Clinical Audit Awareness Week #CAAW24

Part of Clinical Audit Awareness Week 2024, featuring the Clinical Audit Heroes awards

Patient Safety - Effectively Utilising Clinical Audit To Prevent Avoidable Harm

NQICAN Lunch and Learn

Monday 24th June 2024

(12.30-1.30pm)

Your Lunch & Learn Team today

Vicky Patel - Chair NQICAN
Marina Otley - Gen Sec NQICAN
Chris Gush - CEO HQIP
Rachel Pool - Head of Patient Safety Implementation NHSE
Clinical Audit Hero – Patient Safety

Clinical Audit Awareness Week #CAAW24

HQIP
Healthcare Quality Improvement Partnership

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

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





Who is YOUR Audit Hero?

#CAAW24

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Clinical Audit Awareness Week 2024

Lunch & Learn events – welcome from…

Chris Gush, CEO, HQIP

24 June 2024

#CAAW24 NQICAN Patient Safety Lunch & Learn

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Agenda

- HQIP Chris Gush CEO #CAAW24
- Introduction NQICAN and #CAAW
- What does preventing avoidable harm mean to you from a clinical audit perspective?
- Key Speaker - Effectively utilising Clinical Audit to prevent avoidable harm
- Clinical Audit Hero Winner announced
- Winner of the Patient Safety Clinical Audit Hero Award presents
- Opportunity for questions framed on Patient Safety
- Interactive Evaluation
- Close and celebrate #CAAW24!

Please let us know– *what does utilising Clinical Audit to prevent avoidable harm look like to you* - by typing into the chat

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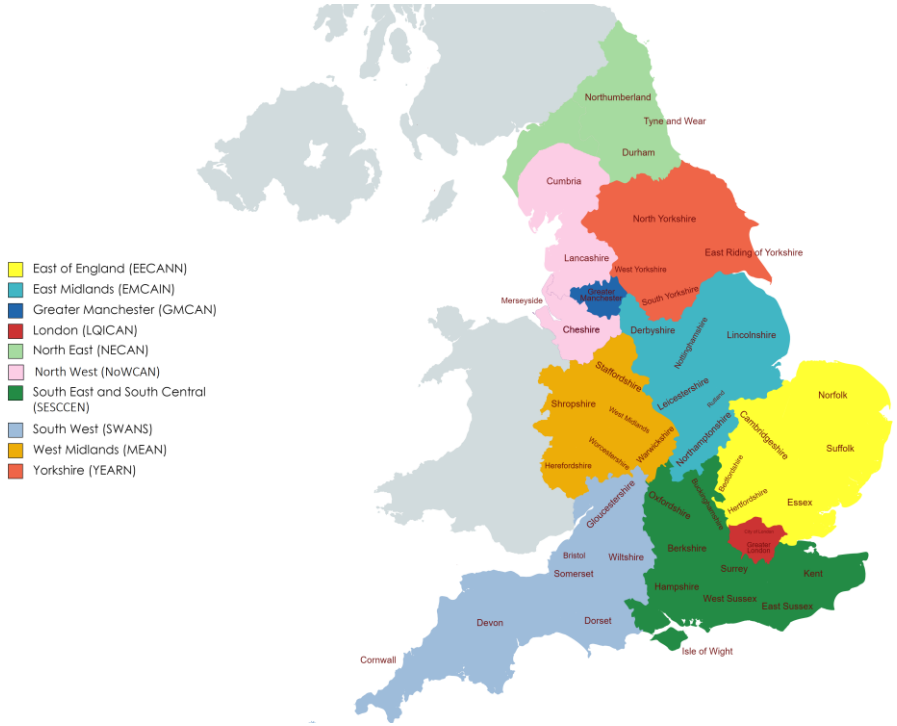

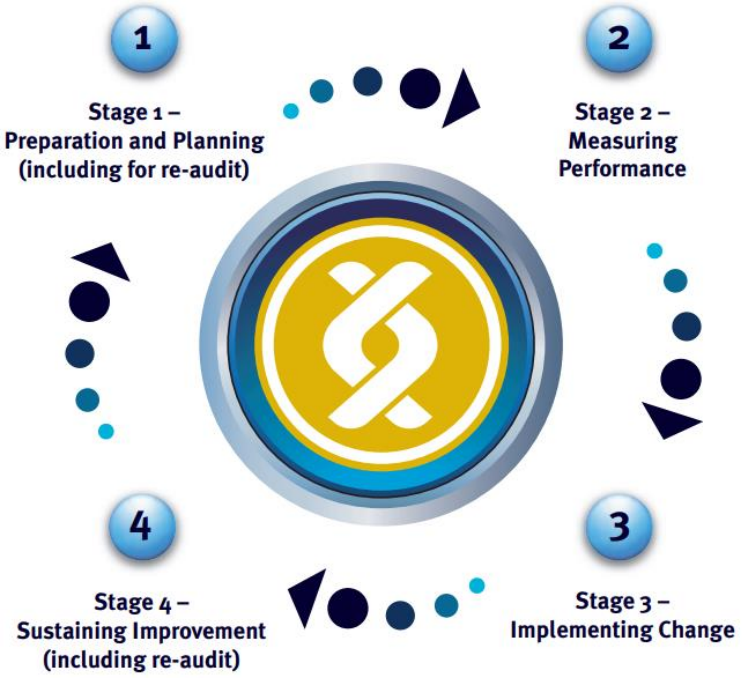

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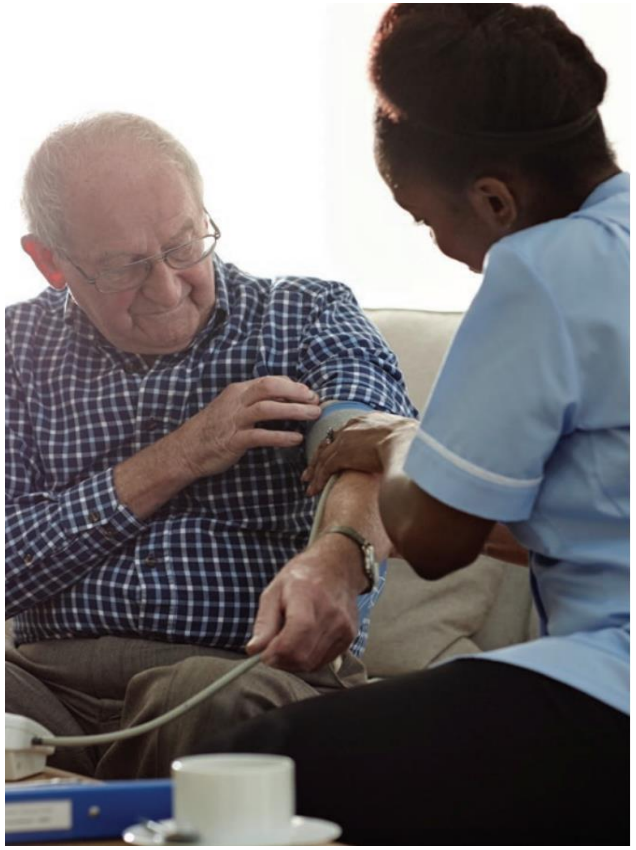

Clinical Audit – measures care against evidence based standards. #CAAW23 challenged attendees to consider Clinical Audit in their own organisation in terms of:

- **Clinical Audit strategies having a clear objective aligning with the PSIRF – go and talk to your Patient Safety Team**
- **Clinical Audit programmes consisting of Clinical Audits that focus measurement on Patient Safety Concerns - evidencing learning from avoidable harm – speak with your Patient Safety Specialists**
- **Clinical Audit findings and action plans taken forward with the focus on preventing avoidable harm – complimenting SIPs not duplicating**

Who is YOUR Audit Hero?

#CAAW24

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- **Implementing Evidence based Care -** do we have effective processes to implement/adopt that are safe? How do we know they are safe & effective? Do we measure when we implement/adopt to ensure we are preventing avoidable harm?
- **Clinical audit programme** – does it include clinical audits driven by patient safety themes/concerns? What are the top 5 concerns in your organisation/ICB/Nationally?
- **Strategic** – does your organization's Clinical Audit & PSIRF policies align?
- **Engagement & Involvement** – do you attend your pt safety committee?
- **Triangulating information** – do you triangulate clinical audit outcomes with Patient feedback & Staff surveys
- **Themes & areas of concern** – any worry spots? Adapt methodology for areas of concern/risks of significance as opposed to low risk areas/no concern
- **Collaboratively working** – do you take forward recommendations and actions with the patient safety and patient experience teams?
- **Education & training** – What is available and what is attendance like?
- **Sharing & learning events** – does your organisation hold these?

Who is YOUR Audit Hero?

#CAAW24

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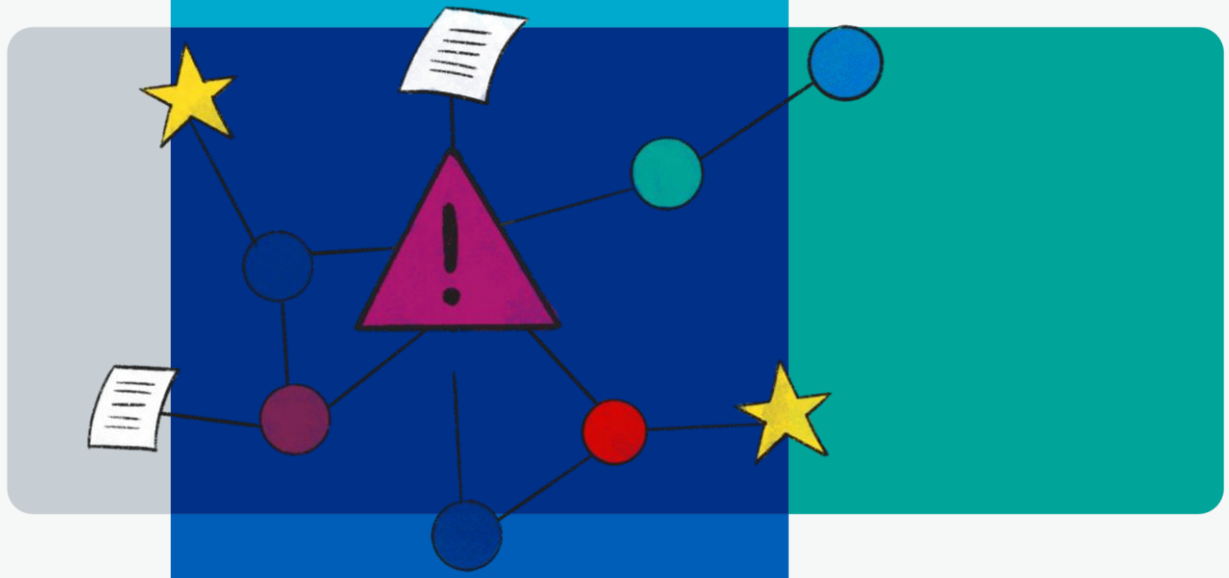
Key Speaker
Rachel Pool
Head of Patient Safety Implementation
NHSE

The Patient Safety Incident Response Framework

NQICAN

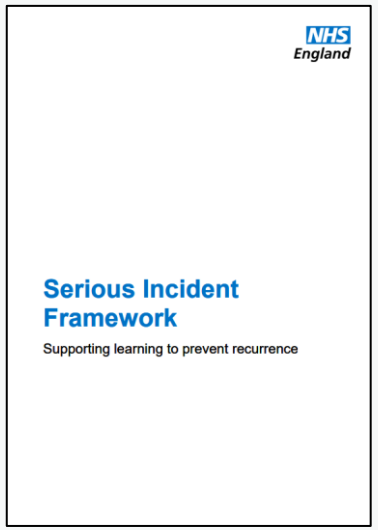


Rachel Pool 24 June 2024

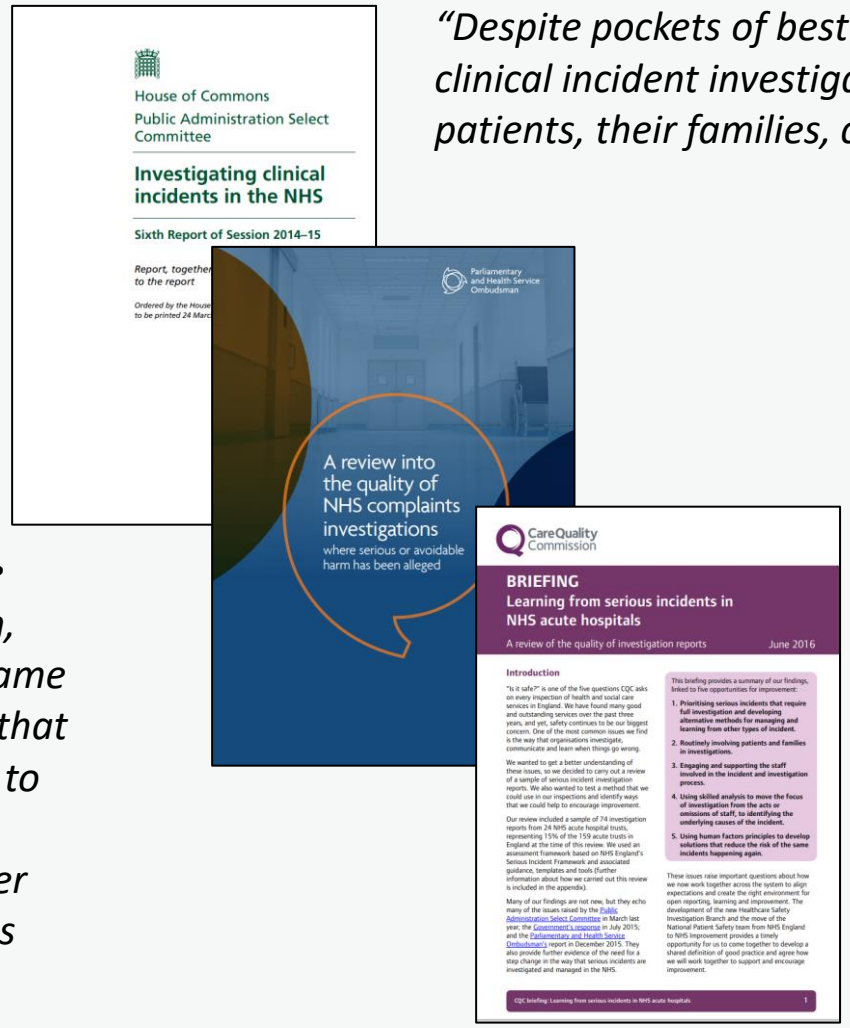
Clinical Audit

Make your mark

Policy context



"The Framework aims to facilitate learning by promoting a fair, open, and just culture that abandons blame as a tool and promotes the belief that 'incidents cannot simply be linked to the actions of the individual healthcare staff involved but rather the system in which the individuals were working'"



"Despite pockets of best practice, good intentions and strong leadership, clinical incident investigation and complaints handling fall far short of what patients, their families, clinicians and NHS staff are entitled to expect"

[1] Peerally MF, Carr S, Waring J, *et al* The problem with root cause analysis *BMJ Quality & Safety* 2017;**26:**417-422.
[2] Card AJ. The problem with '5 whys' *BMJ Quality & Safety* 2017;**26:**671-677.

