

CLINICAL GOVERNANCE

Vol. 6, No. 4, 2006

Bulletin

Editorial: Challenging times for the NHS

Myriam Lugon

Consultant, Clinical Governance and Health-Care Policy, London

Health-care providers have been under considerable strain from conflicting demands over the last few years. The challenges have included:

- meeting financial targets
- delivering comprehensive high-quality services
- introducing new techniques and medical treatments to achieve better outcomes, within defined resources, coupled with the introduction of central initiatives such as choice, payment by results and practice-based commissioning
- the implementation of the consultant contract
- meeting the European Working Time Directive.

Services will also need to transfer from acute to community settings, to meet the goals of the white paper *Our Health, Our Care, Our Say: A New Direction for Community Services*.¹

All these changes will affect the shape and role of the local acute hospitals; it is indeed unlikely that, in future, all services will be found in every district general hospital. Therefore greater collaboration between the different health-care sectors will be needed, as will new models of service delivery, with greater choice being provided in non-emergency care. Ways of working will also change, with some staff operating out of more than one hospital.

The National Leadership Network (NLN) recently published a report entitled *Strengthening Local Services: The Future of the Acute Hospital*,² which states (p. 9) that 'the local

hospital will be one key component of local urgent care networks'. It goes on to suggest (p. 26) the minimum level of services necessary to support an accident and emergency department on site ('acute medicine, level 2 critical care, non-interventional coronary care unit, essential services laboratory and diagnostic radiology') or in the multi-hospitals network ('emergency surgery, trauma and orthopaedics, paediatrics, O&G etc.').

This approach requires the development of effective clinical networks. Competent management will be needed to ensure that the care delivered is safe and of a high standard. Evidence-based care pathways will need to be in place to ensure consistency but will need to cross the boundaries between acute and community care, particularly for patients with chronic diseases. A culture of collaboration and cooperation is thus needed, which will be a real challenge in a system that is introducing greater competition!

Future issues of the *Bulletin* will cover issues such as:

- integrating health-care standards into the clinical governance agenda (e.g. the impact of standards on the clinical governance programme, and how to lead implementation and ensure it is an integral part of day-to-day business)
- service improvements (e.g. delivering efficiency and cost-effectiveness, improving the patient experience, new ways of working)

In this issue

- 1 Editorial: Challenging times for the NHS
- 2 Network development within diabetes
- 4 'Is my X-ray okay doctor?' Is failure to follow up radiological reports a cause for concern?
- 5 Child protection referrals: learning from clinical audit in mental health services
- 7 An audit of the implementation of guidance from the Committee on Safety of Medicines on the use of antipsychotics in the elderly
- 8 Discharge summaries in child psychiatry
- 10 An audit of safe practice for local anaesthetic, fire and medical emergencies in a dental hospital setting



The ROYAL
SOCIETY of
MEDICINE
PRESS Limited

- integrated governance (how it may be defined and the implications it will have for the board business cycle, for the quality infrastructure of the organisation and for delivery of clinical governance)
- board development (e.g. ensuring the organisation is fit for purpose, quality and day-to-day business).

We would welcome your contributions on these topics.

References

- 1 Department of Health. *Our Health, Our Care, Our Say: A New Direction for Community Services*. London: Department of Health, 2006
- 2 National Leadership Network Local Hospitals Project. *Strengthening Local Services: The Future of Acute Hospital*. London: Department of Health, March 2006. Available at www.nationalleadershipnetwork.org. Last accessed June 2006

Clinical Governance Bulletin
 © 2006 The Royal Society of Medicine Press Limited. Apart from any fair dealing for the purposes of research or private study, or criticism or review, as permitted under the UK Copyright, Designs and Patents Act, 1988, no part of this publication may be reproduced, stored, or transmitted, in any form or by any means, without the prior permission in writing of the publishers.

Network development within diabetes

Sally Brooks¹ and Anne Greenley²

¹Writer, National Diabetes Support Team, 1st Floor, St John's House, 30 East Street, Leicester LE1 6NB, email sally.brooks@diabetes.nhs.uk, website www.diabetes.nhs.uk; ²Network Development Manager, National Diabetes Support Team, South of Tees Diabetes Network, Middlesbrough PCT, Riverside House, High Force Road, Riverside Park, Middlesbrough TS2 1RH, email anne.greenley@middlesbroughpct.nhs.uk

- Managed clinical networks operate horizontally as opposed to vertically.
- They bring the potential of seamless and integrated patient care.
- Leadership is of key importance in the managed clinical network.
- The diabetes community has found networks to be very valuable for sharing information.

With the continued modernisation of health services in England, the word 'network' is frequently used. More specifically, where diabetes is concerned, the Delivery Strategy for the National Service Framework (NSF) for Diabetes cites managed clinical networks as the gold standard in managing care for people with the condition.¹ In the four years since the strategy was published, networks in this specialism have grown and become the standard way to deal with the needs of the diabetes community in a sensible, logical and comprehensive way. This article aims to identify the purpose of the managed clinical network and to demonstrate how it has worked for the diabetes health service.

What is a network?

A managed clinical network, as defined by NHS Scotland, consists of: linked groups of health professionals and organisations from primary, secondary and tertiary care,

working in a co-ordinated manner, unconstrained by existing professional and Health Board boundaries, to ensure equitable provision of high quality clinically effective services throughout Scotland.²

What are the advantages of a network?

Managed clinical networks are different to traditional organisations because they operate in a horizontal rather than vertical manner.³ This can be seen through the work of a diabetes network in Peterborough. Kay Hircock, manager of the Greater Peterborough Primary Care Trust NSF Steering Committee, said:

We work as one team. There's no defining line between us. We are very much a cohesive team.

The advantages of this kind of work are identified as:³

- the potential for seamless patient care
- integrated care across existing professional and health-care boundaries
- agreed care protocols and pathways across the network area
- diversity of professional contributions
- more equitable service provision for patients
- prevention of duplication of effort and resources

- multiprofessional and multisite working
- teamwork and collaboration
- flexibility and dynamism
- evolution and change.

How networks have worked within diabetes

The NSF for Diabetes states that the diabetes service should be centred on the needs of people with diabetes. The definition of these needs should be agreed in partnership with health-care staff. The services themselves should be equitable, integrated and focused on delivering the best outcomes for the person with diabetes.⁴ Following on from this, the Delivery Strategy, published in 2003, suggested that one of the key elements of this was:

setting up a local diabetes network, or similarly robust mechanism, which involves identifying local leaders and appointing resourcing network managers, clinical champions and a person(s) with diabetes to champion the views of local people.¹

In England there are now 147 groups working in some way on diabetes, though not all of them are networks.

Structure and functions

Country-wide, there are many variations on how a network is organised.

