Clinical Audit Annual Report

University Hospitals of Morecambe Bay NHS Foundation Trust
2013 -14

Heather Pratt, Head of Clinical Audit & Effectiveness
Eilidh Stewart, Clinical Audit Educator (Deputy)

Approved by:
Quality Committee, 16th June 2014

Clinical audit tool to promote quality for better health services
Contents

Introduction 4

Background 4

Clinical audit project statistics for 2013/14 6

Participation in National Enquiries and Clinical Audits 6

Local recommendations made following participation in National clinical audits 8

At a Glance
Clinical Governance & Quality Committee 9
Clinical Audit Strategy 2011-2014 10

Healthcare Quality Improvement Partnership (HQIP)
History 10
Highlighting the audit process: the HQIP 'Teabreak' 11

Departmental Progression
Processes 11
Department name change 11
Staff commitment 12
Retirement of staff member 12

Maternity Services & Obstetrics: Moving Forward 13

Northwest Regional Network 13

Internal Audit Review 14

Departmental structure existing 2013/14 14

Departmental structure proposed 2014/15 15

Clinical audit leads on our trust sites 16

Clinical Audit Meetings & Mortality
Specialty clinical audit meetings 16
Mortality 16
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education and Training</td>
<td>17</td>
</tr>
<tr>
<td>Induction</td>
<td>17</td>
</tr>
<tr>
<td>One-to-one training</td>
<td>17</td>
</tr>
<tr>
<td>Specialty clinical audit leads</td>
<td>17</td>
</tr>
<tr>
<td>Learning lessons</td>
<td>18</td>
</tr>
<tr>
<td>Links with other organisations</td>
<td>18</td>
</tr>
<tr>
<td>National Institute of Health and Clinical Excellence (NICE)</td>
<td>18</td>
</tr>
<tr>
<td>Commissioning for Quality and Innovation (CQUIN)</td>
<td>19</td>
</tr>
<tr>
<td>Advancing Quality (AQ) - AQuA</td>
<td>19</td>
</tr>
<tr>
<td>Recognition of work undertaken</td>
<td>19</td>
</tr>
<tr>
<td>Our stroke services are among the best in the North West</td>
<td>19</td>
</tr>
<tr>
<td>Award winning advancing quality team</td>
<td>20</td>
</tr>
<tr>
<td>Adult community acquired pneumonia – Junior doctors awards</td>
<td>21</td>
</tr>
<tr>
<td>Summary</td>
<td>21</td>
</tr>
<tr>
<td>Objectives 2014/15</td>
<td>22</td>
</tr>
<tr>
<td>Recommendations Made from Audits Completed 2013-14</td>
<td>23</td>
</tr>
<tr>
<td>Activity from forward audit programme 2014/15</td>
<td>41</td>
</tr>
</tbody>
</table>
**Introduction**

All NHS organisations are required to have in place a comprehensive programme of quality improvement activities that includes healthcare professionals participating in regular clinical audit. Clinical audit is the governance vehicle in relation to clinical practice, and is integral to the core business of the Trust.

The Clinical Audit Department is committed to raising the profile of clinical audit within the Trust and is dedicated in its aim that the annual forward audit programme should be a valuable resource in the Trust’s aim to continually improve patient outcomes and experience. The 2013-14 Trust-wide forward audit programme was implemented at the start of the business year following approval by the Clinical Governance and Quality Committee.

The formulation of this system should act as a driver for the divisions and specialties to assess and determine their priorities, predict and plan their audit activity, where possible, to flow throughout the forthcoming year. The Clinical Audit Department recognises that it is not possible to anticipate all necessary activity and, therefore, pro-actively accommodates additional and / or repeat projects that are required due to unfolding Trust priorities throughout the year.

This report summarises the activity undertaken from the Clinical Audit Annual Programme for 2013-14, as collated by the Clinical Audit Department in collaboration with the clinical audit specialty leads and divisions and including all relevant national audit projects in which the Trust is eligible to participate.

**Background**

Clinical audit forms an integral part of the clinical governance framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic measurement against explicit criteria and the implementation of any necessary change(s): *New Principles of Best Practice in Clinical Audit, HQIP, 2nd Edition, 2011.*

A Clinical Audit Strategy was developed and implemented in 2011 (currently under review) in order to support robust and effective clinical audit activity. This framework supported by the Clinical Audit Policy provides guidance to the clinical teams whilst providing assurance to the Board on the governance aspects of clinical audit.
The Clinical Audit Department maintains a Trust-wide clinical audit database of all clinical audit activity. It also maintains electronic records of completed projects, which include:

- Proposal forms outlining defined criteria and measurable standards.
- Presentations / reports.
- Summary sheets of data collated and analysed.
- Completed action plans outlining opportunities for improvement(s).

In addition, audit presentations are available in PDF format on the Trust intranet along with a range of audit tools, materials and templates for reporting findings, formalising actions and facilitating meetings.

A Clinical Audit Facilitator is assigned to each specialty to support Clinical Audit Leads with the delivery of clinical audit progress reports for priority level audits 1-4 for which definitions are provided below. The plan is divided into 4 distinct elements and is in line with national guidance from HQIP. Clinical audits are prioritised into one of four levels, as per the table below (Table 1), with Level 1 being given the highest priority.

**Key:**

<table>
<thead>
<tr>
<th><em>Level</em></th>
<th><strong>Audit Type</strong></th>
</tr>
</thead>
</table>
| Level 1 audits, ‘external must dos’ | National audits (NCAPOP)  
NICEPOD / Confidential Inquires  
NICE  
CQUIN  
CQC  
Quality Schedules  
DH statutory requirements (e.g. Infection Control Monitoring) |
| Level 2 audits, ‘internal must dos’ | Clinical risk  
Serious untoward incidents  
Complaints  
Re-audit |
| Level 3 audits, ‘divisional priorities’ | Local topics important to the division |
| Level 4 audits | Clinician / personal interest  
Educational audits  
SSMs / SAMP |

Table 1
Clinical audit project statistics for 2013/2014

The table below (Table 2) demonstrates the breakdown of audit activity by division between 1st April 2013 and 31st March 2014. At the close of 2013/14 there were 389 audits identified on the clinical audit progress report, this included topics from the audit forward programme, plus additional audits added to the plan throughout the year. Of these 222 (57%) have been completed.

<table>
<thead>
<tr>
<th>Division</th>
<th>N</th>
<th>%</th>
<th>N completed</th>
<th>% completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate</td>
<td>26</td>
<td>7%</td>
<td>19</td>
<td>73%</td>
</tr>
<tr>
<td>Core Clinical</td>
<td>53</td>
<td>14%</td>
<td>43</td>
<td>81%</td>
</tr>
<tr>
<td>Medicine: Acute</td>
<td>23</td>
<td>6%</td>
<td>14</td>
<td>61%</td>
</tr>
<tr>
<td>Medicine: Elective</td>
<td>43</td>
<td>11%</td>
<td>20</td>
<td>47%</td>
</tr>
<tr>
<td>Surgery &amp; Critical Care</td>
<td>166</td>
<td>42%</td>
<td>86</td>
<td>52%</td>
</tr>
<tr>
<td>WACS</td>
<td>78</td>
<td>20%</td>
<td>40</td>
<td>51%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>389</td>
<td>100%</td>
<td>222</td>
<td>57%</td>
</tr>
</tbody>
</table>

Table 2

2013/14 proposed 315 topics, 2014/15 proposes 281, 10.8% reduction from last year’s total.

Participation in National Clinical Audits and National Confidential Enquiries

The NHS standard contracts for acute hospital, mental health, community and ambulance services set a requirement that provider organisations participate in appropriate national clinical audits that are part of the National Clinical Audit and Patient Outcome Programme (NCAPOP). This is in line with the government’s intention to see increased accountability and transparency in the public sector.

The Healthcare Quality Improvement Partnership hosts the contract to manage and develop the NCAPOP. The programme comprises more than 50 clinical audits that cover care provided to people with a wide range of conditions. Very few of the current audits are applicable to community services, though the number is expected to increase.

The national clinical audit requirements for NHS organisations, including those which are included in the Annual Quality Accounts are defined by HQIP on behalf of the Department of Health. For 2013/14, 32 national clinical audits and 4 national confidential enquiries covered relevant Health Services provided by our Trust.

During 2013/14 our Trust participated in 97% national clinical audits (Table 3) and 100% national confidential enquiries in which we were eligible to participate (Table 4).
### Participation in National Clinical Audits

<table>
<thead>
<tr>
<th>National Clinical Audit Title</th>
<th>Participated</th>
<th>National Clinical Audit Title</th>
<th>Participated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Mix Programme (CMP)</td>
<td>Yes</td>
<td>National Heart Failure Audit</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| National Comparative Audit of Blood Transfusion programme  
  - Audit of the use of anti-D  
  - Audit of patient information and consent | Yes          | National Vascular Registry  
  - Elective Repair of Infra-renal Abdominal Aortic Aneurysm  
  - Carotid Endarterectomy Audit | Yes          |
| National Audit of Seizures in Hospitals (NASH) & Pilot Paediatric NASH | Yes          | Diabetes (Adult) ND(A) | Yes          |
| National emergency laparotomy audit (NELA) | Yes          | Diabetes (Paediatric) (NPDA) | Yes          |
| National Joint Registry (NJR)  | Yes          | Inflammatory bowel disease (IBD)  
  - Patient experience | Yes          |
| Paracetamol overdose (care provided in emergency departments) | Yes          | National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme | Yes          |
| Severe sepsis & septic shock  | Yes          | Paediatric bronchiectasis | Yes          |
| Severe trauma (Trauma Audit & Research Network, TARN) | Yes          | Rheumatoid and early inflammatory arthritis | Yes          |
| Emergency use of oxygen | Yes          | NHFD | Yes          |
| Bowel cancer (NBOCAP) | Yes          | Sentinel Stroke National Audit Programme (SSNAP) | Yes          |
| Head and neck oncology (DAHNO) | Yes          | Elective surgery (National PROMs Programme) | Yes          |
| Lung cancer (NLCA)  | Yes          | Epilepsy 12 audit (Childhood Epilepsy) | Yes          |
| Oesophago-gastric cancer (NAOGC) | Yes          | Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) | Yes          |
| Acute coronary syndrome or Acute myocardial infarction (MINAP) | Yes          | Moderate or severe asthma in children (care provided in emergency departments) | Yes          |
| Cardiac Rhythm Management (CRM) | Yes          | Neonatal intensive and special care (NNAP) | Yes          |
| National Cardiac Arrest Audit (NCAA) | No           | Paediatric asthma | Yes          |

