Audit Tool
Supporting the Implementation and monitoring of the Acute Low Back Pain Model of Care

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Team leader, Outpatient Department & Senior Musculoskeletal Physiotherapist, Physiotherapy Department, Westmead Hospital
The ACI acknowledges the traditional owners of the land that we work on - the Cammeraigal People of the Eora Nation. We pay our respects to Elders past and present and extend that respect to other Aboriginal peoples present here today.
Meet our team

- **Chris Needs**, Rheumatologist, Royal Prince Alfred Hospital; Co-Chair, ACI Musculoskeletal Network
- **Matthew Jennings**, Allied Health Manager, Liverpool Hospital; Co-Chair, ACI Musculoskeletal Network
- **Katherine Maka**, Senior Musculoskeletal Physiotherapist, Westmead Hospital
- **Elise Tcharkhedian**, Senior ED/ASET Physiotherapist, Liverpool Hospital
- **Leigh Marchetto**, Physiotherapist, Emergency Department, Liverpool Hospital
- **Patricia Schlotfeldt**, Neck & Back Pain Triage Physiotherapist, Royal North Shore Hospital
- **Carlos El-Haddad**, Rheumatologist, Liverpool Hospital
- **Lilian Wong**, Physiotherapist, St George Hospital
- **Ian Starkey**, Physiotherapist, Auburn Hospital
- **Robyn Speerin**, Musculoskeletal Network Manager, Agency for Clinical Innovation
Why do we need an Audit tool?

- To evaluate current practice
  - Where does current practice fit within the Model of Care (MoC)?

- What are we doing well
- What could we do better

- Change needed

- A group of ED patient’s thought it would be a useful tool
The Facts

- Data reveals that there is deviations in care from current guidelines
- Liberal use of imaging… **Why?**
  - Should be reserved for serious pathology, persistent pain, neurological compromise
- Opiate analgesia
- Bed rest
- Cost $$$$$
  - $220m reimbursed for imaging 2013
- Early retirement
- 30% remain unrecovered at 12 months
Implementing the model of care

- Best practice
- Better patient outcomes
- Cost benefit
- Sustainable workforce

Who
16 years and over, new episodes of acute low back pain, less than 3 months duration with or without leg pain and preceded by one month of no pain
Audit tool

- The audit tool was developed based on the key principles for the management of people with acute low back pain

- Audit of 40 randomly selected files

- Pre-implementation, 3 months post implementation

- 6 monthly intervals for the first 2 years
**Key principles**

<table>
<thead>
<tr>
<th>Principle 1: Assessment – history and examination</th>
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<tbody>
<tr>
<td>A systematic and formal history and examination including the consideration of red flags is required at the outset to determine the pathway of care for each individual patient.</td>
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<tr>
<th>Principle 2: Risk stratification</th>
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<td>Prognostic risk stratification tools, such as the STarT Back and Örebro questionnaires, stratify patients into low, medium or high risk groups, determining the amount and type of treatment that they require.</td>
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<th>Principle 3: Patient education</th>
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<td>From the first assessment, each person will receive one-on-one discussion and support of self-management, along with electronic and paper-based education packs that detail the best practice management.</td>
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<th>Principle 4: Active physical therapy encouraged</th>
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<td>Physical therapies will primarily be a ‘hands off’ approach. The emphasis is on self-management assisting the patient to understand their condition and a staged resumption of normal activities. Consultation with team members may include a physiotherapist or practice nurse.</td>
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<tr>
<th>Principle 5: Begin with simple analgesic medicines</th>
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<td>Where pain medicines are required it is best to begin with simple analgesics using time-contingent dosing. Non-steroidal anti-inflammatory medications can be used for short time-frames after consideration of possible adverse reactions. Opiates should be avoided.</td>
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**Key principles**

<table>
<thead>
<tr>
<th>Principle 6: Judicious use of complex medicines</th>
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<tr>
<td>In the presence of persisting severe leg pain, some complex medication regimens may support pain control. These include tricyclic anti-depressants, anticonvulsant agents and serotonin noradrenaline reuptake inhibitors. However, caution is required considering the impact of potential mood changes and somnolence. Opiates are less effective in this patient group, and corticosteroid spinal injections offer only short-term pain relief and should not be initiated in the primary care setting.</td>
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<th>Principle 7: Cognitive behavioural approach</th>
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<td>The principles of cognitive behavioural therapy are used to ensure the patient is supported to understand the relationship between beliefs and behaviours, and to develop a goal-orientated plan of care.</td>
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<th>Principle 8: Only image those with suspected serious pathology</th>
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<td>Imaging is only indicated when a thorough patient history and physical examination indicates that there may be a medically serious cause for the lower back pain.</td>
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<tr>
<th>Principle 9: Pre-determined times for review</th>
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<td>Review each individual’s progress at two, six and twelve weeks. If there has been insufficient progress then change the treatment plan as outlined in the MoC.</td>
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<th>Principle 10: Timely referral and access to specialist services</th>
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<td>If the patient has not recovered by twelve weeks arrange for review by a musculoskeletal specialist as outlined in the MoC.</td>
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Audit tool

