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AP in B

Special focus on Quality Improvement and Audit

inside this edition:

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As randomly selected by the editorial group, the following authors of two articles published in APB Edition 4 will receive a free book:

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Editorial: A special focus on quality improvement and audit

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Providing a quality service is in everyone's interest – service-user, carer, practitioner and manager. However, there are several view-points on what constitutes 'quality', which may relate to the differing perspectives of these people – as highlighted by Harvey (1995, Ramsden 2000: 42) and represented in box 1.

Box 1: Views of Quality

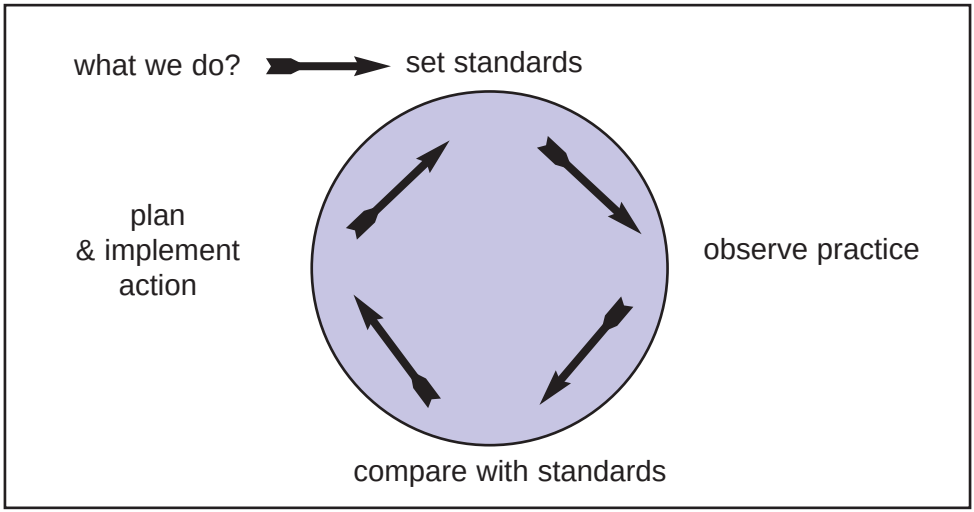
Quality =	excellence consistently flawless outcomes fitness for purpose = fulfilling customer need value for money = return on investment transformation = change

Whilst you will likely have a preferred viewpoint, it is likely that each organisation will draw from many, if not all, of these conceptions (Ramsden 2000). Consider the example of health-care education and the health-care employer where the over-riding concern is with ensuring fitness for practice and purpose (UKCC 1999, DoH 1999) and thus a competent workforce (DoH 2001, UKCC 1999), which forms an increasingly and widely accepted fundamental definition of quality in this context (Boyle & Bowden 1997: 113). Emphasis is placed on developing practitioners / students who are 'fit for purpose with excellent skills, and the knowledge and ability to provide the best care possible' (DoH 1999: 23) in response to health service demand, through a more rigorous approach to developing and assessing clinical competence.

This emphasises the importance of continuing professional development and lifelong learning, based upon a dynamic view of quality and quality improvement, and expressed through planned and systematic action towards intended outcomes that serve the needs of service-users, carers and colleagues (Boyle and Bowden 1997: 115).

Providing quality is therefore surely an aspiration for us all, which is most likely to be achieved through adopting a robust approach in which we systematically make use of a range of helpful methods – one of those which may be more familiar to the health & social-care professional / educator is the well-known dynamic, cyclical standard-setting and audit model of continuous quality improvement, as represented in Fig. 1 (based on: RCN 1986).

Fig. 1 Standards & Audit



This edition of Advancing Practice in Bedfordshire highlights the application of this criterion-based standard-setting and audit process within the practice setting, with the aims of continuing learning and quality improvement in caseload management, the service-user and carer experience of mental health services for older people, and medication management practices in community homes. This issue is concluded with a short practitioner's diary, which we are hoping will become a regular feature for future editions.

We hope you find something to interest you in this edition, and, as exemplified within these papers, we would recommend your use of the standard-setting and audit approach towards quality improvement.

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Monitoring Community Mental Health Team Caseloads: a systematic audit of practitioner caseloads using a criterion-based audit tool

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CASELOAD AUDIT

Introduction:

'Good caseload management and supervision processes are critical to maintaining effective practice. Each mental health provider will need to ensure, and be able to demonstrate, that staff in care coordinator roles are maintaining caseloads of suitable sizes with individuals who have active needs and that support and clinical supervision is provided.' (DH 1999: 23)

This recommendation has been echoed within the Trust's county-wide Care Programme Approach Policy (CPA):

'Individual caseloads of each Care Cordinator will be subject to ongoing monitoring through the established processes of caseload supervision and audit activity. For mental health services, present service specifications emphasise the need for prioritising care to those most in need (i.e. people with severe mental health problems) (DH 1995). An example of a caseload management tool is given. There should be parity in caseload complexity and volume across the teams and the professional groups who manage care. Each agency is responsible for implementing an effective process for the provision of caseload, clinical and/or management supervision…..' (BLCT 2003: 15).

Monitoring caseloads is a complex issue, as limiting such activity to simple numbers of clients on caseloads is potentially misleading of actual workload and does not recognise the many other important activities that are undertaken by practitioners – for example: therapeutic group work; weekly review meetings / case conferences; formal CPA meetings; service development initiatives; offering training; fulfilling significant administrative requirements; and, travel.

In 2000 & 2001, the local community mental health service piloted the use of a criterion-based caseload monitoring tool based upon a thermometer weighting system, which involves giving service users a weighted rating based upon CPA-related criteria (McDermott & Reid 1999, Butler 2001).

As part of the CMHT (Community Mental Health Team) review process, it was agreed to monitor and audit caseloads using an adapted version of this tool, with the aims of: reviewing the level of service-user need across caseloads, matching this with resources, and facilitating service planning and quality improvement by ensuring safe, manageable workloads (Briedel 1993).

Method:
Each qualified mental health practitioner in each CMHT was asked to conduct an audit of their current caseload using an adapted version of the caseload monitoring tool (see appendix for excerpts of audit tool), recording their ratings for each weighted criterion on a specially devised audit data collection record-form. An instruction sheet was written for practitioners to guide their use of the audit tool.

Practitioners were then asked to validate their caseload audit data with their Lead CMHN (Community Mental Health Nurse), Senior Practitioner or Team Manager.

Use of this audit tool requires the practitioner to assess each service-user on their caseload against seven CPA-related criteria (risk, relapse pattern, needs, support, engagement & compliance, contact, and CPA coordination). Each criterion is weighted from 1 – 5, in accordance with specific service-user descriptors. After weighting each criterion, a decision is then made in allocating 1 – 5 weighting points to the service-user – which is most usually the average of weightings for all seven criteria. Completed for each service-user on the practitioner's caseload, this provides an overall caseload profile.

In addition to the above, the CMHT Review Group requested the collection of additional data items: total contact time, total travel time and total administration time for each service-user, in minutes per month; and, the type of service ideally required for the service-user, using definitions from Department of Health Policy Implementation Guides (DH 2001, DH 2002).

Although data collection was initially planned for September 2004, audit data was collected and returned from end September – December 2004. Audit data was forwarded to the author for analysis and reporting.

Findings:
A summary of some of the key findings of this audit are presented below. In addition, a summary of caseload data relating to specific CMHTs was returned to the team managers, highlighting further specific analysis.

The community mental health nurses and social workers of seven CMHTs returned caseload data using the audit tool: *23 Community Mental Health Nurses (CMHNs); 19 Social Workers (SWs); 4 Assistant Social Workers / Community Support Workers (CSWs); and, one psychotherapist. Audit data was validated by the respective Lead CMHNs, Senior Practitioner or Team Leader / Manager.*

Caseload Size
As summarised in Table 1, the total active caseload audited represented 47 team-members and 917 service-users. The Luton CMHNs had the largest caseload sizes, two of whom had the largest caseload sizes of the whole audit sample: 49 (Luton SW CMHT) & 40 (Luton SE CMHT) service-users. The average caseload size for a full-time generic qualified mental health practitioner was 25 service-users, which was exceeded only by the CMHN Teams of the South of County CMHTs.