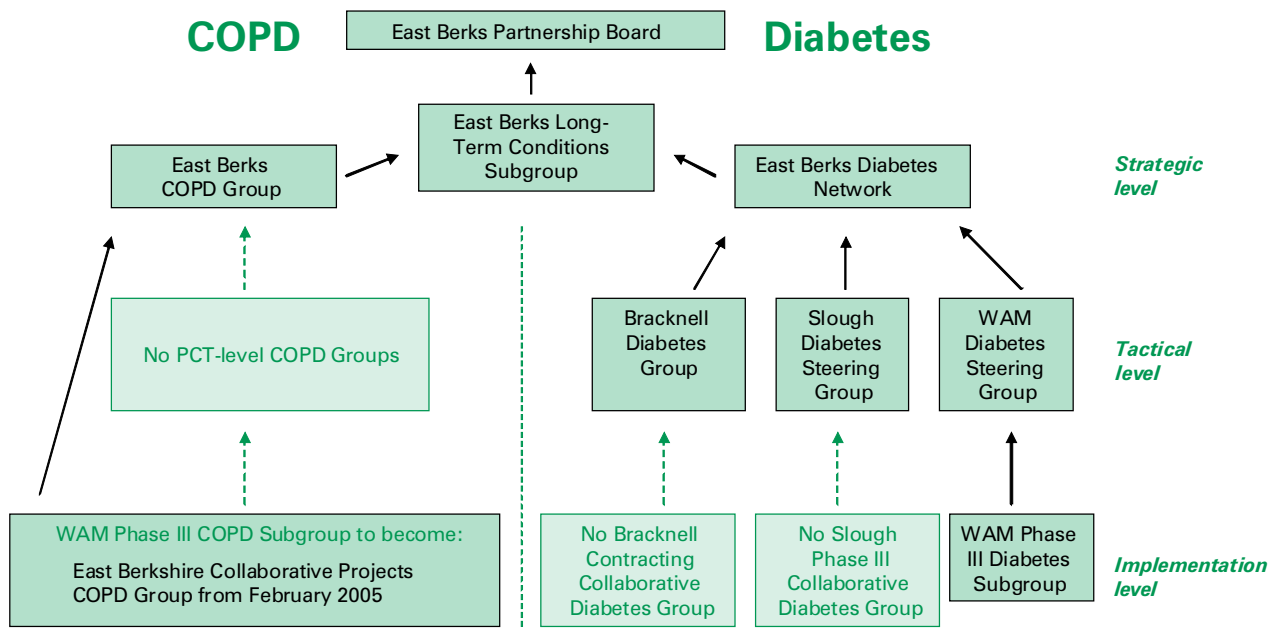


Figure 1. Collaborative projects across East Berkshire primary care trusts (COPD, chronic obstructive pulmonary disease).

The Delivery Strategy states that a network should cover a natural population, so, as a result, some networks cover one primary care trust (PCT), some two or more. However, they all have the same objectives:

- to engage all stakeholders, including clinical and other staff, managers and people with diabetes
- to work across traditional service boundaries
- to have clear lines of accountability
- to demonstrate excellence in leadership and management.¹

Examples of network structures within a region are shown in Figure 1. Managed networks are created to achieve the goals of:

- integrated care
- improved clinical outcomes
- cost-effective services
- improved patient experience
- equity of service provision.¹

North Staffordshire Diabetes Network has made a great deal of progress since the appointment of a network manager in April 2005. Since then, all four PCTs involved have begun to participate in the National Diabetes Audit. Along with this, a multidisciplinary subgroup has been established, looking at a diabetes care pathway for the district. Linked to this is a development and review programme for district-wide

guidelines. Another subgroup has been set up to look at the delivery of podiatry services across the area.

The network allows all the PCTs to pool their resources and tackle these issues together in a coordinated fashion. This in turn boosts both cost-effectiveness and equity of service provision; it also promotes integrated care and improves the patient experience.

Leadership

For a network to be successful, leadership is key. In its documentation the Leicester, Leicestershire and Rutland Diabetes Programme Board describes the role of the network manager in the following way:

- oversees strategic delivery of targets set within the NSF across the six PCTs
- engages all stakeholders
- is creative, imaginative and purposeful within the network
- has strong leadership skills.

So, the employment of a network manager to lead and facilitate the work is a very important feature of a network.

Sharing and learning

Networks need the commitment, drive, enthusiasm and practical support of all those responsible for delivering diabetes care and users of

the services they provide. Christine Jackson, service improvement manager for Torbay PCT and member of South Devon Local Implementation Group, said:

The network has been very useful in sharing models of good practice and finding out what is happening in other areas. It is extremely difficult to impose changes on other groups but it certainly has a strong influence.

The future

The Gloucestershire Managed Network Group for Diabetes has made a positive impact on health-care in the region and is looking to the future. West Gloucestershire PCT Service Development Programme Manager, and network member, Duncan Thomas said:

As we pick off the various standards in the NSF, our next big challenge will undoubtedly be around the identification and management of those as yet undiagnosed with diabetes.

References

- 1 Department of Health. *National Service Framework for Diabetes: Delivery Strategy*. London: DH, 2003
- 2 Scottish Executive Health Department. *Promoting the Development of Managed Clinical Networks in NHS Scotland*. Edinburgh: Scottish Executive, September 2002
- 3 Wall D, Boggust M. Developing managed clinical networks. *Clinical Governance Bulletin* 2003;3(6):2-4
- 4 Department of Health. *National Service Framework for Diabetes*. London: DH, 2001

'Is my X-ray okay doctor?'

Is failure to follow up radiological reports a cause for concern?

Lesley Stuart

Head of Governance, St George's Healthcare NHS Trust, London, email Lesley.Stuart@stgeorges.nhs.uk

- Patient care and treatment are being compromised by the failure to follow up imaging reports.
- Action is required to highlight this issue across the NHS and to consider how current information technology systems can be improved to address the issue.
- Patients should be advised to request the results of their diagnostic tests.

The risk of harmful delays of care arises most commonly after ordering diagnostic tests, laboratory or imaging studies.¹

This quote sums up the driver for this piece of research, behind which was the experience of one patient attending a large acute NHS teaching trust. The patient's radiology report was not read or appropriately followed up, which affected his care and prognosis and had a devastating outcome for him and his family.

This study, undertaken within the trust, had the following objectives:

- to identify the prevalence of such incidents
- to draw local and national attention to a recognised but poorly researched problem, namely clinicians failing to read, act upon or follow up radiology reports ordered for patients
- to consider how systems might be improved to prevent similar adverse patient safety incidents.

A 'patient safety incident' has been defined by the National Patient Safety Agency as:

any unintended or unexpected incident that could have or did lead to harm for one or more patients receiving NHS funded healthcare.²

The issue of error in radiology has been well researched. In the main, this research has focused on the radiology service itself and not on what happens to the radiology report

once it leaves the radiology department or when it reaches the ordering clinician. Most of the research that has been done in this area has been in the USA, where the problem is well recognised, mainly because it has become a focus of litigation;³ however, there is little research on the size or frequency of the problem.

Where might current systems fail?