Patient safety incident response framework (PSIRF)

From prescription to principles

Compassionate

Engage meaningfully with those affected by patient safety incidents through answering questions, addressing concerns, and involving those affected in any learning response.

Proportionate

Not all incidents require a learning response. Focus responses on areas where there's the greatest potential for learning and improvement.

Systems-based

Looking beyond the decisions and actions of people/individuals delivering care to consider the influence of the wider system and the complex interactions that occur.

Supported

Oversight of learning from patient safety incidents should focus on enabling improvement and collaboration.

PSIRF

PSIRF

From a framework to a movement

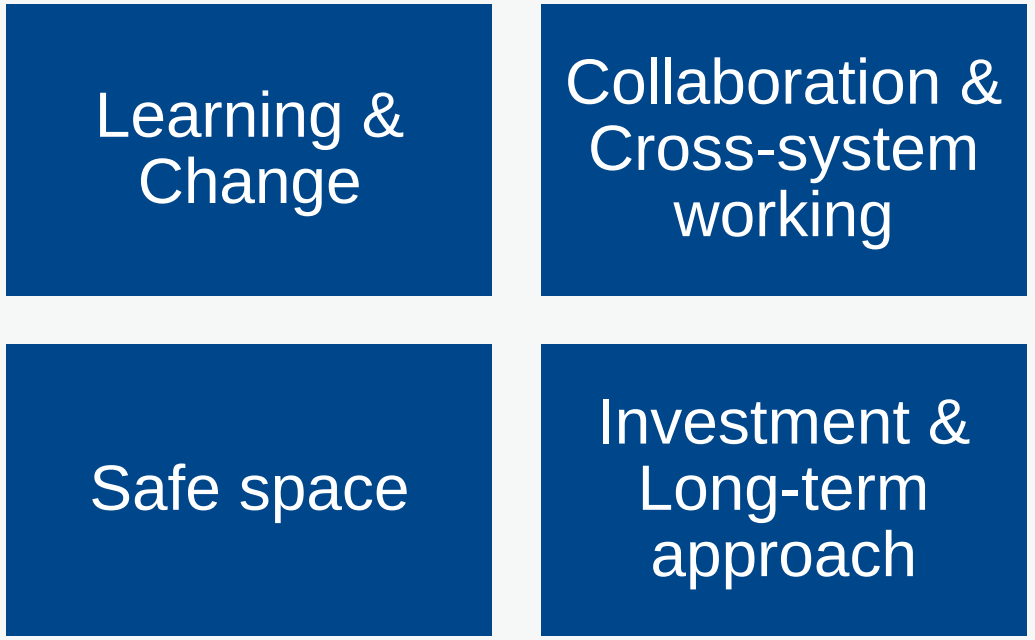
- “Not implementing a framework, leading a culture change”
- Building connections, enabling conversations
- Change in narrative and openness
- Oversight functions less transactional
- Tangible and **measurable** change

PSIRF 2023 Successes

- Learning & Change
- Collaboration & Cross-system working
- Safe space
- Investment & Long-term approach

"At both ICB and regional level PSIRF Groups developed as a safe space to share and learn, escalate concerns, “pinch with pride”, develop whole system working and reduce silos, act as a critical friend, foster self-reflection and provide insight, and act as a professional support network. This is helping to encourage and model the learning healthcare system, patient safety culture, and quality improvement approach that PSIRF is aiming to achieve. "

PSIRF 2023 Successes



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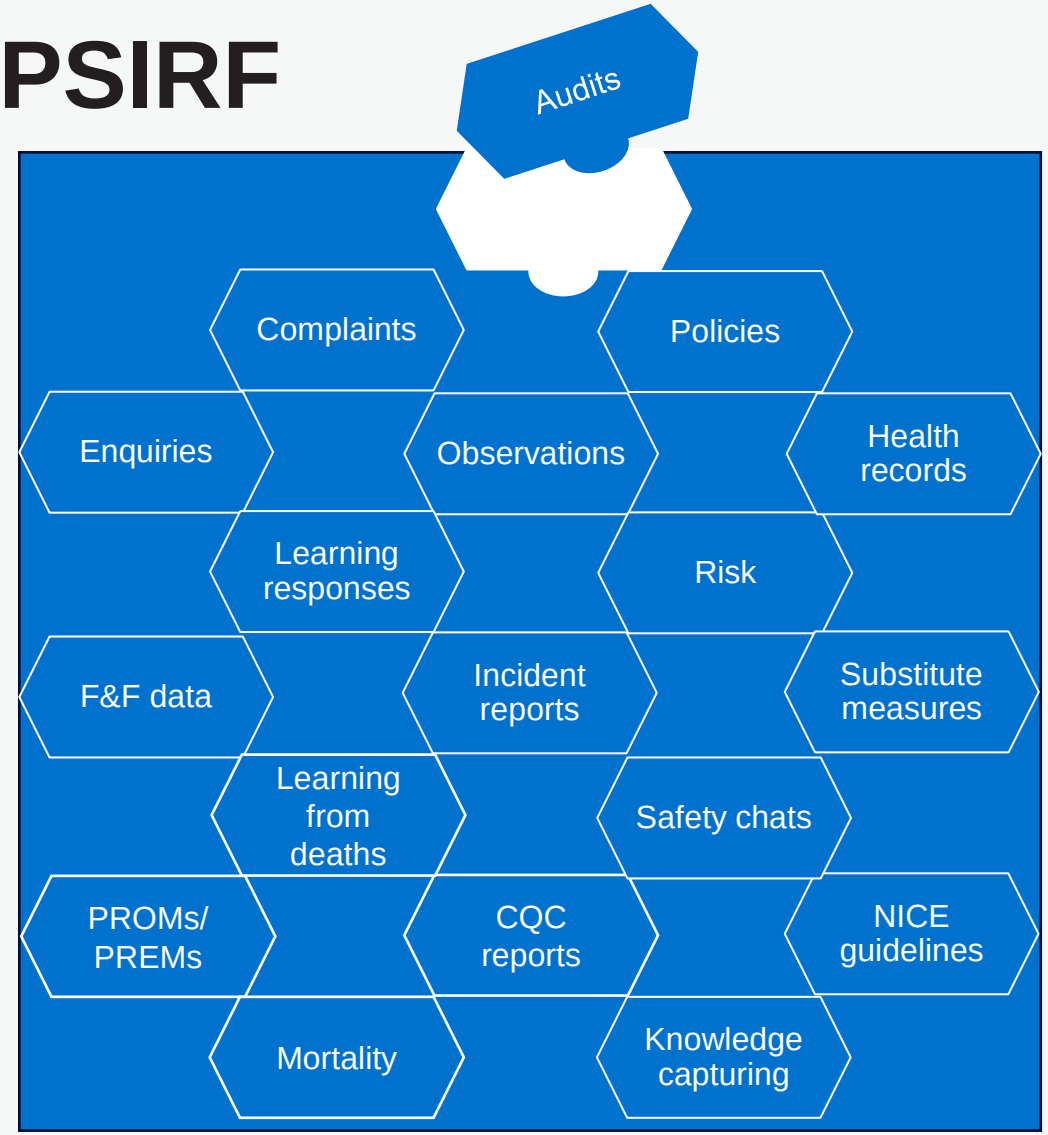
PSIRF

PSIRF

PSIRF, Standards, Oversight roles and responsibilities specification, Supporting guidance, Toolkit

Compassionate Proportionate Systems-based Supported

PSIRF


Audits
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Learning responses
Risk
F&F data
Incident reports
Substitute measures
Learning from deaths
Safety chats
PROMs/ PREMs
CQC reports
NICE guidelines
Mortality
Knowledge capturing


Planning
Learning responses
Improving

Clinical Audit

Make your mark

Clinical Audit

“Are we doing the right thing in the right way” [1]

National Diabetes Audit

1.Is everyone with diabetes diagnosed and recorded on a practice diabetes register?

2.What percentage of people registered with diabetes received the nine National Institute of Health and Care Excellence (NICE) key processes of diabetes care?

3.What percentage of people registered with diabetes achieved NICE defined treatment targets for glucose control, blood pressure and cardiovascular disease risk reduction?

4.What percentage of people registered with diabetes are offered and attend a structured education course?

5.For people with registered diabetes what are the rates of acute and long-term complications (disease outcomes)?

- Governance and quality
- Structure of care[1]
- Process of care[1]
- Outcome of care[1]
- Learning at different levels

1. Benjamin A. Audit: how to do it in practice BMJ 2008; 336 :1241 doi:10.1136/bmj.39527.628322.AD

Citing: Smith R. Audit and research. British Medical Journal 1992; 305 :905 doi:10.1136/bmj.305.6859.905

PSIR Priorities

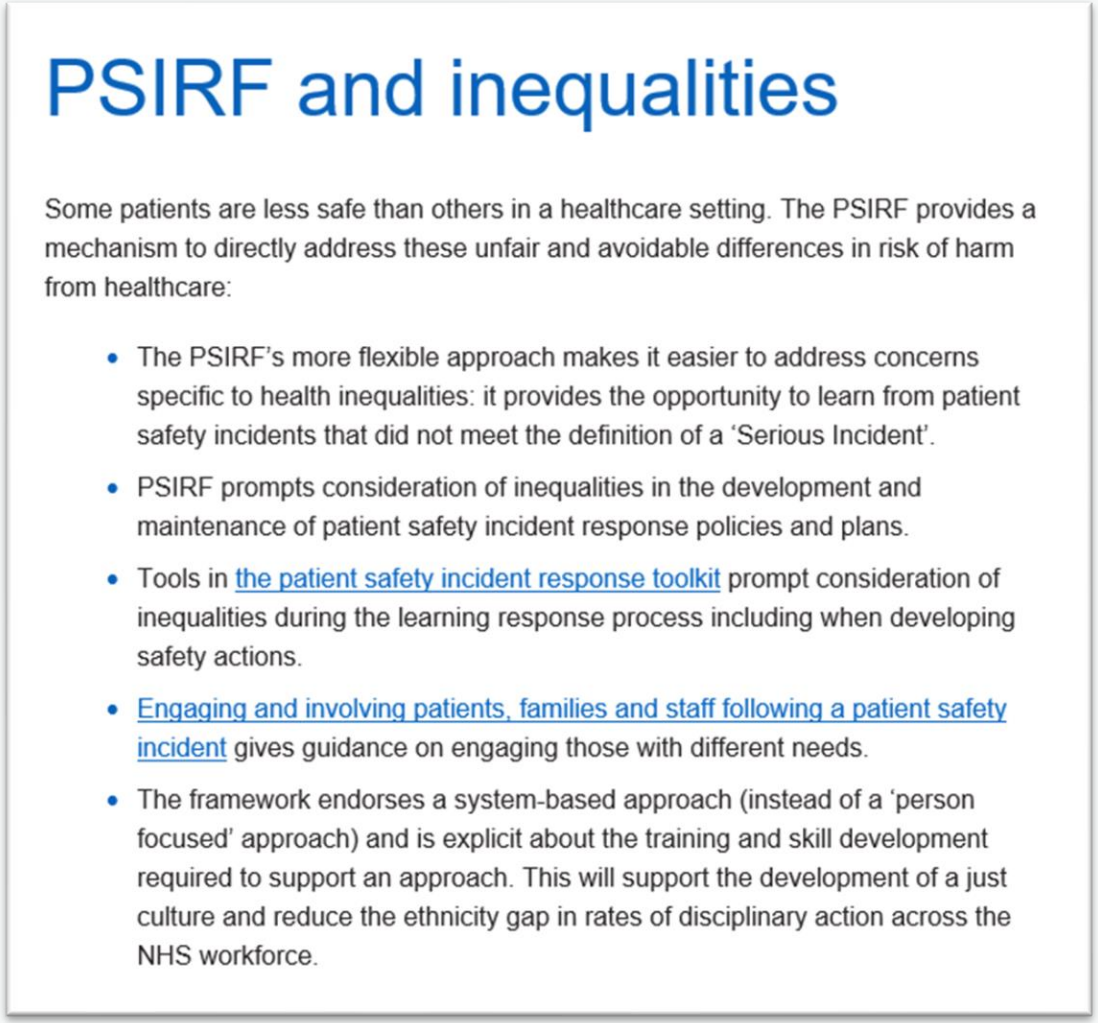
Engagement with public and local HealthWatch

Plan based upon learning and improvement potential

Plan clear to patients and families

With thanks to Tracey Herlihey and Mark Smith

How are inequalities considered?



PSIRF and inequalities

Some patients are less safe than others in a healthcare setting. The PSIRF provides a mechanism to directly address these unfair and avoidable differences in risk of harm from healthcare:

- The PSIRF's more flexible approach makes it easier to address concerns specific to health inequalities: it provides the opportunity to learn from patient safety incidents that did not meet the definition of a 'Serious Incident'.
- PSIRF prompts consideration of inequalities in the development and maintenance of patient safety incident response policies and plans.
- Tools in the patient safety incident response toolkit prompt consideration of inequalities during the learning response process including when developing safety actions.
- Engaging and involving patients, families and staff following a patient safety incident gives guidance on engaging those with different needs.
- The framework endorses a system-based approach (instead of a 'person focused' approach) and is explicit about the training and skill development required to support an approach. This will support the development of a just culture and reduce the ethnicity gap in rates of disciplinary action across the NHS workforce.

