clinical time available for fulfilling health service contracts and income generation. It may also have an impact on the quality of care received by service consumers.

As such, the time devoted to audit should also be subject to cost benefit analysis. In other words audit must itself be audited. I should be very interested to hear from the Working Group how this might be done.

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DEAR SIRS

Dr Halstead has rightly drawn attention to an important point. In the College's response to the White Paper *Working for Patients* with a reference to the *Bulletin*, we have recommended one session per week but did point out the resource implications of this.

However, it is important to emphasise that the mere collection of data is *not* audit. Audit must be a continuous cycle of setting standards, evaluating practice and then putting the recommendations into action. Its sole purpose is to improve the quality of care. A recent leader in the *British Medical Journal* of 13 January 1990, refers to this process as "the closing of the feedback loop", without which "audit may be little more than a pious exercise in self congratulation".

I am grateful to Dr Halstead for drawing attention to the problem of time. Particular difficulties may arise when doctors hoping to get together for a lunch-time meeting, are in an institution which is divided into several sites, separated by horrendous traffic jams and inadequate public transport.

There is no single solution but we hope to publish some examples of good practice in psychiatric audit after the next series of meetings of the working group.

Dr ANN GATH
Registrar

Clinical audit in mental handicap

DEAR SIRS

The clinical audit for the psychiatry of mental handicap is difficult to measure as, in this particular branch, the multidisciplinary approach is crucial and the overlap of socio-economic and cultural factors, combined with the verbal communication problems of the patients, requires time to identify the diagnostic problems and to assess, treat, manage and support the patient and his family in or out of the hospital environment, in community facilities etc.

Over the past ten years we have developed the following procedure for mentally handicapped patients referred to the consultant psychiatrist in mental handicap for assessment and treatment and we are using this procedure in order to standardise the criteria for clinical audit in mental handicap.

We are interested in the views of colleagues about this issue and their methods of measuring clinical audit in mental handicap.

Clinical Audit Procedure

(1) *Prior to admission*
- (a) Written referral from GP.
- (b) Visit by community nurse for information on circumstances and background.
- (c) Visit by social worker for information on social background.
- (d) Out-patient appointment and/or admission to unit if acute psychosis or behavioural problems presented.

(2) *On admission*
- (a) Examination by GP (local GPs cover admission), physical examination and relevant investigations, e.g. FBC, LFT
- (b) Examination by psychiatrist or registrar for assessment, observation, any special investigation, e.g. EEG, thyroid function, blood, glucose, serum anticonvulsant levels monitoring, scanning, specialist referral eg, neurologist.

  GPs carry out physical examination and make referrals for medical or surgical opinions
- (c) Review and follow-up by consultant psychiatrist/registrar once or twice a week as necessary.
- (d) Nursing staff and multidisciplinary team observation and assessment. Individual patient plans (IPPs).
- (e) Clinical psychologist assessment, tests and advice, help in behavioural modification programmes.
- (f) Physiotherapist, occupational therapist, speech therapist, social worker, nursing staff, care assistants, community nurses, relatives whenever possible, and other relevant staff.

(3) *On discharge*
Clinical meeting and review of progress with community nurse, social worker involvement in regular follow-up: day-care, ATC etc.

(4) Discharge letter to GP; copy to community nurse.

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