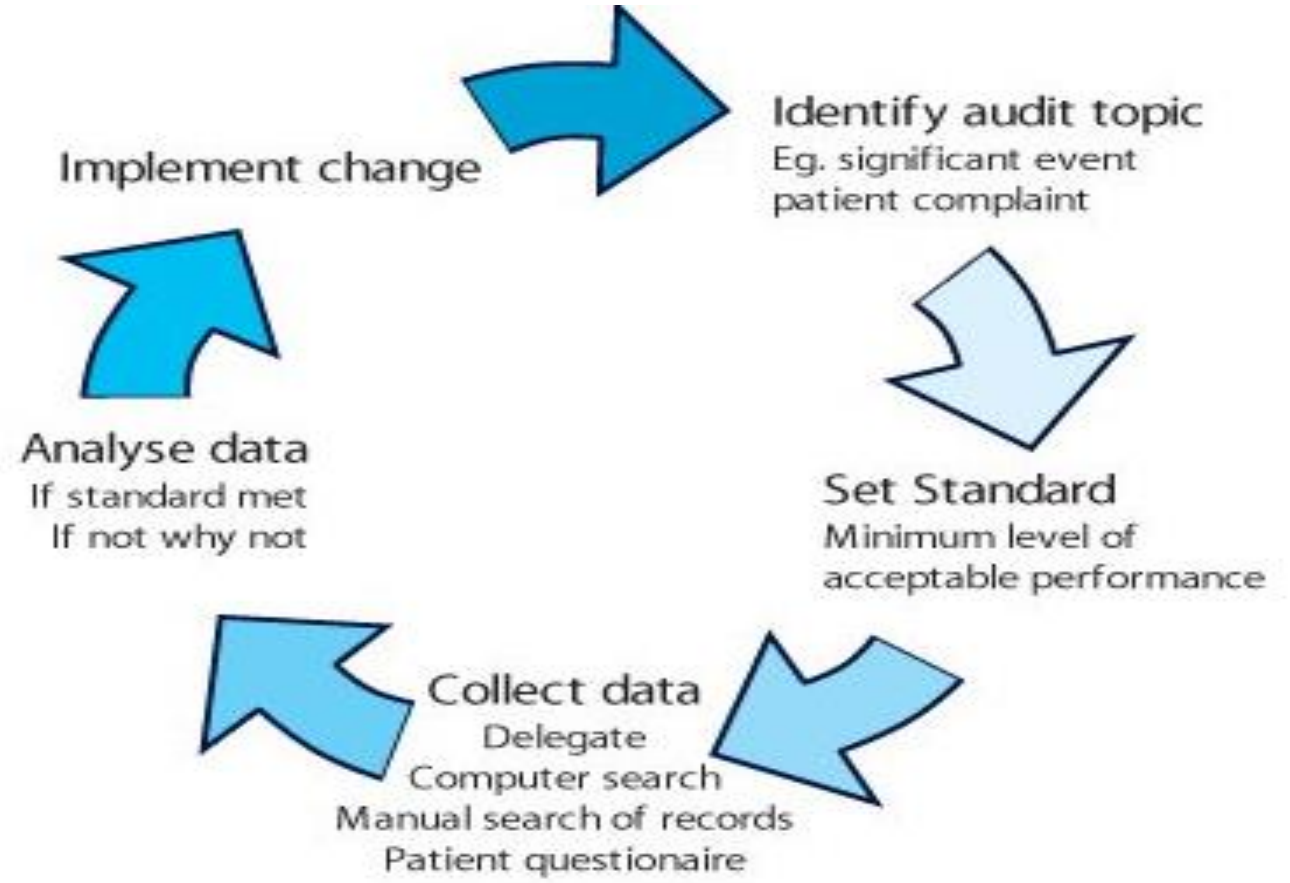
Southport and Ormskirk Hospital NHS Trust

Clinical Audit Annual Report 2017/2018



Introduction

Welcome to the Clinical Audit Annual Report which aims to report the work undertaken by everybody in Southport and Ormskirk Hospital NHS Trust towards supporting and completing the Clinical Audit Programme set out in 2017 / 2018.

We would like to take this opportunity to record our many thanks to the clinical audit and effectiveness department staff for their hard work during the period.

Once again we have had a busy year supporting the Trust in delivering its quality agenda we welcomed Dr Adams who was appointed Clinical Audit Lead for the organisation and chairs the newly established Clinical Audit Leads Meeting (CALM) which meets quarterly.

In March 2018 Mersey Internal Audit Agency (MIAA) undertook a review of clinical audit arrangements and their final report provided significant assurance and identified 2 medium level risks which required addressing.

Following the Care Quality Commission (CQC) visit to the Trust we introduced a new process in January 2018 to follow up clinical audit projects which achieved limited / very limited assurance. Clinical Audit Projects with limited and very limited assurance are now registered as a risk on the DATIX electronic risk register and the actions for improvement are incorporated into the electronic system.

There are further improvements to be made following the CQC visit however a number of positive comments were also made in relation to clinical audit:

- *Paediatrics there was evidence the service investigated serious incidents thoroughly and monitored the impact of recommendations through clinical audit*
- *Paediatrics participated in national and local audit to benchmark the quality of care*
- *In 2016 / 2017 the A&E department results for the national audit of sever sepsis and septic shock were in the upper quartile and they had in place an action plan to address shortfalls*
- *Medicine participated in all relevant national audits they were eligible to complete*
- *Surgery submitted data for internal and external audits in order to benchmark their performance*
- *Surgery completed audits and reported results at directorate and board level.*
- *Spinal monitored the effectiveness of care and treatment*

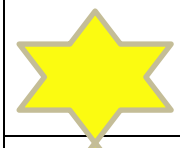
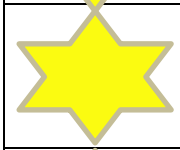
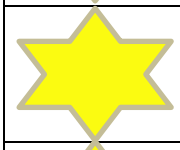
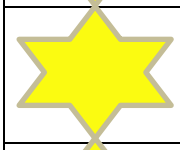
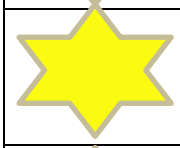
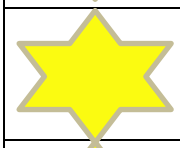
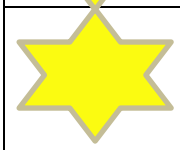
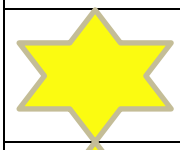
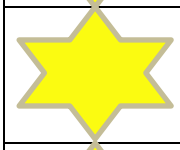
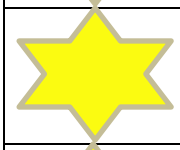
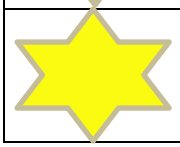
We have seen excellent progress in a number of the mandated national clinical audit projects:

