U.B.H.T.

Clinical Audit Report

2002/2003

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1 Introduction from Chairman of Clinical Audit Committee

During last year the Trust was visited by the Commission for Healthcare Improvement (CHI). Their report commended many aspects of clinical audit within UBHT. Areas for improvement which were identified were those with which all trusts of a similar size and complexity are currently struggling. The projects described in this years report start to reflect the clinical audit strategy for the trust, revised following the CHI visit. The emphasis remains on clinical audit as a process to improve the quality of clinical care. The challenge is to convince all healthcare professionals that this is an integral part of good practice.

There are obstacles to achieving this. There is still a lack of adequate investment in IT support for clinical audit. Clinical staff are left frustrated by the lack of outcome data to inform effectively targeted, process based, clinical audit. Combined with the perceived distortion of clinical priorities by performance targets, there is the risk of producing cynicism about the audit process.

Against this background it is all the more to the credit of the clinical audit team that they have achieved so much during the last year. There have been a number of staffing changes, and a number of staff have been away for significant periods of time due to illness. Colleagues have done an excellent job of providing cover under difficult circumstances.

This year I would like to express my thanks once again to the Charitable Trustees for the United Bristol Hospitals for their ongoing support of the annual audit 'Oscars' event, which provides a chance for exemplar projects to be presented to a Trust-wide audience.

Finally I would like to thank all members of the audit team for their hard work, and for those who have contributed time and energy to the work of the Clinical Audit Committee. Particular thanks are due to Eleanor Ferris, who in her new role as Clinical Audit Support and Information Manager, has compiled the data for the main body of this report.

Graham Bayly
Chairman of the Clinical Audit Committee

2 Clinical Audit Co-ordinator's Report

Achieving Effective Clinical Audit

2.1 Strategy

The UBHT Clinical Audit Strategy (see Appendix A) was updated in January 2003 to reflect priorities identified by the Commission for Health Improvement, but also to clearly demarcate the role of Clinical Audit as fundamentally a quality improvement process.

2.2 Organisational structure

- Clinical Audit team

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

- Lines of reporting

The last year has seen further changes in the mechanisms for reporting on clinical audit between directorates, CAC and the Clinical Governance Committee (CGC):

- Clinical Audit Facilitators (CAFs) update the audit management database on an ongoing basis – quarterly summaries are obtained from the system and made available to all staff via the Clinical Audit web site
- Directorates now formally report annually to the CAC – the format of the report has recently changed from presentation to a written document which is circulated to members in advance of meetings to encourage discussion and shared learning (see Appendix B)
- Directorates also submit half-yearly progress reports on clinical audit to CGC as part of the recently introduced Clinical Governance Performance Management system
- CAC in turn submits quarterly summaries of its business to CGC
- The CACO now provides CAC with quarterly updates on the national NICE/CHI/NSF audit agenda, in liaison with the Trust's Clinical Effectiveness Co-ordinator

2.3 Staff changes

- Clinical Audit team

In 2002/3 we welcomed Louise Hale (Ophthalmology), Frank Lee (O&G/ENT) and Sorrel Hewes (Critical Care) to the audit team. Tanya Bishop also contributed to the audit programme at BCH before moving on from the trust, with Helen Cooney then taking up the PICU/Cardiac audit role. During the year we also said goodbye to Clare Conroy (who left to become a Teacher Practitioner in the Department of Pharmacy at Trinity College Dublin), Michelle Croucher (now an ICP Co-ordinator in Sussex), James Osborne (now UBHT's Clinical Effectiveness Co-ordinator) and Emma Parsons (who left to become the Head of Audit at the South West Cancer Intelligence Service). Emma was succeeded by Eleanor Ferris who moved from her previous post as audit facilitator for St Michael's Hospital – Eleanor's new role carries the title 'Clinical Audit Support and Information Manager', reflecting the direction in which this deputy post has developed in the last couple of years. In 2002/3 Sue Barron was also appointed as Operational Manager at the Homeopathic Hospital – Sue continues to facilitate clinical audit at BHH, as well as supervising Louise Hale's workload at BEH.

- CAC

There were a number of changes in membership of the CAC during 2002/3.

Andrew Davies succeeded Chris Price as convenor for Oncology, Paul Thomas assumed the reins in Laboratory Medicine, and Richard Haynes provided temporary cover for Clare Bailey whilst Clare was on maternity leave. Three directorates also appointed new co-convenors, partly reflecting the increasing demands placed upon the role of convenor: Bev Guard (joining Sue King at BCH); David DeBerker (joining Pat Howard in Medicine); and Fabian Norman-Taylor (joining Jane Blazeby in Surgery, with a specific remit for the T&O programme). Finally, Roy Xavier succeeded Naaz Nathoo as Committee Secretary.

Full details of the Trust's audit team of facilitators and convenors are shown in Appendix C.

2.4 Recruitment and retention

Whilst staff retention has been good during the past years, a number of CAFs have – for a variety of reasons – experienced medium to long-term absences from work, which have made it difficult to maintain momentum in a number of directorates.

2.5 Conference presentations and input into national audit agenda

During the year, Chris Swonnell has delivered presentations at both the Clinical Audit Association conference (designing a web site for a clinical audit department) and Clinical Audit 2003 in Westminster (the impact of CHI on local practice in clinical audit). Emma Parsons delivered a well-received presentation on the subject of UBHT's audit management database at the SECEN (South East Clinical Effectiveness Network) conference, and the Dental Hospital had a poster submission accepted for the NICE (National Institute of Clinical Excellence) conference in December 2002.

The trust's clinical audit website and 'how to' guides continue to receive good press. The website was listed as a recommended resource in the Clinical Governance Bulletin and a number of trusts have expressed interest in adapting the 'how to' concept for their own organisation.

2.6 Optical Character Reader (OCR)

Opportunities to use the new TELEform OCR system have been hampered by a succession of technical/networking problems.

2.7 Financial information

The Clinical Audit funding historically received from Avon Health Authority has been split three ways:

- A contribution to the costs of the MDI (Medical Data Index) system in IM&T
- Audit support for clinical directorates
- Funding for a Clinical Audit Central Office (part of Trust Services Directorate)

The MDI contribution (in the region of £60k – see previous annual reports) is known to have become part of baseline funding for the IM&T directorate. Despite requests from the UBHT Clinical Audit Committee, it has not been possible to identify this money within the IM&T budget for 2002/3.

Funding to clinical directorates has also been devolved. Records held by the Finance Department indicate that directorate expenditure on clinical audit in 2002/3 was in the order of £240k, with

the overwhelming majority of this figure accounted for by staff costs (see staff list in Appendix C).

In 2002/3 the Clinical Audit Central Office was allocated £97,982. Sales of goods and services (e.g. workshops) raised an additional £410, making a total available budget of £98,392, which was spent as follows:

Staff costs	£70,988
Staff recruitment costs*	£1,018
Conferences and seminars*	£3,751
Expenses (training, travel, subsistence)*	£2,864
IM&T support costs	£1,613
Other expenditure	£3,715
Underspend (not carried forward)	£14,443

* these costs are for the UBHT clinical audit team as a whole (recruitment and CPD are co-ordinated via the central office)

2.8 CHI Review

UBHT's clinical audit programme was reviewed by the Commission for Health Improvement in 2002. Feedback was broadly positive and the trust was awarded a level 2c, equating to an acknowledgement of worthwhile progress in clinical audit at both operational and strategic levels. Identified areas for improvement included the further development of multi-professional clinical audit and patient involvement. For 2003/4, all clinical directorates have been asked to identify specific projects which will begin to address this requirement. The Clinical Audit Committee has also actively discussed the different approaches to patient and public involvement open to directorates. One favoured option is to develop links with registered charitable organisations who themselves represent the patient view.

2.9 Clinical Audit 'Oscars'

The fifth UBHT Clinical Audit 'Oscars' event was held in March 2003. This event – an annual showcase for the best audit work in the Trust during the preceding year – is now supported on an ongoing basis by the Charitable Trustees for the United Bristol Hospitals who once again provided cash prizes for the winning projects. First prize was claimed by Dr Rizwan Malik from Bristol Eye Hospital, for an audit of Cataract Listing; second prize was awarded to Dr Bryony Strachan for an audit of NICE Induction of Labour guidelines.

Chris Swonnell
Clinical Audit Co-ordinator

3 Project Reports for 2002/2003

3.1 Contracted audits

In past years, UBHT had a Clinical Audit Contract with Avon Health Authority. Since the change to Avon Gloucestershire and Wiltshire Strategic Health Authority, n0 specific 'contract' has been in place.

The headings below reflect both the general guidance provided by Avon Health and also some of the key themes set out in UBHT's Clinical Audit Strategy. The references are to projects listed in subsequent sections of this report:

National Priorities

- National Service Frameworks & NICE guidance
- National Audits

NICE/NSF								
3.4.2	3.4.18	3.4.25	3.4.28	3.4.31	3.4.18	3.4.23	3.4.30	3.4.29
3.4.24	3.4.27	3.4.22	3.4.21	3.4.19	3.5.24	3.5.21	3.7.19	3.9.3
3.11.36	3.11.25	3.11.7	3.11.9	3.11.35	3.11.20	3.11.19	3.11.23	3.12.12
3.13.11	3.13.4	3.13.16	3.14.4	3.15.16	3.15.1			
National Audits								
3.4.32	3.4.16	3.4.14	3.4.13	3.4.19	3.4.25	3.5.25	3.6.36	3.9.17
3.9.29	3.12.3	3.16.21	3.16.20					

Local/Regional Health Economy Priorities

- Regional Audits
- Local Health Improvement Programme 2000-2003 priorities
- Interface audit (see section 3.2.1 for definition)

Regional Audits								
3.5.20	3.5.12	3.5.46	3.6.7	3.7.26	3.7.17	3.7.23	3.9.2	3.11.13
3.12.10	3.12.8	3.13.12	3.13.2	3.17.2				
Health Improvement Programme Priorities								
Cancer:								
section 3.13		3.5.40 - 3.5.42			3.7.35	3.7.21	3.9.20	3.9.21
3.9.26	3.9.5	3.9.23	3.9.24	3.9.25	3.11.12	3.11.16	3.11.13	3.12.8
3.15.5	3.16.4	3.17.11	3.17.30	3.17.28	3.17.29	3.17.27	3.17.2	
Heart Disease:								
Section 3.4		3.5.16 - 3.5.19		3.6.1	3.6.21	3.6.22	3.6.24	3.6.35
3.11.3	3.11.19	3.11.9	3.15.1	3.15.8	3.16.8			
Stroke:								
3.11.29	3.11.35							
Services for Older People:								
3.11.32 - 3.11.36		3.15.16	3.18.2					
Demand Management/Reducing Waiting Times:								
3.3.4	3.4.18	3.4.28	3.6.12	3.7.31	3.13.4	3.13.8	3.13.9	3.13.10
3.13.11	3.13.13	3.17.27	3.17.28	3.17.29	3.18.3			
Interface Audits								
3.4.28	3.5.24	3.5.32	3.5.21	3.7.18	3.7.19	3.7.20	3.7.24	3.7.37
3.7.14	3.7.12	3.7.29	3.11.35	3.11.21	3.11.39	3.12.10	3.13.3	3.14.2
3.14.1	3.17.12	3.17.11	3.17.23	3.18.3				

3.2 Introduction to Directorate Reports

3.2.1 Introduction & explanation of statistics

All project information for this report is taken from the Clinical Audit Project Management Database, which was implemented in April 2002 and pre-populated with details of any current audits at that time.

The statistics and list of projects are based on the number of audits in progress during the financial year 2002-3, apart from where indicated. This includes projects started in previous years (2001/2 roll-overs) and projects completed in 2002/3. It does not include projects abandoned during the year or projects with a status of 'deferred' at the end of the financial year - for details of these, please see Appendix E and Appendix F. Audits started in 2002/3 are those that were first registered on the database between 1/4/02 and 31/3/03.

Projects are listed under the main directorate, as registered on the database. Projects that a directorate has been involved in but are registered under another directorate, are listed separately. Please see Appendix C for a list of clinical audit staff supporting these directorates.

Definition of terms:

Pre-audit: A project where there are no available standards to measure practice against. A pre-audit should involve the development of standards with which to audit practice against in future.

Re-audit: The repetition of an audit project in order to measure whether practice has improved since the initial audit

Ongoing (continuous audit): The continuous collection of data in order to measure practice. Ongoing audit should involve regular review of data and implementation of changes in practice (where necessary) in order to improve performance.

Linked to NSF, NICE guidance or similar national guidance: This includes Confidential Enquiry recommendations, Royal College guidelines & National Professional Bodies.

Regional: This relates to audits carried out across the local health community.

Interface: Audits across care sectors. These will usually involve primary care (PCTs, Avon Ambulance etc) but may include social care.

Multi-disciplinary: Although strictly speaking, this means the involvement of more than one discipline (i.e. staff from different areas of work, e.g. surgery & anaesthesia), it has been taken to mean the involvement of more than one profession, where this would be a better indicator of team working than cross disciplinary working (e.g. nurses and doctors from surgery).

Other method of consumer involvement / consumer involvement (non-survey): Patients/carers involved in one or more of the following: identification of audit topic; developing audit idea/project design; carrying out audit project; receiving audit results.

Changes in practice: Following completion of audit, action plan recorded on database with one or more actions partially or fully implemented

Measurable benefits to patients: As assessed by the audit lead and/or clinical audit facilitator for completed or ongoing audits. Benefits can only be confirmed following re-audits. For some completed/ongoing projects it may be too early to measure/confirm benefits.

Audits arising from a critical incident: Audits following a problem identified by clinical or incident reporting

Audits with no clinical audit facilitator involvement: Generally means audit first reported to the facilitator after completion of the audit

Audits leading to better ways of working for staff: As assessed by the audit lead and/or clinical audit facilitator for completed or ongoing audits

3.2.2 Summary 'dashboard' of indicators

	Total number of projects *	Pre audits	First audits	Re-audits	Ongoing (continuous) audits	Linked to NSF, NICE or similar national guidance	National	Regional	Interface	Multi-directorate	Multi-disciplinary	Evidence based standards used	Incorporates a Patient Survey	Other method of consumer involvement	Total projects with consumer involvement	Action Plan produced ~	Changes in practice ~	Measurable benefits to patients ~	Confirmed measurable benefits to patients #
Ambulatory Care & Outpatients	5	0%	80%	20%	0%	0%	0%	0%	0%	40%	40%	20%	0%	40%	40%	50%	75%	75%	100%
Cardiothoracic Services	32	22%	6%	6%	66%	50%	19%	0%	3%	34%	53%	56%	13%	6%	13%	27%	15%	4%	100%
Children's Services	52	6%	67%	15%	12%	10%	2%	6%	6%	8%	31%	33%	10%	2%	12%	20%	12%	16%	50%
Critical Care	36	6%	72%	8%	14%	17%	3%	3%	0%	53%	61%	17%	6%	3%	6%	29%	21%	43%	50%
Dental Services	40	3%	70%	25%	3%	23%	0%	8%	20%	10%	55%	70%	10%	10%	15%	89%	68%	68%	33%
Homeopathy	7	43%	29%	14%	14%	0%	0%	0%	0%	0%	0%	14%	57%	14%	57%	50%	50%	50%	N/A
Laboratory Medicine	29	3%	66%	10%	21%	17%	7%	3%	0%	45%	55%	31%	0%	0%	0%	58%	53%	5%	0%
Medical Physics & Bioengineering	4	25%	50%	25%	0%	0%	0%	0%	0%	75%	100%	0%	0%	0%	0%	100%	100%	0%	N/A
Medicine	43	12%	63%	14%	12%	51%	7%	2%	7%	33%	47%	67%	2%	0%	2%	12%	6%	12%	67%
Obs, Gynae & ENT	18	11%	56%	17%	17%	22%	6%	11%	6%	11%	67%	61%	11%	17%	28%	10%	10%	10%	0%
Oncology	18	6%	72%	22%	0%	22%	0%	11%	6%	17%	83%	89%	0%	11%	11%	91%	0%	55%	100%
Ophthalmology	17	12%	59%	29%	0%	6%	0%	0%	12%	0%	18%	24%	6%	0%	6%	78%	78%	67%	50%
Pharmacy	17	6%	59%	6%	29%	18%	0%	0%	0%	24%	12%	6%	6%	6%	6%	0%	0%	0%	0%
Radiology	21	14%	57%	24%	5%	14%	10%	0%	0%	10%	76%	48%	0%	10%	10%	38%	38%	25%	33%
Surgery	30	10%	60%	23%	7%	23%	0%	3%	10%	37%	80%	27%	3%	0%	3%	50%	10%	35%	50%
Trustwide	9	0%	78%	22%	0%	11%	0%	0%	11%	56%	22%	11%	22%	0%	22%	67%	100%	33%	0%
TOTAL	378	9%	60%	16%	15%	23%	4%	4%	6%	26%	51%	42%	7%	5%	10%	43%	28%	31%	46%

N/A = no audit projects of this type (e.g. no completed re-audits in Homeopathy

* in progress or completed during the year. All percentages are based on this total, apart from those in the last four columns.
~ as a percentage of completed first & pre-audits & ongoing (continuous) audits only
# as a percentage of completed re-audits

3.3 AMBULATORY CARE & OUTPATIENTS

SUMMARY FIGURES

2001/2002 roll-overs <<		1
Audits first registered in 2002/3	Pre-audits P	0
	First audits A	3
	Re-audits R	1
	Ongoing monitoring projects >>	0
Total number of audits		5
Completed audits		5
Current (uncompleted) audits carried forward >		0
Ongoing monitoring projects carried forward >>		0

(Previously listed under Surgery directorate)

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	-	-	-	-	1/4	25%
Audits arising from a critical incident:	-	-	-	-	0/4	0%
Audits prompted by a patient complaint:	-	-	-	-	1/4	25%
Audits with consumer involvement (not including surveys)	-	-	-	-	2/4	0%
Audits incorporating a patient/carer survey	-	-	-	-	0/4	0%
Interface audits (involving primary care)	-	-	-	-	0/4	0%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	-	-	0/4	0%
Audits with no clinical audit facilitator involvement	-	-	-	-	2/4	50%
Audits with proposal forms completed BEFORE audit started	-	-	-	-	1/4	25%
Audits using evidence based standards **	-	-	-	-	1/4	25%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	-	-	-	-	5/5	100%
Audits where an action plan was produced:	-	-	-	-	2/5	40%
If action plan NOT produced, number where audit confirmed current good practice:	-	-	-	-	3/3	100%
Figures below include completed first and pre-audits and ongoing monitoring projects only						
Audits resulting in changes in practice:	-	-	-	-	3/4	75%
Audits leading to better ways of working for staff:	-	-	-	-	1/4	25%
Audits leading to measurable benefits for patients:	-	-	-	-	3/4	75%
Figures below include completed re-audits only						
Audits confirming measurable benefits for patients:	-	-	-	-	1/1	100%

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: None									
3.3.1	526	Audit of the quality of correspondence to GPs from UBHT according to UBHT guidelines	Phil David			X			
Specialty: Medical Day Unit									
3.3.2	499	Re audit of Endoscope decontamination	Claire Hodges				X		
Specialty: Outpatient Department									
3.3.3	286	Effectiveness of Clinic Call Centre	Marian Clark; Sharon Nicholson			X			
Specialty: Physiotherapy									
3.3.4	267	The use of Physiotherapy Specialists in Orthopaedic Clinics to Manage Non-Surgical and Less Complex Surgical Cases	Lorna Angles; Nicola Ford			X			
Specialty: Trauma and Orthopaedics									
3.3.5	233	Quality of Multi-Disciplinary Team Reception in the Trauma, Orthopaedic and Plaster Department	Sharon Nicholson	X		X			

EXEMPLAR AUDITS 2002 / 2003

An audit of the use of Physiotherapy Specialists in Orthopaedic Clinics to Manage Non-Surgical and Less Complex Surgical Cases

Lorna Angles & Nicola Ford (Physiotherapists)

Background

Extended scope practitioners are clinical physiotherapy specialists with an extended scope of practise, who see patients referred for assessment, clinical diagnosis and management. The Avon Orthopaedic Project Report supports the development of the ESP in order to reduce outpatient waiting list times, to enable patients requiring non-surgical treatment to be treated earlier and to free up consultants for more operating time.

Aims and objectives

- To independently manage non-surgical cases referred to orthopaedic clinics wherever possible.
- To reduce the waiting list times for the orthopaedic clinics.

Results

The ESP independently managed 74% of patients. This corresponds well to the results published by Daker-White et al (1999) who report that 25.2% of the physiotherapist's caseload required consultation with a senior consultant (compared with 28.2% of the registrar doctor caseload). Anecdotally, waiting times have been reduced for patients, but this has been difficult to measure empirically due to each consultant having their own waiting list.

Actions

- ESPs have had further training to enable them to administer more treatments, such as injections
- Further work is to be done to improve and develop the use of ESPs in clinic.

3.4 CARDIOTHORACIC SERVICES

SUMMARY FIGURES

	2001/2002 roll-overs <<	11
Audits first registered in 2002/3	Pre-audits P	5
	First audits A	2
	Re-audits R	2
	Ongoing monitoring projects >>	12
	Total number of audits	32
	Completed audits	6
	Current (uncompleted) audits carried forward >	5
	Ongoing monitoring projects carried forward >>	21

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	12/24	(50%)	5/10	(50%)	10/21	48%
Audits arising from a critical incident:	0/24	(0%)	0/10	(0%)	1/21	5%
Audits prompted by a patient complaint:	0/24	(0%)	0/10	(0%)	1/21	5%
Audits with consumer involvement (not including surveys)	0/24	(0%)	0/10	(0%)	1/21	0%
Audits incorporating a patient/carer survey	0/24	(0%)	0/10	(0%)	2/21	10%
Interface audits (involving primary care) *	1/24	(4%)	1/10	(10%)	0/21	0%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	4/10	(40%)	11/21	52%
Audits with no clinical audit facilitator involvement **	-	-	-	-	1/21	5%
Audits with proposal forms completed BEFORE audit started	5/24	(21%)	6/10	(60%)	19/21	95%
Audits using evidence based standards **	-	-	-	-	10/21	48%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	3/4	(75%)	2/14	(14%)	5/6	83%
Audits where an action plan was produced:	0/4	(0%)	2/14	(14%)	3/6	50%
If action plan NOT produced, number where audit confirmed current good practice:	0/4	(0%)	0/12	(0%)	2/3	67%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	2/12	(17%)	1/24	(4%)	4/26	15%
Audits leading to better ways of working for staff:	2/12	(17%)	0/24	(0%)	6/26	23%
Audits leading to measurable benefits for patients:	1/12	(8%)	1/24	(4%)	1/26	4%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	1/9	(11%)	1/10*	(10%)	1/1	100%

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: Cardiac Surgery									
3.4.1	486	A protocol for the weaning of long-stay patients	Lisa Mace		X				X
3.4.2	205	Appropriate Use of Pressure Relieving Mattresses	Lisa Mace	X	X				X
3.4.3	206	Audit of Adult Cardiac Surgery: Annual Report	Mr A J Bryan	X				X	
3.4.4	208	Audit of Extubation Data	Kathy Gough	X				X	
3.4.5	482	Audit of Medical Notekeeping Standards	Margaret Anthony				X		
3.4.6	210	Audit of Relationship Between Haemocrit on Admission to ICU Following Coronary Surgery and Postoperative MI and/or Death	Dr A Cohen	X				X	
3.4.7	551	Enteral Tube Feeding Protocol	Claudia Jemmott		X				X
3.4.8	547	Hand wash audit	Liz Bowden		X				

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.4.9	215	Mortality Rate Procedures Based on Parsonnet Scores (CRAM)	Dr S Pryn	X				X	
3.4.10	359	Nausea and Vomiting Post Cardiac Surgery	Lisa Mace		X				
3.4.11	594	Nausea and Vomiting Post Cardiac Surgery (Reaudit)	Lisa Mace				X		X
3.4.12	552	Radial Artery Consent	Fiona Thomas			X			
3.4.13	548	SCTS Cardiac Register	Mr A J Bryan					X	
3.4.14	549	SCTS National Adult Cardiac Surgery Audit Database	Mr A J Bryan					X	
3.4.15	218	To Compare the Administration of Post-Op Bloods	I Channon	X				X	
3.4.16	550	UK Heart Valve Registry	Mr A J Bryan					X	
3.4.17	219	Usage of Blood Products After Cardiac Surgery	Dr A Cohen	X				X	
3.4.18	362	Waiting Times to Cardiac Surgery	Dr J Barry					X	
Specialty: Cardiology									
3.4.19	544	BCIS annual angioplasty audit	Dr A Baumbach					X	
3.4.20	207	Cardiac Rehabilitation: NSF Audit	Caroline Lapin	X				X	
3.4.21	369	Coronary artery stents in the treatment of ischaemic heart disease	Dr A Baumbach					X	
3.4.22	368	Glycoprotein IIb/IIa inhibitors for acute coronary syndromes: NICE Audit	Dr A Baumbach					X	
3.4.23	363	Heart attacks and other acute coronary syndromes: NSF Audit	Jenny Tagney					X	
3.4.24	366	Heart Failure: NSF Audit	Toni Dorrington					X	
3.4.25	223	Myocardial Infarction National Audit Project	Cathy Graeme-Wilson	X				X	
3.4.26	543	Post MI patient care in the BRI	Jenny Tagney			X			X
3.4.27	367	Prophylaxis for patients who have experienced a MI	Dr G Dalton		X				
3.4.28	224	Rapid Access Chest Pain Clinic	Dr Chee Wan Lee	X				X	
3.4.29	365	Revascularisation: NSF Audit	James Thomas					X	
3.4.30	364	Stable Angina: NSF Audit	James Thomas					X	
3.4.31	225	Were patients treated according to NSF guidelines for acute MI in 2000?	Dr A Baumbach	X	X				
Specialty: Thoracic Surgery									
3.4.32	553	SCTS Thoracic Register Return	Mr J A Morgan					X	

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.6.22	434	Resternotomy for bleeding following cardiac surgery	Critical Care
3.9.3	42	Compliance with agreed requesting protocol for Troponin-I	Laboratory Medicine
3.9.13	46	Blood and Blood Product Usage by Wards and Theatres	Laboratory Medicine
3.11.3	266	Audit of patients with suspected cardiac chest pain in the E.D.	Medicine
3.15.1	512	Does the use of statins within UBHT follow the NSF?	Pharmacy

EXEMPLAR AUDITS 2002 / 2003

An audit of Post-MI care at the BRI

Ian Kerslake (Bristol University 3rd year SSM student), Jenny Tagney (Nurse Consultant, Cardiology)

Background

Myocardial Infarction (MI – a.k.a. "Heart Attack") occurs when the flow of blood through the coronary arteries is reduced to such an extent that part of the heart muscle (myocardium) dies. This often occurs suddenly when a coronary artery is occluded by a blood clot (thrombus). Around 300,000 people in the UK suffer a MI each year and around 140,000 die. Prompt access to the right treatment can mean the difference between living and dying. High quality care post-MI care is equally important because appropriate prophylaxis and lifestyle changes can substantially reduce the risks of a second heart attack.

The National Service Framework for Coronary Artery Disease (NSF-CHD) has set acute Trusts, secondary and primary care providers with targets for the treatment and prevention of heart attacks and other acute coronary syndromes. Whilst much audit activity has surrounded the 'front door' aspects of care (e.g. 'door-to-needle' times), little attention has so far been paid to post-MI care. This audit thus focused on 'back door' care – an area at the BRI acknowledged to be lacking in uniform approach and clinical standards

Aim

To improve the level of Post-MI care in the BRI through appropriate and equitable prescription of prophylactic drugs.

Methodology

Pathology blood test data for all BRI samples ordered during April 2002 were electronically searched in order to identify patients who, according to locally agreed clinical protocols, were likely to have suffered a recent myocardial infarction (Troponin-I >2mmol/l). This produced a shortlist of 60 patients. A proforma was designed to enable anonymous data extraction. Four sets of notes were excluded from the sample because they were not myocardial infarctions. A further six could not be obtained, and a further 12 pertained to patients who had died during admission. Thus, a total of 38 casenotes were analysed for patients who had been admitted and treated for a myocardial infarction to see who had cared for them post-MI and whether their prescription rates for prophylactic drugs met NSF-CHD standards.

Results

- 42% (16/38) of patients admitted for MI were transferred to care of a cardiologist. Prescription rates for Aspirin, β-blocker, Statins and ACE inhibitors all met the NSF-CHD standard of 80%.
- 37% (14/38) of patients admitted for MI were cared for by a general physician who sought cardiology opinion. Only prescription rates for Aspirin met the NSF-CHD standard.
- 21% (8/38) of patients admitted for MI were cared for by a general physician alone. The NSF-CHD was not met for any drug group.

Actions arising

The results were presented at the Directorate audit meeting on 8th May 2003 and generated considerable discussion. Agreed key actions were to: 1. Re-audit using a larger sample to establish the influence of age, sex and medical condition; 2. Develop a local variant of the Myocardial Infarction National Audit Project to permit audit on a long-term basis; 3. Invite the Audit facilitator to the weekly review of MI cases in Critical Care; 4. Establish audit links with general surgery and medicine; 5. Develop a nursing 'outreach' plan for management of MI cases across the Trust. Trust-wide mandatory protocols for medical staff were discussed but action is still to be decided in detail.

Radial Artery Consent
Fiona Thomas (Clinical Nurse Manager)

Background
Critical incidents in Cardiothoracic are subject to a rigorous reporting and review procedure aimed at informing all appropriate staff as quickly and effectively as possible. Thus incidents are not only logged and acted upon with immediate effect in the clinical area concerned, but they are subject to review by the Directorate Clinical Governance Committee, Audit Steering Group and discussed at a regular 'slot' at Directorate-wide audit meetings.

This process highlighted an area of concern regarding the obtaining of patient consent for the surgical removal of the radial artery - the radial artery in the arm is one of the conduits that cardiac surgeons can harvest for use in Coronary Artery Bypass Grafting (CABG). Incident forms were received stating that consent to harvest the radial artery had not been obtained in two patients. This generated concern that the patients involved may not have been informed of the procedure and possible complications, and that they may not have agreed to consent if they had been given the option – a basic legal requirement. Secondary concerns were that theatre staff may not necessarily have been sufficiently prepared, or indeed that the correct limb had been marked.