Leahy Taylor⁴ identified transmission of the radiology report as a problem within health-care systems as long ago as 1975, and commented:

Not every hospital would seem to have an efficient system for checking the radiologist's report is brought to the attention of the clinician.

Berlin's research⁵ acknowledges that the 'system of distribution often breaks down'.

There are a number of weak links in the chain from the point at which a radiology report is generated to the point at which the ordering clinician follows it up. The move to the use of filmless imaging and the transmission of images and reports through an electronic picture archiving and communications system (PACS) has substantially reduced the chances of films and reports being lost in transit and improved the speed of transmission. However, the PACS in use in the trust (as in the systems used by many organisations) has flaws, in that it does not provide an audit trail which can identify whether a report has been read or acted upon and, if so, when and by whom.

Methods

In order to investigate the prevalence of failure to follow up or act on radiology reports, a clinician-led retrospective health record review of a number of patients who were already receiving treatment for lung

cancer was undertaken to ascertain whether they had undergone earlier radiological examination (chest radiography) at the trust and, if so, whether signs of the cancer had been noted but not followed up at the time.

One hundred patients with a historical diagnosis of lung cancer in 2004 and previous imaging studies undertaken within the trust were identified. The health records of 87 of these patients were located and reviewed to establish whether these patients had prior reports identifying concerns and a need for follow-up and, if so, whether this been appropriately actioned.

Results

Of the 87 relevant cases with prior films (1 month to 14 years earlier):

- 71 cases were reported as normal or stable (no follow-up required)
- there were 13 reports of suspicious or abnormal findings (follow-up required)
- 3 radiographs were not reported.

Of the 16 patients with abnormal or unreported previous chest radiographs:

- eight had reports with significant findings that were not acted upon and one had significant findings that were unreported (giving nine significant misses in total)
- five had reports that suggested follow-up which did not occur, but which on review of the films was not thought to be relevant
- two had films unreported but the findings were felt on review not to be significant (giving seven near misses in total).

In summary (Table 1), in 18% (16) of the 87 cases reviewed, the ordering clinician had failed to follow up the radiology report. Additional research showed that the trust, like many other

Table 1. Summary of results

	Numbers of cases (n = 87)	Proportion	95% confidence interval
Significant misses	9	10%	5–19%
Near misses	7	8%	3–16%
Any miss	16	18%	11–28%

organisations, had no coherent and consistent approach to ensuring the follow-up of imaging reports. Many existing electronic systems have no barriers to prevent or even identify such errors, or audit trails for checking whether results have been actioned.

Discussion

The trust has taken a number of steps to mitigate the risks of such incidents occurring again since the results of this research highlighted

the problem. However, further action needs to be taken in order to reduce the risks of system and process errors and to seek a more effective solution to the problem. Action is required to highlight this issue across the NHS. There is a need to consider how current information technology systems and initiatives such as the Connecting for Health information technology programme⁶ can be used to address the issue. Patients should also be advised to request the results of their diagnostic tests.

Note added in proof

Lesley Stuart is currently seconded to the National Patient Safety Agency to pursue this project.

References

- 1 College of Physicians and Surgeons of Nova Scotia. Patient follow-up: advice for physicians. *ALERT Newsletter*, winter 2004. Available online at www.cpsns.ns.ca/newsletters/alert-winter-2004.htm. Last checked June 2006
- 2 National Patient Safety Agency. *Seven Steps to Patient Safety. The Full Reference Guide*. London: NPSA, 2004
- 3 Berlin L. The deep pocket. *American Journal of Roentgenology* 2000;**175**:1243–7
- 4 Leahy Taylor J. Medical negligence. *Bulletin of the Hong Kong Medical Association* 1975; **27**:109–13
- 5 Berlin L. Communication of the significant but not urgent finding. *American Journal of Roentgenology* 1997;**168**:329–31
- 6 See www.connectingforhealth.nhs.uk. Last accessed June 2006

Child protection referrals: learning from clinical audit in mental health services

Lindsey Beardsall¹, Val Brooks² and Mike Smith³

¹Health Effectiveness & Audit Lead, Forest House, Southwell Road, Mansfield, Nottinghamshire NG18 4HH, email Lindsey.Beardsall@nottshc.nhs.uk; ²Service Team Leader, Child & Adolescent Mental Health Services, Thorneywood, Nottingham, email Val.Brooks@nottshc.nhs.uk; ³Senior Nurse, Child Protection, Named Nurse Child Protection, Duncan Macmillan House, Nottingham, email michael.smith2@nottshc.nhs.uk

- An audit was undertaken to provide evidence for the Healthcare Commission and for accreditation with the Clinical Negligence Scheme for (mental health) Trusts. It investigated the quality and quantity of information contained within referrals made by our trust to social services.
- The majority of referrals emanated from adult as well as child and adolescent services, mainly from nursing staff, from the city area of our trust.
- The most common reasons for referral were emotional abuse, physical abuse and neglect. Concerns for unborn children and those under the age of one year centred on (suspected) substance abuse.
- The results of this audit have been instrumental in restructuring the trust's child protection services, developing training programmes and identifying areas for further audit and research.

Both locally and nationally, there is a requirement to evidence and improve practice in relation to child protection issues, particularly following the publication of the Climbié report.¹ Both the Healthcare Commission² and the Clinical Negligence Scheme for (mental health) Trusts³ (CNST) encourage the auditing of child protection policy and procedures. These imperatives are reflected in our trust's clinical governance and audit priorities, along with child protection work plans and local 'Safeguarding Children' partner organisations.

The aims of this audit were:

- to determine whether child protection referrals from our trust contain comprehensive and appropriate information to assist social services in the assessment process
- to determine whether the assessment framework was being properly applied within referrals

- to develop the trust's child protection training programme.

Expert clinicians in the field of child protection collected and evaluated the data, namely the trust's child protection named nurse and the service team leader of the child and adolescent mental health service (CAMHS).

Methods

When referrals are made to social services, a copy of the referral letter is sent to the trust's named nurse. The audit studied all referrals made in an 18-month period. (It is acknowledged that a possible limitation to this approach is that it relies on the assumption that copies of all referral letters have indeed been sent to the named nurse.)