- Top performer in the National Paediatric Diabetes Audit
- Excellent results in the National Intensive Care Audit
- Improvement in the National Cardiac Arrest Audit with a decrease in the number of in-hospital cardiac arrests
- National Audit of Inpatient Diabetes indicates we have a low number of insulin errors

There have also been improvements to practice following completion of local audit projects:

- Improving access to medication for palliative care patients
- Introduction of a booklet to improve communication for rapid end of life transfer patients
- Gradual improvement in sexual health documentation due to frequent audits
- Development of a sticker for use in clinical notes to document discussion around driving and DVLA recommendations with patients who had a history of alcohol abuse

Achievements from Clinical Audit During 2017 / 2018

	Lung Cancer National Audit - In the three months to March 2018 we exceeded national expectations of 90% for gathering data, which includes the recording of a patient's performance status (97%), recording of date of treatment (95%) and the recorded staging of diagnosed cancer (97%).
	Lung Cancer National Audit - 97% of all lung patients see a clinical nurse specialist during their diagnosis and treatment, against national expectation is 90%.
	Decrease in the number of hospital cardiac arrests during 2017 / 2018
	Introduction of DECAF score and discharge bundle for COPD patients
	High percentage of diabetic patients receiving a foot inspection within 24 hours of admission
	Lower number of medication errors for diabetic patients compared to national average
	National Rheumatoid and Early Inflammatory Arthritis Audit -rheumatology department developed a new pathway for patients referred with suspected early inflammatory arthritis and a suspected early inflammatory arthritis clinic referral proforma was developed.
	Improving care for end of life patients by the Introduction of a booklet which cuts down on the amount of paperwork & photocopying required which is important as it enables a quicker process to be followed for these critically ill patients.
	Following an audit of nursing documentation there was a review of all nursing documentation within the organisation in consultation with nursing staff to ensure the new documentation is fit for purpose and reduces duplication. Revised nursing documentation was launched on the 30th April 2018.
	To ensure patients with a history of alcohol excess are informed about their fitness to drive in accordance with national DVLA guidelines a sticker was introduced for use in clinical notes to document discussion around driving had taken place and patient had been advised of DVLA recommendations.
	An audit of pharmacy contributions indicates the Trust is not an outlier with our figure of 6% severe contributions compared to the national figure of 5%.

Definition of Clinical Audit and Effectiveness

Clinical Audit is 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"

(Principles of Best Practice in Clinical Audit NICE 2002)

Clinical Effectiveness includes the provision of care in accordance with high quality evidence-based clinical guidelines. The evaluation of practice through the use of Clinical Audit or outcome measures can lead to further improvement in quality of care.

Role of the Clinical Audit and Effectiveness Department

The Clinical Audit and Effectiveness Department forms part of the Integrated Governance and Quality Business Unit which is accountable to the Director of Nursing and Quality. The overall purpose of the Department is to provide support to the Clinical Business Units to monitor the quality of care provided to patients and the resulting outcomes through Clinical Audit and Effectiveness Projects. Current Responsibilities of the team are:

- Facilitating all Audit Projects on the Clinical Audit Forward Plan across both sites including casenote pulling, guidance, information requests.
- Pulling casenotes, developing proformas, requesting information, coordinating data extraction, data entry, data analysis, report and presentation.
- Facilitating NICE guidelines
- Facilitating Confidential Enquiries
- Facilitating all National Audits
- Facilitating National Patient Surveys
- Updating and Monitoring Effectiveness Projects for each Clinical Business Unit
- Facilitating audit meetings, i.e. taking minutes etc
- Advancing Quality lead for organisation

Review of Objectives set for 2017 / 2018

Explore how to integrate patient experience / audit / risk outputs.	This has been achieved as the audit team have started to use the Risk Register module in DATIX to record audit projects with areas of non-compliance.
Encourage a move from audit to PDSA cycles for some projects	The clinical audit policy has been updated to include the PDSA cycle and the audit officers have received training on quality improvement methodology. This will continue to be developed during the coming year.
Align audit department with quality improvement	Work on this is still underway with the appointment of a permanent assistant director of quality in February 2018.
Provide better evidence for cross – cutting areas for improvement to trust board	Annual report includes more detail on changes and improvements made as a result of clinical audit projects.
Develop reporting structure for national clinical audit projects via the newly established clinical effectiveness committee	Clinical Effectiveness Committee has been established and the reporting structure for national audits has been agreed.
Establish reporting mechanism for local clinical audit projects via the newly established clinical effectiveness committee	Clinical Effectiveness Committee has been established and the reporting structure for local audits has been agreed through the business units monthly integrated governance reports.
Ensure audit support throughout the Trust is aligned with the new CBU (clinical business unit) structure	Audit officers are aligned to support the current CBU structure.
Re-establish clinical audit leads meeting	The Clinical Audit Leads Meeting has been re – established and meets bi-monthly.

Objectives for 2018 / 2019

Objective	Source
Improve engagement of clinical audit leads – MIAA identified a number of clinical audit leads that did not regularly attend the clinical audit leads meeting and were therefore not fully engaged in the clinical audit process.	MIAA report – Review of Clinical Audit Arrangements
Improve National Clinical Audit Benchmarking Data at Board –MIAA identified that where national clinical audit benchmarking data has advised to be received at board (by both HQIP and CQC) the Trust should make provision for this requirement to be addressed.	MIAA report – Review of Clinical Audit Arrangements
Link Clinical Audit activity and projects to the Quality Improvement Action Plan	CQC report – March 2018
The paediatric emergency department should continue to audit and improve the standard of nursing and medical documentation	CQC report – March 2018
The Trust should use audit results to drive improvement in consistency in documenting Fresh Eyes reviews for women in labour when appropriate	CQC report – March 2018
A&E department should audit records routinely	CQC report – March 2018
Embed the new process of recording non-compliant audit projects on the DATIX risk register	Revised Clinical Audit Policy
Align audit department with quality improvement	Appointment of assistant director of quality and development of a quality methodology

Clinical Audit Forward Plan

The department follows a schedule for audit each year, the clinical specialities in conjunction with the audit department formulate a Clinical Audit Forward Plan for the following year. This is based on national priorities from NICE, Confidential Enquiries, NPSA, National Audits, other speciality clinical priorities are discussed and added to the Clinical Audit Forward Plan.

The Plan is monitored via the integrated governance reports produced monthly for the business units.

