Clinical Audit Awareness Week #CAAW24

HQIP
Healthcare Quality Improvement Partnership

National Quality Improvement (Inc. Clinical Audit) Network
N-QI-CAN

Effectively Utilising Clinical Audit To Influence Change NQICAN Lunch and Learn Thursday 27th June 2024 (12.30-1.30pm)

Your Lunch & Learn Team Today

Vicky Patel - Chair NQICAN
Marina Otley - Gen Sec NQICAN
Amanda Stephens - Comms Lead NQICAN
Claire Fountain - Associate Director HQIP
Sam Riley – Director of Making Data Count NHSE
Clinical Audit Hero Winner – Influencing Change

Who is YOUR Audit Hero?

#CAAW24

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Monday 24th June 2024 12.20-1.30pm	Tuesday 25th June 2024 12.20-1.30pm	Wednesday 26th June 2024 12.20-1.30pm	Thursday 27th June 2024 12.20-1.30pm	Friday 28th June 2024 12.20-1.30pm
Patient Safety - Effectively Utilising Clinical Audit To Prevent Avoidable Harm	Patient & Public Involvement - Effectively Utilising Clinical Audit To Improve Health & Care by Involving, Engaging & Informing Patients & The Public	Health Inequalities - Effectively Utilising Clinical Audit To Address Inequalities in Health & Care	Influencing Change - Effectively Utilising Clinical Audit To Influence Change At Board Level	Sustainability - Effectively Utilising Clinical Audit For Sustainability
Rachel Pool - NHSE	Kim Rezel - HQIP	Danny Keenan - HQIP & Charlotte Richardson - NHSE	Sam Riley - NHSE	Zoe Lord - NHS Horizons

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#CAAW24 NQICAN Influencing Change Lunch & Learn

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Agenda

- Introduction NQICAN, HQIP and #CAAW - what does 'Effectively Utilising Clinical Audit To Influence Change mean to you?
- Key Speaker - Effectively utilising Clinical Audit to Influence Change
- Clinical Audit Hero Winner announced
- Winner of the Influencing Change Clinical Audit Hero Award presents
- Opportunity for questions framed on Influencing Change
- Interactive Evaluation
- Close and celebrate #CAAW24!

Please let us know– *what does utilising Clinical Audit to effectively influence change look like to you* - by typing into the chat

Healthcare Quality Improvement Partnership (HQIP)

- **What you probably already know about us**

We are a charitable organisation

We commission the 40+ National Audits under NCAPOP and support providers to:

- Develop robust measures that are
  i) based on evidence-based standards
  ii) clinically relevant through extensive co-design with clinicians
  iii) adjusted, risk scores
- Identify variations in care and outcomes using nationwide benchmarks, over time
- Involve Service Users in defining what 'good' looks like through our mature 'SUN' network
- Enable Quality Improvement at provider level
- Examine health care/outcomes inequalities

- **What you might not know**

We host the National Joint Registry (NJR)

We coordinate with national bodies to support the implementation of national recommendations

We advocate for Clinical Audit at national level, to raise the profile of Clinical Audit

We carry out other work for NHS organisations at low cost:

- **Quality Improvement Consulting**
- **Insight / Evaluation projects**
- **Procurement support**
- **Service User & community engagement**

Influencing Change

- **Joint event 26/6/24 NHS England NHS IMPACT team & HQIP** (recording will be available)
- Organisational 'approach' to improvement
- Implore Clinical Audit / Effectiveness professionals to:
  - Familiarise yourselves with the NHS IMPACT framework
  - Have a coffee with your local QI team
  - Support your organisation to integrate Clinical Audit explicitly into the 'organisational approach' + inform trust priorities
- NDA Dashboards and Improvement work – Case study
- Change agent
  - Taking the initiative
  - Making clear how supports Trust priorities
  - Permission to fail, iterate
  - Make the desired behaviour easy to do

Excellent submissions this year

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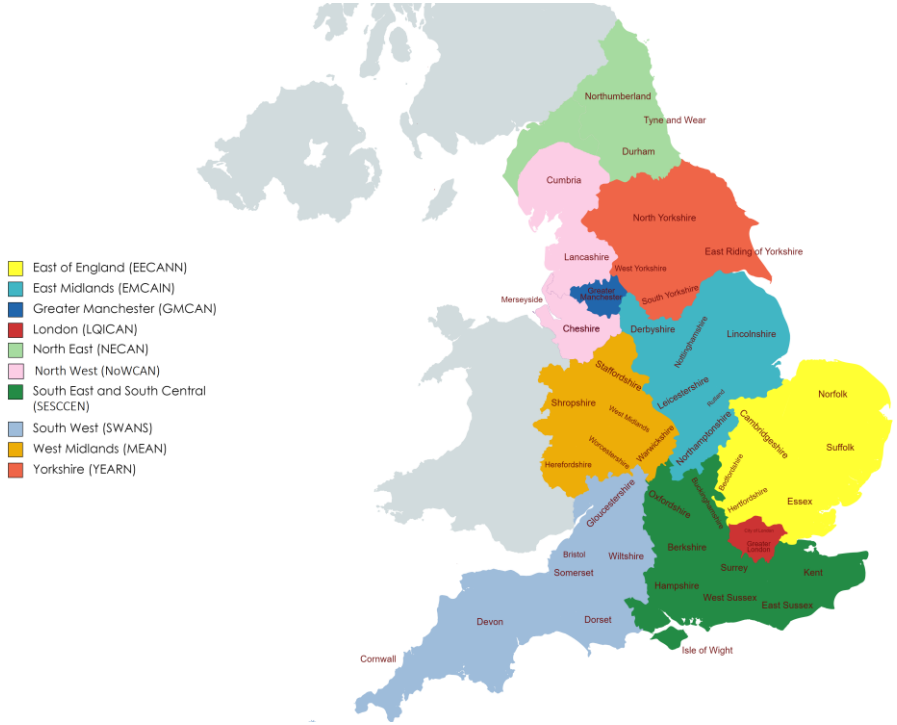

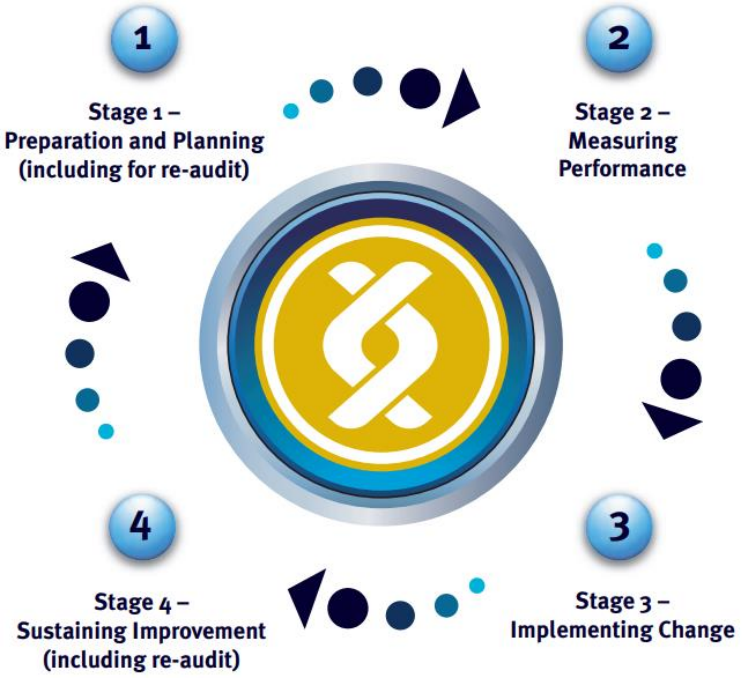

Who is YOUR Audit Hero?

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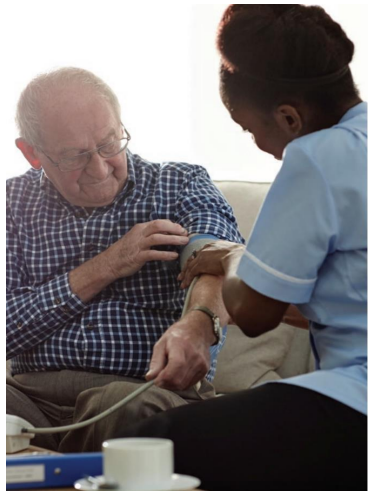

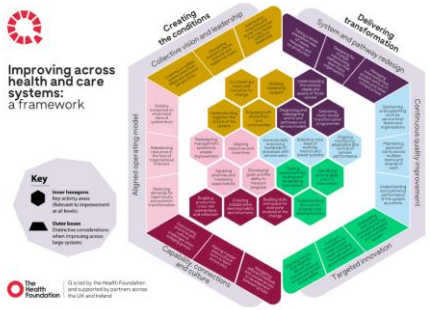

Clinical Audit – measures care against evidence based standards. #CAAW23 challenged attendees to consider Clinical Audit in their own organisation in terms of:

Does your clinical audit strategy have a clear objective to align with:

- the Corporate Strategy?
- The Quality Strategy?

Does your clinical audit programme consist of clinical audits that are in line with:

- the Quality Objectives?
- Improvement priorities?

Signposting to FutureNHS – Making Data Count workspace
Real time data
Senior Buy In
Build your team (stakeholders)
Using SPCs to influence change & plotting change overtime
How to present data to make it accurate and informative – influence your audience
Visualisation of data
SMART actions
Triangulation – what else do we know?
Fostering Discussion for improvement – assurance will naturally then be provided
Think wider – across your systems and pathways

Who is YOUR Audit Hero?

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Key Speaker: Sam Riley
Director
Making Data Count
NHSE

https://future.nhs.uk/MDC

Who is YOUR Audit Hero?

#CAAW24

Optimising patient care

Strengthening our approach to influence change : the role of data

Presented by:
Samantha Riley, Director, Making Data Count
27 June 2024

The journey so far…….

May 2018
Making data count is born

September 2018
First (in person) training session

January 2022
Making data count introduction

June 2022
Using clinical audit to influence change

March 2023
Having improvement focussed conversations

June 2023
Deb's story & transformation

Special day last month

Old Deb

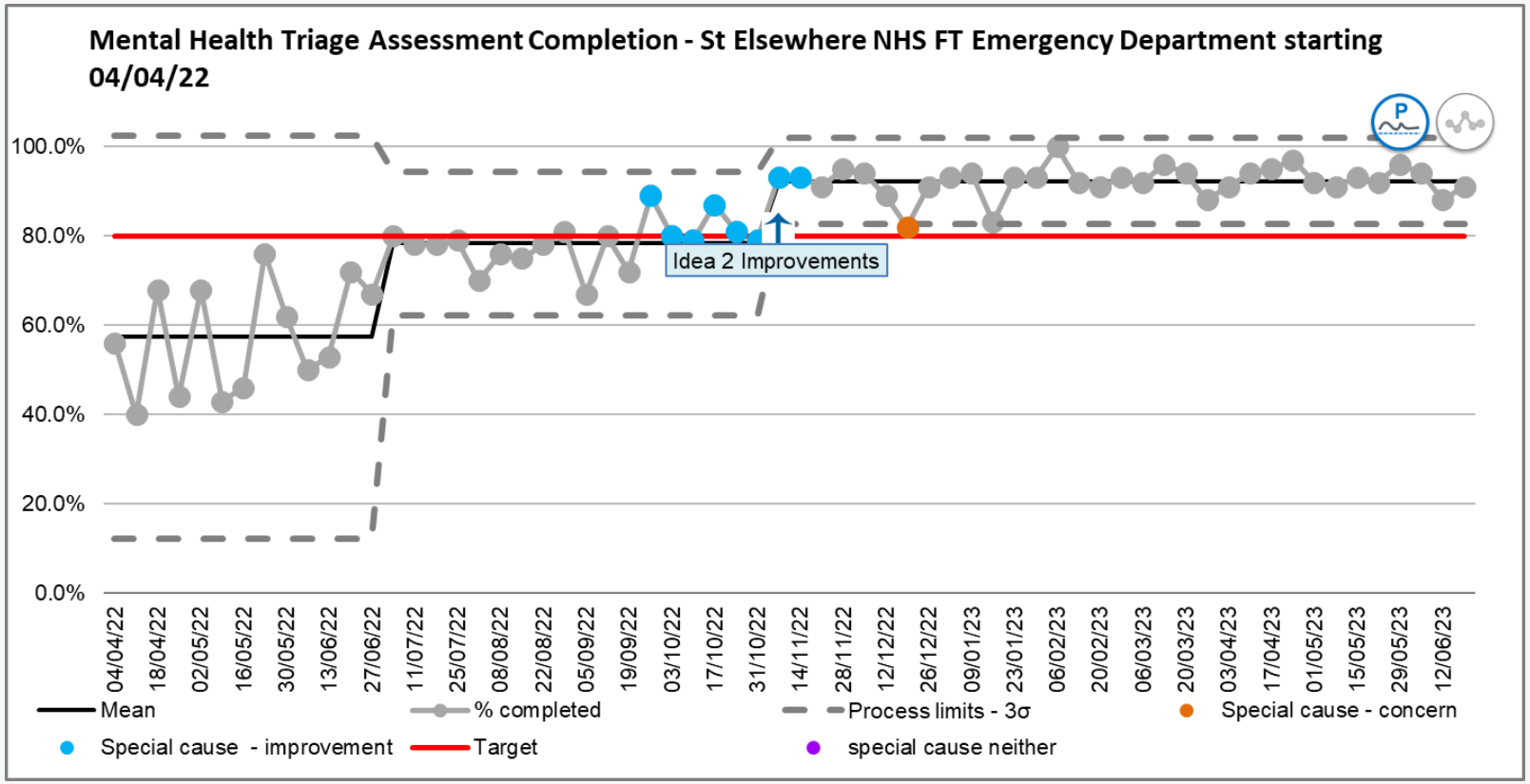
Findings

On average over the audit period, MH triage was carried out **80%** of the time

New (and improved) Deb

- Agreed Trust priority
- Executive sign up
- Robust plan
- Engagement with A&E multidisciplinary team
  - Agreed audit questions
  - Weekly audit, baseline data
  - Agreed improvement plan
  - Understand responsibilities
  - Time for regular reviews
  - Agreed timescales for outcome and feedback

Deb can now evidence improvement



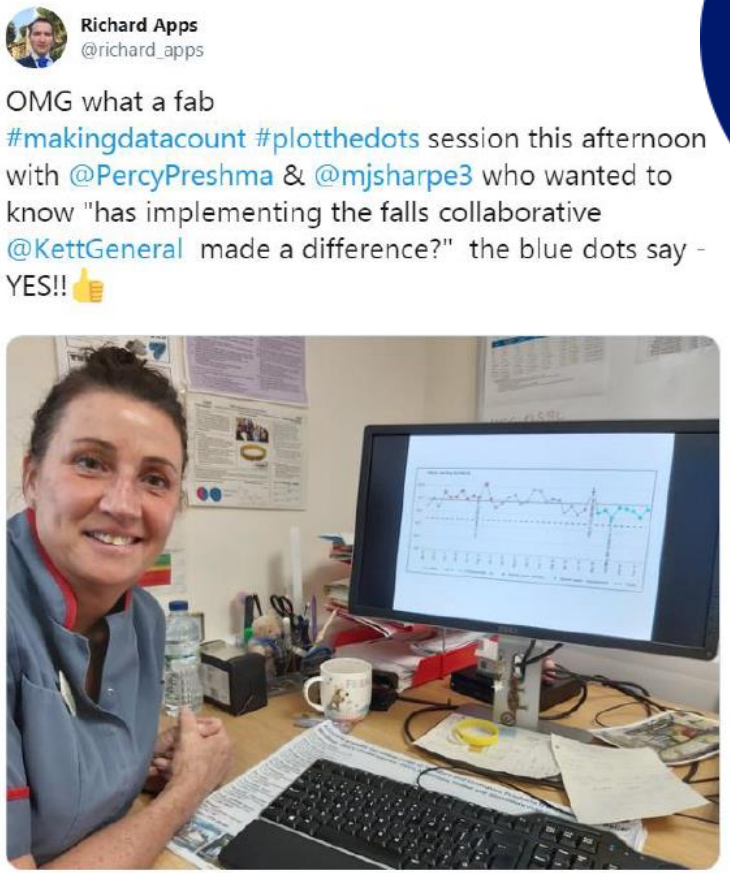
Rie had a question…..

Has the falls collaborative made a difference?

Rie Sharp from the Practice Development team has been leading the Trust's work on reducing harm from patient falls; although a lot has been done, there is no explicit evidence that a change has occurred, or if that change is an improvement.
Rie had one question –

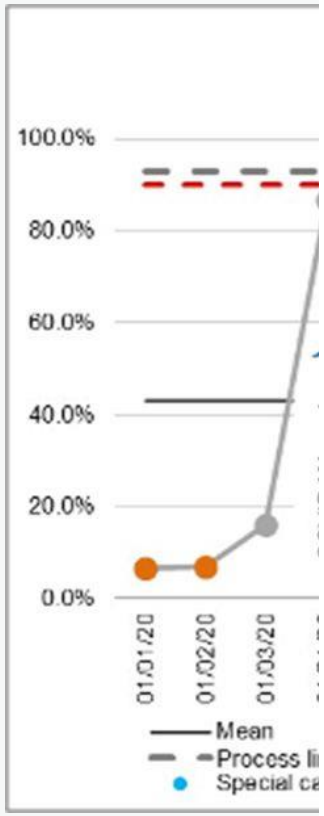
"Has implementing the falls collaborative made a difference?"

