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RE-AUDIT OF PHYSICAL EXAMINATION ON ADMISSION

Andrew Drury, Erik Eriksson, Rebecca Marriott, Christopher Symeon & Jeni Chan
Aubrey Lewis House, Maudsley Hospital, Denmark Hill, London, UK

SUMMARY
Re-audit of the physical examination of older adults admitted to one of two inpatient Older Adult wards at the Maudsley Hospital found that on admission, only 58% of patients had a brief physical examination and 43% had a full physical examination, and after 72 hours only 65% had a full physical examination. This is a slight improvement on the previous audit but still falls short of the target of 90% of patients having a full physical examination within 72 hours of admission. Recommendations include education of junior and senior doctors of the need for physical examination via presentation of audit and distribution of results, consideration of the use of a proforma to gather information on physical examination which may have been done in an acute hospital and a further re-audit to see if outcomes have improved.

Key words: *physical examination - older adults - mental health - South London and Maudsley NHS Foundation Trust*

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BACKGROUND

Limited research has been done on the ability of old age psychiatrists to accurately diagnose physical illness.

A study where a physician's assistants used using a standardized medical history form detected nearly three times as many physical illnesses as the psychiatrists (D'Ercole et al. 1991). However another study by Tench et al. found that old age psychiatrists were as successful in identifying physical illnesses in elderly people as other specialists (Tench et al. 1992).

A detailed physical examination is expected to be performed by the admitting Core Trainee (CT) 1-3 doctor (formerly SHO grade) on admission to any inpatient ward. This is especially important when treating older adults but can prove to be difficult in some circumstances and arrangements may need to be made for it to be completed at a later date (Rodda et al. 2008). The Oxford Handbook of Clinical Psychiatry (Semple et al. 2009) lists five reasons for performing physical examination in psychiatric patients:

- Physical symptoms may be a direct result of psychiatric illness (e.g. alcohol dependency, eating disorders, neglect in severe depression or schizophrenia);
- Psychiatric drugs may have side-effects (e.g. EPSEs and antipsychotics, hypothyroidism and lithium, withdrawal states);
- Physical illness may exacerbate psychiatric illness;
- Occult physical illness may be present;
- In the case of later development of illness (or more rarely, medico-legal cases) it is helpful to have physical findings documented.

The interaction between physical and mental health has recently been highlighted by the RCPsych campaign "No health without mental health", and improvement in physical health care has been targeted by the South London and Maudsley (SLAM) NHS Foundation trust in general and particularly within the older adult directorate.

Physical examination on admission to an Older Adult ward was audited in January 2010 by Dr Davis, and it was found that less than half the newly admitted patients had a full physical examination done at their initial clerking. Recommendations from the original audit included:

- Ward doctors should be aware of the importance of a full physical examination;
- The lack of recent examination is flagged up, e.g. on ward-round patient lists so that it is not forgotten to re-offer this at an appropriate time;
- Use of a proforma to request copies of medical notes of those patients who have been through A&E to gain access to recent clerking, physical examination, investigations and formulations;
- Data on physical examinations on admission to be re-audited in six to twelve months.

WARD EXPERIENCE

On the ward, we have found that physical examination may be delayed or omitted at admission, and that this may not be flagged up until there are problems. For example:

- Admission often takes place at crisis points, and patients may be too unwell to co-operate fully in a physical examination. While this may preclude full examination, we would hope that brief documentation of physical state would be made in the majority of these patients, and that full examination would be carried out when patient is calmer: 72hours being a reasonable time-frame.
- Given time pressures, physical exam might be omitted if patients were transferred from medical settings, where it could be presumed they would have been investigated for physical problems. However, this would only be valid if there is a

handover from the medical setting: preferably A&E or ward notes, ideally scanned onto ePJS.

- We suspect that full examination on admission is more likely to be omitted when the patient is admitted out of hours, and therefore clerked by the duty doctor. The ward doctor may have more interest in the objectives of an examination. We wondered whether examination was more likely if the patient was known to have a physical illness.
- In urgent situations, it is useful to be able to find documentation on the most recent detailed physical examination immediately. This would be best facilitated if it were filed under the assessment tab, but this is rarely done.

