

Basic principles of audit

all you need to know
(but were afraid to ask!)

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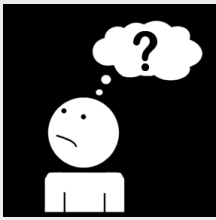




AAUGH!







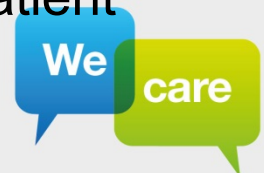
Definition

DOH 1989 'Working for Patients' white paper defined medical audit

The systematic critical analysis of the quality of clinical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient.

NHS executive 1993

Clinical audit is the systematic analysis of the quality of healthcare, including the procedures for diagnosis, treatment and care, the use of resources and resulting outcome and quality of life for the patient





Definition

NICE/CHI 2002: Principle For Best Practice in Clinical Audit

A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit standard and the implementation of change





Definition

Wikipedia: Definition of Clinical Audit

Clinical audit is a process that has been defined as "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"





Audit or Research

‘Research is concerned with discovering the right thing to do; audit with ensuring that it is done right’
Smith R. Audit & Research. BMJ 1992; 305:905-6

- Research seeks new knowledge
- Audit seeks to ensure that existing knowledge is being put into practice.

Aim of Clinical Audit

- Audit seeks to ensure that existing knowledge is being put into practice.
 - By establishing if the healthcare we deliver is inline with standards- either local or national
 - Identifies and promotes good practice
 - Highlights problems
- Leads to improvement in care
- Provides information about effectiveness
- Improves team working and communication





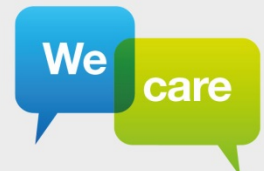
Early Audit

- During the Crimean War of 1853–55.
- Appalled by the unsanitary conditions and high mortality rates.
- Introduced & applied strict sanitary routines and standards to both the hospital and equipment (standard)
- Kept records of mortality rates and with the adherence to the standard mortality rates fell from 40% to 2%
- One of the earliest programs of outcomes management.



Early Audit

- Ernest Codman (1869–1940)
- Codman has been referred to as the first true medical auditor following his work in 1912 on monitoring surgical outcomes.
- Codman was a surgeon whose "end result idea" was to follow every patient's case history after surgery to identify errors made by individual surgeons on specific patients.
- Prompted approaches to quality monitoring and assurance which resulted in establishing accountability, and effective management of resources.
- Codman's approach is more 'clinical' with Nightingale's being more epidemiological.
- Both resulted in improvement to patient outcome.



Audit Process Step 1

The topic

- A local concern
- Wide variance in outcomes
- New procedures / treatment
- Risk Issues
- Trust Priorities (new CQUIN)

Audit Process Step 2

The standard

- Determine the criteria for the current best practice.
- NICE guidance, Royal College Guidance, national service frameworks,
- Local policies.

Audit Process Step 3

Data Collection

- Identify what data needs to be collected,
- How is it being collected and by who.
 - Design audit collection proforma – run a pilot if necessary.
- Decide whether the data will be collected prospectively or retrospectively
- What sample size is required.

Audit Process Step 4

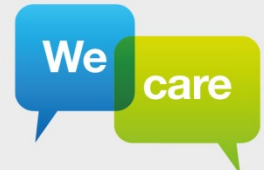
Data Analysis

- Analyse the data collected (actual performance) with the set standard.
- Evaluate how well the standards were met and if not, identify reasons for this.

Audit Process Step 5

Share findings and make a change

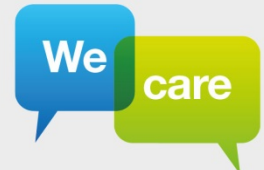
- Present the findings to the relevant people and teams
- Develop and agree an action plan
 - With target dates
 - Accountable individuals



