

Local Guidelines

Robin Davidson, the Chair of GAINs Operational committee has some guidance on guidance

The Operational Committee of GAIN adjudicates on submissions for local audit and guideline projects. We have now two rounds of submissions each year and have established a transparent and efficient process for judging all proposals. Successful projects are supported both financially and administratively by the GAIN office throughout their operational life from germination of the idea to final launch.

I must say that the quality of submissions from groups of local health and social care professionals is exceptional making the selection process very difficult. As well as these specific proposals, the process obviously also allows for top/down requests from, for example, the DHSSPS, RQIA, Service Frameworks and the Coroner's Office. While, in exceptional circumstances, some requests can be 'fast tracked' we apply the same selection rigour to all proposals whatever the source.

The last year saw an increase in requests for audit funding but a decrease in clinical and social care guideline proposals. I think this may be partly due to some uncertainty about the procedures of local guideline development

and partly about misperception of the relationship between GAIN and NICE guidance. The Department has now established a clear pathway for the adoption of NICE guidelines in NI and is in the process of appointing a NICE Facilitation Officer to assist in the uptake and dissemination of NICE guidance. It would therefore be foolish for GAIN to duplicate the role of NICE and to commission local guidance which mirrors recent or imminent NICE publications. There are however guidelines which NICE, or for that matter SIGN, would not commission. This may be for example because a particular clinical area is just too small and/or esoteric to render a full NICE guideline cost effective. This may also be the case if a guideline is relevant to a specific NI issue and the recommendations cannot be generalised to the rest of the UK. Perhaps a guideline straddles health and social care or maybe it is relevant to a small health care sector e.g. elderly care homes or children's residential facilities. It neither case would it be of interest to SIGN or NICE. It is these 'niche guidelines' which GAIN is keen to encourage. GAIN simply does not have the resources to commission wide ranging guidelines for extensive clinical areas requiring a comprehensive and expensive systematic literature review and a huge development group.

So GAIN is not 'NICE lite'. The guidelines produced in NI for local use are qualitatively rather than just quantitatively distinct from those produced by NICE in terms of their scope, width of application and applicability. Finally the key questions about any guideline are *Does it make a difference?* and *Will it permanently alter the behaviour of the health and social care professionals at whom it is aimed?* All too often guidelines are beautifully produced, 700 page booklets which are better at collecting dust than improving the health and wellbeing of patients and clients. I'm sure this will not be the case with GAIN guidance.



Professor Robin Davidson Chairman of Operational Committee (GAIN)

Please note that further guideline information and application forms can be obtained from the GAIN office or website. Further information on NICE is available from the Standards and Guidelines Unit (DHSS).

Changes to Northern Ireland Newborn Bloodspot Screening Programme

The Northern Ireland newborn bloodspot screening programme has been in place since the late 1960's. It offers all five day old babies the opportunity to be tested for a number of rare but serious conditions. For the small number of babies identified as having phenylketonuria (PKU), congenital hypothyroidism (CHT), or cystic fibrosis (CF) early treatment can improve their health and prevent serious disability or death.

On 3 August 2009 important changes to the screening programme took place, with the addition of Medium chain acyl co-A dehydrogenase deficiency (MCADD) to the screening programme. MCADD is an inherited metabolic disorder which means that affected infants have difficulty breaking down fats to make energy for the body. This can lead to serious illness, disability or death.

Newborn bloodspot screening for MCADD means the condition can be recognised and treated early i.e. before clinical presentation in most cases. Treatment is largely dietary, by ensuring regular intake, particularly during periods of illness or stress. About 1 in 10,000 babies born in the UK have MCADD.

The other change to the newborn bloodspot screening programme which occurred on 3 August 2009, was the inclusion of DNA testing to initial screen positive tests for cystic fibrosis, in line with practice in the rest of the UK. This means that most babies with CF are recognised on the initial screening test and a small number of infants with rarer forms of CF are identified. Some 0.5% of infants have DNA testing under the new protocol. About 1 in 2,500 babies born in Northern Ireland have CF.

The UK standards for the newborn bloodspot screening programme were updated in August 2008. A training programme for all midwives, health visitors and paediatric nurses, which provided information on the changes to the bloodspot programme and the new standards, was rolled out across all Trusts earlier in 2009.

Further information including parent information leaflet, training presentation, professional handout and new protocols and guidelines for CF and MCADD can be accessed via the DHSSPSNI website:

<http://www.dhsspsni.gov.uk/index/phealth/php/screening/nbbscreening.htm>

Jackie McGeagh

Regional Antenatal and Newborn Screening Co-ordinator



Beechcroft Regional In-Patient Children's Mental Health Service: 'Fit for Purpose' Referral Forms

Beechcroft Children's Ward is a regional, in-patient children's mental health service, operating in parallel with a regional Adolescent Ward. Referrals to Beechcroft are accepted from out-patient Child & Adolescent Mental Health Services (CAMHS) across Northern Ireland on a 'Consultant to Consultant' basis, although the multidisciplinary team will usually be very much involved in the information sharing and decision making processes around admission.

Referrals to the Children's Ward usually involve a two step process, beginning with a referral form which is then followed up with a joint meeting between the in-patient and out-patient teams and any other relevant agencies. It is important that referral forms facilitate clear information sharing and decision making, in order to ensure safety and quality of service.

An initial audit in 2006/2007 showed that the existing referral forms were not 'fit for purpose'. The quality of information on the referral forms varied in legibility, accuracy and helpfulness. This meant that young people often followed assessment and treatment pathways quite different from those anticipated at the time of referral. The audit recommended various changes to the design and use of the referral form; these were implemented with the aim of improving the setting of clinical goals and communication with referrers.

A re-audit of the newly designed referral form was started in 2009, testing it against the same criteria used in the original audit. Referrer opinion on the utility and helpfulness of the updated referral form was sought using a Likert-style feedback form.

After three months a pilot study was completed. Many of the original difficulties with the referral forms persisted and the response of referring clinicians to the updated form was somewhat ambivalent e.g. people were unsure as to whether the form asked for "the right amount of information and detail". The pilot highlighted the need to work collaboratively with referring clinicians on refining the referral process and to develop best practice regionally. GAIN was contacted at this stage, and suggested a workshop bringing together referring and admitting clinicians as a way forward.