The referrals were checked to see whether the trust's referral form had been used and how complete

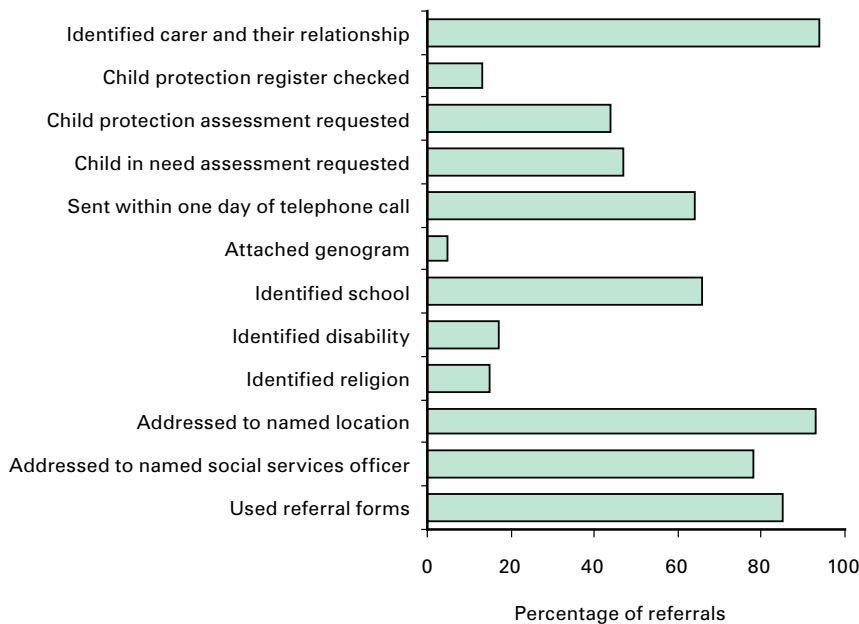


Figure 1. Information submitted in referral letters.

the information was. The reasons for referral were examined. The audit also looked at use of the local assessment framework, which covers parenting capacity, the child's development needs, and family and environmental factors.

Results

Source and content of referrals

A total of 203 referrals were studied, relating to children (including unborn children) up to the age of 17 years. The majority of referrals came from adult services ($n = 113, 56\%$) and the CAMHS ($n = 82, 40\%$). Nursing staff made the majority of referrals ($n = 96, 47\%$) and most

emanated from the city area of our trust ($n = 157, 77\%$).

Referral forms were used in over 80% of the referrals. The completeness of the information submitted in the referral is indicated in Figure 1.

Reasons for referral

The reason for referral was clearly identified in 81% of cases. More than one reason could be identified for any one case, and in total 319 reasons for referral were identified from the 203 referrals studied in this audit (Figure 2). The most common reasons were:

- emotional abuse (36%)
- physical abuse (21%)
- neglect (21%)

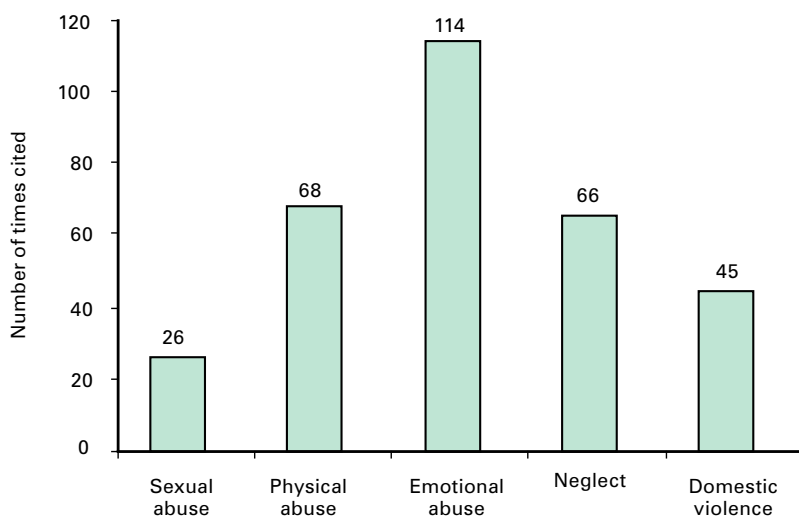


Figure 2. Reasons for referrals.

- substance abuse (actual or suspected) (22%)

Emotional abuse was the most frequently cited for each age group. Physical abuse was the second most frequently cited for those over the age of 11 years, while neglect was the second most frequently cited for those under the age of 11 years.

Substance abuse was not often a reason for referral in itself but rather for its association with, for example, emotional abuse (42%) or neglect (38%). Moreover, 89% of unborn children or those under the age of one year were referred regarding concerns about (suspected) substance abuse.

Evidence of the use of the assessment framework

In 71% of the referrals, the assessment framework was used well to identify child development needs. In total, 436 needs were identified. The most common were:

- emotional and behavioural (33%)
- family and social relationships (28%).

In 74% of the referrals, the assessment framework was used well to identify parenting capacity. In total, 534 parenting capacity issues were identified. The most common were:

- ensuring safety (25%)
- stability (20%)
- emotional warmth (18%).

Finally, in 68% of referrals the assessment framework was used well to identify family and environmental factors. In total, 388 family and environmental factors were identified. The most common was family history and social functioning (36%).

Discussion

The majority of referrals in this study (77%) came from the area of the trust that is largely co-terminus with the city area. The provision of mental health services by the trust is roughly equally spread across the city and the county. Trust child protection services, however, are centrally located, in Nottingham city. This low profile in the county areas may be a factor in their lower referral rates.

The majority of referrals (56%) originated from the adult care group.

This reflects the fact that this is the largest group of service users who are of parenting age. The CAMHS accounted for 40% of referrals. Although the CAMHS is a much smaller service, it is fair to say that younger people accessing mental health services are a particularly vulnerable group.

Outcomes and recommendations

The audit provided baseline information that was instrumental in the restructuring of child protection support services to address issues of under-reporting from rural areas. This resulted in the recruitment of an additional named nurse: we now have one for the city area and one for the county areas. The audit also informed the provision of tailored

training sessions for individual care groups; for example, training given to staff working in adult services now has more of a focus on substance abuse, particularly where patients are parents of young children or are pregnant. The audit also provided evidence for the Healthcare Commission and the CNST.

Further work is planned:

- to explore whether collaborative research with social services can be undertaken to study the outcome of referrals
- to undertake a re-audit
- to continue to evaluate and monitor the uptake of training.

Conclusion

This audit has enabled the trust:

- to check whether referral documentation is being completed appropriately
- to see whether the assessment framework is being used effectively
- to identify the nature, frequency and source of referrals
- to develop child protection resources and training programmes to reflect the trends and needs revealed.

References

- 1 Victoria Climbié Inquiry. *Final Report*. London: HMSO, 2003
- 2 Commission for Health Improvement (CHI) (now Healthcare Commission). *Self Assessment Tool for Child Protection for Clinical Teams*. London: CHI, 2004
- 3 Clinical Negligence Scheme for Trusts. *Mental Health and Learning Disability Clinical Risk Management Standards*. London: NHS Litigation Authority, 2005

An audit of the implementation of guidance from the Committee on Safety of Medicines on the use of antipsychotics in the elderly

Meghana Godbole¹ and Claire Bowler²

¹Senior House Officer in Psychiatry (presently based at Epsom, South West London, and St George's Trust), Nottingham City Hospital, email pollyann77@yahoo.com; ²Consultant in Old Age Psychiatry, Nottinghamshire Healthcare Trust

- The Committee on Safety of Medicines (CSM) issued a warning in March 2004 that atypical antipsychotics should be avoided in patients with dementia in view of the increased risk of cerebrovascular adverse events.
- We conducted an audit before this CSM warning (in March 2003) and after (in September 2004) to evaluate the implementation of the guidance.
- By following CSM guidance a significant reduction in the use of atypical antipsychotics was achieved.
- Audits conducted before and after implementation are crucial in ensuring that clinical guidelines are translated from theory into practice.

