

# Improving MND Care Audit

## Instructions

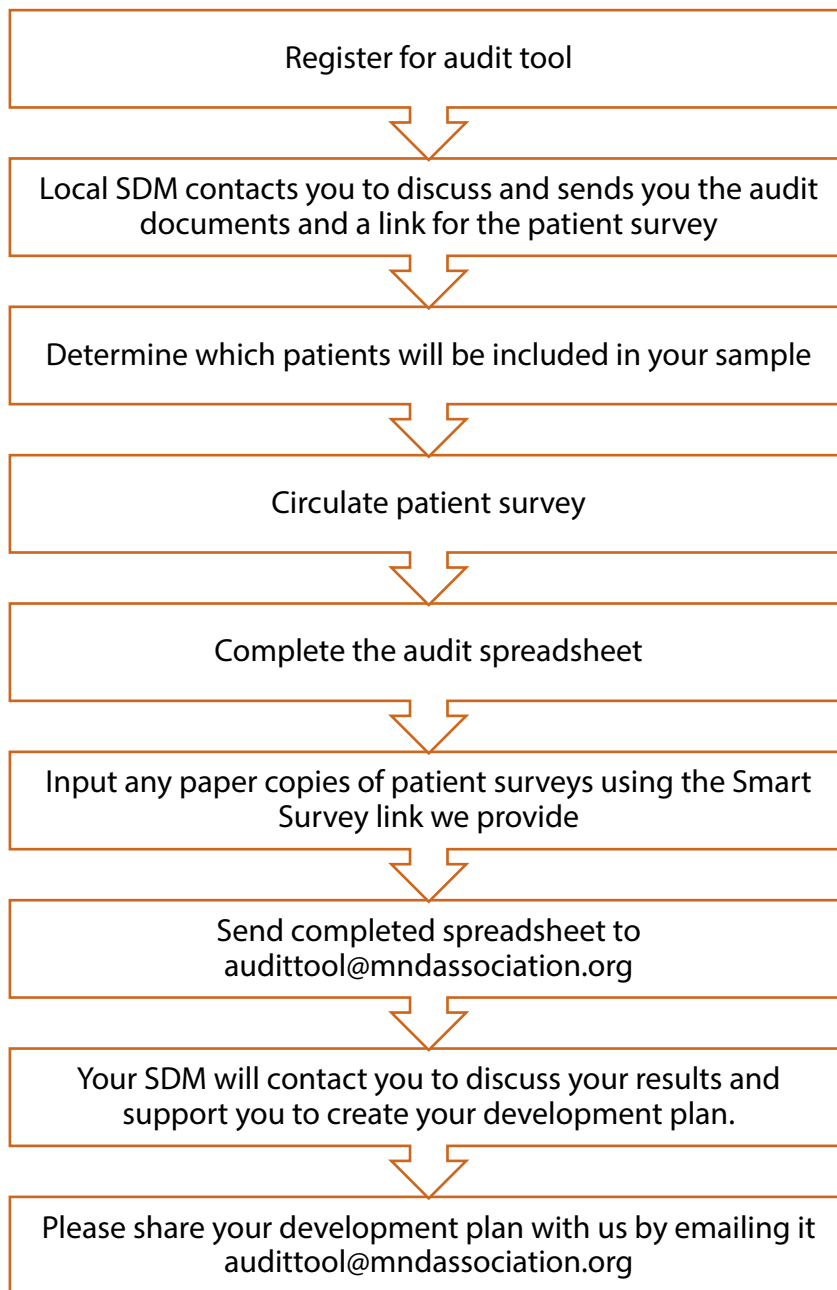
This document explains how to go about completing the Transforming MND Care Audit. A list of frequently asked questions is included at the end.

