



RMAG editorial



Someone once said "nothing endures but change" and it is certainly a time of change throughout the HPSS. This applies equally to the organisation of Regional

Audit; so sadly, you are reading the last edition of Gleanings in its present form. In April a new regional audit and guidelines group is to be established through the merger of RMAG, CREST and NIRAAC. This is a planned and logical evolution in as much as guidelines and audit are two sides of the same 'quality' coin.

RMAG was a product of its time. In the early 90's there was clinical audit, which essentially meant that only doctors were involved in evaluating their own practice. The realisation that

delivery of good quality health and social care was a collaborative business lead to the development of a multiprofessional approach to audit. The early role of RMAG was to promote a culture of curiosity among all the professions by funding local, multidisciplinary, Trust based projects. This eventually led to the establishment of a comprehensive audit infrastructure throughout the province.

As audit became a routine element of day-to-day work, in recent years RMAG has focused on funding large regional projects. Dissemination of good practice is also important hence the introduction of Gleanings and the annual audit conference in 1995. This is the 19th edition of Gleanings and RMAG has funded and mentored almost 400 audit projects, many of which have been aired in this magazine.

RMAG has evolved from early meetings attended by a few interested individuals to a large representative group supported by a full time facilitator. All of these facilitators have moved on to greater and better things but without Paddie Blaney, Eleanor Hayes, Trevor Fleming, Irene Daly and Nicola Porter the group would not have had the same impact. Throughout its life RMAG has also enjoyed the support of committed professionals who gave their time, enthusiasm and expertise in equal measure.

I am sure that activities such as the regional database, the conference, Gleanings and the systematic commissioning of regional projects will continue in some form but I would wish to take this opportunity to thank all of those who have over the years contributed to the work of RMAG.

Professor Robin Davidson
Chairman

CREST editorial



20 health care professionals from the health service in Northern Ireland with an active interest in promoting clinical efficiency. The Chairman is

Dr David Stewart, Director of Public Health, Eastern Health and Social Services Board, Belfast.

In pursuing its work the medical profession in Northern Ireland is invited to suggest specific target areas and CREST then operates by commissioning small sub - groups or task forces to address agreed topics.

2006 has been an extremely busy year for CREST with three major launches,

seven publications and a further two publications before March 2007.

CREST would like to thank all the health care professionals who assisted with the sub-groups and all those who contributed in anyway to the development and production of CREST guidelines.

CREST has launched seven reports to date in 2006:

- Guidelines for Investigation and Management of Transient Ischaemic Attack
- Crest Guidelines for the Prevention of Infection and Decontamination of Respiratory Equipment in Northern Ireland
- Guidelines for the Diagnosis and Management of Coeliac Disease in Adults
- Cardiac Rehabilitation in Northern Ireland

- Chronic Kidney Disease in Northern Ireland
- Safe & Effective Use of Insulin on Secondary Care: Recommendations for Treating Hyperglycaemia in Adults
- Protocol for the Inter-Hospital Transfer of Patients and their Records

CREST has also agreed to address the following topics in the coming year:

- Management of Hypertension
- Better Use Of Blood In Northern Ireland
- Getting Evidence into Practice
- Lymphoedema Services
- Use of Laboratory Facilities
- Management of Chronic Pain

David Stewart
Chair of CREST

Northern Ireland Regional Audit Advisory Committee



The Regional Audit Committee was established in 1989 following an initiative by the Chief and Deputy Chief Medical Officers, Dr James McKenna and Dr Philip McClements. It was felt that existing structures of proven ability should be used to house the Committee which was set up as part of the Postgraduate Council for Medical and Dental Education, with the specific remit to oversee the introduction of medical audit. The first meeting to discuss the introduction of audit was held at the Council offices in Annadale Avenue, Belfast, on Wednesday 18th January 1989 with Prof RW Stout, Dr TT Fulton, Dr JR Hayes, Dr TJ Robinson, Dr JR McCluggage and Miss ML Roberts. The Committee considered the recommendations of the Royal College of Physicians on medical audit. It was decided to contact all College Tutors and Chairmen of Medical Staffs to request their advice and assistance. The educational aspect of audit was emphasised and it was thought better to concentrate on process audit rather than outcome audit. It was agreed to use a proforma to audit case notes and to ask the President of the RCP, Sir Raymond Hoffenberg, if he would be prepared to give a lecture on audit.

The first meeting of the Northern Ireland Audit Advisory Committee (NIRAAC) was held on the 14th September 1989 under the Chairmanship of Mr Derek Gordon, as Chairman of Postgraduate Council. Mr Gordon referred to the recent White Paper on NHS Reform and in particular working paper 6, drafted by Dr McClements, which defined medical audit. Requirements for setting up a

system of medical audit were considered to include allocated time for audit, data protection, an increase in staffing at consultant level, regional diagnostic indices, computerised discharge letters and clerical support. It was felt, in time, that medical audit should be evaluated to determine if it had improved patient care. The terms of reference of NIRAAC were set out as:

- 1 To advise on and support the development of audit across Northern Ireland.
- 2 To organise audit of the smaller specialties on a regional basis in order to facilitate peer review and to maintain the confidentiality of results.
- 3 To arrange for Clinicians to undertake external peer review of particular problem services in Boards.

Further it was felt that audit would need to be formalised in the job description for Consultants and the profession would need secretarial and other resources to undertake audit. Audit for individual specialties was to be considered by the Specialty Advisory Committees (SAC) with audit offices set up at Area level with specific funding for audit. The important question of what power audit committees would have if poor performance was identified was raised. Peer pressure was considered effective in initially ensuring poor performance would be managed. By the second meeting in December 1989, SAC Surgery had devised a diagnostic index applicable across the Province. A list of smaller specialties had been identified and pilot projects in audit were being considered for funding. The concept of audit as educational versus audit as a management exercise engaged the committee. The Professor of Pathology suggested the autopsy rate needed to increase threefold to allow validation of causes of death. Audit in General Practice was proposed. The committee considered 'criterion based' audit was the most effective method of audit and funding for audit resources was allocated to Health Boards from the Department. The original budget was £60,000, which released two Regional GP Facilitators, Dr Terry McGowan and Dr Stephen Garvin, and paid the costs of new regional audit projects.

At this early stage discussions included how to involve other health care professionals in audit, particularly as they did not have any corresponding audit committees.

By the third meeting in January 1990 criterion based audit was considered the way forward. However the Belfast City Hospital Medical Division required to be convinced that this was a valuable exercise! In order to assist a better understanding, a training day was set up for March and Dr Charles Shaw from the Kings Fund and Ms Nancy Dixon from Wessex Regional Health Authority and Mr Stephen Nixon from Lothian Health Authority were invited to speak. This was the start of a long and successful association between Nancy Dixon and audit in Northern Ireland.

By the fourth meeting in May 1990, four Area audit committees were in existence and the Area Audit Committee Chairmen became members of the Regional committee. The Southern, Western and Eastern Boards were making good progress, in that Hospital audit committees had been established and hospital coordinators identified. The Eastern Board produced a quarterly newsletter! The Northern Board however had not made as much progress, as the staff of the Waveney Hospital had rejected the idea of a hospital audit committee and was putting its efforts into specialty-based audit. Here for the first time the idea of setting aside a free afternoon for audit alone was suggested. Audit in principle was accepted by general practice but there was considerable anxiety as to how GPs would find time to participate in audit. Another 'audit day' training session was suggested for the autumn.

By the fifth meeting in October 1990 an audit symposium was organised in the Belfast City Hospital for November of that year. Hospital audit coordinators were being appointed and GP facilitators were being considered. Cross specialty audit was mentioned for the first time and the issue of confidentiality was being considered. Reports were received from Area Audit Chairmen. The National Confidential Enquiry into Perioperative Deaths report was discussed and representation was sought on the Clinical Standards Advisory Group.

The sixth meeting in January 1991 raised concerns that audit data might



be 'used' in disciplinary proceedings if a doctor was being investigated for underperformance. Confidentiality of audit data was again a concern especially to ensure no one patient could be identified. The subsequent meeting in March 1991 set up a training programme in audit methodologies, which was to continue for many years, and is still a subject of discussion today. The budget for audit was not considered sufficient and ways were discussed to improve electronic information access for medical audit. At this meeting the first of several audit reports on trauma in Northern Ireland was discussed.

At the Committee's eighth meeting in November 1991, the Chairman Mr Gordon stood down as the inaugural Chairman and was succeeded by Professor Gary Love. Issues of GP audit, confidentiality, audit in smaller specialties and training occupied proceedings. The first meeting of the Committee in April 1991 under Prof. Love formalised the constitution of the committee and started to look at the work of a Scottish group called the Clinical Resources and Audit Group (CRAG). Subsequent meetings built on previous work and explored the primary /

secondary care audit interface. By the meeting of 13th October 1991 trauma audit was developing well, the first stirrings of a Regional Audit Conference were discussed and audit reports were being pulled together and discussed with subsequent dissemination of best practice. The idea of audit priorities was raised and it was agreed the Committee should be more proactive in audit development. The Regional Audit Conference was well attended and highly successful. A meeting was held to inform Hospital Managers about medical audit, entitled 'Clinical Audit and the Manager', in November 1993 which was attended by 60 General Managers/Chief Executives and key professionals. By now Trust annual audit reports were well established running alongside Area Board reports. The first of the smaller specialties audit committee meetings was held and a wide range of reports were received. By the meeting in October 1994 there was clear rivalry between Trust Audit committees and Area Audit Committees with both producing audit reports. The meeting in April 1995 discussed a report entitled 'Development of Multi-Professional Audit in Northern Ireland' where it was argued cogently that audit should involve other members of the

health care team besides Doctors. The same meeting discussed CREST guidelines on blood transfusion, audits of which still continue to this day.

The meeting in October 1995 welcomed Ms Blaney to the meeting to discuss the development of the Northern Ireland Multi-Professional Audit Database, which for many years recorded audit information around the Province. This same meeting welcomed consumer opinion for the first time and Mrs Jane Graham from the Eastern Health and Social Services Council attended. At this meeting Professor Love was succeeded as Chairman by Dr Don Keegan. By now multi-professional audit was growing and many new projects were possible.

At the meeting in November 1996 discussion took place around the value of audit. Much money and time went into audit and the question was asked by the Committee whether this was time well spent. The multi-professional audit program, the regional audit database, the first of several intensive care audits and the continuing production

Northern Ireland Regional Audit Advisory Committee cont'd

of Trust audit reports went some way to answering this question. A generally agreed benefit of audit was the improvement in case notes. By May 1997 the Regional Audit Committee budget was initiating and supporting audits. Audits on continuity of care for hip replacement patients, an audit of the primary care / A&E interface, an audit of acute asthma, an audit of allergy diagnosis in Northern Ireland and an audit of shared care in cardiology were supported. The Regional Audit Database was up and running, well received and extensively used.

