REGIONAL AUDIT GLEANINGS

THE NEWSLETTER OF GUIDLINES AND AUDIT IMPLEMENTATION NETWORK
ISSUE 2 MARCH 2009

GAIN
GUIDELINES AND AUDIT IMPLEMENTATION NETWORK

# EDITORIAL

As we approach our second annual conference it is useful to summarise the activities of GAIN over the last year. In the last year GAIN has approved 9 audits and 5 guidelines. Some of these have been done at short notice in response to local pressures in the system.

We are working to ensure a more comprehensive presence for Northern Ireland with relevant national bodies.

Nicola has been appointed Finance Officer for the National Audit Governance Group (NAGG), which strengthens and develops our links with that body and have started to forge links with the Healthcare Quality Improvement Partnership (HQIP).

We have also expanded our links with SIGN and we already enjoy useful links with NICE through the Regional Co-Ordinators.

In the GAIN Office we have appointed a full time secretary and are in the process of obtaining a full time regional audit facilitator to allow us to take GAIN directly to the Trusts.

We hope to develop patient and client involvement on all our committees. We will be running patient training to facilitate this at the end of March in collaboration with NICAN. Our training programme has included several successful training seminars such as Systematic Review Training and Clinical Audit Workshops, including an interactive discussion forum on issues surrounding clinical audit, run by Martin Ferris and his team from Sheffield Primary Care Trust.

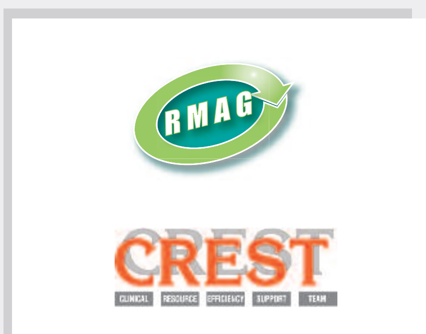
The website continues to develop and we hope it will become a useful means of communicating with the GAIN Office. We will have a section for audit tools on the website in order to make them more accessible and in time would hope to include the results of audits on the website and are happy to include audit reports on the website.

We have held a successful joint workshop with RQIA to explore communication between Primary and Secondary Care and we are hoping to recommence regular meetings with the Trust Audit and Governance

Managers when the GAIN Office is fully staffed. GAIN continues to form a useful part of the Safety Quality and Standards Directorate.

We are grateful to everyone for their continued help and involvement in 2009.

**Tom Trinick**
**Chairman GAIN Strategic Committee**



# Role of the Operational Comittee

As the name suggests the Operational Committee is the group responsible for the management of GAIN's ongoing work programme. The Operational Committee has membership of 23, most of whom are clinicians from a range of specialities and local Trusts. As well as doctors there is dental, nursing, AHP, Pharmacy, social services and medical physics representation. It is however impossible to have an exact proportional speciality, professional and geographical spread. Much more important is that the individuals on the Operational Committee have clinical, research or audit experience and that other essential characteristic, enthusiasm.

The stated remit of the Operational Committee is to commission, monitor, evaluate and disseminate regional audits and guidelines. In practice the key role of the Operational Committee is topic selection. As we have currently an acceptance rate of approximately one third of all submissions, it is critically important that the selection procedure is equitable, workable and transparent. We now have clear selection protocols in place which apply equally to all submissions irrespective of their source. If a member of the Operational Committee is also one of the team who have made a submission they are excluded from all discussions relating to that proposal. Other more general conflicts of interest are to be formally assessed twice a year. As the selection meeting takes place only annually we have retained the capacity to fast-track submissions when necessary. However, these also must undergo the same rigorous selection procedure.

After the topic has been selected and funded the Operational Committee is responsible for ongoing support, monitoring and process evaluation. For example the Operational Committee will select the Chairman of any guideline development group who will then be offered informal induction and training. As part of this process GAIN runs a training programme which includes workshops on issues such as guideline development, systematic reviews and audit methodology. Once the audit or guideline is complete it is published by the Operational Committee and in the case of guidelines there is normally a GAIN sponsored launch.

GAIN regards proactive dissemination as one of the most important ways of ensuring that guidelines and audit *"make a difference"*. Conferences, website, gleanings and launches are all important components of this process.

The Operational Committee has a number of important challenges for

the incoming year. These include the development of more accurate assessment protocols and the meaningful involvement of patients and clients in the work of the committee.

For a group people from such a variety of disciplines and specialities the Operational Committee has very quickly become a thriving, enthusiastic and effective committee. I would want to take this opportunity to thank all of the individuals who have contributed to the work of the Operational Committee over the past year, for their effort, expertise and enthusiasm.

**Robin Davidson**
Chairman of GAIN Operational Committee

# GAIN Medical Devices Committee

It is my pleasure as Chair, to introduce you to GAIN Medical Devices Committee.

This is a new committee; replacing the CREST Medical Devices Committee, which I chaired for 15 years. The GAIN Medical Devices Committee builds on the earlier work of the CREST group, which produced many successful evaluations resulting in significant improvements in Patient and User Safety and highlighted areas of concern which required interventions such as Training.

The emphasis of this new committee is Patient and User Safety in the area of Medical Devices and it is anticipated that it will produce 2 reports per annum.

The Terms of Reference for the committee are as follows:

- The committee will carry out 2 User Evaluations of equipment per annum on topics agreed by the Strategic Committee of GAIN
- The committee will provide resolved advice to the Strategic Committee of GAIN, on which topics should be selected for evaluation, having assessed these in terms of priority against agreed criteria
- The evaluation will include careful attention to risk, safety and quality and recognised variation in user practice
- The committee will develop appropriate methodologies for evaluation based on relevant up to date best practice
- The committee will liaise with NIAIC, MHRA, RSA, RQIA and the Safety Forum as appropriate

This committee looks forward to making a valuable contribution to the Patient Safety agenda through its work with Medical Devices.

I plan to retire end of April 09 and the next meeting will be my last. I would like to take this opportunity to wish this new Committee and GAIN every good wish and success in their future endeavours to improve Patient and Client Safety.

Mrs Elizabeth A Qua, OBE,
Director Health Facility Planning,
Health Estates, DHSSPS

**The current Membership of the committee is as follows:**

| Name | Organisation |
|---|---|
| Liz Qua (Chair) | DHSSPS |
| Eddie Kearney | Belfast HSC Trust |
| June Champion | Belfast HSC Trust |
| Brendan McGrath | Western HSC Trust |
| Bryan Snoddy | NI Ambulance Service |
| Tom McGarey | NI Ambulance Service |
| Brian Patterson | BMA |
| Paul Megarity | GP, Bangor |
| Damien Carson | South Eastern HSC Trust |
| Susan Baxter | South Eastern HSC Trust |
| Timothy Sheehan | South Eastern HSC Trust |
| Paul Kerr | Southern HSC Trust |
| Michael Ross | Southern HSC Trust |
| Michael Scott | Northern HSC Trust |
| Brian McIvor | RSS |
| Paula Rogan | DHSSPS |
| George M Russell | DHSSPS |
| Alan Denham | DHSSPS |
| Nicola Porter | GAIN |

# Quality = Safety and Standards

> ***"No man ever reached to excellence in any one art or profession without having passed through the slow and painful process of study and preparation"***
>
> **(Horace, 65BC – 8BC)**

Quality, like beauty, is in the eye of the beholder. The word seems to be everywhere in health and social care these days, not just here in Northern Ireland! But what does it mean? And does it mean the same thing to different people – patients or clients, policy makers, service providers, and carers?

The USA's Institute of Medicine (IOM) definition of quality (as relevant to our integrated health and social care system) has become widely accepted as a common and generic definition. This defines quality as *"the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."* The two key words in this definition are 'outcomes' and 'knowledge' - improving outcomes for people and doing so by use of the most reliable and up-to-date knowledge, otherwise known as "best practice".

To reflect on Horace's wisdom, we need to **study** best practice and encourage a learning culture, especially one that learns from incidents where things go wrong. Then we need to **prepare** using guidance to deliver services in ways that can achieve high quality outcomes in care.

The IOM, in a more detailed definition of quality, coined the term STEEEP - i.e., all health and social care should be safe, timely, effective, efficient, equitable, and patient or client-centred. While in his review of the NHS in 2008 Lord Darzi highlighted three key components of quality – safety, patient experience and effectiveness (or standards) of care – the quality agenda for us is one focused on the **patient/client, standards** and **safety**.

**Standards**

For Northern Ireland's integrated health and social care system the Government's framework for quality improvement was first outlined in the DHSSPS's 2001 publication Best *Practice Best Care.* This focused on:

- strengthening clinical and social care governance arrangements,
- the development of service standards,
- links with national standard-setting and patient safety bodies, and
- enhanced regulation, inspection and review of services by the Regulation & Quality Improvement Authority (RQIA).

This emphasised setting **standards** - effectiveness, timeliness, equity, etc. This first significant milestone was quickly followed by legislation to provide for a statutory duty of quality on all HSC bodies and the creation of the RQIA (like the Care Quality Commission for England & Wales and Quality Improvement Scotland). It was set up in 2005 as an independent body to monitor, inspect and report on the availability and quality of services provided by HSC bodies, regulate certain statutory and independent service providers and encourage improvement in the quality of services.