Antipsychotics (typical and atypical) are often used, with some benefit, to treat behavioural and psychological symptoms of dementia (BPSD). Review of the research by the Committee on Safety of Medicines (CSM, now the Commission on Human Medicines, part of the

Medicine and Healthcare products Regulatory Agency) found that patients with dementia whose BPSD were treated with risperidone or olanzapine had a three-fold increase in cerebrovascular adverse events and possibly even increased mortality. Subsequently, the CSM issued a warning (in March 2004) stating that atypicals such as risperidone and olanzapine should be avoided as far as possible in this patient group, and more so in those with cardiac and vascular risk factors, and that other antipsychotics should be used, if necessary.¹

Of course, any clinical guidance or guideline will be meaningful only if it is successfully implemented. In this article, we describe how an audit strategy was used to assess the implementation of a clinical guideline.

Methods

We conducted an audit to evaluate the use of antipsychotics in the elderly, and to detect any changes in

the patterns of prescribing for them, before and after the CSM issued its warning. A retrospective case-note and prescription chart review of 80 patients residing at the continuing-care facilities for the elderly mentally ill in Nottingham was carried out. A questionnaire was used to extract the relevant information from patients' notes. This audit was conducted in two phases: phase I (March 2003) was before the CSM warning and phase II (September 2004) was after the CSM warning.

Results

The initial audit (pre-CSM warning) (Figure 1) found that 34 (43%) patients were on atypical antipsychotics (16% on olanzapine, 12% on risperidone and 14% on quetiapine), and 12 (15%) were on haloperidol. In the re-audit (post-CSM warning), only 11 patients (14%) were on atypicals (4% on olanzapine, 3% on risperidone and 8% on quetiapine). The number of patients

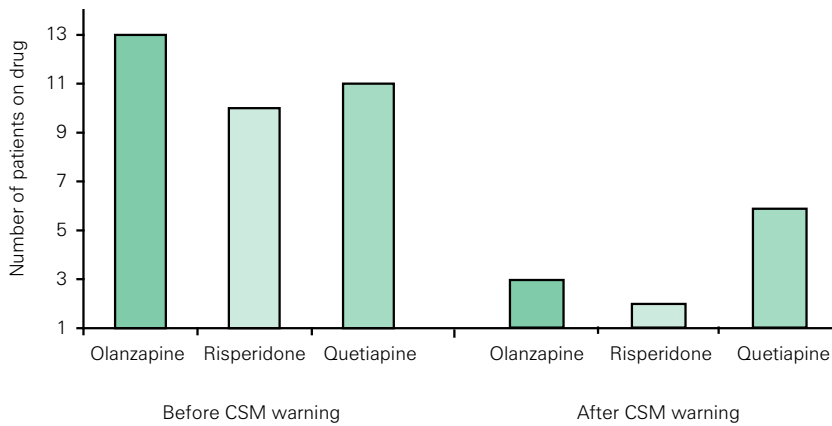


Figure 1. Numbers of patients on atypical antipsychotics before and after the CSM warning.

on haloperidol increased from 12 (15%) to 19 (25%), and those on benzodiazepines increased from 25 (31%) to 32 (40%), while the number on sulpiride remained the same (4%). Following the CSM guidance, patients on olanzapine and risperidone were tried on quetiapine or typical antipsychotics but were either intolerant or non-responsive.

Discussion

It was reassuring to note that the general trend in the use of atypical antipsychotics (as first-line

treatments for BPSD) fell (from 43% to 14%), in accordance with the CSM guidance. However, from a clinical perspective, this guidance needs to be interpreted with some flexibility and the following points need to be borne in mind. First, management of behavioural disturbances in the elderly should initially involve environmental and behavioural interventions, and conventional antipsychotics may be used in cases where pharmacological treatment is deemed necessary. Second, atypical antipsychotics like risperidone and olanzapine are not absolutely contra-

indicated for use in the elderly with BPSD. However, these drugs do need to be used with caution, particularly for patients with cardiac and vascular risk factors. Finally, any decision to start or continue atypical antipsychotics should be adequately documented and the need for continuing with this treatment should be regularly reviewed.

Conclusion

In medicine, given the current socio-political climate, various guidelines are an inevitable part of the day-to-day practice of all clinicians – doctors, nurses and other health professionals. Often such guidelines fail to be adequately translated from theory into practice. We have shown that audit strategies can be used to assess the implementation of such guidelines.

Acknowledgements

We thank Dr Sanju George for his guidance and comments on a draft of this manuscript.

Reference

- 1 Insan P, Cawley D. CSM guidance on antipsychotic use. 'Care of the Elderly in Psychosis' Supplement to *Geriatric Medicine*, July 2004: 6–7

Discharge summaries in child psychiatry

Leela Sivaprasad¹, Ditesh Dhaya² and Sumi Handy³

¹Specialist Registrar, Hatherton Centre, St George's Hospital, Stafford ST16 3AG, email leelas810@yahoo.co.uk

²Specialist Registrar, Bushey Fields Hospital, Dudley; ³Consultant Child Psychiatrist, Birmingham Children's Hospital, Birmingham

- Unlike GPs, child psychiatrists favour lengthier summaries, with details of therapeutic work, special assessments and pending issues.
- Regular review of current practice with regard to communication is invaluable.
- Services provided should be tailored to the needs of those using them.

Discharge summaries are useful documents that can facilitate communication between professionals and enable continuity of patient care.¹ Most psychiatric services use relatively wide-ranging, detailed

discharge summaries. However, information on the quality of and satisfaction with these summaries is scant, particularly in child psychiatry. An audit of discharge summaries in forensic psychiatry² and a more recent one in general adult psychiatry¹ identified several important areas in which the summaries were deficient.

Here we report on an audit of the discharge summaries provided by a 10-bed child psychiatry inpatient unit located within a children's hospital. This regional service receives referrals predominantly from

community child psychiatrists (and occasionally from paediatricians within the hospital) working in the same health region, covering a population of 5 million.

The primary aim was to obtain referrers' views on the relevance and quality of discharge summaries despatched from the unit in the preceding year to evaluate our practice and make necessary changes.

Method of audit

A three-part questionnaire was formulated using the items in our

operational discharge summaries and sent to community child psychiatrists in the region.

Section A

The instruction for the first part of the questionnaire read:

The following are the headings that we currently use in our discharge summaries. Please indicate whether you feel this information is relevant or not.