A workshop was organised. Clinical and managerial staff participated in a focus group style discussion. Referring clinicians had the opportunity to highlight the difficulties they perceived with the current referral process. There was also an opportunity to acknowledge wider policy and practice issues impacting on the referral process, given that CAMHS is facing a time of significant change (e.g. the introduction of regional risk assessment measures). Out-patient clinicians viewed the difficulties in

the referral process differently to the in-patient team, emphasising the practical difficulties associated with form-filling and the value they placed on ease of access to conversations and meetings with the in-patient team when referrals were being planned. Whilst they agreed that it was important to have clear and transparent documentation of information shared and decisions made, they wanted clear referral pathways through a responsive, easy to negotiate and flexible system. A number of creative yet practical solutions were suggested on the day. This included the use of a form that could be added to at various stages of the referral process (e.g. documenting telephone conversations in addition to more formal meetings) and the role of video conferencing. The in-patient teams plan to take these suggestions forward. The workshop created a clear sense of joint ownership and readiness for the changes which need to be implemented.

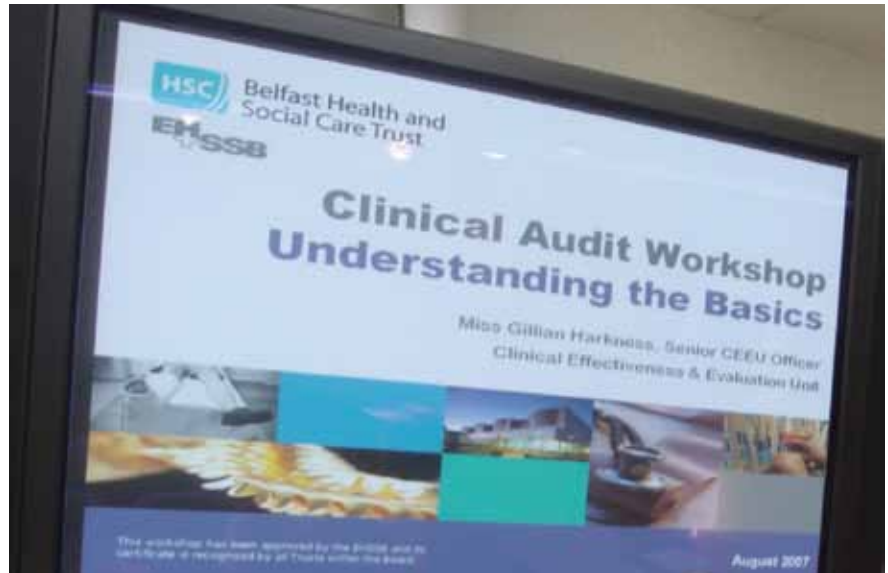
This experience highlights the value of audit as a tool for collaborative service development, even in a multi-layered system where various perspectives need to be taken on board. It also emphasises the importance of re-audit and a willingness to go 'back to basics'. Finally, it demonstrates how qualitative social research methods can be used to complement more traditionally employed audit methods.

Dr Heather Hanna, Child & Adolescent Psychiatrist & Dr Niall Falls, Consultant Child & Adolescent Psychiatrist

Clinical Audit Training in the N Ireland Foundation Programme

The Foundation Programme, an initiative to provide a training structure between medical school and speciality training, was introduced in August 2005 across the four devolved nations. This is a two year programme spanning the previous post of the provisionally registered house officer and the first year post registration as a senior house officer. These grades have been replaced with the Foundation doctors now termed F1 and F2 doctors.

The Foundation programme has a curriculum and the role of clinical audit states that *'Foundation doctors must demonstrate that they understand and apply the principles of clinical audit'*. Since August 2006, all Foundation doctors in Northern Ireland have attended a clinical audit workshop as part of the mandatory regional generic skills training modules. Each module is provided on six occasions with up to forty doctors attending as part of their allocated study leave time.



Under the work-based learning requirement of the curriculum, all Foundation doctors should have undertaken a supervised clinical audit project at the end of their F2 year.

Although clinical audit is an essential part of the clinical governance framework, it has often been seen as a 'tick box' exercise by doctors in training, with the benefits over shadowed by the busy healthcare workplace.

The Clinical Audit Training delivered to the foundation doctors assists them to develop their knowledge and skills in both clinical standards and clinical performance and generates evidence of continued professional development for their career progression. Clinical audit is designed to influence the quality & safety of patient care doctors provide.



F2 Generic Skills – Clinical Audit Training

The clinical audit workshops cover key themes of learning linked to the requirements of knowledge and competencies in the F2 Curriculum. This includes the audit cycle, data sources for clinical audit and managing data confidentiality. Emphasis is laid on completing the clinical audit project for the

F2 year, with practical advice on topic selection and the clinical audit support available in Trusts. Surprisingly each year there are foundation doctors who are not aware that Trusts have dedicated clinical audit staff to provide support and advice to all healthcare professionals.

Diagram 1: (right) Mapping of key themes for Clinical Audit adapted from the Foundation Programme Curriculum (UKFPO website to download full copy)

The Level 1 Clinical Audit Training Standards developed by the EHSSB Clinical Audit Committee in 2004 form the basis of the workshop material delivered.

The graph below shows the number of F2 doctors who attended clinical audit sessions since the workshops were commenced in 2006. The total number of doctor who have attended is now 654. The 2009-2010 sessions begin in August 2009 and this number will climb to 890

08-09 Clinical Audit Training Feedback

As part of the evaluation of the Generic Skills Programme, doctors were asked if they felt better prepared to undertake a Clinical Audit project following the training provided. Based on the 2008-2009 feedback, 208 doctors agreed they felt better prepared while 4 doctors disagreed.

