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Quality improvement report

Lithium monitoring for patients with learning disability: the role of the general practitioner

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ABSTRACT

Aims and method Communication of responsibility for lithium monitoring and the flow of information between primary and secondary care was assessed by postal questionnaire. Guidelines were then introduced and a re-audit carried out two years later.

Results Initial audit showed that the doctor responsible for lithium monitoring was only identifiable in 59% of cases. The majority of general practitioners had received information about monitoring from the consultant prior to taking on the task. Following the introduction of guidelines re-audit showed a marked increase in identification of the responsible professional to 87.5% of cases. There was also a shift towards monitoring in primary care.

Clinical implications Communication between primary and secondary care is vital and can be improved by guidelines.

Keywords: general practitioner, learning disability, lithium monitoring

Introduction

Lithium requires regular monitoring due to its narrow therapeutic index and serious side effects. Lithium is always initiated by a specialist in secondary care, but for patients living in the community, maintenance monitoring may be carried out by the general practitioner (GP).

There is evidence of widespread substandard lithium monitoring and poor communication between primary and secondary care will contribute to this.[1] Responsibility for action lies with the doctor who is receiving the blood test results irrespective of who actually takes the blood. Information is important and Eagles *et al.* (2002) demonstrated that lithium monitoring improved after distribution of monitoring guidelines to both primary and secondary care practitioners.[2]

This interface audit was carried out to assess the communication of responsibility for lithium monitoring between GP and psychiatrist and to pilot the use of monitoring guidelines. The audit results led to standards of communication being set and a re-audit was carried out two years later.

Initial audit

A questionnaire was sent to all learning disability consultant psychiatrists in the Bristol area to identify their outpatients on lithium. For each patient the consultant was asked to name the GP and indicate who was responsible for lithium monitoring. The identified GPs were then sent a questionnaire which included the following questions:

- Are you responsible for the lithium monitoring of each named patient?
- Have you received adequate information from the consultant prior to undertaking the monitoring?

Attached to the questionnaire was an advice sheet on lithium monitoring and the responding general practitioners were asked if they would find it useful.

Results of initial audit

Seven consultant psychiatrists in learning disability identified 22 outpatients under the care of 20 GPs. The rate of return of response questionnaires was 100%.

Figure 1 shows that in 59% of cases there was agreement on monitoring responsibility and in 41% of cases there was conflict. In one-third of cases the psychiatrists thought the monitoring was on a joint basis while the GP did not think this was the case. Sixty per cent of GPs were responsible for monitoring.

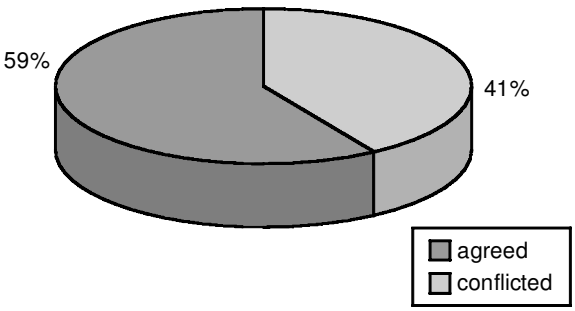

Figure 1 Responsibility for lithium monitoring and adjusting (initial audit)

Information

In total, 75% of the GPs who were responsible for monitoring stated that they received adequate information from the consultant prior to undertaking the task; 60% of the GPs welcomed the advice sheet on monitoring.

Guidelines

The survey showed an unsatisfactory level of agreement about responsibility for monitoring. Guidelines for responsibility in the form of a flow chart were drawn up. This is shown in Figure 2. The main point of the guidelines was that responsibility for monitoring should be clearly stated in writing by the consultant.

To improve communication between GP and consultant, a small handheld record booklet for patients was devised and a supply sent to each consultant. In addition, consultants were asked to send a standard advice sheet on lithium monitoring to the GP of each patient on lithium.

