
LETTERS

Can admission notes be improved by using preprinted assessment sheets?

We were most interested to read Goodyear and Lloyd's report on the improvement achieved with preprinted assessment sheets in a paediatric setting.¹

We performed a similar exercise on our medical records for admissions to the acute wards in the Medicine for the Elderly Unit at Nether Edge Hospital. This was part of a large multidisciplinary project to develop a tool to assess individual patients that would also provide a framework for data collection and audit for each discipline.

An initial all encompassing 14 page form was piloted but rejected after peer review because of its length and lack of free space. After a second trial, a seven sided document was refined to a two sided sheet. This included demographic details, core patient information, and certain standardised assessment scales (abbreviated mental test score,² Barthel activities of daily learning (ADL) index,³ geriatric depression score,⁴ Glasgow coma scale score,⁵ and a modified Winchester disability score⁶). Clerking guidelines specifying what was to be included in the free text were issued to the admitting doctor.

Our initial tool was too ambitious to be suitable for everyday use and only produced data when artificially supported by extra medical and audit staff. In the more concise forms, tests thought to be the realm of nursing or therapy staff were often omitted (a finding consistent with those of other researchers⁷), and feedback on a daily basis to junior doctors was essential to ensure the gathering of other pertinent patient information. Despite consultation with senior and junior doctors at every stage during the 18 month evolutionary period several changes of junior doctors meant changing opinions and necessitated introductory and follow up teaching sessions.

Many lessons can be learnt from our experiences. Clear goals for what the form has to achieve need to be set and it should only include essential information. Consultants should ensure that all information gathered is seen to be used. All interested parties must be represented during its development so that the enthusiasm of users is harnessed. Regular education of new users and follow up of their progress is needed along with recognition of the reluctance of doctors to change. Implementation is time consuming, but by paying attention to organisational issues this process can be shortened.

Importantly, we discovered that in our initial thrust for change the need for an auditable document was insufficient to drive the development of the form and that clinical need was the overriding factor in initiating and maintaining change.

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Bone densitometry at a district general hospital: evaluation of service by doctors and patients

Madhok *et al*¹ report the evaluation of a bone density service at a district general hospital with a questionnaire sent to the patients four weeks after they had a bone density test. The questionnaire asked the patients whether they had been aware of this type of test before they were referred for it. Of those responding to the questionnaire 73 said that they had heard of it. This result contrasts with the results obtained in a questionnaire survey of women's attitudes to hormone replacement therapy taking place at the same time as the bone densitometry survey in North Tees Health District, adjacent to the districts used by Madhok *et al* and using the same bone densitometry service.²⁻⁴ This study included women aged 20 to 69 and yielded 1225 responses (74%). At the request of Madhok the question "Have you heard of bone densitometry?" was included. This was answered by 1214 respondents (99.1%) of whom 330 (27.2%) had heard and 884 (72.8%) had not heard of bone densitometry. As the women in the study of Madhok *et al* had a mean (SD, range) age of 57 (9.95, 16-87) years and had a particular interest in osteoporosis, it is probably more appropriate to make the comparison with women from the North Tees survey in the age group 45-64 (n=465) as these women are more likely to have an interest in the menopause and osteoporosis. Of these women 149 (32%) had heard of bone densitometry and 316 (68%) had not. This survey would indicate that fewer women have heard of bone densitometry than the paper by Madhok *et al* suggests.

Some women may have poor recall of what they really knew before the bone densitometry test was carried out. It is possible that they had heard of it but did not know what it actually was until they had the test. In the North Tees survey these women may well have answered that they had not heard of the test because of the uncertainty of their knowledge. Women who have bone densitometry carried out may be more likely to have taken steps to find out about bone densitometry before seeing their general practitioner about the test or a related issue. The process of deciding about a referral in general practice can take place over several weeks or months so the women may have been involved in discussions with medical professionals about the test before the referral was made.

These suggested reasons for the different results from the two surveys accrue from both the experience of working in general practice and by carrying out an interview

study of women's attitudes to hormone replacement therapy (manuscript in preparation). The results of the two surveys show numerically that women are assimilating information. However, an understanding of the process and thus an explanation of the contrasting numbers can probably only be found through qualitative methods.

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- 1 Madhok R, Kirby P, Fordham J, Stamp P, Green S, Cooper C. Bone densitometry at a district general hospital: evaluation of service by doctors and patients. *Quality in Health Care* 1996;5:36-43.
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SOFTWARE REVIEW

Newcastle Clinical Audit Toolkit: Mental Health. R Balogh, S Bond, J Dunn, H Quinn, A Simpson, A Wilkinson (pp 282; £95). Newcastle-upon-Tyne: The Centre for Health Services Research, University of Newcastle-upon-Tyne, 1996. ISBN 1-870399-65X.

The last time I checked there were seven "off the shelf" mental health audit tools. I reviewed this latest one wondering whether we needed an eighth. Like troglodytes mental health staff have been continually searching for practical tools to enlighten us as to the quality of the job we do. Many of these mental health audit instruments failed because they were trying to measure the unmeasurable. The Newcastle Clinical Audit Toolkit (NCAT) does not make bogus claims of this nature. As such it could possibly be the best honed tool currently available.

In my opinion the NCAT is unique in many respects: it is the first truly multidisciplinary and multiagency audit instrument for mental health. Unlike some of the other tools it was not formulated by an expert panel of academics, but by groups of users, nurses, psychiatrists, psychologists, occupational therapists, and purchasers who met over a period of years to develop it. The end result was five core modules dealing with user's views of care, in patient nursing practices, day care facilities, multidisciplinary functioning, and staff development. There is also a sixth module which can be customised to audit topics not covered in the core modules.

Although a major part of audit should be about education, most of the available tools are little more than glorified collections of data. I found reading the NCAT to be in every sense a learning process. Within each module there are research based literature