Approximately 40% of the service-user sample was weighted as either 4/5 or 5/5 for

CPA coordination, confirming the level of care coordination for service-users requiring enhanced CPA care. This was significantly more likely in the Bedford East CMHN Team (73%), where caseload sizes were therefore understandably smaller. However, for one of the Luton CMHNs (Luton NW CMHT) 25/35 clients were weighted as either 4/5 or 5/5 for CPA coordination.

Only 2/47 practitioners had caseloads of more than 35 clients, both of whom were Luton-based CMHNs. This represents a significant reduction in caseload sizes since a previous audit of CMHN caseloads using this caseload monitoring tool (Butler 2001).

As shown, CMHN caseloads are generally higher than Social Worker caseloads, and Luton-based CMHN caseloads are generally higher than those in other teams.

Those with particularly low caseloads are invariably either working on a part-time basis or have additional roles, whether managerial or educational roles.

Time for Client Work

As would be expected, the findings suggested that service-users being seen by those with higher caseloads receive less total contact time per month (for face to face contact, travel and administration). The average contact time was significantly greater in the Biggleswade CMHT, although this is mainly explained by the significantly greater time spent travelling to see service-users.

It is worth noting that the total time commitment to client-based work as a percentage of total available working hours was highly variable: 64% (40 – 85%) for the Luton CMHN; 59% (26 – 111% - a possible over-estimate) for the Luton Social Workers; 36% (18 – 53%) for the Dunstable CMHT-member; 61% (32 – 114% - a possible overestimate) for the Leighton Buzzard CMHT-member; 64% (31 – 93%) for the Biggleswade CMHT-member; 45% (30 – 55%) for the Bedford East CMHN.

Team Caseload Profiles

Team Caseload Profiles were produced which highlighted the average criterion weightings for each team, with the Luton CMHTs being separated into CMHN and Social Worker Teams. This highlighted that:

- 'risk' weightings are highest for the Bedford East CMHNs & Luton Social Workers
- 'relapse' weightings are highest for the Luton Social Workers & Bedford East CMHNs
- 'complexity of need' weightings are highest for the Luton Social Workers & Leighton Buzzard CMHT
- 'support need' weightings are highest for the Bedford East CMHNs & Leighton Buzzard CMHT
- 'engagement' weightings are highest for the Luton Social Workers & Leighton Buzzard CMHT
- 'contact' weightings are highest for the Leighton Buzzard CMHT & the Luton Social Workers
- 'care coordination' weightings are highest for the Bedford East CMHNs
- overall, the caseloads for the Luton Social Workers & Leighton Buzzard CMHT were weighted most highly

Caseload Weightings

Chart 1 shows the total caseload weightings for individual practitioners within each of the teams.

In their original caseload thermometer weighting tool, McDermott & Reid (1999) suggested an upper total caseload weighting limit of 80 points per full-time CMHN caseload. This would mean that a full-time qualified mental health practitioner should not work with more than 16 'highest priority' service-users (each weighted as 5/5).

If this standard is applied to the caseload weightings across the teams, then 5/9 Luton CMHNs have caseloads weighted in excess of this, with one of these CMHNs having a caseload weighting of 157 points (Luton SW CMHT) – the maximum caseload weighting for this audit sample. Only 5 practitioners in the other teams have caseloads in excess of 80 points (one Luton Social Worker – the only substance use worker in this sample, one Dunstable CMHN, two Leighton Buzzard CMHNs & one Leighton Buzzard Social Worker). This raises questions about how workload is allocated in CMHTs to ensure fairness and equity, how caseload activity is routinely assessed and monitored, and how resources are allocated.

As for caseload sizes, those with particularly low caseload weightings are invariably either working on a part-time basis or have additional roles, whether managerial or educational roles.

Some 46 service-users were given the highest overall case weighting (= 5/5): 10 were seen by the Luton CMHNs; 11 were seen by the Luton Social Workers; 18 were seen by the Leighton Buzzard CMHT; 1 was seen by the Dunstable CMHT; 3 were seen by the Biggleswade CMHT; and, 3 were seen by the Bedford East CMHT. Of these, 39/46 were on Social Worker caseloads, with a maximum of 7 'highest priority' service-users on any one caseload (Luton Social Worker & Leighton Buzzard Social Worker).

Caseload Risk Levels

There is considerable variation in the average risk level of individual caseloads, with risk weightings being generally higher for Social Worker caseloads.

Considering the important issue of the level of risk, effective caseload management would suggest that those practitioners who have larger caseloads would be expected to work with service-users presenting a lower degree of risk - an hypothesis that is represented by the diagonal line in Chart 2 (to visually demonstrate this point, this line has been arbitrarily set at an average risk rating of 2/5 for a caseload of 60 service-users, although no practitioner would be expected to work with this number of service-users).

As shown, the average risk weighting (risk index) falls above the line for 13/47 practitioners. This suggests one or both of the following: either greater levels of workload for these practitioners; and / or, a comparatively reduced contact time for those service-users presenting the highest level of risk.

Service Requirements

As highlighted in Table 2, practitioners provided an indication of the type of service required by their service-users. As expected, whilst the majority appeared to be receiving care appropriately from the Acute / CMHT service, a considerable number of service-users were assessed as requiring a service from the respective continuing care (164 clients), assertive outreach (78 clients) or primary care team (50 clients).

This may highlight some issues relating to accessing the appropriate service and the need for a clear integrated pathway through and between different teams.

It should be noted that since this audit, the local Crisis Resolution and Home Treatment Teams have commenced their operational service (from December 2004).

Conclusion:

This clinical caseload audit tool represents an attempt to achieve a compromise between practical simplicity of use and the known complexity of workload issues. Nevertheless, as with any such tool, it has to be accepted that there is always a degree

of subjectivity on the part of the auditor (practitioner) and validator in agreeing weighted ratings.

As shown by the summary findings, which are supported by the more specific findings for individual teams, there is considerable variation between individual, discipline and team caseloads, which can be summarised as follows:

a caseload sizes are greater in the Luton-based CMHTs

b caseload sizes are greater for the South of County CMHNs

c caseload sizes for CMHNs (especially South of County) are greater than for Social Workers

d caseload sizes exceeded 35 service-users for only two practitioners, both of whom were Luton CMHNs, representing a significant reduction in caseload sizes since a previous audit in 2000-01 – it is worth noting that in a survey of caseloads in six South West London CMHTs (Greenwood et al 2000), the average CMHN caseload was 30.3 service-users (range = 18 – 34), whilst the average Social Worker caseload was 13.1 service-users (range = 9 – 26)

e the average caseload size for a full-time qualified mental health practitioner = 25 service-users

f 40% of service-users were weighted as receiving enhanced CPA care

g 73% of service-users on Bedford East CMHN caseloads were weighted as receiving enhanced CPA care, and as their caseloads were generally lower, this suggests more effective caseload management than for other teams

h the number of service-users receiving enhanced CPA care on individual caseloads varies from 0 – 25 service users per practitioner, which suggests that this workload should be more equitably shared

i the number of service-users weighted as 5/5 (indicating highest priority or at greatest risk and need) on individual caseloads varies from 0 – 7 service users per practitioner, being most likely for Social Worker caseloads and suggesting the need for further attention to routine caseload monitoring, fairness in the allocation of new cases (workload) and/or the development of speciality roles for some practitioners (to engage and work with those in most need)

j some practitioners with large caseloads have a high overall risk index, which suggests the need for reviewing and routinely monitoring caseloads, to ensure equity and safe practice

k there is a general trend suggesting that those with higher caseloads offer less contact time to service-users, as would be expected, although this is subject to a few exceptions

l overall, the Luton Social Workers and Leighton Buzzard CMHT caseloads were profiled as including more service-users with greater needs

m considering McDermott & Reid's (1999) recommended maximum caseload weighting, the caseloads for 10/47 practitioners exceeded their maximum threshold of 80 weighting points, 5 of whom were Luton CMHNs, thus suggesting the need for enhanced caseload management and supervision (e.g. challenging caseloads) and/or for further resources

n whilst 2/3rds of service-users were assessed as appropriately requiring the service of Acute / CMH Teams, the remaining 1/3rd were assessed as ideally benefiting from one of the new services (CRHT, AOT, EIS), a continuing care team or primary care, raising questions about the interface between teams

Given the above, this audit highlights the potential value of systematically using a practical caseload monitoring tool in comparing caseloads between

practitioners, disciplines and teams, in highlighting relevant issues for caseload supervision and effective caseload management. As a tool that is closely based upon CPA-related criteria, this also provides another indicator and guide for the implementation of the Care Programme Approach.

