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Editorial: Integrating quality

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The trajectory taken by most accidents has been well described.¹ While staff are usually responsible for the mistake or violation that triggers an accident, the environment in which they are expected to work can promote the likelihood of that human error. For example, high bed occupancy rates and the resultant lack of order and consistency in the admission of patients to beds in appropriate wards will increase the chances of error.

Placing patients in inappropriate wards – ‘outliers’ – and then moving them to the specialist ward causes profound quality problems, such as poorer clinical outcomes,² loss of multidisciplinary team-working, lengthy ward rounds, large numbers of consultants visiting a given ward, patients not been seen by medical staff for several days, less time for teaching, multiple handovers, less efficient discharge planning, loss of pathology reports and confusion as to the whereabouts of patients.

Industry, passenger aircraft design, the armed services and supermarkets understand the need for spare capacity, tolerance or redundancy. Such tolerance is seen as an essential part of good management.

The multiplicity of government initiatives and agencies attempting to modernize the NHS will no doubt introduce service improvements such as those achieved by organizations that have implemented some of the ‘10 high-impact changes’.³ Pathways of care can also help alleviate the lack of continuity of staff providing care and make explicit what needs

to be done and by whom across the health-care sector.

New ways of working, clinical service redesign, changes in the way chronic diseases are managed and a greater separation of elective and emergency care may in the long run reduce the number of acute beds and operating theatres required. But a degree of tolerance and spare capacity will need to remain to ensure that the quality of the care we provide to inpatients is improved and risks minimized.

The implementation of clinical governance has led to the integration of quality into service delivery and made clinicians and managers more accountable;⁴ it has, however, still a long way to go. Much more needs to be done to ensure that the various quality systems are better integrated and the information they generate used more effectively to indicate where improvement strategies need to be targeted. Quality needs to become a key element of the overall governance responsibility.

References

- 1 Reason JT. The human factor in medical accidents. In: Vincent C, Ennis M, Audley RJ, eds. *Medical Accidents*. Oxford: Oxford University Press, 1993
- 2 Audit Commission. *United They Stand – Coordinating Care for Elderly Patients with Hip Fractures*. London: HMSO, 1995
- 3 NHS Modernisation Agency. *10 High Impact Changes for Service Improvement and Delivery*. London: NHS Modernisation Agency, 2004
- 4 National Audit Office. *Achieving Improvements Through Clinical Governance – A Progress Report on Implementation by NHS Trusts*. London: The Stationery Office, September 2003

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Advanced practitioners: leaping over the boundaries

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- The status of 'advanced practitioner' (AP), which is open to all non-medical staff who belong to a statutory regulated profession, will enable experienced practitioners to undertake some of the interventions currently carried out by medical staff.
- A flexible masters degree has been introduced to provide individualized learning programmes for practitioners who are seeking to become APs. It emphasizes service development and the attainment of targets.
- Advanced practice clinical skills improve access to appropriate specialist services and help to ensure seamless care for patients.
- Challenges remain, particularly in relation to governance issues, such as professional accountability and liability.

The introduction of advanced practitioners (APs) was an initiative of the Greater Manchester Strategic Health Authority (SHA).¹ The AP role is open to all non-medical staff who belong to a statutory regulated profession. The idea is that AP status will enable experienced practitioners to undertake some of the interventions currently carried out by medical staff. The AP role extends the boundaries of traditional professions in a challenging way, by developing knowledge and skills beyond those required for registration.² Examples are given in Box 1.

To support the introduction of the AP role, an associated masters

degree (MSc) in advanced practice was developed in a collaboration between the Universities of Bolton and Salford, the SHA and local NHS trusts. The SHA is demonstrating its support to NHS trusts in a very real way, by:

- providing funding for mentors and assessors
- providing professional cover for staff attending the course (two days per week)
- paying students' academic fees.

The main reason for this enthusiastic support is that it will enable NHS trusts to provide wider career opportunities for highly skilled staff and indirectly support the development of new services, such as case management, tier-2 services and walk-in centres.

The new AP role fits with the SHA's vision of NHS trusts developing their services in order to fill the gaps created by Modernising Medical Careers (a reform of postgraduate medical education) and the planned reduction in the number of hours doctor work. The AP role will also support the NHS Plan by modernising the workforce. The aim is to have a new type of health worker, who has the skills of both an allied health professional (AHP) or nurse and some of those of a doctor. The relevant AHP and nursing skills include communication, negotiation, making decisions in context, analysing the situation from the patient's point

of view and onward referral to other services, while the relevant doctor's skills are those relating to comprehensive systematic health assessments and diagnosis.

At present the students on the masters course are, in the main, nurses within community matron and case manager roles. However, there are also some AHPs, such as a podiatrist, an audiologist, a physiotherapist and an orthoptist. The smaller number of AHPs undergoing training is not due to lack of support by the SHA or the universities, but is more due to a lack of vision (or readiness) by managers and organizations, who do not see the need for APs within their services. However, development work is underway and the number of AHPs in AP roles is increasing.

