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## LETTERS

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### 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.<sup>1</sup>

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,<sup>2</sup> Barthel activities of daily learning (ADL) index,<sup>3</sup> geriatric depression score,<sup>4</sup> Glasgow coma scale score,<sup>5</sup> and a modified Winchester disability score<sup>6</sup>). 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 researchers<sup>7</sup>), 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.

H FOSTER  
B ZINOBER  
A ANDERSON

Central Sheffield University Hospitals Trust,  
8 Beech Hill Road, Sheffield S10 2JF

1 Goodyear HM, Lloyd BW. Can admission notes be improved by using preprinted assessment sheets? *Quality in Health Care* 1995;4:190-3.

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

Madhok *et al*<sup>1</sup> 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.<sup>2-4</sup> 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.

FRANCES GRIFFITHS  
General Practitioner  
Norton Medical Centre,  
Harland House,  
Norton,  
Stockton-on-Tees TS20 1AN

- 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

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**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

reviews and case studies. Clear guidelines are provided for further reading, and networking purposes. Another attraction about the NCAT is the facility to support audit projects which were not initially undertaken within this system.

Included within the package are a set of computer disks. This in itself is not unique among contemporary audit tools. However, they provide easy to use questionnaires and other audit material which can be adapted to suit local circumstances. Word processed documents such as specimen access and information letters for audit participants are also included on the disks. For audit meetings the pack includes forms for agendas, briefing materials, and handouts. All this material comes in a large ring binder along with the computer disks.

If there will ever be any such thing as a definitive mental health audit tool, NCAT may not fill the role. None the less, comparing NCAT with those that do exist, I was very impressed with the comprehensiveness of the package and found little to criticise. It is a well constructed, presented, and thought out instrument. Potential purchasers should not be put off by the bulkiness of the pack; my advice is to use it as a template for one or two small audit projects until team members become familiar with its content.

HUGH P MCKENNA

*Senior Lecturer/Course Director of Nursing,  
School of Health Sciences,  
University of Ulster*

This manual (with associated computer discs) provides a very detailed framework within which to carry out audit of five specific topics (the modules). Useful background to the process of audit precedes the worked examples and the way to use the five modules is made fairly clear. The computer disks provide details of questionnaires that might be used and these can be edited to suit local needs or used as a template for development of other audits. In general, I found the information clearly presented and the computer disks worked without any problems.

I approached this manual from the perspective of a psychiatrist who has coordinated medical audit in a unit for over five years during which time it has gradually metamorphosed towards clinical audit. I was therefore encouraged when in the introduction the aim of the toolkit was stated as being "to stimulate collaborative practitioner based clinical audit among professionals of all disciplines". However, at the end, I was disappointed that there was little in the manual to attract doctors. The audit examples focus very much on the environment and process of care but do not consider treatment issues. Although I entirely agree with the authors that descriptive audits of this nature are valuable and that not all audits can be criterion based or focused on treatment or outcomes, nevertheless it is a pity that one of the modules did not suggest a model for such audits. It is important that the actual way in which treatment is provided (whether drugs or psychological treatments) should be monitored.

I also thought that the balance of the manual was away from strict criterion based audit. I have found this to be a very useful form of audit and would strongly recommend the use of a 100% criterion based audit with predefined and agreed exceptions. This then

allows the audit to focus on those cases not conforming to the criteria.

As a final suggestion to the authors, it might be useful to include a model presentation of actual data from an actual audit done with one of the modules. However, in general, I think the toolkit will allow relative novices to begin multidisciplinary audit although I wish to reiterate that parts of modules can be used and that trying to use a full module all at once would almost certainly create too large a workload for most units.

STEPHEN J COOPER

*Senior Lecturer,  
Department of Mental Health,  
The Queen's University of Belfast*

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## BOOK REVIEWS

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**Professional Education for General Practice.** Peter Havelock, John Hasler, Richard Flew, Donald McIntyre, Theo Schofield, John Toby (pp 192; £25). Oxford: Oxford University Press, 1995. ISBN 0 19 262607 8.