Foundation doctors provided comments and suggestions on improvements which could be made

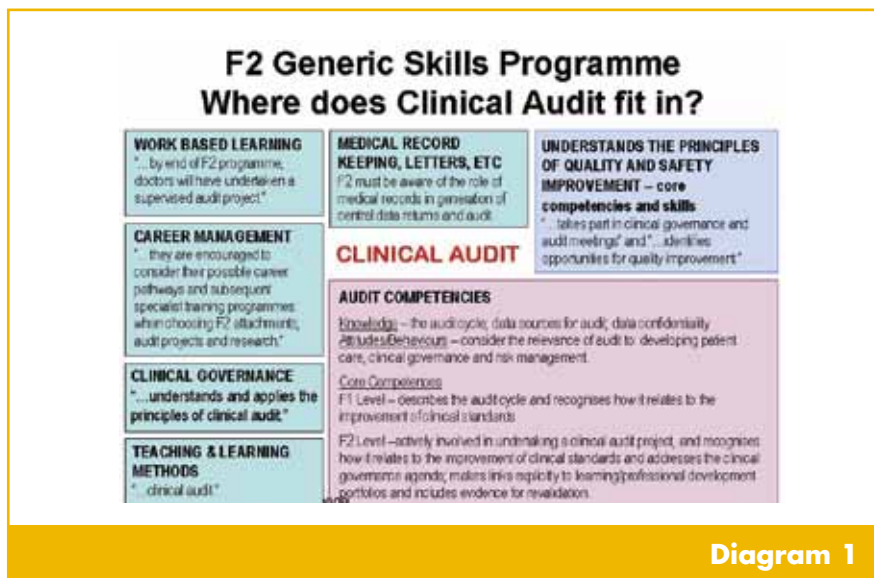
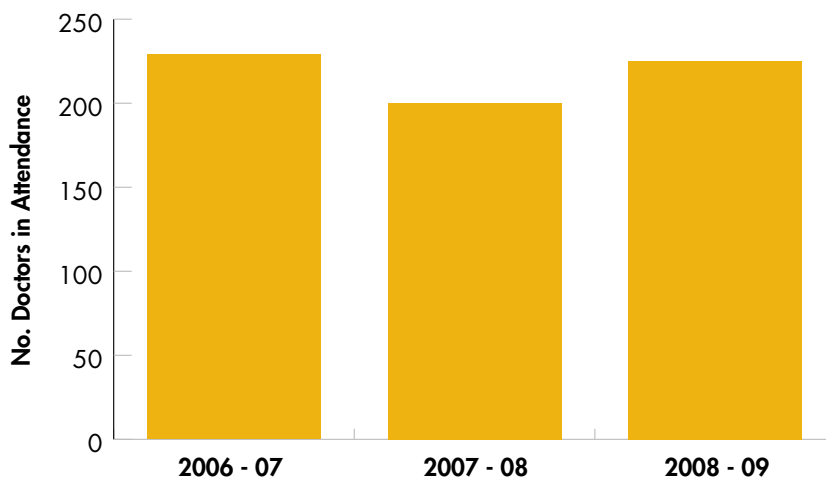


Diagram 1

to the workshops. F2's felt the audit presentation was very helpful and well tailored to their needs. With some commenting that they would welcome more completed audit examples.

Ms Angela M Carragher
NIMDTA Associate Postgraduate Dean for Foundation Training

Miss Gillian Harkness
Clinical Audit Trainer



Acknowledgements

The team would like to acknowledge the work of Debbie Schofield, Clinical Audit Facilitator from the Ulster Hospital, who participated in the training sessions during 2006-07.

Next Issue

Auditing the Clinical Audits of Foundation Doctors – What are the Lessons that can be Learnt?

Audit of Falls in Greenfield RHOP - October 2009

Aim

- To assess the number of falls between September 2008 & September 2009.
- To ensure that residents care plans are fully completed and updated.
- To ensure accident forms are completed for each fall and near miss.
- To ensure measures were taken to manage the prevention of further falls or near misses.
- To ensure Management and Care Staff have training on falls prevention.

Standards

The Following standards were derived from Guidelines for Falls Preventions in Nursing Residential Homes:

- All staff should have formal falls prevention training
- An incident form must be completed for each fall / near miss
- Incident forms must be fully completed
- A falls risk assessment should be completed on admission and regularly updated (3 monthly or more frequently if there is a high risk of falls)
- All staff should be made aware of residents who have a high risk of falls
- Residents and visitors should be informed of their increased risk

of falls and advised to avoid at risk activities if unsupervised

- Relatives and visitors should be advised of residents at risk status
- All residential homes should carry out weekly walking aid checks
- Yearly vision checks should be provided in the residential homes
- An assessment of resident's footwear should be completed for residents who have had a fall.

Environment

- Residents' bedrooms should be clutter free
- Communal areas should be free of obstacles
- Care call systems should be within easy reach of the resident
- All bedrooms and communal areas should have good lighting
- Night-lights should be provided

for all residents' who use the toilet during the night

- Chairs and beds should not be too high or too low, ensure the right resident is sitting on the right chair.

Methodology

Information was collated using the following methods:

- Incident Forms have been checked within the dates 09-2008 & 09-2009 and a table of information collated with regard to the location and the number of falls.
- Falls prevention checklists are completed on a regular basis to assess the residents' environment.
- Questionnaires are also completed if a resident should have a fall with regard to the resident and their environment.

Outcome

No of Falls	Outcome
25 Falls	Transferred to Nursing Home.
8 Falls	8 falls in bedroom. Has alarm mat on chair.
5 Falls	Transferred to nursing home.
5 Falls	Dizziness, Medication Reviewed.
3 Falls	Weight Problem, Referred to Dietician.
4 Falls	Health Deteriorating, General Physical Condition, GP Attending.
20 Falls	Various individual residents with 2 or less falls.
Total 70	

Total number of falls of 6 residents was 50, 20 falls had been individual residents throughout the year.

- All incident forms have been fully completed and falls recorded in residents kardexs'.
- If a resident has more than one fall the resident next of kin, staff and care manager is informed but not always recorded in kardex as discussed and what action is needed
- Most of the falls have occurred in residents' bedrooms, which need to be checked more often to ensure they are clutter free.
- When a resident is sitting in their bedroom at the window only 3 have extensions to care call systems.
- Not all bedrooms have good

lighting; on the bottom floor corridor lighting is poor.

- From the audit not all residents have appropriate chair or bed most too low.

Action List

- There needs to be a record of near misses as none was found to be recorded.
- Footwear of each resident must be checked and recorded.
- On agenda for all management meeting falls prevention and discuss areas that need to be clutter free.
- Weekly checks of all room to ensure clutter free.
- Falls need to be recorded in care plans.
- Falls action checklist must be completed for each resident.
- Yearly vision checklist to be

carried out for a resident following fall.

- All staff to attend falls prevention training arranged for November 2009.
- Record must be kept of all informed, what was discussed and action to be taken.
- OIC to pursue monies for minor capital works and equipment.
- This audit will be discussed at Resident, Care Staff and Management meeting in December 2009.

The action plan as a result of this audit is being implemented currently and a re-audit is scheduled for next June.

