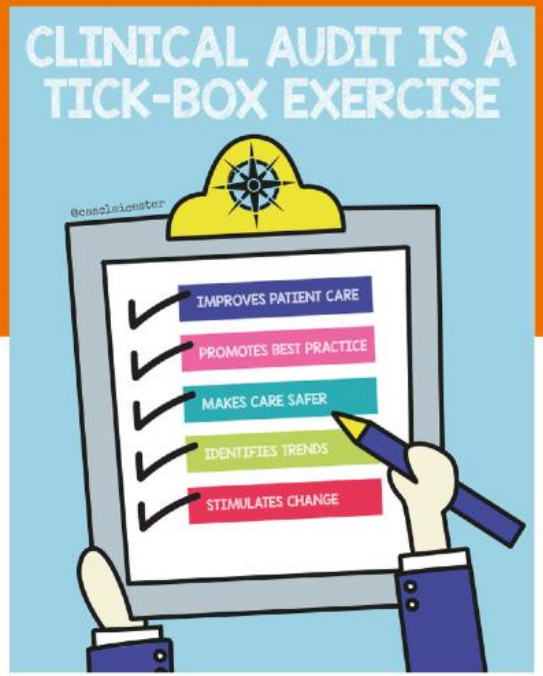
LEARN AT LUNCH #37
22 MAY 2025 AT 12.30

PROMOTING CLINICAL AUDIT: PART II



Join us to look at how we can better promote the value of clinical audit via: publications, webinars, podcasts, social media, training, piggy-backing, etc:

Places are free and all you need to do to book is email: info@clinicalauditsupport.com

The focus for today…

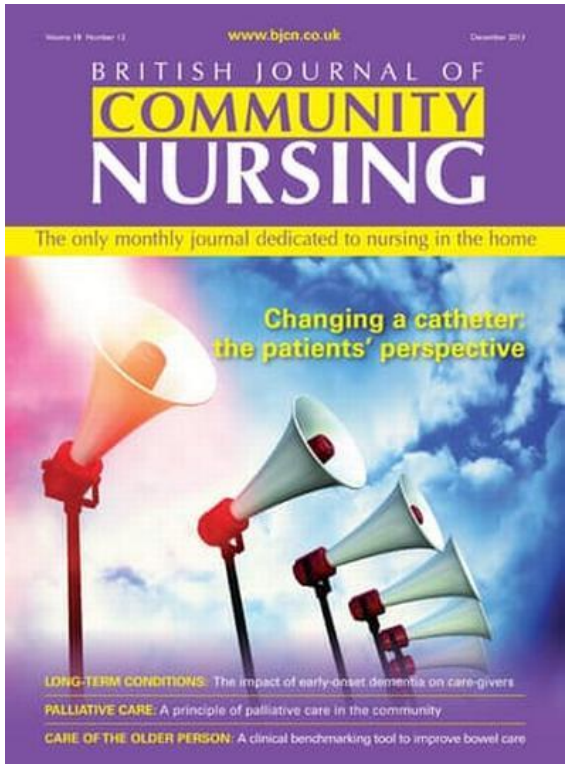
- Publications
- Podcasts
- Blogs
- Social media
- Training
- Piggybacking…

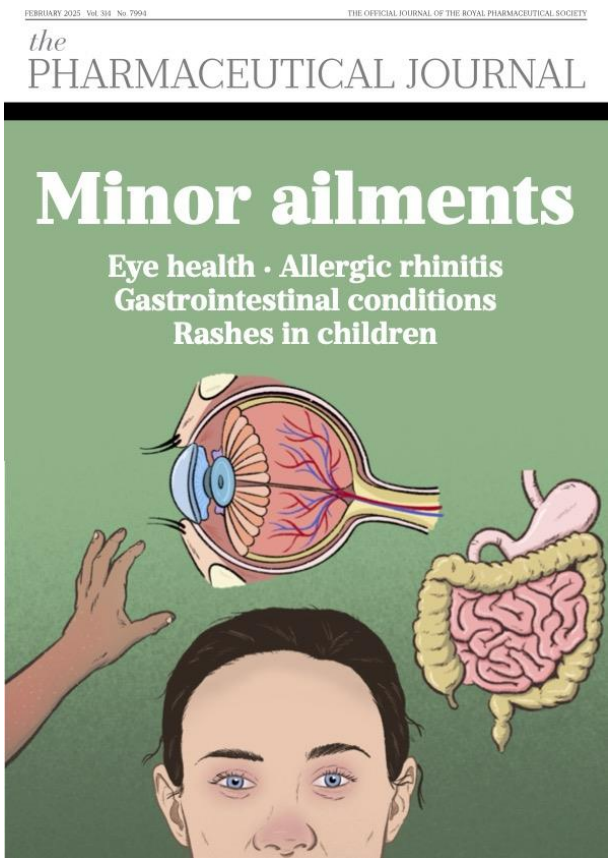

PUBLISH

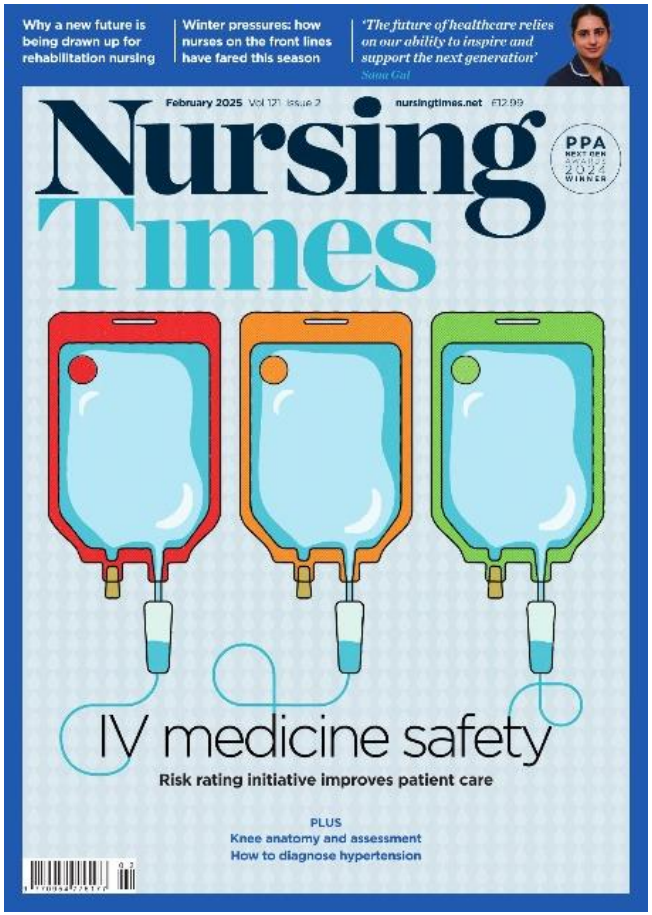
Writing for publication…

The audit iceberg

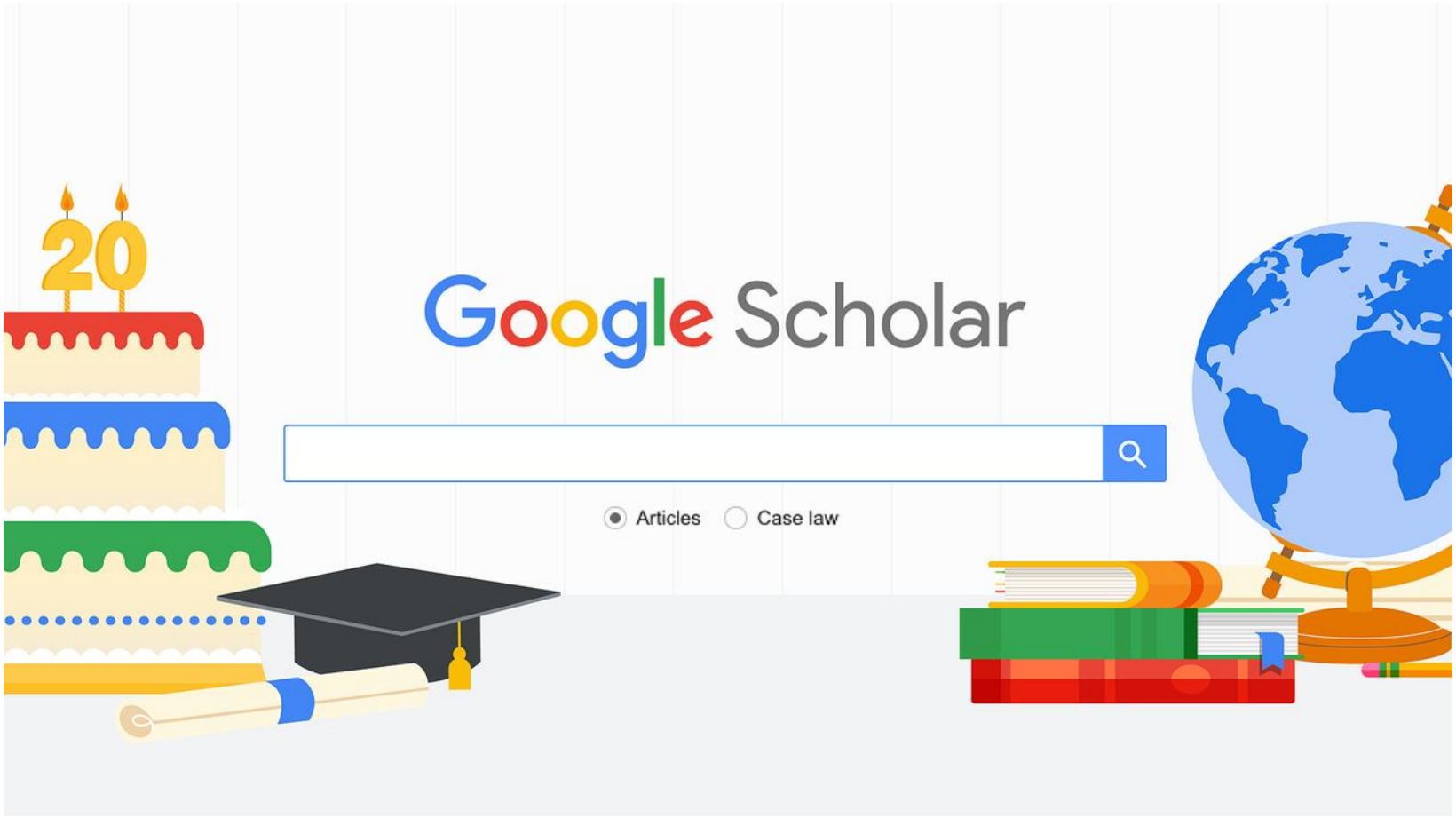
- Lots of clinical audit projects have been published over time
- But only a fraction of clinical audit articles are published in **core journals** (approx. 7.5%)
- Consider what journals and publications you could submit your work to
- There are a growing number of online journals that feature clinical audit projects
- Reminder: most leading clinical journals only publish completed clinical audit cycles.