AIM

To survey the notes of 60 patients admitted to Aubrey Lewis 1 (AL1) and Aubrey Lewis 2 (AL2) wards (older adult inpatient wards) from 1st March 2010, to look for the presence of physical examination in the first 72h of admission, and note any positive or negative contributory factors based on the above observations: patient factors; admission from medical setting; clerking by duty doctor; physical co-morbidity.

DEFINITIONS

- Physical examination - any documentation of physical health made by contemporary observation;
- On admission - documented by the doctor performing clerking at ward of admission and on day of admission;
- Brief exam - documentation of observations (including but not limited to: conscious level, speech, limb use and gait, skin tone and perfusion, comfort at rest) along with any objective vital signs measured;
- Full exam - documentation of examination of general health, respiratory, cardiovascular, abdominal and nervous systems including some objective vital signs;
- Height and weight excluded, as these usually done in nurse's admission protocol. Blood tests, ECG etc. also not considered.

TARGETS

Suggested targets for this re-audit same as initial audit:

- Physical exam on admission: 90% at least brief;:
- 75% full if not objecting or documentation from elsewhere;
- Within 72h: 90% full.

METHOD

The audit was carried out by two ward doctors from AL1 ward and two ward doctors from AL2 ward. The ward admissions book on each ward was used to identify admissions from 01/03/2010. The first 30 admissions from this date on each ward were identified and data collected on these 60 patients using the electronic Patient Journey System (eJPS) clinical notes summary. Paper notes were not searched for transfer documentation from medical settings as this was a retrospective audit and paperwork was not always readily available. The data was transferred to a spreadsheet, with cases identified by hospital number and age and pie charts generated of the data.

RESULTS

Patient and admission characteristics

60 cases were studied with an age range of 53 to 95 years of age and a mean of 76.8 years. They were admitted on dates between 11th March 2010 and 9th July 2010. Slightly more than a third was admitted from the community and just over half from medical or other psychiatric wards.

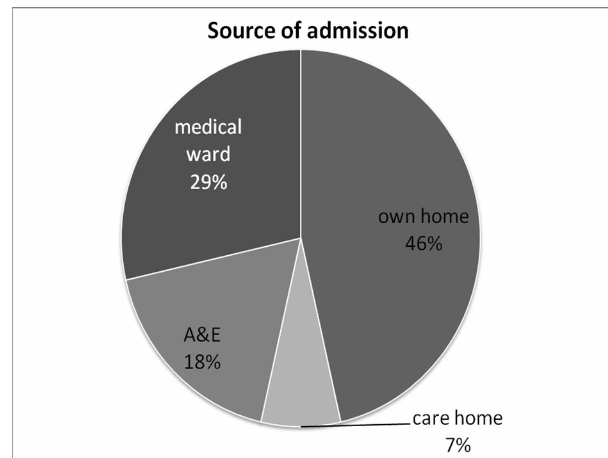
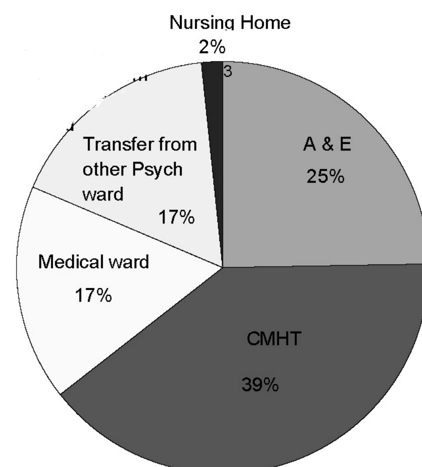


Figure 1. Initial audit sourse of admission



Figuru 2. Reaudit Sourse of Amission

Pre-existing co-morbidities were noted in 50 of these patients (83%) including:

hypertension, osteoarthritis, breast cancer, hypothyroidism, diabetes, atrial fibrillation, cardio-

vascular disease, asthma, prostate cancer, cerebro-vascular accident, leg ulcers, renal failure, cardio-myopathy, inguinal hernia, deep vein thrombosis, gout, chronic obstructive pulmonary disease, lung cancer, chronic cardiac failure, glaucoma, epilepsy, rheumatoid arthritis, gastric ulcer, Alzheimer's disease and Myasthenia Gravis.