**Safety**

*Safety First: A Framework for Sustainable Improvement in the HPSS (2006)* is our Department's substantive policy document on **safety.** In simple terms this consolidated guidance from many initiatives begun much earlier, but crucially emphasised that patient/client safety must have the highest priority for everyone working in HSC services.

In addition, it led to a range of other quality improvement activities, such as:

- Quality Standards for HSC bodies which are used by RQIA to assess and report on the quality of services commissioned and provided by HSC organisations;
- the development of Minimum Care Standards in the regulated sector;
- links with the National Institute for Health and Clinical Excellence (NICE) and the Social Care Institute for Excellence (SCIE);
- the Guidelines and Implementation Network (GAIN) to develop regional guidelines on topics not covered by NICE or SCIE, undertake a regional audit programme linked to priority areas, and evaluate the users' experience of selected medical devices; and
- formal links with the National Patient Safety Agency of the NHS including the National Confidential Enquiries (NCE).

In 2007, the HSC Safety Forum was established to promote

evidence-based interventions known to save lives and minimise harm to patients. Since then there has been significant engagement with front-line staff to bring about change through the application of UK and international best practice guidance. This builds on the work by local Trusts who have been involved with the Health Foundation's Safer Patient Initiative since 2005. Trusts are now required to produce quality improvement plans in areas such as ventilator-associated pneumonia, outlining their chosen interventions, measures and improvement goals.

### The SQS Directorate

The third significant milestone was reached in 2007 with the creation by the Department of the Safety, Quality & Standards Directorate (SQSD) in the Chief Medical Officer's Group. This established a team of policy, administrative and professional people tasked with ensuring a clearer and more proactive focus on quality along three key dimensions – namely, Patient/Client focus, Safety and Standards. This team is responsible for developing and taking forward the policy objectives in respect of quality with a particular focus on clinical and social care as seen in the diagram above. Of course several other Directorates in the Department have their particular focus on quality as well, most often in terms of effectiveness and efficiency (e.g. service design, infrastructure, human resources, etc).

One of the most innovative programmes of work to be led by the SQS Directorate concerns the development of Service Frameworks. The first wave of these service frameworks deals with the most significant causes of ill health and disability – cardiovascular health and wellbeing; respiratory health and wellbeing; cancer prevention, treatment and care; mental health and wellbeing; and learning disability.

Service frameworks will set out the evidence-based standard of care that patients, clients and their carers can expect to receive and will be used by commissioners and providers to drive measurable improvements.

### The Future for Quality

The future work programme for SQSD is varied and extensive. Clearly there is much work yet needed in the immediate future to ensure that there are clear linkages and communication protocols with new HSC bodies like the new HSC Board, Public Health Agency and Patient Client Council. Most importantly, the Directorate will work closely with all HSC bodies to develop a whole-systems 10-year strategy for service quality. That strategy will provide a clear vision for Safety, Quality and Standards in the HSC to guide service design and development long-term.

Over the next 2 years we will re-structure and enhance our adverse incident reporting and learning systems. This year will also see the introduction of a new HSC complaints procedure and further development of service frameworks for children's health and wellbeing and older people's health and wellbeing which will engage other Government Departments. And we will work closely with RQIA, the HSC Safety Forum and GAIN to ensure that their particular and key contributions to quality improvements can be maximised.

A firm foundation for safety, quality and standards has been laid in recent years with key building blocks put in place that provide a platform from which to venture forward. This will require sustained effort, clear vision and a focus on effective delivery to ensure the Northern Ireland health and social care system really can claim to provide the highest quality service along all the quality dimensions for the benefit of its people. The SQS Directorate will seek to provide the leadership needed to make that aspiration a reality.

**Dr Jim Livingstone, Director of Safety Quality and Standards Directorate at the Department of Health, Social Services and Public Safety**

# RQIA and GAIN - Partners in the Drive for Quality Improvement

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 created a new legal framework for raising the quality of health and social care services in Northern Ireland and led to the creation of the Regulation and Quality Improvement Authority (RQIA). RQIA was established on 1st April 2005 as a non-departmental public body responsible for monitoring and inspecting the quality and availability of health and social care services in Northern Ireland.

RQIA's main functions are:

- To inspect the quality of services provided by Health and Social Care Services (HSC) bodies in Northern Ireland through reviews of clinical and social care governance arrangements within these bodies;
- To regulate (register and inspect) a wide range of services delivered by HSC bodies and by the independent sector. Our inspections are based on a new set of minimum care standards which will ensure that both the public and the service providers know what quality of services is expected
- From 1st April 2009, with the transfer of duties of the Mental Health Commission to the RQIA under the Health and Social Care (Reform) Bill, we will undertake a new range of responsibilities for people with a mental illness and those with a learning disability.

RQIA and GAIN share common goals in seeking improvements in the safety and quality of health and social care in Northern Ireland. We have already identified areas for cooperation. The current GAIN guideline development project in relation to Mastitis was proposed by RQIA and the development of a guideline in relation to *Clostridium difficile* followed a recommendation of the RQIA independent review team. This edition of **Gleanings** reports on a joint GAIN- RQIA workshop looking at the interface between primary and secondary care. A proposal to carry out an audit of the implementation of the CREST guidelines on Enteral Tube Feeding in nursing homes is currently under consideration.

RQIA currently inspects 665 regulated establishments including nursing homes, care homes, children's homes, nursing agencies and independent healthcare facilities. We are currently registering a further 631 services, new to regulation, including day care, domiciliary care, residential family centres and adult placement agencies. Our relationship with these regulated services provides opportunities to help disseminate and promulgate GAIN guidance and potentially to the involvement of the independent sector in relevant regional audits.

RQIA looks forward to a strong cooperative partnership with GAIN in the future.

**David Stewart**
**Medical Director RQIA and Vice-Chair, Strategic Committee, GAIN**

# National Audit Governance Group (NAGG)

NAGG, originated following an informal meeting facilitated by the National Institute of Clinical Excellence (NICE) in November 2000. Initially, they were merely a group of people working in the field of clinical audit, who came together to work towards sharing information and representing the clinical audit community, from national and regional backgrounds and sectors (PCTs, Hospital Trusts, Mental Health Trusts),

As time went by, NAGG members took responsibility for sharing information across locally established networks. There are now over 20 members, with representation form all Strategic Health Authority geographic areas.

The group continues to meet quarterly at the Department of Health in London and has its own web-site. **www.nagg.nhs.uk**

Since the Healthcare Quality Improvement Partnership (HQIP) was established in April 2008 to promote quality in healthcare, and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales, NAGG has been keen to work with HQIP and vice versa. NAGG has recently formalised its Governance and membership arrangements, and has appointed a general secretary, a finance officer and a communications officer. The group has always had a Chair; formerly Martin Ferris, Head of Clinical Audit and Effectiveness, NHS Sheffield, who many may remember helped facilitate GAIN's Clinical Audit and Effectiveness Workshop last June. NAGG Chairmanship has since passed to Robin Sasaru, Clinical Audit & Effectiveness Lead, Sandwell Primary Care Trust, whom GAIN have invited along to their conference in March to speak about the work of NAGG. Robin commented that *"NAGG hopes to provide the focal point for NHS regional clinical audit networks, thereby acting as 'the network of networks"*.

Nicola Porter, the GAIN Manager has been appointed as the Finance Officer to NAGG and commented *"This is an exciting era for clinical audit with reviews such as 'Darzi' and what is even more exciting is that the work being undertaken in Northern Ireland will now be nationally recognised."*

**Andrew Taylor**
**NAGG Communications Officer**

# Nicola Porter, Guidelines & Audit Manager

Firstly, may I take this opportunity to thank all those who helped and supported me with invaluable advice and information during my time at University of Ulster, including my long suffering family! Happily, I graduated in July 2008 with an MSc in Management & Corporate Governance.

As you will have read in Tom's editorial there is a lot happening with GAIN. In March 2009 we will be welcoming our new secretary, who will be a valuable asset to the team in assisting with the day to day running of GAIN. We hope to appoint our first audit facilitator to help with undertaking GAIN audits, including service frameworks.

I hope that you find this magazine both helpful and informative. This is your magazine and it is our hope that you use it as a forum to show off your hard work, advertise any up and coming conferences or training sessions. In each edition we will be highlighting key regional, national and international based events which you may find useful.

May I wish you health and happiness in this year that lies before us.

Nicola

# Lymphoedema Network NI – One year on

The Lymphoedema Network Northern Ireland (LNNI) was launched by Chief Medical Officer, Dr Michael McBride alongside the CREST guidance on lymphoedema management at the Tullyglass Hotel in Ballymena, 1st February 2008.

The first year has seen the appointment of:

- The senior management team consisting of Mrs Clare McGartland (Network Chair), Ms Jane Rankin (Network Lead) and Ms Debbie Schofield (Network Project Manager);
- Four of the five Band 8a Trust Clinical Lymphoedema Leads;
- The regional network board and patient & public involvement forum.

The network website (**www.lnni.org**) was launched at the end of October 2008 and feedback received to date has been positive. All constitutions, terms of reference and minutes of meetings can be downloaded from the site. The site is continually updated and we would greatly appreciate your comments and suggestions. Please contact **info@lnni.org**. LNNI are currently developing online discussion fora for registered patients and health care professionals. Register with the website to be kept up to date with news, events and progress at **www.lnni.org/register**.