Rosaleen McConnell, A/SCA &
Joanne Robinson,
Clerical Officer



Caring for dying patients- a priority for Northern Ireland

“How we care for the dying must surely be an indicator of how we care for all our sick and vulnerable patients. Care of the dying is urgent care with only one opportunity to get it right to create a potential lasting memory for relatives and carers ...” Professor Mike Richards, Chair, End of Life Care Strategy Advisory Board, 2007

The Liverpool Care Pathway (LCP) has been recommended for use as a template of best practice in the last hours and days of life in UK national policy (DH 2006, 2008), National End of Life Care strategy (England): Quality Markers and measure for end of life care (2009) and more recently within ‘Living Matters: Dying Matters’: A Palliative and End of Life Care Strategy for Adults in Northern Ireland (2010)



Whilst the LCP has been introduced to a number of acute trusts in Northern Ireland since 2005, with MacMillan and BLF providing financial support for facilitator posts, no formal audit of its use had been undertaken regionally. Although the LCP facilitator posts have been lost from many Trusts the use of the LCP continued in a variety of ward settings.

In 2008, with the support of GAIN and Marie Curie Cancer Care, all Trusts within Northern Ireland were able to take part in the second

round of the National Care of the Dying Audit in hospitals (NCDHA) as a pilot cohort. The audit was led by Marie Curie Palliative Care Institute in collaboration with the Clinical Standards department of the Royal College of Physicians.



This has given us opportunity to reflect on current practice in Northern Ireland and bench mark our results with each other and also with reference to the larger sample for England.

A prospective audit design was used to gather LCP data from up to 30 consecutive adult deaths on the LCP during the period 1 October- 31 December 2008 in each participating Trust. Other Trust organisational data which would be likely to impact on delivery of care in last days/hours were also obtained and submitted electronically to the MCPIL base.



Practical challenges: Variation between Trusts in a) Recording of patients who had died on LCP and b) Retrieval of LCP documentation.

Who took part? Thirteen hospitals from 5 acute Hospital Trusts participated and submitted a total of 274 patient data sets.

What aspects of care were considered?

1. Physical comfort of the patient
2. Psychosocial and spiritual/religious aspects of care (patients and carers)
3. Communication (patient, carer and healthcare colleagues)
4. Appropriate information (giving and receiving)
5. Compliance with appropriate policies and procedures
6. Use of parenteral fluids and sedatives in last 24hrs

Our results:

A copy of the full report is available at www.GAIN-ni.org.

In summary, there was a higher proportion of non-cancer patients in the cohort (65% vs 35%) and patients were cared for on an LCP



for median of 36hours.

Anticipatory prescribing for common symptoms was achieved in over 80%, and pain alone in 94% cases. The highest level of variance (patient discomfort) in ongoing assessment was for respiratory secretions (16%).

Whilst carer insight into diagnosis and patient entering dying phase was recorded at 90% and 91% respectively, the results were

considerably lower for patients (63% and 58%). Spiritual/religious care needs of patients were also low at 42% achieved. Recording of communication with general practice both before and after death was also less well achieved (28% and 45%).

Overall the care after death section of the LCP documentation was well completed with most goals being achieved in over 80% but the recording of having given a bereavement leaflet specifically was disappointing (46%).

Variance of 23% for discontinuation of parenteral fluids was recorded

- challenging the myth that the pathway means cessation of all interventions. Where drugs were prescribed prn for agitation and restlessness they were only given in 41% cases and of drugs used, midazolam was the most frequent with median dose for csci of 10mg over 24hours and 2.5mg as prn dose.

What about Key Performance Indicators (KPI)?

- Spread of LCP: median=100% (IQR 58%-100%)
- Anticipatory prescribing for key symptoms: median=90% (IQR 87-93%)
- Compliance with completion of LCP: median=83% (IQR 80-93%).

A workshop facilitated by MCPCIL team held in October 2009 gave participants an opportunity to consider individual Trust and NI results and a forum for the sharing

of good practice and discussion of challenges and way forward.

This was a most valuable exercise and has helped clinicians and their

teams focus on areas to address in individual Trusts. With the launch of the NI strategy ('Living Matters:Dying Matters': A Palliative and End of Life Care Strategy for Adults in Northern Ireland (2010)) it is hoped that with appropriate support and commitment we will be able to ensure this tool is embedded in clinical practice and we can aim to improve the care provided to dying patients and their families in Northern Ireland.

Thanks to all who participated with such enthusiasm and also to GAIN and Marie Curie Cancer Care who funded the project.

Dr Pauline Wilkinson

Consultant in Palliative Medicine, Belfast Trust/Marie Curie Cancer Care

GAIN funds Regional audit of the management of mastitis for 2010-2011

In 2008 the Regulation and Quality Improvement Authority (RQIA) and the Guidelines and Audit Implementation network (GAIN) commissioned the development of guidelines for the prevention, treatment and management of mastitis. The guidelines were launched in September 2009 and a regional audit has been funded to find out whether the guidelines are being used appropriately to diagnose and manage lactational mastitis. All breastfeeding women should also be provided with the GAIN mastitis leaflet before discharge from hospital. Through this audit we would also like to know whether the GAIN patient leaflet on "mastitis and breastfeeding" was useful to the women.

To make the audit happen we need all health professionals who see/care for women with lactational mastitis to send details to the audit group (contact details below) after obtaining patient consent for participation in the audit. Following

our receipt of the referral and consent form, the woman will be contacted by a midwife auditor who will complete a 10- minute interview (telephone or face to face contact) with the patient. A separate short interview also (telephone or face to face contact) will be carried out at a convenient time with the healthcare professional involved in the management of the patient. The referral and consent form can be obtained from the GAIN- NI website at http://www.gain-ni.org/Audit_Tools/index.asp

After obtaining consent please contact by email or telephone helen.mcilroy@belfasttrust.hscni.net or grace.ong@belfasttrust.hscni.net
Telephone contact: 02890633091 for collection of the form OR
Please send to: Helen McIlroy, Breast Feeding Coordinator, Royal Jubilee Maternity Hospital, Grovenor Road, Belfast BT12 6BA

Dr Grace Ong
Consultant Microbiologist

Prospects Newry Day Opportunities - Supporting Better Access To Healthcare of Patients with Learning Disabilities

Prospects is a voluntary organisation which values and supports Adults with Learning Disabilities so that they can live their lives to the full.

