INTRODUCTION

This report addresses audit activity at St Columba’s Hospice from April 2010 to March 2011. Seven earlier reports analyse audit activity from 1995-2010 (1,2,3,4,5,6,7). Again, as highlighted in the previous report, some activity has centred around meeting the requirements set out by the National Care Standards for Hospice Care (8) and NHS Quality Improvement Scotland Clinical Standards (NHS QIS) (9). The hospice is committed to meeting the requirements set out in the Quality Assessment Framework (Care Commission).

CLINICAL AUDITS CARRIED OUT BETWEEN APRIL 2010 AND MARCH 2011

A wide range of audit topics have been addressed during this period (see appendix 1). The projects continue to have a multidisciplinary approach, with clinicians from special interest groups within the hospice being encouraged to undertake related projects with support from the Clinical Audit and Effectiveness Facilitator. The wide range of clinical interest groups and their role within developing practice is outlined in the Clinical Governance Poster produced by the Information Group (see appendix 2). Many of the audit projects are evidence based and have either been re-audits or these are planned re-audits to be carried out in the near future, thus completing the audit cycle.

Recognition must also be given to areas of work currently being undertaken within the hospice that are categorised as quality improvement and practice development. Examples of these initiatives are outlined in figure 1.

Figure1: Quality Improvement and Practice Development

| • The Infection Control Group have created an action plan working towards the NHS QIS Health Associated Infection Control Standards. Audit is part of this development. |
| • A system is in place for reviewing Clinical Policies. All Clinical Policies have clinical leads and are verified by one of the Hospice Directors. |
| • The most recent version (version 12) of the Liverpool Care Pathway for the Dying Patient was introduced following an education initiative for all clinical staff. |
The National Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy was introduced within the hospice. This was supported by an education session developed from the national materials used to launch the policy and findings from the staff questionnaire.

Following the launch of the Liverpool Care Pathway for the Dying Patient (version 12) and the National DNACPR policy, clinical staff had access to in house communication study days that focused on Difficult Discussions at the End of Life.

The multi-professional Breathlessness Group has developed a Breathlessness Booklet now in use in clinical practice.

Hospice staff have been involved in the Lothian wide implementation of the McKinlay syringe driver and accompanying audit.

AUDIT PRIORITIES SET FOR APRIL 2010-2011

Following discussion at the Clinical Governance, Research and Audit Committee the following areas were highlighted as priorities for April 2010- March 2011

- DNAR
- Audit Activity following the implementation of version 12 of the Liverpool Care Pathway for the Dying patient
- SIGN 106
- Telephone Advice
- Infection Control: Management of Clostriium Difficile
- Named Nursing
- System for Accident and Incident Reporting

The developments in these areas are outlined in appendix 1. It was highlighted that the following areas should be developed in order to develop practice and form future audit initiatives:

- Development of the Patient Profile section of the clinical documentation
- Development of the ward care planning system
- Review of Discharge Planning Documentation following from recent audit results (2009) (see appendix 1)
The system for auditing accident and incident reporting is currently being developed in conjunction with a change of shift patterns within the inpatient unit.

**IN Volvement in National Audit and Standard Initiatives**

The Clinical Research and Audit Committee continue to meet every 6 weeks and since March 2007 has included Clinical Governance within its remit. Again, as in previous years, a large proportion of the work covered in the audit topics has been generated from either clinician interest or directly/indirectly by the National Care Standards for Hospice Care and NHS QIS. All audit proposals will take into consideration their relevance to these standards as well as local policies, clinical guidelines and evidence-based practice. The hospice continues to audit pain assessment as set out by Lothian Managed Clinical Network. This audit is now carried out annually to assess adherence to the SIGN key recommendations (see appendix 1). The use of the Liverpool Care Pathway continues with the Clinical Research and Audit Committee and the LCP clinical interest group being proactive in identifying annual audit priorities and clinical developments within this area (see appendix 1). The hospice has again adapted the new version of this nationally used tool to help meet the requirements set by the National Standards Board for Scotland and NHS Quality Improvement Scotland and local policies.