### Participation in National Confidential Enquiries

<table>
<thead>
<tr>
<th>National Confidential Enquiries</th>
<th>Participated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Lower leg amputation</td>
<td>Yes</td>
</tr>
<tr>
<td>2 Tracheostomy care</td>
<td>Yes</td>
</tr>
<tr>
<td>3 Subarachnoid haemorrhage</td>
<td>Yes</td>
</tr>
<tr>
<td>4 Alcohol related liver disease</td>
<td>Yes</td>
</tr>
<tr>
<td>National Clinical Audit reports received in 2013/14</td>
<td>Details of actions taken or being taken to improve the quality of local services and the outcomes of care.</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| National Paediatric Asthma Audit                | 1. Refer to Respiratory Nurse all asthma admissions.  
2. Arrange follow up with GP within a week post admission and document.  
3. Check and document device technique before discharge – design a checklist to include in discharge pack. Discharge document being revised to include inhaler technique in the checklist  
4. Information leaflet for all admissions  
5. Check/Document Peak Expiratory Flow Rate (PEFR) in patients above 5 years  
6. Asthma Management Plan given at discharge to all patients and documented in notes  
7. Continue data input over longer period using the national audit tool to improve number for comparison.  
8. New doctors awareness (induction) |
| British Thoracic Society National Bronchiectasis audit | 1. Sputum sample prior to starting antibiotics  
2. Recommended Screening for treatable causes – Allergic Bronchopulmonary Aspergillosis (ABPA), Combined Variable Immune Deficiency (CVID), Cystic Fibrosis (CF).  
3. Access to pulmonary rehabilitation  
4. Improve recording of useful clinical information relating to exacerbations in community  
5. Education in secondary and primary care about bronchiectasis |
| Cardiac Rhythm Management (CRM)                  | 1. Increase implant rate of brady pacemakers  
2. Increase implant rate of complex devices especially Implantable Cardioverter Defibrillators (ICD). |
| MINAP                                            | 1. Ensure all eligible patients receive all appropriate secondary prevention measures especially at Furness General Hospital  
2. Ensure all Acute Coronary Syndrome patients are admitted to the cardiac ward |
| National Heart failure database                  | 1. Ensure inappropriately coded patients are re-coded  
2. Ensure all patients have echo to confirm/exclude diagnosis ideally as an inpatient  
3. Use all appropriate treatments in all eligible patients  
4. Ensure appropriate follow up after discharge  
5. Improve communication with GPs patients and carers especially regarding drugs and monitoring  
6. Ensure heart failure patients are cohorted on a cardiology ward  
7. Entry of data on all heart failure patients onto the database |
| Fractured Neck of Femur                          | 1. Minimise the time patients stay in A&E Department, increased awareness of 36 hour time-frame.  
2. Prioritise those patients who are going to theatre  
3. Ensure patients are seen by geriatrician within 72 hours |
| Prescribing of Emergency Oxygen                  | 1. Change to standard prescription chart to record usage in printed type-face  
2. E-learning package for nurse training – implemented |
3. E-learning package for doctor training – implemented
4. Oxygen Policy to be reviewed and amended to incorporate above changes

### Asthma Audit

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Arrange follow-up with GP within a week post-admission and document this.</td>
</tr>
<tr>
<td>2.</td>
<td>Arrange new discharge pack to facilitate the above</td>
</tr>
<tr>
<td>3.</td>
<td>Check and document device technique prior to discharge</td>
</tr>
<tr>
<td>4.</td>
<td>Design a checklist to document inhaler technique</td>
</tr>
<tr>
<td>5.</td>
<td>Design information leaflet for all admissions</td>
</tr>
<tr>
<td>6.</td>
<td>Check and document PEFR in patients above 5 years of age</td>
</tr>
<tr>
<td>7.</td>
<td>Asthma management plan to be given at discharge to all patients, documented in casenotes</td>
</tr>
<tr>
<td>8.</td>
<td>New doctors – raise awareness at induction</td>
</tr>
</tbody>
</table>

### Adult Diabetes In-patient Audit

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Induction of in-patient diabetes specialist nurse to support inpatient care at RLI</td>
</tr>
<tr>
<td>2.</td>
<td>Introduction of ‘Think Glucose Programme’ to ensure inpatients requiring intervention of diabetes teams are seen at FGH and RLI</td>
</tr>
<tr>
<td>3.</td>
<td>Introduction of ward-based education for nursing staff in diabetes care to reduced errors related to insulin and oral diabetes medicine administration</td>
</tr>
<tr>
<td>4.</td>
<td>‘Safe Use of Insulin’ on-line training module made mandatory for all clinical staff who prescribe and / or administer insulin – application to be made to Trust board</td>
</tr>
<tr>
<td>5.</td>
<td>Introduction of Trust-wide foot screening assessments for all patients with diabetes admitted to hospital based on DUK ‘Putting Feet First’ resources</td>
</tr>
</tbody>
</table>

### Paediatric Diabetes Audit

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Improve glycaemic control</td>
</tr>
</tbody>
</table>

---

### At a Glance

#### Clinical Governance & Quality Committee (CG&QC)

The CG&QC is chaired by a non-executive director and is accountable to the Board of Directors. It has met monthly throughout 2013/14. The purpose of this committee is to:

a) Provide a focus on clinical governance, quality and patient safety issues;
b) Oversee clinical performance; and
c) Ensure the organisation responds to the clinical issues raised in national / local reports, patient surveys, serious untoward incidents, clinical incidents and inquests.

Clinical audit reports quarterly to this committee and provides the Trust with assurance that clinical audit effectiveness activity facilitates and supports the Trust to continuously improve the quality of care it provides to patients. It includes progression of local and national audits against the forward audit programme and key issues are identified and addressed in relation to implementing key recommendation and actions and compliance to NICE guidance.
Clinical Audit Strategy 2011-2014
The aim of this strategy is to use clinical audit as a process to embed clinical quality at all levels in the organisation over the next three years, creating a culture that is committed to learning and continuous organisational development.

The clinical audit objectives were as follows:
- to develop a partnership approach to clinical audit
- to establish a robust system for reporting the outcomes of clinical audit activity
- to ensure that staff have the necessary competency and support to participate in clinical audit
- to link with the risk register
- to link clinical audit to appraisal and revalidation
- to ensure organisational compliance with national requirements such as NHSLA
- to demonstrate the benefits of clinical audit
- to develop an approved annual clinical audit forward programme, comprising of national and Trust identified priorities
- to ensure that action plans are monitored and change management reported to the Clinical Audit and Effectiveness Sub-committee
- to provide assurance to the Trust Board with regards to clinical audit activity.

Healthcare Quality Improvement Partnership

History
The Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. HQIP is led by a consortium comprising the following organisations:

HQIP support, advise and train clinical audit professionals and have developed, in collaboration with clinical audit departments many professional tools and materials to assist in the audit processes. The template for this report is one example. The Trust's Clinical Audit Department participated in this at HQIP’s inception. HQIP also provide high-quality, inexpensive (often free of charge) workshops, training sessions and conferences.
Our department has an excellent relationship with HQIP and their representatives have visited Trust staff on several occasions, collaborating with us in order to provide training to clinical audit specialty leads. They also fund, support and attend our North West Regional Audit Network meetings.

**Highlighting the Audit Process: The HQIP ‘Teabreak’**
The Clinical Audit Department was amongst those who participated in the first of HQIP’s Clinical Audit Awareness Weeks 2013. We ran roadshow events in the dining room of each of our three hospital sites using a display board highlighting three audit headlines: ‘*What is Clinical Audit?*, *Why carry out Clinical Audits?* and *Auditing for Improvement.*’ We displayed examples of audits carried out within the Trust which have improved procedures and impacted on patient care, such as a Medical Records completion audit, and a Stroke & TIA audit which was nominated in the HQIP Clinical Audit Awards 2011. We also asked and engaged with members of staff, patients and visitors in discussion and an invitation to complete an informal quiz.

**Departmental Progression**

**Processes**
During 2014/15 we shall continue to evolve and streamline the processes for registration, monitoring of action plans and progress reporting in order to try and minimise the burden on audit leads wherever possible, to ensure we comply with requirements and can confidently respond to requests for provision of evidence relating to the safe practice delivered by the Trust. The reporting of progress against planned activity will become a standard audit meeting agenda item from 2014.

**Department Name Change**
As part of the drive to ensure that audits are of a high standard and result in improvement in patient care and outcomes, the department will from 2014, be known as “The Quality Improvement
Department”. This decision has been made in order to promote the culture of progression and to reinforce the message that the primary function of the audit process is to drive forward change(s).

**Staff Commitment**
The clinical audit facilitators will continue with their personal development plans, these include attendance at all relevant Trust training sessions (in addition to those that are mandated) and will avail themselves of any further opportunities that are both cost-effective and relevant to the Trust requirement. In order to be apprised of developments in the national clinical audit area, staff are keen to attend any events provided by Healthcare Quality Improvement Partnership (HQIP).

In November 2013 the Merseyside Internal Audit Agency (MIAA), in conjunction with HQIP, provided a one-day workshop entitled ‘Raising the Game on Clinical Audit’ which was delivered by Nancy Dixon.

Nancy is a specialist in measuring and improving quality in healthcare and serves as a consultant in the audit field and has written many books and articles on quality-related topics. She has served as a board member for healthcare quality professional organisations and is a highly experienced and respected figure in the national audit arena.

This session was fully funded by HQIP and our Trust was fortunate enough to secure places for the maximum 3 attendees permitted. Our attendees found the session extremely beneficial and provided detailed feedback to the others in the team. The workshop covered areas such as:

- Does current clinical audit practice match best practice?
- Increasing the quality of clinical audits
- Increasing the achievement of improvements using clinical audit

The feedback from last year’s session has been reviewed and will form the basis of this year’s session, ‘Circuit Training in Clinical Audit’. Once again, the Clinical Audit Department is aiming to gain prompt and full subscription to all available places.