Using the SPC tool gave the almost instantaneous answer - YES – a statistically significant reduction in reported patient fall incidents can be seen directly after the introduction of the falls collaborative – and it has sustained…!



The blue dots say yes!!!!

More people are using data to evidence improvement



Open access Quality improvement report

BMJ Open Quality

Novel solutions to old problems: improving the reliability of emergency equipment provision in critical care using accessible digital solutions

Christopher Mark Hunter ,[1] Daniel Paul ,[1] Benjamin Plumb[2]

To cite: Hunter CM, Paul D, Plumb B. Novel solutions to old problems: improving the reliability of emergency equipment provision in critical care using accessible digital solutions. *BMJ Open Quality* 2022;**11**:e001953. doi:10.1136/bmjoq-2022-001953

CMH and DP contributed equally.

Received 16 April 2022
Accepted 16 July 2022

ABSTRACT

Reliable provision of emergency equipment in Critical Care is key to ensure patient safety during medical emergencies and transfers. A problem was identified in incident reports and external inspections of processes that ensured the provision of such equipment for use by critical care teams in non-critical care areas in the form of grab bags. A comprehensive project was undertaken to tackle this including the provision of a bespoke digital system. Existing systems were reliant on staff remembering to check equipment and document checks on paper and there was no formal ability to hand over ongoing problems. A local project management approach, '7 Steps to Quality Improvement', which integrated many of the philosophies and tools from Healthcare Improvement was used. A bespoke digital system was designed and implemented with integrated improvements in equipment stocking ergonomics.

The reliability of documented equipment checks improved significantly, there was a significant reduction in the number of incident reports regarding emergency equipment and the time spent by staff doing equipment checks was reduced substantially with significant cost and resource improvements. This was so successful the format has been rapidly translated and spread to other areas such as operating theatres' difficult airway trolleys.

Undertaking a structured quality improvement approach, using appropriate stakeholder engagement, digitalisation of systems and improvements in basic system ergonomics can have a substantial impact on the reliability and safety of emergency equipment provided for use by members of the critical care team.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ National standards exist for the provision of emergency equipment within critical care. There is no established practice or academic research as to how this should be achieved.

WHAT THIS STUDY ADDS

⇒ This report demonstrates that digital solutions can be used effectively to increase patient safety and reduce costs. It describes the digital system used and its advantages over a paper record over a 2-year period.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ The authors believe this digital system could be used as a model for further implementation both locally for equipment outside of critical care and regionally to address similar issues with documentation.

Check for updates

PROBLEM

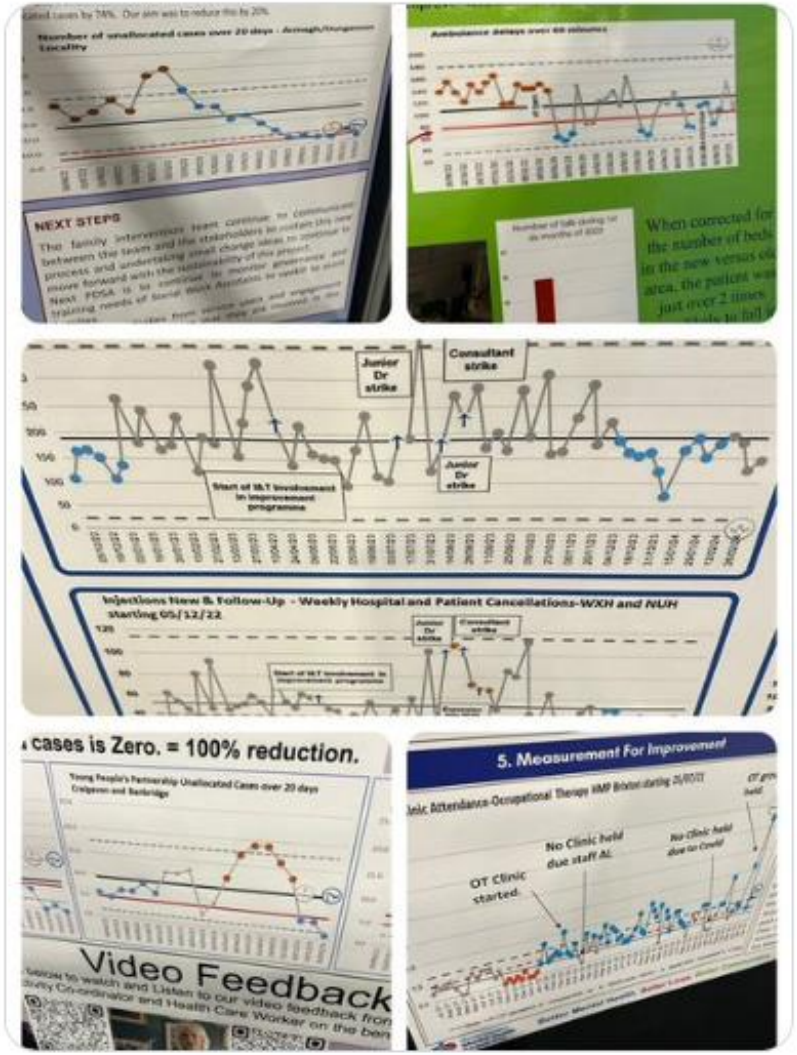
was insufficient evidence of equipment safety checks for transfer bags, emergency drug pouches and airway trolleys. A daily hand-written, paper record of equipment checks was introduced in response.

A subsequent CQC inspection in 2020 highlighted the issue again. The report stated that, "*the checking of the resuscitation equipment was not carried out consistently, as was the case on our previous inspection*" despite these changes.[1] The paper documentation was

[Novel solutions to old problems: improving the reliability of emergency equipment provision in critical care using accessible digital solutions | BMJ Open Quality]

Adam Sewell-Jones @AdamSewellJones · Apr 12

Great to see so many of the posters at #Quality2024 using #plotthedots resources developed by @NHSImprovement for use by improvers across the globe @samriley



Priority for St Elsewhere NHS Trust

ReSPECT Recommended Summary Plan for Emergency Care and Treatment

Full name

Date of birth

Address

NHS/CHI/Health and care number

Preferred name

Date completed

1. This plan belongs to:

The ReSPECT process starts with conversations between a person and a healthcare professional. The ReSPECT form is a clinical record of agreed recommendations. It is not a legally binding document.

2. Shared understanding of my health and current condition

Summary of relevant information for this plan including diagnoses and relevant personal circumstances:

Details of other relevant care planning documents and where to find them (e.g. Advance or Anticipatory Care Plan; Advance Decision to Refuse Treatment or Advance Directive; Emergency plan for the carer):

I have a legal welfare proxy in place (e.g. registered welfare attorney, person with parental responsibility) - if yes provide details in Section 8 ☐ **Yes** ☐ **No**

3. What matters to me in decisions about my treatment and care in an emergency

Living as long as possible matters most to me | **Quality of life and comfort matters most to me**

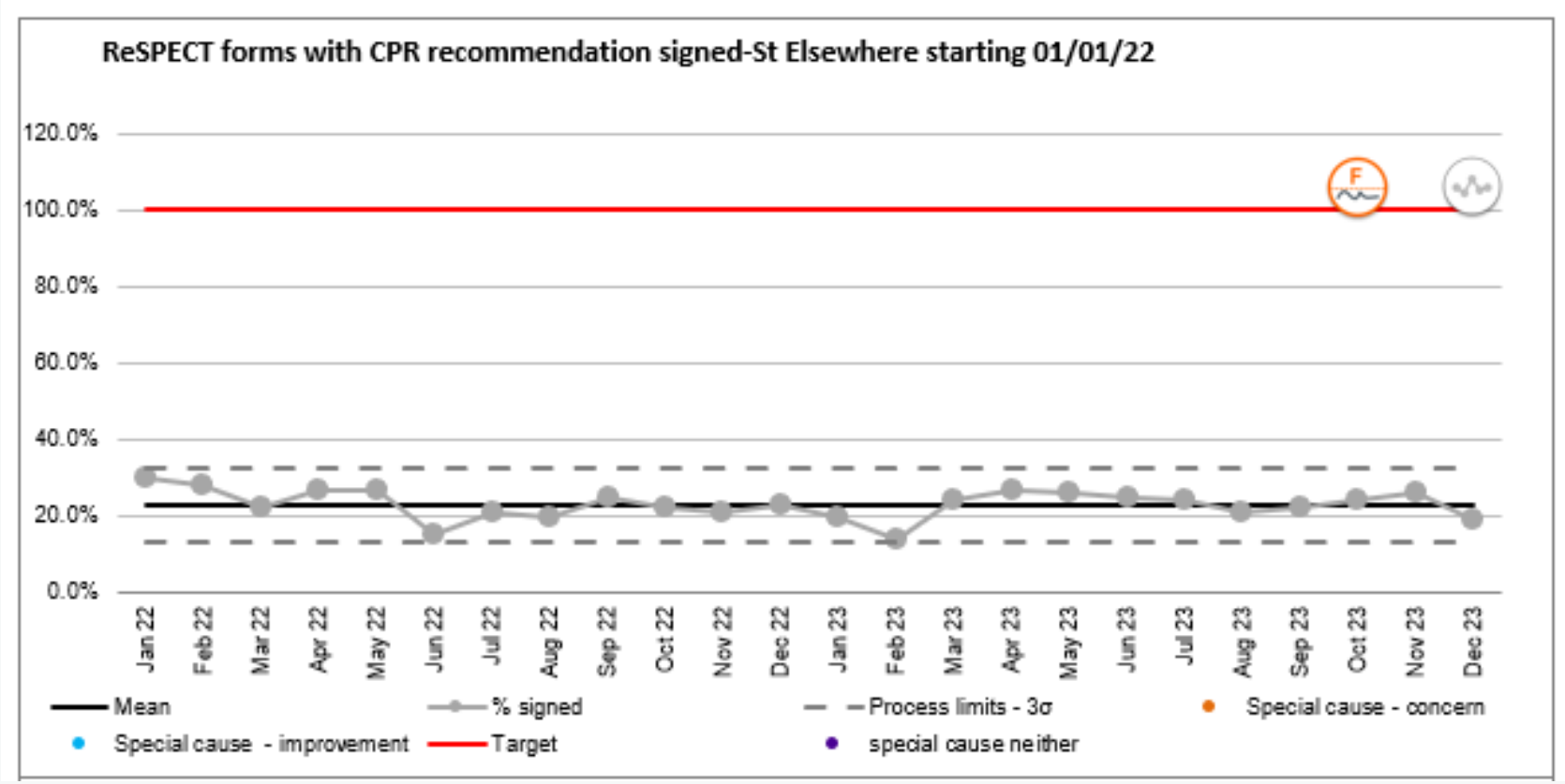
What I most value:

What I most fear / wish to avoid:

4. Clinical recommendations for emergency care and treatment

ReSPECT ReSPECT ReSPECT ReSPECT ReSPECT

How is the Trust doing?



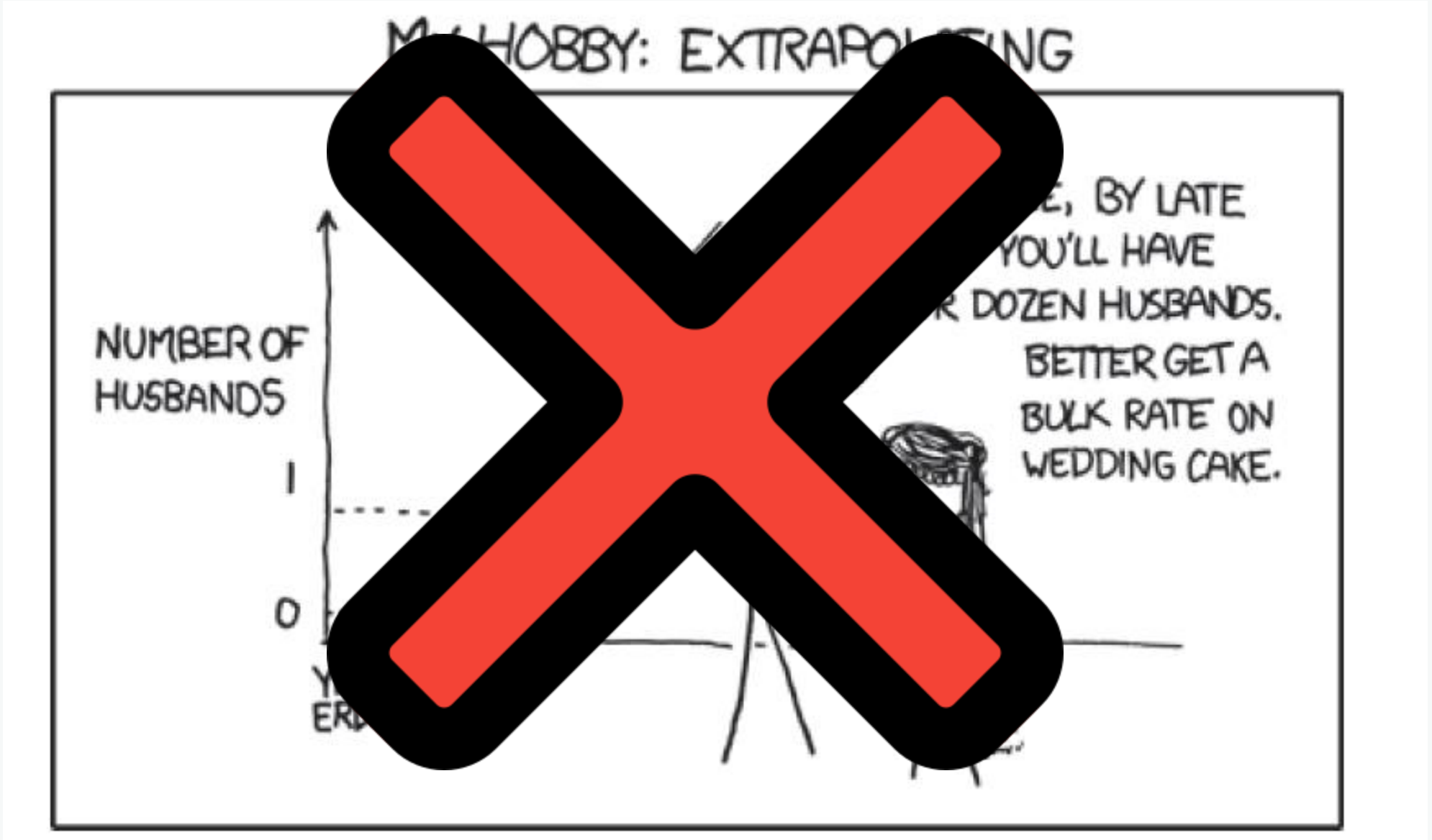
Target

Improvement efforts are not working

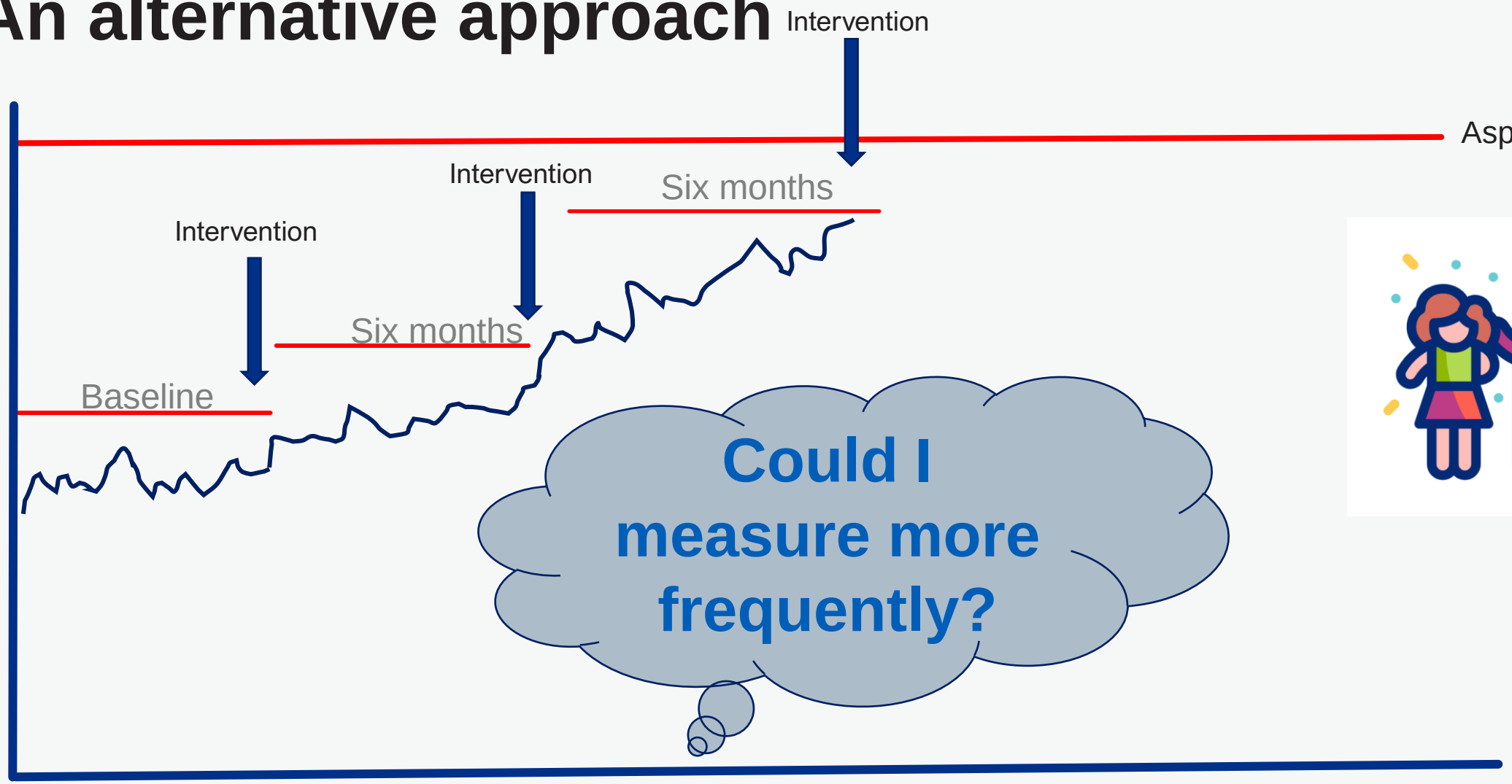
What can we do to improve things?

