data of patients. Before the end of the day all, the files were returned to the medical records each day until the end of data collection.

CHAPTER THREE

3.0 RESULTS

3.1 Discharge Summaries Writing

A total of 2956 patients admitted to the department of psychiatry and mental health in the year 2010. From this study it shows that 1957 patients were admitted at the psychiatric ward as new cases during the year 2010 and 200 discharge summaries for planned discharge were selected. These 200 systematically selected discharge summaries were written by clinicians of different professional qualifications

From the findings it shows that Interns had written majority of discharge summaries 127(63.50%) as compared to Residents 73(36.50%), of the discharge summaries. (See Figure 4) Furthermore the 200 discharge summaries were also written by clinicians of different firms where the patient belongs during inpatient care. The findings shows that Temeke firm had written a total of 56(28.36%), Ilala 51(25.37%), Magomeni 48(23.88%) and Kinondoni 45(22.39%) discharge summaries. (See Figure 5)

Figure 4: Distribution of discharge summaries by professional qualification

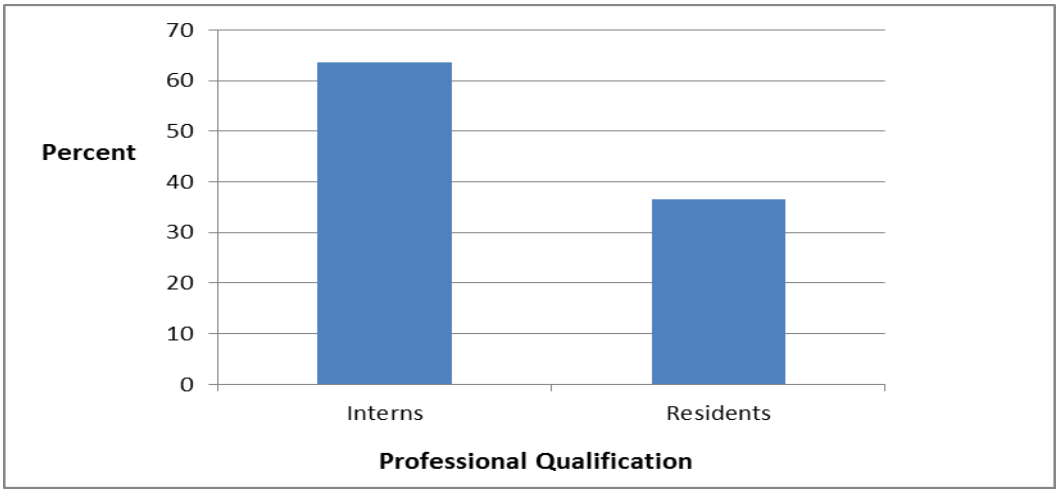
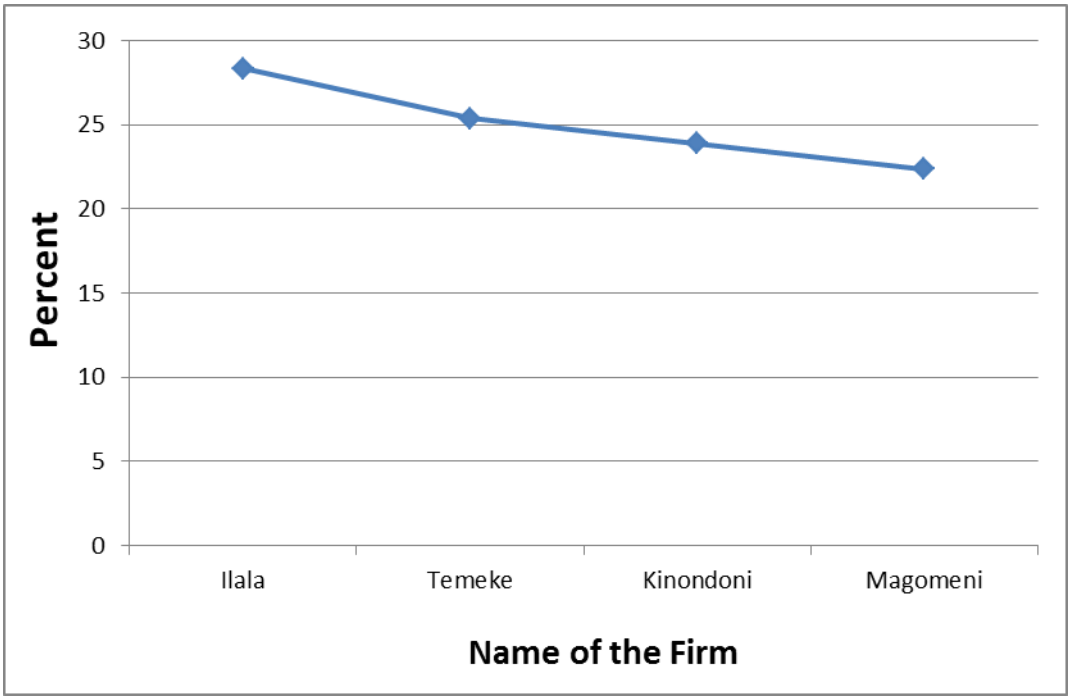


