# REPORT OF THE UEMS SECTION OF PSYCHIATRY

## Quality Assurance of Standards in Specialist Psychiatric Care

### INTRODUCTION

This is a revised and consolidating report based on the Charter on Quality Assurance in Medical Specialist Practice in the European Union (March 1996) together with the three reports of the Section of Psychiatry: Recommendations on Quality Assurance (Budapest, April 1999, revised Palma del Mallorca, October 2002); Quality Assurance of Standards in Specialist Psychiatric Care (Prague, October 2001) and Quality Assurance in Specialist Training in Psychiatry (Thessaloniki, April 2002). The latter three reports are now all superseded by this current report.

The Charter on Quality Assurance in Medical Specialist Practice in the European Union (March 1996) defines Quality Assurance under the headings of: individual specialist; group practice; hospital; professional scientific organisations; EU member state or region, and finally financing of quality assurance. Reference should be made to the aforementioned original charter (March 1996) for the relevant details.

Quality of Medical Practice is the extent to which the total properties of delivered medical care meet the current criteria and demands of medical care. The criteria in medical practice are based on consensus within the profession concerning method and outcome of professional activities. Professional criteria should be set by the profession on the basis of medical evidence on the basis of medical evidence or documented expert medical consensus. Professional criteria are meant for improvement of medical care. They are not meant for cost reduction, but they might contribute to it.

Quality Assurance is a professional concept. It is the sum of the processes of assessing and stimulating the quality of medical practice by measuring outcome and comparing it with current criteria and demands of medical care. It should ensure that medical activities are systematic and controlled. It should affect both specialist and non-specialist members of the medical community at different grades of experience, i.e. from junior trainee to head of department, and every professional working in health care. It can only succeed if the individual doctor accepts that his/her practice should be open to assessment by the profession, and to comparison with demands for medical care and established criteria. It is a moral and ethical obligation for the individual specialist, but basically it should be a voluntary responsibility. A specialist who fails to meet this obligation should receive counselling by the profession, but should not undergo disciplinary action. Professional and scientific organisations are required to develop these quality criteria in their speciality and for this purpose specialists must generate in their practice the instruments necessary to implement quality assurance projects.

Quality Assurance should also cover Post Graduate Training and Continuing Medical Education. Participation of medical specialists in continuing medical education programmes should be encouraged and registered. The records should be made available to the national professional

co-ordinating authority where this body exists. A credit point system operated by a national professional authority should be in existence to assess the participation of the individual medical specialist in continuing medical education. The UEMS European Boards have the task to co-ordinate this system on a European level in each speciality.

## RECOMMENDATIONS ON QUALITY ASSURANCE SPECIFIC TO PSYCHIATRY

From the aforementioned Prague report (October 2001), good quality of psychiatric practice means that every patient has the right to assessment, treatment and rehabilitation, in locally implemented treatment programmes, according to the best knowledge available. The starting point can be the patient-flow (logistics) from the patient's point of view, covering the different phases in the course of their disease and the provision of services.

Five different phases can be recognised:

- Referral phase
- Assessment phase
- Treatment and stabilisation phase
- Transfer to other services and termination of treatment
- Rehabilitation phase

For each phase, indicators (relevant points of investigation), standards of quality (defined acceptable levels and measures (instruments or mechanisms of quantification) should be identified. In quality assurance, measures traditionally concern structure, process and outcome. In this work, outcome will be most recommended since it is of most interest from a patient's point of view, and least dependent upon local traditions.

Referral Phase

Accessibility and availability of an optimal level of effective care:

- *Primary level*: GPs must have access to and be able to consult psychiatric specialists/psychiatric teams, and to refer when needed. Social Services must be competent in supporting psychiatric patients' needs in the community, in active collaboration with psychiatric specialists and GPs.

- *Secondary level*: Psychiatric teams/specialists must be available for emergency assessment and treatment around the clock. For non-emergency cases, an assessment must be obtained within a week of referral.

- *Tertiary level*: When patient assessment, treatment and care needs cannot be met in the patient's home, temporary placement in hospital beds should be provided without delay until the services can be provided on a home basis. The patient's dignity and integrity must be secured throughout the hospitalisation.

