NETWORK DEVELOPMENT TEAM
INITIATIVE REPORT

All Ireland Institute of
Hospice and Palliative Care

Palliative Care Senior Nurses Network

NDT: "Audit in Motion" October 2015

Contents

1. RATIONALE:

Constipation is one of the most common symptoms in the palliative care population. The causes are multifactorial and can lead to great discomfort and even distress if not managed effectively. According to Larkin et al (2008) there is often a lack of awareness with regard to the prevalence, causes and impact of constipation in this population and to date a lack of clear, practical guidance on how to assess, diagnose and manage constipation in patients with palliative needs. Therefore the launch of new guidelines "The Management of Constipation in Adult Patients Receiving Palliative Care" in Ireland is eagerly awaited. The AIIHPC Palliative Care Senior Nurse Network was given an opportunity to pilot the audit tool which accompanies the guidelines and to provide feedback, prior to the launch of the guidelines.

2. BACKGROUND:

The guideline entitled **"Management of Constipation in Adult Patients Receiving Palliative Care Guideline" (2015)** was developed by a subgroup of the Health Service Executive (HSE)/Royal College of Physicians of Ireland (RCPI) National Clinical Programme for Palliative Care, known as the Guideline Development Group (GDG). The guidelines apply to healthcare professionals providing generalist or specialist palliative care to adult patients with an advanced, progressive and life-limiting illness in hospital, hospice and community-based settings.

An audit tool has been developed to accompany these guidelines and a group of Senior Nurses from the AIIHPC Palliative Care Senior Nurse Network (PCSNN) agreed to undertake a project to pilot this tool in practice. The audit tool was developed to encourage and assist clinicians to audit their own practice. The aim is that through the process of audit and reflection on their own practice, the clinicians become more aware of the desired standards regarding constipation management as outlined in the new guidelines. This is not a standard approach to audit but one that has the potential to be both an audit and educational tool.

Aim of Pilot: To pilot the Constipation Audit Tool, in a variety of adult palliative care settings, across the Island of Ireland.

Objectives of the pilot:

a) To obtain an overview of current practise within these settings

b) To determine the applicability of the tool within the individual settings

c) To determine the experience of using the tool from a clinician's perspective

d) To make recommendations in relation to the design and content of the tool for future use

3. ACTIVITIES AND INFORMATION GATHERING:

3.1 AUDIT:

"Clinical audit is a quality improvement process that aims to improve patient care and outcomes by carrying out a systematic review and implementing change. Aspects of patient care – including structure, processes and outcomes- are selected and evaluated against explicit criteria, and, where necessary, changes are implemented at an individual, team or service level. Further monitoring can then be used to confirm the improvements in health care delivery" (National Institute of Clinical Excellence, 2002).

3.2 PROCESS:

Via face to face meetings and tele-conferencing the following process was followed;

- An audit proposal was developed.
- A brief staff questionnaire was developed to accompany the audit tool in order to elicit feedback on the design/usability of the tool itself.
- Pilot clinical areas were identified ensuring geographical representation across the Island of Ireland and representation from a range of settings.
- Explanatory information, to be given to staff prior to participating in the audit, was developed.
- Potential sample size agreed.

Approval to undertake the audit was sought (where necessary) from audit groups within each organisation and where necessary from relevant line managers. The PCSNN subgroup members then identified colleagues within each of their own clinical areas who would be willing to participate, with the Senior Nurse acting as the lead. All participants were given an explanation of the background to the project and the rationale for the audit.

The audit was undertaken over a one day period and in total a sample size of 101 patients was achieved. The senior nurses transferred the data collected from each individual site on to the master copy of the Excel database

See Appendix one for diagrammatic outline of audit process

3.3 SAMPLE:

101 patients, from ten clinical settings across the region of Ireland, were included in this audit (see table one). Fifty two percent (n=53) of the patients were males and 48% (n=48) females, with ages ranging between 38 and 102 years.

CLINICAL SETTINGS WHERE AUDIT WAS UNDERTAKEN	
OLH&CS Blackrock, In-patient Unit	11
OLH&CS Blackrock, Community Palliative Care	14
OLH&CS Blackrock, Day Hospice	10
St Michael's Hospital	6
North West Hospice, In-patient Unit	4
North West Hospice, Community Palliative Care	6
Sligo Regional Hospital, Palliative Care Team	11
University Hospital Limerick	15
Havenwood Nursing Home	7
Macmillan Specialist Palliative Care Unit within AAH, NHSCT	12
Regional Cancer Centre BHSCT	6
	102

Table One

4. RESULTS:

Data was collected individually on each site and transferred onto the electronic excel master data spreadsheet. The findings for each question are outlined as follows;

Question a:

"Did patients with reported constipation have the following components of a comprehensive assessment completed within 24 hours of initial contact (onset of symptoms, aggravating and alleviating factors, frequency and pattern of bowel motions, stool volume and appearance, nausea, abdominal discomfort, bloating, flatus or tenesmus)?