www.bjcn.co.uk
BRITISH JOURNAL OF
COMMUNITY
NURSING
The only monthly journal dedicated to nursing in the home
Changing a catheter: the patients' perspective
LONG-TERM CONDITIONS: The impact of early-onset dementia on care-givers
PALLIATIVE CARE: A principle of palliative care in the community
CARE OF THE OLDER PERSON: A clinical benchmarking tool to improve bowel care


FEBRUARY 2025 Vol. 314 No. 7994
THE OFFICIAL JOURNAL OF THE ROYAL PHARMACEUTICAL SOCIETY
the
PHARMACEUTICAL JOURNAL
Minor ailments
Eye health · Allergic rhinitis
Gastrointestinal conditions
Rashes in children


Why a new future is being drawn up for rehabilitation nursing
Winter pressures: how nurses on the front lines have fared this season
'The future of healthcare relies on our ability to inspire and support the next generation'
Sima Gal
February 2025 Vol 121 Issue 2
nursingtimes.net £12.99
Nursing Times
PPA
IV medicine safety
Risk rating initiative improves patient care
PLUS
Knee anatomy and assessment
How to diagnose hypertension

Start here… with your audit title



Top Tip!

Writing tips….

The Hunter Style of Writing (Guidance by Nancy Dixon)

- We are trained to write in the gatherer style
- Essays and dissertations require us to prepare arguments, share viewpoints and this means we gather information to inform those discussions
- A hunter style of writing allows the author to use a systematic process and define what the audience will read about organizing ideas into a logical structure

The Hunter Style of Writing (Guidance by Nancy Dixon)

- Decide who the intended readers of what you are going to write are likely to be interested in
- Get the specifications of what you are going to write from the publisher
- Get your ideas down and test them yourself for clarity
- Organise your ideas to get them across to your readers
- Edit your own writing before you submit your paper

Steps to improve your writing (Nancy Dixon)

- **Simplify rather than complicate your writing**
  - Use the shortest words possible
  - Use an active rather than a passive voice
  - Keep sentence to 20-25 words
  - Try to keep paragraphs to 6 sentences
  - Remove unnecessary punctuation
  - Remove jargon

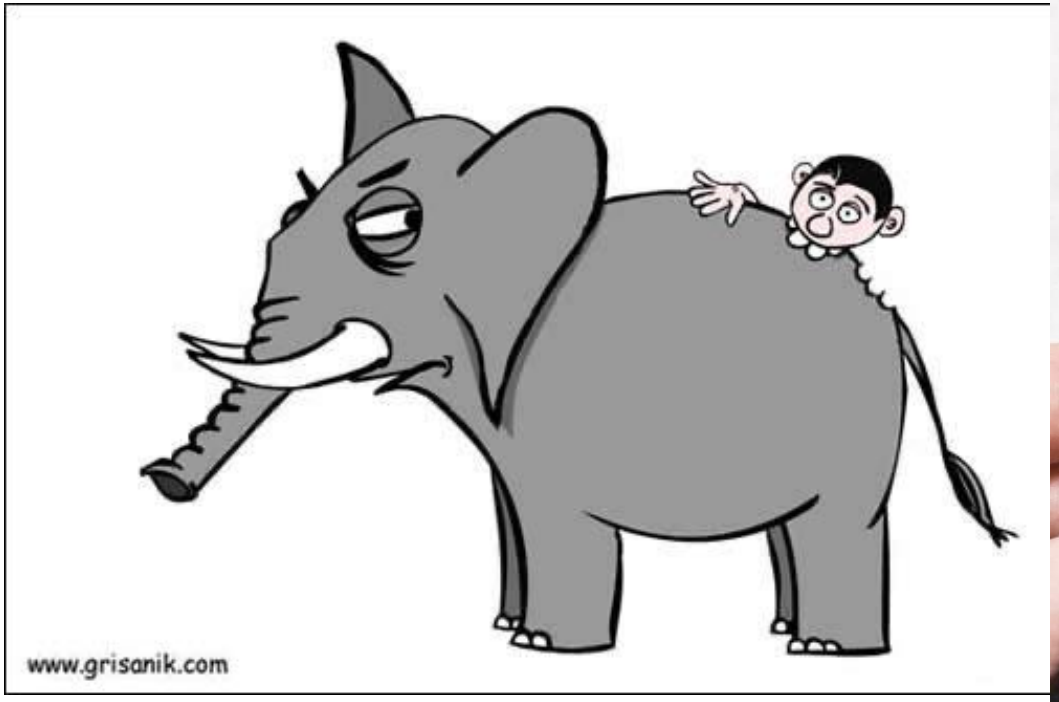
- **Review the structure of your paper and the headings**
  - Check if you have followed the structured prescribed by the journal
  - Rewrite paragraphs until your ideas are described in the clearest and simplest way
- **Recheck the overall meaning**
  - Have you shared your most important ideas clearly
  - Is what you hope readers will get from reading your paper stated as clearly as possible

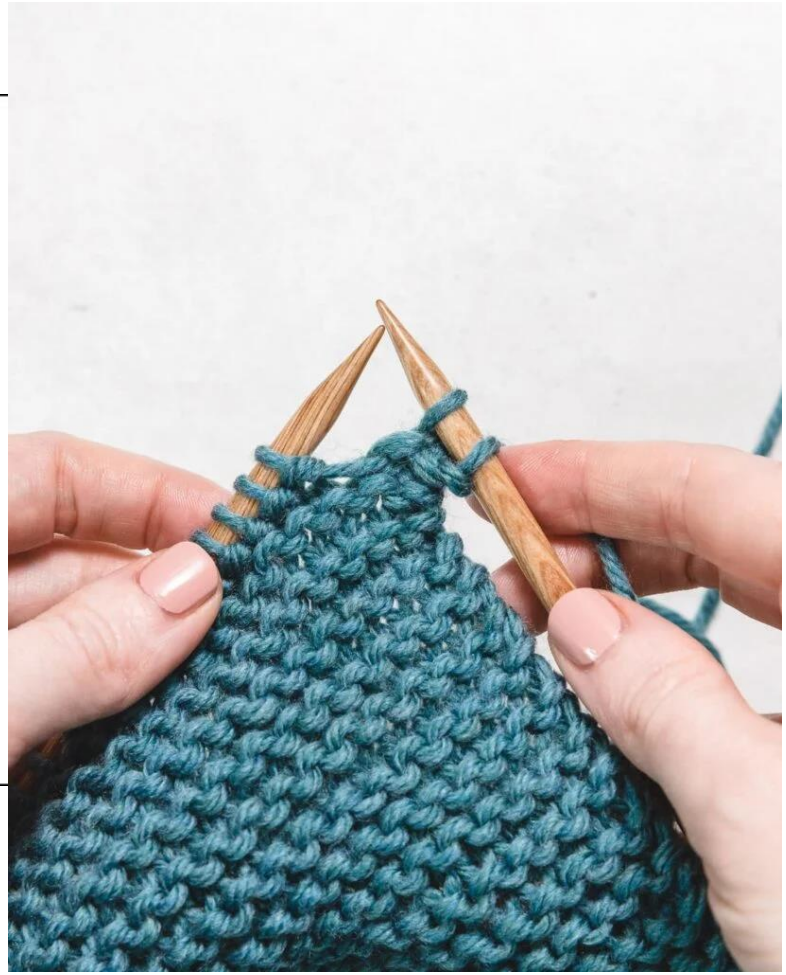
Characteristics of a published audit (R. Banarsee - BMJ article)

