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Audit in practice

Audit in two acute psychiatric units

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The Royal College of Psychiatrists (1989) has recently produced its own preliminary report on medical audit. It defines medical audit as: "The systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patients." This definition is in essence similar to that of the Royal College of Physicians.

Garden (1989) emphasises the fact that there is a paucity of published work on audit within psychiatry in the UK. She also reminds us that the White Paper *Working for Patients* proposes that management should initiate independent professional audit. As clinicians, therefore, we need to develop our own audit urgently.

Garden suggests that after the practice of audit has been established, other topics, such as outpatient care, management of suicide, parasuicide and detained patients, could be included.

Following a series of meetings with the St Helens Clinical team and the local authority, a procedure has been agreed for arranging after-care for patients who are about to be discharged on Sections 3, 37, 47 and 48 of the Mental Health Act, and also for patients detained under Section 2 and for those persons who are informal patients but are to be discharged after a period of hospital admission lasting six months or more.

Shaw & Costain (1989) point out that medical audit and clinical audit are often used interchangeably but clinical audit might be considered to cover all aspects of clinical care, for example, nursing and the role of paramedical staff, whereas medical audit relates to practices initiated directly by doctors only.

In our opinion the more extensive clinical audit is the goal to strive for eventually, especially since an intensification in multidisciplinary community work will result from the closure of the large mental hospitals. Psychiatrists, community psychiatric nurses and others will have to be involved in clinical audit.

The pilot study

At present we are beginning the audit process by instituting our own medical audit. We have devised a schedule for this audit process (St Helens and Knowsley audit schedule, available from the authors) which would be non-threatening and easy to answer but able to elicit all essential information. It should not be time-consuming or tedious to complete but it should provide information about clinical practice and help to highlight deficiencies.

Following three meetings of the consultants at St Helens and Knowsley an audit schedule was agreed. We are now holding audit meetings every month.

We felt it would be interesting and useful to analyse the data for the first two months' audit and present the results in the form of a pilot study.

The pilot study involved 140 patients discharged between 1 February 1990 and 31 March 1990 at Rainhill Psychiatric Hospital and the acute psychiatric wards of Whiston (District General) Hospital.

Findings

Of the 140 patients, 75 (29 male, 46 female) were from Rainhill and 65 from Whiston (34 male, 31 female). The average length of stay of the 75 patients at Rainhill was 27.5 days and at Whiston it was 37.8 days. The range of length of stay was between one and 625 days.

Table I shows the breakdown of the range of length of stay at the two hospitals.

Table II shows how patients were referred. The number of self referrals to both establishments is surprisingly high and needs further investigation.

Table III shows the rank order and percentages of diagnoses assigned to the patients in the study. A total of 13 patients were given a diagnosis of either personality disorder or 'social problems' and raises the question of whether their admissions were really necessary.

Out of 140 patients, only four had electroconvulsive therapy; 19 were detained on a Section of the Mental Health Act; 13 under Section 2; three under Section 3 and three under Section 4.

Comment

The results of our pilot study show that both the acute wards in a traditional mental hospital in the study and

TABLE I
Length of stay

	Rainhill	*Whiston*
1 day	6	12
7 days	20	10
30 days	33	25
Over 30 days	16	19

TABLE II
Agencies which referred the 140 patients

Referral agency	*Total number of patients*	*Number of patients (%)*	
		Rainhill	*Whiston*
GP	67	34 (45)	33 (50)
CPN	17	12 (16)	5 (8)
Self referral	17	12 (16)	5 (8)
Accident and emergency	13	4 (5)	9 (14)
OPD	10	5 (7)	5 (8)
Medical ward	9	6 (8)	3 (5)
Social workers	4	2 (3)	2 (3)
Police	3	0 (0)	3 (4)

TABLE III
Diagnosis at discharge of the 140 patients

Diagnosis	*Total number of patients*	*Number of patients (%)*	
		Rainhill	*Whiston*
Schizophrenia	45	21 (28)	22 (34)
Manic depressive psychosis	25	14 (19)	11 (17)
Alcohol dependency	24	14 (19)	10 (15)
Depressive illness	10	5 (6)	5 (8)
Acute confusional state	7	1 (1)	6 (9)
Personality disorder	7	6 (8)	4 (6)
Neurotic disorder	7	6 (8)	1 (1)
Social problems	6	3 (4)	3 (5)
Others	11	8 (10)	3 (5)

the acute wards in a local district general hospital had similar patterns of admissions and lengths of stay. Of all admissions over two months, 95% were for 90 days or less. This figure itself is high compared, for instance, with Creed *et al's* (1990) figure of 75% (33 out of 48 in-patients). A surprising number in each establishment were admitted for one week or less (37.2% in Rainhill, 31.4% in Whiston). Also these figures show that 8.5% of patients admitted to Rainhill Hospital and 17.2% of those admitted to Whiston in the pilot study period stayed as in-patients for only one day or less. The figure for Whiston in particular is remarkably high and may reflect the fact that the acute psychiatric wards at Whiston Hospital are in the same hospital complex as medical wards and a busy accident and emergency unit. These figures suggest that some form of crisis intervention might have been able to prevent some of these short-term admissions. A crisis intervention centre has recently been established in St Helens and opened its doors in late March 1990. None of the patients in this pilot study would have had the opportunity to have used these facilities (which include three beds for clients for up to three days at a time). It will be an interesting exercise to repeat the audit of patients admitted to the acute psychiatric facilities and to compare the findings with those for the crisis intervention centre in six months time.

Ultimately the outcome of these patients' assessment and management will need to be evaluated as well as patient satisfaction. The relative cost of each treatment option will have to be known in order to use the information for effective planning of future services.

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