The generalist AP masters programme

The MSc Advanced Practice (Health and Social Care) programme is a multi-professional, two-year, work-based programme with workplace mentors and assessors. The course is individually tailored to each student's practitioner role, as is the assessment of the student's competencies (through a portfolio of work). Support for students' work-based learning in practice is provided by university-employed learning facilitators, link tutors and 'champions' within the NHS trusts.

The core dimensions of the programme are clinical, leadership and personal attributes, and the core competency domains are knowledge, intervention, client management, and managing yourself and others (see Table 1). It is competency driven, with links to personal and professional development, portfolio development, action learning and achievement of competencies. A unique part of the competency framework is the emphasis on the student's contribution to service development.

Box 1. Case studies of the AP role

An AP paediatric nurse in the primary care emergency centre carries out whole-body diagnostics, rather than the GP.

An AP triages first-contact care via telephone and offers an appointment with herself rather than the patient waiting three days to see the GP.

An AP in audiology provides seamless care by case managing patients rather than referring them to the otolaryngology department or elsewhere.

Table 1. Summary of the domains and core competencies of APs defined by the SHA

Domains	Core competencies
Knowledge	Anatomy and physiology Pharmacology Standards Legal and ethical issues Risk Policies and procedures Accountability
Intervention	Assessment Observation and evaluation Therapeutic interventions Emotional and psychological health Communication Conflict management
Client management	Prioritizing care Coping strategies Approaches to care and care delivery Vulnerable clients and client empowerment Equity and dignity Consent Documentation Multi-professional, inter-agency team working
Managing yourself and others	Reflective practice Personal development Education, preceptorship and mentorship Organizational and developmental skills Leadership and role modelling

Students are taught systematic health assessment skills; this incorporates the underlying pathophysiology of body systems and the interpretation of data in order to make a differential diagnosis. This enables the APs in training to be able to detect abnormal signs and symptoms, to carry out the appropriate intervention, or to refer to other services.

The SHA has defined a set of core competencies which must be achieved as part of the masters programme (see Table 1). However, there is a tripartite learning agreement with the student, the university and the employing trust to provide an individualized programme of learning for APs in training. Thus the course is designed to develop students' own practice to an advanced level, and in relation to specific service outcomes.

One day per week is taught in university and one day is work-based learning; the latter provides the opportunity to consolidate the information from the taught modules and to apply it in practice.

A great deal of effort is put into ensuring that there is an appropriate and positive learning experience for the APs. It is here that the role of the

learning facilitators is crucial: they support the APs, their mentors and assessors and their organisations to ensure success.

Benefits

The new AP roles provide benefits for patients, clinicians and organizations. Patients benefit from a seamless approach to care, as the AP is able to assess, diagnose and refer directly to specialized services. Further referrals and waiting times are minimized, and patients are directed to the appropriate consultants.

Early feedback indicates that highly motivated non-medical clinicians have found this role has transformed the way they make clinical decisions and practise. They feel they have capitalized on their vast experience and skills to enable them to achieve their full potential as clinicians. Staff recruitment has been improved by the provision of opportunities for innovative clinicians to take on new challenges in a clinical role.

Organizations also benefit by implementing and demonstrating compliance with the core and developmental *Standards for Better Health* (SFBH) criteria³ (see Table

2). For example, risk management and learning from action learning are core competencies within the masters degree and have to be evidenced in the student's portfolio. As APs are engaged in evolving roles and developing new services, many unexpected challenges present themselves; these are used by students in action learning to improve interventions for patients.

Furthermore, the AP role enables practitioners to identify early symptoms of exacerbation in patients with chronic conditions, by applying the underpinning knowledge of pathophysiology learnt on the programme. Relationships with colleagues in secondary care, developed during their practice placements, enable the APs to collaborate with them to identify early preventive interventions in order to reduce hospital admissions, or to refer patients if required.

Finally, on the programme, APs have to review the evidence base for their role, which involves them in consulting a wide range of sources of evidence and research. Local audit, patient surveys, census data, and referral data from GPs are used. This mapping exercise forms the basis of their tripartite learning contract and their personal professional development. It takes a rigorous, structured and evidence-based approach to generate specific learning outcomes and targets. These outcomes and targets will allow the evaluation of the impact of the new role on patient care, such as community matrons reducing hospital admissions.

Thus, as the skills and role of the AP are developing, so is the service in which they work.

Challenges

NHS organisations and students underestimate the enormity of completing a masters programme in two years. Consequently, students are pressurized either by themselves or by their organizations to take on full case-loads or even to begin other courses, such as non-medical prescribing, while on the masters programme. This short-sightedness puts the APs in training under extreme pressure and stress, possibly leading to non-completion. If, for any reason, the new role and new service do not come to fruition, the generous funding provided by the SHA has to be repaid.