- Auditing the right topic
  - Measure best practice
  - Of interest to other organsations
- Large prospective sample
  - Generalisable results
- Linked to research or service innovations
  - Audit often generates research questions and research can complement audit
- Having a completed clinical audit cycle
  - We've said it before makes sure the clinical audit includes a QI/change process
- Articles must be submitted to the right journals in the right way
  - Write in the journal format, take note of author guidance and house-style

Get others to help you…

Write one row at a time*





*Journals typically allow 3000-5000 words per article

Not all ‘audits’ are audits…

Analyzing Factors and Reasons Behind NonAttendance of ENT Patients: Clinical Audit

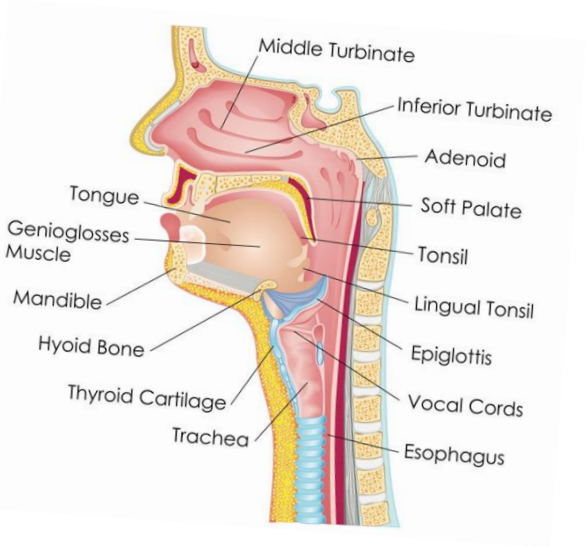
Faris Ahmed Bahammam, MD, EBORL, MRCS, DO-HNS, Neil Tolley, MD, FRCS, DLO, [...], and Matthew Rollin, MBBS, BSc (Hons), FRCS

OnlineFirst | https://doi.org/10.1177/01455613241283798

Contents | PDF / ePub | Cite article | Share options | Information, rights and permissions | M

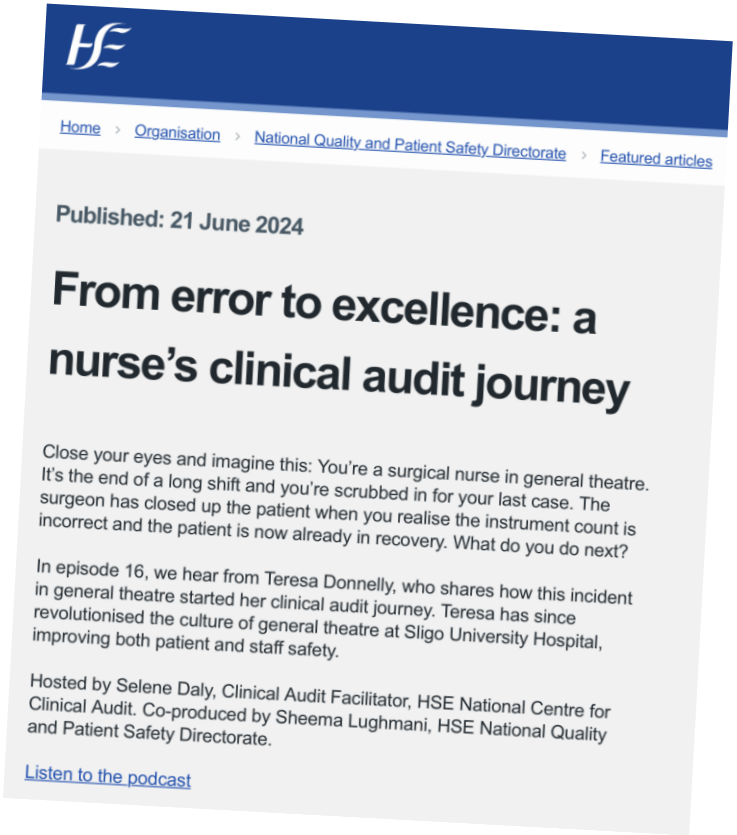
Abstract

Objective: This study analyzed the frequency of follow-up patients at the ENT clinic and identified different factors that are associated with nonattendance at follow-up appointments since nonattendance imposes significant stress on the system of healthcare. **Methods:** This study was an ambidirectional cohort study and conducted a telephonic survey with 104 ENT patients who missed their appointments. **Results:** The findings of the study revealed that patients missed their scheduled appointments because of transportation problems (46%), professional engagement (46%), family problems (44%), and financial problems (32.7%). However, patients didn't identify forgetfulness about the appointment, complete recovery, and health-related issues on the day of the appointment as the barrier to missing their scheduled appointment. The study assessed the relationship between socioeconomic status and the frequency of follow-up patients in an ENT clinic where transportation factor ($P < .000$), working commitments ($P < .004$) affecting the “Lower Middle and Middle Class” individuals, and financial problems ($P < .005$), family problems ($P < .028$), feeling sick ($P < .037$) were significantly affecting the “Middle-Upper Class” and “Middle Class.” Meanwhile, forgetfulness was not associated with the socio-economic status of the ENT patients ($P = .237$). **Conclusion:** This study found transportation, family, financial issues, and professional commitments to be the key barriers to ENT appointment attendance, with Lower-Middle-Class patients particularly affected by forgetfulness. These missed appointments negatively impact patient health and strain the healthcare system.



Brilliant podcast

- Podcast by Selene and Therese
- Therese involved in never event – butterfly clip left inside patient
- Led to her looking into CA and QI
- Undertook a simple audit in theatre that identified:
  - Issues verbalizing checks of kit
  - Major surgery needing longer than 6 mins to account for equipment
  - Poor documentation
- Stakeholders agreed changes
- Audit published, presented in LA
- No similar mistakes in 10 years+



HSE

Home › Organisation › National Quality and Patient Safety Directorate › Featured articles

Published: 21 June 2024

From error to excellence: a nurse's clinical audit journey

Close your eyes and imagine this: You're a surgical nurse in general theatre. It's the end of a long shift and you're scrubbed in for your last case. The surgeon has closed up the patient when you realise the instrument count is incorrect and the patient is now already in recovery. What do you do next?

In episode 16, we hear from Teresa Donnelly, who shares how this incident in general theatre started her clinical audit journey. Teresa has since revolutionised the culture of general theatre at Sligo University Hospital, improving both patient and staff safety.

Hosted by Selene Daly, Clinical Audit Facilitator, HSE National Centre for Clinical Audit. Co-produced by Sheema Lughmani, HSE National Quality and Patient Safety Directorate.

Listen to the podcast

AMaT podcast

The clinical audit and improvement podcast

We bring together experts to talk about a range of topics for the benefit of everyone involved in clinical audit and improvement projects across healthcare.

Our latest guests

Anne-Marie Murkett

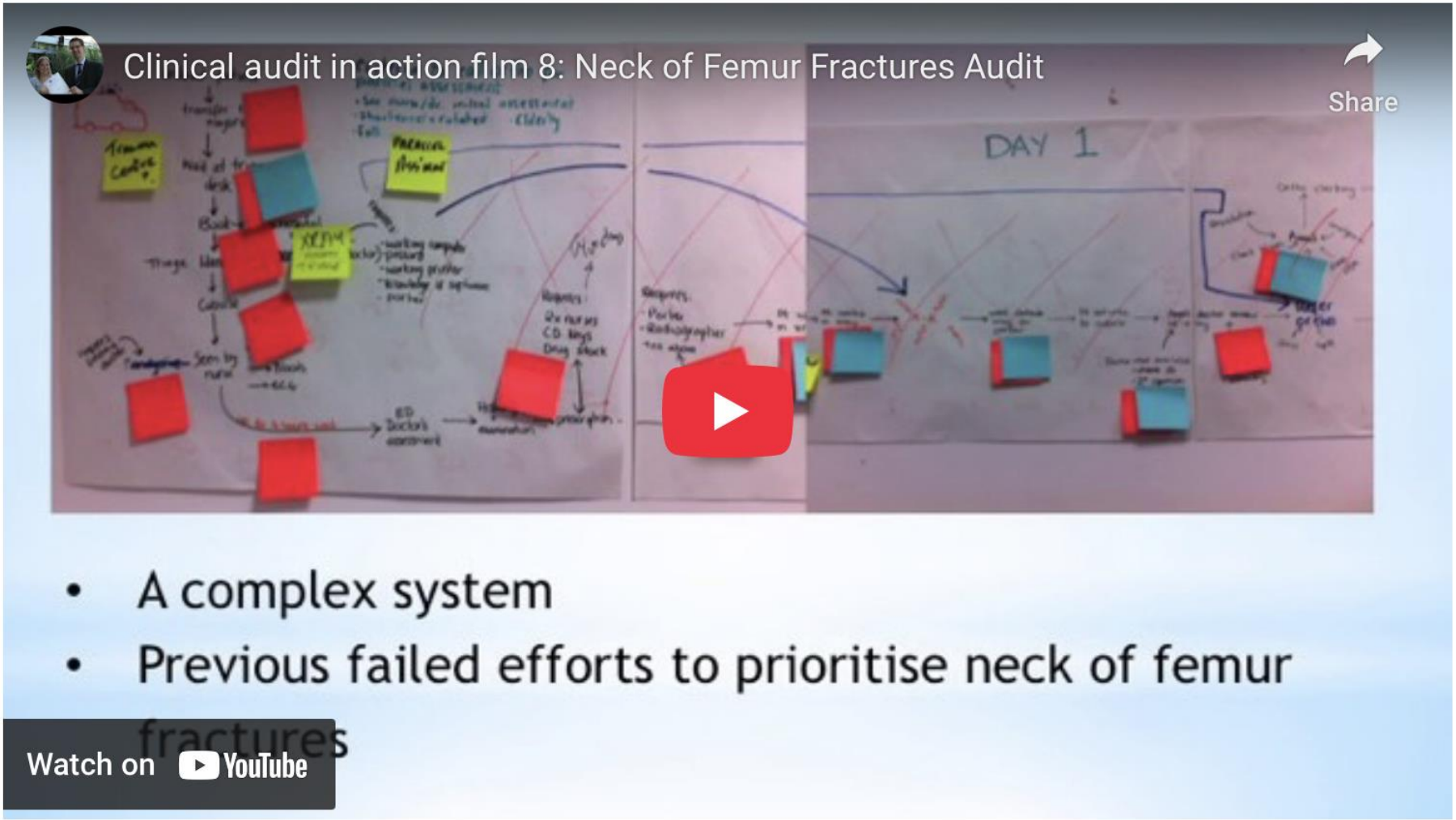
Anne-Marie is the head of quality, governance and compliance for Rainbows Hospice.

