

Improving patient care in complementary medicine: using clinical audit

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INTRODUCTION

The idea behind clinical audit is extremely simple – that patient care can often be improved. Audit is a framework of reflection and action aimed at making appropriate changes in practice happen. This chapter presents audit as an approach that can be applied in anyone's day-to-day practice. It briefly describes the usual components of an audit and then presents several case studies. These illustrate what audit can do and give some pointers to practitioners to help them make choices over different audit approaches. A final section puts audit in context, examining its place in current developments in health care and comparing it with the other, more frequently discussed forms of systematic enquiry.

This chapter is based upon a programme of work carried out at the Research Council for Complementary Medicine in 1998. As part of this programme, 16 complementary therapists attempted clinical audit in their own clinics or professional organizations, the first time that audit as an activity had been implemented across complementary therapy professions in the UK. This chapter depends considerably on the work of these therapists and their work needs to be acknowledged. They found audit to be achievable and useful. They highlighted issues that need to be considered by practitioners preparing for audit. Like any systematic endeavor undertaken by practitioners, audit takes time and other resources and is best done with the support of someone who has successfully done it before. This chapter should enable practitioners to see what audit involves so that they can use it to help improve patient care.

WHAT DOES AUDIT DO?

Audit is a framework that helps change in clinical practice happen. And the reality of clinical practice is that there are always aspects that could be improved: practitioners are often aware of areas of their work where they suspect they could do better; a profession's understanding of good practice develops from year to year. Audit has been developed to deal with this need for change, to help ensure that clinical practice stays responsive to the needs of patients, practitioners and society as a whole. There will be nothing new to complementary practitioners about the idea of reflection followed by action: practitioners are used to thinking about what is best for patients on a case-by-case basis. The main difference between usual practice and audit is in the degree to which this reflection and action are made systematic and explicit. The place of audit in professional practice is discussed further towards the end of this chapter. First, we will look at the components that make audit what it is and illustrate these with examples from actual complementary medicine practice.

What makes an audit?

Audit is often thought of as cyclical. In brief, it starts with looking at an aspect of care and deciding how it should be carried out. It moves on to a reality check, to see how day-to-day practice compares with these aims. At its heart is the next step – actually making changes to the way things are done and checking that these changes have made a difference.

In more detail, at the start of the cycle, practitioners draw upon their own and others' expertise to look at how they want one aspect of patient care to be. For example, a group of herbalists might look at handling answerphone messages left by clients. They would start by identifying a number of criteria for good practice. These might include returning calls within 24 hours or ensuring that outgoing answerphone messages are modified if a therapist is due to be away for more than one day.

The audit then moves on to see if what practitioners currently do actually meets this ideal. In our example, the herbalists might keep a simple record of a week's calls, with notes about how they were handled.

The most challenging part of audit follows: if change is due, practitioners then take steps to make sure it happens. If the herbalists' records show that they are not meeting the standards they have set they could then spend time discussing possible reasons why their current answerphone systems are not working and pool ideas for improving: maybe changing their outgoing answerphone messages in some way. To keep the audit's momentum going, they would then make plans to change and set a date for reassessing. They would possibly repeat the whole exercise if message taking was still not working as they'd like, as long as this area was still a priority for them.

The processes involved in audit are often summed up by an audit cycle (Fig. 6.1).

The audit cycle simply breaks down change into several explicit stages. Each stage is important in itself if valuable and lasting changes are to be made.

- *What am I trying to do?* At this stage, an area of care is selected and ideas about good practice are sought. Research may have been done that indicates that certain approaches are appropriate. Where there is no research, professionals can get together to come up with a consensus.