At the meeting in August 1998 the enquiry into cardiac surgery at Bristol was made public and the committee considered the implications for audit in Northern Ireland. The first discussion of Clinical Governance and Audit took place. Dr Keegan stepped down from the committee as Chairman at the meeting in January 2000 and was succeeded as Chairman by Dr Tom Trinick. There followed a debate on the interface between audit and clinical governance, which occupies the committee to this day and was concerned primarily with ways to improve the service for patients. By this time GP representation had fallen away and needed to be re-invigorated. There was also a need to have lay involvement in a formal way and indeed three representatives from the Health and Social Services Council attended the next meeting by invitation! The committee was keen to see critical incident reporting set up as a means of guiding possible audit requirements. Moves to set up a GP presence on the committee proved very successful and was helped by the strong Eastern Board GP audit group, which was starting to achieve change. A regional audit of thrombolysis time was being set up by Dr McCarthy and was supported by the committee. An audit of intensive care units was being established and an audit of minimally invasive surgery was set up across Trusts.

At its meeting in January 2001 a report was received on a neonatal intensive care audit which the committee had supported, a pilot critical incident reporting system was in place in the City Hospital, the thrombolysis audit and minimally invasive surgery projects were progressing. The committee expressed a strong desire to fund

CREST recommendations and agreed to fund a project from the British Thoracic Society, which examined the Thoracic Medicine service at the Belfast City Hospital. The committee funded a project on paediatric laparoscopic surgery. Other topics for audit included the areas of obesity, foot-care and diabetes. There was feedback from the smaller specialties audit committee, which met once a year to hear reports from smaller specialties and consider the unique audit requirements of this group. The Area Audit Committees were still in existence and were producing strong leadership for audit.

At the meeting in May 2001 the first mention of a rolling audit programme was made, following on from the Eastern Board initiative where a specific half-day a month was set aside for audit. This meant that all specialties audited at the same time and reduced time lost by lack of coordination of audit meetings. At the meeting in October 2001 the Southern and Northern Area Audit Committees were in the process of devolving responsibilities to their Trust committees. Issues of confidentiality, lay representation, GP attendance and training in audit were discussed. A Department of Health document entitled 'Best Practice Best Care' was first discussed and in time the committee made a detailed response.

By May 2002 the committee was starting to consider how it might best interface with RMAG and CREST and much discussion took place around this issue. The Committee was a strong supporter of the GP 'TARGET' programme of audit, which was very successful and was emulated in other Boards. The SALT (SHSSB), STEP (EHSSB), and TARGET projects (NHSSB) delivered significant improvements.

From 1st April 2004 the Northern Ireland Council for Medical and Dental Education was reconstituted as a special agency and was to be known as the Northern Ireland Medical and Dental Training Agency. In addition a review of audit arrangements in Northern Ireland was put in place with a reporting date of September 2004. Notwithstanding these changes, the work of the committee continued and the Northern Ireland Cancer Registry was supported in some of its important

audit work along with audit of the appropriateness of blood transfusion. At the January 2005 meeting Dr Mike Ryan presented his 'audit of audits' and set in place the suggestion that the quality of audits should be carefully examined. The Committee agreed but did not have the resources to do this. However at the same time the Eastern Board Audit Committee called for common training arrangements across the Province in audit, and this approach was commended by the Committee as an achievable approach to improving audit quality.

The review of audit arrangements in Northern Ireland, chaired by Dr David Stewart, was coming together with some conclusions emerging. These were clearly articulated by Dr Diane Corrigan:

- A single regional focus with leadership for audit, absorbing RMAG and NIRAAC.
- Trusts and Boards should review their internal systems.
- The development of a regional audit strategy.
- Clear processes to monitor the implementation of clinical and social care audit standards.
- Development of methods for dissemination of activity and results.

Regular updates were received by the Committee on RMAG, GP audit activity, dental audit activity and the Committee continued to support a wide range of audits, which were submitted annually.

Over the last 17 years there have been a number of recurring themes – a strong desire to improve patient care, a concern with patient confidentiality, a desire to cross professional boundaries and a desire to involve lay membership. Audits on cancer, trauma and on CREST recommendations recur regularly, with a commitment to closing the audit loop. It remains to thank all past members of this committee for their hard work over many years and hopefully this account of the committee will evoke pleasant memories of their deep involvement in creating medical audit in Northern Ireland. The significant successes of this committee have helped to create propitious circumstances for the new audit arrangements and new audit committee in April 2007 and we wish them every success.

The Impact of an Aide Memoir Sticker on Quality of Care in Fractured Neck of Femur

Introduction:

The Emergency Department (ED) management of patients with fractured neck of femur is an important area of care for emergency practitioners. A recent study concluded that patients with fractured neck of femur are at risk for underassessment of pain, considerable delays in analgesic administration after pain is identified, and treatment with inappropriate analgesics in the ED[1]. This area is under consistent review and the British Association of Emergency Medicine (BAEM) have set national standards concerning the following areas[2]:-

- Time from arrival to appropriate analgesia (mod/severe pain);
- Time to hip x-ray being performed;
- Adequate re-assessment of pain score;
- Time to admission to an orthopaedic ward.

Despite improvements in clinical practice, these standards have proved consistently difficult to attain.

Methods:

A simple aide memoir sticker was devised (Illustrated below) and placed on the ED flimsy of any patient with suspected fractured neck of femur at triage.

A retrospective review was performed of thirty consecutive patients with a diagnosis of fractured neck of femur in order to evaluate compliance with the use of the sticker and if its use helped to achieve the set standards. The results are tabulated as shown.

Results:

The sticker was present on only 50% of the flimsies reviewed.

Time from Arrival to Appropriate Analgesia

#NOF Sticker on Flimsy	Met Standard		Requires Review	
	No.	%	No.	%
Yes	7	46.7%	8	53.3%
No	10	66.7%	5	33.3%

Evidence of Re-evaluation of Analgesia

#NOF Sticker on Flimsy	Met Standard		Requires Review	
	No.	%	No.	%
Yes	10	66.7%	5	33.3%
No	2	13.3%	13	86.7%

PS...../10 @.....HRS
 Xray ordered @.....HRS
 Xray viewed @.....HRS
 PS Review...../10

Time to Hip X-ray

#NOF Sticker on Flimsy	Met Standard		Requires Review	
	No.	%	No.	%
Yes	12	80.0%	3	20.0%
No	8	53.3%	7	46.7%

Admission to Orthopaedic Ward within 4hrs

#NOF Sticker on Flimsy	Met Standard		Requires Review	
	No.	%	No.	%
Yes	14	93.3%	1	6.7%
No	10	66.7%	5	33.3%

Discussion:

The results illustrate that for the 30 cases reviewed the presence of a simple sticker resulted in a higher percentage of patients meeting the respective BAEM standards for fractured neck of femur care.

A higher percentage of patients had x-ray and orthopaedic admission within the appropriate timescale. This is of benefit to both the patient in terms of rapid placement in a specialist ward and to the overall flow in the Emergency Department. With the introduction of the four hour rule in the near future this is an area of particular interest.

Furthermore a higher percentage of patients had pain score and analgesia reviewed within the appropriate timescale. As the acute management of patients with fractured neck of femur involves examination and transfer to and from x-ray etc, the administration of appropriate analgesia and subsequent re-assessment of pain score is crucial. Studies have shown that analgesia in such patients is often inadequate [3], making review of analgesia essential to improving care.

No increase was shown in the area of time to appropriate analgesia. This is arguably the most important standard and consistent effort towards improvement should be made. One possible reason for failure to meet standards in this area is the delay

between patient arrival and time seen by a clinician.

In conclusion the results indicate that the use of a simple aide memoir sticker can significantly improve the quality of care provided to patients with fractured neck of femur in the Emergency Department.

References

- 1: J Am Geriatr Soc. 2006 Feb;54(2):270-5.
- 2: BAEM standards For Emergency Departments. 2006 Jan
- 3: Eur J Emerg Med. 2004 Dec;11(6):323-8.

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How NIPEC is developing practice and improving quality across the HPSS

NIPEC's statutory remit is to support the practice, education and professional development of nurses and midwives in order to provide the best nursing and midwifery in Northern Ireland. We do this by providing guidance, leadership and facilitation working in close partnership with various stakeholders from across the HPSS and other agencies at individual, team or organisational level.

In one of its three corporate areas, NIPEC promotes and supports practice and quality activities in order to ensure and improve patient and client care. This work is underpinned by NIPEC's Vision Statement for the Development of Practice www.nipec.n-i.nhs.uk/devofpracticedocuments.htm through a series of statements of intent.

The following projects are currently being progressed in conjunction with the above areas of work.

Organisational Guide to Practice and Quality Improvement

The aim of the Guide is to help create an organisational environment that promotes practice and quality development activities to support the delivery of safe and effective care. The Guide has been developed through an extensive programme of work in partnership with Trust Nurse Directors. The Guide outlines three key requirements of organisational readiness for practice and quality improvement activity; **People**, in this instance Professional Staff, **Infrastructure** to support effective practice and quality improvement, and **Systems** to inform, guide and monitor practice. The guide will be published in March 2007 on the NIPEC web-site www.nipec.n-i.nhs.uk/devofpracticedocuments.htm and can be used as a governance self-assessment framework possibly to complement preparatory work for RQIA performance assessment.

Review of Essence of Care benchmarking work across Northern Ireland

The DHSSPS sponsored a project in 2004 to introduce 'Essence of Care' benchmarks throughout Northern Ireland. The benchmarking process outlined helps practitioners to take a structured approach to sharing and comparing practice, enabling them to identify best practice and to develop

action plans to remedy poor practice. Benchmarks cover nine key areas of patient experience including privacy and dignity, communication, nutrition and so on. Over fifty benchmarking projects across all benchmarks were initiated across statutory and independent settings and NIPEC are currently reviewing progress in these fundamental areas of practice through an evaluative review of this work.