Katie Jukes

Katie Jukes is a children's nurse working in Rainbows Hospice.

Managing clinical audit in hospices

Clinical audit in action film 8: Neck of Femur Fractures Audit



This eight-minute film is narrated by Dr. Narin Suleyman and is entitled 'An Audit of Time to X-ray in Neck of Femur Fractures'. The project audited care against a College of Emergency Medicine clinical standard and was awarded the Martin Ferris clinical audit prize at CASC's 2014 junior doctor awards.


BLOG

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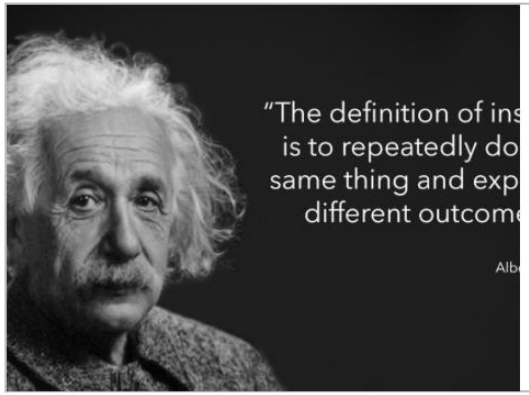
code



CASC
Mar 18, 2021 · 1 min read

Time to say goodbye...

Hello everyone. Hope you are well. Great to see the progress being made fighting COVID-19 and the impressive vaccination roll out having...

37 views 0 comments

CASC
Nov 25, 2020 · 2 min read

Guest blog: a junior doctor's perspective on clinical audit

I am a junior doctor and I like clinical audits! There, I said it. Just to be clear, it was not always the case. In fact when I first...

187 views 5 comments 1

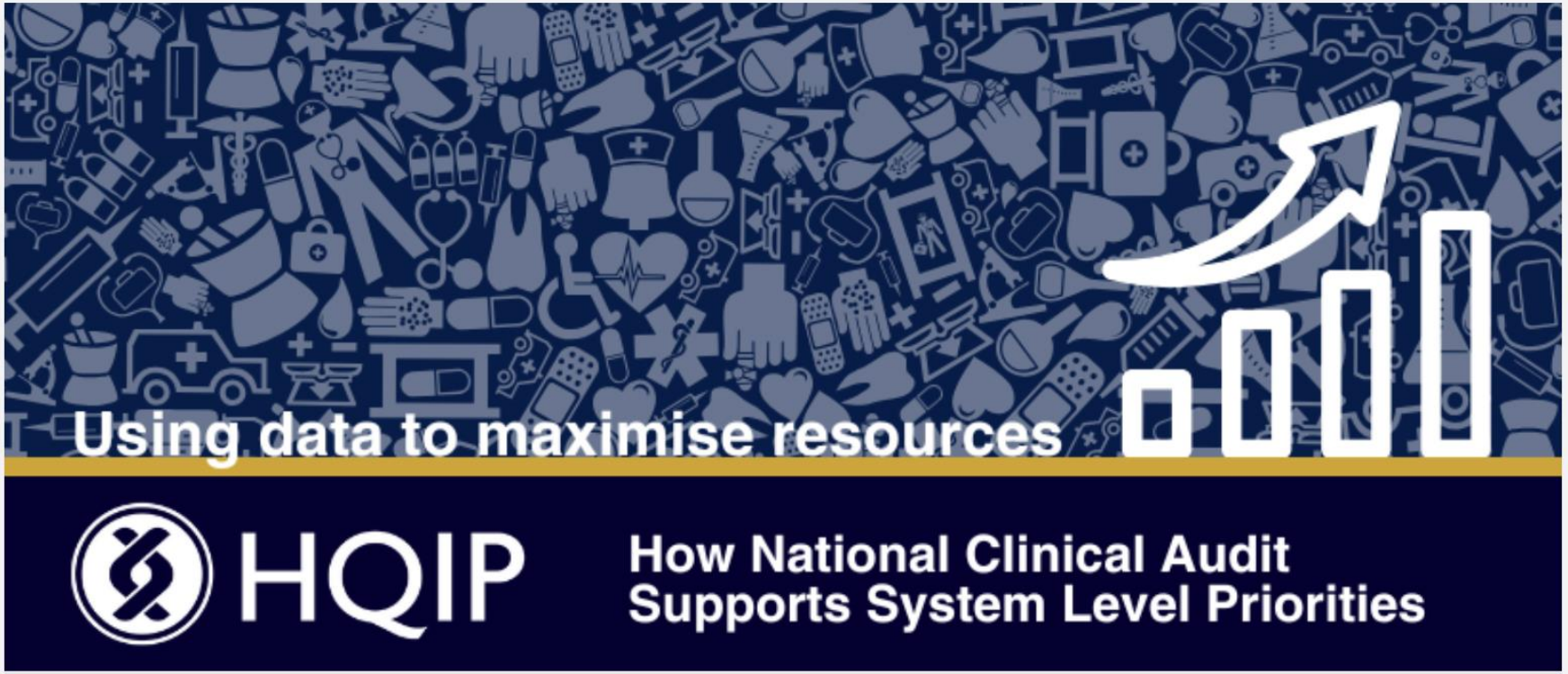
CASC
Nov 23, 2020 · 2 min read

Everyone is a hero in 2020!

Here we are then, #CAAW20 is finally here. Edition 8 runs from 23-27 November 2020. It is certainly going to be different this year, with...

22 views 0 comments 1

WordPress



Article: Using data to maximise resources

Published: 10 Apr 2025

HQIP's CEO, Chris Gush, explains how national clinical audit helps Integrated Care Systems (ICSs) and other healthcare leaders to maximise resources and deliver priorities.


Google
Linkedin
Spotify
Twitter
Facebook
Instagram
Pinterest
Whatsapp

Do you use social media?

CASC tweet: 2023

Tweets from May 2025

WWL ClinicalAudit reposted

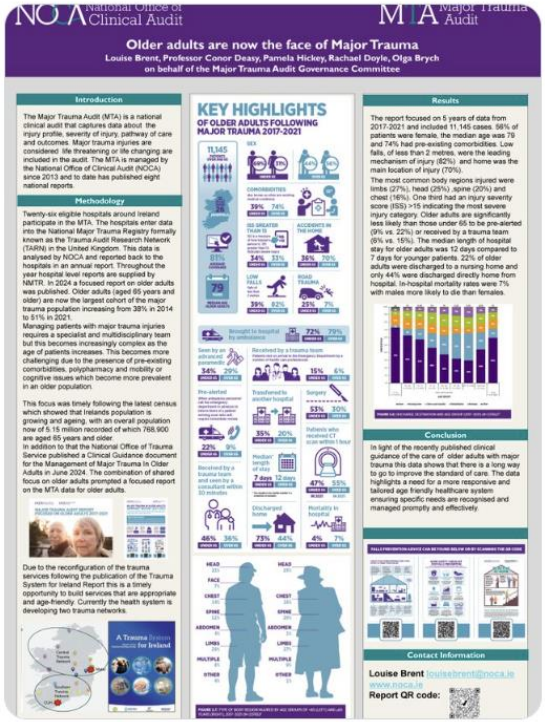
Alison Unsworth @AlisonUnsworth1 · May 15

