

Appendix 1

Summary of Clinical Audit Projects carried out between May 2007 – March 2008

TOPIC	PROFESSIONALS	SUMMARY
Named Nurse in the Day Hospice	Charge Nurse	<p>17 Day Hospice patients were included in this audit over the period of a week.</p> <p>Results:</p> <ul style="list-style-type: none"> • 53% of patients knew who their named nurse was • 23% of patients had their named nurse documented in the notes • 100% of patients had a named nurse allocated on the board in the duty room • 53% of patients stated they had regular access to their named nurse • 23% of patients had received written information regarding the named nurse system
Named Nurse in the In-patient Unit	Charge Nurse Clinical Audit Facilitator	<p>This audit reviewed the following:</p> <ul style="list-style-type: none"> • Patient Questionnaire (19 patients) • Family/Relative Questionnaire (9 relatives) • Reviews of current documentation (19) • Review of admissions over 2 week period (17) • Review of case noted for the last 20 patients who were discharged • Review of case notes for the last 20 patients who had died <p>Where possible, the investigations made every effort to review processes equally from the North and South teams.</p> <p>Results:</p> <p><u>Patient & Family Questionnaire</u></p> <ul style="list-style-type: none"> • 37% of patients knew who their named nurse was • 44% of relatives knew who their relatives named nurse was • 100% of patients and families could approach other staff • 58% of patients had their named nurse documented on the patient profile • 100% of current patient admissions had the named nurse documented on the CTR Board

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		<p><u>Review of Admissions over a 2 week period</u></p> <ul style="list-style-type: none">• 30% of named nurse were allocated on admission• 17% of named nurse were allocated within 2-24 hrs• 24% of named nurse were allocated over 24 hrs• 6% of named nurse were allocated over 72 hrs• 24% of named nurse allocation – time scale not known• All named nurses of the current patient admissions could have had contact with the patient within 24 hours although 53% of notes had documented contact• 59% of named nurses were documented on the patient profile• 70% of named nurses were documented on the CTR board• 29% of named nurses were also the admitting nurse <p><u>Discharge</u></p> <ul style="list-style-type: none">• 13 out of 20 notes could be used• 25% of named nurses were also discharge co-ordinator (55% not known)• 25% of associate nurses were also discharge co-ordinator• 25% of named nurses were the admitting nurse (40% not known) <p><u>End of Life Care</u></p> <ul style="list-style-type: none">• 14 out of 20 sets of notes could be used• 55% of named nurses were admitting nurses <p>The audit also looked at the documented involvement of named nurses and associate nurses.</p> <p>Recommendations from this audit are currently being discussed with the Nursing Director and Ward Managers.</p>

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<p>Use of POS (Palliative Care Outcome Scale) In the Day Hospice (re audit)</p>	<p>Charge Nurse Clinical Audit Facilitator</p>	<p>The initial audit was carried out in July 2005. The audit in 2007 repeated the review of documentation and interviewing of current Day Hospice patients. 10 patients took part.</p> <p>Findings:</p> <ul style="list-style-type: none"> • 9/10 patients felt it was important to carry out the assessment • 7/10 patients felt it was completed in an appropriate time scale • 9/10 patients wanted staff to complete it • Review of documentation showed that 50% of patients had a POS completed on week1, 40% in weeks 2-3 and 10% not known • On average POS was carried out every 8 weeks • 56% had a further POS date planned • Main symptoms identified were pain and breathlessness <p>These results have been fed back to the Day Hospice team and some changes have been made to the document. Guidelines for the use of POS have also been created.</p>
<p>Pain Assessment in the Community (Lothian Sign 44 Initiative – LSI44)</p>	<p>Community Palliative Care Nurse Clinical Audit Facilitator</p>	<p>The Community Palliative Care nurses were asked to complete a questionnaire for every new patient referral over a 2 month period. 22 forms were returned (49%)</p> <p>Results:</p> <ul style="list-style-type: none"> • LSI44 had been started with 13 patients • Reasons for patients not being started was highlighted • Alternative methods to assess pain were identified (e.g. asking questions but not within a formalised tool) and were recorded in the progress notes/report. • These pain results were shared with other healthcare professionals (e.g. district nurses, GP, clinical nurse specialist) by telephone.