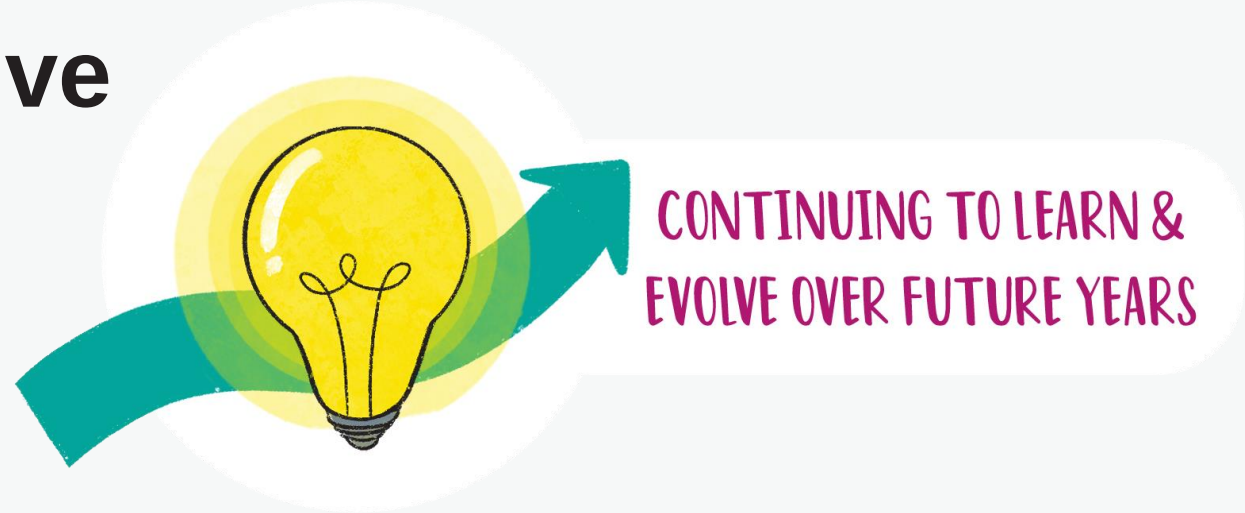
'*Through our implementation of* [PSIRF], *we will seek to utilise data and learning from investigations to identify actual and potential health inequalities and make recommendations to support tackling these. We are already actively considering language barriers and social deprivation in our incident reviews* ~ Acute provider

p7-8 B1465-1.-PSIRF-v1-FINAL.pdf (england.nhs.uk)

With thanks to Tracey Herlihey and Mark Smith

PSIR Planning Retrospective

Just the beginning of the safety journey



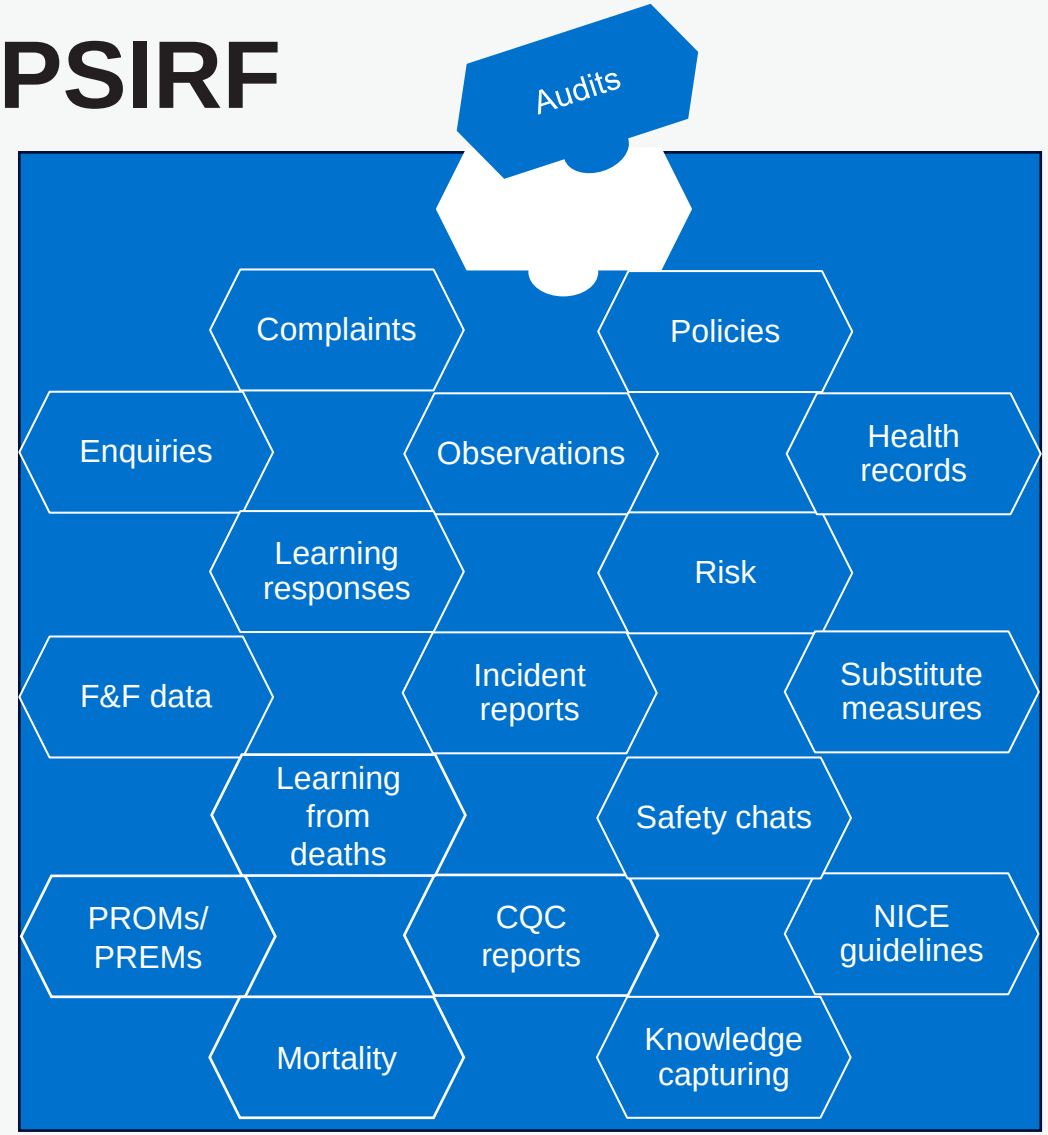
- “Not implementing a framework, leading a culture change”
- Plan enables more informed decision making moving away from reactive/bureaucratic approach
- Rich source of data about safety concerns across trusts in England

Opportunities to:

- Improve clarity for patients
- Focus more on inequalities
- Focus on ‘improvement’ priorities rather than ‘response’ priorities

With thanks to Tracey Herlihey and Mark Smith

PSIRF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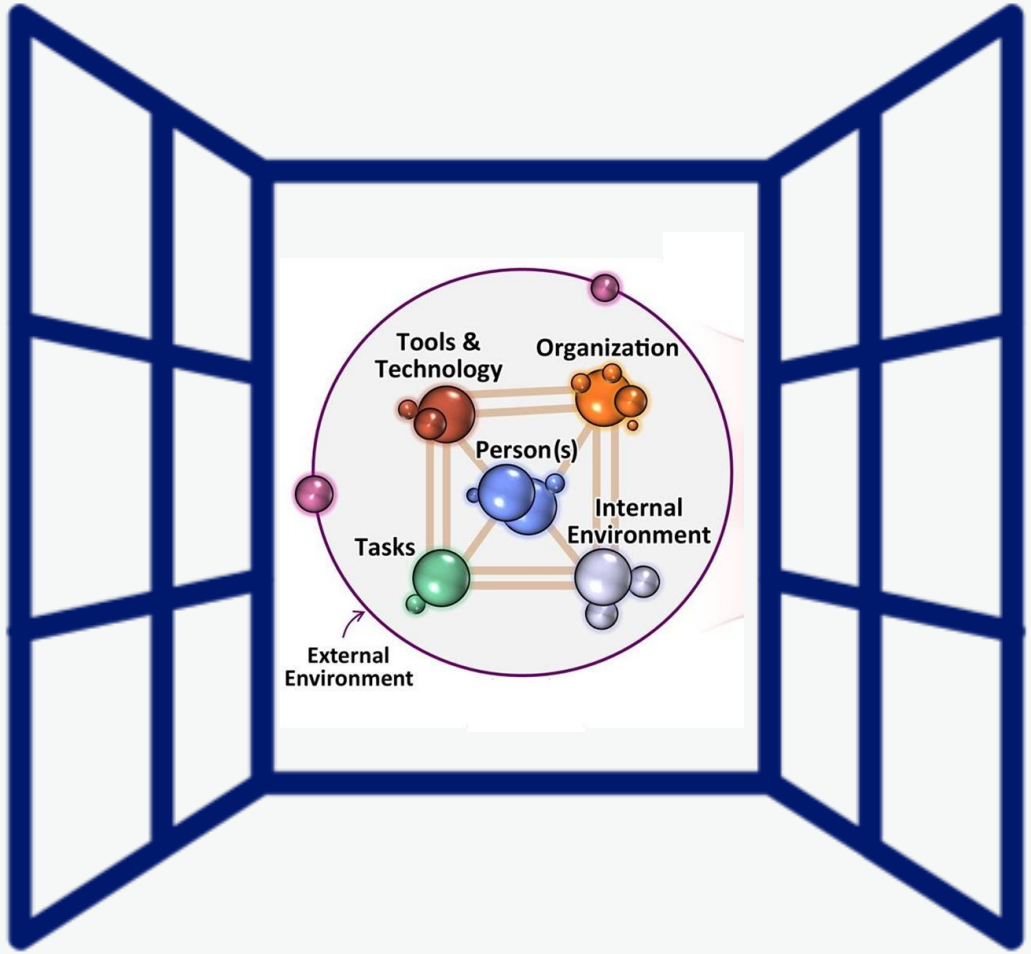
Planning
Learning responses
Improving

Systems based approaches

How is the approach different?

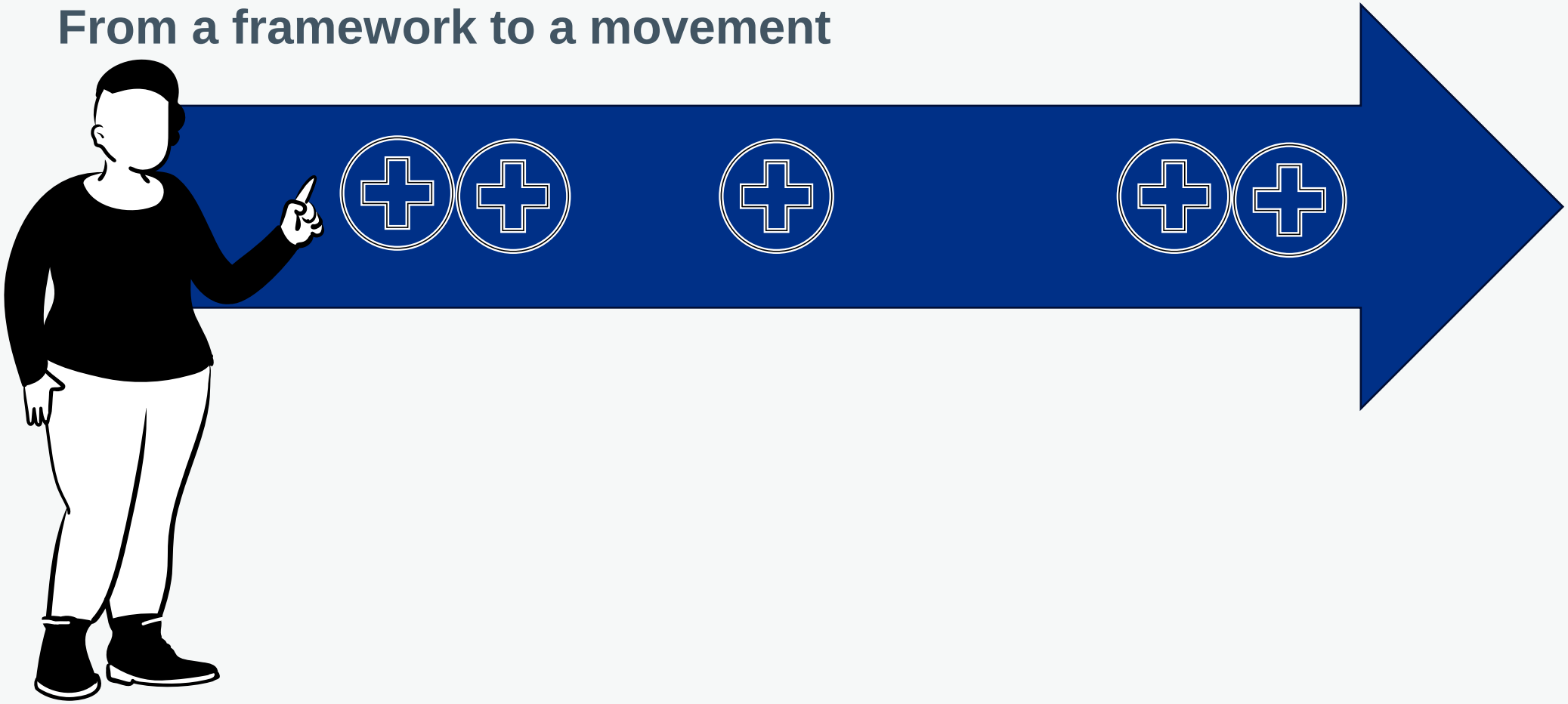
- Uses incidents as a ‘window on the system’



[Analysis of clinical incidents: a window on the system not a search for root causes | BMJ Quality & Safety]

Audit’s role

From a framework to a movement



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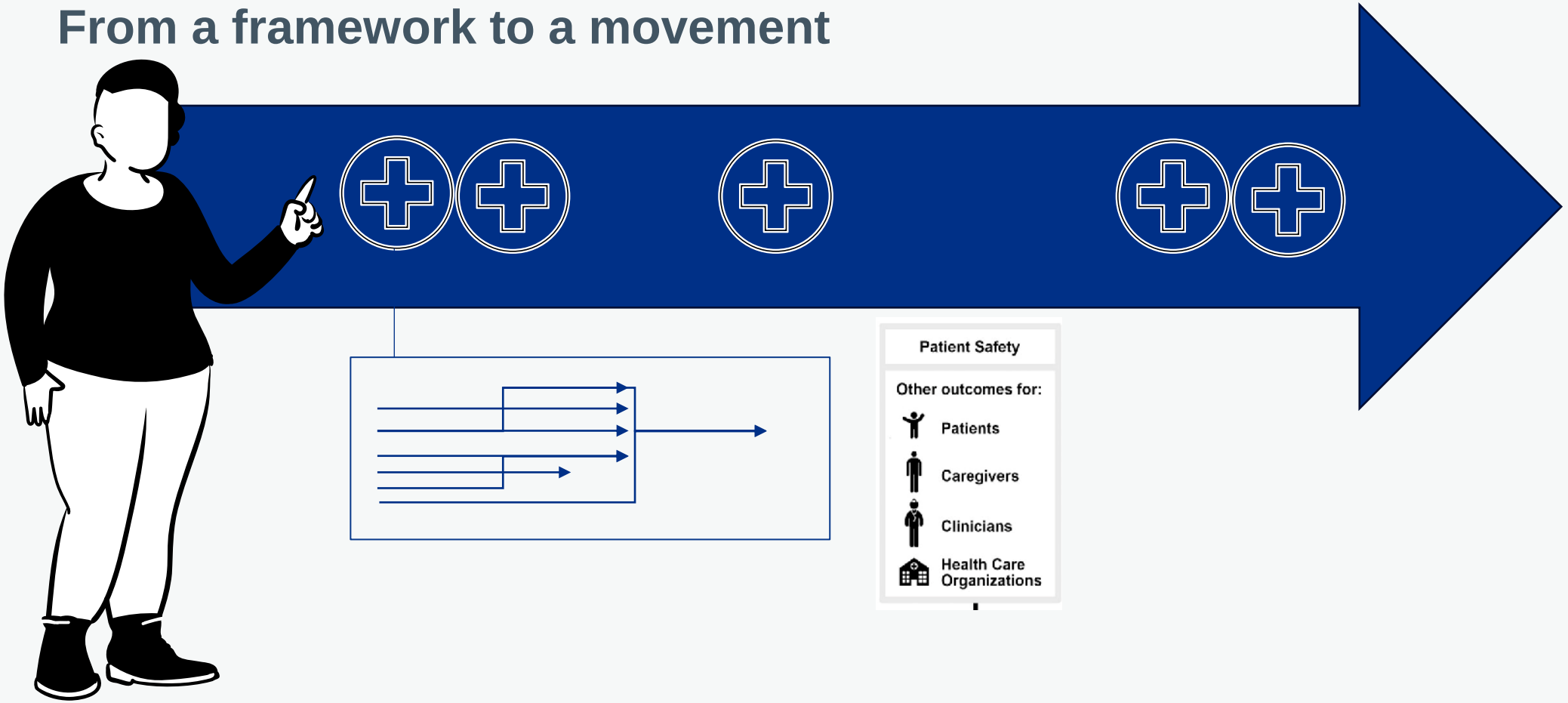