And the winner of the Best Clinical Audit Dr Naqvi award is.....
Rachel Houghton, Surgical ACP for transforming NELA using digital pathways, absolutely amazing work with huge benefits to our patients!
#clinicalaudit
#datasaveslives
#NELA
@WWL_CA
@WWLNHS
@k_mantron

3 5 28 576

National Office of Clinical Audit @noca_irl · May 12

🏆 Congratulations to Louise Brent, Professor Conor Deasy, Pamela Hickey, Dr Rachael Doyle, and Olga Brych, whose poster "Older adults are now the face of Major Trauma in Ireland" has just been announced as the winner of the Eva Huggins Award for Best Nurses and AHP Poster at the
Show more



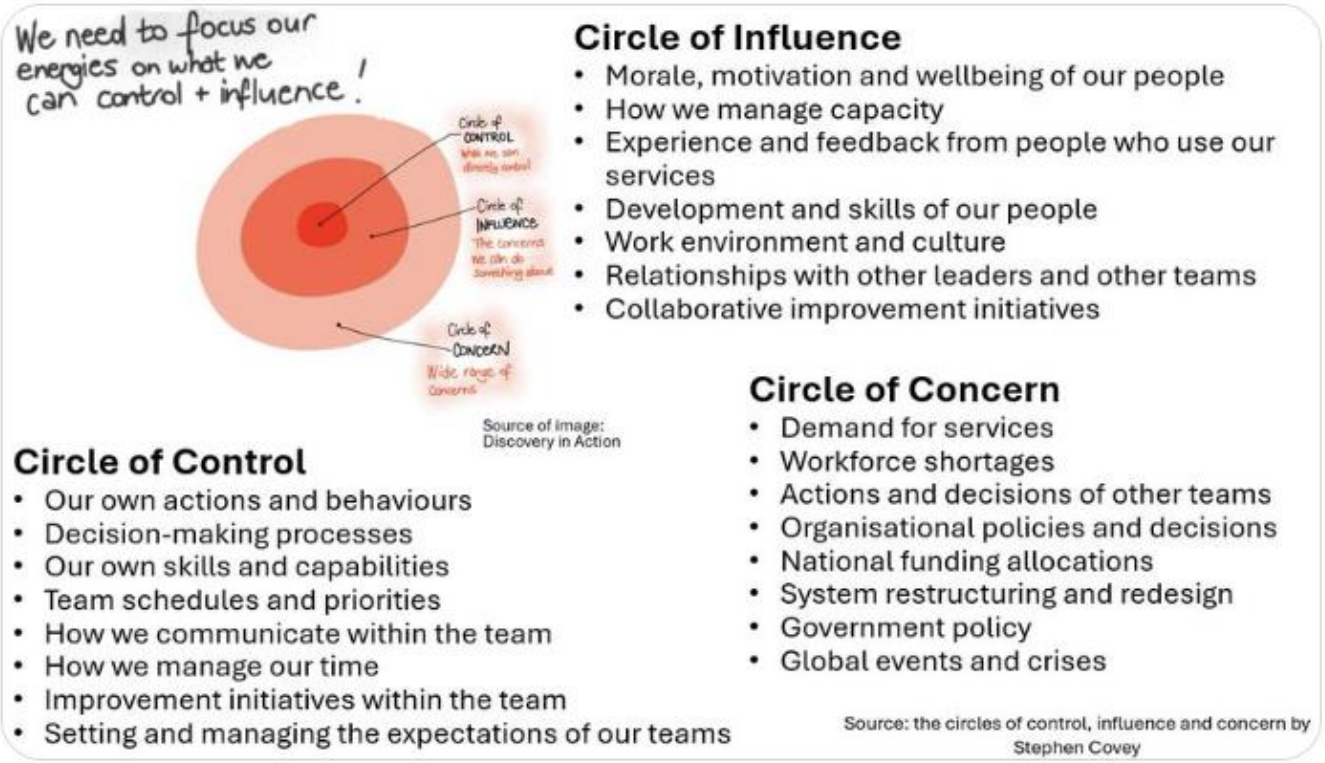
British Geriatrics Society and 7 others

2 12 47 1.8K

Helen Bevan @HelenBevan · Mar 31

There's so much change happening at present. It's easy to feel powerless & overwhelmed. That's why I have gone back to sharing the classic Stephen Covey "circle of control" model with many of the teams I work with. There are lots of big changes happening that are in our "circle

Show more



9 120 401 44K

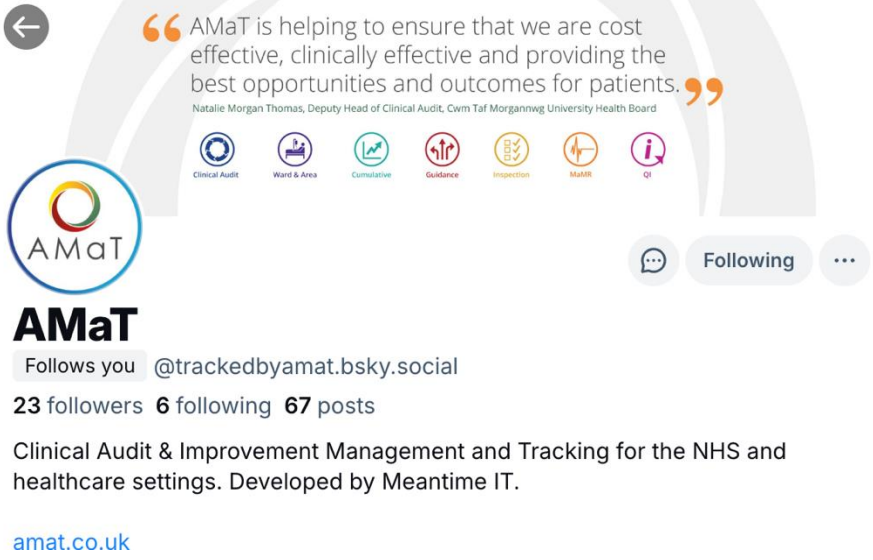
Social media: X and Bluesky

- #CAAW25 X & BLUESKY HEADER – CORAL (IMAGE FILE)
- #CAAW25 X & BLUESKY HEADER – TURQUOISE (IMAGE FILE)
- #CAAW25 X & BLUESKY POST – CORAL (IMAGE FILE)
- #CAAW25 X & BLUESKY POST – TURQUOISE (IMAGE FILE)

Monday 2 June 2025

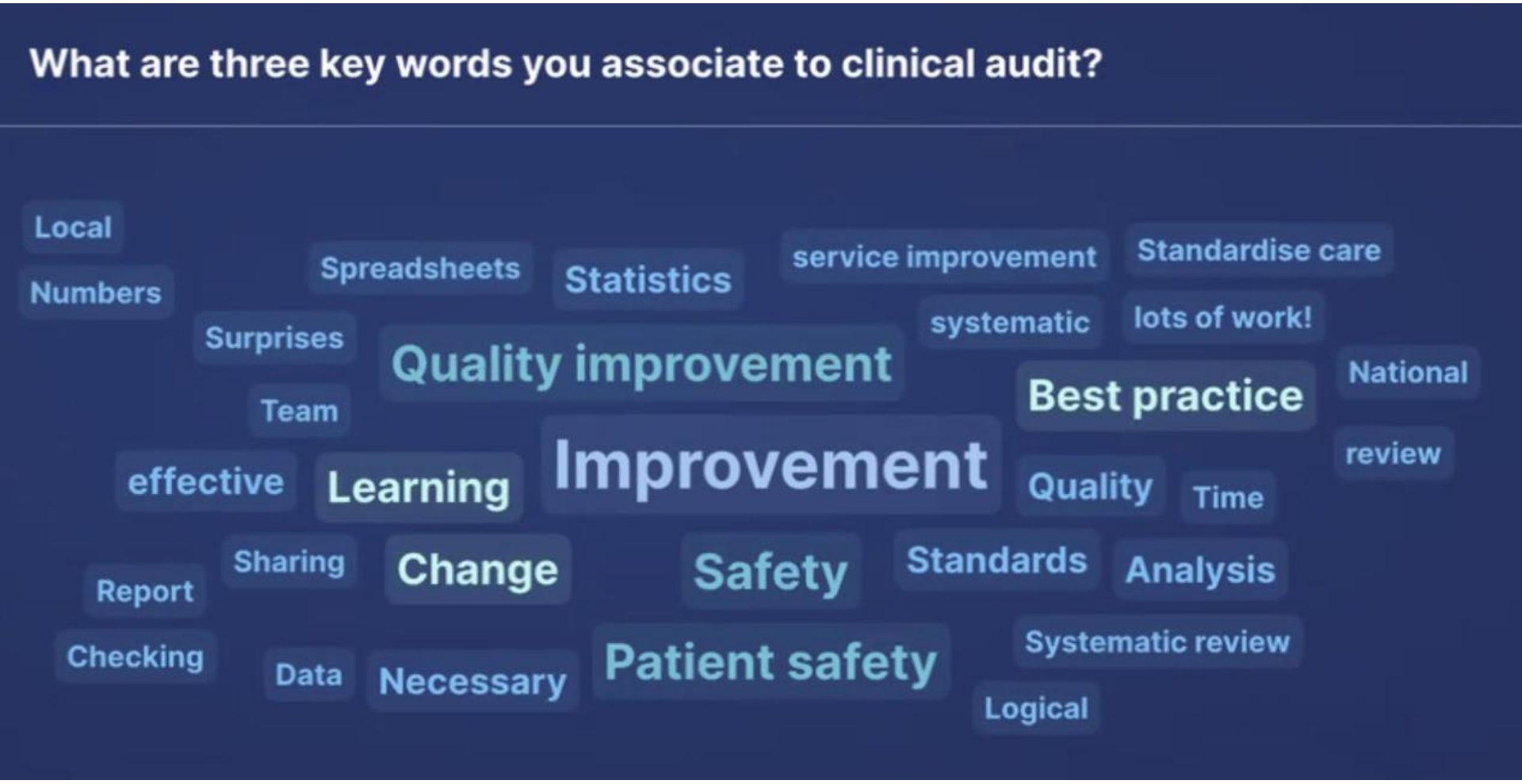
- 9.30am: Signposting to **resources on patient safety** on HQIP's website
- 10am: NEW **video** release on HQIP's website – **Improving sepsis care through clinical audit**, with HQIP's Chair Dr Celia Ingham Clark & Clinical Fellow Dr Ollie Burton
- 12.30–1.30pm: **Online Lunch & Learn** – **Patient Safety**, hosted by NQICAN and featuring Hester Wain, Head of Patient Safety Policy at NHS England, as well as the Patient Safety award announcement (*use this link to REGISTER IN ADVANCE*)
- 2–2.30pm: **Live Q&A** on HQIP's X account – **Balancing learning in clinical audit and quality improvement with patient safety**, with HQIP's Clinical Fellow, Dr Ollie Burton

