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Audit in practice

The therapeutic use of case-by-case audit agreements in an adolescent unit

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The aim of audit is to monitor and evaluate clinical practice with the intention of refining and improving practice. Once implemented the changes can in turn be monitored, creating the audit cycle. This paper illustrates one way to capitalise on the changes generated by an auditing process in an in-patient adolescent unit.

In child and adolescent psychiatry a central problem in choosing outcome evaluation measures is whose perspective to take. In the instance of an in-patient adolescent unit, there are a wide range of perspectives: that of the adolescent, his or her parents, the referrer, Social Services and the Courts (if there is statutory involvement) and the unit staff, let alone the unit manager and the purchasing authority. Furthermore, the time at which evaluation takes place and the relationship between the person doing the evaluation and those being evaluated may influence the results. For instance, the referrers' view of the outcome could be influenced by their prior relationship with adolescent unit staff and in particular whether the referrer and the unit staff are currently able to reach a compatible viewpoint about the problem. This paper describes how such problems may be overcome by using a case-by-case audit agreement in which the adolescent, his or her legal parents, the unit staff and, if necessary, the referrer come to an agreement of the outcome measure to be used, who should use it and when.

The audit process

The Regional Adolescent Unit (RAU) is a multiprofessional team which intervenes in crises involving adolescents and admits adolescents with psychotic, conduct and emotional disorders. When an adolescent's admission to the RAU is suggested, a meeting is arranged between the adolescent, his or her parents and/or legal substitute together with the unit staff and, if possible, the referrer. During the negotiations for admission, which may take place over more than one meeting, the audit agreement is completed; a copy of the audit agreement is given in the Appendix. This focuses on the following issues.

(a) *The definition of the problem.* (*See Question 1a & b of the agreement*). The problems are stated in the clearest and simplest terms possible so that there is the least possible dissention. Behavioural terms are used so that everybody can agree when they have been achieved. For instance, instead of "Alison is psychotic", the following statement was agreed – "Alison says she sees her dead brother who is talking to her and telling her to do certain actions".

(b) *Minimum criteria for discharge.* (*Questions 2b & c*). The main pivot of discussions is usually "What must change before the adolescent will be discharged?" The criteria are stated in terms of what must be said or done. The family's terms are used instead of the professionals'. For instance, instead of descriptions of mental state, behavioural terms are again used. For instance,"for two weeks Jo does not tell her mother that she wants to kill herself and her mother tells staff that she feels Jo is not currently suicidal". Note that a time limit is always stated. These minimum criteria for discharge are then taken as a measure to evaluate outcome, when the audit agreement is reviewed.

(c) *The obligations on each of the signatories.* (*Question 3*). These obligations may vary, for example there may be an undertaking that a member of staff sits silently at the same table while the adolescent eats. Another example may explicitly require the parents of a drug-abusing boy to attend family meetings specifically to focus on how the adolescent need not take illicit drugs again.

(d) *Who decides if and when the discharge criteria are met?* (*Questions 2a & 4*). Any of the signatories can say that the target has been met or the agreement has not been kept and request re-negotiations. This may lead to frequent re-negotiation of the contract which maybe re-negotiated at each family meeting. Thus agreement may change as the problem is seen differently over the time of admission.

Case illustration

Jill, 14, who was referred by a child psychiatrist, had a four year history of obsessions and compulsive rituals. In the last year she was increasingly disabled, because of her phobic avoidance of her father, who also has a long history of self-managed obsessional-compulsive disorder. Out-patient behaviour programmes had failed, precipitating open disagreement between her parents. Her parents requested admission to prevent the alternative, as they saw it, of placing Jill in 'care'.

Both parents, Jill, and referrer agreed to an audit contract. The discharge criterion was that Jill should be at home without avoiding or shouting at her father for three consecutive weekends. The family agreed to abide by a behavioural programme which would be up-dated weekly when successfully completed. The staff agreed to help the family search for explanations for Jill's behaviour. (One such explanation the staff felt they needed to rule out was abuse within the family.)

The contract was reviewed with the family at successive family meetings and renegotiated when either the aims were achieved or were no longer pertinent. The individual contract was audited during case reviews and plans changed in light of whether the targets had been met or not.

How audit structures therapy

Clinical audit is traditionally seen as a distinct function separate from direct clinical work. However, the audit agreement can structure the management of disturbed or disturbing adolescents. It is our contention that the process of auditing can be an integral and inseparable part of the therapeutic process. Forging agreement between the adolescent and all the involved adults may be the first step towards recovery and change.