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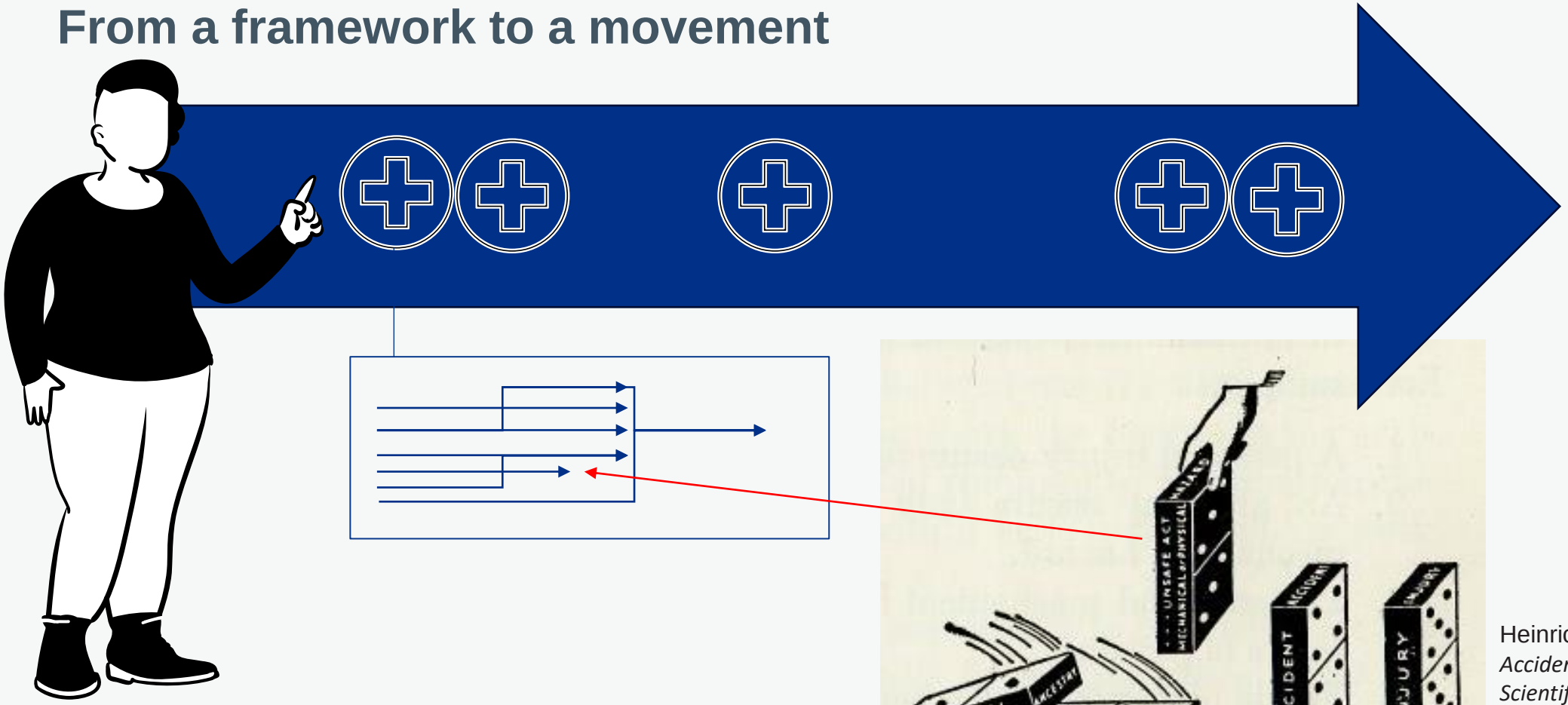

Heinrich, H. (1941) *Industrial Accident Prevention: A Scientific Approach.* Second Edition. New York, McGraw-Hill Book Company.

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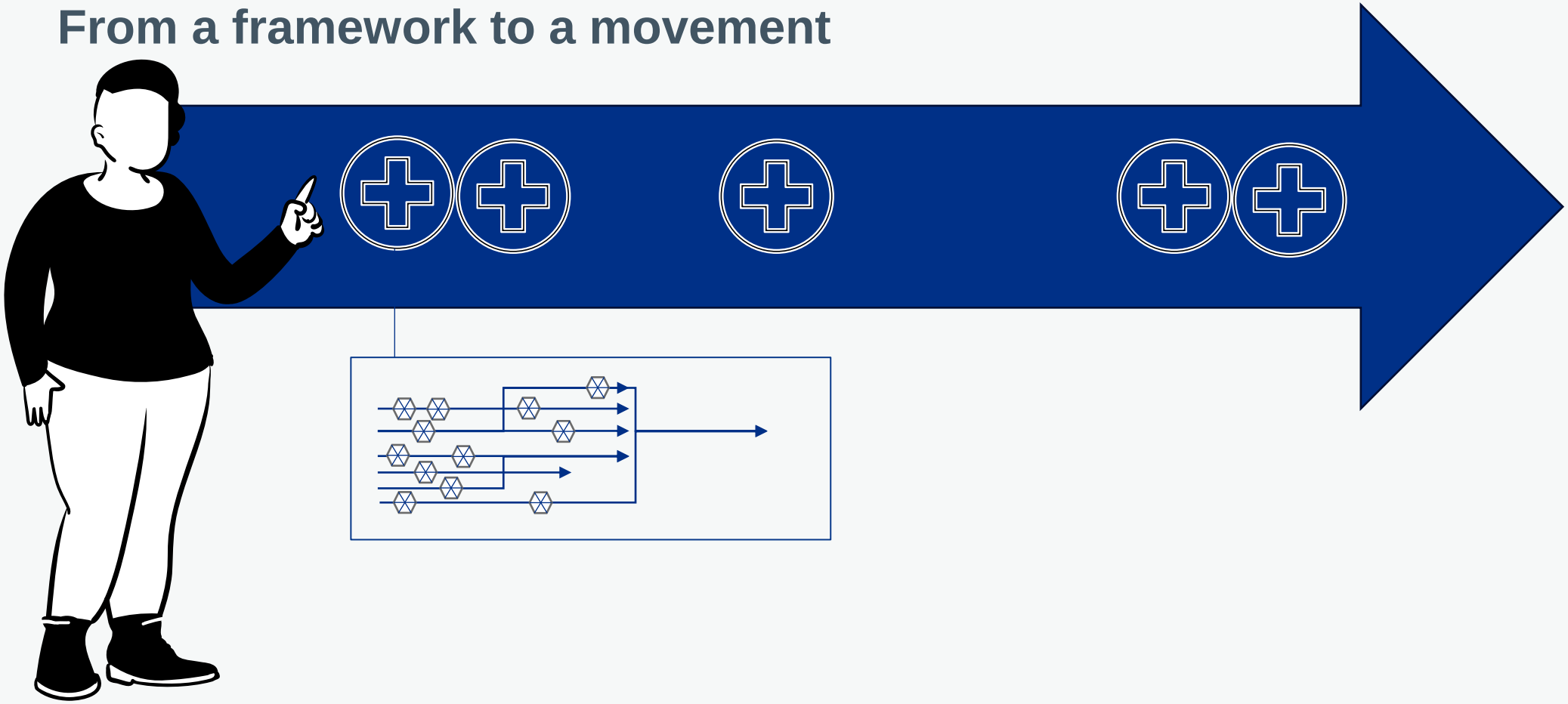
Systems based approaches

How is the approach different?

Fixed range of human capabilities and functioning

Audit’s role

From a framework to a movement



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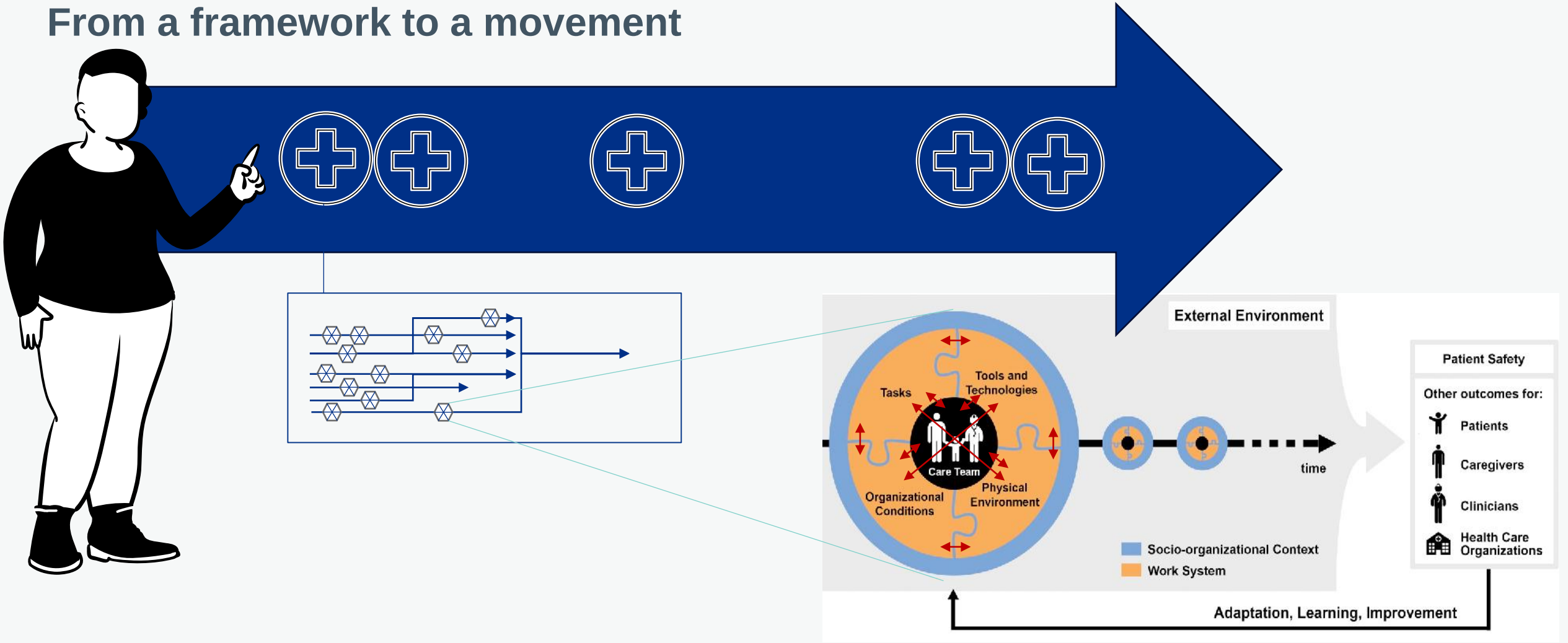

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Audit's role

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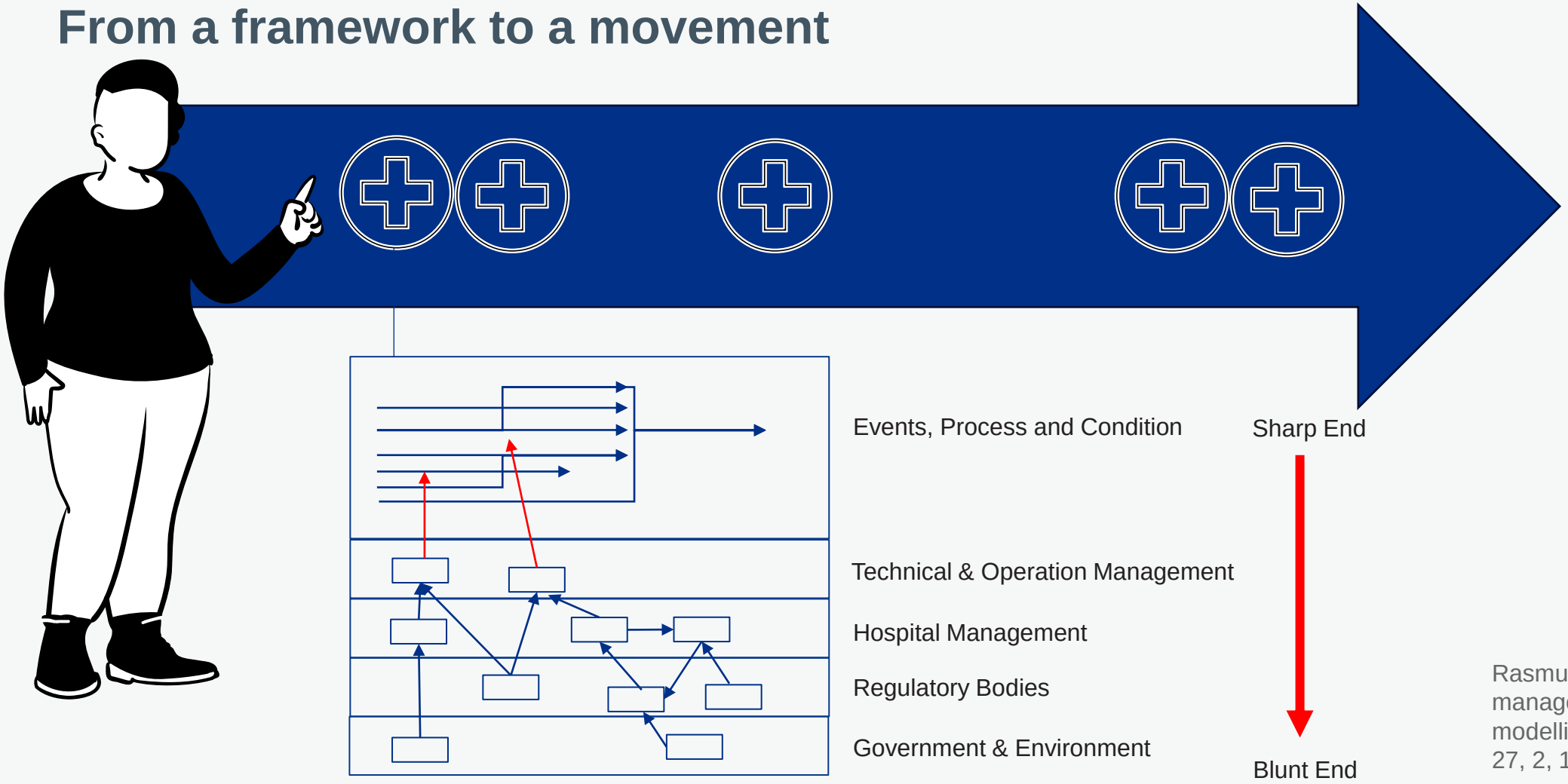

Rasmussen, J. (1997) Risk management in a dynamic society: a modelling problem. Safety Science, 27, 2, 183-213.

