

**Audit Title**

**(Audit Ref: ???)**

XXXXX CARE GROUP

**Audit: Local/Trustwide**

**Type: CQUIN/Re-audit**

**Audit Lead:**

**Date Issued:**

**Clinical Audit Facilitator/Author:**

Standard and Outcome indicators

**Audit Checklist Timeline**

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| **Date Achieved** | **Action** |
| 5 July 2022 | Distribution lists updated to incorporate the new Mental Health & Physical Health Triumvirate structure for Doncaster |
| 15 June 2017 | Draft protocol sent to audit lead(s) for approval |
| 1 July 2017 | Audit lead(s) approved protocol |
| 12 July 2017 | Selection of patient sample for audit |
| 15 August 2017 | Audit material/audit protocol distributed to Team/Trust |
| 1 September – 15 October 2017 | Data collection |
| 15 November 2017 | Final data received for audit |
| 1 December 2017- 20 January 2018 | Data cleansing by clinical audit |
| 1 February 2018 – 15 March 2018 | Data analysis and presentation to audit lead/steering group |
| 16 March 2018 | Draft report shared with identified Care Group lead for action planning. |
| 1 April 2018 | Action plan returned to clinical audit department |
| 2 April 2018 | Update report with action plan details |
| 3 April 2018 | Report sent to Clinical Effectiveness Lead for checking |
| 4 April 2018 | Report approved by Clinical Effectiveness Lead |
| 4 May 2018 | Draft report to go to Care Quality Assurance Group for approval |
| 11 May 2018 | Report formatted by Clinical Effectiveness Administration |
| 12 May 2018 | Final Report circulated by the Clinical Effectiveness Lead. |

Guidance

An example has been created in the table for information.

This check list needs to be a timeline of key dates that are planned and then confirmed as part of the clinical audit cycle. **Please delete this guidance paragraph before sending your report out.**

**Clinical Audit Summary Results**

**Clinical Audit Title: *Insert Title***

**Area Audited: *Area Audited* Care Group: *Corporate Services***



*Example speedometer – select appropriate one*

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| **What?** |

* XXX records were audited across the XX teams/pathways included in the audit
* Records were audited against a set of core questions based on Trust policies

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| **So what?** |

* Outstanding results were achieved in relation to;
* Good results were achieved in relation to;
* Requires Improvement results were achieved in relation to;
* Inadequate results were achieved in relation to;

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| **Now what?** |

Actions

Re-audit plans

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| **Background** |

This audit forms part of the Trust’s clinical audit work programme for 2021/22 which was developed to ‘*measure and improve the effectiveness and safety of healthcare*’ and reflects the requirements of:

Why was the topic selected?

* High risk, high volume, high cost
* Patient safety incident or complaint
* Mandatory (National etc.)
* Links to NICE, CQC Outcome, Quality Markers/Care Group Quality Improvement plans, BAF, Policy, CQUIN, SI, Commissioners choice audit

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| **Aim of the Audit** |

Expressed as a singular statement clearly states what the audit hoped to achieve.

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| **Objectives of the Audit** |

1. Aim is broad, objectives add further clarity
2. Describe the steps needed to measure if the aim has been achieved

* e.g. Assess current records to see if they meet best practice
* Identify examples of good/outstanding practice and cascade
* Identify examples of areas for improvement and highlight to aid training/ quality improvement

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| **Criteria and Standards** |

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| **Criterion** | | **Standard** | **Exception** |
| 1. |  |  | Font size variable |
| 2. |  |  |  |

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| **Sample and Population** |

How was this identified?

* All patient records …

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| **Data Collection** |

* How was it collected, what was collected?
* When was it collected, who collected it?
* Data collection tool as an appendix

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| **Data Analysis** |

How was data analysed?

* e.g. SPSS, Excel

When was the data analysed?

* Time, date and how long did it take

Who analysed the data?

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| **Results** |

*Table for a re-audit*

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| **Criterion** | | **Standard achieved at audit**  **(N=)** | | **Standard achieved at re-audit**  **(N=)** | |  |
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*Table for an audit*

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| **Criterion** | | **Standard achieved at audit**  **(N=)** | |
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| **Observations** |

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| **Outcome Rating** | **Rationale** | **Action Plan Review Follow-up** |
| Outstanding | Achieved 100% for all standards | A self-audit to be conducted by the service in the forthcoming year. |
| Good | Achieved 75% to 99.9% for most standards | A face to face six months action plan review visit (announced) with the clinical audit facilitator and audit lead. |
| Requires Improvement | Achieved 50 – 74.9% for most standards or mixed results | The clinical audit facilitator to conduct an unannounced visit within three months of issuing the audit report. |
| **Inadequate** | Achieved 49.9% or below for most standards | The clinical audit facilitator to conduct an unannounced visit within one month of issuing the audit report. |

The outcome rating is calculated by working out the overall percentage achieved taking into account the numerators and denominators for each criterion.