This question was deemed to be applicable to only 72% of patients (n=73) and of those who were applicable, a comprehensive assessment was only undertaken in 79% (n=58). No comments were recorded for those in whom "Not applicable" was documented. However staff did comment in general feedback that this question included various elements, all of which may not have been included in the assessment yet the format of the questionnaire only allowed for one overall answer.

Question b:

"Was a digital rectal examination (DRE) performed to exclude faecal impaction in the following groups of patients?

1. ***Patients in whom it has been more than 3 days since the last bowel movement***
2. ***The patient complains of incomplete evacuation***

Question b: Section One

This question was deemed to be applicable to 46.5% of patients (n=47), however DRE was carried out in only 8.5% of applicable patients (n=4).

Question b: Section two

This question was deemed to be applicable to 18% of patients (n=18), yet DRE was only undertaken in 17% (n=3) of applicable patients.

The section on whether this was applicable or not was left blank for a significant number of patients.

Question c:

"If a plain film of abdomen was performed, was it done on the basis of a specific consideration?"

A plain film was undertaken in 28 patients (27.7%) but of these only 19 were recorded as being done on the basis of a specific consideration. The questionnaire format did not allow for comment on the reasons why the remaining nine plain films were undertaken, if not for a specific consideration.

Question d;

***"Was education on non-drug measures provided in order to enable patients and caregivers to take an active role in constipation prevention*?"**

This question was deemed to be applicable for 82% of patients (n=83). Education on non drug measures was provided to 77% of applicable patients (n=64). No reasons were given for 'non education' or why it was deemed to be non applicable for some patients.

Question e:

"Was there evidence of consideration of non-pharmacological strategies in the constipation management plan?"

This question was deemed to be applicable to 83% of patients (n=87). Of these patients consideration was given to non-pharmacological strategies in 60% (n= 52). Again it would be useful to know the reasons for non consideration of non-pharmacological strategies and why the recommendation was not applicable to all patients.

Question f:

"In patients with whom more than one laxative was used, was a combination of a softening and a stimulating laxative used"

This question was deemed to be applicable to only 77% of patients (n=78). A combination of a softening and a stimulating agent was used in 90% of applicable patients (n=70).

Question g:

"Was optimisation of a single laxative achieved prior to the addition of a second agent?"

This question was only deemed to be applicable to 65 %(n=66) of patients. It was achieved in 55% of applicable patients (n=36).

Question h:

"Was the laxative dose titrated daily or alternate days according to response?"

This question was only deemed to be applicable to 72 patients and the laxative dose was titrated as recommended above in 71% of the applicable patients (n=51).

Question i:

"Was a bowel regimen initiated at the commencement of opioid therapy?"

This question was only deemed to be applicable to 64% (n=65) of patients. In 55 patients (85% of applicable patients) a bowel regimen was initiated at the commencement of opioid therapy.

Question j:

"Was optimisation of a stimulant laxative achieved prior to the addition of a softening laxative?"

This question was only deemed to be applicable to 61% of patients (n=62). Stimulant laxatives were optimised before the addition of a softening agent in 42% of applicable patients (n=26).

Question k:

"Was the use of opioid receptor antagonists considered in those patients whose treatment is resistant to conventional laxative therapy?"

This question was not applicable to 73% (n=74) of the total patients surveyed. Of the remaining 27 patients the use of opioid receptor antagonists was only considered in 5 cases, or 18.5% of applicable cases.

Question l:

"In patients with partial intestinal obstruction was the use of stool softener considered?"

This question was only applicable to six patients and of these a stool softener was considered in 67% (n=4).

Question m:

"In patients with partial intestinal obstruction were stimulant laxatives avoided?"

This question was only applicable to six patients and the use of a stool softener was only considered in 50% of these patients (n=3).

Question n:

"In patients with complete intestinal obstruction, was the use of all laxative avoided?"

This question was only applicable to two patients and the use of all laxatives was avoided in 50% (n=1).

4.1 STAFF QUESTIONNAIRE FINDINGS:

Staff undertaking the audit were also asked to complete the following questionnaire to ascertain their views on the tool itself.