The Philosophy of Prospects is guided by the Principle of Personal Value which acknowledges in people with Learning disabilities their:

- Individuality
- Integrity
- Dignity
- Independence
- Spirituality

as well as their role as equal citizens in society.

Prospects believe that people with Learning Disabilities are to be Valued & Enabled both to enjoy & to express their personhood.

For this reason Prospects Newry Day Opportunities established an 'in-house' Citizenship Group to support the people within the day service to 'have a voice' on matters that effect their lives. The group has worked tirelessly in bringing to the fore some of the current issues within Learning Disability. Issues that should 'Really' involve equal

Citizenship in today's society

The Groups Motto is: "Having a say is important because we are important"

Everyone supported by the service is involved in the group and everyone supports each other to communicate and work toward change, because they look at 'Real' issues that effect the lives of 'Real' people.

One of the current issues the group are focussing on is 'Better Healthcare' for Adults with Learning Disabilities.

The group has worked on and produced two reports. The initial report, in conjunction with the former Southern Health and Social Services Council (SHSSC), now The Patient and Client Council, 'We Are People Too!' highlighted what adults with learning disabilities thought of GP services. The second report, 'Patient People' again with the support of SHSSC and ARC explores the experiences of people with learning disabilities as 'in-patients' in acute hospitals in the Southern Trust. This report contains a wealth of information and makes important recommendations about

how services can be improved and how to support hospital staff when caring for someone with a learning disability. The group worked with a project officer from ARC Northern Ireland and other members of the project advisory group representing the local Social Care Trust, Prospects Newry Day Opportunities and Mencap. The Citizenship group members shared their experiences as hospital 'in-patients' and outlined what would make for them a 'Dream Hospital Admission'.

The main messages of the report highlighted:

- The frightening nature of their hospital admission experience.
- The difficulties faced in understanding procedures/tests.
- Feelings of not being listened to or 'heard' during the stay in hospital.
- Difficulties in Communication and lack of non-verbal communication skills among hospital ward staff.

The report identifies several areas for action including the need for protocols to aid the admission or treatment of patients with a learning disability, a system for planning in advance for the admission of people with learning disabilities, training of

staff, and an audit of information on conditions and medical interventions to identify 'easy read' information. Both reports can be obtained directly from Prospects Newry Day Opportunities via email: **manager.nydo@prospects-uk.org**

Citizenship Group Facilitator, Eve Carragher said, *"Group members believe that to achieve the vision of an NHS that gives patients and the public information and choice, and has quality at its heart, the care of people with learning disabilities as hospital 'in-patients' must improve. Everyone working with people with learning disabilities in the NHS must be committed to developing their understanding and skills, in order to support with respect and dignity the often complex health needs of adults with a learning disability."*

The Citizenship Group produced a DVD highlighting the main findings and recommendations of the report. There has been keen interest in using the report's findings along with the DVD to support professional training.

Currently Prospects Newry Citizenship Group is involved with GAIN through the GAIN working group on Learning Disability Guidance. The group are looking forward to the launch of the guidelines in June 2010 as they believe the guidance standards will facilitate and regulate future training and best care practice for all patients with learning disabilities in Northern Ireland.

Eve Carragher

Prospects Newry Day Opportunities Manager



Reducing waiting times for admission to Day Therapy Services

Service user quote: 'I feel very fortunate to have been referred to the day therapy service. The holistic approach to my care is just what I needed to support me. I have found the staff and volunteers very helpful and supportive'.

Introduction

Palliative day therapy services aim to improve patients' quality of life by the provision of both multi-disciplinary holistic care and rehabilitation within disease constraints.^{1, 2}

An internal survey involving 30 outpatients, in 2008, highlighted that some patients waited up to one month for their initial appointment.

NICE Guidance^{3, p123} recommends that patients, with specialist palliative care needs, should be

'referred to services without delay' and other work states that successful rehabilitation needs a speedy response.⁴

A more central referral system, where referrals were all coordinated and prioritised by the Day Therapy Manager, and admissions were facilitated by a cooperative and flexible multi-disciplinary team, was subsequently implemented.

Aim

- To measure the differences in waiting times over a three month

period in 2008 and 2009.

- To identify reasons for delay in admission/appointment at day therapy services.

Method

A retrospective file audit compared waiting times for all new patients referred to the Day Therapy service between January to March 2008 and 2009.

A record was made of the date that the referral was received and the date that the initial outpatient appointment was offered.

Details were recorded of any reasons for delay in attendance, which included: patient preference, attendance at hospital appointments, patient declined the service or they were too unwell to attend.

Results

In 2008, 38 new referrals were received, 11 of whom did not attend. Three patients (10%) received an appointment within five working days, eight patients (30%) within 10 days, eight patients (30%) within 20 days and the remainder (30%) within 30 days.

In 2009, 51 referrals were received, nine of whom did not attend. Thirty-one patients (74%) received an appointment within five working days and nine patients (21%) within 10 working days.



Two patients (5%), who requested outpatient complementary therapy services, received an appointment within 15 working days.

Conclusion

Results demonstrate a marked improvement in the waiting times for day therapy services, with an increase from 10% of patients in 2008, to 74% of patients in 2009, being offered an initial appointment within five working days of referral. This improvement, attributed to centrally coordinated referrals and a cooperative and flexible multi-disciplinary team, is a model for good practice.

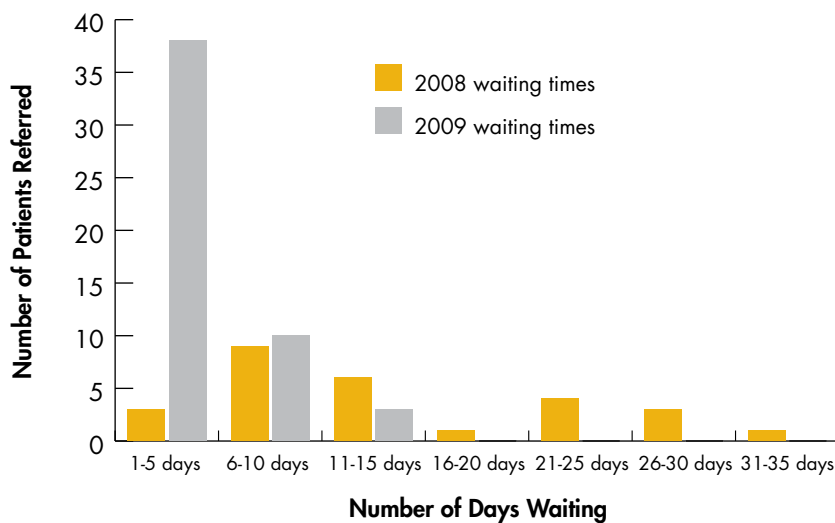
Distributing service information reduced the number of inappropriate referrals.