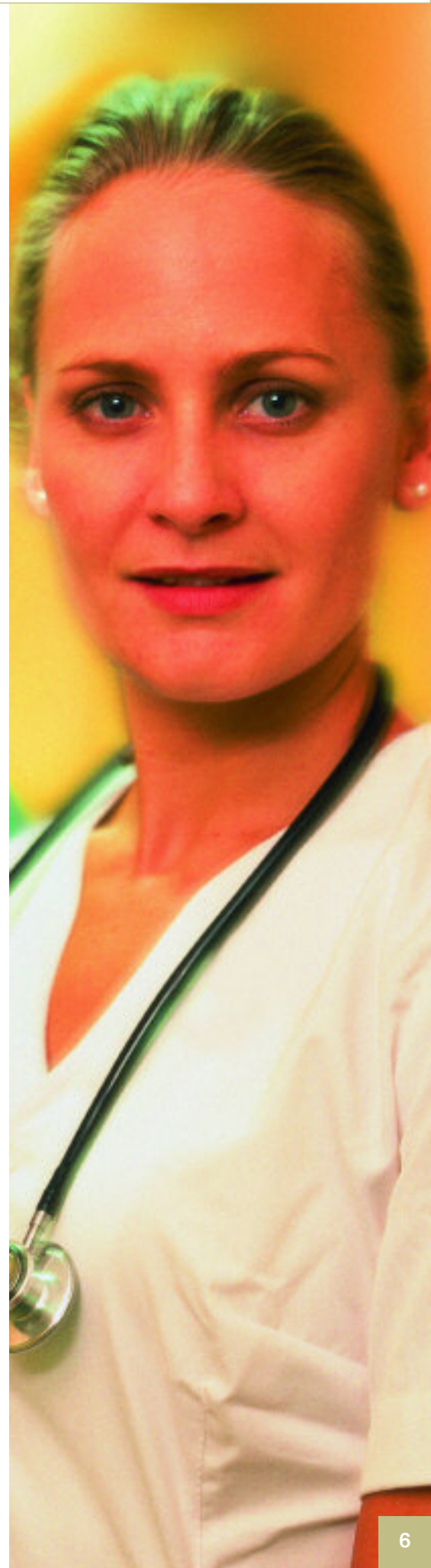
Formation of a Practice and Quality Regional Alliance

Given the NIPEC remit to help support and promote nurses and midwives engagement in practice and quality improvement activity, we recognise that an important part of this is to bring together different groups and colleagues to provide a regular forum for support, debate and to influence planning and policy as outlined in our Vision Statement (2004). We have recently formed the Practice and Quality Regional Alliance to help achieve this. Collectively we believe that this Alliance can help to steer the nursing and midwifery agenda for practice and quality improvement throughout the re-structured HPSS. We are delighted that RMAG are represented on this group.

An All-Ireland Development of Practice Database

NIPEC designed and developed an online database www.nipec.org in 2005, and in collaboration with the National Council for Nursing and Midwifery in the Republic of Ireland, have modified it as an All-Ireland resource. The Database provides a focal point for gathering and disseminating good practice, recognising innovation and personal achievement, and raising awareness of practice initiatives throughout Ireland. We encourage colleagues undertaking audit, quality improvement, benchmarking, service improvement, practice development and research projects to submit their work onto the database.

Further details about any of the above projects can be gained by contacting Dr Bob Brown, Senior Professional Officer (Practice and Quality) at NIPEC, on bob.brown@nipec.n-i.nhs.uk or by telephoning 9023 8152.



Care & Responsibility Provision Within Learning Disability Services Audit Down Lisburn Health & Social Services Trust

Introduction

Care & Responsibility was introduced as a response to the management of clients who display challenging behaviour. Care and Responsibility is delivered via an accredited training programme, facilitated and delivered by the Trust Learning & Development Department and Honestas: Regional Forum for Care and Responsibility Training. It provides a foundation for best practice in training staff to:

- Manage and deal with aggressive and/or physical violence
- Be more informed about triggers leading to aggression and violence
- Defuse and de-escalate potentially dangerous situations
- Only use physical intervention as a last resort

Since its introduction in 1998, a number of staff have completed necessary training and although evaluations are completed by the Learning & Development Department, we now feel the time is appropriate to audit the effectiveness of Care & Responsibility practice.

Background

Regional policy direction continues to manage clients with challenging behaviour in community care and avoid, where possible, any unnecessary hospital admissions, while the regional strategy continues to reduce the long stay hospital population for people with a learning disability.

It is identified from local needs assessment and from non-clinical incident reporting that challenging behaviours and the use of Care & Responsibility poses a significant risk for the individual and organisation. Through carrying out this audit it was anticipated that gaps in the system can be identified and ultimately the safety of clients and staff improved.

Reason for Project

- To measure compliance of Trust policy and procedures for the management of violence:
 - Management of violent incidents against staff
 - Training in relation to violence and aggression
 - Behaviour modification and the use of behaviour techniques
 - On the use of physical restraint
- To measure the effectiveness of

Care & Responsibility training and its implementation in practice

- To develop, evaluate and pilot supporting documentation for Physical Intervention Records
- To identify areas for improvement

Methodology

- The audit was completed in conjunction with 6 Trust residential/daycare facilities and 1 Private Residential Home. The Private Residential Home agreed to work in a partnership approach to complete audit as the facility was used for clients who challenge services and where Care & Responsibility would be used.
- A project lead and steering group was developed to oversee the audit project
- The group worked with the Trust Multiprofessional Audit Department in the development of audit tools.
- The audit was completed by:

- Surveying all staff trained in Care & Responsibility
- Carrying out structured interviews of staff trained in Care & Responsibility
- Completing a Training & Development analysis
- Analysing critical incident records and Physical Intervention Record Forms
- The Trust Multiprofessional Audit Department completed the analysis of results, and evaluation report inclusive of recommendations and audit action plan in conjunction with the Steering Committee.

Proposed Outcomes

- To promote better client care in a very contentious area of work
- To inform risk management in this particular area of work
- To support staff welfare and personal/professional development needs



Comparative study of Barriers in discharging medically fit patients

Abstract

A large number of patients wait discharge from hospital, long after their needs for hospitalization have been met and they are considered to have no medical issues requiring them to remain in the hospital.

It has been our observation that the number of patients whose discharge was delayed by non medical issues is increasing. In one of the recent reports by Comptroller and Auditor General we found that some 8.9% of older patients occupying acute care beds had already been declared fit to leave the hospital¹. In order to clarify the precise reasons for these delays we decided to create a comprehensive map of discharge pathways laid out in the hospital guidelines. We also tried to quantify the contribution of different barriers to discharge, occurring along these pathways.

The study was done in 2005 in Tyrone County Hospital (Omagh) which was a follow up to the initial study done in 2004 in South end General Hospital (Essex). From this we were able to compare the factors influencing delayed discharges between a district general hospital of Northern Ireland and England.

The various factors studied were:

- 1) Social services Assessment
- 2) Occupational therapy Assessment
- 3) Nursing/Residential homes Assessment
- 4) Physiotherapy
- 5) Others: Transport / Psychiatric assessment

Data was collected from the nursing and medical records of all patients who had an active 'Medically Fit for Discharge' decision documented in the notes.

Study done in Tyrone County Hospital was over a period of 28 days, 21 patients identified as delayed discharges out of 216 admissions. 33% of patients awaited discharge to nursing home and a similar number awaited placement in the rehabilitation ward, with only 24% of patients awaiting social services assessment. But on the contrary 61% of the patients waited for social services in Southend general hospital and 33% awaited discharge to a nursing home.

The longest delay time of an average of 15 days was caused by social services

here in Northern Ireland, which was the same average time, but caused while awaiting nursing home placements in England.

The conclusion of the study found that on an average 7.9% of acute medical beds were blocked in Tyrone county hospital, the figure was 20.6% in South end General Hospital as compared to the national figure of 8.9%. Thus we found the discharge system to be more efficient in our hospital in Northern Ireland.

Also according to the department of health, by 2004 no-one should be waiting more than four hours in accident and emergency from arrival to admission, transfer or discharge. Average waiting times in accident and emergency will fall as a result to 75 minutes².

Such initiatives and their requisite resource allocations can only be

effective if availability of acute medical beds is optimized. If this is not the case, and if this study is a reasonable representative example, then the problem we have highlighted will escalate with knock on effects on inpatient care and acute admissions. Our findings implicate that resources need to be targeted as a priority at the final steps in the discharge pathways.

(Author: Dr Nikhil Pal, SHO, Belfast City Hospital)

References

- 1) National Audit Office, Ensuring the effective discharge of older patients from NHS acute hospitals: NAO, 2003.
www.nao.org.uk/publications/nao_reports/ (accessed 16 Nov 2004)
- 2) Department Of Health, The NHS Plan: NHS, 2002.
www.publications.doh.gov.uk/nhsplan/nhsplan.htm (accessed 16 Nov 2004).

Figure 1 Comparison of Patients Delayed (No).

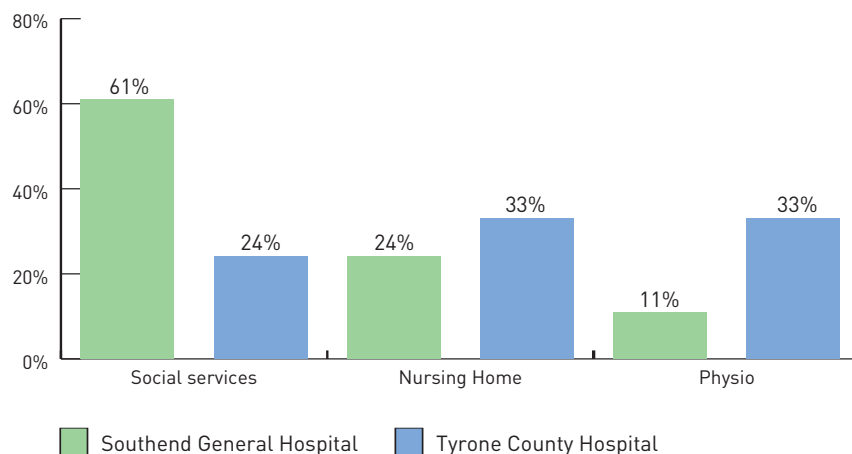
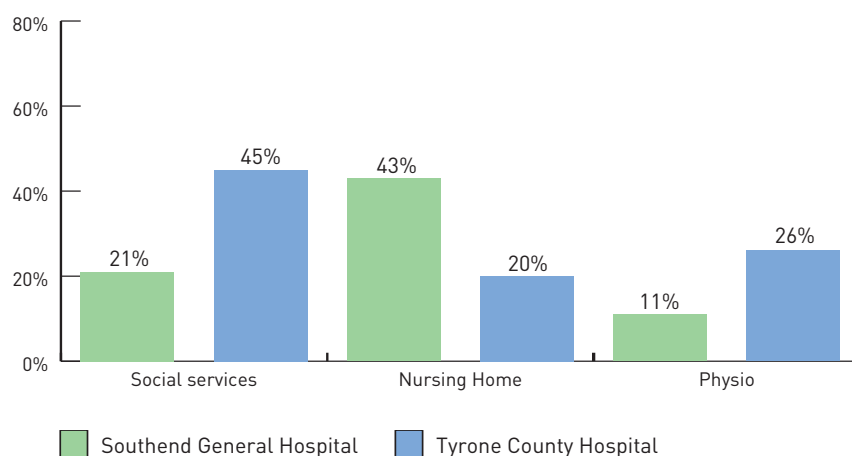


Figure 2 Comparison of Days Delayed.