Table 2. How the AP role supports *Standards for Better Health*³

Standards for Better Health domain	Standards for Better Health criteria	Core competencies evidenced in the student's portfolio	Assignment submission by students
Safety	C1a. Identify and learn from patient incidents and make improvements in practice C5. Assess research evidence and effective clinical outcomes	Risk management, problem solving and demonstrating outcomes from action learning	Completion of a literature review and review of role development, plus a research dissertation based on the student's role in the workplace through action research
	C6. Cooperate with social services and other organizations	Multi-agency working is implicit in the role	
Clinical and cost-effectiveness	D2. Taking account of individuals' requirements, providing seamless services across organizations with decisions based on evidence-based practice	AP deals with complex cases requiring individualized treatment plans with multi-agency interventions based on the most recent research practice	
Governance	C11. Further professional and occupational development commensurate with their work		These roles are at the cutting edge of professional development underpinned by academic knowledge Data are examined to identify where the role may develop most effectively as a local service
	D6. Use of effective integrated information technology systems to enhance patient choice and service planning		
Patient focus	C13. Treat patients with dignity and respect	Core competencies of an advanced practitioner	
Accessible and responsive care	D11. Ensures access to services through a range of routes of access	A key feature of the role of the AP is the development of professional networks across primary, secondary and social care, to provide a continuous package of care for patients	
Public health	C22. Cooperating with each other and the local authority C23. Systematic and managed disease prevention programmes	As for D11, above	The use of AP skills facilitates the management of patients with long-term conditions and complex needs

Other challenges concern governance issues for APs in training, such as supervision of their practice, their continuing professional development after completion of the course and vicarious (i.e. employer) liability and accountability; these are being considered by the employing trusts.

Professional development on course completion

As the APs' roles are new, there is often initially a lack of clarity regarding what their final job description will look like. This uncertainty brings its own challenges to the APs in training, as they feel unfocused and deskilled, and this can lead to a lack of confidence in their new

role. Where organizations have expectations that have been clearly communicated to the student, there are much more likely to be no misunderstandings, and achieved targets and outcomes.

Accountability

The issue of accountability remains unresolved, although work by the professional councils may lead to registration of the title of 'advanced practitioner'.

Vicarious liability

When a mentor or assessor employed by one trust (e.g. an acute trust) approves the competencies of an AP in training who is

employed by another organization (e.g. an NHS primary care trust), it is unclear who has vicarious liability. Giving the mentor or assessor an honorary post with the AP's employer may resolve this question, although ideally the student should be assessed by a member of staff of the NHS trust in which the AP in training will be working. Alternatively, APs could provide their own indemnity cover. As autonomous practitioners adhering to a professional code of conduct, practitioners should be working within their own scope of professional practice and should not undertake any task in which they do not feel they are competent.

The future

The APs need to be given the ability to refer patients directly to specialist services, to improve access for their patients. Protocols need to be set up and colleagues need to view this step forward in a positive light, not as a threat to their authority or role.

Also, as the APs graduate they will need new job descriptions, new professional development plans, new contracts and possibly amended salary bandings.

Conclusion

Despite the challenges of moving into uncharted waters there are benefits for all stakeholders with the AP initiative. The masters programme provides a unique opportunity for innovative practitioners to develop their role and achieve their full potential. Patients benefit from seamless care and speedier access to more appropriate specialist services. Organizations are provided with evidence that they are fulfilling SFBH requirements.

References

- 1 See www.gmsa.nhs.uk/core/dtw/advanced.htm

- 2 Department of Health. *Developing a Shared Framework for Health Professional Learning Beyond Registration*. London: DH, 2003. Available at www.dh.gov.uk/PublicationsAndStatistics/Publications/Statistics/Publications/fs/en

- 3 Department of Health. *Standards for Better Health*. London: DH, 2004. Available at www.dh.gov.uk/PublicationsAndStatistics/Publications/Statistics/Publications/fs/en

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The risks of poor communication about medication between primary and secondary care

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- Over half of drug lists on letters to GPs from hospital outpatient departments do not agree with those held in primary care.
- Nearly 40% of these discrepancies could lead to a critical incident. These discrepancies therefore pose an important challenge to clinical governance.
- Hospitals find it difficult to reply to information about prescribing.
- Template letters may improve communication.
- If patients had access to their records this would be likely to improve safety.
- Practices need support in updating their patients' drug lists.

The problem of potentially unsafe prescription errors arising as a result of poor communication between primary and secondary care, especially for patients who require long-term continuing care, has long been recognized but there are few examples of it being quantified. The National Prescribing Centre suggested in 1998 that better communication between hospital and community pharmacists might reduce the associated risk.¹ The interface between primary and secondary care has always been difficult for patients, as service provision has been hindered by poor communication and coordination.^{2,3} Patients are often left feeling confused and

disempowered as they have moved across this interface.⁴ Discharge summaries are particularly subject to problems.^{5,6}

Why do hospital and practice drug lists differ?

Particularly with long-term conditions, drug changes are made frequently within both primary and secondary care. There are a number of situations in which communication can break down or confusion arise:

- The hospital recommends a drug which perhaps does not suit the patient, so the GP changes it.

There is no agreed mechanism for notifying the hospital of this.