Using the Audit tool will help to identify

- Has a thorough history been taken to identify the pathway of care
- Self management techniques

- Hands off approach
- Pain medication

- Beliefs and behaviours – CBT
- Imaging

- Appropriate follow up
Developing the Audit tool

- Simple list of questions to review current practice

Example:

- Was Past Medical history documented?
- Were Red flags assessed?
- Was a risk stratification tool used?
- Was there an initial "hands off approach" to physical therapy?
- Is there evidence of a staged self-managed exercise program once the acute pain period is resolved?
- Is there documented evidence of a person-focused one on one education consultation?
Developing the Audit tool

- Definitions to help determine if best practice has been provided

Example:

**Were Red flags assessed?**

These would include:

- Signs and symptoms of infection
- Signs and symptoms of inflammatory spondyloarthritis
- Features of cauda equina syndrome or severe neurological deficit
- History of malignancy
- Significant trauma
- Unexpected weight loss
- Consider minimal trauma fractures in the elderly and those on corticosteroids where there are osteoporotic risk factors.
Developing the Audit tool

- Definitions to guide your review of practice

Example:

**Was Past Medical history documented?**

Past history should include previous episodes of LBP, previous trauma, malignancy, osteoporosis, corticosteroid use, recent hospitalisations or surgical procedures, intravenous drug use.
Developing the Audit tool

- Definitions to guide your review of practice

Example:

**Is there documented evidence of a person-focused one on one education consultation?**

Written evidence the patient was involved in discussing strategies they can undertake in partnership with their nominated health professionals with consideration of evidence based practice principles.

For example, emphasis on the good prognosis, staying active, regular walking, avoiding aggravating activities, exercises and educational material (written or visual).
Developing the Audit tool

- Aid consistency in interpretation of documentation

Example:

Were neurological findings documented precisely i.e. a) reflexes, b) sensation and c) myotomes?

Were all components of the neurological exam assessed and documented:

- Reflexes - absent/reduced/increased/equal/Normal
- Sensation - light touch/pin prick/hot/cold
- Muscle strength using the Oxford scale grade out of five.
Section 2

8. Patient gender

9. Patient age

10. Was Past Medical history documented?

Past history should include previous episodes of LBP, previous trauma, malignancy, osteoporosis, corticosteroid use, recent hospitalisations or surgical procedures, intravenous drug use.

11. Was a neurological examination indicated - patient has leg pain or bladder/bowel symptoms?

Indications would include: pain below the gluteal crease, lower limb numbness, weakness, or paraesthesia; as well as acute change in bladder or bowel function suggesting a cauda equina syndrome (see definition in glossary).

12. Was a neurological examination completed?

13. Were neurological findings documented precisely i.e. a) reflexes, b) sensation and c) myotomes?

Were all components of the neurological exam assessed and documented:

- Reflexes - absent/reduced/increased/equal/Normal
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14. Were Red flags assessed?

These would include:

- Signs and symptoms of infection
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Developing the Audit tool

- Portal to upload information to allow for site comparison
- Local data review possible
## Introducing the Audit tool

### Audit tool

#### ACI MODEL OF CARE FOR THE MANAGEMENT OF PEOPLE WITH ACUTE LOW BACK PAIN AUDIT

<table>
<thead>
<tr>
<th>Section 1:</th>
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<th>Comment</th>
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<tbody>
<tr>
<td><strong>Question</strong></td>
<td><strong>Result</strong></td>
<td><strong>Comment</strong></td>
<td></td>
</tr>
<tr>
<td>1 Local Health District</td>
<td></td>
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<tr>
<td>2 Service Setting</td>
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<tr>
<td>3 Is this the first presentation for Acute back pain in the last 3 month?</td>
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<tr>
<td>4 Audit conducted by (Full Name)</td>
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<td>5 Clinical role</td>
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<td>6 Your contact telephone number</td>
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<td>7 Stage of implementation</td>
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<th>Section 2:</th>
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<td>14 Were Red flags assessed?</td>
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Outcomes

- Review current practice against best practice
- Raises awareness of the practice Locally before and after implementation of the MoC
- Assist with embedding the key principles as the “new normal” in the management of ALBP
- Help to inform sites locally
- Future sharing of common mistakes in practice against the MoC
- Help to inform the ACI of current community practice, changes in practice and associated outcomes
- Inform future changes required of the MoC so that the MoC remains relevant to clinical practice
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