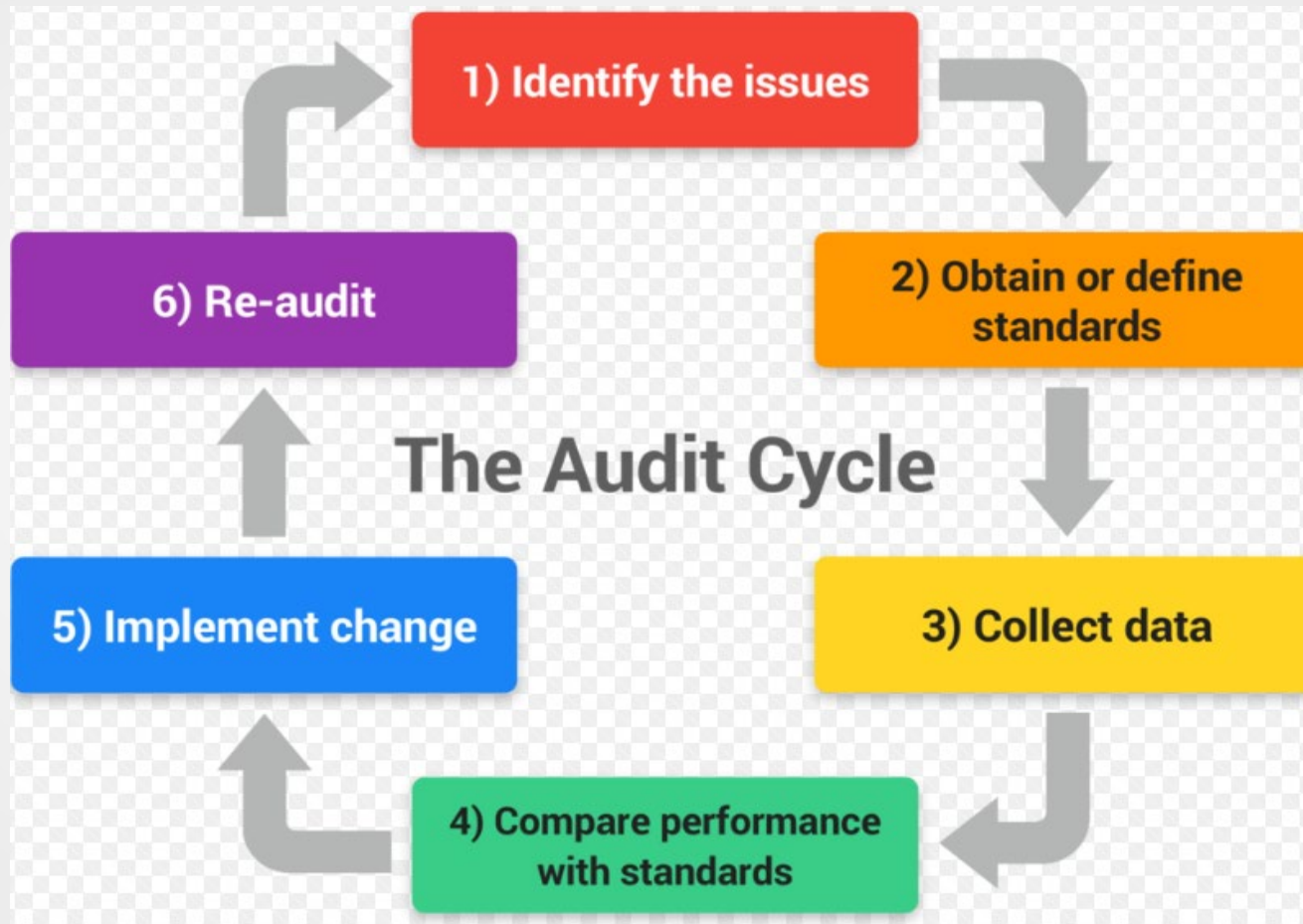
Audit Process Step 6

Close the audit loop

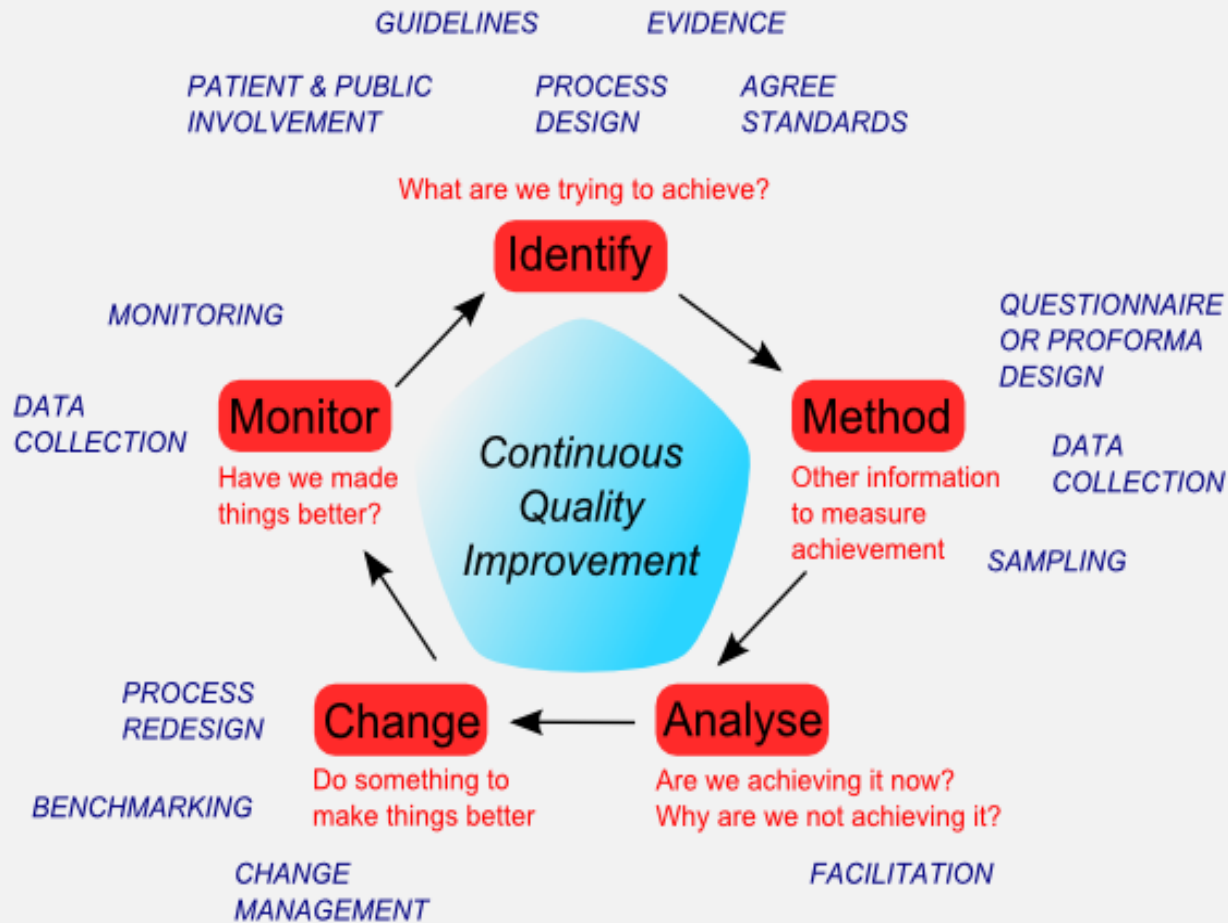
- Allow time for the interventions and actions to take effect.
- Collect new data and analyse with the standard and establish if there was an improvement in practice.
- If not repeat the steps



Audit Cycle



Audit Cycle – more layers







AAUGH!





Do not Experience Death by Audit

- Be Realistic with your resources
 - Once you have identified your cohort can you easily get your data
 - Time for data collection –
 - Time for analysis and write up
 - Sharing results and implementing action plans
- Planning your year
 - NCA 2x per year-quality accounts
 - Pre decide where other audits will fit nicely (topic)
- Design your calendar

EDN Audit

Standard NICE Guidelines for Blood Transfusion (NG24 November 2015)

‘Provide the patient and their GP with copies of the discharge summary or other written communication that explains: the details of any transfusions they had, the reasons for the transfusion, any adverse events, that they are no longer eligible to donate blood.’

Aim

Blood transfusion field was added to EDN's which is to be answered yes or no depending on the patient's blood transfusion history during the episode of care/treatment.

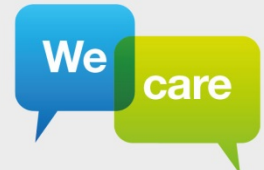
Method

30 random patient EDN's on each of the three acute sites was reviewed to see if the EDN had accurate information relating to the transfusion.



