



**College of Psychiatrists  
of Ireland**

Wisdom • Learning • Compassion

# **CLINICAL (PRACTICE) AUDIT**

**a key component of**

**Professional Competence in Psychiatry**

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## 1. Editors

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## 2. Introduction

Completing an annual clinical (practice) audit to meet the criteria set out in the Medical Council's Professional Competence Scheme poses a challenge for all psychiatrists. Clinical (Practice) Audit within the scope of the Professional Competence Scheme focuses on *personal practice* and as such may differ from previous audits which have been carried out.

This booklet has been compiled by the College of Psychiatry to help psychiatrists devise, plan, and complete meaningful clinical (practice) audits, and in doing so satisfy that requirement of the Professional Competence Scheme.

Can we meet the PCS requirement and at the same time make meaningful improvements in clinical practice and patient care? Yes.

Clinical (Practice) Audit is a mandatory element of the Professional Competence Scheme for Psychiatrists following the introduction of Part 11 of the Medical Practitioners Act 2007 on 1<sup>st</sup> May 2011. While Clinical (Practice) Audit has always been encouraged and practiced in Ireland, there is a need to further develop practitioners' expertise in this area to enable compliance with requirement of the Medical Practitioners Act.

The College has drawn from examples of clinical (practice) audit which have been completed throughout the country in the past five years to produce templates suitable for use in an Irish context.

This was assisted by a competition inviting submissions of audits completed over the past five years. The College hopes that this competition will become a regular event, thus raising standards, building up a bank of clinical (practice) audit examples to aid motivation, enthusiasm and achievement of mandatory requirements in this area.

### 3. Regulations for Clinical (Practice) Audit.

What does the Medical Council expect?

In the Medical Council's document "Professional Competence – Promoting Quality Assurance" published in May 2010, Clinical (Practice) Audit is defined as:

The "systematic review and evaluation of current practice with reference to research based standards [and designed] to improve patient care". The setting of standards, the measurement of practice compared to a 'gold standard', the identification of deficiencies making the appropriate changes to practice and closing the loop with a re-audit are the accepted elements of clinical audit.

All registered medical practitioners will actively engage in audit and participate in one audit exercise annually that relates directly to their area of clinical practice. It is recommended that practitioners spend at a minimum one hour per month in audit activity.

Clinical audit is recognised as having three elements:

1. Measurement - Measuring a specific element of clinical practice
2. Comparison - Comparing results with the recognised standard (in circumstances where comparison is possible)
3. Evaluation - Reflecting the outcome of audit and where indicated, changing practice accordingly.

- Clinical (Practice) Audit is a key and mandatory component of PCS.
- Clinical (Practice) Audit is an activity independent of CPD.
- The Medical Council requires that each individual participant is engaged in one audit per annum.
- The audit must be reflective of the individual participant's personal practice.
- Clinical (Practice) Audits will also be subjected to the Professional Competence Verification Process. This is the process whereby annually a percentage of doctors enrolled on the PCS have the data logged in their CPD diaries confidentially reviewed by the PCS Committee, as directed by the Medical Council.

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## 4. Why we need to do Clinical (Practice) Audit other than for PCS.

### **Clinical (Practice) Audit**

*“The aim of clinical audit is to improve patient outcomes by improving professional practice and the general quality of services delivered. This is achieved through a continuous process where healthcare professionals review patient care against agreed standards and make changes, where necessary, to meet those standards. The audit is then repeated to see if the changes have been made and the quality of patient care improved”*

**Clinical (Practice) Audit is directly related to improving Clinical Practice against a standard that has already been set. Clinical may ask one or more of the following questions:**

1. Whether what ought to be happening is happening.
2. Whether current practice meets or exceeds agreed standards.
3. Whether current practice follows published guidelines.
4. Whether clinical practice is applying up to date knowledge.
5. Whether current evidence is being applied in a given situation.

For the purpose of PCS the audit activity should focus on the individual doctor’s Clinical Practice.

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## 5. What is the audit loop?

There are several identifiable stages to complete a Clinical (Practice) Audit:

- Stage 1**      **Identifying the topic for the audit.** Pick a topic you are interested in, where you suspect that standards could be improved, where the change you expect to recommend is possible.
- Stage 2**      **Select the relevant audit standards.** You may need to do a literature search for the standards in the area you have chosen or it may be more easily accessible through NICE guidelines, department of health guidelines and BNF guidelines etc.
- Stage 3**      **Draft a written protocol.** This should include rationale for doing the audit, population to be surveyed, time frame and data to be measured.
- Stage 4**      **Carry out the data collection.** Decide what data you need to collect. Produce a proforma sheet to gather the data from individual records.
- Stage 5**      **Compare your data against the selected audit standard.**
- Stage 6**      **Identify the changes that you need to make to achieve the standard.** Put in place any actions and plans to correct any shortfall between the actual activity and the selected standard.
- Stage 7**      **Re-audit to complete cycle.**

Clinical (Practice) Audit is only of benefit when the audit loop is closed and the services are improved.

