U.B.H.T.

Clinical Audit Report

2001/2002

Contents

1. Introduction from Chairman of Clinical Audit Committee

As recently appointed chairman of the Clinical Audit Committee I commend to you this annual report of Clinical Audit activity at UBHT. In a slightly different format from last year it contains a summary of around 400 audit projects, with greater detail of some exemplar projects from each directorate. Many projects reflect the increasing emphasis on improving care in line with priorities set out in National Service Frameworks and in guidance from the National Institute for Clinical Excellence (NICE), and it is pleasing to note the considerable impact of the past year's audit programme on local clinical practice (see Appendix A).

The Audit 'Oscars' once again provided a trust-wide forum for notable projects to be presented, and I am pleased to report that this will now become an annual event thanks to ongoing support from the Charitable Trustees for United Bristol Hospitals.

Many challenges remain, and in the absence of a resolution to the issue of protected and resourced time for all health professionals to undertake clinical audit, there will continue to be difficult decisions involved in prioritising audit activities.

I am looking forward to working with the Clinical Audit Committee and thankful for the work they and the wider audit team have accomplished, which is reflected in this report. The grading reassessment of audit facilitators was completed last year, and with notably fewer staff leaving than in previous years this has hopefully gone some way to recognising the importance of their role.

Finally, particular thanks are due to the outgoing chairman Zen Rayter who has guided and directed the Trust audit strategy with vision and enthusiasm over the last four years.

Dr Graham Bayly
Chairman of the Clinical Audit Committee

2. Clinical Audit Co-ordinator's Report

2.1 Preamble

2001/2 was a significant year nationally for clinical audit insofar as it saw publication of the long-awaited Bristol Royal Infirmary Inquiry Report ('The Kennedy Report'). The Government's response to Kennedy underlined the need for clinical audit to be at the centre of local arrangements for ensuring quality of patient care in the NHS. Disappointingly, however, the issue of lack of protected time to enable healthcare professionals to fully participate in clinical governance activities was side-stepped, as was the question of occupational standards for staff working in the field of clinical audit.

UBHT's clinical audit programme continues to grow - hopefully in terms of the quality as well as quantity of project work undertaken. The impact of NICE guidance and National Service Frameworks (NSFs) is starting to be felt as directorates make difficult choices around prioritisation of local audit programmes.

A major step forward for the clinical audit team has been the appointment of a new Clinical Audit Project Manager, Emma Parsons, who has taken a number of important areas of responsibility (links with PCTs, co-ordination of NICE/NSF audit, etc) under her wing. With the support of the audit team, Emma has also developed a new management database for clinical audit which promises to rationalise our ever-expanding reporting requirements.

It is pleasing to be able to report that a grading review of all A&C5 clinical audit posts has been completed, resulting in the creation of new opportunities for existing and future staff as they build their careers in the field of audit and healthcare quality.

UBHT's links with the wider audit community have been maintained through Chris Swonnell's continued co-chairing of the South West Audit Network (SWANS) and presence on the board of the National Audit & Governance Group (NAGG).

Every year seems to bring adjustments in the way this report is presented, as we seek to respond to both Trust and Purchaser requirements, and this year is no exception. Alongside key performance indicators retained from last year's report, we have re-introduced detailed information relating to a number of 'exemplar' projects, in addition to lists of specific benefits which have been derived from the audit programme in the last twelve months.

As ever, my thanks go to Trust's team of audit staff for their hard work and to members of the CAC for their continued support. Thanks in particular to Emma Parsons for preparing the statistical data in the main body of this report.

2.2 Achieving Effective Clinical Audit

2.2.1
Strategy

A new Clinical Audit Strategy was launched in 2000/1 in the form of a Balanced Scorecard (see Appendix B). The Scorecard has drawn a large amount of interest from other NHS Trusts, and was presented at the NICE conference in December 2001.

2.2.2
Organisational structure

- ***Clinical Audit team***

Clinical Audit activity at UBHT continues to be supported by a Central Office (CACO) and a team of directorate-based Clinical Audit Facilitators (CAFs). CAFs are line managed in their directorates, but professionally responsible to the Clinical Audit Co-ordinator (who is based in the CACO). On a day-to-day basis CAFs work closely with Clinical Audit Convenors (clinical leads for audit - usually consultant medics) in their directorates, whilst one of the main functions of the CACO is to support the work of the Clinical Audit Committee (CAC) in developing and guiding UBHT's clinical audit strategy.

- ***CAC***

Clinical Audit Convenors meet every month with the Chairman and Co-ordinator as the Clinical Audit Committee. In the last year, a "CAC pack" has been produced to assist new members of the CAC in getting to grips with their role. This includes an updated job description for convenors. A similar information pack has been developed for use as part of the induction process for new members of the clinical audit team.

- ***Lines of reporting***

The last year has seen a number of changes in the mechanisms for reporting on clinical audit between the directorates, CAC and the Clinical Governance Committee (CGC). As a result of this the CAC now sends a four monthly summary of Committee business to the CGC, accompanied by a single A4 summary sheet listing key performance indicators for the trust's clinical audit programme, derived from the Balanced Scorecard. In a parallel system of reporting, directorates also send quarterly updates on the progress of local audit programmes to the CAC: the CAC in turn refers any significant issues which arise to the CGC, also on a quarterly basis.

Directorates formally present to the CAC roughly every 18 months as part of rolling programme (shortly to be reviewed). Emma Parsons provides the CAC with a bi-monthly update of how UBHT is progressing in terms of audits of NICE guidance and NSFs.

2.2.3
Staff changes

- ***Clinical Audit team***

In 2001/2 we welcomed David Finch (Cardiothoracic Services) and Sarah Spinks (Surgery) to UBHT's clinical audit team, whilst Kate Wathen moved from Specialty Services to a full time audit post in Medicine. Emma Parsons joined the team from her previous post at East Somerset NHS Trust and has assumed the role of CA Project Manager (encompassing that of Deputy CA Co-ordinator). At the end of 2001/2, with the UBHT Community Directorate's move to become part of the Bristol South & West PCT, the team said goodbye to Fiona Clark, although we look forward to maintaining strong links with Fiona in the future.

- ***CAC***

Mr Zen Rayter stood down as Chair of the Committee in February 2002 after serving in this capacity for over four years, and in April Dr Graham Bayly was appointed as his successor. There were a number of other changes in membership of the CAC during 2001/2: Andreas Baumbach assumed joint responsibility for the clinical audit programme in the Cardiothoracic directorate, working alongside Alan Bryan; Diana Terry succeeded Mike Kinsella in Critical Care; Jane Blazeby succeeded Paul Barham in Surgery; Clare Bailey took over the role of convenor for Ophthalmology from John Sparrow; and Susan Whitehead assumed responsibility for clinical audit in the Community directorate until the end of March 2002 when the directorate joined with the new Bristol PCTs. Since April, Andrew Davies has succeeded Chris Price as convenor for Oncology. Finally, changes in the secretarial support structure for clinical governance have meant that Naaz Nathoo has moved on to other duties after over eight years of service as secretary to the Committee: so, a big 'thanks' to Naaz from everyone who has been involved with the CAC during that time. Full details of the Trust's audit team of facilitators and convenors are shown in Appendix C.

2.2.4
Recruitment and retention

The past twelve months have seen continuing discussion about appropriate grading of directorate-based CAF posts. This culminated in a formal review of all nine clinical audit A&C5 posts towards the end of 2001: seven posts were subsequently designated as A&C6, two as A&C5 (see Appendix C). Facilitators in new A&C6 posts have subsequently either been regraded or made the subject of short-term development plans. When staff leave A&C6 directorates, posts will be advertised as 'A&C5/6 depending on experience'.

Staff retention improved considerably during 2001/2, with a number of facilitators presumably waiting to see the outcome of the review process!

2.2.5
CPD for audit team

In the past year Emma Parsons, Chrissie Gardner, Eleanor Ferris, and Fiona Clark have continued their MSc studies in Clinical Audit & Effectiveness at the University of Wales, Swansea. Michelle Croucher has begun studying for an MSc in Managing Quality in Healthcare at the University of Birmingham. Chris Swonnell is studying for an MSc in Strategic Management at the University of Bristol.

During the year, members of the team attended a number of key national conferences, including the Clinical Audit Association Conference 2001, Clinical Excellence 2001 (i.e. the NICE conference) and Clinical Audit 2002.

2.2.6
Developments in Information Management

- ***Management database***

The Balanced Scorecard has also provided a framework for the development of a new clinical audit management database, which was introduced in April 2002. Developed by Emma Parsons, Sue Barron & Eleanor Ferris, the database is intended to simplify and streamline existing methods of reporting. The database is accompanied by revised clinical audit registration documentation (proposal forms, etc), which is part of an ongoing drive to raise the quality of audit projects.

- ***Newsletter***

In January 2002, the CACO launched a new newsletter aimed primarily at keeping clinical audit facilitators and convenors fully briefed about local and national developments in audit - especially items relating to audit of new NICE guidance and National Service Frameworks. *Update* is edited by Emma Parsons and circulated on a bi-monthly basis (see Appendix D).

- ***Web pages***

UBHT's clinical audit web pages (www.ubht.nhs.uk/clinicalaudit - see Appendix E) continue to generate attention from outside of the organisation. We are aware that a number of other NHS Trusts use our site as a reference in matters relating to clinical audit, and the site was cited as a recommended resource at the *Clinical Audit 2002* national conference in February 2002. In June 2002 Chris Swonnell was invited to deliver a presentation about the web site at the Clinical Audit Association national conference, and in the same month the site was listed in the national *Clinical Governance Bulletin* amongst useful clinical audit on-line resources.

The web pages include on-line versions of our popular Clinical Audit *How to…* guides, a concept which has recently been borrowed by both the Sandwell Healthcare & North Bristol NHS Trusts.

- ***Optical Character Reader***

The CACO has also overseen the procurement and installation of a new *TELEform* Optical Character Reader (OCR) as a trust-wide resource. The OCR has the potential to reduce the large amount of staff time currently spent on manual data entry.

- ***Electronic Patient Record***

The CACO continues to be closely involved in developments around the procurement of an EPR system by the Avon Consortium.

2.2.7
Financial information

The identified Clinical Audit budget for 2001/2 was £348,900. £56,900 of this figure was automatically allocated to the IM&T directorate to support the MDI system, and for accounting purposes is considered to be part of IM&T baseline funding. Of the remaining £292,000, £95,500 funded the Clinical Audit Central Office whilst £196,500 was allocated to clinical directorates as follows (figures shown are approximate and are provided for comparative purposes):

Medicine	£24k
Children's Services	£22k
Oncology	£18.5k
Surgery	£18.5k
Critical Care (incl. Anaesthesia)	£18k
Ophthalmology & Homeopathy	£15k
Community Services	£15k
O&G/ENT	£14.5k
Pathology	£12.5k
Radiology	£12k
Cardiothoracic Services	£9k
Dental Services	£8.5k
Specialty Services	£7k
Occupational Health	£2k

Note: whilst the table above describes the distribution of centrally earmarked clinical audit funds, directorates in many cases make additional funds available to support local audit initiatives.

In 2001/2002, the clinical audit budget was used in the following ways (figures approximate):

IM&T	
MDI licence + salary of MDI Co-ordinator	£57k
Directorates	
Staff (Trust team of facilitators + convenor in Medicine)	£190k
Miscellaneous expenses (£500 float allocated to each directorate)	£6.5k
Central Office	
Staff (directorate and central office)	£67k
CPD for audit team (study, training, conferences, meetings – including expenses)	£12k
Final contribution towards total purchase of Optical Character Reader, including PC and support costs	£11.5k
Purchase of new PCs for Central Office	£2k
Purchase of additional server space	£1k
Miscellaneous central office expenses (including books, journal subscriptions, stationery, IM&T charges)	£2k

2.2.8
Auditing Audit

In late 2001 we completed a second round of directorate clinical audit reviews based on a tool originally devised by Kieran Walshe (formerly of the Health Service Management Centre).

Since this time, all directorates have carried out a further evaluation of their audit programmes using a 'traffic light' framework developed around issues which form the basis of Clinical Governance Reviews carried out by the Commission for Health Improvement. As a result of this exercise, all directorates have produced action plans which have been approved by the CGC. In common with all other NHS Trusts, we recognise that there is room for continued improvement in three specific areas of our audit programme:

- ***Multi-professional audit***

47% of projects undertaken in the past year were multi-*disciplinary*. However, we recognise that a significant proportion of this figure is likely to be accounted for by medics from different specialties working together (e.g. surgeons and anaesthetists), as opposed for example to medics working collaboratively with nurses and allied health professionals. In 2002/3, updated project registration documentation means that we will be able to identify levels of true multi-*professional* activity. In the meantime, the CAC has produced a strategy paper aimed at encouraging the development of multi-professional clinical audit projects (see Appendix F).

Discussions have continued through 2001/2 about the best way to co-ordinate clinical audit in areas which do not set neatly with the directorate-based structure of UBHT, namely Nursing and the Allied Health Professions (AHPs). Clear lines of support have been identified within the clinical audit team (see Appendix G) and this has been communicated to Nursing and AHP leads. Whilst nurses and members of the AHPs have been involved in many of the multi-professional projects listed in this report, our

previous system of capturing summary project information does not allow us to provide an in-depth breakdown of this participation – revised project registration documentation should enable this level of analysis in 2002/3.

Appendix H contains a list of uniprofessional AHP projects which we are aware have been undertaken in the past year, but which have not been facilitated or formally registered through the clinical audit team. In 2002/3 we will ensure that this support gap is closed.

- ***Consumer involvement***

8% of projects in the past year involved consumers. However, we recognise that a large proportion of this figure is accounted for by patient *surveys*, rather than direct involvement of users in, for example, agreeing the content of local audit programmes. In 2002/3 our new reporting framework will allow us to identify the different ways in which users have been involved in our clinical audit programme. In the meantime, we have produced a clinical audit *How to…* guide to involving consumers in audit, as a way of raising the profile of this important issue within the Trust. Executive summaries of any clinical audit projects involving patients/users are also now formally discussed at UBHT's Consumer Committee.

- ***Inter-sectoral working***

5% of projects from last year involved collaboration with other organisations. Emma Parsons has recently taken the initiative in convening regular meetings involving the clinical audit leads for Bristol North PCT, Bristol South & West PCT, the Avon Ambulance Trust, Avon & Wiltshire Mental Health Partnership, NHS Direct, Avon, Somerset & Wiltshire Cancer Services, North Bristol NHS Trust and UBHT. It is hoped that by sharing information about local audit programmes and each organisation's respective ways of working, it may be possible to encourage more interface audit projects.

2.2.9
Clinical Audit Training

In 2001/2, eight one-day workshops were held at Barrow Hospital as part of the Staff Development Programme. Feedback from staff attending these courses has continued to be extremely positive. Limited places on the workshops are made available to staff from other NHS organisations - in the past twelve months we have delivered training to audiences including clinical audit and governance staff from Weston Area, Royal United Bath and Wiltshire Health Authority. Additional training sessions are organised in most directorates; both for junior medical staff, and for other healthcare professionals on an ad-hoc basis. In several directorates, CAFs now deliver induction training on Clinical Governance.

2.2.10
Clinical Audit 'Oscars'

The fourth UBHT Clinical Audit 'Oscars' event was held in March 2002. This event – a showcase for the best audit work in the Trust during the preceding year – is now supported on an ongoing basis by the Charitable Trustees for the United Bristol Hospitals who once again provided cash prizes for the winning projects. First prize was claimed by Dr Gavin Lloyd from the BRI Emergency Department for an audit of NSF targets for thrombolysis in Acute MI; second prize was awarded to Dr Thomas Stumpf for an audit of post-operative Endophthalmitis.

2.2.11
Clinical Effectiveness & Evidence Based Practice

The Clinical Audit Co-ordinator continues to work closely with the Director of Research & Development on the development and delivery of the UBHT's Clinical Effectiveness Strategy. A separate Clinical Effectiveness Annual Report for 2001/2 will be produced by the Trust.

Chris Swonnell
Clinical Audit Co-ordinator

3. Project Reports for 2001/2002

3.1 Contracted audits

The clinical contract between UBHT and Avon Health Authority for 2001/2 did not contain specific requests for audit projects to be undertaken. Instead, as general guidance, the contract indicated that priority should be given to the following:

- National Service Frameworks
- National Audits
- Health Improvement Programme priorities (i.e. cancer, heart disease, stroke, care of the elderly)
- Primary Care interface audit

The table below indicates UBHT clinical audit projects relating to these areas in 2001/2 (references are to projects listed in subsequent sections of this report):

NSFs / NICE / Royal College Guidance, or similar					
3.3.3	3.3.22	3.3.26	3.3.28	3.3.31	3.3.32
3.3.33	3.4.2	3.4.22 - 24	3.4.26	3.4.27	3.4.28
3.4.32	3.4.36 - 39	3.4.42	3.4.43	3.6.1	3.6.6
3.7.6	3.9.1	3.9.3	3.9.6	3.9.7	3.9.10
3.9.17	3.9.23	3.9.28	3.9.30	3.9.36	3.9.38
3.9.41	3.10.3	3.10.4	3.10.9 - 14	3.10.30	3.10.24
3.10.25	3.10.28	3.12.7	3.12.8	3.13.40	3.13.29
3.13.37	3.13.38	3.13.21	3.13.23	3.13.8	3.13.9
3.13.16 - 18	3.13.1	3.13.2	3.13.4	3.14.24	3.15.5
3.15.9	3.15.10	3.15.21			
National Audits					
3.3.31	3.4.3	3.4.27	3.6.4	3.6.34	3.6.45
3.9.6	3.9.41	3.10.9	3.10.28	3.13.40	3.13.23
3.13.5	3.14.2	3.15.8	3.7.15		
Health Improvement Programme Priorities					
Cancer:					
3.3.34	3.4.42	3.7.7	3.9.9	3.9.12	3.9.13
3.9.36	3.10.6	3.10.18	Section 3.11	3.13.9	3.13.11
3.13.12	3.13.13	3.13.14	3.13.16	3.13.17	3.13.18
3.14.1	3.14.8	3.15.8	3.15.22	3.16.1	3.16.6
Heart Disease:					
Section 3.3	3.4.16 - 20	3.6.6 - 8	3.6.25	3.6.30	3.6.34
3.9.15	3.9.21	3.9.27	3.13.38	3.14.3	3.14.4
Diabetes:					
3.3.11	3.3.24	3.4.24	3.4.28	3.9.17	3.9.19
3.12.7	3.12.8	3.13.37			
Stroke:					
3.9.6 - 8	3.9.28				
Care of the Elderly:					
3.3.21	3.9.1 - 8	3.9.26			
Other:					
Emergency Vascular Rota		Abandoned during 2001 but listed as part of forward programme for surgery during 2002/2003.			
Primary Care Interface					
3.5.10	3.9.6	3.9.19	3.9.35	3.9.40	3.12.6
3.14.27	3.16.14	3.16.18	3.7.3 - 8	3.7.19	3.7.24

3.2 Summary statistics

Directorate	Total number of projects	New projects, including pre-audits*	Re-audits*	Ongoing monitoring*	National*	Regional*	Multi-Disciplinary*	Interface*	Patient / Carer Involvement *			Linked to NSF, NICE guidance or similar*	Standards - measuring or development*	Use of evidence in standards*	Part of 2001/2002 directorate audit forward plan*	Linked to directorate business plan*	Changes in practice~	Confirmed measurable benefits to patients #
									Survey	Non survey	Total Projects							
Cardiothoracic Services	36	69%	3%	28%	3%	0%	58%	3%	0%	0%	0%	17%	31%	14%	42%	25%	0%	10%
Children's Services	51	55%	14%	2%	8%	6%	27%	0%	6%	6%	6%	31%	45%	49%	37%	6%	70%	60%
Community Services	12	75%	25%	0%	0%	17%	50%	8%	17%	25%	25%	0%	75%	67%	83%	8%	64%	0%
Critical Care	53	74%	7%	19%	6%	6%	32%	0%	2%	0%	2%	4%	92%	68%	6%	0%	30%	9%
Dental Services	33	64%	30%	6%	3%	21%	42%	33%	12%	3%	12%	3%	94%	73%	27%	0%	58%	17%
Homeopathy	10	70%	10%	20%	0%	0%	20%	0%	40%	30%	40%	0%	100%	90%	50%	0%	80%	0%
Medicine	41	80%	12%	2%	5%	2%	58%	10%	15%	15%	17%	29%	76%	71%	32%	17%	25%	0%
Obs, Gynae & ENT	30	63%	20%	17%	7%	10%	50%	0%	7%	0%	7%	40%	93%	67%	37%	0%	21%	27%
Oncology	16	81%	19%	0%	0%	6%	37%	0%	0%	0%	0%	19%	69%	81%	6%	6%	53%	33%
Ophthalmology	19	79%	21%	0%	0%	0%	37%	5%	5%	0%	5%	10%	89%	95%	47%	0%	82%	50%
Pathology	40	53%	25%	22%	7%	2%	67%	0%	0%	0%	0%	35%	65%	42%	95%	22%	61%	23%
Radiology	27	78%	18%	4%	4%	0%	63%	4%	0%	4%	4%	4%	81%	70%	37%	37%	53%	0%
Specialty Services	20	60%	15%	25%	5%	0%	45%	0%	10%	10%	20%	30%	65%	65%	35%	45%	23%	29%
Surgery	28	89%	7%	4%	0%	11%	54%	11%	7%	11%	11%	11%	82%	54%	0%	4%	44%	0%
TOTAL	**416**	**69%**	**15%**	**11%**	**4%**	**6%**	**47%**	**5%**	**6%**	**5%**	**8%**	**18%**	**73%**	**60%**	**36%**	**12%**	**44%**	**20%**

* includes 2000/2001 rollovers ~ does not include 'current' projects (i.e. completed audits only) # calculation based on completed re-audits and ongoing monitoring projects only

note: final row total (new audits + re-audits + ongoing monitoring) does not equal 100% - Children's Services and Medicine registered a number of projects which were not categorised

3.3 CARDIOTHORACIC SERVICES

SUMMARY

Number of 2000/2001 roll-overs **<<**:	26
Number of new pre-audits ▲:	2
Number of new first audits ■:	6
Number of new re-audits ●:	0
No. of new ongoing monitoring projects **>>**:	2
Total number of audits:	**36**
Number of completed audits:	14
Number of current (i.e. uncompleted) audits **>**:	7
No. of ongoing monitoring projects c/forward:	10
Number whose current status is unknown:	5

(Originally 27 but 1 abandoned during 2001/02)

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	9/18	(50%)	12/24	(50%)	**5/10**	**(50%)**
Audits arising from a critical incident:	-	-	0/24	(0%)	**0/10**	**(0%)**
Audits prompted by a patient complaint:	-	-	0/24	(0%)	**0/10**	**(0%)**
Audits directly involving patients/carers (but not including surveys):	4/18	(22%)	0/24	(0%)	**0/10**	**(0%)**
Audits incorporating a patient / carer survey:			0/24	(0%)	**0/10**	**(0%)**
Audits involving representatives from primary care:	2/18	(11%)	1/24	(4%)	**1/10**	**(10%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/24	(0%)	**0/10**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**4/10**	**(40%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**6/10**	**(60%)**
Audits linked to directorate business plan:	-	-	-	-	**3/10**	**(30%)**
Number of proposal forms completed:	-	-	5/24	(21%)	**6/10**	**(60%)**
Number of proposal forms completed BEFORE audit started:	-	-	5/24	(21%)	**6/10**	**(60%)**
Audits measuring against or resulting in development of standards or guidelines:	15/18	(83%)	5/24	(21%)	**6/10**	**(60%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	4/18	(22%)	2/24	(8%)	**3/10**	**(30%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	3/4	(75%)	**2/14**	**(14%)**
Audits where an action plan was produced:	-	-	0/4	(0%)	**2/14**	**(14%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	0/4	(0%)	**0/12**	**(0%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	8/11	(73%)	2/12	(17%)	**1/24**	**(4%)**
Audits leading to better ways of working for staff:	-	-	2/12	(17%)	**0/24**	**(0%)**
Audits leading to measurable benefits for patients:	-	-	1/12*	(8%)*	**1/24***	**(4%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	6/7	(86%)	1/9*	(11%)*	**1/10***	**(10%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: Cardiac Surgery							
3.3.1	Appropriate Use of Pressure Relieving Mattresses	Lisa Reid		✓			✓
3.3.2	Audit of Adult Cardiac Surgery: Annual Report	Mr Alan Bryan	✓			✓	
3.3.3	Audit of Cardiac Rehab Patients	J Victory	✓			✓	
3.3.4	Audit of Discharge Co-ordinators Work	Caroline Smith		✓			
3.3.5	Audit of Extubation Data	Kathy Gough	✓		✓		✓
3.3.6	Audit of Medical Notes	P Dillon	✓	✓			
3.3.7	Audit of Mortality / Morbidity for Urgent Referred Patients	Mr F Ciulli	✓	✓			?

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.3.8	Audit of Nurses' Documentation in Ward 5B	Janet Kew	✓	✓			
3.3.9	Audit of Physiotherapy Data for the First 6 Months of the Financial Year	Physio Dept.	✓	✓			
3.3.10	Audit of Relationship Between Haemocrit on Admission to ICU Following Coronary Surgery and Postoperative MI and/or Death	Dr Alan Cohen	✓			✓	
3.3.11	Characteristics of Cardiac Patients With Diabetes	Ward 5B	✓	✓			?
3.3.12	Critical Pathways	Fiona Thomas	✓	✓			?
3.3.13	Fast-track of Cardiac Patients After Surgery	Mr F Ciulli	✓	✓			?
3.3.14	ITU length of stay and mortality after one year	Dr D Glancy		✓			✓
3.3.15	Mortality Rate Procedures Based on Parsonnet Scores (CRAM)	S Pryn	✓			✓	
3.3.16	Nausea and Vomiting Post Cardiac Surgery	Lisa Reid		✓			
3.3.17	Quality of Catherisation Data	P Dillon, J Sims	✓	✓			?
3.3.18	Sternum Wound Infection	Dr Milan Bates	✓	✓			✓
3.3.19	To Compare the Administration of Post-Op Bloods	I Channon	✓	✓			✓
3.3.20	Usage of Blood Products After Cardiac Surgery	Dr Alan Cohen	✓			✓	
3.3.21	What are the Local Morbidity and Mortality Rates in Cardiac Patients >= 80 Years of Age?	Sharif Al-Ruzzeh		✓			
Specialty: Cardiology							
3.3.22	Are Myocardial Infarction Patients Receiving Clinically Effective Treatment to Prevent Further Infarcts?	Dr Tim Cripps	✓			✓	
3.3.23	Audit into the Provision of Angiograms and PTCAs to Patients from Peripheral Hospitals	Jenny Tagney	✓	✓			
3.3.24	Audit of Care of Patients With Diabetes	Jo Chambers	✓	✓			
3.3.25	Audit of CCU Workload	Roger Owen	✓	✓			
3.3.26	Audit of Door / Symptom to Needle Times	Roger Owen	✓	✓			
3.3.27	Audit of Leg Wounds After Cardiac Surgery	Dr D Metha	✓	✓			
3.3.28	Audit of Secondary Prevention Clinic	Rebecca Gillett		✓			✓
3.3.29	Can we Reduce Bed-Rest Post Angiogram / PTCA?	Jenny Tagney	✓	✓			
3.3.30	Cardiology Audit: Annual Report	Dr A Baumbach	✓			✓	
3.3.31	Myocardial Infarction National Audit Project ***(with Critical Care)***	Prof K Karsch				✓	
3.3.32	Rapid Access Chest Pain Clinic	Dr C Croy				✓	
3.3.33	Were patients treated according to NSF guidelines for acute MI in 2000?	Dr A Baumbach		✓			✓
Specialty: Thoracic Surgery							
3.3.34	Surgery for Lung Metastases With Emphasis on Pulmonary Conversion	Mr L Balacumaraswami		✓			
3.3.35	Thoracic Surgery Audit: Annual Report	Mr J A Morgan	✓			✓	
Specialty: Directorate							
3.3.36	Audit of PATS Data Quality	Paul Dillon	✓	✓			

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Blood and Blood Product Usage by Wards and Theatres - Monitored Throughout Year and Reported Back to Individual Clinical Teams	**(Pathology)**	3.13.22
• Use of Troponin-I as a marker of myocardial infarction	**(Pathology)**	3.13.38
• Audit on Coarctation follow up in GUCH	**(Radiology)**	3.14.3
• Audit on Surgery of Mitral Valve Regurgitation	**(Radiology)**	3.14.4

EXEMPLAR AUDITS 2001 / 2002

Adult Cardiac Surgery Audit Report 2000/01

Mr A J Bryan *Consultant Cardiac Surgeon,* **D J Finch** *Clinical Data Manager*

Background

The usual approach to clinical audit is to develop an audit tool with a specific objective in mind. A well-designed audit tool enables minimum data collection with minimum fuss, and the usual practice is to sample just sufficient patients to achieve clinical significance, thereby prompting action plans for improvement of services. It is then an easy matter to re-audit practice to ensure changes have been beneficial. Whilst this approach has many benefits and many areas of application, it falls short in providing the information needed to understand complex issues surrounding the treatment and care of patients receiving heart surgery.