*Examples of Suitable Indicators:*

- *Primary level*:
    - GPs must have documented basic training in psychiatry
    - GPs must have documented CME in psychiatry
    - Time interval from request to consultation or referral

- *Secondary level*:
    - All patients referred by GPs should be assessed and treated around the clock in emergency cases, and within a week for non-urgent referral cases

- *Tertiary level*:

- Facilities for extensive outpatient (or ambulatory) and home treatment and care should be available
- When outpatient (or ambulatory) or home treatment is unavailable, a sufficient number of hospital beds with physical standards corresponding to the culture of the patient's home should be available
- Proportion of patients treated on an outpatient (or ambulatory) or home basis versus hospital should be compared

- *Others*:

  - Scheduled meetings between primary, secondary and tertiary services should take place to monitor individual cases, as well as general aspects of exchange between services

- *Standards*:

  - Should be discussed and decided upon locally

- *Measures*:

  - Simple standard procedures as part of routine work, preferably computer-based, should be implemented.

Assessment Phase

Assessment is carried out as an interaction between the patient, the psychiatric specialist and the psychiatric team in collaboration with relatives and significant others. The psychiatrist makes the final decision concerning assessment. This should include details concerning psychopathology, personality traits (development, defence strategy, ego-strength), network (the home needs of minors should also be assessed), social development, present life circumstances, somatic history, past and present, level of social functioning and psychiatric history. Relevant available diagnostic tools, for example psychometric tests, neuroimaging and laboratory tests should be used.

*Examples of Suitable Indicators:*

- Team documentation of competence in the above-mentioned areas
- Documentation of standard procedures for assessment
- Availability of diagnostic tools, either on a routine basis or, in specific cases, through referral to more specialised services
- Assessment of social functioning (e.g. *Global Assessment of Functioning,* GAF)
- Contact with family and/or significant others
- Home needs assessment of minors

*Standards*:

- At least 90% of all patients must see the psychiatrist during the assessment procedure
- All staff working autonomously must be licensed or authorised by a national or professional board
- Local guidelines for assessment, based on national guidelines, for major diagnostic and problem groups (professionally accepted "state of the art" guidelines) should be used
- Referral procedures to more specialised services
- At least 90% of all patients should be assessed with e.g. GAF
- Family and/or significant others should be contacted in at least 80% of cases

*Measures*:

- Simple standard routine registrations, preferably computer-based, should be part of everyday work.

Treatment Phase

Based on assessment, the treatment plan should be established in collaboration with patient, psychiatrist and team, family and/or significant others, where appropriate. The psychiatrist has overall responsibility for the implementation of the treatment plan and for assessment of outcome. The treatment plan should actively consider the need for biological, psychotherapeutic and psychosocial treatment. For each treatment modality, purpose, goal and time for evaluation should be documented. The individual treatment plan should be based on local and national guidelines. Each service should be comprehensive and offer a diversity of treatment possibilities in the above-mentioned areas.

*Examples of Suitable Indicators:*

- Locally adapted guidelines based on national standards for treatment for major diagnostic and problem groups
- Documented individual treatment plan
- Documented patient involvement in establishing the treatment plan
- Documented and authorised competence in all treatment modalities
- Balance between treatment needs and treatment capacity
- Outcome measures should be defined e.g. scales for psychopathology and social functioning (e.g. GAF), side effects of treatment, user's satisfaction

*Standards*:

- At least 98% of patients seen as in-patients or out-patients for seven days or more should have a documented treatment plan with relevant treatment offered immediately or within a locally defined acceptable time span, according to assessment of needs
- At least 90% of patients should have documented active involvement in establishing their treatment plan
- Local services, should have documented availability of the major relevant biological, psychotherapeutic and psychosocial methods for all patients after proper assessment

Transfer to other services and termination of treatment

Continuity of treatment should be ensured when a patient is transferred from one level of treatment to another. Mutual agreements between the transferring and receiving levels should be documented. In order to prevent relapse when treatment is terminated, there should be an agreement with the patient concerning how to recognise warning signs of possible relapse, and which specific service to contact.

