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Audit in practice

The one-day census in clinical audit

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Psychiatric care is delivered by a wide range of workers (psychiatrists, hospital nurses, community psychiatric nurses, occupational therapists, psychologists, social workers, counsellors and general practitioners) who work as teams with some patients and as individuals with others. Health authority resources for psychiatric care are widely distributed among facilities both hospital-based (wards, day hospitals, out-patient departments, social work departments, occupational therapy departments) and community-based (community psychiatric nursing departments, community mental health centres and facilities funded jointly with social services and voluntary agencies).

This diversity of professional backgrounds and settings for delivery of psychiatric care makes audit of the broader aspects of service activity difficult. Measures of patient contacts, service availability and workloads would provide useful baselines from which measures of quality, appropriateness and efficiency could be made. Professionals have different working practices and record clinical information in different ways and therefore traditional forms of audit, such as review of patient records and occurrence screening could not capture detailed information about the complex activities of a modern psychiatric unit. The term clinical audit has gained wide acceptance as the term to describe the analysis of the broader activities of the health-care workers from different backgrounds who make up clinical teams.

The design of a one-day census of patient contacts with a district psychiatric service is reported as a model of a cheap, quick and specific clinical audit technique for assessing activity levels and some aspects of quality of complex health-care organisations.

The setting

The Greenwich Health Authority has a catchment population of 218,000. The psychiatric services to the adult and elderly mentally ill include acute and rehabilitation wards, a day-hospital, out-patient clinics in four sites (two hospitals, one community mental health centre and one general practice health centre), community psychiatric nurses, both generic and specialist, based in seven sites, a liaison service to two general hospitals and social work, psychology and occupational therapy departments.

The audit requirement

The unit was formed seven years ago with the decision to close facilities based in a large psychiatric hospital in a neighbouring borough. Since March 1989 Greenwich District has become self-sufficient for psychiatric services. As resources and patients have returned to the borough, local services have rapidly developed and expanded. Lately, in the absence of new resources, a number of suggested developments could only be financed by reorganising existing services. To enable these decisions to be taken a number of questions needed answers.

(a) What are the current workloads of the unit's departments?
(b) How and where are current service users having contact with the service?
(c) Why are users in contact with the service?
(d) What proportion of service users would benefit from each of the proposed developments?

The audit process

The audit questions were printed on a single sheet of paper and copies circulated, through heads of departments, to every worker in the psychiatric unit likely to have direct contact with patients (including secretaries and receptionists). A brief accompanying letter explained that questionnaires were to be completed for every patient the worker had contact with (including by phone) during a specified 24-hour period (9 a.m. 18 April to 9 a.m. 19 April 1990). It was stated that if questionnaires were not completed and returned the workload of the department would be underestimated. To avoid duplication one worker

was detailed to complete single questionnaires for each in-patient and day-patient. A single questionnaire for a single contact could be completed in less than a minute.

The questionnaire (devised in a checklist format) asked workers to identify themselves, the patient and the patient's age (under 18, 18 to 65 or over 65), where the patient was seen, whether it was the patient's first contact with the service, who referred the patient (including self-referrals) and the purpose of the contact (crisis consultation, therapy or for support, advice or practical help). The final section asked workers to state whether any of the list of proposed developments could have improved the service they gave to that patient (these included the development of case management teams, expanded psychotherapy services and access to respite beds).

The entire audit from conception to presentation of results was completed in four weeks. The cost of completing the audit in terms of time was 24 hours of medical time (all but eight hours of this could have been delegated to trained administrative or unit information staff), two hours of management time and 30 hours of clerical/statistical time.

Findings

The questionnaires returned logged 403 patient contacts during the 24-hour census period. Returns were received from all departments. Response from workers was that the demands of recording all contacts over one-day were not unreasonable and did not unduly interfere with other work. The authors themselves ensured that compliance in recording contacts was 100% for in-patient, out-patient and day-patient facilities, while the monitoring of compliance was left to departmental heads of other parts of the service.

Comments

The one-day census is most useful as an audit tool in complex settings with large numbers of patient contacts and/or many autonomous clinical workers in different sites. Obvious examples of such settings, other than psychiatry, are primary care and services for the elderly and paediatrics.

The advantage of the one-day census are:

(a) it is quick to implement and carry out
(b) it produces information about current practices, a "snapshot" of a service
(c) it can answer very specific questions about use of resources and quality of service
(d) repeated censuses can measure the impact of service developments.

The one day census has limitations:

(a) it is not standardised, data are collected by many different individuals
(b) the 24-hour period chosen may be atypical
(c) it is cross-sectional and does not assess quality of care provided to individuals over time
(d) the cross-sectional nature of a one-day census makes it difficult to draw conclusions about the total activity of a service or to what extent it meets the needs of its total client group. Patient types who frequently use out-patient and day-patient facilities or have short admissions would be over-represented. This bias could be corrected statistically by collecting information such as date of last contact for out-patients and day-patients and length of stay for in-patients. A census could not provide accurate information about a services response to infrequent events such as response to psychiatric emergencies.

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