There were three response options: not relevant (scored 1), somewhat relevant (scored 2) and very relevant (scored 3). The headings were as follows:

- patient's name, address, date of birth
- patient's GP
- school
- date of admission
- date of discharge
- name of referrer
- reason for referral
- presenting problems at time of admission
- investigations done during admission
- treatment and progress on the ward
- progress at hospital school
- diagnosis (multi-axial)
- areas identified for further intervention
- medication on discharge
- follow-up arrangements/discharge plan
- signature, name and title of person who prepared the discharge summary
- date the discharge summary was written.

Section B

Simple 'Yes/No' responses were required for the second part of the questionnaire, which comprised the following items:

- Have you received a discharge summary from us in the past year?
- If 'Yes', continue with this section. If 'No', go to section C.
- Were you satisfied with the information given in the discharge summary?
- Were you informed of the discharge prior to the patient being discharged?
- Was the time interval between discharge and receipt of the discharge summary acceptable?
- Did the discharge summary lack any vital or relevant information?
- If 'Yes', please state:

Section C

The third part of the questionnaire asked 'Do you think there is any other information that needs to be included in the discharge summary?' and asked for what this might be, as well as for any other suggestions as to how the discharge summaries could be improved, or any other comments.

Results

Responses were received from 35 of the region's 47 community child psychiatrists who were sent the questionnaire (a 74% response rate), but only 12 of these 35 (34%) had received a summary from the unit in the last year.

Of those who had received a summary, 75% (9/12) were satisfied with the information provided, but two-thirds (8/12) felt that the summaries lacked some vital information.

Ten of the respondents (83%) provided suggestions for improvement. The main suggestions were that the summaries should:

- be sent out promptly
- be checked by the consultant before despatch
- state what the child and family or carer had been told about diagnosis and treatment
- emphasise any special assessments or investigations carried out
- include any child protection concerns and steps taken in this regard
- provide more details of multi-disciplinary and inter-agency elements of care
- clearly state the areas identified for further intervention.

Discussion

Our findings suggest that child psychiatry colleagues value detailed discharge summaries from an inpatient unit, which supports Kerr's comment that separate summaries are probably required to meet the differing needs and expectations of psychiatrists and GPs.³ Although this survey was confined to a single child psychiatry unit, valuable learning

points could still be obtained and applied to other psychiatric services, inpatient ones in particular.

Limitations were that the numbers were small, the information limited to one service, and paediatricians' and GPs' views were not solicited. However, GPs' views have been sought in previous studies and there is sufficient understanding of their views and expectations in this area.³

Preparing discharge summaries raises some important training and supervision issues. Frain *et al.* looked at the views of junior doctors who prepared discharge summaries and found that 'the subject of discharge summaries aroused strong feelings'. The 'lack of guidance given to doctors in preparing summaries' was also raised.⁴ Crossan *et al.* recommended providing junior doctors with some specific training and having the completed summary checked by a senior colleague.¹

A structured format aids in the task. The design and format of discharge summaries needs to account for the nature of the individual service and the expectations of it.⁴ The aim is to achieve a delicate balance of length, detail, timeliness, accuracy and relevance.

Future ventures in this area could compare the views of relevant professionals involved as well as service users and parents or carers, especially in light of Department of Health guidelines on copying correspondence to patients and carers.⁵

References

- 1 Crossan I, Curtis D, Ong Y-L. Audit of psychiatric discharge summaries: completing the cycle. *Psychiatric Bulletin* 2004;28:329-31
- 2 Singhal S. Audit of forensic psychiatric discharge summaries. *Medicine, Science and the Law* 1994;34:167-9
- 3 Kerr MSD. Response to psychiatric discharge summaries: differing requirements of psychiatrists and general practitioners. *BMJ* 1990;300:260-1
- 4 Frain JP, Frain AE, Carr PH. Experience of medical senior house officers in preparing discharge summaries. *BMJ* 1996;312:350
- 5 Department of Health. *Copying Letters to Patients: Good Practice Guidelines*. London: DH, 2003

Clinical Governance Bulletin (ISSN 1470-9023) is published by The Royal Society of Medicine Press Limited, London. For further information, subscription prices and full text online see www.rsmppress.co.uk/cgb.htm.

This publication is published and distributed to targeted professionals in the NHS with financial support from The Health Foundation.

An audit of safe practice for local anaesthetic, fire and medical emergencies in a dental hospital setting

Jennifer Foley¹ and Francesca Soldani²

¹Consultant, Unit of Dental and Oral Health, Dundee Dental Hospital, Dundee DD1 4HN, email jfoley@nhs.net

²Specialist Registrar, Unit of Dental and Oral Health, Dundee Dental Hospital

- The ability to manage both dental and medical emergencies is required of all members of the dental team.
- Audits were conducted that highlighted a number of deficiencies regarding procedures to follow for needle-stick injuries and emergency scenarios.
- Awareness of these issues has been raised and further training in certain aspects of departmental emergency procedures has been put in place.
- Parts of this audit have been expanded to include all members of the dental team working within all clinical sections of Dundee Dental Hospital.

The ability to manage both dental and medical emergencies is a vital requirement for all members of the dental team. Previous workers have investigated both the experiences of staff working within a UK dental teaching hospital and the perception of their readiness to deal with certain types of emergency.¹ This article reports the findings of a questionnaire survey carried out among members of staff from the Unit of Dental and Oral Health, Dundee Dental Hospital and School. The aim of the survey was to determine their knowledge of various emergency situations.

Methods

The study was designed as a prospective, questionnaire-based survey, undertaken during December 2004 and January 2005 in the Unit of Dental and Oral Health, Dundee Dental Hospital, NHS Tayside.

Audit 1

Numbered questionnaires were completed, following a full verbal explanation. Two groups of staff were involved in the audit:

- dental care professionals (DCPs) – dental nurses and dental technicians

- dentists – consultants, lecturers, staff-grade dentists, visiting general dental practitioners and senior house officers.

Details were sought in relation to best practice for certain emergency scenarios. In order to avoid collaboration and to simulate an emergency, the respondents were allowed only 30 s in which to answer each question. The questions are summarised as follows:

Medical emergency

- telephone number to call in the event of a medical emergency
- location of oxygen
- location of emergency drugs.

Fire safety

- telephone number to call in the event of discovering a fire
- location of fire exits
- location of staff/patient assembly point.

Local anaesthetic emergency

- knowledge of safe disposal of a used Ultra Safety Plus® XL injection system (Septodont, Deproco UK Ltd)
- knowledge of safe disposal of a used local anaesthetic cartridge
- procedure to follow in the event of a needle-stick injury.

Subsequently, a model answer for the questionnaire was presented to the participants via a Microsoft PowerPoint® presentation.

Audit 2

A further questionnaire was completed six weeks following audit 1, again with a time limit of 30 s to answer each question.

Data analysis

Differences between audits 1 and 2 were assessed by chi-square analysis (MINITAB™ statistical software, release 13.31).