N. Ireland Cancer Registry

The N. Ireland Cancer Registry, established in 2004 is located in the Centre for Clinical and Population Science, Queen's University Belfast. The aim of the Registry is to provide accurate, timely information on cancers occurring in the population for research, planning and education so that the burden of disease may be reduced. While the Registry's core activities are funded by the Department of Health, Social Services and Public Safety Northern Ireland (DHSSPSNI) it also secured grants from other bodies for research and specific projects including cancer audits. One such audit is described below.

The Campbell Report¹ introduced major changes to the organisation of cancer services including the identification of a Cancer Centre and Cancer Units. The N. Ireland Cancer Registry recognised the importance of monitoring such a change and collected data additional to its core data on over 8,000 patients diagnosed in 1996 and 2001 in N. Ireland with cancers of the breast, lung, colon, rectum, ovary, cervix, prostate, oesophagus and stomach. Pancreas and thyroid were also included but for more recent years. The results of these audits are available in published reports and online at www.qub.ac.uk/nicr

These reports identified changes in the management of patients in line with the recommendations of the Campbell report. They also identified key issues for service providers and service planners including the low levels of recording of cancer staging, the high numbers of operators in some areas, low levels of multidisciplinary team meetings and the high palliative care requirements.

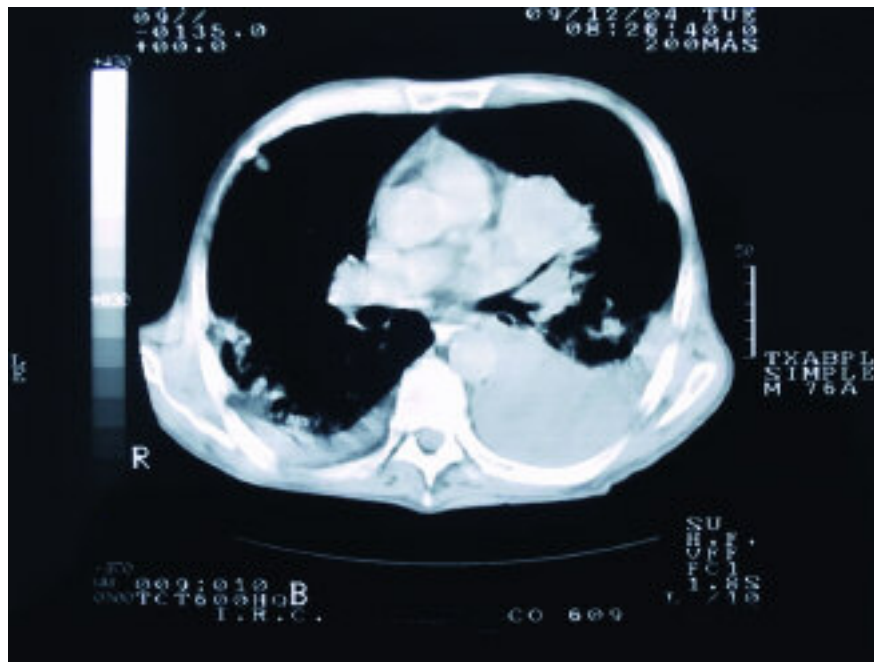
A repeat study is planned for patients diagnosed in 2006.

As a result of these audits the Health Boards funded a project to improve cancer staging. Dr Lisa Ranaghan was appointed. She with Mr Giulio Napolitano from the Registry developed an electronic staging tool which uses the routinely available data eg tumour size, location, spread to assign a tumour stage. This staging tool has been embedded in an electronic Multidisciplinary Team Management System also developed by Dr Ranaghan and Mr Napolitano.

This has been introduced to clinicians via the N. Ireland Cancer Network Tumour Specific Groups. There are MDM Management Systems in operation now for lung, upper GI cancer, breast and haematological malignancies. Development is ongoing for cancers of the colon/rectum and head and neck and neuro-oncology and melanoma.

The Registry is working closely with the Service Delivery Unit of DHSSPSNI and Trusts to provide an electronic addition to the MDM Management System which will allow the tracking of patients to provide information on Cancer Waiting Times as required by the Minister of Health from April 2007.

In addition the Registry is in final preparation of a detailed updated



report on cancer survival in N. Ireland. Each year we produce updated cancer incidence data, 2005 will be available June 2007. We have just produced a Cancer Trends documents see www.qub.ac.uk/nicr. The Registry also undertakes research particularly in the area of early cancer surveillance focusing on the role of PSA testing in detecting prostate cancer and Barrett's oesophagus as a risk factor for oesophageal cancer. Last year the Registry's work contributed to 6 peer reviewed scientific publications.

1. Campbell Report. 'Cancer Services - Investing for the Future'. Department of Health and Social Services, 1996.

Audits funded by:

- Department of Health, Social Services & Public Safety (DHSSPS)
- Eastern Health and Social Services Board
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- Regional Multiprofessional Audit Group
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- Western Health and Social Services Board
- Cancer Services Audit 2001 & 2002: Thyroid (due 2007)
- Cancer Services Audit 1996 & 2001: Ovary and Cervix
- Cancer Services Audit 2001: Pancreas

- Cancer Services Audit 1996 & 2001: Colorectal
- Cancer Services Audit 1996 & 2001: Lung
- Cancer Services Audit 1996 & 2001: Prostate
- Cancer Services Audit 1996 & 2001: Breast
- Cancer Services Audit 1996 & 2001: Oesophagus and Stomach

Hospital at Night Project – Observational Audit of Medical Staff and Lead Nurses

Background

Hospital at Night (HaN) was borne out of the realisation that traditional models of night time working are not the most effective for patients and staff. There is an increasing need to move from cover requirements defined by professional demarcation and grade, to cover defined by competency, patient and service needs. In addition, the introduction of the European Working Time Directive (EWTd) has created the need to reassess how cover is provided in hospitals during the out-of-hours period. A HaN model consists of a multi-disciplinary night team, which has the competencies to cover a wide range of interventions, but also the capacity to call in specialist expertise when necessary. In September 2005 the Royal Hospitals embarked upon a HaN project to identify if a HaN model is appropriate for the Trust and the shape of such a model.

Objectives

The objectives of the project were to impact positively on the quality and safety of care provided to patients and mitigate potential risks to patient safety; to implement a 'fit for purpose' HaN model across a 300 bedded pilot area; to disseminate wider learning from HaN across the entire Trust; to improve team working and communication across professions and speciality interests; to impact positively on junior doctor rotas and increase compliance with EWTd/New Deal; to improve the training and educational experience of junior doctors and other staff with increased opportunities to share learning; to provide ward nurses with access to expert and timely support in the management of patients; and to remove duplication of tasks and provide more efficient management of the patient journey.

Methodology

A multi-disciplinary project Steering Group and Team were established, with the Medical Director as Project Director, a Lead Facilitator and appropriate medical, nursing and risk management leads. Recognising the significant change implications of HaN a Trust-wide Communications Strategy was also adopted. A 300-bedded pilot area including the specialities of Cardiac Surgery, Cardiac Medicine, Coronary Care, Colorectal Surgery, General Surgery, General Medicine, Thoracic Surgery, Vascular Surgery and the Admissions Unit was identified. The

project commenced with a 24x7 observational audit of PRHOs, SHOs, SpRs and Lead Nurses, with observation of 162 shifts. The observational audit involved direct one-to-one shadowing of staff using observers drawn from medical students, allied health profession students, nursing students and Trust staff. Observers applied the standard HaN audit proforma to code all medical activities undertaken and a specifically designed audit form to capture Lead Nurse activities. Data recorded included, type of activity (split into three headings – patient care, interactions with staff/relatives and finding stuff/paperwork), the time of the activity, condition of patient and appropriateness of the activity for the individual concerned. The audit was conducted over a 5-day period and total of 6085 activities were recorded. The audit results were analysed with regard to the appropriateness of the Royal Hospitals to adopt a HaN model and the shape of the model. In addition, patient journey mapping of a sample of patients was also conducted during the audit. The purpose of this exercise was to identify any 'systems' issues which impact on the working day or the patient journey i.e. delay in discharge, delay in drugs from pharmacy etc.

Three potential HaN models of operation were short listed and subject to monetary and non-monetary cost/benefit analysis and risk assessment. The preferred model has been identified and is subject to Steering Group approval in September 2006. The implementation of HaN will commence in the pilot area in October 2006 and will then be subject to post-implementation review.

Audit Results

The results were analysed by application of the NHS Modernisation Agency designed HaN database. The findings were also benchmarked with the four HaN pilot sites in Great Britain, and indicate that the pilot area is a suitable candidate for a HaN approach. High-level results profiled the pattern of the total activity of the pilot area during the audit, the specific patterns of medical and surgical speciality activity and the condition of patients treated. The results demonstrate a similar pattern of activity as the pilot sites in GB, with activity peaking early in the day, marked peaks of activity following



take-in periods and medical specialities remaining busier out-of-hours than surgical specialities. In addition relatively few patients have life-threatening conditions. The audit findings also identified the split of medical staff time as 40% devoted to patient care, 31% interactions with staff/relatives and 29% finding stuff/paperwork – these results were further disaggregated to establish which tasks consumed the greatest percentage of medical staff time and if such tasks are appropriate to the role of the individuals. Overall the results demonstrate that 10% of all activities undertaken during a 24hr period by medical staff could be undertaken by non-medical roles, potentially 40% of the tasks undertaken after midnight by medical staff could be reallocated to non-medical roles (work associated with chasing up notes, portering, duplicate clerking, writing prescriptions, taking bloods etc.) and 15% of the calls to PRHOs after midnight require no action.

Hospital at Night Project – Observational Audit of Medical Staff and Lead Nurses



Lead Nurse Activity follows a similar pattern to that of medical staff. With regard to Lead Nurses 45% of activity is related to patient care, 39% to interactions with staff/relatives and 15% finding stuff and paperwork.

The audit results provided the evidence base from which the short listed HaN models were developed. The results also indicate significant potential for change with regard to more effective management of work out-of-hours, more appropriate alignment of tasks with competencies and roles (including the potential to develop new roles) and opportunities for more effective multi-disciplinary, cross speciality team working.

Summary

The short listed models for HaN all include the implementation of core multi-disciplinary, cross-speciality team working out-of-hours, with access to other speciality interests as required. Central to HaN is the

implementation of multi-disciplinary hand-over morning and evening and the identification of patients under the care of the Critical Care Outreach Team/Patient at Risk Team. The HaN team will also work closely with Critical Care Outreach Team/Patient at Risk Team, which will be piloted in the Trust during 2006/07. The activities of the HaN team will be underpinned by a Competency Framework, which identifies the generic competencies for the HaN team and specific role competencies. All members of the HaN team will be required to demonstrate the competencies required and sign-up to the Competency Framework. In addition, the team will be supported by agreed protocols for bleep filtering, escalation etc. A Nurse Co-ordinator role will be developed to coordinate the activities of team, manage prioritisation of bleeps/calls, provide early intervention to patients and undertake advance prescribing. The clinical lead of the HaN team will be the Medical SpR. A new role of a Health

Care Assistant/Physicians Assistant will also be implemented to undertake some of the 'non-medical' tasks currently undertaken by medical staff. The remainder of the team will be constituted from specialty interests across medicine, surgery, anaesthetics and others as required.