Since April 1996 the Cardiothoracic Directorate of the Bristol Royal Infirmary has therefore taken a somewhat different and more rigorous approach to clinical audit for adult cardiac surgery. The Directorate has invested in a single, comprehensive data capture system used by the entire care team – the Patient Analysis and Tracking System (PATS) – as licensed by Dendrite Clinical Systems Ltd. With low mortality and morbidity rates, a typical approach to audit would require observation for many months or years before decisions can be made to change care/treatment. Continuous prospective data collection enables us to undertake critical audits in a matter of hours or even minutes.

Data are collected prospectively by surgical, anaesthetic, perfusion and nursing staff using a 22 page proforma that follows each patient on their journey from admission ward to discharge. This document provides core data in accordance with guidelines of the Society of Cardiothoracic Surgeons of Great Britain and Ireland, collection of which is now a requirement for all surgical units under the National Service Framework for Coronary Heart Disease. The core data set is supplemented by a number of additional variables, which have been agreed by the various professional teams as being pertinent to a particular area of interest or concern. The PATS database currently holds detailed information on 6,800+ patients and 16,600+ surgical procedures, and is used to compile a detailed annual report on trends in patient profile, patient care, surgical technique and consultant performance. The annual report is published in hardcopy format and is available free of charge. It may also be downloaded from the UBHT website.

Summary of key conclusions

- A fifth consecutive year of comprehensive prospective risk stratified outcomes data for the BRI adult cardiac surgical unit has been successfully completed. This has required substantial human and financial resources to ensure its effective operation.
- The risk profile of the population is steadily trending toward a more elderly and sicker group of patients. More than 40% of patients in the current year were urgent in-hospital patients.
- The proportion of CABG operations performed without CPB continues to increase and stands at 49%. There has been no evidence of an increase in morbidity or mortality associated with this change in practice. There has been an increase in the number of grafts in off pump CABG but this falls short of that in "on-pump" CABG.
- Generally, outcomes were better than UK average or similar, and this applied to morbidity and length of ITU stay and hospital stay.
- The audit system we operate and the methods for monitoring surgical performance are robust and have been accredited by the Society of Cardiothoracic Surgeons of Great Britain & Ireland.

Post-Operative Nausea and Vomiting following Cardiac Surgery

Lisa Reid *Research & Development Nurse*

Rationale for Audit

Postoperative nausea and vomiting (PONV) are frequent adverse events for patients undergoing anaesthesia and surgery. As a surgical procedure, cardiac surgery is not documented in the literature as carrying a high risk of PONV. However, this patient group is notably anxious, experiences pain, uses opiates aggressively, and ambulates early – all factors which have been shown to increase the risk of nausea and vomiting post-operatively.

Aside from being unpleasant for the patient, PONV is generally considered to be a transient state, carrying little long-term morbidity. But for acutely-ill cardiac patients PONV can potentially cause gastric bleeding, surgical site disruption, arrthymias etc which can compromise patient stability. From a patient's prospective, PONV can be more debilitating than pain, with many patients willing to tolerate some degree of pain as the price for control of post-operative emesis. PONV may also heighten patient anxiety, and make the whole surgical experience highly dissatisfying.

Until recently Ward 5, a busy acute pre- and post-cardiac surgery unit, administered anti-emetic therapy in conjunction with patient controlled analgesic (PCA). Owing to safety concerns expressed nationally with the anti-emetic in use, this practice stopped. PONV is now only treated when, and if, it occurs. With constant changes in medical personnel - who all have different ideas regarding the management of PONV - effective treatment is far from ideal.

Audit Methodology
Despite being a multi-disciplinary issue of concern, we were unable even to quantify the extent of the problem for our patients, hence the audit cycle was started at the pre-audit stage. Limited by time, we elected to observe every patient in a two-month period, thereby generating a sample of 200. PONV was assessed over a 72 hour observation period following surgery using an established scoring system (after Walder et al). Other variables known to relate specifically to PONV e.g. pain, gender and age were also collected.

Results
- 67% [133/200] of patients reported nausea (Na) post-operatively; 34% [68/200] actually vomited (Vo)
- Patients were most likely to experience PONV the day after surgery (Na=57% [114/200], Vo=27% [54/200]), however some exhibited PONV on the day of surgery (Na=26% [52/200], Vo=10% [20/200]). A small number still felt sick on the 2nd day (Na=25% [50/200], Vo=7% [14/200])
- 64% [127/200] of patients experienced transient PONV – defined as less than 10% of their total observation time. However, 7% [14/200] were sick for more than one-quarter of their observation time.
- 81% [48/59] of females exhibited PONV as opposed to 60% [85/141] of males (p=0.003, Chi-Square)
- There was a positive relationship between morphine consumed and PONV score (p=0.005, Mann Whitney)
- There was a positive relationship between pain score and PONV score (p=0.01, Mann Whitney)
- 330 anti-emetics and rescue agents were administered during the course of the audit

Conclusions
PONV appears to be an issue for a large number of patients post cardiac surgery, with the majority suffering on the 1st day after surgery. While the duration of PONV for most is short, for a significant number it can last up to one-quarter of their initial post-operative course. A number of patient and post-operative factors associated with PONV were identified, notably gender differences which require further study. PONV clearly has both time and resource implications as well as being a major factor in patient care.

Action plan
- Formulate an anti-emetic protocol, based on best practice guidelines. Consider alternatives to morphine for post-operative pain control
- Education for the multi-disciplinary team regarding PONV
- Consider use of PONV risk-assessment strategies
- First audit 6 months after establishing new practice, then re-audit after one year

3.4 CHILDREN'S SERVICES

SUMMARY

Number of 2000/2001 roll-overs **<<**:	22
Number of new pre-audits ▲:	10
Number of new first audits ■:	8
Number of new re-audits ●:	4
No. of new ongoing monitoring projects **>>**:	1
Number of new projects – type unknown:	6
Total number of audits:	**51**
Number of completed audits:	10
Number of current (i.e. uncompleted) audits **>**:	22
No. of ongoing monitoring projects c/forward:	1
Number whose current status is unknown:	18

(Originally 23 but 1 abandoned during 2001/02)

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	7/15	(47%)	8/28	(29%)	**8/29**	**(28%)**
Audits arising from a critical incident:	-	-	1/28	(4%)	**3/29**	**(10%)**
Audits prompted by a patient complaint:	-	-	1/28	(4%)	**1/29**	**(3%)**
Audits directly involving patients/carers (but not including surveys):	4/15	(27%)	3/28	(11%)	**3/29**	**(10%)**
Audits incorporating a patient / carer survey:			3/28	(11%)	**3/29**	**(10%)**
Audits involving representatives from primary care:	1/15	(15%)	1/28	(4%)	**1/29**	**(3%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/28	(0%)	**0/29**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**12/29**	**(41%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**14/29**	**(48%)**
Audits linked to directorate business plan:	-	-	-	-	**2/29**	**(7%)**
Number of proposal forms completed:	-	-	10/28	(36%)	**20/29**	**(69%)**
Number of proposal forms completed BEFORE audit started:	-	-	6/28	(21%)	**20/29**	**(69%)**
Audits measuring against or resulting in development of standards or guidelines:	13/15	(87%)	11/28	(39%)	**13/29**	**(45%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	10/13	(77%)	13/28	(46%)	**15/29**	**(52%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	3/8	(38%)	**9/10**	**(90%)**
Audits where an action plan was produced:	-	-	1/8	(12%)	**9/10**	**(90%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	0/7	(0%)	**0/1**	**(0%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	2/7	(29%)	2/10	(20%)	**7/11**	**(64%)**
Audits leading to better ways of working for staff:	-	-	3/10	(30%)	**5/11**	**(45%)**
Audits leading to measurable benefits for patients:	-	-	3/10*	(30%)*	**6/11***	**(54%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	0/1	(0%)	0/2*	(0%)	**3/5***	**(60%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: A+E							
3.4.1	Timescales for MRI investigation at Frenchay	Dr S Marriage		✓			?
3.4.2	Accessing Blood	Dr Lisa Goldsworthy		✓			✓
3.4.3	Is the hospital following the APLS protocol for status epilepticus	Dr P Dix		?	?	?	?
3.4.4	Post urethral valves study	Mr J D Frank		?	?	?	?
3.4.5	Sleep systems in orthopaedic surgery	Caroline Tope		✓			✓

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.4.6	What is the correction factor for gas Na + levels?	Dr M Hayden, Dr V Ohlsen, Janet Stone		?	?	?	?
Specialty: Anaesthesia							
3.4.7	Audit of Critically Ill Children	Carol Maskrey				✓	
3.4.8	Could the Level of Drug Errors in PICU be Reduced by Introducing a New Prescribing System?	Dr P Weir	✓	?	?	?	?
3.4.9	O2 Concentration Supplied to Bagging Circuits in PICU	Christina Gillen	✓	✓			?
3.4.10	Pain Experienced on Removal of Chest Drains in PICU	Dr N Morgan	✓	?	?	?	?
3.4.11	Post Operative Pain and Nausea in Day Case Surgery	Dr G Lauder	✓	?	?	?	?
3.4.12	Post operative Pain and vomiting in day stay patients	Dr G Lauder			✓		
3.4.13	Tonsillectomy Day Case	Mr Griffiths, Dr Gill Lauder	✓	?	?	?	?
Specialty: CAMHs (Child Adolescent Mental Health)							
3.4.14	Deliberate Self Harm	Dr Andrew Fogarty	✓		✓		✓
3.4.15	Quality of Routine Note Keeping	Martin Mccrea	✓	✓			
Specialty: Cardiac							
3.4.16	Post-Operative Morbidity Following Cardiac Catheterisation	Dr R Martin	✓	?	?	?	?
3.4.17	Post-Operative Morbidity Following Cardiac Surgery	Dr G Stuart	✓	?	?	?	?
3.4.18	Radiofrequency Ablation in Paediatric Arrythmias	Dr G Stuart	✓	?	?	?	?
3.4.19	Retrospective Review of Blood Usage Products	Dr R Martin	✓	?	?	?	?
3.4.20	Review of Peri-operative Infections	Dr R Martin	✓	?	?	?	?
Specialty: Community							
3.4.21	ADHD Audit	Dr Sam Leonard		✓			✓
3.4.22	Referral and Management of Autism	Dr M Bredow, Dr K Merrett			✓		
Specialty: Dietetics							
3.4.23	Audit of Practice of Placement of Naso Jejunal Feeding Tubes ***(PICU)***	David Hopkins	✓	✓			
3.4.24	Dietetic Care for children with Diabetes (Staff Survey)	Lisa Cooke		✓			✓
Specialty: General Paediatrics							
3.4.25	Asthma	Dr Simon Langton Hewer	✓		✓		✓
3.4.26	Asthma (Interface) (NICE recommendations)	Dr Simon Langton Hewer, Dr Jennifer Langlands		✓			✓
3.4.27	Asthma (National Audit)	Dr Simon Langton Hewer			✓		✓
3.4.28	Audit of Paediatric Diabetic Service in Bristol & Weston Super Mare	Dr R Allen, Dr J Shields, Dr L Crowne	✓	✓			
3.4.29	Empyema referrals ***(Physiotherapy)***	Louise Owen		✓			✓
3.4.30	Investigations for Abdominal Pain	Dr A Duncan	✓	✓			✓
3.4.31	Management of Empyema	Dr T Hilliard	✓	✓			✓

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.4.32	Management of meningitis	Dr K Vijayakumar		✓			✓
3.4.33	Sedation Practice for Lumbar Puncture Procedure	Dr P Sharples, Dr S Subramaniyan	✓	✓			✓
Specialty: Neonatology							
3.4.34	Discharge Planning ***(with Obs, Gynae & ENT)***	Carol Aldridge	✓	✓			✓
3.4.35	How are we managing babies with NAS?	Dr T Ellinson		?	?	?	?
3.4.36	Patent Ductus Arteriosis	Dr M Traunter		✓			
3.4.37	PC02 Levels in Neonates transferred from CDS to NICU	Dr M Thoreson, Dr S Silsby	✓	✓			
3.4.38	Quality of Note Keeping	Claire Duke			✓		
Specialty: Nephrology							
3.4.39	Audit of adequacy of renal replacement	Dr Catherine O Brien		✓			✓
Specialty: Oncology							
3.4.40	Central Venous Catheter Service in Oncology	Mr R D Spicer,	✓		✓		
3.4.41	Does the administration of Itraconazole increase the risk of blocking central venous catheters	Deirdre McGuigan		✓			✓
3.4.42	Guidance for services for children with brain and spinal tumours	Deirdre McGuigan, Dr Steve Lowis, Dr Jackie Cornish		✓			✓
3.4.43	Guidelines for management of Central Lines within Oncology	Mr Spicer, Joanne Rook		✓			✓
3.4.44	Infection rates in Bionecteur and Click loc bungs	Dr A Hoellering		?	?	?	?
Specialty: PICU							
3.4.45	Are PICU patients being transfused unnecessarily	Dr P Robertson, Dr F Donaldson		✓			?
Specialty: Radiology							
3.4.46	Management of Neonatal Hydronephrosis in UBHT / N Bristol (Multi-centred audit)	Dr H Cheow, Dr S King, Dr P Cairns	✓	✓			✓
3.4.47	Parent Satisfaction Audit	Nicola Bigwood, Ingrid Marshall (CIIU)		✓			✓
Specialty: Surgery							
3.4.48	Appendectomy	Mr R D Spicer, Dr Dominic Inman		✓			✓
3.4.49	Fundoplication Audit	Miss E Cusick, Mr M Woodward, Dr N Sudhakaran		✓			✓
3.4.50	Ordering of Blood Products for use in Theatre	Mr K Kumaran, Miss E Cusick		✓			
3.4.51	Safety and Practicality of Drug Prescribing Practices	Miss Huskisson, Dr W Teague	✓	?	?	?	?

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• How good is the dental health of cardiology outpatients?	**(Dental Services)**	3.7.22
• Are babies being readmitted being adequately assessed by community midwives?	**(Obs, Gynae & ENT)**	3.10.19
• What Lessons have been Learned from Monthly Peer Review of Fetal Deaths, Stillbirths and Neonatal Deaths?	**(Obs, Gynae & ENT)**	3.10.29
• Are laboratory turnaround times for paediatric inpatients changed, following the opening of the new Bristol Royal Hospital for Children	**(Pathology)**	3.13.19
• Are paediatric blood samples sufficiently filled to allow a complete FBC measurement?	**(Pathology)**	3.13.20

EXEMPLAR AUDITS 2001 / 2002

Empyema Audit

Dr Tom Hilliard, Dr Simon Langton Hewer, Dr John Henderson, Louise Owen

Background

This multi disciplinary audit looked at the management of empyema in children. Empyema is diagnosed - clinically aided by radiology - and treated by paediatricians, surgeons and physiotherapists. The study was a retrospective case note review looking at 48 children admitted to Children's Services with an ICD 10 code for empyema during a 27 month period.

Objectives

- Identify referral patterns
- Improve surgical & medical management
- Identify complication rate
- Measure effect of surgery on short term outcomes

Standards and Results

The following clinical audit criteria (target 100%) were developed - results achieved are shown in brackets:

- Respiratory consultation for all (48%)
- Ultrasound thorax on all (96%)
- Surgical therapy dependent on ultrasound (77%)
- Inflammatory markers should be repeated (88%)
- BCH follow up on all (96%)

Conclusions

Although the numbers are small (n=48) the following conclusions were made from the study:

- Thoracotomy was associated with shortest stay
- The chest drain group does less well
- Fibrinolysis may have some effect

Recommendations

- Consider use of fibrinolysis with all chest drains
- Early thoracotomy if complicated on ultrasound
- All admissions under surgeons
- Respiratory consultation on all
- Re audit

Physiotherapy input to audit

Louise Owen (Senior Physiotherapist) looked at the physiotherapy input for children with empyema. Variations in practice for referral and management were noted prior to the audit so a pre audit activity took place for this aspect of care. The following results were obtained:

- 82% were seen and treated by physios
- Only 66% were considered appropriate
- No consistent referral criteria
- Inconsistent physiotherapy management

The following recommendations were therefore made:

- Establish guidelines for referral criteria
- Establish guidelines for physiotherapist management

- Ongoing audit (develop criteria based standards)
- We are hoping to re audit this in one years time.

Lumbar Puncture Audit

Background

Lumbar punctures are a routine procedure in Children's Services with 900 performed in total in the calendar year 2000.

The decision was taken to focus on a general sample of patients: this meant that oncology patients (representing 50% of all patients receiving lumbar puncture) were excluded from this audit, as were NICU patients. From a remaining study population of 359 cases (performed in A&E or on the wards), 52 were randomly selected. In the absence of any local clinical standards or guidelines, the study represented a pre-audit of current practice, gathering data on sedation, contraindications and completion of documentation.

Objectives

Procedural safety:

- How were issues of consent dealt with?
- Was there clinical assessment for contraindications?
- What investigations took place prior to LP?
- Complications of procedure?

Sedation and Analgesia:

- Identify nature - local / general / sedatives?

Findings and actions

We found many aspects of practice that needed addressing urgently: in particular there was little documented evidence concerning consent; similarly dating and timing of procedure was not always recorded. A working party was set up to look at these issues – despite concerns expressed about the small sample size used in the audit, it was nevertheless agreed that some basic guidelines should be drawn up to aid better note keeping and clinical practice. In the meantime, a senior registrar is looking at a larger sample of patients. Paediatric oncology is also embarking on an audit of their own practice, to include a patient satisfaction survey.

3.5 COMMUNITY SERVICES

SUMMARY

Number of 2000/2001 roll-overs **<<**:	9
Number of new pre-audits ▲:	0
Number of new first audits ■:	1
Number of new re-audits ●:	2
No. of new ongoing monitoring projects **>>**:	0
Total number of audits:	**12**
Number of completed audits:	11
Number of current (i.e. uncompleted) audits **>**:	1
No. of ongoing monitoring projects c/forward:	0
Number whose current status is unknown:	0

(Originally 11 but 2 abandoned during 2001/02)

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	8/15	(53%)	5/13	(38%)	**2/3**	**(67%)**
Audits arising from a critical incident:	-	-	0/13	(0%)	**0/3**	**(0%)**
Audits prompted by a patient complaint:	-	-	0/13	(0%)	**0/3**	**(0%)**
Audits directly involving patients/carers (but not including surveys):	3/15	(20%)	0/13	(0%)	**2/3**	**(67%)**
Audits incorporating a patient / carer survey:			1/13	(8%)	**1/3**	**(33%)**
Audits involving representatives from primary care:	8/15	(53%)	2/13	(15%)	**1/3**	**(33%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/13	(0%)	**0/3**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**0/3**	**(0%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**1/3**	**(33%)**
Audits linked to directorate business plan:	-	-	-	-	**1/3**	**(33%)**
Number of proposal forms completed:	-	-	12/13	(92%)	**2/3**	**(67%)**
Number of proposal forms completed BEFORE audit started:	-	-	10/13	(77%)	**2/3**	**(67%)**
Audits measuring against or resulting in development of standards or guidelines:	14/15	(93%)	13/13	(100%)	**2/3**	**(67%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	9/14	(64%)	13/13	(100%)	**1/3**	**(33%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	9/9	(100%)	**7/11**	**(64%)**
Audits where an action plan was produced:	-	-	1/9	(11%)	**5/11**	**(45%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	3/8	(38%)	**3/6**	**(50%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	13/16	(81%)	8/9	(89%)	**7/11**	**(64%)**
Audits leading to better ways of working for staff:	-	-	9/9	(100%)	**6/11**	**(54%)**
Audits leading to measurable benefits for patients:	-	-	6/9*	(67%)*	**3/11***	**(27%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	2/2	(100%)	1/3*	(33%)*	**0/2***	**(0%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.5.1	Acute Response Team (ART) Patient Satisfaction Survey	Karen Gay, District Nurse			✓		✓
3.5.2	Are Bank Staff Given Enough Equipment and Information to Perform Their Job?	Karen Cole, District Nurse	✓	✓			
3.5.3	Assessment of Current Practice in the Child Protection and Vulnerable Families Review System	Susan Whitehead, Mary Boyle - Health Visitors	✓	✓			
3.5.4	Catheter Blockage	Angela Perrett, Continence Advisor	✓	✓			
3.5.5	Do Our Clients / Patients Use Re-Usable Pants With Integral Pad, Once They Have Been Supplied by the Health Authority?	Carole Davey, Continence Advisor	✓	✓			

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.5.6	Do we Comply With the Trust Group Protocol for Vitamin K for Neonates? ***(with Obs, Gynae & ENT)***	Rebecca Mullen, Health Visitor & Sue Postlethwaite	✓	✓			
3.5.7	Does Record Keeping in the Community Directorate Meet UKCC Guidelines?	Jess Dougal, Associate Manager	✓	✓			
3.5.8	Informed Choice	Caroline Dunster-Sigtermans, Treatment Room Sister			✓		
3.5.9	Is the Wound Assessment Tool Being Used By District Nurses to Assess All Wounds?	Gail Powell, District Nurse	✓		✓		
3.5.10	Joint Community / PCG Team Brief	Jess Dougal, Associate Manager		✓			
3.5.11	Management of Patients with Indwelling Suprapubic and Urethral Catheters	Angela Perrett, Continence Advisor	✓	✓			
3.5.12	Physiotherapy Triage	Pat Lansdale, Head Physiotherapist	✓	✓			

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Are oral nutritional supplements being used appropriately?	**(Medicine)**	3.9.14

EXEMPLAR AUDITS 2001 / 2002
Child Protection Review Process Audit

Background
Child protection reviews are undertaken by Health Visitors (H/V), School Nurses (S/N) and Clinical Co-ordinators (CCOs) within the UBHT Community Directorate. The focus of this audit was the regular review of all 'vulnerable' families identified by clinical practitioners from their respective caseloads (these cases are reviewed by practitioners and Clinical Co-ordinators). The process is documented by the practitioner in the H/V records, and by the Clinical Co-ordinator in Child Protection management records

Objective
The objective of the audit was to establish current practice in the child protection and vulnerable families review process, and to explore qualitative aspects of this process. This would enable the audit team to evaluate the process and ascertain whether it effectively met the practitioner's requirements.

Methodology
Anonymised questionnaires were sent to all UBHT Community Directorate staff involved in reviews, asking about their views of the process. Overall response rate was 52%, i.e. 5/5 (100%) CCO questionnaires, 52/116 (45%) H/V questionnaires, and 22/30 (73%) S/N questionnaires.

Results
Results were considered by a steering group, consisting of two CCO's, two H/V , two S/N, the Audit Lead and the Clinical Audit Facilitator. A decision was taken to focus attention on areas where there was a variance in responses of 20% or more, i.e. timing of review, environment, sharing of / access to information, content/quality of review, detail of discussion, and outcomes.

Action
For all of the stated topics except sharing of / access to information (further work to be undertaken), a need was identified for training, development of new written standards and reiteration of existing guidelines. The steering group subsequently developed five standards, which were disseminated to staff. Proposals were formulated for a

training and reiteration strategy, and in areas identified by the audit as requiring further work, proposals for sub-groups to take this work on have been written.

Documentation Audit

Rationale
In May 2001, all Health Visitors, District Nurses, School Nurses and Treatment Room Staff were asked to take part in a directorate-wide documentation audit. This audit was to be conducted in two stages, the first stage looking at the basics of how patient notes are filled in and stored, and the second stage looking at the actual content of patient documentation.

Results & actions
For the first stage of the audit, 2155 cases were reviewed. In 13% of cases, notes could not be traced. This result was unexpectedly poor. Different professions had different ways of tracking notes, however there are plans to standardize systems and pilot a new tracking system for notes.

The project steering group agreed to focus on any standards with c30%+ non-compliance. 24% of notes did not containing the patient's date of birth, whilst 70% of sets of notes did not contain the client's ID number on each sheet. In future, by using the printed labels on each page, the client's name, DOB and ID number should always be recorded.

Client's Next of Kin / Carer should always be recorded on the front or reverse sheet of the notes, but the audit showed that this was not always the case, with 34% of notes not containing it. The audit also found that 75% of records did not give details of the client's allergy status. Standards have been written covering these points, and the project steering group is looking at ways to re-design the front sheet, to help facilitate the capture of this information.

79% of notes were not completed in black ink, 64% were not written with 24 hours, and 95% did not contain a signature and printed name by the 1st entry. 75% of corrections were made in a way that did not meet with guidelines. Standards have been written covering the entries and the corrections made in notes.

Consequent to this audit, staff have been reminded of national guidelines for record keeping (UKCC) and a number of local standards have been agreed. Feedback suggests that by taking part in this audit, most staff have had their awareness about documentation raised, and it hoped that the re-audit planned for 2003 will confirm this.