The majority of cases were clerked in by the duty doctor (70%) compared to the ward doctor (30%). This is in comparison to the previous audit where 50% were admitted by the ward doctor.

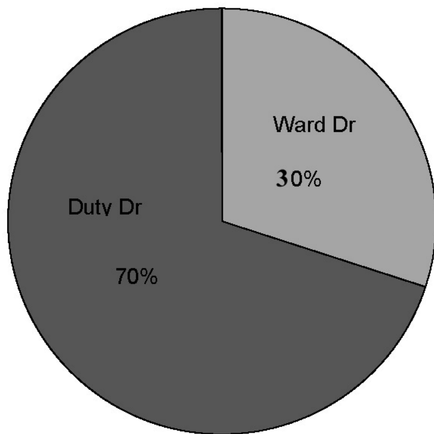


Figure 3. Reaudit who clerked the patient in

Examination on admission

26 out of 60 admissions (43%) had a full examination on admission, while 9 (15%) had a brief exam and 25 (42%) had no examination. Compared to the previous audit, although there were more patients who had a full examination, more also had no examination on admission.

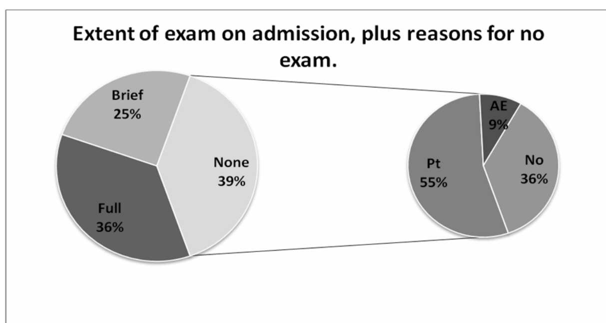


Figure 4. Extent of exam on abmissio plus reasons for no exam

The reasons for not having an examination on admission are shown here. Nearly a quarter refused examination. Just over 40% had come from a medical setting and therefore the physical examination was not repeated (although is it not clear if the notes of the prior examination were obtained). There were 8 cases where there was no documented reason why an examination was not done.

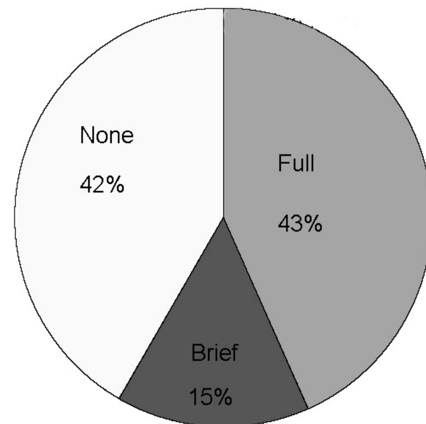


Figure 5. Reaudit Extent of exam on abmission

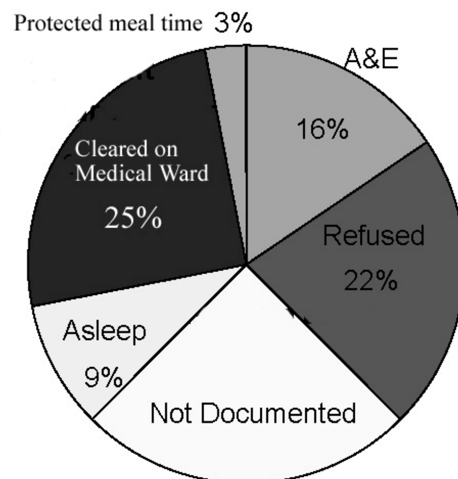


Figure 6. Reaudit reasons for no exam

Examination within 72h

31 out of 60 (52%) of patients had a full examination within 72 hours of admission to hospital. This is an increase in 6 from admission (one who had only been briefly examined, and 5 who had refused initially). However, this is lower than the original audit where 57% of admissions had a full examination after 72 hours.