We could think about setting an interim target!

Great idea!

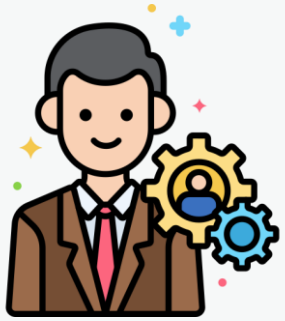

HOBBY: EXTRAPOLATING
NUMBER OF HUSBANDS
1
0
E, BY LATE
YOU'LL HAVE
R DOZEN HUSBANDS.
BETTER GET A
BULK RATE ON
WEDDING CAKE.

An alternative approach

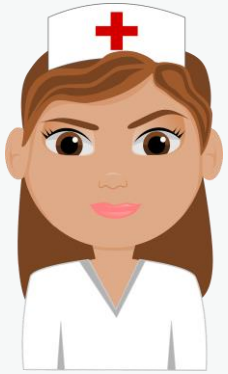


Involve

Engage

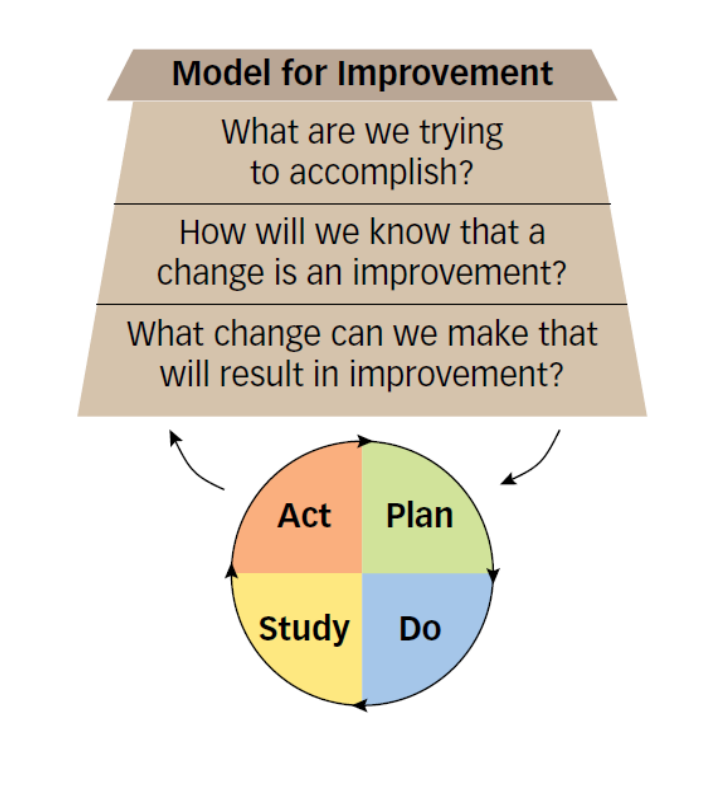


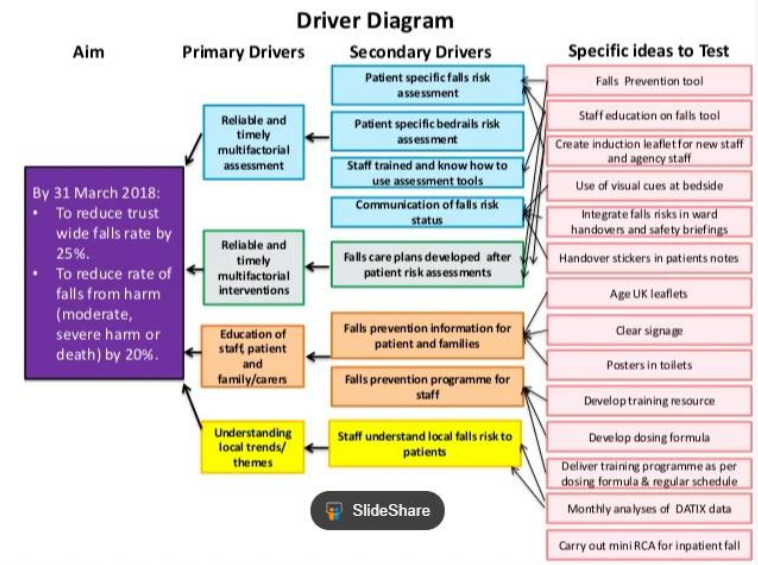
Ownership

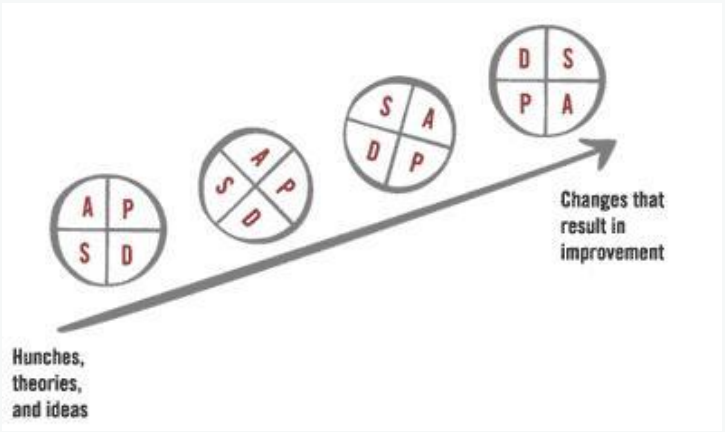


Inspire

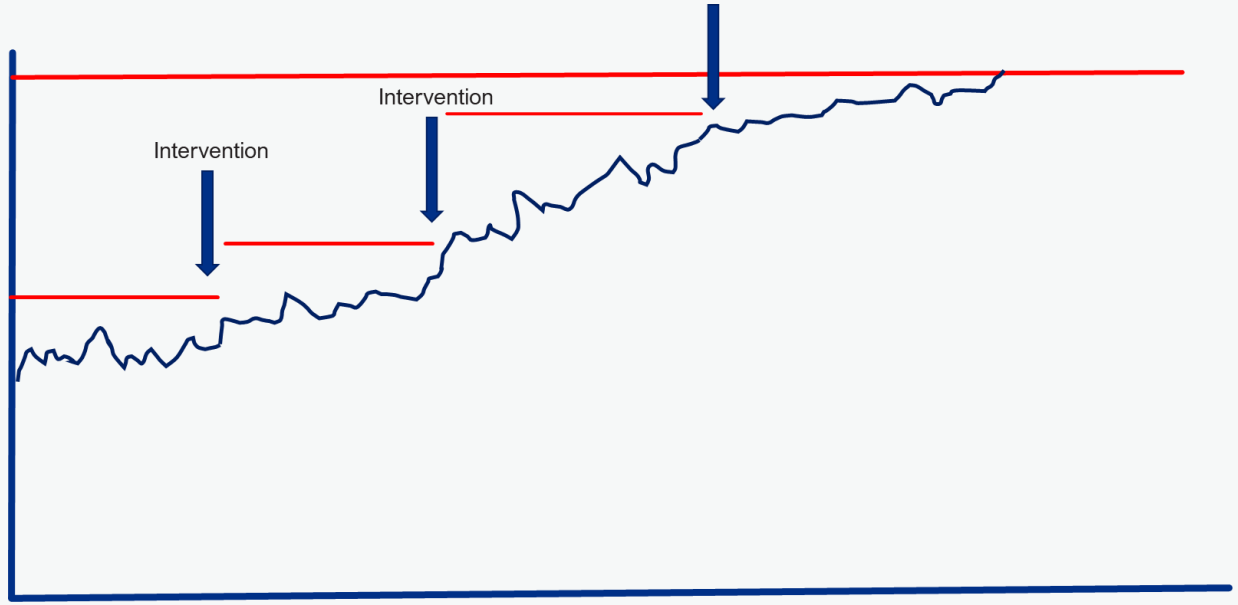
Making a plan of action

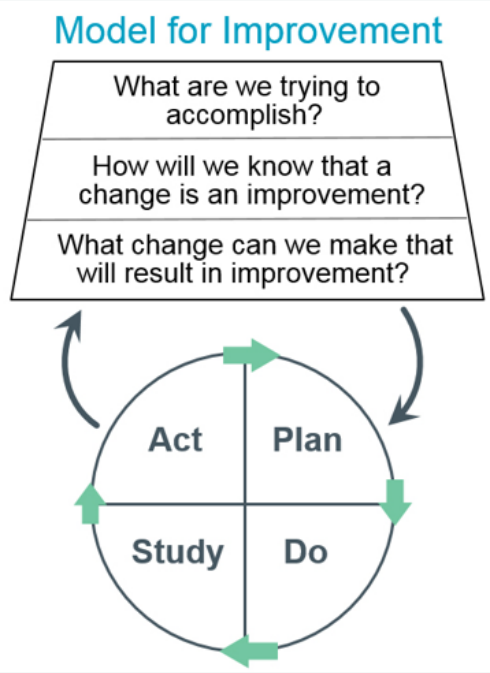




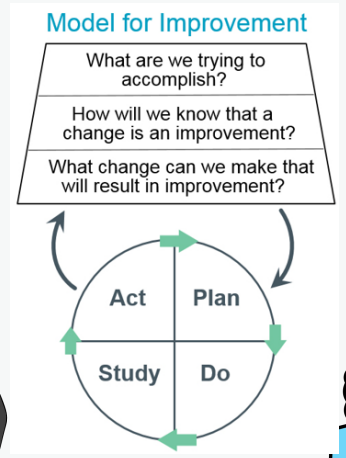


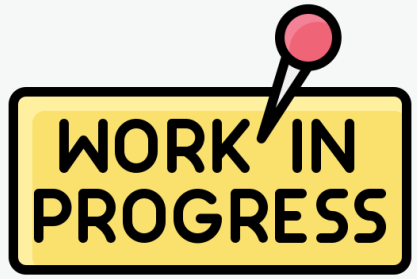
Trajectories & improvement work needs to be linked

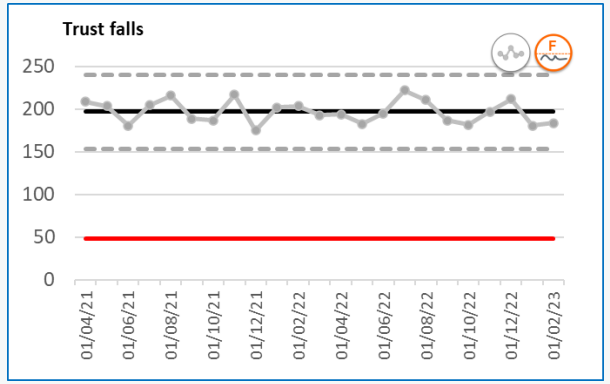




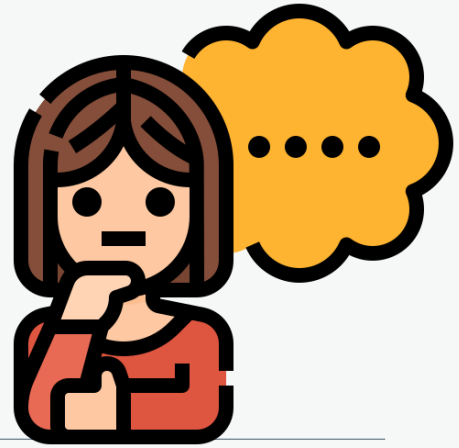
Ingredients for success







Do any of you use qualitative data?



Clinical audit checklist

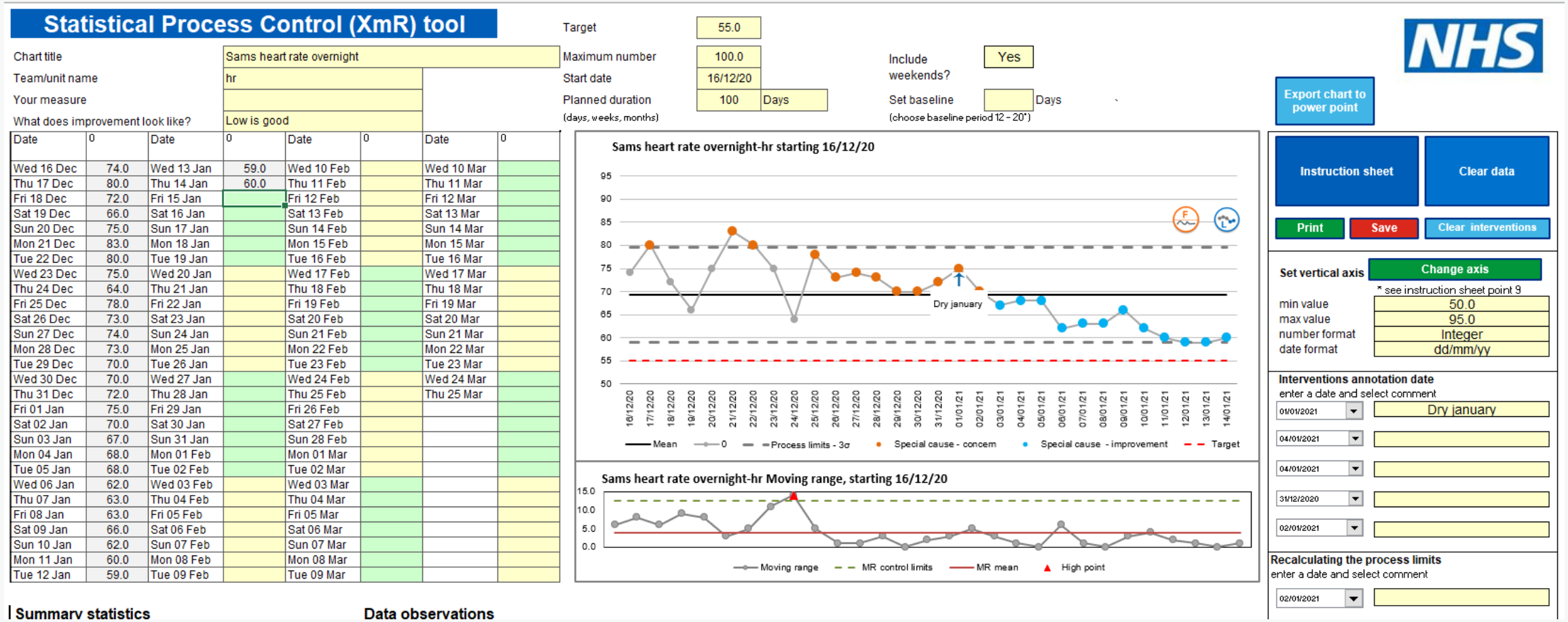
- [x] Has the data been validated? Is it reliable & valid?
- [ ] Has the data been triangulated with other data sources?
- [ ] Have any significant risks or concerns been highlighted?
- [ ] Has the data been translated for all audiences & in particular - Decision makers?
- [ ] Have all proposed 'Actions For Improvement been outlined within a SMART action plan?
- [ ] Have all proposed 'Actions For Improvement' been aligned with wider QI workstreams to avoid duplication?
- [ ] Has the process for assurance reporting been agreed?
- [ ] Do you have a robust feedback loop process in place for wider sharing & learning?
- [ ] Have further metrics been identified for measuring the effectiveness of actions for improvement and to support continuous improvement?