Five Key Recommendations:

1 All qualified mental health practitioners are strongly recommended to maintain an up-to-date (concurrent) profile of their individual caseload using a practical caseload monitoring tool, as a method to support caseload supervision, caseload management and the fair and equitable allocation of workload and resources.

2 Following the more recent appointment of Team Managers for all CMHTs, Team Managers are strongly recommended to ensure the implementation of both clinical supervision and caseload supervision as distinct processes for facilitating effective caseload management. This would allow caseloads and workload to be challenged in a supportive atmosphere, promoting effectiveness, the use of alternative approaches, transfer and discharge.

3 Team and Service Managers are recommended to agree upper caseload weighting limits for individual practitioners, which need to take account of the additional roles and responsibilities fulfilled by some practitioners. In terms of the total caseload weighting for a full-time qualified mental health practitioner, this could be set at 80 weighting points (using this caseload monitoring tool), being reduced for those with agreed additional responsibilities. If an upper limit is not agreed and set, then: the quality of care is likely to be variable across caseloads, and in some cases this may be compromised; the team-member is likely to experience greater and possibly unacceptable levels of stress; and, there will continue to be a lack of any meaningful system for identifying caseload pressures, resource needs or any way of ensuring fairness and equity.

4 Team and Service Managers are recommended to review their specific team caseload data in forming more specific action-plans and considering the option of preparing a case for further resources.

5 It is strongly recommended that an externally validated caseload audit of the whole service is conducted on a periodic basis – the CMHT Management Team are recommended to decide upon the required frequency of service-wide caseload audits, e.g. annual or biannual, and to plan this into their service clinical audit plan.

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Table 1: Caseload Data

CMHT	No. of staff returning caseload data	Ave. caseload for full-time generic workers (range)	Total active caseload (no. of service-users)	Total weighted as >=4/5 for CPA Coord. (% of total caseload)
Luton NW CMHNs	3	33 (30 – 35)	99	37 (37.37%)
Luton SW CMHNs	3	35 (27 – 49)	105	41 (39.05%)
Luton SE CMHNs	3	36 (33 – 40)	77	21 (27.27%)
Luton Social Workers	7	19 (11 – 28)	140	47 (33.57%)
Dunstable CMHT	8	27 (21-34) (CMHNs) 21 (SWs)	98 (CMHNs) 53 (SWs) 10 (CSW)	41 (25.47%)
Leighton Buzzard CMHT	11	32 (27-35) (CMHNs) 22 (20-25) (SWs)	96 (CMHNs) 86 (SWs) 32 (CSWs) 10 (Other)	98 (43.75%)
Biggleswade CMHT	9	20 (16-23) (CMHNs)	68 (CMHNs) 32 (SWs) 9 (CSW)	46 (42.20%)
Bedford East (CMHNs only)	3	20 (19-21)	52	38 (73.08%)
TOTAL	**47** CMHT members	**Ave of 25** service-users per F/T generic worker	**917** service-users	**369 (40.24%)** service-users weighted as >= 4/5 for CPA co-ordination

Key:
CMHNs = community mental health nurses; SWs = social workers; CSWs = community support workers

Table 2: Which service is required?

CMHT	Acute / CMHT	CRHT	EIS	AOT	Cont. Care	PC	Other
Luton NW CMHNs	88	6	0	2	3	0	0
Luton SW CMHNs (for 2 CMHNs only)	30	2	0	1	13	10	0
Luton SE CMHNs	60	0	1	2	12	1	1
Luton Social Workers (for 6 SWs only)	63	3	2	7	31	6	2
Dunstable	10	2	10	2	19	12	16
Leighton Buzzard	11	4	0	0	38	64	62
Biggleswade	75	2	2	3	4	11	12
Bedford East (CMHNs only)	19	0	1	6	25	0	5
TOTALS	551 (64.4%)	23 (2.6%)	8 (0.9%)	78 (8.7%)	164 (18.3%)	50 (5.6%)	22 (2.5%)

Key:
CRHT = Crisis Resolution & Home Treatment; EIS = Early Intervention Service; AOT = Assertive Outreach Team; Cont. Care = Continuing Care Team; PC = Primary Care; Other – included Mental Health for Older People, Personality Disorder Service etc…

Chart 1: Total Caseload Weightings

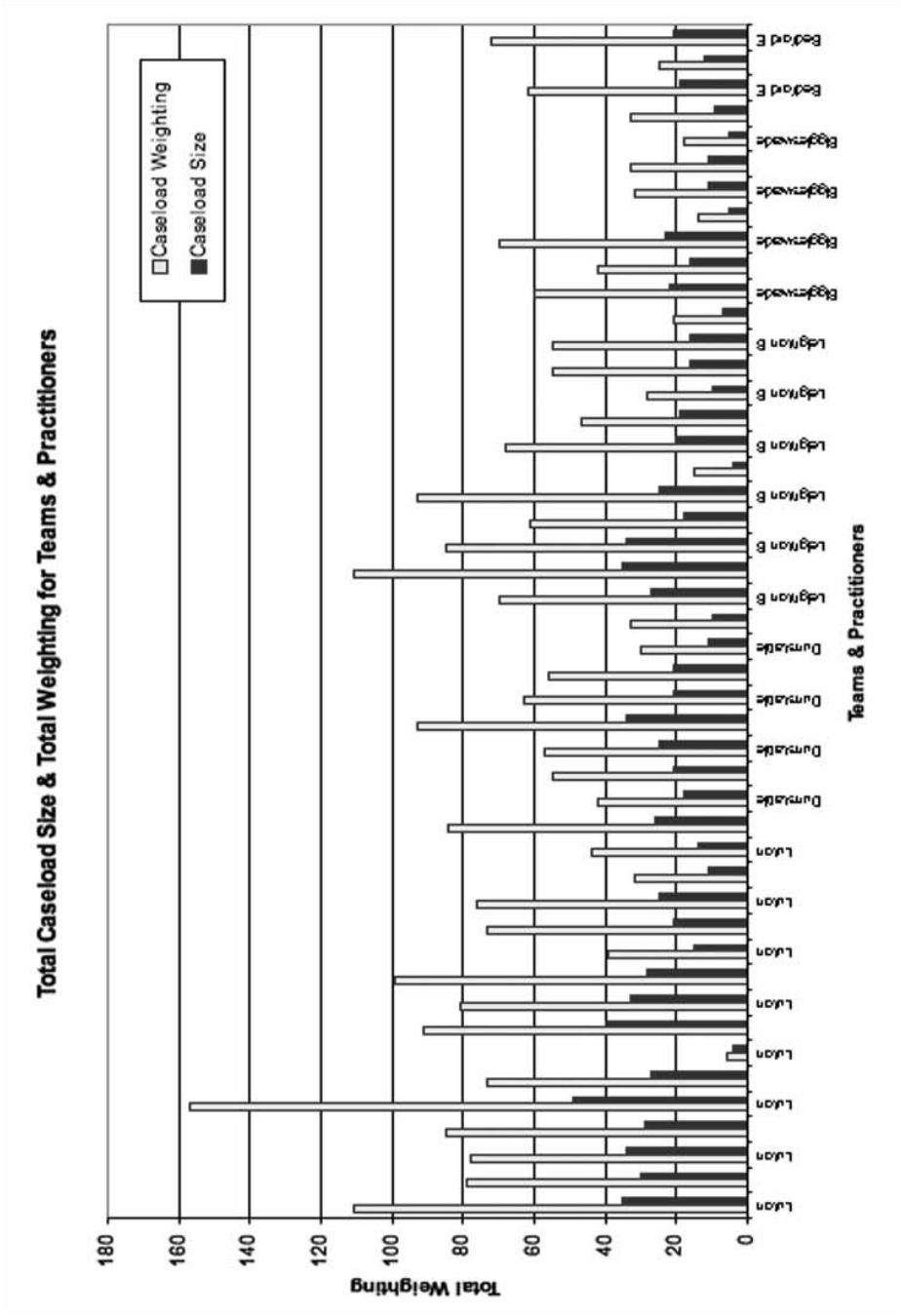
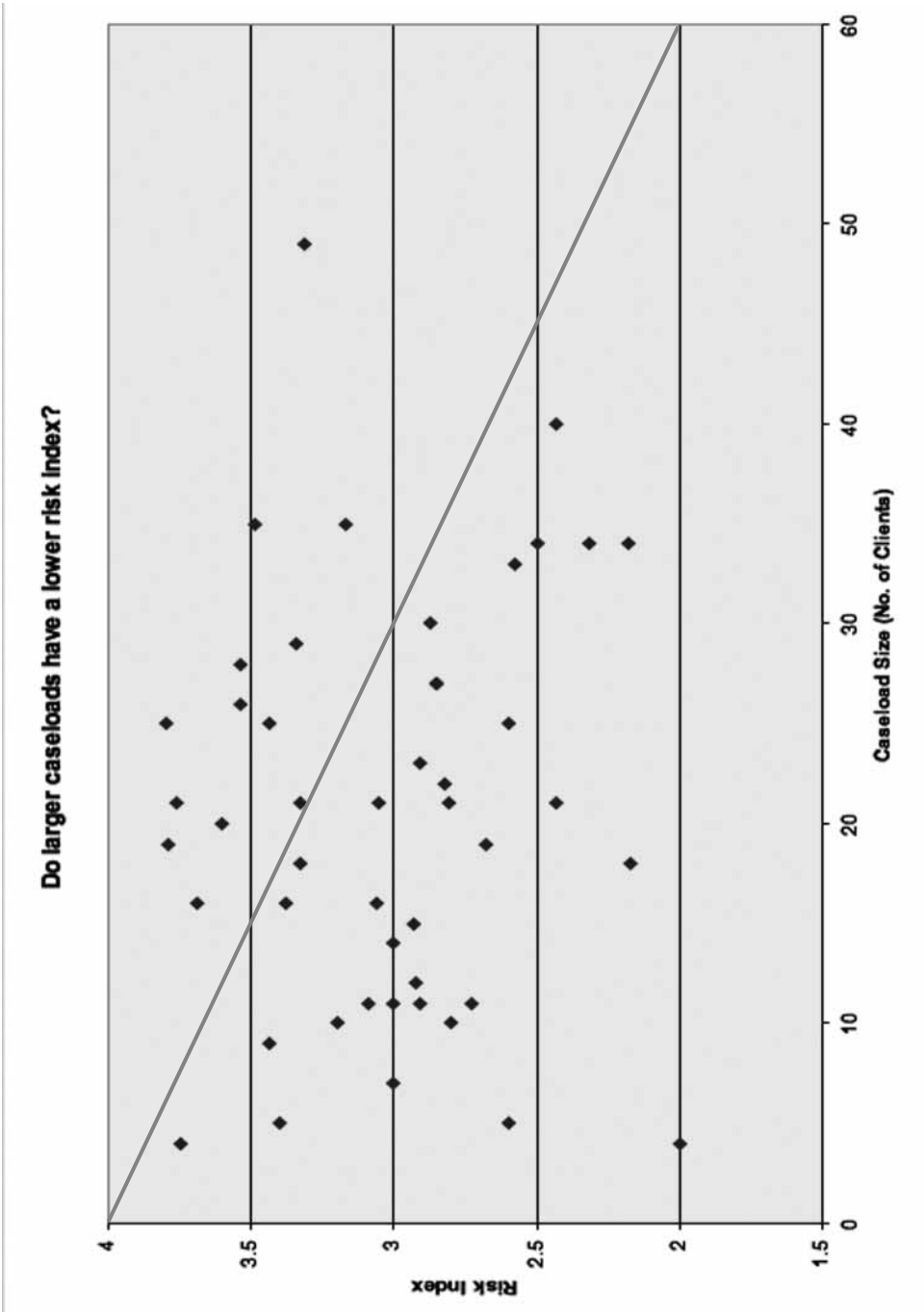