- The consultant recommends a change in prescription. This message is not clearly enunciated in the letter and the GP does not see it. The patient does not receive the new drug.
- The GP, in the referral letter, may not inform the consultant about all the drugs the patient is taking.
- The practice does not update its medication list from hospital letters and discharge notes.

What risks are posed?

- If either consultant or GP (or nurse) does not know the exact list of current medication, new drugs may interact negatively with existing ones.
- Time is wasted and the patient may not receive the benefit of an effective new drug.

An audit of drug lists

Some years ago, a patient in our practice raised the issue of safety in interface prescribing. She had noticed that the drug list held by the hospital about her was different to that held by the practice and that this could cause problems for all three parties: the hospital, the GP and the patient. The practice decided to investigate how widespread this risk is, and ran a simple audit to examine the number of discrepancies and whether they matter.

The aims of the audit were:

- to identify the rate of discrepancies between one hospital's lists of medications and the practice's
- to identify which discrepancies could lead to a critical incident
- to see how many replies the practice received to faxes sent pointing out discrepancies

Table 1. Summary results of audit

	Number (%)
Letters received from hospital	411
Letters with list of drugs relevant to the specialty	60 (15%)
Letters with a discrepancy between the practice and hospital list	31 (52%)
Discrepancies that could lead to a critical incident	12 (39%)
Faxes sent to hospital informing it of the discrepancy	17
Replies from hospital to faxes sent	9
Proportion of faxes sent to hospital that received a reply after a minimum of two weeks	53%
Letters from hospital asking for changes to medication	28

Table 2. Suggested format of a medication change sheet

New medication	Date started	Medication stopped	Date stopped

- to identify the proportion of letters that asked the practice to change medication.

The judgement concerning whether a discrepancy could lead to a critical incident was a subjective one made by the authors. It was based on the likely side-effects and interactions of the two sets of drugs. In addition, where relevant, the risk of not being prescribed a drug which was needed was taken into account.

All letters received by two GPs in the practice were examined, over the course of four weeks for one and over the course of two weeks for the other. The following were recorded:

- the total number of letters received
- the number of letters that had a list of drugs (specifically ones relevant to the hospital department concerned, and which the patient was meant to be taking routinely)
- the number of letters that had a discrepancy between the practice's list and the hospital's
- the number of faxes sent to the hospital to point out discrepancies
- the number of replies from the hospital to those faxes after at least two weeks.

Relatively innocuous drugs such as laxatives were not included in the analysis. Changes recommended by the hospital were not included as discrepancies between lists.

Results

The results of the audit are summarized in Table 1. It can be seen that when the hospital informed the

Box 1. Draft template for outpatient consultant letters to GPs

Date:
 Consultant:
 Contact no./bleep:
 Email:

Patient's full name
 (Mr, Miss, Mrs, Mr, Ms):
 NHS number:
 Hospital number:
 Address:
 Date of birth:

GP:
 Address:
 Email/fax

Dear ...

Your patient was seen by me on...

Diagnosis/problem/READ code:

Investigations undertaken and findings:

Recommended management:

Response to specific query from GP:

Medication advised/prescribed:
 • name of drug and dose
 • added/stopped/dose changed (please specify)
 • reason for change
 • length of treatment/monitoring required

I would be obliged if the practice could do the following:

Information (written/verbal) given to patient:

Follow-up (appointment made or length of waiting list for procedure):

Letter copied to patient: Y / N

Yours sincerely,

Signed:
 Print name:

Consultant/SR/Registrar/SHO

practice about the drugs that the hospital thought the patient was taking, that information was incorrect over half the time. In addition, the local hospital seemed to find it difficult to reply to information about prescribing. A substantial proportion of these discrepancies could lead to a critical incident, and so they pose a challenge for clinical governance.

Possible next steps

Both the primary care trust and the hospital trust should develop an approach that enables changes in medication to be better tracked and responded to. This might mean initially developing a paper form that patients carry between practice and hospital. One such was designed by the patient who pointed out the problem in the first place (Table 2). The best solution would be automatic

electronic updating across the interface.

Practices should be encouraged to update incoming medication information. This could become a quality and outcomes framework target.

Consultants should be encouraged to respond to medication queries. For example, a template letter should be developed for consultants to communicate outpatient advice and medication changes clearly to practices. One such (Box 1) is currently being used across Lewisham Primary Care Trust and is linked to 'choose and book'.

If patients had access to their own electronic health record, this would be likely to improve safety.⁷ If, as is likely in the next year or so, patients will be able to access their records online, it would be quick and easy to show clinicians in hospital the current GP prescription list.