**Changes in Practice As a Result of Audit Activity**

The aim of clinical audit is to improve patient care by reviewing it against agreed standards and implement changes if necessary (10, 11). In order for this process to be effective, areas for audit must be clinician-led and their involvement is key at all stages if they are to influence changes in clinical practice. Many of the audit projects have resulted in changes in practice (see appendix 1). The hospice maintains its close links between the clinical area and audit, research, education and practice development. This is evidenced in the number of clinicians initiating audit projects together with the involvement from the multi-disciplinary team. This approach provides an excellent opportunity to link audit, clinical practice and education together in enhancing patient care.
DEVELOPMENTS FOR 2011-2012

In January 2011, it was decided that the format and membership of the Clinical governance, Research and Audit Committee should change. It was proposed that the group should become a more focused steering group with a smaller membership made up of representatives of each clinical area who would disseminate information to their colleagues. The projects undertaken will have an appointed clinical lead and support will continue to be given by the Clinical Audit and Effectiveness Facilitator. This newly formed group will set priorities for 2011-2012.

CONCLUSION

This year St Columba’s Hospice has continued to undertake a large number of multidisciplinary clinical audits and effectiveness projects. Again, as in previous years, these have included a mixture of new audit and effectiveness topics and re-audits of previous projects. It is hoped that the outcomes of the audits will form structures and will facilitate the hospice in evidencing the standard of care which patients experience throughout their involvement with hospice services. This report illustrates the key role clinical, education, practice development and audit staff have in positively enhancing care delivery and demonstrates the importance that clinical audit has in the hospices commitment to enhancing patient care.

The areas of Clinical Governance, Audit and Effectiveness will be further developed in the forthcoming year. The newly appointed membership of the Clinical Governance Committee will be responsible for taking forward the identified issues into 2011-2012. Central to the success of this initiative lies in continuing the development of the links between audit, effectiveness, clinical practice, education and practice development.
REFERENCES

8. National Care Standards for Hospices- Scottish Executive
11. NICE (2002) Principles for Best Practice in Clinical Audit University of Leicester
## Appendix 1

### Summary of Clinical Audit & Effectiveness Projects carried out between April 2010 – March 2011

<table>
<thead>
<tr>
<th>Topic</th>
<th>Management of Clostridium Difficille- reviewing staff knowledge</th>
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</thead>
<tbody>
<tr>
<td>Professionals Involved</td>
<td>Staff Grade Practitioner and Clinical Audit &amp; Effectiveness Facilitator</td>
</tr>
</tbody>
</table>

### Summary

Results of the audit 2009-2010: 176 sets of notes were reviewed from a six month period. 11 patients had stool samples sent for investigation and of these 1 specimen tested positive for C Diff. One of the findings was that our current documentation is inadequate. The infection control group are currently devising an Infection Control care Plan. This information will also now be recorded on HCAS. There are also plans to assess staff’s knowledge regarding C Diff using a quiz which aims to complement the Infection Control sessions delivered by the Infection Control Group.

### Progress

The care plan is now in place. Two quizzes were devised based on the audit information and Health Protection Scotland best practice guidelines- one for auxiliary nurses and Allied Health Professionals, and one for medical and nursing staff. The quiz was sent to auxiliary staff, Allied Health professionals, nursing and medical staff (total 77). 44 questionnaires were returned (57%). Results were as follows:

- The majority of staff recognise the importance of hand washing with soap and water and the use of gloves and aprons for trying to contain C.difficille infection. AHP’s may benefit from further education on these infection control measures.
- We need to reinforce that alcohol gel is not effective against c.difficille infection.
- Doctors and nurses were also aware of the need to try and either isolate infected patients or group them together. They were less aware of cohorting staff dealing with the patients.
- The need for communication between staff and the patient and their relatives was highlighted.
- The quizzes have generated discussion amongst staff. The plan is to repeat the quiz again in 2011.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Complementary Therapies- Review of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professionals Involved</td>
<td>Complementary Therapies Coordinator and Day Hospice Manager</td>
</tr>
</tbody>
</table>