Aim
To improve the standard of the patient consent process for those undergoing Coronary Artery Bypass grafting through equitable and timely consultation.

Methodology
The Patient Analysis and Tracking Database (PATS) has been prospectively updated with details on 252 variables surrounding the admission, anaesthesia, surgery, nursing and discharge of every patient undergoing cardiac surgery since April 1996. This valuable resource was interrogated for a sample of the most recent surgery cases where the radial artery had been used as a conduit. At the time of the audit this was 1st January 2002 – 30th January 2003. A total of 197 patients were identified in this period, from which a stratified random sample of 32 was chosen. Stratification was made in proportion to activity of the five main surgical firms. Casenotes were independently reviewed for evidence of consent. Review evidence was compared and discussed to ensure accuracy in reporting.

Results
- Seven sets of casenotes had either been lost or were untraceable/unobtainable.
- Of those casenotes reviewed 100% (25/25) possessed signed consent forms for the main CABG procedure. In this aspect the clinical standard was met.
- One set of casenotes did not possess specific evidence of radial artery consent: 96% (24/25). In this aspect the clinical standard was not met.

Actions arising
The results of the audit were presented at the Directorate Audit meeting on 12th March 2003 for discussion amongst junior and consultant surgeons, nurses and theatre staff. Consultants agreed that specific consent for radial artery harvesting would be obtained from all patients without exception and that this would form part of their normal consultation process. The associated issue of marking of limbs for harvesting opened up a series of conflicting issues that could not be resolved within the scope of this audit. A re-audit was tabled for early 2004 to assess compliance.

3.5 CHILDREN'S SERVICES

SUMMARY FIGURES

	2001/2002 roll-overs <<	32
Audits first registered in 2002/3	Pre-audits P	2
	First audits A	14
	Re-audits R	4
	Ongoing monitoring projects >>	0
	Total number of audits	52
	Completed audits	24
	Current (uncompleted) audits carried forward >	23
	Ongoing monitoring projects carried forward >>	5

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	8/28	(29%)	8/29	(28%)	8/20	40%
Audits arising from a critical incident:	1/28	(4%)	3/29	(10%)	1/20	5%
Audits prompted by a patient complaint:	1/28	(4%)	1/29	(3%)	0/20	0%
Audits with consumer involvement (not including surveys)	3/28	(11%)	3/29	(10%)	1/20	5%
Audits incorporating a patient/carer survey	3/28	(11%)	3/29	(10%)	1/20	5%
Interface audits (involving primary care) *	1/28	(4%)	1/29	(3%)	0/20	0%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	12/29	(41%)	3/20	15%
Audits with no clinical audit facilitator involvement **	-	-	-	-	3/20	15%
Audits with proposal forms completed BEFORE audit started	6/28	(21%)	20/29	(69%)	18/20	90%
Audits using evidence based standards **	-	-	-	-	10/20	50%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	3/8	(38%)	9/10	(90%)	7/24	29%
Audits where an action plan was produced:	1/8	(12%)	9/10	(90%)	9/24	38%
If action plan NOT produced, number where audit confirmed current good practice:	0/7	(0%)	0/1	(0%)	0/16	0%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	2/10	(20%)	7/11	(64%)	3/25	0%
Audits leading to better ways of working for staff:	3/10	(30%)	5/11	(45%)	5/25	20%
Audits leading to measurable benefits for patients:	3/10	(30%)	6/11	(54%)	4/25	16%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	0/2	(0%)	3/5	(60%)	2/4	50%

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: A&E									
3.5.1	238	Accessing Blood	Dr Lisa Goldsworthy	X		X			
3.5.2	496	Audit of appropriateness of review in A+E	Dr Alison Milhench; Dr Lisa Goldsworthy			X			X
3.5.3	564	Audit of Guidelines for Petechial /Purpuric rash	Dr S Sivaloganathan			X			
3.5.4	239	Is the hospital following the APLS protocol for status epilepticus	Dr P Dix	X		X			
3.5.5	240	Post urethral valves study	Mr J D Frank	X		X			X
3.5.6	241	Sleep systems in orthopaedic surgery	Caroline Tope	X		X			X
3.5.7	242	What is the correction factor for gas Na + levels	Janet Stone; Dr M Hayden; Dr V Ohlsen	X		X			

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: Anaesthesia									
3.5.8	343	Clinical case mix and outcome for patients seen at the chronic pain clinic	Dr Emma Hoskins; Dr G Lauder			X			
3.5.9	73	Could the Level of Drug Errors in PICU be Reduced by Introducing a New Prescribing System?	Dr P Weir	X		X			X
3.5.10	519	Evaluation of anaesthesia for children undergoing tonsillectomy	Dr Michelle White			X			X
3.5.11	491	Paediatric Acute Pain Audit	Claire Woodman		X				X
3.5.12	520	Perioperative Temperature Management in the Operating Theatre	Dr Subash P Nandalan			X			X
3.5.13	76	Post Operative Pain and Nausea in Day Case Surgery	Dr G Lauder	X			X		
Specialty: CAMHs (Child Adolescent Mental Health)									
3.5.14	78	Deliberate Self Harm	Dr Andrew Fogarty	X			X		
3.5.15	354	Quality of routine note keeping	Martin McCrea			X			
Specialty: Cardiac									
3.5.16	79	Post-Operative Morbidity Following Cardiac Catheterisation	Dr R Martin	X				X	
3.5.17	80	Post-Operative Morbidity Following Cardiac Surgery	Dr G Stuart	X				X	
3.5.18	81	Radiofrequency Ablation in Paediatric Arrythmias	Dr G Stuart	X		X			X
3.5.19	83	Review of Peri-operative Infections	Dr R Martin	X				X	
Specialty: Clinical Genetics									
3.5.20	522	South West of Britain (SWB) Pedigree Audit	Alan Donaldson		X				X
Specialty: Community									
3.5.21	243	ADHD Audit	Dr Justin Daddow	X		X			
3.5.22	355	Referral and Management of Autism	Dr K Merrett; Dr M Bredow				X		
Specialty: Dietetics									
3.5.23	244	Dietetic Care for children with Diabetes (Staff Survey)	Lisa Cooke	X			X		X
Specialty: General Paediatrics									
3.5.24	65	Asthma (NICE recommendations)	Dr Simon Langton Hewer; Dr Jennifer Langlands	X		X			X
3.5.25	66	Asthma (National Audit)	Dr Simon Langton Hewer; Deb Marriage	X		X			X
3.5.26	349	Audit of Head Injury (NICE Guidelines)	Dr Peta Sharples; Dr Narad Mathura; Dr Lisa Goldsworthy			X			X
3.5.27	350	Audit of Paediatric Diabetic Service in Bristol & Weston Super Mare	Dr L Crowne; Dr R Allen; Dr J Shields			X			X
3.5.28	356	Audit of Practice of Placement of Naso Jejunal Feeding Tubes (with PICU)	David Hopkins				X		X
3.5.29	67	Empyema referrals (Physiotherapy)	Louise Owen	X		X			
3.5.30	70	Management of meningitis	Dr L Goldsworthy	X		X			X
3.5.31	348	Status Epilepticus	Dr Ravi Knight; Dr Peta Sharples			X			
Specialty: Neonatology									
3.5.32	84	Discharge Planning (with Obs, Gynae & ENT)	Carol Aldridge	X		X			
3.5.33	85	How are we managing babies with NAS?	Dr T Ellinson	X		X			

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.5.34	352	Patent Ductus Arteriosis	Dr M Traunter; Dr G Russell			X			
3.5.35	351	Quality of Note Keeping	Claire Duke				X		X
Specialty: Nephrology									
3.5.36	245	Audit of adequacy of renal replacement	Dr Catherine O Brien	X		X			
3.5.37	533	Renal transplantation at the Bristol Children's Hospital a 2 year audit	Dr Rokshana Shroff				X		
Specialty: None									
3.5.38	521	Timeliness of reports and clinic letters within out patients	Denise Wells			X			X
Specialty: Nursing									
3.5.39	353	Tissuing cannulars on NICU	Sharron Winterbottom			X			
Specialty: Oncology									
3.5.40	246	Does the administration of Itraconazole increase the risk of blocking central venous catheters	Deirdre McGuigan	X		X			
3.5.41	248	Guidelines for management of Central Lines within Oncology	Chrissie Gardner; Mr Spicer; Mr Haitham Dagash	X		X			X
3.5.42	249	Infection rates in Bionecteur and Click loc bungs	Dr A Foot; Dr J Saunders	X			X		X
Specialty: PICU									
3.5.43	86	Are PICU patients being transfused unnecessarily?	Dr P Robertson; Dr F Donaldson	X					
3.5.44	74	O2 Concentration Supplied to Bagging Circuits in PICU	Christina Gillen	X				X	
3.5.45	75	Pain Experienced on Removal of Chest Drains in PICU	Dr N Morgan	X		X			
3.5.46	72	Regional Audit of Critical Care Outcomes (Audit of Critically Ill Children)	Carol Maskrey	X				X	
3.5.47	341	To investigate the use of non-bronchoscopic diagnostic bronchoalveolar lavages on the paediatric intensive care unit at BCH	Louise Owen			X			X
Specialty: Radiology									
3.5.48	88	Parent Satisfaction Audit	Ingrid Marshall (CIIU); Nicola Bigwood	X		X			
Specialty: Surgery									
3.5.49	89	Appendectomy	Dr Dominic Inman; Mr R D Spicer	X		X			
3.5.50	495	Audit of DDH Protocol	Debbie McMillan; Dereck Robinson			X			X
3.5.51	90	Fundoplication Audit	Miss E Cusick; Dr N Sudhakaran; Mr M Woodward	X		X			X
3.5.52	91	Safety and Practicality of Drug Prescribing Practices	Dr B Eradi; Miss Huskisson	X		X			

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.7.16	542	What is the oral health awareness of patients diagnosed with hereditary coagulation defects?	Dental Services
3.7.34	414	Are dental hygienists utilised in the oro/dental treatment of the bone marrow transplant patient?	Dental Services
3.9.4	404	Contamination of Chemical Pathology samples by K-EDTA from Haematology full blood count tubes	Laboratory Medicine
3.9.11	43	Are laboratory turnaround times for paediatric inpatients changed, following the opening of the new Bristol Royal Hospital for Children?	Laboratory Medicine
3.9.12	44	Are paediatric blood samples sufficiently filled to allow a complete FBC measurement? (with Children's Services and Obs, Gynae & ENT)	Laboratory Medicine
3.12.13	30	Is the Kiwi Ventouse cup being used correctly and safely?	Obs, Gynae & ENT
3.12.15	32	Review of Fetal Deaths, Stillbirths and Neonatal Deaths (with Children's Services & Pathology)	Obs, Gynae & ENT
3.12.16	480	The implications and benefits of performing elective caesarean sections at 39 weeks as opposed to 38 weeks	Obs, Gynae & ENT

EXEMPLAR AUDITS 2002 / 2003

Clinical Audit of the Assessment and Treatment of Attention Deficit Hyperactivity Disorder (ADHD)
Dr Justin Daddow (Specialist Registrar), Dr Liberty Gallus (Specialist Registrar)
Child & Adolescent Mental Health Services

Background
The Child and Adolescent Mental Health Service (CAMHS) decided to undertake this audit to determine whether current practice adhered to NICE guidelines. This exercise was undertaken in direct collaboration with community paediatric staff.

Objectives
- Identify all children diagnosed with ADHD or monitored for this condition between 1-8-00 and 31-7-01
- Compare assessment / prescribing / monitoring practices to the recommendations within the NICE guidelines
- Work closely with community paediatrics to encourage uniformity of practice and facilitate future audit across both services

Methodology
Retrospective medical case note review

Results
- Time from referral to assessment was acceptable, but time from assessment to diagnosis was long (mean approximately 1 year)
- Numbers were low for new cases; this may be because a significant number were prescribed for by paediatricians with CAMHS members involved in, for example, behavioural treatment
- Methylphenidate is prescribed within license in all cases
- Two thirds of new cases had medical parameters documented prior to treatment
- Information was documented to have been given to parents/carers in half of cases
- There was close involvement with schools in the assessment process
- There were very few drug holidays/reductions
- GPs are not involved in prescribing/monitoring
- 4/24 monitoring cases had no documented reviews during the year
- Less than half of children had at least 2 documented reviews during the year
- Overall, medical parameters were only documented in approximately one half of cases
- Unsurprisingly, the children seen more frequently had medical parameters documented more often; this may reflect individual differences between clinicians
- There were wide variations as to where medical parameters were checked and how this information was represented in the case notes

Difficulties / constraints

- Case identification – it was impossible to identify cases from current coding systems. Hospital pharmacy produced a very useful list of children being prescribed methylphenidate. Ultimately, cases were identified by hand-searching filing cabinets.
- Data collection – organisation/legibility/clarity of medical notes was variable at best. It was immensely time consuming to retrieve seemingly simple data from notes. Most sets of notes needed to be read in their entirety.
- Many standards contained within the NICE guidelines are not specific.
- Dedicated time is not allocated for audit – we spent time between patients in clinic and research time collecting data.

Recommendations

- Children referred for an ADHD assessment should initially be assessed by a psychiatrist, or a psychiatrist jointly with another member of the team. This would help to reduce the long assessment – diagnosis time.
- In order to facilitate future audits, we need a coding system which will enable us to quickly identify children with a particular diagnosis and those who are on medication.
- To enable us to meet the above targets and to facilitate future audits, standardised assessment and monitoring sheets for children diagnosed with ADHD should be used – it is hoped that these instruments will be introduced in the Spring of 2003. Ideally this would be in conjunction with community paediatrics in anticipation of a collaborative, cross-service audit at the end of 2003.
- ADHD packs should be introduced, including the above forms, information to be given to parents/carers/schools and children, NICE guidelines and references for further reading. Again, I have developed an ADHD pack and we will be using it from February/March 2003.
- Children on medication should be monitored every 3 to 6 months and have height, weight and blood pressure checked.
- If information is given to children/parents/carers/schools, this must be documented. This could be done on the assessment form.
- Medical examinations must be clearly documented. We need paediatric blood pressure cuffs and paediatric blood pressure charts in CAMHS clinics (currently unavailable). If GPs/school nurses/community paediatricians do these checks, it is the responsibility of the psychiatrist requesting them to document them clearly in the psychiatry file. This should also be done on the monitoring forms.
- More attention must be paid to medication breaks or trial reductions. There are reminders on the monitoring forms.
- Children should not be given 'repeat prescriptions' more than once without a medical review.
- Monitoring forms need to be filled in. This will require input from (already overstretched) admin' staff. One solution is to attach the forms to a standard letter which will not be sent until both are completed.
- This audit needs to be repeated once these recommendations are agreed and implemented. This re-audit should include CAMHS and community paediatrics cases.

<u>Can we reduce the incidence of tissue damage in neonates with IV cannulas?</u>
Sharon Winterbottom (Advanced Neonatal Nurse Practitioner)

Background
This topic – the subject of recurring critical incidents – was highlighted by the clinical risk management lead in discussion at the directorate's monthly clinical audit committee.

Aim

- Assess management of IV cannulation in neonates

Objectives

- To assess insertion technique / protocols
- To note grade of clinician inserting cannula
- To note variations in outcome according to fluid / drug administered
- To observe management of lines in situ i.e. assessment

Methods
Data was collected over a three month period for all babies with cannulae inserted for continuous intra venous infusions (with or without drugs). A questionnaire to collect insertion data and observations of site and pressure were made hourly and a grading system was applied.

Results

Cannula usage

- Continuous infusions of TPN or clear fluids: < 12.4% dextrose
- Antibiotics: Penicillin/Gentamicin/Metronidazole/Fluclox//Vancomycin
- Sedation: Morphine/Midazolam/ Muscle Relaxants
- Caffeine
- Ranitidine/Hydrocortisone/HAS

Cannula Duration

- Range 1 - 6 days
- Median 2 days
- Mean 2 days

- Cannulae discontinued due to tissuing
- Pressure measurements Low, Medium, High
- No change in set pressure in all but 1 tissued cannula
- Assessment Grade 3 / Pressure from low - medium

Conclusions

- Nursing staff were vigilant in their observations and alerting medical staff therefore reducing the incidence of extravasation injuries
- Pressure settings on infusion devices were not a good indicator of tissuing cannulae
- Grading system should supercede current observation of sites

3.6 CRITICAL CARE

SUMMARY FIGURES

	2001/2002 roll-overs <<	22
Audits first registered in 2002/3	Pre-audits P	2
	First audits A	10
	Re-audits R	2
	Ongoing monitoring projects >>	0
	Total number of audits	36
	Completed audits	11
	Current (uncompleted) audits carried forward >	20
	Ongoing monitoring projects carried forward >>	5

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	20/27	(74%)	13/36	(36%)	8/14	57%
Audits arising from a critical incident:	6/27	(22%)	2/36	(5%)	0/14	0%
Audits prompted by a patient complaint:	0/27	(0%)	0/36	(0%)	1/14	7%
Audits with consumer involvement (not including surveys)	7/27	(26%)	0/36	(0%)	1/14	7%
Audits incorporating a patient/carer survey	1/27	(4%)	1/36	(3%)	0/14	0%
Interface audits (involving primary care) *	1/27	(4%)	0/36	(0%)	0/14	0%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	1/36	(3%)	5/14	36%
Audits with no clinical audit facilitator involvement **	-	-	-	-	0/14	0%
Audits with proposal forms completed BEFORE audit started	21/27	(78%)	35/36	(97%)	13/14	93%
Audits using evidence based standards **	-	-	-	-	6/14	43%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	5/11	(45%)	8/20	(40%)	2/11	18%
Audits where an action plan was produced:	7/11	(64%)	8/20	(40%)	5/11	45%
If action plan NOT produced, number where audit confirmed current good practice:	0/4	(0%)	0/12	(0%)	3/6	50%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	7/20	(35%)	6/30	(20%)	3/14	21%
Audits leading to better ways of working for staff:	6/20	(30%)	1/30	(3%)	9/14	64%
Audits leading to measurable benefits for patients:	8/20	(40%)	2/30	(7%)	6/14	43%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	1/10	(10%)	1/11	(9%)	1/2	50%

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: Anaesthesia									
3.6.1	136	Acidosis in cardiac ICU patients	Dr G Hosdurga; Dr T Lovell	X		X			
3.6.2	473	ACT levels during off pump coronary artery bypass grafting	David Healy		X				X
3.6.3	20	Airway problems post operative.	Dina Munim			X			
3.6.4	9	Anaesthetic records documentation	Kate Roberts				X		
3.6.5	137	Are Children Experiencing Acute Pain Following Major Surgery?	Dr P Stoddart	X				X	
3.6.6	138	Are we meeting acute pain recommendations for provision of service to patients and for anaesthetic training?	Dr Nicola Weale	X		X			X
3.6.7	268	Audit of perioperative temperature management.	Dr Subash Nandalan			X			

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.6.8	7	Cancellation and delays in performing ERPC's in theatre 1 during the afternoon and out of hours (St MH).	Lisa Tonkin			X			X
3.6.9	425	Cause for alarm II - a reaudit.	Matthew Molyneux				X		X
3.6.10	474	Central venous cannulation: complications	Mathew Pateril			X			X
3.6.11	139	Competency of ODA/ODP's in inserting cannulas (venous and arterial).	Dr C Monk (Anaesthesia)	X		X			
3.6.12	430	Demand for anaesthetic led antenatal classes	Mark Scrutton			X			X
3.6.13	140	Direct admission after Day Surgery attendance	Dr S Grimes	X				X	
3.6.14	16	Does the use of phenylephrine eye drops significantly affect systemic blood pressure in cataract patients	Catherina Malan			X			X
3.6.15	143	Is the Trust following 2001 Royal College/Trust ICP guidelines for ophthalmic local anaesthesia	Dr Bob Johnson	X		X			
3.6.16	144	Is there sufficient discussion and documentation of invasive anaesthetic procedures in the pre-operative period.	Dr S Martindale	X		X			
3.6.17	146	NCEPOD – review in Day Surgery	Dr Carl Heidelmeyer	X		X			X
3.6.18	147	Post Operative Pain Relief and Side Effects	Jacqui Gannon	X				X	
3.6.19	148	Prospective audit of long term tunneled central venous lines	Dr Simon Massey (Anaesthesia)	X		X			X
3.6.20	150	Re-admission after Day Surgery	Dr Carl Heidelmeyer	X		X			X
3.6.21	151	REAUDIT: Post cardiac surgery pain – are patients receiving adequate analgesia?	Dr Tessa Whitton	X			X		
3.6.22	434	Resternotomy for bleeding following cardiac surgery	Dr Tim Lovell			X			X
3.6.23	152	Safety and economic implications of patient biting of armoured Laryngeal Mask Airways (aLMA)	Dr S Mather	X		X			X
3.6.24	154	What is the national practice with regard to the use of regional anaesthesia for adult cardiac surgery?	Dr Tim Lovell; Dr Tessa Whitton	X		X			X
3.6.25	155	What Problems are Being Experienced with Regional Anaesthesia for Caesarean Section?	Mike Kinsella	X				X	
3.6.26	156	What Resuscitation Training or Competence Assessment is Appropriate for Practicing Anaesthetists?	Dr D Terry	X		X			
Specialty: ICU/HDU									
3.6.27	157	Can critical incidents be prevented by a Medical Emergency Team?	Dr J Hadfield	X		X			X
3.6.28	278	Critical care plan documentation audit	Sr J Scudamore			X			
3.6.29	277	Feasibility of Collecting Augmented Care Period (ACP) Forms from Ward Areas	Sr S McAuslan-Crine			X			
3.6.30	160	Intensive Care National Audit and Research Centre (ICNARC) Database	Dr S Willatts	X		X			X
3.6.31	161	Observation Charts on acute wards.	Dr J Hadfield	X		X			X
3.6.32	409	Swallowing assessment and management in HDU patients	Liz Berry; Eileen Walshe		X				X
3.6.33	162	To examine the discharge process from ICU/HDU.	Sr S McAuslan-Crine	X		X			X
3.6.34	163	What is the outcome of tracheostomy in this hospital? What complications occur?	Dr J Bewley	X		X			X
Specialty: Resuscitation									
3.6.35	165	Is the Trust Following the Procedures for Arrest as Set Out in the Resuscitation Policy?	Jo Bruce-Jones	X				X	
Specialty: Theatres									
3.6.36	421	Operating theatre and pre-operative assessment project (Theatre Modernisation Programme)	Sue Clark			X			X

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.4.1	486	A protocol for the weaning of long-stay patients	Cardiothoracic Services
3.4.3	206	Audit of Adult Cardiac Surgery: Annual Report	Cardiothoracic Services
3.4.4	208	Audit of Extubation Data	Cardiothoracic Services
3.4.6	210	Audit of Relationship Between Haemocrit on Admission to ICU Following Coronary Surgery and Postoperative MI and/or Death	Cardiothoracic Services
3.4.23	363	Heart attacks and other acute coronary syndromes: NSF Audit	Cardiothoracic Services
3.4.9	215	Mortality Rate Procedures Based on Parsonnet Scores (CRAM)	Cardiothoracic Services
3.4.25	223	Myocardial Infarction National Audit Project	Cardiothoracic Services
3.4.10	359	Nausea and Vomiting Post Cardiac Surgery	Cardiothoracic Services
3.4.11	594	Nausea and Vomiting Post Cardiac Surgery (Re-Audit	Cardiothoracic Services
3.4.26	543	Post MI patient care in the BRI	Cardiothoracic Services
3.4.27	367	Prophylaxis for patients who have experienced a MI	Cardiothoracic Services
3.4.17	219	Usage of Blood Products After Cardiac Surgery	Cardiothoracic Services
3.4.32	553	SCTS Thoracic Register Return	Cardiothoracic Services
3.5.11	491	Paediatric Acute Pain Audit	Children's Services
3.17.13	287	Is the locally agreed process regarding patients with high B.P. being adhered to?	Surgery

EXEMPLAR AUDITS 2002 / 2003

Prospective audit of long term tunnelled central venous lines

Dr S Massey - Consultant Anaesthetist; Dr M Taylor - Consultant Anaesthetist; Professor Jill Hows - Professor of Clinical Haematology; Dr Roger Evely - Consultant Haematologist;; Lisa Taylor - Ward 62 Sister; Tracey Arthur - AHU Senior Staff Nurse; Michelle Croucher - Clinical Audit Facilitator; Ruth Hendy - Chemotherapy Clinical Nurse Specialist; Clare Greatorex - Chemotherapy Sister; Michelle Samson - Ward 61 Sister; Clare Bidgood - Ward 61 Clinical Nurse Specialist; Infection Control team

Background

It was perceived in oncology and haematology that long-term lines had a high complication rate. These lines should last the course of therapy but seemed rarely to do so. This has a significant impact on the morbidity and mortality of patients. There is also a material impact on the service in term of staff hours needed to remove and replace lines, equipment costs and theatre time. The individual complication rate for infections, poor line function and 'falling out' was unknown and felt to be high. Review of past years' line failure rate showed that in 98/99 only 34% of lines lasted the course of treatment. In 99/00 this figure was 16%. An audit was needed to determine if the problem lay in the current procedure and if so, implement changes.

Objectives

- To identify true complication rate and range.
- To ensure that line management does not contribute to line failure.
- To improve the efficiency of line management.

Methodology

Multi-disciplinary prospective audit recording all initial insertions on a peri-immediate line placement form and all complications on a post line placement form. BRI patient numbers pseudonymised to connect the two. Data collected by consultants and nursing staff. Data entered and analysed by clinical audit and reviewed by project team on a 6 monthly basis.

Results

- Infective line loss 56% (haematology 38%, oncology 18%)
- PICC have a low complication rate
- Despite high incidence of PWO, use of Urokinase is inadequate

Recommendations
- Continue to leave anchor sutures in - IMPLEMENTED
- Introduce 'sterile' line access methods, as opposed to 'non-touch' methods - IMPLEMENTED
- Investigate chlorhex/alcohol prepacked swabs - IMPLEMENTED
- More aggressive line function rescue – WORKING PARTY IMPLEMENTING
- Encourage use of PICC – WORKING PARTY IMPLEMENTING
- Investigate other CVC lines – WORKING PARTY UNDERTAKING INVESTIGATION
- Continue ongoing audit - ONGOING

Peri-operative Blood Pressure Control In Patients Presenting For Day-case Cataract Surgery

Dr Catherina Malan – Senior House Officer, Claudia Paoloni – Consultant Anaesthetist

Background

Day case cataract surgery is an area of frequent clinical practice in ophthalmics and anaesthesia. High blood pressure in this kind of surgery can lead to complications. The RCOA (Royal College of Anaesthetists) and RCOO (Royal College of Ophthalmologists) produced guidelines as to the management of hypertension in cataract surgery which were updated in 2001. It was felt that UBHT exceeds the standards of management proscribed in the guidelines. An audit was indicated to confirm if this is the case.

Objectives
- To measure the management of hypertension prior to surgery.
- To ensure that UBHTs practice on perioperative blood pressure management is within guidelines.

Methodology

Retrospective sample of 100 day-case cataract patients selected from the PAS by operation code. Case notes reviewed and data entered onto an audit proforma. Data then entered onto spreadsheet by Dr Malan and analysed by Clinical Audit Facilitator (CAF). Questionnaire on procedures and preferences circulated to all ophthalmic anaesthetists. Results collated by Dr Malan and CAF.

Results
- 100% of patients had a preoperative assessment within the 3 months proscribed in guidelines.
- 97% of patients had a BP recorded in the notes at preoperative assessment.
- 31% of patients with elevated BP in the range identified by guidelines were referred to their GP for hypertension management.
- 100% of patients with a pre-op indication had their BP rechecked on the day of operation.
- 88% of cases had their blood pressure rechecked in the anaesthetics room.
- 16% of patients received sedation.
- <1% received general anaesthetic.
- <1% received anti-hypertension medication.

Recommendations
- Review of pre-op assessment clinics local guidelines on GP referring for hypertension management.
- Acute management of blood pressure exceeds the standards laid out but is not felt to be excessive. Therefore no action needed.

Action Plan
- Consultation process with pre-op assessment clinic to be established.
- Interface with primary care identified.
- Local guidelines drawn up on cancellations, use of anti-hypertension meds and general anaesthetics.
- Re-audit written into department forward plans and lead identified.

Potential for future audit

Has indicated areas of audit need.
- Future audit co-ordinating with primary care so consensus on preoperative hypertension management can be achieved.
- The design of the current audit used operation codes to generate the sample so did not give a full picture where operations were cancelled. Preoperative assessments and cancelled operations due to hypertension are indicated as an area of audit need.