Chart 2: Average Caseload Risk Levels



Appendix: *Weighted Criteria - excerpts from audit tool*

Weightings				
1	**2**	**3**	**4**	**5**
Risk				
very low risk, with no special precautions required	low apparent risk, which is manageable; no special precautions are required	medium or significant risk, which is currently manageable; may have an history of moderate to high risk behaviour	high apparent risk but with no immediate risk to self / others / from others; history of high risk behaviour is likely	high and imminent apparent risk AND presently a danger to self / others / from others; history of high risk behaviour is likely
CPA Coordination				
requires a Standard CPA care-plan, but clinician is not the care-coordinator	requires a Standard CPA care-plan AND clinician is the care-coordinator	requires OR most likely requires an Enhanced CPA care-plan, but clinician is not the care-coordinator	requires an Enhanced CPA care-plan AND clinician is the care-coordinator; not subject to a restriction order, but may be subject to Sec. 117	requires an Enhanced CPA care-plan AND is subject to a restriction order (Sec. 2, 3, 37, 41, Supervised Discharge, Guardianship)

Patient & Carer Satisfaction: continuously improving quality for patients and carers

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SATISFACTION SURVEY

Background

The Older Peoples Service felt that a survey was necessary to involve patients and carers in the planning and delivery of care, and to evaluate the service being provided at Fountains Court (an older peoples continuing care unit for people with mental health problems and challenging behaviour).

The survey was necessary to:

- improve the quality of service;
- be more responsive to patients needs;
- be patient focussed in policy and planning decisions;
- improve communication;
- enable a clearer understanding of why and how services need to change.

This carer satisfaction survey was therefore conducted to raise standards, and design services around the choices and needs of the people being served.

Methodology

A multi disciplinary meeting took place to construct specific questions to measure satisfaction in five key areas, which were: the environment; care; food; activities; and, services.

A pilot study was conducted and then the finalised questionnaire (see appendix) was distributed to a sample that consisted of 24 carers of the Fountains Court residents.

Findings

A large number of carers (35%) were not happy about the current level of occupational therapy activities being offered and many commented that they had no knowledge of any activities.

The standard of the meals provided at Fountains Court were predominantly considered to be good (47%) and satisfactory (41%), as opposed to excellent (12%).

The Stakeholder Group did not appear to be widely recognised as only 47% of carers had any awareness of its existence and only 50% of those who did know about the group actually attended the meeting. When asked why they did not attend, the majority of carers stated that they were not aware of when the meetings were held.

70% of carers were satisfied with the standard of the in-house laundry service but the additional comments provided raised some concerns around the general care of clothes, the standard of ironing, and the mixing of colours with whites.

A number of suggestions were offered on ways to improve the services and included ideas such as playing board games, and having a photo board so that residents can identify staff.

Recommendations

1. An occupational therapist should be employed to offer regular therapeutic activity for residents.
2. A timetable of activities and therapies should be designed to inform carers about their relative's day.
3. More information needs to be offered to carers about the Stakeholder group, which needs to include the purpose of the group, how often it meets, what kind of people attend, common topics for discussion, and the availability of refreshments. It may also be worth considering changing the name of the group to make it sound more inviting and less formal.
4. The Stakeholder group needs to be publicised more widely through a variety of mediums such as posters, leaflets placed by the register at the front door, e-mail reminders to carer's personal/ home accounts, and through letters.
5. The menu at Fountains Court should be reviewed. A food-tasting day for carers / staff/residents may be a more productive and enjoyable way to involve carers and will hopefully give a more accurate portrayal of the food on offer.
6. The way that the laundry service is managed in-house needs to be reviewed. Training could be offered to staff that provide the laundry service to instruct them on the appropriate ways to care for clothes.
7. A photo board should be displayed in a prominent place in the Unit so that all residents and carers can identify members of staff.

Progressing the Recommendations

The Unit Manager, Occupational Therapy Department and Recruitment Team composed a job description and then advertised regionally for a full time Occupational Therapy Technician. Now in post, the Occupational Therapy Technician and staff at Fountains Court have successfully broadened the range of activities on offer and have produced a weekly timetable that is displayed in the Unit to keep carers informed of what is happening in the day.

The Chair of the Stakeholder group composed and sent out letters to all carers providing them with background information about the group – for example: the purpose of the group, what kind of people attend,

common topics for discussion, and the dates / times of meetings. New promotional material such as posters and leaflets on the Stakeholder group were designed, and the title of the group was reviewed amongst members and altered to reflect a more friendly and informal group meeting.

The food contractors were invited to be guest speakers at the Stakeholder group to talk about the menu and their produce. A tasting session was also arranged for carers in order to help choose the new menu range, which was also attended by the Estates Contract Manager. Comments were noted during the tasting session, resulting in finger food being added to the menu and a greater variety of soft fruit being offered.

All staff have had their photographs taken and they are now displayed in a glass cabinet in the entrance of the Unit along with their names and job titles.

The contractors in charge of the Fountains Court cleaning contract now provide appropriate training for all domestics who take care of the laundry.

