The Use of Audits to Improve the Quality of your Service

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Key Messages

• Quality Improvement, not Audit

• Its not what you’ve got, its what you do
The National Emergency Laparotomy Audit Quality Improvement Project
Limitations of National Audits
Limitations of National Audits

I think you should be more specific here in step two.
Audit against standards
Limitations of National Audits
What is Quality Improvement?

Formal approach to the analysis of performance and systematic efforts to improve it

• LEAN
• PDSA cycles
• SPC
• Six Sigma
• RPIW
Clinical - Export

Notice for users of Microsoft Excel 2003 and earlier.
If you plan to view the data in Microsoft Excel 2003 or earlier you will not be open up the full dataset due to a limit of 256 columns. You will need three separate exports for Sections 1-3, 4-7 and 8.

Hospital: The James Cook University Hospital (132)

Export type:
- NELA proforma
- NELA proforma PID
- NELA other information
- NELA comments (list by question)
- NELA comments (list by patient)

Locked only: ✓

Date range: From [ ] to [ ] (based on dates patients admitted to)
Using data for Quality Improvement

**Diagram:**

- **Y-Axis:** Time to theatre
- **X-Axis:** Days
- **Legend:**
  - Total
  - Trend

**Table - Urgency:**

1. Immediate (<2 hours)
2. Urgent (2-5 hours)
3. Urgent (6-18 hours)
4. Expedited (>18 hours)
5. Emergency: resuscitation of >2 hours
National Audit

Data collection → Data analysis → Report

16-18 months

Local Quality Improvement

Lots of little changes


16-18 months
Quality Improvement, not Audit

- National (local) Audit has limitations

- Local Quality Improvement is the key
  - Uses local data for local improvement
  - Keeps clinicians interested
  - Provides quicker improvement to care
Key Messages

• Quality Improvement, not Audit

• Its not what you’ve got, its what you do
Sharps Bin – Policy vs Reality
1.5 Emergencies

1.5.0.1 Fully resourced, dedicated daytime emergency and trauma lists are provided

Lists should be provided. Half-day NCEPOD lists are acceptable

Priority 1
Reference: 3.5.2, 5.1.2, 5.1.3, 5.1.4, 5.1.5

CQC KLOEs: Safety, Responsiveness, Well-led

☐ Met    ☐ Not Met    ☐ Not Applicable
2.1 A hospital receiving emergency patients requiring anaesthesia must have 24-hour availability of a staffed and dedicated emergency operating theatre.

2.4 A dedicated emergency theatre may be inappropriate for the smallest institutions, but emergency patients should take preference over elective work. Local policies need to be in place to prevent unnecessary delays to emergency patients.
A reminder of context

• NELA = 194 hospitals
• 30,000+ Emergency Laparotomy

• Huge range
  – Beds: 100-1000+
  – Operating Theatres: 4-38
  – Emergency Laparotomy cases: 25-360 per year
### Fully staffed operating theatre available to EGS patients

<table>
<thead>
<tr>
<th>Sites (%)</th>
<th>Increased with hospital size?</th>
</tr>
</thead>
<tbody>
<tr>
<td>At all times</td>
<td>137 sites (78%)</td>
</tr>
<tr>
<td>Sites (%)</td>
<td>Increased with hospital size?</td>
</tr>
<tr>
<td>-----------</td>
<td>------------------------------</td>
</tr>
<tr>
<td><strong>Fully staffed operating theatre available to EGS patients</strong></td>
<td></td>
</tr>
<tr>
<td>At all times</td>
<td>137 sites (78%)</td>
</tr>
<tr>
<td>With consultant anaesthetist sessions to cover the above ‘in hours’ (Mon-Fri 0800-1800)</td>
<td>130 sites (74%)</td>
</tr>
</tbody>
</table>
2.4 A dedicated emergency theatre may be inappropriate for the smallest institutions, but emergency patients should take preference over elective work. Local policies need to be in place to prevent unnecessary delays to emergency patients.

<table>
<thead>
<tr>
<th>Care pathway or protocol</th>
<th>Number (%) of sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Timing of surgery according to clinical urgency</td>
<td>118 (67%)</td>
</tr>
<tr>
<td>Formalised provision for the deferment of elective activity in order to appropriately prioritise unscheduled admissions</td>
<td>60 (34%)</td>
</tr>
<tr>
<td>Hospital</td>
<td>Cases Entered</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Queens Medical Centre - Nottingham</td>
<td>289</td>
</tr>
<tr>
<td>Chelsea and Westminster Hospital</td>
<td>51</td>
</tr>
</tbody>
</table>
• Qu: Have you audited adequacy of provision of emergency theatres within the last two years?

• 53% said “yes”
Using data for Quality Improvement
5.6.1 Audit – Local

• Recommended locally auditable measures include:
  – seniority of clinician present
  – anaesthetic assessment conducted
  – documented risk assessment
  – decision to surgery interval
  – appropriate level of post-operative care for risk

NELA provides all of this
It's not what you've got, it's what you do

“Participation in the ongoing patient data collection will allow hospitals to assess the adequacy of facilities to ensure standards of care are met.”
Summary

• Forget “audit” (in the traditional sense)

• It is about a Quality Improvement approach

• Use the results of local audit Quality Improvement to improve quality!