

Abstracts

- Waterlow score - an indication of patient frailty.

The DMH can demonstrate that twice as many EOL patients receiving care die at home as those not referred to the hospice.

P85 DEVELOPING AUDIT IN A HOSPICE

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The clinical audit group (CAG) at an independent hospice aims to motivate and encourage staff to undertake audit and to provide support and education for this activity. Many clinical staff have audit included in their job description. It was, however, observed that, while some staff regularly and competently carry out audit, some have not participated in audit and others find it difficult to conduct audit and report on their work, with variable knowledge of the theory and practice of audit. The CAG have, therefore, sought to implement a more robust audit registration and approval system alongside a programme of education to develop audit skills across the hospice in order to be able to produce credible and appropriate audit that demonstrates quality and areas for improvement. A set of resources to support audit was produced and made accessible to hospice staff electronically. A local step by step guide to registering an audit was produced. This included ensuring that CAG members review all audit registrations and recommendations for refinements are made before an audit is approved to start. The education team provides support to plan audits, including survey design, analysis and presentation of data. An audit of audits revealed that the quality of audits had improved (following implementation of some of these steps), while highlighting the a need to strengthen audit reporting, action plans and re-audit planning. A regular newsletter, highlighting audit activity within the organisation has been produced and audit activity has been reported in the general hospice newsletter. More recently, a questionnaire issued to the CAG members demonstrated gaps in knowledge and understanding, suggesting the need for further training to enable them to support their colleagues in undertaking audit. A programme of education has been designed to meet this need. The structure and membership of CAG is also being reviewed.

P86 AUDIT MAPPING AGAINST CQC OUTCOMES

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Audit mapping against CQC Outcomes

Introduction The Care Quality Commission (CQC) requires agencies to provide evidence that they are meeting the CQC outcomes. Clinical Governance is a framework through which organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care. **Aims** The Clinical Governance Reporting Guidelines have been reviewed and restructured inline with the Care Quality Commission (CQC) outcomes. The purpose of this exercise was to streamline the audit reporting process inline with the CQC, make the audits more meaningful, and avoid duplication of work.

Methods Using the hospices existing Clinical Governance Audit Programme, where possible, each CQC outcome was allocated

to an audit. Some audits were allocated more than one 'outcome'

Results Below is an example of how some of the audits are mapped against the CQC Outcomes.

Category	Audit title	Reference number	Frequency of audit	CQC Outcome
Involvement and Info	Peer – Activities	1.1	6 monthly	1a, 1b, 1c, 1f,
Safeguarding and Safety	Safeguarding	3.7	Quarterly	4b, 4i, 7a, 7b,
Personalised Care,	Symptom	2.4	6 monthly	1a, 1b, 1c, 4d,
treatment and support	Management			4e, 4k, 4w, 9a,
Quality of management	A&I	5.1	Quarterly	4b, 11a, 11c,
	Complaints	5.2	Quarterly	16c, 20a, 20b
				16a, 17a, 17e,
				20f, 20h, 20i

Discussion The children's hospice audit programme meets and provides evidence for many of the CQC Outcomes. Evidence for those the outcomes that are not met, can be provided in various other ways.

Conclusion This mapping exercise has been helpful in identifying how the hospice was already providing evidence for the CQC, but also helped to identify any shortfalls. Some audits have been reviewed to ensure that they serve a purpose and also can provide evidence for the CQC.

P87 MAY 12: AUDIT OF DOCUMENTATION OF CONSENT FOR CARE

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Aims Consent to valid treatment and care is central in all forms of healthcare: patients have a fundamental, legal and ethical right to determine what happens to them. Hospice at Home works with community services to fill gaps in end of life care for patients whose preferred place of care is home. Care is provided predominantly by health care assistants, and a few registered nurses (RN's). RN's receive consent training in their nursing studies. The aim was that all hospice at home evaluations should clearly state 'consent status documented for all care interventions given'. Many patients are unconscious and unresponsive when care interventions occur. Hospice policy states 'Consent status must be documented for all personal and invasive procedures'. It was difficult to see at a glance if consent status was recorded in the care plan.

Method A retrospective (random) audit of 204 care plans was performed to determine if consent status for personal care was documented. Confidentiality was maintained at all times. 77% records completed by HCAs and 23% by RNs

Result Cycle 1 -74% of care plans had consent status recorded. 26% records had no evidence of consent status documented. Further analysis identified only 37% of RNs had recorded consent status. Training needs were identified and implemented in various ways to include Consent, Mental Capacity Act (2005), and Record keeping. Cycle 2 Re-audited 6 months later using same criteria and data collection tools. - 93% of care plans had consent status recorded for personal care, improvement in the number of RN's recording consent status- 77% **Results** Care plans now checked daily to identify staff not adhering to policy. The need to replicate audit in other areas of the Palliative Care