### Summary

Project ongoing.
**Topic** | **Discharge Planning**
---|---
**Professionals Involved** | Staff Grade Practitioner and Clinical Audit & Effectiveness Facilitator

**Summary**

In 2008, there were 160 discharges from St Columba’s Hospice. The audit carried out in 2009-2010 looked at a 4 month period (March-June 2008). During that time there were 60 discharges. 50 patients were discharged home, 8 to hospital, 1 to LTC and 1 to NH. A total of 25 forms were completed, with 22 (88%) of these patients being discharged. For discharged patients with no audit form completed, the notes were examined to see when discharge was first mentioned. It was not possible to ascertain from the notes when the patient was fit for discharge.

**Findings**

**Audit Forms**

- The majority of discharges occurred on or before the proposed date of discharge.
- Time from patient Fit - Discharge is 6.25 days (mean). Could this be reduced by starting discharge planning earlier, before patient is medically fit?
- It takes an average of 5.75 days to plan a discharge.
- Of the completed forms, Supply of Funding (48%) and Carers (52%) were requested.
- Evidence that services are responding at appropriate times (eg CPCT seeing patient 1 day before discharge, but discharge delayed due to package of care)
- Only 1 Patient was re-admitted within 7 days of discharge (less than 24 hours)
- 13/14 readmissions (both delayed and not delayed) were for symptom control, therefore not a failed discharge.

**No Audit Form**

- Discharges were generally quicker, but this group of patients included 2 respite admissions, and 2 admissions for blood transfusions.

**Recommendations**

- Discuss at Medical & Nursing Operations Group
- Feedback to CGRAC and clinical team
- Work with Documentation Group to review and redesign Discharge Plan to facilitate process and to allow for further audit

**Progress**

A small multi-professional group has been set up to develop a Discharge Policy and create supporting documentation.
Summary
SIGN 106 Audit (November 2010)

This re-audit of daily pain scores used the same methods and criteria as the September 2009 and March 2010 audits to allow comparable results to determine whether the intervention was successful in improving the rate of daily pain scores and whether this practice had been sustained. The data from the last 30 complete admissions was collected retrospectively from November 2010. Notes were searched for using the HCAS database. Some patients were admitted twice during the sample.

Of the thirty admissions, two had no pain chart and five had no pain on admission so these were excluded from the audit leaving a sample of twenty three. Five notes stated that the patient “denies pain” and in three of these patients went on to have pain scores recorded and there was evidence of pain being an issue within the medical admission. These three patients were included in the data collection.

Patients who were cared for using the LCP, had their pain scores included up until the day prior to commencing the LCP as they then had their pain assessed on LCP.

Findings
Initial pain assessment on admission 20/20 =100% (March 2010-100%)
(No pain/denies pain on admission 5/30, no pain charts 2/30. These were excluded from the audit leaving sample size of 23).

For the 23 remaining admissions:
Number of daily pain scores = 195 (March 2010=280)
Total number of inpatient days pain could have been scored according to inclusion/exclusion criteria = 259

Pain scores achieved on (75.29%) 75% of days available.

Results compared to past

<table>
<thead>
<tr>
<th>Date</th>
<th>Initial pain assessment complete</th>
<th>Daily pain assessment complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>40%</td>
<td>48%</td>
</tr>
<tr>
<td>2007</td>
<td>100%</td>
<td>84%</td>
</tr>
<tr>
<td>2008</td>
<td>100%</td>
<td>83%</td>
</tr>
<tr>
<td>2009</td>
<td>100%</td>
<td>53%</td>
</tr>
<tr>
<td>2009-2010</td>
<td>100%</td>
<td>93%</td>
</tr>
</tbody>
</table>

Of the 23 admissions- 17 drug kardex had pain scores for part or full admission, 6 did not have the pain scores prescribed. The results are:

Prescribed on kardex: daily pain score achieved 81% (March 2010= 98%).
Not prescribed on kardex: daily pain score achieved 55% (March 2010= 85%).
The way forward

The results need to be fed back to Senior Staff and the Clinical Governance Audit and Research Committee.