1. What was your experience of using the tool?
2. How do you feel about auditing your own practice?
3. Is this tool applicable in your clinical setting?
4. What adaptations do you deem necessary?
5. What did you learn from using the tool?
6. What adaptations would you deem necessary

The findings will be discussed separately for each question as follows:-

Question One: What was your experience of using the tool?

The majority of respondents found the tool relatively straightforward and easy to use, however a few found the tool complicated.

"I feel that the tool appeared complicated and because of this took a while to complete" (nurse)

"It appears to overcomplicate what is in reality part of overall care, or possibly the format is complicated as opposed to the information" (nursing home)".

Some of the questions within the tool were deemed to be ambiguous or unclear, for example "Question a" referred to "within 24 hours of initial contact" but it was unclear what was meant by the term initial contact and what time point this referred to. Also it was suggested that the wording of "Question c " could be changed to establish if a plain film was actually carried out and if so was it done on the basis of a specific consideration.
One respondent commented that the tool was more task orientated than patient centred.

Question Two: How did you feel about auditing your own practice?

Respondents appeared to have no significant issues with auditing their own practice as they were used to reflecting on practice, however some felt it might be difficult to remain unbiased.

"Made me stand back and review my own practice which was good, but it did take time to do". (Nursing Home)

"Reflection on and in practice is an essential part of nursing and therefore should be done on a regular basis" (Nursing Home).

Question Three: In your opinion is this tool applicable in your setting?

There were mixed responses to this question. A considerable number of respondents felt that the tool would be applicable in their setting, although highlighted that it may need some adaptations.

Some respondents working within a community setting perceived significant issues in its use as highlighted in the quotes below;

"One of the problems with this sort of tool is that patients at home are in control of their medication compliance, so 100% is not achievable. Rectal examinations are important but again not feasible in the home setting, depending on the patients age, cognition, sexual preferences, mobility, history of abuse" (Community).

*"No – insufficient and inconsistent access to information as patients bowel history in home environment, over reliance on family members who may not be involved consistently in patients care with patients with impaired mental agility due to prognosis (*Specialist In-patient Unit).

Respondents from a Cancer Centre setting highlighted the incidence of bowel dysfunction in spinal cord compression and questioned whether the tool could be modified to reflect this patient group. They also expressed some reservations in relation to DRE as follows.

"Within our clinical setting we would not necessarily agree with some of the recommendations included in the audit such as DRE in question b, therefore would be reluctant to give this tool to other clinicians to use as they may think we endorse this practice" (Cancer Centre).

The majority of respondents working within a hospital based specialist palliative care unit did not feel the tool was applicable to their setting.

There were mixed responses from those working within a nursing home context, who were generally supportive of the tool, however had some concerns mainly due to some practical issues specifically related to this patient groups.

"Yes – Very applicable in almost every case and it's good to pay so much attention to the basics to prevent the basics becoming major problems" (Nursing Home).

"It will have difficulties; mainly;

1. Obtaining and getting consent for DREs from confused residents
2. *Getting adequate and correct stool histories from some people*
3. *A PFA would be virtually impossible to be of any benefit unless the resident was admitted from the RCC to the hospital" (Nursing Home).*

Question Four: What adaptations do you deem necessary?

The following adaptations were suggested:-

- Some of the questions need to be reviewed and made more explicit and concise.
- Questions that have several parts need to allow for each part to be answered individually instead of one global answer.
- It would be useful to have more information on the patient such as diagnosis, co-morbidities/problems which may cause/contribute to constipation, medications which may cause/contribute to constipation, presence of cord compression etc. This would allow more meaningful analysis and interpretation of the data.

- It was suggested that the timing of the comprehensive assessment i.e. within 24 hours of initial contact should be reviewed. Ideally this would take place, however in reality this assessment may take place within a longer time frame.

The issue of DRE appeared to be most controversial, with several participants questioning the underpinning evidence base, in particular the evidence to support the time frame indicated for DRE i.e. "more than three days since last bowel movement". Concerns were raised regarding roles, responsibilities and training implications in relation to DRE. As the practice of DRE has become less common and indeed in some areas is no longer undertaken by registered nurses, it would require a robust competency based training programme and assessment process to enable this to be implemented. This training would need to include the concept of capacity, consent and chaperoning.

Respondents from the hospital based specialist palliative care unit felt DRE should be removed from the tool. It was recommended that there should be recognition of the fact that DRE may not be appropriate for all patients and that the need for such an intervention must be determined on an individual patient basis, taking into consideration the variable factors involved.

