Improving the Care of People with Learning Disabilities: Clinical Audit Project Examples

Kirsty MacLean Steel and Claire Palmer

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Foreword

Services for people with learning disability have undergone tremendous changes over the last 20 years. The White Paper *Working for Patients* (Department of Health (DoH), 1989) recognised clinical audit as an essential part of professional practice in the NHS. Despite some criticism of the impact of clinical audit it has recently been re-emphasised in the concept of clinical governance which encompasses both quality improvement and accountability.

This book illustrates the breadth and depth of a number of audit projects carried out in the UK. They demonstrate that it is possible to improve the quality of care but it is important that audits are linked to evidence and continuing professional development. It is hoped that the book will very much be seen as a resource to enthuse those with ideas for audit projects and to help others get started.

Dr John Morgan
Royal College of Psychiatrists' Learning Disability Faculty
May 1999

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Introduction

Background: health services for people with learning disabilities

It has been estimated that 2% of the UK population has some form of learning disability; 0.4% of the population having severe learning disabilities. Other physical and psychiatric disorders often co-exist and include epilepsy, problems with hearing, vision and speech, heart disease, respiratory problems and skin problems. The prevalence of mental health problems in community studies varies from 27–46%. Prevalence rates for behavioural disorders, which are sometimes included as mental health problems, vary from 10–25%.

In 1991, 85% of people with severe learning disabilities were receiving care in the community with the remaining 15% in hospital. The role of the hospital has been changing from an institution that provided long-term care to one that now provides short-term assessment and treatment. The NHS and Community Care Act 1990 gave the responsibility of assessing the social needs of people with learning disabilities to local authorities. This included the transfer of funds from health services to local authorities for support services in the community.

Background: clinical audit

In recent years, clinical audit has become an important part of all health services. The DoH Working Paper *Medical Audit* (1990) outlined the requirement for all doctors to participate in audit and throughout the 1990s this expectation expanded to include clinicians of all professions. The importance of clinical audit is highlighted in the recent White Paper *The New NHS: Modern*, *Dependable* (DoH, 1997) and will gain increasing importance as clinical governance is implemented.

Clinical audit is a useful and practical method of ascertaining whether services provided are effective, efficient and of a high quality. It is used to review practice by systematically monitoring whether clinical care meets pre-agreed standards.

As this book will demonstrate, many aspects of care and treatment (from admission to discharge and beyond) are amenable to clinical audit. Clinical audit should not be a difficult or daunting prospect – small projects focusing on narrow areas of practice are often as worthwhile as more complex ones. Clinical audit is a multi-disciplinary activity, with all staff whose practice is included in the audit being involved from the beginning.

There are several points which are crucial to carrying out successful clinical audit:
- careful planning;
- setting clear and measurable standards;
- attempting to set standards on the basis of evidence;
- taking a multi-disciplinary approach;

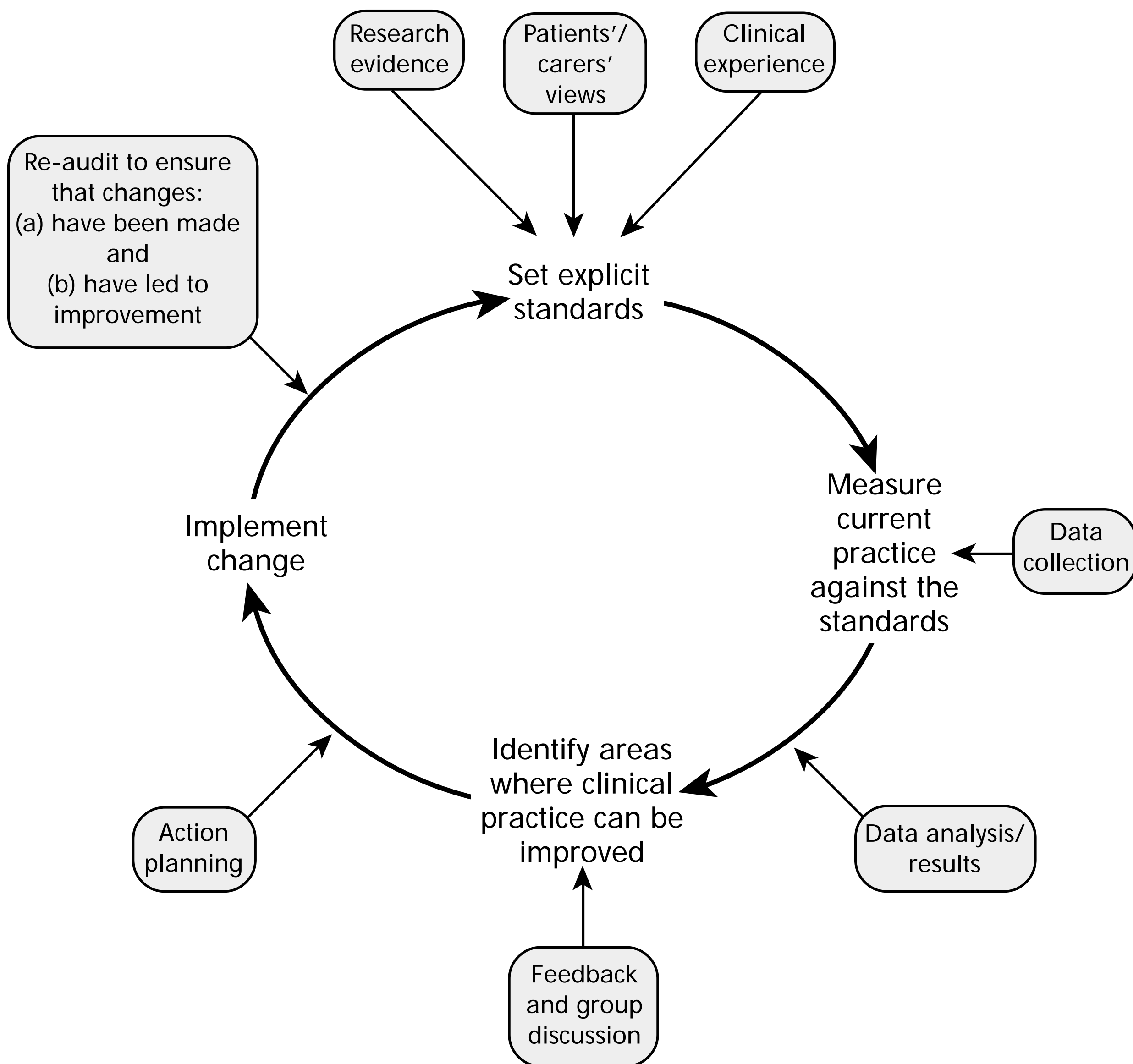

Fig. 1 The clinical audit cycle

- if questionnaires are to be used, ensuring the responses can be clearly interpreted and analysed;
- being clear about methods of analysis when planning a project; and
- avoiding complicated projects – simple ones usually achieve the most and are easiest to carry out.

The aim of the book

This book is intended to support people providing mental health services for people with learning disabilities who are undertaking, or planning to undertake, clinical audit projects, by:

- providing ideas for project topics;
- providing ideas for project methods;
- providing examples of standards from other services which they can use locally

- facilitating benchmarking against other services' standards; and
- providing contact details of others who have undertaken clinical audit projects in health services for people with learning disabilities.

The contents of the book

The book contains 22 clinical audit projects, all of which have been carried out in practice, with some still in progress. The projects have been divided into topic areas and formatted into structured abstracts for ease of use.

It is hoped that the information about the clinical audit projects included in this book is sufficient to help anyone undertaking an audit to begin to design their own project.