Decision of the best way to disseminate the results to clinical team.

Discussion and decision about the best way to maintain and improve daily pain scores.

Is prescribing the daily pain score effective or is education and feedback sessions effective or a combination of the two approaches.

Staff feedback

Audit again within the next year.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Telephone Advice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professionals Involved</strong></td>
<td>Staff Grade Practitioner, Clinical Audit &amp; Effectiveness Facilitator and Specialist Registrar in Palliative Medicine</td>
</tr>
</tbody>
</table>

Summary

Clinical staff have been asked to record the telephone advice they are providing. Results being collated.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Infection Control Audit – Cleanliness Champions Training</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Professionals Involved</strong></td>
<td>Staff Nurse and Clinical Audit &amp; Effectiveness Facilitator</td>
</tr>
</tbody>
</table>

Summary

Audits are carried out as part of the cleanliness champions training pack. Aspects of these audits are discussed in the Infection Control Group, recorded in the group’s annual report and action plan.

<table>
<thead>
<tr>
<th>Topic</th>
<th>“Do Not Attempt Resuscitation” DNAR: Staff Questionnaire</th>
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</thead>
<tbody>
<tr>
<td><strong>Professionals Involved</strong></td>
<td>Senior Clinical Nurse, Consultant, Clinical Audit &amp; Effectiveness Facilitator and Specialist Registrar in Palliative Medicine</td>
</tr>
</tbody>
</table>

Summary

All clinical staff was asked to complete a questionnaire around practice and knowledge in the area of DNAR. 90 questionnaires were sent out to all clinical staff in November 2009. This audit demonstrates that there is a high level of
understanding and expertise amongst clinical staff members surrounding the subject of DNAR. However, it also highlights that uncertainty does exist (irrespective of staff discipline) regarding DNAR decisions, discussions and documentation. There would appear to be variation in our clinical practice between different staff disciplines and between different care settings. The current existence of a local and regional DNAR policy is confusing.

Other significant findings of the audit are:

- DNAR issues affect all clinical staff, across all teams and all services
- Patients initiate DNAR discussions more often than staff members i.e. patients want to talk about it!
- Staff find DNAR discussions difficult
- The majority of staff, across all teams and services, feel that making DNAR decisions and discussing DNAR with a patient is a doctor’s responsibility

Suggestions for the future

As the Scottish DNA CPR Policy is implemented, the timely results from this audit provide an ideal opportunity for the hospice to review current policy. We would suggest that the Scottish DNA CPR policy is embraced here at the hospice as the main guideline. This would replace the existing hospice CPR policy and the current Lothian DNAR policy. We would also suggest however that specific guidance is provided on how the national Scottish DNA CPR policy should be implemented at a hospice level. Education for all clinical staff and multidisciplinary dialogue is essential for this to be successful. The findings from this audit can support educational programmes and target areas for development.

Progress

In July 2010 all clinical staff were invited to attend education sessions to support the launch of the National DNACPR policy in the hospice. The DNACPR working group produced a poster which was presented at the Scottish Partnership in Palliative Care Conference 2010.

| Topic: Practices around Viewing following a Patient’s Death |
|---|---|
| Professionals Involved | Clinical staff (ward)  
Ward Manager  
Clinical Audit & Effectiveness Facilitator |

Summary:

Data was gathered regarding our viewing practices following the death of a patient. This was requested by the New Build Steering Group. Data was collected over a three month period (1st January - 31st March 2011). Where possible the results have been collated for North and South Teams. The reason for this is that the physical environment (e.g. access to single rooms) differs between teams. On reviewing the data collection slips it was clear that some staff were differentiating between viewing at time of death and viewing following death.
65 patients died over January to March. 36 deaths occurred between 1700-0900 hours. 21 deaths occurred between 9-5. 8 audit forms did not include the time of death.

