

## Integrated Mental Health Program Quality Projects 2009

### Quality Project 5: IMHP Clinical File Audit Project

**Title: IMHP Clinical File Audit 2008-9**

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**Project Leader** Dr Ric Haslam, Principal Consultant Community and Specialist Program

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**Rationale:** To inform clinical record procedure and educate in clinical recording standards. Accurate and comprehensively recorded clinical information is critical to team-based mental health care. A quality improvement cycle is employed to audit current files (open and closed), identify deficits and propose improvement, implement improvements, target professional development to enhance learning and monitor effects through regular auditing.

This project was devised to re-new this cycle, and develop an effective instrument and procedure that will be applied by clinicians and managers twice-yearly, and that will align with RCH processes.

#### Expected Outcomes

- Revision of clinical file audit tools and procedures
- Trial of new tools and procedures in all clinical teams
- Presentation of results of new audit procedure for policy and competency development
- Further improvements in twice-yearly clinical file audit in 2009
- Improved record-keeping in line with RCH policy

#### Process

Discovery Phase  
March 2008

Design New Tool  
April-June 2008

Audits conducted  
July, Oct 2008

Phase 1 Results  
presented to  
IMHP clinicians,  
teams and CQ&S  
Committee in  
Dec 2008

#### Methodology

1. Analyse the strengths and areas for improvement in 2007 IMHP clinical audit tools and procedures, by benchmarking with comparable instruments used in Victoria and internationally.

2. Revise Audit Tool and redevelop procedure for ratification by Q&S Committee. Distribute Tools to Team Coordinators for final comment and tailoring to any specific team needs.

3. Conduct Audits in teams in two phases: (i) Community Teams then (ii) Specialist and Hospital teams. Analyze and collate results for reporting. Review feedback from auditors and consider possible improvements in procedures for 2009 audit.

4. Provide 3-level reporting to Q&S Committee, Teams & Individual Clinicians. Identify specific competency needs in report to CQ&S Committee for forwarding to Professional Development & Training Committee for Training Calendar 2009.

Second phase audit and report with interim outcomes due August 2009.

#### Background & Overview

Clinical File Audits have been used in the Mental Health Service to monitor clinical practice for several years. Prior to 2008, small-scale file audits were held bi-monthly within teams and focused on assessing and improving the general level of recording of clinical information. This project aimed to develop this further by implementing a more calibrated and clinically-specific audit of the clinical record across the Service.

The Clinical File Audit Working Group reviewed the existing clinical file audit tools and procedures, and benchmarked these with other CAMHS. This led to preparation of a new audit tool template and procedure, which was ratified by the IMHP Clinical Quality & Safety Committee after consultation with Team Coordinators.

The 2008 Audit was conducted in two phases (July and October) to capture all clinical teams in the program and progress reporting to the IMHP Q&S Committee occurred through tabled reports in March, May, September and December 2008. Clinicians were deployed in a clinical audit process that examined the files of other teams.

### **Issue Definition**

The clinical file is a major tool for supporting appropriate safe quality clinical care, and the documentation reflects the clinical processes used, and allows monitoring of the quality and **appropriateness** of care, as well as the **safety and effectiveness** of clinical care.

Clinical file audit provides a window into the quality of care and allows monitoring of clinician's reliability in applying clinical procedures, and recording of clinical decision-making through the stages of care. Liaison with the RCH Quality Unit has led to IMHP file audits being more aligned with RCH file audits.

### **Activity**

#### **Phase 1 Community Teams Procedure:**

The community team clinical file audit with the revised audit tool took place in July 2008. The tool had 22 items for each file, grouped into the three clinical phases of Assessment, Treatment and Review, and Discharge and Transfer. Scoring was numerically simple. 80 files were audited by a team of clinicians, supervised by the project leader. Files included at least one open file and one closed file for each clinician, and the files were selected in a blinded fashion.

Results were tabulated and aggregate data was prepared for three-level reporting to (a) the IMHP Quality & Safety Committee, to (b) the team coordinator and (c) to individual clinicians.

The aggregated data had nine items where *Program-wide* scores were < 85% of an ideal score. The remaining 13 items showed good-excellent results and covered: assessment report completion and mental state examinations on all patients; formulations that addressed biological, psychological and social factors; signed entries with staff designation for all records; Safety Plans where risk was assessed as at least moderate, and detailed follow-up arrangements at discharge.

Areas for improvement:

- 1) Risk Assessment Form completed where a moderate risk has been identified
- 2) Multiaxial Diagnosis recorded fully
- 3) Formulation includes biological and developmental factors
- 4) Individualised Treatment Plan (ITP) addresses the focal problems in the formulation
- 5) ITP or Review have been prepared in the previous three months
- 6) ITP has been signed by client, parent/carer and consultant
- 7) 3-monthly review completed in all cases open for at least 6 months
- 8) Written communication with General Practitioner and/or referrer

9) Medication and dosage (if applicable) are recorded in Medication section of file

*Individual* audit results were distributed to the case manager (or “clinician”) concerned and where specific deficits were evident, the individual results were discussed with the Team Coordinator.

#### Recommendations made to the Clinical Quality and Safety Committee

Items 1 and 8 will be addressed in Service-wide mandatory training through the new IMHP Competency Framework commencing December 2009.

