635 Linking audit and clinical effectiveness in the lung tumour service

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Objective:

The aim of the audit is 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 treatment time delays.

Methods:

Clinical Audit plays an important role in the evaluation of care and clinical outcomes for all patients. Clinical effectiveness means ensuring that everything you do is designed to provide the best outcomes for patients. In this audit a retrospective chart study was undertaken at the Midlands Regional Hospital Mullingar (MRHM). The lung cancer service has been established for four years and has set its standards in line with NICE guidelines and Irish guidelines for the clinical management of lung cancer. 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. The number of lung cancer cases is projected to increase by 138% by 2025 and by 257% by 2035 (NCR, 08). The aim of the audit is to assess the lung cancer patient's care by measuring lengths of time taken at various junctions in the process, thus to improve clinical effectiveness, advance service quality and improve standards of care by reducing time delays.

An audit tool was developed by the audit facilitator in conjunction with key service personnel. The tool aimed to evaluate length of time taken for key steps in the patients care pathway. A pilot audit was carried out and the tool was evaluated. The audit tool provides accurate recording of information at key points in the patient's care which allows for a thorough service evaluation. The data collected and analysed gives vital information on the quality of service, and showed where there are deficits that need to be addressed. It captured time taken for the individual steps in the patients care pathway. This allows the deficits to be clearly identified, allowing for changes to be made to improve the clinical outcomes.

Results:

The audit captured data on 50 lung cancer patients who attended the MRHM over a nineteen month period from June 2007 to January 2009. Data captured included from the date of first x-ray, date of GP. referral, date of presentation to the Medical Assessment Unit (MAU), date of first and subsequent diagnostics, date of confirmed tissue diagnosis, date of presentation to the multi disciplinary team (MDT), date of final diagnosis to patient, date of referral to treatment/palliative care, and type of treatment commenced. Just 30% of all patients achieved the standard of commencing treatment within four weeks of first presentation. Tissue confirmation from the date of first procedure ranged between 4 and 21 days with the average being 14.7 days. Total treatment time ranged between 7 and 129 days with the average being 53.4.days.

Recommendation from the Audit.

1. A lung cancer education programme should be established and targeted to the GP's in the catchment area specific to the requirement for early intervention. This would provide information on importance of early referral etc/recognition of symptoms etc.
2. A review and subsequent guideline should be established in histology to combat delays.
3. MAU appointment policy/guideline to ensure follow up be arranged within 4 days of referral from gp/a&e etc

Conclusions:

The findings of the audit made it clear where there are delays in the care pathway of the lung cancer patient. It is now within our capacity to set about streamlining the service to meet the 4 week standard recommended by the nice guideline.