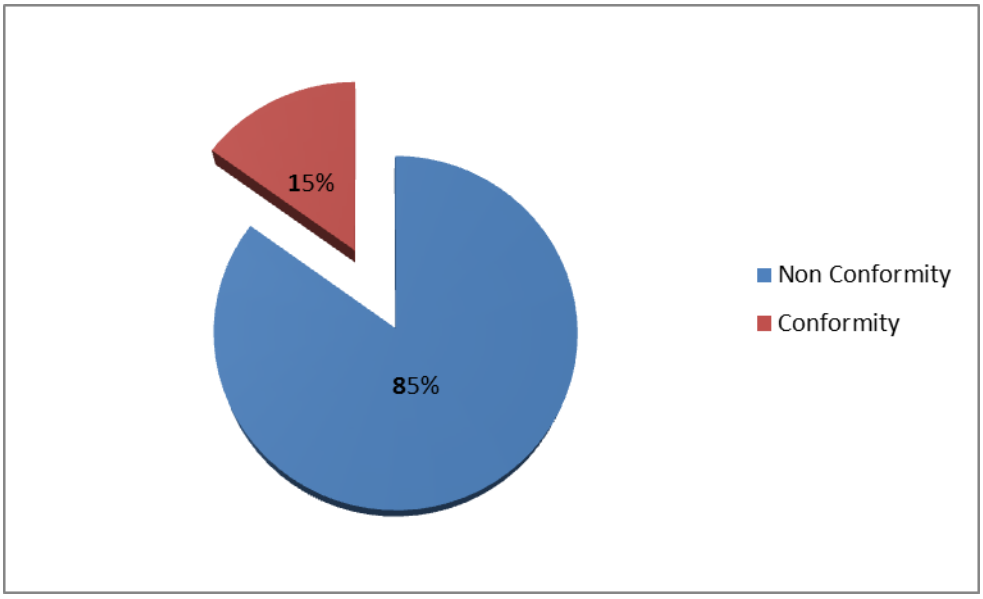
Figure 5: Distribution of Discharge Summaries by Firm



3.2 Conformity to discharge summaries content writing

The standard level of conformity to the discharge summaries writing was taken from previous study and a cutoff point was 88% [10].This study found that, of the reviewed 200 discharge summaries 170(85%) did not conform to the standard Guidelines for best practice of mental health service delivery of the Department of Psychiatry and mental health as summarized by Figure 6.

Figure 6: Proportion of conformity to discharge summary writing (N=200)



3.3 Non conformity to discharge summaries contents

This study found that, of the reviewed discharge summaries the highest proportion of non-conformity was on "providing the patient with telephone contact within working hours" 192 (96.0%) and the least was "documented date of return to outpatient clinic" 22 (11.0%). (See table 1).

Furthermore, non-conformity status was compared across four different firms. This study found that, there are difference between firms in non-conforming to standard guidelines Ilala 50(100%), Temeke 56(100%), Kinondoni 42(95.45%) and Magomeni 41(91.11% The difference on-non conforming to standard guidelines was not statistically significant except on "reporting if patient was on trial discharge prior to full discharge".**(** x^2 10.53, p-value .015.)This means the difference between firms on "reporting if patient was on trial discharge prior to full discharge" is not due to chance. (See table 2).

Non conformity status was further analyzed by professional qualification. From the findings of this study it shows that, all levels of professional qualifications did not conform to the standard guideline when writing discharge summaries for specific variables. This study also found that, there are differences by professional qualification in non-conformity in writing discharge summaries when "documenting MSE on discharge" whereby intern 28 (22.05%) and Residents 26(35.62%). These differences are statistically significant (x^2 - 4.33 P –value 0 .037).This means the difference observed between Interns and Residents when documenting MSE on discharge is not due to chance variation. (See table 4)

Table 1: Discharge guideline standards (contents) and non conformity status

Variables	N=200 Non Conformity **n (%)**
Documented Laboratory Investigation follow up	170(85.0)
Documented MSE on discharge	54(27.0)
Documented Social and family Investigation	179(89.5)
Report on identification with patient main care provider at home	184(92.0)
Patient provided with telephone contact within working hours and documented	192(96.0)
Documented date of return to outpatient clinic	22(11.0)
Patient scheduled first outpatient clinic within one to two weeks after discharge	84(42.0)
Documented review with patient symptoms of drug side effects and advise to manage	176(89.5)
Documented provision of psycho education on the cause and treatment plan for illness	136(68.0)
Documented involvement of family member in discharge process	179(89.5)
Reported if patient was on trial discharge prior to full discharge	189(94.5)