3.6 CRITICAL CARE

SUMMARY

Number of 2000/2001 roll-overs **<<**:	17
Number of new pre-audits ▲:	21
Number of new first audits ■:	8
Number of new re-audits ●:	3
No. of new ongoing monitoring projects **>>**:	4
Total number of audits:	**53**
Number of completed audits:	20
Number of current (i.e. uncompleted) audits **>**:	23
No. of ongoing monitoring projects c/forward:	10

(Originally 24 but 4 abandoned during 2001/02 and 3 now listed under Children's Services)

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	5/16	(31%)	20/27	(74%)	**13/36**	**(36%)**
Audits arising from a critical incident:	-	-	6/27	(22%)	**2/36**	**(5%)**
Audits prompted by a patient complaint:	-	-	0/27	(0%)	**0/36**	**(0%)**
Audits directly involving patients/carers (but not including surveys):	0/16	(0%)	7/27	(26%)	**0/36**	**(0%)**
Audits incorporating a patient / carer survey:			1/27	(4%)	**1/36**	**(3%)**
Audits involving representatives from primary care:	0/16	(0%)	1/27	(4%)	**0/36**	**(0%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/27	(0%)	**0/36**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**1/36**	**(3%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**1/36**	**(3%)**
Audits linked to directorate business plan:	-	-	-	-	**0/36**	**(0%)**
Number of proposal forms completed:	-	-	22/27	(81%)	**36/36**	**(100%)**
Number of proposal forms completed BEFORE audit started:	-	-	21/27	(78%)	**35/36**	**(97%)**
Audits measuring against or resulting in development of standards or guidelines:	11/16	(69%)	19/27	(70%)	**35/36**	**(97%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	3/11	(27%)	19/27	(70%)	**22/36**	**(61%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	5/11	(45%)	**8/20**	**(40%)**
Audits where an action plan was produced:	-	-	7/11	(64%)	**8/20**	**(40%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	0/4	(0%)	**0/12**	**(0%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	12/17	(71%)	7/20	(35%)	**6/30**	**(20%)**
Audits leading to better ways of working for staff:	-	-	6/20	(30%)	**1/30**	**(3%)**
Audits leading to measurable benefits for patients:	-	-	8/20*	(40%)*	**2/30***	**(7%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	3/7	(43%)	1/10*	(10%)*	**1/11***	**(9%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: A&E							
	An audit of the management of asthma in the Emergency Department – are we following the BTS Guidelines?	Dr D Murdoch (SHO)			✓		
3.6.2	Are the E.D. green doting x-rays with an abnormality?	Dr C Parsons (SHO)		✓			
3.6.3	Emergency Department SHO skills audit	Dr H Young (SHO)		✓			
3.6.4	Resuscitation room rapid sequence induction (National)	Dr G Lloyd				✓	✓
3.6.5	Safety levels in the Emergency Department.	N Armstrong				✓	✓
3.6.6	Thrombolysis and MI (NSF)	Dr G Lloyd	✓			✓	✓

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.6.7	Use of beta blockade in ST elevation myocardial infarction.	Dr E Wall (SHO)		✓			
Specialty: Anaesthesia							
3.6.8	Acidosis in cardiac ITU patients	Dr G Hosdurga and Dr T Lovell		✓			✓
3.6.9	Adequacy of post Caesarean section pain relief.	Dr C Laxton		✓			
3.6.10	Are Children Experiencing Acute Pain Following Major Surgery?	Dr P Stoddart				✓	✓
3.6.11	Are Surgical Patients Receiving Appropriate Prophylaxis for Venous Thromboembolism?	Dr J Homewood	✓	✓			
3.6.12	Are we meeting acute pain recommendations for provision of service to patients and for anaesthetic training?	Dr Nicola Weale, Dr Louise Shernman		✓			✓
3.6.13	Competency of ODA/ODP's in inserting cannulas (venous and arterial).	Dr C Monk (Anaesthesia), N Hooper (Theatres)		✓			✓
3.6.14	Direct admission after Day Surgery attendance	Dr S Grimes				✓	✓
3.6.15	Does every thoracic list have a trainee anaesthetist attached?	Dr C Fouque, Dr S Tomkins		✓			
3.6.16	Epidural for Pain Relief -Response Time by the Anaesthetist	Dr M Patteril	✓	✓			
3.6.17	How frequent are anaesthetic incidents and breakdowns in UBHT?	Mr P Smithson (MEMO)		✓			✓
3.6.18	Is an elective line list required in the BRI?	Dr A McIndoe		✓			✓
3.6.19	Is the new usage of Fentanyl for post-operative analgesia working?	Dr S Grimes		✓			
3.6.20	Is the Trust following 2001 Royal College/Trust ICP guidelines for ophthalmic local anaesthesia ***(with Ophthalmology)***	Dr Bob Johnson, Dr Matthew Molyneux		✓			✓
3.6.21	Is there sufficient discussion and documentation of invasive anaesthetic procedures in the pre-operative period.	Dr S Martindale		✓			✓
3.6.22	MRSA in surgical patients post upper GI surgery over 12 months ***(with Surgery)***	Dr L Ward, Dr M Finch-Jones		✓			✓
3.6.23	NCEPOD – review in Day Surgery	Dr Charlie Heidelmeyer		✓			✓
3.6.24	Patient Attendance at ENT Pre-Admission Clinic (PACs) at St MH ***(with Obs, Gynae & ENT)***	Dr L Shutt	✓	✓			
3.6.25	Post cardiac surgery pain: are patients receiving adequate analgesia?	Dr Matthew Taylor		✓			
3.6.26	Post Operative Pain Relief and Side Effects	Jacqui Gannon	✓			✓	✓
3.6.27	Prospective audit of long term tunnelled central venous lines ***(with Oncology)***	Dr Simon Massey (Anaesthesia), Professor Jill Hows (Haematology)		✓			✓
3.6.28	Quantitative: Training opportunities on theatre lists. Qualitative: Quality of training on theatre lists.	Dr R Aspinall			✓		✓
3.6.29	Re-admission after Day Surgery ***(with Surgery)***	Dr Charlie Heidelmeyer		✓			✓
3.6.30	REAUDIT: Post cardiac surgery pain – are patients receiving adequate analgesia?	Dr Tessa Whitton			✓		✓
3.6.31	Retrospective Study of Drug Administration Errors	Dr A Pickering	✓	✓			
3.6.32	Safety and economic implications of patient biting of armoured Laryngeal Mask Airways. ***(with Ophthalmology)***	Dr S Mather, Dr J Ward		✓			✓
3.6.33	Staff questionnaire: Training in fibreoptic intubation	Dr I Gardner		✓			✓

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.6.34	What is the national practice with regard to the use of regional anaesthesia for adult cardiac surgery?	Dr Tim Lovell, Dr Tessa Whitton		✓			✓
3.6.35	What is the Outcome of Aortic Dissection Repair?	Dr T Lovell	✓	✓			
3.6.36	What Problems are Being Experienced with Regional Anaesthesia for Caesarian Section?	Mike Kinsella	✓			✓	✓
3.6.37	What Resuscitation Training or Competence Assessment is Appropriate for Practicing Anaesthetists?	Dr D Terry	✓	✓			✓
3.6.38	Would Pre-Op Assessment Clinic benefit from a lead anaesthetist, anaesthetic input/interest? ***(with Surgery)***	Sr H Page		✓			
Specialty: ICU / HDU							
3.6.39	Can critical incidents be prevented by a Medical Emergency Team?	Dr J Hadfield		✓			✓
3.6.40	Cancellation of planned admissions to HDU.	Dr R Yoo		✓			✓
3.6.41	Clinical Supervision – are junior staff benefiting from clinical supervision?	Sr L Berry		✓			
3.6.42	Critical care plan documentation audit.	Sr J Scudamore		✓			
3.6.43	Feasibility of Collecting Augmented Care Period (ACP) Forms from Ward Areas	Sr S McAuslan-Crine	✓	✓			
3.6.44	In-Hospital Deaths Post-Discharge from ICU / HDU	Dr J Bewley	✓	✓			✓
3.6.45	Intensive Care National Audit and Research Centre (ICNARC) Database	Dr S Willatts	✓			✓	✓
3.6.46	Observation Charts on acute wards.	Dr J Hadfield		✓			✓
3.6.47	To examine the discharge process from ICU/HDU.	Sr S McAuslan-Crine		✓			✓
3.6.48	What is the outcome of tracheostomy in this hospital? What complications occur?	Dr J Bewley				✓	✓
Specialty: Physiotherapy							
3.6.49	Are referrals to A&E Physiotherapy Clinic appropriate and what conditions are being referred?	J Mattell		✓			
Specialty: Resuscitation							
3.6.50	Cardiopulmonary Resuscitation Facilities and Equipment Within the Trust	Keith Lewis	✓		✓		✓
3.6.51	Is the Trust Following the Procedures for Arrest as Set Out in the Resuscitation Policy?	Jo Bruce-Jones	✓			✓	✓
Specialty: Theatres							
3.6.52	Are Patients being Collected Promptly from the Recovery Ward?	Jane Reece	✓	✓			
3.6.53	Cot-Sides on Every Post-Operative Patient Bed	Marion Brown	✓	✓			

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Myocardial National Audit Project	**(Cardiothoracic Services)**	3.3.31
• Is enteral feeding being efficiently and effectively delivered?	**(Medicine)**	3.9.16
• Is the locally agreed procedure for hypertensive patients at pre-op being adhered to?	**(Surgery)**	3.16.14
• Pain scoring in A&E and with physios	**(Surgery)**	3.16.20
• Pressure relieving care for#NOF patients in A&E	**(Surgery)**	3.16.22

EXEMPLAR AUDITS 2001 / 2002

Patient attendance at ENT Pre-Admission Clinic at St Michaels' Hospital (joint audit with ENT)
Dr Les Shutt *Consultant Anaesthetist*, **Sister Hilary Hiscox**

Background
The majority of adult patients scheduled for ENT surgery are admitted on the day of their surgery. This arrangement is possible on the basis that patients for surgery are seen by an anaesthetist in the ENT Pre-Admission Clinic (PAC) prior to their admission for surgery. If patients do not attend PAC, time is taken on the day of surgery for anaesthetic assessment. Occasionally, where pre-existing uncontrolled medical problems are identified, this may lead to the patient having their surgery cancelled.

Objectives
- To highlight problems of non-attendance at PAC
- To improve efficiency of PAC for ENT service

Methodology
A sample of 100 day surgery admissions was chosen (equivalent to one month). Data was collected from patients and their hospital records and recorded on an audit proforma on the morning of their admission to ENT ward 72 at St Michael's Hospital. The anaesthetists and nursing staff collected the data.

Results
- 86% patients attended PAC, of which:
- 93% of patients had had clerking and consent procedures completed
- 70% of patients were seen by an anaesthetist
- 19% of patients were not seen by anaesthetist due to no holiday cover
- 63% of patients had appropriate pre-operative investigations ordered at the PAC
- 56% of patients had all pre-operative investigations available on the day of surgery
- 84% of patients not seen by an anaesthetist were lacking pre-operative investigations
- 60% of patients not attending PAC were urgent admissions

Recommendations
- Urgent re-admissions need pre-operative assessment, and if the patient cannot be assessed in the PAC by an anaesthetist, they must be admitted for assessment one/two days in advance of proposed surgery
- Adequate PAC/nurse/clerical cover to improve pre-operative investigation hit rate, and to retrieve information from PAS prior to admission
- Funding to provide anaesthetic cover for the dedicated PAC anaesthetist holiday leave/absences – to improve quality and quantity of pre-operative preparation
- Invited to present / discuss audit and implementation of recommendations at ENT audit meeting in May 2002

Potential for future work
Re-audit in 2003, with or without take up of recommendations

Meeting National Service Framework goals for patients presenting with acute myocardial infarction *
Dr Gavin Lloyd *Consultant in Emergency Medicine,* and the BRI door to needle audit group

* at the time of this audit, the Emergency Department was part of the Critical Care Directorate (has since become part of Medicine)

This project was awarded first prize at the 2002 UBHT Clinical Audit Oscars

Background
Approximately 300,000 people suffer acute myocardial infarctions (AMI) each year in the UK, of which 140,000 die. The benefit of thrombolysis in AMI is well established with better outcomes in those patients treated early. In March 2000 the National Service Framework for Coronary Heart Disease (NSF) set standards, annual audit specifications and immediate priorities in the management of patients with AMI. The NSF states that 75% of eligible patients with acute myocardial infarction should be thrombolysed within 30 minutes by April 2002 and within 20 minutes by April 2003.
Objective
Continuous evaluation of the Emergency Department's performance against NSF standards.

Methodology
All patients thrombolysed in the ED prospectively included from February 2000 onwards. A critical care pathway was used to record data. All cases were "hot reviewed" within 48 hours by clinical auditors and at a monthly multi-disciplinary audit meeting. The review allowed identification of any problems or delays arising during the initial management which hindered thrombolysis. The audit meeting allowed identification of those patients immediately eligible for thrombolysis. This was based on the NSF criteria and blind consensus agreement. Consistent delays in thrombolysis were also noted. Appropriate action through targeted individual and group education ensued.

Results
- 195 patients were immediately eligible for thrombolysis over the eighteen-month period.
- 77% of these had a door to needle time of less than 30 minutes, and 38% had a door to needle time of less than 20 minutes in 2000.
- 73% of these had a door to needle time of less than 30 minutes, and 50% had a door to needle time of less than 20 minutes in 2001.
- Consistent delays in thrombolysis identified included delay in ECG, hypertensive patients, thrombolysis by duty physicians, and patients presenting with left bundle branch block (LBBB).

Conclusions
This audit demonstrates that the April 2002 target for thrombolysis is achievable.

Action
Improved quality of patient care has been engineered through several initiatives:
- Establishing a critical care pathway
- Setting a target door to ECG time of less than 5 minutes
- Education
- National thrombolysis study days
- Changing GP referral patterns
- Pre-hospital thrombolysis
- On-line handbook (www.ubht.nhs.uk/edhandbook/)
- Electronic submission of data to the Myocardial Infarction National Audit Project (MINAP)

The April 2003 target set by the National Service Framework remains an ambitious goal.

3.7 DENTAL SERVICES

SUMMARY

Number of 2000/2001 roll-overs **<<**:	6
Number of new pre-audits ▲:	1
Number of new first audits ■:	18
Number of new re-audits ●:	7
No. of new ongoing monitoring projects **>>**:	1
Total number of audits:	**33**
Number of completed audits:	12
Number of current (i.e. uncompleted) audits **>**:	19
No. of ongoing monitoring projects c/forward:	2
Number whose current status is unknown:	0

(Originally 8 but 2 abandoned during 2001/02)

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	5/13	(38%)	11/22	(50%)	**11/27**	**(41%)**
Audits arising from a critical incident:	-	-	1/22	(5%)	**3/27**	**(11%)**
Audits prompted by a patient complaint:	-	-	1/22	(5%)	**2/27**	**(7%)**
Audits directly involving patients/carers (but not including surveys):	1/13	(8%)	1/22	(5%)	**0/27**	**(0%)**
Audits incorporating a patient / carer survey:			3/22	(14%)	**2/27**	**(7%)**
Audits involving representatives from primary care:	4/13	(31%)	3/22	(14%)	**11/27**	**(41%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/22	(0%)	**0/27**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**1/27**	**(4%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**8/27**	**(30%)**
Audits linked to directorate business plan:	-	-	-	-	**0/27**	**(0%)**
Number of proposal forms completed:	-	-	20/22	(91%)	**27/27**	**(100%)**
Number of proposal forms completed BEFORE audit started:	-	-	20/22	(91%)	**27/27**	**(100%)**
Audits measuring against or resulting in development of standards or guidelines:	12/13	(92%)	20/22	(91%)	**27/27**	**(100%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	5/12	(42%)	13/22	(59%)	**21/27**	**(78%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	21/21	(100%)	**12/12**	**(100%)**
Audits where an action plan was produced:	-	-	17/21	(81%)	**10/12**	**(83%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	3/4	(75%)	**2/2**	**(100%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	9/13	(69%)	12/22	(55%)	**7/14**	**(50%)**
Audits leading to better ways of working for staff:	-	-	11/22	(50%)	**4/14**	**(29%)**
Audits leading to measurable benefits for patients:	-	-	8/22*	(36%)*	**4/14***	**(29%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	4/5	(80%)	1/7*	(14%)*	**1/6***	**(17%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: Community Dental Service							
3.7.1	A pre-audit to find out how much clinical time is lost by cancellations	A White		✓			
3.7.2	Are medical histories being documented and updated?	M Donnan			✓		✓
3.7.3	Are needles being re-sheathed according to the Trust's sharps policy?	M Donnan		✓			✓
3.7.4	Are radiographic dose reducing techniques being used?	M Donnan		✓			✓
Specialty: Oral & Maxillofacial Surgery							
3.7.5	Are referrals of apicectomies appropriate? - regional	T Aldridge		✓			✓

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.7.6	Does the referral from GDPs requesting 3rd molar extraction follow NICE/departmental guidelines?	Prof Cowpe, C Bell, R Oliver, G Kitima		✓			✓
3.7.7	Head & Neck Oncology - regional	Chris Bell				✓	
3.7.8	Is the radiographic component of GDP new patient referrals as efficient as possible?	Daniel Borge		✓			✓
3.7.9	Is the standard of record keeping in Oral Surgery adequate?	Alison Howe, Esther Hullah			✓		
3.7.10	What causes disruption of admissions/operations in Oral and Maxillofacial Surgery?	C Bell		✓	✓		
3.7.11	Why do Day Case surgery patients fail to attend?	C Bell		✓			✓
Specialty: Oral Medicine							
3.7.12	Are dental students adhering to policies regarding cleaning dental units between patients?	Jane Luker		✓			
3.7.13	Are haematological investigations requested by BDH being accurately recorded in patients' notes and are results available by the next patient appointment?	S Constant		✓			
3.7.14	Is the division following Royal College guidelines for the imaging of patients with TMJ / Facial pain	Rebecca McAlinden		✓			
Specialty: Orthodontics							
3.7.15	A pre-audit to find out how successful combined Orthodontic / Surgical treatment is for Facial Deformity? - national	Nigel Harradine	✓	✓			✓
3.7.16	Do Orthodontic clinical records comply with the British Orthodontic Society's minimum data set? - regional	H Griffiths			✓		✓
3.7.17	Do patients know how to care for their teeth and appliances during orthodontic treatment? - regional	A Williams		✓			
3.7.18	How long are our courses of orthodontic treatment? - regional	N Harradine		✓			
3.7.19	Is the age of referral for unerupted canines acceptable? - regional	Nigel Harradine			✓		✓
3.7.20	Osteotomies - regional	Nigel Harradine	✓			✓	
Specialty: Paediatrics							
3.7.21	Are Patients / Parents Satisfied With the Paediatric Dental Service?	Deborah Franklin	✓		✓		✓
3.7.22	How good is the dental health of cardiology outpatients?	S Davies	✓		✓		
Specialty: Personal Dental Service							
3.7.23	Are patient medical history forms being completed by clinicians?	C Joshi		✓			✓
3.7.24	Are radiographs taken for diagnostic purposes meeting the minimum targets for radiographic quality?	C Joshi		✓			✓
Specialty: Restorative							
3.7.25	Are broken models a frequent occurrence?	Alex Hussey			✓		✓
3.7.26	Are students completing treatment for their patients on Adult Dental Health Level 2 (ADH2)?	S Hooper		✓			✓
3.7.27	Can Oral Hygiene patients reduce their initial plaque score by 50%	Alison Grant		✓			✓
3.7.28	Is the Treatment Plan for Joint Restorative Patients Carried to a Successful Conclusion? In particular, do we set out clear objectives in the treatment plan?	S Clark	✓	✓			✓
3.7.29	What is the retention rate of porcelain veneers placed at BDH?	S Hooper		✓			
Specialty: All Departments							
3.7.30	Are medical histories and allergies recorded?	Bethan Lewis			✓		
3.7.31	Are needles being disposed of according to the Trust's sharps policy?	L Reakes		✓			✓
3.7.32	Are needles being re-sheathed according to the Trust's sharps policy?	L Hemsley			✓		✓

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.7.33	Are needles being re-sheathed according to the Trust's sharps policy?	C Bull		✓			

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Is Our Management of Orbital Injury Patients Efficient and Effective?	**(Ophthalmology)**	3.12.16

EXEMPLAR AUDITS 2001 / 2002

Does the Referral from GDPs Requesting 3rd Molar Removal follow NICE Guidelines? (Oral & Maxillofacial Surgery)
Professor Cowpe, Jemma Kitima, Richard Oliver & Carolyn Southwell

Background
The prophylactic removal of asymtomatic impacted third molar teeth can present risks to patients including post-operative pain, swelling, trismus and of particular concern, temporary or permanent nerve injury. In addition this procedure has major economic implications. A series of audits have been carried out within the Bristol Dental Hospital to improve awareness that third molar teeth are being extracted according to accepted guidelines (including those set by the National Institute for Clinical Excellence, the National Institute for Health in the USA and the Royal College of Surgeons of England). It was noted that General Dental Practitioners may be referring patients for removal of third molars for reasons not contained in published recommendations, or with insufficient clinical information. This audit was part of a 4th Year Student Elective Process.

Objectives
The objectives were to determine:
- whether GDPs were following published recommendations regarding referrals for extraction of third molar teeth
- whether their referral letters contained sufficient information on this matter
- whether the teeth which subsequently underwent removal were removed for the reasons that the GDP had cited.

Methodology
A retrospective assessment of 50 patient casenotes was carried out using a proforma compiled from the guidelines.
Results
- Just under 50% of referral reasons given by GDPs followed published documentation regarding referral for extraction of third molars.
- 32% of referral letters provided the required information regarding the need for tooth removal.
- 48% of referred patients had third molars removed at the Dental Hospital for the same reason as stated in the original referral letter.

One of the main difficulties was the assessment of pericoronitis. This is important because the NICE guidelines state that only one episode of pericoronitis should not be an indication for surgery. The recommendations were that GDPs referring third molar extractions should only refer patients if they met the criteria in the Guidelines and that letters of referral should include the appropriate information.
Actions
The action plan identified from this audit was as follows:
- That a letter be sent to the GDPs including a new referral proforma to facilitate appropriate referral and to re-iterate to GDPs the importance of NICE Guidelines when considering if a referral is appropriate.
- That the letter should include reference to the Dental Hospital website where Guidelines and Audit Reports could be consulted.
- That staff within the Dental Hospital should be reminded of the Guidelines and that a future re- audit should be carried out.

Is the Division following Royal College Guidelines for the Imaging of Patients with TMJ / Facial Pain?
(Oral Medicine)

Dr J Luker

No radiological investigation should be requested unless it can be clinically justified. The result of that investigation, normal or abnormal, is likely to influence the management of the patient. This audit project was designed to assess the referral of patients with facial pain for MRI (magnetic resonance imaging) and CT (computerised tomography) scanning and to determine whether or not the referrals were in accordance with standards set by the Royal College of Radiologists. Sixty-eight patients referred between January 1998 and December 2001, were included in the study. Results show that approximately 97% of referrals were correct with two inappropriate referrals. This suggests that, in general, the dental directorate is complying with Royal College standards in referring patients with facial pain for MRI and CT imaging, however, future re-auditing is necessary.

3.8 HOMEOPATHY

SUMMARY

Number of 2000/2001 roll-overs **<<**:	4
Number of new pre-audits ▲:	0
Number of new first audits ■:	5
Number of new re-audits ●:	1
No. of new ongoing monitoring projects **>>**:	0
Total number of audits:	**10**
Number of completed audits:	3
Number of current (i.e. uncompleted) audits **>**:	5
No. of ongoing monitoring projects c/forward:	2
Number whose current status is unknown:	0

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	0/5	(0%)	0/3	(0%)	**0/6**	**(0%)**
Audits arising from a critical incident:	-	-	0/3	(0%)	**0/6**	**(0%)**
Audits prompted by a patient complaint:	-	-	0/3	(0%)	**0/6**	**(0%)**
Audits directly involving patients/carers (but not including surveys):	0/5	(0%)	0/3	(0%)	**3/6**	**(50%)**
Audits incorporating a patient / carer survey:			0/3	(0%)	**3/6**	**(50%)**
Audits involving representatives from primary care:	0/5	(0%)	0/3	(0%)	**0/6**	**(0%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/3	(0%)	**0/6**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**0/6**	**(0%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**4/6**	**(67%)**
Audits linked to directorate business plan:	-	-	-	-	**0/6**	**(0%)**
Number of proposal forms completed:	-	-	1/3	(33%)	**4/6**	**(67%)**
Number of proposal forms completed BEFORE audit started:	-	-	1/3	(33%)	**4/6**	**(67%)**
Audits measuring against or resulting in development of standards or guidelines:	3/5	(60%)	1/3	(33%)	**6/6**	**(100%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	1/3	(33%)	2/3	(67%)	**5/6**	**(83%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	3/3	(100%)	**3/3**	**(100%)**
Audits where an action plan was produced:	-	-	1/3	(33%)	**3/3**	**(100%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	1/2	(50%)	**N/a**	**N/a**
(figures above include completed audits only)						
Audits resulting in changes in practice:	2/4	(50%)	1/5	(20%)	**4/5**	**(80%)**
Audits leading to better ways of working for staff:	-	-	1/5	(20%)	**3/5**	**(60%)**
Audits leading to measurable benefits for patients:	-	-	1/5*	(20%)*	**3/5***	**(60%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	0/3	(0%)	0/2*	(0%)*	**0/2***	**(0%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.8.1	Adverse reactions to homeopathic treatment	Dr Elizabeth Thompson		✓			✓
3.8.2	Assessing the Effectiveness of Homeopathic Interventions at BHH	Dr David Spence	✓			✓	
3.8.3	How Much Extra Work for Doctors and Pharmacists are 'Out of Clinic' Prescriptions Generating?	Dr Elizabeth Thompson	✓	✓			
3.8.4	Implementing patient information leaflets - Homeopathic Medication	Dr Elizabeth Thompson		✓			✓
3.8.5	Implementing patient information leaflets - Iscador	Dr Elizabeth Thompson		✓			✓
3.8.6	Quality of Information in the medical Notes	Dr Elizabeth Thompson			✓		✓
3.8.7	The Management and Treatment of Asthma	Dr David Spence	✓	✓			✓

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.8.8	The Management of Irritable Bowel Syndrome	Dr Elizabeth Thompson		✓			
3.8.9	The Management of Menopausal Symptoms	Dr Elizabeth Thompson		✓			
3.8.10	What is the DNA (Did Not Attend) Rate at BHH?	Dr David Spence	✓			✓	

EXEMPLAR AUDITS 2001 / 2002

The Management of Menopause

Dr Elizabeth Thompson

Objectives

This audit examined the care of a group of patients being treated for menopausal problems at the Homeopathic Hospital in order to improve care. Specific objectives were as follows:

- To look at the treatment pattern
- To look at DNA/cancellation pattern
- To look at patient outcomes using the hospital outcome scale
- To compare outcomes with those of other comparable homeopathic units
- To explore potential for more detailed outcome measures
- To set auditable standards for the process of care
- To look at the potential effects of the introduction of a package of care

Methodology

A retrospective audit where all new patients treated at the hospital over the 14 month period between November 1998 and December 1999 were selected and followed through the system until 01/08/2001.