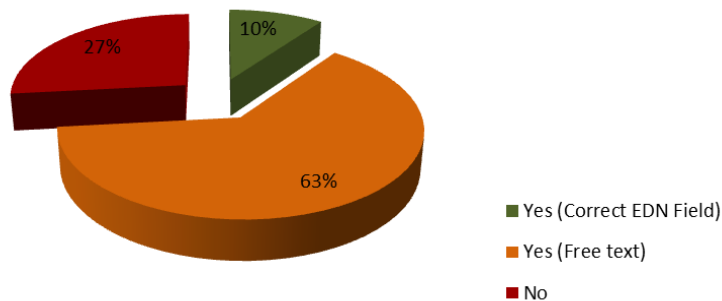
EDN Audit Data Analysis

- The information found on EDN's was placed into one of three categories;
- Yes (correct EDN field) – The blood transfusion field on the EDN was correctly completed with 'yes'
- Yes (free text) – The blood transfusion field on the EDN was completed with 'no' but it was stated in the free text that the patient had received a transfusion.
- No – the blood transfusion field was completed with 'no' and there were no other comments regarding transfusion on the EDN.

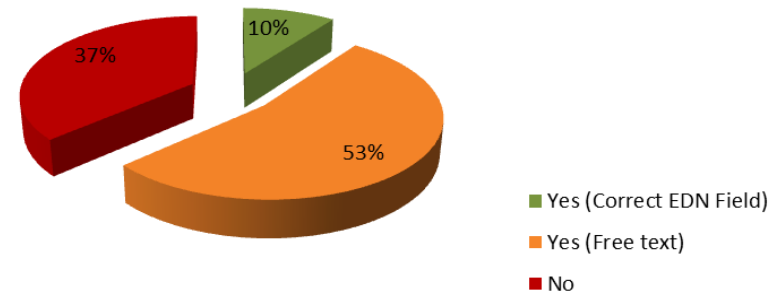


Audit Results

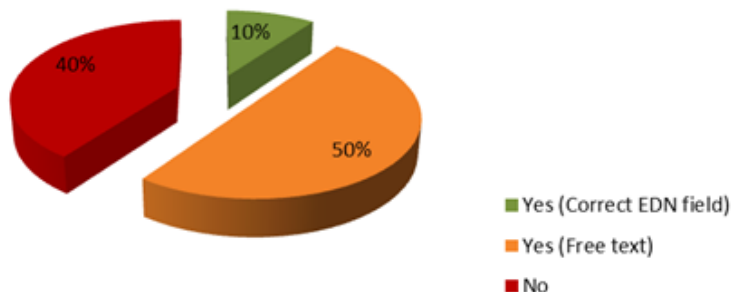
KCH Compliance with Blood transfusion EDN Information




WHH Compliance with Blood Transfusion EDN Information




QEQM Compliance with Blood Transfusion EDN Information



 Transfusion field completed correctly

 Transfusion field stated 'no' but free text included transfusion

 No indication of patient receiving a transfusion found on the eDN



Conclusions

- Poor compliance with completing the blood transfusion EDN field. On many EDN's there was no information stating that the patient had received a blood component transfusion. In turn, this inaccurate record has been electronically sent to the patient's GP.
- Some EDN's there was no blood transfusion field for completion.
- Was highlighted that when completing an EDN, the blood transfusion field defaults to the answer 'no'.

