CASC Learn at Lunch
The Clinical Audit Team of One
Challenges, ideas and approaches

Anne-Marie Murkett

What we will cover today

- Conducting Clinical Audit in a small sized healthcare organisation
- Using After Action Review to support incident investigation and learning.

Hello!

I'm Anne-Marie Murkett, Head of Quality and Governance at Rainbows Hospice for Babies, Children and Young People in Leicestershire and an associate with CASC.

I am a Children's Nurse by background and have worked at Rainbows for nearly 10 years.

Clinical Audit as a "Team of One"

Clinical Audit is the original improvement tool, but how do you get it to really work for your organisation and really demonstrate continuous improvement…especially if you are a team of one?

Together we'll look at:

- Tips
- Ideas
- Challenges.

Clinical Audit Team of One

What are the challenges?

Tips and Ideas

- Inheriting clinical audit programmes and tools:
  - ➢ Audit of Audits
  - ➢ Redesign audit tools.

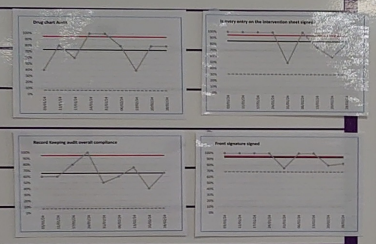
- Engaging the team:
  - ➢ Champions
  - ➢ Build in opportunities to talk about audit with the team e.g. training, team meetings
  - ➢ Team directed audit questions
  - ➢ Local Clinical Audit demonstrating the audit cycle and link back to care and improvement – tight cycles and action planning
  - ➢ Displaying your results.

rainbows
Brightening short lives

Knowing How We Are Doing?

Audit Results

	Date	Result
Weekly		
Record Keeping	4/4/24	20%
Drug Chart	4/4/24	60%
Monthly		
IPC	5/3/24	99%
Hand Hygiene	26/1/24	100%
PPE	26/1/24	100%



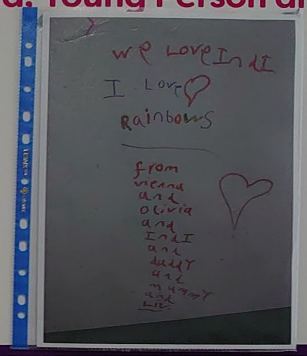
Baby, Child, Young Person and Family Experience

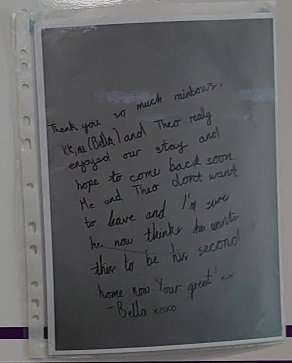
MARCH 24

Complaints: 0

Compliments: 3

Concerns: 1





Staff Zone

Clinical

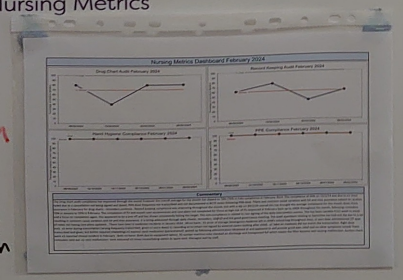
Reminder to all staff to complete elearning in: GDPR • IPC + Fire

- Document all PRN doses in BCYP notes.
- Remember to sign the intervention sheet at every entry + sign the signature sheet.

Quality Improvements

- Development of PEWS
- Opiod Stewardship
- LTV Standards benchmarking
- Shift debrief + recognition

Nursing Metrics



Quality Improvement Projects

What's the pebble in your shoe?

Staff Shout Outs

Lucy W wants to thank Jacqui for all her support + knowledge!

