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Audit in practice

A decade of psychiatric audit in Southampton*

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In Southampton we have been carrying out audit that conforms to the Government's definition in the White Paper *Working for Patients* (1989) for over a decade. During the last six years the results of the audit have been presented in regular meetings, while the specific projects on procedures used for diagnosis and treatment, the use of resources and outcome that we have undertaken date back much longer than this.

Development of audit in Southampton

In 1979 the Department of Psychiatry accepted responsibility for an adult mental illness service for a population of more than 300,000 people with only 60 admission beds. Recurrent financial crises between 1979 and 1982 delayed the planned build-up of beds and staff and we were working under enormous pressure. During this time we had a greater than expected number of suicides within the unit which led to despondency among the staff. Our consciences were, however, eased when it was shown that there was not an increase in the number of unnatural deaths in the district as a whole, suggesting that patients who intended to commit suicide did so in the unit rather than elsewhere.

Following each suicide (and near-miss) we carried out an audit exercise in the form of peer review of the patient's care. We also consulted the Health Advisory Service. The HAS was impressed with the review system that we had introduced and suggested extending it to other areas in the service. When the crises subsided we therefore carried out an audit of the routine care of in-patients and out-patients.

To begin with only consultants and senior registrars came to the audit meetings with attendances of five to 13 of the 16 members of staff eligible. With increased confidence we extended the invitations to registrars and SHOs and varying numbers of people up to 24 have since attended. We debated whether or not other colleagues should come to the meetings, but felt that this would increase the size of the meetings to an unmanageable number and that it would inhibit free discussion.

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Procedure

Case records were selected at random by our medical records officer and to begin with they were handed to the consultant in charge of the case. Later, however, they were given to a consultant who did not know the patient. That consultant makes constructive criticisms of the record keeping and care of the patient. Minutes of the audit meetings are taken and circulated to those involved. No patient is mentioned by name in these minutes for reasons of confidentiality and no doctor or medical team is identified because of medico-legal concern. Wherever possible we try to reach an overall conclusion and make recommendations for improving patient care and the service in general. Recommendations are discussed at subsequent staff meetings and are brought to the attention of the management team where necessary.

At first we carried out audit of the case records of randomly selected in-patients, out-patients and day patients. Comments were largely centred on the adequacy of records; they were sometimes valuable but they frequently contributed little to the quality of care. We therefore progressed to a system in which each meeting was devoted to one aspect of the service. Thus, we carried out audit of patients in the rehabilitation unit and hospital hostel and those attending the university health clinic, crisis clinic, and department of psychotherapy. We also critically reviewed prescription cards and the different lengths of stay in the wards serving the three sectors of the catchment area. At the time, the ward serving the central sector had a length of stay of 10.5 days compared with means of 19.0 and 21.5 days in the wards serving the other sectors. We reviewed the case records of specific groups of patients, including alcoholics, drug abusers and those requiring ECT, sections or seclusion. We audited the notes of patients who were difficult to manage, those who carried out assaults on other patients or staff, and those who made formal complaints about their treatment. We critically assessed the records of those who discharged themselves against medical advice and those who were given a diagnosis of 'no psychiatric abnormality'.

Criticisms

The criticisms could be broadly categorised into those predominantly concerning record keeping and those concerning patient care. We have reported the criticisms of the first 128 patients whose records were reviewed elsewhere (Edwards *et al*, 1987). Most concerned inadequate note-keeping and included lack of information concerning the circumstances leading to admission, failure to record a diagnosis or treatment plan and inadequate information on the response to treatment.

More important were the criticisms of patient care, such as no follow-up appointment being made or no advice offered to the general practitioner, social worker or community psychiatric nurse on discharge when clearly indicated. Follow-up is not invariably required, but when it is not the reason should be recorded – if only for medico-legal reasons. We also found cases in which a social assessment was not carried out when needed, and cases in which there was inadequate liaison with the GP or other hospitals to obtain more background information concerning the patient. Unsatisfactory communication between the duty doctor and duty nurse could possibly have been relevant in the case of a patient who committed suicide on her first night of admission. We also found instances of inadequate liaison between the crisis service and sector team and inadequate communication with relatives.

Some patients appeared not to have been fully investigated. For instance, in one patient it was noted that a serum T4 was indicated but not followed through. More importantly, we encountered a case in which too much reliance was placed on a normal blood sugar in a patient who died of hyperosmolar coma. We found examples of irrational drug treatment, while other criticisms include insufficient effort being made to find an interpreter, an excessive delay in recommending admission on a section of the Mental Health Act and patients being seen by no-one more senior than an SHO.