Item numbers 2 and 3 were new to the audit procedure at RCH and were designed to detect baseline scores, prior to specific Service-wide competency training in Assessment and Diagnosis.

Items 4,5,6,7 were also to establish a baseline prior to the introduction of a Clinical Governance and Supervision Framework which commenced in November 2008.

Item 9 is being addressed through a Consultant Psychiatrist professional development process which commenced in February 2009

#### **Phase 2 Hospital and Specialist Teams Procedure:**

An identical process was used for to develop specific audit tools for the following IMHP Teams: Banksia Adolescent Inpatient Unit, CAMHS and Schools Early Action Program (Conduct Disorder), the Specialist Autism Assessment Team and Intake Service.

Results: As each form was slightly different, there was no comparison across teams.

#### *Banksia: (n=10)*

1. Risk Assessments (5 items) – good (>85%).
2. Medication (9 items) - there were low scores on the provision of information to clients and carers about medications and potential adverse effects.
3. Treatment Plans (4 items) – these were good (>85%).
4. Continuation Notes (3 items) - 100% scores.
5. Leave Planning (5 items) - rather low scores generally (all <85%) that indicated need to improve collaborative leave planning, identify risks systematically, strengthen Safety Planning for leave, and provide more systematic information about managing risks.
6. Discharge Planning (10 items) - generally around 75-85% but lowest on recorded risk assessments and Safety Plans, Written Medication Plans, Written Medication information and the responsible GP identified.

These results are being utilised by the Banksia team to improve performance.

#### *Intake: (n=10)*

There were 29 items reviewed, not all applicable in each instance. In general there was >85% scores in the items in the files reviewed. Seven items scored lower - these were:

1. Formulation – statement of problem outcome
2. Formulation – summary of the referrer understanding of the referred problem.
3. Educational history – details of the client’s education history to capture the educational context and probability of learning problems.
4. MSE recorded presence or absence of suicidal thoughts – reliability of recorded inquiry about self-harming or suicidal risk.
5. Other community agencies – contact details of staff from other agencies who may be involved with the referred child.
6. GP or paediatrician contact details recorded – to facilitate contact.
7. Referrer notified of appointment time and clinician – to inform referrer of the arrangements made for the management of the referral.

These results were fed back to individual clinicians, and are being used by the Intake team leader to improve Intake processes.

*Autism: (n=6)*

There were 22 items in total. The quality of clinical records was high and scores exceeded 85%. The items scoring lowest were:

1. Paediatric Report - Bradma labels were not attached to every page of the continuation notes.
2. Medication recorded – comprehensive details of medication, dosage and form unreliably recorded.
3. Documentation of the recommendations provided was not fully comprehensive.
4. Treatment and Discharge/Review - medication or client needs could be more clearly described.
5. The Allied Health Report - Bradma labels not attached to every page of the continuation notes.
6. The Allied Health report did not record the Differential Diagnosis reliably.

These results were fed back to individual clinicians, and to the Autism Team Coordinator.

*CASEA: (n=10)*

There were 18 items in the Audit Tool. In general, scores exceeded 89%. The items scoring less than 85% were:

1. Assessment: Bradma labels were not attached to every page of the continuation notes.
2. Any medication being taken by children was not reliably recorded / or identified as “On no medication.
3. The child’s Educational History was not reliably recorded in detail.
4. Risk Assessment was not reliably completed - when a degree of risk was indicated in the list of presenting problems.
5. The Treatment and Discharge/Review Report did not have a Bradma label attached to every page of continuation notes.
6. The Classroom observation form was not reliably completed and filed.

These results were collated and fed back to individual clinicians and to the team Coordinator.

**Summary**

The IMHP Clinical File Audit Project successfully developed and trialled a new audit tool and procedure. The results were reported at three levels across the Service, leading to local re-education about recoding standards, practice change and fine-tuning of the Audit process itself.

A second Clinical File Audit was conducted in July 2009 in the Community Teams, Banksia Adolescent Inpatient Unit, CASEA, Consultation-Liaison, Autism and Intake Teams. This data is now being compiled for comparison and feedback with Audit 1. File Audits will be conducted twice-yearly with reports to the RCH Clinical Quality and Safety Committee, aligned with RCH File Audits.

Outcome – What happened	Evaluation method – how do you know it worked?	Evidence
The IMHP Clinical File Audit	This data provides a	Quality Reports. A graphical

Tool has been improved and will allow some inter-team comparison and a baseline to monitor the appropriateness of clinical care.	benchmark to monitor change at further Audits.	summary of performance over time is being developed to show trends and change over time.
The IMHP File Audit provides information about the degree to which clinicians are following the guidance of the IMHP Operations Manual. This Manual is updated bi-annually to ensure that it aligns with RCH Policies and Procedures, and reflects current DHS guidance.	Areas of Audit non-compliance are reviewed to ensure operational guidance is unambiguous and clear.	Coherence and revision dates of sections of IMHP Operations Manual.

**Current Improvement activities planned or underway:**

<b>What are you going to improve?</b>	<b>Proposed Evaluation Method (how will you know it has worked?)</b>	<b>Who is responsible?</b>	<b>By When</b>
Ongoing audits planned	Rates & trendlines will be established	Dr Ric Haslam	Twice yearly