Question five: What did you learn from using the tool?

The tool appeared to raise/reinforce awareness of the need for comprehensive assessment of constipation and documentation of same. In general it was felt that the tool served as useful guidance for what should be included in the effective management of constipation in palliative care, with the caveat that not everyone agreed with all the recommendations included. Some respondents were uneasy about the differences between some of the recommendations and their current practice and did not agree with them.

"Did not know that you needed to max on one single laxative prior to addition of a second, don't necessarily agree with this" (Specialist In-patient Unit).

"The DRE is not routinely carried out, nor am I sure it is necessarily appropriate especially in patients who are only day 3 if they have an established irregular pattern" (Specialist In-patient Unit).

Some respondents found the information related to more complex symptoms such as bowel obstruction was particularly useful. It was suggested that implementation of the guidelines and subsequent audit tool would require a significant investment in education/training of staff.

Respondents from the hospital based specialist palliative care in-patient unit did not feel that using the tool added to their knowledge base as they felt constipation was normally well managed in their unit.

Question six: Did it encourage you to reflect on your practice?

Reflection was acknowledged as an integral part of the respondents' usual clinical practice. The majority of respondents felt that the tool did encourage reflection on practice, but also highlighted that reflection was already recognised as an important part of any audit cycle and was not unique to this tool.

"It also encouraged us to discuss (together) constipation management on the ward currently" (Specialist Palliative Care In-patient Unit).

"Yes, it encouraged me to take more notice of bowel patterns at the end of life and in the time before that when residents may be becoming frailer" (Nursing Home).

5. SUMMARY OF KEY POINTS:

- Overall the auditors were very receptive to auditing their own practice and welcomed the use of a tool. This positive response lends itself to considering such an approach with other guidance documents implemented locally and nationally.

- The auditors found the concept of an audit tool a good resource for education when implementing new guidance.

- The auditors welcomed the opportunity to reflect on their own practice.

- The audit highlighted gaps in current practice in comparison to the best practice approved recommendations. This was evident not just in acute settings but also in specialist palliative care day settings and community settings.

- Some of the best practice recommendations were questioned e.g "maximising on one single laxative before the addition of a second" and "optimisation of a stimulant agent before adding a softener".

- A consistent challenge for auditors was the recommendations related to "DRE". Concerns were raised re roles, responsibilities and competency. In addition the time frame indicated i.e. "more than three days since last bowel movement", was questioned.

- It was acknowledged that some recommendations would be difficult to implement in particular clinical settings e.g plain film x-ray for patients in a Nursing home setting.

- It was acknowledged that the tool may need to be modified to suit the various clinical settings

6. RECOMMENDATIONS:

- There should be explicit instructions as to when and with whom the audit tool should be used eg. Is this tool for all adult palliative care patients or only those who are identified as constipated?

- Some of the questions need to be reviewed and made more explicit and concise. In particular, questions that have several parts need to allow for each part to be answered individually, instead of one global answer. This may negate the call for setting specific audit tools.

- The wording on the formal audit report on the Excel Clinical Audit Tool database needs to be reviewed to accurately reflect the findings, (for example criteria 11).

- More room for making comments would be useful, especially when "Not applicable" is selected.

- The inclusion of more patient related information, such as diagnosis, and the presence of co-morbidities or treatments which may cause/contribute to constipation, would make interpretation of the data more meaningful.

- An appendix at the back of the guidelines with a flow chart outlining the management of constipation would be useful.

- The issue of DRE needs particular attention and if the recommendations in the guidelines remain unchanged, there would need to be a robust, competency based training programme and assessment process to address this. This programme would need to take into consideration the various settings in which these patients may be cared for and also the various clinical contexts in which DRE may be contra-indicated.

- The pilot audit highlighted that the guidelines often differ from current clinical practice. In order to support the national launch of the Guidelines, local organisations should endorse the Guidelines and raise awareness amongst clinicians.

- As the auditors on this occasion were nurses, it remains to be seen what challenges remain when implementing the national guidance document with medical staff therefore suggest consideration of this group before launching the document.

7. BUDGET:

Given the nature of this initiative no money has been spent from the budget to date, which has generated potential monies for other NDT development. A minimal amount may be required in the future in order to produce copies of the findings within participating sites and to support opportunities for dissemination of findings within each site.

8. ACKNOWLEDGEMENTS:

The NDT members are grateful to the AIIHPC for affording us the opportunity to participate in the development programme and to undertake this piece of work.