**Retirement of Staff Member**
September saw the retirement of Lilian Wood, one of our experienced clinical audit facilitators. Due to budgetary constraints and the department’s participation in the Trust-wide Cost Improvement Programme, it has not been possible to refill Lilian’s 30-hour / week post. The remaining facilitators have worked very hard to absorb Lilian’s audit portfolio and their dedication, resilience, team work and efforts are very much appreciated.
2013-14 was the first year in which the Trust has had a Clinical Audit Midwife working on the extensive Maternity audit portfolio. Preparatory work was undertaken prior to this appointment whereby the Clinical Audit Department devised and presented 16 Clinical Audit Workshops. The workshops, attended by all grades of the obstetric and maternity teams, were of 2-hour duration and outlined the Trust and national requirements along with the audit tools and methodology that the Clinical Audit Department had devised in order to facilitate this workload.

The Clinical Audit Department has worked closely with, and acted as a mentor for, the appointee. The department is proud of the achievements that have been made in this inaugural year. The Audit Midwife has shown marked dynamism and passion for the audit process and the changes it can bring. Whilst rolling out each of this year’s projects she has worked closely with the Governance Lead for WACS to review, evaluate and restructure the necessary guidance / protocol for each audit topic and has actively implemented a robust action-planning process. Many of these action points have been fully implemented and the required re-audits undertaken. The Clinical Audit Department would like to acknowledge these efforts and thank the Clinical Audit Midwife and the Governance Lead for the WACS division for all their efforts.

Northwest Regional Network

The Cumbria and Lancashire Clinical Audit Network (CALCAN) was established in May 2010. Coverage ranges from North Cumbria Acute Trust to Southport & Ormskirk and over to Blackburn. Membership comprises of acute Trust, mental health Trust, ambulance services and NICE. The networks were initiated, and are supported by, HQIP in a concerted effort to promote the sharing of knowledge and good practice within audit departments and to provide a framework of self-support to audit teams within each network.

CALCAN was one of the first networks in the Northwest Region and our RLI site was the venue for the inaugural meeting. It is very pleasing to note that the visiting members have elected the RLI site as the permanent venue. The network meets on a quarterly basis, is thriving and proving to be a valuable resource. There is frequent attendance by an HQIP representative and a regular attendance from a representative from NICE. In addition, there are external speakers, for example representatives from NCEPOD, CQC and NHSLA.
Internal Audit Review

During the year, 'Internal audit' undertook an audit to confirm whether the clinical audit function was appropriately designed to deliver the agreed annual plans and that activities were effectively conducted / monitored by the clinical audit department and divisions.

As the system was in the process of being changed they did not give an assurance rating as they recognised that since the previous review, the process in place to monitor and report on clinical audits had been improved and strengthened with additional information been reported. However as the changes were in the very early stages and are not yet fully embedded they felt it was not appropriate to give an assurance rating but as part of the Internal Audit process will revisit the department later in the year to assess the progress and at that stage will give a formal assurance statement.

Departmental Structure Existing 2013/14

- Head of Clinical Audit & Effectiveness
  - Cross-Bay
  - 1 WTE (Band 8b)

- Clinical Audit Facilitators (3 posts)
  - RLI
  - 2.64 WTE (Band 4)

- Clinical Audit Facilitators (5 posts)
  - FGH
  - 3.32 WTE (Band 4)

- Clinical Audit Administrator (1 post)
  - RLI
  - 0.5 WTE (Band 3)

- Clinical Audit Casenote Clerk (1 post)
  - RLI
  - 0.69 WTE (Band 2)

- Clinical Audit Casenote Clerk (1 post)
  - FGH
  - 0.67 WTE (Band 2)
Departmental Structure Proposed for 2014/15

Head of Clinical Audit & Effectiveness
Cross-Bay
1 WTE (Band 8b)

Clinical Audit Educator & Deputy Manager
Cross-Bay
1 WTE (Band 6)

Clinical Audit Facilitator & Team Leader
RLI
1 WTE (Band 5)

Clinical Audit Facilitator & Team Leader
FGH
0.76 WTE (Band 5)

Clinical Audit Facilitators (2 posts)
RLI
1.64 WTE (Band 4)

Clinical Audit Facilitators (3 posts)
FGH
1.75 WTE (Band 4)

Clinical Audit Administrator (1 post)
RLI
0.5 WTE (Band 3)

Clinical Audit Casenote Clerk (1 post)
RLI
0.69 WTE (Band 2)

Clinical Audit Casenote Clerk (1 post)
FGH
0.67 WTE (Band 2)
Clinical Audit Leads on our Trust Sites

The audit lead for each specialty (Table 6) within the Trust is as follows:

<table>
<thead>
<tr>
<th>Specialty</th>
<th>FGH</th>
<th>RLI</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &amp; E</td>
<td>Miss F MacMillan</td>
<td>Dr S McBride</td>
</tr>
<tr>
<td>Anaesthetics</td>
<td>Dr S Costigan</td>
<td>Dr C Rimmer</td>
</tr>
<tr>
<td>ENT</td>
<td>Mr M Mian</td>
<td>Mr P Hans</td>
</tr>
<tr>
<td>Medicine</td>
<td>Dr A Barton/Dr F Wood</td>
<td>Dr L Ottewell</td>
</tr>
<tr>
<td>Maxillofacial</td>
<td>Mr D Fisher</td>
<td></td>
</tr>
<tr>
<td>Microbiology</td>
<td>Dr M Pasztor</td>
<td></td>
</tr>
<tr>
<td>Histopathology</td>
<td>Dr S Katti</td>
<td></td>
</tr>
<tr>
<td>Obstetrics &amp; Gynaecology</td>
<td>Mr S Sinha</td>
<td>Dr N Shantha</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Christine Halstead / Dr R Ajit</td>
<td></td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>Mr V Kamalanathan</td>
<td>Mr P McGuire</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>Dr A Kale</td>
<td>Dr P Nardeosing</td>
</tr>
<tr>
<td>Radiology</td>
<td>Dr S Slater</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td>Miss P Patel</td>
<td>Mr T Raymond</td>
</tr>
<tr>
<td>Breast</td>
<td>Mr R Parmeshwar</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>Mr M Naseem</td>
<td></td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>Sian Beard</td>
<td></td>
</tr>
<tr>
<td>Safeguarding</td>
<td>Liz Thompson</td>
<td></td>
</tr>
<tr>
<td>Health and Safety</td>
<td>Anna Smith</td>
<td></td>
</tr>
</tbody>
</table>

Table 6

Clinical Audit Meetings & Mortality

Specialty clinical audit meetings
The clinical audit specialty meeting known as the specialty rolling half day audit meetings provides the Trust with assurance that the results and actions from clinical audit are being disseminated to clinical staff. This supports the Care Quality Commissions Regulation, NHSLA Risk Management Standards and the Royal Colleges requirements for clinical staff participation in clinical audit.

Mortality
Regular mortality reviews of patients who have died in hospital are presented at the specialty audit meetings which are used as an opportunity for education and learning.
Education and training

Induction
The Clinical Audit team participated in the ‘Market Stall’ event which was held on each site on doctors’ induction days in August and February. During these sessions each in-coming clinician is made aware of the clinical audit department and its role within the Trust. At these events, all discussion is individually tailored to fit the specialty to which the doctor is attached and all audit meetings and any available topics are highlighted at this time. This is a useful opportunity to inform new members of staff about clinical audit and the training and support that is available to them.

One-to-one training
In addition to the above events, the Clinical Audit Facilitators work closely with all grades of staff across all specialisms. They deliver one-to-one training, support and advice on a daily and ad hoc basis. Each project is individual, even if it’s a repeat project, and the staff remain adaptable and available to provide the support necessary as it is required.

Specialty Clinical Audit Leads
Even though the clinical audit team can provide technical expertise, advice and support, the delivery of successful audits which result in better care for patients needs strong clinical leadership as well. Leadership is critical to the success of most things. Clinical audit is no different. This year has seen us more explicitly define the role of a speciality clinical audit lead. The role is recognised as additional responsibility which should is reflected in their job plan.

The aims of a clinical audit lead are to:
- Champion audit within their specialty
- Adopt a systematic approach to developing a clinical audit programme for their specialty that addresses important areas of National and local concern.
- Encourage colleagues to participate in appropriate audits.
- Ensure that improvement in patient care and services occurs as a result of clinical audit.

We developed 3 training sessions in conjunction with HQIP, which was designed to empower and support specialty audit leads to fulfil the role and to see audit more effectively used within their service.
Learning Lessons

Learning is part of life and key to improving our services and our working lives. No one can claim they know everything about their job’s impact or its effectiveness. We pick things up from so many sources including our colleagues and routinely incorporate good ideas into our work. It’s not about being formal or academic; it’s about sharing our experiences and making sure we keep getting better. We can learn from audit and mortality and this is picked up in the audit report summary sheet “learning points”. As a department we are aware that we need to share with the wider community and are currently working with the Library so that clinical audit can feature in the quarterly bulletin which will incorporate main themes and trends.

Links with other organisations

National Institute of Health and Clinical Excellence (NICE)
The National Institute of Health and Care Excellence’s (NICE) role is to improve outcomes for people using the NHS and other public health and social care services. They try to achieve this by:

- Producing evidence-based guidance and advice for health, public health and social care practitioners.
- Developing quality standards and performance metrics for those providing and commissioning health, public health and social care services;
- Providing a range of information services for commissioners, practitioners and managers across the spectrum of health and social care.

Since 1999 they have provided the NHS, and those who rely on it for their care, with an increasing range of advice on effective, good value healthcare. In April 2013 NICE gained new responsibilities for providing guidance for those working in social care.

NICE produces guidance on public health, health technologies, clinical practice and medical devices. Its role is to provide patients, health professionals and the public with authoritative, robust and reliable guidance on current ‘best practice’.

