

Linking Audit and Clinical Effectiveness in the Lung Cancer Service

- Clinical Audit Facilitator Sharon Gorman
- Clinical Nurse Specialist Caroline Doyle
- Consultant Respiratory Physician Adain O'Brien

Lung Cancer A Few Facts



- Lung cancer is a rising phenomenon in the Irish health care setting.
- It is the leading cause of cancer mortality in Ireland, accounting for approximately 20% of all cancer deaths.
- On average 1,640 new cases of lung cancer are diagnosed yearly in Ireland causing an increased strain on limited resources.
- The number of lung cancer cases in Ireland in 2005 was recorded as 1831 and is projected to increase by 138% by 2025 and by 257% by 2035 (National Cancer Registry, 2008).

Definition of Clinical Audit

- “the systematic, critical analysis of the quality of care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient.”

Quality and Fairness: A Health System for You. (2001)

Another definition

- “A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change”
- *Principles for Best Practice in Clinical Audit* (2002, NICE)

Clinical Audit Cycle (Steps)



- Choose something to Audit (Audit Topic)
- Measure against something (Audit Criteria, Standards and PPG's).
- Collect data, (Measurement Phase)
- Compare what we are doing with outlined criteria and standards (Analysis)
- Make changes and measure again (Re-Audit).

Audit Topic /Objective

- Audit of the assignment to treatment times from first x ray for patients presenting with Lung Cancer.
- The aim of the audit was to capture the lung cancer patient's care pathway, to improve clinical effectiveness, advance service quality and improve standards of care by reducing diagnosis and assignment to treatment delays.

Standards, Criterion



- The lung cancer service has been established for five years and has set its standards in line with the National Institute for Clinical Excellence (NICE) Guidelines (2005).
- And Irish Guidelines for the Clinical Management of Lung Cancer (2004).
- NICE (2005) recommended in guideline 24 that 'further research be carried out into the symptoms and signs associated with early- and late-stage lung cancer and the factors associated with delays in presentation and treatment'.

Data Collection



- A retrospective chart audit was undertaken to measure time frames in the patients care pathway of lung cancer patients who attended the service.

Pilot Audit

- A pilot audit was carried out on five sample charts and the tool was evaluated.
- The pilot demonstrated that the audit tool provided accurate recording of information at key points in the patient's care
- The data collected gave vital information on the quality of service,

What data was gathered?



- The audit tool aimed to record the length of time taken for key steps in the patients care pathway.
- Data captured included the date of first x-ray,
- Date of GP/A&E referral,
- Date of presentation to the Medical Assessment Unit (MAU),
- Date of first and subsequent diagnostics,

Data gathering continued



- Date of confirmed tissue diagnosis,
- Date of presentation to the multi disciplinary team (MDT),
- Date of final diagnosis to patient,
- Date of assignment to treatment/palliative care, and type of treatment.

Comparison Against Standards



- The median time taken from the initial abnormal chest x-ray to GP referral was 0 days i.e. same day referral (range 6-36 days).
- The median time to attend MAU/OPD after initial x-ray was 3 days (-1-45);
- The median time taken to CT was 0 days (-14-49);
- The median time from CT to first diagnostic procedure was 5 days (0-33);
- The median time from first diagnostic test to final tissue confirmation was 9 days (2-43);

Comparison Against Standards Continued

- The median time between tissue diagnosis and the patient being informed was 2 days (- 3-20);
- The median time from patient being informed to presentation at MDT was 6.5 days (-4 to 25). (However patients may have been referred to speciality services prior to MDT)
- The median time from the initial abnormal CXR to assignment to treatment was 36 days (range 7-141 days).
- 40.5% of patients received assignment to treatment within the 4 week standard set out by NICE

Comparison Against Standards Continued

- The average treatment time for 87.5% (42/48) patients accessing the service was 49.67 days
- Patients who were referred into the service via their GP had an average total treatment time which was 4.58 days longer than their counterparts who accessed the service via A&E.

Making Changes

- The data collected gives vital information on the quality of the service, and highlights areas to be addressed by the Respiratory Medicine Department and Allied Health Services.
- Multidisciplinary discussion meetings have taken place where key objectives have been outlined to improve service delivery

Service Improvements



- An excel data base to capture data on an ongoing basis to support re-audit
- Abnormal X- ray findings are sent directly to the consultant for review.
- Additional staff and voice recognition software has now been commenced in the histology dept
- Improved recording of MDT/Referral process

Why engage in clinical audit?

- Critical analysis of your own service, own skills and ways of working (self improvement)
- Critical look at the system that delivers care to your patients (i.e. your environment)
- You can make a real difference and change things for the better (quality improvement)

What does clinical audit achieve?

- Improves care for patients.
- Enhances the quality of service provision.
- Aids in efficient use of resources.
- Supports continuing education.
- It makes explicit what is being done.
- It communicates expectations and records excellence.

Lourdes Hospital Enquiry 2006

"Failure to engage in effective peer review and independent audit will ensure that history repeats itself"

Judge Harding-Clarke, 2006

Thank You

Sharon Gorman