- *Am I doing it?* This stage is the one that requires measurement, to see how close current practice is to good practice. The techniques and tools used for measuring in audit are relatively simple.
- *Why am I not doing it?* It is often far easier to see what it is you are not doing than to work out why. And yet, knowing why aspects of your work are not getting done is usually key to working out what can be done to improve matters.
- *What can I do to make things better?* Simply wanting to improve an aspect of practice is rarely enough. A plan of action helps. Frequently, new systems need to be set up.
- *Have I made things better?* This stage is used to check whether the plan of action has (a) been carried out and (b) been effective. If the plan hasn't worked, it may be necessary to go back a stage, maybe working further with colleagues who hold the key to change taking place. If things have gone to plan, the audit cycle has been completed, at least for the time being. The cycle can be repeated if ideas about good practice develop further or if it is suspected that actual practice is again not as it should be.

The next section illustrates the purpose and possibilities of audit further, using a set of four case studies.

Learning points

- * Audit is a framework that helps change in clinical practice happen.
- * Audit aims to make the process of clinical reflection and action systematic and explicit.
- * Audit can be summed up as a cycle that asks and then addresses the implications of the following questions in turn: What am I trying to do? Am I doing it? Why am I not doing it? What can I do to make things better? Have I made things better?

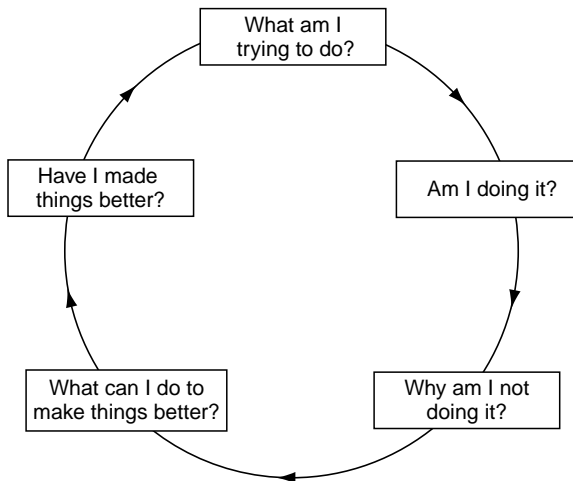


Figure 6.1 A basic audit cycle.

CASE STUDIES: CLINICAL AUDIT IN ACTION

The following case studies use fictional settings but are based around real audit projects carried out by complementary therapists as part of the Research Council for Complementary Medicine's Clinical Audit Project. They illustrate how different audits may be appropriate at different times for different practitioners. Look out for the kinds of changes that these audits helped bring about and ask whether such an approach may be suitable for you.

The case studies have also been chosen in order to start showing what audit can do and what its limitations are, something that is discussed further in the last section of this chapter. Practitioners might find it helpful to look at the audits and think over whether bringing about change really is their immediate goal or whether they are more interested in focusing in more detail on what is going on or how different approaches might affect patients. If the latter is the case, they may be more interested in undertaking survey or outcomes-focused research.

The case studies illustrate how individual practitioners can choose their own audit topics and then use the principles of audit in a relatively flexible way. When it comes to this kind of 'practitioner-driven' audit the goal of bringing about valuable change is ultimately far more important than carrying out each audit stage as outlined in a text book. Another distinct but valuable approach to audit is occasionally demanded of practitioners by therapy bodies working on behalf of the profession as a whole. This type of audit will be discussed towards the end of this chapter.

The audits described here all take slightly different routes around an audit cycle. They help illustrate a number of key audit concepts. A more theoretical approach to audit methods and further examples from outside complementary medicine can be found in a large number of easily available texts (see Further Reading). Look out for the following key concepts in each case study.

- *Defining the problem.* Why this area of care is important.
- *Purpose of the audit.* This makes the aims of the audit explicit from the start.
- *Criteria.* These are definitions of good practice. They can be generated from many sources, including research evidence, professional organizations, the Patient's Charter, peer group consensus, etc.
- *Standards.* These show how vital it is that each criterion is met. Some criteria will be more critical than others and so need a higher standard. While it is not always done, setting standards helps prioritize action.
- *Data collection.* Tried and tested techniques can investigate how well you are doing. Data may be previously recorded information. Fresh data can be collected by questionnaires or forms, both of which need careful thought in preparation if they are not to be problematic. Most audits summarize information using simple data collection sheets.
- *Analysis.* Having collected information about your practice, it is time to compare your results against the standards set at the start of the audit. This stage asks, 'Where am I meeting the standards, where not?'
- *Discussion.* Discussion with colleagues or peers helps even if they are not directly involved with your audit project. Reassess your criteria and standards

and generate ideas about what can be done to improve things. Sometimes an audit of one area will highlight problems in another area. An audit of record keeping, for example, may suggest that more time is needed for a first consultation.