At our Trust we are committed to treating NICE guidance as high priority and are working towards compliance with National Guidance, such as NICE clinical guidelines, NICE interventional procedures and NICE technology appraisals. This has prompted the need to develop robust mechanisms to report, discuss and monitor compliance. This system will ensure in the future that the optimum in patient care, in its entirety, remains at the forefront of the organisations involved in the health and well-being of patients.
Commissioning for Quality and Innovation (CQUIN)
The CQUIN framework makes a proportion of providers’ income conditional on quality and innovation. Its aim is to support the vision set out in High quality care for all of an NHS where quality is the organising principle (Institute for Innovation & Improvement). In 2013/14 the clinical audit department has assisted the Trust in developing mechanisms on how best to collect and report data required to support this for the Advancing Quality Regional CQUIN.

Advancing Quality - AQuA
Advancing Quality (AQ) aims to improve standards of healthcare provided in NHS hospitals across the North West of England and reduce variation.

Working with clinicians, AQ provides NHS Trusts with a set of quality standards which define and measure good clinical practice in several clinical areas which affect many patients in the region – heart attack, heart bypass surgery, heart failure, hip and knee replacement surgery, pneumonia, stroke, dementia and first episode psychosis. The idea is that if each measure is delivered to every patient, they will receive the highest standard of care in hospital.

The Trust participated in 5 audits. The data runs retrospectively by 4 months. AQ will not be included in the 2014/15 CQUIN schedule for Cumbria but will be for North Lancs. The Trust will continue to submit data for all 3 hospitals.

Recognition of Work Undertaken

Advancing Quality – Our stroke services are among the best in the North West!
Stroke services at FGH and the RLI were among the best in the North West according to the latest figures from a healthcare quality organisation. We were rated third out of 22 hospitals in the rankings for the Advancing Quality programme. AQ measures have seven key performance targets including how long it takes for patients to be admitted to specialist stroke units, how well they are swallowing and their brain activity and whether they have had swift access to physiotherapy and occupational therapy.

The stroke ward at FGH now offers a seven-day-a-week service and around 10% are given clot-busting treatment. Telemedicine – out of hours diagnosis via videocall from the emergency department, means patients can be quickly assessed for suitability for the clot-busting drug, which dramatically increases, their recovery rate.
Advancing Quality – Team of the Year

We were very pleased that our Advancing Quality team were honoured for their hard work and dedication to improving patient care, by winning Team of the Year at the Advancing Quality awards.

In December 2011, we were only meeting one of the AQ standards. Since then, much work has taken place to ensure each clinical area across our hospitals understands the measures, and has reviewed their practices and agreed how future improvements could be made and monitored.

The main improvements include:

- **A move from retrospective data to real time data** - The Orthopaedic and Stroke team have helped to drive improvements by moving from collecting data retrospectively to having data available in real time. This has improved the accuracy of the data, and also, saved time as there is no longer a need to go back and locate patient notes to look at once the data was available.

- **Launch event** – An event was held in February 2012 to raise awareness of the AQ standards and the parts staff had to play to ensure the standards of care patients receive are as high as possible.

- **Mandatory training** – Information about AQ and the standards is now part of the Mandatory Training Workbook, that all staff have to complete on an annual basis.

- **Junior Doctor training** – Education sessions are held with junior doctors across the Trust to ensure they are aware of the standards expected.

**AWARD WINNING ADVANCING QUALITY TEAM**
Adult Community Acquired Pneumonia (CAP) Audit – Junior Doctor Awards

This audit was accepted as a poster by the Clinical Audit Support Centre (CASC) a nationally recognised team of audit professionals, which regularly participates at national audit events. Drs Bowen, Bannerjee and Bari worked hard to succeed as finalists at the CASC Junior Doctor Awards. Speakers at the event included Professor Danny Keenan (HQIP Medical Director) and various members of NICE.

Summary

The clinical audit team has continued to work hard to further develop relationships with the divisions and to encourage reporting of clinical audit projects and outcomes.

All divisions have been involved in clinical audit, however capturing the changes to clinical practice and closing the ‘cycle of improvement’ remains a key priority. Improvements to the follow up of actions arising from clinical audit will be implemented during the year using the Ulysses system to develop a clinical audit module.

During 2014/15, we shall continue to improve our processes, ensuring that we keep abreast of changes announced by the Department of Health, the Healthcare Quality Improvement Programme and the Care Quality Commission to ensure we comply with requirements and are
able to respond confidently to requests for information by any external agencies with associated evidence.

**Objectives for 2014/15**

The objectives for clinical audit for 2014/15 are outlined below:

- To develop an approved annual clinical audit forward programme, comprising of national and trust identified priorities.
- Full delivery in all national clinical audits as defined by HQIP.
- Establish a robust system for reporting the outcomes of clinical activity and monitoring action plans.
- Develop a clinical audit module in Ulysses to monitor action plans.
- Work with the divisions to embed action plan monitoring, progression and reporting.
- Clinical audit and NICE compliance to be a standing agenda item at all the divisional governance forums.
- To ensure organisational compliance with national requirements such as NICE and CQC.
- To provide assurance to the Trust Board with regards to clinical audit activity and NICE compliance.
- To ensure that staff have the necessary competency and support to participate in clinical audit.
- Maintain and update specialist knowledge with changes nationally and locally.
- Ensure clinical audit policy and strategy is up-to-date.
- Liaise with Risk Management to identify key areas of concern.
- Clinical audit staff to be proactive in relations with audit leads.
- Feed into the Learning Lessons quarterly bulletin.
- Develop a divisional dashboard for clinical audit.
- To hold a clinical audit awareness day.
Recommendations Made from Audits Completed 2013-14

As a result of the audits completed 2013/14 within the Trust at Divisional level, the following recommendations have been confirmed (Table 7).

<table>
<thead>
<tr>
<th>Local Audit Recommendations from Forward Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACUTE MEDICINE</strong></td>
</tr>
<tr>
<td><strong>Prescribing</strong></td>
</tr>
<tr>
<td>• Educate trainees on appropriate documentation when prescribing</td>
</tr>
<tr>
<td>• Raise awareness in local medical/surgical meetings</td>
</tr>
<tr>
<td>• Provision of rubber stamps with name and GMC number on to all prescribers</td>
</tr>
<tr>
<td>• Re-audit</td>
</tr>
<tr>
<td><strong>VTE</strong></td>
</tr>
<tr>
<td>• Introduce new prescription chart</td>
</tr>
<tr>
<td>• Improve documentation of advice given to patients</td>
</tr>
<tr>
<td><strong>ELECTIVE MEDICINE</strong></td>
</tr>
<tr>
<td><strong>CARDIOVASCULAR</strong></td>
</tr>
<tr>
<td><strong>Rapid access chest pain clinic</strong></td>
</tr>
<tr>
<td>• Improve access to functional testing</td>
</tr>
<tr>
<td>• Re-look at info from exercise tolerance test</td>
</tr>
<tr>
<td>• Approve the CT angiogram/caesium scoring business case</td>
</tr>
<tr>
<td>• Re-audit</td>
</tr>
<tr>
<td><strong>Management of Lung cancer/surgical resection</strong></td>
</tr>
<tr>
<td>• Look into quality of data collection in regards to Performance Status, Forced Expiratory Volume 1 &amp; co-morbidity score</td>
</tr>
<tr>
<td>• Number of Positron Emission Tomography Scan before biopsy</td>
</tr>
<tr>
<td>• Faster pathway</td>
</tr>
<tr>
<td>• Encourage Early referral to capture Stage 1 disease</td>
</tr>
<tr>
<td>• Standardise diagnostic pathway on three sites</td>
</tr>
<tr>
<td>• Increase 2nd opinion from surgeons.</td>
</tr>
<tr>
<td><strong>CORE CLINICAL SERVICES</strong></td>
</tr>
<tr>
<td><strong>DIETETICS</strong></td>
</tr>
<tr>
<td><strong>Protected Meal Time and Meal Time Assistance: March 2013</strong></td>
</tr>
<tr>
<td>• Ensure each ward displays its own protected mealtime poster</td>
</tr>
<tr>
<td>• Each ward to develop its own standard operating procedure for mealtimes</td>
</tr>
<tr>
<td>• Continue to promote ward rounds to take place away from mealtimes</td>
</tr>
<tr>
<td>• Arrange staff breaks away from protected mealtimes so staff are available to offer assistance as appropriate</td>
</tr>
<tr>
<td>• Medications should be administered away from mealtimes where possible so that the focus can be on the patient's mealtime experience</td>
</tr>
<tr>
<td>• All wards need to ensure that they are communicating about patients who require assistance</td>
</tr>
<tr>
<td>• Ensure handovers and staff breaks are arranged away from mealtimes- this has also been raised at the nutrition link nurse meetings</td>
</tr>
<tr>
<td>• Ensure that those patients who require assistance are offered help at appropriate times</td>
</tr>
<tr>
<td>• Involve the patients in decisions regarding assistance required</td>
</tr>
<tr>
<td>• Assign a specific member of staff each mealtime to offer assistance to individual patients as required</td>
</tr>
<tr>
<td><strong>Protected Meal Time and Meal Time Assistance: May 2013</strong></td>
</tr>
</tbody>
</table>
• Always weigh patients when able using the scales available on the ward, instead of relying on self-reported weights
• Calculate the BMI using charts or calculations available on the MUST (Malnutrition Universal Screening Tool) tool.
• Calculating Step 2 for weight loss on admission should be calculated from their usual weight in the past 3-6 months – this can be obtained from the patient, relatives, GP notes, nursing homes or safety bundles from previous admission.
• If a previous weight is not available subjective criteria could include; loose fitting clothes, dentures or rings in addition to signs of muscle wastage or fat losses – ensure this is documented on the MUST tool under ‘usual weight in the last 3-6 months’.
• Ensure when that the care plan is completed and signed and the appropriate actions taken as discussed on the back of the MUST tool dependant on the MUST score
• All patients should be rescreened weekly if appropriate
• When patients are rescreened it is important to calculate weight loss from their usual weight or their admission weight (i.e. NOT from the previous week)

Protected Meal Time and Meal Time Assistance: December 2013

Mealtime assistance:
• All wards need to ensure that they are communicating about patients who require assistance
• Ensure handovers and staff breaks are arranged away from mealtimes-this has also been raised at the nutrition link nurse meetings at RLI
• Ensure that those patients who require assistance are offered help at appropriate times
• Involve the patients in decisions regarding assistance required
• Assign a specific member of staff each mealtime to offer assistance to individual patients as required

Protected mealtimes:
• Ensure each ward displays its own protected mealtime poster
• Each ward to develop its own standard operating procedure for mealtimes and ensure staff member are aware of this and where it is.
• Continue to promote ward rounds to take place away from mealtimes
• Continue to promote protected mealtimes to all staff.
• Arrange staff breaks away from protected mealtimes so staff are available to offer assistance as appropriate
• Medications should be administered away from mealtimes where possible so that the focus can be on the patient’s mealtime experience
• Discuss with X-ray around break-time being 12-1 not from 1pm.? Same for Oncology DU

PHARMACY

Audit of safe & secure storage of medicines – (on going)
• Process in place via MMSC for divisions to report on their regular audits on safe & secure storage of medicines.