If you need further help, email [audittool@mndassociation.org](mailto:audittool@mndassociation.org)

### The basic steps to complete the audit are as follows:

1. Register your organisation's interest in completing the Transforming MND Care Audit by completing our online form at [www.mndassociation.org/audittool](http://www.mndassociation.org/audittool)
2. Your local Service Development Manager (SDM) will contact you to discuss this further, and agree with you which sections of the audit you will complete. Services can choose to undertake the full audit, covering 13 of the areas covered by the NICE guidance, or those relevant to your team or the needs of the area. Some sections may be strongly recommended, depending on what type of service you provide.
3. You will be sent the following documents, covering the topics you agreed with your SDM:
  - The Audit Tool spreadsheet:** This is the Excel document which you input your service's data onto. It should be returned to [audittool@mndassociation.org](mailto:audittool@mndassociation.org) after completion, and we will work with you to create a development plan.
  - Patient survey:** This is the survey which you should send to a sample of patients to support the data you input on the Audit Tool spreadsheet. We will provide you with a Smart Survey link to enter the information.
4. Agree which patients will be included in your audit – see *Sampling* on page 2.
5. Circulate the patient survey for completion – see *Patient survey* on page 5.
6. Your completed spreadsheets should be sent to [audittool@mndassociation.org](mailto:audittool@mndassociation.org). **The results of your audit are confidential.** The MND Association does not share this information with any other organisations.
7. Your SDM will contact you to discuss your results and support you to create your development plan. Once you have completed your development plan, please send it to [audittool@mndassociation.org](mailto:audittool@mndassociation.org). This helps the Association to collate ideas for improvement across England, Wales and Northern Ireland. Your development plans will never be shared without your express permission to do so.

# Flowchart



## Sampling

The requirement for this audit is to sample either a minimum of 20 patients or all your caseload if your caseload is less than 20. These sets of notes should be selected from those people with MND recently seen by the multidisciplinary team or service. If you have more than 20 patients on your caseload, you can sample more than 20 if you wish to, which will increase the accuracy of the sample.

The sample should be taken from your core caseload for whom you have ongoing care responsibility, whether in a shared-care arrangement or sole responsibility. Do not include those people who are seeing you for research purposes, or who are seeing you for a second opinion.

# Collecting data

There are two main ways of collecting data for the Audit Tool spreadsheet:

- a) analyse the records of the most recently seen patients (for example, notes of the last x number of people seen in clinic, or in their home).
- b) collect the data at the same time as seeing the patient (eg during a clinic session). Some services already have databases set up, so are routinely using these as a checklist during clinic.

Good professional practice relies on full and accurate record-keeping. The best maxim is 'if it hasn't been recorded in the patient's notes, it hasn't happened. If you find there are generally poor standards of record-keeping, then this may be something you wish to improve by addressing it in your development plan. Even though you may know that something has been done, it is important the evidence can be drawn from the records.

## Audit Tool spreadsheet

This section outlines each tab on the Audit Tool. Please note that orange tabs are for data entry and those in grey are for information.

Tab name	Details
Cover page	This tab is for your information only and does not require input.
Introduction	This tab is for your information only and does not require input.
Registration and team	<p>The registration and team tab has two sections.</p> <p>Section one - Registration details is compulsory for all auditing organisations. You should complete the registration details table, with details of the lead organisation, lead person completing the audit and the period the audit was completed.</p> <p>Section two – Team details is optional. It is the team details table, where you can type in the name, position, organisation/place of work and email address. It is for your reference if multiple people are contributing to the completion of the audit.</p>
Patient information (modular version only)  <i>Note: The full audit does not have the Patient Info tab as it is just one continuous workbook. The modular version has this tab so that you do not need to enter people's unique ID and year of diagnosis on multiple sheets.</i>	<p>This tab is for you to enter each patient you have chosen in your sample. Please enter each person's year of diagnosis. This information is pulled through to the Audit input tabs (see next row) to help you keep track of which patient the data refers to. This tab also includes an optional space for you to add any identifiers or codes you are using to help you keep track. Please do not use the patient's name.</p> <p>Please note that in the <i>Recognition and Referral</i> and <i>Information and Support at Diagnosis</i> tabs, results are filtered to only show patients diagnosed in the past two years to allow you to get a current picture of your service. All the other sections are based on all patients in the audit sample regardless of when they were diagnosed.</p>