3.7 DENTAL SERVICES

SUMMARY FIGURES

	2001/2002 roll-overs <<	19
Audits first registered in 2002/3	Pre-audits P	0
	First audits A	17
	Re-audits R	4
	Ongoing monitoring projects >>	0
	Total number of audits	40
	Completed audits	27
	Current (uncompleted) audits carried forward >	12
	Ongoing monitoring projects carried forward >>	1

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	11/22	(50%)	11/27	(41%)	15/21	71%
Audits arising from a critical incident:	1/22	(5%)	3/27	(11%)	0/21	0%
Audits prompted by a patient complaint:	1/22	(5%)	2/27	(7%)	2/21	10%
Audits with consumer involvement (not including surveys)	1/22	(5%)	0/27	(0%)	4/21	19%
Audits incorporating a patient/carer survey	3/22	(14%)	2/27	(7%)	2/21	10%
Interface audits (involving primary care) *	3/22	(14%)	11/27	(41%)	4/21	19%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	1/27	(4%)	6/21	29%
Audits with no clinical audit facilitator involvement **	-	-	-	-	0/21	0%
Audits with proposal forms completed BEFORE audit started	20/22	(91%)	27/27	(100%)	20/21	95%
Audits using evidence based standards **	-	-	-	-	20/21	95%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	21/21	(100%)	12/12	(100%)	27/27	100%
Audits where an action plan was produced:	17/21	(81%)	10/12	(83%)	26/27	96%
If action plan NOT produced, number where audit confirmed current good practice:	3/4	(75%)	2/2	(100%)	1/1	100%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	12/22	(55%)	7/14	(50%)	13/19	68%
Audits leading to better ways of working for staff:	11/22	(50%)	4/14	(29%)	15/19	79%
Audits leading to measurable benefits for patients:	8/22	(36%)	4/14	(29%)	13/19	68%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	1/7	(14%)	1/6	(17%)	3/9	33%

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: All departments									
3.7.1	375	Are medical histories adequately documented and updated in patient records? Are reported allergies recorded on the PAS system?	Sarah Bain				X		
3.7.2	250	Are needles being disposed of according to the Trust's sharps policy?	L Reakes; Carolyn Southwell	X		X			
3.7.3	502	Are needles being disposed of according to the Trust's sharps policy? - a re-audit	Lee Hemsley				X		
3.7.4	251	Are needles being re-sheathed according to the Trust's sharps policy?	L Hemsley	X			X		

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.7.5	534	What are the reasons for delay for patients receiving medication requiring staff nurses?	Chris Bell			X			X
Specialty: Community Dental Service									
3.7.6	181	A pre-audit to find out how much clinical time is lost by cancellations and appointments not being kept	A White	X	X				
3.7.7	342	Are Community Dental Service staff aware of the oral health promotion message?	Heather Frenkel			X			
3.7.8	182	Are medical histories being documented and updated?	M Donnan	X			X		
3.7.9	183	Are needles being re-sheathed according to the Trust's sharps policy?	M Donnan	X		X			
3.7.10	184	Are radiographic dose reducing techniques being used?	M Donnan	X		X			X
3.7.11	503	Have the General Anaesthetic Protocols for special needs patients been implemented?	Petrina Wood			X			X
Specialty: Oral Medicine									
3.7.12	312	Are appropriate referrals being made by GDPs to the Primary Care Unit	Dr Jane Luker			X			
3.7.13	373	Are dental radiographs being reported in the patients' notes?	Dr Jane Luker				X		
3.7.14	270	Are TMJ Referrals to the Oral Medicine Consultant Clinics appropriate?	Dr Jane Luker			X			
3.7.15	415	What are the reasons for failed attendances in the Oral Medicine department?	Esther Hullah			X			
3.7.16	542	What is the oral health awareness of patients diagnosed with hereditary coagulation defects?	Tony Brooke			X			X
Specialty: Oral Surgery									
3.7.17	271	Are dental injuries to teeth being treated appropriately?	Mr C Bell			X			
3.7.18	185	Are referrals of apicectomies appropriate? - regional	T Aldridge	X		X			X
3.7.19	186	Does the referral from GDPs requesting 3rd molar extraction follow NICE/departmental guidelines?	C Bell; R Oliver; G Kitma; Prof Cowpe	X		X			
3.7.20	188	Is the radiographic component of GDP new patient referrals as efficient as possible?	Daniel Borge	X		X			
3.7.21	448	What is the percentage of satisfactory fine needle aspirate cytology (FNAC) procedures in Oral and Maxillofacial Surgery?	Hannah Pepper			X			
3.7.22	189	Why do Day Case surgery patients fail to attend?	C Bell	X		X			
Specialty: Orthodontics									
3.7.23	190	Do Orthodontic Clinical Records comply with the British Orthodontic Society's minimum data set?	H Griffiths	X			X		
3.7.24	191	Is the age of referral for unerupted canines acceptable? - regional	Nigel Harradine	X			X		X
3.7.25	192	Osteotomies - regional	Nigel Harradine	X				X	
3.7.26	488	What is the quality of cephalometric lateral skull radiographs?	Nigel Harradine			X			
Specialty: Paediatrics									
3.7.27	193	Are Patients / Parents Satisfied With the Paediatric Dental Service?	Deborah Franklin	X			X		
3.7.28	337	Are primary molar teeth being restored appropriately?	Deborah Franklin			X			X

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.7.29	429	What is the quality of letters of referral for children's General Anaesthetics?	Joanna Haskova			X			
Specialty: Personal Dental Service									
3.7.30	252	Are patient medical history forms being completed by clinicians?	C Joshi	X		X			
3.7.31	463	Are patients in pain seen within 24 hours of contact at City Gate Access Centre	Chandi Joshi			X			X
Specialty: Restorative									
3.7.32	453	Are all restorative junior staff carrying out treatment that conforms to a consultant directed treatment plan?	Peter Willy				X		
3.7.33	194	Are broken models a frequent occurrence?	Alex Hussey	X			X		
3.7.34	414	Are dental hygienists utilised in the oro/dental treatment of the bone marrow transplant patient?	Natasha Greaves			X			
3.7.35	410	Are dental hygienists utilised in the oro/dental treatment of the head and neck oncology patient?	Sharon Collett			X			
3.7.36	195	Are students completing treatment for their patients on Adult Dental Health Level 2 (ADH2)?	S Hooper	X		X			X
3.7.37	531	Are TMJ Referrals to the Restorative Consultant Clinics appropriate?	Martin Woodhead			X			X
3.7.38	196	Can Oral Hygiene patients reduce their initial plaque score by 50%	Alison Grant	X		X			
3.7.39	492	Can the introduction of a 'new' safety syringe reduce the frequency of needlestick incidents on ADH2?	Roger Yates			X			X
3.7.40	197	Is the Treatment Plan for Joint Restorative Patients Carried to a Successful Conclusion?	M Jerreat	X		X			X

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.13.2	411	Are Patients with Head & Neck Cancer who are undergoing Radiotherapy receiving appropriate Prostrodontic Care?	Oncology
3.14.16	179	Is Our Management of Orbital Injury Patients Efficient and Effective? (with Dental Services)	Ophthalmology
3.17.10	478	Does the number of patients seen on the Oral and Maxillofacial Clinic exceed the Royal College of Surgeons (RCS) guidelines? - a pre-audit	Surgery
3.17.11	187	Head & Neck Oncology - regional	Surgery

EXEMPLAR AUDITS 2002 / 2003

What is the quality of referral letters for children's general anaesthetic extractions?
Deborah Franklin (Consultant); Joanna Haskov (SHO)

Background
Letters of referral for procedures under general anaesthesia in dentistry must comply with General Dental Council guidelines. These are set out in the Maintaining Standards document and states that letters of referral for general anaesthesia must contain the following information:

- The patient's full medical history
- The patient's dental history
- Clear justification for general anaesthesia.

This audit looks at whether referring General Dental Practitioners are following these guidelines, and making appropriate referrals for extractions on paediatric patients.

A pro-forma has been produced by the UBHT for referring dentists. This includes prompts for all administrative details of the patient and referring dentist, a full medical history, dental history and reason for referral clearly set out. Some practitioners prefer to use a covering letter with the pro-forma, or refer using a letter alone.

Aim
To improve the quality of letters of referral for children's general anaesthesia.

Standards
In accordance with Maintaining Standards, published by the General Dental Council, all referral letters for general anaesthesia should contain details of the patients' medical and dental histories and clear justification for general anaesthesia. The target level of performance for these criteria is therefore 100%.

Methodology
Data was collected from the referral letters of 100 patients who attended the general anaesthesia pre-assessment clinic in the months of March and April 2002.

Results
The results show that referral letters fell short of the standards set. The inclusion of a full medical history and justification for general anaesthesia was found in 80% of letters while a dental history had only been included in 70% of referral letters. Overall only 54% of referrals fulfilled all three set criteria required by the General Dental Council.

The use of the hospital pro-forma was seen to improve the quality of referrals by fulfilling the necessary criteria.: general dental practitioners should be encouraged to use this pro-forma when referring patients for general anaesthesia.

Action Plan
Send referring practitioners a copy of the General Dental Council Guidelines
Amend GA request pro-forma to highlight dental history and distribute copies of the pro-forma to referring practitioners. Also put a copy on the dental hospital website.
Re-audit after a suitable period to monitor compliance.

Audit of Temporomandibular Joint (TMJ) Dysfunction Syndrome
Tony Brooke (Senior Dental Officer)

Introduction
TMJ dysfunction syndrome is typically described as pain in or around the temporomandibular joint with associated crepitus or clicking on opening or closing. Less commonly there may also be intermittent locking of the joint.

Background
There appears to be an increased number of patients referred to Consultant clinics at the Bristol Dental Hospital with TMJ dysfunction that have not had simple treatment measures carried out by the referring general dental practitioner. Many patients referred respond to simple treatment modalities and therefore do not necessarily require a consultant opinion.

Aim
The primary aim of the audit was to gauge the quality and amount of information provided in the original referral letter by the referring practitioner with particular reference to the patient's presenting symptoms.

Standards
All referral letters contain a full history and record of management to date of the disorder (Target 100%)
Simple treatment measures to be carried out and evaluated before referral to a consultant clinic (Target 100%)

Methodology
A sample group of 50 patients was selected who had been referred for temporomandibular joint symptoms to any of five oral medicine consultant clinics during the period of May-November 2002 and the referral letters scrutinised.

Results
86% of the referral letters had no mention of symptoms of the patient's condition.
76% of the referral letters had no mention of any treatment carried out by the practitioner.

Recommendations
If there is no clear evidence from the referral letter that any forms of advice or treatment have been provided then a letter should be sent to the referring practitioner. The letter would outline the initial diagnosis and early treatment of TMJ dysfunction syndrome as a first stage. The letter would also include a jaw exercises instruction sheet, and a tick box history/treatment form for the practitioner to complete after the various treatment stages have been undertaken.

A review of the dental post graduate teaching programme with specific reference to updating practitioners knowledge of the diagnosis and early treatment modalities for temporomandibular joint dysfunction syndrome

Action Plan
Letter which includes exercises and history/treatment form to be sent to referring practitioners if referral letter is inconclusive with regard to patients symptoms and previous advice and treatment for their condition.

3.8 HOMEOPATHY

SUMMARY FIGURES

	2001/2002 roll-overs <<	6
Audits first registered in 2002/3	Pre-audits P	0
	First audits A	0
	Re-audits R	1
	Ongoing monitoring projects >>	0
	Total number of audits	7
	Completed audits	1
	Current (uncompleted) audits carried forward >	5
	Ongoing monitoring projects carried forward >>	1

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	0/3	(0%)	0/6	(0%)	0/1	0%
Audits arising from a critical incident:	0/3	(0%)	0/6	(0%)	0/1	0%
Audits prompted by a patient complaint:	0/3	(0%)	0/6	(0%)	0/1	0%
Audits with consumer involvement (not including surveys)	0/3	(0%)	3/6	(50%)	0/1	0%
Audits incorporating a patient/carer survey	0/3	(0%)	3/6	(50%)	0/1	0%
Interface audits (involving primary care) *	0/3	(0%)	0/6	(0%)	0/1	0%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	0/6	(0%)	0/1	0%
Audits with no clinical audit facilitator involvement **	-	-	-	-	0/1	0%
Audits with proposal forms completed BEFORE audit started	1/3	(33%)	4/6	(67%)	1/1	100%
Audits using evidence based standards **	-	-	-	-	1/1	100%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	3/3	(100%)	3/3	(100%)	0/1	0%
Audits where an action plan was produced:	1/3	(33%)	3/3	(100%)	1/1	100%
If action plan NOT produced, number where audit confirmed current good practice:	1/2	(50%)	N/a	N/a	0/0	N/A
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	1/5	(20%)	4/5	(80%)	1/2	50%
Audits leading to better ways of working for staff:	1/5	(20%)	3/5	(60%)	1/2	50%
Audits leading to measurable benefits for patients:	1/5	(20%)	3/5	(60%)	1/2	50%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	0/2	(0%)	0/2	(0%)	0/0	N/A

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: None									
3.8.1	555	Improving the Quality of Information in the Medical Notes	Dr David Spence				X		X
3.8.2	198	Adverse reactions to homeopathic treatment	Dr Elizabeth Thompson	X	X				
3.8.3	199	Assessing the Effectiveness of Homeopathic Interventions at BHH	Dr David Spence	X	X				X
3.8.4	200	Implementing patient information leaflets - Homeopathic Medication	Dr Elizabeth Thompson	X		X			X
3.8.5	201	Implementing patient information leaflets - Iscador	Dr Elizabeth Thompson	X		X			X
3.8.6	203	The Management and Treatment of Asthma	Dr David Spence	X	X				X
3.8.7	204	What is the DNA (Did Not Attend) Rate at BHH?	Dr David Spence	X				X	

EXEMPLAR AUDIT 2002 / 2003

Adverse Reactions to Homeopathic Medicines – Improving information for patients
Dr Elizabeth Thompson (Consultant)

Background

Homeopathic medicines are safe but not without effect. Practitioners are used to seeing a number of remedy side effects and although these reactions are described in the literature no formal evaluation had been done in any of the UK Homeopathic Hospitals. A previous patient survey had identified that patients wanted more information on homeopathic medication. The aim of this project was to identify and quantify the various reactions to remedies using a patient questionnaire, so that patients could highlight areas that were important to them and then information based on patient experience could be developed.

Objectives

- To survey a group of patients asking about their reactions to symptoms
- To compare results with reported side effects in the literature
- To provide information to patients
- To develop a protocol for the unit on giving information on remedy reactions

Methodology

A questionnaire was developed by audit team, reception staff and patients. This was given to patients to complete when they arrived for their first follow up consultation

Results

Results showed 80% of patients experienced a change in symptoms varying between an aggravation of presenting symptoms, a return of old symptoms and the development of new/proving symptoms. Only 13 of the 116 patients experienced an adverse reaction, equating to 10%, which mirrors that found in the literature. 20% of patients felt they had not been given sufficient information on possible reactions to medicines.

Actions

- Development of a recording protocol for the notes.
- Updated patient literature.
- Protocol for reception/medical staff on informing patients of potential reactions to medication.
- Standard set on reviewing potential reactions by asking patient to return a standard slip to the hospital.

3.9 LABORATORY MEDICINE

SUMMARY FIGURES

	2001/2002 roll-overs <<	17
Audits first registered in 2002/3	Pre-audits P	1
	First audits A	10
	Re-audits R	1
	Ongoing monitoring projects >>	0
	Total number of audits	29
	Completed audits	14
	Current (uncompleted) audits carried forward >	9
	Ongoing monitoring projects carried forward >>	6

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	20/30	(67%)	17/27	(63%)	6/12	50%
Audits arising from a critical incident:	2/30	(7%)	2/27	(7%)	0/12	0%
Audits prompted by a patient complaint:	2/30	(7%)	0/27	(0%)	0/12	0%
Audits with consumer involvement (not including surveys)	0/30	(0%)	0/27	(0%)	0/12	0%
Audits incorporating a patient/carer survey	0/30	(0%)	0/27	(0%)	0/12	0%
Interface audits (involving primary care) *	0/30	(0%)	0/27	(0%)	0/12	0%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	10/27	(37%)	3/12	25%
Audits with no clinical audit facilitator involvement **	-	-	-	-	1/12	8%
Audits with proposal forms completed BEFORE audit started	11/30	(37%)	7/27	(26%)	3/12	25%
Audits using evidence based standards **	-	-	-	-	6/12	50%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	4/16	(25%)	2/13	(15%)	1/14	7%
Audits where an action plan was produced:	10/16	(63%)	9/13	(69%)	9/14	43%
If action plan NOT produced, number where audit confirmed current good practice:	3/6	(50%)	2/4	(50%)	0/5	0%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	14/23	(61%)	12/22	(54%)	10/19	53%
Audits leading to better ways of working for staff:	9/23	(39%)	11/22	(50%)	12/19	63%
Audits leading to measurable benefits for patients:	9/23	(39%)	4/22	(18%)	1/19	5%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	2/9	(22%)	3/13	(23%)	0/1	0%

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

Please note that the vacancy in the post of Clinical Audit Facilitator for Laboratory Medicine is unfilled for financial reasons and therefore the above figures and below project list may contain inaccuracies due to the incompletion of database entries for projects. Exemplar Reports are also unavailable this year.

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: All Departments									
3.9.1	63	Continuous Participation in National External Quality Assurance Schemes	Dr Morgan Moorghen	X				X	
Specialty: Chemical Pathology									
3.9.2	333	Complement Investigation in Meningitis	Dr Mark Gompels			X			X
3.9.3	42	Compliance with agreed requesting protocol for Troponin-I	Dr Wolf Woltersdorf	X		X			

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.9.4	404	Contamination of Chemical Pathology samples by K-EDTA from Haematology full blood count tubes	Dr Graham Bayly				X		
3.9.5	313	Laboratory investigation of diagnostic Tumour Markers	Dr Graham Bayly			X			X
3.9.6	443	Low volume tests - are we doing them well enough and often enough?	Mr Mark de Hora			X			
3.9.7	316	Reporting Paediatric Test Results	Ms Ann Bowron			X			
3.9.8	40	Review of Reference Ranges for commonly requested tests	Dr Andrew Day	X		X			
3.9.9	41	Systematic Review of Minor and Major errors Identified by the Laboratory	Dr Paul Thomas	X				X	
3.9.10	314	White Cell Enzymes	Dr Janet Stone			X			
Specialty: Haematology									
3.9.11	43	Are laboratory turnaround times for paediatric inpatients changed, following the opening of the new Bristol Royal Hospital for Children?	Mrs Liz Worsam	X		X			X
3.9.12	44	Are paediatric blood samples sufficiently filled to allow a complete FBC measurement? (with Children's Services and Obs, Gynae & ENT)	Mrs Liz Worsam	X		X			
3.9.13	46	Blood and Blood Product Usage by Wards and Theatres	Mr Ian Martin	X				X	
3.9.14	387	Compliance with Reflex Testing Protocol for Blood Films Following Initial FBC	Mr Sharif Van Heulen		X				
3.9.15	47	Continuous Participation With Serious Hazards of Transfusion Sentinel Audit	Dr Ed Massey	X				X	
3.9.16	428	Laboratory & clinical consequences of abnormal INR results in warfarinised patients	Dr Jackie James			X			X
3.9.17	427	National Blood Service Audit of UK Transfusion Practice	Dr Edwin Massey			X			X
Specialty: Histopathology									
3.9.18	49	Annual Audit of Adult Autopsies Carried Out at BRI Mortuary (Trustwide)	Dr C Collins	X				X	
3.9.19	50	Are we Complying with Laboratory Procedures Relating to the Retention of Tissue From Autopsy Examinations?	Dr Richard Daly	X			X		X
3.9.20	53	Correlation between Bone Marrow Aspirates and subsequent Trephine Biopsy Tissue	Dr Joya Pawade	X		X			
3.9.21	55	Correlation between Histology of Ovarian Tissue and Radiological Examination (with Radiology)	Dr Guy Martland	X		X			X
3.9.22	56	How Many Supplementary Reports are Issued and do they lead to Changes in Diagnosis?	Prof Massimo Pignatelli	X		X			
3.9.23	384	Standard of Reporting of Bladder Tumour Biopsies	Dr Jonathan Williams			X			X
3.9.24	385	Standards of Reporting of Lung Resection Specimens	Dr Chandan Sen			X			
3.9.25	386	Standards of Reporting of Melanoma	Dr Jooti Gupta			X			
3.9.26	57	Standards of reporting of oesophageal resection tissue	Dr Morgan Moorghen	X			X		X
Specialty: Infection Control									
3.9.27	58	Annual Trustwide Infection Control Audit	Mrs Christine Perry	X		X			
3.9.28	60	Ward-Based Surveillance Programme of Infection Control Procedures in Action	Mrs Christine Perry	X		X			
3.9.29	61	What is the Trust's Hospital Bacteraemia Rate – continuous monitoring (Trustwide)	Mrs Christine Perry	X				X	

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.7.21	448	What is the percentage of satisfactory fine needle aspirate cytology (FNAC) procedures in Oral and Maxillofacial Surgery?	Dental Services
3.11.2	437	Audit of Pathology specimen processing times for specimens sent from the E.D	Medicine
3.11.13	535	Melanoma project	Medicine
3.12.15	32	Review of Fetal Deaths, Stillbirths and Neonatal Deaths (with Children's Services & Pathology)	Obs, Gynae & ENT
3.12.8	231	The Collection of Regional Gynaecological Cancer for the Purposes of Audit and Improvement of Management	Obs, Gynae & ENT
3.13.12	476	Prescription of Irradiated Blood Products	Oncology
3.14.11	472	Management of Microbial Keratitis	Ophthalmology
3.17.2	540	An audit of the standard of reporting for ASWCN for oesophageal & gastric cancer	Surgery
3.17.3	258	Anastomotic leak rates in lower GI patients	Surgery

3.10 MEDICAL PHYSICS & BIOENGINEERING

SUMMARY FIGURES

	2001/2002 roll-overs <<	3
Audits first registered in 2002/3	Pre-audits P	0
	First audits A	1
	Re-audits R	0
	Ongoing monitoring projects >>	0
	Total number of audits	4
	Completed audits	1
	Current (uncompleted) audits carried forward >	3
	Ongoing monitoring projects carried forward >>	0

2000/2 figures relate to previous directorate of Specialty Services (consisting of Medical Physics & Bioengineering & Pharmacy)

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	11/23	(48%)	5/13	(38%)	1/1	100%
Audits arising from a critical incident:	0/23	(0%)	3/13	(23%)	0/1	0%
Audits prompted by a patient complaint:	0/23	(0%)	0/13	(0%)	0/1	0%
Audits with consumer involvement (not including surveys)	2/23	(9%)	1/13	(8%)	0/1	0%
Audits incorporating a patient/carer survey	2/23	(9%)	1/13	(8%)	0/1	0%
Interface audits (involving primary care) *	0/23	(0%)	0/13	(0%)	0/1	0%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	5/13	(38%)	0/1	0%
Audits with no clinical audit facilitator involvement **	-	-	-	-	0/1	0%
Audits with proposal forms completed BEFORE audit started	9/23	(39%)	7/13	(54%)	1/1	100%
Audits using evidence based standards **	-	-	-	-	0/1	0%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	10/14	(71%)	10/13	(77%)	0/1	0%
Audits where an action plan was produced:	1/14	(7%)	7/13	(54%)	1/1	100%
If action plan NOT produced, number where audit confirmed current good practice:	5/13	(38%)	1/6	(17%)	0/0	N/A
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	5/18	(28%)	5/18	(28%)	1/1	100%
Audits leading to better ways of working for staff:	7/18	(39%)	4/18	(22%)	0/1	0%
Audits leading to measurable benefits for patients:	6/18	(33%)	5/18	(28%)	0/1	0%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	1/5	(20%)	2/7	(29%)	0/0	N/A

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: MEMO									
3.10.1	166	Effectiveness of Servicing Methods for Infusion Devices Used by UBHT	Mr Peter Smithson	X			X		X
3.10.2	167	How frequent are anaesthetic incidents and breakdowns in UBHT?	Mr Peter Smithson	X		X			X
3.10.3	376	MDA Notice Distribution and Implementation	Mandy Gemmell			X			X
3.10.4	597	To investigate the current utilisation of infusion devices (with a view to writing a business case for an Equipment Library)	Mandy Gemmell	X	X				

EXEMPLAR AUDIT 2002 / 2003

Distribution of MDA Notices and Implementation of Recommendations – Does Our System Work?
Mandy Gemmel (Medical Device Trainer)

Background
The NHS Executive Controls Assurance standard for Medical Devices Management requires that Trusts keep a record of advice and recommendations issued by the Medical Devices Agency (MDA); that notices are distributed to the appropriate people in the organisation; and recommendations contained in the notices are implemented. In this Trust, the dissemination of MDA Device Alerts to all directorates via nominated leads is managed by our Medical Equipment Management organisation. Directorate leads are then expected to disseminate relevant alerts to clinical areas and ensure recommended action is implemented.

Aim
The aim of this audit is to measure compliance with these criteria for Medical Device Management and to evaluate the effectiveness of our current system.

Objectives
- To check the current records comply with the standard.
- To ensure all directorates received MDA notices.
- To identify potential weaknesses in the current system.
- To check the system records that appropriate action is implemented - where relevant.

Results
- The distribution system and records held by MEMO were robust but not updated regularly.
- Although on average 88% of those on the circulation list read the message alerts from MEMO only 56% responded as requested.
- Three areas were identified as apparently lacking representation and senior managers invited to review their current arrangements.
- Of the nominated leads interviewed, only one used the circulation list recommended by the MDA.
- Only a small percentage of alerts were thought to be relevant by the nominated leads.
- The majority of alerts were circulated electronically. No training sessions were run.
- Approximately one third of respondents kept a record detailing any action required. Few monitored implementation of relevant recommendations.
- Only 1 respondent expected progress reports.

Conclusion
The Trust (through MEMO) does keep a record of advice and recommendations by the MDA (now MHRA). Notices are circulated to appropriate personnel but would be more effective if the recommended circulation list on each alert was followed. Currently we have no mechanism in place to ensure that relevant recommendations reach clinical staff and are implemented. We do not yet achieve 100% compliance with this criteria.

Recommendations
- Leads should keep a summary of the alerts received and review implementation of the action required.
- Directorate leads should follow the alerts recommended circulation list, which will ensure all relevant healthcare professionals are informed.
- Where recommended action is required there should be a review to ensure action is implemented effectively.
- Lines of responsibility and roles should be clarified at directorate level.
- Directorates should review MHRA Medical Device Alert lead arrangements on a regular (annual?) basis and also following any changes in management structure.

Action Plan

Task	Target Date	Facilitator
1. Circulate report to MEMO, and summary report to Circulation List	May 2003	MG
2. Monitor responses on monthly basis and review after 6 months	May 2003 – Nov 2003	Logistics/MG
3. Clarify roles and lines of responsibility from directorate to clinical level	July 2003	Lead Managers
4. Ensure mechanism to monitor implementation of recommendations	Aug 2003	Lead Managers
5. Audit compliance with implementation of relevant recommendations	Sept 2003	MEMO/Directorate audit teams

3.11 MEDICINE

SUMMARY FIGURES

	2001/2002 roll-overs <<	19
Audits first registered in 2002/3	Pre-audits P	4
	First audits A	14
	Re-audits R	5
	Ongoing monitoring projects >>	1
	Total number of audits	43
	Completed audits	15
	Current (uncompleted) audits carried forward >	32
	Ongoing monitoring projects carried forward >>	5

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	7/43	(16%)	11/21	(52%)	11/24	46%
Audits arising from a critical incident:	0/43	(0%)	0/21	(0%)	1/24	4%
Audits prompted by a patient complaint:	1/43	(2%)	1/21	(5%)	1/24	4%
Audits with consumer involvement (not including surveys)	0/43	(0%)	2/21	(9%)	0/24	0%
Audits incorporating a patient/carer survey	0/43	(0%)	3/21	(14%)	0/24	0%
Interface audits (involving primary care) *	0/43	(0%)	3/21	(14%)	2/24	8%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	5/21	(24%)	17/24	71%
Audits with no clinical audit facilitator involvement **	-	-	-	-	10/24	42%
Audits with proposal forms completed BEFORE audit started	33/43	(77%)	7/21	(33%)	14/24	58%
Audits using evidence based standards **	-	-	-	-	18/24	75%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	20/31	(65%)	10/12	(83%)	8/15	53%
Audits where an action plan was produced:	8/31	(26%)	6/12	(50%)	3/15	20%
If action plan NOT produced, number where audit confirmed current good practice:	0/23	(0%)	0/6	(0%)	1/12	8%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	12/32	(38%)	3/13	(23%)	1/17	6%
Audits leading to better ways of working for staff:	7/32	(22%)	3/13	(23%)	2/17	12%
Audits leading to measurable benefits for patients:	12/32	(38%)	2/13	(15%)	2/17	12%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	4/7	(57%)	0/4	(0%)	2/3	67%

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

Please note that due to the absence of the Clinical Audit Facilitator for Medicine, the above figures and below project list have not been checked and may contain inaccuracies.