A key recommendation from the CREST guidance was the development of a regional clinic for lymphoedema patients presenting with complex comorbidities. The consultant clinical team includes Dr Nabla McLoone, Consultant Dermatologist, Northern HSC Trust; Dr Angela Garvey, Palliative Care Consultant, Western HSC Trust; and, Mr Paul Blair, Consultant Vascular Surgeon, Belfast HSC Trust. A pilot clinic has been run successfully. There will be four clinics held throughout 2009.

A service mapping project has been piloted across the Belfast, Northern and South Eastern trusts. This will allow the LNNI project team to identify current service provision, patient throughput and garment provision across the province. The team will then be in a position to evaluate resources and prioritise future improvement projects including local lobbying, formulating business cases for additional funding and directing education packages. Data collection will now be rolled out across all 5 HSC trusts. The mapping project will be supported by the information produced using the minimum dataset, which is currently under development.

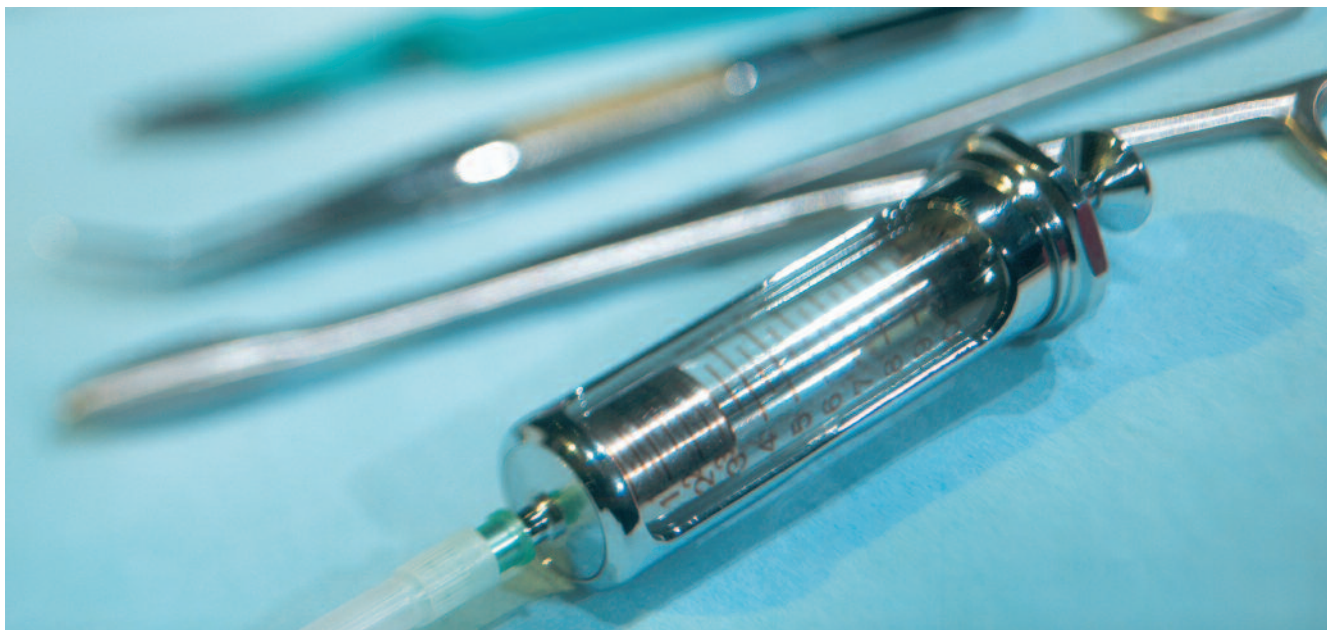
Another key aim of the network is to promote screening and early diagnosis of lymphoedema. Funding has been provided by the Friends of Cancer Centre to support bioimpedance research.

The LNNI inaugural stakeholder event took place 18th February 2009 in the Postgraduate Education Centre, Belfast City Hospital. Following presentations on regional and individual HSC trust progress from the LNNI project team, stakeholders took part in a visioning workshop which was chaired by Jennifer Welsh, Director of Specialist Services, Belfast HSC Trust. The recently published

L-R: Jane Rankin, Network Lead; Peggy Moore, PPI Representative & Network Board member; Debbie Schofield, Network Project Manager & Clare McGartland, Chair of the Network.

patient information leaflets for those at risk of developing lymphoedema were launched and will be made available across the province. A stakeholder survey to determine preferred levels of involvement with the network has since been distributed to all LNNI stakeholders. The results will be made available on the website **www.lnni.org**.

If you would like more information about the network or would like to register as a stakeholder please contact:
Debbie Schofield, LNNI Project Manager at 028 9069 9369 or debbie.schofield@belfasttrust.hscni.net



# A Re-audit of Decontamination of Patient Care Equipment in Community Facilities – Western Health and Social Care Trust – 2008

**Background to the audit**

Decontamination: *"A process which removes or destroys contamination and thereby prevents micro-organisms or other contaminants reaching a susceptible site in sufficient quantities to initiate infection or any other harmful response".*

The audit was first carried out in September 2006 by the former Foyle Trust as there was concern regarding decontamination of patient care equipment in community facilities. After the first audit an action plan was sent to each area for completion and recommendations were circulated. Thirty-seven facilities took part in the first audit. A workshop was arranged and widely attended by representatives from 36 of the 37 areas included in the audit.

**Aim of Re-Audit**

- To assess that there is a system in place, which ensures that all reusable equipment is properly decontaminated prior to use.
- To ensure risks associated with decontamination processes are adequately managed.

**Objectives**

- To establish if equipment is decontaminated as per guidelines in the Decontamination Policy in the Infection Control Manual.
- To establish that audited areas have carried out the recommendations from the initial audit.
- To investigate existing knowledge and training of staff in relation to decontamination.
- To identify gaps in knowledge and training needs.

**Standards**

- Medical Devices Directive 93/42/EEC
- Decontamination Policy, Western Health & Social Care Trust, 2007
- Infection Prevention & Control Manual; Western Health and Social Care Trust, 2008

**Methodology**

Audit tools based on the Infection Control Nurses Association Audit Tools for Monitoring Infection Control and Guidelines within the

*continued on page 10*

*continued from page 9*

Community Setting were used and were adapted for local use.

The elements audited included : -

- Knowledge of decontamination.

Decontamination of:

- General patient care equipment.
- Patient monitoring equipment.
- Manual handling equipment.
- Oxygen, suction, respirator equipment.
- Sanitary equipment.

The Infection Prevention and Control Nurse and 6 Infection Prevention & Control Link Staff collected data over a 2-week period.

**Results**

Forty-two community facilities, all from the legacy Foyle Trust, were included in the re-audit, an increase of 5 facilities.

Results showed that 92% had access to an infection control manual. In the previous audit, the trust had 3 manuals. In January 2007, the new updated Infection Control Manual was introduced and is available on the Trust Intranet. The Decontamination Policy was also re-written in 2007.

The audit shows that staff are more aware of the need to keep manufacturers' instructions and the importance of contacting Infection Control Staff when purchasing new equipment.

Examination of manual handling, sanitary and monitoring equipment indicated that there was an increased level of knowledge about appropriate decontamination practices.

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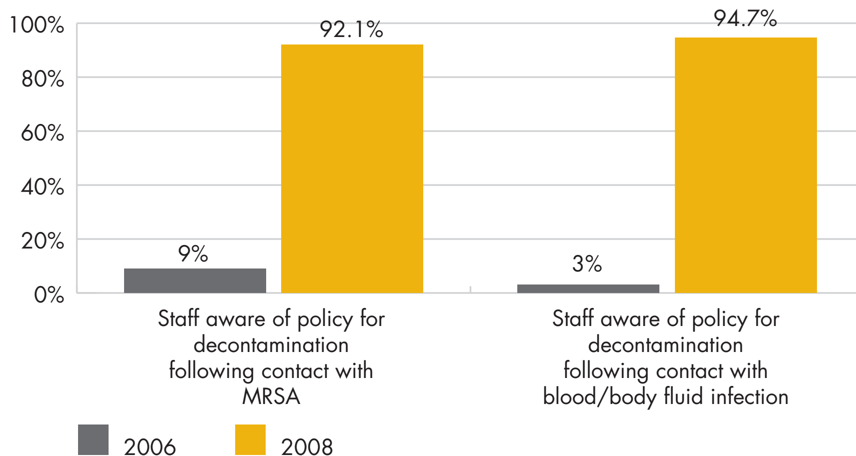



There was an improvement of 83% in staff understanding of the correct procedures when decontaminating equipment potentially contaminated with MRSA. Knowledge of the correct procedures following contamination with body fluids increased by 91%.

Staff are now more aware of the need to use the gentle detergent for cleaning and not the hand soap, as noted in the first audit.

Results showed that some pieces of equipment were reduced in cleaning standards, e.g. medicine cups, shower chairs and patients' bedside lockers and tables. The latter pieces of equipment are cleaned by Support Services daily and then cleaned when required by facility staff.