Table 2: Discharge guideline contents and non conformity status by firm

Variables	Non conformity status by Firm				Total 200 n (%)	p-value
	Ilala 51 n (%)	Temeke 56 n (%)	Kinondoni 45 n (%)	Magomeni 48 n (%)		
Documented Laboratory Investigation follow up	46(92.00)	46(82.14)	38(86.36)	40(88.89)	170(85.0)	0.819
Documented MSE on discharge	15(30.00)	13(23.21)	11(25.00)	15(33.33)	54(27.0)	0.756
Documented Social and family investigation	45(90.00)	51(91.07)	41(93.18)	42(93.33)	179(89.5)	0.819
Report on identification with patient main care provider at home	48(96.00)	52(92.86)	43(97.73)	41(91.11)	184(92.00	0.162
Patient provided with telephone contact within working hours and documented	49(98.00)	55(98.21)	44(100.00)	44(97.78)	192(96.0)	0.239
Documented date of return to outpatient clinic	5(10.00)	7(12.50)	3(6.82)	7(15.56)	22(11.0)	0.693*
Patient scheduled first outpatient clinic within one to two weeks after discharge	18(36.00)	23(41.07)	18(40.91)	25(55.56)	84(42.0)	0.387
Documented review with patient symptoms of drug side effects and advise to manage	45(90.00)	51(91.07)	41(93.18)	39(86.67)	176(88.0)	0.346
Documented provision of psycho education on the cause and treatment plan for illness	32(64.00)	38(67.86)	33(75.00)	33(73.33)	136(68.0)	0.638
Documented involvement of family member in discharge process	48(96.00)	51(91.07)	40(90.91)	40(88.89)	179(89.5)	0 .363
Reported if patient was on trial discharge prior to full discharge	**50(100.0)**	**56(100.0)**	**42(95.45)**	**41(91.11)**	**189(94.5)**	**0 .015**

P value from x^2 for differences between firms *Fisher's exact Test

Table 3: Discharge Guidelines (Contents) and Non-Conformity Status by Professional Qualification

Variable	Non-conformity By Professional Qualification		Total N=200	p-value
	Intern 127 **n (%)**	Resident 73 **n (%)**		
Documented Laboratory Investigation follow up	108(85.04)	62(84.93)	170(85.0)	0.98
Documented MSE on discharge	**28 (22.05)**	**26(35.62)**	**54(27.0)**	**0.04**
Documented Social and family investigation	113(88.98)	66(90.41)	179(89.5)	0.75
Report on identification with patient main care provider at home	118 (92.91)	66(90.41)	184(92.0)	0.53
Patient provided with telephone contact within working hours and documented	122 (96.06)	70(95.89)	192(96.0)	0.95
Documented date of return to outpatient clinic	13(10.24)	9(12.33)	22(11.0)	0.65
Patient scheduled first outpatient clinic within one to two weeks after discharge	50 (39.68)	34(47.22)	84(42.0)	0.30
Documented review with patient symptoms of drug side effects and advise to manage	109 (85.83)	67(91.78)	176(88.0)	0.21
Documented provision of psycho education on the cause and treatment plan for illness	92 (72.44)	44(60.27)	136(68.0)	0 .08
Documented involvement of family member in discharge process	115(90.55)	64(87.67)	179(89.5)	0.52
Reported if patient was on parole discharge prior to discharge	118(92.91)	71(97.26)	189(94.5)	0 .19

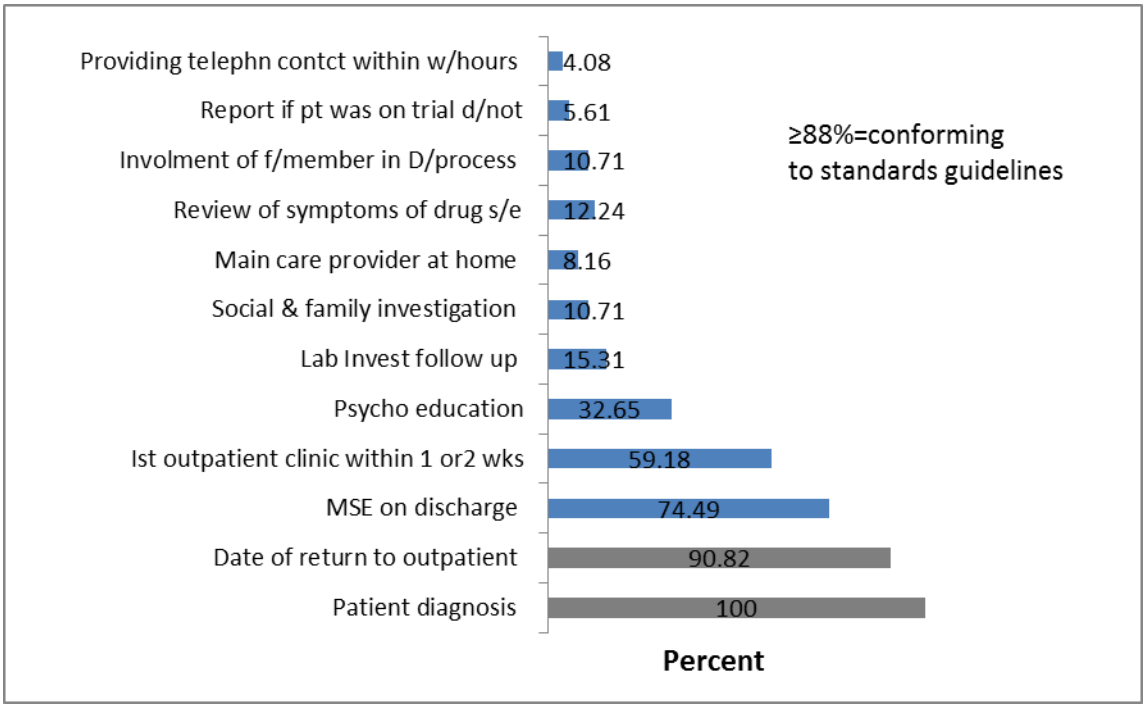
P value from x^2 for differences between firms