References

- 1 National Prescribing Centre. *GP Prescribing Support. A Resource Document and Guide for the New NHS*. Leeds: NHS Executive, 1998
- 2 Duerden M, Walley T. Prescribing at the interface between primary and secondary care in the UK. Towards joint formularies? *Pharmacoeconomics* 1999;15:435-43
- 3 Gandhi TK, Sittig DF, Franklin M, Sussman AJ, Fairchild DG, Bates DW. Communication breakdown in the outpatient referral process. *Journal of General Internal Medicine* 2000;15:626-31
- 4 Preston C, Cheater F, Baker R, Hearnshaw H. Left in limbo: patients' views on care across the primary/secondary interface. *Quality in Health Care* 1999;8:16-21
- 5 Colemann A. Discharge information needs to be improved to prevent prescribing errors. *Pharmaceutical Journal* 2002;268:81-6
- 6 Shepperd S, Parkes J, McClaren J, Phillips C. Discharge planning from hospital to home. *Cochrane Database Systematic Review* 2004;(1):CD000313
- 7 Fisher B, Dixon A, Honeyman A. Informed patients, reformed clinicians. *Journal of the Royal Society of Medicine* 2005;98:530-1

Using the Liverpool Integrated Care Pathway to manage elderly patients with terminal illnesses

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- The Liverpool Integrated Care Pathway (LICP) is a structured instrument which has proven beneficial in managing the terminal phase of a wide range of conditions in old age.
- The LICP is not just a care pathway but also a medium for training, service development and quality assurance.
- The LICP helps staff explain to carers and relatives the needs of dying patients and how these will be met.
- Concentrating the introduction of the LICP on a 'champion' ward was successful in ensuring smooth implementation on other wards.

The care of people in the terminal stages of malignant disease has improved greatly over the last 20 years, due largely to the development of palliative medicine as a specialty and the work of charities such as

the Macmillan Trust. However, patients with end-stage non-malignant illnesses, such as cardiac failure and fibrosing alveolitis, often have distressing symptoms and there is evidence that, in the UK, they usually do not have access to specialist palliative care.¹

To some extent it is possible to transfer the principles and techniques of palliative medicine to all terminally ill patients using care pathways, the most well known of which is the Liverpool Integrated Care Pathway (LICP).² Originally conceived for the management of terminal heart failure, the LICP can be used to manage most dying patients in their last few hours or days. It is not just a care pathway but also a medium for training, service development and quality assurance. The LICP helps staff explain to carers and relatives the needs of dying patients and how these will be met.

This paper describes the systematic adoption of the LICP for frail elderly patients in a ward dedicated to palliative geriatric medicine.

Preliminary survey

We initially conducted an open, fact-finding survey of nursing and medical staff's opinion about the quality of end-of-life care for elderly people across our trust. This was done in one-to-one and small-group discussions. Some carers were also included. Several consistent themes emerged:

- Most dying patients received adequate but not optimal management of their symptoms.
- A small proportion of patients had clearly inadequate terminal care.
- The main shortcomings in relation to symptom control concerned poor management of pain, breathlessness, nausea and anxiety.

- Ward staff and junior medical staff were sometimes unsure about an individual patient's palliative 'status', and whether or not to embark upon further therapeutic interventions.
- These factors had led to informal and formal complaints in some cases.
- Nursing and medical staff varied greatly in their knowledge of palliative treatments and the timing of those treatments.
- Sporadic attempts to use the LICP on some wards had faltered due to a lack of knowledge, training and experience with it.
- Many staff were aware of the LICP and felt that it could be very useful, particularly to help provide a more holistic and complete plan for individual patients.

Introduction of the LICP

To address the concerns revealed by the survey it was decided that the LICP would be adopted and subjected to a formal assessment of its performance. The LICP has an established track record, is based on available evidence of good practice and is designed for multi-professional use. It gives structure to symptom control through anticipatory prescribing (i.e. it provides flexibility for nurses to manage symptoms) and the discontinuation of inappropriate interventions, and it prompts staff to consider psychological, spiritual and family issues.

One ward, already used for care of elderly patients too frail or with conditions too complex to allow their discharge, was chosen for the pilot study. The ward leaders had experience in formal palliative care settings. Training for medical and nursing staff was provided in the use of the LICP documents and a consultant geriatrician with an interest in palliative care provided senior medical supervision.

The LICP requires that, before starting a patient on the pathway, the medical and nursing (and sometimes other) staff must agree that the patient is dying. Then, two or more of the following criteria should apply to the patient (though these are not rigidly applied):

- bed-bound state
- reduced level of consciousness
- not able to take anything (including tablets) by mouth except sips of fluid.

Table 1. Mean results^a of a questionnaire survey of 14 trained nursing staff

Item	Mean rating
The LICP was useful to you as a nurse	4.4
The LICP was acceptable to you as a nurse	4.6
The LICP saved you time	4.1
The LICP is beneficial to patients	5.0
The LICP helps carers understand palliative care	4.1
The LICP covers all the needs of a dying patient	4.8
The LICP helps staff develop skills in palliative care	5.0
The LICP should be adopted on this ward from now on	5.0
The LICP should be used by all wards	5.0

^aOn a five-point Likert scale (5 = strongly agree, 1 = strongly disagree).

The patient's carers were given a full explanation of the purpose of the LICP by a doctor or senior nurse. The patient then received all the nursing care required and drugs to control symptoms were given parenterally, most often as a continuous subcutaneous infusion by syringe driver, or via subcutaneous injection, or transdermally. A full description of the drug management of terminal symptoms is beyond the scope of this paper; the most commonly needed drugs were diamorphine (or morphine), midazolam, hyoscine and anti-nauseants. Artificial feeding and hydration, if being given, were withdrawn.