Trustwide (Nursing, End of Life, Safeguarding)

	Number	%
Number of Audits on Trust Audit Forward Plan	**49**	
Number of projects no longer required	0	-
Number of projects carried over to 2018 / 2019	27	55%
Number of projects completed	22	45%

Planned Care

	Number	%
Number of Audits on Trust Audit Forward Plan	**114**	
Number of projects no longer required	11	10%
Number of projects carried over to 2018 / 2019	37	32%
Number of projects completed	66	58%

Specialist Services (Pharmacy, Radiology, Cancer Services, Blood Transfusion)

	Number	%
Number of Audits on Trust Audit Forward Plan	**43**	
Number of projects no longer required	5	12%
Number of projects carried over to 2018 / 2019	19	44%
Number of projects completed	19	44%

Urgent Care

	Number	%
Number of Audits on Trust Audit Forward Plan	**67**	
Number of projects no longer required	2	3%
Number of projects carried over to 2018 / 2019	9	13%
Number of projects completed	56	84%

Women's and Children

	Number	%
Number of Audits on Trust Audit Forward Plan	**71**	
Number of projects no longer required	0	-
Number of projects carried over to 2018 / 2019	18	25%
Number of projects completed	53	75%

What others say about Clinical Audit

Mersey Internal Audit Agency (MIAAA) – Review of Clinical Audit Arrangements

In February and March 2018 MIAA undertake an external audit reviewing clinical audit arrangements.

The audit provided ***significant assurance*** with the acknowledgment there are some weaknesses in the design and / or operation of controls which could impair the achievement of the objectives of the system, function or process. However it was felt their impact would be minimal or would be unlikely to occur.

The audit focused on 3 areas:

-Robustness of the clinical audit system
-The extent to which clinical audit is embedded across the organisation
-Where referenced in national guidelines the board are appropriately informed of compliance against standards.

The report identified 2 medium level risks which required addressing:

Engagement of clinical audit leads – identified a number of clinical audit leads that did not regularly attend the clinical audit leads meeting and were therefore not fully engaged in the clinical audit process.

National Clinical Audit Benchmarking Data at Board – identified that where national clinical audit benchmarking data has advised to be received at board (by both HQIP and CQC) the Trust should make provision for this requirement to be addressed.

Care Quality Commission (CQC)

In March 2018 the CQC published its reports on the Trusts November 2017 inspection visits: The areas highlighted as requiring improvement have been incorporated in the clinical audit team objectives for the coming year.

	Area	Comment
	Paediatrics	The paediatric emergency department should continue to audit and improve the standard of nursing and medical documentation
	Paediatrics	In Paediatric urgent and emergency care there was a focus on continual learning and improvement supported by annual training days and the local audit programme.
	Paediatrics	We saw evidence that the service investigated serious incidents thoroughly and monitored the impact of recommendations through audit.
	Paediatrics	The quality of documentation and approach to frequency of observation was inconsistent (A&E). Both issues were being addressed through repeated audit and the issue of a new protocol to standardise observations.
	Paediatrics	The service participated in national and local audit to benchmark the quality of care. We saw that changes were made in response to RCEM audit outcomes, for example taking blood sugars on children experiencing possible or actual fits.

	Paediatrics	Governance structures, processes and systems of accountability were clearly set out in the paediatrics unit and the specialist services directorate. Regular governance meetings took place at department and directorate level to monitor and review the quality of care and risk management.
	Maternity	The Trust should use audit results to drive improvement in consistency in documenting Fresh Eyes reviews for women in labour when appropriate
	Trustwide	Clinical and internal audit processes had been implemented inconsistently
	A&E	The emergency department used both NICE and RCEM guidelines to guide the care and treatment they provided to patients
	A&E	In 2016 / 17 RCEM audit for severe sepsis and septic shock. SDGH was in the upper quartile. The dept also had an action plan in place to address any shortfalls
	A&E	The department did not audit records routinely. This remained unchanged since the last inspection
	A&E	20.2% of patients aged over 30 admitted to SDGH for chronic chest pain in 2016 / 17 were seen by a consultant, what was in the upper quartile compared to other hospitals. This however did fail to meet the RCEM standard of 100%
	Medicine	The service provides care and treatment based on national guidance and evidence of its effectiveness. In the main managers checked to make sure staff followed guidance.
	Medicine	Medical services participated in all relevant national audits they were eligible to complete
	Medicine	The Trust took part in the quarterly Sentinel Stroke Audit Programme. On a scale of A-E the Trust achieved overall a level C, which shows overall improvement
	Medicine	Results for the national heart failure audit Apr 16-March 17 were worse than the England and Wales average for all four standards of in-hospital care
	Surgery	The service submitted data for internal and external audits in order to benchmark their performance
	Surgery	The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them
	Surgery	The service completed audits and reported results at directorate and board level. Staff could tell us about audits they have actively completed.
	Surgery	The service provided care and treatment based on national guidance and evidence of its effectiveness
	Spinal	Care and treatment was based on national guidance and evidence of its effectiveness was monitored
	Spinal	The service provided care and treatment based on national guidance and evidence of its effectiveness. Managers checked to make sure staff followed guidance.
	Spinal	The service monitored the effectiveness of care and treatment and used the findings to improve them. They compared local results with those of other services to learn from them.
	Spinal	The service collected, analysed, managed and used information well to support all its activities.

Improvements and Changes made following National Clinical Audit Projects

National Paediatric Diabetes Audit

The Pediatric team looking after children with diabetes at Ormskirk hospital has been recognised as one of the best in the country.

The national audit found they were among the top performers for supporting children with type 1 diabetes in terms of quality improvements.

The National Paediatric Diabetes Audit showed the Ormskirk team had continued to make significant quality improvements.