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<p>Lothian Sign 44 Initiative (LSI44)</p>	<p>Senior Clinical Nurse Clinical Audit Facilitator LSI44 Staff</p>	<p>Staff were given feedback of the results of data collected from 62 in-patients over the period of 1 month. 1/3 of patients had a pain score of severe on admission. The audit identified excellent adherence to Sign 44 key recommendations. 100% of initial pain assessments were completed within 24hrs (an increase from 40% in the previous audit). 84% of patients had a daily pain assessment score (an increase from 48% in the previous audit).</p> <p>The Hospice Community team and Day Hospice services were also asked to provide data for new referrals. 2/17 patients from the community were started on LSI44 with 14 patients deemed not appropriate. The 2 patient's referrals for Day Hospice were deemed inappropriate.</p> <p>Patient discharged from in-patient ward with LSI44 pain assessment tool showed that 61% of patients been discharged with the document.</p> <p>Inpatient audit repeated in September 2007 showed:</p> <ul style="list-style-type: none"> • 89% of patients had a daily pain assessment documented • 100% of initial pain assessments were completed • Excellent adherence of key recommendations • Significant improvement in 'Time to Pain Control' <p>Community and Day Hospice data in September 2007 showed:</p> <ul style="list-style-type: none"> • LSI44 started 10 out of 20 patients • Day services started LSI44 on 1 out of 2 patients <p>Results have been fed back to staff. Discussions are taking place to ascertain future developments around data collection to meet the sign guidelines.</p>

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Audit of Occupational Therapy Referrals	Occupational Therapist Clinical Audit Facilitator	<p>Data was collected from referral forms from April 06 – April 07.</p> <p>The findings highlighted the following areas:</p> <ul style="list-style-type: none"> • Why are staff not referring, why do some refer more than others? • Less than half of verbal referrals are followed up by written referral (45%) • Referral forms are not always complete (65% completed) • 53% referrals are inaccurate • Recommendations were to re-design the referral form, produce a leaflet 'End of Life Creative Activities' and education for staff.
Documentation (Patient Records) – Review of the New system	Senior Clinical Nurse Clinical Audit Facilitator	<p>A new multi-professional documentation system was introduced to patient records in April 2007. Six months following introduction a review of 20 case notes took place. These notes were taken for all 3 services (in-patient, Community Palliative Care, Day Hospice).</p> <p>Results showed:</p> <ul style="list-style-type: none"> • 90% of case notes now had a family tree (significant increase from the previous documentation system) • 75% of case notes had the support network section complete • Excellent documentation in the newly designed medical section <p>Some areas for development were identified:</p> <ul style="list-style-type: none"> • Patient information checked, admission time and reason for admission were often omitted. (Review in next audit) • No improvement in the documentation of spiritual issues • Little documented evidence to show if patient have been offered a 'Patient and Carer Information' booklet <p>All these results have been feedback to staff during education sessions.</p>