Results

Twenty-four members of staff were questioned in audit 1 (8 dentists and 16 DCPs) and 17 in audit 2 (5 dentists and 12 DCPs). Less than 40% of dentists were aware of the number to telephone in the event of a medical emergency, although this increased significantly to 100% in audit 2 ($\chi^2 = 89.85$, $P = 0.001$). A similar improvement in knowledge was seen for the DCPs and, again, this was statistically significant ($\chi^2 = 6.82$, $P = 0.009$). Regarding the location of emergency oxygen within the department, knowledge improved for both dentists and DCPs between audits and, again, this was statistically significant ($\chi^2 = 90.22$, $P = 0.001$ and $\chi^2 = 9.23$, $P = 0.002$, respectively). Overall, comparing knowledge in relation to the location of emergency drugs, there were no statistically significant inter- or intra-group differences (Figure 1).

A statistically significant improvement in knowledge in relation to the fire assembly point for both groups (to 60% and 100% for dentists and DCPs respectively) was noted in audit 2 ($\chi^2 = 25.06$, $P = 0.001$ and $\chi^2 = 54.78$, $P = 0.001$, respectively). Knowledge of the location of the fire exits, however, decreased from 75% to 50% for dentists between audit cycles and this was statistically significant ($\chi^2 = 13.33$, $P = 0.001$). In both audits, the DCPs' knowledge of the contact telephone number in the event of fire was significantly greater than that of the dentists ($\chi^2 = 106.59$, $P = 0.001$ and $\chi^2 = 79.45$, $P = 0.001$, respectively) (Figure 2).

Regarding needle-stick injuries, 62% of dentists and 45% of DCPs were aware of NHS Tayside policy in audit 1; audit 2, however, revealed no significant change in knowledge regarding the protocol for such injuries. Concerning the disposal of a used Ultra Safety Plus® XL

Discussion

The present study was designed to determine knowledge among the dental team of both common and uncommon emergencies within a UK-based hospital dental service. While the sample sizes in both audits were relatively small, they would appear to give a snapshot view of knowledge within a group of dentists and DCPs.

Regarding medical emergencies, in the initial audit staff dentists knew less about emergency protocols than did the DCPs. For both staff groups, however, awareness of both the telephone number and the location of oxygen within the department had increased in the follow-up audit. Such findings would indicate a continual need for training, both for permanent staff but also for those individuals on short fixed-term contracts.

It is important that all members of the dental team are confident in their skills in cardiopulmonary resuscitation (CPR). Previous workers, however, have reported that over 60% of recent dental graduates working within general dental practice felt unprepared for medical emergencies and 96% expressed a desire for further training.² Within NHS Tayside, training in CPR is an integral component of induction days that all newly appointed senior house officers must attend; further life support/simulator training is provided throughout the duration of the 12-month appointments. A further rolling programme of training in medical emergency scenarios also occurs for all staff within Dundee Dental Hospital. In the majority of cases, however, CPR training takes place outwith the main department in which dentists and DCPs undertake their daily activities. This may explain, in part, why the respondents were unsure of the location of oxygen and emergency drugs within the department. Perhaps another reason for the less than optimal responses was the time limit of 30 s during which respondents were allowed to answer each question, although this is not an unrealistic response time for an emergency.

Concerning knowledge of procedures for fire emergencies, in both audits the proportion of dentists who knew the emergency number to telephone in the event of discovering a fire was disappointing. Indeed, there

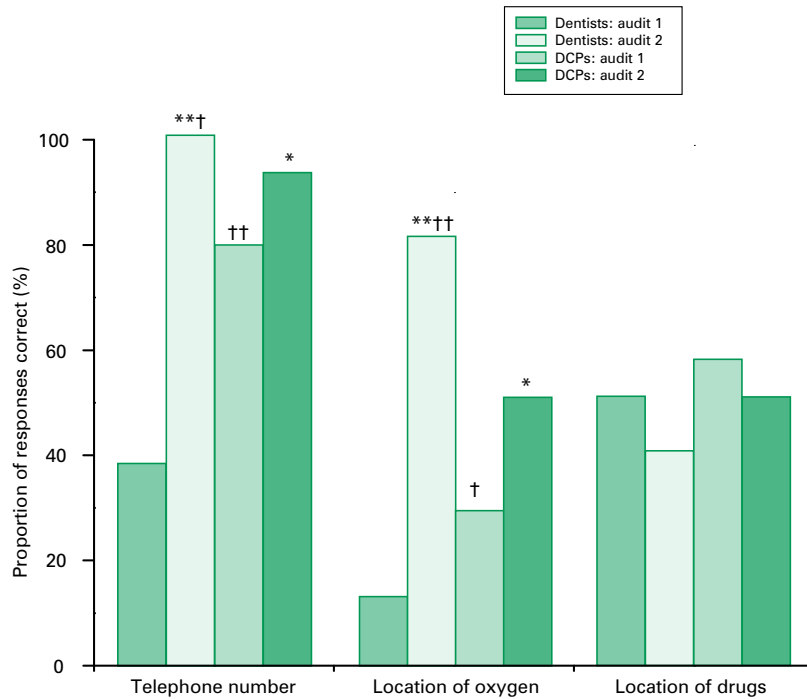


Figure 1. Comparison of responses to questions relating to medical emergencies between audits 1 and 2: intra-group, * $P < 0.05$, ** $P < 0.001$; and inter-group (comparisons between dentists and DCPs), † $P < 0.05$, †† $P < 0.001$ (1 d.f. for all groups).

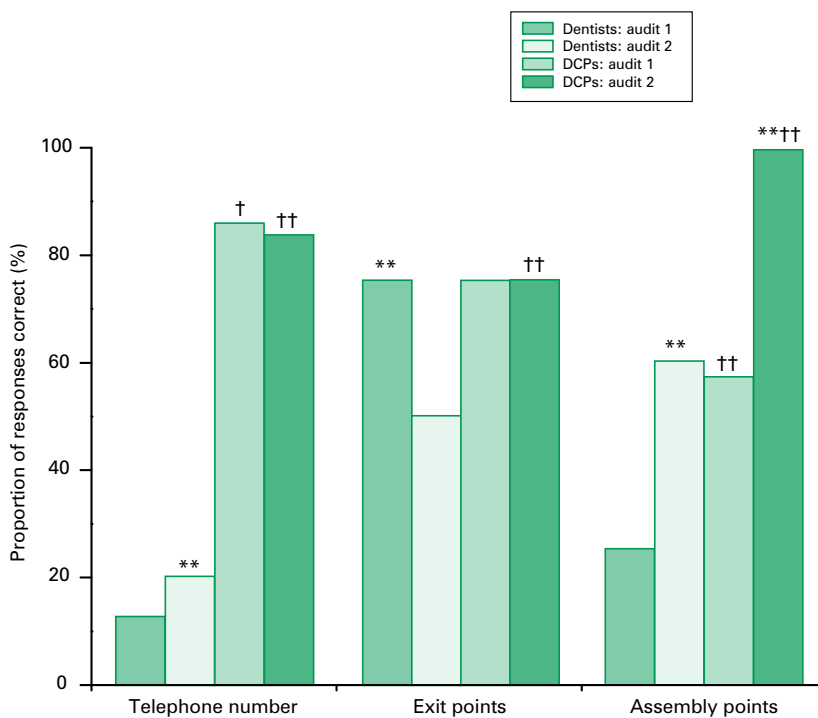


Figure 2. Comparison of responses to questions relating to fire safety between audits 1 and 2: intra-group, * $P < 0.05$, ** $P < 0.001$; and inter-group (comparisons between dentists and DCPs), † $P < 0.05$, †† $P < 0.001$ (1 d.f. for all groups).