- *Managing change.* The most critical part of the audit comes when you decide what can be improved and how. If you are working in a team it is important to reach agreement about what needs to be changed and the means of doing it. It is equally important to take steps to manage the changes. Agree what will be done, by whom, by what date. Implement the changes and re-audit at an agreed date in the future.

Case study 1: recording patient information – the initial consultation

Defining the problem

The collection and recording of information during a patient's first consultation is a fundamental aspect of clinical practice. Certain information needs to be in a patient's notes for reference. Some say that if it isn't written down, it didn't happen. Nevertheless, poor standards of note taking are common across all health professions. Few complementary medicine professions have looked into this aspect of practice.

Purpose of this audit

This audit was carried out by four osteopaths working in a multi-partner clinic. They wanted to:

- see how well they collected and recorded information from patients in a first consultation
- compare practice amongst themselves
- compare this with best practice and improve where necessary.

Criteria

Practitioners are taught to collect and record specific clinical information during their undergraduate training. Often techniques are then adapted with experience. The osteopaths referred to documents produced by their professional body and decided that the following should be recorded at a first consultation.

Box 6.1 Benefits of this audit

- Vital information about each patient will be in place for future consultations.
- Notes will act as a record that certain questions have been asked.
- Colleagues will be more able to use notes, improving the continuity of patient care.
- Notes will be of more use in future audit or research projects.

- *Personal details.* Name (first and surname), address, telephone number, date of birth, gender, occupation, GP name and contact details.
- *Presenting complaint.* Site, nature, date of onset, causative factors, duration and progression, factors affecting symptoms, past history.
- *Medical history.* Current general health, medication, investigations and treatments, illness/accidents/surgery.
- *Other.* Family medical history, diagnosis, treatment plan. Records should also be signed, dated and legible.

Standards

The osteopaths decided:

- just over half of their criteria were 'critical' and needed targets of 100% (e.g. name, address, gender, site and nature of presenting complaint)
- others (e.g. GP details and medical history criteria) were considered a lower priority and were therefore set lower targets of 80% or 90% in this audit round.

Data collection

- The osteopaths in our program wanted an up-to-date picture of their practice and so sampled all new patients over the previous month ($N=36$).
- Figure 6.2 shows the simple data collection sheet developed to assess patient records.
- The criteria were defined in detail to make assessment as precise as possible.
- A '1' was entered in the appropriate box when the criterion was met fully, a '0' inserted when the criterion was not met fully (e.g. to receive a tick for the first criterion, a record should contain the patient's name in full; a record featuring only the second name would receive a '0').

Criterion	Record no.					Total %			
	1	2	3	4	5	35	36		
Name in full	1	1	1	0	1	1	1	33	92
Address including postcode	1	1	1	1	1	1	1	36	100
Telephone no.	1	1	1	1	1	1	1	36	100
Date of birth	1	1	1	1	1	1	1	36	100
Gender	1	0	1	0	0	1	0	15	4
Occupation	1	1	1	1	1	1	1	36	100
GP name, surgery and tel. no.	1	0	1	0	0	1	1	27	75
Site of complaint	1	1	1	1	1	1	1	36	100
Date	1	1	1	1	1	1	1	36	100
Legible – mark 1 if assessed readable by practice manager	0	1	1	1	0	1	1	21	58

Figure 6.2 Data collection sheet. Patient information collected at first consultation.

- Simple percentages were used to sum up how well each criterion was met over all the sample and for each osteopath.