All the projects in this book were submitted by either the clinical audit lead or the clinical audit department from a number of NHS trusts. We were overwhelmed by the enthusiasm and support of these individuals and groups. We hope that those reading the book will be inspired by the great range of projects.

Themes arising from the projects

Some useful points were raised by the contributors to this publication that are worth considering outside of the context of any particular clinical audit project. Although no one overall theme came through, some people mentioned the importance of involving the multi-disciplinary team. All relevant professionals should be involved as early as possible in the planning or commission of a clinical audit. This may help gain cooperation and involvement and predispose people to changing (and thereby improving) clinical practice.

Other points raised by contributors:
- Good planning is essential.
- Good communication is important.
- Allow plenty of time for audit and discussion.
- Research Assistant time is important.
- Beware of leading questions.
- Consider users' possible interpretation of questions and their ability to answer them – be prepared to rephrase questions.
- Obtain commitment from a support or steering group.
- Obtain or negotiate access to IT at an early stage.
- Using national guidelines to measure performance is very useful and helps to structure the audit.
- Keep things simple.

Key to reading the clinical audit project reports

Background	Why the audit was considered important.
Aim	The aims and objectives of the project.
Standards	Measurable standards against which practice was compared.
Evidence	Evidence on which the standards were based.
Staff involved	The staff involved in the clinical audit project.
Sample	The patients, clients, etc. involved in the project.
Data collection	How the data were collected.
Data analysis	What type of analysis the data were subjected to.
Key findings	Findings relating to the standards.
Feedback	Who the findings were fed back to and in what form.
Change	Suggestions for changes in practice arising from the findings. Also any significant things which either helped or prevented change from being implemented.
Re-audit	Plans for re-audit.
Resources	The amount of staff time taken to complete the audit cycle and other costs or resources needed.
Notes	Problems encountered in undertaking the clinical audit project, aspects that the contributors would change if repeating the project and advice for anyone attempting to conduct a similar audit.
Contact	Details of the person to whom further enquiries about the specific project example should be directed.

Shading draws attention to stages of the clinical audit cycle which are crucial and which are often omitted.

This book contains example of 'real-life' clinical audit projects. The projects are examples of the range of audit topics and methods undertaken in mental health services for older people, and the information has been willingly volunteered by people working within these services. Some of the examples do not contain information under all the above headings.

The projects in this book are not intended to be recommended gold standard audit projects.

Important note

The projects described in this book have been submitted to the Royal College of Psychiatrists' Research Unit by mental health service staff. Inclusion in this book does not indicate endorsement by the Research Unit, and the College takes no responsibility for the quality of the projects reported herein. All questions concerning specific projects should be directed to the submitting trust.

The clinical audit projects

Admissions

Background	There was concern about inappropriate admission to the service. The first cycle of the audit identified a need to agree standards for admission.
Aims	1 To improve clinical processes. 2 To define socio-demographic and clinical characteristics of patients admitted to the service. 3 To gain insight into reasons for admission and effectiveness of admission procedure.
Standards	1 Differential diagnosis must be written in case notes. 2 Routine admissions will be carried out Mon–Fri 9am–5pm by each consultant's own team. 3 Planning meetings will be held before routine admissions. 4 All emergencies will be admitted within 24 hours. 5 Urgent cases will be admitted within 7 days.
Evidence	Local consensus after survey of present procedure.
Staff involved	Medical, nursing and audit staff and senior management.
Sample	Cycle 1 – 1995 of all admissions over a 12-week period (*n*=79). Cycle 2 – 1996 all admissions over an 8-week period (*n*=48).
Data collection	Proforma and case note audit.
Data analysis	SPSS.
Key findings	• A differential diagnosis was written in 94% of case notes on admission. • 100% of routine admissions were carried out Mon-Fri 9am-5pm by each consultant's own team. • Planning meetings were carried out prior to routine admissions in 94% of cases. • 100% of emergencies were admitted within 24 hours. • 100% of urgent cases were admitted within 7 days. • 78% of external agencies informed of admission within 72 hours.
Feedback	Medical staff, nursing, purchasers, Trust board, senior management.
Change	The name and date of the agencies informed is to be included on the admissions check-list.
Re-audit	Standards are now monitored on a random sample of admissions wards as part of organisational audit international monitoring.
Resources used	Difficult to assess.
Notes	It was felt to be a successful audit.
Contact	Pam Richold, Trust Quality Officer, Northgate Hospital, Northgate & Prudhoe NHS Trust, Northumberland, NE61 3BP. Tel: 01670 394275; Fax: 01670 394002.

Care planning system

Aim	To establish the effectiveness of care planning management and implementation in achieving identified goals within stated times.
Standards	1 Administration: • All statements within the care plan must be signed. • The next care plan review date must be recorded. • Summary statements must be written. 2 Patient involvement: • Problem statements must be discussed with the patient. • Patients must be involved in deciding and agreeing with the interventions set. 3 Statements based on fact/assessment: • Statements must be factual and confined to relevant information. • Problem statements must indicate how the patient was before the problem arose.
Staff involved	All nursing staff.
Sample	12 care plans (6 current and 6 completed) from each of 8 locations.
Data collection	Data was collected using a specially designed audit tool.
Data analysis	Analysis was done manually.
Key findings	1 Administration: • Few statements within the care plan were signed. • The next care plan review date was recorded on some care plans. • Summary statements were written on some care plans. 2 Patient involvement: The full involvement of patients was low due to a profound degree of learning disability. • Problem statements were not always discussed with the patient. • Patients were not always involved in deciding and agreeing with the interventions set. 3 Statements based on fact/assessment: • Statements were generally factual and confined to relevant information. 91% of evaluation statements of interventions carried out were confined to reporting relevant information. • 87% of problem statements indicated how the patient was before the problem arose. 21 of 23 completed care plans demonstrated achievement of the goal within the allotted time.
Change	The Care Plan Coordinator should state in the interventions that summary statements are to be written and, if so, how often and what they should record. Further training in the use of the system has taken place.
Re-audit	Deferred due to organisational changes.
Contact	Mrs N. Osborne, Clinical Audit Facilitator, Dumfries and Galloway Primary Care Trust, High South, Crichton Royal Hospital, Dumfries, DG1 4TG. Tel: 01387 244012; Fax: 01387 244344.

Group organisation: children's services

Aim	To improve organisational processes and user/carer satisfaction.

Standards

1. Each child will have an individual folder with a photo and all the child's care requirements. It will be updated monthly by trained staff and keyworker.
2. Every child must have a keyworker and named trained nurse overseeing his/her care and parents must be informed of who these key people are.
3. Every child will either have a single room or will share with one other person. Those children who require downstairs accommodation may have to share with two others, but curtains will be provided to ensure dignity and privacy.
4. All care carried out with the child will be as per planned care guidelines and care programmes that are drawn up with parents on admission.
5. Children's care will be carried out respecting their dignity, privacy and rights.
6. The environment will be clean, well-decorated and child-friendly to a high standard. A monthly inspection will be carried out by management to ensure this.
7. Toys, specialist equipment and play activities will be provided for children during their stay.
8. The ratio of staff to children will be 2:1 and in exceptional circumstances 3:1. At night it will be one waking staff member, one sleep-in – unless the unit sleeps more than 12 children and then it will be 2 waking staff.
9. All staff will wear a name badge giving name and job title.
10. Parents will be able to visit any time to see their child and will be able to comment on any aspect of care and remove their child from our care at any time unless protected under law.
11. Anyone wishing to make a complaint or requesting to see the manager will be contacted within 3 working days by the manager. In the manager's absence, this will be undertaken by the deputy, if the shift leader is unable to assist.
12. Emergencies will be accepted immediately and care provided for at least the initial 24 hours followed by a review.
13. Parents/carers will be informed of any major changes in a child's care or any emergency arising immediately.
14. A respite agreement will be drawn up with professionals and parents which will give dates for a 6-month period of respite. These dates will always be honoured unless exceptional circumstances, e.g. staff sickness or health and safety issues concerning the building.
15. Parents/carers will always be dealt with in a courteous and professional manner by all staff.
16. On discharge, parents/carers will always receive a letter giving
17. details of their child's stay and the care they received.
18. A staff room/relatives' room will be provided.
19. All items will be returned on discharge.
20. An annual service review questionnaire will be sent out to all parents requesting their views on the service they received.
21. All staff will attend regular training sessions.