Clinical audit action plan template

Clinical Audit Improvement Action Plan							
Concern:							
Improvement Aim 1:	Improvement Action:	Resources Required:	Named Lead:	Target completion date:	Evidence that action implemented (policies, meeting minutes, training programmes etc.)	Evidence of improvement (triangulate information/metrics/data etc.)	Agree future or continuous measurement for improvement and/or assurance
	1.1						
	1.2						
	1.3						
	1.4						
Concern:							
Improvement Aim 2:	Improvement Action:	Resources Required:	Named Lead:	Target completion date:	Evidence that action implemented (policies, meeting minutes, training programmes etc.)	Evidence of improvement (triangulate information/metrics/data etc.)	Agree future or continuous measurement for improvement and/or assurance
	2.1						
	2.2						
Concern:							

Named Lead & Role for Monitoring progress with Implementation of the action plan:			
Meeting/Committee where action plan was approved:			Date:
Meeting/Committee where action plan reviewed:		Date:	Comments/Outcomes:
Meeting/Committee where action plan reviewed:		Date:	Comments/Outcomes:
Named Lead & Role for Monitoring progress with Implementation of the action plan:			
Meeting/Committee where Action Plan Completion agreed and signed off:			Date:

We have SPC tools



Date	0	Date	0	Date	0	Date	0
Wed 16 Dec	74.0	Wed 13 Jan	59.0	Wed 10 Feb		Wed 10 Mar	
Thu 17 Dec	80.0	Thu 14 Jan	60.0	Thu 11 Feb		Thu 11 Mar	
Fri 18 Dec	72.0	Fri 15 Jan		Fri 12 Feb		Fri 12 Mar	
Sat 19 Dec	66.0	Sat 16 Jan		Sat 13 Feb		Sat 13 Mar	
Sun 20 Dec	75.0	Sun 17 Jan		Sun 14 Feb		Sun 14 Mar	
Mon 21 Dec	83.0	Mon 18 Jan		Mon 15 Feb		Mon 15 Mar	
Tue 22 Dec	80.0	Tue 19 Jan		Tue 16 Feb		Tue 16 Mar	
Wed 23 Dec	75.0	Wed 20 Jan		Wed 17 Feb		Wed 17 Mar	
Thu 24 Dec	64.0	Thu 21 Jan		Thu 18 Feb		Thu 18 Mar	
Fri 25 Dec	78.0	Fri 22 Jan		Fri 19 Feb		Fri 19 Mar	
Sat 26 Dec	73.0	Sat 23 Jan		Sat 20 Feb		Sat 20 Mar	
Sun 27 Dec	74.0	Sun 24 Jan		Sun 21 Feb		Sun 21 Mar	
Mon 28 Dec	73.0	Mon 25 Jan		Mon 22 Feb		Mon 22 Mar	
Tue 29 Dec	70.0	Tue 26 Jan		Tue 23 Feb		Tue 23 Mar	
Wed 30 Dec	70.0	Wed 27 Jan		Wed 24 Feb		Wed 24 Mar	
Thu 31 Dec	72.0	Thu 28 Jan		Thu 25 Feb		Thu 25 Mar	
Fri 01 Jan	75.0	Fri 29 Jan		Fri 26 Feb			
Sat 02 Jan	70.0	Sat 30 Jan		Sat 27 Feb			
Sun 03 Jan	67.0	Sun 31 Jan		Sun 28 Feb			
Mon 04 Jan	68.0	Mon 01 Feb		Mon 01 Mar			
Tue 05 Jan	68.0	Tue 02 Feb		Tue 02 Mar			
Wed 06 Jan	62.0	Wed 03 Feb		Wed 03 Mar			
Thu 07 Jan	63.0	Thu 04 Feb		Thu 04 Mar			
Fri 08 Jan	63.0	Fri 05 Feb		Fri 05 Mar			
Sat 09 Jan	66.0	Sat 06 Feb		Sat 06 Mar			
Sun 10 Jan	62.0	Sun 07 Feb		Sun 07 Mar			
Mon 11 Jan	60.0	Mon 08 Feb		Mon 08 Mar			
Tue 12 Jan	59.0	Tue 09 Feb		Tue 09 Mar			

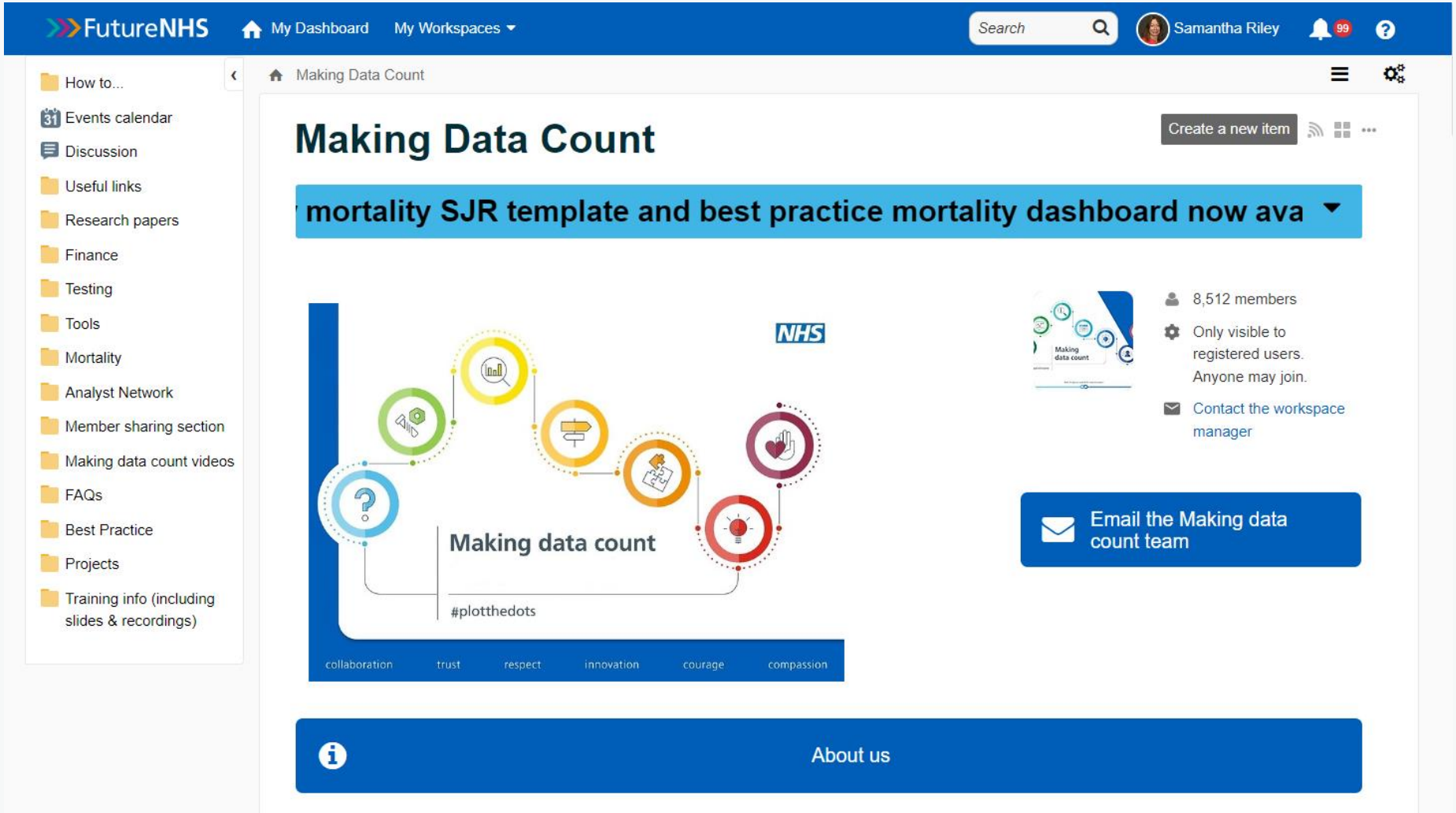
Our series of training modules

- Introduction to Making Data Count
- Our Tools – What's Available and How to Use Them
- Narrative Writing – How to Drive Action
- Digging Deeper – Add to your SPC Knowledge
- Benchmarking & Comparisons
- Improvement Techniques
- Triangulating Data
- Data Driven Conversations
- Making Qualitative Data Count
- Targets & Trajectories

9

10

Everything you need is here!



https://future.nhs.uk/MDC/grouphome


THANK YOU!

CLINICAL AUDIT AWARENESS WEEK 2024

***Featuring the* Clinical Audit Heroes Awards**

INFLUENCING CHANGE

And the winners are...

#CAAW24

INFLUENCING CHANGE

And the winners are...

Dr. Marisha Sharma
(team member)
Diabetic Foot Infection Team

Infection Prevention
Specialist Nurses
Infection Prevention &
Management Team

NHS
Ashford and St. Peter's Hospitals
NHS Foundation Trust

NHS
University Hospitals
Plymouth
NHS Trust

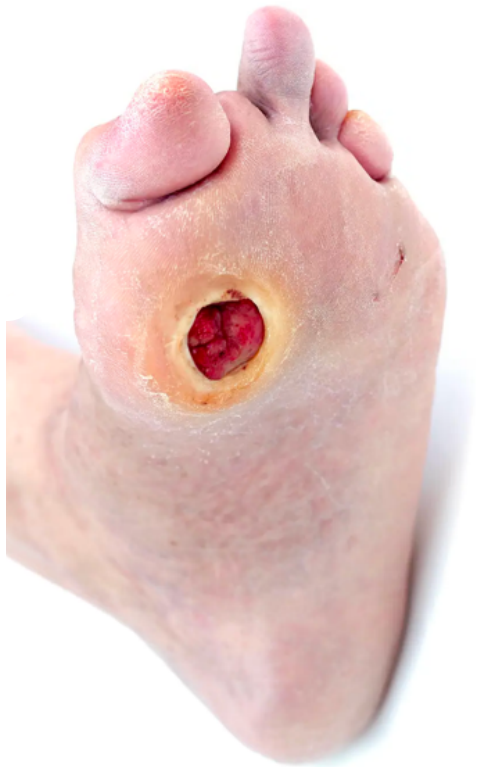
Together we care

Ashford and St. Peter's Hospitals
NHS Foundation Trust

Improving Outcomes in Diabetic Foot Infection

K Bajaj, M Sharma, A Eleftheriadou, A Aden,
G Das, A Unnithan, S Greensmith, C. Parsons, L. Ritchie

DIABETIC FOOT ULCER – THE PROBLEM



Diabetic foot

- 4.3 million people in the UK
- Neuropathy and Ischaemia •50-86% •20-42%
- Foot Ulceration and Charcot Neuropathy •10-34% •0.05-8%
- Infection •50-60% •20% OM
- Amputation •2-4%

5-Year mortality

- Foot ulceration • 30.5%
- Charcot Neuropathy • 29.0%
- Minor Amputation • 46.2%
- Major Amputation •56.6-80%

Diabetes UK
Diabetes Foot NICE NG19 Guidance
J Clin Orthop Trauma. 2021 Feb 8;17:88-93.
Eurodiale study.Diabetologia. 2007;50:18–25
J Foot 16Ankle Res. 2020 Mar 24;13(1):.
Int Wound J. 2007 Dec;4(4):286-7.

RESULTS

Timeframe

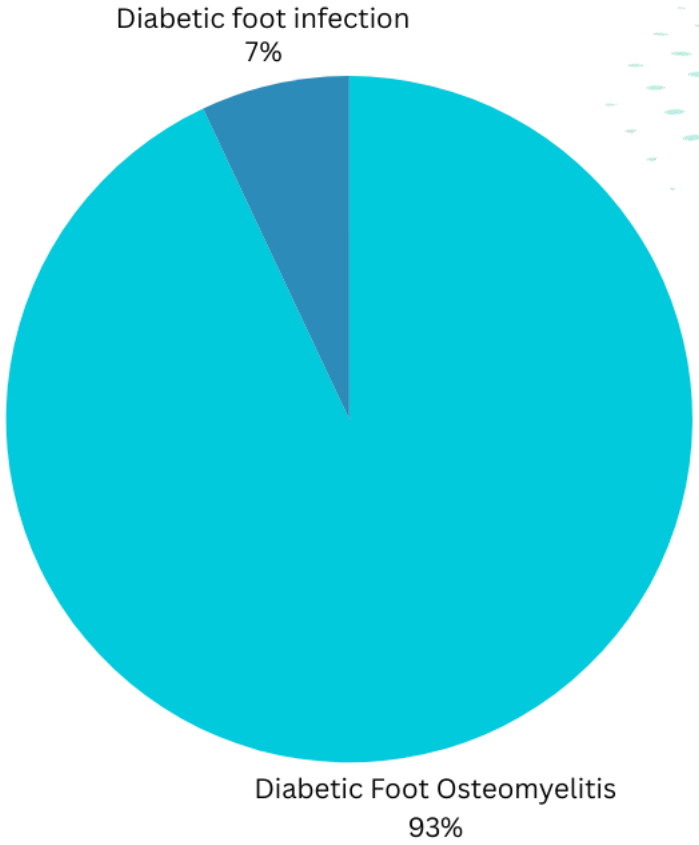
IV Home + Hospital - Aug ‘21-Aug’23

59

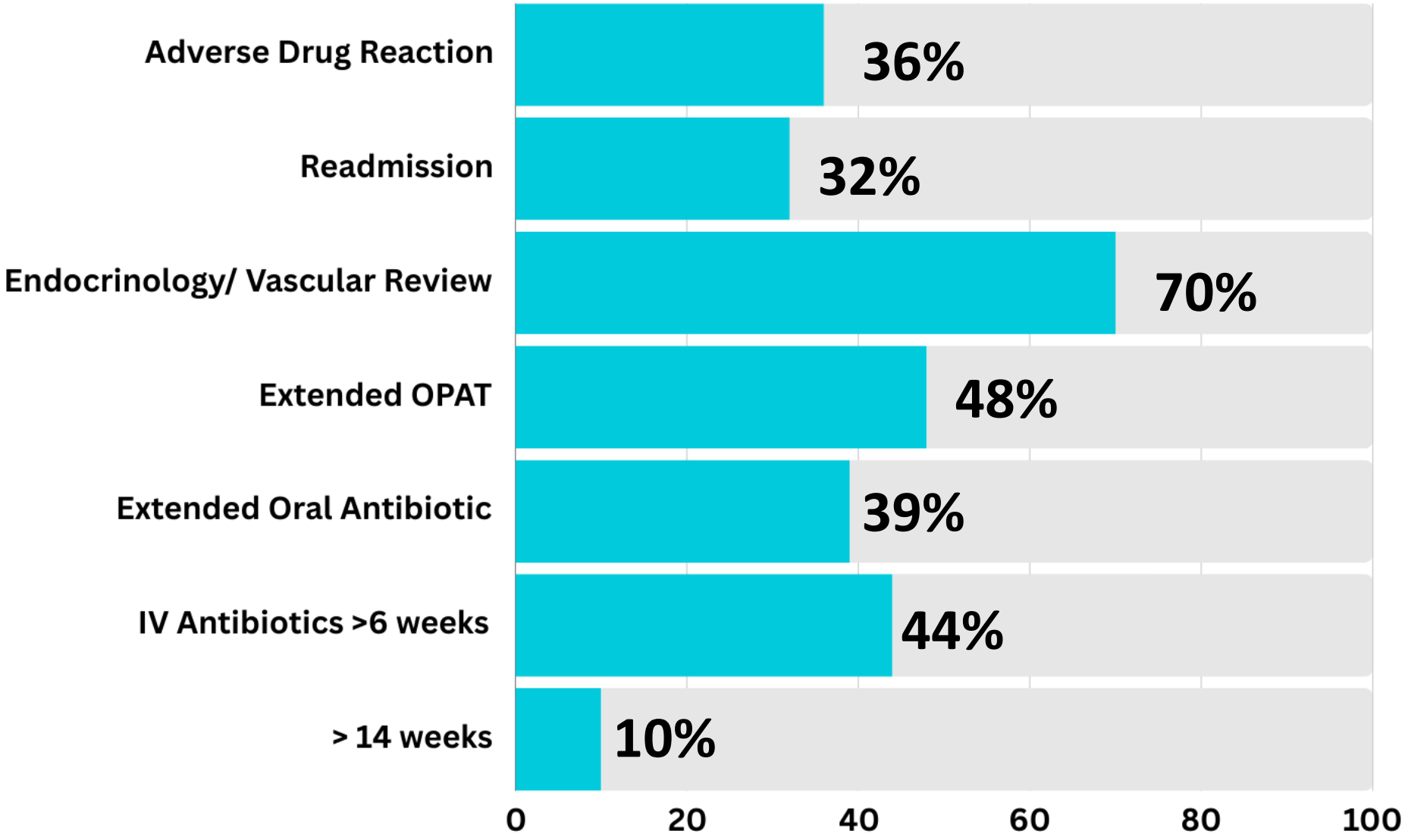
48 11

Mean Age 65 +- 16.8 years

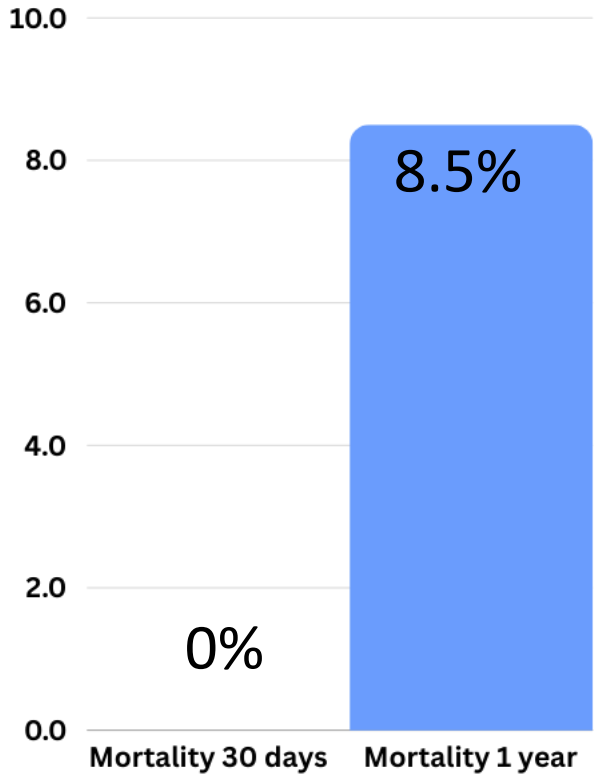
Uncontrolled Diabetes in 56%



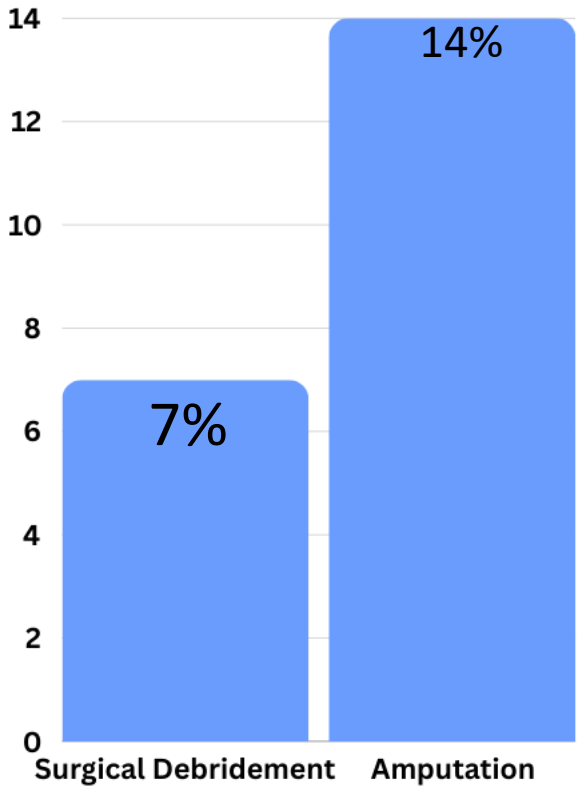
FINDINGS


Adverse Drug Reaction
36%
Readmission
32%
Endocrinology/ Vascular Review
70%
Extended OPAT
48%
Extended Oral Antibiotic
39%
IV Antibiotics >6 weeks
44%
> 14 weeks
10%
0
20
40
60
80
100