The majority of facilities did have in place documented cleaning rotas, all of which were dated and signed for evidence.

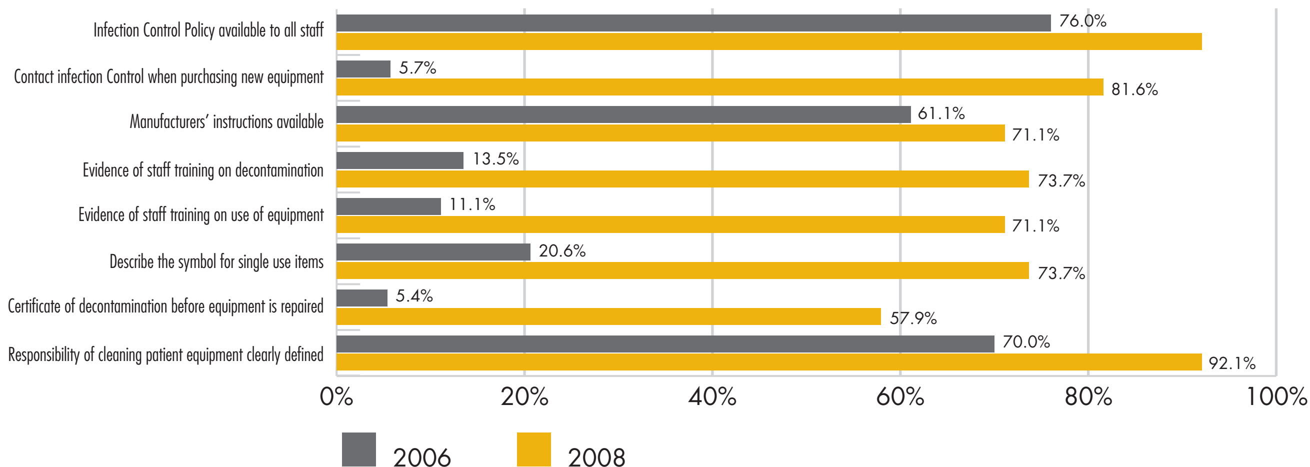
A workshop took place on 8th May 2008 in order to meet managers of each facility and their Infection Control Links. The Infection Prevention and Control Nurse and Link members fed back the audit results. Each facility was given a personalised action plan. Staff from all facilities included in the audit have worked closely with the Infection Prevention and Control Nurse to ensure all actions have been implemented. The Infection Prevention and Control Nurse also carried out follow up visits between September and November 2008.

**Impact of the Audit**

Staff now understand the importance of decontamination of all patient care equipment before reuse. They are more aware of the need to retain evidence of training. Seventy one per cent can describe the symbol for single use (an increase of 53%).

On follow up visits staff have indicated their usage of the A – Z index on decontamination included within the infection prevention & control manual. The decontamination certificate is now available and in use in the majority of facilities.

## Knowledge of Decontamination




There has been an increase of staff attendance at mandatory infection control training. Manager and staff are now recording evidence of training.

Due to the positive results and improvement in decontamination practice from this audit it has been agreed to roll this audit out across all acute hospitals and community facilities within the Western Trust. This audit is currently ongoing.

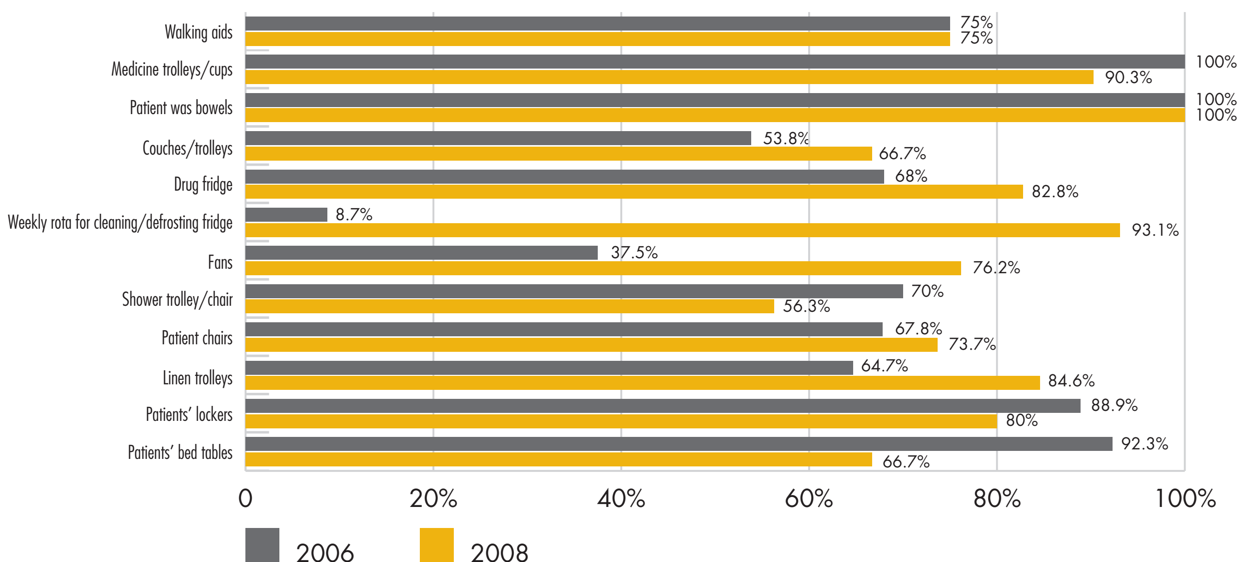
**References**

Infection Control Nurses Association; 2004, Audit Tools for Monitoring Infection Control
Infection Control Nurses Association; 2005, Guidelines within the Community Setting
Western Health & Social Care Trust:; 2007, Decontamination Policy
Western Health & Social Care Trust: 2008, Infection Control Manual
93/42/EEC; Jan1995-June 1998, Medical Devices Directive

**Acknowledgements**

Infection Control Link Members: Helen Brolly, Nuala Devine, Marion Deeney, Wendy Ferris, Kareen McCauley, Diane Parker, Elizabeth Gallagher, Professional Audit Co-ordinator and Deirdre Kelly, Professional Audit Facilitator Angela Thompson, Infection Prevention and Control Nurse

## General Patient Care Equipment



# Seeking to improve the interface between Primary Care and Secondary Care in Northern Ireland - December 2008

Key stakeholders in primary and secondary care in Northern Ireland have raised concerns about the quality of communication between practitioners in each sector. They felt specifically that the standard of immediate discharge information was deficient in content, structure and production which constituted a significant patient safety concern. To begin to address this issue RQIA and GAIN agreed to hold a workshop to elicit further information and views on this subject and begin to formulate an action plan to address any identified problems.

The workshop was held on 1 December 2008 and brought together key stakeholders in Northern Ireland to share, inform and examine issues relating to communication between the sectors.

The workshop aimed to:

- Explore the current interface between Secondary Care and Primary Care across the five health and social care trusts
- Identify problems;
- Look at good practice from other areas
- Make recommendations for a way forward to deal with any identified problems

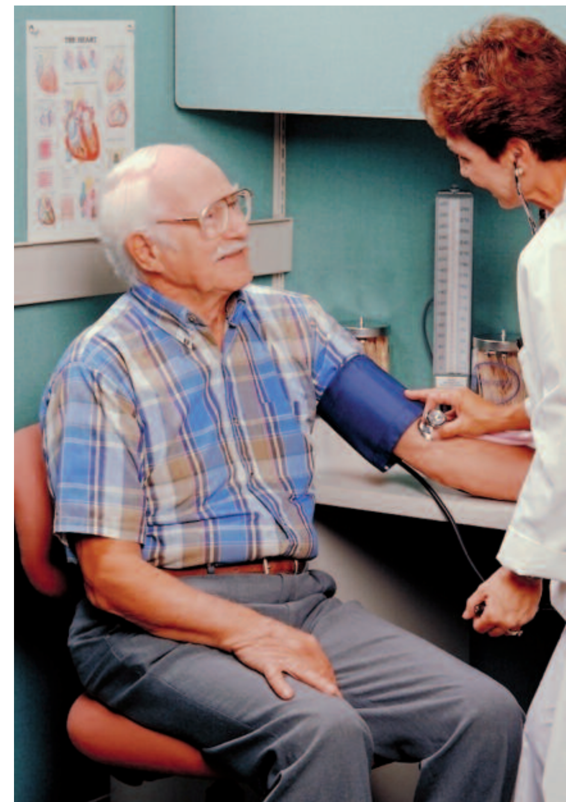
A number of presentations were given throughout the day.

The keynote presentation was given by Dr Zygmunt Krukowski, Consultant Surgeon Aberdeen Royal Infirmary, who outlined his work as chair of a SIGN guideline development group which had developed the immediate discharge documentation in Scotland in 2003.

A number of local speakers shared their experiences on communication between primary care and secondary care.  The presentations included:

- A primary care perspective provided by Dr Colin Fitzpatrick, GP and NCAS Representative.
- A secondary care perspective provided by Dr William Dickey, Consultant Gastroenterologist, Altnagelvin Hospital
- Pharmacy perspectives provided by a team representing Prescribing Advisors
- An ICT perspective provided by Mr Brian McKeown Acting Director of Information Services DHSSPS

Finally Dr Sloan Harper provided a review of a recent visit to the Kaiser Permanente organisation in America, outlining their approach



to both primary and secondary care and also the interaction between these two aspects of healthcare.