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## 6. What is the difference between Clinical (Practice) Audit and Clinical Research?

Clinical research may be described as looking at data to see (and prove) that there is a right way to do things, whereas Clinical (Practice) Audit may be seen as proving that we are doing things right (in other words, meeting our own standards). Sometimes the boundary between clinical research and Clinical (Practice) Audit may be less than clear and in these cases, it is recommended the clinician ask themselves some questions about their proposal before carrying out the work.

- Am I trying to find a new way of doing things?
- Is there any element of choice in the investigations or treatments that may be altered for those that are being audited on this occasion?
- Will the audit influence the treatment of current patients?
- Is there any element of randomisation or control groups involved?
- Is there an element of comparison of newer and older treatments?
- Will this audit interfere with the care of patients to any degree other than in the most minimal of ways?

If the answer to any of these questions is yes, you should discuss the audit proposal with the clinical audit department or an independent extern. A thorough discussion of the issues may resolve these issues or modify the audit being considered. If doubt persists, one should consult the hospital's audit or ethics committees.



## 7. What other issues must be considered in Clinical (Practice) Audit?

- All audits should be governed by some key principles governing audit.
- The data collected must be anonymised.
- Data must be stored securely.
- Data collection proforma sheets should be destroyed after the analysis is completed.
- Data can only be used for the explicit purpose of the Clinical (Practice) Audit.
- Be aware of the Data Protection Act when collecting data - consider all relevant professional, ethical and constitutional protections of data.
- Areas of unsatisfactory practice identified while doing a Clinical (Practice) Audit need to be acted on appropriately.

## 8. What is Best Practice for Audit of Personal Clinical Practice.

In drafting guidance on best practice in Clinical (Practice) Audit we drew extensively from The Royal College of Psychiatrists' revalidation guidance (2010):

- 1) The topic for the audit is a priority.
- 2) The audit measures against standards.
- 3) The audit method is described in a written protocol.
- 4) The target sample should be appropriate to generate meaningful results.
- 5) The data collection process is robust.
- 6) The data is analysed and the results reported in a way that maximises the impact of the audit.
- 7) An action plan is developed to take forward any recommendations made.
- 8) The audit is a cyclical process which demonstrates that improvement has been achieved and sustained.
- 9) The organisation enables the conduct of the audit.
- 10) The audit engages with relevant stakeholders.
- 11) Patients or their representatives are involved in the audit if appropriate.

## **9. Audit Report: Summary for use as evidence for the Verification Process.**

**Audit Title:**

**Reason for choice of audit:**

**Standards used:**

**Audit findings:**

**Learning outcome and changes made:**

**New Audit target:**

**How your outcome will improve patient care:**

**Consultant Name:**

**Year Audit carried out:**

## 10. Audits for Starters!

This section contains suggested audit topics for those who may be embarking on or renewing their audit practices, and who are at a loss as to where to begin. We have tried to identify examples of useful audit subjects where gold standards are more readily available and that will improve personal practices for people.

The audit topics outlined over the next few pages are:

- 10.1 Mental Health Act 2001 Legislation
- 10.1 Review of completion of Admission Order forms.
- 10.3 Prescribing Medication
- 10.4 Benzodiazepine / Z drug prescribing in Any Patient Group.
- 10.5 Physical Health of Any Patient Group.
- 10.6 Monitoring of Physical Indices of Patients on Depot Antipsychotics.

Resources:

- BNF
- Maudsley guidelines
- MIMS
- NICE guidelines
- RCPsych reports
- Evidence based mental health journal
- Local policy documents
- Mental Health Act
- SIGN – Scottish Intercollegiate Guidelines Network ([www.sign.ac.uk](http://www.sign.ac.uk))

## ***10.1 Mental Health Act 2001 Legislation***

We have a duty of care to patients who are affected by this act to ensure our practices are of a high standard in order to protect their human rights in accordance with the spirit of the act.

### **Suggested Audit Topics for Treating Consultants.**

- Completion of Admission order processes.
- Completion of Patient Notification process.
- Completion of Revocation order process.
- Completion of Transfer Order process.
- Completion of Seclusion order process.
- Completion of Restraint process.
- Completion of Section 60 process.