22 Parents will be sent a news sheet with information regarding unit activity on a quarterly basis.
23 The telephone will be answered within 8 rings and answered by a member of staff giving their full name and department.
24 The doorbell will be answered within 1 minute of ringing and staff will greet visitors and check identification if necessary.
25 All correspondence in to the unit will be answered within 3 working days.
26 All shift leaders will receive an annual drug assessment.
27 The Investors in People Award will be completed and its standards maintained.
28 All queries and missing items will be dealt with promptly and feedback will occur within 24 hours.

Key findings	In progress.

Handling and moving

Background	High-risk area. Trust-wide 'no lifting' policy.
Aim	To evaluate clinical processes, organisational processes and use of resources and to ascertain whether assessment in care planning had taken place and appropriate equipment/facilities were available for use.
Standards	1 Assessment of need must be completed. 2 Care plans must be available. 3 Care plans must be specific and relate to assessment. 4 Identified equipment must be made available. 5 The environment must be conducive to safe handling and moving practice.
Evidence	Trust policy and national guidance.
Staff involved	Senior nurse and local practitioners delivering care.
Sample	Random sample of clients with identified mobility needs (n=28).
Data collection	On-site examination of client records and of equipment, policies, etc.
Data analysis	Percentage results calculated for each area.
Key findings	• Assessment: some areas had excellent assessment which could be shared with others requiring development. Further training in assessment needed. • Planning: in all instances where a need was identified, care plans were available and were related to the assessment. A number of care plans were found not to be sufficiently specific, requiring further detail. • Equipment: all equipment identified as being required was available to the individual client. • Environment: there were no particular environmental problems identified, many homes have been purpose built or specially adapted.
Feedback	To each practitioner via audit report including percentage scores.
Change	Update staff training, formalise 'local' training and develop assessment and care planning methods.
Re-audit	In 18 months.
Resources used	Approximately 120 hours.
Notes	*Advice*: allow plenty of time for on-site audit and discussion – involve practitioners.
Contact	Debbie Webster, Senior Nurse, Learning Disabilities Directorate, Bradford Community Health, Westwood Hospital, 84 Cooper Lane, Bradford BD6 3NJ. Tel: 01274 424203; Fax: 01274 883469.

Occupational therapy referral system

Background	It was the first clinical audit undertaken by the Occupational Therapy (OT) department in learning disabilities. It was felt to be a good starting point, of a manageable size with workable results. A useful tool to see if the newly designed forms were working.
Aims	To improve organisational processes. To assess if the new referral form that been implemented recently was working for OTs and other professionals.
Standards	OT staff will accept written referrals that will be responded to within 2 weeks.
Evidence	National guidelines and guidelines within learning disabilities directorate.
Staff involved	All OT services in gathering information/data. Other professionals were informed about the audit.
Sample	All referrals received by OT service, both hospital-based and community, over a 3-month period.
Data collection	Specially designed forms were used by the receiving OTs.
Key findings	62% of referrals were written without input from an OT.
Feedback	Findings were fedback to the OT service and all professionals within the learning disabilities directorate. The results were discussed at an OT meeting and copies of the audit were sent to other departments.
Change	The form is to be amended to include keyworkers. Ensure the OT referral forms are accessible to the relevant people/ establishments and extend this as and when new professionals contacts are made.
Re-audit	18–24 months
Resources used	4–6 hours over a 3-month period for staff completing the audit. 20+ hours for staff coordinating the audit. Use of IT department's facilities.
Notes	Once the purpose of the audit was explained, staff were willing to assist as much as possible. *Advice*: Good communication between all involved is important. If the aims are well-defined and explained then people are more willing to be involved. Keep the methods of gathering information as simple as possible.
Contact	Jackie McAndrew, Occupational Therapist, Broxtowe Community Learning Disability Team, Sunnyside Road, Chilwell, Nottingham NG9 4FR. Tel: 0115 9431086.

Privacy and dignity

Background	Severn NHS Trust is committed to providing personal care in ways that: maintain the dignity of the individual service user; are sensitive to their needs and preferences; maximise safety and comfort and protect against intrusion and abuse.
Aims	1 To improve service user/carer satisfaction. 2 To ascertain the level of staff sensitivity to client's privacy. 3 To restore and maintain a high standard of individualised care, prioritising people's basic rights of privacy and dignity.
Standards	When entering rooms such as bathrooms, toilets and bedrooms: 1 staff must knock; 2 staff must pause prior to entering; 3 staff must enter slowly by putting their heads around the door; 4 staff must wait for affirmation; and 5 if a client says no, this must be respected.
Evidence	Locally agreed consensus.
Staff involved	The clients and staff (qualified and grades A, B & D).
Sample	132 separate observations undertaken at peak times of activity and spot checks during other times.
Data collection	Nominated staff completed a basic check-list.
Data analysis	Simple frequency analysis.
Key findings	• Compliance for Standard 1 (staff must knock times before entering a room) was 97.6%. • Compliance for Standard 2 (staff must pause prior to entering) was 68.2%. • Compliance for Standards 3 and 4 was poor. • There are no compliance calculations for Standard 5 as no patients came within this category.
Feedback	To all staff in unit.
Change	Improve staff awareness of privacy and dignity and respect issues for people with learning disabilities by including session on staff workshop/ away day. Staff now have supervisory sessions where privacy and dignity is included in clarifying their role. This has helped people improve their attitude towards privacy and dignity.
Re-audit	Planning to re-audit in 1999.
Resources used	2 hours preparation and design, 3–5 hours collecting data, 2 hours analysing data. Total 7–8 hours.
Notes	Results may be influenced by the fact that staff knew they were being observed (although they didn't know what was being observed in respect of their behaviour).

If repeating this project, standard 4 would be deleted. This was found to be unrealistic as not all clients are capable of giving affirmation. Also, not all clients will respond to or understand the significance of someone knocking.
Advice: This audit only looked at one very simple aspect of privacy and dignity. There are many others that could, or should, be included.

