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Audit in practice

General medical care of long-stay psychiatric patients: a pilot study

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Studies have shown that significant physical morbidity exist within psychiatric units (Honig *et al*, 1989), yet general medical care is often left in the hands of psychiatrists who may not always be the most appropriate people to deliver it (Colenda *et al*, 1988). The new general practice contract places certain obligations on the general practitioner (GP) with regard to his or her patients, especially the elderly, yet these provisions do not extend to many of our patients. Our study looks at four areas of health care and examines how they are delivered to long-stay patients in a district pyschiatric unit with no GP input.

The study

Park Prewett Hospital is the psychiatric catchment hospital for Basingstoke & North Hampshire and Winchester Health Authorities. At the time of our study it had 239 long-stay residents.

Our study looked at four areas of health care delivery: chronic illness – diabetes; prevention – tetanus; health promotion – smoking; and prescribing – review of drug charts.

Chronic illness – diabetes

A questionnaire was circulated to all wards asking about the age, date of diagnosis, date of last admission to hospital, type and frequency of testing and treatment of all diabetic patients. Staff were also asked whether they had a physical examination, blood pressure measurement or an eye examination within the last year and what the nature of the latter was. The chiropodist, diabetic nurse and a consultant ophthalmologist were also questioned and pharmacy computer returns examined.

Prevention – tetanus

The notes of all patients on two wards and the pharmacy's computer records of tetanus toxin dispensed were examined.

Health promotion – smoking

A questionnaire asking about the number of smokers and non-smokers among staff and patients was circulated to all wards. Enquiries were made as to smoking policy and 'non-smoking areas'. Exhaled carbon monoxide amongst smokers and non-smokers was measured.

Prescribing – review of drugs charts

The drug charts and notes of three random patients from each ward were examined. Age, date of admission, date of first and last entries on their current drug chart and date of any drug review recorded in the notes were noted. Drugs were recorded according to group.

Findings

Chronic illness – diabetes

There were 17 diabetics (7.1% of the population). All but one were over the age of 60. The diagnosis was made between one and 17 years ago (where known). Testing was by fingerprick in eight cases, urine testing in seven, and three were not tested. Two patients were tested monthly, eight weekly, three daily and one twice daily. Twelve took oral hypoglycaemics and four were controlled by diet alone. Four patients on oral drugs were not treated by diet as well.

All patients had had a physical examination within the last year including blood pressure measurement. Only three patients had had an eye examination by a specialist within the last year; those examined by the ward doctor did not have fundoscopy. Thirteen patients were being seen by the chiropodist.

Prevention – tetanus

Nine of the 39 patients had received at least one tetanus injection; only two had had a full course ever. Thirty-five doses of tetanus toxin were dispensed to the whole hospital in the year from May 1989 to

May 1990. No full courses were given during this time.

Health promotion – smoking

Thirty-seven per cent of staff and 46% of patients were smokers. Three wards had no patients who smoked. Eight out of the 14 wards had more non-smoking than smoking members of staff. Twelve wards had some sort of ward policy on smoking. Half the wards designated the office as a non-smoking area and none of them allowed smoking in bedrooms and at least one other area.

Twenty-seven patients (24 smokers) and 33 staff (20 smokers) had the carbon monoxide level of their exhaled breath measured. There was a universal lack of interest and/or appreciation of the risks of smoking among the patients surveyed, even in those who could understand.

Prescribing – review of drug charts

Forty-two sets of notes and drug cards were surveyed (18% of patients). Of these, 62% recorded that their drugs had been reviewed in the last year. All were in response to a 'stimulus' (mostly some change in behaviour); 76% of drug charts had been rewritten within the last year; 79% of the patients were over 60.

Some form of anti-psychotic medication was taken by 66%; 33% in depot form. Of these, 75% also took anti-cholinergic drugs; 55% took laxatives and 24% had enemas. Fifty per cent were written up for analgesics. Twenty-four per cent had night sedation and 36% had treatment for skin conditions.

Comment

Chronic illness – diabetes

The incidence of diabetes was higher than the national average (just above 4%) for people of a similar age (British Diabetic Association, 1988). That three patients were not tested at all and only three had specialist eye testing was of concern, whereas the high rate of chiropody treatment was gratifying.

As a result of our findings a diabetic policy for the hospital was formulated and implemented. This included proposals to screen all patients, and for all diabetic patients to be seen regularly by an ophthalmologist, chiropodist and diabetic specialist nurse. Hypertension should be treated energetically, and urine/blood testing carried out weekly as a minimum. A nurse with a special interest in diabetes was identified in the hospital.