### **Suggested Audit Topics for MHC Panel Consultants.**

#### ***Section 17 reports:***

- Requirements clearly indicated in legislation:
  1. To review patient files.
  2. To interview patient.
  3. To interview responsible consultant psychiatrist.
- Quality of reports.
- Timeliness of reports.

#### ***Tribunal members:***

Audits are considerably more limited for those only practising in this capacity.

Suggestions include:

- Review of notes prior to tribunal process.
- Familiarisation with case in hand including accuracy of admission documents.
- Clarification of psychiatric terms/diagnostic criteria for non-medical members of tribunal where required.

Also; not yet written into legislation but mandatory, is the completion and evidence of a multidisciplinary care plan in file for all in patients with a likely extension of this to all active patients in the community.

## *10.2 Review of completion of Admission Order forms.*

### **Background**

In November 2007 the Mental Health Act came into law in Ireland. The Mental Health Act 2001 involves a number of procedures regularly dealt with on a day to day basis either in an approved centre or in a tribunal setting.

The **admission order** can be brought about in 2 ways. The first is where an application is made by completion of forms 1 to 4 by a relative, member of the garda, concerned member of the public or a designated officer. This is followed by a recommendation by a medical doctor, often the patients' GP and completion of form 5. Completion of form 6 by the responsible consultant psychiatrist completes the admission order. Completion of the admission forms comes under close scrutiny at the tribunal stage and cases have been revoked on the basis of serious errors made at this stage. All these forms can be audited. The second method is via Section 23 which is not being considered in this example.

### **Gold Standards**

Forms 1 to 6 are available from the Mental Health Commission website.

The Mental Health Act document also advises on correct completion of these forms.

### **Aims and methods**

- The aims may depend on particular problems an approved centre may be experiencing with completion of forms and experiences at tribunals.
- Methods will usually involve the cooperation of the Mental Health Administrator in the approved centre. Collection of data may be retrospective or prospective, although retrospective collection may be more timely in terms of identifying problems and bringing about changes to improve issues. The use of an excel spreadsheet or homemade A4 size chart will facilitate easy collection of data.
- Results are easily presented in percentages and hence problem areas are easily identified.

## **Outcomes/Interventions**

- Make available a set of laminated forms in each admission unit clearly outlining the problem areas. This allows staff in each unit to quickly help enquiring applicants and doctors regarding the correct methods of completion to avoid errors.
- Inclusion of admission problems on regular management/consultant meetings to air difficulties and promote peer group learning from errors and issues.
- Regular education of nursing staff and medical staff in relation to the identification of problematic forms.
- The audit cycle should be repeated to ascertain improvements and assess the need for further interventions such as liaison with GPs, GP on call service, A&E staff, & Garda.

## **10.3 Prescribing Medication**

Prescribing practices require constant review. It is imperative that we remain conscious of our own prescribing habits and our success at maintaining high standards.

Gold standards exist for the prescribing of most if not all medications and all can be audited depending on the needs and experiences of your patients and practice.

Audits of prescribing could focus on areas such as;

- Diagnoses.
- Doses used.
- Monitoring of doses.
- Dose alterations.
- Documentation of side effects and reasons for changes of dose.
- Documentation of involvement of patients in treatment choices of treatment including reference to likely side effects.

Examples of drug groups suitable for auditing include the following;

- Benzodiazepines and Z drugs (Zopiclone/Zolpidem).
- Antidepressant medications.
- Antipsychotic medications.
- Mood Stabilising medications.
- Anticholinergic medications.
- Rapid Tranquilisation.
- PRN prescribing.

## **10.4 Benzodiazepine / Z drug prescribing in Any Patient Group.**

### **Background**

Reason why the topic is of interest to the auditor: i.e. special interest, particular population mix, awareness of overuse or incidents arising from use of such medications.

### **Gold Standards**

Gold Standards are available from any number of sources including the British National Formulary and Maudsley Guidelines regarding:

- Indications.
- Lengths of use.
- Recommended dosing schedules.
- Discontinuation Benzodiazepine/Z drug prescribing in any patient group regimes.
- Also consider local policies in relation to prescribing standards.

### **Methods**

Data collection is easiest for this type of audit using a tick box type questionnaire indicating question such as:

- Name of drug prescribed.
- Number of such drugs prescribed per service user.
- Indication.
- Dose.
- Type of dose e.g. as required/regular.
- Indication for 'as required' dose.
- Length of prescription outlined.
- Discontinuation plan outlined.
- Discontinuation completed.
- Adverse incidents including side effects related to use of these medications.
- Information regarding how particular service users were chosen is required, e.g. random or entire populations.
- Demographic information regarding the service users involved is also required.