Contact

Heather McCabe, Clinical Audit Officer, Severn NHS Trust, Rikenel, Montpelier, Gloucester, GL1 1LY. Tel: 01452 891153; Fax: 01452 891158; email: caudit@clinaudit.demon.co.uk

Referral administration

Aim	To determine out-patient practice against self-developed standards and to determine outcome for clients one year after referral.
Standards	Staff must record: 1 source of referral; 2 date referral letter received; 3 date client first seen by psychiatrist; 4 professionals involved in client's care 5 an action plan 6 items in the action plan having been carried out; 7 the person the clients was referred to; 8 any change in the client's mental state after a year; 9 outcomes applicable to the client; 10 whether or not the client is discharged from the care of the psychiatric team;
Staff involved	Junior doctors, consultant, secretary.
Sample	Patients referred over a period of 12 months (n=62)
Data analysis	Descriptive statistics
Key findings	• Age range: 16–65 years (mean=33), 61.3% male & 38.7% female. • Referrals: GPs 30.6%; Community Team for Learning Disabilities (CTLDs) 21%; psychiatrists 4.8%; and social workers 4.8%. • The mean interval in days between the referral of the patient and the date first seen by the psychiatrist was less than two months (51 days); there was a delay in 19.3% of cases; causes of delay were owing to communication problems with other professionals (3.2%), refusal of the patient to attend (4.8%), practical difficulties on the part of professionals (9.7%), and practical difficulties on the part of the patient (1.6%). • Professionals most involved in client care following referral were the senior registrar (35%), consultant (31%) and the registrar (21%) and other professionals in very few cases (social workers, psychologist and IBIS workers). In 13% of cases, other professionals were involved in client care, usually a care manager. • There was an action plan in 100% of cases. • Most clients received follow-up at out-patients: 13 clients had their medication changed, 13 were referred to other professionals and 2 were admitted to a psychiatric ward. Most referrals were to CTLD (n=22) or psychologists (n=17) and a small number to social services (n=5), voluntary services (n=1) or day activity (n=2). (Where more than one action or outcome was taken or more than one professional was involved, relevant tables have shown clients' numbers to be over 62.) • Over 61% of patients (n=38) exhibited a change in mental state and only 21% showed no change. • With regard to outcome for patients, improved care and understanding was shown in 48% of cases, improved living conditions in 21% and improved day care in 11%.

Change	Delays in referral need to be reduced.
Contact	Rosalind E. Bates, Consultant Psychiatrist, Ravensbourne NHS Trust, Bassetts Resource Centre, Acorn Way, Starts Hill Road, Farnborough, Orpington, Kent, BR6 7WF. Tel: 01689 853388; Fax: 01689 861232.

Evaluation of a health care screening protocol

Background

East Yorkshire Community Healthcare NHS Trust developed a health care screening protocol. The aim of the protocol was to provide clients with learning disability with a health screening tool that would identify their health needs and enable them to access the appropriate services. The protocol was implemented as a pilot project Trust-wide from 1 January 1996 and completed in August 1996. The learning disability nursing services together with the clinical audit department have developed an audit tool to evaluate the protocol.

Aim

To establish that a comprehensive health care screening process is available to adults referred to the East Yorkshire Community Healthcare NHS Trust Learning Disability Nursing Service.

Standards

1 Documentation must be completed.
2 Documentation must be written in black ink.
3 Outcomes of screening must be noted.

Sample

New/re-referrals of adults to the learning disability nursing service and existing clients with an identified health need within the period of the pilot study (n=55).

Key findings

1 Documentation must be completed – results for each section were:

- eyesight 100%
- epilepsy 100%
- mobility 100%
- smoking 100%
- chiropody 100%
- activity 100%
- continence 100%
- contraception 100%
- hearing 100%
- medical history 89%
- vaccinations 92%
- weight 97%
- height 94%
- urine 95%
- alcohol 97%
- dental 97%
- cervical screen 65%
- breast screen 65%
- testicular screen 73%
- menstrual problems 71%
- menopause 55%
- mental health 97%
- behaviour 96%
- communication 97%

2 Documentation must be written in black ink – 96%.

CLINICAL PROCESSES

	3 Outcomes of screening must be noted: • medical history – 2 referrals • weight – 38 referrals • activity – 9 referrals • blood pressure – 1 referral • urinalysis – 12 referrals • smoking – 2 referrals • alcohol – 0 referrals • epilepsy – 7 referrals • dental – 4 referrals • hearing – 1 referral • eyesight – 5 referrals • mobility – 4 referrals • chiropody – 9 referrals • continence – 15 referrals • cervical smear – 12 referrals • breast screening – 5 referrals • testicular screening – 4 referrals • menstrual problems – 2 referrals • menopause – 0 referrals • mental health – 5 referrals • behaviour – 6 referrals • communication – 0 referrals
Change	The personal and medical history section should include somewhere for the nurse to document that assessment has been considered and may not be applicable. The sexual health section should include a 'not applicable' for each option. Also somewhere to document that assessment had been considered and why it was not applicable. The ethical issues affecting people with a learning disability giving informed consent for sexual health screening should be addressed. All areas should have access to scales for weighing, multistix for urinalysis and a sphygmomanometer to measure blood pressure. Health care screening for people with a learning disability should continue to be offered to new/re-referrals. All clients should be given the opportunity to have a bi-annual health care screening. If they request a health care screening before this time, or present with new problems, the screening should be repeated.
Contact	Dr Saadi A. Ali, Consultant Psychiatrist, East Yorkshire Community Healthcare, Community Mental Health Unit, Manor Road, Beverley, HU17 7BZ. Tel: 01482 886441; Fax: 01482 880026.

Implementation of the Bexley Care Package

Background	The Bexley Care Package (BCP) integrates a number of Department of Health initiatives – the Care Programme Approach, Risk Assessment, Section 117 and the Supervision Register. It is a systematic model of care adopted for all clients who have continuing or substantial mental health needs but did not address the needs of clients with mental health problems or challenging behaviour in the Learning Disability Service.
Aim	To evaluate current practice in the Learning Disability Service in the context of the standards set out in the BCP.
Standards	1 Every client must be regularly reviewed to meet their level of need. 2 Every client must have a standardised risk assessment. 3 Every client must have a written care plan including the client's health (mental and physical), social and behavioural needs, goals and interventions. 4 Every client must have a care coordinator/keyworker. 5 Every client must have an initial assessment and a BCP assessment.
Sample	51 people with a learning disability with severe challenging behaviour with or without mental health needs.
Key findings	• 57% of clients were regularly reviewed to meet their level of need. • 29% of clients had a Challenging Behaviour Risk Assessment; 10% had a Mental Health Risk Assessment; 31% had a Risk Assessment Review. • 51% of clients had a written care plan. • It was unclear how many clients had care coordinators or Keyworkers. However in 22% of cases professionals considered themselves to fulfil the role of the care coordinator/keyworker. • It was unclear how many clients had initial assessments or BCP assessments.
Change	The BCP should be implemented in the Learning Disability Service. Implementation of the BCP in the Learning Disability Service must be in the context of the Challenging Behaviour/Mental Health Working Party report and the study population. The Learning Disability Service must develop and adapt the existing policies and processes of the BCP to meet the needs of the services and clients. Appropriate management and administration and IT supports for the BCP must be present and include access and links with trust BCP/IT administration systems. Implementation of the BCP and Learning Disability Service must address appropriate client involvement, with particular focus on enabling participation and a clearly developed process for the assessment and documentation of mental capacity. The Supervision Register should be implemented in the Learning Disability Service.

	The BCP in the Learning Disability Service should not exclude clients in the residential service, although special criteria for access might need to be considered.
Contact	Kala Ratnajothy, Clinical Audit Coordinator, Oxleas NHS Trust, Pinewood House, Old Bexley Lane, Bexley, Kent, DA5 2BF. Tel: 01322 625756; Fax: 01322 555491.

Nursing and assessment

Background

The DoH states that service providers should have the means to conduct assessments of individual need and produce clear plans of care for people with learning disabilities. There is an apparent trend that nurses in the field of learning disability use their own professional judgement to identify the needs of their clients rather than approach assessment in a scientific and systematic way. This view supports the need for nurses to develop a criteria that will ensure that their professional judgement is evidence-based and objective.

This project was carried out to determine whether the current nurse practice with regard to assessment was evidence-based.

Aim

To establish an evidence-based criteria for individual assessment of learning disability clients.

Standards

1 An initial assessment must be carried out.
2 Where an initial assessment is undertaken, the community nursing record must be used.
3 Where the need for further assessment is not identified, the reason must be identified in the action section of the community nursing record. Where further assessment is required the type of assessment should be noted.