We would like to acknowledge the authors of the Guidelines for the vast amount work involved in creating this document.

We would also like to thank all those staff who agreed to participate in the audit within each organisation.

9. Members of NDT:-

Geraldine Tracey
Fiona Gilmour
Trish Curran
Nuala Ginnelly
Edith McMahon
Jean Barber
Lesley Rutherford

References:

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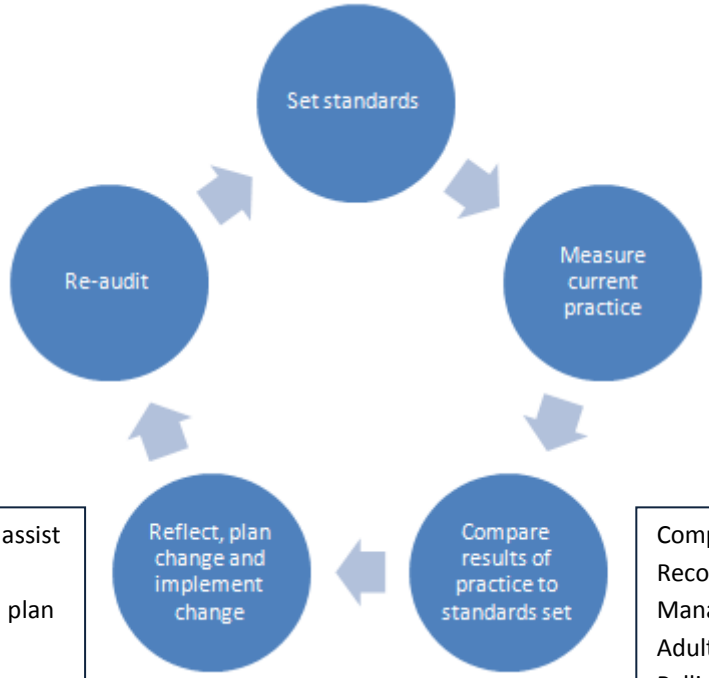
APPENDIX ONE:

Proposed audit cycle:

Set from 'The Recommendations in Management of Constipation in Adults Patients Receiving Palliative Care'[2]



Re-audit as required to demonstrate that improvement has been achieved and sustained

Using the Data Collection Form 'The Recommendations in Management of Constipation in Adults Patients Receiving Palliative Care'[2]

Formulate an Action Plan to assist in the development and implementation of an action plan to take forward any recommendations made.

Compare results to 'The Recommendations in Management of Constipation in Adults Patients Receiving Palliative Care'[2]. Compliance aims to be 100%.

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APPENDIX TWO

Audit Plan: Information shared with participants in preparation for the audit.

Introduction: Management of Constipation in Adult Patients Receiving Palliative Care Guideline was developed by a subgroup of the Health Service Executive (HSE)/Royal College of Physicians of Ireland (RCPI) National Clinical Programme for Palliative Care, known as the Guideline Development Group (GDG). The Guideline Development Group was supported by senior multidisciplinary service leads assembled by the National Clinical Programme for Palliative Care who evaluated the quality of the development process and documentation at key time points. This group was called the Guideline Group.

This guideline applies to healthcare professionals providing generalist or specialist palliative care to patients with a life-limiting illness in hospital, hospice and community-based settings. This guideline should not be used in patients without an advanced, progressive and life-limiting illness. This guideline does not apply to children.

Rationale: Constipation is one of the most frequently encountered symptoms in the palliative care population. It can significantly impact on a patient's quality of life and may necessitate the use of additional medications, emergency visits and hospitalisation. The consequences of untreated constipation place a significant burden on the healthcare system. Management of this debilitating symptom and prescribing practice lack consistency and despite laxative therapy, up to seventy percent of patients receiving palliative care continue to experience symptomatic constipation. The expected outcome of the recommendations made in this guideline is to prevent or reduce constipation and improve quality of life. This Guideline complements the National Clinical Guideline, Pharmacological Management of Cancer Pain in Adults which has also developed by the National Clinical Programme for Palliative Care.

Aim of Pilot: To pilot introducing the Constipation Audit Tool in different clinical settings where adults receive palliative care-

- Specialist Palliative Care In-patient Unit
- Day Hospice/Care,
- Community Palliative Care Teams
- Specialist Palliative Care Out-patient Clinics.
- Hospitals SPC
- Nursing Home setting.

The objectives are to gain insight from clinicians participating in the pilot as to-

1. Was the tool applicable in their particular setting?
2. What the clinician's experiences were in carrying out this type of audit?