FINDINGS



MORTALITY DATA



SURGICAL INTERVENTION

INFECTION OUTCOME

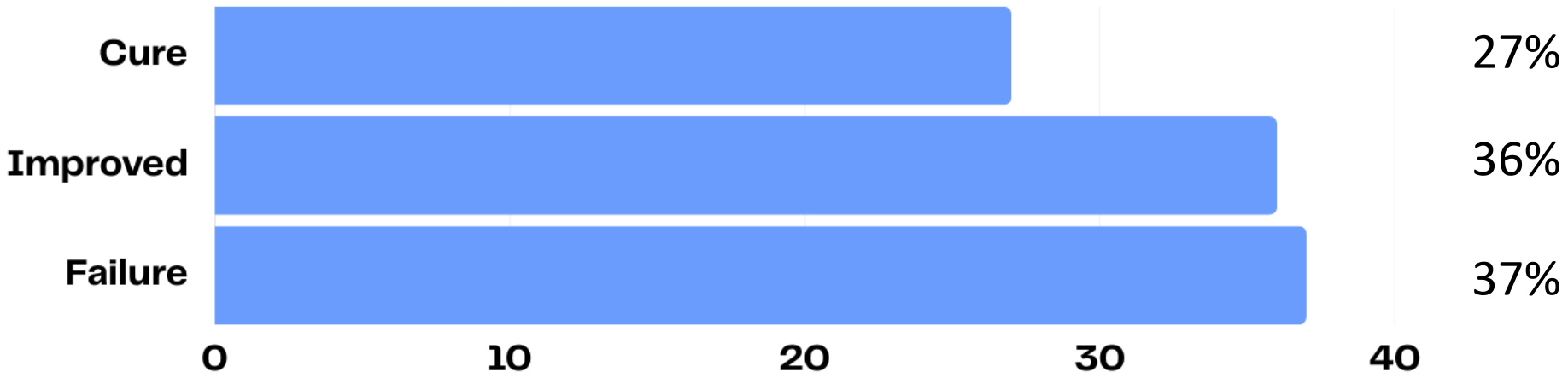


Image 1. Infection outcome was defined as (i) cure (completed OPAT therapy+ oral stepdown for the defined duration with a resolution of infection and no re-requirement for long-term antibiotic therapy); (ii) improved (completed OPAT therapy+oral stepdown with partial resolution of infection but need for further follow-up, or completed OPAT therapy but required escalation of antimicrobial therapy during OPAT + oral stepdown); and (iii) failure (progression or non-response of infection, required admission, surgical intervention or died for any reason). (Gilchrist et al,2022)

OPAT OUTCOME

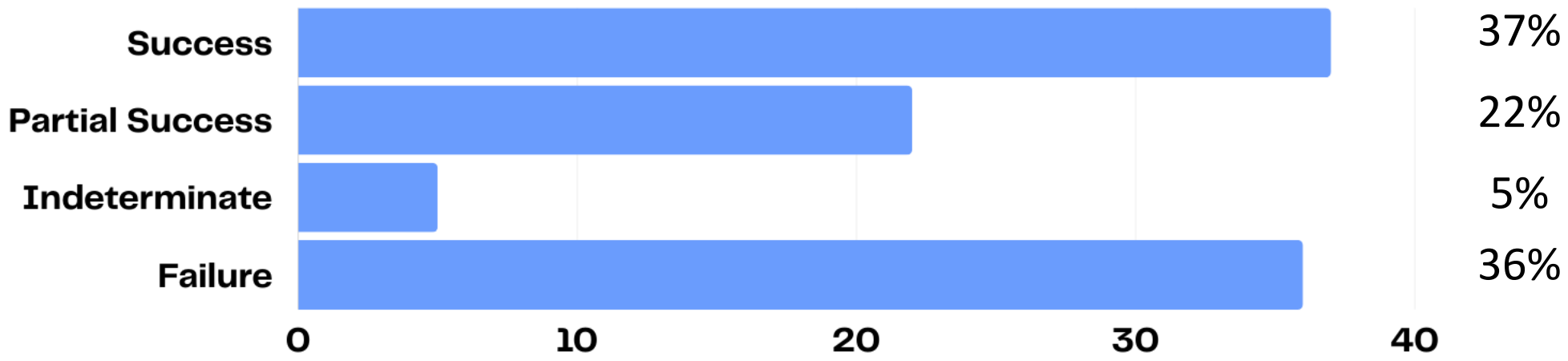


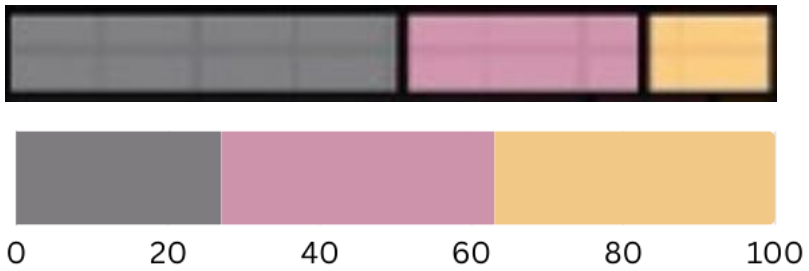
Image 2. (i) Success (completed therapy in OPAT with no change in antimicrobial agent, no AEs, cure or improvement of infection and no re-admission); (ii) Partial success (completed therapy in OPAT with either change in antimicrobial agent or AE not requiring admission); (iii) Indeterminate outcome (re-admission due to unrelated event); and (iv) Failure (re-admitted due to infection worsening or due to an AE, or death by any cause during OPAT). (Gilchrist et al,2022)

IN COMPARISON

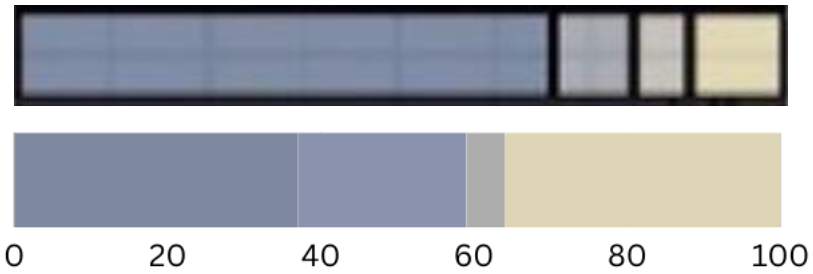
BSAC National Outcomes Registry (2015–19)