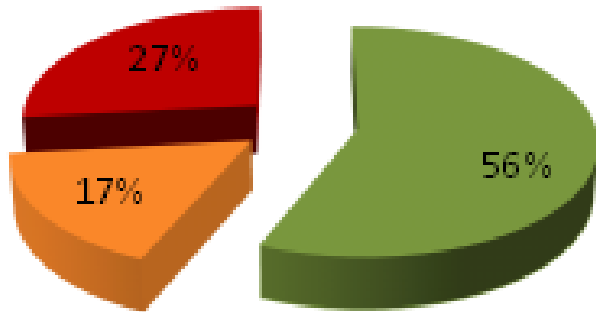


Action Plan

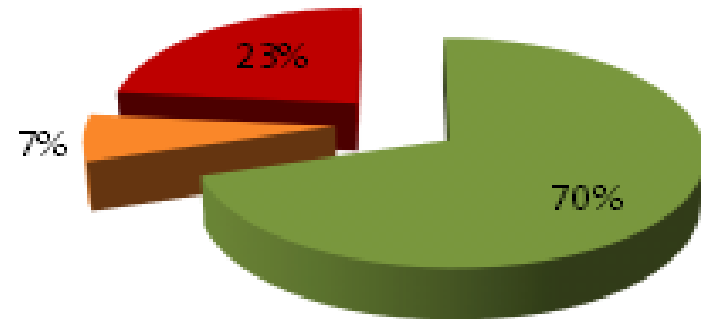
Recommendation from Audit Report	Key Action(s) to be taken	Co-ordinator for Action	Target of Action	Location for Action	Timescale for Action	Indicator of Outcome for Action
Share results with all applicable staff	Cascade results to staff via Ward Managers, Matrons and Consultants	EKHUFT Transfusion Practitioner Team Ward Managers, Matrons and Consultants	All staff responsible for completing clinical information on EDN's	Email circulation. Staff meetings /teaching sessions.	November 2017	Increased awareness and improved audit results
Blood Transfusion field to be available on all EDN templates	Transfusion Practitioner Team to contact EDN team	EKHUFT Transfusion Practitioner Team & EDN Team	EDN Team	IT/EDN Team	June 2017	Improved re-audit results
EDN field to be updated so it does not default to 'no'	Transfusion Practitioner Team to contact EDN team	EKHUFT Transfusion Practitioner Team & EDN Team	EDN Team	IT/EDN Team	June 2017	Improved re-audit results
Continue to monitor blood transfusion EDN information	Inclusion of re-audit in 2017 Transfusion Practitioner audit calendar	EKHUFT Transfusion Practitioner Team	EKHUFT Transfusion Practitioner Team	As many applicable clinical areas as possible trust wide	December 2017	Completed re-audit

Re- Audit Results

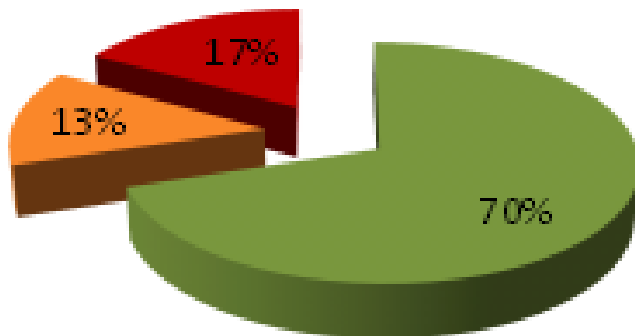
K&CH



WHH



QEQM



■ Transfusion field completed correctly

■ Transfusion field stated 'no' but free text included transfusion

■ No indication of patient receiving a transfusion found on the eDN

We care

Conclusions

- Across the Trust much better compliance with accurate recording of the transfusion on the EDN
- Transfusion field still missing from the maternity EDN.
- Trust changed the patient pathway
 - patients changed site during their
 - transfusions early in admission not being noted.



Action Plan

Action Plan

Audit title		Trust Wide eDN Audit December 2017			Audit reference number	
Action number	Audit recommendation	Action to be taken	Evidence of action	Responsible person(s) or group	Target completion date	Outcome
1	Share audit findings with all staff responsible for completing eDNs	Distribute via Ward Managers, Matrons, medical teams and learning facilitators Trust wide	Communication sent to relevant staff at KCH, QEQM and WHH. Ward Managers/ Matrons/PDNs to cascade information. At QEQM - Email sent to administrator in education centre to be forwarded to all doctors at QEQM.	EKHUFT Transfusion Practitioner Team Ward Managers, Matrons, medical teams, learning facilitators	End Feb 2018	Completed
2	Promote awareness of accurate Blood Transfusion information on eDNs	Distribution of audit results (as above) Include information in teaching sessions with doctors and other staff responsible for completing eDNs	Discussed during junior doctors induction/ teaching sessions.	EKHUFT Transfusion Practitioner Team Ward Managers, Matrons, medical teams, learning facilitators	Dec 2018	Completed
3	Blood Transfusion field to be added to Maternity eDN templates	Transfusion Practitioner Team to contact EDN team	26.02.18 – eDN staff emailed for changes to be made to Maternity eDN template.	EKHUFT Transfusion Practitioner Team	March 2018	Completed (Reply email 09.04.2018 – change made)
4	Continue to monitor blood transfusion eDN information	Inclusion in the 2018/19 Transfusion Practitioner audit calendar	Re-audit July 2018	EKHUFT Transfusion Practitioner Team	August 2018	Completed

Thank you to my team who perform all our clinical audits