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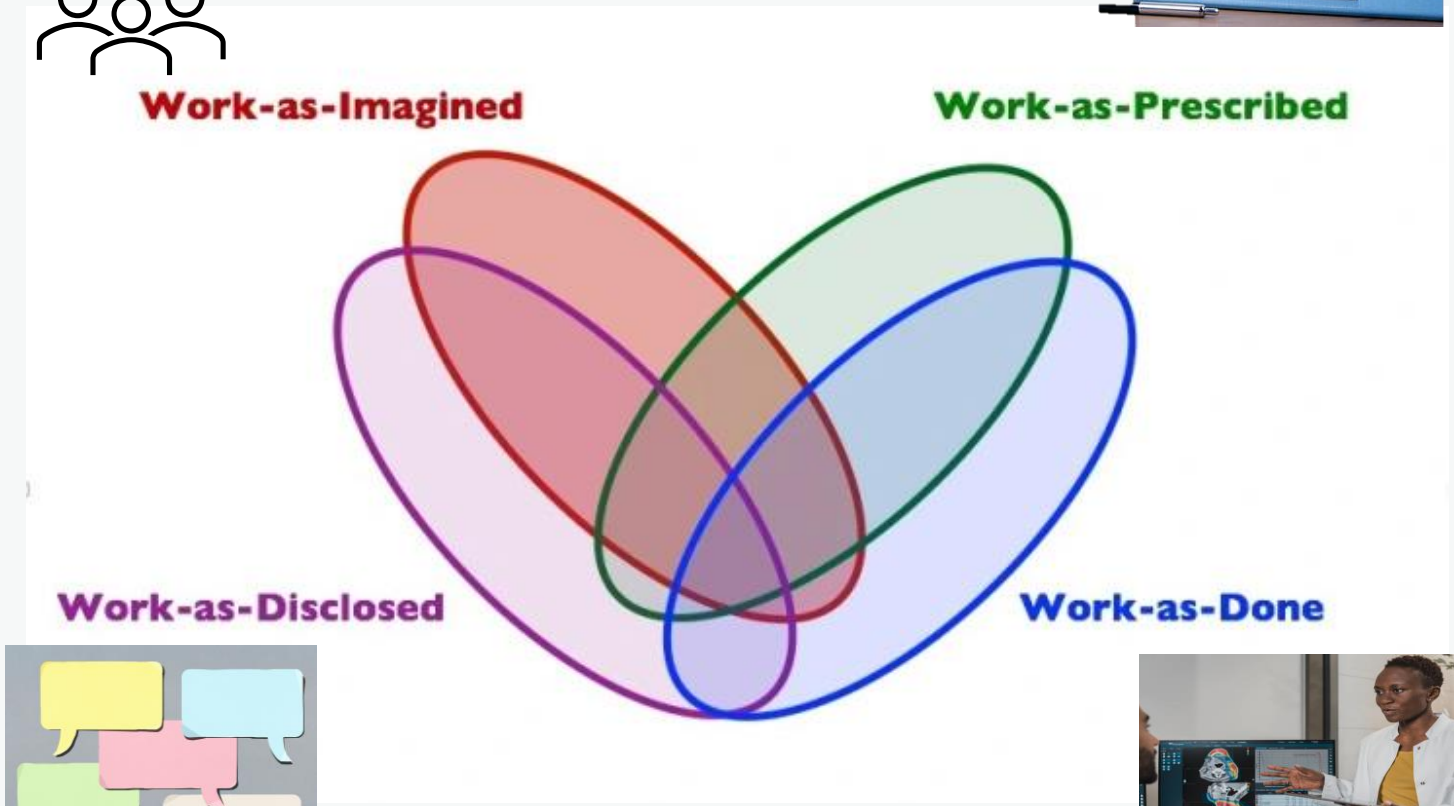
Work-as-Done

- Gap between types of work
- Adaptions can be the resilience to make healthcare function
- Disclosure of drivers and barriers
- Operational know-how

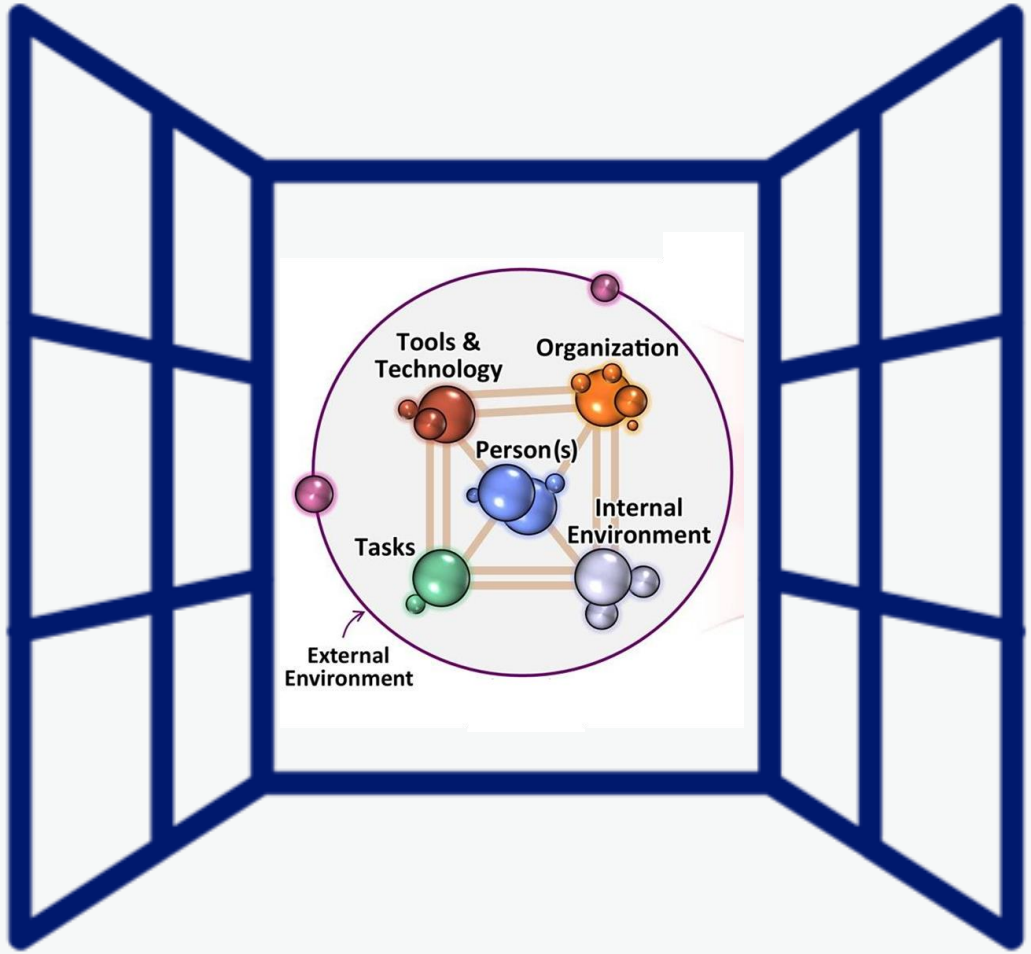


Shorrock, S. (2016) The Varieties of Human Work – Humanistic Systems. Available from: https://humanisticsystems.com/2016/12/05/the-varieties-of-human-work/ (Accessed: 2 February 2022).

Systems based approaches

How is the approach different?

- Uses incidents as a ‘window on the system’
- Recognises safety arises from interactions and not from a single component as such learning does not focus on uncovering a (root) cause, but instead explores multiple contributory factors
- Emphasis on exploring everyday work shifts the focus from developing quick fixes to understanding wider system influences



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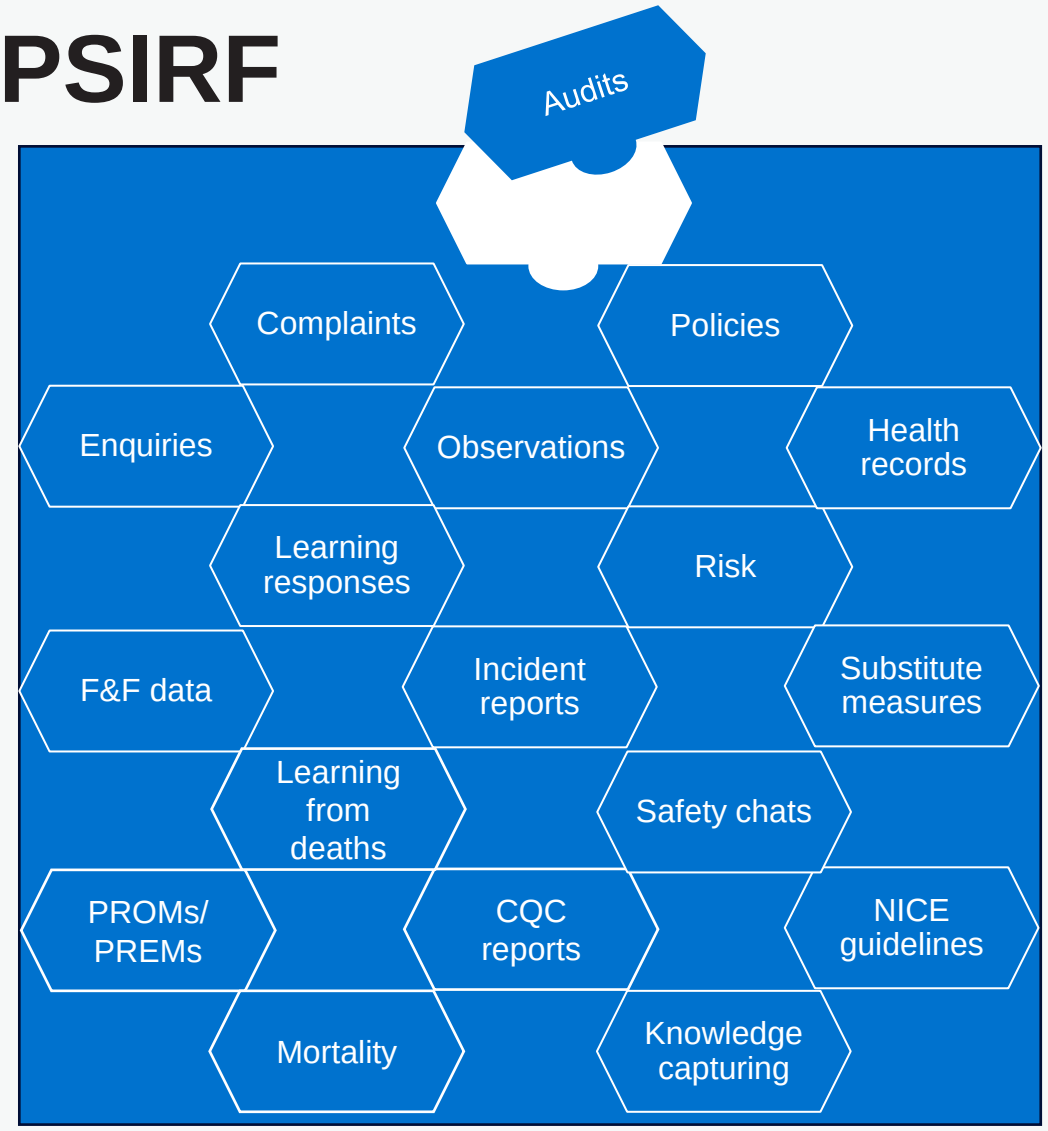
Clinical Audit

Make your mark

PSIRF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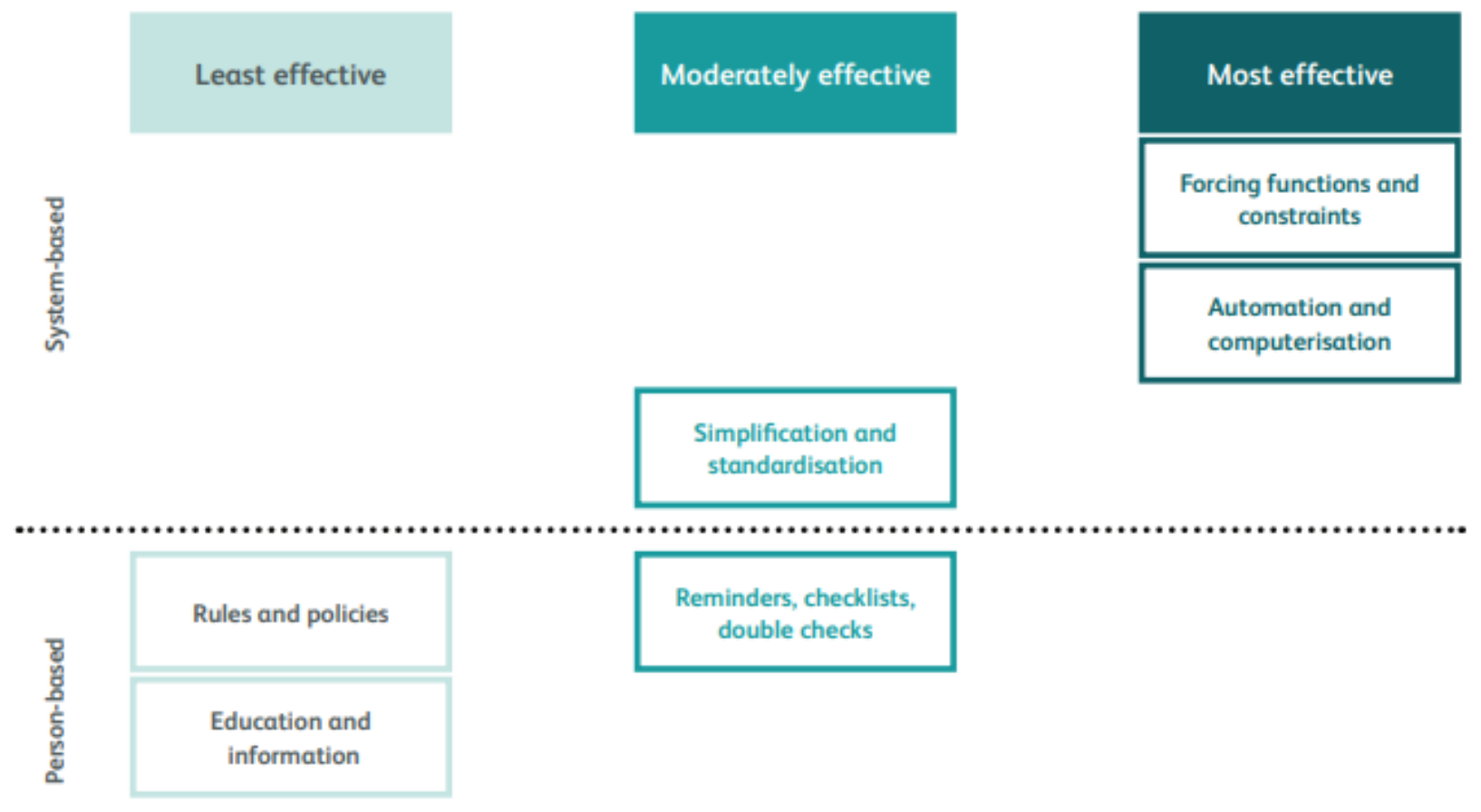
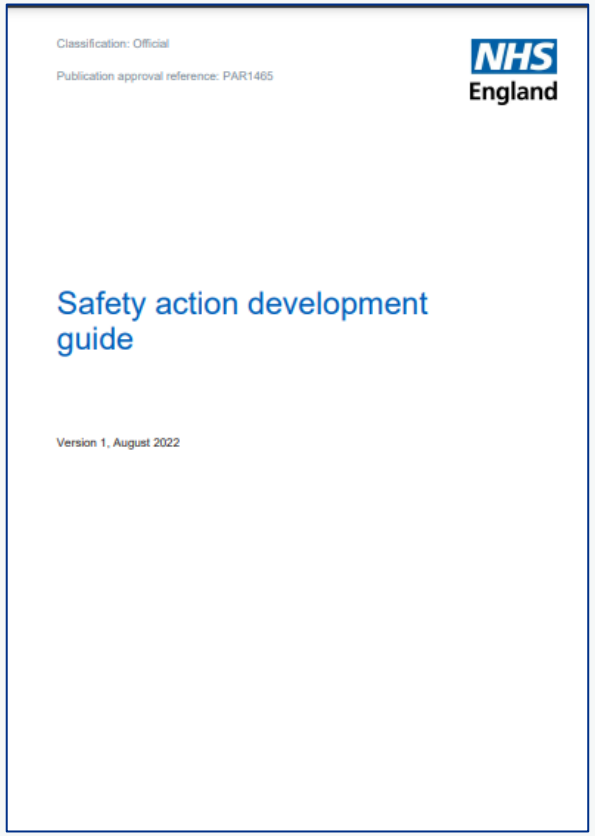
Learning responses
Improving