It should be noted that there may be occasions when the rating may be altered if any criteria is rated Red and is deemed to be a clinical/staff risk.

For example, if the overall rating is ‘good’ it may mean that the rating will be changed to ‘Requires Improvement’ where the risk is seen as high and will automatically become a re-audit.  This decision will be made initially by the Clinical Lead for the audit and the Clinical Audit Facilitator and agreed at the relevant meeting (For example: Care group or Medicines Management Committee [MMC] meeting) where the Clinical Lead for the audit is presenting their report.

The overall rating for this audit is ‘**??????’** which achieved ??%

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| **Recommendations** |

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| 3 |  |
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**Actions**

Specify what actions need to be carried out, what will be implemented, ensuring these are: **S**pecific, **M**easurable, **A**chievable, **R**elevant, **T**imely. Also complete the rag rating using the key below. **(Please delete this paragraph prior to issuing the final report)**

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| **Quality & Patient Care Action Rag Rating Key:** | Acceptable quality standard | Minor quality concerns  Slight deviation from acceptable quality standard  Do not create risks to patients or registration | Major quality concerns  Deviation from acceptable quality standard  Adverse patient harm or registration impact |

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| **Action Number** | **Audit Criteria** | **Action to be Implemented and Rag Rating** | **Evidence** | **Name and Title of Lead** | **Date for completion** | **Change Status\*** |
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**\*Key (Change Status)**

1. Recommendation agreed but not yet actioned

2. Action in progress

3. Recommendation fully implemented

4. Recommendation never actioned (please state reason)

5. Other (please provide supporting information)

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| **Action Plan Review** |

Date of review XXXX

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| **Action Plan Review** | **Criteria** | **Action Implemented** | **On Initial Review** | **Action to be Taken** | **Date of Further Review** | **Outcomes** |
| No follow up |  |  |  |  |  |  |

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| **Action Plan Review** | **Criteria** | **Action Implemented** | **On Initial Review** | **Action to be Taken** | **Date of Further Review** | **Outcomes** |
| 6 months post audit (announced) |  |  |  |  |  |  |

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| **Action Plan Review** | **Criteria** | **Action Implemented** | **On Initial Review** | **Action to be Taken** | **Date of Further Review** | **Outcomes** |
| 3 months post audit (unannounced) |  |  |  |  |  |  |

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| **Action Plan Review** | **Criteria** | **Action Implemented** | **On Initial Review** | **Action to be Taken** | **Date of Further Review** | **Outcomes** |
| 1 month post audit (unannounced) |  |  |  |  |  |  |

**Please delete “Action Plan Review” sections that do not apply**

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| **Re-audit** |

A ### month (announced/unannounced) action plan review is to be carried out in ###########.

A re-audit will be subject to the action plan review findings.

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| **Distribution List** |

Who will the report be sent to? **(Please delete which Care Group(s) does not apply).**

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| **Identified person for Audit Distribution**  **Children’s Care Group** |  | |
|  | **For Action** | **For Information** |
| Care Group Director  Christina Harrison |  | ✓ |
| Lead Consultant  Dr Alison Davies |  | ✓ |
| Associate Nurse Director  Kate Jones |  | ✓ |
| **Identified People for Actions** | | |
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| **Identified person for Audit Distribution**  **Doncaster Mental Health Care Group** |  | |
|  | **For Action** | **For Information** |
| Care Group Director  Lisa Connor |  | ✓ |
| Associate Medical Director  John Bottomley |  | ✓ |
| Associate Nurse Director  TBC |  | ✓ |
| **Identified People for Actions** | | |
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| **Identified person for Audit Distribution**  **Doncaster Physical Health Care Group** |  | |
|  | **For Action** | **For Information** |
| Care Group Director  Cora Turner |  | ✓ |
| Associate Medical Director  John Bottomley |  | ✓ |
| Associate Nurse Director  TBC |  | ✓ |
| **Identified People for Actions** | | |
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| **Identified person for Audit Distribution**  **North Lincs Care Group** |  | |
|  | **For Action** | **For Information** |
| Interim Care Group Director  Wendy Fisher |  | ✓ |
| Associate Medical Director  Dr Andrew Heighton |  | ✓ |
| Associate Nurse Director  Vicky Clare |  | ✓ |
| **Identified People for Actions** | | |
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| **Identified person for Audit Distribution**  **Rotherham Care Group** |  | |
|  | **For Action** | **For Information** |
| Care Group Director  Julie Thornton |  | ✓ |
| Associate Medical Director  Dr Diarmid Sinclair |  | ✓ |
| Associate Nurse Director  Michaela Bateman |  | ✓ |
| **Identified People for Actions** | | |
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| **Identified person for Audit Distribution**  **Medicines Management** |  | |
|  | **For Action** | **For Information** |
| Steve Davies  Chief Pharmacist |  | ✓ |
| Emma Finnegan  Personal Assistant / Project Support Officer |  | ✓ |

Date Final Report Sent to identified person for Distribution: #######

**Further appendices**