Staff involved

Community nurses.

Sample

Clients with a learning disability on the community nurses active caseload (*n*=56).

Key findings

- An initial assessment must be carried out – 50/56 (89%).
- Where an initial assessment is undertaken, the community nursing record must be used – 37/56 (66%). Other assessments were an adapted version of the community nurse record (7/56 (12.5%)), Community Team forLearning Disabilities (CTLD) (2/56 (4%)) and CTLD Bridlington/Driffield/Pocklington assessments (4/56 (7%)).
- Where the need for further assessment is not identified, the reason must be identified in the action section of the community nursing record (18/37 (32%)).
- Where further assessment is required the type of assessment should be noted – 25 (45%). 17 assessments related to health care needs (12 x health care screen, 3 x epilepsy assessment, 2 x continence assessment), 4 related to behaviour (behaviour assessment, risk assessment, positive intervention, functional analysis), 2 related to interpersonal skills (sexuality/relationships assessment), and 2 were comprehensive and did not relate to a specific area of need.

Change

Once the client has been accepted on to the nurse's active case-load, a community nursing record should be completed. The community nursing record should reflect the need for further assessment within the 'Action Taken' section. If the need for further assessment is not initially apparent and, therefore, not recorded, but later becomes so, this needs to be indicated in the community nursing record. This should apply to all areas while the client is on the active case-load. There is a need to develop additional documentation to support this.

A working group should be convened to look at the identified areas of client need where further assessment tools need to be developed or purchased.

Any assessment tools developed locally need to:

- be based on a person-centred philosophy that reflects the individual needs in a valued and dignified way;
- be research-/evidence-based; and
- be accessible to the nursing service trust wide.

To promote equitable opportunities for the client group – include and work with other disciplines in the formulation of the assessments where necessary.

Training opportunities should be provided to update skills in all areas of assessment techniques.

Contact

Dr Saadi A. Ali, Consultant Psychiatrist, Hull & East Riding Community Healthcare, Community Mental Health Unit, Manor Road, Beverley, HU17 7BZ. Tel: 01482 886441; Fax: 01482 880026.

Nutrition

Background

In light of the report *Hungry in Hospital* (Community Health Councils for England and Wales, 1997), long-term institutional care has been linked with malnutrition.

Aim

To improve organisational processes, user and carer satisfaction and the use of resources. Measure performance against national standards set by the DoH.

Standards

1. Nutritional content must be in line with recommended daily allowance (for protein, energy, fat, vitamin C, iron, folic acid, fibre, etc).
2. There must not be any repetition of main meals in a 14-day period.
3. Standardised recipes must be used in the Trust.
4. The catering department must comply to standards relating to commodity specification.
5. A nutritional risk assessment must be carried out on all adult in-patients.
6. All patients must be weighed on admission.
7. All patients must be weighed on a monthly basis.
8. Vegetarian meals must be available.
9. Vegetarian meals must meet the nutritional content recommended daily allowance, as outlined in Standard 1.
10. Wards must be adequately staffed at meal times.
11. Food must be served immediately on arrival at the ward.

Evidence

National standards.

Staff involved

Dietician, medical staff, nursing, catering managers, senior managers, audit staff.

Sample

Visited 28 wards across 2 hospital sites.

Data collection

Audit check-list.

Data analysis

Qualitative analysis of findings from audit check-list. Analysis of nutritional content of menus.

Key findings

- Nutritional content was in line with recommendations. 100% of special patient groups met this standard.
- There was no repetition of main meals in a 14-day period (100%).
- Standardised recipes were used in the Trust (100%)
- Catering department complied to standards relating to commodity specification (100%)
- Nutritional risk assessments were carried out for all in-patients.
- All patients were weighed on admission.
- All patients were weighed on a monthly basis, or more frequently.
- 50% had a vegetarian option.
- The vegetarian meals did not meet the recommended daily allowance of protein.
- 96% of wards visited were adequately staffed at meal times.
- 64% of wards had food served immediately on arrival.
- 48% of wards required clarification of content of some meals on the menu.

Feedback	Senior management, board, purchasers. Poster presentation at National Conferences.
Change	Need to improve vegetarian choice; need to change delivery times; clarity of menus to be improved; need more dietetic input in some areas; ordering of food to be simplified; need food representative; need to implement nutritional assessment score sheets.
Re-audit	Areas for action will be followed up in 12 months.
Resources used	Unknown.
Notes	*Advice*: Using national guidelines to measure performance was very useful – helped to structure the audit.
Contact	Pam Richold, Trust Quality Officer, Northgate Hospital, Northgate & Prudhoe NHS Trust, Northumberland, NE61 3BP. Tel: 01670 394275; Fax: 01670 394002.

Seizure control in out-patient clinic services for adults with learning disabilities

Background	Epilepsy accounts for one half of out-patient clinic (OPC) contacts in the learning disabilities services.
Aim	To set guidelines leading to standards of local practices compared with best practices in the UK.
Standards	Staff must record/include on file: 1 syndrome diagnosis; 2 last seizure date; 3 frequency of seizures; 4 type of anti-epilepsy drug (AED) and dose; 5 side-effects; 6 AED level note; 7 blood profile note; 8 monotherapy/reduction attempt; 9 quality of life note; and 10 GP letter with cc. to team.
Evidence	Local consensus, feedback from service users.
Staff involved	Consultant psychiatrist and South Wales medical consultant audit.
Sample	*n*=15.
Data collection	From OPC files.
Data analysis	Descriptive statistics.
Key findings	• Syndrome diagnosis was recorded in 93% of cases. • Last seizure date was recorded in 73% of cases. • Frequency of seizures was recorded in 93% of cases. • AED type and dose was recorded in 93% of cases. • Side-effects were recorded in 40% of cases. • AED level note was included in file in 73% of cases. • Blood profile note was included in file in 55% of cases. • Monotherapy/reduction attempt was recorded in 40% of cases. • Quality of life note was included in file in 80% of cases. • GP letter with cc. to team was included in file in 93%.
Feedback	South Wales Consultant Audit for Learning Disabilities.
Change	Proactive register needed. Clinical nurse specialist needed. Health promotional counselling needed. GP satisfaction service needed. Closer monitoring of AED (in full) polypharmacy needed. Epilepsy Wales now formed SNAP at Welsh office level to promote nurse specialist appointment. Epilepsy clinic started at WGH (in full).

Re-audit After 4 years. Using same population to assess outcome of closer monitoring.

Resources used Not recorded.

Notes The clinical files were not focused on epilepsy and so there was no database to refer to.
If re-doing this project, a wider population would be used and this would be compared to country and city practices.
Advice: Research assistant time is essential. Obtain GP cooperation for use of their databases. Use either Telemedicine or a practice nurse to obtain current details of seizures and medication and family attitudes.

Contact Dr Terry Jones, Consultant Psychiatrist, Pembroke Dock Health Care Centre, Water Street, Pembroke Dock, SA72 6DW.