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: A&E (Emergency Department)									
3.11.1	556	Audit of glove use in the BRI Emergency Department.	Gavin Dreyer			X			
3.11.2	437	Audit of Pathology specimen processing times for specimens sent from the E.D	Dr Ian Higginson		X				
3.11.3	266	Audit of patients with suspected cardiac chest pain in the E.D.	Jenny Tagney; Sarah Tosh			X			X
3.11.4	557	Do homeless patients get a raw deal in the ED at BRI?	Naomi Jobson			X			

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.11.5	541	Management of suspected NOF fractures in the Emergency Department	Lara Morris			X			
3.11.6	280	REAUDIT: Are the E.D. green doting x-rays with an abnormality?	Dr N el Hindy				X		
3.11.7	133	Resuscitation room rapid sequence induction (National)	Dr G Lloyd	X				X	
3.11.8	134	Safety levels in the Emergency Department.	N Armstrong	X				X	
3.11.9	135	Thrombolysis and MI (NSF)	Will Seargent	X				X	
3.11.10	259	Use of X-ray in acute knee injuries in the E.D.	Peter Puhl			X			
Specialty: Dermatology									
3.11.11	396	Comparison of Treatment Regimes with National Guidelines for Bowen's Disease	Dr Katherine Finucane			X			X
3.11.12	98	Management of Melanoma	Dr Narayan	X		X			X
3.11.13	535	Melanoma project	David deBerker		X				X
3.11.14	100	Myocosis Fungoides	Dr Maureen Connolly	X		X			
3.11.15	566	NHSIA Data Set	David deBerker			X			
3.11.16	101	Referral Standards for Patients with Basal Cell Carcinoma	Dr M Kirkup	X		X			X
Specialty: Dietetics									
3.11.17	6	Are Oral Nutritional Supplements being used Appropriately?	Julie Gardner; Jackie Eastwood	X	X				X
3.11.18	105	Is enteral feeding being efficiently and effectively delivered? (with Critical Care)	Nathan Lewis	X		X			X
Specialty: Endocrinology & Diabetes									
3.11.19	468	Management of Cardiovascular Risk in Type 1 Diabetes	Jamie Smith			X			X
3.11.20	327	Are we following the National Guidelines for the Management of Blood Lipids for Diabetic Patients?	Dr Graham Bayly			X			X
3.11.21	107	Diabetes Clinic – DNA rate	Helen Silvers	X		X			X
Specialty: Gastroenterology									
3.11.22	108	Are we Following the Guidelines for the Management of Patients with Gastrointestinal Bleeds?	Dr T Creed	X		X			X
3.11.23	595	Retrospective Audit of the Use of Infliximab for Gastrointestinal Disease?	Dr Sue Turner			X			
Specialty: General Medicine									
3.11.24	328	Are Nursing Care Standards Being Maintained?	Jan Lyn					X	
3.11.25	111	Are patients being treated effectively on an intermediate care ward?	Victoria Eavis	X		X			X
3.11.26	320	Are we following nebuliser guidelines in the BRI?	Fiona Barlow		X				X
3.11.27	113	Are we Following UBHT Antibiotic Prescribing Policy?	Debbie Campbell	X			X		X
3.11.28	329	Audit of Contract Nursing Home Beds. Are We Following the Guidelines?	Debbie Harrison				X		X
3.11.29	330	Management of Continence (Stroke)	Pauline Baker				X		X
3.11.30	331	Mouthcare	Sue Jones			X			
3.11.31	114	Post-take Ward Round	Katherine Bale; Dr J Catterall	X		X			X
Specialty: Medicine for the Elderly									
3.11.32	94	Are we prescribing metformin appropriately? (with Specialty Services)	Dr Simon Croxson	X		X			X
3.11.33	323	Effectiveness of Falls Service	Ruth Cowell; Paulette Nuttal				X		
3.11.34	95	How Appropriate is our Management of Hypercalcaemia?	Dr S Tamane	X		X			

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.11.35	325	National Sentinel Audit for Stroke	Sarah Cains			X			
3.11.36	18	Review of Current OT Practice in Screening and Assessment of Fallers	Scott Allan; Sarah Jenkins; Jo Cannon		X				X
Specialty: None									
3.11.37	92	Are Tracheostomy Patients being Safely Managed?	Sue Jones	X			X		
Specialty: Respiratory									
3.11.38	116	Annual Review of Cystic Fibrosis - Does This Contribute to the Effective Management of Patients?	Dr Nabil Jarad	X				X	
3.11.39	467	Audit of Treatment of confirmed/suspected pulimonary TB in a TB clinic	Dr Tina Memta			X			X
3.11.40	117	COPD Home Care	Dr Catterall	X		X			X
3.11.41	118	Inpatient Management of COPD (Chronic Obstructive Pulmonary Disease)	Suzanne Gilson-Jones	X		X			X
3.11.42	322	National Audit of Management of Chronic Obstructive Pulmonary Disease	Katherine Bale			X			
Specialty: Sexual Health									
3.11.43	471	Is the Milne Centre following National Guidelines regarding the management of gonococcel infection in adults	Michael Clark; Arnold Fernades				X		X

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.4.26	543	Post MI patient care in the BRI	Cardiothoracic Services
3.5.11	491	Paediatric Acute Pain Audit	Children's Services
3.5.26	349	Audit of Head Injury (NICE Guidelines)	Children's Services
3.7.17	271	Are dental injuries to teeth being treated appropriately?	Dental Services
3.15.1	512	Does the use of statins within UBHT follow the NSF?	Pharmacy
3.16.1	305	Joint re-audit of misinterpreted A&E film based on the 'Green-dot' system	Radiology
3.17.8	131	Use of 'bleed beds' on ward 11	Surgery
3.17.23	234	Is the Trust following the Royal College of Physicians Guidelines for the treatment of patients with Fractured Neck of Femur (#NOF)	Surgery
3.18.4	433	Is there a role for an extended scope practitioner physiotherapist (ESP) within the Emergency Department - a pilot study	Trustwide

EXEMPLAR AUDITS 2002 / 2003

Audit of the efficacy of enteral tube feeding in patients following cardiac surgery
Nathan Lewis (Senior Dietician)

Aim
To determine enteral tube feeding (ETF) practice on the cardiothoracic intensive care unit (CICU) with a view to setting standards and implementing guidelines

Objectives
- To identify the number of patients fed via enteral tubes following cardiac surgery over 12 months
- To identify the time that ETF was started post-operatively
- To identify causes of cessation of ETF and frequency of occurrence
- To identify time delay before 100% of nutritional requirements were met
- To identify the health professional recommending cessation of ETF

Methods
An audit tool was developed around the proposed enteral feeding standards and audit objectives. 50 patients were randomly selected from 132 patients referred between 01/02/2001 – 01/02/2002.

Results
The median time for starting ETF was 24-35 hours post-op
Patients were tube fed for a total of 347 days with interruptions occurring on 124 days (36%)
Oral diet was the most common interruption (26%), followed by displacement of enteral feeding tubes (17%). Large gastric aspirate (8%), vomiting (7%) and diarrhoea (6%) were infrequent interruptions
The median time for meeting patient's nutritional requirements was greater than 96hrs post-op
58% of patients had no documentation within medical or nursing notes of the health professional recommending cessation of tube feeding

Action
Dietetics, in conjunction with the CICU team, are implementing ETF guidelines and standards on CICU

Retrospective Audit of the Use of Infliximab for Gastrointestinal Disease
Dr Sue Turner (SpR, Gloucester) and Dr Chris Probert (Consultant, Dept of Gastroenterology, BRI)

Aims & Objectives
- Identify all patients with gastrointestinal disease treated with infliximab (excluding patients treated as part of a clinical study)
- To see whether we meet the standards set out in the NICE guidelines
- Identify any deficiencies & make recommendations to change clinical practice if necessary

Methods
The pharmacy department identified all patients treated with infliximab for gastrointestinal disease. Patient demographics and clinical data were collected form the hospital notes. Data items were recorded on a proforma and then analysed.

Results
- 36/37 patients had severe active Crohn's disease as defined in the NICE guidelines
- All the patients had been on a range of, or combination of, drugs at some stage in the management of their disease. The NICE guidelines were fulfilled, as they were either refractory to this treatment or had developed side-effects, before infliximab treatment took place
- From the records available only 9/36 patients had a Chest X-Ray within 6 months prior to infliximab
- 72% of patients with severe active Crohn's disease, refractory to immunomodulator therapy & where surgery has been felt inappropriate, responded to an initial dose of infliximab. 65.3% of these patients had an incomplete response or relapse & required further infusions. 58.8% responded to their 2nd or 3rd infusion, particularly those with perianal fistulating disease.

Actions
- The NICE guidelines for the use of infliximab should be adhered to wherever possible. However, there may be exceptions, if is felt appropriate by both the clinician & patient
- All patients should have a CXR within 6 months of infliximab to exclude pulmonary TB
- Patients should be appropriately counselled with regard to potential outcomes of this treatment & any possible adverse effects – particularly the risk of anaphylaxis with repeated dosing

3.12 OBSTETRICS, GYNAECOLOGY & ENT

SUMMARY FIGURES

	2001/2002 roll-overs <<	10
Audits first registered in 2002/3	Pre-audits P	0
	First audits A	5
	Re-audits R	3
	Ongoing monitoring projects >>	0
	Total number of audits	18
	Completed audits	9
	Current (uncompleted) audits carried forward >	6
	Ongoing monitoring projects carried forward >>	3

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	15/23	(65%)	8/19	(42%)	4/8	50%
Audits arising from a critical incident:	2/23	(9%)	1/19	(53%)	1/8	13%
Audits prompted by a patient complaint:	0/23	(0%)	0/19	(0%)	1/8	13%
Audits with consumer involvement (not including surveys)	0/23	(0%)	0/19	(0%)	2/8	25%
Audits incorporating a patient/carer survey	5/23	(22%)	0/19	(0%)	0/8	0%
Interface audits (involving primary care) *	0/23	(0%)	0/19	(0%)	1/8	13%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	7/19	(37%)	3/8	38%
Audits with no clinical audit facilitator involvement **	-	-	-	-	0/8	0%
Audits with proposal forms completed BEFORE audit started	11/23	(48%)	7/19	(37%)	7/8	88%
Audits using evidence based standards **	-	-	-	-	7/8	88%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	12/15	(80%)	14/19	(74%)	0/9	0%
Audits where an action plan was produced:	8/15	(53%)	8/19	(42%)	1/9	11%
If action plan NOT produced, number where audit confirmed current good practice:	4/7	(57%)	4/11	(36%)	0/8	0%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	12/20	(60%)	4/24	(17%)	1/10	10%
Audits leading to better ways of working for staff:	14/20	(70%)	8/24	(33%)	1/10	10%
Audits leading to measurable benefits for patients:	12/20	(60%)	4/24	(17%)	1/10	10%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	8/12	(67%)	3/11	(27%)	0/2	0%

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

Project List

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: Audiology									
3.12.1	228	Is the referral protocol from Audiology to ENT appropriate and effective?	Pat Smith	X		X			
Specialty: Contraceptive & Sexual Health Services (CASH)									
3.12.2	527	Audit of Pill-Teaching	Dr. Sharon Bodard				X		X
Specialty: Ear, Nose & Throat (ENT)									
3.12.3	35	National Comparative Audit of Surgery for Nasal Polyposis & Rhinosinusitis in England and Wales	John Browne (RCOG); Mr Maw (UBHT)	X	X				X
3.12.4	33	Review of Mortality & Morbidity in ENT	M Saunders	X				X	

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: Gynaecology									
3.12.5	229	Is medical management of ectopic pregnancy successful?	K Edey	X	X				
3.12.6	230	Referrals to Early Pregnancy Clinic (EPC)	J Mears	X		X			
3.12.7	447	Safe Entry Techniques in Laparoscopy	Louise Ashelby			X			X
3.12.8	231	The Collection of Regional Gynaecological Cancer for the Purposes of Audit and Improvement of Management	J Murdoch	X				X	
Specialty: Obstetrics & Midwifery									
3.12.9	481	Antenatal management of pregnant women with epilepsy at St Michael's Hospital	Jeremy Astin			X			X
3.12.10	436	Antenatal Rubella Audit	Petra Derrington			X			X
3.12.11	29	Are the standards for UNICEF Baby Friendly Accreditation being met?	Belinda Cox	X		X			
3.12.12	335	Efficacy of new IOL(Induction of Labour) regime for post-dates	Naomi Jobson				X		
3.12.13	30	Is the Kiwi Ventouse cup being used correctly and safely?	Louise Ashelby	X		X			
3.12.14	31	Is UBHT providing a high quality screening service of pregnant women for Down's syndrome?	B Strachan	X		X			
3.12.15	32	Review of Fetal Deaths, Stillbirths and Neonatal Deaths (with Children's Services & Pathology)	P Kyle	X				X	
3.12.16	480	The implications and benefits of performing elective caesarean sections at 39 weeks as opposed to 38 weeks	Sonia Barnfield			X			X
3.12.17	374	Use of ECV at St Michael's for term breech	Izuwah-Njoku N.F.				X		
3.12.18	398	Women referred to DAU as raised risk for Down's syndrome	Fran Tester; Peggy Woodward			X			

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.5.32	84	Discharge Planning (with Obs, Gynae & ENT)	Children's Services
3.6.8	7	Cancellation and delays in performing ERPC's in theatre 1 during the afternoon and out of hours (St MH).	Critical Care
3.6.12	430	Demand for anaesthetic led antenatal classes	Critical Care

EXEMPLAR AUDIT 2002 / 2003

Implementation of NICE Induction of Labour (IOL) guidelines at St. Michael's Hospital
Dr Bryony Strachan (Consultant Obstetrician)

Background

The NICE guideline for Induction of Labour (IOL) was published in June 2001 and following multi-disciplinary review and agreement on implementation, a new IOL regime was implemented in St Michael's hospital on 6th February 2002.

Methodology

The audit focused on inductions for post-dates (pregnancies beyond 41 weeks). The audit was carried out retrospectively by compiling information from the IHCS systems database – Stork. A three month period form March to May 2002 was compared to a four month period from April to July 2000. The data obtained from Stork was used as a basis and added to by data from a previous audit carried out in 2000, and from data obtained from patient casenotes in 2002.

Results

- New IOL regime is being followed – 100% of cases met standard or exceptions, meaning that patients were offered IOL at the correct time and received a prostin tablet.
- Time from start of IOL to delivery has increased by 3-4 hours but operative delivery rate not significantly different than prior to implementation of NICE guidelines. However, operative rates in 2002 appear to have increased while instrumentals have almost halved.
- More prostins are being used in 2002 but this was not statistically significant. Savings due to the introduction of the guideline for post-dates inductions were shown to be around £144 per month in drug costs.

Action

- need to ensure that the youngest unborn children (classified by gestation period) are delayed first if the Central Delivery Suite is busy.
- need to find out if the increase in duration of labour is caused by prostin tablets or syntocinon. Changes in practice of these were introduced simultaneously.
- need to find out if there is a real trend of increasing operative and decreasing instrumental deliveries and if so, why.

3.13 ONCOLOGY

SUMMARY FIGURES

2001/2002 roll-overs <<		0
Audits first registered in 2002/3	Pre-audits P	1
	First audits A	13
	Re-audits R	4
	Ongoing monitoring projects >>	0
Total number of audits		18
Completed audits		14
Current (uncompleted) audits carried forward >		4
Ongoing monitoring projects carried forward >>		0

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	13/21	(62%)	0/7	(0%)	15/18	83%
Audits arising from a critical incident:	1/21	(5%)	0/7	(0%)	2/18	11%
Audits prompted by a patient complaint:	0/21	(0%)	0/7	(0%)	0/18	0%
Audits with consumer involvement (not including surveys)	0/21	(0%)	0/7	(0%)	2/18	11%
Audits incorporating a patient/carer survey	0/21	(0%)	0/7	(0%)	0/18	0%
Interface audits (involving primary care) *	0/21	(0%)	0/7	(0%)	1/18	6%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	2/7	(29%)	4/18	22%
Audits with no clinical audit facilitator involvement **	-	-	-	-	4/18	22%
Audits with proposal forms completed BEFORE audit started	13/21	(62%)	2/7	(29%)	13/18	72%
Audits using evidence based standards **	-	-	-	-	16/18	89%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	13/15	(87%)	15/15	(100%)	12/14	86%
Audits where an action plan was produced:	13/15	(87%)	4/15	(27%)	13/14	93%
If action plan NOT produced, number where audit confirmed current good practice:	1/2	(50%)	4/11	(36%)	0/1	0%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	12/15	(80%)	8/15	(53%)	0/11	0%
Audits leading to better ways of working for staff:	8/15	(53%)	5/15	(33%)	2/11	18%
Audits leading to measurable benefits for patients:	6/15	(40%)	5/15	(33%)	6/11	55%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	1/2	(50%)	1/3	(33%)	3/3	100%

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: None									
3.13.1	464	An audit of BHOC lung radiotherapy protocol and non conformities	Tom Wells; Amanda Gee			X			
3.13.2	411	Are Patients with Head & Neck Cancer who are undergoing Radiotherapy receiving appropriate Prostrodontic Care?	Catherine Maytum			X			
3.13.3	399	Audit of GP Letters following Radiotherapy and including GP Views	Amanda Gee				X		
3.13.4	455	Audit of waiting times & interruptions in patients having radical radiotherapy for squamous cell lung cancer	Ion Boiangiu			X			

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.13.5	490	Completeness of Chemotherapy Referral Progress Forms	Ruth Hendy			X			X
3.13.6	344	Documentation of Resuscitation Decisions in BHOC	Clare Bidgood; Michelle Samson; James Harding			X			
3.13.7	517	Timeliness and content of discharge letters on Ward 61	Rebecca Huckett			X			X
3.13.8	412	Waiting Time and Treatment Delays in Head & Neck Cancer	Judy Cox; Jo Parkinson; Arshad Kamil			X			
3.13.9	397	Waiting Time for Commencement and Completion of Radiotherapy for Cervical Cancer	Amit Bahl; Sam Gugliani; Judy Cox			X			
Specialty: AHU									
3.13.10	417	Audit of Patient Waiting Times -AHU pm Wednesday Clinic	Julia Ashley; Jacky James			X			
3.13.11	452	Haematology 2 week wait referral system	Dr Karunanithi; Julia Ashley			X			
3.13.12	476	Prescription of Irradiated Blood Products	Edwin Massey				X		
3.13.13	450	Re-audit of out-patient waiting times (Wed. pm haematology clinic)	Julia Ashley; Jacky James				X		
3.13.14	466	Satisfaction survey for patients having a bone marrow test at AHU day unit and medical documentation of bone marrow biopsies	Dr Mimi Chen; Dr Jacky James		X				
3.13.15	475	The use of G-CSF in peripheral blood stem cell mobilisation - a clinical audit of AHU practice	Rachel Proteroe				X		X
3.13.16	465	Use of Rituximab in AHU	Paul Kerr			X			
Specialty: Palliative Medicine									
3.13.17	372	Are the Bristol Palliative Care Collaborative fentanyl guidelines being followed in BHOC?	Joanne Lee; Gaye Senior-Smith			X			
3.13.18	413	Audit of Pain Guidelines	Maria Malpass; James Rice			X			X

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.7.16	542	What is the oral health awareness of patients diagnosed with hereditary coagulation defects?	Dental Services
3.9.5	313	Laboratory investigation of diagnostic Tumour Markers	Laboratory Medicine
3.12.8	231	The Collection of Regional Gynaecological Cancer for the Purposes of Audit and Improvement of Management	Obs, Gynae & ENT
3.17.3	258	Anastomotic leak rates in lower GI patients	Surgery

EXEMPLAR AUDITS 2002 / 2003

Radiotherapy Waiting Time & Treatment Interruptions
Tom Wells (Research Registrar)

Background
Unplanned prolongation of overall treatment time of radical radiotherapy affects cure and local control in certain tumours. There is strong evidence for this in squamous cell cancer head and neck, squamous cell cancer cervix and non-small cell lung cancer (NSCLC). Guidelines have been formulated categorising cancers with the intention of prioritising radiotherapy treatments so that different cancers are given treatment in appropriate time intervals.

(1) radical squamous cell lung radiotherapy
(2) radical and palliative head and neck radiotherapy
(3) radical and palliative cervix radiotherapy.

The aim of the project was to assess compliance with national and local standards

Summary of findings
Radiotherapy waiting times and treatment interruptions studied in this audit did not comply with national and local standards. Waiting time for treatment was prolonged in all groups and interruptions in treatment occurred in most groups. In squamous cell lung cancer radical radiotherapy delay occurred in 13 of the 21 (62%) cases investigated. In head & neck cancer 19 of the 41 (46%) radical treatments suffered delay and 1 of the 3 (33%). Palliative. In cervical cancer radiotherapy there were delays in 4 of the 12 (33%) radical treatments and 1 of the 2 (50%) palliative cases investigated. Waiting time delays may be due to capacity limitation within BHOC and a prospective audit would enable more detailed clarification. Treatment interruptions could be addressed by offering two treatments per day where an interruption has occurred.

Recommendations (NB. not implemented yet)

- Prospective audit to identify reasons for delay
- Suggest offering two treatments per day where treatment interruption has occurred

Clinic Waiting Times Avon Haematology Unit
Jacky James (Consultant Haematologist)

Background
Changes to the Wednesday afternoon clinic resulted in a reduced number of consultants attending therefore there was more reliance on middle grade staff, who were often delayed at the start of clinic. Two separate appointment lists were maintained although patients were seen jointly. Some patients arrived excessively early. Combined with a delay in seeing patients, this caused the clinics to be very full at all times.

As a result of an initial audit changes were made to the scheduling of appointments, patients were advised of new plans which would mean those arriving early would have to wait. Patients were now being seen more by appointment time than arrival time. Following the implementation of these changes a re-audit was carried out to 'close the loop'.

Aim
The aim of the audit was to ensure that patients in this clinic are seen in accordance with the national standard.

Results
Compliance with the standard was much improved (94%) (previously 77%). 73% were seen within 15 minutes (previously 54%) and the average wait was 12 minutes. Patient behaviour had also changed (average arrival time 17 v 25 minutes)

Action Plan

- Continued vigilance to ensure improvements are maintained.
- Random check audits.

3.14 OPHTHALMOLOGY

SUMMARY FIGURES

	2001/2002 roll-overs <<	10
Audits first registered in 2002/3	Pre-audits P	0
	First audits A	5
	Re-audits R	2
	Ongoing monitoring projects >>	0
	Total number of audits	17
	Completed audits	13
	Current (uncompleted) audits carried forward >	4
	Ongoing monitoring projects carried forward >>	0

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	6/13	(46%)	4/11	(36%)	1/7	14%
Audits arising from a critical incident:	0/13	(0%)	2/11	(18%)	1/7	14%
Audits prompted by a patient complaint:	0/13	(0%)	0/11	(0%)	0/7	0%
Audits with consumer involvement (not including surveys)	0/13	(0%)	0/11	(0%)	0/7	0%
Audits incorporating a patient/carer survey	1/13	(8%)	1/11	(9%)	0/7	0%
Interface audits (involving primary care) *	0/13	(0%)	1/11	(9%)	1/7	14%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	2/11	(18%)	0/7	0%
Audits with no clinical audit facilitator involvement **	-	-	-	-	0/7	0%
Audits with proposal forms completed BEFORE audit started	13/13	(100%)	9/11	(82%)	6/7	86%
Audits using evidence based standards **	-	-	-	-	1/7	14%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	8/8	(100%)	10/11	(91%)	10/13	77%
Audits where an action plan was produced:	6/8	(75%)	10/11	(91%)	10/13	77%
If action plan NOT produced, number where audit confirmed current good practice:	2/2	(100%)	1/1	(100%)	2/3	66%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	8/9	(89%)	9/11	(82%)	7/9	78%
Audits leading to better ways of working for staff:	5/9	(56%)	8/11	(73%)	7/9	78%
Audits leading to measurable benefits for patients:	6/9	(67%)	7/11	(64%)	6/9	67%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	1/2	(50%)	2/4	(50%)	2/4	50%

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** Comparable indicator not collected in previous years
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**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: Directorate Wide									
3.14.1	17	A Pre -Audit of Biometry for Cataract Surgery	Derek Tole	X	X				
3.14.2	8	Aftercare of BD8 patients	Clare Bailey			X			
3.14.3	173	Appropriateness of Listing for Cataract Surgery	Riz Malik	X	X				X
3.14.4	300	Are the Outcomes of Surgery for Childhood Esotropia Reaching Acceptable Standards?	Steven Rowley	X			X		
3.14.5	15	Audit of diabetic retinopathy pending list for outpatient appointments	Clare Bailey			X			
3.14.6	13	Audit of suitability of patients for fast track cataract lists	Clare Bailey			X			

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.14.7	301	Does the Outcome of Horizontal and Vertical Adjustable Squint Surgery in Adults Meet Acceptable Standards?	Steven Rowley	X		X			
3.14.8	584	Improving the Accuracy of Biometry within Ophthalmology	Mr Derek Tole				X		
3.14.9	459	Is current practice for investigating ocular disease by carotid duplex ultrasonography and echocardiography requests, appropriate?	Richard Lee				X		X
3.14.10	304	Is the Service for Children with Amblyopia Efficient and Effective?	Elizabeth Newcomb	X			X		
3.14.11	472	Management of Microbial Keratitis	Derek M Tole			X			X
3.14.12	177	Nurse Led Cataract Follow Up Clinics	Helen Julian	X		X			
3.14.13	299	The Rate of and Management of Endopthalmtis	Tom Stumpf (2001 lead)	X			X		
3.14.14	562	Timing of Vitreo Retinal Surgery	Atul Shah			X			X
3.14.15	303	What are the outcomes and complications of cataract surgery undertaken by consultants at BEH	John Sparrow	X		X			
Specialty: Orthoptics									
3.14.16	179	Is Our Management of Orbital Injury Patients Efficient and Effective? (with Dental Services)	Helen McCarthy	X		X			
3.14.17	180	Referral of Community Orthoptic Patients to BEH	Penny Warnes	X		X			

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.6.14	16	Does the use of phenylephrine eye drops significantly affect systemic blood pressure in cataract patients	Critical Care
3.11.13	535	Melanoma project	Medicine

EXEMPLAR AUDITS 2002 / 2003

The Bristol Eye Hospital Cataract Listing Pre Audit
Rizwan Malik (Senior House Officer)

This project was awarded 1st Prize at the 2003 Clinical Audit Oscars

Background
Cataract Surgery is the most common type of surgery within the Ophthalmological specialty. Approximately 225,000 cataract operations are done in the UK each year. Bristol Eye Hospital does approximately 4,000 cataract operations per year and 2040 patients are presently on the waiting list at Bristol Eye Hospital for surgery.

Presently Snellen visual acuity is the main measure for listing patients for surgery, however, knowledge of the patients visual impairment is vitally important and should be included in the listing process. A patient's quality of life relating to sight will impact on all areas of everyday life. Patients will good visual acuity may have very poor quality of life.

Aim
- To establish the visual impairment of pre operative patients scheduled for cataract surgery at BEH in order to discuss the feasibility of prioritising for surgery using quality of life questionnaire (VCM1) as part of the listing process

Objectives

- To estimate the proportion of patients with mild and severe visual impairment listed for surgery
- To compare waiting times of surgery with National Average, Government Target
- To set standards to establish a protocol for prioritising the listing process including the VCM1 questionnaire

Methodology

This pre-audit focused on all patients scheduled for Pre Operative Assessment in June 2002 (inclusions – all cataract patients only, exclusions – all other operations and patients under the age of 50 years, patients with mental illness). VCM1 questionnaires were sent by post to patients attending POA in June 2002. Further questionnaires were given at POA. A proforma was completed during POA and any missing data was retrieved by retrospective case note analysis. A pilot study was undertaken for 2 pre operative sessions and an audit circular was sent to all staff informing them of the audit.

Results

BEH was found to be listing a significantly higher proportion of patients with good vision (6/12 or better) compared with the National Survey (1998). A high proportion of these patients (41%) had visual impairment of mild or no concern. 98% of patients were meeting the Government Waiting Target of 12 months. 88% of patients were waiting equal or less than the 8 month National Average. Patients with severe visual impairment seemed to be waiting just as long as patients with no visual impairment – evidence of the need for a priority grading system to ensure that patients positively benefit by being involved in their listing decisions.

Grading Surgical Priority

VA VQOL	6/12 or better	6/18-6/60	<6/60
'mild'	3	3	2
'mod'	3	2	2
'severe'	1	1	1

Grade 1 – High Priority	Within 2 months
Grade 2 – Medium Priority	4-8 months
Grade 3 – Low Priority	8-12 months

Action Plan

- To set up a "Working Party" Group which is affiliated with the "Action on Cataracts" Group to discuss how best to implement the recommendations from the audit – to discuss and finalise the priority listing table incorporating the VCM1 scores. Meeting to be held in June 2003.

<u>BD8 Registration Audit (Blind / Partial)</u>

Val Walling (Social Worker) & Sharon Bambrick (Patient Support Nurse)

Background

Blind / Partial Registration can be a traumatic experience for patients. Home Visits are no longer done routinely, therefore outpatient visits may be the only opportunity for face to face contact for the Social Worker and/or Patient Support Nurse with the patient. Numerous surveys have indicated the need for early referral (A Sharper Focus – DoH). Previous data from January-December 2001 showed that of 436 patients who were registered only 51% or 224 patients were referred to the Social Worker for help and support.

Objectives

- To increase the level of referrals to Social Work Department
- To ensure patients are referred in a timely fashion
- To highlight the need for patients to get support

Standards – agreed as part of audit

- 100% of patients for whom BD8 Registration is appropriate should be seen by Social Worker on site (exceptions:- patient choice SWD unavailable.
- If SWD is unavailable then patient details should be passed to Social Work Department within 24 hours of the appointment
- Patients not seen on site should be contacted by Social Work Department within 2 weeks of clinic appointment (A Sharper Focus – Department of Health).

Methodology

The sample for this audit consisted of all patients for whom BD8 registration was completed between 7 May 2002 and 2 August 2002. 124 patients were registered during this time and data was collected using an audit proforma from BD8 Registration Forms and patient case notes.

Results

- 76% of patients were not referred on day of clinic to the Social Work Department (exceptions met in 24% of cases).
- If the Social Work Department was unavailable, 75% of cases that were referred were passed to SWD within 24 hours of the clinic.
- 50% of patients who were not seen on site were not contacted within 2 weeks – not meeting the standard.

Actions

- All patients being registered Blind or Partially sighted must be referred to Social Work Department on the day of the clinic / registration. If no one is available from the SWD then the Patient Support Nurse should be contacted on the day of clinic / registration. If neither are available then a message MUST be left via message form with Social Work Department – Medical Staff to hand notes to Out Patient Nurse who is responsible for filling in the message and contacting the SWD
- Medical notes returned to Medical Secretaries following clinic including BD8 forms should detach them from the notes and place at front of pile so they can be passed directly to Social Work Department

Note: this audit refers to the referral at time of registration BUT registration is not a prerequisite for Social Services provision. Awareness of referral at any stage of sight loss is paramount.

3.15 PHARMACY

SUMMARY FIGURES

	2001/2002 roll-overs <<	4
Audits first registered in 2002/3	Pre-audits P	1
	First audits A	9
	Re-audits R	1
	Ongoing monitoring projects >>	2
	Total number of audits	17
	Completed audits	1
	Current (uncompleted) audits carried forward >	11
	Ongoing monitoring projects carried forward >>	5

2000/2 figures relate to previous directorate of Specialty Services (consisting of Medical Physics & Bioengineering & Pharmacy)

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	11/23	(48%)	5/13	(38%)	2/13	15%
Audits arising from a critical incident:	0/23	(0%)	3/13	(23%)	0/13	0%
Audits prompted by a patient complaint:	0/23	(0%)	0/13	(0%)	0/13	0%
Audits with consumer involvement (not including surveys)	2/23	(9%)	1/13	(8%)	1/13	8%
Audits incorporating a patient/carer survey	2/23	(9%)	1/13	(8%)	1/13	8%
Interface audits (involving primary care) *	0/23	(0%)	0/13	(0%)	0/13	0%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	5/13	(38%)	3/13	23%
Audits with no clinical audit facilitator involvement **	-	-	-	-	4/13	31%
Audits with proposal forms completed BEFORE audit started	9/23	(39%)	7/13	(54%)	9/13	69%
Audits using evidence based standards **	-	-	-	-	1/13	8%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	10/14	(71%)	10/13	(77%)	0/1	0%
Audits where an action plan was produced:	1/14	(7%)	7/13	(54%)	0/1	0%
If action plan NOT produced, number where audit confirmed current good practice:	5/13	(38%)	1/6	(17%)	0/1	0%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	5/18	(28%)	5/18	(28%)	0/5	0%
Audits leading to better ways of working for staff:	7/18	(39%)	4/18	(22%)	0/5	0%
Audits leading to measurable benefits for patients:	6/18	(33%)	5/18*	(28%)	0/5	0%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	1/5	(20%)	2/7	(29%)	0/1	0%

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

Please note that the above figures and below project list may contain inaccuracies due to the vacancy in the post of Clinical Audit Facilitator for Pharmacy for most of the year, and the subsequent incompletion of database entries for projects. Exemplar Reports are also unavailable this year.