Participants took part in three discussion sessions during the day:

- Delegates were asked to discuss and identify the five key issues to be resolved regarding communication between primary and secondary care.
- Delegates were divided into two groups, primary care and secondary care. Each group was asked to consider and

identify the challenges and barriers to improving communication between sectors and how to overcome them.

- Delegates were asked to consider ways of taking the issue of improving communication between the sectors forward, with particular regard to immediate discharge documentation.

**Workshop Recommendations**

The delegates considered that there is an urgent need to address the patient safety issues which emerged at the workshop and that the priority area should be to focus on improving the quality of information provided at the time of patient discharge from hospital.

Recommendations for next steps are:

1) A regional group should be established by GAIN/RQIA, with primary care and secondary care representatives from relevant disciplines, to define a standard discharge dataset for use in Northern Ireland;

2) The regional group should evaluate the Scottish solution for immediate discharge information, as drafted by the Scottish Intercollegiate Guidelines Network. as a possible "fit for purpose" solution for Northern Ireland.

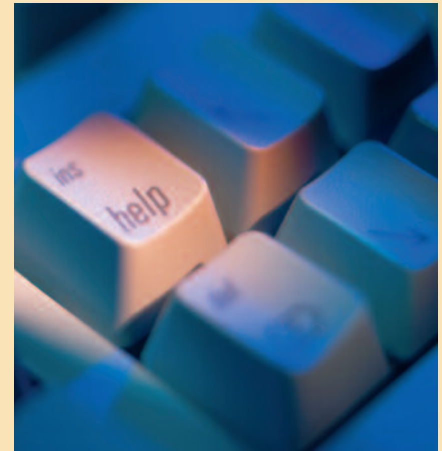
**Hall Graham**
**Head of Primary Care Review, RQIA**

# Better Information for Audit - Developing a Mental Health Minimum Dataset

Whether it's an MLA's urgent question to the Assembly or a local professional audit, we all need information that is accurate, up to date and intelligible. Surprising though it may seem for the 21st century, in Northern Ireland we do not yet have a central information system that can meet these needs.

The Service Delivery Unit (SDU) is now leading a process of service improvement across the entire system of health and social care. The development of a single information point for mental health and learning disability services that helps drive service improvement is one of the top priorities for the SDU.

In Phase One of this project, due for completion by April 2009, the focus will be on in-patient services. Software has been commissioned which will enable five different systems to upload data to a central warehouse where the combined data from the five Trusts will be available for a wide number of potential uses – performance management against agreed targets, local professional and/or clinical audit, local management of services, local and regional assessments of need and the commissioning of additional services where there are gaps.




It is intended that the data will eventually become accessible through the SDU web portal. With appropriate permissions and safeguards, the data can be used for the variety of purposes described above at both regional and local level.

In Phase 2, planned for 2009/10, the focus will broaden to include community and outpatient services.

The vision is that the data in the warehouse, collected consistently and refreshed on a very regular basis, will be a rich source of information to a very wide variety of partners and will represent a huge leap forward for mental health and learning disability service providers, managers, commissioners and policy makers.

**Seamus Logan, Programme Director, (Mental Health, Social and Community Care), Service Delivery Unit**

# Guidelines on the Treatment of Hyperkalaemia in Adults

In response to clinical need and a request from the Department of Health and Patient Safety a working group chaired by myself produced the guideline for the Treatment of Hyperkalaemia in Adults under the auspices of CREST in January 2006. The guideline addressed aspects in relation to the management of hyperkalaemia including the aetiology of hyperkalaemia, assessment of the patient, monitoring of the patient, and treatment of the raised potassium level. In particular, the safe and effective use of insulin in reducing the potassium level was emphasised.

The original guidance was well received and was not only quoted on the National Patient Safety Agency website but CREST had requests from other interested parties as far away as Australia for permission to use the guidelines.

Following publication of the 2006 guideline further work was undertaken, initially in the Belfast City Hospital, to develop a customised kit to treat hyperkalaemia in the adult patient. The kit was piloted in units within the Belfast City Hospital and was very well received. The work was considered of sufficient importance that under the auspices of GAIN the original 2006 CREST guideline was updated to incorporate the recommendation that the customised kit should be employed to treat a significantly raised serum potassium level in adults. Further emphasis was placed on the safe and effective use of insulin combined with glucose in the treatment of hyperkalaemia. There was particular attention paid to the requirement for the use of an insulin syringe and of a second check of insulin volume (number of units) by a senior nurse before administration to the patient.

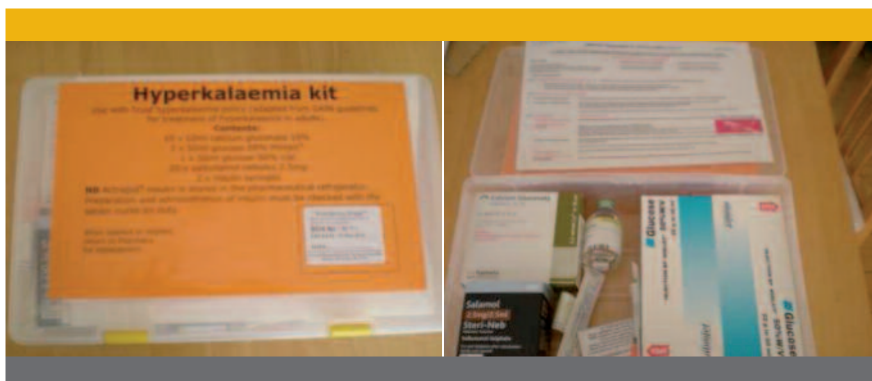
The hyperkalaemia kit has now been rolled out across all trusts in Northern Ireland and an e-learning package on the Management of Hyperkalaemia, based on the Regional Guidance produced by GAIN, will be available on the NIMDTA website. Recognition for this work resulted in the

**How to make up 10 units of Actrapid® (soluble) insulin in 50ml glucose 50% Minijet® using the hyperkalaemia kit**

Protect the cardiac membrane: give 10ml of calcium gluconate 10% IV over 2 mins (NB if patient on digoxin, and calcium gluconate required, give slowly over 20 mins in 100ml of glucose 5%).

1. With the nurse in charge, obtain an Actrapid® vial from the pharmaceutical fridge.
2. Take the glucose 50% Minijet® glass vial from the kit. Remove its blue protective cap.
3. Measure 10 units of insulin using an insulin syringe from the kit:
   a. Draw the plunger back to the 10 unit mark on the insulin syringe. Check the 10 units of insulin obtained with the senior nurse on duty.
   b. Note 10 units of insulin is contained in 0.1ml
   c. Record administration of this and other medicines used to treat hyperkalaemia on the Kardex. Ensure both signatures for double check are documented on the Kardex.
4. Inject the 10 units of insulin through the blue stopper of the glucose 50% Minijet® glass vial.
5. Mix.
6. Remove the yellow protector cap from the Minijet® injector.
7. Thread the glucose 50% Minijet® glass vial into the Minijet® injector three half turns or until the needle penetrates the stopper.
8. Remove the yellow cap from the tip of the Minijet® injector and expel air.
9. Administer into a large vein by slow IV injection over 5 mins.
10. If difficulty in administering insulin/glucose using the Minijet® (preferred method), use the glucose 50% vial in the kit.
11. Monitor and document blood glucose 30 mins after administration of insulin/glucose and then hourly up to 6 hours after completion of administration.
12. Monitor U&Es 30 mins after each administration of insulin/glucose. If good response, check U&Es 1-2 hours after last intervention.

hyperkalaemia entry winning the Chairman's Award for the Belfast Trust. The award was presented to Ms Sharon O'Donnell, Medicines Governance Pharmacist who accepted the award on behalf of the team that included Professor Gary McVeigh, Dr Paul Hamilton, Professor Peter Maxwell, Ms Cora Sonner, Dr Julian Johnston, Dr Tony Stevens, Ms Louise Skelly and Ms Colette McBride. However, it is important to acknowledge all of those who not only contributed to the development of the guidelines but all other initiatives relating to the project to manage hyperkalaemia safely and effectively in adults. I would like to acknowledge the contributions of Dr Sean O'Hare and Ms Christine Murphy.




**Gary McVeigh,**
**Professor of Cardiovascular Medicine, Belfast HSC Trust**

# What is CHAIN?

**CHAIN (Contact, Help, Advice and Information Network)** was established to enable people in health and social care to exchange ideas and knowledge, and to facilitate networking between those who have common interests or complementary aspirations. CHAIN now has around 7000 members from UK and beyond.

**Who is CHAIN for, and what are the benefits?**
The network is for anyone working in health and social care who is interested in Research and Implementation, Widening Participation in Learning, Innovation and Improvement or Cancer Support & Services. This ranges from front line health and social care professionals, to educators, librarians, information specialists, researchers and managers.