After 20 years of vocational training for general practice in the United Kingdom the training programme, particularly educational aspects, needed reappraisal. Therefore the authors, trainers, course organisers, and regional advisors in the Oxford region started a course for experienced trainers. This considered what seemed to be the most pertinent issues: how to devise a curriculum and assess the learner; how to broaden the range of teaching and learning techniques; and how to enhance the quality of the training practice and of one to one teaching. This book mirrors this course, in three parts. The first is about the history of the vocational training and gives some background information about adult and professional learning and about educational tasks. The second and main part deals with detailed information about various aspects of teaching and learning. The third part looks at opportunities for the future. There are six appendices: the priority objectives for vocational training as originally published by the Royal College of General Practitioners (1988, occasional paper 30); the Oxford Region experienced trainers' course; an example of teaching about management and prevention of ischaemic heart disease; about teamwork; about criteria for the approval of trainers and training practices in Oxford; and about education for junior hospital doctors, also in Oxford. The book has three pages of references, mainly about the situation in the United Kingdom, and a detailed index.

The first part of the book – after the overview of the development of general practice and of the vocational training of general practitioners in the United Kingdom – has a chapter about adult and professional learning. This is important because it sets down the main viewpoint of the authors: not teaching but learning by experience from daily activities, reflection, and awareness of literature is the most important element of the vocational training. This viewpoint is reflected in chapter 3 on educational tasks. It describes the educational processes needed for adults learning a new profession, and

gives information about important stages of the learning processes of the trainee: the new trainee being assessed and introduced to the practice; the practising trainee seeing patients, playing a full part in the activities of the practice, and learning the core knowledge, skills, and attitudes required for general practice; and the practitioners, now more able to choose the direction of their learning and to allocate time appropriately.

The core of this book is part 2. The first chapter (chapter 4) is about constructing a curriculum based on the three stage model of training and the well formulated objectives for vocational training mentioned in appendix I. The curriculum has to deal with the widening range of context or situations within which the trainee will be required to practise. These are care of individual patients, care of groups of patients, the practice population, the practice and healthcare team, the community, and the profession.

Assessment and curriculum planning go hand in hand. Chapter 5 deals with different aspects of assessment for learning, especially with formative (or educational) assessment. It gives practical information about the steps in assessment and about effective feedback as part of it.

The next chapter considers the environment for learning especially at the training practice as a learning resource, at the trainer, and at the partners of the team. It is clear that the practice and its members have a powerful influence on the learning process. The practice should provide the highest standard of care and trainees need to understand how this comes about. Good doctors are not necessarily good teachers. The importance of courses in the development of teachers cannot be underestimated. They provide opportunities for reflection about teaching and facilitate the interchange of ideas and values between colleagues. It is nice to see that in the chapter on teaching methods these are connected with the learning styles of the trainees. This is once again an example of the learning centred approach of the book. Specific methods of learning such as learning from patients, learning from the team, learning from topics, and learning independently are described. As the trainees' educational needs, learning style, and experience change then the framework of the teaching needs to change as well and the time for teaching and learning needs to be used differently. The chapter about the developing relation between the trainee and the trainer is also important. Everybody who starts thinking about becoming a trainer and every trainee in general practice should read this chapter.

Vocational training schemes, especially the half day or day release courses, are the subject of the next chapter, based on the situation in the United Kingdom. Other European countries have more experience with the day release course (The Netherlands) and have already solved some of the problems mentioned in this chapter. Of the three years of vocational training in the United Kingdom the trainee has only one year training in general practice. The authors are not happy with this scheme and are in favour of five years for vocational training with two years in hospital. In the chapter about learning in hospital they describe several issues considered on a national scale to change the hospital part of training for general practitioners. One of the basic principles is that the learning of many skills which are best acquired in hospitals are