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Schering Health Care Award - Poster Prize
Staff awareness, acceptance and compliance with locally developed guidelines within a community family planning service

Amanda Smith, CaGr Registrar; **Christine Peacock**, SCMO (retired) *Community Health Care Service (North Derbyshire) NHS Trust*

Correspondence: *Amanda Smith, Saltergate Health Centre, Chesterfield, Derbyshire S40 15X, UK*

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Introduction
The Audit Core Group developed clinical and administrative guidelines with reference to available literature[1,2] and staff feedback. Their purpose is to facilitate access to information required for the delivery of a consistent standard of agreed good practice. 'Launched' at a staff meeting, one copy was taken back to each clinic by the nurse. Two years later the Audit Core Group evaluated their implementation.

Methods
A questionnaire covering awareness, ease of locating and usefulness of the 'documentation', 'condom', 'combined oral contraception (COC) first visit' and 'COC follow-up visit' guidelines, was posted to staff.

Using the guidelines, 'must do' and 'should do' criteria that clinical staff seeing new or follow-up clients requesting the COC need fulfil were identified.

Notes of new and follow-up COC users at each clinic over the previous 14 months were checked against the criteria.

Main findings
Staff survey

Of responders, 85.4% were aware of the guidelines, but the response rate was low. More clinical than clerical staff felt they would be able to find the manual in their base clinic without help (Table 1). The proportion of responders who had read the guidelines varied by staff role and guideline subject (Figure 1). Only 1/2 clinical staff who had read the COC first visit guideline found it useful, but 4/5 found the COC follow-up visit guideline useful.

Free-text responses indicated general satisfaction with, and willingness to work to, the guidelines. However, they needed a higher profile within the service and a standard location within each clinic.

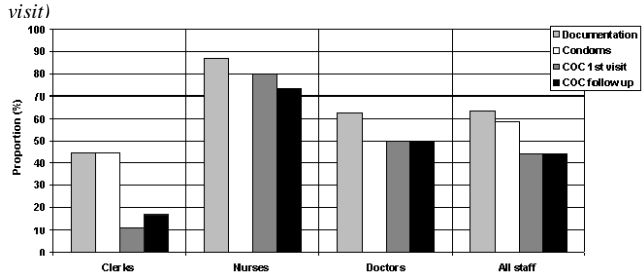
Most locums had only a vague awareness that the guidelines existed.

Table 1 *Response rates, awareness and ease of locating guideline manual*

	Clerk (31)	Nurse (57)	Doctor (38)	All
Responses	18 (58.1)	15 (26.3)	8 (21)	41 (32.5)
Aware of guideline	14 (77.8)	15 (100)	6 (75)	35 (85.4)
Perceive can find guideline without help (base clinic)	11 (61.1)	14 (93.3)	6 (75)	31 (75.6)

Percentage values are given in parentheses.

Figure 1 *Proportions of responders who had read each of four guidelines (documentation, condom, COC first visit and COC follow-up visit)*



Compliance with COC guidelines

COC first visit notes (262). Criteria required to be documented on a structured history card are more frequently recorded than those required to be documented in free text (Tables 2–4).

Table 2 *Presence or absence of possible contraindications recorded on history card ('must do' criteria A)*

Risk factor/possible contraindication	Presence or absence recorded in notes	%
Smoking status	250	95.4
Weight/body mass index (BMI)	235	89.7
Significant medical problem[a]/medication	240	91.6
Personal/family history thromboembolic disorder	234	89.3
Personal/family history breast cancer	229	87.4
Gynaecological history	248	94.7

[a]Migraine, epilepsy, diabetes, liver/heart disease, BP.

Table 3 *Discussion of aspects of COC prescribing recorded in notes ('must do' criteria B)*

Subject	Discussion recorded in notes	%
Pros and cons of COC	133	50.8
Side effects	131	50.0
Pill teach done	90	34.4
'3 pill rules'	60	22.9
Need for condoms/safer sex advice	227	86.6
Bleeding pattern to expect	44	16.8

Table 4 *Recorded evidence of 'Should do' criteria*

'Should do' criteria	Number	%
Need for smear/vaginal exam appropriately identified	155	59.2
Menstrual diary card given	5	1.9
Follow-up appointment given	262	100

COC follow-up visit notes (220) (Box 1). Although all had been seen by the nurse, only 26 (11.8%) contained a completed COC checklist. Seven percent had no documented evidence that the doctor had addressed a problem identified by the nurse. It was impossible to judge in 2/3 notes whether details had been checked for accuracy.

BOX 1: Criteria for COC follow-up visits

'Must do' criteria

1. 'Oral hormonal contraception checklist' to be completed by the nurse *(unless client seen only by doctor).*
2. Client is seen by the doctor if 'No' is recorded on the checklist *(or if a problem is identified by the nurse and recorded in the notes when checklist is not available).*

'Should do' criteria

1. Evidence that patient's details have been checked for accuracy.
2. Changes recorded in correct places.
3. Changes dated.
4. Follow-up appointment given.

Discussion

Possible reasons for the poor response rate include the high proportion of locum staff and the use of only one mail shot. More nurse responders had read the guidelines. Indeed, some were involved in disseminating the manuals. With their extended role in COC issuing, the guidelines may more frequently be of use to them.

Responders who didn't find the guidelines useful might feel they add no further improvement to their current practice.

We have not evaluated the effectiveness of our service before or after the guidelines. The development of evidence-based guidelines is, however, an integral part of clinical governance.[3,4]

Action plan

1. Areas of confusion (e.g. use of 'oral hormonal contraception checklist' and menstrual diary card) were discussed, rewritten and updated with reference to new national standards.[5]
2. Because few clerks could access relevant guidelines (probably because the manual was kept in the clinical area), three sets would in future be kept in standard, agreed places in each clinic.
3. All new and locum staff would be informed in writing of the location and function of the guidelines.
4. Guidelines are more likely to be effective if implemented through patient-specific reminders.[6] A stamp stating that the client's health and personal details have been checked once a year has been implemented.
5. Guidelines are more effective if disseminated by an active educational intervention.[6] The survey results were presented to staff. The service leaders endorsed the guidelines and highlighted their importance.
6. To encourage ownership, staff were asked to feedback on the guidelines and make further suggestions.

For guidelines to achieve their aim, staff need to be aware of them, to be able to find them, read and refer to them easily, accept them and practice within their framework (unless the situation of an individual patient justifies a deviation).

This survey highlights the difficulties of introducing guidelines and changing practice in a multidisciplinary user group. The implementation of future guidelines and any new evidence-based practice will benefit from the lessons we have learned and with reference to research on putting evidence into practice.[6]

References

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6 Effective Health Care. *Getting evidence into practice*. York: NHS Centre for Reviews and Dissemination, Volume 5, Number 1, February 1999.