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: Pharmacy									
3.15.1	512	Does the use of statins within UBHT follow the NSF?	Elizabeth Rose			X			X
3.15.2	530	Is Tramadol being prescribed appropriately during the pre and post -op period in patients in the BRI?	Mair Bowden			X			X
3.15.3	458	Are patients having their dose of ACE inhibitor adequately titrated?	Sherrie Williamson			X			X

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.15.4	294	Are storage facilities of medicines compliant with the Duthie Report?	Sarah Hepburn			X			X
3.15.5	293	Are the UBHT policies on intrathecal/intravenous administration of chemotherapy and vinca alkaloids being adhered to?	Steve Brown			X			X
3.15.6	292	Audit of Medical Directorate Antibiotic Policy	Debbie Campbell				X		
3.15.7	168	Dispensing Error Level of Occurrence	Richard Cattell	X				X	
3.15.8	402	Do patients undergoing cardioversion for Atrial Fibrillation (AF) have successfully managed anti-coagulation prior to procedure?	Mair Bowden					X	
3.15.9	169	Do PODs/Ward Staff conduct an effective PODs Scheme?	Mary Nicholls	X		X			X
3.15.10	460	Is I.V and oral ciprofloxacin being prescribed effectively?	Julie England			X			X
3.15.11	457	Is Sodium valproate being used appropriately and safely at Barrow Hospital?	Jack Hair			X			X
3.15.12	297	Is the prescribing of Clopidogrel at the BRI evidence-based?	Rachel O'Donnell			X			X
3.15.13	170	Outpatient Dispensing Workload	Richard Cattell	X				X	
3.15.14	171	UBHT Homecare Services (Hightech Homecare Services) - Audit of Service to Avon Health Authority	Liz McCullagh	X				X	
3.15.15	340	What effect does a ward-based technician have on drug trolley rationalisation?	Mary Nicholls					X	
3.15.16	295	What percentage of elderly patients re-admitted are taking medicines different from that documented on their first discharge?	Rachel Beckett			X			X
3.15.17	403	Why do patients fail to bring their own medication into hospital?	Mary Nicholls		X				X

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.9.16	428	Laboratory & clinical consequences of abnormal INR results in warfarinised patients	Laboratory Medicine
3.11.17	6	Are Oral Nutritional Supplements being used Appropriately?	Medicine
3.13.15	475	The use of G-CSF in peripheral blood stem cell mobilisation - a clinical audit of AHU practice	Oncology
3.13.17	372	Are the Bristol Palliative Care Collaborative fentanyl guidelines being followed in BHOC?	Oncology
3.13.18	413	Audit of Pain Guidelines	Oncology

3.16 RADIOLOGY

SUMMARY FIGURES

	2001/2002 roll-overs <<	8
Audits first registered in 2002/3	Pre-audits P	2
	First audits A	8
	Re-audits R	3
	Ongoing monitoring projects >>	0
	Total number of audits	21
	Completed audits	10
	Current (uncompleted) audits carried forward >	10
	Ongoing monitoring projects carried forward >>	1

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	8/11	(73%)	14/20	(70%)	12/13	92%
Audits arising from a critical incident:	2/11	(18%)	0/20	(0%)	0/13	0%
Audits prompted by a patient complaint:	0/11	(0%)	4/20	(20%)	0/13	0%
Audits with consumer involvement (not including surveys)	0/11	(0%)	1/20	(5%)	2/13	15%
Audits incorporating a patient/carer survey	1/11	(9%)	0/20	(0%)	0/13	0%
Interface audits (involving primary care) *	0/11	(0%)	1/20	(5%)	0/13	0%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	2/20	(10%)	3/13	23%
Audits with no clinical audit facilitator involvement **	-	-	-	-	0/13	0%
Audits with proposal forms completed BEFORE audit started	6/11	(54%)	16/20	(80%)	12/13	92%
Audits using evidence based standards **	-	-	-	-	9/13	69%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	7/7	(100%)	15/17	(88%)	8/10	89%
Audits where an action plan was produced:	5/7	(71%)	11/17	(65%)	3/10	33%
If action plan NOT produced, number where audit confirmed current good practice:	2/2	(100%)	3/6	(50%)	4/7	57%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	4/9	(44%)	9/18	(50%)	3/8	38%
Audits leading to better ways of working for staff:	4/9	(44%)	3/18	(17%)	2/8	25%
Audits leading to measurable benefits for patients:	4/9	(44%)	8/18	(44%)	2/8	25%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	0/2	(0%)	0/4	(0%)	1/3	33%

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: A&E (Suite E)									
3.16.1	305	Joint re-audit of misinterpreted A&E film based on the 'Green-dot' system	Dr C.Wakeley			X			X
Specialty: Breast Screening Unit									
3.16.2	306	Audit of image quality	Mrs C Walsh			X			
Specialty: General Radiology									
3.16.3	393	An Audit of Unreported X-Rays. Are the Guidelines Being Followed?	Dr N Matcham; Mrs S.King; Dr A Jones				X		
3.16.4	121	Assessment of Liver Biopsies - Complication Rates, Cancellations	Dr M Callaway	X				X	
3.16.5	394	Audit of colonic stricture findings to differentiate between benign and malignant strictures	Dr V.Markos; Dr J.Virjee		X				X

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.16.6	572	Audit of haematuria clinic renal/bladder ultrasound scans, compared to urological findings	Gill Hoult; Jane Holmden; Tina Stoyles			X			X
Specialty: Paediatrics									
3.16.7	309	Are two views of the clavicle required?	Donna Dimond; Dr S.Barnard; Dr S.King			X			
3.16.8	122	Audit to Determine the Indications for CXR Prior to Paediatric Cardiac Investigations	Dr A Duncan; Dr P Davison	X			X		X
3.16.9	123	How appropriately are requests for erect abdomen radiographs in paediatric radiology?	Dr A W Duncan	X		X			X
3.16.10	307	How long does it take for Paediatric DMSA scan reports to be available on the computer system?	Dr S P Prabhu; Dr S King			X			
3.16.11	124	Paediatric Red dot reporting	Mrs D Dimond	X	X				X
3.16.12	511	Re audit of mobile chest Radiographs on paediatric ITU	Dr M.Shaw				X		
3.16.13	392	Re-audit of DMSA Reporting at the Bristol Children's Hospital	TBA				X		
3.16.14	506	Re-Audit of mobile chest radiographs on the paediatric ITU.					X		
3.16.15	126	Re-audit of Requests for Abdominal Ultrasound and Outcome of Those Examinations for Patients with Non-Specific Abdominal Pain	Dr A Duncan	X		X			X
3.16.16	308	Ultrasound examinations on PICU - How do they alter patient management?	Dr N Matcham; Dr D Grier			X			
Specialty: St Michael's - Obstetric Ultrasound									
3.16.17	255	Antenatal Diagnosis of Isolated Talipes.	Dr P Davison; Dr Helen Lockyer	X		X			X
3.16.18	256	Audit of pick up rate of ectopic pregnancies with U/S findings suggestive of. Update of previous study	Mrs R Burke; Dr H Andrews	X			X		X
3.16.19	257	Audit of ventricular atrium measurements and action taken		X		X			
Specialty: Vascular									
3.16.20	509	Are below knee angioplasties being performed in accordance with currently available evidence?	Dr M.Bradley		X				X
3.16.21	559	National Angioplasty Audit, complication rates	Dr P.Murphy			X			

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.5.26	349	Audit of Head Injury (NICE Guidelines)	Children's Services
3.5.48	88	Parent Satisfaction Audit	Children's Services
3.7.26	488	What is the quality of cephalometric lateral skull radiographs?	Dental Services
3.12.14	31	Is UBHT providing a high quality screening service of pregnant women for Down's syndrome?	Obs, Gynae & ENT
3.12.18	398	Women referred to DAU as raised risk for Down's syndrome	Obs, Gynae & ENT
3.13.4	455	Audit of waiting times & interruptions in patients having radical radiotherapy for squamous cell lung cancer	Oncology
3.13.8	412	Waiting Time and Treatment Delays in Head & Neck Cancer	Oncology
3.17.1	395	An Audit of PTC	Surgery
3.17.3	258	Anastomotic leak rates in lower GI patients	Surgery
3.17.19	462	Are we following the UBHT protocol for suspected Scaphoid Fractures?	Surgery

EXEMPLAR AUDIT 2002 / 2003

An Audit of Unreported X-Rays – Are the Guidelines being followed?
Dr N. Matcham (Sp Registrar – Radiology) and Dr A. Jones (Consultant Radiologist)

Background
Royal College of Radiologists (RCR) recommendations state that:

- Every examination which utilises ionising radiation must be reported, either by a doctor trained for the purpose or by proper delegation to a radiographer. In certain situations, when responsibility is transferred by written agreement, that doctor may be a non-radiologist
- If certain examinations are not reported within the department, then a policy to transfer responsibility .... should be agreed in writing with the referring doctors and managers ... and should be audited
- Failure of referring doctors to return a folder of previous images or to return unreported films to the department transfers the responsibility for providing a written interpretation to the referring doctor

IR(ME)R 2000 states "a clinical evaluation of the outcome of each medical exposure should be reached"

A nationwide RCR audit of inpatient reporting, 2000 found that:

- A substantial % of plain films were going unreported by radiologist
- Formal protocols for transferring responsibility to clinicians often not in place/not being audited

A letter was sent to UBHT consultants and juniors in January 2001 to the extent that they were "obliged to return unreported films to the department, otherwise responsibility transfers to the referrer for providing a written interpretation in the patients notes ... the above are now both European and UK law"

Aim
For Z1 inpatient Chest X-Rays (CXRs) - to determine whether all examinations are being reported, and whether referrers are fulfilling their responsibility for providing a written report in the patients notes, where a formal radiologist's report is not sought.

Standard
All Z1 inpatient CXRs should be reported, either by a radiologist, or by the referring doctor in the patient's medical notes.

Methodology
A list of inpatient CXRs was issued with a Z1 report from computer for an average week in June 2002 (Mon-Fri) and the entire month of October 2002. All CXRs were included for the week in June but only medical and non-cardiac surgery in October (Cardiac surgery was not selected in the second pull due to the high volume and arrangements for these, which would put spurious readings on the findings). Patient notes were reviewed post-discharge, and the computer checked for formal reports.

Results

	June 2002	October 2002	Overall
Number of inpatients issued with Z1 report during week	37	40 (20 medical, 20 surgical)	
Number of notes available	29	27	56
Report of some kind found in notes	15/29 (52%)	10/27 (37%)	25/56 (45%)
Radiologist's report present (at 10 months, all within 2 weeks)	7/29 (24%)	1/27 (4%)	8/56 (14%)
Written interpretation provided in notes	11/29 (38%)	10/27 (37%)	21/56 (38%)

Conclusions

- Most inpatient Z1 CXRs are not being reported at all
- Referrers are not fulfilling their responsibility according to trust policy (assuming that films returned to the department are reported)
- May be a problem with packets being returned to the department on discharge – won't be a problem with PACS in the future but shortage of radiologists will persist
- Major implications for clinical governance and risk management

Recommendations
The following recommendations have been agreed and are in various stages of implementation

- Make clinicians aware of legal responsibilities as referrers
- Ensure that "unreported" films are returned to the department on discharge
- Re-audit following implementation of action plan

3.17 SURGERY

SUMMARY FIGURES

	2001/2002 roll-overs <<	7
Audits first registered in 2002/3	Pre-audits P	3
	First audits A	14
	Re-audits R	5
	Ongoing monitoring projects >>	1
	Total number of audits	30
	Completed audits	25
	Current (uncompleted) audits carried forward >	4
	Ongoing monitoring projects carried forward >>	1

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	13/36	(36%)	10/20	(50%)	19/23	83%
Audits arising from a critical incident:	0/36	(0%)	1/20	(5%)	2/23	9%
Audits prompted by a patient complaint:	0/36	(0%)	0/20	(0%)	2/23	9%
Audits with consumer involvement (not including surveys)	1/36	(3%)	2/20	(10%)	0/23	0%
Audits incorporating a patient/carer survey	3/36	(8%)	1/20	(5%)	1/23	4%
Interface audits (involving primary care) *	1/36	(3%)	1/20	(5%)	1/23	4%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	1/20	(5%)	4/23	17%
Audits with no clinical audit facilitator involvement **	-	-	-	-	3/23	13%
Audits with proposal forms completed BEFORE audit started	13/36	(36%)	10/20	(50%)	20/23	87%
Audits using evidence based standards **	-	-	-	-	7/23	30%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	5/12	(42%)	8/16	(50%)	15/25	60%
Audits where an action plan was produced:	6/12	(50%)	8/16	(50%)	15/25	60%
If action plan NOT produced, number where audit confirmed current good practice:	3/6	(50%)	2/8	(25%)	3/10	30%
Figures below include completed first and pre-audits and ongoing monitoring projects only ***						
Audits resulting in changes in practice:	6/15	(40%)	7/17	(41%)	2/20	10%
Audits leading to better ways of working for staff:	4/15	(27%)	3/17	(18%)	3/20	15%
Audits leading to measurable benefits for patients:	7/15	(47%)	0/17	(0%)	7/20	35%
Figures below include completed re-audits only ****						
Audits confirming measurable benefits for patients:	2/5	(40%)	0/2	(0%)	3/6	50%

* figures for 2000/1 & 2001/2 are sum of audits involving primary care & audits involving Avon Ambulance Service representatives
** Comparable indicator not collected in previous years
*** figures for 2000/1 & 2001/2 relate to all completed audits & ongoing projects
**** figures for 2000/1 & 2001/2 include ongoing projects as well as completed re-audits

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: General Surgery									
3.17.1	395	An Audit of Percutaneous Transhepatic Cholangiograms	Richard Morgan; Mark Calloway; Upper GI Team		X				X
3.17.2	540	An audit of the standard of reporting for ASWCN for oesophageal & gastric cancer	Miss J Blazeby; Miss P King; Dr M Moorghen			X			X
3.17.3	258	Anastomotic leak rates in lower GI patients	Paul Durdey; Anne Pullyblank			X			
3.17.4	282	Catheter Management	Wendy Hurn			X			
3.17.5	283	Handwash audit	Sr Liz May				X		
3.17.6	514	Outcomes for patients operated on by BRI surgeons at Weston GH	Naresh Pore; John Vickers; Upper GI Team			X			

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.17.7	260	The use of CVP lines in surgical patients	Ben Ayers; Clare Faber; Jane Blazeby			X			
3.17.8	131	Use of 'bleed beds' on ward 11	Karen Holliwell	X			X		
Specialty: Hand Unit									
3.17.9	130	Re audit of time use in hand clinic	Sr Dawn Grzlinska	X			X		
Specialty: Maxillofacial Surgery									
3.17.10	478	Does the number of patients seen on the Oral and Maxillofacial Clinic exceed the Royal College of Surgeons (RCS) guidelines? - a pre-audit	Dr Andy Armstrong		X				
3.17.11	187	Head & Neck Oncology - regional	Chris Bell	X					
Specialty: Outpatient Department									
3.17.12	263	Are discharge summaries/MDI forms being filled out fully and accurately?	Shirley Ellmore				X		
3.17.13	287	Is the locally agreed process regarding patients with high B.P. being adhered to?	Caroline Spoors			X			
3.17.14	390	Is the standard of note preparation adequate for colorectal clinics?	Anne Rollings; Jane Pawlawska				X		X
Specialty: Trauma and Orthopaedics									
3.17.15	310	#NOF Collaborative: Are patients being operated on within 24 hours of decision that they are fit for surgery by a senior member of the clinical team?	Andy Newton			X			
3.17.16	311	#NOF Collaborative: Pain scoring for #NOF patients on ward 4	Claire Peacock			X			
3.17.17	288	#NOF Collaborative: Patient Satisfaction	Andy Newton			X			
3.17.18	232	#NOF: Non-clinical factors delaying discharge for #NOF patients (with Medicine)	Andrew Newton; Celia Wogan	X		X			
3.17.19	462	Are we following the UBHT protocol for suspected Scaphoid Fractures?	Andy Barnett; Adrian Taylor; Mr Norman-Taylor			X			X
3.17.20	264	Effectiveness of weekend physiotherapy service for reducing length of stay for orthopaedic patients	Celia Wogan			X			
3.17.21	261	Infection rates after surgical repair of #NOF	Nikki Freeman				X		
3.17.22	438	Is the protocol for the T&O Clinical Nurse Specialist being followed?	Sharon Nicholson; Juliet Pitman				X		
3.17.23	234	Is the Trust following the Royal College of Physicians Guidelines for the treatment of patients with Fractured Neck of Femur (#NOF)	Angie Nicholson	X		X			
3.17.24	235	Pain scoring in A&E and with physios (with Critical Care)	Mark Jackson (Cons); Celia Wogan	X		X			
3.17.25	408	Pin site infection audit	Claire Longhorn			X			
3.17.26	236	Pressure relieving care for #NOF patients in A&E and on the ward (with Critical Care)	C/N Raul Chandrasekura	X		X			
Specialty: Urology									
3.17.27	407	An audit of the demand for Intravesical Therapy for bladder cancer	Bernadette Greenan; Raj Persad		X				
3.17.28	405	An audit of the demand for Truss and biopsy examinations for suspected prostate cancer patients	Bernadette Greenan; Raj Persad			X			

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
3.17.29	406	Demand for and feasibility of nurse-led clinics for follow-up prostate cancer patients with stable disease	Bernadette Greenan; Raj Persad			X			
3.17.30	290	Quality of life of patients with prostate cancer DOH funded (local audit)	Raj Persad; Biral Patel					X	

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.3.4	267	The use of Physiotherapy Specialists in Orthopaedic Clinics to Manage Non-Surgical and Less Complex Surgical Cases	Ambulatory Care & Outpatients
3.4.26	543	Post MI patient care in the BRI	Cardiothoracic Services
3.11.13	535	Melanoma project	Medicine
3.11.36	18	Review of Current OT Practice in Screening and Assessment of Fallers	Medicine
3.14.9	459	Is current practice for investigating ocular disease by carotid duplex ultrasonography and echocardiography requests, appropriate?	Ophthalmology
3.15.10	460	Is I.V and oral ciprofloxacin being prescribed effectively	Pharmacy
3.16.6	572	Audit of haematuria clinic renal/bladder ultrasound scans, compared to urological findings.	Radiology

EXEMPLAR AUDITS 2002 / 2003

The Use of Central Venous Pressure Lines in General Surgery and Urology Patients

Miss Jane M Blazeby (Consultant General Surgeon), Dr Ben Ayers (HO), Dr Claire Fabre (HO)

Background

The 2001 report of the National Confidential Enquiry into Perioperative Deaths (NCEPOD) made several principal recommendations. It believed there was a gap in the amount of medical and nursing expertise between intensive care and surgical wards with respect to central venous pressure (CVP) management and interpretation. As a result, the report recommended further education and training of staff as well as the provision of sufficient ward equipment, in particular transducers for central pressure monitoring. It also suggested multidisciplinary audit between surgeons and anaesthetists as another principal recommendation. Therefore an audit was undertaken to assess the knowledge of medical and nursing staff on the topic of central lines, and to study the indications, use and complications of central lines in surgical patients at the Bristol Royal Infirmary (BRI) over a two-month period, April to May 2002. It is planned to present this work to both the surgical and anaesthetic departments to allow a wide range of views on the data to be considered.

Aims & Objectives

- To assess the use of CVP lines in general surgery and urology patients.
- To investigate the provision of equipment to enable accurate CVP monitoring.
- To examine the knowledge of nursing and medical staff in the interpretation and use of CVP.

Methodology

Data was collected on general surgical and urology patients in the BRI. Questionnaires about knowledge and management of CVP lines were also completed by surgical junior doctors (House Officers and Senior House Officers) and senior nursing staff. Patient data was collected in two ways.

1. Daily visits to all the surgical wards, ITU and HDU to assess the use and complications over a two-month period.
2. Snapshot study (24hrs) of all patients on surgery wards to determine those that may have benefited from a central line during their stay. Criteria based BRI's Medical Emergency Team Criteria

Results

- Staff knowledge varied on the use of CVP and there was no UBHT protocol on the management of central lines.

- Only one of the surgical wards had a transducer for continuous and accurate CVP monitoring and concerns were raised about the need for continuous use and training with such equipment to prevent becoming deskilled. There are few training opportunities for surgeons to insert central lines since anaesthetists tend to insert them. Central lines were not always inserted when perhaps indicated and 2 such cases involved difficult fluid balance in patients with significant cardiac and/or renal co-morbidity.

Actions

- All SHOS to receive CVP insertion and management training when they rotate through HDU
- A protocol to be written for ward management of CVP (team to be identified)
- It is recommended that all CVP lines are inserted in a clean environment
- It is the responsibility of the surgical team to insert CVP lines on ward patients (not the anaesthetists)

An Audit of the Standard of Pathology Reporting in Oesophageal and Gastric Cancer

Miss Polly King (SHO), Miss Jane M. Blazeby (Consultant Surgeon), Dr M Moorghen (Consultant Pathologist), Professor Derek Alderson (Consultant Surgeon) & Dr Joyti Gupta (Consultant Surgeon, Gloucester)

Background

The complete pathology report is one of the most important factors in staging patients with oesophageal and gastric cancer. Information such as completeness of resection and the TNM staging plays a vital role in deciding patient management and providing prognostic information. The upper gastrointestinal cancer site specialist group agreed to audit the pathological staging of oesophageal and gastric cancer specimens within the Avon, Somerset and Wiltshire Cancer Network in May 2002.

Standards

The collected reports were compared with the minimum datasets provided by the Royal College of Pathologists in 1998 and 2000.

Methodology

- Using the SNOMED coding system within the participating hospitals all pathology reports for oesophageal and cancer resection specimens for the whole of 2001 were collected.
- To ensure validity of the data evaluation, 20 reports were selected at random and given to both a consultant surgeon and SpR in pathology to assess. Differences in the evaluation were discussed at a meeting and the main data collector then re – evaluated all the reports on the basis of the discussion.
- Individual reports were analysed to see how complete they were and also which categories were most commonly omitted or only partially completed.

Results

- The standard of reporting oesophageal and gastric cancer specimens in the ASWCN was generally good.
- The main finding of this audit was that some areas consistently fall below national standards. Categories most poorly completed were those requiring several parameters to ensure that all aspects had been reported. To improve standards of reporting the use of a proforma is recommended (Rigby 1999).
- In addition, the minimum standards documents did not allow for specimens that show a complete pathological response to neoadjuvant treatment. Neither did they allow a representative description of the degree of response to pre-operative chemotherapy.

Action plan

- The use of a standard proforma based on the minimum datasets provided by the Royal College of Pathologists for oesophageal and gastric cancer resection specimens is recommended. Work at UBHT has started to develop this
- A modification/expansion of the minimum data set is needed to allow for the inclusion of specimens from patients who have undergone neoadjuvant treatment.

3.18 TRUSTWIDE

SUMMARY FIGURES

	2001/2002 roll-overs <<	2
Audits first registered in 2002/3	Pre-audits P	0
	First audits A	5
	Re-audits R	2
	Ongoing monitoring projects >>	0
	Total number of audits	9
	Completed audits	4
	Current (uncompleted) audits carried forward >	5
	Ongoing monitoring projects carried forward >>	0

Please refer to definition of terms in Section 3.2.1	2000/2001		2001/2002		2002/2003	
Figures below relate only to audits started in 2002/3, i.e. not including 2001/2 roll-overs						
Multidisciplinary audits:	-	-	-	-	2/7	29%
Audits arising from a critical incident:	-	-	-	-	0/7	0%
Audits prompted by a patient complaint:	-	-	-	-	0/7	0%
Audits with consumer involvement (not including surveys)	-	-	-	-	0/7	0%
Audits incorporating a patient/carer survey	-	-	-	-	2/7	29%
Interface audits (involving primary care) *	-	-	-	-	1/7	14%
Audits linked to NSF, NICE guidance, or similar national guidance	-	-	-	-	1/7	14%
Audits with no clinical audit facilitator involvement **	-	-	-	-	0/7	0%
Audits with proposal forms completed BEFORE audit started	-	-	-	-	4/7	57%
Audits using evidence based standards **	-	-	-	-	1/7	14%
Figures below relate to completed audits only						
Audits where a formal report was filed at the end of the project:	-	-	-	-	4/4	100%
Audits where an action plan was produced:	-	-	-	-	3/4	75%
If action plan NOT produced, number where audit confirmed current good practice:	-	-	-	-	0/1	0%
Figures below include completed first and pre-audits and ongoing monitoring projects only						
Audits resulting in changes in practice:	-	-	-	-	3/3	100%
Audits leading to better ways of working for staff:	-	-	-	-	0/3	0%
Audits leading to measurable benefits for patients:	-	-	-	-	1/3	33%
Figures below include completed re-audits only						
Audits confirming measurable benefits for patients:	-	-	-	-	0/1	0%

This section contains audits that have a Trust-wide focus, or are led by Allied Health Professionals who are not allied to any particular directorate. Please note that AHPs will also be involved in audits that are registered to other directorates.

PROJECT LIST

The "No." refers to the registration number of the project on the Audit Project Management Database
X indicates the audit is of the type specified

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: Occupational Therapy									
3.18.1	507	Staff Time Activity audit	Jayne Weare				X		X
Specialty: Physiotherapy									
3.18.2	525	Are the standards for use of outcome measures for elderly rehabilitation being achieved, and do they show an improvement in patient function?	Susie Tyrrell			X			X
3.18.3	508	Evaluation of Physio Direct service	Rachel Goodwin			X			X
3.18.4	433	Is there a role for an extended scope practitioner physiotherapist (ESP) within the Emergency Department - a pilot study	Carey McClellan; Sarah Brown			X			X
3.18.5	497	Response time to new neurology outpatients	Mel Falk			X			X

				Type of Audit					
Ref	No.	Project Title	Audit Lead/s	<<	P	A	R	>>	>
Specialty: Trustwide									
3.18.6	12	Audit of Loose Filing in Front Pocket of Patient Notes	Bridget Wright	X		X			
3.18.7	456	Audit of Medical Records in UBHT	Nicola Henderson; Sue Jones			X			
3.18.8	227	Audit of Red ID Bands	Bridget Wright	X		X			
3.18.9	510	Re-audit of Loose Filing in Front Pocket of Patient Notes	Nicky Henderson; Bridget Wright				X		

Please also see following audits listed under other directorates:

Ref	No.	Project Title	Directorate
3.4.24	366	Heart Failure: NSF Audit	Cardiothoracic Services
3.9.27	58	Annual Trustwide Infection Control Audit	Laboratory Medicine
3.9.28	60	Ward-Based Surveillance Programme of Infection Control Procedures in Action	Laboratory Medicine
3.9.29	61	What is the Trust's Hospital Bacteraemia Rate – continuous monitoring (Trustwide)	Laboratory Medicine
3.11.37	92	Are Tracheostomy Patients being Safely Managed?	Medicine

EXEMPLAR AUDITS 2002 / 2003

Re-audit of Loose Filing in Front Pocket of Patient Notes
Bridget Wright (Clinical Risk Manager), Nicola Henderson (Clinical Risk Management Assistant)

Background
UBHT are members of the Clinical Negligence Scheme for Trusts (CNST) and in December 1999 achieved both level one and two of CNST risk management standards. The trust was due for reassessment of these two levels in February 2003 and needed to review all criteria to achieve these. One of the 8 risk management standards relates to medical records. There are many criterion within this standard but one in particular relates to the use of the front pockets of medical notes.

A CNST standard, criterion 4.1.2 states "Records are bound and stored so that loss of documents and traces are minimised for in-patients and out-patients." The CNST guidance states that "there should be no inside pockets or flaps as these can lead to mis-filing or loss of documents. If they do exist (i.e. for patient identification labels only) there will need to be a convincing system in place to maintain and monitor this arrangement.

The presence of loose filing in the front pocket of patient notes was identified by CNST as an area of concern in their assessment in 1999 and, following their visit, an action plan was devised to ensure the filing of all loose documents was undertaken appropriately and standards introduced to improve this area. It was stated in the action plan that an audit would be undertaken to review the effectiveness of this plan.

An audit was done in July 2002 to establish the levels of compliance with those standards within UBHT (project 12 on audit database). This showed that inappropriate filing did occur. An action plan was put in place to review systems of filing across the Trust and re-audit, which was done in January 2003. The standard was that nothing but patient labels should be filed in the front pocket of notes.

Objectives
- To establish whether inappropriate filing in the front pocket of patient case notes has been reduced since the July 2002 audit
- To identify the types of items still being inappropriately filed in the front pocket of patient case notes

Methodology
10 casenotes of inpatients in each ward and 10 patient notes from selected clinics were reviewed from each of the following hospitals: Dental, Eye, St Michael's (Obs, Gynae & ENT) Children's, Oncology, General (2nd Stage Care & Rehabilitation), Keynsham (Rehabilitation) and Bristol Royal Infirmary (Medicine, Surgery, Cardiac, Trauma & Orthopaedics, Outpatients). This was done in the week commencing 6th Jan 2003 and

totalled 696 patients (some wards having less than 10 patients). A Clinical Risk lead (or other identified person) collected data for their area on a proforma devised by Nicola Henderson (with assistance from Eleanor Ferris).