62.3% of our patients received 4 or more HbA1c measurements in a year, compared to the North West average of 41.1%	85.5% of our patients received structured education about their diabetes compared to the North West average of 83.8%
56.5% of our patients were referred and seen by psychology services compared to the North West average of 24.6%	

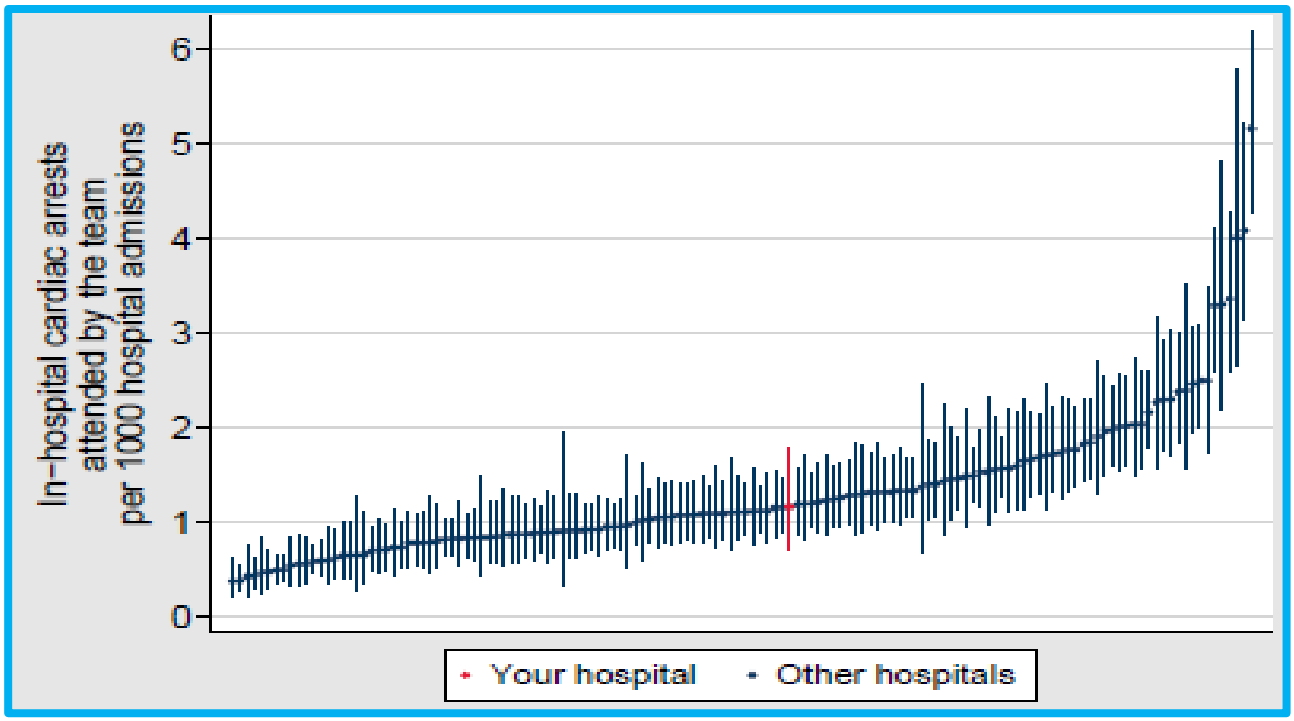
National Intensive Care Audit

The national audit completed by our Intensive Care Unit, indicates a good level of care is provided.

Metric	CQC Key Question	2015/16 Report	2016/17 Report	National Aggregate (England, Wales & N. Ireland)	National Aspirational Standard	Comparison to other hospitals
Case ascertainment	Well Led	Not reported for this audit			None	N/A
Crude non-clinical transfers	Responsive	0.2%	0.2%	0.4%	0%*	0 Within expected range 10.0
Crude, non-delayed, out-of-hours discharge to ward proportion	Responsive	3.4%	4.1%	1.9%	0%*	0 Within expected range 20.0
Crude delayed discharge (% bed-days occupied by patients with discharge delayed >8 hours)	Responsive	3.4%	7.1%	4.9%	0%*	Not in the Worst 5% of Units
Risk-adjusted hospital mortality ratio (all patients)	Effective	1.11	1.14	1.0	None	0.5 Within expected range 2.0
Risk-adjusted hospital mortality ratio for patients with predicted risk of death <20% (lower risk)	Effective	1.17	1.18	1.0	None	0.1 Within expected range 3.16

National Cardiac Arrest Audit

We review every cardiac arrest that occurs within the Trust and learning from this process has led to a decrease in the number of in hospital cardiac arrest throughout 2017 / 18.



National Chronic Obstructive Pulmonary Disease Audit

The project has resulted in the introduction of new paperwork which aims to standardise the care patients with chronic obstructive pulmonary disease (COPD) receive and follows best practice guidance.

We have introduced the DECAF score onto our medical clerking in sheet which is a robust predictor of mortality, using indices routinely available on admission. Its generalisability is supported by consistent strong performance; it can identify low-risk patients (DECAF 0–1) potentially suitable for early supported discharge services, and high-risk patients (DECAF 3–6) for escalation planning or appropriate early palliation.

The national audit has also led to the introduction of a discharge bundle for all COPD patients.

National Rheumatoid and Early Inflammatory Arthritis Audit

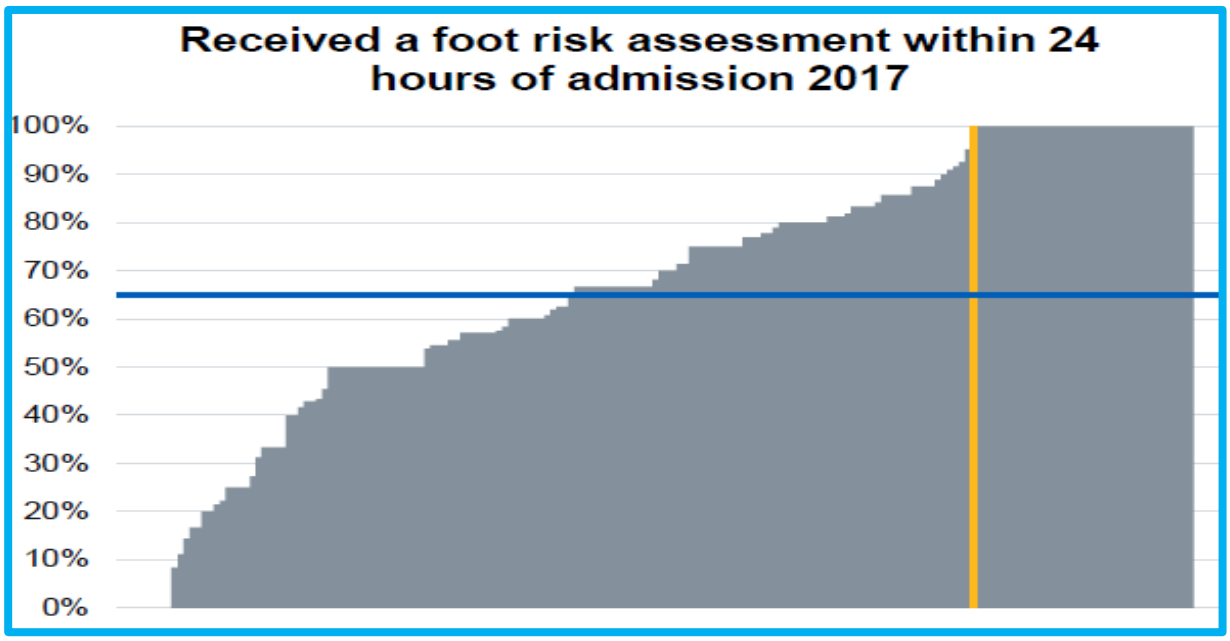
In January 2106 the 1st national report for this audit indicated the Trust had a low response rate. As a result of this the Rheumatology department developed a new pathway for patients referred with suspected early inflammatory arthritis and a suspected early inflammatory arthritis clinic referral proforma was developed. Following the introduction of the pathway a local audit was undertaken which indicated the referral rate had increased.