- Searchable online directory
- Receiving targeted information from CHAIN
- Publicising information on the network

**The main features of CHAIN**
- An unparalleled pool of experience and tacit knowledge
- Multi-professional, cross-organisational
- Non-hierarchical, low key & informal
- All members join voluntarily
- Members are responsive and supportive
- Messages are precisely targeted
- Contacts can be found locally, from within one country or internationally
- Membership is undemanding
- CHAIN is free to join and use

**How CHAIN works**
There are currently 4 main components of CHAIN which reflect members' primary interests. Networking is possible within and across these components. CHAIN also includes more than 10 crosscutting thematic sub-groups and 20 special interest groups which enable members from different components of the network to focus on areas of common interest. For example:

**Join now**
Having a role in a relevant organisation and being willing to share experience and aspirations and to respond to other members' questions are the only criteria for joining. To join CHAIN, visit

# Mobile Bearing Total Knee Arthroplasty without Patellar Resurfacing. Survivorship at a Minimum 10-year Follow-up.

**Does the unresurfaced patella affect outcome?**

Whether or not the patella should be resurfaced during total knee arthroplasty (TKA) remains controversial with few published studies showing the long term results of non-resurfacing. The aim of this study was to evaluate the long-term outcomes of mobile-bearing TKA without patella resurfacing and to investigate the impact of non-resurfacing on re-operation rates for anterior knee pain.

We examined the outcome of 503 consecutive patients (600 knees) with a cemented Low Contact Stress (LCS) mobile bearing TKA (DePuy Orthopaedics Inc, Warsaw, Indiana) without patellar resurfacing at a minimum follow-up of 10 years (Range 10-13 years).

Out of 365 patients (434 knees) still alive at the last review, 315 patients were able to attend for both clinical and radiological assessment while 50 patients were reviewed by telephone. Four knees had been revised, 2 for deep infection, 1 for tibial component loosening and 1 for collapse of the lateral femoral condyle. 9 patients (1.5%), all with a primary diagnosis of osteoarthritis, had secondary resurfacing of the patella for anterior knee pain and 2 patients had bearing dislocation (spin-out) treated by open reduction and cast immobilization for 8 weeks.

Radiographs were available for 312 knees none of which showed radiolucent lines or osteolytic defects around the prostheses.

With re-operation for any reason as the endpoint the overall survivorship was 98%. We conclude that the Low Contact Stress mobile bearing TKA has excellent survivorship at 10 years and non-resurfacing of the patella does not affect long-term outcome.

Seamus O'Brien (PhD) and Mr David Beverland (MD FRCS)

# Regional Discharge and Patient Transfer Protocol for Patients with *Clostridium difficile* Infection

The prevalence of *Clostridium difficile* infection has risen at an accelerating rate over the last decade, initially in hospitals and more recently in the community. It is predominantly a disease of the frail elderly who may have pre-existing debilitating conditions which necessitate hospital and/or residential care. Such patients often move between different care settings, and may also require therapeutic interventions which increase their susceptibility to *C. difficile* infection. The condition is readily transmissible between susceptible individuals but standard infection control measures are effective. For this reason it is essential that all those involved in the care of patients who have had *C. difficile* infection are informed of the patient's *C. difficile* status.

In the spring of 2008 the RQIA performed an independent review on *C. difficile* in the Region, and in their report, recommended that Regional guidance should be developed for effective communication about *C. difficile* between different care settings. Information should be available for guidance about treatment for patients being admitted to different facilities. Concern was expressed that hospitals could not easily identify patients who had a history of *C. difficile* infection during previous admissions to health and social care facilities.

In order to address this gap in current communication arrangements GAIN formed a multidisciplinary group of healthcare professionals, from a variety of backgrounds, which was chaired by Dr Hugh Webb, Head of Microbiology and Infection Prevention and Control Doctor in the South Eastern Health and Social Care Trust.

The guideline is not aimed at experts in the field, but at healthcare professionals who may be involved in the referral, transport, admission or discharge of patients who have or have had *C. difficile*infection. Particular emphasis has been placed upon the needs of those professionals for whom contact with *C. difficile* patients may be an uncommon event. The guideline has been produced in 3 months in order to achieve early implementation. This will support and augment all the measures which are being directed towards reducing the incidence of *C. difficile* infection in health and social care. The short timescale precluded a regional IT-based solution and a paper based system has been chosen.

The principle of the system is that every patient referral to hospital will be accompanied by a simple statement of the patient's *C. difficile* status. All admissions will have an infection prevention and control admission risk assessment, and all discharges/transfers of patients who have had *C. difficile* infection will be accompanied by a *C. difficile* checklist.

These specific actions are supported by general advice for GP's and Care Homes concerning the nature of *C. difficile* infection, and the core principles of prevention, diagnosis and management. These are not intended to be exhaustive and for more detailed information GP's and carers are referred to the Regional Infection Prevention and Control website.

The guideline also contains recommendation to improve communication between Trusts and Public Health services, in particular to enable identification of case clusters in the community.

Sample audit tools to assess the utilisation of the system are provided.

**Hugh Webb**
**Consultant Microbiologist, South Eastern HSC Trust, Ulster Hospital**

# GAIN Mastitis Guidelines

The GAIN Regional Mastitis Guidelines Working Group has been meeting regularly since February 2008. This multi-disciplinary working group is tasked with developing regional clinical guidelines on the prevention, management and treatment of mastitis. The aim of the guidelines is to aid appropriate diagnosis, treatment and care for women with lactational mastitis Approximately 1 in 5 breastfeeding women will experience mastitis and unfortunately women do not always receive the information or support they need to avoid mastitis or manage it if it does occur. Mastitis is associated with breastfeeding problems and early cessation of breastfeeding. The symptoms of mastitis include flu like symptoms, pyrexia and breast pain and can be extremely debilitating, if treated inappropriately can result in a breast abscess in 3% of cases. The need for these guidelines was highlighted by RQIA and subsequently a working group was convened by GAIN. Janet Calvert, Regional Breastfeeding Coordinator is chairperson of the group. Membership includes representatives from breast care, general practice, microbiology, accident and emergency, pharmacology, obstetrics, midwifery, health visiting, a user perspective, breastfeeding specialists and a quality and improvement manager.

The mastitis guidelines working group began this project by examining available research evidence and any existing guidelines. Julie Neill, Health Development Officer with the Health Promotion Agency undertook this initial task. It then became apparent that an evidence table was required and Magda Sachs who is a well known breastfeeding researcher and academic was consulted and asked to support the group by providing expert guidance and to undertake developing the evidence table for the guidelines. The process of involving an external consultant has proved extremely useful and has helped to ensure the project has progressed quickly.

The group agreed that it was imperative that the guidelines should be a useful multi-disciplinary document which will be an accessible and effective resource for all who care for breastfeeding mothers. With this in mind it was decided that the main guidance document should have accompanying Flow charts, one for management of mastitis and the other a pharmacological flow chart, both to used to support best practice and make the information as accessible as possible for practitioners. A new leaflet on mastitis for breastfeeding mothers based on a publication by the breastfeeding network has also been developed and will be available within the health care system here.

The guidelines and accompanying resources will be out for consultation during February 2009 and then will be for implementation following consultation by May 2009. If you would like further information about the new mastitis guidelines please contact Janet Calvert on j.calvert@hpani.org.uk or Nicola Porter on nicola.porter@dhsspsni.gov.uk. Further information about the work of GAIN can be viewed at www.gain-ni.org

**Janet Calvert**
**Regional Breastfeeding Co-Ordinator, Health Promotion Agency**

# Amber Drugs - An audit of the process of 'agreeing' shared care between specialist and GP, and of the information sent to the GP

**Background - How safe is the transfer of care for specialist drugs?**
This was a question asked by the GP Audit Team in June 2008 regarding the current Red/Amber system used in Northern Ireland. The system identifies where prescribing responsibility should lie with Amber drugs being suitable for shared care.

Amber drugs are by nature uncommon and may be new or unfamiliar to GPs. The recommendation is that they should be initiated under a consultant or specialist clinician and arrangements made to 'share care' with the local GP. This shared care system has been in place for approximately 5 years and hospitals are encouraged to supply a shared care guideline (SCG) to the GPs on a named patient basis when an amber drug is initiated. The Interface Pharmacists Network on Specialist Medicines has been working with local hospital clinicians in a number of specialties to develop shared care guidelines for amber drugs (available on line at http://www.ipnsm.n-i.nhs.uk/). It should be noted that the number of amber drugs is increasing and regular monitoring is often required.

**Reasons to undertake the audit**
There is anecdotal evidence from GPs that receipt of SCGs for named patients from the hospital has been inconsistent and concerns have been raised that hospital written requests to prescribe amber drugs have been perfunctory, or even non-existent, with the assumption that the GP will automatically comply. More importantly, critical information provided by hospital clinicians can be patchy which has major implications for patient safety, especially if the drug is being prescribed outside licence. GPs have good reason to question as:

*'In its guidelines on responsibility in prescribing between hospitals and general practitioners, the Department of Health has advised that the legal responsibility for prescribing lies with the doctor who signs the prescription.' (Circular EL (91) 127)*

**Aim of the audit:**
To ensure that locally agreed Amber Drug Guidelines are adhered to.

Objectives:
To ensure that the procedures laid down to transfer prescribing responsibility and monitoring of amber drugs to GP are carried out.

