LETTERS

Clinical risk management in psychiatry

The very day Dr Maurice Lipsedge's impressive summary of risk management for violent or suicidal patients¹ arrived on my desk, I dispatched copies to my three community trust colleagues responsible for quality, risk management, and management of (specialist) mental health services, respectively. Coming immediately after the inquiry into Jonathan Newby's death, it could not have been more timely in preventing similar tragedies in "community care."

In one respect the article may have been misleading to readers, by separating dangerous and suicidal behaviours. We found that often dangerous and self harming behaviours are combined in the same patient in rapid succession,² and the risks are not managed independently in these patients. None the less, the paper's highlighting of key issues, such as following section 117 of the Mental Health Act in predicting patients' aftercare needs or taking a longitudinal view of each client's evolving pattern of behaviour over time to assess risk, could be pertinent all over Great Britain. However, to reduce the risks in psychiatry will need something in addition to circulating a catalogue of "why do things go wrong."¹

That something extra is audit. Dr Lipsedge elegantly summarises factors which predict violence and which predict suicide. The legal constraints are also clarified. But if mental health practice is going to improve then standards need to be agreed for just these items and the audit cycle set rolling.³ William Boyd's *Confidential Inquiry into Homicides and Suicides by Mentally Ill People*⁴ recommended that health authorities took a lead "to develop systems of audit" which took account of the circumstances of serious incidents." Such clinical audit is much more likely to reduce risks to staff, patients, and the public if feedback from audit is closely linked to staff training,^{2,3} as appropriate under the management of Health and Safety at Work Regulations. Aspects of service policy which have recently been creating particular concerns for community care, and which seem to have failed catastrophically in the Newby case, are appropriate responses to *threats* of violence⁵ and to *dual diagnosis* clients⁶ who present with simultaneous problems related to schizophrenic illness and alcohol. The time is ripe for audits in these areas, as an avenue to better understanding of good clinical practice and a spur to learning new clinical skills.

WOODY CAAN
Head of Research and Development,
Lifespan Healthcare,
Cambridge CB1 5EE

1 Lipsedge M. Clinical risk management in psychiatry. *Quality in Health Care* 1995;4: 122-8.

- 2 Powell G, Caan W, Crowe M. What events precede violent incidents in psychiatric hospitals? *Br J Psychiatry* 1994;165:107-12.
- 3 Caan W. Caring for the mentally ill - time for review? *British Journal of Health Care Management* 1995;1:227.
- 4 Boyd W. *A preliminary report on homicide*. London: Confidential Inquiry into Homicides and Suicides by Mentally Ill People, 1994.
- 5 Caan W. An addict who threatens the GP for a prescription. *Prescriber* 1994; Oct 19:13-8.
- 6 Caan W. Continuity of care key to dual diagnoses. *Nursing Standard* 1995; Jun 28:42.

Identifying the missing link in the audit cycle

In clinical audit, practice is compared against standards and if care fails to meet these standards, steps are taken to improve practice.¹ Such improvements may not be achieved because the strategy chosen to secure change may not take into account the reasons why standards are not met.² Such an oversight has recently been labelled as the "missing link" in the audit cycle.³

In 1993 our initial audit of the management of anticoagulation in inpatients identified non-compliance with some aspects of the hospital guidelines.⁴ These guidelines, based on those issued by the British Society of Haematology,⁵ were displayed at the fortnightly hospital audit meetings and were incorporated into a junior doctors' handbook. To facilitate an effective closure of the audit cycle we investigated reasons for non-compliance - the missing link. We adopted a qualitative approach⁶ and conducted in-depth interviews with 10 junior doctors (four house officers and six senior house officers) to explore awareness of, acceptability, and applicability of these guidelines.

Awareness - Although all of the junior doctors had a handbook and had attended at least one of the regular audit meetings at our hospital, only three knew that hospital guidelines for managing anticoagulation in inpatients existed. The junior doctors' handbook was criticised for not being "user friendly," and seven doctors stated that they were too busy to attend audit meetings where they would have the opportunity to obtain the guidelines.

Acceptability - The junior doctors agreed that it was useful and helpful to have guidelines on the subject, but four used other guidelines on anticoagulation. Two of those who knew of the guidelines at the study hospital had only ever referred to them for specific requirements. When shown the guidelines and asked to comment on them seven doctors criticised them for being too detailed.

Applicability - Six junior doctors pointed out that certain tasks in the guidelines were not always appropriate in practice and that the guidelines made "unreasonable" demands - for instance, doing an activated partial thromboplastin time test (APTT) four hours after starting a patient's treatment with continuous intravenous infusion by heparin. They added that they felt too intimidated at the audit meetings to express their personal views about the guidelines. Furthermore, they did not view all recommendations as

being within their control - for example, the monitoring of microscopic haematuria by dipstick testing was regarded as a nursing responsibility.

The interviews highlighted real problems with the dissemination, applicability, and acceptability of the guidelines. After discussion at an audit meeting the following developments occurred over six months: (1) the guidelines were extensively revised by the consultant haematologist and reviewed by radiologists, cardiologists, physicians, and nursing and administrative staff; (2) the guidelines were, in addition, distilled into 12 "practice points"; and (3) the revised guidelines and practice points were incorporated into clinical ward manuals, sent to each clinician and ward manager, pinned to all ward noticeboards, and incorporated onto the hospital computer screen, so that they appeared whenever coagulation tests were ordered.

A second audit on the compliance with these hospital guidelines was conducted after all these developments were in place. Most changes were small, but significant improvements in clinical practice occurred in four of the 17 recommendations, resulting in patients being therapeutically maintained by day 4 in the second audit as opposed to day 6 in the first audit.⁷

Setting standards and attempting to improve clinical practice are important steps in the audit cycle. The results of this study suggest that the value of guidelines is lost if measures are not taken to ensure applicability and acceptability and if key staff instituting care are not consulted. By listening and discussing difficulties experienced by junior doctors, changes were introduced which resulted in increased compliance with hospital guidelines and better clinical practice. We recommend that, in view of the rapid turnover of junior doctors, regular examination of compliance and reasons for non-compliance need to be incorporated into routine audit programmes.

F C TAYLOR
G B TAN
M E RAMSAY
A RENTON
Academic Department of Public Health
H COHEN
Department of Haematology,
St Mary's Hospital Medical School,
London

J GABBAY
Institute of Public Health Medicine,
University of Southampton

- 1 Eddy DM. Designing a practice policy. Standards, guidelines and options. *JAMA* 1990;263:3077-84.
- 2 Grimshaw J, Russell I. Effect of clinical guidelines on medical practice: a systematic review of rigorous evaluations. *Lancet* 1993;342: 1317-22.
- 3 Crombie I, Davies H. Missing link in the audit cycle. *Quality in Health Care* 1993;2:47-8.
- 4 Tan G, Cohen H, Taylor F, Gabbay J. Audit of start of anticoagulation in inpatients. *J Clin Pathol* 1993;46:00.
- 5 Colvin BT, Barrowcliffe TW on behalf of the British Committee for Standards in Haematology, Haemastasis and Thrombosis Task Force. The British Society for Haematology guidelines on the use and monitoring of heparin 1992: Second revision. *J Clin Pathol* 1993;46:97-103.
- 6 Pope C, Mays N. Opening the black box: an encounter in the corridor of health services research. *BMJ* 1992;306:315-8.
- 7 Taylor F, Ramsay M, Renton A, Cohen H. Guidelines for anticoagulation. *BMJ* 1994; 309:197.