Special thanks go to: Jason Chung, Maggie Nicholls & Mandy Quarmby.

For more information, please feel free to contact Louisa on 01234 299979 or Louisa.Tanner@blpt.nhs.uk

Appendix: the carer satisfaction survey

Fountains Court Carer Satisfaction Survey 2004

Recognising the importance of carers to the health and well-being of our clients, Bedfordshire & Luton Community Trust wishes to ensure that your needs are met by our services. This survey is to find out what you think of our service delivery at Fountains Court. Your opinions are very important and greatly valued as a realistic way of receiving feedback that we can use to improve our service in the future. We hope you will feel able to complete this questionnaire, and would like to assure you that your answers will be kept strictly confidential and you will not be asked to put your name or any identifying information on this questionnaire.

Q1 Do you find the environment at Fountains Court

	Yes	No
Clean	☐	☐
Tidy	☐	☐
Welcoming	☐	☐
Homely	☐	☐
Gives adequate privacy	☐	☐
Is tastefully decorated	☐	☐

Please could you tell us more?

Q2 When you come into contact with the staff at Fountains Court do you feel they give you enough:

	Yes	No
Information	☐	☐
Support	☐	☐
Help	☐	☐

Please could you tell us more?

Q3 Are you satisfied with the nursing care that your relative is receiving at Fountains Court?

Yes ☐ No ☐

Please could you tell us more?

Q4 Are you satisfied with the current level of occupational therapy and activities being offered?

Yes ☐ No ☐

Please could you tell us more?

Q5 Are you satisfied with the medical care given by the Consultant Psychiatrist that your relative is receiving at Fountains Court?

Yes ☐ No ☐

Please could you tell us more?

Q6 Are you satisfied with the medical care given by the General Practitioner that your relative is receiving at Fountains Court?

Yes ☐ No ☐

Please could you tell us more?

Q7 Are the Care Review Meetings held at a time that is convenient to you?

Yes ☐

No ☐

Please could you tell us more?

Q8 Do you feel able to contribute at the Care Review meetings?

Yes ☐ No ☐

Please could you tell us more?

Q9 Are you aware of the existence of Fountains Court Stakeholder group which meet bimonthly?

Yes ☐

No ☐

Q10 If you answered 'yes' to Q9 could you say if you attend this meeting?

Yes ☐

No ☐

Q11 If you answered 'no' to Q9 could you say why?

Q12 What do you think of the meals provided for residents at Fountains Court?

Excellent ☐

Good ☐

Satisfactory ☐

Poor ☐

Please could you tell us more?

Q13 Are you satisfied with the standard of our in house laundry service?

Yes ☐

No ☐

Please could you tell us more?

Q14 Please would you tell us about any ways that you think we could improve our services at Fountains Court that we might not have covered in our questions.

Thank you for taking the time to complete this questionnaire your responses are very important to us. Please would you return the completed questionnaire in the pre-paid envelope provided.

The Ordering, Storing and Administration of Medication in Community Homes: an audit of medication management practices

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CLINICAL AUDIT

Introduction

All of the processes that relate to the residential service-user's medication, whether ordering, storing or administering medication, are potentially high risk areas that need to be well managed within community homes.

Following the identification of problems within one community home of the Services for People who have a Learning Disability (SPLD) directorate of Bedfordshire and Luton Community Trust (BLCT), it was considered that similar problems were likely to occur in other homes. This project was thus developed to evaluate the situation within the Directorate, with a view to ensuring that the correct processes are being followed.

Aim

The aim of this project was to ensure that all elements of medication management are safely and consistently implemented within SPLD community homes.

Objectives

Three objectives were agreed for this project:

- to ensure that all staff who are able to administer medications are correctly trained to do so;
- to ensure that procedures for the ordering, storing and administration of medications are correctly implemented;
- to ensure that the right service-users are given the right medications at the right time from their own prescriptions.

Methodology

A multidisciplinary audit team was convened consisting of an SPLD Developmental Manager, an SPLD Home Manager and members of the Trust Clinical Audit Department (CAD).

It was agreed that, given the number of community homes within SPLD, it would be too difficult to carry out an audit involving all homes. Therefore, three homes were selected as a representative cross section of the service: a 'busy' home, an 'intermediate' home and a 'quiet' home.

Data collection for this audit consisted of the following elements:

- to interview all staff working in three units who were able to administer medication;
- to audit the drug cabinets and drug trolleys of each of the units;
- to audit the medication administration records (MAR's) for each service user in each of the three units.

Data collection tools were developed, approved and tested through a pilot at a separate community home. No changes were considered necessary following the pilot. One member of the audit team agreed to carry out the audit of the drug cabinet / trolley and the MARs, and the two members of CAD agreed to conduct staff interviews.

Each of the three homes were contacted and advised that they had been selected to participate in the audit and arrangements were made to visit each staff member to conduct interviews. Interviewees were reassured both at the initial contact and at the beginning of their interviews that anything disclosed would be confidential and that the interview would not include taking identifying information, thus maintaining anonymity. Interviews were recorded and transcribed by CAD team-members, following which the recordings were erased.

Following an unforeseen delay, the audits of the medicine cupboards / trolleys and the MARs were completed in January 2005. The audit of the MARs was undertaken using a revised audit tool, which had been piloted by the SPLD Nurse Practitioner. The audit of the MARs was conducted by the Nurse Practitioner and a CAD team member during April / May 2005.

Summary of Results:

1. Staff Interviews (N=19)

Seven staff-members were interviewed at each of two community homes and five were interviewed at the third home (a total of 19 staff interviewees).

- 100% (19/19) of staff said they had received training to give medication.
- 17/22 respondents indicated that training had been conducted by staff managers, and 5/22 indicated that they had been trained by external trainers (staff were able to indicate that they had received training from both sources).
- 68% (13/19) of staff said they had received initial training only.
- Approximately 50% of staff had received their training within the last 12 months.
- 100% (19/19) of staff said they felt competent to deal with medication.
- 89.5% (17/19) of staff said they had a specific member of staff in their home that ordered medication.
- 16% (3/19) of staff said that they were involved in aspects of medication management, with a further 26% (5/19) saying they were involved 'sometimes'.

2. Medication Administration Records (N=17)

Six records were audited in each of two community homes, with five records being audited in the third home (N=17).

- 100% (17/17) of service-users had a current MAR.
- 88% (15/17) of records showed that all

of the medication ordered for each service-user had been signed for upon entering the community home. This was 'sometimes' for a further 12% (2/17).

- The quantity of medication received from the pharmacy was recorded for every service-user every time – 100% (17/17) of cases.
- 100% (17/17) of service-users had been given the appropriate medication at the appropriate time, every time.
- If for any reason the service-user had not been given their medication, this was always recorded on the MAR – 100% (4/4) of cases.
- All 17 service-users were prescribed PRN (as required) medication.
- 53% (9/17) of service-users had been given PRN medication.
- Medication reviews by a doctor were carried out:
  ♦within the last 3 months for 3/17 service-users;
  ♦within the last 4-6 months for 1/17 service-users;
  ♦within the last 7-11 months for 3/17 service-users.
- There was no evidence of a medication review by a doctor for 10/17 service-users.

3. Audit of Drug Cabinet / Trolley (N=3)

For the three community homes:

- The drug cabinet / trolley was clean in all cases.
- Medicine bottles were clean in all cases.
- Medicine packages were in good order in all cases.
- Medicines were grouped by service-user in 2/3 cases.
- A staff-member was nominated as responsible for maintaining the drug cupboard / trolley in only one case.
- Records of when the cupboard / trolley was cleaned were available in 2/3 cases.
- Medication stock was returned to the pharmacy when becoming out of date in 2/3 cases.
- Unused PRN medication was returned to the pharmacy within its expiry date in all cases.
- The shelf life of all opened medication was recorded in only one case (although this was not applicable in one case).
- A medication refrigerator was available in 2/3 cases (there was no reply for the other home).

Conclusion: a discussion of key findings

Most SPLD staff that administer medications in SPLD community homes have been trained in-house, usually by the home manager or deputy, and half of those interviewed had received that training within the last 12 months. Staff comments indicated that they felt competent to deal with medication management, although most deal only with the administration and storing, and not with the ordering of medication.

