Appraisal of completion of Psychiatric assessment document

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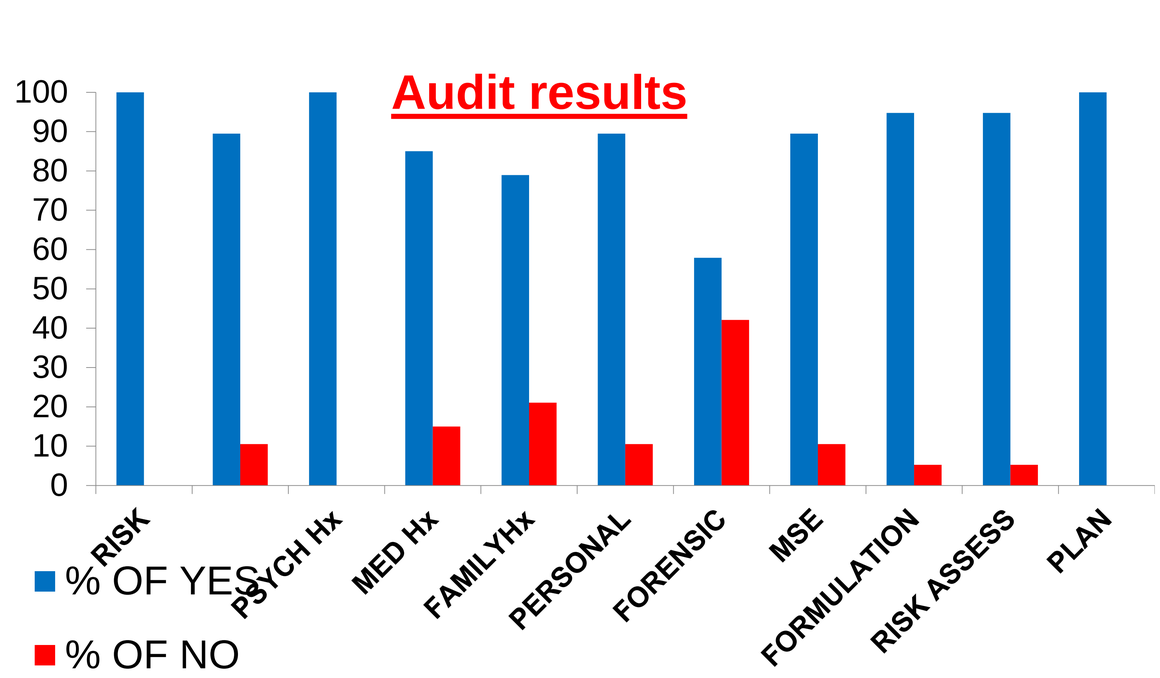
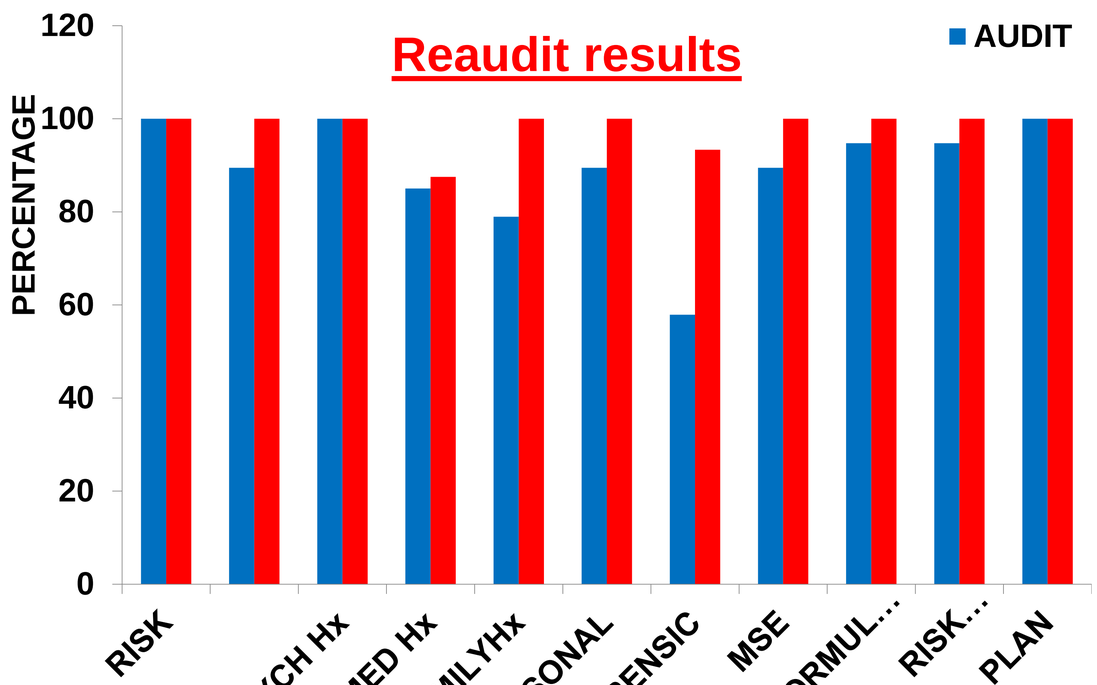
BACKGROUND- The assessment document used for patients at Royal Cornhill hospital, Aberdeen forms a standard template to record the presenting complaints and past history of every patient referred for assessment or admission. The document provides a condensed version of all salient features of a patient's often vast and prolific background. There is a requirement for all sections of the document to be completed so information is available at a glance to anyone involved in that patient's care including colleagues who may not be familiar with the patient's background. An audit was undertaken to appraise the completion of various sections of part 1 & 2 of the Psychiatric assessment document at the time of admission.

AIM & OBJECTIVES- To improve the quality of care provided based on information available in the Psychiatric assessment document. The objective is to appraise and improve the information available by recording information in the assessment document.

METHODS- An audit was registered with the quality improvement and assessment team after permission was obtained from the clinical director of mental health and learning disability service, NHS Grampian. A list of patients admitted to Royal Cornhill hospital, NHS Grampian for the month of January 2020 was obtained from the health intelligence department at NHS Grampian. Confirmation of the availability of above patients case records on CCUBE was procured from medical records department, NHS Grampian. A random time period of 2 weeks from 01 January to 15 January 2020 was selected for the audit and yielded 23 patients of which 3 patients whose details were not available on CCUBE were excluded. Part 1 and 2 of the assessment document were investigated. In part 1 risk, substance misuse, Psychiatry history, Medical history, personal history, Forensic history, Mental state examination, formulation, risk assessment & Plan were considered. In part 2 medicine reconciliation form with one and two sources of information, allergies, medication history, Medical history, Observations. Physical examinations included cardiovascular system, respiratory system, gastrointestinal system, neurological exam, cranial nerves exam, power, tone, sensation, reflexes. ECG and admission blood testing were also appraised. A reaudit was undertaken 21 July to 04 August to complete a full audit cycle.

RESULTS- Forensic history was not completed in 42% of patients. Family history was completed in 21% of patients. Admission bloods were not recorded in the assessment document in 72% of patients. 94% patients had ECG performed at admission. Reaudit results demonstrated an improvement in completion of the medical history, family history, personal history, forensic history, MSE, formulation and risk assessment sections.





DISCUSSION & CONCLUSION- This audit and subsequent reaudit was undertaken as a means of appraising and improving the content available by recording information in different sections of the assessment document. The results demonstrate an improvement in completion of the assessment document .