49 of the 62 patients were viewed following death. In the majority of cases it was the family who requested to view (27 families). Staff offered viewing on 9 occasions. However, in 21 occasions, it was not clear whose decision was to view.

38 families returned either later on the day of death or following days to view.

48 families returned to collect the death certificate (8 not known). Only 6 families collected the death certificate at time of death.

The impact of single room or multi-occupancy rooms does not appear to have an impact on the number of viewings at time of death or the practice of families returning to view either later on the day of death or the following day. It appears from the data collected that families are requesting to view significantly more than staff are suggesting to view. 39 families viewed at the time of death with 34 of these families only viewing once at the time of death regardless of whether their relative died in a single or multi-occupancy room. The viewing room was used in a total of 34 occasions out of 72 viewings following death. These viewings took place later on the day of death or the day after death.

From the results, between 48-56 families returned to collect the death certificate. 21 of the 62 deaths occurred between 9-5 where death certificates may have been able to be provided.

<table>
<thead>
<tr>
<th>Topic</th>
<th>Care Assistants’ Clinical Supervision Questionnaire</th>
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<tbody>
<tr>
<td>Professionals Involved</td>
<td>Counsellor and Clinical Audit and Effectiveness Facilitator</td>
</tr>
</tbody>
</table>

**Summary:**

17 questionnaires were sent out to care assistant staff working day and night duty. 13 questionnaires were returned (response rate= 76%). Of the 13 responses, 6 members of staff were not attending supervision and 7 members of staff were attending supervision. Of the six staff who did not attend, 3 said they would not be interested in attending if clinical supervision continued. It was highlighted that this was difficult if working night duty.

Of the 7 staff who were attending clinical supervision, all found it valuable, one member of staff found it difficult to be released from their clinical duties and 6 were willing to attend if the service continued.
**Summary:**

**Review of Notes:** 27 sets of notes were reviewed. The range of time patients were known to the services was between 6 and 917 days (median 42 days). The senior staff were asked to review the case notes and to subjectively score aspects of the notes using current relevant policies (e.g. Named Nurse Policy, Documentation Policy). Findings were that the optimal allocation of named nurse days was 9-10 days but there was little difference in the scores for the allocation of 4, 5, 7 and 8 days.

**Patient Interviews:** 6 patients were interviewed. One third of patients knew their Named Nurse. All Named Nurses were recorded in the notes and the CTR notice board. All patients interviewed felt that their Named Nurse knew about their care, as well as the associate nurses who were approachable when the Named Nurse was not duty. Two patients said they had received an information leaflet about Named Nursing and had found this helpful. 3 patients could not remember if they had been given a leaflet. Patients expressed the following views:

- "They are all very good, nothing a bother."
- "They are all very helpful lovely people."

**Relative/Family interviews:** 4 relatives were interviewed. All 4 knew the Named Nurse who was looking after their relative. All Named Nurses were recorded in the notes and on the CTR notice board. All relatives felt they could approach other members of the nursing team when the Named Nurse was not on duty and that other members of the team were able to answer their questions. 3 of the 4 relatives said they had received a booklet about Named Nursing.
Appendix 2 - St Columba’s Hospice Supporting Clinical Governance

**Bereavement Support Steering Group**
The Bereavement Support Service Steering group is a multidisciplinary group which meets quarterly
- To review current bereavement support
- To oversee Times of Remembrance/Memorial Services
- To explore ways of improving pre and post bereavement care across the whole hospice community

**Clinical Governance**
This representative group is responsible for ensuring that good clinical governance and risk management are central to all Hospice practice. Audit and research proposals (both internal and external) are discussed and completed projects are presented. Meets every 6 weeks

**DNACPR Group**
The remit of this multiprofessional working group is to oversee the implementation of the National DNACPR Policy until embedded in practice. This will be achieved by the group acting as a source of information and support to all the clinical staff, conducting audit activity and taking a proactive approach to issues arising from audit and practice.