The pilot study

Over six months, 40 patients (31 female) were managed with the LICP. Their mean age was 85.3 years (range 74–97). The diagnostic breakdown was stroke/cerebrovascular disease (15), malignancy (5), chronic obstructive pulmonary disease (3), dementia (5), heart failure (4), fibrosing alveolitis (4), multiple sclerosis (1), idiopathic myopathy (1), subarachnoid haemorrhage (1), Parkinson's disease (1).

An audit of the LICP documents was conducted. The main findings were as follows:

- The documentation was operationally complete and there was no evidence of the standard of record keeping falling over time.
- The documents were easily found in the case-notes.
- The mean duration on the pathway was 6.5 days (range 1–19).
- No patient needed to come off the pathway.
- The commonest departure from the pathway was continuation of transdermal fentanyl rather than

changing to morphine/diamorphine. This occurred in patients in whom the pain control was already satisfactory on fentanyl.

- During and after the pilot study there were no formal or informal complaints about the LICP from patients, carers, nurses, doctors or GPs (who were normally informed).

We conducted a questionnaire survey of 14 trained nursing staff on the pilot ward, with a five-point Likert scale (5 = strongly agree, 1 = strongly disagree). The mean results are shown in Table 1.

The next phase

After the formal pilot phase described above, the ward used the LICP for another 40 patients with no adverse incidents. The LICP was then introduced in two further wards after staff consultation and introductory training. No difficulties have been encountered and a further plan for a general roll-out can now be made with confidence. This has been more successful than previous attempts, probably because of the demonstrable success on the pilot ward and informal networking among the nurses.

References

- 1 Murray SA, Boyd K, Kendall M, Worth A, Benton TF, Clausen H. Dying of lung cancer or cardiac failure: prospective qualitative interview study of patients and their carers in the community. *BMJ* 2002;325:929–32
- 2 Ellershaw JE, Murphy D, Shea T, Foster A, Overill S. Development of a multi-professional care pathway for the dying patient. *European Journal of Palliative Care* 1997;4:203–8
- 3 Ellershaw JE, Ward C. Care of the dying patient: the last hours or days of life. *BMJ* 2003;326:30–4

Clinical audit of the Care Programme Approach, records and risk: an integrated approach for mental health and learning disabilities trusts

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- An integrated approach to audit, rooted in improving and enhancing patient care, can save time, effort and paper.
- It is possible to develop a single, integrated audit tool (which can be used by other mental health providers).
- The process of peer review is beneficial for auditors in auditing their own and others' case-notes (particularly on other sites).
- The process of audit allows managers and clinicians to identify examples of good practice (and of what is not working so well).
- The trust has made significant improvement in implementing the Care Programme Approach, but there is still work to do.

Derbyshire Mental Health Services NHS Trust annually audits key minimum clinical and practice standards (Care Programme Approach, clinical records and clinical risk). Historically, these key areas have been audited at different times of the year and not all service areas (adults, older adults, child and adolescents, learning disabilities) have participated. In 2005, however, those managing the three audit areas and the trust clinical audit coordinator worked together to provide an integrated approach.

Development of an audit tool

A single audit tool, that is, a data-collection form, was produced. It covered clinical standards in three key areas:

- the Care Programme Approach (CPA) (a set of national standards for the community care of people within mental health services)

- clinical record keeping
- evaluation of risk.

All questions were related to the standards shown in Table 1.

The aim was to produce a tool which followed, in chronological order, a hypothetical set of case-notes so there was no need to carry out three separate audits (i.e. looking at the same set of case-notes on three separate occasions).

Arguably, there was a pragmatic rather than evidence-based approach to setting the targets (percentages) shown in Table 1. The CPA standards had been audited by the trust for each of the previous five years and it was thought unacceptable to achieve any less than 100%. Records standards had been audited across the trust twice in its latest configuration (there was a trust merger in April 2002), in 2003/4 and 2004/5, when the target was set at 50% 'across the board'. Therefore, in 2005/6 it was decided to increase the target from 50% to 75%. In 2005/6 the risk standards were being audited for the first time since the merger and hence they were set at 50%. (Of course, trusts interested in using the audit tool can choose their own targets.)

As well as setting targets, it is standard practice to set 'exceptions' when setting audit criteria. Arguably, this is most effective with local, smaller audits, but becomes unwieldy when carrying out a trust-wide audit. However, we sought to avoid such problems with the present audit tool by paying particular attention to the wording of the criteria. For example, one standard read 'Service users to be offered copies of their care plan' rather than 'Service users to be given copies of their care plan', as the latter wording might require an 'exclusion',

if for instance a service user declined to have a copy of the plan. Again, trusts interested in using the audit tool can choose whether to set 'exceptions'.

