Audit and the team: an interview with the Adelaide Medical Centre team

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A recent policy statement from the NHS Management Executive makes explicit the move towards multiprofessional clinical audit. The intention is that clinical audit should become part of a wider quality management programme that spans all aspects of care in hospitals and the community. For this to be achieved it is necessary to understand those factors that enable people from different professional groups to work together to improve quality. The merits of teamwork are attracting growing attention, and there are examples of successful multiprofessional teams in many sectors of the health service. Walsh and Coles (p 189) have highlighted the need for evaluation of audit, but multiprofessional audit is a new development and the criteria by which it should be judged and the methods of assessment have not yet been established. The aim of this interview is to illustrate the factors that have contributed to the success of one particular team, in this case a primary health care team, and to identify some of the issues that must be addressed before multiprofessional audit can be evaluated.

Adelaide Medical Centre

The Adelaide Medical Centre is housed in one part of a modern but deserted shopping development in a deprived inner city district of Newcastle upon Tyne. Most of the windows are protected by iron bars, and a notice secured to the wall announces that all video equipment has been removed and that petty cash is no longer kept on the premises. Someone has sprayed paint in a jagged pattern on the front door. In 1990 the team of health professionals who work from this centre set out in a team manifesto their objectives for the service they would provide.

The members of this team were interviewed individually in March 1993. In the report that follows, extracts from these interviews have been combined into three sections: the weekly team meeting, perceptions of the team about audit, and audits that have been undertaken. Individual members of the team will not be identified but will be referred to by their positions.

Weekly team meeting

The primary health care team has a meeting each week. It was clear that this forms an important focal point and the team members were asked about its role and value.

PRACTICE NURSE: The team meets every Monday lunchtime. Everybody knows that he or she has to be there; it’s useful because the doctors are not here full time, so it’s not easy otherwise to get them all together. If I want to share a problem I write a note in the agenda book to discuss at the meeting. Everybody has an equal opportunity (a) to hear the problem and (b) to do something about it or find ways of doing something. There is nearly always either constructive advice or a sound reason for not making changes.

HEALTH VISITOR: The whole team is encouraged to attend the meetings and join in the discussions. We have looked critically at what we have been doing jointly, everybody in the team — all members of staff from myself, GPs, practice nurse, manager, receptionist staff, district nurses, secretaries, and even staff who are attached in a loose sense, like the dietitian and community psychiatric nurses. Anybody can put anything on the meeting agenda. This approach gives a tremendous amount of job satisfaction. There are a lot of stresses on workers in the inner city area, but if we have the back up of people all working for the same end with a similar philosophy, it makes such a difference. The work is much more satisfying.

GENERAL PRACTITIONER: Sometimes topics come out of the meeting that we then choose to audit. For instance, it was apparent that there might be a problem in open surgeries in the mornings with patients asking to see a specific doctor. So we thought we would look at the figures, asking the receptionists to mark with a red star the name of every patient who asked for a specific doctor.

Team members’ perceptions of audit

During the interviews it seemed that audit and team work were closely related activities, with audit compelling people to work together to solve problems. The team members were asked about their attitudes to audit and their participation.

PRACTICE MANAGER: We always try to advocate team working and that everybody’s contribution is worth while. I think it helps secretaries/receptionists to know that they can bring a problem to the team meeting and offer a solution or request the doctors’ help. We either do something about the problem or at least look at it thoroughly and then report
back. If there is a reasonable explanation for taking no action the receptionists accept that. I think that they feel that it’s not just doctors’ problems or patients’ problems that are looked at in audit.

We definitely have listening doctors. I have worked in another, much bigger, practice with more doctors. Pressure of work on doctors is one factor, but very often a set of doctors are not listening doctors and they don’t regard receptionists, only themselves and perhaps the nurses, as part of the team; everyone else just works in the practice. It would be possible to achieve good teamwork in other surgeries if the doctors were keener to accept that receptionists have a vital role and that without receptionists they would really be disadvantaged.

SECRETARY/RECEPTIONIST: The teamwork here is really good. I have never worked before in a situation where bosses can acknowledge that they have faults and that they are there to share whatever problems you have with you and help you through them. This practice does help you to improve your work, no matter what you’re doing, whereas in another practice that I worked in you were on your own, a problem in your work was pushed on to you to deal with.

HEALTH VISITOR: Good teamwork is essential – it’s very difficult to audit effectively without good communication between the team members. Here we do have a good system. As an attached worker but based in the practice premises, that makes a lot of difference to me and makes communication much easier. But good teamwork depends on how the team works and whether it functions truly as a team. Everybody’s role here is valued, everybody’s opinion is sought. There is a lot to communicate, and we have a fairly good channel of communication through both message books and also the fact that we can easily leave information and talk to each other during any day of the week; whenever people are around it’s quite easy to get access to each other.