National Inpatient Diabetes Audit

This project audited patients who were inpatients within the hospital during census day in 2017. Our results indicate that patients receive a good level of care.

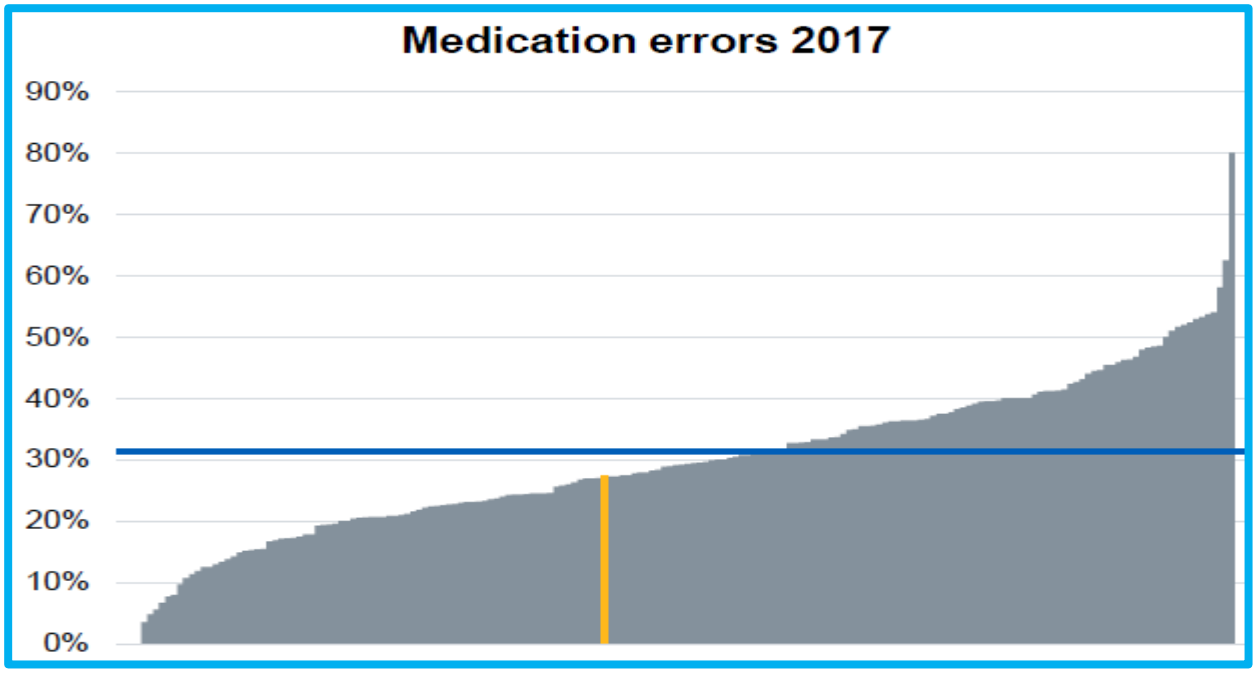
High percentage of patient receiving a foot inspection within 24 hours of admission

The yellow line on the graph indicates the Trust position compared to other Trusts who participated in this national project.



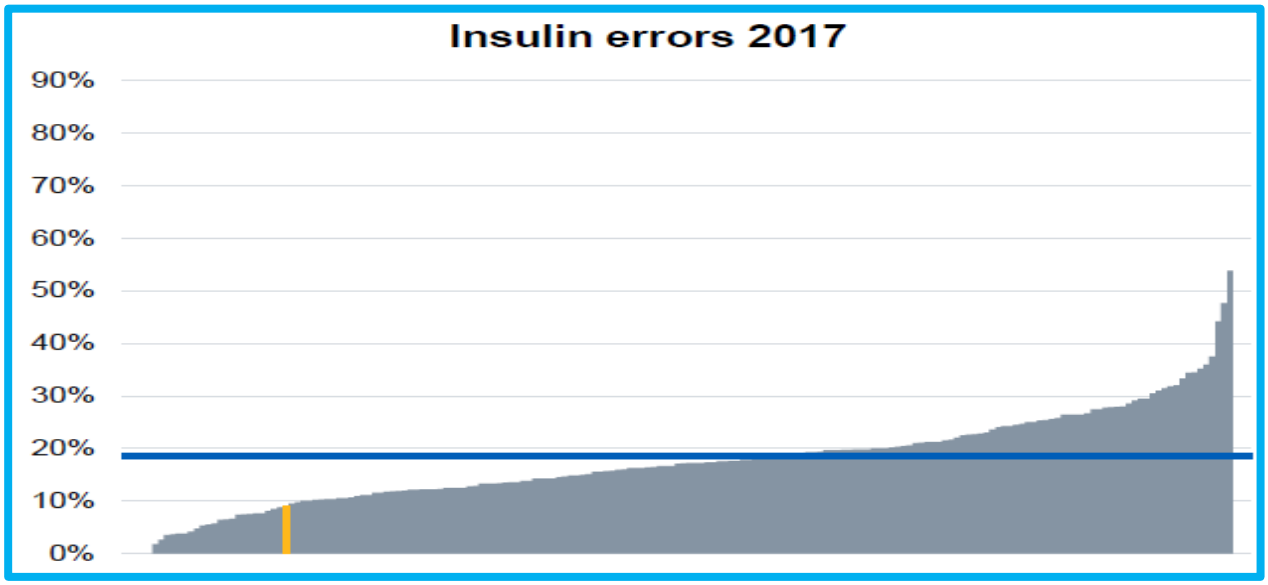
Lower number of medication errors compared to national average

The yellow line on the graph indicates the Trust position compared to other Trusts who participated in this national project.



Low number of insulin errors compared to national average

The yellow line on the graph indicates the Trust position compared to other Trusts who participated in this national project.



National Emergency Laparotomy Audit (NELA)

The national emergency laparotomy audit indicates the Trust is a positive outlier for 4/5 measures.