Holistic care of clients with epilepsy

Aim	To improve the care of people with learning disabilities who have epilepsy.
Standards	**Medical:** 1 A client with epilepsy will have no more than 2 epilepsy drugs prescribed without a documented reason for doing so. 2 Drugs for epilepsy control will not include phenytoin or phenobarbitone without a documented reason for doing so. 3 Clients who have been 'seizure-free' for 3 years will have their medication reviewed and this documented in the case notes. 4 The following blood tests will be performed annually: folate, thyroid function, serum calcium, alkaline phosphatase levels and full blood count. 5 There will be a 6-monthly medication review of clients with epilepsy by the Community Medical Officer (CMO). **Nursing**: 6 Following a seizure, the following information will be recorded in the nursing records: date, time, length of seizure, type of seizure, injury sustained if applicable, post-seizure recovery state, whether the client was incontinent and treatment. 7 History of epilepsy will be documented in the individual risk assessment on admission to a supported tenancy and a copy of this is available in the day care clients' records. 8 A monthly seizure chart will be part of the nursing records for each client with epilepsy and will be completed for each seizure. 9 All prescribed medication will be recorded as given on the drug kardex unless there is a documented reason for not doing so. 10 All referral forms received by the resource centre will have details regarding the presence or absence of epilepsy for each client referred. **Physiotherapy**: 11 The physiotherapy treatment card will have a completed information sheet by the main carer for all clients with epilepsy who attend hydrotherapy sessions.
Evidence	Consensus.
Staff involved	CMO, nurse managers, clinical nurses, support workers, physiotherapists, speech and language therapists, occupational therapists.
Sample	25 clients with a diagnosis of epilepsy.
Data collection	Retrospectively from case notes and other records.
Key findings	**Medical:** • 5/24 (21%) clients were prescribed 3 different drugs for epilepsy control. • 2/24 (8%) clients were prescribed phenytoin for epilepsy control. • No clients were prescribed phenobarbitone for epilepsy control.

	• It was unclear from the medical casenotes in 3/24 clients whether they had been seizure-free for 3 years. • 7/24 (29%) clients had a thyroid function test performed in the previous year. • 12/24 (50%) clients had folate, serum calcium and alkaline phosphatase levels in the previous year. • 19/24 (79%)clients had an FBC performed in the previous year. • 2/24 (8%) clients had documented requests for blood screening that were not received by the laboratory. • 22/24 (92%) clients had 6-monthly medical reviews. **Nursing:** • Documented of seizures is not standardised. • Seizures were documented in up to 4 different records within some tenancies. • The standard of recording for individual seizures was not met. • 20/25 (80%) clients had epilepsy identified inthe individual risk assessment on admission to a supported tenancy. • 20/25 (80%) clients had an epilepsy care plan. • 10 of the 23 drug sheets audited had no missing entries. **Physiotherapy** • All clients using the hydrotherapy pool had a completed information sheet in their physiotherapy records.
Feedback	Within the various directorate meetings.
Change	A working group has designed a standardised seizure recording chart. Information regarding seizures will be passed between centres via a client diary which will be sent with the client. Care plans for all clients with a history of epilepsy are now in place. Dispensing and signing of drugs has been standardised according to good practice guidelines. Funding has been allocated for 2 nurse practitioners who attend university for epilepsy diplomas. A medical review proforma has been developed. All support workers are to attend the 'Investors in People' training. Consideration is being given to developing annual epilepsy updates and extending the length of the epilepsy component of the current training. An educational chart has been developed via a working group, which is be laminated and displayed in all tenancies and the resource centre. An epilepsy guideline has been formulated to add to the directorate guidelines file and will incorporate the agreed standards and recording chart. A monthly communications meeting has been set up.
Re-audit	In 1999.
Resources used	Clinical audit and learning disabilities staff.
Contact	Jan Codling, Clinical Audit Services, Stockport Acute Services & Stockport Healthcare (NHS Trusts), Stepping Hill Hospital, Stockport, Cheshire, SK2 7JE. Tel: 0161 419 5964; Fax: 0161 419 5745.

Needs of people aged 16 and over with autism and in contact with mental health and/or learning disability services

Background	A multi-professional group concerned about the lack of appropriate services. A strategic goal for health and social services in 1997.
Aim	To improve clinical and organisational processes, health outcomes, user/carer satisfaction and use of resources – database, assessment of needs and recommendations.
Standards	1 People with autism must have access to diagnostic and assessment services locally. 2 School-leavers must have a satisfactory transition into adult services. 3 People with autism and their carers must have access to information about residential and day services. 4 Staff working with clients with autism must have access to information.
Evidence	Local consensus, research evidence, national guidelines, feedback from service users (no references provided).
Staff involved	Clients, carers and staff.
Sample	76 people selected by a professional steering group.
Data collection	Structured interview.
Data analysis	Relational database set.
Key findings	The results identified: • lack of information; • lack of skilled staff; and • no coordinated approach.
Feedback	Written report was presented to all the participants, carers and families, health and social services practitioners and management.
Change	The audit steering group had been charged with recommending specific targets. A series of recommendations is being worked on, with a time table for goals achievement. Problems include the issue not being a priority for services, lack of coordinated strategy and very limited resources.
Re-audit	After 3 years, if finance permits.
Resources used	12 months of a full-time researcher.
Notes	Needed time from devoted practitioners. Would obtain or negotiate access to IT at a much earlier stage if doing this audit again. *Advice*: obtain commitment from a support/steering group, good day to day supervision, good planning.
Contact	Magda Sereda, Psychology Service, 309 Cressex Road, High Wycombe, HP12 4QG. Tel: 01494 426918; Fax: 01494 426852.

Antipsychotic drug prescribing for people with learning disabilities

Background	Concern about inappropriate use of drugs and risk of side-effects with this client group.
Aim	To improve clinical and organisational processes and health outcomes.
Standards	1 Drug names (generic) must be identified in case notes. 2 Dosage and schedule must be identified in case notes. 3 Discussion of short-term side-effects must be documented. 4 Discussion of long term side-effects must be documented. 5 Indication for antipsychotic treatment documented. 6 Enquiry for side-effects at follow-up. 7 Attempt or consideration must be made of reduction of medication or of achieving minimum dose. 8 Drug must be within British National Formulary limits. 9 No more than 2 antipsychotic drugs will be prescribed.
Evidence	Local consensus.
Staff involved	All consultants in learning disability, Mersey region.
Sample	10 random case notes for each district.
Data collection	Collected by doctors.
Data analysis	Analysed by doctors.
Key findings	Poor documentation of consent. Poor documentation of explanation of side-effects (need results relating to standards).
Feedback	To all doctors in region.
Change	Development of standard format for out-patient review.
Re-audit	Developing new standards currently.
Resources used	Secretarial time.
Notes	Would need to have a more structured review process in future.
Contact	Marie Hand, West Cheshire Hospital, Liverpool Road, Chester CH2 1UL. Tel: 01244 364101; Fax 01244 364106.

Neuroleptic prescribing for patients with learning disabilities

Background	Many hospitalised patients with learning disabilities were found to be receiving neuroleptic medication, but the rationale behind the prescribing was not always clear. While lacking proven efficacy, neuroleptics remain widely used in the treatment of behavioural problems in-patients with learning disabilities. Other medication has been found to be clinically useful in the management of aggression, self-harm and hyperactivity but may be less frequently utilised. Widespread use of neuroleptic medication poses risks in the form of potential side-effects, including the development of tardive dyskinesia and neuroleptic malignant syndrome.
Aims	1 To improve prescribing practice. 2 To ascertain prevalence of, and rationale for, prescribing regular and discretionary neuroleptic medication for patients with learning disabilities, with the aim of improving the supervision of treatment.
Standards	1 Reasons for prescribing neuroleptic medication must be recorded in notes. 2 Medical notes and drug prescription charts must be taken to ward meetings.
Staff involved	Charge nurses, junior medical staff, consultant psychiatrist, specialist nurse manager.
Sample	43 patients with learning disabilities in long-term care: 19 were prescribed regular neuroleptic medication and 24 were prescribed discretionary neuroleptic medication (15 were prescribed both).
Data collection	Data was collected from nursing notes, medical notes and drug prescription charts.
Data analysis	Descriptive statistics.
Key findings	Prevalence: regular 39%, discretionary 49%, both 31%. • Reasons for prescribing neuroleptic medication was not recorded in 3 cases. • One-third of wards were routinely taking medical notes and drug prescription charts to ward meetings. After guidelines were implemented, this figure rose to two-thirds.
Change	Guidelines were drawn up and distributed to charge nurses responsible for each ward and all junior medical staff. The number of neuroleptic prescriptions being administered was reduced owing to improved supervision of treatment. There was also a reduction in the prescribing of anticholinergic medication and an increase in discussion and problem-solving sessions within clinical teams to deal with alternative treatment and management strategies.