It is difficult for us to always understand each other’s roles, and there are different ways you can learn more about each other. Multi-disciplinary training is one way. Sometimes there can be a complete lack of understanding of roles and also just poor communication; sometimes there is a “them” and “us” situation between the doctors and other staff. It is very hard to work if you do not feel valued and to give your best and to let people understand what you are able to offer. It’s not relaxing, and it makes it difficult sometimes to say what you feel constructively. Undoubtedly, we need to work together. The common aim is ensuring the health of the patients of a practice population – that is much more effectively addressed by a team.

Team audits
To illustrate the contribution of different team members they were asked briefly to describe some of the audits they had been involved with.

Auditing lost notes
PRACTICE MANAGER: There was an anxiety in the practice every time a person went to collect a set of notes and found them missing. Many sets of notes seemed to be “lost.” We undertook an audit that involved the entire team, devising a chart so that if we went to the record cabinet and discovered that a set of records was missing we would note the patient’s name and then proceed to look for those records, recording when we subsequently found them and where. Some sets of records were not found, and on one occasion a set of records suddenly appeared from nowhere and the next day vanished again after we had recorded that they had been found.

We improved the situation because everyone was involved. We devised a protocol for lost records and a chart of where to look, which directed the search in all the possible places in the shortest possible time; the next step was to look through all the notes in the record cabinet that started with the same letter as the initial letter of the surname and, if unsuccessful, those from A through the entire cabinet. In the course of that event we did find one or two other sets of records that had been misplaced. The audit also highlighted that records that are not in the cabinet are not necessarily lost, they are simply being used. It took the stress out of the situation when everyone realised that notes have to be out of the cabinet sometimes.

Nursing audits
PRACTICE NURSE: The main audits I have been involved with are of cervical cytology and diabetes. I run the cervical cytology recall programme taking most of the smears. It is important for me to know how well I perform in terms of the quality of the smears, what percentage of people are turning up, and trying to find out whether there is a way of contacting people who persistently default. You have to know how to do audits and you have to try to improve all the time. In the audit of diabetes we know what we ought to be doing for the annual reviews, but through the audit we find out what is actually happening – how many people were seen or missed. By doing audit we are made aware of the reality of the situation. Until you see the written results showing how many people have had their funduscopic examination you can’t be sure how well you are performing, and to do that you have to take the time to check everybody’s records. With the diabetic audit I and one of the doctors had a lot of help from the audit coordinator [from the MAAG] at one point. Now I think we are more able to do the audit ourselves – we know what we are looking for. My role is to initiate the audit every year, or however often we decide we ought to do it, and to gather some of the information.

Auditing repeat prescriptions
SECRETARY/RECEPTIONIST: Repeat prescriptions in the practice were a great problem, not just for the secretaries and receptionists but also for the doctors. The existing system was
working but it had pitfalls. The trainee GP in the practice took over an audit of repeat prescriptions, and one of the practice partners is evaluating it, but we have all contributed something and the system is working better. There have been some improvements, such as making a note that treatment has been reviewed. A record of the patient’s prescription is now in their notes, so the doctors making home visits can see the treatment being received; and items that are not being used are taken off the computer to reduce the chance of mistakes. Also it is easier for doctors to request treatment to be indicated as a repeat item on the computer, which in turn makes it easier for patients to obtain the correct repeat prescription.

Auditing teenage pregnancy

General Practitioner: The audit of teenage pregnancy arose from the West End Audit Group (a local audit group of GPs from different practices), which I had joined. The group was talking about teenage pregnancy in the context of Health of the Nation2 and was looking at the number of girls under 16 years who had become pregnant, whatever the outcome: a baby, a termination, or a miscarriage. The group wanted to look at the number of GP consultations that had occurred in the year up to the time of pregnancy, in order to identify the opportunities for discussing contraception.

I asked the secretaries here whether we could get the information. We could have identified some patients from the FP24 forms, (claim forms for maternity care) and some from the birth book, but that didn’t identify the terminations and the miscarriages. Unfortunately we only started putting all hospital admissions and referrals on to the computer in June 1992, and we started the audit at the end of 1992 so we had only six months’ information. To be sure that I was going to identify all the girls we had to obtain a computer printout for girls aged between 12–17 and then retrieve their notes individually, which I did with the help of the part time receptionist.

The findings were not startling – in the six months no girls in the practice became pregnant. Because I had to examine all the records I could look at other criteria at the same time – for example, girls who hadn’t become pregnant but had attended for contraception. The information was collated by the West End Audit Group with data of all the other practices that had taken part. The conclusion was that, although teenage pregnancy is important in personal terms, it is not in terms of numbers in the west end of Newcastle.

Another audit group, the Team Audit Group (TAG), which looks at various members of the family health care team taking part in audit, and includes our health visitor, was doing a similar audit. The health visitor knew of my involvement and was able to use the names already identified, which made her work easier. If both groups had known of each other’s activities we could have done a more ambitious project. However, the study revealed quite a lot about using a computer system for audit – and showed that our computer data are not very good.