In addition to the implementation of a HaN model to the pilot area generic recommendations arising from the audit will be implemented Trust-wide. Such recommendations include those associated with streamlining the patient journey, improving processes, team working, communication and management and prioritisation of tasks. Implementation of the HaN model and other associated changes will commence October 2006.

Care & Responsibility Provision Within Learning Disability Services Audit Down Lisburn Health & Social Services Trust

- To report to Trust Multiprofessional Audit Committee for dissemination of best practice
- To determine future care and practice in the management of violence
- To respond to staff concerns

Conclusion

Results from this audit have revealed the following:

Training Modules attended

- 98% of employees have attended breakaway module training.
- 82% of employees have attended team working module training.

Reason for attending Care and Responsibility training

- 51% of employees asked to attend the training.
- 29% of employees attended training because they were sent as a result of appraisal.
- 19% of employees attended training as it was part of their induction.

Does training provide adequate information?

- Employees felt that training does provide adequate information in relation to the following modules:
 - Management of aggression/physical violence (95%).
 - Triggers leading to aggression and violence (80%).
 - Defusing and de-escalation of potential dangerous situations (89%).
 - Understanding of why difficult behaviour occurs and why it is maintained (72%).

Timing of Training

- 80% of employees indicated that they were offered/sent to training at the right time.

Training update attendances

- 71% of employees stated that they had attended a training update.
- 29% of employees stated that they had not attended a training update.
- Of those 71% of employees who have attended a training update:
 - 71% of those employees have attended an update within the last 18 months.
 - 27% of those employees have not attended an update within the last 18 months.

Aspects of Training

Team working

- A total of 44% of employees stated they had used team working in practice in the last 18 months.
- A total of 49% of employees stated that they had not used team working in practice in the last 18 months.

Breakaway

- 36% of employees indicated they have used breakaway training in practice in the last 18 months.
- 57% of employees indicated they have not used breakaway training in practice in the last 18 months.

De-escalation/Diffusion

- 71% of employees have used de-escalation/diffusion training in the last 18 months.
- 22% of employees have not used de-escalation/diffusion training in the last 18 months.

Physical Intervention

- 98% of employees felt that physical intervention should always be used as a last resort in their workplace.

Personal Benefit of Training

- 94% of employees believe that the knowledge and skills they have acquired as a result of training has been of benefit to them personally.

Workplace Benefit of Training

- 92% of employees believe that the knowledge and skills they have acquired as a result of training has been of benefit to their workplace.

Negative experiences encountered

- 31% of employees stated they have not encountered negative experiences as a result of using Care and Responsibility.
- 15% of employees stated that they had encountered negative experiences.
- 54% did not make any comment.

Is Care and Responsibility incorporated into care plans/service plans?

- 64% of employees feel that, in their experience, Care and Responsibility is incorporated into care plans/service plans.
- 23% of employees feel that, in their experience, Care and Responsibility is not incorporated into care plans/service plans.

Current Benefit of Reporting and Recording

The 85 employees felt that current reporting and recording was of benefit to one or more of the following:

	No. of Staff
Management	68 (80%)
Yourself	67 (79%)
The Organisation	67 (79%)
The Client	62 (73%)
Other	12 (14%)

Feedback received as a result of Reporting/Recording

- 50% of employees said that they have received feedback and/or support as a result of reporting/recording.
- 43% of employees said that they have not received feedback and/or support as a result of reporting/recording.

Feedback/Support Source

- The 42 employees who stated they received feedback and/or support specified that it came from one or more of the following:

	No. of Staff
Line Manager	34 (81%)
Peer	17 (40%)
Other Agencies	14 (33%)
Senior Manager	12 (29%)
Corporate Affairs	-
Other	2 (5%)

Adequate support received after an incident?

- 72% of employees felt they have received adequate support after an incident.
- Only 17% of employees felt they have not received adequate support after an incident.

Workplace Policies and Procedures

- 95% of employees said they are aware that there are workplace policies and procedures regarding violence and aggression.
- 97% of employees know how to get access to these policies and procedures.
- 91% of employees would feel confident in applying workplace policies and procedures.

Implementation of Care and Responsibility training/policy/procedures

- 77% of employees are of the opinion that Care and Responsibility

Care & Responsibility Provision Within Learning Disability Services Audit Down Lisburn Health & Social Services Trust

training/policy/procedures are implemented fully in their workplace.

- 18% of employees believe that Care and Responsibility training/policy/procedures are not implemented fully in their workplace.

Enough numbers to initiate/apply Care and Responsibility

- 28% of employees stated that they have experienced a situation where Care and Responsibility was used/could have been used and not enough people were available to initiate/apply it.
- 65% of employees have not experienced a situation where Care and Responsibility was used/could have been used and not enough people were available to initiate/apply it.

Improvements in the management of aggression/violence in the workplace

- 49% of employees felt that they could identify an improvement in the management of aggression/violence in the workplace.
- 45% of employees felt that they could not identify any improvement in the management of aggression/violence in the workplace.

Could training be enhanced?

- 26% of employees feel that training could be enhanced.
- 67% of employees feel that training could not be enhanced.

Incidents and Care & Responsibility Utilisation

- Care & Responsibility was utilised in 25% of incidents recorded, while there have been no such occasions when Care & Responsibility has been utilised in the Struell Lodge and Glenwood facilities.
- Physical interventions were utilised in 46% of cases because of the behaviour of clients towards staff members.
- The most common technique used during restraint was a straight arm hold which was used in 48% of cases.

Recommendations

- Care & Responsibility needs to be clearly defined and acknowledged to include physical interventions,

breakaway and de-escalation for necessary record keeping and care planning.

- Care & Responsibility training should be reviewed in context with this report to consider:
- Adequate information content on why difficult behaviour occurs and why it is maintained.
 - The frequency of updates.
 - The necessity of mandatory updates and staff being supported to complete same when deemed necessary.
- Offering training as early as possible to reduce staff experience of aggression/violence before being trained.
- Adequate knowledge on policy and procedures and record keeping specific to Care & Responsibility.
- Comments made by staff on how training could be enhanced.
- Each facility should ensure that when Care & Responsibility is a known requirement for a clients care intervention that this is included within the client individual care plan. (This should include the use of breakaway and de-escalation also).
- Information recorded to specify negative experiences encountered as a result of using Care &

Responsibility should be further reviewed with facilities.

- The process for facility/team feedback support/post-incident support should be further reviewed and recommendations provided to support individual staff – comments made by staff who encountered negative experiences when using Care & Responsibility should be reviewed.
- The use of the Physical Intervention Record Form (PIRF) will continue to be used in all facilities. The PIRF will be reviewed to ensure information reflects the detail required.
- Ensure all employees who are involved within Care and Responsibility are aware of workplace policies and procedures regarding violence and aggression as well as knowing how to get access to these items of information. Documental evidence should be retained in the facility of the employee's awareness.
- Continue to develop workforce planning within the Disability Programme of Care which will contribute to securing the resources with which staff can carry out their Care and Responsibility roles effectively.
- A re-audit should be carried out within 2 years.



Shoulder Stabilisation Surgery in Altnagelvin Area Hospital

Reasons for Audit

To assess the standard of shoulder stabilisation surgery in AAH and compare outcomes against literature standards

Aetiology

The shoulder is the commonest dislocated joint in body
98% of dislocations of the shoulder are in an anterior direction

There is a bimodal distribution, peaks in men 20-30 years (m:f 9:1) and women aged 61-80 years (f:m 3:1).

In young adults, the rate of re-dislocation is greater than 50%

Traumatic injuries are associated with permanent damage to the front of the joint (Bankart lesion)

Atraumatic injuries are usually multidirectional and occur in patients who have lax soft tissues

Literature standards

Incidence of re dislocation following surgery 11-18% (Gill 2003)

Capsular shift operation is the gold standard if multidirectional instability is present

Bankart repair operation is the gold standard if a Bankart lesion is present

Putti platt operation is effective but is associated with a decrease in the range of movement (Miller 2004)

Methodology

A retrospective analysis of a sample of 31 patients charts who had been operated on over a ten year period
Parameters included age, sex, no of dislocations prior to surgery, whether MRI carried out, type of operation, review period, complications, need for revision surgery. These were then compared against peer reviewed literature

Results

Age: 20-30 (60%), 31-40 (25%), >40(15%)

Gender: male (87%), female (13%)

Number of previous dislocations: 2-5 (39%), 6-10 (22%), >10 (39%)

Fracture present: 3%

MRI carried out: 55%

MRI result: Bankart lesion (53%), no Bankart lesion (41%), normal (6%)

Operation type: Capsular shift (48%), Capsular shift and Bankart repair (29%), PuttiPlatt (23%)

Operator: Consultant A (48%), Consultant B (3%), Consultant C (48%)

Date of surgery: 1996-97 (3%), 98-99 (6%), 2000-01 (16%), 2002-03 (52%), 2004-05 (23%)

Review period: 3 months (64%), 6 months (26%), >6 months (10%)

Complications: further dislocation (16%), wound infection (3%)

Patients requiring revision surgery: 16%

Conclusions

There is an acceptable standard of care

For a period more than one surgeon operated and the amount of operations reflected this.

Recommendations

Single surgeon dedicated to these procedures, re audit 2007.



Audit of Domestic Violence Interagency Guidelines Newry & Mourne Trust

Background

During the last decade there has been an increasing awareness of the prevalence and serious impact of domestic violence on adult victims and their children. Recent research has dispelled the myth that domestic violence was less likely to occur during pregnancy and has in fact highlighted that pregnancy can itself be a high risk factor for domestic violence. A survey of 127 women living in refuges in N.Ireland found that 60% of them had reported violence during pregnancy (Casey 1989). Studies in the U.S.A. have shown that 37% of obstetric patients were at risk of abuse and 48% of abused women were assaulted during pregnancy.

Two Confidential Enquiry into Maternal Deaths reports, "Why Mothers Die 1994-1996 and 1997-1999" also endorse this ethos. These reports made key recommendations for professionals providing services to pregnant women.

Following the 1994 -1996 Enquiry report Newry & Mourne Trust developed inter-agency guidelines for the identification of vulnerable women who are pregnant and the provision of support for them and their families. These guidelines relate to the identification of women during the antenatal stages of pregnancy and therefore encompass the care of the pregnant woman, the unborn child and any other children within the family.

This audit was conducted to assess practice against the above interagency guidelines using funding provided by the Regional Multiprofessional Audit Group (RMAG).