Provision of information to patients about their medication on discharge from hospital
• Explanation of changes on discharge, only 33% of forms returned. This information may not be readily available at the point of discharge, but in most cases these changes will have been explained to the patient at the time of prescribing.
• Future audits to include collection of nil returns to ensure total data capture.
• Currently no reliable method for counting number of TTOs outside working hours that require TTO medication.

Adherence to the prescribing policy (standards of prescription writing)
• Feedback to individual doctors and summary presented to MMSC and foundation board for agreed actions
• Repeat audit in March/April 2014

Audit of missed doses of critical medicines
• To be repeated and on-going as a requirement; in particular we need to target prevention of missed doses for critical medicines (as per NPSA requirement).
• As nurses are also responsible for ordering stock they should note if patients’ medication is running low or out of stock so that it can be ordered as soon as possible.
• Should be highlighted to staff that packaging can change.
• Nurse re-education highlighting critical medicines.
• Protected drug time for nurses should ideally be reviewed.
• Highlight to ward staff the importance of doses not being omitted especially critical medicines.
• Highlight the importance of corticosteroid, glaucoma and antibacterial eye drops.

### Audit of compliance against controlled drugs procedure

• Actions as a result of monitoring lessons learned are shared and reiterated to the individuals concerned and divisions with immediate effect following any incidents.
• Any trends are monitored and lessons learned via the medication safety group.

### Aseptic quality control North West audit (EL97(52))

• Action plan drawn up for minor improvements, no major improvements required.

### Medicines reconciliation: time taken to complete & verify prescription charts

• Reduced performance with Trust policy on medicines reconciliation, actions to rectify to be agreed via MMSC.

### Aseptic Unit – internal audit as per GMP Section 9

• Currently working with Quality Control North West to implement internal audits to complement external audits by QCNW and MHRA.

### Audit of prescription chart annotations by Pharmacists

• Lessons learned and implication will be agreed at MMSC so that the divisions and Pharmacy can work towards improving practice.

### Audit of clinical incident reports relating to medicines

• Results of this audit will be fed back to prescribers, nurses and Pharmacy department staff.
• Lessons learned and implication will be agreed at MMSC so that the divisions and ourselves can work towards improving practice.

### RADIOLOGY

#### GP lung cancer 2 week wait service

• New CT scanner
• Discuss with CT applications specialist regarding doses
• Educate other radiologists about low dose protocol
• Re-audit doses following changes to ASIR, noise index etc.

#### CT Head for head injury – Are we adherent to NICE guidelines?

• Stop doing plain films etc prior to CT unless urgently needed
• Improve portering and nurse escort services for urgent cases
• Start CT scanner before radiographer arrives to save time
• CT radiographer to inform radiologist as soon as scan is performed
• New CT scanner to improve access during the day

### Trauma CT

• To be more consistent in management of trauma as a radiology group.
• Also aiming to improve time to scan.

### WHO surgical safety checklist for Radiological intervention

• Better documentation.
• Scanned digital copy in the future.
• Consultants need to take charge of this change.
• Allow other members of the department to cultivate this learning point

### Quality of abdominal radiographs
- Staff training issues identified to improve the consistency of abdominal radiographs

### CT guided thoracic (lung) biopsy outcomes
- Repeat the audit to assess whether positive diagnosis rate has risen and pneumothorax rate fallen to the target levels proposed in the audit template.
- Abandon the use of 20 gauge needles owing to the unexpectedly high pneumothorax rate (and also complaints from the pathology department about the quality of specimens achieved.)
- Discuss with referring clinicians whether criteria for biopsy referral need to be tightened to reduce the number of biopsies resulting in benign histology.

### Lumbar spine radiographs
- Develop ways to engage with referrers in Primary Care
- Discussion with intermediate MSK pathway to agree guidelines of appropriate referral. This will cover some patients in North Lancs.
- As services reconfigure use that as an opportunity to change referral pattern in S Lakes and if possible remaining patients in North Lancs

### COPORATE

#### INFECTION CONTROL

### Cleanliness Audits – (on-going audit)
- Core Clinical areas are meeting the CQC outcome 8 standards, and actively working towards the National Hospital Cleaning standard.

### Commode cleaning (on-going audit)
- Information, instruction and training of staff is on-going.
- Weekly reviews to be undertaken for any wards with reduced performance.

### Sharps Bin Contents
- Legal requirement to segregate waste correctly and consign waste by correct code is actively being worked towards.
- Information, instruction and training of staff is on-going.

### Waste
- Information, instruction and training on-going to ensure complex and non-routine waste is handed in line with Trust waste policy.
- Legal requirement to segregate waste correctly and consign waste by correct code is actively being worked towards.

### MRSA screening (on-going audit)
- Maintain and improve compliance by improving awareness of the policy.

### SURGERY and CRITICAL CARE

#### ANAESTHETICS

### Check and challenge: Anaphylaxis malignant hyperthermia and local anaesthetic toxicity
- Removal of old guidance from the department
- Implementation of new emergency guideline folders with a standardised location – in the anaesthetic machines

### Check and challenge defibrillation: ALS (Advanced Life Support)
- Associate Specialists should attend the ALS update course that they are offered
- Update ALS guidelines with location of nearest resuscitation trolley stated in emergency guideline folders.

### Enteral feeding ITU
- Change guideline to introduce pro-kinetic at 250ml
- Generic metoclopramide prescription box on chart
- Re-educate nursing and medical staff.

### Efficiency of Brachial Plexus Blocks for upper limb surgery
- Arrange regional courses at site
- Regular teaching sessions for teaching anatomy for blocks
- Correct block choice
- Improve documentation about regional blocks especially and on anaesthetic chart in general
- Introduce stickers for block documentation
- Re-audit with large data size at RLI & FGH.

**BREAST SURGERY**

**Key Worker Support in Breast Cancer Patients**
- Easier access to Breast Care Nurse by phone.

**Keyworker Sticker Audit**
- Identify and record each patient’s key worker.
- Stickers to be sourced and printed with each staff members name and job title to be used in notes to improve the process.
- Business cards to be printed and given to the patient with their individual Key Worker’s name on one side, a contact telephone number, and all the Breast Care Nurses on the other side.

**Patient Experience Survey**
- Ensure clinic nurses and radiographers inform patients about tests as well as clinicians
- Maintain training of clinic nurses: observe procedures
- Peer assessment: observation of individual’s practice and feedback, across whole team
- Cancer diagnosis consultation to be combined activity of surgeon and Macmillan nurse
- Refresh course Communication Skills from Cancer Network for team: find facilitator
- Ensure verbal explanation is supported by written information
- Modify terminology used

**Lipomodelling**
- High patient satisfaction and clinical outcome for reconstruction – re audit in 12 months to check standards are maintained.

**Immediate Reconstruction with ADM and Implant with Strattice**
- Forward planning for Department is important due to audit showing higher proportion of patients getting IBR (immediate breast reconstruction) with a rise of use of Strattice based reconstruction.

**Clinical Lines of Enquiry: Mastectomy Rate**
- Level remains with national average – re audit in 12 months.

**Clinical Lines of Enquiry: Receptor Status at the Time of Diagnosis**
- Data entry; MDT (multi-disciplinary team) outcomes data missing from SCR
- Consultant to enquire if Her 2 can be reported in RLI to speed up the process
- Consultant ask for receptors in the MDT and MDT Co-ordinator to record live in meeting
- Pathology to try to get ER/PR ready for the meeting.

**Immediate Breast Reconstruction**
- Re-audit to ensure current high standards are maintained.

**Serious Diagnosis Disclosure Information to GP**
- All results provided within 24 hours – no recommendations
- Re-audit in 12 months to check standards are maintained
- Audit to see if GP’s are receiving results letters within 24 hours of patients receiving results in Furness General Hospital over a 2 month period. This will enable us to have full cross bay figures.

**Unit Coding Audit**
- Updated training session on clinical codes
- E-outcome to be used by all Clinicians/BCN’s from 21st October 2013
- Improved co-ordination between Clinicians, Clinic Nurses, BCN’s and reception staff
- Re-audit in 12 months

**Patient Pathway Breast Cancer (Re-audit)**
- Re-designing of forms, re-structure of clinics and more communication to assist with reducing waiting times
- Breast Unit refurbishment plan to improve patient environment

**GENERAL SURGERY**

**Tolerance & quality of Moviprep as a bowel preparation**
- Selected bowel prep should be documented on request form
- Alternative bowel prep should be documented
- Renal function must be checked in all patients before test requested
- Review patient instruction leaflet

**Re-admissions**
- Coding to suggest ways to avoid coding elective admissions as readmissions
- IT and coding to liaise with individual consultants to determine the validity of readmission.

**Ultrasound in suspected acute appendicitis**
- Larger numbers needed to re-audit practice in due course

**Use of entonox during colonoscopy**
- There were no specific recommendations from this audit apart from the fact that it reports a positive experience with the use of Entonox

**Flexible sigmoidoscopy patient survey**
- Consider pre-op assessment at site or by telephone
- Development of an information leaflet for GPs to give out to patients at time of referral
- Inform GPs of the survey results
- Re-audit

**MAXILLOFACIAL**

**One stop head and neck clinic**
- Educate practitioners (doctors and dentists) set up meetings locally or in practices.
- Encourage use (correctly) of 2 week forms and try to get better design of these
- Set up readjust clinic to see all intra-oral lesions within three weeks
- Obtain better imaging turnaround at Lancaster. Need for management?