Results

- Higher than expected DNA/cancellation rate, wasting a significant number of slots
- Outcome figures were comparable to published data from other homeopathic units

Action plan

- It was agreed to repeat the project for another group of patients prior to the implementation of a package of care (this was achieved looking at Irritable Bowel Syndrome)
- A package of care to be implemented for each patient giving a new patient appointment and up to 4 follow ups (to be extended if clinically beneficial)
- GPs to be informed of the package of care in the letter following a new patient appointment. Package of care to be discussed at initial appointment with the patient - stress up to 3-4 visits
    - encourage patients to persist with treatment if not initially successful
    - set up the idea that patients will be discharged and need re-referral for a new problem
- The point reached by patient in their package of care is to be documented in the notes
- Standard set for DNA rate (to be audited in the future)

Pharmacy Audit - an Assessment of Prescribing Workload

Dr Elizabeth Thompson

Background

This audit was initiated as the hospital pharmacy had highlighted an increased workload over recent months, leading to a backlog and increased waiting times for patients receiving prescriptions. In addition, the homeopathic hospital clinicians felt that the lack of follow up slots available for patients and the resulting long wait between appointments was causing an increasing need for postal reports and telephone calls from patients between appointments. This was in turn leading to a need for repeat or new prescriptions to be written creating a substantial non financed workload for the department. The aim was therefore to assess the current workload.

Objectives

- To undertake a baseline assessment of prescriptions generated
- To determine the level of additional non-consultation and therefore non-financed workload
- To assess the quality of the prescription sheets faxed to pharmacy

Standards
As this was a baseline assessment, there were no appropriate standards to set for the workload. It was hoped that once the assessment was complete there would be data for future re-audit to assess whether the situation had improved. For the quality of the prescription sheets, the following standard was agreed:

	Level of performance	*Exceptions*
Re-faxes of prescriptions should not be necessary	*100%*	*fax machine problem* unclear label

Methodology
For 15 weeks starting 1st May 2001, data was collected for all patients for whom a prescription had been generated.

Results
- 44% of all prescriptions written related to out of clinic prescribing
- Doctor error on 28/1838 prescriptions (1.5%)

Action Plan
- Feedback results of audit to the pharmacy department
- Doctors agreed to take additional care over writing of prescriptions
- Results to be used to highlight the need for more clinical sessions at the hospital

3.9 MEDICINE

SUMMARY

Number of 2000/2001 roll-overs **<<**:	20
Number of new pre-audits ▲:	3
Number of new first audits ■:	13
Number of new re-audits ●:	3
No. of new ongoing monitoring projects **>>**:	0
Number of new projects – type unknown:	2
Total number of audits:	**41**
Number of completed audits:	12
Number of current (i.e. uncompleted) audits **>**:	16
No. of ongoing monitoring projects c/forward:	1
Number whose current status is unknown:	12

(Originally 24 but 4 abandoned / superceded by new project during 2001/02)

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	9/18	(50%)	7/43	(16%)	**11/21**	**(52%)**
Audits arising from a critical incident:	-	-	0/43	(0%)	**0/21**	**(0%)**
Audits prompted by a patient complaint:	-	-	1/43	(2%)	**1/21**	**(5%)**
Audits directly involving patients/carers (but not including surveys):	2/18	(11%)	0/43	(0%)	**2/21**	**(9%)**
Audits incorporating a patient / carer survey:			0/43	(0%)	**3/21**	**(14%)**
Audits involving representatives from primary care:	2/18	(11%)	0/43	(0%)	**3/21**	**(14%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/43	(0%)	**0/21**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**5/21**	**(24%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**6/21**	**(29%)**
Audits linked to directorate business plan:	-	-	-	-	**5/21**	**(24%)**
Number of proposal forms completed:	-	-	35/43	(81%)	**14/21**	**(67%)**
Number of proposal forms completed BEFORE audit started:	-	-	33/43	(77%)	**7/21**	**(33%)**
Audits measuring against or resulting in development of standards or guidelines:	15/18	(83%)	37/43	(86%)	**16/21**	**(76%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	10/15	(67%)	36/43	(84%)	**13/21**	**(62%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	20/31	(65%)	**10/12**	**(83%)**
Audits where an action plan was produced:	-	-	8/31	(26%)	**6/12**	**(50%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	0/23	(0%)	**0/6**	**(0%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	8/15	(53%)	12/32	(38%)	**3/13**	**(23%)**
Audits leading to better ways of working for staff:	-	-	7/32	(22%)	**3/13**	**(23%)**
Audits leading to measurable benefits for patients:	-	-	12/32*	(38%)	**2/13***	**(15%)**
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	0/3	(0%)	4/7*	(57%)*	**0/4***	**(0%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: Care of the Elderly							
3.9.1	Are suspected stroke patients referred within effective time frames? ***(with Radiology)***	Kaye Harrington		✓			✓
3.9.2	Are we prescribing metformin appropriately? ***(with Specialty Services)***	Dr Simon Croxson		✓			✓
3.9.3	Effectiveness of Falls Service	Paulette Nuttal, Ruth Cowell	✓	✓			
3.9.4	How Appropriate is our Management of Hypercalcaemia?	Dr S Tamane	✓	✓			✓
3.9.5	Is Resuscitation Status Recorded in the Medical Notes?	Dr Mark Haslam	✓	✓			
3.9.6	National Sentinel Audit for Stroke	Sarah Cains			✓		

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.9.7	The Management of Patients Admitted with Acute Stroke	Dr Terlevich, Dr Murphy, Angie Nichols	✓	✓			✓
3.9.8	The Patient's Day in the Stroke Rehabilitation Unit	Pauline Baker	✓	✓			✓
Specialty: Dermatology							
3.9.9	Management of Melanoma	Dr Narayan		?	?	?	?
3.9.10	Minor Surgery in Dermatology Outpatients	Jackie Dark	✓	✓			?
3.9.11	Myocosis Fungoides	Dr Maureen Connolly		✓			✓
3.9.12	Referral Standards for Patients with Basal Cell Carcinoma	Dr M Kirkup	✓	✓			?
3.9.13	Standards of Care for Patients with Non-Melanoma Skin Cancer	Dr de Berker/Dr Shalini Narayan	✓	✓			?
Specialty: Dietetics							
3.9.14	Are oral nutritional supplements being used appropriately? ***(with Specialty Services and Community Services)***	Julie Gardner, Jackie Eastwood		✓			✓
3.9.15	Are we Meeting the Dietary Objectives of Patients on the Cardiac Rehabilitation Scheme?	Diane Reid	✓	✓			?
3.9.16	Is enteral feeding being efficiently and effectively delivered? ***(with Critical Care)***	Nathan Lewis		✓			✓
Specialty: Endocrinology							
3.9.17	Are we Following the National Guidelines for the Management of Blood Lipids for Diabetic Patients?	Dr Graham Bayly	✓	✓			
3.9.18	Are we Using the Test D-Dimer Appropriately?	Dr G J Van Rensbury	✓	✓			?
3.9.19	Diabetes Clinic – DNA rate	Helen Silvers		✓			✓
Specialty: Gastroenterology							
3.9.20	Are we Following the Guidelines for the Management of Patients with Gastrointestinal Bleeds?	Dr T Creed	✓	✓			?
3.9.21	The Incidence of GI Bleeds After Cardiac Surgery. Are we Managing These Patients Appropriately?	Dr A Jay	✓	✓			?
Specialty: General Medicine							
3.9.22	Are needles being disposed of according to the Trust's sharps policy?	Carolyn Southwell		✓			✓
3.9.23	Are patients being treated effectively on an intermediate care ward?	Victoria Eavis		✓			✓
3.9.24	Are Patients Receiving Supplements?	Claire Phillips		✓			?
3.9.25	Are we Following UBHT Antibiotic Prescribing Policy?	Debbie Campbell	✓		✓		✓
3.9.26	Audit of Contract Nursing Home Beds. Are we Following the Guidelines?	Debbie Harrison	✓		✓		
3.9.27	Elevated blood glucose following an Acute MI	Dr Alison Cameron		✓			
3.9.28	Management of Continence (Stroke)	Pauline Baker			✓		
3.9.29	Mouthcare	Jennie Papps (now Sue Jones)		✓			
3.9.30	Patients with Communication Problems	Hannah Yates		✓			
3.9.31	Post-take Ward Round	Dr J Catterall & Katharine Bale		✓			✓
3.9.32	Review of the Hepatitis C Clinic	Anne Rollings	✓	✓			
3.9.33	Unstable Angina	Dr Sally Evans		?	?	?	?

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.9.34	Are Tracheostomy Patients being Safely Managed? ***(Trustwide)***	Sue Jones			✓		✓
Specialty: Respiratory							
3.9.35	Annual Review of Cystic Fibrosis - Does This Contribute to the Effective Management of Patients?	Dr Nabil Jarad	✓			✓	
3.9.36	Are we Meeting Referral Standards for Patients with Lung Cancer?	Martin Ball	✓	✓			
3.9.37	COPD Home Care	Dr Catterall		✓			?
3.9.38	Inpatient Management of COPD (Chronic Obstructive Pulmonary Disease)	Suzanne Gilson-Jones	✓	✓			?
3.9.39	Is BiPAP being used appropriately?	Dr Patrick Fitch		✓			✓
3.9.40	Is LTOT being appropriately prescribed by PCTs?	Katharine Bale		✓			✓
3.9.41	National Audit of Management of Chronic Obstructive Pulmonary Disease	Katharine Bale	✓	✓			

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Are staff following hand washing standards in 4 of UBHT's medical wards	**(Pathology)**	3.13.2
• How useful are urine bile pigments assay in the investigation of liver disease?	**(Pathology)**	3.13.30
• Treatment of Hyperlipidaemia in the UBHT Diabetes Clinic - Are we meeting NICE Standards	**(Pathology)**	3.13.37
• Use of Troponin-I as a marker of myocardial infarction	**(Pathology)**	3.13.38
• Effectiveness of outpatient call-centre	**(Surgery)**	3.16.13
• Is the Trust Following the Royal College of Physicians Guidelines for the Treatment of Patients with Fractured Neck of Femur (#NOF)	**(Surgery)**	3.16.15

EXEMPLAR AUDITS 2001 / 2002

Are we applying best practice the management of our nurse-led hepatitis C treatment clinic?
Anne Rollings *Clinical Services Manager*

Background
The impact of hepatitis C and the growing number of hepatitis C positive patients being referred to gastroenterology and hepatology services led to the development of the nurse led clinic. The audit topic was generated by the concerns expressed by a patient who suggested problems with her treatment attending a nurse led clinic.

Results
- 74% of patients received their appointment following liver biopsy after the 4 week standard. Although this represented an improvement on previous practice, there was nevertheless a need to revisit the pathway of patients from GP referral to treatment.
- 92% of patients had their blood chemistry taken and monitored monthly and were seen at regular intervals.
- 74% of patients were satisfied with the information they received, however 14% did not receive contraceptive advice
- 43% of patients experienced between 1 and 5 side effects; 38% between 6 and 10. This appeared to raise the question of whether practitioners were more interested in clinical indicators and test results than the actual range of symptoms experienced by the patients
- 86% of patients knew about the existence of help line and pager

Comment

Time, training and the lack of a systematic approach appears to have inhibited the development of health promotion and information about treatment, within the current environment.

Changes in practice

- Documentation/treatment plans revised
- Pager and helpline now publicised
- Clinical Nurse Specialist for Hepatitis appointed - plays a large role in promoting health promotion and harm reduction strategies.
- Sought support of outside agencies (Hepatitis C support group)
- Visits to prison unit
- Future research on impact of disease/treatment through (HRQoL) studies

Benefits

- Better understanding of the effects of illness and care on patients
- Better targeted services
- Patients know their views are taken into account
- Greater sense of ownership of services to patient

Reducing risk of falls in the elderly

Ruth Cowell *Nurse*, **Ruth Bailey** *Physio*, **Margaret Macmahon** *Consultant*, **Mandy Miles** *OT*

Background

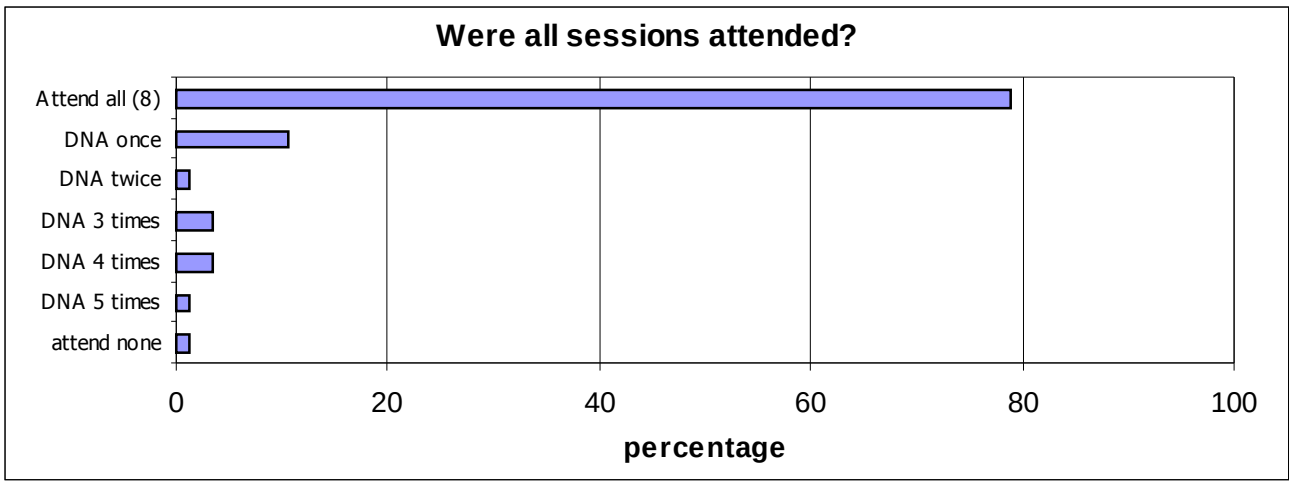
The William Lloyd Unit offers a multiprofessional falls prevention programme for elderly community dwellers. Patients are entered into a high or low ability group of 8 sessions over 4 weeks. This includes education and exercise. Patients are discharged with a home exercise programme and progress is reviewed 12 weeks after discharge.

Methodology

The team undertook a prospective audit of 100 consecutive patients to evaluate the effectiveness of the programme (uptake and outcomes). Nursing, physiotherapy and occupational therapy data was recorded for the assessment visit, at discharge and 12 weeks after discharge. The audit sample consisted of 80 women (mean age 81.3, range 68-100) and 20 men (mean age 83.2, range 75-95).

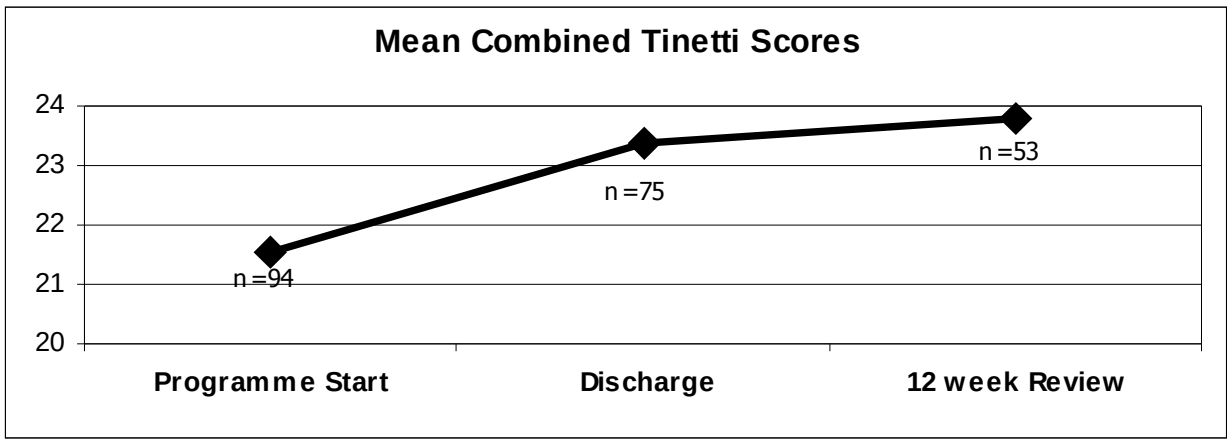
Results

- All patients assessed by nursing and physiotherapy; 80% assessed by Occupational Therapy
- 11 patients were not suitable for the programme and 4 declined
- Of the 85 patients who entered the programme, 92% completed, although 21 patients did not return for 12 week review



- The majority of people who did not complete were severely depressed (GDS > 17, Brink (1982)) and depression was a significant variable in non-attendance at 12 week review

- Patients improved Tinetti sores (measure of balance and gait) at discharge and 12 wk review



Conclusion

- Overall improvement in performance
- No single variable appeared to affect the Tinetti scores
- Research indicates that multifactorial interventions are effective in reducing falls risk (Tinetti 1994) but this audit shows need to look more closely at those patients who get worse

Bibliography

- Brink et al "Screening tests for geriatric Depression" Clinical Gerontologist 1982; Vol 1(1) ;37 -43
- Tinetti et al " A multifactorial intervention to reduce the risk of falling among elderly people living in the community" N Eng J Med 1994;331;821-827

3.10 OBS, GYNAE & ENT

SUMMARY

Number of 2000/2001 roll-overs **<<**:	11
Number of new pre-audits ▲:	0
Number of new first audits ■:	14
Number of new re-audits ●:	4
No. of new ongoing monitoring projects **>>**:	1
Total number of audits:	**30**
Number of completed audits:	19
Number of current (i.e. uncompleted) audits **>**:	6
No. of ongoing monitoring projects c/forward:	5
Number whose current status is unknown:	0

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	2/11	(18%)	15/23	(65%)	**8/19**	**(42%)**
Audits arising from a critical incident:	-	-	2/23	(9%)	**1/19**	**(53%)**
Audits prompted by a patient complaint:	-	-	0/23	(0%)	**0/19**	**(0%)**
Audits directly involving patients/carers (but not including surveys):	2/11	(18%)	0/23	(0%)	**0/19**	**(0%)**
Audits incorporating a patient / carer survey:			5/23	(22%)	**0/19**	**(0%)**
Audits involving representatives from primary care:	0/11	(0%)	0/23	(0%)	**0/19**	**(0%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/23	(0%)	**0/19**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**7/19**	**(37%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**6/19**	**(32%)**
Audits linked to directorate business plan:	-	-	-	-	**0/19**	**(0%)**
Number of proposal forms completed:	-	-	12/23	(52%)	**8/19**	**(42%)**
Number of proposal forms completed BEFORE audit started:	-	-	11/23	(48%)	**7/19**	**(37%)**
Audits measuring against or resulting in development of standards or guidelines:	9/11	(82%)	18/23	(78%)	**19/19**	**(100%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	9/9	(100%)	13/23	(56%)	**12/19**	**(63%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	12/15	(80%)	**14/19**	**(74%)**
Audits where an action plan was produced:	-	-	8/15	(53%)	**8/19**	**(42%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	4/7	(57%)	**4/11**	**(36%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	11/15	(73%)	12/20	(60%)	**4/24**	**(17%)**
Audits leading to better ways of working for staff:	-	-	14/20	(70%)	**8/24**	**(33%)**
Audits leading to measurable benefits for patients:	-	-	12/20*	(60%)*	**4/24***	**(17%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	1/1	(100%)	8/12*	(67%)*	**3/11***	**(27%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: Audiology							
3.10.1	Are Hearing Assessment forms being completed correctly?	P Smith (Chief Audiologist)		✓			
3.10.2	Is the referral protocol from Audiology to ENT appropriate and effective?	P Smith (Chief Audiologist)		✓			✓
Specialty: ENT							
3.10.3	Are operation notes meeting RCS standards?	C Hari (SpR), M Saunders (Cons), E Ferris		✓			
3.10.4	Are Parotidectomies in Bristol and Weston being performed appropriately?	P Counter (Regional SpR)		✓			
3.10.5	Can lessons be learned from regular peer review of Mortality & Morbidity in ENT?	M Saunders (Consultant)				✓	

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.10.6	Can the Inadequacy Rate of Fine Needle Aspirations in ENT be Improved? ***(with Pathology)***	R Sim (SpR), S Gore (SHO) B Philpotts & C Calder (Pathology)	✓		✓		
3.10.7	Is ENT Inpatient Admission Documentation Reaching Acceptable Standards?	M Saunders (Cons) & E Ferris	✓			✓	
3.10.8	Is ENT surgery being effective?	D Pinder (SpR)		✓			
3.10.9	National Comparative Audit of Surgery for Nasal Polyposis & Rhinosinusitis in England and Wales	M Saunders (Cons)	✓	✓			✓
Specialty: Family Planning							
3.10.10	Are the Pregnancy Advisory Service Following the RCOG Guidelines for the Care of Women Requesting Induced Abortion?	S Bodard (SCMO)	✓	✓			
Specialty: Gynaecology							
3.10.11	Are RCOG guidelines being followed for surgical ectopic pregnancies?	D Wooster (Senior Theatre Nurse)			✓		
3.10.12	Are Regional Cancer Organisation (RCO) Guidelines for Stage 1 Ovarian Cancer Being Followed?	A Olaitan (Subspecialty Trainee)	✓	✓			
3.10.13	Are the RCOG guidelines for female sterilisation being followed?	E Treloar (SHO)			✓		
3.10.14	Is chlamydia testing done prior to investigative operations for infertility, as recommended by RCOG guidelines?	B Peyton-Jones (Sen SHO)		✓			
3.10.15	Is medical management of ectopic pregnancy successful?	K Edey (SHO)		✓			✓
3.10.16	Management of Hyperemesis	B Clewer (SHO)		✓			
3.10.17	Referrals to Early Pregnancy Clinic	T Kelly & J Mears (SpRs)		✓			✓
3.10.18	The Collection of Regional Gynaecological Cancer for the Purposes of Audit and Improvement of Management ***(with Oncology & Pathology)***	J Murdoch (Cons)	✓			✓	
Specialty: Obstetrics & Midwifery							
3.10.19	Are babies being readmitted being adequately assessed by community midwives? ***(with Children's Services)***	J Moxham (Clinical Risk Manager)		✓			
3.10.20	Are Community Midwives Following the Protocol for Returning Handheld Maternity Notes to St Michaels?	E Ferris & J Moxham (Clinical Risk Manager)	✓		✓		
3.10.21	Are the standards for UNICEF Baby Friendly Accreditation being met?	B Cox (Midwife)	✓			✓	
3.10.22	Contraception & Screening in Drug Using mothers	D Murphy (Consultant Lecturer), A Makins (SHO) & S Barnes (Medical Student)			✓		
3.10.23	Fetal Loss After Invasive Prenatal Diagnosis	R Nanal (SHO)		✓			
3.10.24	Is ECV, as recommended by RCOG for breech deliveries at term, being performed successfully?	J Hughes (SpR)			✓		
3.10.25	Is Placenta Praevia being managed according to RCOG guidelines?	R Bahl (Sen SHO)		✓			
3.10.26	Is the Kiwi Ventouse cup being used correctly and safely?	D Pasupathy (Sen SHO)		✓			✓
3.10.27	Is UBHT providing a high quality screening service of pregnant women for Down's syndrome?	B Strachan (Cons), J Ford & P Woodward (Midwives), D Barclay (SHO)		✓			✓

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.10.28	National Sentinel Caesarean Section Audit	R Lear & J Butler (Midwives)	✓	✓			
3.10.29	What Lessons have been Learned from Monthly Peer Review of Fetal Deaths, Stillbirths and Neonatal Deaths? ***(with Children's Services & Pathology)***	P Kyle (Cons)	✓			✓	
Specialty: Other							
3.10.30	Can we Increase the Percentage of Out-Patients in ENT and Gynaecology Clinics who are Seen by 30 Minutes after their Appointment Time?	L Richardson (Head of Midwifery)	✓	✓			

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Discharge Planning	**(Children's Services)**	3.4.33
• Patient Attendance at ENT Pre-Admission Clinic (PACs) at St MH	**(Critical Care)**	3.6.24
• Do we Comply With the Trust Group Protocol for Vitamin K for Neonates?	**(Community Services)**	3.5.6
• Are paediatric blood samples sufficiently filled to allow a complete FBC measurement?	**(Pathology)**	3.13.20

EXEMPLAR AUDITS 2001 / 2002

Audit of Pregnancy Advisory Service 2000

Dr Sharon Bodard, Eleanor Ferris & PAS staff

Background

Following the publication in 2000 of the Royal College of Obstetricians & Gynaecologists (RCOG) Evidence Based Clinical Guideline *The Care of Women Requesting Induced Abortion*, there was a decision to audit UBHT's Pregnancy Advisory Service (PAS) service against the RCOG guideline. The aim was to ensure women considering induced abortion are provided with a high quality service at UBHT, as outlined in the RCOG guideline recommendations.

Objectives

- To determine whether women receive a timely assessment & procedure
- To determine whether women are given full & accurate information
- To determine whether appropriate pre-abortion management is given in all cases

Results

- 100/129 (78%) women seen in May 2000 waited longer than 3 weeks from initial referral to abortion (i.e. didn't meet main waiting times standard in these cases)
- Patient Information leaflets given, but leaflet information not always in accordance with RCOG guidelines
- All doctors gave patients verbal advice, with information conforming to RCOG guidelines (peer observation of 2 consultations each)
- Pre-abortion management standards met in 100% of cases (blood tests done, contraception discussed, infection screening done) and 98% of cases (cervical screening history taken) of 50 patients seen in February 2000
- All nurses conducted ultrasound scanning in sensitive manner (peer observation of 2 scans each)

Actions

- Changes made to patient information leaflets, to bring them into line with RCOG recommendations
- Further patient satisfaction survey to be undertaken to obtain user views and confirm results of peer observation
- Computer programme set up to monitor waiting times continuously
- Business case submitted for increased funding to PAS service to allow more weekly sessions & an increase in terminations in local area (to improve timeliness of assessments and procedures)
- Series of meetings set up involving service providers, commissioners and other interested parties to look at ways of improving services. Audit results used in preparing report to commissioners

Contraception & Screening in Drug Using Mothers

Dr D Murphy, Dr A Makins, S Barnes

Background

In August 2000 the weekly clinic delivering care to drug-using pregnant women became consultant-led. Two audits were done to evaluate the impact of this change in service, looking at the infection screens women were given (namely Hepatitis C and HIV) and whether they were discharged with reliable contraception. The behaviour of pregnant drug users puts them at high risk of Hepatitis C and HIV, and it is important to identify infected women in order to minimise the risk of transmission to their baby at birth and post-natally by appropriate treatment. Discharge of women with reliable contraception is felt to be important as many pregnancies in drug users are unplanned and unwanted, and a short inter-pregnancy interval is associated with poor pregnancy and childhood outcomes.