Aim

The overall aim of this project is to ensure that the service provisions for this group of patients are in accordance with requirements of the patient, the Trust and legislation.

Objectives

1. To ensure that Newry & Mourne Trust Inter-Agency Guidelines for Domestic Violence & Pregnancy are adhered to.
2. To reduce the risk of obstetric patients, their unborn children and other children being harmed due to non-compliance with the above guidelines.

Methodology

Explicit multiprofessional audit standards were designed and agreed by a multiprofessional team using the following:

1. N&M HSS Trust Inter-Agency Guidelines for Domestic Violence in Pregnancy (2001)
2. Southern Area Child Protection Committee Guidelines for Domestic Violence on Children (2000)

An audit project assistant was appointed to collect retrospective anonymised data from the antenatal/postnatal records and A&E notes of 111 women.

Recommendations

The issue of domestic violence should be discussed at the booking in visit for all women and this should be documented in the patient's casenotes and recorded on the NIMATS or other electronic system.

Current documentation in the casenotes in relation to domestic violence issues should be improved.

All women should have their consent obtained for referral to Social Services Family Support / Child Protection unless it is a child protection issue in which case consent is not needed.

The process of identifying the audit sample group was hindered by the fact that many of the women were listed on the Patient Administration System with multiple addresses, different surnames and dates of birth. It would be useful if the records/hospital episodes of women at risk of domestic violence could be linked together.

The Interagency guidelines should be reviewed and amended so that they provide more concise guidance for staff.

Action

Multidisciplinary training has already begun in relation to 1) Awareness of Domestic Violence, 2) Interventions, 3) Risk Factors.

It is understood that the DHSSPSNI are drafting Regional Guidelines for Domestic Violence. The above recommendations will be reviewed in light of any regional guidance. The results of this audit will also be forwarded to the Southern Area Domestic Violence Partnership.

Reaudit

A re-audit will be conducted following the implementation of recommendations.



Evaluation of the Hospital At Night Project Newry & Mourne Trust

Background

The Hospital at Night model proposes that the way to achieve effective clinical care at night is to have one or more multidisciplinary teams working in the hospital, who between them have the full range of skills and competencies to meet patients' immediate needs.

The project was born out of an original idea by Dr Elizabeth Paice, Postgraduate Dean Director for London, who was concerned by the deleterious effects on patients and junior medical staff of traditional models of night-time working. Since then, the imperative to reduce the working hours of junior doctors and the subsequent move to full shift working, in order to comply with the European Working Time Directive, has provided added impetus to change traditional medical working practices out of hours. The Joint Consultants Committee (JCC – comprising representatives of the Academy of Royal Colleges and the BMA) identified, in December 2002, that a move to multidisciplinary, competency-based working, could help hospitals achieve European Working Time Directive compliance.

The Hospital at Night project has gathered a significant body of evidence³ about what happens in the hospital during the out-of-hours period. This evidence provides strong support for a competency-based, multidisciplinary approach to staffing the hospital at night. The evidence also signals opportunities:-

- For non-medical staff to take on a proportion of the work traditionally done by doctors at night.
- To move a significant proportion of the work at night into the extended day.
- To reduce unnecessary duplication of work – especially through a reduction in multiple clerking.

Daisy Hill Hospital was identified as one of the pilot sites for the hospital at night project. Following the appointment of a project coordinator a pilot study was conducted and evaluated. We would like to present the results of this pilot at a regional forum as we feel that hospital at night will impact upon all acute hospitals in Northern Ireland.



Night Multiprofessional Handover

The pilot study has already identified:-

- Some of the key components of successful multidisciplinary working during the out-of-hours period.
- Opportunities to improve the working lives of staff at night, and most importantly significant opportunities to improve the quality of patient care at night.

Methodology

- Concurrent data was collected using the NHS modernisation agency proforma by medical staff and Night Coordinators during a 9 day period on 709 tasks/calls. Specialties involved included Medicine, Surgery, Paediatrics and Obs&Gynae. The project looked at doctors' out-of hours calls from 5 pm to 9 am on weekdays and all day at weekends.
- Descriptor codes for each task were allocated by medical staff and validated by hospital at night coordinator and clinical audit manager.
- As a follow up, doctors were surveyed to ascertain their thoughts/opinions on the hospital at night initiative.

Results

The Hospital at Night pilot results for Daisy Hill Hospital were similar to National results for pilot sites in England. The main issues we found were:-

- A very small proportion of out-of-hours work related to patients in a life threatening situation. Only 4% of calls were deemed to be life threatening.
- There was high activity from 17:00hrs – 2300hrs after which time workload gradually declined.
- 70% of tasks were conducted by a medical SHO – continued at lower level after bedtime.
- Much work could be transferred to a competent person.
- There was very little surgery in theatre – NCEPOD success.

Action

This Hospital At Night initiative has now been implemented in Daisy Hill Hospital and is monitored by a working group.

Reaudit

A reaudit will be conducted as part of the projects monitoring arrangements.

Audit of Delays in Discharge from Marie Curie Hospice Belfast And Preferred Place of Death Marie Curie Hospice Belfast

Background

A 'Regional Audit of Delays in Discharge' (Taylor & Doyle 2004) highlighted issues regarding bed availability in hospices and the burden of delayed discharges. NICE Guidance (2004) recommends that the preferred place of death should be noted and that systems should be in place for those wishing to die at home. The Preferred Place of Care Plan (Storey et al 2003) records the patient's preferences.

Aims

To explore the causes and extent of delays in discharge for patients and to compare the preferred and actual place of death for patients

Method

Questionnaires utilised in the regional audit (Taylor & Doyle 2004) were completed by medical and social work staff to collate factual data. Information included demographic data, date of admission, date and place of discharge, reasons for delay, date and place of death and preferred place of death.

Sampling criteria included Marie Curie Hospice Belfast in-patients, who were declared medically fit for discharge or who were nearing the terminal phase of illness and requested to die at home and whose discharge had been initiated during the audit period. This yielded a sample of 36 patients (15 male and 21 female; aged 39-83 years) out of a total population of 70 patients. The regional standard (Taylor & Doyle 2004) that discharges should take place within 2 working days of the patient's readiness, was applied.

Results

Findings concluded that 91.6% of patients were discharged into the community. Although 42.4% of patients met the agreed discharge standard, the remaining 57.6% were delayed by 3-58 days. Reasons for delay included medical (24%); social (20.7%); equipment/ adaptations (6.9%); patient & carer reasons (20.7%) and care package reasons (27.5%).

Regarding preferred place of death, data was available on 75 % of patients. Of those patients who expressed their wishes, results indicated that 81% of patients died in their place of choice compared to 19% of patients who did not die in their place of choice. Data was not available for 25%. It was found that many patients changed their mind about their preferred place of death as

their illness progressed and needs increased.

Conclusion

Due to the nature of hospice work it is difficult to fully adhere to discharge standards. 'Preferred Place of Care' documentation could help to ensure accurate data collection, anticipate future service delivery needs and prevent unnecessary delays in discharge. However, it needs to be sensitively revisited as the disease progresses, to record changing needs and wishes.

References

National Institute for Clinical Excellence (2004) Guidance on Cancer Services Improving Supportive and Palliative Care for Adults with Cancer NICE: London

Taylor, D & Doyle, J (2004) 'A Regional Audit of Delays in Discharge' EHSSB: Belfast

Storey, L., Pemberton, C., Howard, A. & O'Donnell, L (2003) Place of death: Hobson's choice or patient choice?' Cancer Nursing Practice 2(4) 33-38

Figure 1 Reasons for Delay in Discharge.

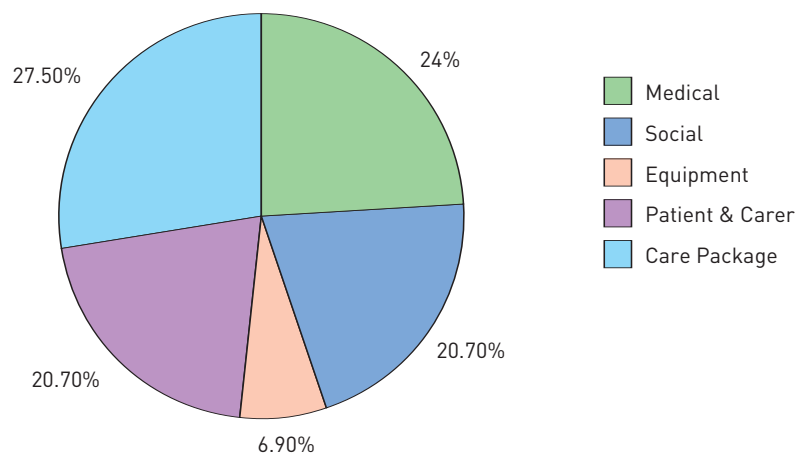
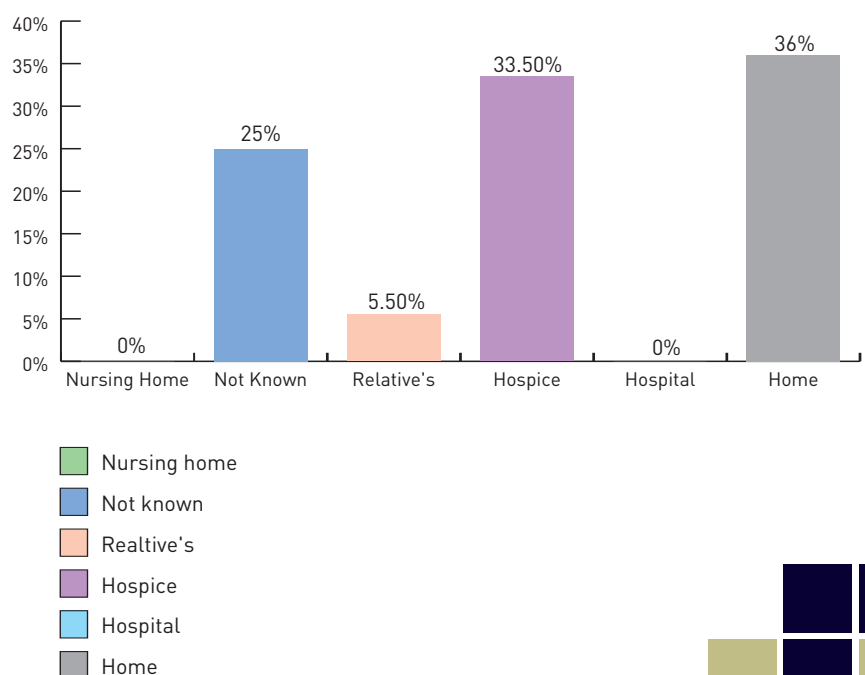


Figure 2 Preferred Place of Death.



