Psychiatric Bulletin (2000), **24**, 109–110

original papers

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Mental state examinations by psychiatric trainees in a community NHS trust

The importance of a standardised format

AIMS AND METHOD
To investigate the recording of Mental State Examination (MSE) findings by psychiatric trainees as well as dating, timing and signing of entries into the clinical record. Data were collected from randomly selected case notes in three acute psychiatric units.

RESULTS
There was an initial decline of MSE recording from 69% to 58% in the first re-audit. Introduction of a standardised format and involvement of consultant trainers in the supervision of MSE recording led to an improvement to 83% in the second re-audit. Adherence to medico-legal standards also improved.

CLINICAL IMPLICATIONS
The introduction of an MSE format and consultant supervision of records improved the standard of MSE recording as well as basic medico-legal requirements by psychiatric trainees.

The Mental State Examination (MSE) is fundamental in psychiatric evaluations and, together with a good psychiatric history, forms the basis of accurate professional formulation, current diagnosis and consequent management. The study described here comprises an audit of MSE documentation within a community and mental health National Health Service (NHS) trust and two subsequent re-audits.

The overall aim of the study was to determine whether or not psychiatric trainees recorded the MSE as per agreed trust standards. The re-audit results also examined if psychiatric trainees append date, time, and signature to entries in the clinical record.

Literature

A thorough literature search showed that MSE recording differs in scope, heading, pattern and format from author to author (Fuller, 1994; Thomb, 1995; Aquilina & Warner, 1996; Gelder *et al*, 1996). There is, however, a consensus among clinicians that good medical practice involves appending appropriate date, time and signature to medical record entries. This basic medico-legal requirement has been re-iterated in a recent publication by the Medical Defence Union (Hoyte, 1998). No previous audit on this topic had been undertaken by the trust and no record of a similar study could be found on the audit database of the then Anglia & Oxford Region.

Standard for MSE recording

The appropriate recording of MSE findings is particularly important to psychiatric trainees both for examination purposes and in developing a tradition of sound documentation, which is necessary in the maintenance of seamless patient care and for medico-legal reasons.

In order to define an appropriate standard for the purpose of this study O.S.K. and consultant psychiatrists within the trust agreed, in consultation with a Royal College of Psychiatrists examiner, on a standard that MRCPsych candidates would be expected to meet at examination.

The study

This study was undertaken within a community and mental health NHS trust in the rural area of north Northamptonshire serving a population of approximately 270 000. It was carried out over two years from January 1997 to December 1998 and may be divided into three distinct phases – an initial audit, a subsequent re-audit and second re-audit. The main focus of the study was the documentation of MSE findings by psychiatric trainees.

Methods

A concurrent review of in-patient case notes was carried out. Sixty randomly selected case notes were included in each of the three phases of the study. These were obtained from three acute psychiatric in-patient units of the Mental Health Directorate.

Certain case notes were excluded from the study. These comprised those in which:

(a) the MSE was not completed by a psychiatric trainee due to ascribed reasons;
(b) the MSE had not yet been performed (e.g. emergency admissions still undergoing assessment).

Data were examined using a data collection pro forma. Parameters were recorded as either correctly or incorrectly documented compared with the standard. Parameters recorded under inappropriate headings were considered to be incorrectly recorded.

Findings

The initial audit showed that 456 of a possible 660 parameters (11 parameters in each of 60 case records) were correctly recorded (69%). The most commonly

https://doi.org/10.1192/pb.24.3.109 Published online by Cambridge University Press

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Table 1 Findings

Parameter	Initial audit n = 60	Re-audit 1 n = 60	Re-audit 2 n = 60
Appearance	47	42	56
Behaviour	49	40	56
Attitude	42	26	45
Speech	48	42	58
Mood	57	44	54
Suicidal intention	36	35	44
Thought	54	43	50
Perception	48	40	55
Obsessive–compulsive disorder	5	2	32
Cognition	39	36	48
Insight	31	36	53
Total	456 (69%)	386 (58%)	551 (83%)

recorded findings were mood (95%) and thought (90%). Other parameters, for example obsessive–compulsive phenomenon, were less frequently recorded (8%).

There was an overall improvement in the levels of documentation by psychiatric trainees from the initial audit to the second re-audit, with 83% meeting the standards in the second re-audit. However, it should be noted that in the first re-audit, carried out six months after the initial study, a deterioration in the standard of documentation was noted, with only 58% of entries meeting the required standards. This will be discussed further later in this text. Full findings are contained within Table 1.

Basic medico-legal requirements, such as the dating and signing of entries, were examined in both re-audits. Although there was a decrease in the number of entries timed from 20% to 16.7%, the dating of records and attaching the signature to it were found to increase. Full results are displayed in Table 2.

Comment

The need for thorough MSE and its accurate documentation is, as we have already stated, fundamental in arriving at our diagnosis and deciding upon subsequent management. In our experience, most psychiatric training schemes in the UK do not insist upon a definite MSE recording format or scheme, thus trainees employ their discretion on how and which MSE findings to record. The result of this may be that important MSE headings and parameters are often unexamined or unrecorded. This pattern is probably reflected in the poor recording of obsessive–compulsive phenomenon in the initial audit and first re-audit.

During the course of this study, all new psychiatric trainees received training in the trust's standard for recording MSE. After the first re-audit, which highlighted a deterioration in record keeping from 69% to 58%, further feedback and training was carried out and all trainees were provided with a copy of the standard. Consultant trainers also became involved in the checking

Table 2 Time, date and signature

Parameter	Initial audit n = 60	Re-audit 1 n = 60	Re-audit 2 n = 60
Entry timed	Not examined	20%	16.7%
Entry dated	Not examined	77%	81.7%
Entry signed	Not examined	82%	90%

and supervision of MSE records. The impact of this was then to raise the level of adherence to the standard from 58% to 83%, as illustrated in Table 1, thus highlighting the importance of appropriate training. This also illustrates the significance of feedback and dissemination of audit findings and subsequent re-audit.

This audit is not relevant just to psychiatric trainees. As Hoyte (1998) states, accurate record keeping is a basic medico-legal requirement. As we develop a more litigious society, the importance of dating, timing and signing all entries as well as documenting all findings at examination, both positive and negative, cannot be underestimated.

The government has placed quality and risk management at the top of the health service agenda (Secretary of State for Health, 1997). It is committed to *Modernising Mental Health Services* (Secretary of State for Health, 1998). If care is to be of the highest quality, a thorough patient assessment must be carried out and recorded, thus enabling the information obtained to inform the care planning process.

We would recommend a multi-centred audit of this nature to dispel or ascertain our proposal for a standard MSE format for psychiatric trainees in the UK. Such guidelines may then be adapted to meet the need of individual trusts and psychiatric disciplines.

Acknowledgements

We wish to acknowledge the assistance of Dr M. Theresa Christian, Dr Margaret Branford and colleagues within the mental health directorate of Rockingham Forest NHS Trust.

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https://doi.org/10.1192/pb.24.3.109 Published online by Cambridge University Press