It would appear that for most staff in residential units, the expectation of CSCI that they receive external training to deal with medication is not necessarily the most effective use of nursing or financial resources, if a charge is to be made for this. If required, perhaps external training could be offered to the staff members of the residential home who actually deal with the whole process of medication management. However, there were some requests from staff for more advanced training in specific areas – for example, the circumstances in which residents should not be given medication such as lorazepam, updates on the side effects of new medications or new prescriptions for individual service-users, and actions to take in the event of problems

related to giving residents their medication. Perhaps such training could be provided in the home if the leads responsible for medication management were themselves trained in these areas.

Homes have different medicine administration systems and approaches: two of these homes had computerised systems for ordering medications and one did not; there was also a difference between external pharmacy and GP pharmacy ordering processes. The residential unit that did not have the MAR system was keen to have it, as they saw it as a means of saving staff resources. Medication ordering using the MAR system is simpler, and medications come ready labelled for ease of checking and storing. It was also felt that the MAR system reduces the possibility of running out of medications as it consists of a four-week on-going process. However, the audit of the MAR type information did not find significantly different levels of compliance with the criteria, indicating that the medication management in the GP pharmacy home is, in practice, being conducted as well as in the other homes.

Related to the medication ordering processes was the request from staff that pharmacies deliver medication to the homes. The rationale given for this was to save staff-members time and minimise problems relating to ordering. Concern was also raised that regular collections of medications by staff-members could be noted externally, with staff being open to attack and the potential for medicines to be stolen. This request seems to be a sound one, and it might be that service agreements with pharmacies, whether these are GP or external providers, should insist that this occurs.

There are also different systems in place for actually giving medication to residential service users: two homes brought residents to the office and the other took medication to the residents. There also seemed to be differences in how the medication was given to residents: either in a medication dispensing 'cup', or on top of a 'carrier', such as a yoghurt, although staff were very clear that they did not try to hide the medication and always advised the resident that they were being given it. Perhaps the greatest difference was the practice of giving residents medication such as lactulose from a general supply, rather than from the individual's own prescription in one of the homes. Staff from the home that used carriers and general store medicines seemed to be most concerned that they ensured their residents were aware that they were being given their medication, but less so about the practice of giving medication from a general source rather than the residents own prescribed source.

When it came to the storage of medications, one home did not have a medicine refrigerator, two of the three homes grouped medications in drug cabinets by resident rather than by medication, and no home had a medication trolley. Drug cabinets and individual medicine bottles / packages were found to be clean and sound. In one home, there was a nominated member of staff responsible for cleaning the medicine cupboard, and recording when cleaning took place was carried out in two of the three homes. Staff comments related to the drug cabinets centred around the lack of space for medications, leading to a request for larger cabinets. Larger cabinets would certainly help to address the problems that can be caused if two or more residents who are prescribed the same medication, have their medications located together in the drug cabinet – medication could be more easily re-located and separated onto different shelves or areas of the cabinet. All these suggestions seem to be sound and reasonably simple to implement.

The recording of medication management was generally extremely well done in all homes audited. However, there are some issues surrounding PRN medicines. Firstly, the recording of the results of PRN administration, the initials of staff making the recording and the time of the recording of the results of PRN administration were not generally carried out by home staff. This represents an area for review which will need to involve advising staff of what is expected of them. Staff also commented that many PRN medications are actually given regularly, which highlights the need to re-prescribe as regular medication.

When looking at how long it had been since residents in the three homes had last had a medicine review by a doctor, it was found that seven of them had had a review within the last 12 months. However, for ten of the nineteen cases, no evidence could be found of a review. This is of major concern and highlights the need to share the findings with medical colleagues in SPLD, with a view to implementing standardised practice standards for reviewing medication – for example, that a medication review will take place for every SPLD community home resident at least annually. Doctors will also need to ensure that information relating to medication reviews is clearly recorded in the resident's records.

Many staff members discussed the difficulty of medicine packaging, for example, bottles of tablets with hard to open lids, which sometimes has resulted in tablets spilling onto the floor. This appears to be of major irritation to staff, many of whom asked that blister packs of tablets are supplied instead of bottle containers.

There was a difference of opinion in staff about the best way to count out and administer medications. The general practice is for two members of staff to focus on the medication preparation in order to reduce the chance of medication errors taking place. However, they were honest enough to say that it was not always given their full attention – especially if they were the one not actually physically dispensing the medicines, but observing the other member of staff. Two related issues were raised: a suggestion was made that if one person was responsible for preparing the medication alone, they would be more likely to give this task their full attention; secondly, it was mentioned that when the home only has a staffing level of three workers, and two of them are dealing with medication preparation, only one staff member is left to deal with any issues that might arise with the residents. Whilst there are requirements for nurses to be observed when dispensing and administering controlled medicines, perhaps the Directorate might consider whether it would be possible for one member of staff to manage the preparation of non-controlled medicines. However, if this approach is to be considered, it would be important to ascertain the feelings and concerns of staff and professional bodies prior to implementing any changes in practice.

Recommendations

Upon completion of this audit, a number of recommendations were made:

1. SPLD community home staff should be formally thanked for participating in the project and commended on the generally high standard of their medication management.
2. SPLD should consider the best form of medication-related training to be provided to community staff. It is recommended that SPLD consider providing external training (e.g. that provided by Pharmacies) only for staff that will be completing the full medication management process and that these staff members cascade

training, which should include updates on medication indications and contraindications, to other team members that are not involved in the whole medication management process. It is recommended that externally trained staff are best placed to advise other team members about medication administration problems, as discussed above, once they have been trained themselves. It is further recommended that regular training updates related to medication management should be provided in the homes, each 3 – 6 months, and be recorded in the home records when it takes place.

3. SPLD to consider implementing the MAR system in all the community homes.
4. SPLD to consider implementing agreements with pharmacies to deliver all medication to all community homes.
5. SPLD community home staff to be advised that the practice of dispensing medication from a general store is not acceptable and that they must use the resident's own prescriptions.
6. SPLD to consider a review of medication cabinets / trolleys / fridges in ensuring that there is enough space for each resident's medications to be safely stored in all community homes.
7. SPLD community home staff should implement a system for the regular cleaning and clear out of medication cabinets / trolleys / fridges, where appropriate, with a view to returning unused, out-of-date or un-needed medication, thus reducing storage space requirements. These should be documented in the homes records.
8. SPLD community home staff should seek ways of separating each resident's medication, where two or more residents are on the same medication, in order to reduce possible errors in administration.
9. SPLD should consider the supply of tablets to all community homes in the form of blister packs, wherever this is possible.
10. SPLD to consider changing the practice of two staff members being involved in medication preparation to one person, wherever this is possible. The opinions of staff and the professional body should be sought prior to any such implementation, which, in any event, may best be achieved as a pilot study within a few community homes.
11. SPLD to implement a system for ensuring regular medical reviews of each resident's medication, and ensuring that medical staff correctly document these in the resident's personal records.

Action Plan

In completing the audit cycle, an action-plan based upon the findings and recommendations has been agreed, as shown in Table 1.

Table 1: *Action Plan*

Recommendation	Action	Timescale	By whom
SPLD to ensure external training is provided by pharmacies as required by CSCI.	Senior Managers to liaise with local pharmacies to provide training.	March 2006	SPLD Senior Managers
Organise limited external training (& secure funding).	Funding to be provided by SPLD.	April 2006	SPLD Associate Director in liaison with BLPT Financial Director
Medication update from staff to staff relating to management of medication.	Meetings to take place. Actions to be recorded	Quarterly from January 2006	Home Managers
SPLD to consider implementing MAR system in all community homes.	Investigate the possibility of implementing the MAR system.	January 2006	Home Managers & Development Managers
To investigate implementing a local agreement with pharmacies for delivery to all community homes.	Enter into discussion with local pharmacies.	ASAP	Home Managers
Dispensing of medication from a general store must end.	All residents to have their own prescriptions and be given medication from these.	ASAP	Home Managers
Adequate storage to be provided for the safe storage of all residents medication.	Home Managers to ensure medication is properly stored.	ASAP	Home Managers
Medicine cabinets to be kept clean. Unused or out-of-date medication to be properly disposed of.	Each Home Manager to identify a system for the disposal of medicines and a cleaning rota.	ASAP	Home Managers
Each home to consider using blister packs or dosette boxes to avoid confusion with residents who are on the same medication.	Each Home Manager to negotiate with the local pharmacy.	ASAP	Home Manager
Each home to ensure that regular reviews of residents' medication takes place.	Reviews must be documented in the resident's personal folder.	ASAP	Home staff, Home Manager and Medical Practitioners

An Evaluation of a Memory Clinic in Mental Health for Older Peoples Services (MHOP)

Swee-In Blackeby[1] & Mandy Quarmby[2]
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SERVICE EVALUATION

Introduction

A memory clinic was established in the South of the county in May 2004, to run as a pilot project in the first instance. The clinic is a one-stop assessment centre, at which attendance is for a continuous 4 week period, culminating in the service-user being given a diagnosis. This should greatly reduce the waiting time service-users were previously experiencing for their diagnosis and the anxiety levels for both the service-users and their families / carers.