Implementation of the Infection Control Nurses Association (ICNA) Electronic Audit Tool in Newry & Mourne Trust

In order to make auditing infection control standards more user friendly and efficient Margaret Markey (Infection Control Nurse) in conjunction with Tony Black of the Trusts Clinical Audit Department have recently started to implement the Infection Control Nurses Association (ICNA) electronic audit tool.

The ICNA Tool software application is designed to assist staff in performing a wide range of infection control audits. It allows the auditor to enter the assessment for a set of specific questions directly into the application so that it can be stored in the database and reports produced automatically. The audit results data can be interrogated using a range of reports e.g. individual, summary or annual reports. Initially a verbal report on compliance is given, prior to the auditor leaving, this is then followed by a written report which is issued to the relevant manager for action on the same day.

In September 2006 infection control link nurses in the Coronary Care Unit and in Crossmaglen Health Centre were trained in the use of the handheld pocket PC. Data was collected on aspects such as Safe Handling & Disposal of Sharps, Hand Hygiene, Personal Protective Equipment, Vaccine Transport & Storage and Body Fluids. The main benefits of the ICNA tool are:-user friendly database, simplified data entry process, encrypted data protection, improved feedback processes with rapid report generation This method of electronically capturing data in real time is just one of the ways in which Infection Control audit is conducted within the Trust to provide a systematic review of standards against explicit criteria bringing issues to light improving practices.



Left to Right: - M. Markey (ICN) with Infection Control Link Nurses, Michaela Kane (CCU/MMW), Margaret Dillon (Crossmaglen Health Centre)



Audit of Histopathological Diagnosis of Hydatiform Moles (HM) Within the Paediatric Pathology Department

Gold Standard

There is no true gold standard. We audited our diagnoses against histopathological diagnoses made in the UK National referral centre for gestational trophoblastic disease: Charing Cross Hospital, London.

Retrospective assessment of possible HM from Sept 03 – Sept 04.

Prior to Sept 03, there had been reporting by up to 8 different general histopathologists: after there was reporting by one of two Paediatric Pathologists.

Background

There appears to be an increased pick-up of HM within the Royal Group of Hospitals trust over the last five years.

Objectives

1. To establish whether there has been an increased pick-up.
2. To determine the cause for any

increased pick-up.

3. To establish the degree of confidence of the histopathological diagnoses by examining the phraseology of the reports
4. To compare the diagnoses given, compared to those issued from Charing Cross hospital.
5. To determine how many HM were suspected clinically.

Results

1. Published incidence of HM in Europe: 1 in 1000. Of 983 products of conception (POCs) examined in RGHT, there were 40 HM (incidence: 0.041% - ~ 20 fold published incidence).
2. Increased pick-up is likely attributable to introduction of sub specialisation in Sept 03 & increasing awareness of refined criteria for diagnosis of early complete HM.
3. Of 62 cases in which a diagnosis of

HM was initially considered, 18 were downgraded in supplementary reports to non-molar change following receipt of conflicting flow cytometry reports. 44 cases were submitted to Charing Cross with diagnoses of possible HM in 5 cases, probable HM in 2 cases and definite HM in 33 cases.

4. Of 44 cases reviewed by Charing Cross there was concordance in diagnosis in 40 cases (91%).
5. Suggested clinical diagnosis of HM in 7/62 cases (increased HCG in 5 of these 7 cases) – no suspicion in 88.7%.

Conclusions

1. There is an increased pickup of molar pregnancies.
2. ~ 90% of proven moles are not suspected clinically.

Given the two preceding conclusions, all POC's should be sent for histopathological examination.

Tackling Childhood Obesity: Results Of A Pilot Intervention Programme

Background

Halting the rising prevalence of childhood obesity is a public health priority. Currently by the age of 12 up to 10% of Ulster children are obese, while 15% of boys and 21% of girls are overweight. The estimation by 2020 is that 1 in 5 boys and 1 in 3 girls will be obese. From research undertaken by Mary Flynn et al in 2004 (1) key points for best practice to reduce obesity in children were identified. These included:

- Increase physical activity
- Increase school based physical activity
- Decrease sedentary behaviours
- Modify eating behaviour
- Increase involvement of families

These points reinforce other research findings that family based programmes that involve parents, increase physical activity, provide dietary education and target reductions in sedentary behaviour may help reduce childhood obesity(2).

This project attempted to incorporate all of these aspects.

Objectives

- To provide a focused and supportive approach to the management of diet and lifestyle issues associated with obese children in a local community.
- To increase families confidence in their ability to cook and eat a balanced diet.

- To increase families motivation to see exercise as a normal fun part of daily activity.
- To demonstrate a reduction in BMI of individual children.

Methods

Following funding by the Northern Investing for Health Partnership a family centred pilot project was set up which combined fun physical activity for children aged between 6-11. The Project was a partnership between the Joey Dunlop Leisure Centre, the Northern Area Physical Activity Strategy Co-ordinator and the Causeway Trust Paediatric Dietetic Department with support by a Consultant Paediatrician. Sixteen families were involved in 12 consecutive weekly sessions of 2-hour duration involving the whole family. A Paediatric Dietitian delivered specialist 'Cook-It' sessions to all parents. A paediatric dietitian also facilitated interactive nutrition workshops for the children. Qualified fitness instructors delivered fun exercise sessions to the children. Age ranges were 6 to 11 years, (mean 9.8 years). BMI measurements ranged from 26.1 to 36.9, (mean 30.3).

Results

Attendance at the sessions was excellent, 89% for parents and 85% for children. All parents reported that they as a family had made positive changes

to their diet and lifestyle. 14 out of 16 children (87.5%) had a reduction in BMI measurement at the end of the programme. This group programme was so popular with the participants that the majority have opted to have dietetic follow up as a group.

This family fun food and fitness pilot programme directly targeted at overweight and obese children has proved to be popular with families. Due to the success funding for a second pilot project has been secured. If similar findings are reproducible and proven sustainable then a potential referral pathway could be developed for health professionals to help families struggling to tackle child obesity.

1. Reducing Obesity and related Chronic Disease in Children and Youth: A Synthesis of evidence with 'Best Practice' Recommendations; Flynn et al, 2004.
2. Effective Health Care: The prevention and treatment of childhood obesity Vol 7 No 6 2002.

Professionals involved

A Toman, A Mc Kee PAEDIATRIC Nutrition & Dietetic Department, CHSST; M Rollins, Consultant Paediatrician, CHSST; P Lyness, Leisure Services Manager, Joey Dunlop Leisure Centre; N Browne, Northern Area Physical Activity Strategy Co-ordinator.



National Institute of Clinical Excellence NICE TO BE HERE

The Northern Ireland link with NICE was formally launched at a conference 20 November 2006. Around 200 delegates from across the HPSS together with representatives from patient groups, voluntary organisations and the pharmaceutical industry gathered at the Stormont Hotel, Belfast to find out how NICE guidance is to be applied in the HPSS.

Delegates heard how the Institute's guidance published from 1 July 2006 is to be reviewed locally for its applicability to Northern Ireland. Where NICE guidance is found to be applicable, it will be endorsed by the Department for implementation in the HPSS.

Speaking at the conference, Health Minister, Paul Goggins said *"This is a significant step forward for Northern Ireland and is a key element in my Department's drive to improve the quality of services here."* The Minister added that *"good practice guidance developed for the NHS should generally apply to the HPSS as people*

in Northern Ireland are entitled to have access to the same treatments and specialist drugs as their counterparts in the rest of the United Kingdom."

Chief Medical Officer for Northern Ireland, Dr Michael McBride emphasised that local experts, be they healthcare professionals or patient representatives, are the cornerstone of the local review process. Dr McBride called for more people to come forward and join the Department's pool of experts willing to comment on individual NICE guidance. NICE Chairman, Sir Michael Rawlins and Chief Executive, Andrew Dillion, also encouraged people from Northern Ireland to come forward and nominate for the various committees and groups that help inform the work of the Institute.

In lively workshops and question and answer sessions it was made clear that CREST will continue to have a role in developing clinical guidelines for Northern Ireland in topics not covered by NICE. The development of a network

across Boards and Trusts to address issues about the dissemination and implementation of NICE guidance was only seen as a key to the success of this initiative.

Look out for the first set of locally reviewed NICE technology appraisals. These cover therapies such as statins for cardiovascular disease, treatments for psoriatic arthritis, and a number of cancer drugs appraised under NICE's new fast stream assessment process known as the "Single Technology Appraisal". The Department aims to issue advice on the local status of this guidance in December.

Further information on the how NICE guidance is to be applied in Northern Ireland is available at:

http://www.dhsspsni.gov.uk/nice_guidance_01-06.pdf or by contacting the Department at SGU inbox: sgu-niceguidance@dhsspsni.gov.uk.

**Gerard Collins
Head of Standards & Guidelines Unit
DHSSPSNI**



Left to Right: Andrew Dillon CBE, Chief Executive, NICE, Sir Michael Rawlins, Chairman, NICE, Paul Goggins, Minister of Health for Northern Ireland, Michael McBride, Chief Medical Officer for Northern Ireland. Photo: Anna Morrison.

A Word from the Facilitator

There have been many changes that are currently ongoing such as RPA, Agenda for Change and the introduction of NICE to Northern Ireland. However, we are also watching and waiting as the transition commences for Audit and Guidelines throughout Northern Ireland.

As the RMAG Facilitator during the last three years, I have been privileged to work alongside some truly amazing people who are dedicated and committed to the improvement of patient services and care.

During the transformation of Audit and Guidelines, I would like to see the development of stronger links, more widespread sharing of learning through greater dissemination and an altogether greater structured audit and guidelines body.

As this is the last edition of Gleanings (albeit in its current format), I have asked past facilitators to reflect on the changes they have seen since the commencement of audit. Below Paddie Blaney reflects on the progress of audit and quality.



"I was Regional Nursing Audit Facilitator for a year and a half from 1994 to 1995 and subsequently Multi-professional Audit Facilitator for almost two years to October 1997.

The graduation to multi-professional audit was inevitable given the evolution of quality improvement at that time and the emerging realisation that audit was best undertaken by the team involved in the area of practice whether that be uni-professional or multi professional.

Reflecting on the progress for audit and quality improvement both during my time as Regional Facilitator and since there have been important drivers such as policy directives, project funding and the Regional Multi-professional Audit Facilitator post. There have however been significant tensions around the area of audit and the whole concept of continuously improving professional practice within the health and social care service. As Chief Executive of the Northern Ireland Practice and Education Council for Nursing and Midwifery (NIPEC) which has as part of its remit the responsibility to support practice and quality development some of these tensions continue to exist today.

Tensions still exist about what Audit actually is. I always favoured a simple definition:

- What should be done (informed by evidence, standards, indicators)
- What is being done (measuring objectively using various tools)

- What needs to happen (to address the difference if any between what should be and is actually happening)
- What has improved (measuring again and comparing results, including planning further work if necessary)

Important elements in Audit activity were leadership, ownership and involvement, use of best available evidence and having a systematic approach. Frequently if any of these elements were missing the ultimate outcome would be lessened.