National Avg

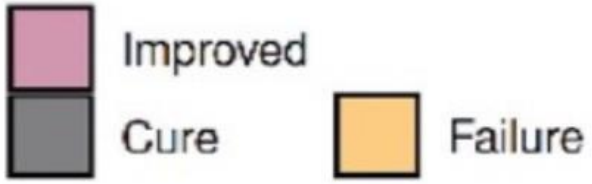
SPH

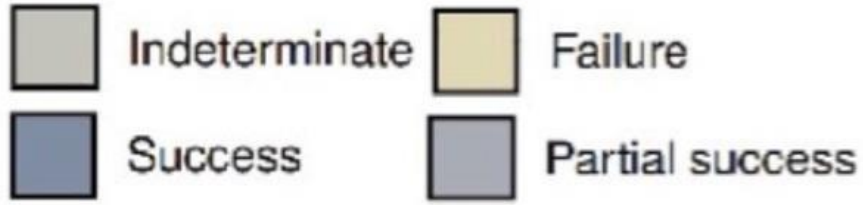


Infection Outcome

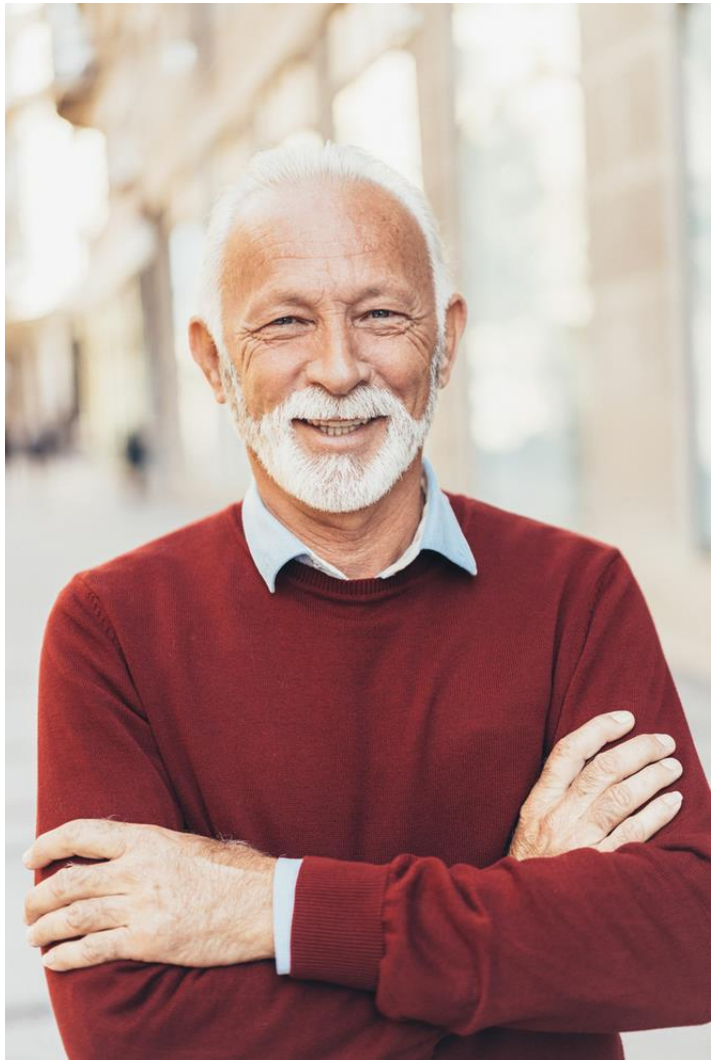


OPAT Outcome





TYPICAL PATIENT



85/M

Diabetic Foot Osteomyelitis

IV Flucloxacillin

25/03

8 IP Days

12/04
Endocrinology Appointment

20/04
MDT

17/05
Endocrinology Appointment

27/05
MRI

01/06

05/06
MRI Report

Oral ABX

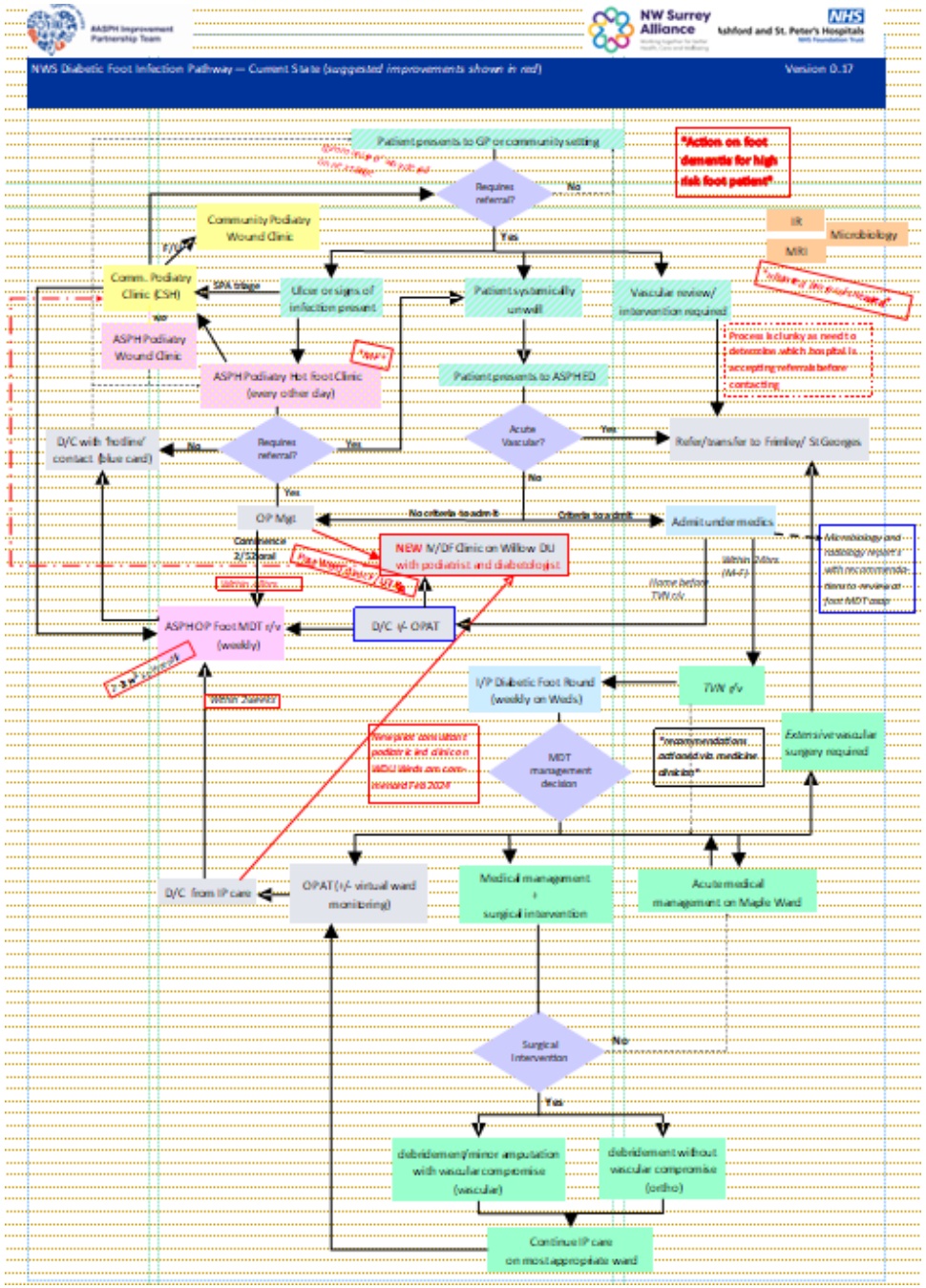
OPAT Planned Treatment

30 Days

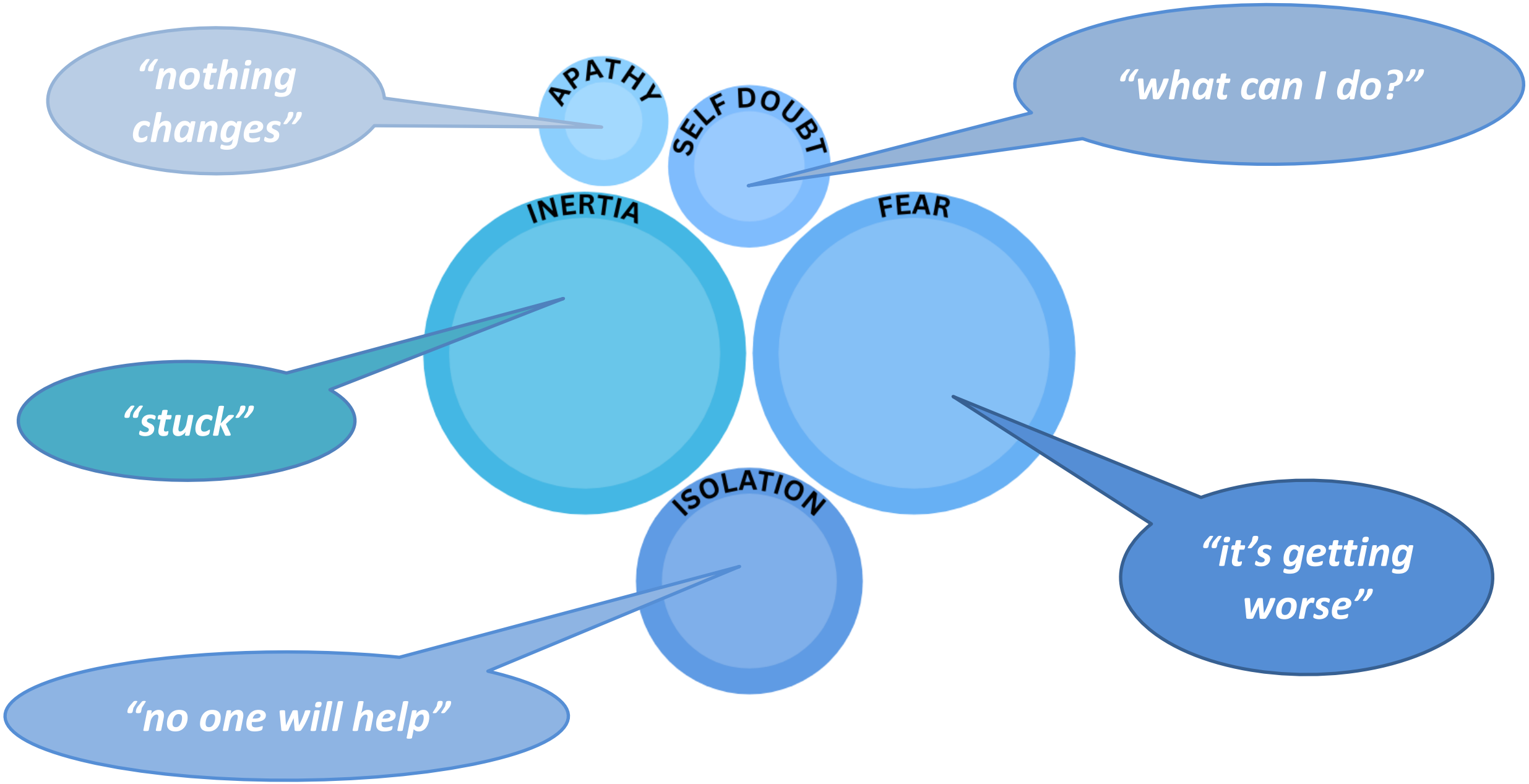
OPAT Actual Treatment

69 Days

TAKING AN IMPROVEMENT APPROACH



ACTION INHIBITORS



ACTION MOTIVATION THROUGH IMPROVEMENT

01 CREATE A SENSE OF URGENCY

- Break down the complexity and find the problems

02 FIND THE HOPE

- Look for the opportunity

03 YOU CAN MAKE A DIFFERENCE

- Form a strong team, meet regularly

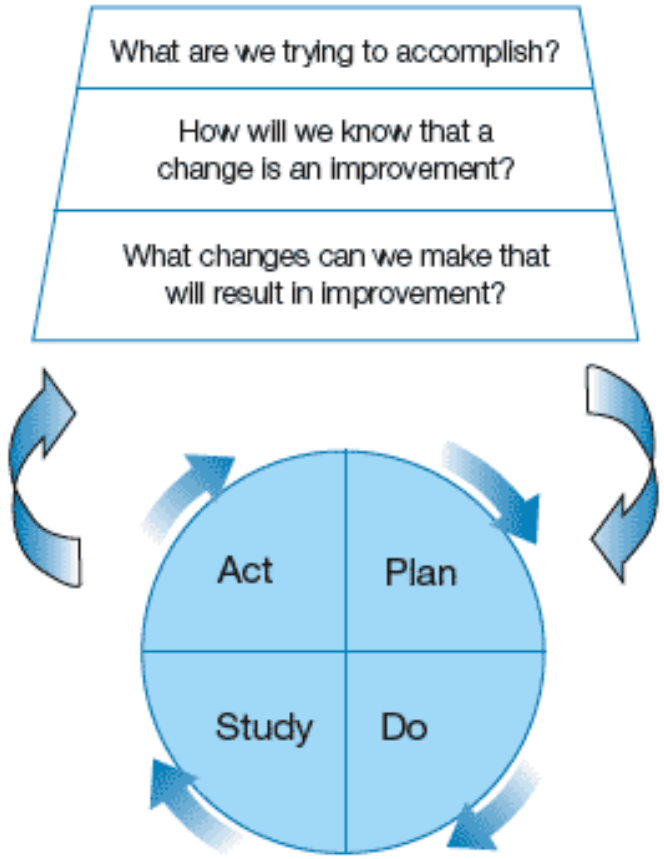
04 SOLIDARITY IN PURPOSE

- Do not get distracted, stay focused on the goal

05 MAKE A STRONG CASE FOR CHANGE

- ‘Do something’, PDSA is your friend

IHI Model for Improvement



Proposed CHANGES

To improve outcomes for our patients we identified three key areas within the pathway where there are opportunities for improvement

Phase 1- INPATIENT

Streamline inpatient care by defining departmental responsibilities, updating urgent referral criteria, empowering junior doctors to identify critical conditions, and standardising the clerking process.

Phase 2- OUTPATIENT

Identified bottle-necks at hot foot clinic resulting in delays to post-discharge follow-up and increased use of OPAT. Pilot project started to test a new post discharge follow up clinic to provide regular and consistent follow up in high-risk patients.

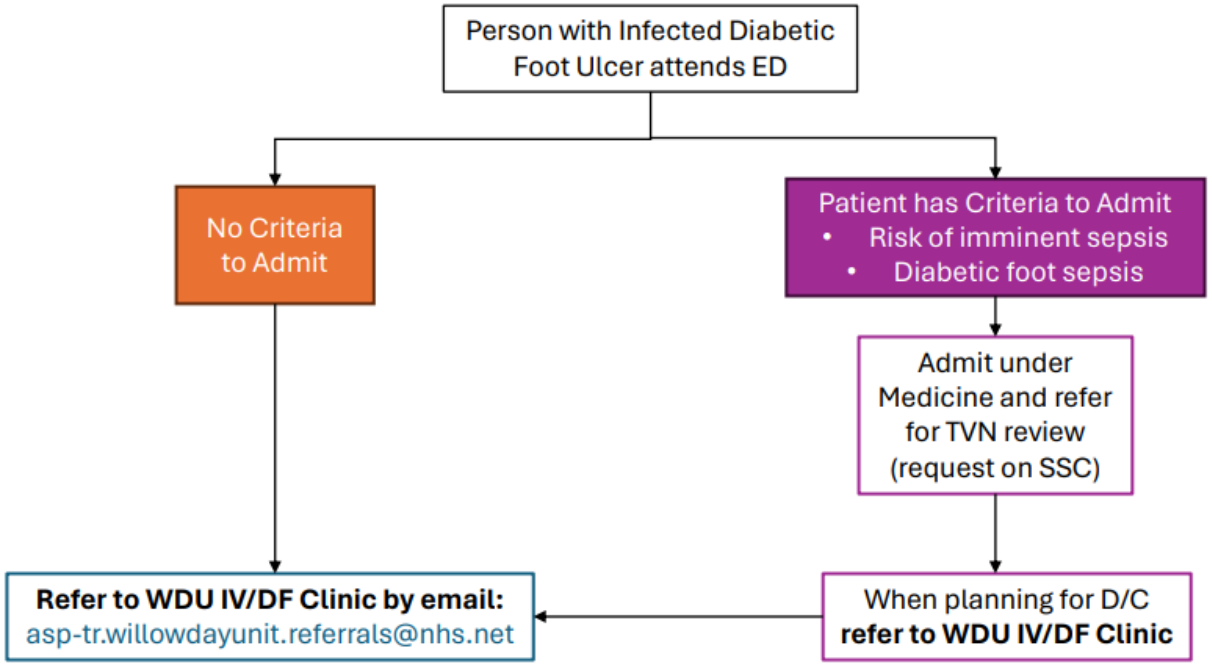
Phase 3- COMMUNITY

Understand the various levels of care that contribute to the management of diabetic foot infection in the community, including the patient themselves. Understand and clearly define roles and pathways.

Willow Day DF Clinic

Started 7th February with aim to off-load the Hot-Foot Outpatient Clinic and enable full healing with consistent and timely post discharge follow up

Evolving Diabetic Foot Pathway – When to Refer to the New Willow Day Unit IV/DF Clinic



Willow Day DF Clinic

When: every Wednesday

Where: Willow Day Unit Infusion Suite, St Peter's Hospital

Staff: Consultant Diabetologist, Podiatric Surgeon, IV Specialist Nurse

Purpose: to provide timely follow-up post hospital discharge for high-risk patients
and to reduce the burden on the overloaded diabetic hot-foot clinics

Interventions: OPAT review, debridement, wound dressing, diabetes check

New innovations: Trialing Stimulan® antibiotic beads, research proposal in progress for using 'thermology health' temperature imaging system

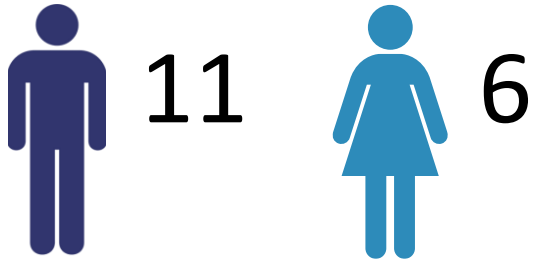
Biocomposites®

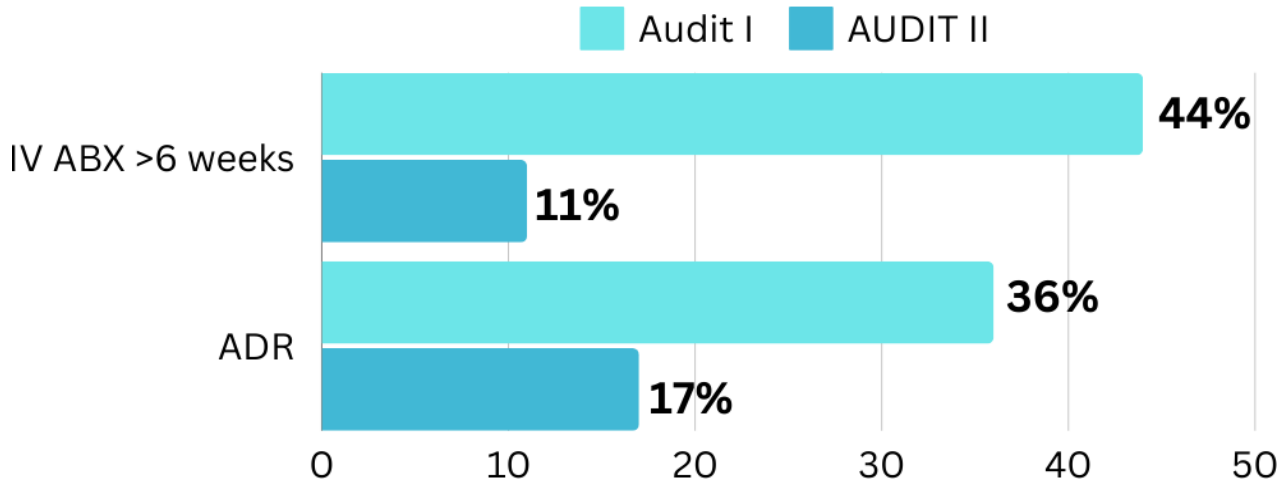
thermology health

PRELIMINARY RESULTS: RE-AUDIT

17

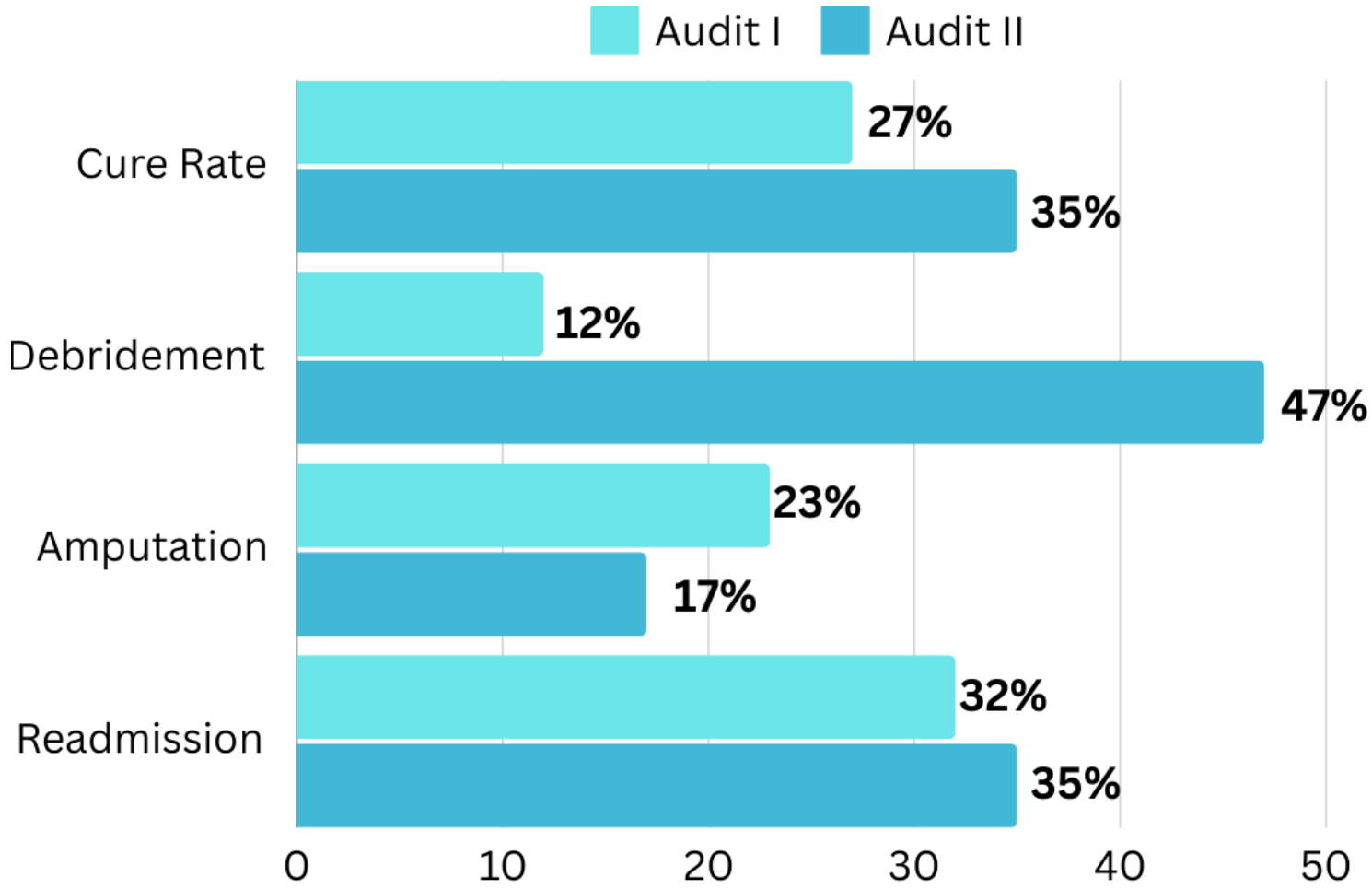
On IV ABX





IV ABX Treatment Duration & ADR

TREATMENT OUTCOMES



Ashford and St. Peter's Hospitals
NHS Foundation Trust

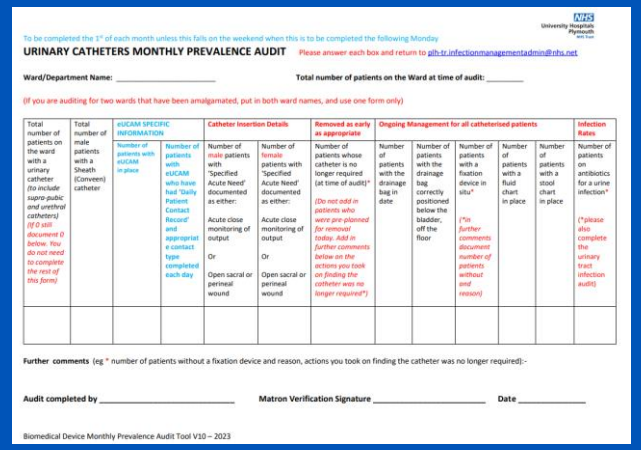
Help us make a difference to Patient Outcomes

Thank You

INFECTION PREVENTION & MANAGEMENT

NHS University Hospitals Plymouth NHS Trust

Biomedical Device Monthly Prevalence Audits



To be completed the 1st of each month unless this falls on the weekend when this is to be completed the following Monday

URINARY CATHETERS MONTHLY PREVALENCE AUDIT Please answer each box and return to plh-tr.infectionmanagementadmin@nhs.net

Ward/Department Name: _____ **Total number of patients on the Ward at time of audit:** _____