Metric	CQC Key Question	Year 2[1]	Year 3[2]	National Aggregate (England & Wales)	National Standard	Comparison to other hospitals
Case Ascertainment	Well Led	77%	88.4%	82.0%	80%	Higher than 80%
Crude proportion of cases with pre-operative documentation of risk of death	Effective	61%	88.9%	70.7%	80%	Higher than 80%
Crude proportion of cases with access to theatres within clinically appropriate time frames	Effective	88%	88.5%	82.7%	80%	Higher than 80%
Crude proportion of high-risk cases (≥5% predicted mortality) with consultant surgeon and anaesthetist present in theatre	Effective	42%	65.4%	79.2%	80%	Between 50% and 80%
Crude proportion of highest-risk cases (>10% predicted mortality) admitted to critical care post-operatively	Responsive	97%	91.9%	86.6%	80%	Higher than 80%
Risk adjusted 30-day mortality	Effective	10.4%	14.9%	10.6%	None	Within expected range

National Lung Cancer Audit

The results below indicate that in the three months to March 2018 we exceeded national expectations of 90% for gathering data.

Metric	CQC Key Question	2016 Report [1]	2017 Report [2]	National Aggregate (England & Wales)	National Aspirational Standard	Comparison to other trusts
Crude proportion of patients seen by a Cancer Nurse Specialist	Responsive	75.0%	92.4%	N/A	90%*	Meets the national minimum standard of 90%
Case mix adjusted one year relative survival rate	Effective	Significantly worse than the national level	40.4%	37.0%	none	Within the expected range
Case mix adjusted percentage of patients with Non Small Cell Lung Cancer (NSCLC) receiving surgery	Effective	Not significantly different from the national level	14.3%	17.5%	17%*	Within the expected range
Case mix adjusted percentage of fit patients with advanced Non Small Cell Lung Cancer (NSCLC) receiving Systemic Anti-Cancer Treatment	Effective	Not significantly different from the national level	47.7%	62.0%	65%*	Within the expected range
Case mix adjusted percentage of patients with Small Cell Lung Cancer (SCLC) receiving chemotherapy	Effective	Not significantly different from the national level	62.6%	68.0%	70%*	Within the expected range

Improvements and changes made following Local Clinical Audit Projects

Audit Project	Improvement / Change
Improving access to medication for palliative care patients	This project aimed to make it easier and quicker for palliative care patients to get the medication they needed. Following the first round of the audit it was agreed to change practice and it was decided that the Palliative Care Nurse Specialists could inform the hospital team of changes to the patient's prescription.
Rapid End of Life transfers re-audit	Introduction of a booklet which cuts down on the amount of paperwork & photocopying required which is important as it enables a quicker process to be followed for these critically ill patients.
Audit of Triage waiting times on Maternity Assessment Unit	This audit provides full assurance that women are provided with timely assessment on arrival and care in line with Maternity Unit guidelines.
Audit of documentation in Sexual Health Clinic records, documentation and completion of consent forms.	Through periodic ongoing auditing of documentation in sexual health throughout 2017 / 2018. Documentation has improved and the most recent audit undertaken in January 2018 provided significant assurance
Audit of proton-pump inhibitors for upper GI Bleeding	Development of prescription chart which will improve compliance with prescribing medication timely for patients.
Audit of nursing documentation	Following this audit there was a review of all nursing documentation within the organisation in consultation with nursing staff to ensure the new documentation is fit for purpose and reduces duplication.
Audit of Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR)	During 2017 / 2018 there has been improvement in DNACPR documentation including a clear summary of reasons for the DNACPR being documented, evidence of discussion with relatives / carers and clear documentation stating if DNACPR is indefinite of for review. There is also a change in policy which means the DNACPR travels with the patient from the community to hospital and back again, improving communication and continuity of patient care.
Pharmacy Contributions audit	This project indicates the Trust is not an outlier with our figure of 6% severe contributions as the national figure is 5%.
Patients with a history of alcohol excess being informed about their fitness to drive in accordance with national DVLA guidelines.	Sticker was introduced for use in clinical notes to document discussion around driving had taken place and patient had been advised of DVLA recommendations.
Ensuring safe and effective handovers over weekends	A junior doctor audited the handover process and created a new form which has improved handovers.

Clinical Audit and the link with NICE guidelines

The Trust reports on NICE monthly via the clinical business units centrally produced integrated governance report and a quality dashboard. As part of our assurance process we also undertake clinical audit projects measuring compliance against NICE standards.

Examples of audits undertaken

Audit of Rehabilitation after Critical illness (Project Number 17-346)

BACKGROUND

NICE have produced a guideline (CG83) for the rehabilitation of patients after critical illness. This guideline covers rehabilitation strategies for adults who have experienced a critical illness and stayed in critical care. It aims to improve physical, psychological and cognitive outcomes in people who have been discharged from critical care.

AIMS & OBJECTIVES

The audit aims to measures the Trust compliance with NICE CG 83 standards.

COMPLIANCE

During the critical care stay		
-Short clinical assessment completed	109/115	95%
-Patient given information	115/115	100%
-If patient at risk - Comprehensive clinical assessment completed and goals agreed	37 / 41	90%
Before Discharge from Critical Care		
-Short clinical assessment completed if patient previously identified as low risk	95 / 98	97%
-If patient at risk - Comprehensive clinical assessment completed and goals agreed	14 / 14	100%
During Ward Based Care		
-Short clinical assessment completed if patient previously identified as low risk	53 / 79	67%
-If patient at risk - Comprehensive clinical assessment completed and goals agreed	6 / 22	27%

ASSURANCE LEVEL

Assurance Level	Calculation of assurance
Full	To be used when 90%-100% of standard has achieved a score of 90% or above and rated Green
Significant	To be used when 65%-89% of standards have achieved a score of 90% or above and rated Green.
Limited	To be used when 35-64% of standards have achieved a score of 90% or above and rated green
Very Limited	To be used when 0-34% of standards have achieved a score or 90% or above and rated green.
Total number of standards	***7***
Number of standards 90% or above and rated green	***5***
% of standards 90% or above and rated green	***71%***

Re-Audit of Head Injury Management in A&E (Project Number 18-142)

Background &Aims of Project

The audit aims to measure the compliance with NICE CG 176 for initial assessment and neuro observations in Head Injury Management published in 2014.