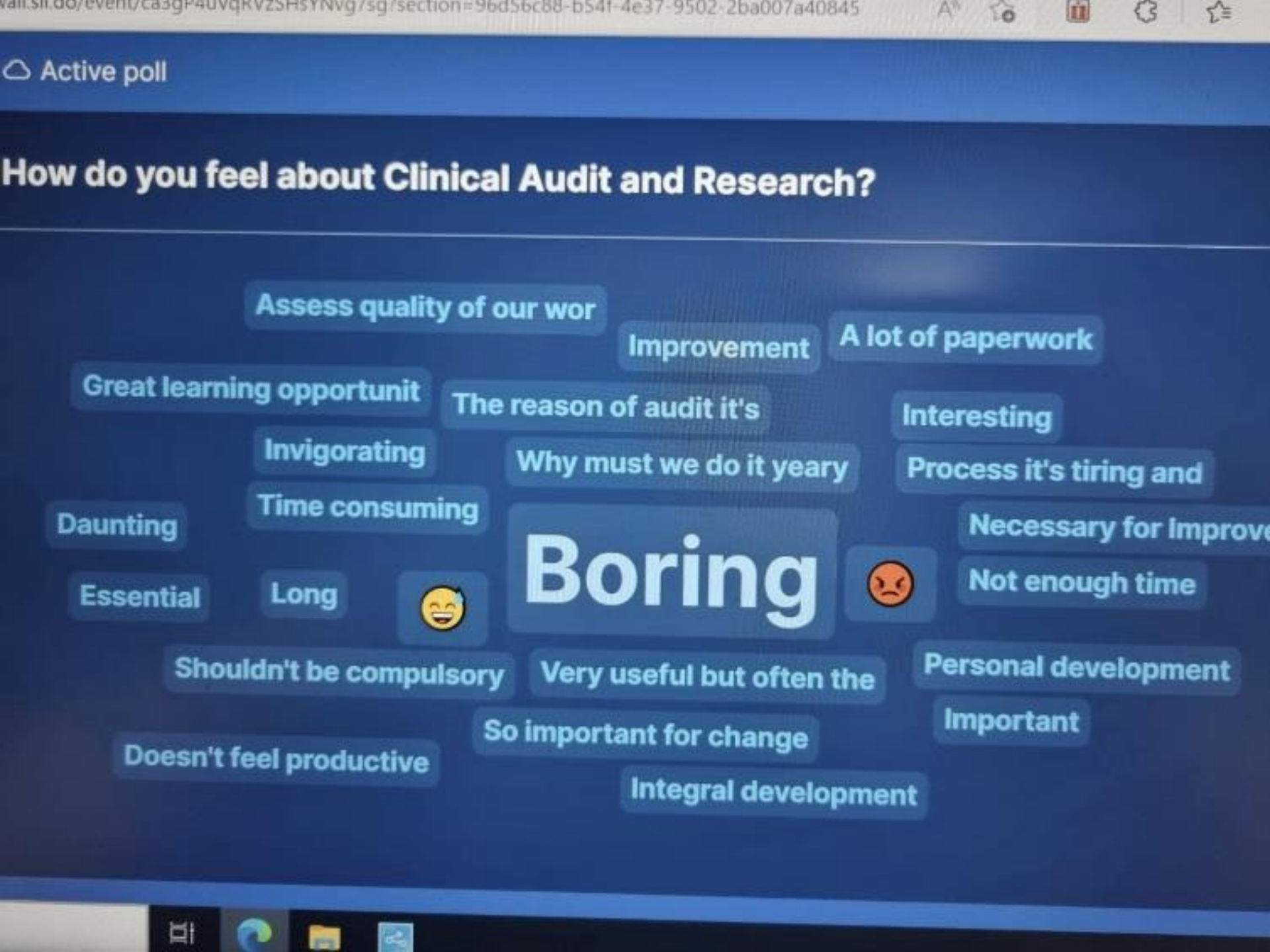
Take a look at Bluesky…




30%
70%
BUSINESS PLAN
time
money
quality
IT TRAINING
EXPENSES
TAX
PROFIT
INCOME
cost
quality
price

What are three key words you associate to clinical audit?




Active poll
How do you feel about Clinical Audit and Research?
Assess quality of our wor
Improvement
A lot of paperwork
Great learning opportunit
The reason of audit it's
Interesting
Invigorating
Why must we do it yeary
Process it's tiring and
Time consuming
Daunting
Necessary for improv
Boring
Essential
Long
Not enough time
Shouldn't be compulsory
Very useful but often the
Personal development
Important
So important for change
Doesn't feel productive
Integral development

Is it clinical audit?/CASC's 4 Step Guide

Developed by CASC and based on historical work carried out by Bath University. Ask these 4 questions of your project:

Clinical Audit

01

CLINICAL AUDIT IS AN IMPROVEMENT PROCESS

Start by asking **Is the purpose of the proposed project to try and improve current care?** Clinical audit is an improvement tool so your answer should be **YES**. As a minimum audit should seek to assure care.

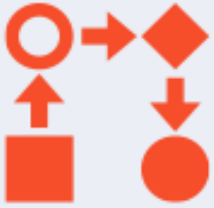
02

CLINICAL AUDITS ARE STANDARDS - BASED

Question 2: **Will the project involve measuring current practice against agreed best practice (e.g. standards, guidelines, protocols, etc.)?** For your project to be a clinical audit the answer to Q2 must be **YES**. Audit measures care against standards.

03

CLINICAL AUDITS FOCUS ON ROUTINE CARE



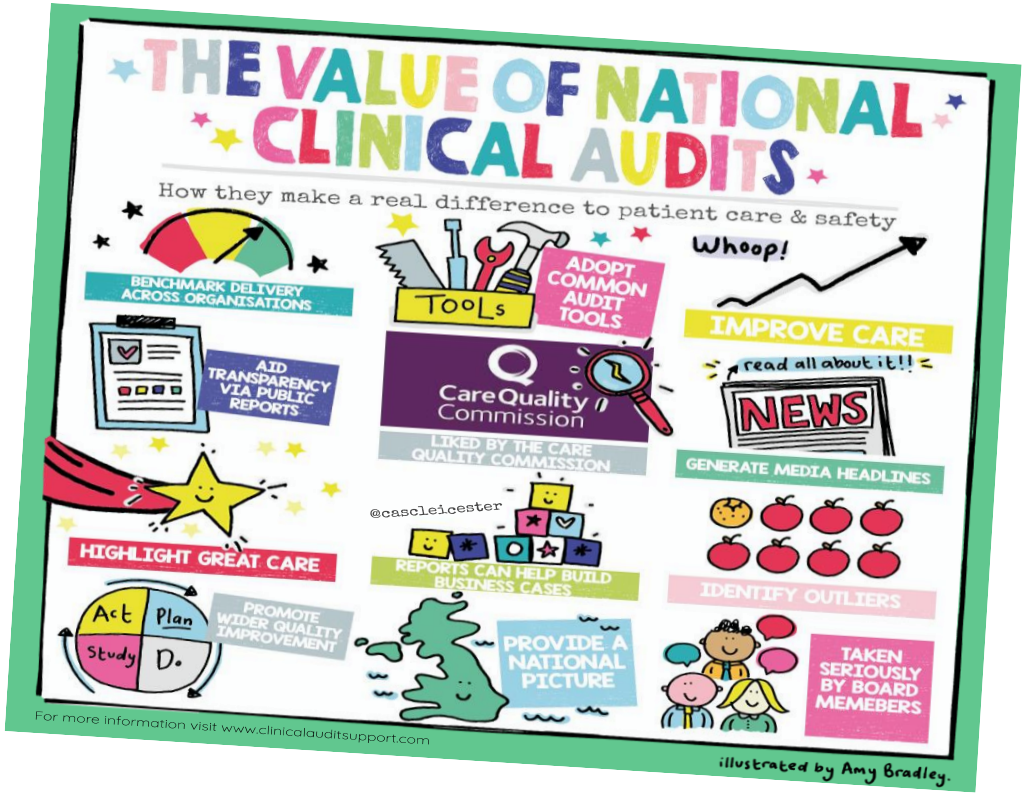
Question 3: **Does the project involve anything being done to the patient that would <u>not</u> have been part of their routine management?** If you answer **NO** to this question you are likely to be conducting a clinical audit.