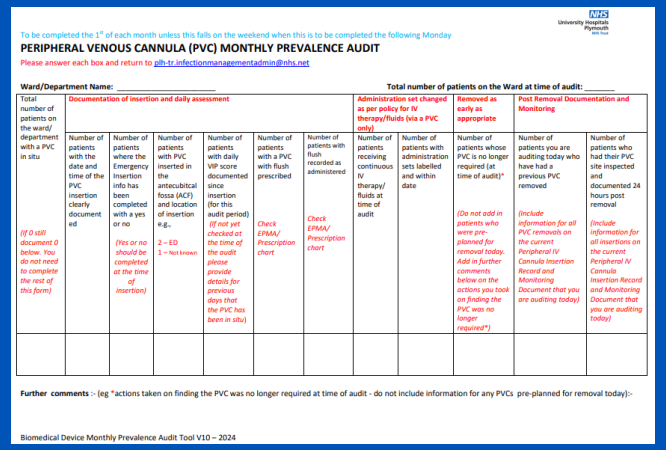
(If you are auditing for two wards that have been amalgamated, put in both ward names, and use one form only)

Total number of patients on the ward with a urinary catheter *(to include supra-pubic and urethral catheters)* *(If 0 still document 0 below. You do not need to complete the rest of this form)*	Total number of male patients with a Sheath (Conveen) catheter	eUCAM SPECIFIC INFORMATION: Number of patients with eUCAM in place	eUCAM SPECIFIC INFORMATION: Number of patients with eUCAM who have had 'Daily Patient Contact Record' and appropriate contact type completed each day	Catheter Insertion Details: Number of male patients with 'Specified Acute Need' documented as either: Acute close monitoring of output Or Open sacral or perineal wound	Catheter Insertion Details: Number of female patients with 'Specified Acute Need' documented as either: Acute close monitoring of output Or Open sacral or perineal wound	Removed as early as appropriate: Number of patients whose catheter is no longer required (at time of audit)* *(Do not add in patients who were pre-planned for removal today. Add in further comments below on the actions you took on finding the catheter was no longer required*)*	Ongoing Management for all catheterised patients: Number of patients with the drainage bag in date	Ongoing Management for all catheterised patients: Number of patients with the drainage bag correctly positioned below the bladder, off the floor	Ongoing Management for all catheterised patients: Number of patients with a fixation device in situ* *(*in further comments document number of patients without and reason)*	Ongoing Management for all catheterised patients: Number of patients with a fluid chart in place	Ongoing Management for all catheterised patients: Number of patients with a stool chart in place	Infection Rates: Number of patients on antibiotics for a urine infection* (*please also complete the urinary tract infection audit)

Further comments (eg * number of patients without a fixation device and reason, actions you took on finding the catheter was no longer required):-

Audit completed by _____ **Matron Verification Signature** _____ **Date** _____

Biomedical Device Monthly Prevalence Audit Tool V10 – 2023



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PERIPHERAL VENOUS CANNULA (PVC) MONTHLY PREVALENCE AUDIT

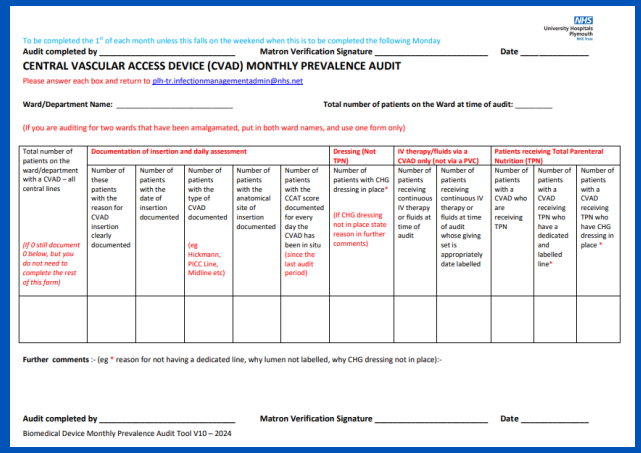
Please answer each box and return to plh-tr.infectionmanagementadmin@nhs.net

Ward/Department Name: _____ **Total number of patients on the Ward at time of audit:** _____

Total number of patients on the ward/ department with a PVC in situ *(If 0 still document 0 below. You do not need to complete the rest of this form)*	Documentation of insertion and daily assessment: Number of patients with the date and time of the PVC insertion clearly documented	Documentation of insertion and daily assessment: Number of patients where the Emergency Insertion info has been completed with a yes or no *(Yes or no should be completed at the time of insertion)*	Documentation of insertion and daily assessment: Number of patients with PVC inserted in the antecubitcal fossa (ACF) and location of insertion e.g., 2 – ED 1 – Not known	Documentation of insertion and daily assessment: Number of patients with daily VIP score documented since insertion (for this audit period) *(If not yet checked at the time of the audit please provide details for previous days that the PVC has been in situ)*	Documentation of insertion and daily assessment: Number of patients with a PVC with flush prescribed *Check EPMA/ Prescription chart*	Documentation of insertion and daily assessment: Number of patients with flush recorded as administered *Check EPMA/ Prescription chart*	Administration set changed as per policy for IV therapy/fluids (via a PVC only): Number of patients receiving continuous IV therapy/ fluids at time of audit	Administration set changed as per policy for IV therapy/fluids (via a PVC only): Number of patients with administration sets labelled and within date	Removed as early as appropriate: Number of patients whose PVC is no longer required (at time of audit)* *(Do not add in patients who were pre-planned for removal today. Add in further comments below on the actions you took on finding the PVC was no longer required*)*	Post Removal Documentation and Monitoring: Number of patients you are auditing today who have had a previous PVC removed *(Include information for all PVC removals on the current Peripheral IV Cannula Insertion Record and Monitoring Document that you are auditing today)*	Post Removal Documentation and Monitoring: Number of patients who had their PVC site inspected and documented 24 hours post removal *(Include information for all insertions on the current Peripheral IV Cannula Insertion Record and Monitoring Document that you are auditing today)*

Further comments :- (eg *actions taken on finding the PVC was no longer required at time of audit - do not include information for any PVCs pre-planned for removal today):-

Biomedical Device Monthly Prevalence Audit Tool V10 – 2024



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Audit completed by _____ **Matron Verification Signature** _____ **Date** _____

CENTRAL VASCULAR ACCESS DEVICE (CVAD) MONTHLY PREVALENCE AUDIT

Please answer each box and return to plh-tr.infectionmanagementadmin@nhs.net

Ward/Department Name: _____ **Total number of patients on the Ward at time of audit:** _____

(If you are auditing for two wards that have been amalgamated, put in both ward names, and use one form only)

Total number of patients on the ward/department with a CVAD – all central lines *(If 0 still document 0 below, but you do not need to complete the rest of this form)*	Documentation of insertion and daily assessment: Number of these patients with the reason for CVAD insertion clearly documented	Documentation of insertion and daily assessment: Number of patients with the date of insertion documented	Documentation of insertion and daily assessment: Number of patients with the type of CVAD documented (eg Hickmann, PICC Line, Midline etc)	Documentation of insertion and daily assessment: Number of patients with the anatomical site of insertion documented	Documentation of insertion and daily assessment: Number of patients with the CCAT score documented for every day the CVAD has been in situ (since the last audit period)	Dressing (Not TPN): Number of patients with CHG dressing in place* (If CHG dressing not in place state reason in further comments)	IV therapy/fluids via a CVAD only (not via a PVC): Number of patients receiving continuous IV therapy or fluids at time of audit	IV therapy/fluids via a CVAD only (not via a PVC): Number of patients receiving continuous IV therapy or fluids at time of audit whose giving set is appropriately date labelled	Patients receiving Total Parenteral Nutrition (TPN): Number of patients with a CVAD who are receiving TPN	Patients receiving Total Parenteral Nutrition (TPN): Number of patients with a CVAD receiving TPN who have a dedicated and labelled line*	Patients receiving Total Parenteral Nutrition (TPN): Number of patients with a CVAD receiving TPN who have CHG dressing in place *

Further comments :- (eg * reason for not having a dedicated line, why lumen not labelled, why CHG dressing not in place):-

Audit completed by _____ **Matron Verification Signature** _____ **Date** _____

Biomedical Device Monthly Prevalence Audit Tool V10 – 2024

NHS University Hospitals Plymouth NHS Trust

THE 10 STANDARD INFECTION PREVENTION AND CONTROL PRECAUTIONS TO BE USED

BY ALL STAFF, IN ALL CARE SETTINGS, AT ALL TIMES, FOR ALL PATIENTS

PATIENT PLACEMENT | SAFE DISPOSAL OF WASTE | PERSONAL PROTECTIVE EQUIPMENT | SAFE MANAGEMENT OF CARE EQUIPMENT

SAFE MANAGEMENT OF LINEN | RESPIRATORY & COUGH HYGIENE | SAFE MANAGEMENT OF BLOOD AND BODY FLUID SPILLS

OCCUPATIONAL SAFETY | SAFE MANAGEMENT OF CARE ENVIRONMENT | HAND HYGIENE

University Hospitals Plymouth NHS Trust

Biomedical Device Monthly Prevalence Audits

Each month all clinical areas within University Hospital Plymouth NHS Trust submit monthly prevalence audits on the first day of the month for:

- Urinary Catheters
- Peripheral Venous Cannulas and
- Central Vascular Access Devices

University Hospitals Plymouth NHS Trust

Audit Findings

The monthly prevalence audits enable us to review accurate data on clinical care across our organisation.

- Immediate concerns are followed up by the clinical teams at the time of the audit and localised learning put in place e.g. daily audits, team safety huddles, education boards

The data results for all three audits are reviewed by the Infection Prevention & Management Team (IP&M team) & reported to:

- Matron Leads for each of the devices

- The Infection Prevention Sub-Committee

University Hospitals Plymouth NHS Trust

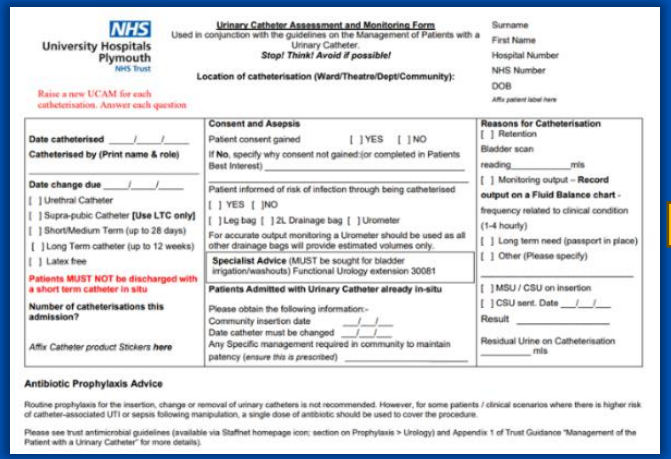
Actions from Biomedical Device Monthly Prevalence Audits

The actions form part of wider Quality Improvement Project work to improve care and management of biomedical devices.

University Hospitals Plymouth NHS Trust

Improving Urinary Catheter Care

Data from the audit was critical in the development of an electronic urinary catheter assessment and monitoring (eUCAM) tool



Urinary Catheter Assessment and Monitoring Form

Used in conjunction with the guidelines on the Management of Patients with a Urinary Catheter

Stop! Think! Avoid if possible!

Location of catheterisation (Ward/Theatre/Dept/Community):

Surname
First Name
Hospital Number
NHS Number
DOB

Raise a new UCAM for each catheterisation. Answer each question

Consent and Asepsis

Patient consent gained [ ] YES [ ] NO

If No, specify why consent not gained (or completed in Patients Best Interest) _____

Patient informed of risk of infection through being catheterised [ ] YES [ ] NO

[ ] Leg bag [ ] 2L Drainage bag [ ] Urometer

For accurate output monitoring a Urometer should be used as all other drainage bags will provide estimated volumes only.

Specialist Advice (MUST be sought for bladder irrigation/washouts) Functional Urology extension 30081

Patients Admitted with Urinary Catheter already in-situ

Please obtain the following information:-
Community insertion date ___/___/___
Date catheter must be changed ___/___/___
Any Specific management required in community to maintain patency (*ensure this is prescribed*) _____

Reasons for Catheterisation

[ ] Retention
Bladder scan
reading_____mls
[ ] Monitoring output – **Record output on a Fluid Balance chart** - frequency related to clinical condition (1-4 hourly)
[ ] Long term need (passport in place)
[ ] Other (Please specify)
_____
[ ] MSU / CSU on insertion
[ ] CSU sent. Date ___/___/___
Result _____

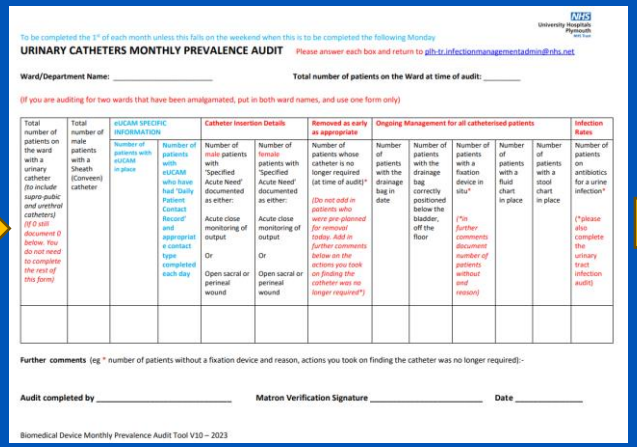
Residual Urine on Catheterisation _____ mls

Date catheterised ____/____/____
Catheterised by (Print name & role)
_____
Date change due ____/____/____
[ ] Urethral Catheter
[ ] Supra-pubic Catheter **[Use LTC only]**
[ ] Short/Medium Term (up to 28 days)
[ ] Long Term catheter (up to 12 weeks)
[ ] Latex free
Patients MUST NOT be discharged with a short term catheter in situ
Number of catheterisations this admission?
Affix Catheter product Stickers here

Antibiotic Prophylaxis Advice

Routine prophylaxis for the insertion, change or removal of urinary catheters is not recommended. However, for some patients / clinical scenarios where there is higher risk of catheter-associated UTI or sepsis following manipulation, a single dose of antibiotic should be used to cover the procedure.

Please see trust antimicrobial guidelines (available via Staffnet homepage icon; section on Prophylaxis > Urology) and Appendix 1 of Trust Guidance "Management of the Patient with a Urinary Catheter" for more details).



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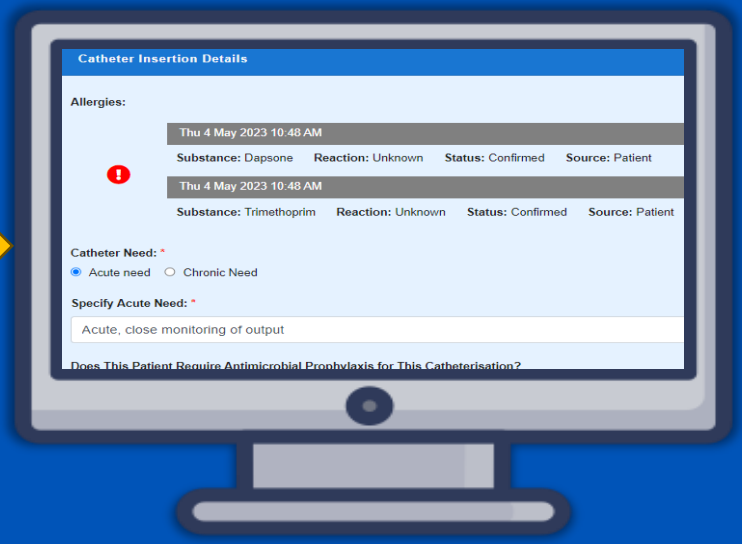
(If you are auditing for two wards that have been amalgamated, put in both ward names, and use one form only)

Total number of patients on the ward with a urinary catheter (*to include supra-pubic and urethral catheters*) (*If 0 still document 0 below. You do not need to complete the rest of this form*)	Total number of male patients with a Sheath (Convene) catheter	eUCAM SPECIFIC INFORMATION: Number of patients with eUCAM in place	Number of patients with eUCAM who have had 'Daily Patient Contact Record' and appropriate contact type completed each day	Catheter Insertion Details: Number of male patients with 'Specified Acute Need' documented as either: Acute close monitoring of output Or Open sacral or perineal wound	Number of female patients with 'Specified Acute Need' documented as either: Acute close monitoring of output Or Open sacral or perineal wound	Removed as early as appropriate: Number of patients whose catheter is no longer required (at time of audit)* (*Do not add in patients who were pre-planned for removal today. Add in further comments below on the actions you took on finding the catheter was no longer required*)	Ongoing Management for all catheterised patients: Number of patients with the drainage bag in date	Number of patients with the drainage bag correctly positioned below the bladder, off the floor	Number of patients with a fixation device in situ* (*In further comments document number of patients without and reason*)	Number of patients with a fluid chart in place	Number of patients with a stool chart in place	Infection Rates: Number of patients on antibiotics for a urine infection* (*please also complete the urinary tract infection audit*)

Further comments (eg * number of patients without a fixation device and reason, actions you took on finding the catheter was no longer required):-

Audit completed by _____ **Matron Verification Signature** _____ **Date** _____

Biomedical Device Monthly Prevalence Audit Tool V10 – 2023



NHS
University Hospitals Plymouth NHS Trust

Monthly Prevalence Audit data established the baseline measurement of urinary catheter care and management with concerns regarding:

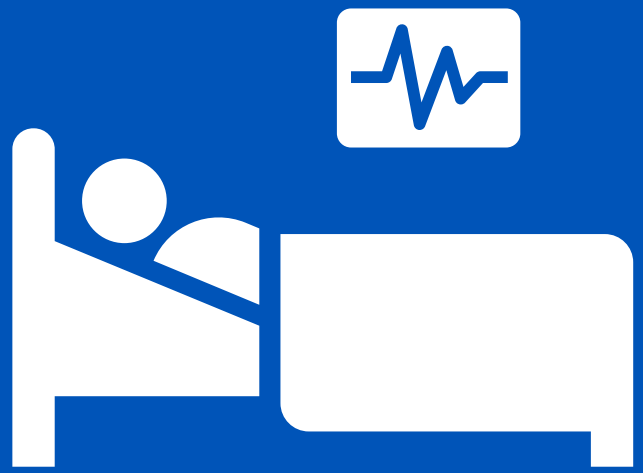
- Stubbornly unchanging urinary catheter fixation device use
- Lapses in or absent paper documentation on urinary catheter care and management
- Compliance concerns with reviewing a patients fluid monitoring and bowels
- Urine drainage bags being inappropriately placed/not in date

The audit data alongside investigations into catheter related bacteraemia's enabled us to lead a Quality Improvement Project (QIP). The QIP was to develop and digitalise the paper urinary catheter and assessment and monitoring tool.