Hierarchy of Effectiveness



Taken from: Weaver, S., Stewart, K. & Kay, L. (2021) Systems-based investigation of patient safety incidents. Future healthcare journal. [Online] 8 (3), e593–e597. Available from: doi:10.7861/fhj.2021-0147.

Improvement


Classification: Official

Publication approval reference: PAR1465

NHS England

Safety action development guide

Version 1, August 2022

Table 1: Overview of safety action development according to context

	Local context	Organisation context
Definition	Specific area for improvement highlighted by a single (or multiple) learning responses	Broader area for improvement identified across several learning responses – likely not in response to any single patient safety incident but incidents with common contributory factors across events. Likely require radical system redesign
Examples of areas that may require improvement	Environment layout and characteristics (eg light, noise) Tool design Task design Training	Deep routed organisational issues, likely with long histories and dynamics, eg: • Staffing, rotas, etc • IT infrastructure • Workload • Fatigue • Culture • Handovers • Procurement • Policies
Development team	Learning response team Involvement of local team to design and implement Quality improvement team Those affected by the incident	Learning response team Involvement of local **and** broader team to design and implement (eg leadership, management) Quality improvement team Those affected by the incident
Tools	SEIPS/HFIX (see Appendix A) iFACES (see Table 3)	
Methods for developing safety action	Interviews Observations Focus groups Desktop reviews Simulation/testing Standards quality improvement methods such as PDSA cycles	Qualitative review of patient safety learning response findings Surveys Literature reviews – what has worked well elsewhere? Focus groups Consensus panel – reaches a wider group of members with experience of work
Expectation for recording	Included in learning response report (eg patient safety incident investigation (PSII) report) after an individual incident response or in wider safety improvement plan as appropriate.	Included in a safety improvement plan bringing together findings from various responses

Area for improvement		Set out where improvement is needed
Work system	Person(s)	How **can individual or team characteristics** be modified or changed to reduce risk or improve performance?
	Tasks	How can the **task or activity** be modified or redesigned to reduce risk or improve performance?
	Tools and technology	How can **tools, equipment or technology** be modified or redesigned to reduce risk or improve performance?
	Internal environment	How can the **physical environment** be modified or redesigned to reduce risk or improve performance?
	Organisation	How can **organisational factors** be modified or redesigned to reduce risk or improve performance?
	External environment	How can **regulatory or societal factors** be modified or redesigned to reduce risk or improve performance?

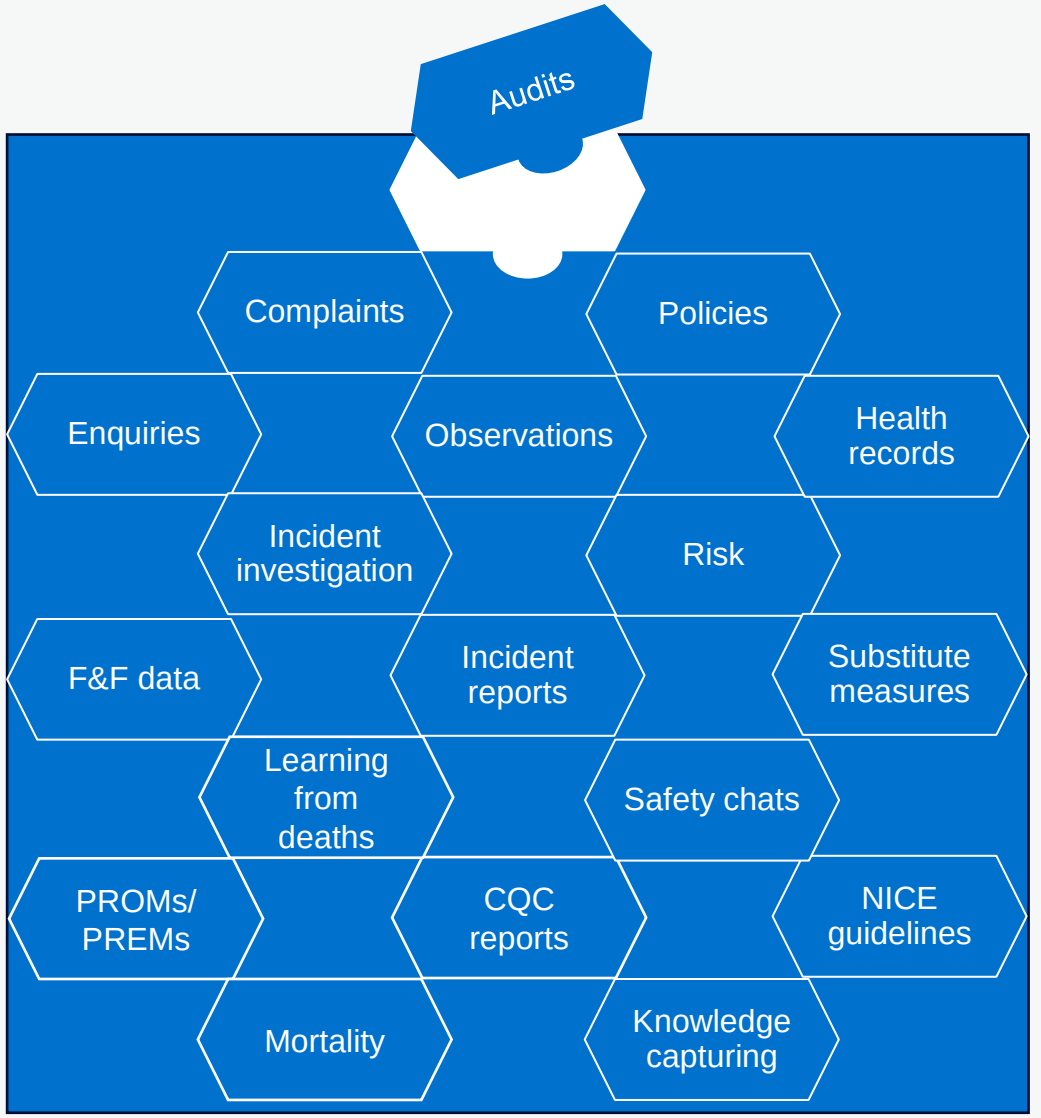
Table 3: iFACES criteria and scoring rubric

Criterion	Low (1)	(2)	Medium (3)	(4)	High (5)
Inequality Does the intervention ensure fair treatment and opportunity for all?	The intervention is not accessible to the diverse population that will use it.		The intervention accommodates some inequalities but further investigation is needed.		Inequalities are reduced by this intervention.
Feasibility Can the change be implemented relatively easily or quickly?	The intervention does not exist today nor is it likely to become available in the near future; it is highly impractical and not suitable for your organisation.		The intervention exists but is not readily available or will require modifications to better fit the context in which it is intended to be used.		The intervention is readily available and could be implemented in a relatively short period of time without much effort.
Acceptability Will those being impacted by the intervention readily accept the change?	The intervention will not be tolerated by those it impacts. People are likely to consistently resist the change and attempt to work around the change.		The intervention will be tolerated by those it impacts. There may be moderate resistance but attempts to undermine the change will not be wide spread.		The intervention will be readily accepted by those it impacts. People are likely to welcome the change and make every attempt to ensure it works.
Cost/Benefit Does the benefit of the intervention outweigh the costs?	The cost of the intervention is exorbitant relative to its minimal expected impact on safety and performance.		The intervention is moderately expensive but cost could be justified by its expected benefit. Return on investment (benefits) is relatively equal to cost.		The cost of the intervention is nominal relative to the expected impact on safety and performance.
Effectiveness How effective will the intervention be at eliminating the problem or reducing its consequences	The intervention will not directly eliminate the problem or hazard and it relied heavily on wilful compliance with the change and/or requires humans to remember to perform the task correctly.		The intervention reduces the likelihood of the problem or hazard occurring but relies in part on human memory and/or wilful compliance with the change.		The intervention will very likely eliminate the problem or hazard and it does not rely on wilful compliance with the change or require humans to remember to perform the task correctly.
Sustainability How well will the intervention last over time	The impact of the intervention will diminish rapidly after it is deployed and/or will require extraordinary effort to keep it working.		The benefits of the intervention may have a tendency to slowly dissipate over time and will require moderate efforts to maintain its benefits.		The impact of the intervention will persist over time with minimal efforts being required to maintain its benefits.

NHSE. (2022) Safety action development guide V1.1
Available at: https://www.england.nhs.uk/wp-content/uploads/2022/08/B1465-Safety-action-development-v1.1.pdf (Accessed 23/11/2022)

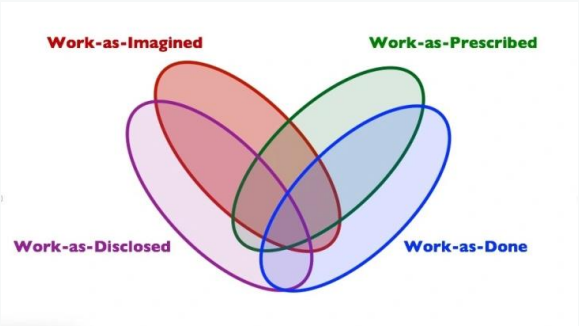
Clinical Audit

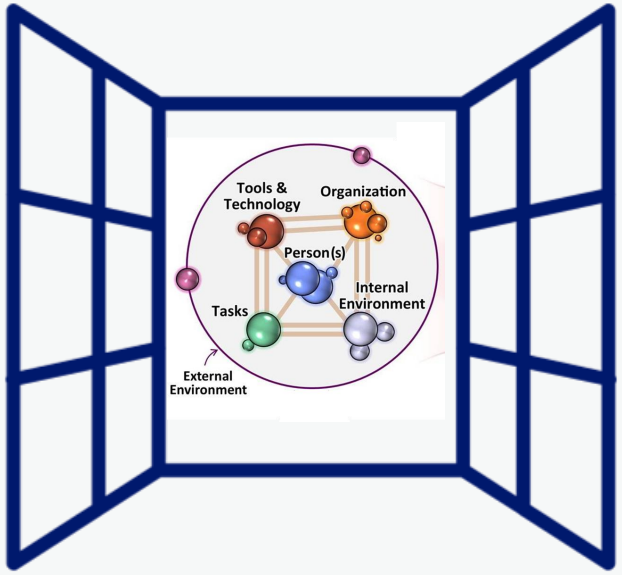
1. Audit can inform the safety profile of an organisation and PSIR planning

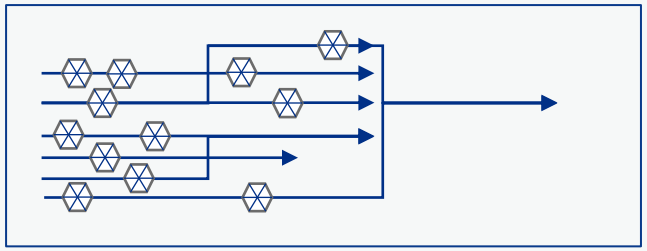


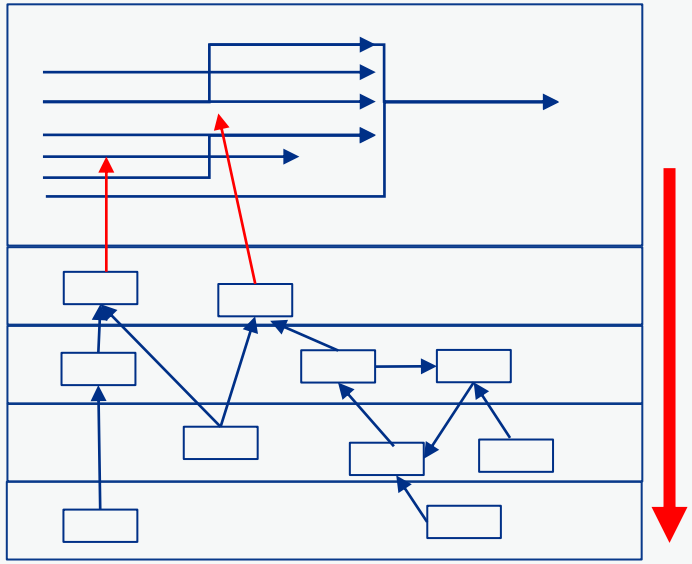
Clinical Audit

1. Audit can inform the safety profile of an organisation and PSIR planning
2. PSIR and PSIRF can be used to understand better what audit is highlighting (PSIRF toolkit)









Clinical Audit

1. Audit can inform the safety profile of an organisation and PSIR planning
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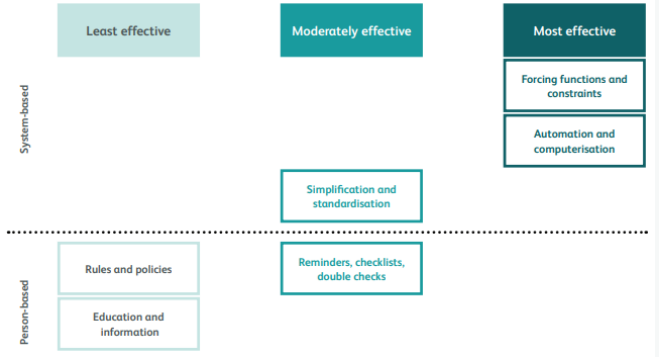
3. PSIR focus on effective improvement rather than response (PSIRF toolkit)
4. Audit can be used throughout PSIR