Results

- Levels of antenatal screening improved from previous 1999 audit - 33% for HIV, 42% for Hepatitis C - to 84% and 87% respectively (55 patients, September 2000 to May 2001)
- Infection rates were low (19% Hepatitis C, 0% HIV), however presence of risk factors supports need for blanket screening policy (introduced August 2000 by consultant in charge of clinic)
- Timing of screening varies, as opportunistic – should aim to screen at first presentation of woman at clinic then repeat in third trimester (as infection status may change)?
- Discharge on reliable contraception improved from 19% (32 consecutive drug-using women, February to June 2000) to 76% (29 women, September 2000 to January 2001)

Action

- Midwifery training in siting of implant contraceptives arranged

3.11 ONCOLOGY

SUMMARY

Number of 2000/2001 roll-overs **<<**:	9
Number of new pre-audits ▲:	2
Number of new first audits ■:	4
Number of new re-audits ●:	1
No. of new ongoing monitoring projects **>>**:	0
Total number of audits:	**16**
Number of completed audits:	15
Number of current (i.e. uncompleted) audits **>**:	1
No. of ongoing monitoring projects c/forward:	0

(Originally 10 but 1 abandoned during 2001/02)

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	3/13	(23%)	13/21	(62%)	**0/7**	**(0%)**
Audits arising from a critical incident:	-	-	1/21	(5%)	**0/7**	**(0%)**
Audits prompted by a patient complaint:	-	-	0/21	(0%)	**0/7**	**(0%)**
Audits directly involving patients/carers (but not including surveys):	1/13	(8%)	0/21	(0%)	**0/7**	**(0%)**
Audits incorporating a patient / carer survey:			0/21	(0%)	**0/7**	**(0%)**
Audits involving representatives from primary care:	0/13	(0%)	0/21	(0%)	**0/7**	**(0%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/21	(0%)	**0/7**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**2/7**	**(29%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**0/7**	**(0%)**
Audits linked to directorate business plan:	-	-	-	-	**0/7**	**(0%)**
Number of proposal forms completed:	-	-	13/21	(62%)	**3/7**	**(43%)**
Number of proposal forms completed BEFORE audit started:	-	-	13/21	(62%)	**2/7**	**(29%)**
Audits measuring against or resulting in development of standards or guidelines:	13/13	(100%)	18/21	(86%)	**3/7**	**(43%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	11/13	(85%)	19/21	(90%)	**5/7**	**(71%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	13/15	(87%)	**15/15**	**(100%)**
Audits where an action plan was produced:	-	-	13/15	(87%)	**4/15**	**(27%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	1/2	(50%)	**4/11**	**(36%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	9/10	(90%)	12/15	(80%)	**8/15**	**(53%)**
Audits leading to better ways of working for staff:	-	-	8/15	(53%)	**5/15**	**(33%)**
Audits leading to measurable benefits for patients:	-	-	6/15*	(40%)*	**5/15***	**(33%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	1/1	(100%)	1/2*	(50%)*	**1/3***	**(33%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.11.1	An Audit of Private Patient Documentation at BHOC	Tracy Goolam-Hossen	✓	✓			
3.11.2	An audit to ensure that GP letters following Radiotherapy are filled in correctly	Amanda Gee, Superintendent III Radiographer		✓			
3.11.3	Getting the Most from your SHOs Part II	Dr Claire Rice			✓		
3.11.4	Intravenous Immunoglobulin Audit	Dr Ray Denis		✓			
3.11.5	Late Severe Bowel Toxicity after Radical Radiotherapy for Cervical Cancer	Amit Bahl		✓			
3.11.6	Management and Care of Groshong Lines - Are Groshong lines being inserted and managed appropriately?	Clare Bidgood, Clinical Nurse Specialist	✓	✓			

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.11.7	Neo-Adjuvant Chemotherapy in Breast Patients	Paul Dillon	✓	✓			✓
3.11.8	Patient Consent - Level of Compliance	Dr Boinagiu	✓	✓			
3.11.9	Patient Consent for Clinical Trials	Paul Dillon	✓	✓			
3.11.10	Pre-Operative Tamoxifen Prescribing in Operable Early Breast Cancer Patients	Dr Hugh Newman, Dr Pippa Riddle, Dr Henry Barlow		✓			
3.11.11	Radiotherapy Waiting Times	Judy Cox	✓		✓		
3.11.12	The Role of CT - Chest and Broncho-Alveolar Lavage [BAL]	Dr Paul Cahalin		✓			
3.11.13	Treatment Delays in Breast Cancer Patients - To evaluate waiting times for breast cancer patients from GP referral through surgical management to first oncology treatment	Dr Thomas PE Wells, research registrar in clinical oncology	✓	✓			
Specialty: AHU							
3.11.14	Out of Hours Duties for SHO's - Getting the Most from your SHOs	Dr Thomas Johnson		✓			
Specialty: Palliative Medicine							
3.11.15	Analgesic Prescribing	Dr C Reid	✓		✓		
3.11.16	Laxative Prescribing - Audit of laxative use in BHOC	Dr C Thompson, Sr Gaye Senior-Smith	✓	✓			

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Prospective audit of long term tunnelled central venous lines	**(Critical Care)**	3.6.27
• The Collection of Regional Gynaecological Cancer for the Purposes of Audit and Improvement of Management	**(Obs, Gynae & ENT)**	3.10.18
• Avon, Somerset and Wiltshire Cancer Standards for Breast Cancer	**(Surgery)**	3.16.1

The directorate has experienced problems in compiling data for this report due to the absence of the facilitator for six months on long-term sick leave.

3.12 OPHTHALMOLOGY

SUMMARY

Number of 2000/2001 roll-overs **<<**:	8
Number of new pre-audits ▲:	2
Number of new first audits ■:	7
Number of new re-audits ●:	2
No. of new ongoing monitoring projects **>>**:	0
Total number of audits:	**19**
Number of completed audits:	11
Number of current (i.e. uncompleted) audits **>**:	8
No. of ongoing monitoring projects c/forward:	0
Number whose current status is unknown:	0

(Originally 9 but 1 abandoned during 2001/02)

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	3/12	(25%)	6/13	(46%)	**4/11**	**(36%)**
Audits arising from a critical incident:	-	-	0/13	(0%)	**2/11**	**(18%)**
Audits prompted by a patient complaint:	-	-	0/13	(0%)	**0/11**	**(0%)**
Audits directly involving patients/carers (but not including surveys):	0/12	(0%)	0/13	(0%)	**0/11**	**(0%)**
Audits incorporating a patient / carer survey:			1/13	(8%)	**1/11**	**(9%)**
Audits involving representatives from primary care:	2/12	(17%)	0/13	(0%)	**1/11**	**(9%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/13	(0%)	**0/11**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**2/11**	**(18%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**8/11**	**(73%)**
Audits linked to directorate business plan:	-	-	-	-	**0/11**	**(0%)**
Number of proposal forms completed:	-	-	13/13	(100%)	**11/11**	**(100%)**
Number of proposal forms completed BEFORE audit started:	-	-	13/13	(100%)	**9/11**	**(82%)**
Audits measuring against or resulting in development of standards or guidelines:	12/12	(100%)	13/13	(100%)	**9/11**	**(82%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	7/12	(58%)	13/13	(100%)	**10/11**	**(91%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	8/8	(100%)	**10/11**	**(91%)**
Audits where an action plan was produced:	-	-	6/8	(75%)	**10/11**	**(91%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	2/2	(100%)	**1/1**	**(100%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	8/9	(89%)	8/9	(89%)	**9/11**	**(82%)**
Audits leading to better ways of working for staff:	-	-	5/9	(56%)	**8/11**	**(73%)**
Audits leading to measurable benefits for patients:	-	-	6/9*	(67%)*	**7/11***	**(64%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	1/4	(25%)	1/2*	(50%)*	**2/4***	**(50%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: Ophthalmology							
3.12.1	An audit of Biometry using new formulae for calculating lens power	Derek Tole			✓		
3.12.2	Appropriateness of Listing for Cataract Surgery	Riz Malik		✓			✓
3.12.3	Are Ophthalmologists Following Current Fluorescein Request Guidelines and Do The Guidelines Need Revising?	Quresh Mohammed	✓	✓			
3.12.4	Are Patients Who Attend / Are Referred to A/E Appropriate?	Karen Goodinson	✓	✓			
3.12.5	Are the Outcomes of Surgery for Childhood Esotropia Reaching Acceptable Standards?	Steven Rowley	✓		✓		
3.12.6	Can the aftercare of BD8 registered patients be improved?	Clare Bailey/Sharon Bambrick		✓			✓

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.12.7	Can we meet NICE guidance on waiting times for new diabetic referrals	Clare Bailey		✓			✓
3.12.8	Delays in Diabetic Retinopathy Appointments for Follow Up Patients	Clare Bailey		✓			✓
3.12.9	Does the Outcome of Horizontal and Vertical Adjustable Squint Surgery in Adults Meet Acceptable Standards?	Steven Rowley	✓	✓			
3.12.10	Nurse Led Cataract Follow Up Clinics	Helen Julian		✓			✓
3.12.11	Suitability of patients for fast track cataract lists	Clare Bailey		✓			✓
3.12.12	The Rate of and Management of Endophthalmitis	Thomas Stumpf			✓		
3.12.13	What are the outcomes and complications of cataract surgery undertaken by consultants at BEH	John Sparrow		✓			
3.12.14	What is the Outcome and Complication Rate for Trabeculectomy Surgery Compared to Local and National Standards?	Caspar Gibbon	✓		✓		
3.12.15	What is the outcome and complication rate of retinal detachment surgery	Yash Ramkissoon		✓			
Specialty: Orthoptics							
3.12.16	Is Our Management of Orbital Injury Patients Efficient and Effective? ***(with Dental Services)***	Helen McCarthy	✓	✓			✓
3.12.17	Is The Orthoptic Department Following its "Community Discharge Policy" and Does the Policy Need Amending?	Ann Starbuck	✓	✓			
3.12.18	Is the Service for Children with Amblyopia Efficient and Effective?	Elizabeth Newcomb	✓	✓			
3.12.19	Referral of Community Orthoptic Patients to BEH	Penny Warnes		✓			✓

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Is the Trust following 2001 Royal College/Trust ICP guidelines for ophthalmic local anaesthesia	**(Critical Care)**	3.6.20
• Safety and economic implications of patient biting of armoured Laryngeal Mask Airways.	**(Critical Care)**	3.6.32

EXEMPLAR AUDITS 2001 / 2002

Audit of Standards of Discharge for Children seen in the Community
Ann Starbuck *(Senior Orthoptist)*

Background
In March 2000 new standards for discharging patients attending the Orthoptic Community Clinics were developed. As there are no national guidelines these were agreed locally by the Orthoptic department and in June 2000 approved by the Clinical Director. There were already agreed standards for discharge of children with amblyopia or squint which were used both by the hospital and community orthoptic services. When setting the standards the problem discussed was how to safely discharge young children with the minimum number of clinic attendances whilst also allowing the parents a route back into the system if a problem should arise in the future. It was therefore agreed that these standards should be audited against regularly and amended if any problems were identified.

Objectives
- To ensure the locally agreed discharge standards are being met
- To ensure the standards are appropriate

Methodology
Data was collected from the case notes of the first 150 patients discharged from the community orthoptic clinics using an audit pro-forma.

Results

- 95% of cases adhered to clinical care standards: the 5% who did not meet the standards were legitimate exceptions (i.e. 100% adherence achieved for audit purposes)
- 110 patients were discharged as NAD with an average attendance of 1.5 visits. If the department was able to discharge all cases on the first visit the number of attendances could have been reduced by 55 in the 3 month period covered by the audit. This is equivalent to 16 -20 orthoptic sessions in one year. This would be possible if patients could be refracted at their first visit. Unfortunately this would put an unreasonable extra burden on the Optometry service. It would also involve a separate visit for the patient. This problem may be overcome either by training Orthoptists to refract or with the use of an auto refractor.
- Problem identified with documentation of advice (fed back to orthoptists at audit meeting)
- Problem identified with communication to GP/referrer (fed back to orthoptists at audit meeting)

Actions

- Standards for patients who are too young to obtain monocular visual acuities but do not demonstrate any visual defect to be applied to the hospital as well as the community as this would be appropriate for many of the patients referred directly to the hospital
- All patients to be offered auto-refraction by orthoptists, which will reduce the number of clinic visits needed and offer a non-invasive examination for young children

<u>The Incidence and Management of Endophthalmitis</u>
Thomas Stumpf ***(SpR)***

This project was awarded second prize at the 2002 UBHT Clinical Audit Oscars

Background

Post-operative endophthalmitis is a rare but serious complication of cataract and other forms of intraocular surgery which may result in loss of all useful vision in the affected eye.

Objectives

- To monitor the annual incidence
- To compare the Bristol Eye Hospital (BEH) rates with published National and International rates and with the previous years' rates
  To assess the effect of changes in practice on the rate
- To try and identify potential risk factors
- To improve the process of care for patients diagnosed with endophthalmitis

Methodology

The period covered in this audit was from 1 August 2000 to 30 September 2001. Four separate sources were utilised to try and identify all the cases. These were the hospital database (PAS), critical incident forms, the theatre intravitreal antibiotic logbooks, and the Gloucester ward-record book. The clinical notes of all potential cases identified were retrieved and scrutinised. Only those cases that were genuine postoperative endophthalmitis were included and only those occurring within one month of surgery at Bristol Eye Hospital were used in calculating the rates

Standards

A number of standards were agreed relating to the rate of endophalmitis, the diagnosis and treatment of the condition.

Results

Current rate of endopthalmitis: National rate for cataract surgery = 0.1%

	2000-2001		1999-2000	1998-1999
	14-month data	12-month data	12-month data	12-month data
Intra Ocular Surgery	0.18%	0.19%	0.34%	0.65%
	9 of 5001	8 of 4313	13 of 3857	21 of 3234
Cataract Surgery	0.18%	0.18%	0.26%	0.62%
	8 of 4390	7 of 3788	9 of 3499	17 of 2727

Many of the process standards set following the previous years audit had been met at 100%, and in other cases the rates had improved e.g. reporting of endophthalmitis on critical incidence forms improved from 38% to 86%.

Actions

- Definition of endophthalmitis to increase to 3 months in line with national reporting
- All cases to have diagnostic procedure and intravitreal antibiotics within 3 hours of presentation

- Post Operative endophthalmitis care pathway pack to be developed (to include critical incidence form and antibiotic form/guidance)
- Additional consultant named as undertaking a pars plan vitrectomy operation if required
- Drug protocol amended in agreement with micro-biologists

3.13 PATHOLOGY (LABORATORY MEDICINE)

SUMMARY

Number of 2000/2001 roll-overs **<<**:	13
Number of new pre-audits ▲:	3
Number of new first audits ■:	15
Number of new re-audits ●:	8
No. of new ongoing monitoring projects **>>**:	1
Total number of audits:	**40**
Number of completed audits:	13
Number whose current status is unknown:	0

(Originally 15 but 2 abandoned during 2001/02 or no longer part of Pathology audit programme)

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	11/13	(85%)	20/30	(67%)	**17/27**	**(63%)**
Audits arising from a critical incident:	-	-	2/30	(7%)	**2/27**	**(7%)**
Audits prompted by a patient complaint:	-	-	2/30	(7%)	**0/27**	**(0%)**
Audits directly involving patients/carers (but not including surveys):	0/13	(0%)	0/30	(0%)	**0/27**	**(0%)**
Audits incorporating a patient / carer survey:			0/30	(0%)	**0/27**	**(0%)**
Audits involving representatives from primary care:	0/13	(0%)	0/30	(0%)	**0/27**	**(0%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/30	(0%)	**0/27**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**10/27**	**(37%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**26/27**	**(96%)**
Audits linked to directorate business plan:	-	-	-	-	**4/27**	**(15%)**
Number of proposal forms completed:	-	-	13/30	(43%)	**7/27**	**(26%)**
Number of proposal forms completed BEFORE audit started:	-	-	11/30	(37%)	**7/27**	**(26%)**
Audits measuring against or resulting in development of standards or guidelines:	9/13	(69%)	22/30	(73%)	**19/27**	**(70%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	4/9	(44%)	14/30	(47%)	**13/27**	**(48%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	4/16	(25%)	**2/13**	**(15%)**
Audits where an action plan was produced:	-	-	10/16	(63%)	**9/13**	**(69%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	3/6	(50%)	**2/4**	**(50%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	10/13	(77%)	14/23	(61%)	**12/22**	**(54%)**
Audits leading to better ways of working for staff:	-	-	9/23	(39%)	**11/22**	**(50%)**
Audits leading to measurable benefits for patients:	-	-	9/23*	(39%)*	**4/22***	**(18%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	1/6	(17%)	2/9*	(22%)*	**3/13***	**(23%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: Infection Control							
3.13.1	Annual Infection Control Audit - A ward-based surveillance programme of Infection Control procedures in action - phased throughout year ***(Trustwide)***	Mrs Christine Perry			✓		✓
3.13.2	Are staff following hand washing standards in 4 of UBHT's medical wards ***(with Medicine)***	Mrs Liz Bowden			✓		
3.13.3	Bench -top sterilisers	Mrs Christine Perry		✓			✓
3.13.4	Ward-Based Surveillance Programme of Infection Control Procedures in Action	Mrs Christine Perry	✓			✓	
3.13.5	What is the Trust's Hospital Bacteraemia Rate – continuous monitoring ***(Trustwide)***	Mrs Christine Perry				✓	
3.13.6	What is the Trust's Hospital Bacteraemia Rate, Used as a National Clinical Indicator? ***(Trustwide)***	Mrs Christine Perry	✓			✓	

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: Histopathology							
3.13.7	Annual Audit of Adult Autopsies Carried Out at BRI Mortuary ***(Trustwide)***	Dr Ed Sheffield	✓			✓	
3.13.8	Are we Complying with Laboratory Procedures Relating to the Retention of Tissue From Autopsy Examinations?	Dr Morgan Moorghen	✓		✓		✓
3.13.9	C3 & C4 Grade Breast Cytology	Dr Jyoti Rao, Dr Caroline Calder			✓		✓
3.13.10	Continuous Participation in Clinico-Pathological Meetings as a means of constantly auditing practice and investigations relating to individual patients through multi-professional peer review ***(Trustwide)***	Dr Morgan Moorghen	✓			✓	
3.13.11	Correlation between Bone Marrow Aspirates and subsequent Trephine Biopsy Tissue	Dr Hasina Ahmad, Dr Joya Pawade		✓			✓
3.13.12	Correlation between Breast Core Biopsy Tissue and subsequent Breast Resection Tissue	Dr Alessandro Vespa, Dr Caroline Calder		✓			
3.13.13	Correlation Between Cervical Smear Results and subsequent 'Lletz' Cervical Excision Biopsy Tissue	Dr Joya Pawade	✓		✓		✓
3.13.14	Correlation between Histology of Ovarian Tissue and Radiological Examination ***(with Radiology)***	Dr Guy Martland		✓			✓
3.13.15	How Many Supplemental Reports are Issued and do they Lead to Changes in Diagnosis?	Prof Massimo Pignatelli	✓	✓			✓
3.13.16	Standards of reporting of head & neck resection tissue	Dr Max Robinson		✓			
3.13.17	Standards of reporting of lung resection tissue	Dr Lakmini Mudduwa, Dr Ed Sheffield			✓		
3.13.18	Standards of reporting of oesophageal resection tissue	Dr Chandan Sen, Dr Morgan Moorghen		✓			✓
Specialty: Haematology							
3.13.19	Are laboratory turnaround times for paediatric inpatients changed, following the opening of the new Bristol Royal Hospital for Children ***(with Children's Services)***	Mrs Liz Worsam		✓			✓
3.13.20	Are paediatric blood samples sufficiently filled to allow a complete FBC measurement?	Mrs Liz Worsam		✓			✓
3.13.21	Audit of newly published UBHT Transfusion Policy ***(Trustwide)***	Dr Edwin Massey		✓			✓
3.13.22	Blood and Blood Product Usage by Wards and Theatres - Monitored Throughout Year and Reported Back to Individual Clinical Teams ***(with Cardiothoracic Services and Surgery)***	Mr Ian Martin	✓			✓	
3.13.23	Continuous Participation With Serious Hazards of Transfusion Sentinel Audit	Mr Ian Martin, Mrs Elizabeth Worsam	✓			✓	
3.13.24	The Use and Abuse of ANCA Testing	Mr Peter Hopes, Dr Mark Gompels	✓	✓			✓
3.13.25	Thyroid Antibody Screening in Borderline Hypothyroid Patients	Dr Mark Gompels, Ms Nicola Marden	✓	✓			
Specialty: Chemical Pathology							
3.13.26	Are the pathology reports getting to the notes? ***(Trustwide)***	Mr James Osborne, Dr Graham Bayly			✓		✓
3.13.27	Are we delaying the release of laboratory results at the clinical authorisation stage?	Mr James Osborne			✓		
3.13.28	C1-Esterase Inhibitor Studies	Dr Mark Gompels		✓			
3.13.29	Do we comply with CPA standards when telephoning results to wards?	Dr Paul Thomas			✓		
3.13.30	How useful are urine bile pigments assay in the investigation of liver disease? ***(with Medicine)***	Dr Paul Thomas & Mr Jeff Scott		✓			
3.13.31	Laboratory Information System & Reference Ranges	Dr Paul Thomas		✓			✓
3.13.32	Laboratory turnaround times for inpatient Electrolytes ***(Trustwide)***	Mr Ken Jones			✓		✓

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.13.33	Provision of the Regional White Cell Enzyme Screening Service	Dr Janet Stone		✓			
3.13.34	Reporting Paediatric Test Results	Ann Bowron		✓			
3.13.35	Review of Reference Ranges for commonly requested tests	Dr Andrew Day		✓			✓
3.13.36	Systematic Review of Minor and Major errors Identified by the Laboratory	Dr Paul Thomas	✓			✓	
3.13.37	Treatment of Hyperlipidaemia in the UBHT Diabetes Clinic - Are we meeting NICE Standards ***(with Medicine)***	Dr Graham Bayly		✓			
3.13.38	Use of Troponin-I as a marker of myocardial infarction ***(with Medicine and Cardiothoracic Services)***	Dr Wolf Woltersdorf		✓			✓
3.13.39	USTAR Research Support Unit Service – Is it providing a good service	Dr Andrew Day		✓			
Specialty: All Departments							
3.13.40	Continuous Participation in National External Quality Assurance Schemes - Across All Laboratory Disciplines As a Formal Requirement to Maintain Laboratory and Professional Accreditation	Dr Morgan Moorghen	✓			✓	

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Can the Inadequacy Rate of Fine Needle Aspirations in ENT be Improved?	**(Obs, Gynae & ENT)**	3.10.6
• The Collection of Regional Gynaecological Cancer for the Purposes of Audit and Improvement of Management	**(Obs, Gynae & ENT)**	3.10.18
• What Lessons have been Learned from Monthly Peer Review of Fetal Deaths, Stillbirths and Neonatal Deaths?	**(Obs, Gynae & ENT)**	3.10.29

EXEMPLAR AUDITS 2001 / 2002

Are staff following hand wash standards in 4 medical wards? (Infection Control)
Liz Bowden *Infection Control Nurse*

Background
As part of the ongoing drive to minimise the hospital acquired infection rate, an audit of hand wash compliance was carried out in 4 wards of the Medical Directorate - Ward 21 (dermatology), Wards 25 & 27 (general medical) and Ward 29 (respiratory).

Objectives
- To assess the level of hand wash compliance
- To raise awareness of the need for good hand wash compliance
- To improve hand wash compliance by observational audit, feedback and education

Standards
Hands should be washed (even if wearing gloves):
- Before all procedures
- When moving from patient to patient
- After visiting the toilet
- Before handling food
- When moving from a 'dirty' to a 'clean' task on the same patient

Methodology
The chosen wards were contacted and asked if they would agree to take part in the audit. The infection control support nurse visited each ward for a number of 2 hour periods each week for 4 consecutive weeks. Hand wash compliance and technique was noted and recorded on a formulated audit tool. Feedback was provided weekly – with additional educational sessions offered

Results	Location	1st week compliance	4th week compliance
	Ward 21	33%	52%

Ward 25	20%	96%
Ward 27	20%	56%
Ward 29	23%	89%

Ward staff were surprised that compliance was initially so poor, however only one of the wards took up the offer of additional training. Hand wash compliance by domestics and doctors was noticeably poor across all 4 wards and improvement slight over the 4-week period. Nursing hand wash compliance was overall the best of the staff groups.

Actions

- An improved hand wash preparation has been installed into all wards at all washbasins. This new liquid soap has a pleasant smell and is not harsh to the skin.
- Link infection control nurses will conduct a re-audit to establish if improvement has been maintained, or the effect we have observed is due to the Hawthorne Effect.

Treatment of hyperlipidaemia in the Diabetes Clinic: Are we meeting NSF & NICE standards?

(Clinical Biochemistry)

Dr Graham Bayly *Consultant*

Background

Diabetics are at increased risk of coronary heart disease (CHD). Lowering lipid levels by the use of the 'statin' drugs is an effective way of reducing their risk of myocardial infarction (MI). Recent NSFs and impending NICE guidance provide clear national standards for statin use. The management of lipid lowering is a service led by clinical biochemists within UBHT.

Objectives

- To audit recording of CHD risk factors at diabetic annual review
- To audit treatment of hyperlipidaemia against local and national standards in patients with a history of MI or a 10 yr CHD risk >30%
- To estimate the additional number of patients with risk factor profiles requiring lipid lowering treatment under forthcoming NICE guidelines, currently published in draft form

Standards

CHD Risk Factors

- BP, smoking and history of previous MI should be recorded
- Cholesterol, Triglyceride and HDL should be measured in the laboratory

Secondary prevention (post MI)

- If cholesterol >5 mmol/L patients should be on statin treatment unless contraindicated

Primary prevention (no history of MI)

- 10-yr CHD risk should be calculated based on annual review data
- If 10-yr CHD Risk >30% and cholesterol >5 nmol/L then patient should be on a statin unless contraindicated

Methodology

- Retrospective analysis of data from diabetes annual review database (1245 patients)
  - previous 12 months
  - patients aged 30-70 yr attending clinic
- Retrospective case note review of patients where there is
  - a history of MI and Cholesterol >5 mmol/l (21 patients)
  - no history MI and Cholesterol > 5 mmol/l and CHD risk >30% (40 patients)

Results	Achieved	Std.	Met Std?
• Blood pressure and smoking recorded	99%	100%	No
• MI recorded	45%	100%	No
• Cholesterol measured	93%	95%	No
• Triglyceride and HDL measured	75%	95%	No
• MI patients on statin if Cholesterol >5 mmol/L	55%	85%	No
• Patients on statin if CHD risk >30%	55%	85%	No

Actions

- Re-audit during 2002
- Based on draft NICE guidance, we anticipate 32% rather than 8% of adult diabetics without other evidence of vascular disease will need statin treatment.