The Team Audit Group (TAG)

Health Visitor: I am part of a team audit group (TAG), which is a limb of the medical audit advisory group set up to promote team audit by involving attached and other staff. The idea is to enable more people to understand audit and the importance of teamwork, and the group is showing that without teamwork audit is very difficult. The philosophy is to promote multidisciplinary audit for achievable targets and to do it partly by example and by presenting what we are doing and showing how effective it can be. There are members from many areas of general practice, practice managers, practice nurses, attached nurses, and GPs. There is value in the group supporting team members who want to do audit in the same way that the MAAG supports teams who are doing audit, but the team audit group is looking at it in a more multidisciplinary way.

Auditing open surgery

Practice Manager: The audit of open surgery arose from a problem raised by the receptionists. By its nature the open surgery accommodates patients who do not have an appointment and feel they need to be seen that day. It is held every morning and two doctors always do that surgery. We take names as people arrive and put all the records together in a box, the doctors taking the record at the front. We can’t tell the patient which doctor will see them, and similarly we don’t expect the patient to voice preferences. The problem was that too many patients were requesting to see one particular doctor. The practice policy is that, normally, patients needing to see a particular doctor must make an appointment outside the open surgery.

We needed to talk about it in the team meeting to ask the doctors if they wanted to see a patient again to ask the patient to make an appointment, avoiding confrontation with the receptionist at open surgery time. We decided to record over a month how many patients said they had returned to see a particular doctor. We wanted also to know how many patients expressed a wish to see a female or a male doctor. When a patient had been seen in open surgery the notes were returned to the receptionist, who then recorded in the appointments book which doctor had seen which patient. The receptionists added a red asterisk next to the names of the patients who had actually requested to see that doctor.

We took the data to the weekly audit meeting and decided fairly quickly that we didn’t seem to have a problem. Once we had gathered the information for a month we discovered that people who had asked to see a particular doctor had had good reason, generally because of continuity of care.
Accommodating their wishes had been quite easy as patients were quite evenly distributed between doctors. No additional problems had been recorded.

Even without the term audit we would still be looking at what we do and trying to improve. From the administrative side, anyway, that has been ongoing long before the word audit became commonplace.

**Auditing breast feeding**

**GENERAL PRACTITIONER:** Audit on a small scale in the practice, looking at a particular issue – even if you do not finish it or draw any conclusions – actually makes you think about an issue. For example, the medical student is looking at how many women breast feed. Initially, he found a problem because the doctor doing the antenatal clinic is not recording in the notes whether women are intending to breast feed but is merely keeping a mental record. The information is, however, recorded in the health visitors' records and the midwife's records. As a result the health visitor and I designed a stamp for the notes that will record whether breast feeding has been discussed, whether the women will breast feed or not, and also a range of other information such as whether the mothers are supported, whether they have a partner, and their parity. Even though the student has not finished the audit, he brought a problem to our attention. Just starting to think about the audit uncovers quite a few problems; just in that respect it is a useful exercise.

**Conclusions**

The experiences related by the members of this team will be recognised by many others working in primary care. Some teams may have undertaken more audits and many other teams fewer, but the issues are similar.

Several factors have contributed to the successes of the Adelaide Medical Centre team. The doctors take audit seriously and through their leadership have communicated this attitude to the rest of the team. They have also given authority to the team to identify problems for audit, to plan and conduct audit, and to implement change. In a busy inner city practice they have found time for audit by giving it a high priority and by involving team members and others. Audit has been a positive and rewarding experience with each team member contributing and seeing benefits in terms of improvements in their daily work.

But how should audit of this type be evaluated? It is evidently possible to evaluate several different but related phenomena and arrive at conflicting conclusions about what is ostensibly “audit.” The focus chosen for evaluation might be the improvement in the problem chosen for audit such as the number of patients asking to see a particular doctor in an open surgery or the proportion of mothers who breast feed. However, additional factors might be included, such as the new awareness of the team about the patient’s perspective of continuity of care or the improved method of recording details about antenatal patients. The evaluation might even be extended to encompass the consequences of audit on team spirit or communication and cooperation between members. Judgements on audit depend not only on those aspects of audit projects to be included but also on how audit is defined. The choice of approach depends on an opinion about the purpose of multi-professional audit. As clinical audit develops it ceases to be a single or even a series of projects but takes on a wider importance as it matures into an integrated and daily activity concerned with all aspects of quality. Those planning to evaluate audit should state explicitly the view they select for the purpose of audit, making clear those aspects they will be omitting from the evaluation. Failure to follow this advice could lead to hasty and inaccurate conclusions.

I thank the members of the Adelaide Medical Centre, all of whom gave their time and openly expressed their opinions about audit and teamwork.