**OPHTHALMOLOGY**

**NICE Glaucoma 2013**
- Continue with current practice regarding baseline diagnostic assessment
- Agree to set/document a clear IOP (intraocular pressure) target when initiating treatment
- Incorporate glaucoma assessment data and a target IOP box in electronic glaucoma patient records on Lorenzo.

**Viscocanalostomy**
- Audit results could be used when consenting patients for the procedure; Viscocanalostomy can help improve IOP (intraocular pressure) and quality of life in patients with glaucoma
- Re-audit in 2-3 years to see long term IOP control and assess visual function results

**Endonasal DCR (Dacrocystorhinostomy)**
- Failure on 1st attempt decreases the chances of success on revision – patients may want to be aware of this
- Lacrimal irrigation to be done before discharge to confirm the patency of the lacrimal system
- 1 year follow up is recommended rather than the current practice of 6 months to determine the success rate over a longer period

**ORTHOPAEDICS**
X-ray on arrival using image intensifier for 2-week follow-up of post-operative stable open reduction and internal fixation procedures

- DVR fixation need post-operative radiographs only if there is fracture fixation unstable at fixation or elderly osteoporotic comminuted fracture
- Surgeon should document the stability of the fracture and the need for PO radiographs
- Post op radiographs should not be considered routinely unless clinically indicated

Fracture Neck of Femur Pathway

- Improve education to Foundation Year/Core Trainee doctors (Education session to be included during induction at changeover with feedback. Provide the Neck of Femur fracture protocol)
- Early medical review on admission
- Reinforced by on call team (post take round) and none admitting seniors
- Identify post-op patients in trauma meeting
- Longer trauma theatre
- Re-audit following the education session

UROLOGY

Mid Urethral Tape Audit

- Streamlining of Trust guidelines
- Patient pathway to be modified

Audit of Recurrent UTIs

- Audit highlighted unnecessary cystoscopies with recurrent UTI’s in females. Recommend cystoscopy only with persistent haematuria.
- Re-audit in 12 months

WACS

OBSTETRICS & GYNAECOLOGY

Management of Third or Fourth Degree Perineal Tears

- Agreed process for assessing rotational registrars, at induction, of competence to undertake repair of third or fourth degree tears
- Proforma for third or fourth degree tears to include documentation of agreed antibiotics, agreed laxatives, debrief by registrar or consultant, counselling regarding future deliveries
- Escalate all information to clinical audit leads; audit leads; clinical governance lead; deputy head of midwifery governance lead, audit project manager
- Audit clinical leads; audit leads need to respond to findings in standards section of summary and formulate an action plan for changes
- Communicate results through communication boards
- Re-design audit proforma using SMART (Specific, Measurable, Accurate, Realistic, Timely) ensuring data on clinical audit proforma is covered on the data collection proforma eg. Training analysis; debrief; physio referral
- Update information leaflet, Trust format; presentation to guideline group for comment and ratification →publication (take into account equality diversity needs eg. languages and planning for this)
- Include in data collection if woman has been reviewed prior to discharge from hospital as per our guideline
- Include in data collection proforma mode of delivery as per request from senior clinicians

Emergency Caesarean Section Grades 1 and 2

- Review and update the audit proforma
- Audit midwife now in post and will check that a copy of the debrief document is filed in the casenotes
- Escalate all information to clinical audit leads; audit leads; clinical governance lead; deputy
head of midwifery governance lead; audit project manager

- Discuss with governance lead suitability of augmentin intravenously prior to knife to skin in relation to possible effects on pre-term neonate/ neonate
- Further amendments to audit proforma following group discussion at audit meeting
- Ensure reason for caesarean section is documented clearly
- Clear documentation of times of administration of antibiotic prophylaxis and time of incision
- Re-audit with regular feedback to capture every case

**Handover of Care**

- Dedicated time for handover
- Bleep free (unless emergency)
- Presence of all team members including anaesthetist
- If no patients in a particular category (i.e. nil for induction of labour) then document ‘nil’, don’t leave blank
- Longer audit period
- Consider having computerised handover:
  - Accessed on any MBHT computer – may be helpful for anaesthetist
  - Easy to update & prevents duplication (allows e.g. obstetric & gynaecology doctors to access & complete separate sections)
  - Practiced in other specialities e.g. paediatrics
  - Re-audit in 6 months’ time

**Obstetric Haemorrhage >2000mls**

- Review and update the audit proforma. Separate into post-partum or ante-partum haemorrhage. Use SMART (Specific, Measurable, Accurate, Realistic, Timely) approach
- Escalate all information to clinical audit leads; audit leads; clinical governance lead; deputy head of midwifery governance lead; audit project manager
- Review guideline
- Comments and action plan from audit leads regarding use of POTTs (Patient Observation Track and Trigger System)
- Use audit forward plan to be more specific with information required for
- Liaise with practice educators/clinical governance lead to develop documentation aid/ audit tool

**Postnatal length of stay**

- To audit the postnatal stay of those patients who underwent elective caesarean section to look into reasons for prolonged stay, if applicable

**Effects of Maternal Use of Psychotropic Medication on the Neonate**

- Discussion regarding place of birth for infants on medication. Specific discussion on small 3:1000 risk pulmonary hypertension with SSRI. Discussion regarding whether enhanced chart for post natal observations decided this was unnecessary
- Majority of ‘withdrawal’ happens after the 24 hour mark, therefore value of keeping in for 24 hours
- If woman aware of risks and requests birth at Helme Chase Maternity Unit could individualise management plan be developed– Governance Lead to forward Department of Health document
- Paediatrician and specialist midwife to present at Paediatric Seniors meeting to discuss with Paediatric Team 10.4.13
- Further discussion to take place with all Paediatric Seniors (who were unable to be present at meeting) regarding: recommendations for neonatal observations / length of stay if appropriate / place of birth. Paediatrician to feedback to multi-professional group
- Guideline to be reviewed
- Patient information leaflets re: medication to be reviewed

**Effects of Maternal Use of Psychotropic Medication on the Neonate**
Discussion regarding place of birth for infants on medication. Specific discussion on small 3:1000 risk pulmonary hypertension with SSRI. Discussion regarding whether enhanced chart for post natal observations decided this was unnecessary.

Majority of ‘withdrawal’ happens after the 24 hour mark, therefore value of keeping in for 24 hours

If woman aware of risks and requests birth at Helme Chase Maternity Unit could individualise management plan be developed– Governance Lead to forward Department of Health document

Paediatrician and specialist midwife to present at Paediatric Seniors meeting to discuss with Paediatric Team 10.4.13

Further discussion to take place with all Paediatric Seniors (who were unable to be present at meeting) regarding: recommendations for neonatal observations / length of stay if appropriate / place of birth. Paediatrician to feedback to multi-professional group

Guideline to be reviewed

Patient information leaflets re: medication to be reviewed

Severe pre-eclampsia and eclampsia

Review and update the audit proforma; separating severe pre-eclampsia and eclampsia. Ensure whether case is antenatal and postnatal is identifiable; include clear definition of pre-eclampsia in order to make decision to complete proforma clear.

Design eclampsia proforma to ‘double up’ as a documentation aid as per direction of audit lead (condition rarely seen – to aid and prompt)

Audit midwife now in post and will check if post natal follow up carried out and outcome of this regarding brief and management plan (if applicable)

Escalate all information to clinical audit leads; audit leads; clinical governance lead; deputy head of midwifery governance lead; audit project manager with a view to action plan being completed by clinical audit leads in response to standards.

Improve awareness of clinical incident triggers. Improve documentation of clinical incident reporting

Communicate good points to staff via audit report on display boards; G drive information

Communicate areas that require improvement as above once leads have developed an action plan

Possible further amendment to audit proforma following group discussion at audit meeting to amend investigation numeric result values when making diagnosis

Decision to be made regarding removing “Papilloedema” as a symptom and replacing with “clonus” and “reflexes

Shoulder dystocia

Review and update the audit proforma

Audit midwife now in post and will track audit proformas completed

Escalate all information to clinical audit leads; audit leads; clinical governance lead; deputy head of midwifery governance lead; audit project manager

Liaise with clinical governance lead/practice educators re updating documentation aid to be RCOG (Royal College of Obstetricians) compliant

Once documentation aid adopted to guideline ensure x bay use and disseminate information of new aid in place

Design documentation aid to be able to be used as an audit tool

Devise a more suitable method of tracking clinical incident reporting

Teenage Pregnancy
- Increase the appropriate numbers of referrals to the Healthy Start Scheme from 60% to 100%
- Increase the numbers of teenagers receiving advice to prevent unplanned future pregnancies from 78% to 100%
- Increase the numbers of referrals to the contraceptive nurse in pregnancy from 43% to 100%
- A new check list suggested to help in making a decision regarding the need for re-transfusion drains in total knee replacement

### PAEDIATRICS

#### Newly diagnosed diabetes
- Good compliance with recommendations in all areas. Need to maintain performance

#### National asthma audit
- Refer all asthma admissions to respiratory nurse
- Arrange and document follow up with GP within 1 week of discharge
- Check and document device technique before discharge – design a checklist to include in discharge pack/?discharge document being revised to include inhaler technique in the checklist
- Information leaflet to be given to all admissions
- Check and document peak flow in all children over 5 years
- Asthma Management Plan given at discharge to all patients and documented in notes
- Continue data input over longer period using the national audit tool to improve number for comparison (proforma allows)
- Include in induction for new junior doctors

#### Head injury in children
- Audit findings need to be shared with paediatric medical staff, paediatric nursing staff, and emergency department medical and nursing staff cross bay.
- Emergency department leads to be made aware of delay in triage and address underlying causes for this.
- Consider whether a proforma for assessment of paediatric head injury should be made to aid documentation
- Emergency department leads to be made aware of low rates of emergency department staff requesting CT scan when indicated.
- Separate audit with radiologists is required to assess the time taken to complete and report scans.
- Use of new documentation already introduced relating to consideration of safeguarding concerns should assist in improving recording of this and prompt discussion with paediatricians where required.
- Ward Managers for RLI and FGH to raise awareness of audit findings with nursing staff in relation to completeness and frequency of observations.
- Importance of information leaflets at discharge to be emphasised to ward nursing staff through ward managers and to medical staff.
- Repeat audit.