Results

- 13 wards/areas had no filing in the front pocket other than patient labels. These areas were distributed across the trust (2 Eye Clinics, 1 Dental Clinic, 3 Children's Clinics, Antenatal clinic & Gynae ward at St Michael's, 1 medical & 1 surgical ward in BRI, 1 Keynsham ward & 2 General wards)
- 12 areas had 10 to 20% of notes with filing in front pockets, 18 had 25-50% of notes with front pocket filing, 13 had between 60% & 71%, and 20 areas had at least 80% of their notes with front pocket filing.
- Directorates varied from 5% (BDH) of notes with front pocket filing (other than patient labels) to 85% (cardiac)

Actions

B Wright & N Henderson led actions, in conjunction with Medical Records and clinical staff:

- New casenotes without front pockets provided for all new attenders at UBHT from April 2003
- Current patient casenotes to continue to use front pockets with an ongoing stress on correct filing

N Henderson to lead re-audit in September 2003.

Is there a role for an Extended Scope Practitioner physiotherapist (ESP) within the Emergency Department?

Carey McClellan (Extended Scope Physiotherapy Practitioner)

Background

There is increasing pressure on the emergency services to achieve the NHS plan target that by the end of 2004 patients should be seen, treated and discharged, transferred or admitted within 4 hours of arrival in Emergency Departments ("arrival to disposal time"). At the time of planning this study, the BRI was struggling to meet national standards. There were nurses working in an extended role within the Emergency Department (ED) but the only physiotherapy input was provision of clinic sessions where the medics could refer patients who have suffered soft tissue injuries for urgent advice and treatment. The consultants and nursing staff in A&E strongly supported the need for a physiotherapist also to work full time in an extended role within the ED to entirely manage a large proportion of the soft tissue injuries that attend the minor end of the ED.

An unpublished pilot study was undertaken at the Countess of Chester hospital in England in March 2001, and showed that an Extended Scope Physiotherapist (ESP) was well-received within the ED department and there was potential for reducing waiting times. Introducing this service to the BRI would have two major benefits:

- Improve quality of care provided to patients attending ED with soft tissue injuries, as they would receive appropriate advice and management on their initial visit, avoiding the need for a return visit to physio clinic in the ED
- Free up medical staff to concentrate on the more complex of major cases and so aid throughput in ED, reducing waiting times for all

Objectives

- To assess the viability of an ESP service in the ED
- To review the possible impact an ESP might have on waiting times
- To evaluate patient satisfaction with the ESP service

Methodology

This pilot study took place in the adult Emergency Department (ED) at the Bristol Royal Infirmary in the period from 06/02/2003 to 05/03/2003 (inclusive). Audit data was collected between 09:30-12:30 hours, and 13:30-16:30 hours on weekdays only. Patients who presented at the ED were triaged by the nursing staff and categorized depending on their condition into categories P1 (immediate priority) to P4 (lowest priority). The ESP then screened all P3 & P4 patients and treated where appropriate, according to defined inclusion and exclusion criteria (based on ESP protocols used in other A&Es and agreed by all the ED consultants).

All patients presenting at the emergency department were informed that they were seeing an ESP and not a doctor, giving them an opportunity to refuse this option without asking them specifically for consent. A patient satisfaction questionnaire was given to the patient at the point of discharge and they were asked to complete it and place it in a designated collection point in the emergency department.

Data was collected using an audit proforma which was completed after each patient contact by the ESP. The patient's arrival, review and discharge times were recorded, together with their diagnosis and outcomes of treatment. In addition, every morning between 8:30 and 9:30am, a retrospective audit was undertaken of all the previous day's P4 arrivals at the ED during the pilot study times, in order to identify any patients that would have been suitable for ESP management (whether or not they were actually seen by the ESP) and to compare waiting times.

Results

- The total number of patients seen by the ESP physiotherapist was 171, which represents 20% of the total ED patient arrivals during the pilot study (n=853). With a few exceptions, these were all P4 patients, with the ESP physiotherapist treating 40% of the P4 patients
- An identified patient group of 30% of the total ED arrivals could be managed by an ESP
- 98% of patients treated by the ESP were discharged within the national targets of under 4 hours
- The average arrival to disposal time of ESP patients was 1 hour 37 minutes compared with 2 hours and 7 minutes for other P4 patients
- The percentage of ED arrivals processed in under 4 hours increased from 45% to over 65% over the period of the ESP study. Although other initiatives were also introduced in this time, the percentage decreased again when the ESP study finished, despite the other initiatives still being in place, which suggested that the presence of the ESP decreased waiting times.
- There was a high patient satisfaction with the treatment by an ESP physiotherapist

Actions

- Funding has been found for the ESP to work for a further 7 months period starting in July 03

Appendix A - Clinical Audit Strategy

This document updates and revises previous Clinical Audit strategy documents written in 1996, 1999 and 2001. It is next due for review in January 2005.

1. Definition

All healthcare professionals are expected to participate in clinical audit[1]: it is not an 'optional' activity.

The 1997 White Paper The New NHS and subsequent Government publications such as A First Class Service and Clinical Governance - Quality in the new NHS have reinforced the position of Clinical Audit as an integral part routine practice for healthcare professionals working in the NHS, at the heart of Clinical Governance.

According to NICE[2]:

"Clinical Audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, processes and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery"[3]

A similar definition is advocated by the National Audit & Governance Group:

"Clinical Audit is a clinically-led initiative in which healthcare professionals compare actual practice against agreed, documented, evidence-based standards with the intention of modifying their practice where indicated, thereby improving patient care."

Things which are not (always) Clinical Audit

The Clinical Audit Committee supports the view that Clinical Audit is fundamentally a quality improvement process, rather than data analysis (although data analysis is a crucial part of the audit cycle). It is recognised that not all activity undertaken in the name of clinical audit conforms to the definitions given above: the Committee's position on a number of familiar 'grey areas' is outlined below:

Counting things (numbers of operations, etc)

The collection of data which is not related to clinical standards (criteria) is not considered to be clinical audit. Whilst data collection with the explicit purpose of setting standards of best practice may sometimes be considered to be a legitimate audit activity (called 'pre-audit'), it is important the audit cycle is observed and that standards are established as a result of the project.

[1] This principle was established (for all medics) in the 1989 White Paper Working for Patients and later extended to all healthcare professionals in successive initiatives culminating in 1997's White Paper The New NHS and subsequently Clinical Governance – Quality in the new NHS
[2] The National Institute for Clinical Excellence
[3] Principles for Best Practice in Clinical Audit, NICE/CHI, 2002

Investigations

Similarly, clinical audit staff are sometimes asked to "find out more about what's happening here". Whether or not these kinds of request constitute clinical audit is also dictated by the presence or absence of clinical standards.

Research

The boundary between what is legitimate clinical audit activity and what is research is not always easy to identify, however pre-audit must not be allowed to become a backdoor route to undertaking research (thereby avoiding Research Ethics Committee processes).

Morbidity & Mortality Review

Although early NHS definitions of Clinical Audit mention peer review, this is notably absent from more recent Government-approved literature. Morbidity and Mortality (M&M) review should be encouraged and naturally complements clinical audit activity, however M&M must not be seen as a substitute for criterion-based clinical audit, and should not be allowed to dominate the workload of UBHT clinical audit staff.

Routine Monitoring of Clinical Outcomes

The identification and measurement of clinical outcomes may form a significant part of a clinical audit project, however routine ongoing monitoring of outcome data for purposes including performance monitoring should not be considered to be Clinical Audit unless this is explicitly linked to the change process (implicitly this means that process measures must also be monitored, as this is how practice – and outcomes – will be improved).

2. Aims of the Clinical Audit programme at UBHT

The overarching strategic aims of Clinical Audit activity at UBHT continue to be:

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

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

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

ii. Delivering high quality local training to clinicians and managers

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

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

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

3. Clinical Audit management framework and accountability

Strategic direction for the UBHT Clinical Audit programme is determined by the trust's Clinical Audit Committee. Membership of the CAC is as follows:

- Chair of Clinical Audit
- Clinical Audit Co-ordinator
- Clinical Audit Support & Information Manager
- Directorate Clinical Audit Convenors
- Head of Consumer Unit
- Nursing Representative
- AHP representative
- Executive lead for Clinical Audit

The annual Clinical Audit programme is determined at directorate level, based around three priority categories established by CAC, namely (in no particular order):

Category A – responding to the national agenda
- National Clinical Audits (NICE / CHI / Royal Colleges)
- Audits of National Service Frameworks
- Local audits of NICE guidance and guidelines

Category B – responding to CHI requirements
- Audits linked to Trust / directorate priorities (as identified in Business Plans, etc)
- Audits which directly involve patients and carers (see below)
- Projects undertaken with the aim of ensuring that all clinical professions are engaged in the clinical audit process
- Audits which evaluate and encourage multi-professional working
- Audits which link UBHT with the local health economy (e.g. PCTs)
- Audits which link Clinical Audit with other strands of Clinical Governance activity (e.g. complaints, critical incidents, PALS, etc)

Category C – miscellaneous
- Audits of locally developed clinical guidelines
- Regional audit projects
- Re-audits of previous projects where practice has subsequently been changed

Other clinical audit projects should only be entertained if directorates are satisfied that Categories A-C have already been adequately addressed in their local audit programmes.

The directorate clinical audit planning process for each new financial year should start in the January of the previous financial year, based on the categories above.

Responsibility for organising and delivering the programme at directorate level rests with Clinical Audit Convenors (clinical leads) and Clinical Audit Facilitators (CAFs). Directorates receive funding for their CAFs via the Clinical Audit Central Office (CACO). Clinical Audit Facilitators are line managed within their directorates, but professionally responsible to the Clinical Audit Co-ordinator.

All clinical directorates should have a Clinical Audit steering group (committee) to oversee the local programme; alternatively the functions of this group may be encompassed within a broader Clinical Governance steering group. Either way, all directorates must have a clear mechanism for assuring the quality and appropriateness of local clinical audit activity: registration documentation must be completed and signed-off for all new clinical audit projects prior to their commencement. Similarly, all directorates should develop a systematic approach for monitoring the agreement and implementation of local action plans resulting from clinical audit projects. All directorates should provide an appropriate forum for the presentation and discussion of clinical audit results.
Progress of the Clinical Audit programme is monitored principally via quarterly reports from directorates to CAC. The CACO in turn produces a quarterly report on behalf of CAC which is sent to

the Trust Clinical Governance Committee (CGC). This reporting system utilises a clinical audit management database developed and maintained by the CACO.

At the end of each financial year, the Clinical Audit Annual Report is produced by the CACO and approved by CAC, CGC and UBHT Trust Board.

4. Lines of support

Most UBHT clinical audit activity is facilitated/supported through the clinical directorates, however some projects are facilitated through the CACO. The flowchart shown in Figure 1 describes lines of support.

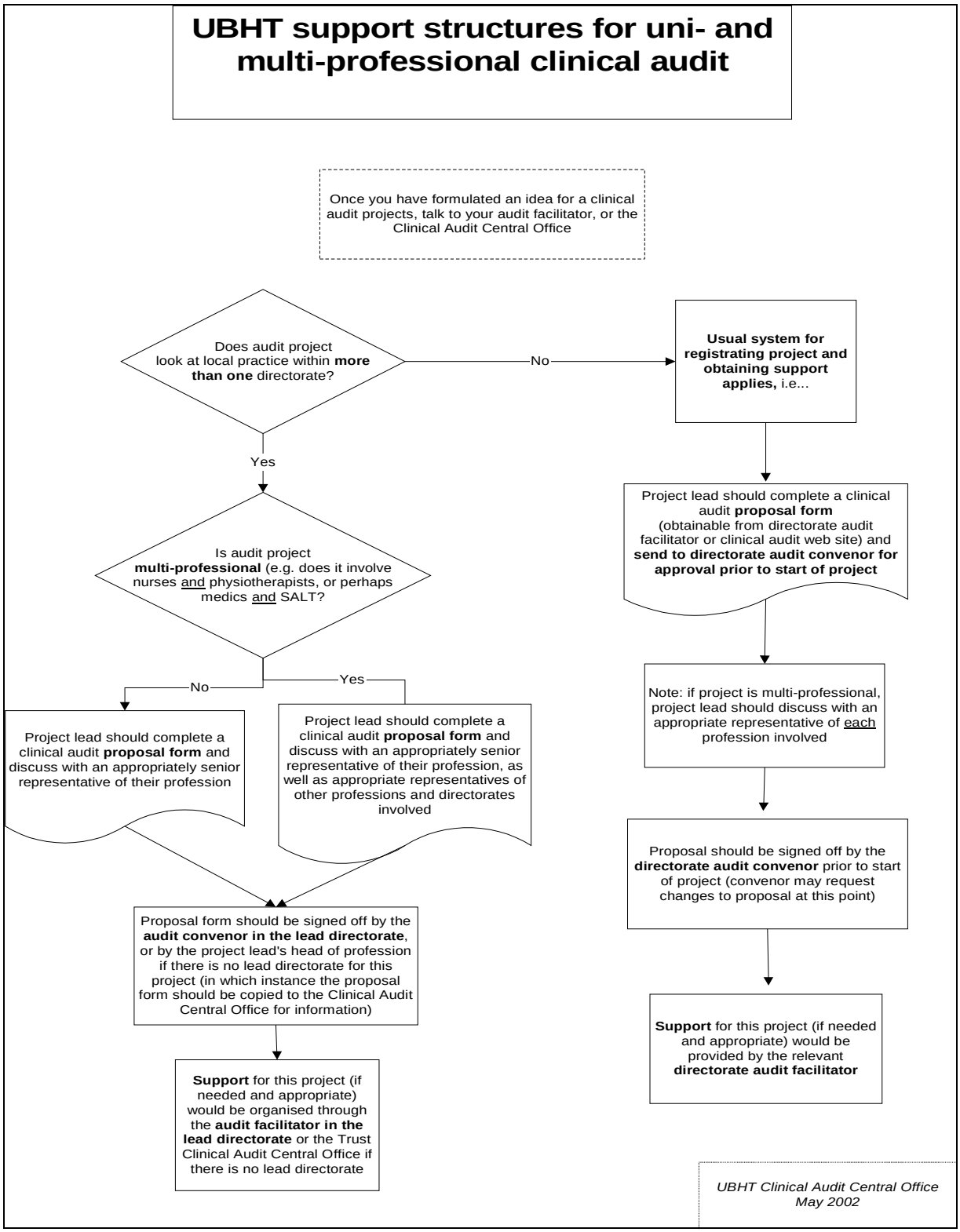
It should be noted that that the primary function of Clinical Audit Facilitators is to facilitate clinical audit; the responsibility for doing clinical audit rests with healthcare professionals.

5. Multi-professional clinical audit

In May 2002 the CAC approved the following strategy for promoting multi-professional clinical audit, the starting point for developing multi-professional clinical audit being to ensure that all clinical professions actually participate in clinical audit:

Issue	Action
N&AHP staff are not always represented on clinical audit steering groups at directorate or Trust level	Directorate audit steering groups to ensure representation from both Nursing and AHPs (directorates must also therefore ensure that they have a steering group!) In addition, because N&AHP services do not always follow the directorate structure, both nursing and the allied health professions are to be represented on the Trust Clinical Audit Committee. The remit of these individuals will be to represent the views of N&AHP staff to the CAC at a corporate level, and to provide progress reports on the development of clinical audit within the N&AHPs and the involvement of N&AHP staff in multi-professional projects Heads of profession will be asked to liaise with the Trust's Clinical Audit Project Manager to ensure that the progress of all N&AHP projects is monitored through the four monthly clinical audit returns
N&AHP staff perceive clinical audit as medically dominated: that somehow non-medical audit is 'second class'. This in turn creates fears amongst N&AHP staff about presenting audit results in multi-professional meetings.	In addition to ensuring representation on directorate steering groups, Audit Convenors to give clear lead to N&AHP staff that their input is important and valued Directorate clinical audit facilitators (CAFs) to actively encourage clinical audit activity amongst N&AHP staff within their directorate
Clinical audit resources are devolved to directorates. N&AHP services are not always directorate-based. Many N&AHP audits will be service-wide or trust-wide	A support structure and reporting system for N&AHP audit has been set out by the Clinical Audit Co-ordinator in consultation with N&AHP leads (see Fig 1)
A greater emphasis is needed on multi-professional audit: i.e. doctors, nurses and allied health professionals working collaboratively on audit projects.	Directorate steering groups to identify areas which naturally facilitate multi-professional audit, e.g. where services are structured as multi-professional teams Steering groups (or convenors - whoever has the responsibility for signing-off projects) to routinely apply the question, "should this project have multi-professional input?" whenever audit proposals are considered CAFs to ensure that multi-professional audit is routinely promoted through staff training and education. Similarly this message is to be reinforced at Staff Development workshops (Barrow). Steering groups to disseminate good examples of multi-professional audit through local audit/governance newsletters. CAFs to bring such examples to the attention of the Clinical Audit Co-ordinator for possible inclusion in the UBHT Clinical Governance Newsletter.

Fig 1.



6. Consumer involvement

The Clinical Audit Committee is committed to the principle of patient/carer involvement in clinical audit. The Committee actively encourages consumer involvement both directly through participation of identified individuals on project steering groups or directorate audit committees, and indirectly through the completion of some kind of questionnaire, usually at the end of the patient's episode of care.

7. Data protection and ethics

All clinical audit activity at UBHT should take account of the requirements of the Data Protection Act and Caldicott Principles.

8. Equality & Diversity

Due consideration must be given by project leads to appropriate representation of gender, or of particular ethnic or social groups in samples designed for clinical audit, depending on the nature of the project/s in question.

9. Clinical Audit Performance Management

Progress of Clinical Audit at strategic and operational levels is monitored externally through the Commission for Health Improvement's programme of Clinical Governance Reviews.

Locally, as part of a commitment to realising the strategic aims set out in this document, the CACO has developed a 'Balanced Scorecard' of key performance indicators (approved by CAC April 2001). The majority of these indicators are monitored by CACO/CAC on a quarterly basis:

A 'Balanced Scorecard' for the UBHT Clinical Audit function

Stakeholders

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

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

Customer

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

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

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

Internal Processes

What processes do we need to be good at?

Objective	Measure
Ensure audit is planned	Proportion of directorates with annual forward programmes for audit
Ensure local audit activity is co-ordinated	Proportion of directorates with a multi-professional (if appropriate) steering group to oversee progress of audit programme
Ensure projects are thoroughly planned	Proportion of projects with a proposal form Proportion of projects with a form signed-off before the commencement of the project
Link audit activity to clinical risk	Proportion of directorates linking audit to previously identified high risk activity (e.g. through risk profiling)
Audit high volume activity	Proportion of directorates linking audit to previously identified high volume activity (e.g. through quality impact analysis)
Link audit to patient complaints process	Number of projects based on patient complaints
Ensure audits lead to change and re-audit as appropriate	Proportion of projects with clearly defined action plan or confirmation that no action is indicated (note: recommendations alone are not sufficient)

Staff & Learning

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

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

Appendix B - Directorate Report to Clinical Audit Committee

Directorate:

Name of person/s responsible for report:

Date:

1. Please list projects contained in your current annual plan and briefly comment on progress to date (no more than one sentence – if project was abandoned, please state why)

Project title	Progress report

(if you are writing this report towards the end of the financial year, i.e. January-March) please feel free to list any ideas you have had for your forward programme for the coming year – bullet points will suffice)

Please briefly explain the mechanism by which this plan was agreed:

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2. Please list <u>all</u> major national/regional audit initiatives relating to your directorate, and comment on whether/how these are being addressed locally through your clinical audit programme (if they are not being addressed, please provide a rationale):

National/Regional initiative	Details of audit activity
National Audits (i.e. NICE/CHI-led, or Royal College or equivalent)	
1.	
2.	
etc.	
National Service Frameworks:	
1.	
2.	
NICE guidelines:	
1.	
2.	
NICE technology appraisals ('guidance'):	
1.	
2.	
Implementation of National Confidential Enquiry recommendations:	
1.	
2.	

3. Similarly, please list any relevant local initiatives:

Local initiative	Are these guidelines/techniques being audited? (please provide brief details)
Locally developed Clinical Guidelines:	
1.	
2.	
New Techniques/Procedures introduced through Clinical Risk Management Committee:	
1.	
2.	

4. What are you currently doing to address the following development areas for Clinical Audit?

Patient/Public Involvement:
Multi-professional audit:
Primary Care Interface audit:
Sharing learning from audit within your directorate:
Sharing learning from audit with other UBHT directorates:

5. Please describe any other changes to the management structures and systems for clinical audit in your directorate within the past 12 months

6. Are you facing any specific problems or challenges at the moment? (in managing the strategic direction of audit within your directorate)

7. What do you think other directorates can learn from your experience in Clinical Audit in the past year?

Appendix C - UBHT Clinical Audit Staff (as at 30/05/03)

DIRECTORATE	AUDIT SUPPORT	GRADE (A&C)	ROLE / W.T.E.	AUDIT CONVENOR
Cardiothoracic Services	David Finch	6	Audit (0.5) & data manager	Mr Alan Bryan Dr Andreas Baumbach
Children's Services	Chrissie Gardner Helen Cooney	6 5	Audit (1.0) Audit (0.1)	Dr Sue King and Dr Bev Guard
Critical Care	Sorrell Hewes	5	Audit (1.0)	Dr Diana Terry
Dental Services	Carolyn Southwell	6	Audit (0.5) & Information	Mr Nigel Harradine
Homeopathy	Sue Barron	6	Audit (0.4)	Dr Elizabeth Thompson
Laboratory Medicine	(Vacant)			Dr Paul Thomas
Medical Physics & Bioengineering	Tracey Saunders	4	Audit (0.2)	Mr Phil Quirk
Medicine	Kate Wathen	6	Audit (1.0)	Mrs Pat Howard & Dr David Deberker
Obs, Gynae & ENT	Frank Lee	5	Audit (0.8)	Miss Bryony Strachan
Oncology	Mairead Dent	6	Audit (1.0)	Dr Andrew Davies
Ophthalmology	Louise Hale	5	Audit (0.4)	Ms Clare Bailey
Pharmacy	Tracey Saunders	4	Audit (0.2)	Ms Rachel O'Donnell
Radiology	Sally King	Radiographer	Radiography & Audit	Dr Charles Wakeley
Surgery	Sarah Spinks	6	Audit (1.0)	Miss Jane Blazeby Mr Fabian Norman-Taylor

Central Office	Chris Swonnell Eleanor Ferris Carl Thomas	SMP SMP 3	Audit (1.0) Audit (1.0) Audit (0.8)

Please note that the following are facilitated by clinical audit facilitators other than the relevant directorate facilitator:

Ambulatory Care & Outpatients Directorate - jointly facilitated by Sarah Spinks, Kate Wathen & Sorrel Hewes
Emergency Department (Medicine Directorate) - facilitated by Sorrel Hewes
Maxillofacial Surgery (Surgery Directorate) – facilitated by Carolyn Southwell
Trust-wide audit section - facilitated by Eleanor Ferris

Membership of the Clinical Audit Committee
Graham Bayly (Chairman)
Chris Swonnell (Clinical Audit Co-ordinator)
Audit Convenors - see above
Eleanor Ferris (Clinical Audit Support & Information Manager)
Roy Xavier (Secretary to CAC)
Carol Rainbow (Nursing Representative)
Bob Johnson (Trust Board Representative)
Bette Baldwin (Chair of Consumer Committee)

Appendix D - Summary of benefits, actions or changes achieved in 2002/2003

Ambulatory Care & Outpatients

- An audit on the quality of multi-disciplinary team reception in the trauma, orthopaedic and plaster department led to a consumer survey, which in turn has led to improvements in the department, including the adequate provision of patient information leaflets.
- The use of physiotherapy specialists (ESP) in orthopaedic clinics to manage non-surgical and less complex surgical cases was shown by an audit to reduce waiting lists for patients to be seen by an orthopaedic consultant. The ESPs have since had further training to be able to relieve more of the waiting lists.
- The use of a call centre to remind patients of their clinic appointments was audited and showed that significant number of DNAs (patients who did not attend their appointment) had been avoided. The service has subsequently been adopted by the BRI and expanded.
- An audit of the quality of correspondence to GPs from UBHT according to UBHT guidelines has led to improved data entry onto hospital systems by ward clerks and medical secretaries.

Cardiothoracic Services

- Various changes in practice following monitoring through the Myocardial Infarction National Audit Project have enabled the Trust to reach and maintain the NSF-CHD standard for 'door-to-needle' times.
- Drug prescription rates for patients who have suffered a myocardial infarction have improved slightly as a result of raising awareness though the audit process. These are now well above the NSF-CHD target for the Directorate.
- An audit of the discrepancies in drug prescription rates between cardiologists and general physicians for post-MI patients has been mandated in order to understand why the latter appear to fall considerably below the NSF-CHD standard.
- Closer linkage of monthly 'door-to-needle' review meetings in Accident and Emergency to the audit process in order to strengthen evidence for action plans.
- A change in practice has reduced bed rest post arterial sheath removal without affecting morbidity. Patients are now able to go home earlier.
- The patient consent process for radial artery harvesting for coronary artery bypass grafting has been tightened up by consultant surgeons to ensure a 100% standard is reached at re-audit.
- Anaesthetists were alerted to an up-turn in transfusion rates that were caused by problems with new drugs, greater numbers of higher risk cases and a relaxation in practice. A number of changes in practice have been adopted.
- An anti-emetic protocol has been developed and introduced as the result of an audit of post-operative nausea and vomiting for cardiac surgery cases.
- The percentage of patients receiving arterial grafts has increased as a result of performance monitoring of surgeons using PATS.
- The percentage of 'beating heart' operations for coronary artery bypass grafting has increased as a result of performance monitoring of surgeons using PATS.
- Substantial improvements in medical note-keeping standards have been achieved as a result of a rolling annual re-audit to constantly remind and instruct staff.

Children's Services

- Introduced a new drug manual for commonly used drugs in paediatric surgery
- Development of new guidelines for the management of Petechial Rash
- Introduction of phlebitis grading system to NICU (Tissuing Cannulars)
- Development of referral guidelines to Physiotherapy for children with Empyema
- Autism - Overall multidisciplinary input improved
- Postoperative pain and nausea and vomiting guidelines have been developed which will hopefully reduce the discomfort from PONV and pain following day surgery
- Discharge planning audit – an improvement in the process between pilot phase and actual audit - combining doctors and nursing staff will bring benefits to staff and patients for a smoother discharge
- Deliberate Self Harm - 50% improvement on follow ups to CAMHs team
- Accessing Blood - Endorsing the use of broken green needles and the safe disposal of sharps
- Development of new guidelines to prevent unnecessary transfusion of PICU patients; a reaudit will assess their effectiveness

Critical Care (incorporating A&E and Theatres)

- Development of a multidisciplinary working group for management of lines
- Identification and initiation of a patient group who can feed into critical care clinical audit.
- Confirmed good practice in the peri-operative temperature management of at risk surgical patients.
- Informed and supported a revision of the format of the pain round.
- Demonstrated an improvement in practice in the completion of anaesthetic records.
- Confirmed good practice in blood pressure monitoring in cataract surgery.
- Confirmed good practice in the management of post operative airway problems.
- Demonstrated a low complication rate on cannulations made by ODPs.
- Verified good levels of completion of documentation on the ITU.
- Established
- Provided evidence in support of the implementation of new national consent forms.
- Agreed a new approach to resuscitation training for consultant anaesthetists.
- Demonstrated an improvement in the outcomes of patients having CVC lines tunnelled.

Dental Services

- Operators re-sheathing and disposing of their own needles to reduce risk of needlestick injuries
- Staff conforming to mandatory regulations of reporting on radiographs in patients' notes
- Updated referral proforma for General Anaesthetic requests sent to all General Dental Practitioners with the emphasis on providing more dental history
- A stamp for patients' notes produced to record various information given in order to reduce the risk of oral disease in the head and neck oncology patient and bone marrow transplant patient
- Letter sent to all General Dental Practitioners reminding them to telephone the Primary Care Unit so that sufficient numbers of staff will be available on department to see emergencies
- Guidelines on the treatment of dental injuries produced for the Primary Care Unit, BDH and the A&E department, BRI
- Improved layout of Medical History form for ease of patient completion at the Personal Dental Service clinics.
- Theatre session lists that would otherwise be cancelled re-organised for use by other Oral Surgeons thus making better use of staff time and reducing waiting list
- Positive responses to the new paediatric information leaflet which showed an improved understanding of the various stages of the visit.
- Improved recording of medical histories in the Community Dental Service
- Letter sent to referring General Dental Practitioners suggesting simple treatment and exercises with tick box proforma. This has led to a reduction in unnecessary referrals
- A stamp produced for referral letters when radiographs enclosed so that the radiographs are returned with the next letter to General Dental Practitioners. This should encourage more GDPs to send in X-rays so requiring less radiographs to be taken at BDH
- An improvement in orthodontic clinical record keeping since the introduction of a new proforma.
- The purchase of larger boxes to store restorative work to reduce the number of remakes/visits
- Letter with tick box referral proforma, giving reasons for referral, sent to all General Dental Practitioners to reduce the number of unnecessary referrals for Wisdom teeth extraction

Homeopathic Medicine

- Development of a recording protocol for the notes
- Updated patient literature on medication
- Protocol for reception/medical staff on informing patients of potential reactions to medication.
- Standard on reviewing potential reactions by asking patient to return a standard slip to the hospital.
- Baseline outcomes benchmark data developed by diagnosis/age/sex for use in future management of conditions.

Laboratory Medicine

Due to the vacancy in the post of Clinical Audit Facilitator for Laboratory Medicine, a list of benefits has not been able to be prepared.

Medical Physics & Bioengineering

- MDA Notice Distribution and Implementation audit report circulated to MEMO staff. Department to ensure a mechanism to monitor implementation of recommendations and to audit compliance in September 2003.