Recommendations

Allocation of services is centrally coordinated and monitored on a weekly basis, to maximise availability of valuable Day Therapy resources.

Alice McCrory, Marie Curie Day Therapy Manager, Northern Ireland & Audrey Agnew, (Research Facilitator, Marie Curie Cancer Care NI

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Audit – Analgesia for Open Reduction and Internal Fixation (ORIF) Surgeries

Introduction

Effective pain management has a humanitarian role, but there are also additional medical and economic benefits for rapid recovery and discharge from hospital.

Why did we do this audit?

A previous audit 'Acute pain service (APS): User Satisfaction Audit' showed that amongst all surgical patients those who had undergone ORIF surgery of limbs (excluding hip fractures) were more likely to complain of inadequate analgesia. So we decided to look at this subset of patients and their pain control issues.

Audit Aims

To assess efficacy of various analgesia regimens for ORIF limb

surgery against national standards, as well as assessing patient satisfaction and complications / side effects related to pain relief

Standards

We set our standards based on 'Raising the Standard: A compendium of audit recipes (Second edition 2006)', The Royal College of Anaesthetists. In recovery: 100% of our patients should be pain free before discharge, 100% of patients should have regular and break through analgesia prescribed for ward 1. At Ward level: 100% of patients should be pain free at rest, 100% of patients should be satisfied with information on pain relief and service provision. Patients should also be reasonably pain free on

continues on next page

movements, enabling them to mobilise early.

Data Collection

Data was collected from thirty nine patient identified on the day of surgery and data was collected prospectively for the next two days. Anaesthetic and analgesic details were noted. Pain scores were measured on a four point scale

(0- no pain, 1- mild pain, 2- moderate pain, 3- severe pain). Sedation and nausea was also scored on similar 4 point scales. Patient satisfaction was assessed on a 5 point likert scale where 1 = very unhappy and 5= very happy.

Results

Majority of cases (24 out of 39) were ankle operations as shown

in Fig 1. All patients received a general anaesthetic and half of these patients (51%) received a regional analgesic technique as shown in Fig 2. Only one patient received a regional block infusion, while the rest of the regional blocks were performed with a single shot technique.

Prior to their discharge from recovery, none of the patients had a pain score above 1. All patients were prescribed post op pain relief. Twenty three patients received a PCA (Patient Controlled Analgesia) with morphine, 10 patients were prescribed morphine or cyclimorph boluses, 4 patients were implanted with Pain Buster® elastomeric local anaesthetic infusion, oxycodone was prescribed for 2 patients and one patient received a regional block infusion. Some patients received a PCA in combination with other modalities of pain relief.

Pain scores on Day 1 and Day 2 are as in Fig 3 & Fig 4.

Eighty seven percent patients were pain free at rest on Day 1 and Day 2. However, only 52% patients were pain free on movements (as assessed by dynamic pain scores).

As shown in Fig 5, 9 out of 10 patients who were prescribed morphine by intramuscular or intravenous routes on ‘as required’ basis had inadequate analgesia. Fourteen out of 24 patients received adequate pain relief with PCA morphine. The effect of intra-op anaesthetic technique and the post op pain modalities are presented in Fig 7. Patients who received a PCA, irrespective of the use of a regional technique, were more pain free than those who did not receive a PCA.

Thirty four patients were happy with their pain relief and would prefer the same pain relief technique again. Two patients were not happy with the pain relief, while five patients were unsure about the adequacy of pain relief.

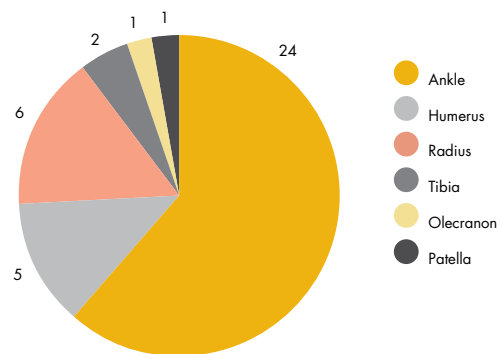


Fig 1. ORIF Regions

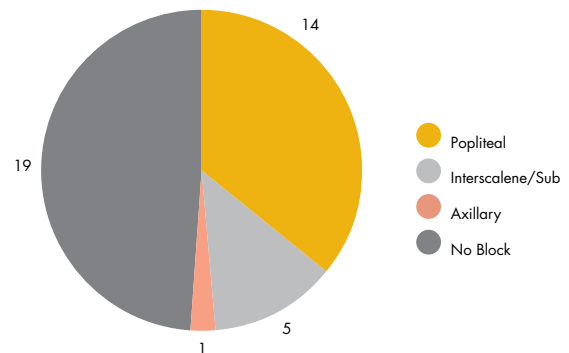


Fig 2. Regional techniques usage

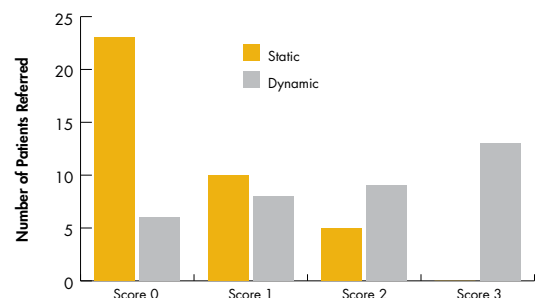


Fig 3. Pain Scores on Day 1

Discussion

All patients were pain free on discharge from recovery and so this standard was achieved regardless of technique. At ward level patients had a wide variation of pain relief strategies. Though most of the patients were reasonably pain free at rest, almost half of them were in significant pain on movement. Though there is no standard demanding 100% dynamic pain relief, pain relief on movement is desirable as it may help with early mobilisation, and thus reduce post-op complications and facilitate earlier discharge.