3.4 Specific content areas of deficits

From the findings it shows that areas of conformity are; “review with patient diagnosis and early symptoms of relapse” 200(100%), “date of return to outpatient clinic” 178(90.82%).The rest of the content areas had deficits and they include “documenting MSE on discharge 146(74.49%), “scheduling patients on the first outpatient clinic within one to two weeks after discharge” 116(59.18%) and “documenting provision of psycho education on the cause and treatment plan for illness” 64(32.65%).

In addition "documenting laboratory Investigation follow up" 30 (15.31%), "documenting Social and family investigation" 21(10.71%), and "report on identification with patient main care provider at home"16 (8.16%)). Also "documented review with patient symptoms of drug side effects and advise to manage" 24(12.24%). Moreover "documenting involvement of family member in discharge process" 21(10.71%) and "documenting if patient was on trial discharge prior to full discharge" 11(5.61%) and the least being "providing patient with telephone contact within working hours" 8(4.08%). (See Figure: 7 below)

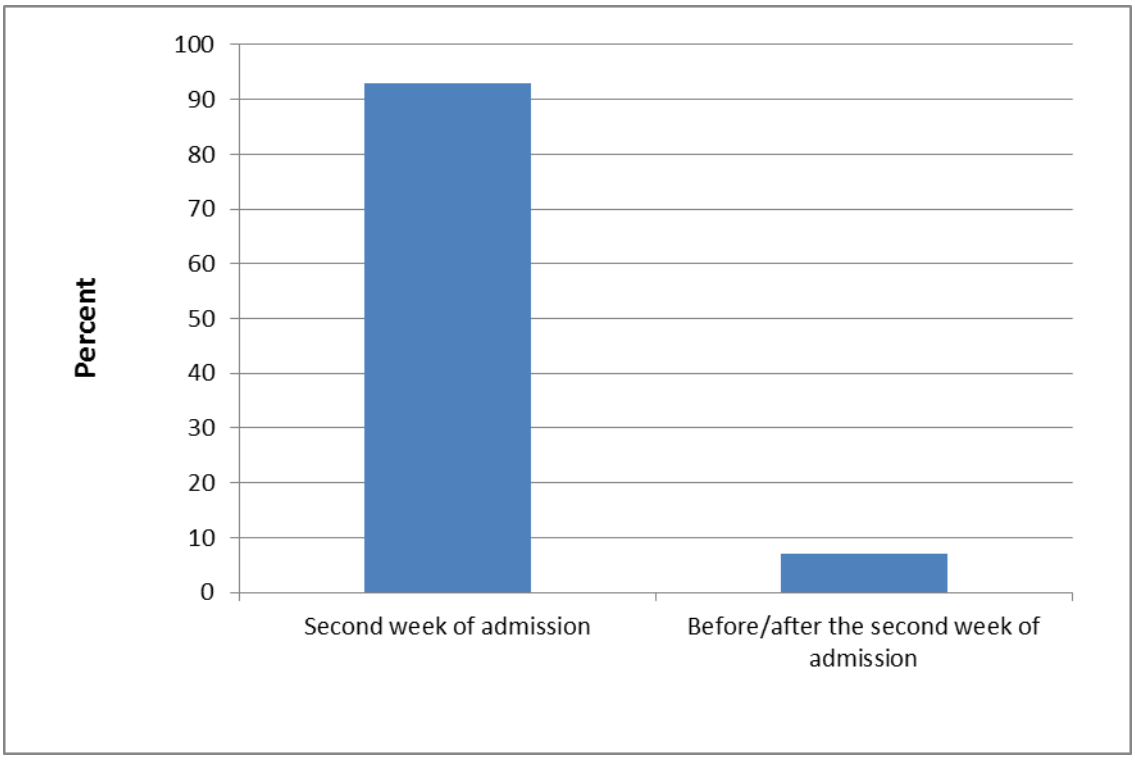
Figure7: Specific contents areas of deficits



3.5 Timing of discharge summary writing

Findings were also analyzed to see at what time after admission clinicians mostly write discharge summaries. Time was divided into two categories of Second week of admission and before/after second week of admission. From the finding of this study shows that of the reviewed 200 discharge summaries, 186(93%) were written in the second week of admission and only 14(7%) were written either in the first week or the third. This means that the usual time for writing discharge summaries at the department is on the second week and rarely on the first or third week of admission. See Figure 8 below.