Medicine

- Flowchart created to aid effective prescribing of nutritional supplements at Bristol General Hospital
- A screening tool to identify appropriate referrals to the Falls Programme has been introduced within the Occupational Therapy departments at the BRI and Bristol General Hospital
- A business case for an Equipment Library is to be written and a location has been identified
- Enteral Tube Feeding guidelines and standards are being implemented on the cardiothoracic unit
- An audit on the Post-take Ward Round has led to a number of changes:
    - The timetables of all SpRs and consultants in Medicine have been reorganised so that they don't compete with clinics or lists on the afternoons of take days, or on the following mornings
    - All consultants now do an evening round on their take day
    - Medical staff have been reorganised into fewer but larger teams, facilitating cross-cover
    - A system has been devised for calling additional junior medical staff to the emergency department between 2pm and 5pm (an increase from 3pm - 5pm)
    - A new rota ensures that staff are available for clerking patients even during the consultant led evening round
    - A new scheme is being developed whereby most of the emergency medical admission patients can be treated entirely by the emergency department staff and their general practitioner
    - A new form for medical admissions has been written to keep better record of admission times and to aid monitoring of in-house delays

Obs, Gynae & ENT

- The Safe Entry Techniques in Laparoscopy audit resulted in a new laparoscopy form being produced
- Following the ERPC audit carried out by Critical Care, a Consultant Lead has been appointed for Early Pregnancy Clinic, who is due to start on 1st September 2003. The need for a NCEPOD list has become part of the Theatre Utilisation Review. (This will allow emergency operations to be carried out as a dedicated list instead of interrupting normal lists or extending lists beyond reasonable times)
- The Anaesthetic Provision for caesarean section audit (carried out by Critical Care) confirmed excellent provision in service. Change of practice – If emergency LSCS required and epidural is sub-optimal, then a spinal anaesthetic is used. (This significantly reduces the need and number of general anaesthetics used for this procedure)
- Following the audits on '3 year morbidity of women having an operative delivery in 2nd stage of labour' and the Kiwi Cup, the Southwest Obstetric Network is devising a regional training initiative for obstetric assisted deliveries
- Timing of Elective Lower Caesarean Section audit - discussion ongoing regarding provision of Dating Scans, which should be informed by the publication of the Children's NSF
- A Coelia-Schauta versus Wertheims Hysterectomy audit confirmed good outcomes for the relatively newly introduced Coelia-Schauta technique. The plan is to re-audit when more cases have been done and devise a patient information leaflet.

Oncology

- A protocol will be devised to handle problems identified by an audit of radiotherapy waiting times to enable patients to complete their course of radiotherapy within the prescribed time
  Treatment policy will be reviewed to bring about improved dental care following an audit of dental care in head and neck cancer patients
- Reduced waiting times in AHU clinic as a result of changes made to booking schedules following an audit.
- Education programme to be arranged following audit of pain guidance

Ophthalmology

- Education for Medical Staff on BD8 registration process and availability of social worker support
- Improved protocol for BD8 registration and referral to social worker/specialist nurse
- Improved identification of and documentation for fast track cataract patients
- Improved management of diabetic retinopathy outpatient clinics
- Improved accuracy of the biometry service using 3rd generation formulae

- Improvements to management of nurse led cataract follow up clinics, including a change in listing threshold for 2nd eyes
- New dilation and examination protocol for nurse led cataract follow up clinics
- Improved documentation for orthoptists to record consultation with Orbital Injury Patients
- New Protocol for the Management of Orbital Injury Patients in Collaboration with Dental Services

Pharmacy

- Prescribing of sodium valproate in accordance with mental health trust guidelines in the majority of patients. Steps taken to publicise guidelines as some psychiatrists unaware of their existence.
- UBHT Homecare Services satisfaction questionnaire allowed patient's opinions to be considered when planning the service for the forthcoming year
- Re-audit of Medical Directorate Antibiotic Policy demonstrated that policy poorly complied with (56%), and that the majority of medical staff are not in possession of the policy. Policy to be circulated at induction of new medical staff. Cost of pre-printed antibiotic regime that can be attached to drug charts to be investigated.
- Audit of ACE inhibitor dose concluded that dose is adequately titrated in 40% of patients. Guidelines to be devised and implemented to improve practice.
- The audit of effective prescribing of IV and oral ciprofloxacin recommended emphasising the bio-equivalency of oral and intravenous ciprofloxacin to prescribers as only 31% of patients receiving intravenous ciprofloxacin were reviewed at 3 days to assess suitability for oral therapy.

Radiology

- Auditing the Chest x-rays returned unreported as requested, has demonstrated a need to re-educate clinicians of their medico-legal responsibilities, for the benefit of the Trust and Patients.
- National Audit of Peripheral Angioplasty has confirmed achievement of standards (i.e. within targets for complications etc.)
- Audit of image quality confirmed best practice was being followed; equipment and techniques are to the required standards.
- Audit of DMSA Scan reporting has enabled a change in practice to ensure scans go directly to BCH Radiology for reporting. This has enabled scans to be reported within the standard time scales, and for reports to be are available for when the patient attends clinic for results.
- Audit of clavicle views for paediatrics has enabled a change in protocol whereby one view is undertaken initially and a second if first appears normal or other concerns dictate further imaging required. The prime benefit is that there is a reduction in ionising radiation, which is both beneficial to patients & staff and is cost saving.

Surgery

- From the audit forward Plan 2001/2, the use of CVP lines has been audited as per the recommendations from NCEPOD. A Trustwide group has been set up as a direct result of the audit to monitor the actions from the audit. The actions include SHOs to receive training on CVP insertion and management on rotation through HDU.
- An audit on the use of 'bleed beds' has led to greater understanding of what the beds are to be used for and which patients are eligible to have one. This is because the protocol, written by the physicians, has been made available to emergency admissions wards and added to the new doctor's handbooks. A policy of having one bleed bed empty by 8pm every evening (created and upheld by the site management team) should help to ensure that patients in need of the specialist care get it in one of those specifically designated beds. An audit of the compliance with these new standards will be started in collaboration with the directorate of medicine this year.
- The results of an audit looking at the rate of anastomotic leaks in patients that have had lower anterior resections has led to a research project to establish the scientific reasons behind the rate.
- Catheter management. This trust-wide audit, led by the Urology specialist nurse has resulted in the streamlining of products to ensure uniformity, reduced costs, improved catheter training and awareness (the training has been extended to primary care).
- An audit looking at the outcomes of patients having been operated on by UBHT surgeons in Weston has confirmed good practice, in that patients are not having complications that the team at Weston are not able to cope with.
- The standard of reporting to Avon, Somerset and Wiltshire Cancer Network for oesophageal and gastric cancers was audited at a regional level but led by the surgeons at the BRI. This has led to the development of a new pathology form including the minimum data set required for ASWCN.

- Ongoing #NOF collaborative work using Plan, Do, Study, Act (PDSA) cycles has led to a number of changes in practice:
  - Trauma Co-ordinator post created
  - Purchase of a number of pressure mattresses for wards 2&4
  - A feasibility study into weekend physiotherapy service
  - Improved documentation of pain scores and greater understanding amongst staff of pain issues owing to training in collaborative with the specialist pain team.
- Re-audit of time use in the Hand Unit has led to the creation of a new post to help clinical staff with clerical duties.
- Interface audit with the GP Trust Advisory Group (GPTAG) on the quality and timeliness of discharge summary forms has led to the implementation of a new discharge typing team and new methods of working for medical staff to ensure discharge letters are received by the GPs within 10 days of the patient leaving the hospital. This is currently being re-audited.
- An audit on the use of physiotherapy specialists to manage non-surgical cases has led to a further training for the specialists to further assist the reduction of time to wait to see a consultant on T&O lists.
- An audit on the pin-site care methods for Ilizarov Frame patients has confirmed that using the 'Bristol method' is best practice and has reduced the rate of infection from using the 'British method'
- An audit looking at the protocols for the T&O nurse specialist revealed that her clinics are reducing the time it takes for patients to be seen and that she is working within defined parameters. There is scope to increase the role she plays in terms of nurse-led clinics.

Trust-wide

- Re-audit of loose filing in patient notes showed that the front pocket was still being used for filing in all directorates therefore patient wallets without front pockets were introduced for new attenders from April 2003. A re-audit is to be done in September 2003.
- An audit showed moderate compliance trust-wide with use of red ID bands to denote patient allergies with excellence in some areas. An update memo has been issued to raise staff awareness
- A pilot study demonstrated the demand for an Extended Scope Physiotherapy Practitioner in A&E and a high patient satisfaction with the ESP service, and indicated that the presence of the ESP improved waiting times. Funding has been found for a further 7 months period starting in July 03
- The audit of Medical Records in UBHT showed a number of areas of good practice, such as the good use of pre-printed proformas. The use of the approved abbreviations listed in the Record Keeping Resource Pack for Nurses and Midwives 2002 has been flagged up at directorate meetings.
- Majority of new urgent neurology outpatients seen by Physio within 10 working days, but minority of routine patients seen within 30 days. Further work is now being done on measurement of Demand & Capacity, and guidelines for length of treatment.
- An audit of Occupational Therapy Staff Time found that tasks were being undertaken by OT staff that could be shared with others. Subsequently a standard was set that each OT will deliver 5 direct clinical sessions per working day (assuming an average session lasts 60 minutes)

Appendix E - Audit projects abandoned during 2002/2003

Please note that the below list only contains projects that were abandoned after the project was started. Projects abandoned before start (i.e. before data collection commenced) have not been included in this report unless they were mentioned in last year's annual report (see Appendix G)

Directorate	Specialty	Project Database ID	Project Title	Reason Abandoned
Cardiothoracic Services	Cardiac Surgery	211	Characteristics of Cardiac Patients With Diabetes	Pending new staff
Cardiothoracic Services	Cardiac Surgery	214	ITU length of stay and mortality after one year	End of SHO placement
Cardiothoracic Services	Cardiac Surgery	217	Sternum Wound Infection	Staff changes
Cardiothoracic Services	Cardiac Surgery	360	Audit of Leg Wounds After Cardiac Surgery	Staff no longer in post
Cardiothoracic Services	Cardiac Surgery	371	Use of Monte Carlo Forecasting for Cardiothoracic Surgery	Changed staff roles
Cardiothoracic Services	Cardiology	221	Audit of Secondary Prevention Clinic	Loss of staff
Cardiothoracic Services	Cardiology	485	FFR use in clinical practice	
Children's Services	Anaesthesia	77	Tonsillectomy Day Case	Hospital move planning to reaudit in the future
Children's Services	Cardiac	82	Retrospective Review of Blood Usage Products	SHO left
Children's Services	General Paediatrics	347	Brain injured children	Clinician changed hospital
Children's Services	Surgery	346	Appendectomy	Clinician moved away
Critical Care	Anaesthesia	142	Is an elective line list required in the BRI?	Problems with obtaining the data through SwiftOp
Critical Care	Anaesthesia	272	Failure to go home from the Day Surgery Unit	Merged into project 140
Laboratory Medicine	All Departments	37	Are the pathology reports getting to the notes? (Trustwide)	GM takes the view that we cannot change practice
Laboratory Medicine	Chemical Pathology	315	Laboratory diagnosis of coeliac disease	Difficulties in collection of multi-centre data
Laboratory Medicine	Haematology	48	The Use and Abuse of ANCA Testing	Difficulties in CAF analysis of data, data now out of date, not thought to be of value to recollect current data.
Laboratory Medicine	Histopathology	51	C3 & C4 Grade Breast Cytology	
Laboratory Medicine	Histopathology	52	Trustwide continuous participation in multi-professional peer review Clinico-Pathological Meetings	
Laboratory Medicine	Histopathology	54	Correlation Between Cervical Smear Results and subsequent 'Lletz' Cervical Excision Biopsy Tissue	Key audit lead left Trust
Medicine	Gastroenterology	109	The Incidence of GI Bleeds After Cardiac Surgery. Are we Managing These Patients Appropriately?	New project lead has not been appointed
Medicine	General Medicine	112	Are Patients Receiving Supplements?	Project lead left, data was feedback to department
Medicine	General Medicine	115	Unstable Angina	Poor results, data insignificant

Directorate	Specialty	Project Database ID	Project Title	Reason Abandoned
Medicine	Medicine for the Elderly	97	The Patient's Day in the Stroke Rehabilitation Unit	data collected no longer valid, new approach is planned
Pharmacy	Pharmacy	296	An audit to determine to what extent injectable preparations are being re-used in the BRI?	Ran out of time
Surgery	General Surgery	5	Choosing appropriate treatment for leg ulcers	This audit was not finished as there were not enough patients presenting with this condition to make the audit worthwhile. Audit lead consulting with Dr Murphy, Consultant Radiologist about taking the project in a different direction to make use of the data
Surgery	General Surgery	128	Hepato-Biliary Management	Project lead changed job
Surgery NB. listed under Critical Care in 2001/2 report	General Surgery	145	MRSA in surgical patients post upper GI surgery over 12 months	No contact from lead at all on progress or abandonment
Surgery	Trauma and Orthopaedics	11	Pain scoring for #NOF patients	Project lead left the trust
Surgery	Urology	132	Treatment for renal colic patients at UBHT	No contact from lead. Attempts made
Surgery	Urology	291	Management of Uteric Stones (Regional)	Lead left Trust and project not handed over

Appendix F - Audit projects with status of 'deferred' at end of 2003 financial year

Directorate	Specialty	Project Database ID	Provisional Title of Project	Reason if project deferred
Children's Services	General Paediatrics	71	Sedation Practice for Lumbar Puncture Procedure	National guidelines published - resources have been allocated to implement. Audit will follow implementation.
Children's Services	Radiology	87	Management of Neonatal Hydronephrosis in UBHT / N Bristol (Multi-centred audit)	Project has led to a need for further research
Critical Care	Anaesthesia	149	Quantitative: Training opportunities on theatre lists. Qualitative: Quality of training on theatre lists.	
Critical Care	Anaesthesia	153	Staff questionnaire: Training in fibreoptic intubation	Staff member on maternity leave
Critical Care	ICU/HDU	158	Cancellation of planned admissions to HDU.	
Critical Care	ICU/HDU	159	In-Hospital Deaths Post-Discharge from ICU / HDU	
Critical Care	Resuscitation	164	Cardiopulmonary Resuscitation Facilities and Equipment Within the Trust	
Laboratory Medicine	Infection Control	59	Are the Trust's benchtop sterilisers managed, used and maintained to a safe standard?	Trust wide action to cease use of bench top sterilizers
Medicine	A&E	279	Major Trauma Outcome Study (MTOS)	This audit is on hold; there are problems with the data collection due to funding and resource difficulties
Medicine	Dermatology	99	Minor Surgery in Dermatology Outpatients	to be discussed with dermatology dept
Medicine	Dietetics	104	Are we Meeting the Dietary Objectives of Patients on the Cardiac Rehabilitation Scheme?	Project lead on maternity leave
Medicine	Endocrinology & Diabetes	106	Are we Using the Test D-Dimer Appropriately?	new project lead to be appointed
Medicine	General Medicine	269	Standardised Cognitive Function Tests during Medical Admission	APL on maternity leave
Medicine	Medicine for the Elderly	93	CT Scans: Are suspected stroke patients referred within effective time frames? (with Radiology)	APL left, reaudit planned for May 2003
Medicine	Medicine for the Elderly	96	The Management of Patients Admitted with Acute Stroke	Results to be fed into forthcoming Stroke work. New APL not yet appointed by Professional Lead
Medicine	Respiratory	119	Is BiPAP being used appropriately?	Project lead has left, project may be continued by next SpR
Obs, Gynae & ENT	ENT	34	Is ENT Inpatient Admission Documentation Reaching Acceptable Standards?	intermittent audit done at audit meetings. Hasn't been done for a while. For new CAF to re-start?
Ophthalmology	Directorate Wide	14	Audit of new diabetic retinopathy referrals to BEH	Audit lead on maternity leave - to recommence upon return
Ophthalmology	Directorate Wide	302	Are the Psycho-Social Needs of Enucleation Patients Being Addressed Within the Hospital?	The audit is on hold as the numbers of enucleation patients is small and at present a re-audit is not viable.
Radiology	Radioisotopes (Suite F)	254	An audit of the Myocardial Perfusion Service	Service changed, need to reconsider parameters

Appendix G - Roll-over projects from 2001/2 annual report not appearing in 2002/3 report

Ongoing or uncompleted projects from 2001/2 not appearing in the project list in the directorate reports are listed below if they have not already been accounted for in Appendix E or Appendix F. A few projects are listed under different directorates or specialties this year than they were listed under in last year's report - if you cannot find a roll-over project from 2001/2 in either the main directorate list, or Appendices E, F or G, please check under any other logical specialties in the directorate or other directorates.

Directorate	Specialty	2001/2 Ref	Provisional Title of Project	Reason for non-appearance in 2002/3 report
Cardiothoracic Services	Cardiac Surgery	3.3.3	Audit of Cardiac Rehab Patients	Merged into project 207
Cardiothoracic Services	Cardiac Surgery	3.3.7	Audit of Mortality / Morbidity for Urgent Referred Patients	Abandoned before start
Cardiothoracic Services	Cardiac Surgery	3.3.12	Critical Pathways	?> in last report but recorded on database as completed 31/3/00
Cardiothoracic Services	Cardiac Surgery	3.3.13	Fast-track of Cardiac Patients After Surgery	Abandoned before start
Cardiothoracic Services	Cardiology	3.3.17	Quality of Catherisation Data	?> in last report but recorded on database as completed 31/3/00
Cardiothoracic Services	Cardiology	3.3.22	Are Myocardial Infarction Patients Receiving Clinically Effective Treatment to Prevent Further Infarcts?	Abandoned before start
Cardiothoracic Services	Cardiology	3.3.30	Cardiology Audit: Annual Report	Abandoned before start
Cardiothoracic Services	Thoracic Surgery	3.3.35	Thoracic Surgery Audit: Annual Report	Abandoned before start
Children's Services	A&E	3.4.1	Timescales for MRI investigation at Frenchay	Abandoned before start
Children's Services	General Paediatrics	3.4.25	Asthma	Merged into project 66
Children's Services	General Paediatrics	3.4.30	Investigations for Abdominal Pain	Abandoned before start
Critical Care	Anaesthesia	3.6.17	How frequent are anaesthetic incidents and breakdowns in UBHT?	> in last report but recorded on database as completed 30/3/02
Dental Services	Orthodontics	3.7.15	A pre-audit to find out how successful combined Orthodontic / Surgical treatment is for Facial Deformity? - national	Completed in 2001/2 - marked as roll-over by mistake (should have been 3.7.1 that rolled-over)
Dental Services	Personal Dental Service	3.7.24	Are radiographs taken for diagnostic purposes meeting the minimum targets for radiographic quality?	Abandoned before start (audit lead left & project not taken on by new lead)
Laboratory Medicine	Infection Control	3.13.6	What is the Trust's Hospital Bacteraemia Rate, Used as a National Clinical Indicator?	Merged with project 61
Laboratory Medicine	Haematology	3.13.21	Audit of newly published UBHT Transfusion Policy (Trustwide)	Abandoned before start (superseded by participation in National Blood Service Audit (427)
Laboratory Medicine	Chemical Pathology	3.13.31	Laboratory Information System & Reference Ranges	> in last report but recorded on database as completed 30/3/02
Laboratory Medicine	Chemical Pathology	3.13.32	Laboratory turnaround times for inpatient Electrolytes (Trustwide)	> in last report but recorded on database as completed 30/3/02
Medicine	Dermatology	3.9.13	Standards of Care for Patients with Non-Melanoma Skin Cancer	Split into different projects (98,100,101)

Directorate	Specialty	2001/2 Ref	Provisional Title of Project	Reason for non-appearance in 2002/3 report
Medicine	General Medicine	3.9.22	Are needles being disposed of according to the Trust's sharps policy?	Included by mistake? (Dental directorate audit)
Medicine	General Medicine	3.9.40	Is LTOT being appropriately prescribed by PCTs?	Abandoned before start
Oncology		3.11.7	Neo-Adjuvant Chemotherapy in Breast Patients	Abandoned before start
Pharmacy	Pharmacy	3.15.19	What Contribution does a 'PODS' Scheme Make to Improving Medicines Management?	>> in last AR but recorded on database as completed 28/10/01
Radiology	Paediatrics	3.14.17	Patient survey. Are users of the BCH X-Ray department satisfied with the service. Would they participate in a user group.	?> in last report but recorded on database as completed 01/02/02
Surgery	General Surgery	3.16.1	Avon, Somerset and Wiltshire Cancer Standards for Breast Cancer (with Oncology)	>> in last report but recorded on database as completed 30/3/02
Surgery	Hand Unit	3.16.8	Is there a need for a referral to a counsellor in certain cases?	Abandoned before start

Appendix H - UBHT Clinical Audit Forward Plan 2003/4

Key

PPI – whether audit involves consumers
MP / MD – whether audit is multi-professional/multi-disciplinary
Int. – Interface audit, i.e. involves representatives from primary care / other healthcare sectors

Ambulatory Care & Outpatients

This directorate is likely to be merged back into the Medicine and Surgery directorates in the next financial year, therefore no forward plan has been obtained.

Cardiothoracic Services

Project	Speciality	Lead	Rationale for audit	PPI	MP	Int
BCIS Annual Angioplasty Audit	Cardiology	Dr A Baumbach	National Audit assessing outcomes			
MINAP (with Critical Care)	Cardiology	Cathy Graeme-Wilson	National Audit assessing NSF-CHD targets for AMI. Nurse Consultant is also using results to improve practice. As a result poor > needle %age treated within 30mins has risen from 56% to 72%		X	
Rapid Access Chest Pain Clinic	Cardiology	Dr C W Lee	PCI/PPI audit of key clinical area against NSF standards. Will be used to improve service in four areas: diagnostic accuracy, reduced waiting times, improved referral and environment	X	X	X
Prophylaxis for patients who have experienced a myocardial infarction	Cardiology	Jenny Tagney	Assess practice against NICE guideline. Includes audit to pinpoint problem areas to be remedied through general SHO training		X	
Glycoprotein IIb / IIIa inhibitors for acute coronary syndromes	Cardiology	Dr A Baumbach	Assess practice against NICE guideline.			
Coronary Artery Stents in the Treatment of Ischaemic Heart Disease	Cardiology	Dr A Baumbach	Assess practice against NICE guideline.			
Drug eluting Stents	Cardiology	Dr A Baumbach	Assess practice against NICE guideline. Also to be used to assess whether new intervention is improvement			
Implantable cardioverter defibrillators for arryhthmias	Cardiology	TBA	Assess practice against NICE guideline			
SCTS Cardiac Register	Cardiac Surgery	Mr A J Bryan	National Audit assessing outcomes			
SCTS National Adult Cardiac Surgery Database	Cardiac Surgery	Mr A J Bryan	National Audit assessing outcomes			
UK Heart Valve Registry	Cardiac Surgery	Mr A J Bryan	National Audit tracking valve patient health in long term			
Post-operative nausea & vomiting	Cardiac Surgery	Lisa Mace	Develop evidence-based local protocol. Major improvement in patient care in progress	X	X	

Project	Speciality	Lead	Rationale for audit	PPI	MP	Int
Early extubation of patients	Cardiac Surgery	Kathy Gough	Develop evidence-based local protocol. Major improvement in patient care established though change in practice		X	
Weaning of long-stay patients	Cardiac Surgery	Dr I Ryder	Develop evidence-based local protocol. Will result in major improvement in practice and care of critically ill patients		X	
Blood product usage	Cardiac Surgery	Dr A Cohen	Reduce transfusion rates and thus risks to patient. Used to ensure improved practice doesn't slip back		X	
Pressure relieving mattresses & pressure sores	Cardiac Surgery	Lisa Mace	Assess practice against NICE guideline. Will result in improvement in patient care & mattress management	X		
Enteral Tube-feeding protocol	Cardiac Surgery	Claudia Jemmott	Improve nutrition post-surgery to aid recovery. Will result in improvement in practice and care of patients		X	
Radial Artery Consent	Cardiac Surgery	Fiona Thomas	Critical Incident requiring audit of patient consent			
Waiting times to Cardiac Surgery	Cardiac Surgery	Dr J Barry	Assess service provision against NSF targets			
SCTS Thoracic Register return	Thoracic Surgery	Mr A J Morgan	National Audit assessing outcomes			
LUCADA	Thoracic Surgery	Mr A J Morgan	National Audit assessing Cancer Care (lung)		X	
Early outcomes of stage I lung cancer	Thoracic Surgery	Dr R Ahsan	Develop evidence-based local protocol. To be used to guide change in practice for better outcomes			

Children's Services

PROJECT	SPECIALTY	LEAD	MD/PPI/ INT	RATIONALE FOR AUDIT
Appropriateness of reviews in the emergency department	A+E	Dr L Goldsworthy Dr A Milhench	MD / PPI	PERCEIVED LOCAL PROBLEM
Management of Petechial Rash	A+E	Dr S Sivaloganathan Dr L Goldsworthy	MD	RE- AUDIT
Pain relief for children undergoing Tonsillectomy	ANAESTHESIA	Dr Judith Nolan Dr Michelle White		CG – VARIATION IN PRACTICE RE- AUDIT
Perioperative Temperature Management	ANAESTHESIA	Dr S Nandalan Dr B Guard		NATIONAL GUIDELINES PATIENT /CARER FEEDBACK
Referral and management of Attention deficit hyperactivity disorder (ADHD)	CAMH'S / COMMUNITY	Dr Collette Lewin Dr Maria Bredow Dr Justin Daddow	MD / PPI	NICE GUIDANCE PPI – REAUDIT
Asthma inhalers for the under 5's	GENERAL PAEDS (RESPIRATOLOGY)	Dr S Langton Hewer	MD	NICE GUIDANCE
Asthma management	GENERAL PAEDIATRICS (RESPIRATOLOGY)	Dr S Langton Hewer		NATIONAL AUDIT RE- AUDIT
Diabetic services in Bristol and WSM	GENERAL PAEDS (ENDOCRINOLOGY)	Dr Liz Crowne Dr Julian Shields (multidisciplinary)	MD	NSF - but building on previous audit work. RE –AUDIT

PROJECT	SPECIALTY	LEAD	MD/PPI/ INT	RATIONALE FOR AUDIT
Management of Meningitis	GENERAL PAEDIATRICS (NEUROLOGY)	Dr P Sharples	MD	REVIEWING GUIDELINES
Management of Head injuries	A+E RADIOLOGY NEUROLOGY	Dr L Goldsworthy Dr Sue King Dr P Sharples	MD	NICE GUIDANCE
Lumbar punctures performed in Children's Services	GENERAL PAEDIATRICS (NEURO) / ONCOLOGY	Dr P Sharples Dr A Cundy Dr H Kershaw		PERCIEVED LOCAL PROBLEM
Audit of adequacy of renal replacement	NEPHROLOGY	Dr J Tizzard		REGIONAL AUDIT (ONGOING)
Guidelines for management of central lines in oncology	ONCOLOGY/ SURGERY	Dr A Foot Mr R Spicer		INFECTION CONTROL RISK MANAGEMENT GUIDELINE REVIEW
Fundoplication audit	SURGERY (GENERAL)	Miss E Cusick	MD/PPI	VARIATION IN PRACTICE
Post urethral valves audit	SURGERY (UROLOGY)	Mr J D Frank		NATIONAL AUDIT
Safety and practicality of drug prescribing	SURGERY (GENERAL)	Miss L Huskisson		RISK MANAGEMENT RE AUDIT
Developmental dysplasia of the hip	ORTHOPAEDIC SURGERY	Mr D Robinson Mr F Norman Taylor Debbie McMillan (SENIOR PHYSIOTHERAPIST)	MD /PPI	GUIDELINE REVIEW

PICU & Cardiac (Children's Services)

Project	Specialty	Lead	Rationale for audit	PPI?	MP?	Int?
Regional Audit of Critical Care Outcomes (Audit of Critically Ill Children)	PICU	Carol Maskrey	National/regional comparative audit			
Are PICU patients being transfused unnecessarily?	PICU	Drs F. Donaldson & P. Robertson	Reaudit to assess whether the new guidelines produced as result of the original audit have been implemented successfully.			
To investigate the use of non-bronchoscopic diagnostic bronchoalveolar lavages on the paediatric intensive care unit at BCH	PICU	Louise Owen	Perceived local problem.		X	
Standard of feeding attained post cardiac surgery	PICU	David Hopkins	Perceived local problem.			
Audit of the documentation of Invasive Procedures undertaken on PICU and consent for Invasive Procedures undertaken on PICU	PICU	Michaela Dixon	Local problems identified by Clinical Incident Reporting; and to ensure adherence to NICE guidelines.	X	X	
Audit of naso jejunal tube placement on ITU	PICU	David Hopkins	A reaudit of a previous audit in the light of new research evidence; also this remains an area of local concern and high cost. Possibly to disseminate results to other trusts.		X	

Project	Specialty	Lead	Rationale for audit	PPI?	MP?	Int?
Paediatric Intensive Care Study Group (PICSG) Sedation Working Party. Sedation: Ascertainment of Current UK Practice. Pre-audit.	PICU	Gerald Davis	A preaudit will be planned once an initial research phase is complete. Possibly to be done with other PICUs in UK.		X	
Post-Operative Morbidity Following Cardiac Catheterisation	Cardiac	Dr R. Martin	Ongoing monitoring project.			
Post-Operative Morbidity Following Cardiac Surgery	Cardiac	Dr G. Stuart	Ongoing monitoring project.			
Radiofrequency Ablation in Paediatric Arrythmias	Cardiac	Dr G. Stuart	Perceived local problem.			
Review of Peri-operative Infections	Cardiac	Dr R. Martin	Perceived local problem.			