### **Results**

Results in relation to the guidelines and data collection as outlined above will help define how well a service is doing in relation to the guidelines, as well as identify its short comings and changes in practice that are needed.

### **Recommendations**

Recommendations are based on the findings and often refer to the need for;

- Improved documentation.
- Improved access to guidelines for more junior doctors.
- More regular review of prescription of such drugs.
- Further audit cycles.

## 10.5 Physical Health of Any Patient Group.

It is clear that patients with mental health problems have an increased susceptibility to physical problems which have not always been adequately taken into account. These physical difficulties relate to the types and chronicity of illness, medications used, social circumstances and level of function of the various patient groups involved.

Gold standards for care of certain patient groups exist. Others are being developed.

Examples include

- Patients in long term residence within the Mental Health settings
- Patients with chronic illnesses such as Bipolar Affective Disorder
- Patients on medications known to have potential adverse effects on physical health, such as those on with cardiovascular and metabolic effects.
- Patients on medications with inbuilt mandatory monitoring of certain systems such as thyroid function, liver function and white cell counts, to name but a few.
- Management of Alcohol Withdrawal.

This is an audit that is suitable for all patient settings

### **Background.**

It is well accepted that a core component of any psychiatric assessment involves a comprehensive and systematic investigation of physical health, whether or not the admission is acute or prolonged. In settings where admissions tend to be prolonged it becomes more important not to overlook such assessments and reviews as would more typically be routinely completed in the primary care setting.

### **Standards**

Examples of gold standards include:

- NICE Guidelines 2006
- Royal College of Psychiatrists 2009 report: *Physical Health in Mental Health*
- Mental Health Commission guidelines
- Local policies and guidelines



## **Methods**

Data collection can depend on the needs of the audit.

Information re:

- Completion of assessment.
- Timing of assessment in relation to admission/length of stay.
- Documentation of assessment in notes.
- Contents of assessment including weight, height, BMI, Blood pressure etc.
- Investigations required following assessments.
- Results of investigations of assessments.
- Arrangements regarding required follow up appointments.
- Documentation of existing medical problems, bearing in mind that some complications may be present following psychiatric treatment, and review of these.

Data such as the above can be easily collected on an on-going basis by the design of a data sheet that can be maintained within the patient file and accessed as required.

## **Results**

Results need to include findings as well as difficulties in carrying out such as audit, e.g. access to investigations.

## **Recommendations**

These may include:

- Multidisciplinary involvement.
- Inclusion of physical health in multidisciplinary care planning.
- Negotiation with other disciplines in hospital settings to aid timely investigations.
- Resources to allow easier access to hospital appointments etc.
- Completion of the audit cycle to continue to improve or maintain standards.

## ***10.6 Monitoring of Physical Indices of Patients on Depot Antipsychotics.***

### **Background**

There is an increased awareness of the adverse effects on physical health available treatments may have on our patients. Individuals with enduring mental health problems have higher than expected rates of physical morbidity and mortality in comparison with members of the general population. Many studies have shown a prevalence of diabetes and obesity among individuals with schizophrenia and affective disorders is up to two times higher than the general population. This seems to be as a result of a greater inherent predisposition to develop metabolic abnormalities coupled with potential adverse effects of antipsychotic drug treatments on physical health.

### **Gold Standards Include:**

- Maudsley Guidelines
- MIMS
- NICE guidelines.
- SIGN (Scottish Intercollegiate Guidelines Network [www.sign.ac.uk](http://www.sign.ac.uk))

### **Method**

- Review of case notes for all attending a depot clinic.
- Physical indices depend on the service and may include;
  - Weight.
  - Height.
  - BMI.
  - Lipid profile.
  - Fasting blood Glucose.
  - Thyroid Function.
  - Liver tests and renal function.
  - Full Blood Counts.
  - Prolactin levels.
  - Electrocardiogram.
  - Documentation and Health of injection sites.

### **Results and Recommendations**

- Results can be heavily influenced by the type and timing of the clinic as well as the staffing levels and numbers attending.
  - Access to laboratories and timing of the clinics is clearly relevant.
  - Relationship with General practitioners and involvement of GPs in the care of these patients is clearly a contributory factor.
  - Re-auditing and completion of the audit cycle to improve and maintain monitoring is vital.
-