04

CLINICAL AUDIT DATA IS MAINLY QUANTITATIVE

Question 4: **Do the vast majority of your questions ask for quantitative (yes/no/not applicable) answers as opposed to qualitative (free text) answers?** If the answer is **YES** you are likely to be conducting a clinical audit.

Focusing on NCAs



NOCA National Office of Clinical Audit

IPCCA Irish Paediatric Critical Care Audit

IRISH PAEDIATRIC CRITICAL CARE AUDIT SUMMARY REPORT 2021-2022

The Irish Paediatric Critical Care Audit (IPCCA) was established by the National Office of Clinical Audit (NOCA) and reports on the care of patients in paediatric critical care units (PCCUs). NOCA works with the Paediatric Intensive Care Audit Network (PICANet) in the UK to collect and monitor the data. The audit also reports on paediatric patients admitted to adult ICUs, using data from the Irish National ICU Audit.

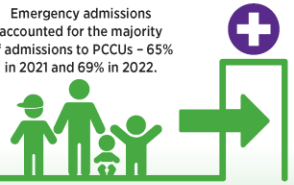
In Ireland, there are two dedicated PCCUs currently located in Dublin at Children's Health Ireland (CHI) at Crumlin, which has 23 beds and Children's Health Ireland (CHI) at Temple Street, which has 9 beds. These units accept patients from all counties in Ireland. Paediatric patients are defined as children aged under 16 years.

DRAWING BY SOPHIE SWAN

3329
2021 & 2022
3329 admissions in 2021 and 2022 – an increase of 14% when compared to 2018. This rise shows that more children have required critical care in recent years compared to the time before the pandemic.

1098 **2021**
1092 **2022**
CHI at Crumlin had the third highest number of PCCU admissions of all units in the UK and Ireland in 2021, with 1098 admissions and 2022, with 1092 admissions.

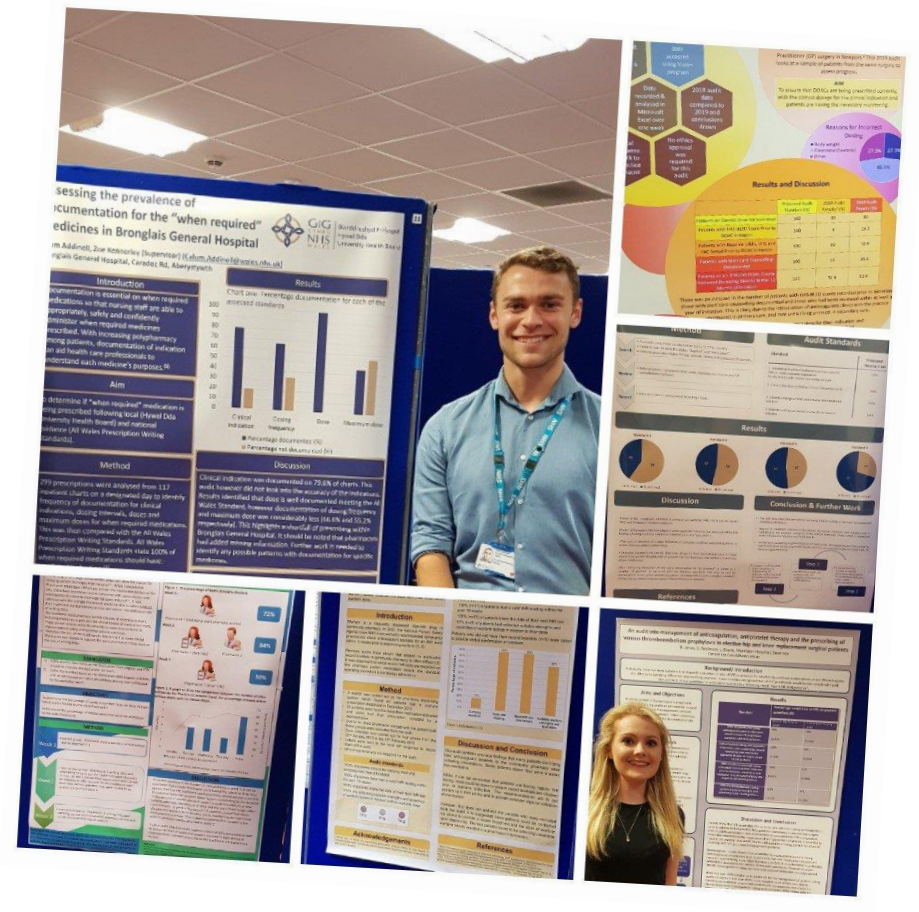
65% **2021**
69% **2022**
Emergency admissions accounted for the majority of admissions to PCCUs – 65% in 2021 and 69% in 2022.



TRENDS 2018-2022

	STANDARD	2018	2019	2020	2021	2022
	Transport retrieval mobilisation time within 1 hour When a patient needs to be transported from one hospital to another, the target time it takes the specialist team to come together and start the journey should happen within one hour.	68%	72%	72%	77%	77%
	Transport team time to bedside within 3 hours The time it takes between the specialist team's decision to transfer the child, to arrival at the bed in the destination hospital.	57%	68%	55%	57%	67%
	PCCU Bed Occupancy Standard: Limit of 85%	95%	94%	85%	87%	92%
	Number of qualified nurses per bed – 5.5 whole time equivalent (WTE) The recommended standard is 5.5 WTE staff nurses per critical care bed. Consistency in staffing allows the beds to remain open.	5.37	5.61	5.64	5.20	5.22

Local case studies



The service recognised a concern in relation to the completion of MEOWS raised by midwives and conducted an audit in January 2023. The results showed a lower level of compliance with MEOWS guidelines. The service took action to re-write the MEOWs guideline to ensure suitable escalation and a focus on training for staff. Further monitoring and audits would be used to review the levels of compliance. This shows the service was reactive to concerns and ongoing action was developed when required to make improvements.

A system was in place to support women and birthing people with their birthing journey, which was triaged based on the levels of concern. Staff completed risk assessments for women and birthing people on arrival at the hospital, using a recognised tool, and reviewed this regularly, including after any incident. The triage system used was based on, The Birmingham Symptom-specific Obstetric Triage System (BSOTS). This system provides a standardised assessment of women on presentation, followed by clear guidance developed to help midwives and clinicians determine the clinical urgency in which women need to be seen.

This system had only been in place for 2 months and was not completely embedded in relation to the recording of times when women were seen by the midwife and the doctor. An audit process was in place to review this area and to develop the service.

After our inspection we were provided with data which reflected the maternity triage waiting times and times to be seen by a doctor. We saw the overall waiting times were within the agreed timeframes. Feedback from women and birthing people using triage had been obtained and reflected a positive experience, with their risk or concern being addressed swiftly and in a kind and caring manner.

The service provided a telephone contact service supported by a midwife. They were able to provide advice and direct the person to attend the triage unit to address the concern. Any women or birthing person who did not attend following advice to do so, was followed up. This ensured any potential risk for the women, birthing person, or baby was mitigated.

Staff knew about and dealt with any specific risk issues. Cardiotocography (CTG) was used to monitor fetal heart rate and uterine contractions. Best practice had a "fresh eyes" or buddy approach for regular review of CTGs during labour. We looked at the CTG audits which showed 100% compliance. On site we observed how staff recorded the fresh eyes on the electronic system and on the wipe board as a visual reminder for the next planned time check.

Stella Vig

Clinical Audit Support Centre's 30.04.25 Learn at Lunch

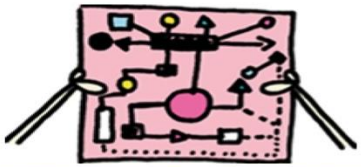
"What we do know is that if you are a highly performing organisation, then quality improvement and audit are business as usual... it is really interesting at provider-level how people have gone into two factions and we need to join that up and bring that together"

PATIENT SAFETY INCIDENT RESPONSE FRAMEWORK

PSIRF: a new era in patient safety for the NHS and healthcare

DOING THINGS DIFFERENTLY

MAXIMISING LEARNING OPPORTUNITIES



SYSTEMS THINKING

PLANNING & COLLABORATION

APPLYING NEW TOOLS AND TECHNIQUES

@cascleicester

PROPORTIONATE RESPONSE

COMPASSIONATE ENGAGEMENT

ANALYSING TRENDS

LISTENING TO PATIENTS, FAMILIES AND STAFF

SUPPORTIVE OVERSIGHT

EXPERT INVESTIGATORS

PSYCHOLOGICAL SAFETY

illustrated by Amy Bradley.

