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Analysis of Quality of Clinical Letters Written in Psychiatry Community Clinic

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Abstract

Aims: Clinical letters are vital for Clear and effective communication. Our aim was to evaluate the quality of clinical letters against audit standards in a community psychiatry clinic.

Methods: In the first cycle of the audit we assessed quality of letters All letters (n=30) written by the author for patients who attended community mental health clinic between last two weeks of September 2015. The 2nd cycle of the audit we assessed letters (n=29) written in last two weeks of November 2015. The audit standards were developed as per recommendations of 21st European Congress of Psychiatry and relevant literature research.

Results: The standard of clinical letters in the first cycle of audit varied significantly. The information related to bio data details (name, D.O.B. address, diagnosis and pharmacological treatment) was accurately stated 100% (30/30) in the letters. The All Day Living activities (ADLs) and standard length of letter were found in 66.7% (20/30) and 73.3% (22/30) of letters respectively. The quality of letters improved in the 2nd cycle of the audit as per audit standards.

Conclusion: Using a standard template can give a better quality and structure to clinical letters.

Keywords: Psychiatry • Outpatient • Clinic • General Practice

Introduction

Sharing information with General Practitioners (GPs) through letter writing constitutes a key part of psychiatric practice and a cornerstone of good client care. Copying these letters to GPs is recognized as best practice in the interests of effective communication and patient-centered care. To guide how a practitioner should write to a GP, we took guideline from this research abstract published in the 21st European congress of Psychiatry [1]. This Guideline took into consideration the seminal work of and department of health UK guidelines of good medical practice 2003 together both form the basis of many Trust guidelines on best clinical practice in this area [2-6].

Aims

The aims of this study were to assess quality of clinical letters and thus provide useful information to GPs which subsequently will improve patient care and further enhance psychiatrist's communication skills. We also wanted to develop a standardized template for letters.

Audit standards

The letters were assessed against following set of standardized information derived from Royal college of psychiatrist guidelines, European congress of psychiatry 2013, department of Health UK recommendations and literature review [4,5].

- The ICD code should be stated on top of all letters.
- Full name, D.O.B and address of patient should be mentioned on top of letter.
- Current diagnosis/impression is stated on top along with current medications.
- Reason for referral/review is important information which should be described in letter.

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- Initial body of letter must contain brief account of current problems.
- Activity of daily life of patient should be described in letters in terms of ADLs.
- Current mental state examination is an integral part of letter.
- Always mention the risk status of patient in letter.
- The results of blood tests carried on previous visit should be mentioned on letter.
- Always describe all three aspect of treatment that includes pharmacologic, psychological, and psychosocial aspects.
- The expected next follow up plan should be present in letter.
- Details of psychiatrist (grade, place of practice, supervisor name and contact number of place) should be written on letter.
- The overall length of clinical letter should be between 200 to 300 words.

Methods

In this retrospective study using systematic approach we selected 30 letters written for all male and female patients who attended clinic for 2 weeks at Maryville CMHC in September 2015. The second cycle of audit was completed on 29 letters dictated in the last two weeks of November 2015.

A list of 23 variables were printed out on a paper with possible answers of yes, no or not applicable whereas all clinical files of clients were given specific audit codes to anonymize the identity.

In some categories, we had to exclude certain letters as they were not fulfilling the criteria e.g. many clients needed no recent blood tests, some were not receiving any psychological treatment.

Results and Discussion

The results of first cycle of the audit showed variables related to demographic details e.g. name, age, D.O.B. address of client, current diagnosis/impression and current medication were found in all of letters 100% (30/30).

There was no ICD-10 code on any letter while data about Patient education was present in 16% (5/30) and reason for referral was stated on 36.6% (11/30) letters.

ADLs were described in only two third of letters (20/30) while standard length of letters in terms of word count met standard requirement in 22 out of 30 letters as shown in Figure 1.

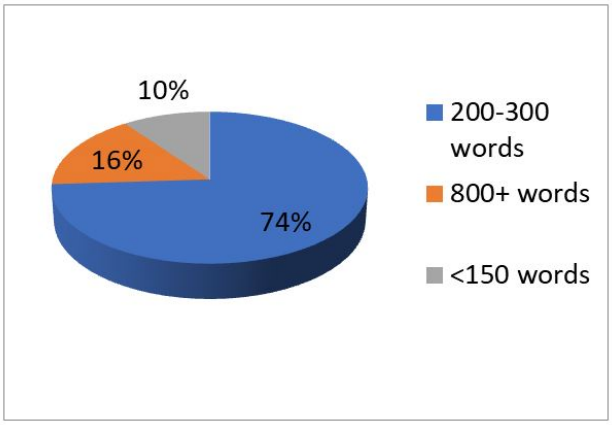

Figure 1. The percentage of letter's length which matched standards and those varied.

Only 5 out of 14 (35%) letters reported results of recent blood tests while 16 letters were excluded as those patients didn't require blood tests.

The risk status was mentioned in 90% of letters (27/30) while only three letter 9.9% missed the risk assessment.

Less than half of letters described psychological treatment 33% (4/12) of letters whereas 18 letters were excluded as those patients needed no Psychological intervention.

Similarly, only 45% letters (5/11) mentioned current social worker input while 19 letters were excluded as there was no indication for social worker intervention as shown in Figure 2.

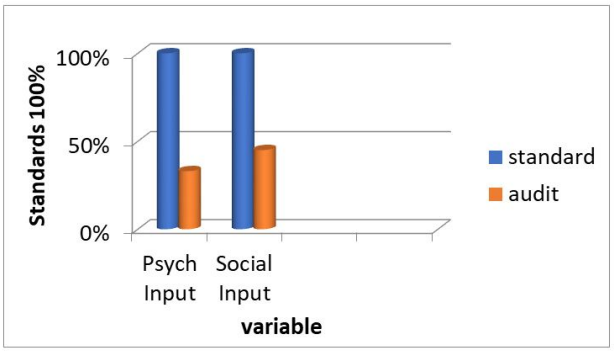

Figure 2. Standards against audit findings.

2nd cycle of audit showed significant improvement in the quality of the letters as a lot of it contained needed information. ICD-10 code was present in 43.3% (13/30) letters. The reason for referral mentioned in 86% of letters in the second study while notes on patient education were present in 90% (27/30) of the letters. The Pharmacologic treatment was noted in all letters whereas psychological and psychosocial treatment which were present in the notes of the letters in 86.6% and 93% respectively. 84.6% letters (11/130) now described results of recent blood tests, fair rise as compared to first study. Almost all letters (86%) had the standard length of word count.

Conclusion

The results clearly show that useful information e.g. patients risk status, All Day Living (ADL), reason for referral and bio-psychosocial treatment was not being transferred to GPs in the first cycle of the audit however there were improvement in the standards of the letters in the 2nd cycle of the audit. Following a standard template as per department of health UK guideline which are in line with recommendations from the psychiatry congress and Royal College of psychiatrist can improve information sharing between psychiatrist and GPs.

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