



VITAL ASPECTS OF NURSING CARE (VANC)

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Background

In previous years there have been a number of high profile criticisms of nursing care nationally, which resulted in a call to return to basic values that underpin good quality nursing care.

In 2001 The Essence of Care benchmarks were launched by the Department of health.

Since the launch of Essence of Care, Poole Hospital Trust undertook a series of audits to gather information on the quality of care in the wards. This experience identified how we could improve the process and lead to greater improvements in care.

From this the Vital Aspects of Nursing Care (VANC) Audit was launched.



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What is the VANC audit?

The VANC audit is designed to support nurses in practice to understand how they deliver care, identify what works well and where further improvement is needed. It consists of a series of questions that aim to identify the standard of care in the following areas;

Privacy & Dignity

Pressure Ulcers

Food & Nutrition

Principles of Self-care

Continence, Bladder & Bowel care

Personal & Oral Hygiene



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What is the VANC audit?

Communication
Safety of Clients
Record Keeping
Infection Control



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The Process

The VANC Tool has been written as an electronic spreadsheet structured from quantitative yes / no / not applicable questions under the previous 10 benchmark categories.

The questions are divided into two groups, direct patient related issues and leadership / managerial issues.

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		Matrons					
Record Keeping	Are all the areas of the Adult Inpatient Record fully completed?						
Record Keeping	Does the date and time on the admission sheet indicate that it was commenced within the nursing shift of admission?						
Record Keeping	Do the patient records hold a basic nursing assessment dated within 24 hours of admission?						
Record Keeping	Does the patient records show a full nursing care plan dated within 48 hours?						
Record Keeping	Have the progress notes been updated at the end of each shift?						
Record Keeping	Does observation of handover/report show that information is complete and tallies with the written records?						
Record Keeping	There are no more than one consecutive '2' recorded on the drug chart						
Record Keeping	Where '6' is recorded does the patient report having taken their medication?						
Record Keeping	All records are legible						



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Data Collection

Data is collected every quarter.

A hard copy of the questionnaire is used for the audit prior to the results being entered onto the computer.

The audit responsibilities are shared amongst key members of staff.

5 patients are reviewed and involves reviewing all nursing documentation, observation of patient / staff interaction and observation of the patient environment.

Data does not need to be collected at once but needs to be consistently done.



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Data Collection

The data is entered onto a spreadsheet and the findings are represented as figures, percentages and a spider graph (radar chart).

Action plans are produced for benchmarks scoring under 75% and for areas of concern.

Action plans are reviewed at ward meetings, at the Care Group Quarterly Performance Review and through discussion with the Clinical Practice Development Committee.



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Summary of Results

In our recent audit, areas of good practice was shown in the following benchmark areas;

Self Care

Privacy & Dignity

Continence

Personal Care

Communication

Safety of Clients

Infection Control

Nutrition



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Summary of Results

Areas for improvement, where we scored less than 75%, were identified in the following two benchmark areas;

Record Keeping

Pressure Ulcers



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Negative Aspects

Time constraints.

Negative attitude of staff – another paper exercise.

A large piece of work to be completed quarterly.



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Positive Outcomes of the Audit

Record keeping and standard of documentation improved

Staff awareness & responsibility improved

Attitude to audit has changed, no longer seen as a negative process.

Confirmation of high standards in some areas has improved moral

Ability to transfer best practice from other clinical areas



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Conclusions

Since adopting the VANC audit we've experienced a measurable improvement in areas of record keeping and standard of documentation.

It is now regarded as a core piece of work generating positive outcomes and maintenance of standards.

Evolving process as it's completed quarterly and kept under constant review and adapted where necessary.



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The strength of the VANC audit is in the fact that it is a tool emphasised at getting the basics right, allowing nurses to take a structured patient focused approach to sharing and comparing practices.

The ease of use of the VANC tool helps nurses to focus on their nursing practice rather than burdening them with yet more audit and administration work in areas that may be out of their control.



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Best Practices

Staff involvement – generates ownership and responsibility.

For ease of completion the question order has been changed.



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