Critical Care

PROJECT	SPECIALTY	LEAD	MD?	PPI?	Int?	RATIONALE FOR AUDIT
Management of Head Injuries – transfers to neurosurgery	A&E	Lisa Bell	X			NICE / National
Preoperative tests: The use of routine preoperative tests for elective surgery	Anaesthesia	Not yet formalised	X	X		NICE / National / RCA
Preaudit on complications of manually inserted cannulas	Anaesthesia	Matthew Patteril				NICE – Technical Guideline 49
Resus room rapid sequence induction	A&E	To be decided	X			NICE / NSF
MINAP – Thrombolysis in Emergency Medicine	A&E	Will Sargeant				National Audit Project
Deaths following Day Surgery	Anaesthesia	Carl Heidelmeyer				National Audit Project
Direct admissions following Day Surgery	Anaesthesia	Siobhan Grimes	X			National Audit Project
Potential Donor Audit: Deaths on the ITU	ITU / HDU	Sarah Cabourn (not UBHT)			X	National Audit Project
Post-operative pain control	Acute Pain Service	Resource shortage identified	X	X		National Inpatient Survey
Are essence of care recommendations being met?	ITU / HDU	Sarah McAuslin-Crine	X			Essence of Care
Operating theatre and pre-operative assessment project	Theatres	Sue Clarke		X		Theatre modernisation project
Epidural use in ITU setting	ITU / HDU	Nick Barron				Local concerns
Admissions 1 - 28 days following day surgery	Anaesthesia	Carl Heidelmeyer				Local concerns
Insulin regime for ITU patients	ITU / HDU	To be decided	X			Local concerns
Managing inappropriate referrals to the ITU	ITU / HDU	Andy Giorgio	X			Local concerns
Regional Anaesthesia failures in C Section	Anaesthesia	Mike Kinsella				Local concerns
Post-operative gynaecological epidurals	Anaesthesia	Mike Kinsella				Local concerns
Central Venous Lines Audit	Anaesthesia	Simon Massey	X			Ongoing audit

PROJECT	SPECIALTY	LEAD	MD?	PPI?	Int?	RATIONALE FOR AUDIT
Management of Fractured Neck of Femur (#NOF) in the ED	A&E	To be decided	X			Reaudit
Resus staff training DNAs	Resuscitation	Keith Lewis	X			Reaudit
Perioperative temperature management (adults)	Anaesthesia	To be decided				Reaudit
Pre-operative hypertension management	Anaesthesia (with ophthalmology)	To be decided	X		X	Royal College guidelines

Dental Services

Project title	Name of lead	Rationale for project	Type
Why do Day Case surgery patients fail to attend? - re-audit	Chris Bell Oral Surgery	Re-audit to check if measures to re-allocate cancelled sessions to other Oral Surgeons are working	Multi disciplinary, Patient involvement
Does the referral from GDPs requesting 3rd molar extraction follow NICE/departmental guidelines? - re-audit	Chris Bell Oral Surgery	Re-audit to see if GDPs are using the tick box proforma and departmental guidelines in their referrals	Interface
Are TMJ referrals to the Oral Medicine Consultants Clinics appropriate? - re-audit	Tony Brooke Oral Medicine	Re-audit to see whether a letter, sent back to GDPs after their referral letter, which includes exercises and guidelines, will reduce inappropriate attendances	Interface
Are haemophilia patients receiving adequate dental treatment?	Tony Brooke Oral Medicine	Joint audit with Oncology Directorate involving public participation in the planning stages	PPI, Multi disciplinary, Multi directorate
Is the age of referral for unerupted canines acceptable? - re-audit	Nigel Harradine Orthodontics	The age of referral has lowered since reminder letters were sent to GDPs after the first audit and a previous re-audit, and a check needs to be made on continued good practice	Interface
Are primary molar teeth being restored appropriately?	Deborah Franklin Paediatrics / Community Dental Service	An audit undertaken in the Hospital and in Community on the correct restorations of primary molar teeth	
Are students completing treatment for their patients on ADH2? - re-audit	Susan Hooper Restorative Dentistry	Re-audit after introduction of new systems for recording student treatments	
Are patients in pain seen within 24 hours?	Chandi Joshi Personal Dental Service	An audit to check on compliance with Department of Health Targets for the Dental Access Centre at CityGate	Multi disciplinary

Homeopathy

Project	Specialty	Lead	Rationale for audit	PPI?	MP?	Int?
What difficulties prevent a clear discharge from the clinic		Dr Elizabeth Thompson(CL)	New package of care policy needs to be assessed			
How is the directorate chronic fatigue form used and can it be improved		Dr Julie Geraghty(PL)	Impression that the form is not being used			
Information in the letters to GPs		Dr David Spence(PL)	Re-audit of a project completed a couple of years ago			?

Project	Specialty	Lead	Rationale for audit	PPI?	MP?	Int?
Re-audit of the processes of ordering prescriptions from pharmacy	Doctors, reception staff and pharmacy	Dr David Spence(CL)	Re-audit of a previous project but in addition will be multi –d with pharmacy		X	
Pre-audit of the efficiency and effectiveness of the cancer clinics		Dr Liz Thompson(PL)	Need to set standards			
Improving the management of childhood eczema		Dr Elizabeth Thompson(PL)	Most common condition treated and therefore a need to set standards with potential to involve patients in a focus group	X		
The Use of LM potencies		Dr Elizabeth Thompson (CL)	Need for a pre-audit to set standards			

Laboratory Medicine

Control of Infection

Confirmation dependent on infection control programme that has yet to be developed by Infection Control Committee but here is a brief outline.

1. Are we managing care of patients isolated to prevent spread of infection appropriately?
Chris Perry - Appropriate care of the isolated patient is important to ensure that well being of the individual patient as well as to prevent spread of infection to other patients

2. Are staff decontaminating their hands appropriately and effectively?
Joanna Davies - Hand decontamination is an important activity in the prevention of healthcare associated infection

3. General infection control audit - we had said we would stop this - but recent experience tells me that we need to continue this so will need to be rolled forward for 2003/4

You may need to note that there is a targeted action plan for healthcare associated infection being developed by DoH that may dictate other audit activity for the year.

Histopathology

1. Auditing the work of the molecular laboratory in the histopathology department.
Sam Mangawa & Joya Pawada Define current work load and assess added value of results.

2. Audit accuracy and reproducibility of reporting koilocytosis in biopsy samples as compared with HPV PCR status.
Joya Pawada & Sue Glew - Koilocytosis is on of the commonest histological findings in HPV infection and it is difficult to be consistent in reporting this abnormality.

3. Audit histological reporting of prostate cancer in radical prostatectomy samples.
Lazlo Intzodi – Comparison of reporting against RCPath guide lines

Laboratory Haematology

1. Audit of phoning abnormal results
L Worsam – Following a grade "C" clinical incident new guidelines have been introduced to ensure significantly abnormal results are phoned, this will audit compliance with these procedures.

2. Audit of new service for D-Dimers estimation
Name to be confirmed – D-dimers are used in the diagnosis of pulmonary embolism, this audit will look at new method for estimating D-dimers.

Clinical Biochemistry

1. Vertical sample tracking audit
D Stansbie – This audit will track a number of samples going through the laboratory to ensure that all stages of analysis comply with current documented procedures. This will be a new accreditation standard

2. Compliance with second line thyroid function test protocol
P Thomas – Audit individual compliance with current protocol for requesting second line thyroid function tests and develop new protocols if required.

3. Audit against national sweat test guidelines
J Stone – The department currently provides a service for sweat testing to the children's hospital, new guidelines national guidelines have recently been published for this service.

4. Abuse of HbA1c testing as a diagnostic test
N Marden – Southmead hospital has identified a number of inappropriate diagnostic HbA1c tests on a recent audit, we will duplicate this audit. At the same time the implications of recent NSF guidelines on workload will be assessed.

Medical Physics & Bioengineering

Project Name	Name of Lead	Rationale for Project	PPI	MP	Int
Audit of the implementation of Hazard & Safety warning notices	Mandy Gemmell	To comply with medical devices management		Y	
Do patients receive adequate instruction prior to taking devices, prescribed by trust staff, into the community?	Mandy Gemmell	There is demand for audit to include patient involvement and meeting controls assurance standard	Y		
Effectiveness of Servicing methods for Infusion Devices Used by UBHT	Peter Smithson	To determine the level of effectiveness of current service methods in various teams and manufacturers.		Y	
How frequent are anaesthetic incidents and breakdowns in UBHT?	Peter Smithson	Can we learn from a review of the nature and frequency of breakdowns or incidents to try and improve maintenance and use practice		Y	
Is there an unmet demand for equipment in the BRI?	Mandy Gemmell			Y	
Audit of Precision Intracranial Radiotherapy (P.I.R.T) at Bristol in UBHT	Cathy Hall	New technique			

Medicine

PROJECT	SPECIALTY	LEAD	RATIONALE FOR AUDIT	MP?	PPI?	Int?
NHSIA Cancer Data Set Audit	Dermatology	D deBerker	National			
Patient Consent	Dermatology	D deBerker	DOH directive			
Amputation re. to diabetes	Diabetes & Endo		Regional (RD&E)			
Pregnancy re. to diabetes	Diabetes & Endo		Regional (RD&E)			
High creatinine levels-appropriate referrals	Diabetes & Endo		Local concern			
CVD Risk in diabetes	Diabetes & Endo	J Smith	Re-audit part of ICP			
Hyperlipids	Diabetes & Endo	G Bayly	Re-audit			
Discharge Waiting Times	Diabetes & Endo	DSNs	Business Plan	✓		
Leg Ulcers	Diabetes & Dermatology		NICE	✓	✓	✓
Enteral Feeding post Cardiac Surgery	Dietetics	C Jemmott	Re-audit			

PROJECT	SPECIALTY	LEAD	RATIONALE FOR AUDIT	MP?	PPI?	Int?
Nutritional Supplements at BGH	Dietetics	J Gardner	Re-audit			
Infliximab	Gastro	C Probert	Re-audit - NICE guidelines			
Discharge Planning Process	General Medicine		Business Plan	✓	✓	
Emergency Medical Admissions	General Medicine	J Catterall	Re-audit			
Hyperglycaemia in Acute MI patients	General Medicine	SHO	Re-audit Cardiac ICP			
Hypnotic & Sedation Policy Compliance	General Medicine		NSF	✓		
Stroke	Medicine for the Elderly	S Duckworth	NICE & NSF ICP re-audit RCP- National Sentinel Audit	✓ ✓ ✓		
Waiting times for CT Scan	Medicine for the Elderly & Respiratory	S Duckworth	Re-audit (NSF guidelines) Nat Lung Ca guidelines			
Elderly Prescribing	Med4Elderly/ Pharmacy		NICE	✓	✓	
Medical Devices	Nurse led	H Bishop	Re-audit Pre Equip Library Practice Development Group			
Nebuliser Therapy	Nurse led	S Jones	Re-audit			
BiPAP audit	Nurse led	S Harris	Practice Development Group			
COPD	Respiratory	J Catterall	RCP – National			
Informing GP/DNs of a Lung Cancer diagnosis	Respiratory	M Ball	Re-audit National Cancer guidelines			✓
Management of Mesothelioma	Respiratory	N Jarad	Re-audit			
Management of Asbestosis	Respiratory	N Jarad	Re-audit			
Waiting list times	Rheumatology		Government directive Local Concern			
Temperal Artery Biopsy in Polymyalgia Rheumatica	Rheumatology		Local Concern			
HIV Screening	Sexual Health	P Greenhouse	New Government Initiative	✓		

Obstetrics, Gynaecology and ENT

PROJECT	SPECIALTY	LEAD	RATIONALE FOR AUDIT	PPI?	MP?	Int?
Swabs: What is the time elapsed from collection to result being returned to professional.	Contraceptive and Sexual Health (CASH)	Dr.Nikki Jeal (Reproductive Health)	The process of collection, despatch and return of results from routine screening to the appropriate person is a major issue	N	Y	
Effectiveness of Patient Counselling/ Referrals to psycho-sexual clinic	Contraceptive and Sexual Health (CASH)	Dr.Katherine Coulson	Do patients benefit from being seen in the psychosexual clinic No standards or guidelines available for Psycho-sexual Clinics	Y	Y	Y
Third degree tears	CDS (Central Delivery Suite)	Dr. John Laherty/ Emma Cockerell (Midwife)	Audit of management at 6 weeks post tear.	Y	Y	Y

PROJECT	SPECIALTY	LEAD	RATIONALE FOR AUDIT	PPI?	MP?	Int?
Blood Wastage	CDS (Central Delivery Suite)	Annie Tizzard	Blood ordered and then not used			
Post – dates Policy NB. JOINT WITH Ante-Natal	CDS (Central Delivery Suite)	Katrina Calvert Registrar	Local policy of scan and review compared to national policy – what are the standards.	Y	Y	Y
NICE Induction PROM and Stretch and Sweep procedure	CDS (Central Delivery Suite)	Bryony + Moira Nunn, Midwife	Repeat of IOL Audit	Y	Y	Y
Symphis Pubis problems- audit of process and advice given for labour.	CDS (Central Delivery Suite)	Dianne Paton, Sr. Physiotherapist	Physios see some mums ante-natally and advise on positioning of legs during labour and suturing – is advice practised ?			
Domestic Violence	Ante-natal	Belinda Cox	Implementation of NEW Published guidelines Perhaps to do in 2004.	Y	Y	Y
Hep B and HIV	Ante-natal	Jenny Ford/ Ante-natal Clinic	Govt. states 100 per cent of pregnant women should be offered screening for hep. B and HIV	Y	Y	Y
Post – dates Policy	Ante-natal	Katrina Calvert Registrar	Local policy of scan and review compared to national policy – what are the standards.	Y	Y	Y
Postnatal GTTs for gestational diabetics – with primary care!	Ante-natal	Sue Sellers				
Audit of cardiac patients -.	Ante-natal	Jo Trinder				
Audit of new careplan form	Post-natal care	Hilary Miller Midwife/nurse on Neo-natal unit	Form records planned care on unit and invites parents to participate in planning of care.	Y	Y	
An audit of all infertility referrals in St Michael's in 2001 (census year) with follow up of outcome	Reproductive Medicine	Julian Jenkins	No current reliable data of fertility need and treatments performed in the UK despite radical changes in practice e.g. ICSI. Possibly in conjunction with Southmead			
Tubal surgery	Reproductive Medicine	Uma Gordon	Many tubal surgery cases are severe with little hope of successful surgery – aim to see if the money could be better spent funding one cycle of IVF. Publication of NICE guidelines expected			
Colposcopy audit	Oncology /Colposcopy	Dr Hussein / Robert Anderson	To be finalised			
Effectiveness of Patient Counselling/ Referrals to psycho-sexual clinic	Oncology /Colposcopy	Dr.Katherine Coulson	Do patients benefit from being seen in the psychosexual clinic? There are no standards or guidelines available for Psycho-sexual Clinics	Y	Y	Y
C T G	Obstetrics					
Notes Audit	Obstetrics & Gynaecology					

PROJECT	SPECIALTY	LEAD	RATIONALE FOR AUDIT	PPI?	MP?	Int?
National Audit of Multiple pregnancy's and assisted conception	Obstetrics		Royal College audit, 6-12 April 2003			
Confidential Enquiry into Maternal and Child Health (CEMACH)	Obstetrics		Recently launched by NICE. CEMACH formed from amalgamation of CESDI (still-births and deaths in infancy)and CEMD(maternal deaths)			
NCEPOD (the National Confidential Enquiry into Perioperative Deaths)	Directorate-wide		Focuses on perioperative deaths and now extended to include unexpected deaths from medical intervention			
Children being seen as urgent referrals and emergencies at St Michael's	ENT	Dr. Catherine Ashworth (ENT Registrar)		Y		
Laryngectomy	ENT	Guna (Dr. Sinnappa Gunasekaran Clinical Fellow ENT)	Laryngectomies at St.Michael's since 1991 with relation to national standards, specifically looking at incidence of post–op. fistula	N	N	N
Sino-Nasal Outcome Test	ENT	Dr. Mario Jaramillo, SpR				
Barium Swallow	ENT	Mr. Saunders	Barium swallows are carried out frequently, is this necessary ?			
Grommet	ENT	Dr. Catherine Ashworth				
Balance	Audiology	Pat Smith	Change in practice/referral method initiated. Audit of effects suggested for later in year as pt. numbers low at present			

Oncology

Project title	Name of lead	Rationale for project	Type
Use of temozolomide in brain cancer	Sudipta Datta Spr	As per Nice guidance	MD
Use of trastuxumab in breast cancer	Suzanna Alexander Spr	As per Nice guidance	MD
Pancreatic cancer – gemcitabine	Emma Heath SpR	As per Nice guidance	MD
Use of fludarabine in leukaemia (CLL)	Jacky James Cons Haematologist	As per Nice guidance	MD
Ward discharge letters	SHO's	Content & timeliness of ward discharge letters – ward 61	MD
Prescribing of oral graniseteron	Clare Greaterex Specialist Nurse	To establish if prescribing pattern meets directorate guidance	MD
Clinic Wait Times Onc. Outpatients	Sue Bailey Sr Outpatients	Measure against national standard	MD

Awaiting feedback from discussions regarding patient involvement. A re-audit of bone marrow tests, currently under discussion in AHU, will include a patient satisfaction survey.

Ophthalmology

Project	Specialty	Lead	Rationale for audit	PPI?	MP?	Int?
Retinopathy of Prematurity Screening	Ophthalmology and Paediatrics	Miss Cathy Williams, Consultant Paediatric Ophthalmologist	Audit of New Service in relation to National Standards	N	Y	N
Nurse Led Follow Up Clinics (Cataract Surgery)		Helen Julian, Clinical Nurse Manager	Re audit	N	N	N
Glaucoma Follow Up Clinics	Doctors and Optometrists	Heather Harris, Shared Care Practitioner	Re audit	N	Y	N
Entropion Surgery		Mohan Mundasad, Associate Specialist	Success of Entropion Surgery types	N	N	N
Photodynamic Therapy		Miss Clare Bailey, Consultant Ophthalmic Surgeon	Nice Guidance	N	N	N
Admission for Occlusion Therapy in Children		Liz Newcombe, Senior Orthoptist	Perceived local issue	N	N	N
The Laser Service		Alison Meakin, Laser Nurse	Potential for improved service delivery	N	N	N
The implications of macular hole surgery with and without ILM peel		Mr Rodney Grey, Consultant Ophthalmic Surgeon	Evidence of improved results for surgery with ILM peel	N	N	N
A&E Referrals – Improving Access		Cheryl Voisey, A&E Nurse	Government 4 hour A&E target	N	N	N
Basal Cell Carcinoma Audit		Richard Harrad	Suitability of referrals and success of surgery	N	N	N

PPI project: Still in discussions regarding possible PPI project regarding 'posturing' after retinal detachment surgery

Pharmacy

Project	Lead	Rationale for audit	PPI?	MP?	Int?
Annual audit of high-tech homecare services	Colleen Abbot	UBHT policy, reaudit	Y	Y	Y
Are combination inhalers prescribed according to MAG guidance?	Michelle Haddock	MAG recommendations		Y	Y
Are prescribing standards being adhered to?	Kevin Gibbs – Jul 03	UBHT policy Medicines code 9,12,14		Y	
Does clinical pharmacy conform to regional standards?	Kevin Gibbs – Nov 03	UBHT policy, Wessex guidelines			
Has the prescribing of clopidogrel improved?	Rachel O'Donnell	UBHT policy, re-audit		Y	Y
What proportion of discharges are DPs involved in?	Barbara Wilson	Discharge support		Y	
Do benefits from the 1-stop dispensing pilot ward extrapolate to care of the elderly wards?	Debbie Campbell/Rachel Beckett – Sep 2003	NSF for older people Pharmacy in the Future, medicines management.	Y	Y	Y
Are storage facilities for medicinal products compliant with the Duthie Report?	Sarah Hepburn – Dec 2003	UBHT policy, re-audit Controls Assurance		Y	

Project	Lead	Rationale for audit	PPI?	MP?	Int?
Are critical incidents reported, and fed back to staff in a timely manner?	Meena Aggarwal/Sarah Hepburn- Dec 2003	Managing risk/re-audit			
Risk assessment of use of strong potassium solutions in UBHT	Meena Aggarwal/Sarah Hepburn –Dec 2003	Managing risk National Patient Safety Agency		Y	
Do surgical patients receive adequate information about their medicines on discharge?	Mr Rayter/Barbara Wilson	Pre-audit, national patient survey	Y	Y	Y
Do patients receiving growth hormone conform to NICE criteria?	Mike Dunn	NICE guidance		Y	Y
TPN usage on PICU	Sue Jarvis	Pre-audit		Y	
Are COX-II inhibitors being prescribed appropriately?	Plans to create specific post to implement and audit NICE guidance	NICE guidance		Y	Y
Are the appropriate patients prescribed ramipril?		NICE guidance		Y	Y
Are pioglitazone & rosiglitazone used appropriately in type II diabetes?		NICE guidance		Y	Y
Is the use of TNF-α inhibitors appropriate in rheumatology patients?		NICE guidance		Y	Y

Radiology

Project	Specialty	Lead	Rationale	PPI?	MP?	Int?
Liver biopsy patient information	Radiology Suite A US	Mrs T.Stoyles	Part of informed consent	Y	Y	N
Pre-op Chest X-rays pre & post guidelines	Suite C General	tba	NSF Guidelines	N	N	N
Audit of Percutaneous Biliary Intervention and outcome for 2002	Suite A G.I.	Dr M.Callaway	To assess complication / success rates	N	N	N
P.E. Diagnosis audit of appropriate examination	Radioisotope / CT	Dr J.Kabala	Cost effectiveness Response times	N	Y	Y

Surgery

Project title	Lead	Rationale for project	MP/ PPI/ interface
Fast-Track Barium Enema: Are we meeting the Two Week Wait rule for patients with suspected colorectal Cancer?	Mr Durdey Mr Thomas Mr Sylvester Miss Anne Lyons	Assess practice against national two-week standard for cancer referrals	
Are Vascular outpatients having relevant risk factors identified and acted on appropriately?	Mr Lamont, Mr Baird, Mr Smith, Mr Robert McCarthy, Mr David Williams	Identified at pre-op assessment as a clinical risk issue. Assessing current practice against locally agreed guidelines.	MP
False aneurysm protocol	Mr Baird, Mr Lamont, Mr Smith, Miss Teresa Robinson	Develop and assess evidence based local protocol	MP
Nutrition for oesophagectomy patients	Upper GI Team Miss Sharon Lamb, Dietician, Miss Stephanie Farnell, CNS	Assessing practice against the national document, "Improving Outcomes for Gastro-Intestinal Cancers" (2001)	MP PPI
Are GPs receiving full and accurate discharge letters within the prescribed 10 working days?	Mrs Helen Bond, GP Liaison, THQ Mrs Gill Cross	Re audit assessing revised practice against local guidelines.	MP IF with PCTs

Project title	Lead	Rationale for project	MP/ PPI/ interface
Quality of life of patients with prostate cancer (ongoing audit)	Mr Persad Mr Biral Patel	Ongoing monitoring project assessing patient based outcomes.	
Is the standard of note preparation adequate for colorectal clinics?	Sr Anne Rollings Sr Jane Pawlawska	Ongoing project from 2002 assessing current preparation of nursing notes against locally agreed guidelines.	MP
Are we following the UBHT Protocol for suspected Scaphoid Fractures?	Mr Norman-Taylor Mr Adrian Taylor	Assessing practice against locally agreed protocol for Scaphoid fractures	
Are T&O patients in the BRI receiving care according to the guidelines on: time to ward from A&E, time to theatre and appropriate 'nil by mouth' times?	Mr J Livingstone Sr Gerry Baber	Assessing current practice against national and local guidelines.	MP
Audit of the rate of re-excision for patients who have had a wide local excision of their breast cancer	Mr Z Rayter Miss Z E Winters Dr Amit Patel	Audit assessing current practice against regionally agreed standards. (Avon, Somerset and Wiltshire Cancer Network)	MP
Regular audit of the standard of medical case notes	Miss J Blazeby General Surgery and Urology Teams	Regular audit assessing the standard of medical case notes against Royal College of Surgeons guidelines (2000)	
An audit of the quality of medical handovers in general surgery teams	Miss J Blazeby Mr R N Baird Mr Robert McCarthy Mr Damian Glancy	Audit to investigate current standards of practice against recommendations from the General Medical Council, "Teamworking in Medicine" (2002)	
Audit of post-operative pain	Mr Z Rayter (tbc) Sr A Jarrett (tbc)	Assessing practice at the BRI against the results of the National Inpatient Survey (2003)	MP
Audit of the use of bone-scans for prostate cancer treatment	Mr R Persad Mr R Thurairaja	Assessing UBHT practice against NICE guidance, "Improving outcomes in Urological Cancer" (2000)	MP

Trust-wide

Please note that Physiotherapy projects listed are potential projects – priority projects will be selected from this list & forward plan finalised within the next few months

Specialty	PROJECT	Lead	Rationale	PPI?	MP?	Int?
Dietetics	Most audits are multiprofessional & therefore done via appropriate directorate. Service-wide calendar to be available by about July 2003					
Infection Control	Reporting via Pathology					
Occupational Therapy	Audit of care of people with palliative care needs in BRI	Jayne Weare		?	Y	?
Occupational Therapy & Physiotherapy	Upper Limb Assessment	Helen Clarke/ Louise Wilson	Audit use of new multi-disciplinary (OT & Physio) assessment form	N	Y	N

Specialty	PROJECT	Lead	Rationale	PPI?	MP?	Int?
Physiotherapy	Neuro outpatients exercise group	Mel Falk	First evaluation of group which has been established for 2 years	Y	N	N
Physiotherapy	To establish the equity of inpatient physiotherapy for patients with an exacerbation of COPD (primary diagnosis)	Jenny Hudson	To gain information to assist setting standards for the physio management of patients with COPD so to assist equity of service regardless of patient location within BRI			
Physiotherapy	Establishing training needs for weekend staff	Kate Davis with assistance from A. Touboulic / K. Montague	Identifying the skills and teaching that physiotherapy staff need to feel competent to manage a weekend caseload			
Physiotherapy	How effectively is the Aquatherm humidification system being used?	Ann Touboulic	Suspected poorly used therefore want to establish the type of problems and frequency of their occurrence			
Physiotherapy	Can physiotherapists accurately predict which cardiac patients will need minimal post-op respiratory input in their acute recovery phase?	Kate Warsap	To identify whether (as the research is suggesting) there is scope for no intervention in some day 1 post – op patients. This would facilitate more effective prioritisation of patients on the cardiac unit.			
Physiotherapy	How is IPPB being used nationally in other cardiac centres?	Laura Tiley / Kate Warsap	To assist the identification of best practice guidelines and to identify any staff training needs			
Physiotherapy	How is CPAP being used nationally in other cardiac centres?	Kate Warsap	To assist the identification of best practice guidelines and to identify any staff training needs			
Physiotherapy	Who makes requests for protected catheter specimens and what is their rationale for doing so?	Kate Warsap	To assist microbiology in identifying appropriate referral criteria for this very invasive and potentially risky procedure			
Physiotherapy	A one-year review of the community CF physiotherapy service	Sharon Jameison	To establish service criteria, the patients' perspectives and best practice guidelines (NB. registered with Medicine directorate as 'under consideration')			

Specialty	PROJECT	Lead	Rationale	PPI?	MP?	Int?
Physiotherapy	How well are Care of the Elderly Assessment standards being met?	Gayle Bryant	Are NSF standards being met? How equitable is the service across BRI? How could this be facilitated?			
Physiotherapy	Is ankle ROM affected in the acute phase of CVA?	Joanna Whitehead	Suspect that ankle ROM is lost in this patient group which affects their functional potential – would like to clarify this			
Physiotherapy	How are falls risk factors being documented?	Gayle Bryant	To answer this question and then allow standardisation			
Physiotherapy	How well are Stroke Assessment standards being met	Jo Whitehead	Are NSF standards being met?			
Physiotherapy	Are subjective & objective markers improved following the osteoporosis group?	Melissa Domaille	To evaluate effectiveness of the osteoporosis group			
Physiotherapy	Outcome following flexor tendon injury?	Duncan Pearson, clinical specialist, hand unit, BRI	To establish how effectively a formula based on scoring ROM of digits is at measuring outcome			
Physiotherapy	Prioritisation of referrals to musculoskeletal outpatient physiotherapy	Rachel Midcalf	To ensure that prioritisation of referrals is standardised to provide an equitable, efficient service.			
Physiotherapy	Musculoskeletal physiotherapy treatment outcomes	Lorna Harvey	To implement treatment outcomes for common musculoskeletal conditions so that a quality equitable service can be provided			
Physiotherapy	A review of the new occupational health physiotherapy service	Rachel Goodwin	To monitor the physiotherapy service provided to the UBHT occupational health department			
Physiotherapy	UBHT physiotherapy services for patients with back pain?	Rachel Goodwin / Lorna Harvey	To establish whether the physiotherapy back pain services is operating within the nationally recommended guidelines			
Speech & Language Therapy - Adult	Re-audit of Early Identification & Measurement of patients with dysphagia	Vicki Weekes / Jackie Griffiths	Re-audit to ensure dysphagia training introduced following 1999/2000 audit has led to improvement in implementation of SLT recommendations by ward staff.	N	N	N

Specialty	PROJECT	Lead	Rationale	PPI?	MP?	Int?
Speech & Language Therapy - Childrens	Are speech & language therapy programmes being carried out by school implementers as specified?	Simon Watts, Rachel Thompson, Lizzie Elford	Perceived problem; common area of practice; working across organisational boundaries	?	N	Y
Trust-wide Nursing	Are UBHT recommendations for mouth care being followed?	Carole Rainbow/Sue Jones	UBHT resource package issued in February 2002 – need to check that all areas have implemented	N?	N?	N
Trust-wide Nursing	Is care of patients with tracheostomies improving?	Sue Jones	Second re-audit of implementation of recommendations from tracheostomy care group *	N	Y	N
Trust-wide Nursing	Is patient assessment and treatment of pressure sores improving?		Incidence monitoring of all areas with audit of process on areas that don't seem to be doing well **	N	N	N

* This was previously carried out under the directorate of Medicine, and will continue to be facilitated by Kate Wathen

** It is hoped to audit this in the near future, especially in light of NICE guideline on Pressure relieving devices due August 2003, however the Trust Tissue Viability nurse will be absent for approximately 1 year from June 2003 and it might not therefore be possible to audit this topic next year. NICE guideline on pressure ulcer management is due Jan 2005.