In the final version of the tool there are 12 sections:

- Access to the file
- General recording standards
- Each episode of care (specific criteria)
- Front section of the file (specific criteria)
- Logs, history sheets, notes
- Assessment
- Risk assessment
- Participation
- Care plan
- Care plan distribution
- Review
- Carers

These sections contain 122 questions. Each question is a simple rephrasing of one of the audit criteria (see Table 1 for examples).

The audit tool also asks for service identification data:

- Team and service
- Clinical network (choice of 'Adult', 'Older people', 'Child and family', 'Learning disability')
- Base
- Primary care trust area
- Social services area
- Level of need (choice of 'standard' or 'enhanced' CPA tier)
- Contact, auditor.

In using the tool, auditors are required to tick or circle 'Yes', 'No' or 'Not applicable'. As a result of the standards and the design, all the data collected are quantitative. It takes approximately an hour to audit one set of case-notes against all three sets of standards.

Table 1. Standards and example audit criteria

	CPA	Records	Risk
Description	Robust standards	Minimum standards for clinical and practice records	Clinical risk standards
Source	National	Trust	Trust
Number of standards	14	12	13
Number of (audit) criteria relating to these standards	48	47	27
Target (proportion of standards met)	100%	75% (50% in 2004)	50% (as in baseline audit)
Examples of criteria	Carers to know who is the service user's care coordinator, and how to contact him/her	Service users to be given advice on how to access their records	Risk documentation to be on 'gold' (standardized) paper
	Service users to have a say in decisions about their care	Service users to be given the opportunity to receive a copy of letters written to other professionals	Initial assessment of risk to be communicated to those involved in service user's care within 7 days
	Care plan reviewed within last 6 months	Service user's name/NHS number to be written on every page and on charts	Outcome of risk assessment to be communicated to referrer within 7 days
	Service users to be offered copy of care plan on discharge from hospital	Record to contain date of birth	Risk management plan to be formulated
	Service users to be asked if they would like a friend, relative, or advocate involved in their care	Record to be written in black ink	Risk management plan to be part of CPA care plan
	Carers to be offered a copy of the service user's care plan	Entries recorded on same day or shift or next working day or shift	

Study audit

The data were collected via peer review. Fifteen service managers were each asked to ensure that 20 sets of case-notes were audited (giving 300 sets in total). Teams could audit their own notes or those of other teams. The only exclusion criterion was that no auditor (if a clinician) could audit her or his own case-notes.

The data were then collated using the Access database and the initial results produced. 'Not applicable' and 'not known' responses and missing data were excluded.

Results

The good news was that the development of the single integrated tool

aided the process of data collection, entry and analysis. The actual audit results showed that:

- some improvement had been achieved in nearly all areas of the CPA
- there were some significant improvements overall
- the trust was still falling significantly short in 'must do' areas of the CPA
- the trust was still failing to achieve 100% on some of the basic areas of records and clinical risk.

Written reports and presentations were made to senior managers, professionals, service users and carers. Further analysis and understanding led to the production of action plans

Discussion

Use of the audit tool will be most effective with a multi-professional electronic record system and indeed the trust is exploring how much of the quantitative data can now be reliably drawn from an improved electronic records system. In terms of the CPA this will lead to regular updates for managers, professional leads and clinical staff on compliance with required standards.

For neither clinical risk nor clinical records can the trust currently move to regular electronic reporting, as the audit requires examination of the physical record. Once we have a comprehensive electronic record then most elements will be auditable from that.

In all cases, the potential to move from data collection from paper records to automated data collection will open the possibility to look more at the qualitative aspects of CPA and clinical risk, such as the quality of care planning and the quality of clinical risk profiling.

It is hoped that other trusts will adopt and adapt the audit tool, which is the intellectual property of Derbyshire Mental Health Services NHS Trust, but a simple acknowledgement of copyright will suffice.

Questionnaire seeking your views

After six years we are keen to relook at the focus of CGB to ensure that it continues to meet the need of our readership and deal with current issues. Could you please complete the brief questionnaire enclosed with this issue and return it to the RSM by the end of May.

With grateful thanks.

The Editor

Putting evidence into practice: use of a bedside falls form on a rehabilitation ward for older persons

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- A simple bedside falls form improved the frequency and adequacy of fall risk assessment.
- Falls prevention measures were used more frequently.
- There was a reduction in falls on a rehabilitation ward after introduction of a form.
- Simple falls forms are an economical and effective way of translating falls research into everyday clinical practice.

Falls are common on hospital wards that specialize in the care of the elderly. Recurrent falls are a strong predictor of admission to residential care institutions and are associated with considerable morbidity and mortality.¹ Falls prevention can reduce the incidence and complications of falls.² However, a gulf exists between the world of falls research and everyday practice. For instance:

- it is unclear whether interventions should be targeted only at those identified as being at high risk or whether attention should be paid to common reversible risk factors in all patients
- falls-prevention protocols designed for research may be too complex for use in the day-to-day hurry of ordinary hospital wards.

In an attempt to put recent research findings into practice we developed a simple bedside falls chart that

encouraged risk assessment and prompted interventions, and then audited its effectiveness on a rehabilitation ward.