#### Constipation
- Recommendations
- Improve constipation related history taking and physical examination
- Improve documentation of assessment for faecal impaction
- Oral medications to be used before rectal medications
- Movicol to be used as first line treatment for disimpaction in all cases
- Early and frequent review of impacted patients needed
- Issues in maintaining treatment should be discussed in all cases
<table>
<thead>
<tr>
<th>Section</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Movicol to be used as first line treatment for maintenance therapy in all cases</td>
<td></td>
</tr>
<tr>
<td>Constipated patients who are toilet training should be followed up</td>
<td></td>
</tr>
<tr>
<td>Written information should be given to all patients and this should be documented in notes</td>
<td></td>
</tr>
<tr>
<td><strong>Feverish illness in children</strong></td>
<td></td>
</tr>
<tr>
<td>Raise awareness of latest version of NICE guideline (CG160) and change practice – (departmental teaching, present audit results to RLI colleagues)</td>
<td></td>
</tr>
<tr>
<td>Continue local audit on a cross-bay basis</td>
<td></td>
</tr>
<tr>
<td>Traffic light system for identifying risk of serious illnesses as part of documentation/admission pack</td>
<td></td>
</tr>
<tr>
<td>Cross-bay re-audit</td>
<td></td>
</tr>
<tr>
<td><strong>Chronic fatigue syndrome / myalgic encephomyelitis</strong></td>
<td></td>
</tr>
<tr>
<td>Information leaflets should be given to parents / young people.</td>
<td></td>
</tr>
<tr>
<td>Increase staff awareness about diagnosis / management.</td>
<td></td>
</tr>
<tr>
<td>Improve communication and documentation by adopting a check list.</td>
<td></td>
</tr>
<tr>
<td><strong>Senior review documentation</strong></td>
<td></td>
</tr>
<tr>
<td>Re-audit should be performed. It may be helpful to audit a winter period with higher levels of activity to see if the service manages to support this although direct comparison with this audit will then be difficult.</td>
<td></td>
</tr>
<tr>
<td>All doctors should be reminded of the importance of ensuring that entries are timed, dated and signed. This is aided by the use of a proforma already for the initial medical review and may explain why rates of recording are higher for the initial review.</td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes telephone advise</strong></td>
<td></td>
</tr>
<tr>
<td>The on call service should continue and a further audit of calls received by RLI ward is required.</td>
<td></td>
</tr>
<tr>
<td>Training is required for ward staff (doctors and nurses) particularly on the management of vomiting and poor oral intake in children with diabetes.</td>
<td></td>
</tr>
<tr>
<td>All ward staff should be reminded of the availability of guidelines to assist with phone advice.</td>
<td></td>
</tr>
<tr>
<td>All ward staff should be aware of the need to involve the general medical team before contacting the on call service.</td>
<td></td>
</tr>
<tr>
<td>Escalation policy to be changed to include: If admission is being considered and the child does not sound as if they are in diabetic ketoacidosis or having severe hypoglycaemia then discuss with on call service. This should help to prevent unnecessary admissions.</td>
<td></td>
</tr>
<tr>
<td>Ward nursing staff should be advised not to give advice regarding insulin doses without medical support.</td>
<td></td>
</tr>
<tr>
<td>All team members reminded at team meeting of importance of documenting contacts on Lorenzo</td>
<td></td>
</tr>
<tr>
<td>Repeat audit at FGH</td>
<td></td>
</tr>
<tr>
<td><strong>Neonatal jaundice</strong></td>
<td></td>
</tr>
<tr>
<td>Add tick box for previous sibling jaundice in risk factor box in purple notes</td>
<td></td>
</tr>
<tr>
<td>Provide some transcutaneous bilirubinometers for the department</td>
<td></td>
</tr>
<tr>
<td>Use of graph to record SBR result in all cases of suspected jaundice</td>
<td></td>
</tr>
<tr>
<td>Include accurate time of sample (time of recording may confuse)</td>
<td></td>
</tr>
<tr>
<td>Delay in lab</td>
<td></td>
</tr>
<tr>
<td>Provide information to parents and document</td>
<td></td>
</tr>
<tr>
<td><a href="http://www.nice.org.uk/guidance/CG98">www.nice.org.uk/guidance/CG98</a></td>
<td></td>
</tr>
<tr>
<td><strong>Diarrhoea in Children Under 5</strong></td>
<td></td>
</tr>
<tr>
<td>Only send stool samples if indicated</td>
<td></td>
</tr>
<tr>
<td>Document hydration status</td>
<td></td>
</tr>
<tr>
<td>Clinical response to therapy should be documented</td>
<td></td>
</tr>
<tr>
<td>Documentation of leaflets given to patients.</td>
<td></td>
</tr>
</tbody>
</table>
### Moderate or Severe Asthma in Children – Care Provided in the Emergency Department

College of Emergency Medicine

- Present findings to Emergency Department doctors
- Highlight important points, particularly documentation
- Nursing staff to improve recording timings of observations
- Ensure treatment initiated within 10 minutes

**Local Audit Recommendations not on Forward Plan**

#### ACUTE MEDICINE

**Clostridium Difficile**

- GP Education
- General increased awareness of Proton Pump Inhibitor
- Review of Proton Pump Inhibitor as soon as patient admitted
- Consider carefully starting Proton Pump Inhibitor as Inpatient
- Cautious use of antibiotics in hospital

#### ELECTIVE MEDICINE

**CARDIOVASCULAR**

**Acute Stroke Thrombolysis**

- Reduce time to CT scan during out of hours
- Increase patient, family and carer knowledge

**DERMATOLOGY**

**Biological Clinic For Psoriasis**

- Use of unified British Association of Dermatologists checklist
- HIV testing
- Doctors review upon commencing therapy
- Joint clinic with Rheumatologist

**ELDERLY MEDICINE**

**Medication in hospitalised patients with Parkinson's Disease**

- All patients to have PD medications prescribed ASAP and correctly on admission therefore need to prioritise PD patients for early clerking on AMU. Need to facilitate access to letters on PD patients particularly making PD nurse letters characterised as PD
- All patients to have PD meds given with no missed doses - need additional nurse and junior doctor training
- Need to pre-empt possible problems with on line prescribing and timing of medication

**GENERAL MEDICINE**

**Deliurium**

- Fill out the Cognitive screen proforma on admission
- Bed pressures need to be managed differently e.g. trying not to delay discharge of patients that are medically fit due to social worker review

**Polymyalgia rheumatica**

- Need to improve prescription of bone protection
- Information from audit needs to be presented to primary care as well as it clearly reflects some of what happens prior to referral / this may involve multiple patients who are NOT referred.
- Explicit advice on dose tapering should be included.
- DEXA (bone density scan) scanning should be requested in patients <65 years who commence on steroids for Polymyalgia rheumatica
### Management of Acute Coronary Syndrome at FGH
- Consider implementation of an Acute Coronary Syndrome pathway document
- Consider pros and cons of implementing GRACE (global register of acute coronary events) scoring system (?via pathway)
- To be discussed at audit meeting.

### Allergy recording
- Educational Intervention - doctors and nurses
- Update local guidelines (Prescribing Medicines Policy)
- Clear Trust guidelines on using wristbands
- Educational intervention to unify bracelet management

### Standard of medical record keeping
- When undertaking a re-audit clinicians should use the same methodology to increase the sample size.
- All medical wards should be included in the sample

### Oxygen prescribing
- Educate the nurses to sign the oxygen prescriptions after each drug round.
- E-learning
- Quality improvement project
- Re-Audit after the E-learning

### RESPIRATORY

#### Asthma admission and re-admission
- Provide education and training of asthma management to nursing and medical staff in A&E
- Discuss the use of E-referral/referral form to respiratory nurses
- Discuss the use of an asthma proforma in A&E
- The importance of accurate documentation.
- The need to increase the presence of Respiratory Specialist nurses in A&E as all asthma patients should be seen by Respiratory nurse specialists (BTS, 2012)
- Re-audit in 12 months

### Prevention of Thromboembolism
- Remind importance of VTE assessment
- Clarifying whether patients are on warfarin during admission clerking, clarify indication and check International Normalised Ratio (INR)
- If sub-therapeutic INR, take action depending on indication - may need specialist advice
- When altering dose of Warfarin make arrangements to check INR

### Oxygen Prescribing
- Identify patients with risk of hypercapnic respiratory failure
- Oxygen therapy should always be prescribed on drug chart

### RHEUMATOLOGY

#### Use of Biologics in Ankylosing Spondylitis
- The use of a proforma in order to improve documentation.
- To be prepared for a change to the ASAS (Assessment of SpondyloArthritis International Society) assessment tool.

### Bone mineral density in patients on aromatase inhibitors
- DEXA scan results on Lorenzo
- Breast Cancer specialists - prescribe Aromatase inhibitors so crucial role in preventing side effects – Present to team
- Local GPs – newsletter or presentation to PCT
- Rheumatology team - interpretation of Bone Mineral Density in view of history of Aromatase inhibitor use. Careful not to conflict Aromatase inhibitor algorithm in comments unless
clinically indicated – Presented at local Multi-Disciplinary Team meeting
• Re-audit in 1 year

Secondary prevention of fragility fractures
• Review of Fractured Neck of Femur proforma – include vitamin D on admission
• Needs presentation to orthopaedics teams
• Multi-Disciplinary Team involvement in querying need for bisphosphonate

Osteoporosis assessing the risk of fragility fractures
• Send letters to patients who meet the criteria for Bisphosphonate treatment or further Bone Mineral Density measurement

CORE CLINICAL

PHARMACY

Thalidomide
• No recommendations; audit is an annual requirement of the drug provider to maintain supply.