To ensure that information needed to provide care in primary care is

**Summary of Results**

| Audit Criteria | Amber Drugs Total (52 pts) | DMARDs (32 pts) | ADHDs (20 pts) | Standard Set |
|---|---|---|---|---|
| The patient's clinical record should have a record of the initiating source of the drug (hospital and specialty). | 94% (49 of 52 pts) | 100% (32 of 32 pts) | 85% (17 of 20 cases) | 100% |
| Shared care guidelines for a named patient should have been sent to the GP. | 33% (17 of 52 pts) | 44% (14 of 32 pts) | 15% (3 of 20 cases) | 100% |
| The shared care guideline should be held in the patient clinical record. | 33% (17 of 52 pts) Note - 3 cases were in patients chart only | 44% (14 of 32 pts) | 15% (3 of 20 pts) Note – In patient chart only | 100% |
| Relevant up-to-date test results should be held in the patient's clinical record. | 73% (38 of 52 pts) | 88% (28 of 32 pts) | 50% (10 of 20 pts) | 100% |

provided, at outset and as needed on an ongoing basis.

To ensure that the information enable the GP to safely prescribe the drug is available when either the patient consults or a script is requested, to enable the GP to safely prescribe the drug.

**What was done**

EHSSB practices with an attached practice pharmacist were invited to take part in the audit and ten participated from a range of localities in the EHSSB area. Practice data was collected during July and August 2008 on a maximum of six patients started on either Methotrexate, other DMARDs or ADHD treatment (Ritalin/Stattera or equivalent). These drugs were chosen as shared care guidelines exist and they straddle the specialists initiating the majority of amber drugs (excluding warfarin). A total of 52 cases were audited.

Some positive comments on shared care relating to DMARDs:

- *"Hospital monitoring patient and supplying test results, but GP is prescribing the drug".*
- *"Thorough, detailed letter from clinic to GP clearly highlighting shared care guidelines".*

Concerned comments on shared care relating to DMARDs:

- *"No reference made to shared care, just a request for GP to prescribe azathioprine".*
- *"Unable to tell if any blood tests were carried out by hospital".*

Positive comments on shared care relating to ADHDs and shared care guideline was in patient record:

- *"Effective communication between GP, dietitian and paediatric psychiatrist. Letter emphasised need for BP, weight & height measurements in addition to guidelines".*

Concerned comments on shared care relating to ADHDs

- *"Handwritten note with patient name, DOB, drug and signature. No explanation or further details about the prescriber".*
- *"Patient was on combination of Strattera & Concerta, so extra information would have been very useful".*

**Discussion of results**

The audit confirmed that in the majority of cases there was no record of a shared care guideline being received. The results were mixed depending on initiating hospital or speciality, but not unexpected. It was reassuring that ongoing monitoring of patients was happening despite a shared care guideline not being supplied by the hospital or being available in the patient's record.

**What has happened since the audit**

A series of Clinical Governance Workshops in October/November 2008 allowed EHSSB GPs to discuss the results, the problems encountered and potential solutions. A number of useful suggestions were made and the Board is currently following these up with the Integrated Pharmacist Network for Specialist Medicines.

It is encouraging that the range of indications covered on the regional shared care guidelines has been extended to cover the majority of instances where amber drugs are prescribed. This should help improve the numbers of patients for whom shared care guidelines are available.

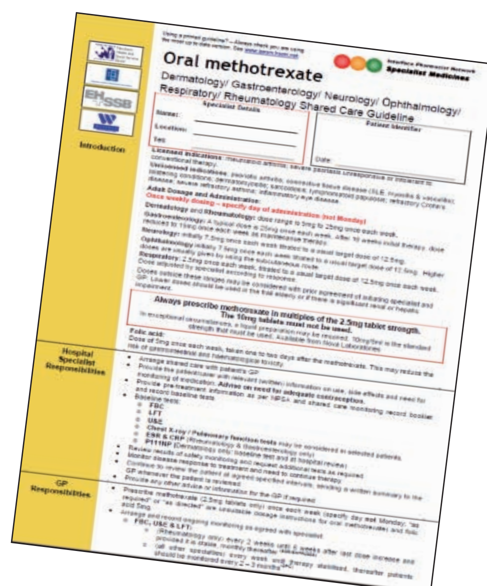
In addition, new structures resulting from the re-organisation of Trusts is providing a means for raising awareness of shared care policies by hospital prescribers.

**Key messages from the audit and discussions with GPs**

- A hard copy of the shared care guideline sent to the GP is imperative and at present this is done in a minority of cases only.
- Patient safety is compromised where responsibility is not clear and there is a lack of information transferred between secondary and primary care.
- The provision of a shared care guideline from secondary care to the GP for a named patient is essential as it shows the referring doctor's awareness of the patient's shared care status and the respective clinical responsibility of both parties.

**Acknowledgements**

James Taggart, Integrated Pharmacist Network for Specialist Medicines, Belfast HSC Trust



Oral methotrexate

Dermatology/ Gastroenterology/ Neurology/ Ophthalmology/ Respiratory/ Rheumatology Shared Care Guideline

Specialist Details

Name:

Location:

Tel:

Patient Identifier

Date:

Introduction

**Always prescribe methotrexate in multiples of the 2.5mg tablet strength. The 10mg tablets must not be used.**

Hospital Specialist Responsibilities

GP Responsibilities

**Dr Jean McClune, Denise Taylor, EHSSB GP Audit Team. Greg Miller, Locality Prescribing Advisor, EHSSB Prescribing Team.**

# Systematic Review Training – 2008

Professor Robin Davidson, Chair of GAIN Operational Committee

On 20 November 2008 members of the SIGN Team, Robin Harbour, Quality & Information Director, and Michele Hilton Boon, Programme Manager/Information Officer, came across to deliver training on Systematic Review, as this is the key component of any guideline. There has also been a recent emphasis on proper use of appropriate methodology when carrying out systematic review.

This workshop was organised as a pilot and also to help members of the GAIN Committees develop their skills in this area.

The day covered information on:

- What makes a good guideline?
- Practical exercise 1: Setting key questions and defining outcomes
- Identifying and evaluating evidence
- Practical exercise 2: evaluating an individual trial
- Summarising evidence – systematic reviews and evidence tables
- How good is your evidence?
- Practical exercise 3: Considered judgement and setting a level of evidence

Robin Harbour, Quality & Information Director, and Michele Hilton Boon, Programme Manager/Information Officer

If you would be interested in attending a future Systematic Review Training Day, please email the office with the words 'interest – systematic review training' in the subject field.

# Patient & Public Involvement

**Purpose of Patient and Public Involvement**

The purpose of Patient and Public Involvement is to provide a unique platform through which the voices of individuals affected by cancer can be heard and acted upon. Involvement which is both active and meaningful will ensure that patients and the public are enabled to participate in the planning and development of cancer services. Involvement can be at individual level in planning their own care through to active involvement in the development of regional policies or standards.

**A brief history of PPI**

In the past when patients, their carers, or indeed the public in general, have been involved in the health service their input has often been little more than a box ticking exercise. However, over recent years things have been gradually changing. The Department of Health has been encouraging health care professionals to involve the public in such a way that their involvement can be seen to make a real difference.

In the area of cancer things have been changing in many ways with the modernisation of our cancer services. Today in Northern Ireland we live in a climate where involving patients and the public is greatly encouraged.

**What does Patient and Public Involvement look like within the Cancer Network?**

Patient and Public Involvement is currently being developed in a variety of ways;

NICaN PPI Forum - the forum brings together a group of patients and the public in order to steer the development of PPI within NICaN and to contribute to service planning and delivery across NICaN's clinical networks.

The PPI Forum Leads, Mr Alex McGuiggan and Ms Nicola Porter sit on the Cancer Network Board.

Members of the PPI forum represent patients at meetings of the Clinical

# ACRONYMS FOR BEGINNERS

**AGREE**

Appraisal of Guidelines Research & Evaluation (AGREE) is an international collaboration of researchers and policy makers who seek to improve the quality and effectiveness of clinical practice guidelines by establishing a shared framework for their development, reporting and assessment.

The collaboration has the participation of a core of European countries: Denmark, Finland, France, Germany, Italy, the Netherlands, Spain, Switzerland and the United Kingdom as well as Canada, New Zealand and the USA

**GAIN - Guideline & Audit Implementation Network**

Established in August 2007 through the amalgamation of RMAG, NIRAAC and CREST. GAIN  has a safety and quality improvement role in Northern Ireland's Health and Social Care Services through the commissioning of regional audit and guidelines, the promotion of good practice, and the publication and facilitation of guideline implementation.

**Chairs**

Strategic Committee - Dr Tom Trinick, (Vice Chair Dr David Stewart)

Operational Committee - Professor Robin Davidson

Medical Devices Committee - Mrs Elizabeth Qua

**G-I-N – Guidelines International Network**

Founded in 2002, G-I-N has grown to 89 organisational members and partners representing 38 countries from Africa, America, Asia, Europe and Oceania. A number of international organisations such as the WHO are also members.

G-I-N is an international not-for-profit association of organisations and individuals involved in the development and use of clinical practice guidelines.

G-I-N seeks to improve the quality of health care by promoting systematic development of clinical practice guidelines and their application into practice, through supporting international collaboration.