*Examples of Suitable Indicators:*

- Documented agreement between transferring and receiving levels of treatment
- Documented agreement with the patient about recognising warning signs and which service to contact

*Standards:*

- 100% of patients transferred to another service should have a documented agreement
- 100% of patients should have a documented agreement about how to recognise warning signs and which service to contact if needed

Rehabilitation and Re-socialisation Process

Rehabilitation is a re-socialisation process through which the patient, relatives or significant others are supported to regain as much psychological, and social autonomy and function as possible. The patient should be supported to choose the relevant network among family, significant others, and social, educational, vocational and psychiatric services. Lost abilities which cannot be regained should be compensated. Support should be provided to sustain

function, when needed. Training measures should be applied to help regain function where possible.

*Examples of Suitable Indicators:*

- Documented rehabilitation plan worked out in collaboration with patient, the rehabilitation team and the supporting network
- Documented patient involvement in network planning
- Identified professional responsible for co-ordination (e.g. case manager) should be appointed
- Outcome measures should be defined e.g. quality of life, satisfaction and level of functioning
- Defined procedures for evaluation and readjustment of plans
- Documented agreement clarifying responsibility between social and psychiatric services

*Standards*:

- When rehabilitation is required 100% of patients should have a documented rehabilitation plan
- When social services are part of the rehabilitation plan, 100% of such patients should have a documented agreement
- 100% of patients should have an appointed professional responsible for co-ordination

The overall purpose of the above standards is to improve psychiatric services for patients in the most secure way possible. Furthermore, this should contribute to the enhancement of patient autonomy and satisfaction. Finally, these standards may facilitate the provision of services in the most cost-effective manner possible.

RECOMMENDATIONS ON QUALITY ASSURANCE IN SPECIALIST TRAINING IN PSYCHIATRY

In April 2002 (Thessaloniki), the UEMS Section for Psychiatry stated that good quality in training of a psychiatrist means that every training programme should have defined goals, appropriate requirements for the training process and appropriate means for evaluation.

- The aim of training is to achieve the necessary knowledge and clinical experience required to work as a specialist in psychiatry. It should enable subsequent CME, which is a life-long learning process, concerned with professional as well as personal development.

- The national requirements for specialist training in psychiatry should be compatible with the UEMS Board of Psychiatry Recommendations.

- An individual training programme aimed at fulfilling these requirements should be developed in collaboration with, and approved by, trainee, educational supervisor and training co-ordinator.

- The national logbook compatible with the UEMS Board of Psychiatry Recommendations is a tool to secure proper training. It should be used by the trainee to record clinical and theoretical training as described in the recommendations. The educational supervisor and the training co-ordinator could use the logbook when assessing the trainee's progress.

- The training co-ordinator is responsible for the annual assessment of the trainee's progress as well as the final evaluation in the form of a written report.

- The training co-ordinator and the educational supervisor should have at least 5 years experience in specialist psychiatry and appropriate training for their task.

- Training institutions should be recognised by an appropriate national authority. A distinction should be made between institutions where complete training and where only partial training can be provided.

- There should be an effective and independent appeal procedure for the trainee who wishes to express complaints or appeal against the decisions about training matters.

- A national system for regular scheme inspections based on the UEMS Charter on Visitation of Training Centres should be in existence.

Based on the information gathered from a questionnaire on quality assurance (Budapest, April 1999 and reviewed Palma de Mallorca, October 2002), the UEMS Section for Psychiatry proposed the following recommendations as realistic to achieve by 2004:

I Working groups on QA in all National Psychiatric Associations (NPAs) should be established with the purpose of:

- formulating QA policies according to national standards

- stimulating the development of QA activities in professional psychiatric bodies and in clinical psychiatric practice at a local level

II NPAs should identify areas of priority both at a national and local level

III NPAs should start formulating clinical guidelines on diagnosis and/or problems from within the areas of priority

IV Working groups at a local/clinical level should be established in the public sector to identity local areas for QA projects e.g.: management of violence, treatment with neuroleptics, treatment without consent, suicide prevention.

V Systems for documenting activity and outcome measures (e.g. GAF) should be in place in the public sector

VI The above mentioned recommendations should also apply to private practice

It is now recommended that all NPAs should audit the current situation in their own member states and take any necessary remedial action to bring themselves into line with these recommendations.