Analysis and discussion

The group of osteopaths each received a summary of their own record keeping along with anonymous copies of their colleagues' results. As a group they found that:

- they were meeting just over half of the criteria at near to or above the desired standard
- the remainder of the criteria were being met less than 60% of the time.

They were shocked by their findings and looked again at their professional guidelines.

- Few had realized that signing and dating made notes more valuable as legal documents.
- They initially disagreed about whether it was necessary to record gender if also recording a full name but finally agreed that names alone can mislead.
- The group felt that they would be far more likely to record gender and the other patient details now that the reasoning behind their professional guidelines was clear to everybody.

Managing change

The osteopaths:

- agreed to a re-audit of their notes in 1 month and in a further 3 months time
- suggested printed case notes with prompts as a possible solution
- decided to wait for the results of the next audit round to see what effect increased awareness had on their record keeping. Most standards were met on their first re-audit but they plan to re-audit again to see if this continues.

Box 6.2 Is this audit for me?

- Case note taking is simple to assess and is a common first topic for practitioners new to audit.
- This audit will help you see where you need to record more carefully and, perhaps, where you are doing more than you need to.
- Look at the criteria described and ask yourself, 'Am I 100% certain that I am recording the patient information that I should be?'.

Case study 2: communicating with other health professionals – letter writing

Defining the problem

A growing number of complementary therapists find that they need to write letters to their patients' GPs. These might describe a course of treatment or ask for information.

Box 6.3 Benefits of this audit

- Good communication between health professionals improves continuity of care; for example, reducing the number of unnecessary tests patients receive.
- A letter-writing system can reduce workloads for both writer and reader.

Illegible, poorly structured correspondence is common in all health professions. It is possible to systematize letter writing to some extent so that it takes less time and still transfers vital information.

Purpose of audit

A peer group of four chiropractors from several different practices used this audit because they were concerned about the relevance and content of their letters to GPs.

Criteria and standards

The chiropractors consulted their professional body's guidelines and met with local GPs. They decided that 100% of patients who consent to contact with their GP should have a letter written within a month of their initial presentation. These letters should:

- have no errors in legibility or spelling (in 100% of cases)
- contain a brief history, X-ray report, summary of diagnosis, treatment type, advice given, outcome and prognosis (in at least 90% of cases – the chiropractors thought these aspects were likely to be a problem and wanted to be realistic in early audit rounds)
- be short – no longer than one side of A5/250 words (in at least 80% of cases – the chiropractors felt this criterion was a lower priority).

Data collection

- The chiropractors drew up a data collection sheet (Fig. 6.3).
- All the last 3 months' records were searched for new patients giving consent for GP contact and letters written.
- The last 20 letters for each chiropractor were examined by the clinic manager for compliance with the remaining criteria.

Analysis and discussion

Each chiropractor received their results and those of the practice as a whole. They found that, for the group:

- only 76% of letters were being sent on time
- 90% were too long

- 1) Number of new patients: 60
- 2) Marked as 'do not inform GP': 10
- 3) Number of 'eligible' letters [1–2]: 50
- 4) Number of 'eligible' letters sent within 1 month of presentation: 38
- 5) Proportion of 'eligible' letters that were not sent on time [(3–4)/3]: 24%

Sample of 20 consecutive letters sent since: 1/11/97
 Practitioner: 02

Case no.	No. words in letter	Too many words?	Spelling errors	Legible	Outcomes of care	Prognosis
A123	160	0	1	0	1	0
A141	350	1	0	0	1	0
A142	450	1	1	1	1	1
Total		18	8	10	20	16
%		90	40	50	100	80

Figure 6.3 Summary sheet of letters written to GPs.

- except for prognosis, the clinical content of letters was sufficient over 90% of the time
- they did poorly on spelling and legibility (meeting standards in 50% or fewer cases).