Some general considerations

Criticisms should be made in relation to the circumstances under which care is delivered. An incomplete history of a patient seen in an emergency, for example, should not be criticised, whereas more details would be expected on a patient under prolonged care. Although criticisms are directed at individuals, it is often elsewhere in the hierarchy that responsibility for deficiencies in the service lie. Consultants are legally responsible for the failings of their trainees, while management and health authorities are resonsible for imbalances in staffing in different parts of a unit or in different specialities. In the ultimate analysis, it is the Department of Health and the Government that are responsible for many grass root problems by imposing excessively heavy demands on NHS staff with inadequate resources to deal with them. When deficiencies are encountered it is important for doctors to put them in writing to the appropriate authority and request a written answer on how the gap will be filled, rather than be scapegoated at a later date (Inskip & Edwards, 1979).

However, we can do little about problems that originate in the higher echelons of the NHS, although we can make significant changes in our everyday practice. Audit highlights problems that would not otherwise be identified, promotes discussion that would not otherwise take place and increases awareness of our imperfections. It helps us formulate collective advice and thereby improves patient care and the quality of the service. It is not threatening and destructive as some fear; on the contrary, it is constructive and provides mutual support and a valued prop. It shows colleagues that we are not alone in either our failings or successes.

What we do not know, however, is whether or not we are doing any good – or even if we are doing harm. It is therefore crucial that we carry out audit of audit, including its risks and side effects.

Side effects of audit

The most obvious of these is the risk that we may be spending time on audit that could be more productively spent on direct patient care or research. We are, for instance, at risk of collecting data on that which we already know or on that which we cannot change. Alternatively, we could waste precious time auditing the extent to which some fashionable, ephemeral treatment or management policy of unproven worth has been implemented while the clinician, who out of concern for his patients is unprepared to do this, may be regarded as difficult or uncooperative.

Secondly, we are at risk of collecting data that is wide open to misinterpretation. Take, for example, a simple item like number of patients seen. The psychiatrist who spends a considerable time with small numbers of patients could be seen as not pulling his weight, while the psychiatrist who sees large numbers of patients could be regarded as practising 'conveyor belt' psychiatry and trying to impress with numbers. Think how demoralising it could be for someone doing his best to be seen as either lazy or uncaring. Think also how worrying it could be when he knows that the manager on the local C-award committee could be more concerned with numbers and economy than with quality of care. It is crucial, therefore, that the results of audit should be seen in relation to outcome.

A way of addressing these issues is to follow the guidelines suggested by the Royal College of Physicians (1989). To paraphrase these it is necessary to:

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define a standard that should be achieved; assess how performance measures up to that standard; explore the factors that prevent the standard being achieved; take steps to narrow the gap between current performance and the new target; and repeat the assessment to ensure that change has taken place. As audit becomes more structured in this way it will become closer and closer to research.

Audit or research?

I see audit as crude research that is relatively quick and cheap to carry out. It is the new religion and something that is popular with health service managers. In contrast, research is more refined, time-consuming and expensive to carry out. Sadly, it is seen by some as the hobby-horse of doctors, something that is irrelevant and a distraction from service commitments. For these reasons research is unpopular with some managers. The main advantage of audit is that it is flexible and responsive to immediate needs, while research needs much more careful planning. The two are not mutually exclusive and there is room for a happy marriage. Unless this marriage takes place much audit will be sloppy and a waste of time.

During the last decade my colleagues and I have carried out projects that we regarded as research at the time but which we later found fell within official definitions of audit. These include research (audit) into procedures for diagnosis (the use of physical investigations in psychiatric practice), the use of resources (emergency clinic and service for opiate addicts) and outcome (the effectiveness of a rehabilitation ward and the service for opiate addicts). We also carried out studies of out-patient satisfaction, physical assaults, the psychiatric advice given to our Punjabi Seikh population and a method of improving house physicians' assessment of self-poisoning (references available on request).

Conclusions

(a) Despite being the in thing, there is little new about audit. Good doctors have always practised it.

(b) We welcome the extension of audit that will result from the Government's White Paper so long as it is in the best interest of patient care and the quality of service rather than purely a cost-cutting exercise. This can best be assured by insisting that audit is led by doctors.

(c) It is crucial that good methodology is used for the accurate collection and proper interpretation of clinical data, even if this means crossing the boundary from audit to research.

(d) The educational aspects of audit cannot be over-emphasised.

(e) To produce a meaningful and sustained improvement in practice, time has to be set aside for audit. It cannot be squeezed into a time-table bulging at the seams and I wonder what aspect of our work will have to be sacrificed to make room for audit.

(f) Good audit cannot be got on the cheap. It must be adequately funded with proper administrative and technical support, especially secretarial assistance. This support is taking a long time to reach the shop floor.

(g) Finally, however well we manage and audit our service, it will have only a relatively small effect on the sum total of human suffering caused by some of the worst diseases known to mankind. Major progress will only come from research and my plea therefore is that, after routine audit is running smoothly, we should move towards making our audit as research orientated as possible.

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