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<p>Liverpool Care Pathway (2 audits)</p>	<p>Senior Clinical Nurse Staff Nurse Clinical Audit Facilitator</p>	<p>The Hospice received results from the Marie Curie Palliative Care Institute following the implementation of the Liverpool Care Pathway.</p> <p>Results for 20 sets of notes:</p> <ul style="list-style-type: none"> • CPR recording has increased from 10% to 80% • Documentation of discontinuing nursing interventions increased from 40% to 90% • Evidence that there is good discussion with the family around diagnosis, recognition of dying and assessment of spiritual care. <p>Results highlighted that this may be happening less with patients with 35%[^] of patients comatose when the Liverpool Care Pathway was introduced</p> <p>Staff were invited to feedback sessions to discuss these results.</p> <p>The first independent audit of the Liverpool Care Pathway was carried out in October 2007. 65 sets of notes were reviewed.</p> <p>Results:</p> <ul style="list-style-type: none"> • 66% of patients who had died had been cared for using the Liverpool Care Pathway • The median time on the Pathway was 62 hours (range 6 – 369 hours) • The most common variance was agitation, followed by pain then respiratory tract secretions <p>A poster titled 'Coming Full Circle: Implementing the Liverpool Care Pathway in a Hospice setting has been presented at the Scottish Partnership in Palliative Care Conference, Edinburgh (August 2007) and the National LCP Conference, London (November 2007).</p>

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Use of Gabapentin in the Hospice setting	Staff Grade Practitioner	Data has been collected from patient's notes over a six month period which has identified 6 patients have been prescribed gabapentin. Decision has been made via CGRAC not to continue this work.
Review of the Complementary Therapy Service	Complementary Therapist Charge Nurse	<p>Complementary Therapy Service started in January 2006 providing therapies for patients and main carers. Documentation is incorporated in the patient's notes from the point of referral. The audit aimed to identify the origins of referral, patient's expectations plus accurate and complete documentation by renewing patients notes. 125 sets of notes were reviewed.</p> <p>The results showed:</p> <ul style="list-style-type: none">• The vast majority of referrals came from the in-patient unit. The Community Palliative Care team appears to be referring more frequently in 2007• Many patients don't know what to expect as many had not experienced Complementary Therapies before, but the vast majority were pleasantly surprised• Completion of the documentation has improved and has been redeveloped as the service has progressed <p>Future plans are to integrate Complementary Therapies more fully into the clinical setting, introduce a wider range of therapies and to continue auditing activity to influence service development.</p>

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The use of the Symptomatic Relief Policy in the Hospice In-patient Unit	Staff Nurse Clinical Audit Facilitator	<p>We reviewed 33 patients' drug kardexes from patients who had been admitted in April 2007. A total of 491 days were reviewed (range 1 – 40 days).</p> <p>Results:</p> <ul style="list-style-type: none">• 32 out of 33 patients had the SRP started• 24 out of 33 patients had some medicines prescribed on the drug kardex and SRP• Paracetamol and simple linctus were the most commonly used medicines from the SRP <p>This information has been fed back to the CGRAC and Medicines Management Committee.</p>
Lidocaine Audit	Clinical Pharmacist Medical Staff	Audit is a prescribing requirement set out by the Drug and Therapeutics Committee. Currently awaiting audit report.

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Review of Information for Patients and Carers Booklet	Clinical Psychologist Clinical Psychology Student	<p>This work was a progression of work carried out with Day Hospice patients in 2006. 10 patients and 10 relatives were interviewed regarding the booklet 'Information for Patients and Carers' which is produced by the Hospice.</p> <p>Findings:</p> <ul style="list-style-type: none"> • Patients admitted from the Western General Hospital had often not seen the booklet prior to admission • The inclusion of photographs in the text may make booklet friendlier • Map on the back of the booklet is too small • Telephone numbers and 'housekeeping' information should be nearer the front of the booklet • Include explanations of the word 'Hospice' and 'Palliative' • Several relatives wanted to know about finding and how to make a donation • Information about refreshments, mobile phone use and visiting would be helpful • Same information about how to approach staff and the named nurse system would be helpful <p>Action Plan: Results feedback to CGRAC and information group for further discussion. Results will be considered in the re-write of the booklet.</p>
Discharge Planning	Staff Grade Practitioner	This audit is in the initial planning stage. It aims to highlight issues which may be resulting in delays in patient discharges.
Management of Clostridium Difficile	Staff Grade Practitioner Clinical Audit Facilitator	This audit is in the critical planning stage