Re-audit	Not planned.
Contact	Mrs N. Osborne, Clinical Audit Facilitator, Dumfries and Galloway Primary Care Trust, High South, Crichton Royal Hospital, Dumfries, DG1 4TG. Tel: 01387 244012; Fax: 01387 244344.

Use of neuroleptic medication

Background

It was not known how many patients were prescribed neuroleptics and whether medication and response to it were regularly reviewed. Also uncertain was the frequency with which possible side-effects were explained and whether or not consent was sought on initial prescribing.

Aims

1 To measure clinical care given to patients prescribed neuroleptics against standards.
2 To make recommendations to improve care.

Standards

1 Prescribing of neuroleptics must be part of an integrated care plan.
2 Medication, response to treatment, presence or absence of side-effects must be reviewed at least every 6 months.
3 Medication must be rationalised in that polypharmacy must be avoided and British National Formulary limits adhered to unless clinical justification for otherwise.
4 Consent must be obtained where possible or, if not, relatives consulted and possible side-effects explained.
5 Entries in notes must be signed and dated.

Staff involved

Junior doctors – senior house officer, specialist registrar and consultant, secretary

Data collection

Every third set of notes, stored alphabetically and by gender, was extracted, and the notes of those clients prescribed neuroleptics between 1.2.95 and 21.1.97 reviewed ($n=50$).

Data analysis

Descriptive statistics.

Key findings

- 31 men and 19 women, age range: 26–66 for men (mean age 41) and 46–66 for women (mean age 48).
- 74% lived in a community home, 16% in the family home and 10% independently.
- 44% suffered from borderline/mild disability, 22% moderate and 34% severe/profound.
- 24% showed some degree of autism.
- 68% had a diagnosis of mental illness, most commonly affective (34%) and 20% schizophrenic. The remainder had a combination of diagnoses or 'other'.
- When initially prescribed, 68% showed some form of challenging behaviour, usually aggressive (28%) followed by self-injury (14%). The remainder were a combination of forms of challenging behaviour. At present, 20% show some challenging behaviour with aggressive and self-injury equal at 8% each.
- The vast majority (98%) had a stated reason for prescribing. Other professionals were identified and contributed to the care plan in 94% of cases.
- In 70% of cases medication was reviewed 6-monthly between 1 February 1995 and 31 January 1997.
- In 8% of cases, more than one neuroleptic was prescribed, and in one of these cases (2%) a reason was documented.
- Clinical response was recorded in 96% of cases.
- Presence/absence of side-effects was documented in 30% of cases.

	Dosage was within British Nation Formulary limits in 92% of cases and in the 8% that fell outside, 4% gave a reason. In those able to consent (60%), none was asked for consent. Of those unable to consent (40%), 25% of relatives were consulted. In only one case (2%), were possible side-effects mentioned and documented. All entries in medical notes were signed and dated.
Change	To monitor and record presence/absence of side-effects. Seek and document consent on prescribing neuroleptics in those able to consent. Consult relatives in those unable to consent. Explain possible side-effects to patient and/or carers and record in notes. Re-audit to evaluate to what extent recommendations have been implemented.
Contact	Rosalind E. Bates, Consultant Psychiatrist, Ravensbourne NHS Trust, Bassetts Resource Centre, Acorn Way, Starts Hill Road, Farnborough, Orpington, Kent, BR6 7WF. Tel: 01689 853388; Fax: 01689 861232.

Assessment of challenging behaviour

Background	Upon reflection of services to people with learning disabilities, we felt we could improve on our assessment services for those people who had challenging behaviour.
Aim	To find out what assessment tools are used for people who have challenging behaviour and to find out what the assessment package (tool) contains.
Standards	1 All people with a learning disability who have challenging behaviour will have a comprehensive assessment of their needs. 2 Consent must be sought from either the client or his or her carer. 3 A detailed assessment must be taken of the client's personal information including a personal profile, communication repertoire, mental health issues, health/medical issues, personal attributes, social network and likes and dislikes. 4 The challenging behaviour must be measured (duration and frequency). 5 An analysis of events leading to and consequences of the challenging behaviour must be carried out. 6 All assessment must contain details of all previous placements.
Evidence	Developed by specialist nurses within the service.
Staff involved	Clinical nurse specialist and challenging behaviour specialist nurse.
Sample	69 adults with learning disabilities and challenging behaviour.
Data collection	Data collection forms, designed using Formic software, were used to collect retrospective information from client notes and care staff.
Data analysis	Descriptive statistics.
Key findings	• 75% of clients did not have an assessment for challenging behaviour. • 60% of these had the consent of either the client or the client's carer. • 100% of assessments included fully documented personal details. • 80% of assessments included assessment of physical health problems and mental health needs. Details of clients' leisure activities, access to community, clients' skills and like and dislikes were well documented (over 80%). Clients' personal attributes, social network and communication environment were documented in around 50% of cases. • Details of the challenging behaviour were mostly well documented • (70–90%), except for duration (60%). • 40% of clients had an analysis carried out of events leading to and consequences of the challenging behaviour. • 60% of assessments did not contain the previous placements. From the 33% who did, all had 'behaviours displayed' included, with 'interventions and effects' included in 80% of cases.
Feedback	To all professionals within the Thameside Learning Disability Service.

Change	Planned training for all nurses on assessment. Assessment tool has been developed.
Re-audit	6 months after training of staff.
Resources used	140 hours, development of assessment tool and training package for staff.
Notes	Give a good definition of challenging behaviour to all of those individuals who will supply information.
Contact	John Cronin, Thameside Community Healthcare NHS Trust, 1 Heath Close, Billericay, Essex, CM12 9NW. Tel: 01277 631968; Fax: 01277 653832.

Seclusion policy

Background	Seclusion must be conducted under strict guidelines. Identified need to measure adherence to policy.
Aim	To ensure adherence to procedures at all times.
Standards	1 Seclusion room must meet regulations set down. 2 The Responsible Medical Officer (RMO) must be informed immediately. 3 Point of contact must be informed immediately if manager or clinical coordinator is not available. 4 Seclusion must be observed. 5 Record of seclusion must be completed.
Evidence	National guidelines in Mental Health Act Code of Practice, local consensus.
Staff involved	Nursing, clinical audit and medical staff and senior management.
Sample	All reported incidents of seclusion
Data collection	Audit check-list.
Data analysis	Qualitative owing to small numbers.
Key findings	• All rooms complied. • RMO informed within 10 minutes. • On 2/16 occasions, over 10 minutes was taken for point of contact to be informed. • Observation well-documented. • Documentation, record-keeping good.
Feedback	Corporate management team, Trust board, staff on wards involved, medical staff.
Change	Need to ensure point of contact/senior nurse attends ward within 10 minutes of being informed, maximum time period.
Re-audit	Routine 6-monthly audit.
Resources used	2 hours every 6 months.
Notes	Continual monitoring vital.
Contact	Pam Richold, Trust Quality Officer, Northgate Hospital, Northgate & Prudhoe NHS Trust, Northumberland, NE61 3BP. Tel: 01670 394275; Fax: 01670 394002.