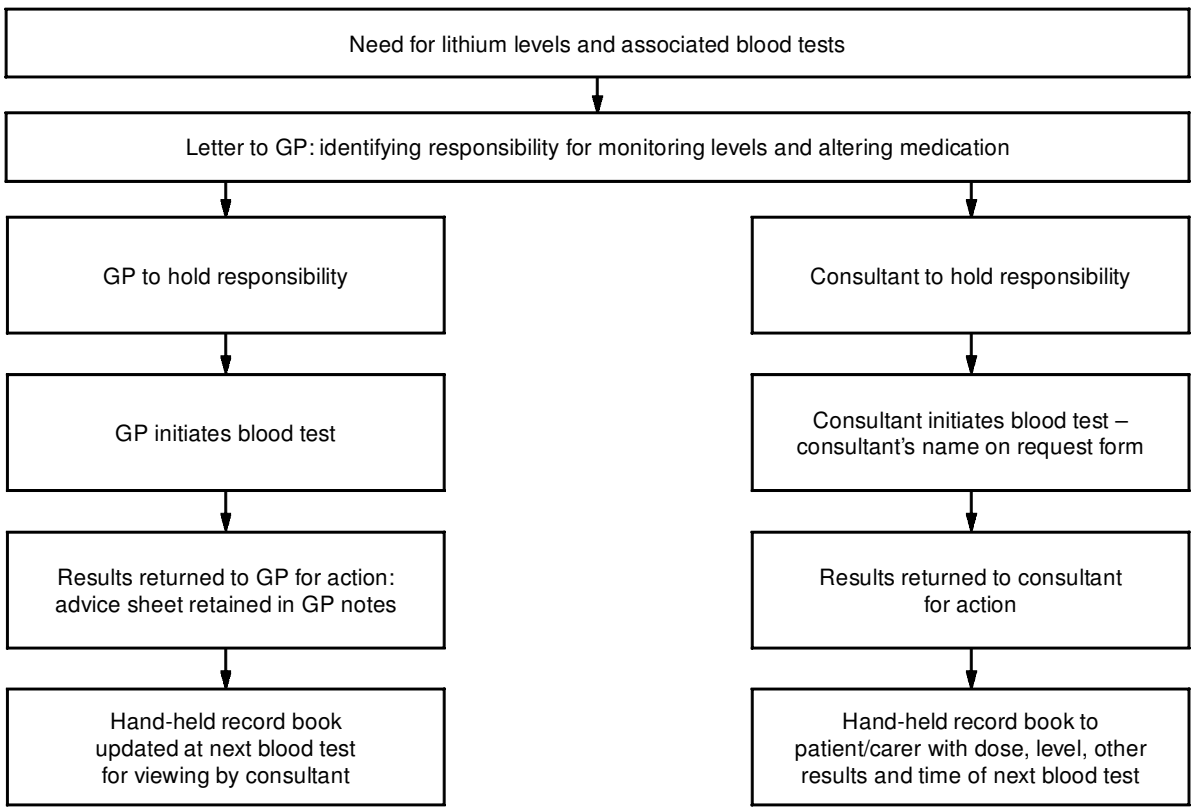

Figure 2 Guidelines for responsibility for monitoring lithium

Re-audit of guidelines

Re-audit was undertaken two years after the guidelines for responsibility of monitoring were adopted. The same method of identification of patients was used as in the initial audit. For each patient the consultant and GP were asked to identify who was responsible for lithium monitoring. The GPs were also asked if they received adequate information and a lithium monitoring guidance sheet from the consultant before taking on the responsibility.

Results of re-audit

Data was collected from six consultant psychiatrists and 22 GPs on 24 patients being prescribed lithium. There was again 100% return of questionnaires.

Figure 3 shows that the responsible professional was identifiable with 87.5% of patients, which represents an increase of 28.5% from the original audit. There was also an increase of 24.3% in the number of GPs responsible for monitoring.

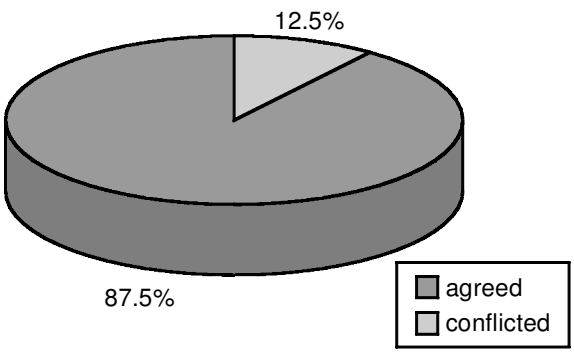

Figure 3 Responsibility for lithium monitoring and adjusting (re-audit)

Information

The response from GPs regarding information received remained the same – 75% expressed satisfaction.

Summary

The results of the re-audit suggest there is an increasing shift towards GPs taking on responsibility for lithium monitoring. Improvement in communication of responsibility between primary and secondary care was demonstrated when guidelines were introduced. It is important to review this communication to ensure those responsible for monitoring are aware that they are the named person and that they have sufficient information for the task.

The structure of health provision for patients with learning disability and mental illness is going through a period of rapid and frequent change. This audit demonstrates that communication between primary and secondary care can improve. The long-term aim must be for further improvement to take place.

REFERENCES

1 Ryman A (1997) Lithium monitoring in hospital and general practice. *Psychiatric Bulletin* **21**: 570–2.
2 Eagles JM, McCann I, MacLeod TNN and Paterson N (2000) Lithium monitoring before and after the distribution of clinical practice guidelines. *Acta Psychiatrica Scandinavica* **101**: 349–53.

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