HFIX & iFACES



PSIRF

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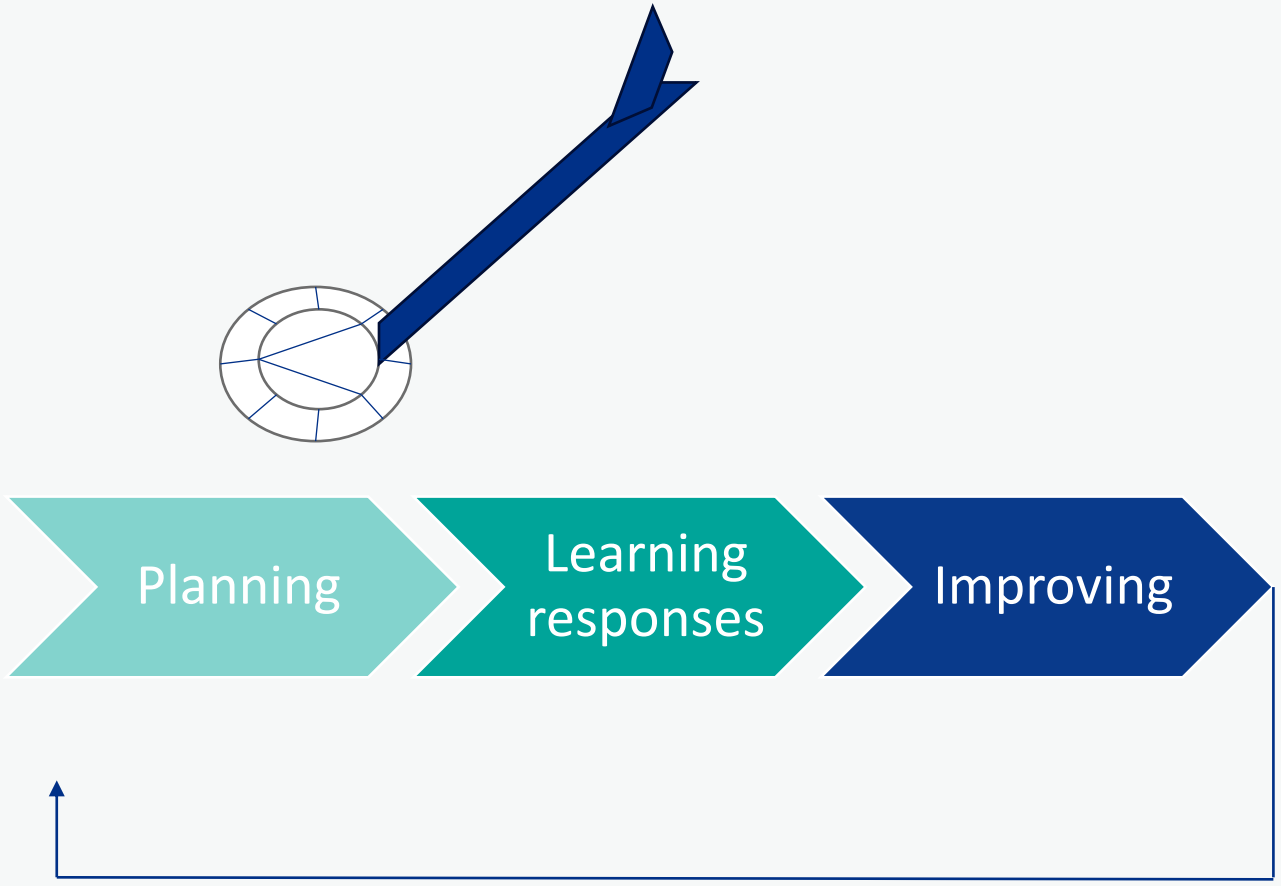

Rachel.pool2@nhs.net
Head of Patient Safety Implementation

Thank You

@ptsafetyNHS

https://www.england.nhs.uk/patient-safety/incident-response-framework/

CLINICAL AUDIT AWARENESS WEEK 2024

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

HQIP
Healthcare Quality Improvement Partnership

PATIENT SAFETY

And the winners are...

#CAAW24

INFLUENCING CHANGE

Highly Commended

Gastroenterology Department Sandwell and West Birmingham NHS Trust

NHS
Sandwell and West Birmingham
NHS Trust

INFLUENCING CHANGE

And the winners are...

Northumbria Parkinsons Disease QIP Team
Northumbria Healthcare NHS Foundation Trust

NHS
Northumbria Healthcare
NHS Foundation Trust

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THE NORTHUMBRIA WAY
PEOPLE CARING FOR PEOPLE

Healthcare Quality Improvement Partnership Clinical Audit Heroes Award 2024

Dr James Fisher (on behalf of the Northumbria Parkinson's Disease QIP team)

The Northumbria Parkinson's QIP Team

Dr. James Fisher, Consultant Geriatrician

Amanda Gordon, Practice Development Lead

Rachel Carter, Director of Patient Safety

Amber Cruddos, Practice Development Nurse

Suzanne Herkes, Patient Safety Improvement Facilitator

Charlotte Scott, Senior Clinical Pharmacist

Rachel Magee, Speech & Language Therapist

Elaine Bolam, Speech & Language Therapist

Michael Hardy, Pharmacy Technician Team Leader (Informatics)

Dr. Giovanni Di Paolo, Internal Medicine Trainee

Callum Brown, Improvement Facilitator, Patient Safety and Improvement Team

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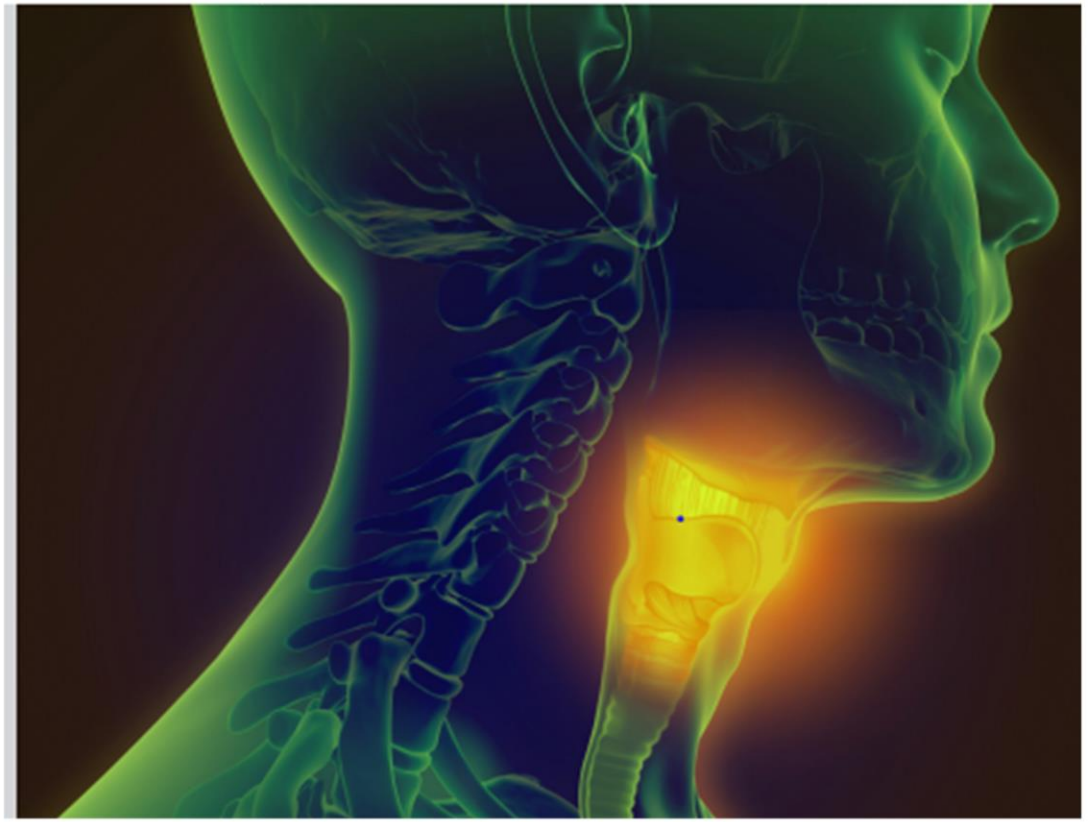
NHS Foundation Trust

Why Parkinson's?

Hard to Swallow?

A review of the quality of dysphagia care provided to patients with Parkinson's disease aged 16 years and over who were admitted to hospital when acutely unwell



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NCEPOD

Aims & Objectives

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- To reduce delays in time critical medications
  - Eradicate delays in administration of Parkinson's (PD) medicines of over 60 minutes
  - Ensure that 95% of PD medicines are administered within 30 minutes

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NHS Foundation Trust

PART 1: THE FIRST 24-48 HOURS AS IN-PATIENT

Confirm their medicine regime	Ask the patient and their relatives what they take and when
	Refer to most recent information - clinic letter, repeat prescription or discharge summary
Get the medicines in **on time**	When was the last dose given? When is the next dose due? Ensure handover to colleagues
	Zero tolerance for missed meds - they are always available - consult Omniview / on-call pharmacist
Think swallow for **all** patients	Can they swallow food, fluids and their medicines?
	Ask for an early ward-based swallow assessment for all patients and then, if indicated, a speech and language therapy (SaLT) review.
What to do if nil by mouth?	Don't let patients miss their medications: suddenly stopping them can be life-threatening
	Use our non-oral medication calculator to determine dose / route required: pdmedcalc.co.uk
Being proactive	Aim to sit the patient out of bed or, at the very least, up in bed (to reduce risk of pneumonia)
	Early referral to physiotherapy
	Ensure bowels are working - constipation very commonly causes worsening PD symptoms
Avoid culprit drugs	These include: haloperidol, metoclopramide, prochlorperazine
Let us know they are an in-patient	Contact the PD team on 0191 2934167 or parkinsons@northumbria-healthcare.nhs.uk
	Leave a message if there is no one available and we will get back to you

Staff Nurses	Junior Doctors	Pharmacists and Pharmacy Tech
Advanced Care Practitioners	Nutritional Assistants	Speech & Language Therapists
Physicians' Associates	Ward Managers	Ward Sisters
Healthcare Assistants	Trainee Nursing Assistants	Consultants & Registrars

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172 staff trained across 3 wards


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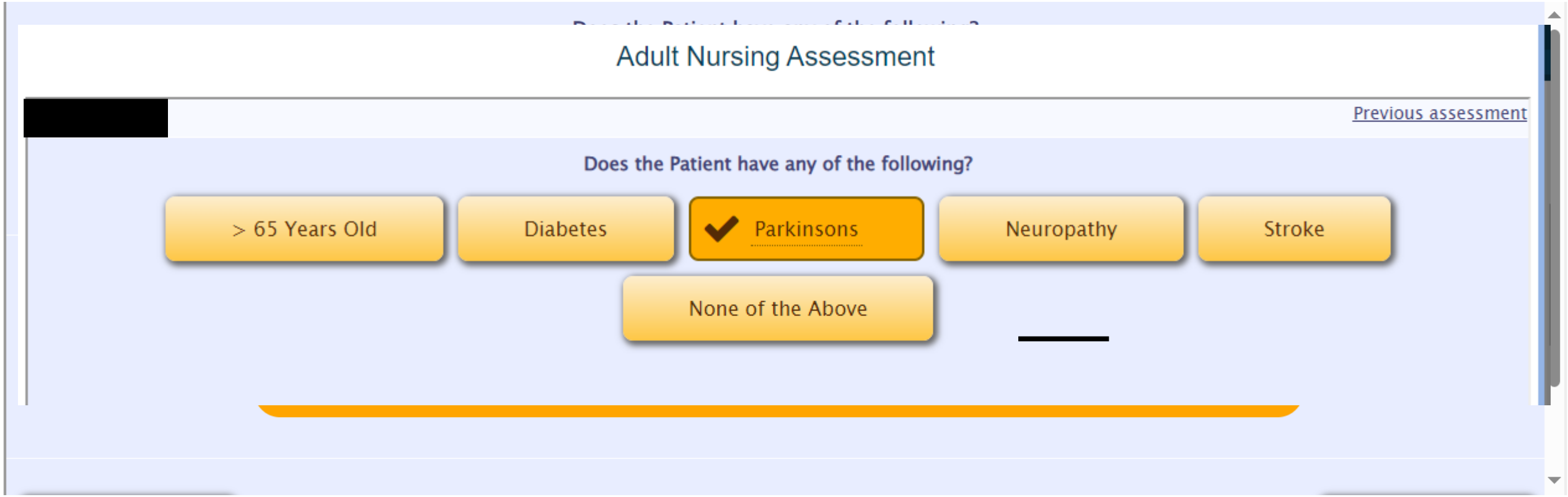
NHS Foundation Trust
Parkinsons think medication!
Get it on time
Zero tolerance for missed meds
Think swallow
Contact the PD team
Search 'Parkinsons' on the staff portal to find out more


Adult Nursing Assessment
[redacted]
Previous assessment
Does the Patient have any of the following?
> 65 Years Old
Diabetes
Parkinsons
Neuropathy
Stroke
None of the Above

pdmedcalc.co.uk

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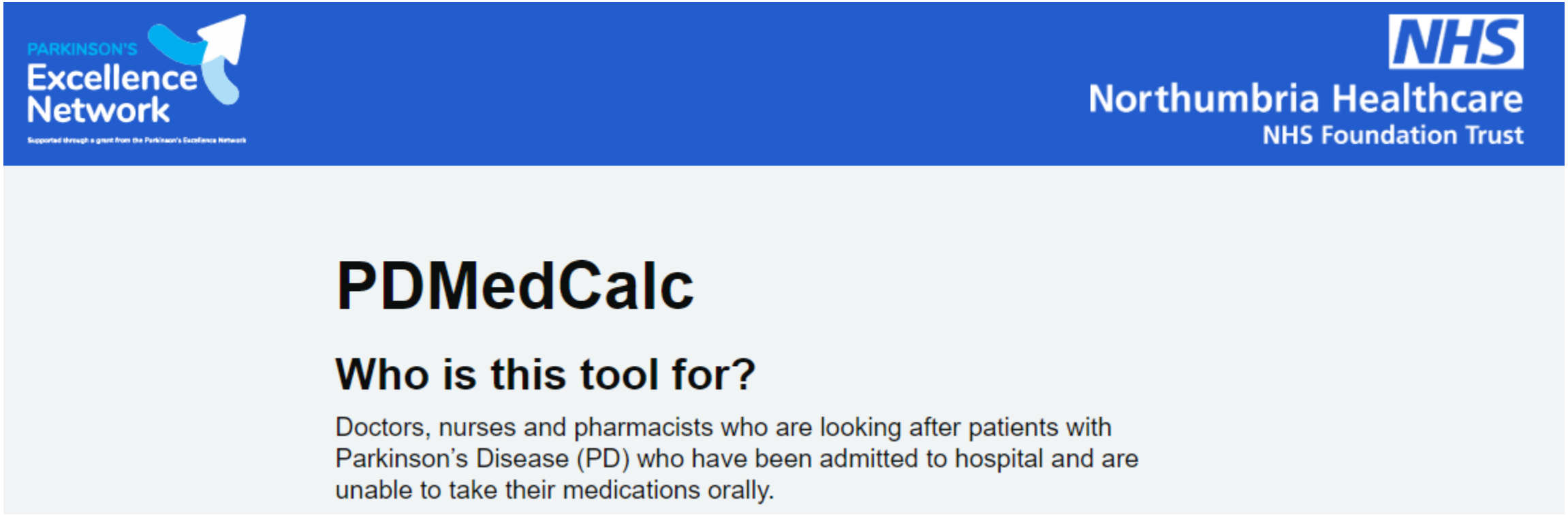