**Documentation Group**
The purpose of the group is to ensure patient documentation reflects the patient-centred care offered at the Hospice, meets legal and professional requirements and facilitates effective multidisciplinary communication.

**Health & Safety**
This Group consists of a representative from all areas of the Hospice. Its function is to review and assess risks in relation to Health and Safety and to implement the appropriate control measures. Meets quarterly.

**The Heads of Department**
The Heads of Department throughout the Hospice meet formally on a three monthly basis. The aim is to share information interdepartmentally. This meeting also reinforces that all departments are part of the overall Hospice Team.

**Infection Control**
The purpose of this Working Party is to develop an infection control philosophy within St Columba’s Hospice, which facilitates a culture of adherence to stringent infection control policies, procedures and guidelines. The infection Control Group reports to the Hospice Clinical Governance Committee.

**Information Group**
St Columba’s Hospice produces a variety of information for patients covering many clinical issues. The remit of the group is to monitor this information, facilitate document control and provide a resource for staff. Meets every 6 weeks.

**Journal Club**
Multidisciplinary meeting to promote education, to disseminate information amongst members of the multidisciplinary team and to allow members of the team to present in a safe environment. Variety of topics discussed (e.g. journal reviews, research and audit). Both internal and external speakers.
LCP
The remit of this multi-professional group is to support the ongoing use of the LCP in clinical practice supporting the delivery of best practice for the patient and family at end of life. This will be achieved by educating new staff, acting as a resource for all clinical staff, updating and reviewing the document whilst planning and contributing to the audit process. Meets 3 monthly

Library Committee
This multidisciplinary group of Hospice staff and students provides a forum for the exchange of ideas in relation to the Hospice’s specialist palliative care library and information service. The group helps in the review of current library stock, identification of new books, journals and other materials that should be purchased. Their key role is encouraging the dissemination of information on the Library to staff and students and contribute to plans for the current and future development of the library. Meets six monthly.

Medicine Management Group
The remit of the Medicines Management Group is to:
- Agree and review procedures for managing medicines.
- Agree and review prescribing guidelines.
- Review drug incident reports.
- Monitor expenditure on medicines.
- Provide an annual drug update session for medical and nursing staff.

Medical and Nursing Operational Group
This group meets every two - three months. Its remit is to discuss the process of referral, admission to and discharge from the in-patient, Community Palliative Care and Day Hospice Services.

Multidisciplinary Forum
The forum is a meeting of the allied health professionals to facilitate communication and information sharing amongst the team. Meets every 6 weeks.

Multidisciplinary Team
This meeting is a forum for the future care of each individual patient and their family. All members of the MDT are invited to contribute. A meeting for each team (North and South) is held on a weekly basis. Attendance is recorded, and any discussion / actions are documented.

Named Nurse Group
St Columba’s Hospice believes that the Named Nurse concept reflects best practice in meeting our philosophy of care. The Named Nurse role is key to providing:
- Holistic patient care
- Co-ordinated care from pre-admission to discharge/death in partnership with the patient / family.
- Clear transparent multidisciplinary documentation and communication.
The Named Nurse group facilitates and promotes the named nurse initiative.

New Build Steering Group
The New Build Steering Group is a strategic decision making group where all departments across the organisation are represented by the Senior Management Team. The group considers the design implications for our future operational requirements in relation to the New Build. Consultations from all departments are fed back to the New Building Steering Group and discussed. The Steering Group is accountable to the New Build Committee. Meets every month.