Violent incidents

Background	Information regarding violent incidents was already collected by the Learning Disabilities Service and the Health and Safety Department, and it was considered that this information could be used in a clinical context.
Aim	To make the data collection forms more clinically useful by: providing information on antecedents and consequences of violent behaviour; identifying predisposing factors; giving an index of severity and duration of problematic behaviour; and providing information about behaviour whichcould be mapped against changes in service provision.
Standards	1. Individual patient reports must be compiled on a 6-monthly basis to provide clinical feedback to the residential care team to aid the clinical review process. Reports must be available on request in between times, e.g. for Mental Health Act Reviews, annual Life Planning Meetings, etc.on an 'as needs' basis. 2. A yearly service report must be compiled to provide information for service planning.
Evidence	Standards based on discussions by the multi-disciplinary and management team.
Staff involved	Residential nursing and care staff, consultant clinical psychologist, consultant psychiatrist, Learning Disability Service manager.
Sample	Data collected from 2 residential in-patient services ($n=38$).
Data collection	Data was collected on specifically designed data collection forms. Over the years the forms have been adapted and reviewed according to clinical need and IT software availability and suitability.
Data analysis	Data collated and analysed on Microsoft Access and collated into descriptive statistics.
Key findings	Both standards were met 100% of the time.
Feedback	Findings were fedback throughout the service at multi-disciplinary meetings, clinical reviews, management meetings etc.
Change	The forms have been re-designed to focus on triggers and outcome of the incidents as well as brevity and user-friendliness, in order to increase accuracy of the recording and the usefulness of the information. Staff are more aware of potential triggers for individuals and may now work in a more preventive way with challenging behaviour. This has improved the clinical care of individuals. Regular feedback of data and simplification of the form has helped to motivate staff to fill in the forms quickly and accurately.
Re-audit	This audit is planned to be continuous but with regular review of the process by the multi-disciplinary team and Clinical Effectiveness Department.
Resources used	4 hours per week to collate data and 14 hours to compile individual six-monthly reports.

Notes	Look at what information is already being collected to see if it can be modified to provide useful clinical information.
Contact	Lesley Barrington, Loddon NHS Trust, The Bridge Centre, New Road, Basingstoke RG21 7PJ. Tel: 01256 316309; Fax 01256 316320.

Clients' life experiences

Background	Often an oversight, difficult to assess, essential to be aware of clients' perceptions.
Aim	To evaluate user satisfaction.
Standards	People with learning disabilities should have similar life experiences to those of the general public.
Evidence	*Life experiences checklist* (Agar, 1990).
Staff involved	Senior nurse and service users.
Sample	13 service users.
Data collection	Interview.
Data analysis	Comparing percentage to experiences of the general public.
Key findings	There was an identified difference between service users and the public in the area of relationships.
Feedback	Verbally to participants, reports to nurses/nurse managers.
Change	To extend opportunities for users to build meaningful relationships.
Re-audit	Ongoing.
Resources used	45 hours, cost of check-lists and manual.
Notes	Problems: users interpretation of questions and ability to answer. *Advice*: be prepared to rephrase questions and beware of leading questions.
Contact	Debbie Webster, Senior Nurse, Learning Disabilities Directorate, Bradford Community Health, Westwood Hospital, 84 Cooper Lane, Bradford BD6 3NJ. Tel: 01274 424203; Fax: 01274 883469.

Health of the Nation Outcome Scales – Learning Disabilities

Aim	To improve clinical processes, health outcomes and use of resources. Determine areas in which the multi-disciplinary team (MDT) achieved good health and social gains.
Standards	Improvement in Health of the Nation Outcome Scales – Learning Disabilities (HoNOS–LD) scores across all domains during MDT interventions.
Evidence	HoNOS–LD measured domains based upon national consensus as to relevant aims for learning disabilities services.
Staff involved	All learning disabilities staff.
Sample	100% of learning disabilities service users.
Data collection	By MDT, rating at Care Programme Approach or service planning reviews.
Data analysis	SPSS.
Key findings	Not yet known – in progress
Feedback	Will be fedback to all clinicians in team, directorate management group, Tees Health Authority.
Notes	*Advice*: be wary of low interrater reliability within HoNOS–LD draft format. Use group ratings if possible.
Contact	Malcolm Bass, Assistant Clinical Director, Hart Lodge, Hartlepool & East Durham NHS Trust, Jones Road, Hartlepool, TS24 9BD. Tel: 01429 868837.

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The College Research Unit's activities include coordinating national audits and producing information sheets, guidelines bibliographies, evidence-base briefings and clinical audit publications.

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Feedback form

We hope that you have found *Improving the Care of People with Learning Disabilities: Clinical Audit Project Examples* useful and we would very much appreciate your feedback. Your comments will be incorporated, where possible, into future editions of this publication.

1 Have you found this book useful? ☐ Yes ☐ No
If yes, please describe briefly how this book has been used in practice.

2 Are there information sources that you think ought to have been included in this book? Please list full references where possible.

3 Do you have suggestions for topics areas in which you would like to see future clinical audit books developed?

4 Do you have any general suggestions about this book that would improve its usefulness?

5 What is your profession?

6 How many people in your organisation have access to this CAPE?

If you have any further comments, please feel free to attach extra paper.

Thank you for taking the time to complete this form. Your comments will be considered carefully.
Please photocopy and return to:
Kirsty MacLean Steel, Royal College of Psychiatrists' Research Unit, FREEPOST – LON602, 11 Grosvenor Crescent, London, SW1X 7YS. Fax: 0171 235 2954.

Project submission form

If you have any clinical audit projects you would like included in future editions of this book, please copy and complete this form and return it to:

Kirsty MacLean Steel
Royal College of Psychiatrists' Research Unit
11 Grosvenor Crescent
London SW1X 7EE

Name: ______________________________

Address: ______________________________

____

Telephone: ______________ **Fax:** ______________

Email: ______________________________

Clinician responsible for audit (if different from above): ______________

Date of audit (year) and period of time over which data were collected:

____

Notes about the completion of form: please continue on separate sheet if necessary and attach your audit report to refer to if this is easier. If you have any questions regarding the information requested on this form, please contact Kirsty MacLean Steel or Claire Palmer on 0171 235 2351, ext. 282.

Clinical audit project title	
Background Why was this audit considered important (i.e. why was this topic selected)?	
Aims and objectives Did the audit aim to improve (please tick more than one if appropriate):	(a) clinical processes (e.g. assessment, treatment) ☐ (b) organisational processes (e.g. waiting times, information recording) ☐ (c) health outcomes ☐ (d) service user or carer satisfaction with service ☐ (e) the use of resources ☐

Standards Did you set explicit, measurable standards against which practice could be compared? Please outline:	Standard 1: ____________ Standard 2: ____________ Standard 3: ____________ Standard 4: ____________ Standard 5: ____________
On what were the standards based, e.g. local consensus, research evidence, national guidelines, feedback from service users etc.?	
Involvement Who was involved in the audit?	
Assessing practice against the standards What was the sample size and how was it selected? How were the data collected? How were the data analysed?	
Key findings	
Feedback of findings To whom were the results of the study communicated and how?	

Suggestions for change Following the audit have you come up with suggestions for changes in practice? If so, what are they? If not, why not?	
Changing practice Have there been any significant things which have either helped, or prevented, change from being implemented? Please describe.	
Re-audit After how long do you plan to re-audit?	
Resources Approximately how much staff time was taken to complete the audit cycle (hours)? Were any other costs or resources needed?	
Evaluating the audit What problems did you encounter (if any) in undertaking the audit? If you were doing this project again, are there any aspects of the audit you would change?	
What advice would you offer to someone attempting a similar audit?	