An evaluation of the clinic was identified as a priority on the 2004-5 clinical audit forward plan for the MHOP directorate, to ensure that any problem areas could be identified prior to this service being implemented across the county.

Aim

The effectiveness of the memory clinic is assessed.

Objectives

- ☐ To ensure the memory clinic meets the needs of the service-users and their carers.
- ☐ To ensure the GP referrers are clear about the process for referral and are satisfied with the information provided and feedback received.

Methodology

After some discussion, the audit group decided it was not appropriate to survey service-users who had attended the clinic, as the nature of their condition may mean that the responses they gave could be unreliable. There was a further risk that this vulnerable group of service-users may find the survey distressing or confusing if they did not have a good recollection of attending.

The group decided to focus the project on the views of the carer/ family and the referrer (the client's GP) for which two questionnaires were designed (see appendix).

Following a pilot of both questionnaires, no changes were necessary. The referrer's survey was sent out to all GPs who had referred clients to the clinic since it's opening in May last year. The carers survey was sent to the carer or identified family member of all service-users who had attended the clinic to date. The questionnaires were despatched by the clinic in order to protect service-user identities and a prepaid envelope was included to increase the return rate.

Summary of Findings

A total of 16 GP referrers and 44 carers completed the survey.

- 14/16 (87.5%) GPs were aware of the existence of the memory clinic.
- 11/16 (69%) GPs stated they were satisfied or very satisfied with the information they received following their patient's appointment and that this information answered their questions or addressed their concerns.
- Following their patient's visit to the clinic, 14/16 GPs reported they had found the service beneficial (2 GPs did not reply to this question). The same number stated that they had also received sufficient information regarding the carer's ability to care for the patient.
- Half of the GPs felt they had received sufficient advice on how to provide support for the carers and 9 GPs (56.5%) had received information on contacts for providing additional support.
- Favourable comments were received commending the service, and one suggestion was for the Trust to provide an information booklet detailing all the services in the area.
- The ethnic group of the majority of service-users (95.5%) attending the memory clinic was white British.
- 36/44 (82%) carers felt either satisfied or very satisfied with the quality of the information they received prior to the appointment, with 31/44 (70%) reporting satisfaction with feeling prepared for the clinic visit.
- All carers stated that the politeness and patience of the memory clinic staff was good or very good, with 42/44 (95.5%) rating the helpfulness of staff as good or very good.
- 41/44 (93%) carers stated they had had the detail of how the assessment would be carried out explained to them and 29/44 (71%) reported fully understanding the assessment.
- There were many positive comments made about the interviewing of carers separately from their relative.
- When asked to evaluate the diagnosis, 77% of carers rated the clarity of the explanation as good or very good, and the detail given was rated as good or very good in 79% of respondents. 80% of carers reported that the way in which the diagnosis was given was good or very good and 82% felt the opportunity to ask questions was good or very good.
- 37 carers reported that the test results were explained to them and 27 of these said they had fully understood the results.
- A variety of information was given out to carers, and although not all carers received all the information, this may have been because it was not required or appropriate.
- Only 3 carers reported that they were not very satisfied with the usefulness of the clinic, with 70% of carers rating themselves as fairly satisfied, satisfied or very satisfied with their ability to cope from now on.

- 35 carers (80%) were fairly satisfied to very satisfied with the use of their time in attending the clinic.
- A total of 33 carers (75%) were fairly satisfied to very satisfied in how the clinic addressed the needs of their relative / friend.
- 37 carers (84%) rated their satisfaction between fairly satisfied and very satisfied in how comfortable they were made to feel at the clinic.
- 41 carers (93%) were satisfied with the cleanliness and heating at the clinic and 43 carers (98%) were satisfied with the welcoming nature of the clinic environment.

In summary, the majority of GPs were aware of the existence of the Memory Clinic and found the service to be beneficial. The main area for development was highlighted as being the provision of support to carers. The feedback received from the carers was very positive, with a particular emphasis on how sensitive staff had been when helping them through a potentially upsetting process.

Conclusions

It was concluded that there is a need to review the information given to GPs on how to provide support for carers. It is important for staff to be aware that information given to carers at the diagnosis stage may be difficult to absorb.

This pilot clinic is clearly fulfilling a need for GPs, service-users and carers and speeds up the diagnosis stage of each service-user's condition. This accelerated process results in reduced anguish for the service-user and carer alike, which in turn improves the patient experience.

Recommendations

1. To write to GPs asking them which additional information and advice they would like to have, to enable them to provide fuller support for the carers.
2. At the stages of explaining the assessment process and giving results, staff need to consider whether repeating certain aspects of the information, where they feel the carer may not have fully understood the detail, would enable the carer to gain a fuller understanding.
3. To follow up carers with a telephone call after the last appointment, to see whether they require more information or a further explanation of anything covered at the last appointment.

These recommendations were formed into an action-plan upon completion of the audit.

Special thanks go to:
Sarah Jeffrey (Assistant Psychologist)
Reena Bhatt (Assistant Psychologist)
Seema Jassi (Clinical Data Analyst)
Hajra Ali (Clinical Audit Assistant)

For more information, please feel free to contact: Swee-In Blackeby.

References

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Appendix: Survey Forms - Carer Survey & GP Referer Survey

Memory Clinic Audit - February 2005
Carers' Survey

You may recall that you recently accompanied a family member/friend attending the Memory Clinic at Limetrees, to which they would have been referred by their GP. The Memory Clinic is in fact a pilot scheme that has been running for the past year. This service is currently only available in the south of the county but we hope that it can be offered in the North too. In order to improve the quality of the service we provide and to ensure we are meeting the needs of our clients and carers we would appreciate some feedback on your experience of the Memory Clinic. We would be grateful if you would complete this short questionnaire and return it to the address shown overleaf, in the prepaid envelope provided. We thank you in anticipation of your support.

Q1 Please indicate the ethnic group of the family member/friend who attended the memory clinic:

- White British ☐
- White Irish ☐
- White Other ☐
- Indian ☐
- Pakistani ☐
- Bangladeshi ☐
- Other Asian Background ☐
- Chinese ☐
- Black Caribbean ☐
- Black African ☐
- Other black background ☐
- White and Black Caribbean ☐
- White and Black African ☐
- White and Asian ☐
- Other mixed race ☐
- Not stated/unknown ☐

Q2 Please complete the grid below to indicate how satisfied you felt with the following, prior to attendance at the clinic:

	Very Satisfied	Satisfied	Fairly Satisfied	Not Very Satisfied	Very Un-satisfied
Quality of information received	☐	☐	☐	☐	☐
How prepared you felt for your visit	☐	☐	☐	☐	☐

Please add any further comments:

Q3 Please use the grid below to indicate your evaluation of staff on the following:

	Very Good	Good	Fair	Bad	Very Bad
Politeness	☐	☐	☐	☐	☐
Helpfulness	☐	☐	☐	☐	☐
Patience	☐	☐	☐	☐	☐

Please add any further comments:

Q4 Was the detail of how the assessment would be carried out explained to you?

- Yes ☐ Go to Q5
- No ☐ Go to Q6

Q5 If yes, did you understand the assessment:

- Fully ☐
- Partly ☐
- Not at all ☐

Q6 During the session we interview you and your relative/friend separately, how did you feel about this?