<p>Audit input tabs</p> <p><i>Note: The full version of the audit does not have multiple input tabs, as it is just one continuous workbook.</i></p>	<p>These are the individual tabs for the sections you agreed to complete with your SDM.</p> <p>Each individual patient is designated a single column (headed by a patient number). All entries are made via drop down lists. The options for each question are Yes, No or Exception. See <i>Exceptions</i> below.</p> <p>Depending on your selections, the tabs may include:</p> <ul style="list-style-type: none"> <li>• information and support at diagnosis</li> <li>• cognitive assessments</li> <li>• organisation of care</li> <li>• psychological support</li> <li>• planning for end of life</li> <li>• management of muscle problems</li> <li>• saliva management</li> <li>• equipment and adaptations</li> <li>• nutrition and gastrostomy</li> <li>• communication</li> <li>• cough effectiveness</li> <li>• respiratory symptoms.</li> </ul> <p><b>Exceptions</b></p> <p>The Audit Tool spreadsheet allows you to mark exceptions, where a particular recommendation was not applicable to a particular patient.</p> <p>If there is an exception listed and it applies to the patient, select exception on the drop down rather than yes or no. Exceptions do not contribute towards the overall compliance rates in either direction.</p>
<p>Audit print – all questions</p>	<p>This tab is for your information only and does not require input. It includes all of the questions from the full audit, including the topics you are not currently auditing in a print-friendly format.</p>

# Patient survey

The patient survey is designed to capture the elements of the NICE Guideline on MND which need to come directly from the patient. For example, the guideline states that people with MND should be given 'sufficient' or 'appropriate' information, and we feel that the best person to answer this sort of question is the person themselves.

Ideally, the patient survey should be conducted with the same patients whose notes have been audited. The survey includes a covering letter for people with MND, which you should edit based on your information.

The Patient Survey is an essential part of the Transforming MND Care Audit and should be completed even if you conduct regular patient satisfaction surveys.

The survey is provided as a Word document for you to add your organisation's details and logo. We will also send you a link to a Smart Survey that you can share with your patients for them to complete the survey online if they wish.

There are two options for patients to complete the survey, and you can choose to use either or both depending on which you or your patients prefer:

1. The surveys can be posted to patients, with a stamped addressed envelope, or completed in the clinic setting, with help from someone at arm's length from those delivering the care (eg. a clinic volunteer or administrator) if needed. We would advise against the professional actually delivering the care completing the survey face-to-face with the patient, as this may skew the responses.
2. Alternatively, the survey can also be completed online. Your Service Development Manager will provide you with a web link to give to patients.

Once the responses from the patient survey have been received, any hard copies should be input to Smart Survey using the link we will provide you with.

Your local Service Development Manager can help link up services in your area to reduce the likelihood of someone receiving multiple surveys from separate teams.

Often only a proportion of the people you send it to will respond. If you wait for around four weeks this should give enough time for people to respond if they are going to, then you can input the responses.

# Frequently asked questions

## **Do I need to tell anyone within my own Trust that I am undertaking this audit?**

It is advisable to conduct this audit in collaboration with the clinical audit/effectiveness team within your own organisation. They can advise you about any local arrangements or protocols that need to be followed. In some cases, the clinical audit/effectiveness team may be able to assist in conducting the audit.

## **How long will the audit take to complete?**

We expect it to take between 30-60 minutes per patient, but this will vary depending on a wide range of factors, for example, whether your clinical records are collected electronically or on paper, the record-keeping practices within your team and the skills and abilities of the person completing the audit.

## **How often does the audit need to be done?**

This will depend to some extent on your development plan, however, good practice recommends it should be done annually, or as a minimum every two years.

## **Is the audit compatible with my computer?**

All documents are compatible with Microsoft Office 2010 onwards.

## **Are there any Data Protection issues to consider?**

As you are not being asked to record any patient identifiable information there are no data protection issues to consider. However, it is worth checking with your Information Governance or Clinical Audit/Effectiveness team to ensure that all possible safeguards are being taken and that you comply with any locally agreed arrangements.

If you have any questions or need further help after reading this document, please email [audittool@mndassociation.org](mailto:audittool@mndassociation.org)