Admission is marked by the signing of the agreement, discharge marked by completion or review of the target, the minimum criteria for discharge. Bruggen *et al* (1973) showed how clarification and agreement about the problems necessitating admission can be therapeutic in itself. Furthermore, setting targets for the adolescent, parents and staff may make it more likely the goals are achieved (Galano, 1977). By focusing on the smallest necessary change the final goal, discharge, may appear more achievable. The goal set for discharge at the family meeting can be used as an aim in planning individual work with adolescents during their stay on the unit. A nursing care plan, later formalised as an agreement between the adolescent and his or her individual worker, is integrated into the audit agreement.

As in the unit described by Wells *et al* (1978) the "staff believe that negotiating a partnership with a youngster and putting it in the form of a therapeutic contract conveys to him that he is taken seriously and is expected to respond in a responsible way". Further, we believe that once the adolescent knows that his or her parents are united in successfully defining the conditions for discharge, he or she is more likely to achieve this. In a survey of delinquent American boys, success of residential treatment varied with the degree of parental agreement with their management (La Barbera *et al*, 1982).

Seeking and affirming agreement between adults responsible to and for an adolescent clarifies the adolescent's relationship with the adults involved. Audit contracts are open for re-negotiation when there is a perceived change in parental-adolescent relationship, for instance when the adolescent reaches 16 or the parents are divorcing.

This auditing process not only entails clarification of the role of the parents in admission but also it can be used to differentiate the specialist role of the professionals involved. In doing so it may highlight the ambiguity of authority in these relationships and forces clarification. In our experience adolescents are more likely to take part in re-negotiation of the audit contract if they are part of the monitoring and evaluation process.

Is this audit?

This audit procedure was proposed, evaluated and developed during audit meetings and a review at one year is planned. Throughout the audit process the unit's admission policy and in-patient management was inevitably questioned. The audit process which is proposed differs from most medical audits in two respects. Firstly, monitoring, evaluation and changing of clinical practice is on a case-by-case basis. (Comparison between cases has limited validity as expectations, problems and discharge criteria vary and the contract may be re-negotiated repeatedly throughout admission). The aim of the audit contract is to effect therapeutic change. This therapeutic change may affect the adolescent and his or her social network including the adolescent unit team. For instance, the auditing process may limit the expectation of staff and alert them to times when there is a minimum prospect of change or they are unable to contain the adolescent. Secondly, this auditing process includes the patient and his or her family. For audit to play a central role in adolescent in-patient psychiatry, the adolescent and his or her parents must be involved in negotiating the goals of treatment.

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Appendix 1

AUDIT AGREEMENT BETWEEN FAMILY AND ADOLESCENT UNIT

Name ..... Date .....

1. a) Are there any problems requiring admission? If so what?
   b) Does adolescent agree? If not please comment.
2. a) who decides the problems are sufficiently alleviated before the adolescent can be discharged?
   b) How will that person/s know?
   c) What is the earliest time the adolescent could be discharged?
   ..... weeks
3. What would each party like to achieve before the next family meeting?
   a) parents
   b) adolescent
   c) RAU staff
   d) referrer
4. When should this agreement be re-negotiated?
5. After one year how will admission be judged a success and by whom?

Signed by: Parent/s .....

Unit case manager .....

Adolescent .....

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The journal clubs at St Edward's Hospital – a ten year audit

From The Keele Rotation, North Staffordshire

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During their period of training, trainee psychiatrists are usually involved in multiple educational activities. Clinical activities include case demonstrations at the bedside, ward rounds, and other multidisciplinary team meetings. Another group of activities, not directly clinical, include didactic teaching in the form of lectures, case presentations at conferences, seminars, audit and journal clubs.

On average, the time (in hours) spent in the latter activities per annum at Keele are lectures 60; seminars & other interactive teaching 60; case presentations 30; audit 15; and journal clubs 30.

This article deals with the last of these not directly clinical activities – journal clubs (JCs).

Historical background

There is very little recorded information relating to JCs and the views of Mark Linzer (1987; Linzer *et al*, 1986) have, since the mid 1980s, been the beacon light. In his historical review of the journal club and medical education in the last 100 years he gives the results of his literature search: "The first ever record of Journal Clubs was by Cushing who described Osler's first Journal Club in Montreal in 1875." Much earlier than that was a reference to the term journal club in Stephen Paget's work as reported by James Paget in the years 1835–1854 (Linzer, 1987). Since then journal clubs have been held regularly and it is hoped that this article will serve as an impetus for further research into this important activity.

The word "journal" comes from the Latin "diurnus" (dies = day) through Middle English and Old French ("jurnal"), Modern French (journal), Italian ("giornale"), which refers to either a periodical issued on a daily, fortnightly, monthly or yearly basis, or to a newspaper, a newsletter, or