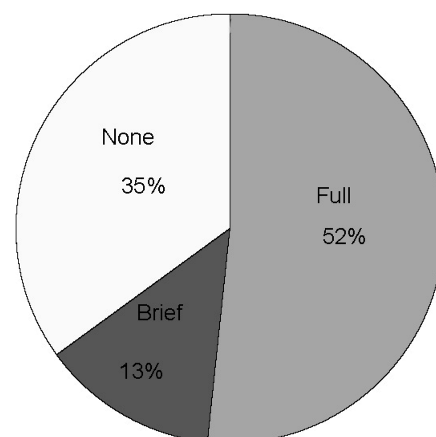


Figure 7. Extent of exam after 75 hours

This figure does not compare favourably when compared to the target figures. However, if we look in more detail at why a physical examination was not done, we can see that 50% of these cases were from medical wards or AE (where it can be assumed that the patient has been physically examined), just over a quarter refused (which may be a difficult figure to reduce) and in less than a quarter of these cases (and 6 out of a total of 60=10%) there was no reason documented as to why an examination was not done.

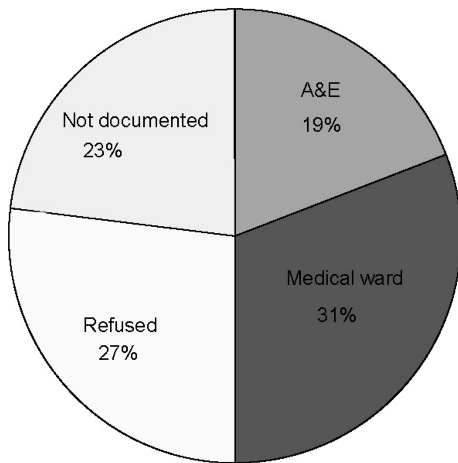


Figure 8. Reaudit why patiernts did not receive a full examination after 72 hours

However, if we look at the number of patients who had a full examination or were seen in AE/medical wards, we find that the figure is nearly 80%, with 10% refusing and with just over 10% having no reason for not having an examination.

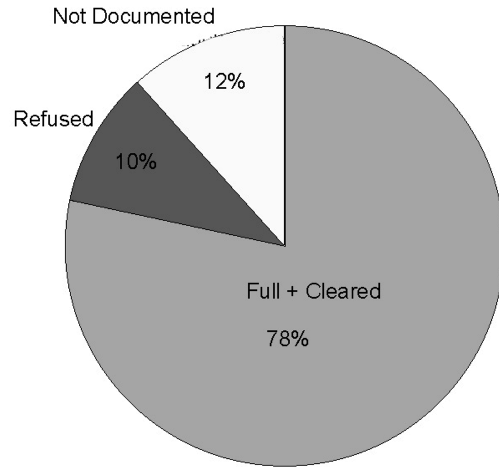


Figure 9. Re-audit Patients Having A Full Examination + Cleared Vs. No Examination After 72 Hours

Known physical conditions do not seem to have made examination any more likely.

Documentation

Only two of the patients had a detailed physical exam in the assessment tab of ePJS. As this was a retrospective audit it was not practical to search paper notes to find copies of medical notes of patient's transferred from AE or medical wards.