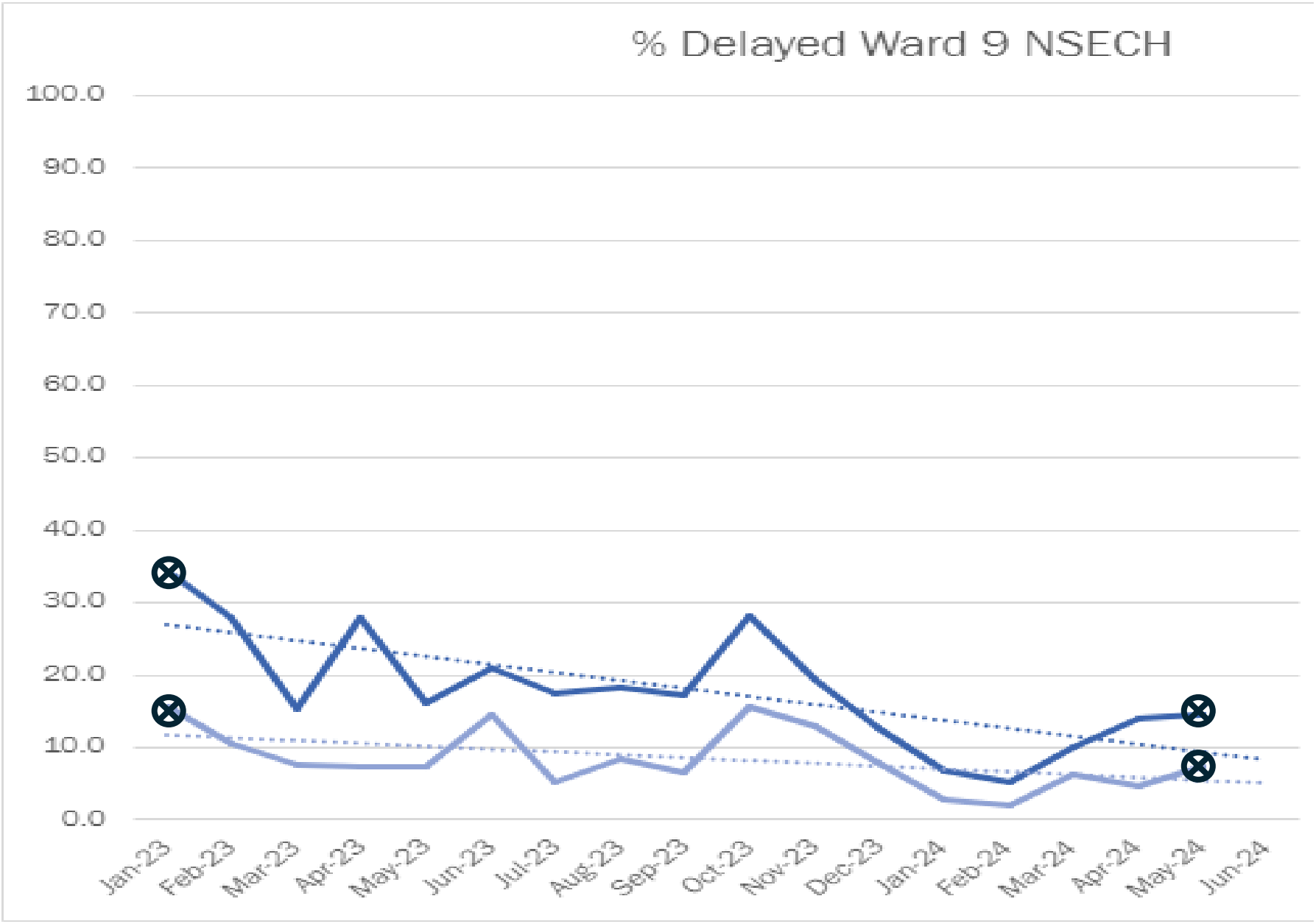
% Delayed Ward 9 NSECH
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80.0
70.0
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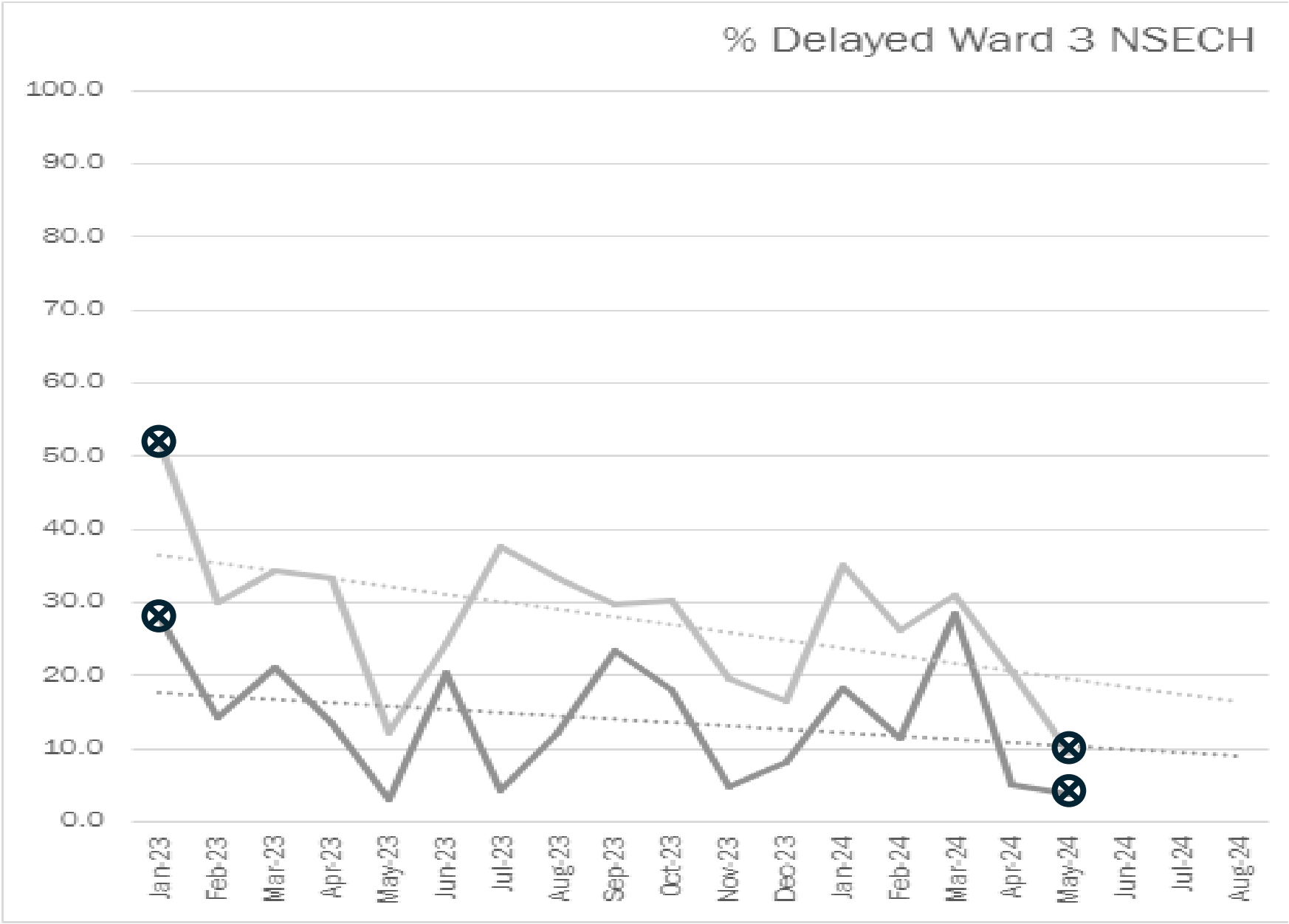
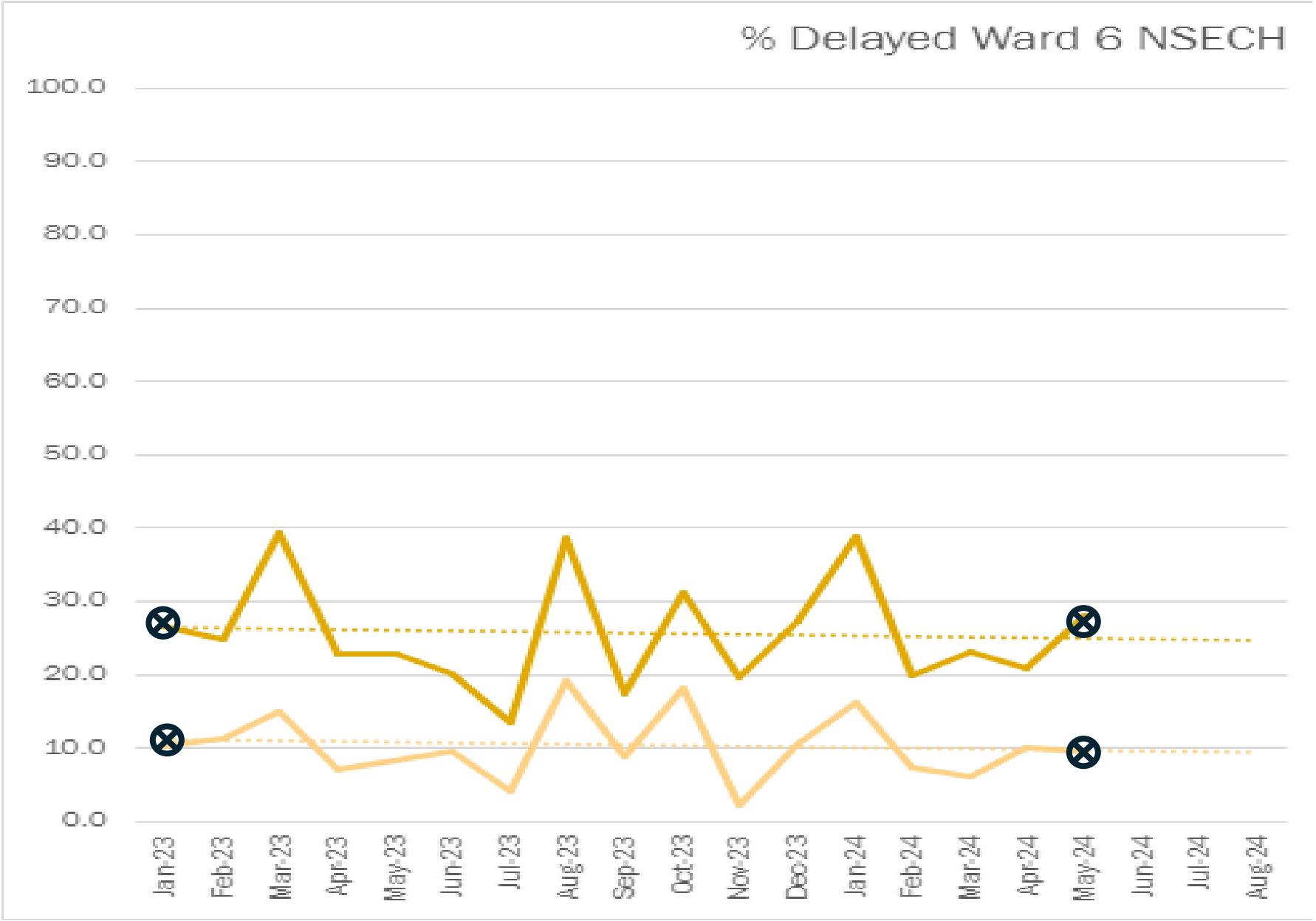


Northumbria Healthcare
NHS Foundation Trust


% Delayed Ward 6 NSECH
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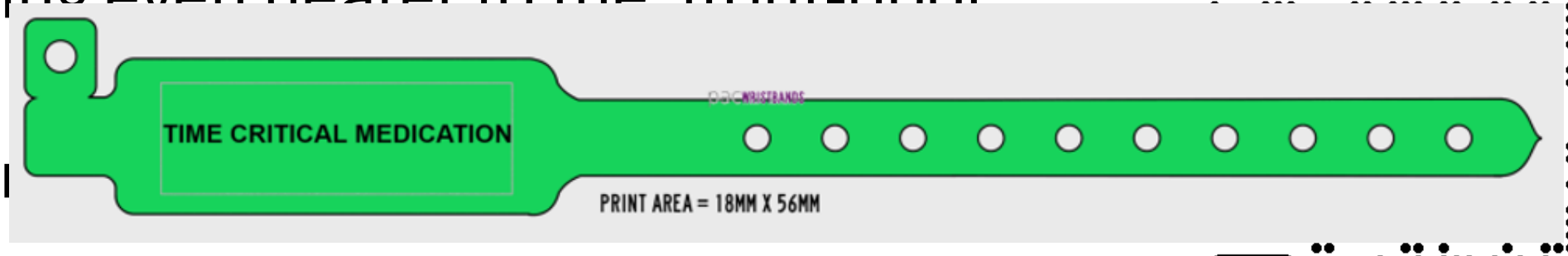
Aug-24

What next?

- Time critical medicine wrist-band
- Pushing even nearer to the ‘front-door’
- Parki
- Microteaching part 2



Lessons to share

- Harness the power of patient experience to win hearts and minds
- Micro-teaching, macro-impact!
- Embedding learning in the workplace
- Tech solutions offer potential, but pain… get expert help early!

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Thank you

James.Fisher@nhct.nhs.uk

pdmedcalc.co.uk

Clinical Audit Awareness Week #CAAW24

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

Opportunity for questions

Clinical Audit Awareness Week #CAAW24

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EVALUATION – MENTI

Your feedback is important to us

Please take a couple of minutes to complete our evaluation form

Part of Clinical Audit Awareness Week 2024, featuring the Clinical Audit Heroes awards

Evaluation

Who is YOUR Audit Hero?

#CAAW24

Clinical Audit Awareness Week #CAAW24

HQIP Healthcare Quality Improvement Partnership

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

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 Patient & Public Involvement

Who is YOUR Audit Hero? Nqican.org.uk www.hqip.org.uk/clinical-audit-awareness-week #CAAW24