Explanation: This audit tool was developed to encourage and assist clinicians to audit their own practice. Through the process of audit and reflection on their own practice, the clinicians become more aware of the desired standards in constipation management as outlined in the Management of Constipation in Adult Patients Receiving Palliative Care. This is not a standard approach to audit but one that has the potential to be both an audit and educational tool.

<u>Pilot Proposal</u>

Pilot areas: The pilot will be carried out in the services where the members of the Palliative Care Senior Nurse Network (PCSNN) NDT 1 Audit in Motion[3] work.

- Hospital
- CPCT
- Extended care
- Hospital

- Day Hospice

Permission: The Director of Nursing and Medical Lead in each area must give permission for the audit to take place and give an undertaking to act on any changes identified by the audit.

Lead: A lead is identified by the organisation to-

- Gain authorisation from the organisations Audit Committee where present.
- To manage the process.
- Support staff.
- Collate and feedback results.

For the purpose of this pilot the 'Leads' will be the PCSNN members[4].

Preparation: Once all permissions/authorisations have been granted the Lead must identify the clinicians who will be involved and provide-

- Data collection forms
- Audit ID- Code the Data Collection Forms using a letter to decipher the setting and a number for each patient i.e. D1, D2, D3 (for Day Care) The data collection forms must be anonymous.
- Explanation –
    - about the upcoming National Management of Constipation in Adult Patients Receiving Palliative Care Guidelines launch
    - about the audit tool
    - about the experiential questionnaire- the clinicians experience
- Instruction on how to use the tool-
    - Each clinician audits all their bowel care management on a particular day. They fill out an audit form for each patient they cared for on the chosen day, who fulfils the inclusion criteria below.
    - Agree confidentiality of findings and a 'no blame' culture
    - No patient identifiable information should be recorded
    - Record for each patient whose constipation management is being audited
    - Audit ID, Sex and Age
    - Record for each question Yes, No or NA/Notes. NA/Notes allows the clinician to explain why
    - The questions are answered either during or soon after the clinicians contact with the patient because all the required information for this audit may not be recorded in the notes.
- Inclusion criteria- all adult patients who have an advanced progressive illness receiving palliative care (at any level) but who are not actively dying.
- The audit can be carried out by specialist or non-specialist healthcare staff.
- The clinicians are requested to complete the experiential questionnaire.

Experiential Questionnaire: Answering the following questions will help understand how this type of audit impacts on clinicians.

1. What was your experience of using this tool?
2. In your opinion was this tool applicable in your setting?
3. What adaptations do you deem necessary?
4. What do you think of this type of interactive audit?
5. What did you learn from using the tool?
6. Did it encourage you to reflect on your practice?

Audit: This is the baseline audit. Once the audit has been completed the Lead collates the results. The results are compared to the audit standards, based on the Guidelines for the Management of Constipation in Adult Patients Receiving Palliative Care[2].

Compliance: The Palliative Care Clinical Programme recommends 100% compliance.

Results:

1. The audit Leads
    - Collate their local findings
    - Analyse the results
    - An action plan is developed in response to findings. An Action Plan template is provided to assist in the development and implementation of an action plan to take forward any recommendations made.
    - Feedback is given to the clinical areas
    - Collect the Experiential Questionnaires and forward these to NDT1 'Audit in Motion'

2. Members of NDT1 'Audit in Motion' will
    - Collate all the local audit results
    - Collate the experiential findings
    - Analyse the results
    - Make recommendations
    - Feedback to the Palliative Care Clinical Care Programme
    - Feedback to the participants.

Re-audit: To continue the audit cycle and demonstrate that improvement has been achieved and sustained re-audits.

Feedback: Organisations can ask a question about the tool or provide feedback by emailing the Palliative Care Clinical Care Programme Manager at sineadfitzpatrick@rcpi.ie

APPENDIX THREE

Participant Experience Questionnaire.

Post Completion of Audit Tool Experiential Questionnaire: *Answering the following questions will help understand how this type of audit impacts on clinicians.*

What was your experience of using this tool?
Comments:

How did you feel about auditing your own practice?
Comments:

In your opinion was this tool applicable in your setting?
Comments:

What adaptations do you deem necessary?
Comments:

What did you learn from using the tool?
Comments:

Did it encourage you to reflect on your practice?
Comments:

Please feel free to add additional notes to the end of this questionnaire if you feel there is additional information that would be valuable.

Thank you in advance for taking the time to participate and complete this tool.