Half of our audited patients received a regional block in addition to a general anaesthetic. Our results showed that the blocks did not contribute to much pain relief on Day 1 or Day 2 after surgery. Though all patients who used a PCA were not guaranteed dynamic pain relief, most of them were pain free in contrast to those who did not use a PCA.

As a result of this audit, we have agreed to increase the use of PCA for post-op pain relief in patients undergoing ORIF surgery (excluding hip fractures) and discourage the prescription of 'as required' morphine. Regional block infusions could be preferable over single shot infusions in clinically indicated patients.

References

1. RCOA- Raising the Standard: A compendium of audit recipes (Second edition 2006)
2. Post-operative Pain management-Good Clinical Practice; General recommendations and principles for successful pain management; in consultation with ESRA
3. BJA 2008 Dec 2008;10(16) Effectiveness and safety of post-operative pain management; a survey of 18925 consecutive patients between 1998 and 2006(2nd revision)

M Chogle; J Mathews; A Eggleton; D Hughes
South Eastern HSC Trust, Ulster Hospital,
Dundonald

Laryngectomee Concerns about Treatment and Care

Laryngectomees (permanent neck-breathers) are concerned about any treatment and care that they might receive outside of ENT wards. This is due to the

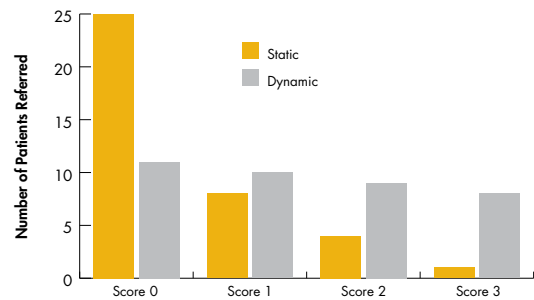


Fig 4. Pain Scores on Day 2

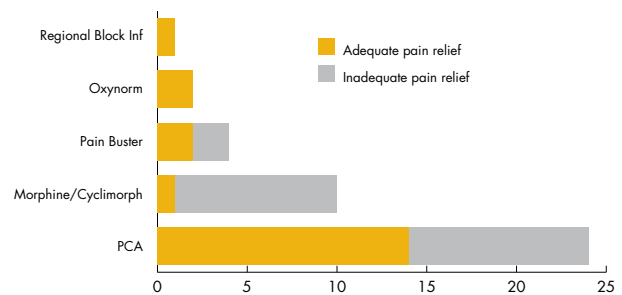


Fig 5. Post-op pain relief and adequacy of analgesia

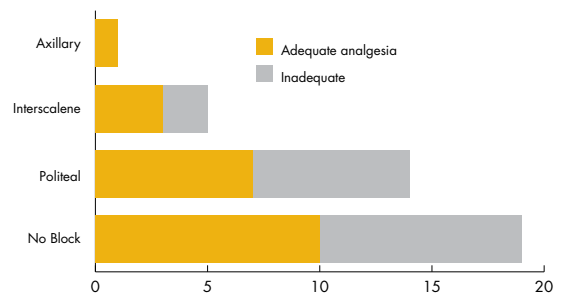


Fig 6. Regional technique and adequacy of pain relief

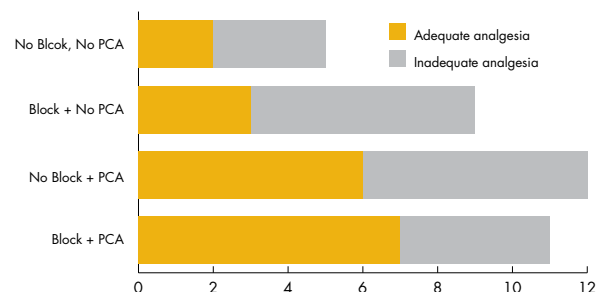


Fig 7. Adequacy of analgesia related to Intra-op and post op pain relief strategy

ignorance that exists amongst health professionals with regards to this condition. Such ignorance has led to laryngectomees receiving inappropriate treatment with

continues on next page

some serious incidences resulting as a consequence. It is important to note that no one is saying that any deliberate harm has been inflicted on laryngectomees. Rather that harm has resulted due to inappropriate treatment being received. The National Association of Laryngectomee Clubs (NALC) in conjunction with the National Patient Safety Agency (NPSA) carried out a survey regarding treatment of laryngectomees and the results of this survey confirmed the above. As a result of this a warning alert was raised by NPSA and circulated to all relevant trusts in England and Wales and then subsequently through the government health authorities to trusts in Scotland and N. Ireland.

However, this still has not assured that all pertinent health professionals are receiving the recommended training necessary to care for this vulnerable group of patients. Consequently, NALC have produced training presentations and trained a number of laryngectomees to deliver these, on invite from health professional trainers, in various training environments. We are happy to say that this training has/is been/being well received. The training, amongst other things, involves both

Last December Alex received recognition from BUPA through a Life Time Achievement Award. This award highlighted Alex's ongoing work in striving to ensure both the safety of laryngectomees as well as their quality of life after a laryngectomy, through training for health care professionals and provision of information to patients and their carers. As this programme develops the aim is to roll it out across acute and community sectors. The training has even been sought from Australia.

In addition, Alex has given considerable time to the Northern Ireland Cancer Network in his role as Lead of the Regional Patient and Public Involvement (PPI) Forum and PPI Representative on the NICaN Board. Along with Nicola Porter

resuscitation and care of the stoma for laryngectomees. A drawback encountered has been that such engagements have been in the main, ad hoc and we are trying to redress this.

In N.Ireland we are indebted to GAIN for gathering together representatives from all of the trusts and the ambulance service to explore how we can redress this situation. Work is ongoing and looks very promising for a positive outcome.

After surviving the trauma of a laryngectomy, laryngectomees just want to stay safe no matter which area of our health service they venture into to receive treatment and care.

Alex McGuiggan is NALC's contact here in N. Ireland and is willing to assist any trainers in accomplishing the above outcome at no cost to any establishment that wishes to avail of NALC's services. Should you wish to contact Alex, please contact the GAIN Office.

Alex McGuigan



Alex tirelessly seeks to promote the work of the Cancer Network and specifically the need to have partnership working between our health care professionals and individuals who have been affected by cancer.

Sincere congratulations go to Alex on this award- it could not be given to a more deserving person.

Janis McCulla, Regional Co-Ordinator Patient and Public Involvement, NICaN

Since the last edition of Gleanings, a lot has taken place within GAIN...

