

St Columba's Hospice



Clinical Audit Report May 2007-March 2008

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INTRODUCTION

This report addresses audit activity at St Columba's Hospice from May 2007 to March 2008. Four earlier reports analyse audit activity from 1995-2007 (1,2,3 and 4). 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 (5) and NHS Quality Improvement Scotland Clinical Standards (formerly the Clinical Standards Board for Scotland: specialist palliative care (6). The hospice is committed to meeting the requirements set out in the Quality Assurance Framework.

PROGRESS MADE ON THE RECOMMENDATIONS FROM THE LAST AUDIT REPORT

The previous report from May 2006 -April 2007 made five recommendations. Progress has been made on these as follows:

Recommendation: The Liverpool care pathway (LCP) has been introduced in the in-patient unit. An ongoing programme for audit activity to measure end of life care should be considered. The facilitators should continue to address the educational and support needs of staff based on the results of the audit.

Progress: The hospice has carried out its first independent audit (see appendix 1). The hospice will aim to audit different aspects of the LCP every six months initially. Plans regarding the next audit are currently being discussed.

Recommendation: All audit proposals are measured against Care Commission and Quality Improvement Standards.

Progress: All staff wishing to carry out clinical audit should discuss this with the Clinical Audit Facilitator who will highlight particular standards or evidence based practice as measurement tools. The Clinical Audit Facilitator attends many of the clinical interest groups, and can be involved with other projects as necessary.

Recommendation: A clinical policy and procedures review is currently in the planning phase.

Progress: All current clinical policies and procedures have been given to clinical staff for updating. Some new policies have been identified by the Clinical Governance, Research and Audit Committee (CGRAC) and are currently being developed. This work will identify a review system. This project is progressing.

Recommendation: The CGRAC should identify and plan the medium and longer term goals based on clinical priority areas identified by the hospice. The use of DNAR forms has been highlighted as a priority area for audit.

Progress: The Clinical Audit Facilitator has met with representatives of all the clinical groups to identify clinical priorities. This has gone to the Hospice Directors for further consultation. These priorities will form the recommendations for future audit activity. The use of DNAR forms will be a priority as this has not been audited due to difficulties with documentation.

Recommendation: A new documentation system for patient records has been implemented. This should be audited three months after implementation.

Progress: This system was audited and the results are shown in appendix 1. These results were feedback to clinical staff in the form of an interactive education session. Some minor changes to the document have been made following feedback from staff at the sessions and the audit results. Plans are currently being made to introduce this new documentation to all patients in all three services.

CLINICAL AUDITS CARRIED OUT BETWEEN MAY 2007 AND March 2008.

A wide range of audit topics have been addressed during this period (see appendix 1). It continues 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 facilitator. 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. These are listed in figure 1. Areas highlighted in the last two reports (e.g. multi-disciplinary documentation and breathlessness care plan) have all been further developed.

Figure1: Quality Improvement and Practice Development

- The medicines management group continues to review and produce procedures and guidelines involved in prescribing and administering medicines.
- A questionnaire was carried out to ascertain patient and staff views of the exercise class in the day hospice.
- The admissions and discharge group continue to address areas effecting access to hospice services.
- The information group has completed its work in reviewing the patient and carer information booklet involving patients (from day hospice and in-patient units) and carers (see appendix 1). They also have plans to review all clinical information.
- Communication study days for nursing staff.
- Representation on the Lothian Do Not Attempt Resuscitation (DNAR) continues. The hospice has taken part in a multi-centred questionnaire to assess knowledge within this area.
- Breathlessness group have presented a poster “Breathing life into palliative care” at the Help the Hospices conference outlining the results from the audit (see Annual report 2006-2007) and the developments of the assessment tool in the clinical area. They are also developing a patient information booklet.
- Bereavement group have developed a patient and carer risk assessment form and have provided education for staff regarding its use.
- Questionnaires given to volunteers to assess their support needs.

INVOLVEMENT 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. 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 Quality Improvement Scotland. 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 work closely with the Lothian SIGN 44 Initiative (Control of pain in patients with Cancer) in carrying out six monthly audits to assess adherence to the SIGN 44 key recommendations (see appendix 1).

The use of the Liverpool Care Pathway continues with a six monthly audit programme in place. The hospice has adapted 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 (7, 8). The hospice maintains its close links between research, audit, education and practice development. This is evidenced in the numbers of degree students initiating audit projects and clinician involvement from the multi-disciplinary team in many projects. In January 2008 the hospice appointed a Practice Development Facilitator. Again, this role provides an excellent opportunity to link audit, clinical practice and education together in enhancing patient care. 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).

RECOMMENDATIONS FOR FUTURE AUDIT ACTIVITY.

Priorities identified by the clinical teams and the Hospice directors are as follows:

- Reasons for referrals
- Drug Accountability Training effectiveness (impact on clinical practice)
- DNAR
- Controlled Drugs
- Infection Control
- Telephone Advice

The hospice will continue to audit the following:

- Patient Documentation
- Named Nurse
- Liverpool Care Pathway
- SIGN 44
- Annual Review of Patient Incidents

CONCLUSIONS

This year St Columba's Hospice has continued to undertake a large number of multidisciplinary clinical audits. Again, as in previous years, these have included a mixture of new audit 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 staff have in carrying out audit and demonstrates the importance that clinical audit has in the hospices commitment to enhancing patient care.

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