injection system, there was a statistically significant improvement in knowledge for the dentists between audits ($\chi^2 = 12.77$, $P = 0.001$); there was, however, a significant decrease in knowledge among the DCPs ($\chi^2 = 15.67$, $P = 0.001$). In relation to

the safe disposal of a used cartridge of local anaesthetic solution, there was a statistically significant decrease in knowledge for both groups between audits ($\chi^2 = 5.13$, $P = 0.024$ and $\chi^2 = 39.52$, $P = 0.001$, respectively) (Figure 3).

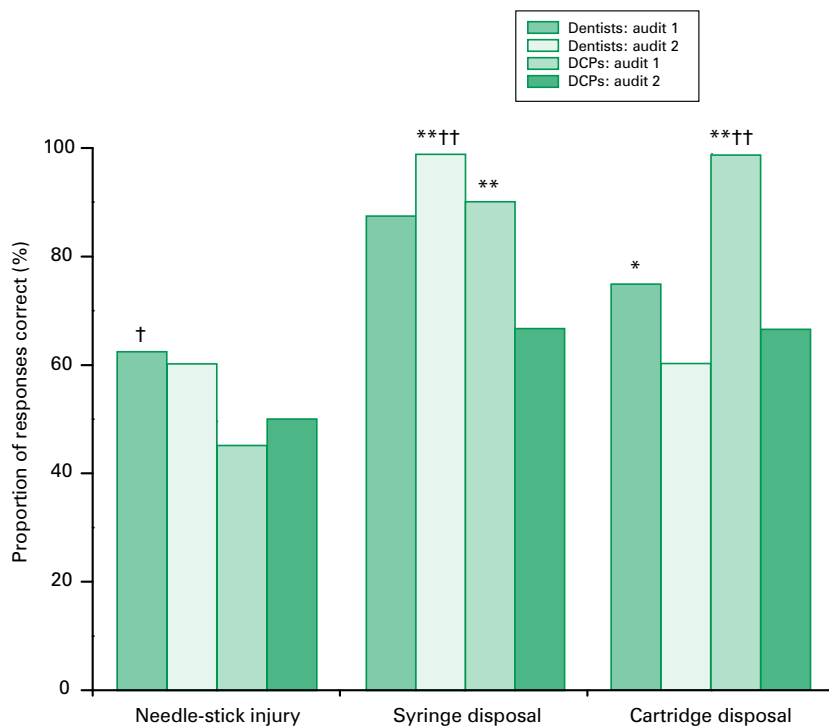


Figure 3. Comparison of responses to questions relating to the use of local anaesthetics between audits 1 and 2: intra-group, * $P < 0.05$, ** $P < 0.001$; and inter-group (comparisons between dentists and DCPs), † $P < 0.05$, †† $P < 0.001$ (1 d.f. for all groups).

appeared to be confusion among staff between the different numbers to telephone for medical collapse and fire discovery. Other workers have noted that a single emergency telephone number is desirable for alerting the fire brigade and the cardiac arrest team and have highlighted that valuable time is wasted by connecting and transferring emergency calls between the different centres.³ While there is a rolling programme of training in medical emergency scenarios as well as of fire lectures within the hospital, the findings of the current study perhaps suggest not only a continual need for staff training but also for further training in other aspects of fire/medical emergency management, such as the location of oxygen and the assembly points following evacuation of the building.

Regarding safe practice in the use of local anaesthetic agents, DCPs' knowledge regarding the disposal of both the syringe and the anaesthetic cartridge decreased between audits, as did dentists' knowledge of the latter. Concerning needle-stick injuries, less than two-thirds of both dentists and DCPs were aware of the correct procedure to follow; indeed,

there was no statistically significant difference between the two audits for either group. Again, however, it may have been the time limit for completion of questions which resulted in the less than optimal response to the scenarios surrounding the safe practice of local anaesthesia. A recent short-life working group on needle-stick injuries in NHS Scotland has estimated that 11 million needles are used in Scotland per annum. It is not known, however, how many are involved in contact with patients or microbiological hazards. For the period 1996–99, the total number of needle-stick injuries was 6811 across NHS Scotland, although anecdotal evidence would suggest that the actual number may be higher, given that staff are inclined to self-assess and not to report such incidents. Among dental personnel, needle-sticks account for approximately 2% of all professional injuries; the figures, however, do not include those individuals based in dental practice in primary care. Overall, it has been estimated that 15% of all needle-stick injuries result from poor clinical practice while the remainder result from incorrect use or disposal of the

equipment (e.g. concealed sharps and needle resheathing).⁴

The cross-infection risks from needle-stick injuries among dentists, dental undergraduate students and dental nurses have been well documented. To minimise such injuries, all staff must be educated not only in safe working practices, including disposal of devices, but also in the procedures to follow in the event of such an injury and for reporting such injuries.

A recent study determined the types of dental syringes currently being used in British and Irish dental schools; 9 of the 16 schools which were contacted were currently using a safety syringe within some or all departments, while a further four were considering conversion to safety dental syringes.⁵

Conclusions

These audits have shown significant improvement in some areas of safe practice in relation to the use of local anaesthesia and the procedures to follow in the event of either a medical emergency or fire within the department involved. Importantly, staff awareness of these issues has been raised and the need for further training in certain aspects of departmental procedures has been identified. Subsequently, parts of this audit have been expanded to include all members of the dental team working within all clinical sections of Dundee Dental Hospital.

References

- 1 Atherton GJ, Pemberton MN, Thornhill MH. Medical emergencies: the experience of staff of a UK dental teaching hospital. *British Dental Journal* 2000;188:320–4
- 2 Atherton GJ, McCaul JA, Williams SA. Medical emergencies in general dental practice in Great Britain. Part 3: Perceptions of training and competence of GDCPs in their management. *British Dental Journal* 1999;186:234–7
- 3 Diehl P, Mauer D, Schneider T, Dick W. The emergency telephone number – the essential weak link in an emergency system. Prospective studies involving cardiac arrests observed by bystanders. *Anaesthetist* 1992;41:348–53
- 4 Scottish Executive. *Needlestick Injuries: Sharpen Your Awareness*. Edinburgh: Scottish Executive, 2001
- 5 Zakrzewska JM, Boon EC. Use of safety dental syringes in British and Irish dental schools. *British Dental Journal* 2003;195:207–9