Methods

A two-phase audit was carried out on a 28-bed ward that specializes in the rehabilitation of elderly patients. The following audit standards were used:

- All patients should have a falls risk assessment during their admission.
- The assessment tool should be completed correctly.
- Falls prevention measures should be taken in patients at high risk of falling and these should be documented.

Phase 1: initial audit

The medical notes of 52 consecutively discharged patients were audited against the defined standards. The incidence of falls was determined by searching the medical notes, the falls logbook on the ward and the adverse incident logbook.

The intervention: a bedside falls form

After phase 1 a new falls form was designed. We created a form that identified common fall risk factors and that served as a bedside chart for formulating a care plan. In addition, the chart contained a section on

which to document whether any of the prevention measures were in use at 14:00 and 24:00 each day.

The risk factor assessment section was simplified to encourage completion. It comprised the following items:

- past history of falls
- confusion (restless, agitated or wandering)
- unsafe gait (in cases of doubt, classed as unsafe)
- urinary incontinence

The falls-prevention section of the form consisted of a list of measures to implement to prevent falls:

- wrist band
- call button
- footwear
- clear clutter
- toileting
- safety instructions
- medication changed (by doctor)

The form also highlighted measures that should be specially considered in those found to be at a high risk of falling:

- bed rails
- ambulatory alarms
- observation beds
- furniture changes
- nurse patient on floor
- hip protectors
- attendance at balance group
- other

Table 1. Comparison of phase 1 and phase 2 audit results: number (%) of positive responses

	Phase 1 (before introduction of the bedside falls form) (n = 52)	Phase 2 (after introduction of the bedside falls form) (n = 100)	P-value (chi-square test)
Was a falls risk assessment performed?	30 (58%)	98 (98%)	< 0.0001
Was the assessment adequately completed?	0 (0%)	96 (98%)	< 0.0001
Were falls prevention measures documented?	9 (17%)	97 (97%)	< 0.0001
Incidence of falls on the ward	11 (21%)	16 (16%)	= 0.5

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Phase 2: Completing the audit cycle

A repeat of the phase 1 audit was carried out on 100 consecutively discharged patients.

Results

Table 1 compares the results from the two audits. In phase 1, 30 patients (58%) had a falls risk assessment but in no case was this assessment adequately completed. Nine patients (17%) had falls prevention measures identified. Eleven (21%) had one or more falls on the ward. In phase 2, after the introduction of the bedside falls form, 98 patients (98%, $P < 0.0001$) had a falls risk assessment, and in 96 of these cases (98%, $P < 0.0001$) this was adequately completed. Ninety-seven patients (97%, $P < 0.0001$) had falls prevention measures identified. Sixteen patients (16.0%, $P = 0.5$) had one or more falls on the ward.

Discussion

This audit showed that a bedside falls form was effective.

- Fall risk assessment was more frequent.
- Preventive measures were used more frequently.
- There was a reduction in the incidence of falls on the ward (the difference did not reach statistical significance but the sample sizes were relatively small).

The presence of the form at the bedside encourages its use and makes risk assessment and falls prevention part

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of the everyday nursing routine. The risk factor assessment was simple. It used only four common risk factors that consistently emerge as important predictors of falls.³ Simplified and accessible forms encourage more frequent falls assessment.

The falls form encouraged the formulation and documentation of a care plan. This has beneficial risk management and medico-legal implications. A higher proportion of the patients who fell were found to have documented evidence of preventive measures, which would provide supportive evidence if legal concerns were raised after a fall.

Limitations of the study

- The use of yet another bedside chart increases the burden of work on the nursing staff. However, we have tried to keep it simple and, in time, the form may replace other procedures.
- The audit took place on a rehabilitation ward that already had a philosophy of falls prevention. Any audit cycle necessarily uses historical controls and therefore does not allow for historical trends in the fall rate before and after the intervention. The reduction in the incidence of falls on the ward may be historical and not a consequence of the intervention.

- The audit should be repeated in a variety of settings, with a larger number of subjects, to assess the benefits of the bedside falls form further.

Conclusion

Recent evidence suggests that targeted prevention strategies effectively reduce the incidence of falls in hospital.^{2,4} The challenge now is to find ways to encourage falls assessment and prevention on ordinary hospital wards. The use of a simple bedside falls form, for both risk assessment and as a prompt for prevention, may help provide a cost neutral way of achieving this goal.

References

- 1 Donald IP, Bulpitt CJ. The prognosis of falls in elderly people living at home. *Age and Ageing* 1999;28:121-5
- 2 Healey F, Monro A, Cockram A, Adams V, Heseltine D. Using targeted risk factor reduction to prevent falls in older in-patients: a randomised controlled trial. *Age and Ageing* 2004;33:390-5
- 3 Oliver D, Daly F, Martin FC, McMurdo MET. Risk factors and risk assessment tools for falls in hospital in-patients: a systematic review. *Age and Ageing* 2004;33:122-30
- 4 Oliver D, Hopper A, Seed P. Do hospital fall prevention programs work? A systematic review. *Journal of the American Geriatrics Society* 2000;48:1679-89