Prevention – tetanus

No patients were already immunised before admission to hospital (the majority were admitted prior to the introduction of general immunisation in this country in 1961). With few exceptions, patients received tetanus injections only as a result of an injury. This was illogical as without following up the initial injection with a full course of tetanus toxin the patient was not protected for the future. This led to a sense of false security among staff but wasted the 17p per injection. A programme of immunising all long-stay patients was implemented.

Health promotion – smoking

Our research showed that it is very difficult to explain the health risks of smoking to patients. The negative attitude of staff does not bode well for changes in patients' behaviour.

The fact that only 37% of staff smoke came as a surprise to everyone; this fact could be fed back to enforce the non-smoking rules. This has important implications for management in view of the connection between environmental tobacco smoke, air pollution and disease (Spitzer *et al*, 1990).

Prescribing – review of drug charts

Although it is encouraging that a majority of patients get their drug charts reviewed annually, it is of some concern that this is mostly in response to behavioural change. The need for continued anticholinergic medication should be reviewed as its prophylactic use is no longer recommended (WHO, 1990). Other areas which could be reviewed include the need for night sedation, analgesics and laxatives.

Conclusions

With regard to diabetes and tetanus, we feel that useful and practical measures have already been taken in order to deal with the problems identified. Further work needs to be done to evaluate the benefits in future. The problems associated with smoking need to be addressed by management and health promoters alike and doctors should take steps to ensure that medication is reviewed regularly.

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Audit in psychotherapy: the concept of Kaizen

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When any organisation is exposed to pressure to change, this not only mobilises considerable anxieties within the organisation but calls a variety of defensive operations into play. The work of Jaques (1955) and Menzies Lyth (1959, 1988) has demonstrated that this can result in the central problem ceasing to be the focus of attention, with primitive defensive mechanisms (often of an obssesional or paranoid kind) being mobilised. This process may either lead to energy being devoted to isolated elements of the situation, or staff withdrawing into a state of passivity and hopelessness. Indeed, Jaques has observed that when changes are imposed on an institution in a way which fails to take account of the functions that existing structures serve in relation to the deeper needs and anxieties of those working within the institution, such changes are likely to be resisted, and may even fail.

When, by contrast, the needs, motivation and anxieties of the members of the institution are properly taken into account, and changes are introduced by working *with* staff, they are more likely to succeed, and efficiency and morale may improve. The Japanese concept of 'Kaizen', which has proved of value in industry, involves the application of some of these notions.

One response of the present government to the serious problems facing the NHS has been to '... redefine the problems of the NHS as the need to find ways to control costs in the face of limitless demands for health care, identify value for money, and increase consumer choice,' an interpretation which Plamping (1991) describes as 'highly selective'.

The pressure to subject clinical work (and teaching) within different branches of medicine to audit has, so far, had a number of effects – some useful, but many of them wasteful. It has aroused unease and confusion among some clinical staff, and has led to plans for a considerable expenditure in manpower and resources. This investment *may* prove cost-effective over a period of time, but its value is far from proven. The reservations about these moves are not only the response to change and innovation, nor do they simply express the defensiveness of a group of professionals unused to this type of scrutiny. Good medical practice has always involved the constant review of procedures, though in ways very different from those being proposed. The fact that there is scope for improving the range, depth and effectiveness of such scrutiny is not in dispute.

There is a danger, however, that the approach to audit which is being supported by central government, which represents an experiment not previously implemented in this field, may cause serious damage to the morale and effective functioning of staff within a number of areas in medicine. The basic philosophy of attempting systematically to monitor what is actually done, its cost, and (as far as feasible) its effectiveness has much to commend it. However the *methods* by which these highly complex tasks are to be carried out are by no means clearly worked out, and require thoughtful co-operation between the representatives of central government, local management, and clinicians.

Some clinicians, however, have responded to pressures from inexperienced and unsophisticated management (themselves under pressure) by resorting to equipment and systems of data collection which are expensive, and which may temporarily satisfy local managers that 'something is being done in audit', but which can actually contribute little towards an improvement in the service. There is often a sense of threat, an adversarial atmosphere, the notion of managers 'watching' in a rather persecutory fashion, and having to be appeased by data of little real value.

By contrast, the Japanese concept of 'Kaizen' places the emphasis on *process* rather than outcome, as the most effective means of improving a service (or product). It requires a number of conditions: "Managers must create an environment in which people are enthusiastic to identify deficiences and work together to right them. Fear must be abolished" (Smith, 1990). The steps in the process must first be charted and measured. This may involve the use of organised data, and/or statistical techniques, and this exercise may be revelatory in itself. An attempt is then made to identify where improvements can be made, and further assessment or measurements made after these improvements have been instituted, and so on.