What is a Quality Improvement Audit project?

Clinical audit is the activity whereby clinical practice is considered against some measure or standard in order to identify possible areas for improvement.

Clinical audit can be directed at *processes* of care or *outcomes* of care. Most clinical audits in healthcare are directed at measures of process, as outcome is much more difficult to measure.

A Quality Improvement Audit project is one that follows the Quality Improvement cycle. This cycle can be described as follows:

1. Define the aspect of practice to be measured, for example, 'adequacy of my patient records' or 'utilisation of supervision or peer review in my psychotherapy practice'

2. Determine the *standard* or *indicator* to be used in measurement (see below for further definition of these terms)

3. Identify data relevant to the standard or indicator, such as case records, feedback from target groups or aspects of practice process or structure

4. Collect data and analyse results. Engage in reflective process (which could be enhanced by discussion with a peer review group or supervisor) about the findings

5. On the basis of the results, implement change, if change is workable and warranted

6. Re-audit after a suitable period (say, twelve months) to review changes in practice.

A *standard* is a specific criterion of adequate process, which may be based on common practice, may be defined by a particular service, or may be recorded in clinical guidelines. Given the variability of psychotherapy practice, guideline-based standards are often not relevant. However it is quite permissible for practitioners to define and document their own standards for particular processes. For example, I might define a standard for 'adequacy of my medical records' with reference to common categories including history, mental state, formulation, risk assessment, correspondence, record of supervision discussions, and so on. If I found a pattern of omission or inadequacy in one or more areas, I could seek to remedy this deficit before re-audit.

An *indicator* is a measure that allows monitoring of change over time, without implying that any particular score on the indicator is reflective of 'good practice'. For example, in general hospital psychiatry a commonly used indicator is 'proportion of patients with unplanned re-admission within 28 days'. Unplanned re-admission might be a good thing (if it means care is being actively followed up) or a bad thing (if it means the origin admission was incomplete). The *indicator* only points to certain cases that might warrant further analysis. Similarly, in psychotherapy practice I might measure the proportion of my patients discussed in supervision or peer review in the last three years. I could then do case reviews of samples of the patients that were discussed, and of those not discussed, to determine if there were any particular factors related to the fact of their discussion (or non-discussion). If I found that there

were particular kinds of cases that I chose to discuss (or not discuss), I might consider making changes.

When the Quality Improvement Audit project has been completed, the project should be described in a brief one-page document, as a record that can be produced to show that the audit activity has taken place. This document should contain no patient-identifiable data. All the information about cases remains in the control of the author of the project. What should be recorded is the planning, structure, implementation and outcome of the project.

To suggest some further ideas, we would like to share with you the audit projects which we (the members of the FOP Working Party on CPD) are currently working on:

- Assessing the adequacy of the psychotherapy supervision I provide by means of a systematic questionnaire sent to supervisees, eliciting feedback about the structure and processes of supervision. In this case there is no specific ‘standard’ to measure against, so the findings will be discussed in peer review with other supervisors to make an assessment against ‘common practice’. (Simon Byrne)

- Examination of my adherence to the frame in terms of my punctuality in commencing and ending the session. This was done by taking one month of my practice and noting my punctuality. In this case, the variations in the session duration as determined by the frame of therapy is an ‘indicator’, and is being used to identify non-conforming cases. Reflection on these variations may help to identify patient or therapy variables related to departures from the frame. (Paul Foulkes)

- An assessment of the adequacy of my private practice structure/set-up. I am considering various aspects of my practice structure against a ‘standard’, the RANZCP *A guide to private psychiatric practice.* Having identified conformity or otherwise with the standard I will engage in reflective process, initially individual and possibly with a peer review group to consider reasons for variations and scope for changes. (Melinda Hill)

- A review of the processes of discharge planning and implementation. The sample is made up of all the patients discharged from care in the last year, including those seen for therapy as well as those who attended for assessment. The data set included the discharge discussion with the patient, the arrangements for future contact (if any), and the nature of the communication to the GP. I reflected on the actions taken and considered them in relation to a ‘standard’ of ‘common practice’ as exemplified in my peer review group. (Jenny Randles)

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