Please turn overleaf

Q7 **Please complete the grid below to evaluate the diagnosis on the following:**

	Very good	*Good*	*Fair*	*Bad*	*Very Bad*
How clear the explanation was	☐	☐	☐	☐	☐
How detailed the explanation was	☐	☐	☐	☐	☐
The way in which it was said to you	☐	☐	☐	☐	☐
Your opportunity to ask questions	☐	☐	☐	☐	☐

Q8 **Were the results of the psychological tests, medical tests and occupational therapy assessment explained to you?**

Yes ☐ Go to Q9

No ☐ Go to Q10

Q9 **If yes, did you understand the results:**

Yes, fully ☐

Yes, partly ☐

No, not at all ☐

Q10 **Please add any further comments you may have regarding the diagnosis or results:**

Q11 **Please tick all that apply. Following the diagnosis I was given information regarding the following:**

How I can help my friend/relative ☐

What may happen in the future ☐

Social support available ☐

Legal issues ☐

Services and care available ☐

Financial benefits available ☐

Please add any further comments you may wish to make about the information you were given:

Q12 **Please tick as applicable to rate how satisfied you felt on the following, after attending the clinic:**
(1=Very Satisfied, 5=Very Unsatisfied)

	1	*2*	*3*	*4*	*5*
Usefulness of visit	☐	☐	☐	☐	☐
Ability to cope from now on	☐	☐	☐	☐	☐
Use of your time	☐	☐	☐	☐	☐
Addressing the relative/friend's needs	☐	☐	☐	☐	☐
How comfortable you were made to feel	☐	☐	☐	☐	☐

Q13 **Please indicate whether you were satisfied with the environment of the memory clinic:**

	Yes	*No*
Cleanliness	☐	☐
Welcoming	☐	☐
Adequately Heated	☐	☐

Q14 **Please enter any further comments regarding your experience of the memory clinic that you would like to share with us:**

Thank you for completing this questionnaire, your views will help us to improve the quality of the service we give to our clients.

Memory Clinic Audit February 2005- GP Referrer's Survey

As you may be aware we have been running a memory clinic since last May and we are hoping to evaluate how effective this service has been. In order to assist the Trust in an audit of the Memory Clinic, we would be grateful if you could please complete one of these data collection forms to provide some feedback on your experience of contact with this service. The memory clinic is in fact a pilot scheme which has been running for the past year and your comments will help us improve the quality of this valuable service, with a view to rolling out the service across the county.

GP Practice Name.....

Q1 **Were you aware that this service was available?**

Yes ☐

No ☐

Q2 **After your patient had been assessed in the clinic, please rate your satisfaction with the information you received on the following: (1=Very Satisfied, 5=Very Unsatisfied)**

	1	2	3	4	5
The diagnosis	☐	☐	☐	☐	☐
Patient's psychological & behavioural condition	☐	☐	☐	☐	☐
Patient's somatic condition	☐	☐	☐	☐	☐
Patient's functional competence	☐	☐	☐	☐	☐

Q3 **Please add any comments regarding the information you received on the patient's condition:**

Q4 **Did the information you receive answer your questions and address your concerns?**

Yes, completely ☐

Yes, partly ☐

No ☐

Q5 **Subsequent to receiving the memory clinic diagnosis, did you find the referral to this service to be beneficial?**

Yes ☐

No ☐

Q6 **Did you receive sufficient information regarding the carer's ability to care for the patient?**

Yes ☐

No ☐

N/A/no carer ☐

Q7 **Did you receive sufficient advice on how to provide support for the carers?**

Yes ☐

No ☐

N/A/no carer ☐

Q8 **Did you receive information on contacts which may be useful in providing additional support for the patient?**

Yes ☐

No ☐

Q9 **Is there anything not provided by the clinic that would be useful? Please comment:**

Q10 **Please add any comments or suggestions on your experience of the memory clinic:**

Thank you for completing this questionnaire, your views will help us to improve the quality of service we give to our clients.

A Week in the Life: an Approved Social Worker in an Assertive Outreach Team

by Jill Gale
Approved Social Worker
Assertive Outreach Service, Luton
Bedfordshire and Luton Mental Health and Social Care Partnership NHS Trust

PRACTITIONER DIARY

Monday

A social work student starts her placement with me today. She is very enthusiastic and I'm sure her questioning will challenge my knowledge and my practice.

I take her with me to undertake a Mental Health Act Assessment on an Acute Ward. I am not on duty today but have to cover as the duty ASW has gone off sick. It gives my student an insight into the difficulties of carrying out an assessment that I have not set up which leads to some communication problems with the GP. As ASWs, we try to accommodate GPs in assessments where practical, as this is best practice. I am concerned that a confusion over the assessment time will alienate this particular GP who will then not be willing to attend in the future.

Tuesday

A day of meetings! This morning I attend a meeting for social workers and social care staff in our area. It is an opportunity to preserve our professional values and roles, which we are concerned may be eroded now we are part of the new Partnership Trust. An ASW stresses the importance of using GPs in Mental Health Assessments – an issue that I had been reflecting on only the day before.

In the afternoon, I am the Union Representative for a meeting to discuss issues for social care staff being transferred into the Trust. The subject on today's agenda is training provision. I ask about the opportunities for staff to access training across different disciplines. I am mindful of a health support worker I have advised who is considering social work training. There is some discussion around future training for a combined nursing and social work degree. I wonder what the future is for Social Workers – my chosen profession?

Wednesday

I attended ward round today, accompanied by my student, for our clients who are currently in-patients. Our consultant uses the ward

round as a teaching session, especially when students are present. However, there is always the dilemma of large ward rounds, which enable students to learn but can affect the client who can be intimidated by the large number of people.

After ward round, I have a difficult meeting with a carer. She is finding it hard to let go of her 30 year old son with a diagnosis of schizophrenia. I feel some progress is made as she discusses her past which gives insight into her attitude as a carer.

Thursday

I'm attending a CPA review meeting for a carer's son – from yesterday. The carer is present and manages to relinquish some control. Her son is very unwell but her level of support is maintaining him in the community. I also assessed a 17 year old girl in the community who is an active drug user. I decide that there are not grounds to detain her, much to her mother's dismay, as she wants her daughter to be safely locked up away from harm.

Friday

I visited a client with a diagnosis of bipolar disorder at day care. I am pleased with how he was coping with this new activity which seems to have improved his concentration span. I am glad that I had referred him.

I make a whistle-stop tour to three clients with my student in the afternoon. This is not the ideal way to wind down before the weekend. I continued working with one man on relapse indicators. Sometimes it is difficult to find common ground with this client because his cultural perceptions of mental illness are beliefs that he can not relinquish. I wonder if there is some way for him to understand his mental health problems that fits with his beliefs – as why should he embrace mine.

Writing for the Journal

GUIDELINES FOR CONTRIBUTORS

Practitioners and clinicians are encouraged to share their work through this quarterly multi-professional publication of the Bedfordshire & Luton Mental Health & Social Care Partnership NHS Trust, produced with the aims of:

- informing practitioners and clinicians about innovative practices taking place in Bedfordshire
- promoting learning and development and, in particular, its impact on clinical practice
- sharing and advancing good clinical practice, clinically effective and evidence-based practices

Articles, reports & ideas for content are welcomed on the following:

- an outline of an innovative clinical practice
- an outline of a recent or current audit, project or research study
- the development of a new clinical tool / resource
- the outcome of a partnership initiative
- the impact of learning and development on practice
- service-user and carer experiences
- the service-user's personal story

- the carers personal experience
- short reports on the latest research findings which impact on clinical practice
- recommended resources and web-sites
- where to find recent, new and forthcoming national and local guidance and publications
- discussion forum / letters

Format for Submission:

Reports and articles for submission should be saved as Microsoft Office compatible files.

Reports, articles and suggestions for content should be submitted either on a virus-free floppy disc or via e-mail (preferably) to the Editor.

Length:

Main articles should be 1500 – 3000 words in length and research reports, reviews and short articles should be 500 – 1000 words.

Author(s):

Remember to include the names of all of the authors, each with job title and qualifications.

Referencing Style:

In the text, cite the authors' names followed by the date of publication. If there are three or more authors, the first author's name followed by 'et al' will suffice. If more than one reference is cited for the same authors, they should be cited in chronological order. Contributors should follow the examples shown below for referencing style.

Llewelyn S (1998) Challenging the Vicious Cycles. *Mental Health Care* 1(7): 236-238

Blackburn IM & Twaddle V (1996) *Cognitive Therapy in Action*. Souvenir Press, London.

Williams JMG (1997) Depression. In: Clark DM & Fairburn CG (eds) *Science and Practice of Cognitive Behaviour Therapy*, 259-284. Oxford University Press, Oxford.

Submissions:

Please send submissions to:

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All submissions will be reviewed by at least two members of the editorial panel.

Please Note:
handwritten scripts cannot be accepted

A free book / voucher will be offered to the authors of two articles per edition, as randomly selected by the editorial panel.

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