Figure 8: Description of timing of discharge summaries writing



CHAPTER FOUR

4.0 DISCUSSION

This study is the first of its kind to be conducted in Tanzania that attempts to provide evidence on implementation of mental health practice in a highest level of patient care in the study context. Furthermore the study determines the extent to which discharge summaries do conform to The Guidelines for Best Practice Mental Health Service Delivery at The Department of Psychiatry and Mental Health in terms of contents and timing at MNH. Implementing best-practice is demanding but rewarding process. It requires the joint effort and commitment of all mental health practitioners involved in the care and treatment.

This study provides an understanding of the current practice in implementing best clinical practice through standardized guidelines in discharge summary writing in terms of its content and timing that will enhance the improvement in the communication of managed care among mental health practitioners. Further it identifies areas of deficits in writing discharge summaries through this clinical audit which will be significant to the understanding of applicability of standard guidelines to ensure improvement of quality of clinical care and good outcome.

In reviewing the clinical audit in developing countries, the example of audit undertaken in the medical department of Queen Elizabeth Central Hospital, Blantyre, Malawi, illustrates the feasibility and benefits of local audits[24]. The review reported that a successful example of a national level audit is the model NTP of Malawi developed by the International Union against Tuberculosis and Lung Disease[25] and implemented in numerous developing countries throughout the world, with technical support of the WHO Global Tuberculosis Programme.

4.1 Conformity to Discharge Summaries Writing

In this study 85% of discharge summaries at the department of psychiatry and mental health at MNH do not conform to the set standard guidelines. It is possible that there is good conformity in other aspects of mental health practice, it is not so when writing discharge summaries. These results are contrary to the results of a study done in UK[10] which had 88% conformity. However these two studies were done in different context with different resources. Despite these differences, still data on other clinical audit of discharge summaries against local guidelines in an acute psychiatric inpatient setting in context of its timing and content indicates non-conformity to discharge summaries writing. For instance a study done in United Kingdom by Kader & Singh[19] revealed that despite setting local guidelines for discharge summaries related to local needs, the guidelines were not being fully met. Again the same situation was reported by N. Panagiotopoulou *et al* [22]. The quality of the discharge summary also fell short of expected standards of the addresses was also reported by Wye P *et al*[21].

In addition, from a theoretical perspective of the image theory, it is suggested that clinicians incorporate evidence based practices (EBPs) into their decisional processes through the mechanism of screening. According the standard guideline of the Department of Psychiatry and Mental Health, discharge checklist is supposed to be filled for all patients on the day of the decision to discharge as a guideline to discharging patients but still the discharge summaries fell short of standards. This may indicate that clinicians use mechanism of screening as a cognitive process when writing discharge summaries as described by Falzer *et al*[40]. Furthermore, before their using a guideline to assist in making a choice, clinicians assess the guideline's applicability by using pertinent clinical facts as screening criteria[40]. Thus, clinicians will follow the guideline unless there is sufficient reason not to follow and it may determine that the guideline is not appropriate for a clinical practice[40].

Therefore from this study non conformity to the clinical guidelines may be due clinician's decision and this may be due to some reasons that need to be explored through a qualitative study.

4.2 Non conformity to discharge summaries contents

From the finding of this study, the proportion of none conformity to discharge summaries writing as per agreed standard guidelines of the department in terms of its contents shows the highest level of non-conformity on "providing the patient with telephone contact within working hours" 192(96.0%) and the least was "documented date of return to outpatient clinic" 22(11.0%).

The study results also show that there are differences between firms for different variable in non-conformity. For instance when "reporting if patient was on trial discharge prior to full discharge" whereby Ilala and Temeke 50 (100%), 56 (100%) respectively, Kinondoni 42(95.45%) and Magomeni 41(91.11%) The difference between firms is statistically significant with **(**x^2 10.53, p-value .015).This means there is little evidence that the observed difference is due to chance.

Again the finding shows that all levels of professional qualifications did not conform when writing discharge summaries for specific variables. The results show that there are differences by professional qualification in non-conforming when writing discharge summaries especially on "documenting MSE on discharge" whereby intern 28 (22.05%) and Residents 26(35.62%).The differences between professional qualifications are statistically significant with (x^2 4.33 P –value 0 .037).This shows that there is little evidence that the observed difference is due to chance.

