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ORIGINAL ARTICLE

Providing critical care patients with a personalised discharge summary: A questionnaire survey and retrospective analysis exploring feasibility and effectiveness

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Summary
Objectives: This paper reports on the potential value and feasibility of providing patients with a personalised discharge summary of their critical care stay.
Design and methods: Fifty-one patient discharge summaries, written by nurses during a randomised controlled trial, were retrospectively analysed for readability, structure and quality. A questionnaire survey completed by trial patients ($n = 42$), their relatives ($n = 21$) and nurses ($n = 170$) explored user experience and feasibility. Quantitative questionnaire data were analysed descriptively and inferentially; qualitative data were subjected to content analysis.
Results: Most completed summaries achieved at least an average readability score and were of an acceptable quality. Motivation, time constraints and competing priorities were identified as key barriers to writing an effective summary; however, in the majority of cases, writing them had taken less than 15 minutes. Questionnaire data support that patient discharge summaries can help patients, relatives and ward nurses better understand and patients accept, what happened in critical care.
Conclusion: Patient discharge summaries are likely to be a useful adjunct to existing discharge information, but further work is required to determine when and how they should be

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provided. With appropriate training and support, it is feasible for nurses to write discharge summaries in a busy critical care environment.

Implications for Clinical Practice

- Patient discharge summaries may help critical care recovery, by aiding patients' understanding of their critical illness experience.
- Patient discharge summaries may help ward nurses better understand the patient experience and better support patients' ongoing recovery.
- Critical care nurses do not always know their patients well enough to write a patient discharge summary.

Introduction

This paper reports on the potential value and feasibility of providing patients with a personal discharge summary of their critical care stay. We postulated that the use of a discharge summary (provided in conjunction with a discharge information pack) would help patients better understand the medical treatment they received and fill in gaps about their time in critical care, which can be forgotten (Jones et al., 2000; Löf et al., 2008) or distorted due to physical illness, drugs or lack of communication.

Patients commonly receive copies of hospital discharge or outpatient letters and in some specialities (for example, midwifery) may hold their own medical notes. On discharge from critical care, summaries detailing the patient's condition, therapeutic interventions and other relevant data, are also provided to ward doctors, nurses and other allied health care professionals (AHPs). In contrast, the information the patient receives is usually limited to ad-hoc verbal information and/or a generalised discharge information booklet (Bench and Day, 2010; Wickham and Wong, 2012).

The rationale for patient discharge summaries draws on previous research around the use of patient diaries (Garrouste-Orgeas et al., 2012; Jones et al., 2010; Knowles and Tarrier, 2009). Patient diaries were introduced as a therapeutic means of helping patients recover from critical illness in the 1980s (Egerod et al., 2011). It is generally agreed that diaries can help the patient recover from their critical illness (Egerod et al., 2011) by encouraging reflection on what they have experienced, thereby enabling understanding (Robson, 2008) and enhancing the ability to contextualise both their illness and in-hospital treatment. Randomised controlled trials have demonstrated that patient diaries can reduce anxiety, depression (Garrouste-Orgeas et al., 2012; Knowles and Tarrier, 2009) and post-traumatic stress disorder (Garrouste-Orgeas et al., 2012; Jones et al., 2010).

The production of a patient diary is, however, intensive of time and effort and may not always be feasible or suitable for all patients. Diaries are usually completed over a period of days or weeks, often producing lengthy material (Phillips, 2011). Although this detail may be valuable later on in the recovery period, the difficulty of absorbing such information at the point of discharge is evident from literature highlighting the poor concentration of patients at this time (Bench and Day, 2010; Bench et al., 2011).

In contrast to an extended diary, a patient discharge summary is brief, enabling patients to start the process of reflection immediately after discharge to the ward. Several authors describe having a front page summary in patient diaries explaining why the patient was admitted to Intensive Care (Åkerman et al., 2010; Gjengedal et al., 2010). Patient discharge summaries extend this concept by additionally including information, written using lay terminology, about a patient's treatment, key points of medical significance and how patients reacted during their stay (Bench et al., 2012), for example, whether they were in distress or had delirium. Although medicalised information is unlikely to be of benefit to the physically and psychologically vulnerable critical care patient, a brief discharge summary, written in lay language, may offer the immediate information that is needed to help patients recover during the early critical illness rehabilitation phase.

Aims and objectives of the study

Using data collected during a pilot randomised controlled trial (RCT) evaluating the effectiveness of a critical care discharge information pack (Bench et al., 2012), the aims of this study were to determine the feasibility of providing patients with a personalised discharge summary, written by nurses as part of the intervention and to explore the views of patients, relatives and nurses about its value i.e., the perceived impact of its use on the critical care discharge and early critical illness recovery period. For the purposes of this study, feasibility is defined as 'the extent to which it is possible' to use patient discharge summaries successfully in this population group.

Specific objectives were:

1. To explore whether a patient discharge summary improves the critical care discharge experience for adult patients.
2. To assess the feasibility of discharge summaries as perceived by adult patients, relatives and nurses.
3. To identify any resource implications and factors that might aid or hinder the effectiveness of patient discharge summaries.