3.14 RADIOLOGY

SUMMARY

Number of 2000/2001 roll-overs **<<**:	7
Number of new pre-audits ▲:	1
Number of new first audits ■:	17
Number of new re-audits ●:	2
No. of new ongoing monitoring projects **>>**:	0
Total number of audits:	**27**
Number of completed audits:	17
Number of current (i.e. uncompleted) audits **>**:	4
No. of ongoing monitoring projects c/forward:	1
Number whose current status is unknown:	5

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	10/13	(77%)	8/11	(73%)	**14/20**	**(70%)**
Audits arising from a critical incident:	-	-	2/11	(18%)	**0/20**	**(0%)**
Audits prompted by a patient complaint:	-	-	0/11	(0%)	**4/20**	**(20%)**
Audits directly involving patients/carers (but not including surveys):	0/13	(0%)	0/11	(0%)	**1/20**	**(5%)**
Audits incorporating a patient / carer survey:			1/11	(9%)	**0/20**	**(0%)**
Audits involving representatives from primary care:	1/13	(8%)	0/11	(0%)	**1/20**	**(5%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/11	(0%)	**0/20**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**2/20**	**(10%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**8/20**	**(40%)**
Audits linked to directorate business plan:	-	-	-	-	**8/20**	**(40%)**
Number of proposal forms completed:	-	-	7/11	(64%)	**16/20**	**(80%)**
Number of proposal forms completed BEFORE audit started:	-	-	6/11	(54%)	**16/20**	**(80%)**
Audits measuring against or resulting in development of standards or guidelines:	12/13	(92%)	9/11	(82%)	**18/20**	**(90%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	8/12	(67%)	8/11	(73%)	**15/20**	**(75%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	7/7	(100%)	**15/17**	**(88%)**
Audits where an action plan was produced:	-	-	5/7	(71%)	**11/17**	**(65%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	2/2	(100%)	**3/6**	**(50%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	7/12	(58%)	4/9	(44%)	**9/18**	**(50%)**
Audits leading to better ways of working for staff:	-	-	4/9	(44%)	**3/18**	**(17%)**
Audits leading to measurable benefits for patients:	-	-	4/9*	(44%)*	**8/18***	**(44%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	0/1	(0%)	0/2*	(0%)*	**0/4***	**(0%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.14.1	Assessment of Liver Biopsies - Complication Rates, Cancellations	Dr M Callaway	✓			✓	
3.14.2	Audit of Radiology services – The Radiology component of the Audit Commission's Acute Hospital Portfolio.	Audit Commission + S.King, P.J.R.			✓		
3.14.3	Audit on Coarctation follow up in GUCH ***(with Cardiothoracic Services)***	Dr Onofrei, Dr Stuart, Dr Wilde		✓			
3.14.4	Audit on Surgery of Mitral Valve Regurgitation ***(with Cardiothoracic Services)***	Dr Dragnea, Mr Underwood, Dr Nightingale, Dr Wilde		✓			
3.14.5	Radiation Doses of GI Studies - How do we compare against NRPB standards? ***(with Specialty Services)***	J Oduko, S King, T Stoyles	✓		✓		

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: A&E (Suite E)							
3.14.6	A&E Reporting what is the duration?	Dr S.Khan, Dr C.Wakeley		✓			
3.14.7	Missed A&E Fractures & delay in reporting	Dr C.Wakeley		✓			
Specialty: Breast Screening Unit							
3.14.8	Audit of image quality, following replacement of Mammography equipment	Mrs C.Walsh Supt Radiographer		✓			
Specialty: Echo-cardiography (Suite D)							
3.14.9	Echo-cardiograms, Out Patient – DNA In Patient – Non-attendance.	Senior Radiographer - Mrs P.Kelly, Supt Radiographer Mrs B.Oakley		✓			
Specialty: Medical Physics							
3.14.10	Radiation Doses for CT Scans (Head, Chest, Abdo, Pelvis). How do we Compare with Other Centres and Against NRPB Standards? ***(with Specialty Services)***	Sally King, Jenny Oducko	✓		✓		
Specialty: MRI							
3.14.11	Is the MRI 'Emergency' slot an efficient use of scanner/staff time?	Mrs K.Isaacs, Snr Radiographer		✓			
Specialty: Paediatrics							
3.14.12	Are two views of the fractured clavicle necessary?	Dr S.Barnard, SpR Radiology		✓			
3.14.13	Audit to Determine the Indications for CXR Prior to Paediatric Cardiac Investigations	Dr P Davison, Dr A Duncan	✓	✓			?
3.14.14	How appropriately are requests for erect abdomen radiographs in paediatric radiology?	Dr A W Duncan	✓	✓			?
3.14.15	How long does it take for Paediatric DMSA scan reports to be available on the computer system?	Dr S.P.Prabhu, SpR; Dr S.King, Cons Radiologist		✓			
3.14.16	Paediatric Red dot reporting – to establish current level of skill and determine learning needs.	Mrs D.Dimond Supt Radiographer		✓			✓
3.14.17	Patient survey. Are users of the BCH X-Ray department satisfied with the service. Would they participate in a user group.	Dr S.King		✓			?
3.14.18	Re-audit of Requests for Abdominal Ultrasound and Outcome of Those Examinations for Patients with Non-Specific Abdominal Pain	Dr A Duncan	✓		✓		?
3.14.19	Success & complication rates for the reduction of interssusception by air/barium enema	Dr N.R.Jefferson SpR; Dr D.Grier Cons Radiologist		✓			
3.14.20	What are the screening times and DAP readings for common Paediatric procedures?	Dr D.Grier Cons Radiologist		✓			
Specialty: Radioisotopes (Suite F)							
3.14.21	An audit of the Myocardial Perfusion Service	David Hall, Snr Physicist		✓			?
3.14.22	Radiographer reporting of VQ Scans	Mrs V.Parkin		✓			
3.14.23	The role of VQ scanning in pregnant and post partum women	Dr S.J.Prabhu, SpR; Mrs V.Parkin Supt Radiographer		✓			
Specialty: St MH - Obstetrics US							
3.14.24	Antenatal Diagnosis of Isolated Talipes. To Assess the Accuracy of Antenatal Diagnosis of Isolated Talipes	Dr P Davidson, Helen Lockyer	✓	✓			✓

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.14.25	Audit of pick up rate of ectopic pregnancies with U/S findings suggestive of. Update of previous study	Dr H.Andrews, Consultant Radiologist; Mrs R.Burke, Senior Radiographer			✓		✓
3.14.26	Audit of ventricular atrium measurements, average measurements and action taken on those measuring 10mm and greater and there outcome.			✓			✓
3.14.27	Audit to assess the amount and appropriateness of dating scan referrals from midwives over a month period, of this non-funded service.			✓			

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Are suspected stroke patients referred within effective time frames?	**(Medicine)**	3.9.1
• Correlation between Histology of Ovarian Tissue and Radiological Examination	**(Pathology)**	3.13.14

EXEMPLAR AUDITS 2001 / 2002

Audit of Echocardiogram DNA rates following the use of the Trust Call Centre

Background

Patients are contacted by the Call Centre Staff a maximum of one week in advance of the appointment date. The outcome of the call is recorded on their call sheets, which are then returned to us the following day. The call sheets contain useful information, e.g. Patient requires transport, Patient has had scan done privately, or unable to contact etc. It is then possible to follow up transport requirements, add an extra in-patient etc. therefore utilising the time slots more effectively. This study covers the period from 15 october 2001 to 8 January 2002. A total of 860 patients were scanned during this time, inc. In-patient, Out-patient and GP referrals.

Results

There was a short period of time when the Call Centre was not utilised, this had quite an impact on the DNA rates, i.e. there were more DNA's during this time than all the rest put together.

	IP 434	OP 343	GP 79	A&E 4
Total No.	24	25	3	
DNA	5.5%	7.2%	3.8%	
Deceased	2	2		

If we remove the data from when the Call Centre was not utilised it is as follows:

	IP N/A	OP 298	GP 65	A&E N/A
Total No.	N/A	9	2	
DNA		3%	3%	

The 3% of the study sample who did not attend were all patients whom the Call Centre was unable to contact. In-patients included patients cancelled at short noticed, i.e. on the day. The breakdown of these patients is as follows:

Discharged	8
Cancelled /Not needed	12
Patient Refused to attend	1

DNA ?	1
Deceased	2

Our original DNA rate prior to utilising the Call Centre was almost 10%.

Success and complication rates for reduction of intussusception by air/barium enema
Dr N .Jefferson & Dr D Grier

Background
The Royal College of Radiologists (RCR) quotes a success rate of 60-95% for pneumatic/hydrostatic reduction of intussusception and a perforation rate of 0-5.9%. The largest survey of UK practice (GOS) suggested an achievable success rate of >70%. Attempted reduction carries significant potential for harm to an already sick patient thus the potential benefit to the patient (i.e. avoiding surgery) should outweigh the risk of the procedure. Net benefit can more easily be assumed in a centre with good success rate and low complication rates.
Objectives
To examine whether success and complication rates for reduction of intussusception in this Trust compare favourably with rates achieved in other centres and also with those recommended by the Royal College of Radiologists.
Methodology
Data was gathered retrospectively for the period May 1993 – June 2001. Consecutive patients undergoing attempted fluoroscopic reduction of an intussusception were considered for inclusion in the study. All patients had an abdominal ultrasound scan confirming the diagnosis and then a subsequent attempted fluoroscopic enema reduction. A database had been kept with the outcomes of all the procedures carried out. This was supplemented with information contained in the formal reports for these procedures and where necessary from the notes. In each case it was noted whether barium or air had been used to reduce the interssusception and individual success rates noted for each method. The number of perforations in the sample population was noted.
Results

Total number included = 190	
Successful	138 – 72.6%
Unsuccessful	52 – 27.4%
Perforation	1 – 0.5%

Individual success rates for air & barium				
	N	Successful	Unsuccessful	%
Barium	16	9	7	56%
Air	173	128	45	74%
Ba/Air	1	Air	Ba	

Outcomes fall within the recommended limits.

Conclusions
In our centre all intussusception reductions are carried out either by, or in the presence of, a Consultant Paediatric Radiologist. This practice has produced favourable results and, given the potential for harm inherent in this procedure, should continue. Success rates should be re-audited in a few years to ensure good practice continues. The practice at this centre is that recommended by the Royal College of Radiologists. There are also guidelines regarding the maximum number of attempts, which are considered safe and the maximum pressure which should be applied.

3.15 SPECIALTY SERVICES

SUMMARY

Number of 2000/2001 roll-overs **<<**:	7
Number of new pre-audits ▲:	3
Number of new first audits ■:	8
Number of new re-audits ●:	1
No. of new ongoing monitoring projects **>>**:	1
Total number of audits:	**20**
Number of completed audits:	13
Number of current (i.e. uncompleted) audits **>**:	2
No. of ongoing monitoring projects c/forward:	5

(Originally 11 but 4 abandoned during 2001/02)

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	3/10	(30%)	11/23	(48%)	**5/13**	**(38%)**
Audits arising from a critical incident:	-	-	0/23	(0%)	**3/13**	**(23%)**
Audits prompted by a patient complaint:	-	-	0/23	(0%)	**0/13**	**(0%)**
Audits directly involving patients/carers (but not including surveys):	2/10	(20%)	2/23	(9%)	**1/13**	**(8%)**
Audits incorporating a patient / carer survey:			2/23	(9%)	**1/13**	**(8%)**
Audits involving representatives from primary care:	2/10	(20%)	0/23	(0%)	**0/13**	**(0%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/23	(0%)	**0/13**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**5/13**	**(38%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**4/13**	**(31%)**
Audits linked to directorate business plan:	-	-	-	-	**8/13**	**(61%)**
Number of proposal forms completed:	-	-	14/23	(61%)	**8/13**	**(61%)**
Number of proposal forms completed BEFORE audit started:	-	-	9/23	(39%)	**7/13**	**(54%)**
Audits measuring against or resulting in development of standards or guidelines:	7/10	(70%)	19/23	(83%)	**10/13**	**(77%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	2/7	(29%)	12/23	(52%)	**9/13**	**(69%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	10/14	(71%)	**10/13**	**(77%)**
Audits where an action plan was produced:	-	-	1/14	(7%)	**7/13**	**(54%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	5/13	(38%)	**1/6**	**(17%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	5/7	(71%)	5/18	(28%)	**5/18**	**(28%)**
Audits leading to better ways of working for staff:	-	-	7/18	(39%)	**4/18**	**(22%)**
Audits leading to measurable benefits for patients:	-	-	6/18*	(33%)*	**5/18***	**(28%)***
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	1/4	(25%)	1/5*	(20%)*	**2/7***	**(29%)***
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: MEMO							
3.15.1	Are Medical Devices being utilised & deployed effectively in the Trust?	M Gemmell		✓			
3.15.2	Effectiveness of Servicing Methods for Infusion Devices Used by UBHT	Mr Peter Smithson	✓		✓		✓
3.15.3	How frequent are anaesthetic incidents and breakdowns in UBHT?	Mr Peter Smithson		✓			✓
Specialty: Pharmacy							
3.15.5	A preliminary audit to establish the effectiveness of the clinical incident reporting procedures at UBHT	Lisa John, Pre-Registration Pharmacist		✓			
3.15.6	An audit of Warfarin anti-coagulation in BRI inpatients	Renata Poole, Pre-Registration Pharmacist		✓			

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.15.7	An audit to determine to what extent injectable preparations are being re-used in the BRI? ***(Trustwide)***	Steve Brown, Director of Pharmacy		✓			
3.15.8	Are guidelines designed to prevent vinca alkaloids accidently being administered intrathecally being adhered to?	Clare Conroy		✓			
3.15.9	Are instructions on POD medicines labels inadequate on PODs brought in by elderly patients?	Mary Nicholls, Snr Technician		✓			
3.15.10	Are storage facilities of medicines compliant with the Duthie report? - Audit of medicinal product storage within UBHT	Sarah Hepburn		✓			
3.15.11	A Re-Audit of the Medical Directorate Antibiotic Policy	Debbie Campbell	✓		✓		
3.15.12	Dispensing Error Level of Occurrence	Sarah Hepburn, QA Pharmacist	✓			✓	
3.15.13	Do PODs/Ward Staff conduct an effective PODs Scheme?	Mary Nicholls				✓	
3.15.14	Has the implementation of a bleep sticker containing the anti-biotic policy been successful	Debbie Campbell			✓		
3.15.15	Is Infliximab Being Appropriately Prescribed in Patients with Crohn's Disease?	Clare Conroy	✓	✓			
3.15.16	Is the prescribing of Clopidogrel at the BRI evidence-based?	Rachel O'Donnell, Clinical Pharmacist		✓			
3.15.17	Outpatient Dispensing Workload	Jayne Thornton, Operations Manager	✓			✓	
3.15.18	UBHT Homecare Services (Hightech Homecare Services) - Audit of Service to Avon Health Authority	Liz McCullagh, Pharmacy Manager	✓			✓	
3.15.19	What Contribution does a 'PODS' Scheme Make to Improving Medicines Management?	Mary Nicholls	✓			✓	
3.15.20	What effect does a ward-based technician have on trolley rationalisation?	Mary Nicholls		✓			
3.15.21	What percentage of elderly patients re-admitted are taking medicines different from that documented on their first discharge?	Rachel Beckett, Care of the Elderly Pharmacist		✓			

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Are we prescribing metformin appropriately?	**(Medicine)**	3.9.2
• Are oral nutritional supplements being used appropriately?	**(Medicine)**	3.9.14
• Radiation Doses of GI Studies - How do we compare against NRPB standards?	**(Radiology)**	3.14.5
• Radiation Doses for CT Scans (Head, Chest, Abdo, Pelvis). How do we Compare with Other Centres and Against NRPB Standards?	**(Radiology)**	3.14.10

EXEMPLAR AUDITS 2001 / 2002

A Preliminary Audit to Establish the Effectiveness of Clinical Incident Reporting in Pharmacy
Lisa John

Background
In response to the publication of *An Organisation with a memory* and *Building A Safer NHS for Patients*, UBHT has embraced clinical governance by the introduction of a Clinical Incident Reporting Procedure, whereby any incident or 'near miss' is reported and subsequently investigated. The aim of this is to reduce clinical risks, increase the quality of patient care and reduce or avoid the costs associated with these clinical risks. In order to do this, clinical incident reporting and investigation needs to be efficient and effective. A retrospective audit was therefore conducted with the aim of analysing the timeliness of Clinical Incident reporting, the appropriateness of the allocated gradings, and the quality of recording of clinical incidents originating in the Pharmacy department.

Objectives
To retrospectively examine clinical incident forms and investigate:

- Time scales between incident occurrence and recording, reporting, logging onto the Trust Clinical Incident Database (Ulysses), and investigation
- Appropriateness of the allocated gradings
- Adequacy of outcome recording.

Standards
This was a preliminary audit undertaken with the intention that the audit should enable the development of standards for re-audit in the future.

Methodology
Pharmacy Department Clinical Incident Reporting Forms, detailing incidents which occurred over a four month period (12/04/01 – 10/08/01), were examined by a pre-registration pharmacy student.

Findings

- The majority of Clinical Incident Reporting Forms were completed promptly
- However, most did not subsequently reach Quality Assurance (QA) within a time period that would allow a rapid instigation of investigation
- Incidents were not consistently logged onto the Trust Database in a timely manner
- There was also much room for improvement of incident investigation time
- Analysis of the Clinical Incident forms showed that investigation outcomes were not recorded in sufficient detail, and there was no record of reviews being undertaken of the effectiveness of any system or procedure changes

Recommendations

- Recommendations made for a departmental Clinical Incident Reporting Procedure to be drawn up
- It should be endeavoured to log incidents onto the Trust Database within five days of entry of the form into QA, and to investigate them within thirty days
- Detailed records of issues raised, action taken and outcome of investigations should be made, and regular feedback should be sent to the respective departments
- Re-investigation should take place after an appropriate time period into the effectiveness of any system or procedure change.

Is Clopidogrel Prescribing at the BRI Evidence-based?
Rachel O'Donnell *Pharmacy Department, BRI*

Background
Clopidogrel is an antiplatelet agent that inhibits the binding of adenosine diphosphate (ADP) to its platelet receptor and so prevents activation of the GPIIb/IIIa complex. It was decided to audit the prescribing of clopidogrel as there were no BRI guidelines on this, and use had escalated since its launch in 1998. As clopidogrel is significantly more expensive than aspirin, this has important cost implications.

Project aim
To assess whether the prescribing of clopidogrel at the BRI evidence based.

Objectives

- Identify why clopidogrel prescribed
- Assess whether loading dose prescribed
- Calculate proportion of patients receiving aspirin and clopidogrel.
- Compare number of patients started on clopidogrel at the BRI with those admitted on it
- Identify reason for prescribing clopidogrel instead of aspirin where applicable

Methodology
Consultants and relevant ward staff were informed prior to data collection. Over a 17 day period, BRI inpatients receiving clopidogrel were identified by clinical pharmacists, pharmacy technicians, and computer records. Data was recorded with respect to:

- indication of therapy
- co-administration with aspirin
- loading dose
- aspirin hypersensitivity.

Patients were followed up for 4 weeks. Audit end points included stopping clopidogrel therapy, discharge or death. Prescribing was considered to be evidence based from the following criteria:

- Clopidogrel only prescribed in place of aspirin in hypersensitive patients
- Aspirin and clopidogrel only prescribed concomitantly in ACS or post stent insertion.
- For ACS and stent insertion, a loading dose of 300mg clopidogrel is administered.

Findings
Although prescribing of clopidogrel in the BRI is predominantly evidence-based, approximately £481 per month is wasted on inappropriate prescribing. This figure may be an underestimation as it assumes that all prescribing initiated in primary care is evidence-based.

Recommendations
- After presentation of these results to the Medicines Advisory Group (MAG), guidelines for the prescribing of clopidogrel in ACS, ischaemic heart disease, peripheral vascular disease, coronary artery stent insertion and stroke are being developed.
- Re-audit will be necessary 6 months after the implementation of the guidelines in a multidisciplinary setting - it may be helpful to collect data over a longer time period, to record the use of heparin/LMWH and glycoprotein IIb/IIIa inhibitors in ACS patients and to involve cardiology staff in defining the type of MI if necessary. It may also be useful to record any incidences of bleeding.

3.16 SURGERY

SUMMARY

Number of 2000/2001 roll-overs **<<**:	8
Number of new pre-audits ▲:	2
Number of new first audits ■:	16
Number of new re-audits ●:	2
No. of new ongoing monitoring projects **>>**:	0
Total number of audits:	**28**
Number of completed audits:	16
Number of current (i.e. uncompleted) audits **>**:	9
No. of ongoing monitoring projects c/forward:	1
Number whose current status is unknown:	2

(Originally 36 but 1 was abandoned during 2001/02, 26 have been removed as their status has been unknown for more than a year and the projects pre-date the current audit facilitator and convenor. 1 project is now listed under Oncology)

	1999/2000		2000/2001		2001/2002	
Multidisciplinary audits:	9/19	(47%)	13/36	(36%)	**10/20**	**(50%)**
Audits arising from a critical incident:	-	-	0/36	(0%)	**1/20**	**(5%)**
Audits prompted by a patient complaint:	-	-	0/36	(0%)	**0/20**	**(0%)**
Audits directly involving patients/carers (but not including surveys):	3/19	(16%)	1/36	(3%)	**2/20**	**(10%)**
Audits incorporating a patient / carer survey:			3/36	(8%)	**1/20**	**(5%)**
Audits involving representatives from primary care:	2/19	(11%)	1/36	(3%)	**1/20**	**(5%)**
Audits involving representatives from Avon Ambulance Service:	-	-	0/36	(0%)	**0/20**	**(0%)**
Audits linked to NSF, NICE guidance, or similar:	-	-	-	-	**1/20**	**(5%)**
Audits which formed part of directorate audit forward plan for 2001/02:	-	-	-	-	**0/20**	**(0%)**
Audits linked to directorate business plan:	-	-	-	-	**1/20**	**(5%)**
Number of proposal forms completed:	-	-	14/36	(39%)	**12/20**	**(60%)**
Number of proposal forms completed BEFORE audit started:	-	-	13/36	(36%)	**10/20**	**(50%)**
Audits measuring against or resulting in development of standards or guidelines:	12/19	(63%)	14/36	(39%)	**18/20**	**(90%)**
Audit projects incorporating evidence about best practice (i.e. thorough review of relevant literature undertaken):	9/12	(75%)	15/36	(42%)	**10/20**	**(50%)**
(figures above do not include 2000/2001 roll-overs)						
Audits where a formal report was filed at the end of the project:	-	-	5/12	(42%)	**8/16**	**(50%)**
Audits where an action plan was produced:	-	-	6/12	(50%)	**8/16**	**(50%)**
If action plan NOT produced, number where audit confirmed current good practice:	**-**	**-**	3/6	(50%)	**2/8**	**(25%)**
(figures above include completed audits only)						
Audits resulting in changes in practice:	4/12	(33%)	6/15	(40%)	**7/17**	**(41%)**
Audits leading to better ways of working for staff:	-	-	4/15	(27%)	**3/17**	**(18%)**
Audits leading to measurable benefits for patients:	-	-	7/15*	(47%)*	**0/17***	**(0%)**
(figures above include completed audits and ongoing monitoring projects only (including those audits within this group which confirmed current good practice)). * Other projects in this section – may be too early to confirm measurable benefits						
Audits leading to confirmed measurable benefits for patients:	2/4	(50%)	2/5*	(40%)*	**0/2***	**(0%)**
(figure above includes completed re-audits and continuous monitoring projects only) **** Other projects in this section – may be too early to confirm measurable benefits***						

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
Specialty: General Surgery							
3.16.1	Avon, Somerset and Wiltshire Cancer Standards for Breast Cancer ***(with Oncology)***	Zen Rayter	✓			✓	
3.16.2	Catheter Management	Wendy Hurn	✓	✓			
3.16.3	Cholesterol 2000	Dave Bolton		✓			
3.16.4	Endoscope decontamination	Claire Hodges	✓	✓			
3.16.5	Hepato-Biliary Management	Sr Stephanie Farnell	✓	✓			✓
3.16.6	Is the Breast ICP being followed?	Zen Rayter, Andrew Sheppard		✓			

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.16.7	Quality of patient casenotes	Jane Blazeby		✓			
Specialty: Hand Unit							
3.16.8	Is there a need for a referral to a counsellor in certain cases?	Fiona Brassington		✓			✓
3.16.9	Re audit of time use in hand clinic	Sr Dawn Hollis			✓		✓
3.16.10	Use of Time in Hand Unit	Dawn Hollis	✓	✓			
Specialty: Lower GI							
3.16.11	Anastomotic leak rates in lower GI patients	Paul Durdey (Cons), Anne Pullyblank (SpR)		✓			✓
Specialty: Medical Day Unit							
3.16.12	Endoscope Decontamination audit	Claire Hodges		✓			
Specialty: Outpatient Department							
3.16.13	Effectiveness of outpatient call-centre ***(with Medicine)***	Sr Sharon Nicholson		✓			
Specialty: Pre-Op Clinic 10							
3.16.14	Is the locally agreed procedure for hypertensive patients at pre-op being adhered to? ***(with Critical Care)***	Sr Caroline Spours		✓			
Specialty: Trauma & Orthopaedics							
3.16.15	#NOF: Non-clinical factors delaying discharge for #NOF patients ***(with Medicine)***	Andrew Newton (AGM), Celia Wogan (physio)		✓			✓
3.16.16	#NOF: Patient satisfaction	Andrew Newton (AGM)		✓			
3.16.17	Are we Providing a Friendly and Efficient Reception by a Well-Informed Multi-Disciplinary Team Throughout the Trauma, Orthopaedic and Plaster Department?	Sharon Nicholson	✓	✓			?
3.16.18	Is the Trust Following the Royal College of Physicians Guidelines for the Treatment of Patients with Fractured Neck of Femur (#NOF) ***(with Medicine)***	Angie Nicholson	✓	✓			✓
3.16.19	National #NOF Collaborative: Are patients operated on within 24hrs by senior clinical team	Sarah Spinks, Gerry Baber		✓			
3.16.20	Pain scoring in A&E and with physios ***(with Critical Care)***	Mark Jackson (Cons), Celia Wogan (physio)		✓			✓
3.16.21	Plaster Boot Audit. (Diabetic Sandwich Cast Against Use of 'Aircast' Walking Boot)	Steve McDonagh	✓	✓			
3.16.22	Pressure relieving care for #NOF patients in A&E ***(with Critical Care)***	C/N Raul Chandrasekura		✓			✓
3.16.23	Utilisation of open appointment system	Sr Nicky Burns		✓			
Specialty: Upper GI							
3.16.24	Use of 'bleed beds' on ward 11	Sr Karen Holiwell		✓			✓
Specialty: Urology							
3.16.25	Management of uteric stones	Raj Persad (Cons), Martin Moody (SpR)		✓			
3.16.26	TCC Bladder Management	Raj Persad/Alan Thomas		✓			
3.16.27	Treatment for renal colic patients at UBHT	Paul Foster		✓			?
Specialty: Vascular							
3.16.28	Handwash Audit	Sr Liz May			✓		

Please also see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• MRSA in surgical patients post upper GI surgery over 12 months	**(Critical Care)**	3.6.22
• Re-admission after Day Surgery	**(Critical Care)**	3.6.29
• Would Pre-Op Assessment Clinic benefit from a lead anaesthetist, anaesthetic input/interest?	**(Critical Care)**	3.6.38
• Blood and Blood Product Usage by Wards and Theatres - Monitored Throughout Year and Reported Back to Individual Clinical Teams	**(Pathology)**	3.13.22

EXEMPLAR AUDITS 2001 / 2002

Has the Outpatient Courtesy Call Centre Reduced DNA Rates?
Sharon Nicholson *Sister Outpatient Department*

Background

The outpatient improvement plan for the UBHT 2000-2001 was designed to introduce sustainable improvements in performance by considering service design from the patient perspective, improving patient access to outpatient services and improving patient waiting time. The aim of the Call Centre was to provide a service to meet the needs of the patient and general practices by facilitating out of hours access during the partial booking process. The aim was also to provide a courtesy call service reminding patients about their appointments, helping to further reduce the Did Not Attend rate, (DNA),

Project aim

To ensure efficient use of booking systems and use of appointments.

Standards

Patients in all clinics (those involved in Call Centre trial) to be called in the week before their appointment date. Target 100%, Exceptions: Clinic cancelled, an extra clinic booked one week prior to clinic date.