Non-conformity is also reported by the study done in United Kingdom by National E-Health Transition Authority Ltd[6] which reported non-conforming discharge summary from the psychiatric unit by 67% for some vital information. Non-conformity to discharge summary writing was also reported by N. Panagiotopoulou *et al* [22]

4.3 Areas of Deficits in Conformity

From the findings of this study it shows that there are only two areas of conformity which are; "review with patient diagnosis and early symptoms of relapse" 200(100%), and "date of return to outpatient clinic" 178(90.82%). The remaining 10 contents areas show deficit. These includes "documenting MSE on discharge" (74.49%), "scheduling patients on the first outpatient clinic within one to two weeks after discharge" (59.18%) and "documenting provision of psycho education on the cause and treatment plan for illness" (32.65%).

Further areas of deficits included are "documenting laboratory Investigation follow up" (15.31%), "documenting Social and family investigation" (10.71%), and "report on identification with patient main care provider at home" (8.16%)). Also "documented review with patient symptoms of drug side effects" (12.24%) and "advise to manage, documenting involvement of family member in discharge process" (10.71%) and "documenting if patient was on trial discharge prior to full discharge" (5.61%) and the least being "providing patient with telephone contact within working hours" (4.08%).From these findings it may mean that clinicians consider some content areas as being very important compared to other contents areas during their screening process when making decision. This is well explained by the image theory of two process decision making as reported by Falzer *et al* [40].

Also the study which was done in United Kingdom by Kader & Singh [19] reported on several important areas in which the summaries were deficient. For instance out of the forty[19], 40 (83.3%) discharge summaries full psychiatric history, and mental state examination on admission, physical examination on admission was recorded in 8 (20%), 30 (75%), and 8 (20%) respectively. Further in 38 (95%) discharge summaries, progress on the ward was mentioned and investigations done were mentioned on 9 (22%) of discharge summaries[19].

In only 10 (25%) of discharge summaries level of effective care coordination was recorded. While follow up arrangements were recorded in majority (90%) of summaries, name of coordinator was recorded only in 15 (37%) of summaries. Information on risk involved and whether any referrals made or pending was not mentioned in any of the summaries[19]. The presenting complaint or circumstances leading to admission were recorded in the majority (80%) of discharge summaries. Rest of the history like past psychiatric history, past medical history, family history was recorded in 16(40%), 13(32%) and 10(25%) respectively. Moreover, in 9(22%) discharge summaries, personal history and drug & alcohol history were recorded. However, forensic history and premorbid personality was recorded only in 7 (17%) and 4 (10%) of discharge summaries, respectively[19].

Professional accountability have been suggested as being less rigorous in developing than in developed countries[26], however, from this study and study in United Kingdom by Kader & Singh[19] reveals no difference in discharge summaries writing though the context was different. Therefore there may be other factors involved that need to be explored to get the source of the problem including in Tanzanian setting more specifically at MNH department of psychiatry and mental health. It is suggested by other studies done in UK by Frain *et al*[18] that preparing discharge summaries raises some important training and supervision issues. Lack of guidance given to junior doctors in preparing summaries' was also raised. The recommendation for providing junior doctors with some specific training and having the completed summary checked by a senior colleague was given[18].This can also be the case in our setting as the results indicate profound deficits in contents of discharge summaries writing although orientation is done for every new intern and guidelines are available at the acute ward.

4.4Timing of Discharge Summary Writing

As per standard guidelines of the department, all in-patients should have documented decisions for discharge plans by the end of the second week of admission and discharge should be done on the third week of admission. From the findings of this study, 186(93%) discharge summaries were written in the second week of admission and only 14(7%) were written before/after second week of admission.

The findings suggests that most of the patients are discharge before the third week and this could mean they get better before the third week and only few are discharged before/after the second week of admission. The reason for the patients to be discharge before/after second week of admission could be misdiagnosis prior to admission, quick recovery or delay of family members/social support to assure continuity of care at home/secondary health provider.

Finding from other studies done in United Kingdom by Kader & Singh[19]shows that only 50% of discharge summaries were written within two weeks of discharge and a quarter was done only after four weeks. From the finding of this study it is clear that the actual time of writing discharge summaries is on the second week of admission.

However both this study and study done by Kader & Singh[19] shows that some of the discharge summaries are written either earlier or later after discharge plans have been made. Unfortunately both studies do not indicate the reasons for the differences in time when writing discharge summaries and this need to be explored by a qualitative study.

4.5 Limitations of the study

Apart from these limitations this study was able to tell to what extent the current practices of writing a discharge summary conforms to the standard guidelines of the MNH psychiatry and mental health as tool for implementing best practices in mental health. This study is a quantitative clinical audit that assessed the current practice against the agreed standard guidelines and therefore it could not observe the clinician's actual practices or asses their awareness on standard guidelines of the department and or collect their opinions on their experience when writing discharge summaries.

Furthermore, this study employed only quantitative methods due to limitation of time and resources and qualitative component might have complemented the findings. Again this study focused on one department and on discharge summaries and therefore could not be generalized to other aspects of clinical practice such as medication, psychotherapy or occupational therapy. Also a qualitative study asking patients how useful the discharge summary was in terms of their continued care.