Firstly on behalf of GAIN, can I congratulate Dalrene (Regional Audit Facilitator) and Colin on the safe arrival of Conor Campbell Mason. Congratulations also to Catherine (GAIN Secretary) and Mickael on the birth of their first baby James Nelson Le Guiniee.

I would also like to take this opportunity to welcome Susan Hamilton who is Catherine's maternity cover and Clare Jennings who is Dalrene's cover. Both will be with us until the New Year.

I am not going to repeat any of what Robin has touched on about the second round of funding, only to remind you that the dates will now be:

May & September

Invitation to apply

September & December

Decisions on applications made by GAIN Operational Committee

September & January

All applicants informed of decisions

October & April

Commencement of all Guidelines and audits

The **closing dates** for acceptance of applications will be **Monday 2 August 2010 and Monday 15 November 2010**. Applications received after each closing date will be held until the following round of funding.

Application forms can be downloaded from <http://www.gain-ni.org/Support/Funding/index.asp> There is a poster format of this

information at the back of this issue which you may wish to photocopy and circulate to colleagues.

As you know the GAIN Committees are made up of multiprofessionals from across the healthcare spectrum. Below one of our members, Dr Tom King, GP, Springfield Road, Belfast tells us a bit about himself.

Tom King

Hello! My name is Tom King. I am one of the members of the GAIN Operational Committee. I am a general practitioner working in North & West Belfast. For over 16 years I have also held a part time post in the Health and Social Services Board where I have helped (I hope!) to facilitate the update of Audit and Clinical Governance in Primary Care. I have sat on various audit related committees. I joined the GAIN committee by kind invitation at its inception. I appreciate the honour of being part of an organisation which is aimed specifically at promoting better care of patients in Northern Ireland. I would encourage others to become involved.

I am interested in walking, cycling and gardening and since I am fat you can work out yourselves how much of each I manage to do. General practice is busy!!

Clare Jennings

Hi Everyone
Thank you for the warm welcome from GAIN. I look forward to meeting and working with you all

over the following year, and I hope I can maintain the standards that Dalrene has set before me.

I am new to the audit and guidelines arena as I just qualified as an occupational therapist last year (don't be surprised if I absent mindedly issue you with a commode!) but I am excited about the new challenges I will face when working with GAIN. I also hope that my AHP background will be beneficial to existing and upcoming audit projects.

If I have not already met you, I am sure I will soon and if not please feel free to contact me at the GAIN office. *Clare*

Susan Hamilton

I joined GAIN in mid April this year to take on the role of Secretary during Catherine McQuaid's maternity leave. Previously, I worked for the Safe and Effective Care Department at the Ulster Hospital and prior to that, I lived and worked in London for twenty years - mostly in personnel related roles in the voluntary sector. I am enjoying being back in Northern Ireland and having the opportunity to find out more about the health sector and how the work of GAIN contributes to it. *Susan*

Gain Conference 2010 – Quality Outcomes - Health Improvement

GAIN held its Third Annual Conference on Wednesday 24 March 2010 at Greenmount Agricultural College, Antrim. The day was extremely informative with many distinguished speakers keeping us updated on the latest local and national audit and guideline information.

This year we have recorded some of the speakers which can be found on our website at www.gain-ni.org

The morning was opened by **Dr Michael McBride**, Chief Medical Officer for Northern Ireland and very ably chaired by Dr David Stewart, Vice Chair of GAIN Strategic Committee and Medical Director RQIA.

Speakers included:

Dr Michael McBride, Chief Medical Officer, DHSSPSNI

Dr Tom Trinick, Chair of GAIN Strategic Committee

Dr James Livingstone, Assistant Secretary, Standards & Guidelines Unit, DHSSPS

Professor Chris Price, Visiting Professor in Clinical Biochemistry at the University of Oxford, and Clinical Director of the Cumbria and Lancashire Pathology Commissioning Network

Mr Chris Connell, NICE Field Co-Ordinator

Mrs Janis McCulla, NICaN, Patient & Public Participation Co-Ordinator



Left – Right: Chris Connell, Martin Ferris & Prof Chris Price

Mr Martin Ferris, Clinical Effectiveness Manager, Sheffield PCT

Mrs Maeve Bradley, Northern Trust Community Dentistry

Mrs Wendy Megarrell, Four Seasons Group of Nursing Homes

Professor Peter Maxwell, Regional Renal Unit, BCH

Dr Damien Carson, Chair of GAIN Medical Devices Committee

Presentations & recordings are available on the website at www.gain-ni.org

Nicola Porter



Back Row Left – Right: Dr Jim Livingstone, Chris Connell, Dr David Stewart, Dr Damien Carson, Front Row Left - Right: Nicola Porter, Janis McCulla, Dr Michael McBride & Prof Chris Price



GUIDELINES AND AUDIT
IMPLEMENTATION NETWORK

On a yearly basis GAIN send out an invitation to the health community to apply for funding for the development of regional guidelines or the undertaking of regional audits.

The invitation process will be:

May & September
September & December

Invitation to apply
Decisions on applications made by GAIN
Operational Committee

September & January
October & April

All applicants informed of decisions
Commencement of all Guidelines and audits

Closing dates for acceptance of applications will be **Monday 15th November 2010**. Applications received after each closing date will be held until the following round of funding.

Funding application forms and guidance can be downloaded by clicking on:
<http://www.gain-ni.org/Support/Funding/index.asp>

All applications **MUST** be signed and dated. No electronic signatures will be accepted.

GAIN welcomes applications from all health and social care areas.

Resources

Guidelines & Audit Implementation Network www.gain-ni.org

Scottish Intercollegiate Guideline Network www.sign.ac.uk

Irish Society for Quality & Safety in Healthcare www.isqsh.ie

National Institute of Clinical Excellence (NICE) www.nice.org.uk

Healthcare Commission www.chai.org.uk

Department of Health (NI) www.dhsspsni.gov.uk

Department of Health www.doh.gov.uk

General Medical Council www.gmc-uk.org

Healthcare Events www.healthcare-events.co.uk

Northern Ireland Practice and Education Council for Nursing and Midwifery www.nipec.n-i.nhs.uk

Royal College of Nursing www.rcn.co.uk

Healthcare Quality Improvement Partnership www.hqip.org.uk

National Audit Governance Group www.nagg.nhs.uk

Clinical Audit Support Centre www.clinicalauditsupport.com

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