Results

- Of the 5303 calls made in this audit, 3209 (60%) confirmed patients' intention to attend the following week
- 2094 patients did not confirm appointments, of whom:
    - 744 were unobtainable
    - 1188 didn't answer although telephone rang
    - 120 cancelled as a direct result of courtesy call

Conclusions

The audit clearly highlighted that operational systems need to have patient information updated at all patient entry points and that it is essential GP practices also take responsibility for this with 'New Patient' referrals. The evidence produced by this audit suggests that the Call Centre has led to a reduced DNA rate: definite prevention of 78 DNAs over the 4 month period, i.e. 78 appointment slots that we were able to utilise for other patients, thus reducing waiting times overall. Partial booking has highlighted the need for GPs to be accountable for patients' information to ensure that they inform us of any changes in patient details.

Recommendations

A number of recommendations were made as a result of this audit and include: highlighting the need for accurate information to staff (presentation of audit) and patients (poster in OPD); discussions with IM&T about adding a section on PAS to include mobile numbers.

Are the locally agreed procedures followed when a patient is hypertensive at the POA clinic?
Caroline Spours *(Sister Clinic 10 - Pre-op)*

Background

The main reason for postponed operations following POA is hypertension which is not controlled by admission date.

Project aim

To ensure that operations are not postponed unnecessarily due to hypertension and that patients with hypertension receive appropriate treatment before admission.

Objectives

- To ascertain the number of patients who require further investigation/ treatment for hypertension pre-operatively
- To determine whether locally agreed standards are being adhered to

Standards

- All patients found to be hypertensive at POA will be referred to their GP
- All patients referred will have appropriate treatment to control BP before admission date
- All referrals will be followed up by telephone call
- All patients whose BP is not controlled before admission date will be referred to Anaesthetist

Methodology

A three month sample of patients with hypertension attending the pre-op clinic was selected (32 patients).

Results

- 98% referred to GP for treatment
- 100% of patients referred to GP had their appointment followed up
- 50% of patients had BP controlled before their admission
- 50% of cancelled operations were due to hypertension were patients seen at POA at short notice

Recommendations

- Patients to be seen at POA in advance of TCI
- Guidelines from Anaesthetic Dept for Hypertension in POA
- Re-audit

3.17 TRUSTWIDE

			Type of Audit				
Ref No.	**Project Title**	**Audit Lead/s**	**<<**	**▲ or ■**	**●**	**>>**	**>**
3.17.1	Audit of Red ID Bands	Bridget Wright, Trust Clinical Risk Manager		✓			✓
3.17.2	Audit of Loose Filing in Front Pocket of Patient Notes	Bridget Wright, Trust Clinical Risk Manager		✓			✓

Please see following audits listed under other directorates:

Title	Lead Directorate	Code No.
• Are Tracheostomy Patients being Safely Managed?	**(Medicine)**	3.9.34
• Annual Infection Control Audit - A ward-based surveillance programme of Infection Control procedures in action - phased throughout year	**(Pathology)**	3.13.1
• What is the Trust's Hospital Bacteraemia Rate – continuous monitoring	**(Pathology)**	3.13.5
• What is the Trust's Hospital Bacteraemia Rate, Used as a National Clinical Indicator?	**(Pathology)**	3.13.6
• Annual Audit of Adult Autopsies Carried Out at BRI Mortuary	**(Pathology)**	3.13.7
• Continuous Participation in Clinico-Pathological Meetings as a means of constantly auditing practice and investigations relating to individual patients through multi-professional peer review	**(Pathology)**	3.13.10
• Audit of newly published UBHT Transfusion Policy	**(Pathology)**	3.13.21
• Are the pathology reports getting to the notes?	**(Pathology)**	3.13.26
• Laboratory turnaround times for inpatient Electrolytes	**(Pathology)**	3.13.32
• An audit to determine to what extent injectable preparations are being re-used in the BRI?	**(Specialty Services)**	3.15.7

Appendix A

Summary of benefits, actions or changes achieved over the last year (2001/2002) as a result of Clinical Audit

Children's Services

- The oncology central lines theatre list improved in terms of communication, a check list for theatre was produced and a middle grade was designated responsible for co-ordinating the patients on this list
- A new protocol was produced after an audit of hydronephrosis – this was a multidisciplinary audit which included a radiologist, a surgeon and a nephrologist from North Bristol Trust

Community Services

- Identified an area of cost saving (Incontinence Pants audit)
- Raised awareness of UKCC guidelines (Documentation audit)
- New wound assessment tool devised, leading to more accurate assessments of wounds (Wound Assessment Re-audit)
- Male Catheterisation audit led to a re-design of the training programme, enabling more nurses to attend for follow-up training
- The Foreign Travel audit led to improved communication between GPs / Treatment Room staff, as to the considerations to be taken into account prior to patients receiving immunisations
- The Treatment Room audit at Montpelier Health Centre led to reduced waiting times for patients in both the 'open' and 'booked' appointment sessions

Critical Care (incorporating A&E and Theatres)

- Development of a multi-disciplinary working group for venous thromboembolism, in order to produce evidence based guidelines for venous thromboembolism prophylaxis
- Accurate completion of anaesthetic patient records re-iterated at the meeting with the Medical Defence Union
- All anaesthetic machines now have standard settings agreed for common parameters (blood pressure, heart rate, gas analysis) for standardisation
- Improved multi-disciplinary communication between BDH and Anaesthesia for day case inappropriate admissions by giving advanced warning of cases, the introduction of advance bookings, and anaesthetic attendance at dental clinics
- Confirmed good practice against the Royal College of Anaesthetist standards set for anaesthetist response time for epidural requests
- Numerous changes in practice (such as Emergency Doctors and not duty physicians to thrombolyse patients, collaboration with Cardiology, development of the Critical Care Pathway) has enabled the Emergency Department to achieve the National Service Framework targets set for patients presenting to the Emergency Department with acute myocardial infarction
- A liaison group with Pharmacy has been set up re: drug administration errors audit
- An alerting hazards system is displayed on all anaesthetic rotas
- Review of existing drug checking policies
- Defibrillators standardised Trust-wide
- All anaesthetic consultants must attend in-house BLS retraining
- Identified patient group requirements for cot sides on recovery beds
- To distribute equally the number of Anaesthetic trainees on theatre lists
- Agreement on using the Association of Anaesthetists checklist for anaesthetic machine checks
- Documentation of machine checks must carried out by the person who carries out anaesthetic machine checks
- Introduction of a feedback mechanism for follow-up of anaesthetic machine problems
- The recommendation of a proper replacement and standardisation policy of anaesthetic equipment Trust-wide
- A confirmation system introduced in Accident and Emergency physiotherapy services, in order to improve patient attendance rates

Dental Services

Oral Medicine

- *Are dental students adhering to policies regarding cleaning dental units between patients?*
  - Written guidance on infection control procedures on display on every unit on Primary Care and increased emphasis at Induction. Benefit is greater compliance with infection control policies
- *Are haematological investigations requested by BDH being accurately recorded in patients' notes and are results available by the next patient appointment?*
  - Increased timing of review appointments following haematological investigations from 2 to 3 weeks. Also improved logging system being used. Benefit is less re-attendance of patients and more efficient service with less time being wasted

Hospital wide

- *Are needles being re-sheathed according to the Trust's sharps policy?*
  - Laminated illustrations of re-sheathing needles using single scoop technique displayed on each unit on the clinics. Benefit is less risk of injury from needles
- *Are medical histories and allergies recorded? (re-audit)*
  - Results of audit distributed to clinicians and medical records staff. Working party to discuss alternatives. Benefit would be better recording and less risk to patient of inappropriate management

Oral Surgery

- *Is the standard of record keeping in Oral Surgery adequate? (re-audit)*
  - Results of audit circulated to all clinicians in Oral Surgery. Benefit would be improved record keeping

Orthodontics

- *Do patients know how to care for their teeth and appliances during orthodontic treatment?*
  - British Orthodontic Society information leaflets issued to patients and issue date noted in the patients' notes. Benefit would be increased awareness by patients

Restorative

- *What is the retention rate of porcelain veneers placed at BDH?*
  - Different techniques implemented. Benefit is improved retention

Homeopathic Medicine

- Introduction of a package of care for patients (Menopause/IBS Audit)
- A Hospital Discharge Policy (Menopause/IBS Audit)
- Reduction in the DNA Rate(DNA Audit)
- Baseline data on pharmacy workload (Pharmacy Audit)

Medicine

- *Cystic Fibrosis*
  - Funding for an audit database
  - Funding for a data collection clerk
- *Home Enteral Feeding*
  - Manufacturer to sponsor production of feeds
  - Grant received for further work on scheme
- *Antibiotic Policy*
  - Raised trust-wide awareness of policy, huge increase in compliance, saving of time and money
- *Hyperglycaemia in Acute MI*
  - Contributed to revision of ICP for MI patients (incorporating evidence-based practice)
- *Hep C Clinic*
  - Employment of Clinical Nurse Specialist
  - Created links with CAAD and Drug Rehab Service
- *Tracheostomy*
  - Identified training needs, set up successful programme of away days – policy compliance appears to have improved (re-audit in progress)

Obs, Gynae & ENT

- Laparoscopic sterilisation re-audit confirmed benefit of using pre-operative proforma (improvement in percentage of patients having appropriate counselling). Separate proforma produced for antenatal clinic for sterilisations planned at time of Caesarean Section. This audit selected as poster for 2002 Evidence in Practice conference
- Re-audit showed increased screening and uptake of contraception in drug-using mothers following the change of this service to become consultant-led in August 2000. Midwifes trained in siting implant contraceptives.
    - Protocol for management of Obstetric Cholestasis in Day Assessment Unit produced (finally implemented this financial year but counted in last year's Annual Report as implemented change, as in process of developing and implementing)
    - PAS audit confirmed meeting of standards apart from those of waiting times – this is thought to require extra funding to improve and a business case has been prepared. Patient leaflets have been amended. This audit selected for presentation at UBHT Clinical Audit Oscars 2002
    - Monthly ENT-Pathology meeting set up, to include discussion of FNA results
- Placenta Praevia – current practice acceptable (90 – 96% meeting of obstetric standards)
- National Sentinel Caesarean section audit – St Michael's performance better than national average
- Reason for ENT Surgery - 86% of aims of surgery were achieved at follow-up
- Surgical Management of Ectopic Pregnancy - % of patients having laparoscopic surgical treatment increased and maintained to around 55% (laparoscopy rather than laparotomy recommended by RCOG)
- ECV success rates comparable to literature rates (ECV recommended by RCOG for breech deliveries at term – if successful, woman is unlikely to have Caesarean Section)
- Return of handheld maternity notes – re-audit showed improved rate of return so more notes available for follow-up appointments and to refer to in future pregnancies
- Fetal Loss After Invasive Prenatal Diagnosis - Fetal loss rate within 2 wks of amnio, CVS or FBS comparable to literature rates of 1-2%
- ENT operation notes audit - Raised awareness of standards of documentation for operation forms. List of allowable abbreviations being prepared for use across St Michael's & North Bristol ENT depts
- Parotidectomies in Bristol and Weston - UBHT had by far the highest % of pre-op FNA investigations in region

Oncology

- *Audit of Laxative Prescribing*
    - Changes to the Guideline regarding the need for thorough initial bowel assessment
    - Prescribing of softening and stimulant laxatives for patients on opioids
    - Access to PRN laxatives for patients on other constipating medications
    - Increased emphasis on this area in Palliative Care teaching sessions
- *Audit of Total Parenteral Nutrition*
    - Introduction of new protocol
    - More standardisation of practice
    - More input from Dietitian
- *Audit of Insertion and Management of Groshong Lines*
    - Change of clinical practice - sutures are now left in permanently to prevent migration or falling out

Ophthalmology

- Improvement in listing procedure for trabeculectomy operations in order to reduce waiting times for surgery
- Improvement in record keeping for anti-metabolite use in trabeculectomy operations
- A/E guidelines for referrals from GPs improved
- Improved feedback to GPs on referrals to A/E
- Update to orthoptist discharge standards

- Improved service for patients as all patients to be offered auto-refraction by orthoptists which will reduce the number of clinic visits and offers a non-invasive examination.
- The development of a squint proforma for the notes to improve note-keeping and to facilitate future outcomes analysis for the success of squint operations
- All amblyopic children to be seen and treated by a paediatric ophthalmic consultant
- Updated standards for the management of amblyopia
- Action taken to improve compliance with patching
- A review of methods of visual acuity testing being undertaken to assess the most effective method of visual acuity testing in the younger age group
- Improved documentation of fluorescein (photograph of the eye) requests
- New, more efficient scheme devised by medical staff for reviewing films after fluorescein photographs
- Improved procedure for requests for fluorescein from outside hospitals or non-ophthalmologists
- New and Updated guidelines for doctors on when to request a fluorescein
- Clearer requests from doctors when patients should return for follow up after fluorescein to improve booking procedure
- An additional fluorescein session per week has been authorised due to the increased volume of requests for fluoresceins
- Improved record keeping for retinal detachment operations using a proforma in the notes
- Monthly VR meetings including review of all failed retinal detachments
- Consideration of primary vitrectomy for all patients presenting with proliferative vitreoretinopathy
- Standard developed for time between diagnosis of endophthalmitis and treatment
- Update of drug protocol for endophthalmitis
- Introduction of a Post Operative Endophthalmitis Care Pathway /Pack for the Notes

Pathology

Chemical Pathology

- *Treatment of Hyperlipidaemia in the UBHT Diabetes Clinic - Are we meeting NICE Standards*
  - Improved documentation of risk factors
  - Treatment brought into line with current NICE guidance
- *USTAR Research Support Unit Service – Is it providing a good service*
  - Improved communication within unit
  - Appropriate costings developed for setting up projects
- *Do we comply with CPA standards when telephoning results to wards?*
  - 90% of results to be phoned are telephoned with 60 minutes of the result becoming available
- *C1-Esterase Inhibitor Studies*
  - Laboratory assessment of C1-Esterase deficiency has been reviewed across local Trusts
  - All abnormal results are now reviewed by a consultant immunolgist
- *Laboratory Information System & Reference Ranges*
  - Led to improved accuracy of reporting within the laboratory
- *Systematic Review of Minor and Major errors Identified by the Laboratory*
  - Results in improved quality of service
- *How useful are urine bile pigments assay in the investigation of liver disease?*
  - We have discontinued providing the urine bile pigments assay as we have found they are of no value
- *Reporting Paediatric Test Results*
  - Identified a number of reporting errors in our reporting system that have been corrected

Haematology

- *Blood and Blood Product Usage by Wards and Theatres - Monitored Throughout Year and Reported Back to Individual Clinical Teams*
  - Minimising unnecessary blood product usage reduces overall transfusion associated risk
  - Optimising blood product usage reduces waste as blood products have limited 'shelf-life'

Histopathology

- *Correlation between Breast Core Biopsy Tissue and subsequent Breast Resection Tissue*
  - Provision of more detailed information pertaining to malignant breast tumour prior to treatment
- *Standards of reporting of lung resection tissue*
  - To highlight which data ought to be reported in lung resection reports
- *Standards of reporting of head & neck resection tissue*

  - Demonstrated high standard of comliance with national reporting standards
- *Continuous Participation in Clinico-Pathological Meetings as a means of constantly auditing practice and investigations relating to individual patients through multi-professional peer review*
  - Provide opportunity to make more comprehensive diagnoses to clinicians
  - Ensure correct interpretation of pathological assessments, particularly for cancer reporting

Infection Control
- *Annual Infection Control Audit - A ward-based surveillance programme of Infection Control procedures in action - phased throughout year*
  - Highlights the need for good infection control practice
- *Are staff following hand washing standards in 4 of UBHT's medical wards*
  - Spirigel installed between bed spaces on some of the medical wards, to improve hand washing compliance

Radiology

- Ability to prioritise Ultrasound scans for Testes more effectively.
  - Following a review of 1000 cases, the most common clinical finding is a painless lump indistinguishable from the testes, these patients should be since as a priority. These constitute 1% of referrals, which present with a tumour.
- Proved use of Call Centre in reducing DNA rate for Echo-cardiograms.
  - Now to utilise the Centre for other examination areas.
- Demonstrated the benefits to patient, GP and Trust of having an Open Access Ultrasound service.

Specialty Services

Pharmacy
- *Is prescribing of Infliximab within the BRI appropriate?*
  - The results demonstrate that local outcome to patients reflect those published
  - Dissemination of a prescribing policy will ensure the appropriate selection of patients, and repeat dosing only in those patients who respond to Infliximab.
- *Inappropriate Secondary Care Prescribing of PPIs has a Significant Influence on Primary Care: Fact or fiction*
  - The impact of inappropriate secondary care prescribing on primary care expenditure is not significant.
  - Better communication within the Trust regarding PPI choice is required. DIG should be encouraged to look into the information transferred on discharge to primary care relating to newly prescribed PPIs.
- *Is the prescribing of Clopidogrel at the BRI evidence-based?*
  - Guidelines for the prescribing of clopidogrel in ACS, ischaemic heart disease, peripheral vascular disease, coronary artery stent insertion and stroke are being approved by MAG. Re-audit will be necessary 6 months after the implementation of the guidelines.
- *A preliminary audit to establish the effectiveness of the UBHT clinical reporting procedure.*
  - To draw up a departmental memo to be drawn up alerting staff to the rationale and importance of recording and reporting clinical incidents. Date record to be attached to each clinical incident form. Written feedback to be sent to the manager of each pharmacy within UBHT, for dissemination among staff.
- *UBHT Homecare services – an audit of the service to Avon HA.*
  - Service satisfaction questionnaire enabled patients to express their views on the therapy and support provided by UBHT.
- *What contribution does a PODs scheme make to improving medicines mismanagement?*
  - Improved drug history taking
  - More accurate prescribing, and hence a reduction in drug administration errors or omission of treatment
- *Are instructions on POD medicine labels adequate for elderly patients?*
  - Verification of dosage instructions on poorly labelled/unlabelled OTC medicines in the elderly ensures accurate dosing in this vulnerable patient population.
- *Has the provision of a discharge pharmacist service to medical wards been successful?*
  - Good awareness and satisfaction with the service offered by the DP.
  - DP to become more involved in counselling patient on discharge
  - DP to liase with primary care.
- *Impact of a Ward Pharmacist on Medication errors in PICU*

- Introduction of a new prescribing system on a PICU, resulted in a 46% prescribing error reduction from the drug charts previously used in this unit.
- Future developments for consideration include the development of patient specific labels, and accompanying syringe labels.

- *Are current storage facilities for medicinal products within UBHT satisfactory, as outlined by the Duthie Report?*
  - Better storage of refrigerated items required.
  - The need for individual min/max thermometers for each fridge; importance of reading and recording fridge temperatures on a regular basis, and avoiding storage of medicinal products in public access areas, has been highlighted by the audit and will be conveyed to ward/clinic managers

Medical Physics, MEMO & Medical Illustration

- *How frequent are anaesthetic incidents and breakdowns in UBHT?*

- Paper presented at IPEM meeting at Belfast. Presented to joint Anaesthetics & MEMO meeting. Action points developed.
  Action Plans / Main discussion points:
- The importance of reporting equipment that has been involved in a critical incident – equipment should be quarantined immediately after a C.I., and send off for investigation.
- Ensure that the Directorate has a copy of the inventory of equipment, in order for MEMO to track the equipment, and therefore service and maintain it.
- Procedure for alerting MEMO of new equipment:
  - Give MEMO at least two weeks notice (if possible) before the arrival of any new equipment
  - Give MEMO the equipment information paperwork/manual to copy
  - Ask MEMO to provide a MEMO number for the equipment
  - Ask MEMO to carry out functional checks with/without the assistance of the manufacturer (if required)
  - Ask MEMO to provide service and maintenance during and after the machine warranty period (where required)
- For all loan equipment, fill out a delivery note stating the date received and the time period machine loaned for – however, it must be taken into account that the machine will not be covered by UBHT after the end of the stated loan period
- Ensure that all machine faults are reported to MEMO, and also entered into the machine's logbook (to allow linking between faults, equipment and outcome)
- BS Kite marking shows that a machine has undergone vigorous testing - be wary about using machines without an BS Kite mark, or machines that just have the CE mark

Surgery

- From the 2001/2 forward plan we have successfully audited the effectiveness of the Breast ICP. This audit has been presented in many places, most notably the European Breast Conference 2002 in Barcelona. Recommendations are currently being formulated into an action plan to include outpatient appointments at the end of the ICP (there are often complications from surgery that are picked up at this stage).
- Endoscope decontamination audit: This audit has led to a tracking system for all the endoscopes on the medical day unit. This came out of an incident and has been hailed as excellent practice. This will be re-audited very soon.
- Referral processes for patients with high blood pressure from pre-op clinic: This audit, alongside an audit on DVT prophylaxis (Critical care led) has led to the formation of a Trust-wide group looking at referrals to the anaesthetists from the POA Clinic and DVT across the trust.
- Utilisation of open appointment system – a protocol is currently being written for distributing open appointments to patients to ensure that there is consistency in the department.

Appendix B

U.B.H.T.
CLINICAL AUDIT STRATEGY

1. Definition

Clinical audit is a clinically-led initiative which seeks to improve the quality and outcome of patient care through structured peer review whereby clinicians examine their practices and results against agreed standards and modify their practice where indicated.

2. Context

The 1997 White Paper *The New NHS* and 1998's *A First Class Service* reinforced the position of clinical audit as an essential element of professional practice in the Health Service. Clinical audit is therefore at the heart of UBHT's arrangements for **Clinical Governance** and integral to its **Clinical Effectiveness** strategy.

This document updates and revises previous clinical audit strategy documents written in 1996 and 1999.

3. Aims

The overarching strategic aims of clinical audit activity at UBHT are:

1. **To deliver demonstrable improvements in patient care**
2. **To encourage evidence-based practice**
3. **To contribute to the process of continuing clinical education**

As part of a commitment to realising these strategic aims, the UBHT Clinical Audit Committee & the Trust Clinical Audit team have developed and agreed the following specific objectives and associated measures of performance:

April 2001

A 'Balanced Scorecard' for the UBHT Clinical Audit function

Stakeholders

What results do we need to deliver to our stakeholders: patients, the Trust Board, local Primary Care Groups, the local Health Authority?

Objective	Measure
Undertake a required volume of activity	Number of audit projects undertaken
Promote evidence-based practice	Proportion of projects based on a thorough review of published evidence of clinical effectiveness
Ensure local agreement on best practice	Proportion of projects incorporating clinical standards or guidelines
Operate within budget	Annual balance sheet
Fulfil national audit requirements (NICE, NSFs, etc)	Evidence that requirements have been identified and appropriate audits put in place
Ensure all projects are formally documented	Proportion of projects with report submitted
Improve ways of working for staff	Proportion of projects leading to improved ways of working
Improve things for patients	Proportion of projects leading to identifiable benefits for patients
Involve patients and carers in the audit process	Proportion of projects incorporating patient survey Proportion of projects incorporating other methods of user involvement
Ensure participation of all professional groups in the audit process as appropriate	Proportion of projects with multi-professional input
Provide contracted service to Primary Care Groups/Trusts	Number of interface projects

Customer

What do we need to deliver to the clinicians and managers who use our service?

Objective	Measure
Ensure that customers receive useful, timely advice in a courteous manner	Annual customer survey (independent)*

* implementation is dependent on being able to identify an appropriate independent agency to undertake the survey

Internal Processes

What processes do we need to be good at?

Objective	Measure
Ensure audit is planned	Proportion of directorates with annual forward programmes for audit
Ensure local audit activity is co-ordinated	Proportion of directorates with a multi-professional (if appropriate) steering group to oversee progress of audit programme
Ensure projects are thoroughly planned	Proportion of projects with a proposal form Proportion of projects with a form signed-

Objective	Measure
	off before the commencement of the project
Link audit activity to clinical risk	Proportion of directorates linking audit to previously identified high risk activity (e.g. through risk profiling)
Audit high volume activity	Proportion of directorates linking audit to previously identified high volume activity (e.g. through quality impact analysis)
Link audit to patient complaints process	Number of projects based on patient complaints
Ensure audits lead to change and re-audit as appropriate	Proportion of projects with clearly defined action plan or confirmation that no action is indicated (note: recommendations alone are not sufficient)

Staff & Learning

To achieve our vision, how must clinicians and audit staff learn and work together?

Objective	Measure
Ensure that clinical staff are participating in and learning from the audit process	Attendance records at directorate audit presentations (analysed by profession)
Link personal goals of audit staff to strategic objectives of CA function	Proportion of audit staff with personal objectives linked to CA strategy/scorecard
Link training and development of audit staff to personal goals (see above)	Proportion of audit staff with evidence of appropriate CPD (continuing professional development) activities
Retain audit staff	Staff turnover
To realise the benefits of the audit process	Proportion of projects that are re-audits
To provide training for clinicians in clinical audit skills	Number of clinicians attending clinical audit training (analysed by profession)

In seeking to deliver the service described above, the Clinical Audit Committee is committed to:

1. Supporting audit staff in working towards appropriate and relevant qualifications in healthcare quality

2. Delivering high quality local training to clinicians and managers

3. Sharing information about Trust audit resources and where appropriate, the results of UBHT audit, via the World Wide Web

4. Participating in local development in Information Technology to ensure that future requirements of Clinical Audit are as far as possible anticipated and incorporated.

5. Close collaboration with other strands of UBHT's work on Clinical Governance and Clinical Effectiveness, e.g. R&D, Clinical Risk, Consumer Involvement, Complaints.