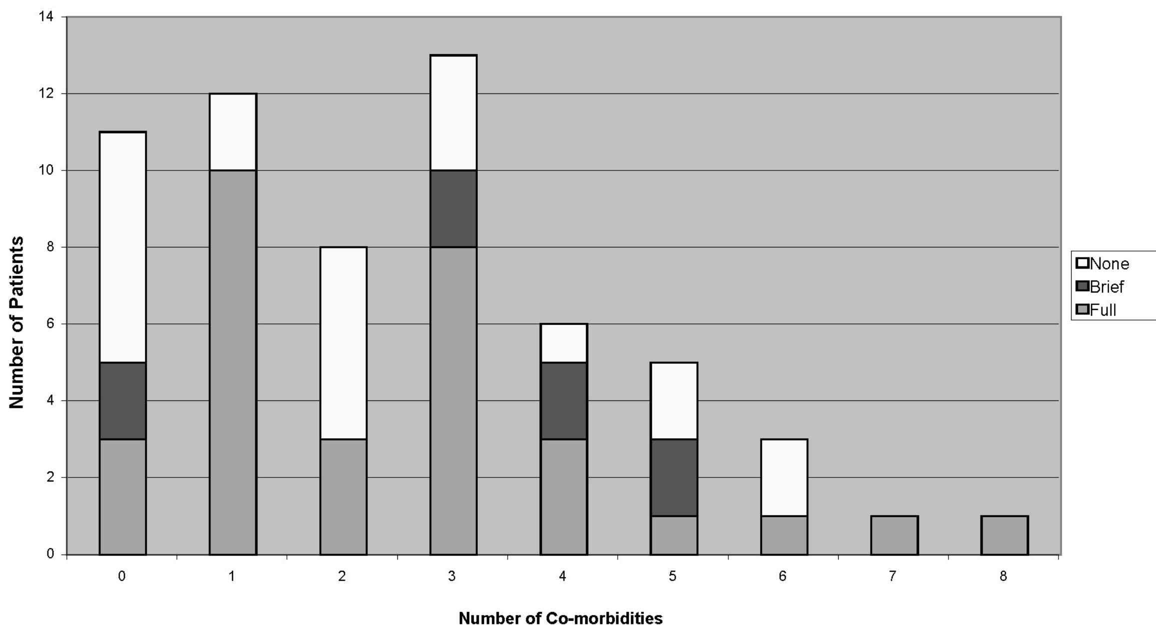


Figure 10. Number of Patients with Multiple Co-morbidities Examined Within 72 Hours

DISCUSSION

Comparison with our suggested targets shows that there is some way to go, and confirms our impression that the Older Adult wards are still performing sub-optimally in this area.

Table 1. Comparison of suggested targets with Actual Examinations achieved

	Suggested	Actual (first audit)	Actual (re-audit)
Physical exam on admission			
Brief (without exceptions)	90%	61%	58%
Full (with exceptions)	75%	53%	43%
Within 72h			
Full	90%	57%	65%

CONCLUSIONS

Doctors of all grades and on all wards and those on duty should be aware of the importance of a full physical examination, especially in the older adults due to physical symptoms being a direct result of psychiatric illness, poly-pharmacy, occult physical illness and the risks of further illness occurring.

Less than half the newly admitted patients had a full physical examination at their initial clerking. The recommendation from the previous audit was that a lack of recent examination for any particular patient should be flagged up, e.g. on ward-round patient lists, so that it is not forgotten to re-offer this at an appropriate time. Results from the re-audit do show a slight improvement in the percentage of people who had a full physical examination within 72 hours, although the target of 90% is still not being met.

This audit report shows that there is still much work to be done to raise awareness to CT1-3 doctors of the need for a physical examination to be completed. This will be done, if thought appropriate, by circulating this report more widely to the CT1-3s on rotation and by presenting this re-audit at the Clinical audit meeting.

The previous audit recommended using a proforma whereby the admitting doctor or primary nurse could request the notes quickly and conveniently for those patients who have been through A&E. This audit did not specifically look at this aspect, but this could be a further audit going forwards to see if this would help improve the statistics.

We would recommend that the data on physical examinations on admission is re-audited in six to twelve months to assess the recommendations of this audit.

REFERENCES

1. *D'Ercole A, Skodol A.E, Struening E, Curtis J, Millman J. Diagnosis of physical illness in psychiatric patients using axis III and a standardized medical history. Hosp Community Psychiatry. 1991 Apr; 42(4):395-400.*
2. *Tench D.W, Benbow S.M, Benbow E.Y. Do old age psychiatrists miss physical illnesses? International Journal of Geriatric Psychiatry. 1992; 7: 713-718.*
3. *Rodda J, Boyce N, Walker Z. The Old Age Psychiatry Handbook, a practical guide. John Wiley & Sons Ltd, Chichester, 2008.*
4. *Semple D, Smyth R. The Oxford Handbook of Clinical Psychiatry. Oxford University Press, Oxford, 2009.*

Correspondence:

Christopher Symeon , CT1 in Psychiatry on Aubrey Lewis 1 and 2 Wards
Aubrey Lewis House Maudsley Hospital, Denmark Hill, London, UK
E-mail: c-symeon@yahoo.co.uk