4.6. Strength of the study

Since discharge summaries are the tool of communicating information about care given to a patient to secondary service provider the findings of this study have identifying the areas of improvement so as the implementation of good clinical care for good clinical outcome. In addition implementing best practice in mental health will be enhanced as per standard guidelines of MNH psychiatry and mental health.

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

Apart from the availability of standard guidelines of writing discharge summaries; implementing good clinical practice in metal health when writing discharge summaries in the department of psychiatry and mental health at MNH remains a challenge for clinicians. Further studies are needed to explore the reasons to why clinicians do not conform to the agreed standard guidelines when writing discharge summaries.

Again there is a need for a regular clinical audit for improvement of identified content areas of deficits and support the implementation of good clinical care and best practice by all practitioners in mental health including clinical psychologists.

Moreover the timing of discharge summaries writing need to provide all mental health clinicians at the department of psychiatry and mental health time to make sure that all aspects of the patient's mental illness have been cared for as per standard guidelines and be able to communicate the managed care to secondary service provider in a discharge summary.

5.2 Recommendations

Discharging clinician's should follow standard guidelines for good clinical practice as agreed by the department to reduce areas of deficits in clinical practice in mental health. Interventions are needed to ensure clinicians are conforming to the standard guidelines when writing discharge summaries. There is a need of doing a 2 to 3 yearly clinical audit done for evaluation and monitoring purposes of mental health practice when writing discharge summaries at the Department of Psychiatry and Mental health at MNH

From the findings of this study, clinicians should improve on the conformity deficits as required by standard guidelines of discharge summary writing of the Department of Psychiatry and Mental Health of MNH. Training/orientation on standard operating procedures and discharge summary writing and integrate clinical audit in routine case of patients to inform best clinical practice

Furthermore there is a need for clinicians to review the current standard guidelines to leverage the deficits identified if are still relevant or should be modified to current practice. Again clinicians should review the current discharge summary to see if it caters the needs of the department in implementing best clinical practice since the current discharge summary is used by all other department in Muhimbili National Hospital.

Moreover, there is a need for discharge summaries to include sections for psychiatrist, clinical psychologists, social workers, occupational therapists and other clinicians involved in managed care during inpatient stay of a mentally ill patient to suggest a way forward after discharge.

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APPENDICES

Appendix I-Data Collection Tool

Tick in box if yes and put **X** if No in the appropriate box for the below items of a discharge summary:

1. Is the name and title of a discharging Clinician who wrote the discharge summary indicated?

   ☐ Yes ☐ No

2. If **Yes**, is the discharging Clinician (Tick in one of the box/ write clinician Name)

   ☐ Intern

   ☐ Resident

3. Which firm does the patient belong?

   ☐ Kinondoni

   ☐ Magomeni

   ☐ Ilala

   ☐ Temeke

4. Date of admission indicated?

   ☐ Yes ☐ No

5. Date of discharge indicated?

   ☐ Yes ☐ No

6. Is mental status examination on discharge reported on the document?

☐ Yes ☐ No

7. Are Laboratory investigations followed up and documented?

☐ Yes ☐ No

8. Any report on social investigation and family work up

☐ Yes ☐ No

9. Is Identification with patient main care provider in the event of discharge reported

☐ Yes ☐ No

10. Patients was provided with telephone contact within working hours

☐ Yes ☐ No

11. A date to return for outpatient clinic documented on the discharge summary

☐ Yes ☐ No

12. Is Patient scheduled first outpatient within one to two week of discharge

☐ Yes ☐ No

13. Review with patient diagnosis and early symptoms of relapse documented

☐ Yes ☐ No

14. Review with patient symptoms of drug side effects and advised on how to minimize side effect documented

☐ Yes ☐ No

15. Was psycho-education on the cause and treatment plan for illness provided and understood by the patient

☐ Yes ☐ No

16. Family member(s) or major care provider at home was involved in discharge process and documented.

☐ Yes ☐ No

17. Report indicating if patient was on trial discharge prior to a full discharge

☐ Yes ☐ No

Appendix II-discharge checklist guideline

Tick in box if yes for the below items:

- ☐ Affect/mood appropriate
- ☐ Denies suicidal/homicidal ideations
- ☐ Precipitating factors identified and addressed in management plan
- ☐ Logical coherent speech
- ☐ Adequate sleep and appetite
- ☐ Ability to perform activities of the daily living
- ☐ Reports fewer hallucination and delusion
- ☐ Laboratories follow up schedule in place
- ☐ Completed social investigation and family work up
- ☐ Identify with patient main care provider in the event of discharge
- ☐ Patient was on home-leave prior to discharge
- ☐ Patient was discharged against medical advice
- ☐ Patients was provided with telephone contact within working hours
- ☐ Patient was provided with a date to return for outpatient clinic
- ☐ Patient was schedule first outpatient within one to two week of discharge
- ☐ Reviewed with patient early symptoms of relapse
- ☐ Reviewed with patient symptoms of drug side effects and advised on how to minimize side effect
- ☐ Provided psycho-education and cause and treatment plan for illness was understood
- ☐ Family member(s) or major care provider at home was involved in discharge process.