Chris Swonnell
UBHT Clinical Audit Co-ordinator
Approved by Clinical Audit Committee, 12/04/01

Appendix C

UBHT Clinical Audit Staff (as at 24/06/02)

DIRECTORATE	AUDIT SUPPORT	GRADE (A&C)	ROLE / W.T.E.	AUDIT CONVENOR
Cardiac Services	David Finch	6	Audit (0.5) & data manager	Mr Alan Bryan Dr Andreas Baumbach
Children's Services	Chrissie Gardner	6	Audit (1.0)	Dr Sue King and Dr Bev Guard
Critical Care	Michelle Croucher	6	Audit (1.0)	Dr Diana Terry
Dental Services	Carolyn Southwell	5	Audit (0.5) & Information	Mr Nigel Harradine
Homeopathy	Sue Barron	6	Audit (0.4)	Dr Elizabeth Thompson
Medicine	Kate Wathen	5	Audit (1.0)	Mrs Pat Howard & Dr Nabil Jarad
Obs, Gynae & ENT	Eleanor Ferris	6	Audit (0.75)	Dr Bryony Strachan
Oncology	Mairead Dent	5	Audit (1.0)	Dr Andrew Davies
Ophthalmology	Louise Hale	5	Audit (0.4)	Ms Clare Bailey
Pathology	James Osborne	MLSO grade	Audit (0.5) and CE training	Dr Ed Sheffield
Radiology	Sally King	Radiography	Radiography & Audit	Dr Charles Wakeley
Specialty Services	Clare Conroy – *Pharmacy* Tracey Saunders – *other*	Pharmacist 4	Pharmacy & Audit Audit (0.2)	Mr Phil Quirk
Surgery	Sarah Spinks	6	Audit (1.0)	Miss Jane Blazeby

Central Office	Chris Swonnell Emma Parsons Carl Thomas	SMP SMP 3	Audit (1.0) Audit (1.0) Audit (0.8)

Membership of the Clinical Audit Committee

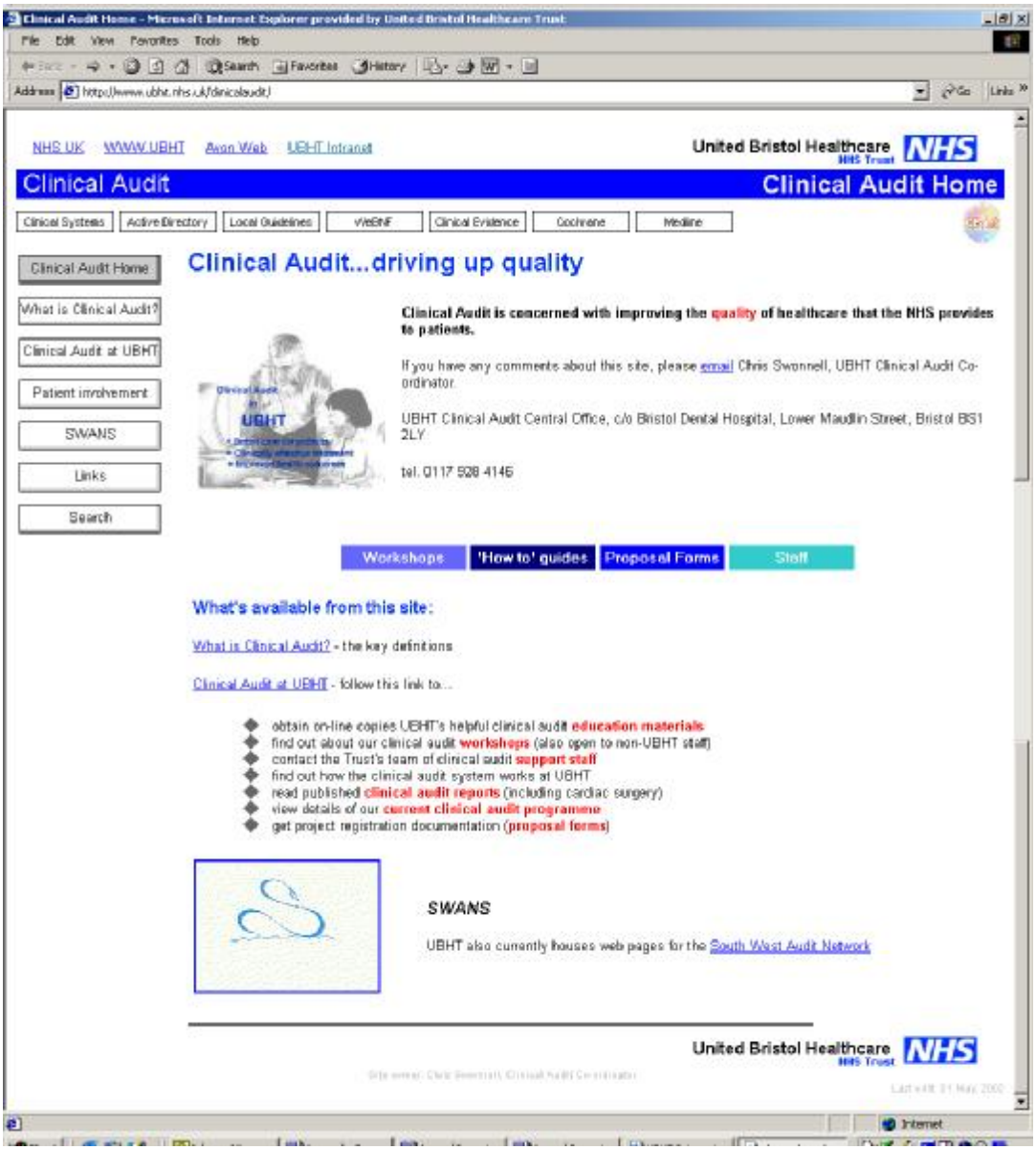
Graham Bayly (Chairman)
Chris Swonnell (Clinical Audit Co-ordinator)
Audit Convenors - see above
Emma Parsons (Clinical Audit Project Manager)
Carol Rainbow (Nursing Representative)
Nicholas Bishop (Trust Board Representative)
Bette Baldwin (Chair of Consumer Committee)
Ms Kath Kemp (Temporary Secretary to CAC)

Appendix D

Copy of 'Update' Newsletter

Appendix E

Home page of UBHT Clinical Audit web site
http://www.ubht.nhs.uk/clinicalaudit



Appendix F

Strategy for developing multi-professional clinical audit

Issue	Action
Multi-professional audit cannot begin until N&AHP staff are fully involved and represented in UBHT's clinical audit structures	• **Directorate audit steering groups to ensure representation from both Nursing and AHPs** (directorates must also therefore ensure that they have a steering group!) • In addition, because N&AHP services do not always follow the directorate structure**, both nursing and the allied health professions are to be represented on the Trust Clinical Audit Committee.** The remit of these individuals will be to represent the views of N&AHP staff to the CAC at a corporate level, and to provide progress reports on the development of clinical audit within the N&AHPs and the involvement of N&AHP staff in multi-professional projects • **Heads of profession will be asked to liaise with the Trust's Clinical Audit Project Manager to ensure that the progress of all N&AHP projects is monitored** through the four monthly clinical audit returns
Greater emphasis must be placed on multi-professional audit: i.e. doctors, nurses and allied health professionals working collaboratively on audit projects.	• **Directorate steering groups to identify areas which naturally facilitate multi-professional audit,** e.g. where services are structured as multi-professional teams • Steering groups (or convenors - whoever has the responsibility for signing-off projects) to **routinely apply the question, "should this project have multi-professional input?" whenever audit proposals are considered** • CAFs to ensure that multi-professional audit is routinely **promoted through staff training and education.** Similarly this message is to be reinforced at Staff Development workshops (Barrow). • Steering groups to **disseminate good examples of multi-professional audit through local audit/governance newsletters.** CAFs to bring such examples to the attention of the Clinical Audit Co-ordinator for possible inclusion in the UBHT Clinical Governance Newsletter.

Specific points about audit support for N&AHP staff:

N&AHP staff have historically perceived clinical audit as being medically dominated: that somehow non-medical audit is 'second class'. This in turn creates fears amongst N&AHP staff about presenting audit results in multi-professional meetings.	In addition to ensuring representation on directorate steering groups, • Audit Convenors to give clear lead to N&AHP staff that their input is important and valued • Directorate clinical audit facilitators (CAFs) to actively encourage clinical audit activity amongst N&AHP staff within their directorate
Clinical audit resources are devolved to directorates. N&AHP services are not always directorate-based. Many N&AHP audits will be service-wide or trust-wide	• A support structure and reporting system for N&AHP audit has been set out by the Clinical Audit Central Office in consultation with N&AHP leads

Approved by Clinical Audit Committee
May 2002

Appendix G

UBHT support structures for uni- and multi-professional clinical audit

Appendix H

Uni-professional projects undertaken by Allied Health Professions during 2001/2 which were not formally registered and facilitated through the UBHT clinical audit team

Speech & Language Therapy

- Use of Blom Singer valves for patients with Laryngectomy
- Use and outcome of Videofluroscopy for patients with Dysphagia

Physiotherapy

- Fracture clinic - appropriateness of referral / UTA rates / DNA rates
- A&E – (as per fracture clinic audit)
- Length of stay for #NOFs for the hip collaborative
- Length of stay for T&O patients receiving weekend Physiotherapy
- Audit of throughput of musculoskeletal patients in the A&E dept re. times of attendance etc - is there a role for an Extended Scope Physiotherapy Practitioner?
- Cystic Fibrosis patients - identifying the effect of exercise on respiratory saturation levels
- Rheumatology patients' satisfaction with Osteoporosis group and 1st appt DNA's over 4 week period

Physiotherapy and Occupational Therapy

- Audit of day to day workload activity (May and June) being undertaken by therapists in the Hand Unit

Appendix I

'Incomplete' or 'Status Unknown' projects from 2000/2001 annual report which do not appear in the 2001/2002 report

The following projects are not listed in this year's report. Some were abandoned (e.g. because the project lead left the organisation); in other cases, the outcome of the audit was unknown.

Directorate	Project Title	2000/2001 Report Code
Cardiothoracic Services	Use of Monte Carlo Forecasting on Cardiothoracic Surgery	3.5.18
Children's Services	Telephoning Requests for Results to Radiology Department	3.6.29
Community	Are Vulnerable Adults Being Assessed Effectively by Health Visitors?	3.7.2
	Has Integration of Health Visitor Older People / District Nurse Teams Lead to Increased Work for District Nurses? Is Referral Information to the Team Appropriate?	3.7.13
Critical Care	Major Trauma Outcome Study (MTOS)	3.8.1
	Tonsillectomy Audit	3.8.16
	What Can we Learn from Critical Incident Reporting?	3.8.18
	Can we Predict Likelihood of Death for Patients Over the Age of 65 who have Perforated Large Bowel at Laparotomy?	3.8.25
Dental Services	Are Avulsed Permanent Teeth Being Reimplanted Adequately?	3.9.6
	What Proportion of Patients in General Dental Practice have evidence of toothwear requiring clinical treatment?	3.9.27
Medicine	Are All Patients With Skin Cancer Seen by a Specialist Physician?	3.11.11
	Are we Prescribing Metformin According to the Guidelines?	3.11.2
	Are Nursing Care Standards Being Maintained?	3.11.36
	In-patient Nutritional Policy	3.11.42
Oncology	Are High Grade Glioma Patients Seen by Oncologists being Appropriately Assessed for Prognosis and Treatment?	3.14.1
Ophthalmology	What are the Patients Perceptions of the Benefits or Drawbacks of Trabeculectomy Surgery Performed for Primary Glaucomas?	3.15.10
Pathology	Urological Audit of Bladder Tumours	3.16.24
	Requests for Laboratory Investigations Post Needlestick Injury	3.16.31
Specialty Services	Does the Radiotherapy Physics Unit Spend Too Much Time Calibrating Radiotherapy Treatment Machines?	3.18.24
	Audit of Efficacy of Antibiotics in Neutropenic Fever in Oncology Patients (Granisetron audit)	3.18.9
	The Accuracy of the Writing of the Initial Drug Chart Pre BMT	3.18.21
Surgery *	Are the Post Operative Complications of Patients Being Accurately Recorded on the Hospital MDI System?	3.19.5
	Trial without catheter	3.19.48
	Testicular Implants Management	3.19.47
	Testicular Cancer Management	3.19.46
	Is the Trust Following the Guidelines for the Management of Acute Upper GI Bleeds?	3.19.45
	Clinical Management of Bladder Tumours	3.19.43
	Are Patients Going Home Adequately Nourished After Major Oesophago-Gastric Surgery?	3.19.41
	Are the Breast Care Nurses Meeting the ASWCS Standards?	3.19.4
	Spine Fracture at Neck	3.19.39
	Quality of Occupational Therapy Service for Patients With Fractured Neck of Femur (#NOF)	3.19.37
	Is Internal X-Raying of Greenstick Distal Radial Fractures Useful?	3.19.34
	How Are Long Bone Fractures Being Treated and What Are the Outcomes?	3.19.33
	Knee Arthroscopy Exercise Group	3.19.30
	Hydrotherapy Patient Forms	3.19.29
	Waiting Times for Fractured Neck of Femur Patients From A&E to the Ward	3.19.25
	Use of Anti-Embolic Stockings	3.19.24
	Therapeutic Adequacy of Wide Local Excision	3.19.23
	The Management of Patients with Biliary Gallstone Disease	3.19.22

Directorate	Project Title	2000/2001 Report Code
	The Incidence of Hypocalcaemia After Total Thyroidectomy	3.19.21
	Resuscitation Orders	3.19.18
	Is There a Correlation Between the Extent of Axillary Dissection Being Described Operatively Versus Pathological Number of Lymph Nodes Being Accrued?	3.19.15
	Is the Theatre Swab and Instrument Policy Being Adhered to and is it Relevant?	3.19.14
	Hip Replacement Management	3.19.13
	Epidural and Heparin Management	3.19.12
	23 Hour Admissions	3.19.1
	Are we Providing Patients with an Acceptable Standard of Oral Hygiene?	3.19.6
	Day Case Admissions (Are Patient Admissions to Wards Following Day Surgery Avoidable?) *(abandoned)*	3.19.11

* There are a large number of unfinished audits in surgery. These are listed but the present convenor (appointed Jan 2002) and Facilitator (appointed May 2001) are unable to trace any documentation about them.

Several new mechanisms have been established to prevent this happening again:

- Projects are not recorded with the audit office until the proposal is completed and signed
- A permanent member of staff is recorded as the audit lead
- There is regular contact between the audit facilitator and the audit leads.

It is also hoped that more support will become available to improve the quality of audit.

Appendix J

New audit projects abandoned during 2001/2002

Directorate	Specialty	Project Title	Reason Abandoned
Children's Services	A&E	Time to analgesia for trauma patients	The SPR working on this project left the hospital
	Community	Investigations for Special Needs	The SHO who undertook this audit has left the hospital
	Dietetics	Feed Tolerance Audit	This project was a staff survey looking at optimum feed tolerance
	General Paediatrics	Growth Charts	The SHO doing this project left the hospital
Community		Foot Clinic	Orthopaedic support withdrawn, so project was abandoned.
		Orientation Standard	Abandoned due to staff shortages
Critical Care	Anaesthesia	Is the Greig Smith 2 morning emergency session used efficiently?	Abandoned due to the closure of Greig Smith theatres
	Anaesthesia	What is the complication rate after pneumonectomies?	Staff involved have left
Dental Services	Restorative	Are staff aware of the guidelines involving sodium hypochlorite?	Clinical guidelines not agreed on
Medicine	General Medicine	Effective Clerking Proforma	
	Dietetics	Vitamin Supplementation in Adult CF patients	abandoned before started
	General Medicine	Ward 16 Orientation Programme	never started
Obs, Gynae & ENT		Are cord gases being taken appropriately?	Audit lead took maternity leave then got job at another trust. Audit may be restarted when another lead identified and as part of NICE EFM guideline implementation (in 2002/3 forward plan).
		Thromboprophylaxis in instrumental and spontaneous deliveries	Based on recommendations of Confidential Enquiry into maternal deaths. Audit lead left hospital without completing project. May be restarted if new audit lead found.
Surgery	Medical Day Unit	Are patients receiving information leaflets prior to procedure	Project abandoned before it started due to other pressures
	None	Are patients being cancelled due to lack of information/casenotes at screening?	Project abandoned due to project lead leaving the Trust
	None	Effective treatment of T1 Rectal Cancer	Unable to contact project lead
	None	Effectiveness of Rapid Access Clinic (coloproctology)	Project lead abandoned this project due to other clinical priorities
	None	Nursing assessment forms for flexible systoscopy	Project abandoned due to poor communication between project lead and their manager
	Vascular	Acute Vascular Admissions	Project lead changed house and project was abandoned
	Vascular	Vascular rota audit	Audit abandoned due to lack of communication between audit leads in both Trusts involved

Appendix K

Clinical Audit Forward Programme 2002-2003

Children's Services

- Accessing blood (Dr L Goldsworthy) – (A&E)
- Postoperative pain and nausea (PONV) (Dr G Lauder) – (Anaesthesia)
- Deliberate Self Harm (Andrew Fogarty) – Reaudit (Child And Adolescent Mental Health (CAMH))
- Referral and management of Attention Deficit Hyperactivity Disorder (ADHD) (Dr Collette Lewin, Dr Maria Bredow) – Interface Audit (CAMHs / Community)
- Post-operative outcome of BT shunts in PICU (Deirdre Murray) – Reaudit (Cardiology / PICU)
- Diatetic care for children with diabetes (Lisa Cooke, Chief Dietitian) – Reaudit (Dietetics)
- Asthma inhalers for the under 5's (Dr S Langton Hewer) – (General Paediatrics / Respiratology)
- Asthma management (Dr S Langton Hewer) - (General Paediatrics / Respiratology)
- Management of Empyema (Dr S Langton Hewer) – Reaudit (General Paediatrics / Respiratology / Physiotherapy)
- Diabetic services in Bristol and WSM (Dr Liz Crowne, Dr Julian Shields) - (General Paediatrics / Endocrinology)
- Management of Meningitis (Dr P Sharples) - (General Paediatrics / Neurology)
- Lumbar punctures performed in Children's Services (Dr P Sharples, Dr A Cundy, Dr H Kershaw) - (General Paediatrics / Neuro / Oncology)
- Guidelines for treatment of Patent Ductus Arteriosis (PDA) (Dr G Russell) – (Neonatology (NICU))
- Discharge planning (Dr G Russell) – Reaudit (Nursing (NICU))
- Tissuing cannulars (Sharon Winterbottom (ANNP)) – (Nursing (NICU))
- Audit of adequacy of renal replacement (Dr J Tizzard) – Regional (Nephrology)
- Guidelines for management of central lines in oncology (Dr A Foot, Mr R Spicer) – (Oncology / Surgery)
- Sleep systems in orthopaedic surgery (Caroline Tope) – (Physiotherapy)
- Hydronephrosis (Dr S King) – reaudit (Radiology)
- Radiation Doses in CT Scans (Dr S Prabu) – reaudit (Radiology)
- Fundoplication audit (Miss E Cusick) – (General Surgery)
- Safety and practicality of drug prescribing (Miss L Huskisson) – (General Surgery)
- Post urethral valves audit (Mr J D Frank) – National (Urology)

Critical Care (incorporating A&E and Theatres)

Anaesthesia

- Anaesthetic follow-up post-operatively after day surgery procedures
- Cancellation and delays in performing ERPCs in theatre 1 during the afternoon and out of hours (St Michael's)
- NCEPOD: An audit of the out of hours emergency operating because of a lack of an emergency theatre list (St Michael's)
- Re-audit of day theatre list changes
- Re-audit of response times for epidural requests (St Michael's)
- Re-audit of alarm settings on anaesthetic machines in UBHT

ITU/HDU

- A documentation audit of Care Plans (re-audit)
- A documentation audit of planning, implementation and evaluation of care of bladder and bowel assessments
- An audit of drug prescription and administration
- An audit of personal and oral hygiene checks
- An audit of product usage in the management of diarrhoea
- An audit to assess the requirement of nutritional support from a Trust dietician
- An audit to assess the requirement of support from a Trust speech and language therapist
- Audit of the incidence of pressure ulcers and the prevention products used
- Catering audit
- Excess out of hours workload

Emergency Department

- An audit of the patient X-ray process
- An audit of the investigations process
- An audit of the usage of the Observation Unit
- TARN
- Re-audit of the sedation procedure
- An audit of safety procedures and monitoring involved in Biers Blocks
- An audit of DVT management

Dental Services

- What is the quality of intra-oral radiography taken and processed on ADH2? (Susan Hooper) – (Restorative)
- Are we restoring primary teeth appropriately? (Deborah Franklin) – (Paediatric Dentistry)
- Do orthodontic clinical records comply with the British Orthodontic Society's minimum data set? (Helen Griffiths) – reaudit (Orthodontics)
- Are patient medical history forms being completed by clinicians? (Chandi Joshi) – (Personal Dental Service)
- Why do Day Case surgery patients fail to attend? (Chris Bell) – (Oral Surgery)
- Are TMJ referrals to Oral Medicine / Oral Surgery clinics appropriate? (Jane Luker) – (Oral Medicine)
- Are appropriate referrals being made by GDPs to the Primary Care Unit? (Russell Duncan) – (Oral Medicine)

Homeopathic Medicine

- Information in medical notes – re-audit
- Pharmacy audit – a re-audit including pharmacy
- Package of care and discharge policy – audit to assess the new policy
- Quality of Letters to GPs – a re-audit
- Iscador Information to GPs - to follow on from the audit of patient views
- A Pre –Audit of the Cancer Clinics

Medicine

Care of the Elderly

- Syncope/Collapse (Dr MacMahon/SHO) - New
- Stroke Management (Dr Murphy/SHO) - Re-audit
- Intermediate Care (Vicky Eavis/Colin Domaille) - New
- Falls (Ruth Cowell) - Re-audit

Dermatology

- Rapid Access Skin Cancer Clinic (Dr Narayan) - Ongoing
- Mycosis Fungoides (Dr Connolly) - New
- Review of Liver Biopsy Arrangements (Dr Kirkup) – New

Endocrinology

- Forthcoming NSF for Diabetes – New
- Diabetes: AR Documentation & Referrals (Judith Wood) – New (district level)
- Diabetes: Pregnancy, Limb Amputation (Dr Corrall) – (Regional)
- Diabetes: Annual Review - DNA rates (Helen Silvers) - Re-audit

General Medicine

- Nutritional Standards (Pat Howard/Nathan Lewis) – new project
- Equipment Library (Mandy Gemmell) - Re-audit
- Emergency Admissions Protocols (Dr Catterall) – Ongoing
- Discharge Summary Audit (DAT Team) – Ongoing
- DVT - Re-audit
- Nursing Home Beds (Discharge Liaison Co-ordnr) – New
- Paracetamol Overdose (Emma Kay Reid/Clive Roberts) - Re-audit
- Audit of PDU - Waiting Times - New

- Compliance with antibiotic policies (Debbie Campbell?) - Re-audit
- Tracheosteomy audit (Sue Jones) - Re-audit (Trustwide)

Respiratory
- Pulmonary Embolism (Dr Jarad/SHO) - New
- Asthma - pre ICP (Dr Catterall/Dr Jarad) - New
- ERA system (Mrs Suzanne Gilson-Jones)
- Lung Cancer Collaborative - Ongoing (Regional)
- Cystic Fibrosis (Dr Jarad) - Ongoing (Regional)

Obstetrics, Gynaecology & ENT

Obstetrics and Gynaecology
- Infection Control in Theatres (delayed from last year's forward programme as awaiting arrival of OMR)
- Antenatal HIV testing (from 2001/2 Directorate Business Plan)
- Audits of implementation of EFM & IOL NICE guidelines
- Major Obstetric Haemorrhage Protocol
- Gynaecological Cancer Service (part of Directorate Business Plan 2002/3)
- Third Degree Tear – reaudit
- Perinatal Mortality – continuing audit
- Regional Gynaecological Cancer – continuing audit

NICE/NSF topics:
- Technology appraisals
- Routine anti-D prophylaxis for rhesus negative women in pregnancy – expected April 2002
- Guidelines
- Clinical guidelines on Pre-operative investigations – expected October 2002 (TBC)
- Clinical guidelines on Caesarean section – expected Spring 2003
- Clinical guidelines on Infertility – TBC
- Service guidance for Supportive and palliative care - Part A September 02 TBC
- Routine Antenatal Care – TBC (part of Children's Services NSF)

Also see Critical Care & Anaesthesia Forward Plan for Obstetric Anaesthetic audits

ENT
- Fistula rate in major head and neck procedures
- Outcome of septal and turbinate surgery
- Evaluation of Tinnitus clinic (Audiology)
- Nurse-Led Aural Treatment Room
- Post-tonsillectomy bleeds - reaudit
- Fine Needle Aspiration (with Pathology) - reaudit
- Documentation – continuing audit
- Mortality & Morbidity – continuing audit

NICE/NSF topics:
- Technology appraisals:
- review of new advances in hearing aid technology for hearing disability - TBC
- Guidelines:
- Clinical guidelines on Pre-operative investigations – expected October 2002 (TBC)
- Service guidance for Supportive and palliative care - Part A September 02 TBC

Also see Children's Service for Paediatric ENT audits

Oncology

The forward plan for Oncology has not yet been agreed.

Ophthalmology
- Biometry – Multi-Professional Re–Audit

- Endophthalmitis – Re-Audit
- Cataract Care-Pathway Audit
- Diabetic Retinopathy – Follow Up Appointment Delays
- Diabetic Retinopathy – New Referrals Waiting Times comparison with NICE guidance
- Suitability of Patients for Fast Track Cataract Lists

Pathology

Chemical Pathology
- CHD risk in the diabetic clinic
- Bile pigments
- Paediatric reporting/reference ranges
- Toxicology Requesting
- Clinical approval/turnaround times
- Compliance with troponin protocol
- White cell enzyme repertoire
- Diagnostic tumour markers
- Multi-centre coeliac audit

Infection Control - (draft forward programme)
- Compliance with hand washing policy
- Tracking of instruments through decontamination process to patient
- Management and use of bench top steam sterilisers
- Management of isolated patient

Radiology

- How long does it take for the Paediatric DMSA scan reports to be available. – Re-audit.
- Audit of the DNA rates following the use of the Call Centre. – Re-audit.
- Continued programme of dose monitoring and review of DRLs (Dose Reference Levels) in comparison to national standards.
- Missed A&E fractures and delay in radiological reporting.
- Delays in arrival of patients from the Children's Hospital for CT Scans. Why is this happening?

Specialty Services

Pharmacy
Adhering to UBHT Policies:
- Is the Heparin Policy being adhered to?
- Have bleep stickers improved compliance with the Medical Directorate Antibiotic Policy? (reaudit)
- Has the prescribing of Clopidogrel improved? (re-audit)
- Are storage facilities for medicinal products compliant with the Duthie Report? (re-audit)
- Are prescribing standards being adhered to? (Medicines code 9,12,14)
- Does clinical pharmacy practice conform to regional standards?

NICE Guidance
- Are COX-II inhibitors appropriately prescribed?
- Are the appropriate patients being prescribed Ramipril?
- Are Pioglitazone & Rosiglitazone being used appropriately in Type II Diabetes?
- Is use of TNF-alpha inhibitors appropriate in rheumatology patients?

Discharge Support:
- What proportion of discharges are DPs involved in?

Financial Planning:
- Are future medicine cost pressures addressed in all Directorates?

Investors in People:
- Are staff personal development needs being met post-IDPR?

Customer Care:
- Are outpatient waiting times acceptable?
- Are customer complaints being fed back and acted on by UBHT dispensary staff?

Forming Relationships with Primary Care:
- What are the benefits of One Stop Dispensing?
- What are the benefits of implementing a self-administration scheme?

Prescribing:

- Can patient care be improved by implementing a new prescribing system?

Managing Risk:

- Adverse Drug Reactions
- Do Pharmacists effectively anticipate medication errors?
- To what extent are single use pharmaceuticals being re-used?
- What is the risk associated with medicines administration in theatres and a medical ward?
- What are the delays between medicine prescribing and administration?
- Are critical incidents reported, and fed back to staff in a timely manner? (re-audit)

MEMO

- Effectiveness of Servicing methods for Infusion Devices Used by UBHT (P.Smithson)
- How frequent are anaesthetic incidents and breakdowns in UBHT? (P.Smithson)
- Is there an unmet demand for equipment is the BRI? (equipment library) (M.Gemmell)
- Audit of the implementation of Hazard & Safety warning notices (M.Gemmell)

Medical Physics

- Use of Screening techniques in Theatres (M. Smail)

Surgery

- CVP (NCEPOD)
- Emergency GI Cancer Admissions
- Continence (NSF for Older People)
- Vascular Rota (with Frenchay and Southmead) (Regional)
- Nutrition
- Fractured Neck of Femur (ongoing National Collaborative work)
- 'Essence of Care' – Practice Development Group will look at a number of nursing practice areas across medicine and surgery including: Nebuliser Therapy, Tracheostomy care, Catheter care, Mouth care, Pressure sores (ongoing)