INFLUENCING CHANGE WITH.....

NHS
University Hospitals Plymouth
NHS Trust

EVERY PATIENT



EVERY CATHETER

INFLUENCING CHANGE WITH.....

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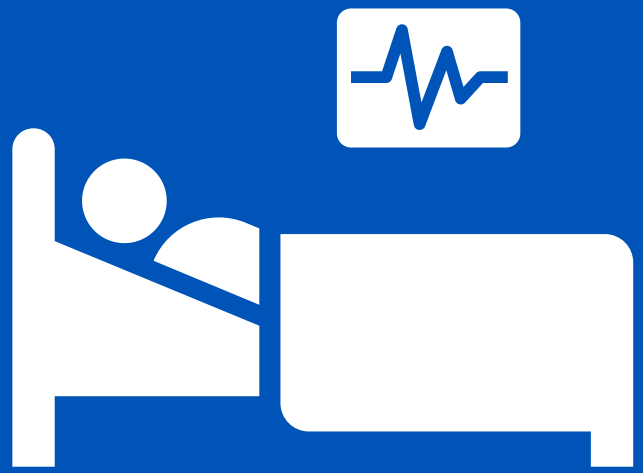
EVERY TEAM



INFLUENCING CHANGE WITH.....

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ACUTE TRUST

COMMUNITY HOSPITALS

HOMES

University Hospitals Plymouth NHS Trust

Monitoring Catheter Care
Post Implementation of the eUCAM

The urinary catheter monthly prevalence audit has been crucial in influencing change by identifying successes with digitalising the paper UCAM & where changes to the tool have been required.

As the audit tool is so well embedded in practice, we have also been able to make changes to it when different aspects of care need to be measured.

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Outcome Measures

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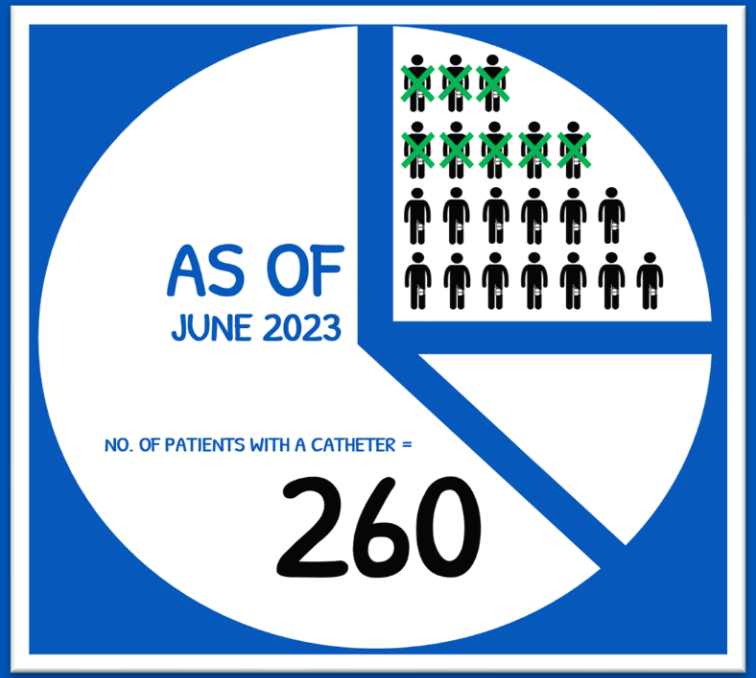
Urinary Catheters in situ

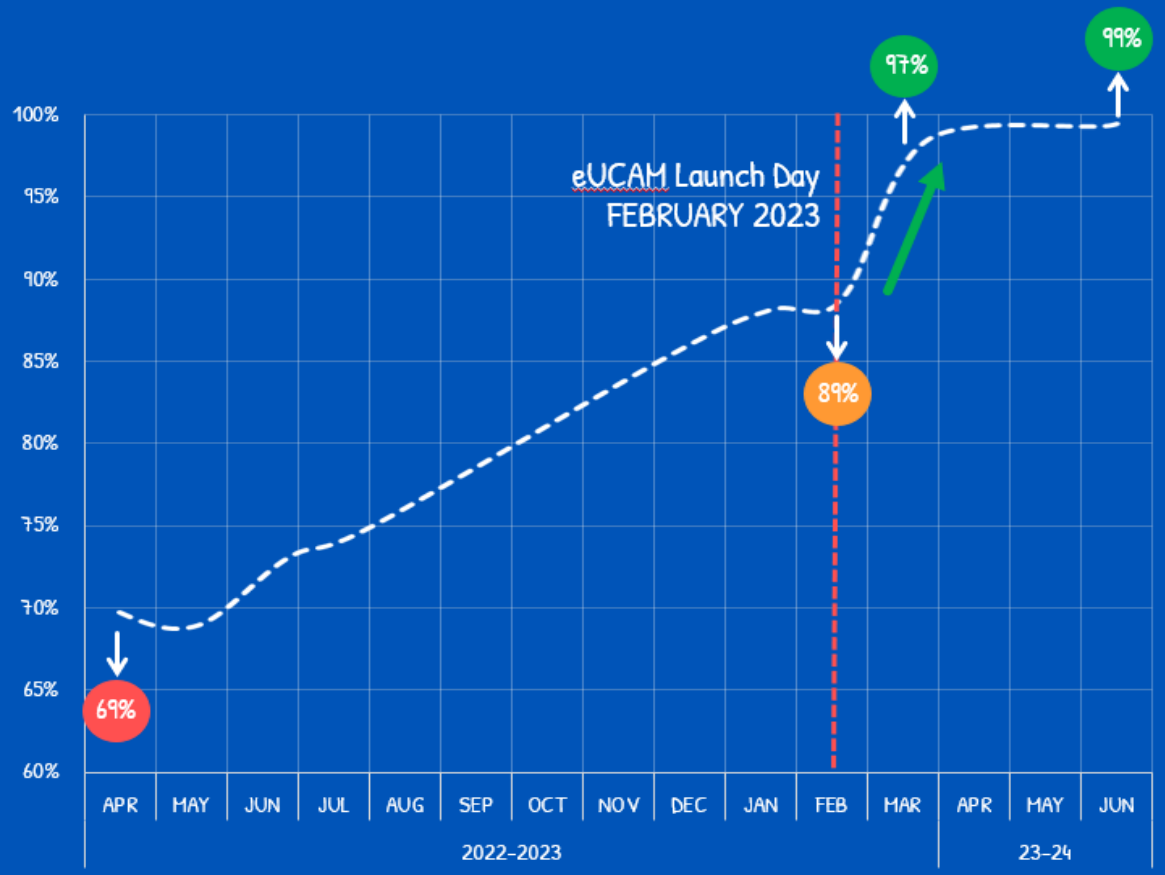
Day of launch of the eUCAM 320 urinary catheters in situ within a few months there was a reduction to 260 and this reduction in catheter numbers has continued.



20%

Post Audit Findings

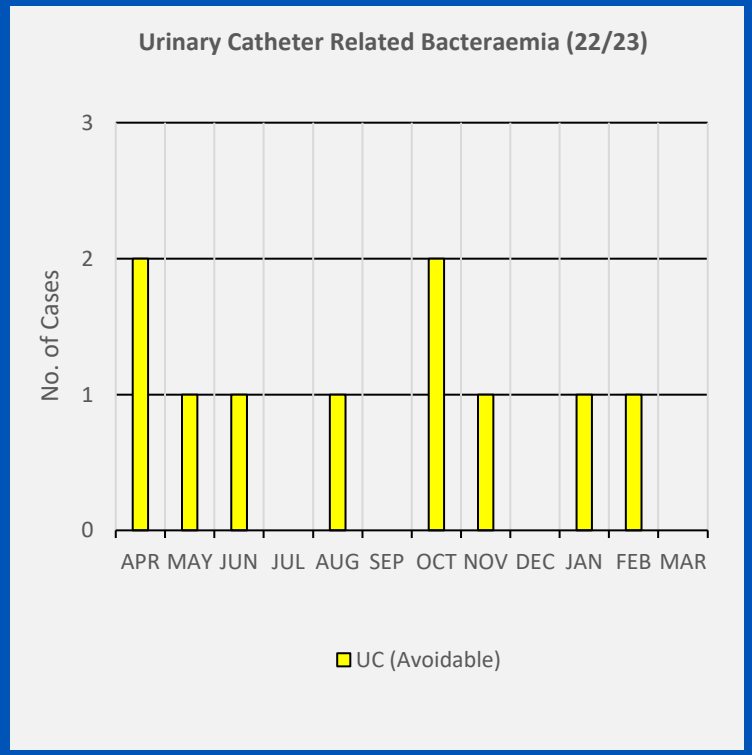
Improvements with urinary catheter fixation device use. Therefore, preventing pistoning of the catheter that can cause bacteria to be drawn into the bladder.

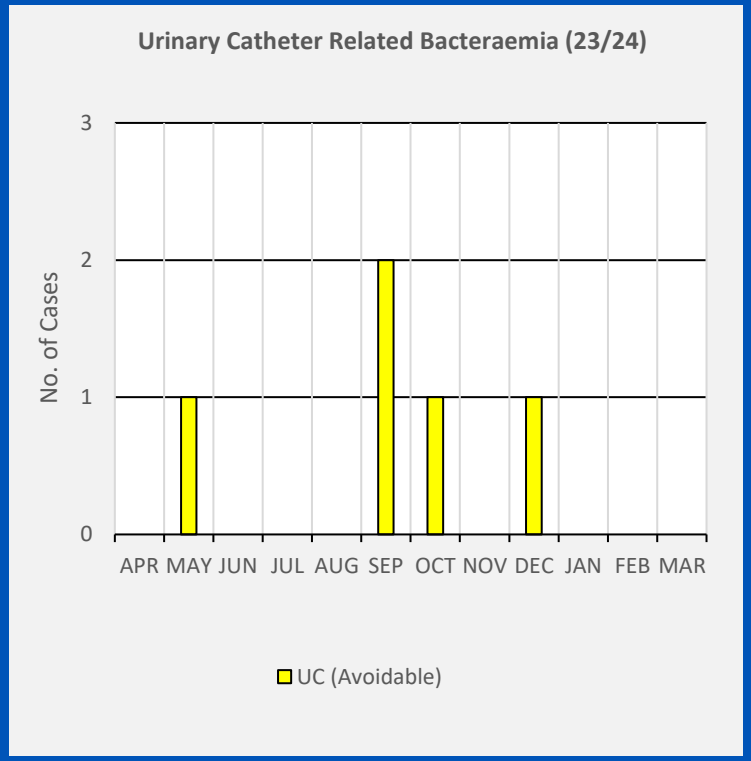


Holroyd, S. (2019) The importance of Indwelling Urinary Catheter Securement. *British Journal of Nursing, 28 (15), pp 1-5 doi: org.rcn.idm.oclc.org/10.12968/bjon.2019.28.15.976*

Urinary catheter related bacteraemia

A reduction by 50% of UHPs avoidable urinary catheter related bacteraemia's based on University Hospital Plymouth - internal reporting process





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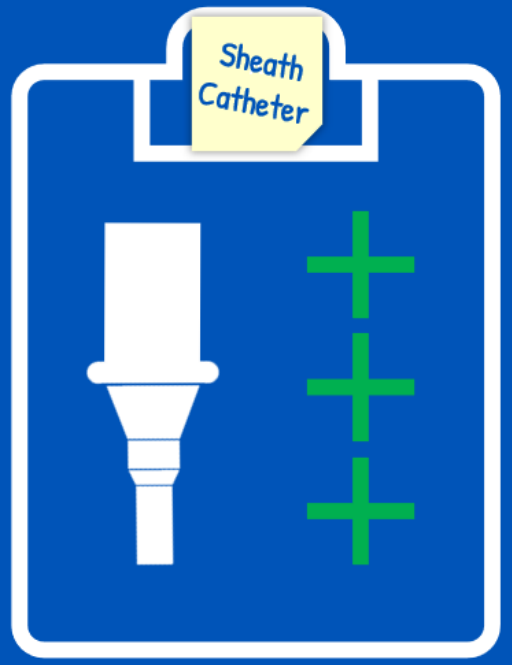
And Finally:

The Infection Prevention and Management Team has just completed an additional Quality improvement Project as a result of the Monthly Prevalence audit data, to influence change and promote the use of Sheath Catheters.



The project ran from February 2024 to May 2024.

Findings identified avoidance of urinary catheterisation in 6 out of the 11 patients who had a sheath catheter used.

Being able to monitor the project success through the audit has led to the wider use of sheath catheters and is another great example of how clinical audits can influence change!

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Our Clinical Audits support 'Prevention being Better than Cure'

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THANK YOU

FROM UNIVERSITY HOSPITALS PLYMOUTH NHS TRUST

INFECTION PREVENTION & MANAGEMENT

NHS University Hospitals Plymouth NHS Trust

Clinical Audit Awareness Week #CAAW24

HQIP
Healthcare Quality Improvement Partnership

National Quality Improvement (Inc. Clinical Audit) Network
N-QI-CAN

Opportunity for questions





Clinical Audit Awareness Week #CAAW24

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N-QI-CAN

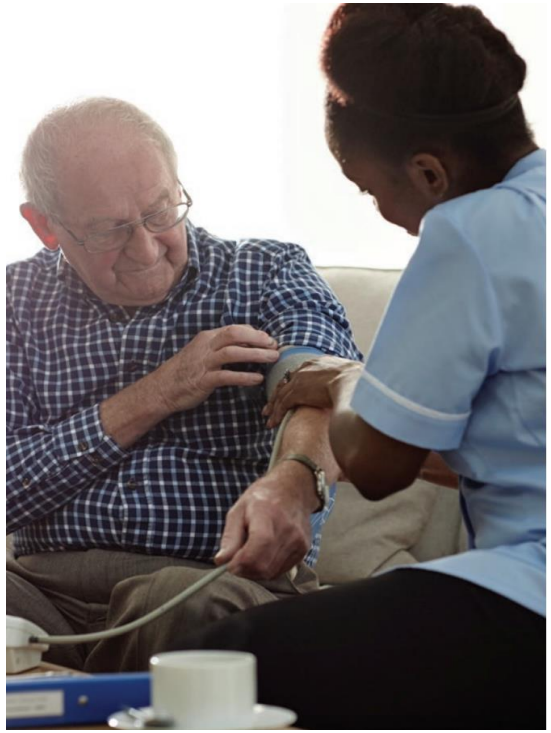
EVALUATION
Your feedback is important to us

Please take a couple of minutes to complete our evaluation form

Evaluation

https://www.smartsurvey.co.uk/s/NQICAN-Change/

Effectively Utilising Clinical Audit To Influence Change



Clinical Audit – measures care against evidence based standards. #CAAW24 challenges attendees to consider clinical audit in their own organisation in terms of:

- **Access FutureNHS Making Data Count Resources & Training**
- **Build a collaboration with your Informatics Team to effectively utilise data to inform**
- **What else do you know? Context**
- **Consider carefully what data you utilise, how you plot it and how you present this to your decision makers**
- **SMART Improvement Plans**
- **How will you evidence the impact?**
- **Sharing & Learning**

Clinical Audit Awareness Week #CAAW24

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Monday 24th June 2024 12.20-1.30pm	Tuesday 25th June 2024 12.20-1.30pm	Wednesday 26th June 2024 12.20-1.30pm	Thursday 27th June 2024 12.20-1.30pm	Friday 28th June 2024 12.20-1.30pm
Patient Safety - Effectively Utilising Clinical Audit To Prevent Avoidable Harm	Patient & Public Involvement - Effectively Utilising Clinical Audit To Improve Health & Care by Involving, Engaging & Informing Patients & The Public	Health Inequalities - Effectively Utilising Clinical Audit To Address Inequalities In Health & Care	Influencing Change - Effectively Utilising Clinical Audit To Influence Change At Board Level	Sustainability - Effectively Utilising Clinical Audit For Sustainability
Rachel Poole	Kim Rezel	Dr Charlotte Richardson & Danny Keenan	Sam Riley	Zoe Lord

Thank you for joining us today

Please join us again tomorrow for a focus on Sustainability

Who is YOUR Audit Hero?

#CAAW24