Appendix-III: Matrix of standards

Area	Standard
Mental health care	1. All patients referred from casualty will be seen by an intern/registrar within half an hour of arrival at the unit and by a specialist within 24 hours if admitted to the wards 2. All in-patients will be comprehensively assessed by a psychiatry nurse at least once a week 3. The management of inpatients will be reviewed daily by specialists for patients in the acute wards and at least twice weekly for patients in the general wards 4. All patients' prescribed antipsychotic medication above a defined dose level should have baseline liver functions and ECG assessed and documented. 5. All patients assessed as needing ECT should be involved (or their relatives if too disorganized) in a documented informed consent process. 6. Social work, community psychiatry, occupational therapy and psychotherapy services will be provided as part of individualized management plans developed by the mental health care team for each patient. 7. Formal written referrals are a requirement for social work, community psychiatry nursing, psychiatry rehabilitation and occupational therapy and psychotherapy inputs requested within mental health care teams 8. Preliminary reports of assessments by social work, community psychiatry, nursing and occupational therapy will be provided within a week of referral 9. All home/employer/school visits made by outreach staff for patients under the care of the department will be registered and documented in patient's case notes within 24 hours of completion of the visit. 10. All in-patients should have documented decisions for discharge plans by the end of the second week of admission 11. A discharge checklist will be filled for all patients on the day of the decision to discharge 12. All in-patients will be adequately managed to keep at a minimum readmissions occurring within a month of discharge (below 10% of all readmissions) 13. All out-patients on monthly depot antipsychotic medication will be prescribed depot medication on a separate prescription sheet and will receive medication at the community psychiatry nurse's depot clinic. 14. A maximum of 40 adult patients will be scheduled for outpatient follow-up clinics per firm and seven for the new cases clinic 15. A maximum of seven children and adolescents will be seen on follow-up clinics and two on new cases clinics

Appendix IV: Letter of Ethical Clearance

MUHIMBILI UNIVERSITY OF HEALTH AND ALLIED SCIENCES
DIRECTORATE OF POSTGRADUATE STUDIES

P.O. Box 65001
DAR-ES-SALAAM
TANZANIA
Telefax: 255-022-2150465
Telegrams: UNIVMED

E-MAIL dpgs@muhas.ac.tz
TEL: (255-022)-2150302-6 Ext. 207
Direct line: 2151378

Ref. No. MU/PGS/SAEC/Vol. VI/

19th October, 2011

Mr. Heriel Mfangavo,
MSc. Clinical Psychology,
School of Medicine,
MUHAS.

Re: APPROVAL OF ETHICAL CLEARANCE FOR A STUDY TITLED "A CLINICAL AUDIT OF DISCHARGE SUMMARIES LOOKING AT THE CONTENTS AND TIMING IN THE DEPARTMENT OF PSYCHIATRY AND EMTNAL HEALTH – MUHIMBILI NATIONAL HOSPITAL"

Reference is made to the above heading.

I am pleased to inform you that, the Chairman has on behalf of the Senate approved ethical clearance for the above-mentioned study.

Thus ethical clearance is granted and you may proceed with the planned study.

Please liaise with bursar's office to get your research fund.

Prof. Z. Premji
DIRECTOR, POSTGRADUATE STUDIES

/emm

cc: Vice Chancellor, MUHAS
cc: Deputy Vice Chancellor-ARC
cc: Dean, School of Medicine.

Appendix V: Muhimbili National Research Clearance Letter

MUHIMBILI NATIONAL HOSPITAL

Cables: "MUHIMBILI"
Telephones: 255-22-2151367-9
FAX: 255-22-2150234
Web: www.mnh.or.tz

Postal Address:
P.O. Box 65000
DAR ES SALAAM
Tanzania

In reply please quote:
Ref:

14th Nov 2011

TO WHOM IT MAY CONCERN
MUHIMBILI NATIONAL HOSPITAL

RE: RESEARCH CLEARANCE NO.153 2011/2012

Name of Researcher	**DR HERIEL MFANGAO**
Research Title	A CLINICAL AUDIT OF DISCHARGE SUMMARIES LOOKING AT THE CONTENTS AND TIMING IN THE DEPARTMENT OF PSYCHIATRY AND MENTAL HEALTH-MUHIMBILI NATIONAL HOSPITAL
Type of Research	RETROSPECTIVE, CROSS-SECTIONAL CLINICAL AUDITS AIM AT ASSESSING THE STANDARD OF DISCHARGE SUMMARIES AGAINST LOCAL GUIDELINES IN CONTEXT OF ITS CONTENTS, TIMING AND DEFICITS AT PSYCHIATRY DEPARTMENT
Valid Between	**NOVEMBER 2011 TO JANUARY 2012**

The above named has been allowed to conduct the stated research.

Please accord him/her and his/her assistants the necessary assistance/cooperation.

Sincerely,

Dr H.F. Swai
DIRECTOR OF MEDICAL SERVICES