1.8.6 For patients admitted for head injury observation the minimum acceptable documented neurological observations are: GCS; pupil size and reactivity; limb movements; respiratory rate; heart rate; blood pressure; temperature; blood oxygen saturation.
1.8.7 Perform and record observations on a half-hourly basis until GCS equal to 15 has been achieved. The minimum frequency of observations for patients with GCS equal to 15 should be as follow:
-half hourly for 2 hours
-Then 1 hourly for 4 hours
-Then 2 hourly thereafter

COMPLIANCE

Standard	Aug 2016 Compliance	March 2018 Compliance
100% of patients should have a head injury pathway initiated.	**5 / 19 (26%)**	**10 / 11 (91%)**
100% of patients should have the following documented on initial assessment		
Temperature	**16 / 19 (84%)**	**11 / 11 (100%)**
Heart Rate	**17 / 19 (90%)**	**11 / 11 (100%)**
Respiratory Rate	**17 / 19 (90%)**	**11 / 11 (100%)**
Blood Pressure	**18 / 19 (95%)**	**11 / 11 (100%)**
Oxygen Saturation	**17 / 19 (90%)**	**11 / 11 (100%)**
GCS	**18 / 19 (95%)**	**11 / 11 (100%)**
Pupil size and reactivity	**14 / 19 (74%)**	**11 / 11 (100%)**
Limb Movements	**11 / 19 (58%)**	**11 / 11 (100%)**
If GCS was less than 15 observations should be performed and record observations on a half-hourly basis until GCS = 15	**(33%)**	**100%**
When GCS = 15, minimum frequency of observations is: -half-hourly for 2 hours / -then 1-hourly for 4 hours	**(37%)**	**(67%)**

ASSURANCE LEVEL

Assurance Level	Calculation of assurance
Full	To be used when 90%-100% of standard has achieved a score of 90% or above and rated Green
Significant	To be used when 65%-89% of standards have achieved a score of 90% or above and rated Green.
Limited	To be used when 35-64% of standards have achieved a score of 90% or above and rated green
Very Limited	To be used when 0-34% of standards have achieved a score or 90% or above and rated green.
Total number of standards	***11***
Number of standards 90% or above and rated green	***10***
% of standards 90% or above and rated green	***91%***
Assurance Level	***Full***

UTI Antibiotics Treatment in paediatrics department, Project Number 17-454

BACKGROUND

Urinary tract infection (UTI) is a common childhood illness that can effectively be treated with antibiotic medication. Most children with lower UTIs who have low risk of serious illness are seen and treated in the primary care centres or GP surgeries. For children presenting to hospital with UTI, a number of factors determine the choice of antibiotics and route of administration. These include age of the child; risk of serious illness, previous UTI or other illnesses[1]. Particularly important in patient hospitalised with UTI is the microbial cause and the sensitivity pattern. Urine culture and sensitivity are therefore very important investigation in children presenting to hospital with suspected UTI especially those with systemic symptoms.

AIMS & OBJECTIVES

The audit aims to measures the Trust compliance with NICE CG 54 standards.

Compliance

Standard	Achieved
1.All children presenting with suspected UTI should have urine dipstick result documented in their medical notes	**100%**
2. All children hospitalised with suspected UTI should have urine microscopy.	**100%**
3. All Positive urine microscopy should have culture and sensitivity reported	**100%**
4. Infant less than 3 months with UTI should be treated with parenteral antibiotics.	**100%**
5. First line parenteral antibiotics for UTI should be those with low resistance pattern such as cephalosporin or co-amoxiclav	**95%**
6. First line antibiotics for UTI should be reviewed with urine culture and sensitivity	**100%**
7. Antibiotic prophylaxis for UTI should not be routinely given without documented valid indication	**33%**

ASSURANCE LEVEL

Assurance Level	Calculation of assurance
Full	To be used when 90%-100% of standard has achieved a score of 90% or above and rated Green
Significant	To be used when 65%-89% of standards have achieved a score of 90% or above and rated Green.
Limited	To be used when 35-64% of standards have achieved a score of 90% or above and rated green
Very Limited	To be used when 0-34% of standards have achieved a score or 90% or above and rated green.
Total number of standards	***7***
Number of standards 90% or above and rated green	***6***
% of standards 90% or above and rated green	***86%***
Assurance Level	***Significant***

Using DATIX to record audit projects with non-compliant statements

In January 2018, following the CQC inspection visits we introduced a new process where audit projects with very limited or limited assurance will be added to the DATIX Risk Register.

Actions for improvement will be monitored through DATIX rather than paper action plans.

A total of 26 projects were recorded on the risk register and are listed below:

CBU	Audit Title	DATIX number on risk register
Planned Care	Re-audit of testes pathway	1741
Specialist Services	Bowel Cancer (NBOCAP)	1812
Urgent Care	Falls and Fragility Fractures Audit programme (FFFAP)	1734
Urgent Care	National Diabetes Audit - Adult Inpatients	1814
Trustwide	Audit of GSF registered patients admitted from A&E	1742
Urgent Care	PTWR Form Completion	1791
Trustwide	Audit of QS89 - Pressure Ulcers	1784
Trustwide	Audit of VTE Process	1738
Planned Care	Audit of Consultant Review before discharge	1799
Specialist Services	Menorrhagia	1740
Planned Care	Audit of compliance with NICE guidelines for IV fluids	1779
Specialist Services	Re-audit Medicines Reconciliation	1808
Planned Care	Cholecystectomy Following Acute Biliary Pancreatitis	1836
Urgent Care	Audit of USS in A&E	1797
Specialist Services	An audit of Meropenem use in Inpatients in SOHT	1778
Trustwide	Benchmarking Professional Curiosity / Routine Enquiry	1785

Trustwide	Audit of dependent recording on nursing notes	1787
Trustwide	MCA / DOLs benchmark	1786
Planned Care	Catheter passport documentation feedback	1819/1820
Planned care	Carers satisfaction questionnaire from critical care	1743
Specialist Services	Audit of Paediatric Sepsis Pathway	1777
Urgent Care	Audit of care for patients with decompensated chronic liver disease	1749
Urgent Care	Audit into use of intravenous proton pump inhibitors	1750
Urgent Care	Audiology outpatients experience	1798
Specialist Services	HDU Care - fluid balance	1780
Specialist Services	Audit of TTO documentation	1811

Audit Meetings

During 2017 / 2018 each speciality organised meetings to present the results of clinical audit findings and discuss action plans.

Table 3 illustrates the number of meetings undertaken in each specialty

Table 3

Speciality	**Number of audit meetings held during 2017-2018**
General Surgery	6
A&E	3
General Medicine	5
Paediatrics	3
Ophthalmology	6
Obs & Gynae	6
Radiology	1
Sexual Health	4
Spinal Unit	4
Anaesthetics	8
Urology	6
Orthopaedics	6
Pharmacy	2

Trust Hosted Regional Clinical Audit Staff training day at Southport Education Centre

As the clinical audit network chair for the Lancashire and Cumbria network and the local clinical audit representative with HQIP the Head of Audit volunteered to host the annual clinical audit training day for clinical audit staff in the North West region.