The Network has the world's largest Guideline Library and is regularly updated with the latest information about guidelines of the G-I-N membership. As at  February 2009 more than 5,600 documents are available on their site.

**HQIP – Health& Quality Improvement Partnership**

Established in April 2008 to promote quality in healthcare and in particular to increase the impact that clinical audit has on healthcare quality in England and Wales. It is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing and National Voices (formerly the Long-term Conditions Alliance).

Chief Executive - Robin Burgess

**NAGG**

NAGG, originated following an informal meeting facilitated by the National Institute of Clinical Excellence (NICE) in November 2000. Initially, they were merely a group of people working in the field of clinical audit, who came together to work towards sharing information and representing the clinical audit community, from national and regional backgrounds and sectors (PCTs, Hospital Trusts, Mental Health Trusts.

**Chair** - Robin Sasaru

**NICE**

The National Institute for Health and Clinical Excellence (NICE) is the independent organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health.

NICE produces guidance in three areas of health:

**Public health** - guidance on the promotion of good health and the prevention of ill health for those working in the NHS, local authorities and the wider public and voluntary sector

**Health technologies** - guidance on the use of new and existing medicines, treatments and procedures within the NHS

**Clinical practice** - guidance on the appropriate treatment and care of people with specific diseases and conditions within the NHS.

**Chief Executive** – Andrew Dillon

**SIGN**

The Scottish Intercollegiate Guidelines Network (SIGN) was formed in 1993. Their objective is to improve the quality of health care for patients in Scotland by reducing variation in practice and outcome, through the development and dissemination of national clinical guidelines containing recommendations for effective practice based on current evidence.

**Chairs** - Dr Keith Brown & Professor John Kinsella

# GAIN CONFERENCE 2009

## GAIN & Quality Improvement

GAIN will hold its second conference on Wednesday 25 March 2009 at the Rosspark Hotel, Kells, Ballymena. The day will be made up of Strategic and Operational information which will be beneficial to all healthcare professionals. This informative day will have many distinguished speakers keeping us updated on the latest local, national and even international audit and guideline information.

The morning session included speakers such as:

- Professor Clifford Hughes, Chief Executive of the Clinical Excellence Commission, New South Wales, Australia
- Dr Michael McBride, Chief Medical Officer for Northern Ireland
- Dr James Livingstone, Assistant Secretary, Standards & Guidelines Unit, DHSSPS
- Mr Robin Burgess, Chief Executive of HQIP
- Mr Robin Sasaru, Chairman of NAGG
- Mr Steve Sparks, NICE Field Co-Ordinator

The afternoon session will break out into three separate sessions on Guideline & Audit Reports, Clinical Audit and Cochrane Review Masterclasses. Speakers included:

**Session 1 - Audit Masterclass**

- Martin Ferris, Audit & Effectiveness Unit, Sheffield Primary Care Trust

**Session 2 - Cochrane Masterclass**

- Mike Clarke, Director, Cochrane UK

**Session 3 - GAIN Funded Guideline & Audit Reports**

- Janet Calvert, Regional Breastfeeding Co-Ordinator, Health Promotion Agency
- Hugh Webb, Consultant Microbiologist, South Eastern Trust, Ulster Hospital
- Gary McVeigh, Professor of Cardiovascular Medicine, Belfast HSC Trust
- Seamus O'Brien, Outcomes Department, Musgrave Park Hospital
- Christine Murphy, Clinical Audit Manager, Belfast HSC Trust

If you would like to book a place at this conference, please contact the GAIN Office.

Although this conference is free to those attending there will be a £20 imposed if people fail to attend.

Copies of the presentations will be available on the website at www.gain-ni.org approximately one week after the conference.

## Clinical Audit Workshop – 19 June 2008

Following the Conference in March 2008 and an extremely successful presentation GAIN were asked to bring Martin back to look at areas such as:

- Planning, performance and processing audit data
- Incorporating audit into Trust fabric and ethos, how it can be used to best effect
- (Aspects of) mental health audit
- Setting up an audit
- More national audits
- Examples of audits with change
- How patient/user involved in audits
- How NICE guidelines were implemented in Trust, etc
- Matching audit technical outcome that can show measurable improvements in patient safety (e.g. NPSA work)
- User involvement
- Lessons learnt
- Best Practice

Martin was joined by his colleagues Beverley Ryton and Rachel Smith. Bev looked at the area of Patient & Public Involvement in Clinical Audit and Rachel focused on Setting up audits giving examples from Sheffield. Further information can be seen by logging on to **www.gain-ni.org**

# Applying for Funding

On a yearly basis GAIN will send out an invitation to the health community to apply for funding for the developments of regional guidelines or the undertaking of regional audits.

The invitation process will be:

**September**
Invitation to apply

**December**
Decisions on applications made by GAIN Operational Committee

**January/February**
All applicants informed of decisions

**April**
Commencement of all Guidelines and audits

Information will follow after the summer period on exact start and close dates for the applications. GAIN welcomes applications from all healthcare areas.

Multiprofessionals discuss the fabric and ethos of audit

Beverley Ryton and Rachel Smith discuss patient and public involvement in clinical audit

## GAIN FUNDED PROJECTS FOR 2009/2010

N I Audit: Dying, Death & Bereavement. Phase 2: The experiences of bereaved people and those delivering primary care services

Performance Audit of Ultrasound Therapy Systems within N Ireland

Audit on the Effectiveness of the Root Cause Analysis (RCA) Approach/Tool for Reducing Health Care Associated Infections (HCAIs)

Audit on record keeping in the acute Hospital Setting

Corticosteroids in palliative Care

Regional Audit of Current Treatment of Acute Leukaemia and Lymphoma in N Ireland

Audit of Northern Ireland Prison Service Medication Administration Record Cards

Right Patient Right Treatment

Northern Ireland Oxygen Therapy Audit

Audit of out of hours services for people (adults and children) with asthma

Guidelines for Clinical Standards of Care for Patients with Diabetes in nursing & Residential Homes

Guidelines for Oral Health Care of Older people living in Nursing Homes & Residential Homes

Standards for the Provision of Domiciliary Eyecare in Nursing, Residential Homes and Day Care Facilities

Guidelines for the use, care and maintenance of long term Central Venous Access Devices (CVADs) in Children's Services

Guidelines for Screening for Sexually Transmitted Infections in Cases of Suspected Child Sexual Abuse

Guidelines for Obtaining Paediatric Forensic Medical Assessment in Cases of Suspected Child Sexual Abuse

Northern Ireland Immediate Discharge Protocol

For further information on any of these audits or Guidelines please contact the GAIN Office

# Upcoming Events

**Tackling Concerns: Managing Poor Performance and Supporting Clinicians in Difficulty**
**24th February 2009,** 76 Portland Place, London. Further information can be found at **www.healthcare-events.co.uk**

**Effective Clinical Director**
**05 March 2009,** 76 Portland Place, London. Further information can be found at **www.healthcare-events.co.uk**

**Clinical Outcomes 2009**
**10th & 11th March 2009,** Savoy Place, London. Further information can be found at **www.healthcare-events.co.uk**

**International Forum on Quality and Safety in Healthcare**
**17–20 March 2009,** ICC Berlin, Germany. Further information can be found at **www.internationalforum.bmj.com**

**GAIN – Quality Improvement Conference**
**25 March 2009,** Rosspark Hotel, Kells, Ballymena. Further information can be found at **www.gain-ni.org**

**Consultant Job Planning 2009**
**31 March 2009,** 76 Portland Place, London. Further information can be found at **www.healthcare-events.co.uk**

**HQIP Conference – Working together to Reinvigorate Clinical Audit**
**3pm 29 April 2009 – 3pm 30 April 2009,** Sutton Coalfield, West Midlands. Further information can be found at **www.hquip.org.uk**

**Good Practice Consent**
**06 May 2009,** 76 Portland Place, London. Further information can be found at **www.healthcare-events.co.uk**

**Enhanced Appraisal and Revalidation**
**14 May 2009,** Manchester Conference Centre, Manchester. Further information can be found at **www.healthcare-events.co.uk**

**NICE 2009: Annual Conference**
**2-3 December 2009,** Manchester Conference Centre, Manchester. Further information can be found at **www.nice.org.uk**

If you would like to be kept up to date with events happening locally, nationally and internationally please email the GAIN Office.

# Resources

Guidelines & Audit Implementation Network **www.gain-ni.org**

Scottish Intercollegiate Guideline Network www.sign.ac.uk
Irish Society for Quality & Safety in Healthcare **www.isqsh.ie**

National Institute of Clinical Excellence (NICE) www.nice.org.uk
Healthcare Commission **www.chai.org.uk**

Department of Health (NI) **www.dhsspsni.gov.uk**

Department of Health **www.doh.gov.uk**

General Medical Council **www.gmc-uk.org**

Healthcare Events **www.healthcare-events.co.uk**

Northern Ireland Practice and Education Council for Nursing and Midwifery **www.nipec.n-i.nhs.uk**

Royal College of Nursing **www.rcn.co.uk**

Healthcare Quality Improvement **Partnership www.hqip.org.uk**

National Audit Governance Group **www.nagg.nhs.uk**

Clinical Audit Support Centre **www.clinicalauditsupport.com**

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