Managing change

The team was heartened by their findings on the clinical content but concerned by the late and overlong letters. They decided to:

- improve their clinic system for notifying chiropractors when letters were due
- try to shorten letters and use computer spellchecks
- do a second, identical assessment of letters in another 3 months, raising their standards for the criteria about clinical content to 100%.

Three months later the chiropractors found that all but one of the criteria were met – their record on recording prognosis was still slightly below target. They agreed to continue auditing letters to ensure that their standards did not slip.

Box 6.4 Is this audit for me?

- It is relatively simple to assess the letters you already send, perhaps using your own criteria or those described here.
- Getting feedback from health professionals in your vicinity will take more planning and persistence but will improve relations if it is done well.

Case study 3: communicating with patients – individuals who discontinue treatment

Defining the problem

Patients who fail to complete a course of treatments may not get the full benefits of a therapy. There will be different reasons for not returning but misunderstandings about what treatment involves are common. Effective communication, both before and during a first consultation, increases attendance at further treatment. Many therapists do not know how many of their patients fail to complete treatment or why this might be. It is often possible to improve communication.

Purpose of audit

This audit was done by an osteopath who worked in a GP practice. He was concerned that several patients had recently not completed their planned courses of treatments. He suspected that they might not have known what to expect and had been disappointed. His audit aimed to:

- identify the numbers of patients discontinuing treatment
- find out patient perceptions about why they discontinue
- identify mismatches between patient expectations of treatment and reality and take steps to address these.

Criteria

The osteopath wanted to ensure that 100% of his patients:

- received diagnostic information at their first consultation
- felt that they had had treatment explained to them
- felt that they had been told about the expected number of treatments.

Data collection – stage 1

The osteopath:

- wanted a longer term picture so looked at all patients seen in the previous 3 months
- identified patients who had failed to rebook appointments using the clinic's appointments register and patient notes

Box 6.5 Benefits of this audit

- It is essential to find out how much non-attendance is a problem to a clinic before you take any steps to change clinic procedures. The perceived problem may not be too great after all.
- Feedback from patients is always enlightening, as long as good questions are asked. Patients who have not completed treatment are an ideal group to question about possible shortcomings.

- drew up a summary sheet that listed each patient who did not attend for the expected number of treatments.

Analysis and discussion – stage 1

- Out of 480 patients, 53 had not completed their expected number of treatments.
- The osteopath presented these findings to colleagues, including the practice manager and receptionist. The group decided that this was a high enough number for concern and talked about the kind of information patients might need.
- The GPs gave some feedback to the osteopath from their discussions with patients.
- The group drew up several questions to ask discontinuing patients. The questions asked about information requirements both before and during treatments.

Data collection – stage 2

- The osteopath drew up a draft questionnaire. This was tested on five discontinuing patients identified in stage 1. Figure 6.4 shows some questions from the final version.
- The questionnaire was posted to the remaining discontinuing patients.

Analysis and discussion – stage 2

When the questionnaires were back all the responses were typed onto a single, large summary sheet for quick reference. The osteopath asked himself:

- how do questionnaire responses compare with my criteria and standards?
- are there any surprises in my results? If so, what is surprising?
- does the questionnaire indicate particular problems with my service? If so, what can be done?

Feedback on the osteopath's skills in explaining treatment was encouraging but patients often reported that they did not feel that their condition had been explained. While the osteopath often remembered a discussion there was rarely mention of it in the notes. Patients reported practical reasons for discontinuing that were not related to treatment; 50% said that they would like better information before treatment.

The osteopath looked again at his criteria for good communication. Patients may forget about aspects of their treatment and it will often be better to record discussion of diagnosis in the notes and audit this; 100% patient satisfaction is extremely rare.

Managing change

- The case note form was modified to prompt and record discussion about diagnosis and treatment. An audit of case notes is planned.

- A second questionnaire to a further 20 patients found that they still wanted more information.
- The clinic manager has drawn up a leaflet to give to patients on referral. Another questionnaire to discontinuing patients is planned to obtain feedback on the leaflet's contents. It is likely that lower targets for satisfaction will be set.