TTOs turnaround time
• Action plans are to be put in place involving MDT

Enhanced discharged input for medical patients on GTN, Strong Opiods, Warfarin and Insulin
• Enable Trust printing of information leaflets and available at ward level to support further information provision
• Follow up contact of patients at home to determine suitability of provision of information.

Adherence to prescribing policy (re-audit)
• Re-inforce the importance of weight, allergies and VTE prophylaxis appearing on all drug charts.

RADIOLOGY

Initial Imaging Investigation Of Suspected Acute Renal Colic
• Adopt CTKUB (non-contrast CT scan) as the first line imaging for most patients with suspected renal colic
• Plain film should not be performed when CTKUB is planned
• Consultants to liaise with Urology/A+E consultants with a view to agreeing a local clinical guideline for referral for CTKUB, and ensure their awareness that this obviates the need for plain film.

SURGERY and CRITICAL CARE

ANAESTHETICS

Anaesthetic care station
• Encourage the use of Isoflurane for further savings
• Re-auditing including the gas usage in the anaesthetic rooms and soda lime canisters usage

Post-op analgesia for lap cholecystectomy
• Employing a standardised analgesic protocol has been encouraged following this audit.
• Amendments to local protocol have been offered

ICU post discharge follow up
• To set up intensive care unit follow up clinics

BREAST SURGERY
**Breast Wound Infections**

- Laminate flooring in theatres
- Patient segregation – designated Ward nurse to look after Breast patients
- Early review by Consultant if high infection rate is suspected
- Triple antibiotic cavity wash
- Use of disposable drapes
- Review antibiotic policy
- Re-audit infection rate in 12 months and compare

**Breast MRI: For the Diagnostic Work-up of Breast Cancer Patients**

- Continue with practice of MRI (magnetic resonance imaging) for ILC (invasive lobular cancer)
- Extend indication of MRI for IDC (invasive ductal cancer) if size lesion is undefined
- All axilla’s should be ultrasound and FNA’s taken
- Contralateral cases need US and biopsy
- Multifocal enhancement needs careful second look and concordance with clinical picture
- Suspicious MRI enhancement with negative second look US need MRI guided biopsy, preferably in our own unit

**GENERAL SURGERY**

**Privacy & dignity in the endoscopy unit at FGH**

- Educate wards re. “Quality Standards Dec 2012” – with focus on Dignity and Privacy
- Re-audit in 3 months to review improvement in practice
- Consider stock of dignity trousers on ward
- Educate ward doctors and staff regarding consent and special cases, encourage consent on wards
- Educate ward doctors and staff regarding Bowel Prep at the beginning of each new rotation (now implemented)

**Privacy & dignity in the endoscopy unit at FGH Re-audit**

- Significant improvement in consent and cannulation
- Slight improvement in day to day running
- Overall improvement in time utilisation
- Less wasted slots / incomplete procedures
- Slightly increased uptake of dignity trousers
- Some improvement in dress
- Re-audit to sustain the improvement in May 2014

**Junior doctors perspective of ward rounds at FGH**

- Daily educational opportunities
- Feedback easily available
- Encouraged to develop skills and self-directed learning

**Post discharge telephone follow up in laparoscopic cholecystectomy**

- Discontinue day fifteen phone call
- Provide feedback to day case staff
- Need to recruit another member of staff to help with data collection.
- Explore possibility of improving quality of telephone consultation
- Reaudit day one calls in one year

**Patients perspective of surgical ward rounds at FGH**

- Information leaflets
- All patients to be told when ward rounds happen so that they can be ready with any questions

**Fluid balance administration & record keeping**

- Disseminate audit findings to matrons
- Educate nursing staff about the importance of accurate fluid balance documentation
- Fluid Balance Patient Identifier needs to be produced

**Emergency oxygen**
- Educate the nurses to sign the oxygen prescriptions after each drug round.
- E-learning
- Quality improvement project
- Re-Audit after the E-learning

**MAXILLOFACIAL**

**Referral Letters To Restorative Clinical Network**
- To review effect of audit over 1 year. Currently the number of referrals are more appropriate and the DwSI (Dentists with Special Interest) is also being more critical of referrals.
- Re-audit if an upward trend of referrals are noted. However referrers have now been re-educated in the use of pathway

**OPHTHALMOLOGY**

**Patient experience survey 2013**
- To maintain current high standards
- To continue to work on patient access (for queries/concerns) and information
- To consider questions for next year with regard to the type of information provided

**Peripheral Iridotomy**
- Trust guidelines to be agreed and then implemented

**Missing case notes in Ophthalmology clinics**
- To ensure that the standard operating procedure for managing case notes is followed at all times
- All tertiary referrals to the glaucoma clinic, especially from Barrow and Kendal, should be identified, and medical records sent to Lancaster at least one week before the clinic
- In the case of missing notes the clinician must decide in each individual case whether or not there is sufficient information to see a patient safely. Information should be sourced from Lorenzo, PACS system, Indigo, Diabetic retinopathy screening, FFA reports and past GP letters where appropriate

**Intra-Ocular Lens Implant Process audit**
- Records more accurately completed and doctors made aware of areas highlighted.

**ORTHOPAEDICS**

**Current Osteoporosis Treatment in Secondary Prevention of Fragility Fractures for Patients Admitted with a Fracture of their Distal Radius**
- To place a copy of the National Institute of Clinical Excellence (NICE) pathway for fragility fractures in fracture clinic and on the orthopaedic wards by the end of March 2014
- To conduct a re-audit by the end of December 2014
- To add information about fragility fracture guidelines into induction packs for new junior doctors before they begin in April 2014

**WACS**

**OBSTERICS & GYNAECOLOGY**

**Cardiotocography (CTG) Record-keeping**
- Staff to print their name and post on each CTG and in casenotes
- Sign at each occasion where an “event” occurs on the CTG tracing
- Record the number of each tracing taken as they are performed
- Verify the date and time of the start of the CTG on the tracing at the commencement
- Document the time and mode of birth at the end of the CTG
• Complete a full review and a “fresh eyes” review, as per the guideline
• Record the maternal pulse at the commencement of the CTG
• Labour rooms clocks are required to be digital format, in order to correctly agree timings of events

**Day Assessment Unit at Royal Lancaster Infirmary**
• Since relocation of Day Assessment Unit, there has been no requirement to close the Central Delivery Suite to incoming patients
• Increase in capacity whilst increasing safety and quality of care for patients

**Management in cases of risk of neonatal infection and/or prevention of hypoglycaemia**
• Escalate information to risk team/head of midwifery/governance lead
• Discuss with clinical governance lead/audit leads findings; standards and observations
• Prepare an action plan in response to comments from the above personnel

**Termination of Pregnancy**
• Standardized pre-printed consent forms
• STI screening for all attendees
• Better documentation regarding counseling provision.
• Consideration for future audit to include pain management, post procedure follow-up, failure rates and rates of complications.

**PAEDIATRICS**

**Feverishness in Children < 5 years of Age**
• Use of discharge advice sheet to guide patients/parents
• Continue using and stressing use of traffic light system
• Verbal advice should be documented in the notes

**Paediatric Standards in a Consultant Delivered Service**
• Senior Review by 4 hours – change expectations in medical and nursing staff
• Improve documentation of cases discussed with seniors
• Consultants to review new patients on morning ward round
• SHO cover – ?Clinic on day when integrated SHO is present
• Clinic rota for middle grades
• Re audit – prospective audit of 1 month of attendance, with nurse involvement
• Patient & Staff satisfaction questionnaire

**Coeliac Screening and Biopsy in Children 0-16 years**
• Staff education- children for whom test is appropriate, sample quantities required by lab, multiple tests, age of testing, documentation of pre-test counselling
• Clear plan for management post-diagnosis
• Local protocol required
• Liaise with local “satellite” path labs - avoid unnecessary and insufficient samples / pre-analytical errors
• Consider regular rotation of data input duties to reduce human error
• Staff training / induction to ensure standard input language/abbreviations used-ensures transparency when externally audited

**Pathway development for Lower respiratory tract infection & asthma**
• Clear and concise treatment pathways & guidelines. (Care bundles).
• National Guidance is followed such as NICE and Thoracic.
• Consultant led advice line :- patient flowchart.
• Improved documentation :- Patient Assessment Form
• Identification of equipment needs & provision of saturation monitors in General Practice.
• Development of a Bronchiolitis Management Plan.
• Patient education:- provision of Management Plans, Information leaflets, across every care setting.
- Training needs analysis and training package
- Improved clinical decision making across all care settings

**KELD**

**CLINICAL SKILLS**

**Cannula Spot Check August 2013**

- Audit findings rolled out throughout divisions
- Action Plan developed from clinical skills
- Audit findings presented to key groups
- Repeat cannula audit yearly
- Information shared with Infection Prevention and chief nurses

*Table 7*
Forward Audit plan 2014/15
This table (Table 8) summarises the number of clinical audits on the Clinical Audit Forward Plan for 2014-15 provided by the Clinical Audit Department in collaboration with the clinical audit specialty leads and divisions compared to 2013/14.

<table>
<thead>
<tr>
<th>Division</th>
<th>2013/14</th>
<th>2014/15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safeguarding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Medicine and Elective Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Elective</td>
<td>37</td>
<td>26</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>12</td>
<td>7</td>
</tr>
<tr>
<td>Surgery and Critical Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anaesthetics &amp; Critical Care</td>
<td>54</td>
<td>45</td>
</tr>
<tr>
<td>Maxillofacial</td>
<td>9</td>
<td>9</td>
</tr>
<tr>
<td>Ophthalmology / Orthoptics</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>ENT</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>General surgery</td>
<td>16</td>
<td>20</td>
</tr>
<tr>
<td>Breast surgery</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>Urology</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Upper GI</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Colorectal</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Vascular</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>WACS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatrics</td>
<td>32</td>
<td>19</td>
</tr>
<tr>
<td>Obstetrics and Midwifery</td>
<td>33</td>
<td>42</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Clinical Support Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood transfusion</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Radiology</td>
<td>16</td>
<td>13</td>
</tr>
<tr>
<td>Infection Prevention</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Medicines Management</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Dietetics</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Pathology</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>KELD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Skills</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>315</strong></td>
<td><strong>281</strong></td>
</tr>
</tbody>
</table>

*Table 8*