Risk profiling at a local level

- GIRFT data
- Never events data
- Claims data
- Complaints data
- Survey data
- QI projects
- Action plans from SI's
- CQC reports
- Prevention of future death reports, etc.
- **What about clinical audit?**

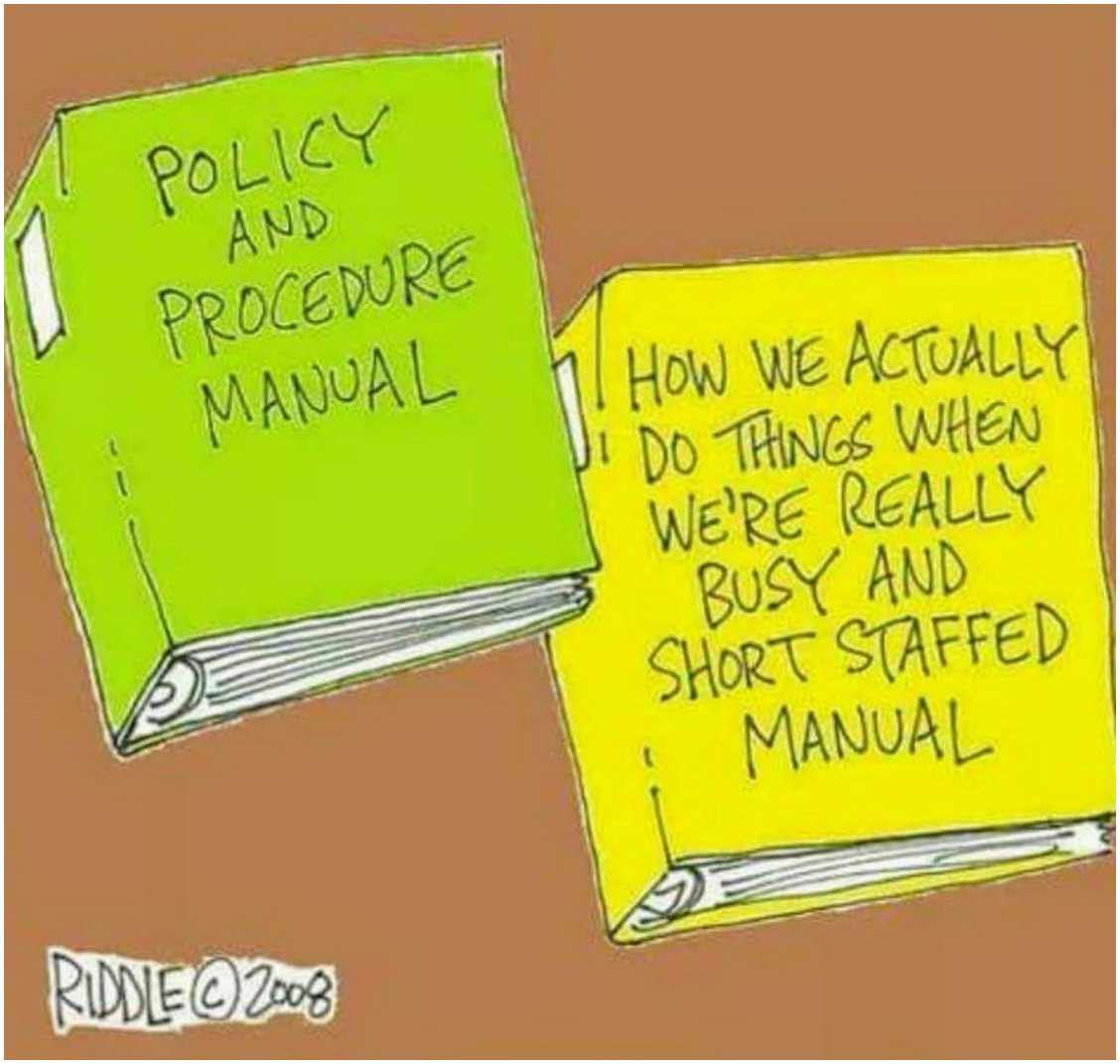
Liverpool Women's Hospital

Patient Safety Incident Response Plan

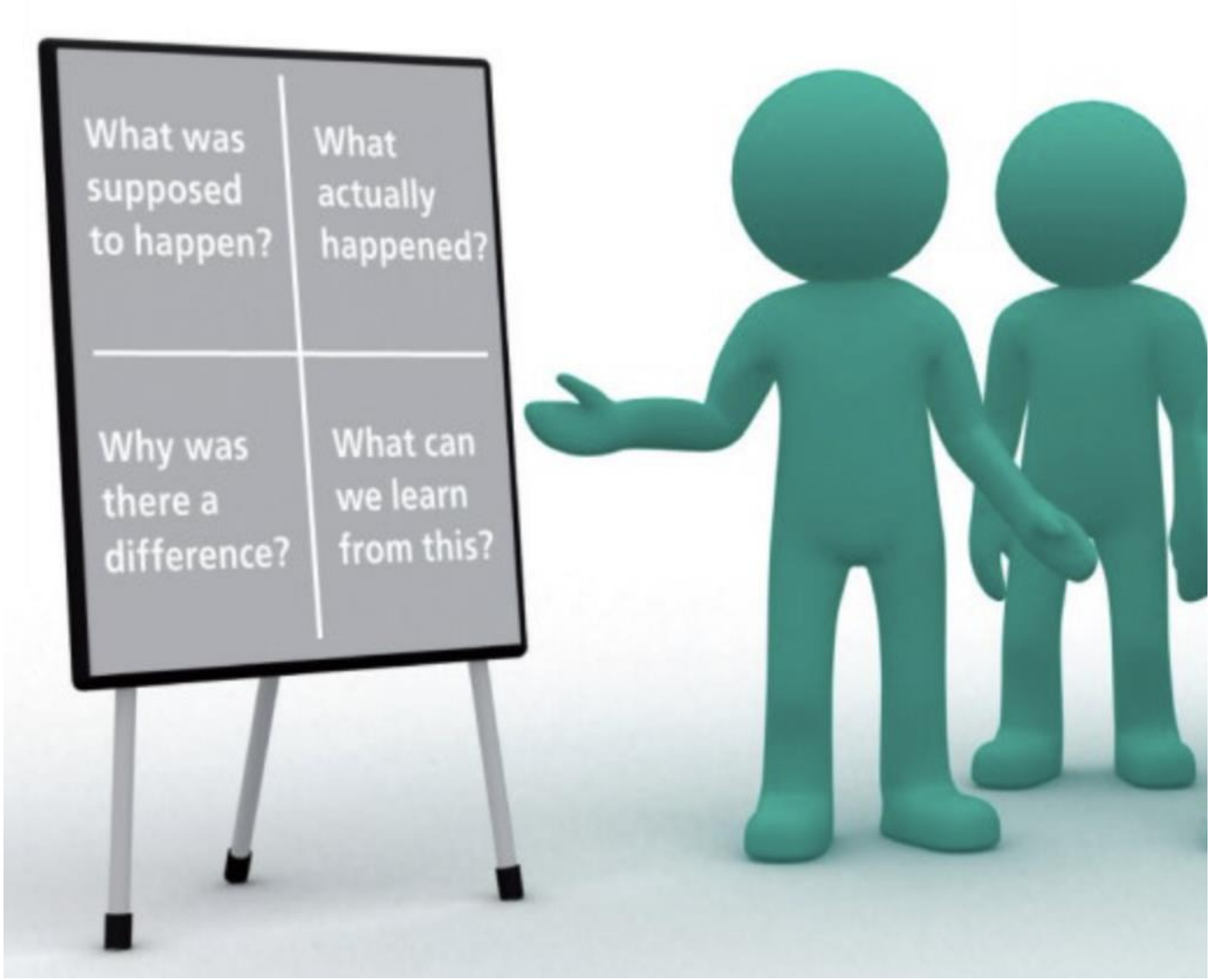
In addition to incidents, a number of data sources were collated and reviewed to ensure that the Trust focus included but was not limited to those incidents reported on to the Ulysses System. These sources included:

- Serious Incident Investigations (last 5 years)
- Health inequalities data (associated with SI review)
- Formal Reviews
- HSIB investigations
- Complaints / PALS / PALS+
- Safeguarding reviews
- Mortality reviews
- Freedom to speak up concerns
- Trust staff survey annual results
- Legal claims (new / ongoing / settled)
- Inquests
- Quality improvement and Service evaluation projects
- Clinical audits – initial and reaudit
- PMRT

Work as done v Work as imagined…



After Action Reviews



What works for you?