In addition an Audit project might fail to complete at least a full cycle. This was really frustrating. At best those involved failed to get the positive feedback of the outcome of the "audit" or at worst the "audit" failed to achieve its maximum impact in terms of improvement of patient care. Tensions about what is research and what is audit also continue to exist and sometimes Audit is confused with undertaking a survey or measuring activity.

On a more positive note however, and possibly with the advent of more partnership working and clinical and social care governance, the proper involvement of members of the relevant team does appear to have improved. In addition whilst the involvement however of patients/users/carers remains patchy, there are some innovative examples where their involvement has been given priority.

One of the more disappointing areas of development I think is the relative lack

of value given to audit activity as a developmental activity which can create significant job satisfaction. As an important activity in relation to building the professional workforce capacity and mechanism to provide positive feedback it is vital that more regional and organisational recognition is given to this important professional activity.

Lastly the Audit journey started with a very useful Policy Directive which I believe greatly helped its strategic development. I would hope that there will be renewed policy directive given to this important professional activity along with the proper focus on the necessary elements. Perhaps the move to five HSS Trusts and the establishment of the HSS Authority will provide the dynamic context for this.

Finally, I view the personal development of being a Regional Audit Facilitator highly and the competencies the experience allowed me to develop have proved valuable in my subsequent career development. I am indebted to Paul Simpson (DHSSPS) for the policy support and to Dr Philip McClements (DHSSPS) for his leadership and support and the many professional colleagues who provided me with the opportunity to share their audit journey."

Paddie Blaney
Chief Executive, NIPEC

RMAG CONFERENCE 2006

RMAG held a second Conference on Thursday 12 October 2006 at the Rosspark Hotel, Kells, Ballymena. The day was packed full with many presentations from multiprofessional whom we thank most sincerely for taking the time to prepare and present their extremely interesting presentations. Your contribution made the day a total success.

We had approximately 176 delegates turn up on the day with approximately 9% no show on the day (an increase on the March Conference when we only had a 3% no show). Delegates came from both North and South of the Border.

Opening Remarks, Professor Robin Davidson, Chairman RMAG/Consultant Clinical Psychologist

Speakers included:

Dr Philip McClements, *The History of RMAG*

Noel McCann, Director of Planning & Performance Management, DHSSPSNI, *The Future for Audit, Guidelines and Standards*

Professor Robin Davidson, Chairman RMAG/Consultant Clinical Psychologist, *Getting Evidence into Practice*

Mrs Yvonne Kirkpatrick, Governance Manager, Belfast City Hospital, *Governance & Audit*

Audits included:

Orthopaedics

- Regional Lower Limb Amputations in Northern Ireland During 2001.
- An Audit of Scoliosis Surgery in Northern Ireland.
- Improving Informed Consent & Notekeeping in Spinal Decompression Surgery – Will Audit Help?
- Internal Fixation of Proximal Humeral Fractures with PHILOS.

Cancer

- Assessment of FDG PET & Pathological Responses Following Neoadjuvant Chemotherapy for Oesophageal carcinoma.
- Bed Utilisation (Oncology).
- An Audit of Coexistence of Prostatic Carcinoma in Patient undergoing

Radical Cystoprostatectomy for Urothelial Carcinoma

- Chemotherapy Complications

Diabetes

- Review of Community Diabetes Nursing Service in Sperrin Lakeland Trust.
- Medication Counselling for Women with Diabetes.
- Review of Podiatry Services Following Introduction of New Diabetes Screening Format.
- Audit of Insulin Storage at the Midland Regional Hospital, Portlaoise.

Obs & Gynae

- Smoking in Pregnancy – An Observational Study.
- Medical Management of Miscarriage.
- Royal Jubilee Maternity Service – Patients Transferred and Delivery Deferred – Reasons, Risks and Outcomes
- Incidental Ultrasound Findings - Audit of Incidental Ultra Sound Scan Findings (UKCTOCS)



Left to Right: Mr Noel McCann, Director of Planning & Performance, DHSSPSNI. Dr Glenda Mock, Principal Medical Officer, DHSSPSNI.

RMAG CONFERENCE 2006

Life Span

- Audit to Evaluate a Specialist Multi-Professional Visual Assessment Clinic for Adults with Learning Disabilities.
- Audit of Appropriateness of Resuscitation and Documentation of 'Do not Resuscitate Orders'
- Development of Continence Services.
- Moving up to Adult Services – The Adolescent Challenge

Patient Care

- Appropriateness and Effectiveness of the Pulmonary Rehabilitation Team, Medical Specialities Team
- Best Practice Initiative, Emergency Department.
- Predictor of Excess Mortality Post Myocardial Infarction in Females.

Key Regional Issues

- Tackling Childhood Obesity: Results of A Pilot Intervention
- Analysis of Neuro-Rehabilitation Functional Outcomes

- Chronic Obstructive Pulmonary Disease in Primary Care

Thanks also goes to Professor Robin Davidson, Dr Denis Morrison and Mr Noel McCann, who very kindly chaired morning and afternoon sessions.

All presentations can be obtained by contacting the RMAG office. If you have any comments you would like to make regarding anything you heard at the conference, please feel free to contact the RMAG Office.



Left to Right: Dr Denis Morrison, Pharmaceutical Advisor, NHSSB, Professor Robin Davidson, Chairman, RMAG.

Funding for 2006/2007

Trust/Board

Belfast City Hospital

Craigavon Area Hospital

DHSSPSNI
Diabetes UK (N Ireland)

HMP Hydebank

HMP Hydebank

Nursing & Midwifery (QUB)

Royal Jubilee Hospital

Ulster & Community Hospital

Ulster & Community Hospital

Ulster & Community Hospital

Title

Audit of System and Processes for Core Activity of the MacMillan Support and Information Service

Multidisciplinary Audit of Trauma Service Provision in CAHGT

Regional Audit on Consent

Regional Audit of Structured Diabetes Education in Northern Ireland

Audit of Self Administration of Medicines within NI Prison Service

Audit of Inmates Medical Records (IMRs) within the NI Prison Service

Prospective Regional Audit of Planned Caesarean Section at Term

Audit of Paediatric Critical Care Transfers in Northern Ireland

Regional Audit of Pre-Hospital Anaemia Management in Patients Requiring Blood Transfusion

Regional Audit of Care After Death: Systems, Processes and Practices in Bereavement Care

Regional Audit of the Risk Assessment and Management of Sex Offenders

Next Issue

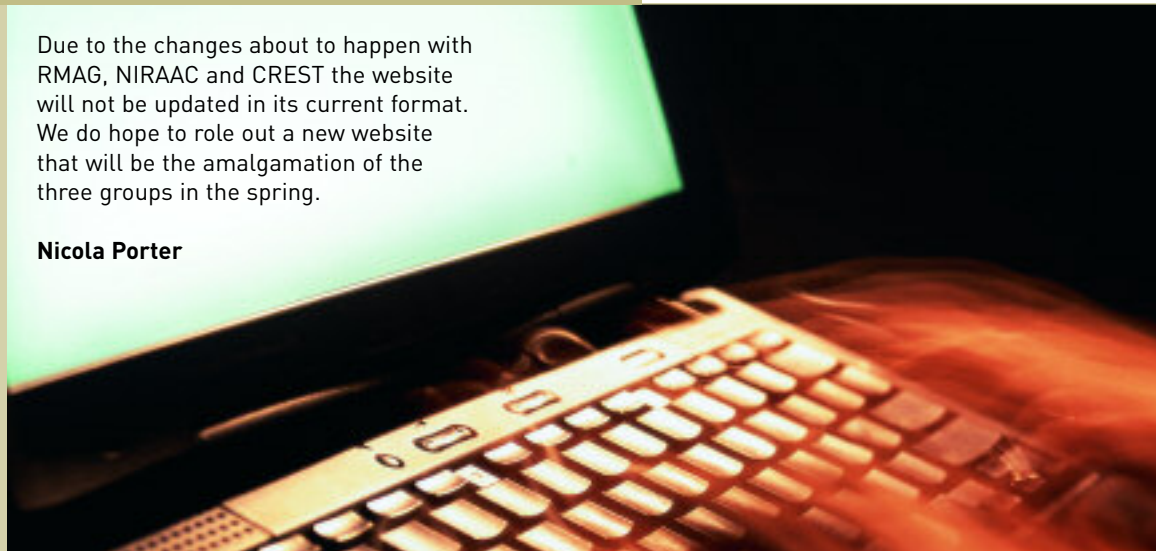
We are currently unsure what format the next edition of Gleanings will take. It will still include however:

- Completed Audit Summaries
- Information on Trust/Board Audit Days/Study Days
- Information on the Implementation of the new Audit and Guidelines Body.

RMAG Website

Due to the changes about to happen with RMAG, NIRAAC and CREST the website will not be updated in its current format. We do hope to roll out a new website that will be the amalgamation of the three groups in the spring.

Nicola Porter



Moving On

In March of this year Louise Dunlop started her new post as Manager in the Registrar's Office in Queen's University, Belfast. Louise had spent the last four years of her career at Green Park Healthcare Trust as the Clinical Governance Manager, with responsibility for Audit. We wish Louise every success in her future career and thank her for her time and commitment to clinical audit

Also on the move are Carol Lutton from Down Lisburn Trust and Jill Taylor. Carol has been seconded into the post of Clinical & Social Care Governance Co-Ordinator and Jill has been seconded as Multiprofessional Audit Manager. We wish them both well.

Nicola Porter

Resources

Regional multiprofessional Audit Group
Clinical Resources & Efficiency Team
Irish Society for Quality & Safety in Healthcare
National Institute of Clinical Excellence (NICE)
Healthcare Commission
Department of Health (NI)
Department of Health
General Medical Council
Healthcare Events
Northern Ireland Practice and Education Council for Nursing and Midwifery
Royal College of Nursing

www.rmagni.gov.uk
www.crest.org.uk
www.isqsh.ie
www.nice.org.uk
www.chai.org.uk
www.dhsspsni.gov.uk
www.doh.gov.uk
www.gmc-uk.org
www.healthcare-events.co.uk
www.nipep.n-i.nhs.uk

www.rcn.co.uk

2007 Conferences

Good Practice in Consent

Tuesday 30 January 2007 at Portland Place, London. Contact Healthcare Events on 020 85411399 or email hayley@healthcare-events.co.uk

Clinical Audit 2007 – Seventh Annual Conference

Tuesday 6 – Wednesday 7 February 2007 at Savoy Place London. Contact Healthcare Events on 020 85411399 or email Naomi@healthcare-events.co.uk

NICE 2007: Annual Conference

Wednesday 5 – Thursday 6 December 2007, in Manchester. Conferences information will be on the NICE website at a later date. www.nice.org.uk

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