The day focused on how clinical audit links to quality improvement and what are the barriers to making change, 90 clinical audit staff working in the North West attended the event.

Dr Ted Adams the Clinical Audit Led for the Trust was the opening speaker for the day and shared his thoughts on the link between clinical audit and quality improvement.

Clinical Audit Poster Submissions

The clinical audit team encourages clinicians to submit audit projects to national and international conferences to share good practice.

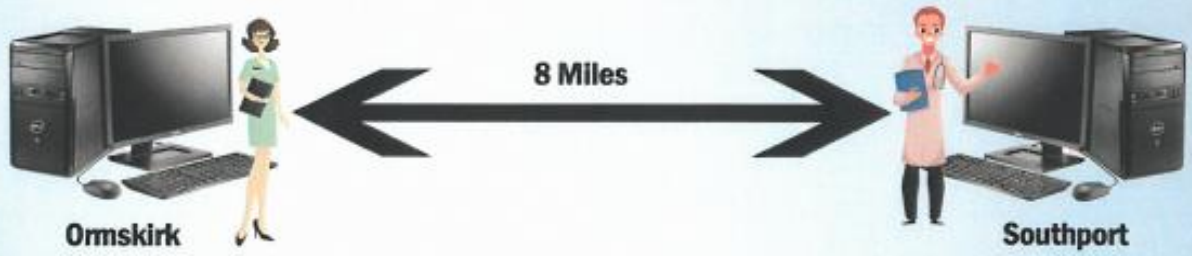
NHS
Southport and Ormskirk Hospital
NHS Trust
Southport and Formby District General Hospital
Ormskirk and District General Hospital

Audit of Virtual Orthopaedic Consultation from Paediatric A&E (via e-folder)

Usha Natarajan, John Gilbert and Sharryn Gardner
Paediatric Emergency Department, Ormskirk DGH, UK

Background

- Difficulties in communication between orthopaedic on call and paediatric A&E clinicians due to split site
- Orthopaedic doctor not available on site to review patients out of hours
- Senior orthopaedic input not always available
- Therefore, delays in decision making
- A shared orthopaedic folder was set up to facilitate orthopaedic referrals from paediatric A&E as QIP
- Paediatric A&E clinicians input clinical details.
- Clinical details & X-ray viewed by senior orthopaedic team in trauma meeting following day
- Management plan communicated via e-folder, actioned by A&E clinician



Aims and Objectives

- This audit aims to test current performance of the referral process

Methodology

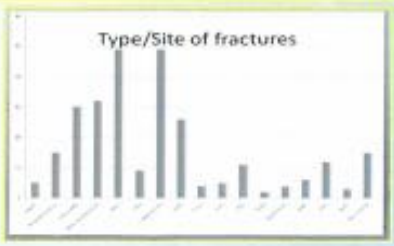
- Study period 1 year: 2015
- Retrospective analysis of documentation
- Data and results analysed on Excel spreadsheet.

Conclusion

- Virtual consultation via shared folder has shown to be an effective quality improvement programme in a setting of split site services
- Virtual consultation provides consultant-led decisions for all children referred, in a timely fashion.

Results

Ortho Trauma meeting outcome
Outpatient Fracture clinic: 192
Ward review/Surgery: 50
MUA: 22
MUA + ORIF: 19
Other surgery (Complex laceration/FB): 3
Urgent clinics review, special imaging, etc.



Southport and Ormskirk Hospital NHS Trust

A Clinical and Coding Collaboration to improve patient safety – Second Cycle

HT Wai*, J Drybrough*, H Garrod*, M Lyttle*, R Kinney**, R Mistry*

*Department of Urology, Southport and Ormskirk Hospital NHS Trust

**Department of Clinical Coding, Southport and Ormskirk Hospital NHS Trust

Background:

Five years on from the Francis reports on Mid Staffordshire scandal, hospitals are still under pressure to ensure the standard of care is met.

- Previously our trust had an elevated Hospital Standardised Mortality Ratio (HSMR) for urinary tract infection.
- It was identified that UTI and urosepsis shares the same code (N390) despite differences in prognosis.
- Only 52% of patient coded under N390 has clinically proven sepsis of urinary tract source.
- Incomplete/Inaccurate documentation had implication on patient safely as reflected on HSMR.

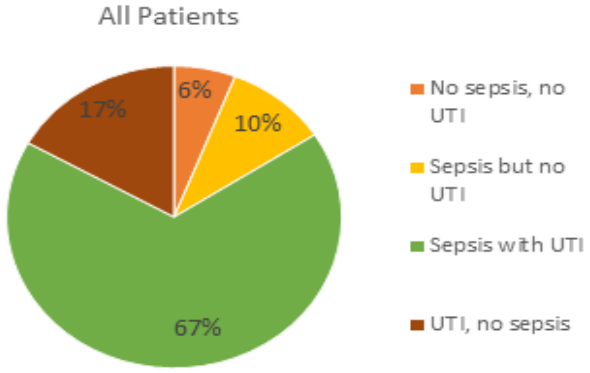
Updated Coding in 2017:

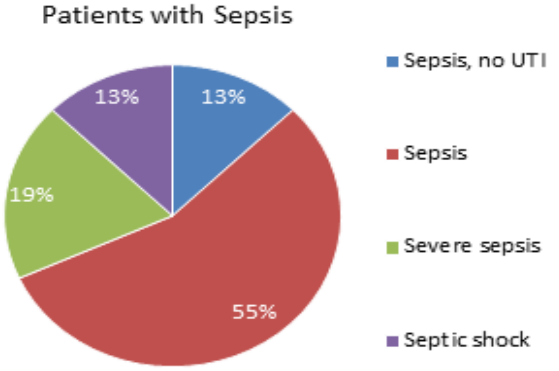
- International Statistical Classification of Diseases and Related Health Problems (ICD) published its 10th revision.
- This allows sepsis (A41) to be coded with a specific origin e.g. UTI (N390)

Methods:

- 82 patients coded under A41 + N390 reviewed retrospectively (May to July 2017).
- Those clinical records were reviewed using a standardised proforma to examine evidence for
    - Sepsis (SIRS
    - Severe sepsis
    - Septic shock
    - UTI
- Primary diagnosis, other conditions treated for, and co-morbidities are also reviewed for coding purposes.

Clinical results:





Financial results:

- The updated tariffs resulted in a net gain of £7,854 to the trust.

Conclusion:

- Accuracy of coding has improved with the new ICD-10.
- Areas for improvement include documentation of severity of sepsis, and co-morbidities.
- Accurate records allow accurate coding, which determines HSMR and finical tariffs for the trust.