We care for babies, children and young people in the East Midlands – wherever they are.
Hospice | Hospital | Home

Tips and Ideas

- Small organisation / independent organisation audit professional's support

➢ Regional audit networks (N-QI-CAN Regional Networks – National Quality Improvement (incl. Clinical Audit) Network (N-QI-CAN) (nqican.org.uk)

➢ Hospices Sharing Good Governance Group

➢ N-QI-CAN sharing forum

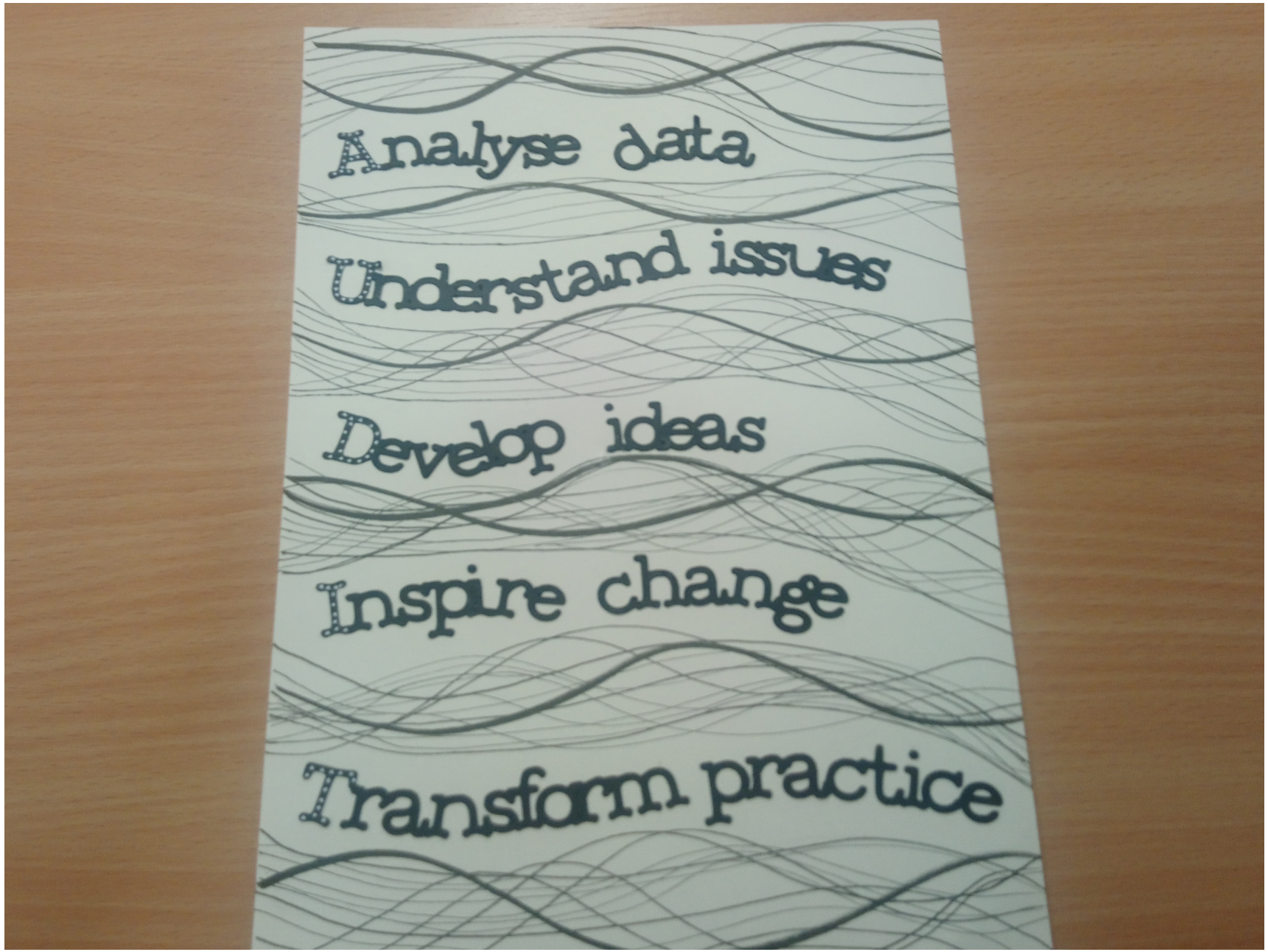
➢ Others?

Tips and Ideas

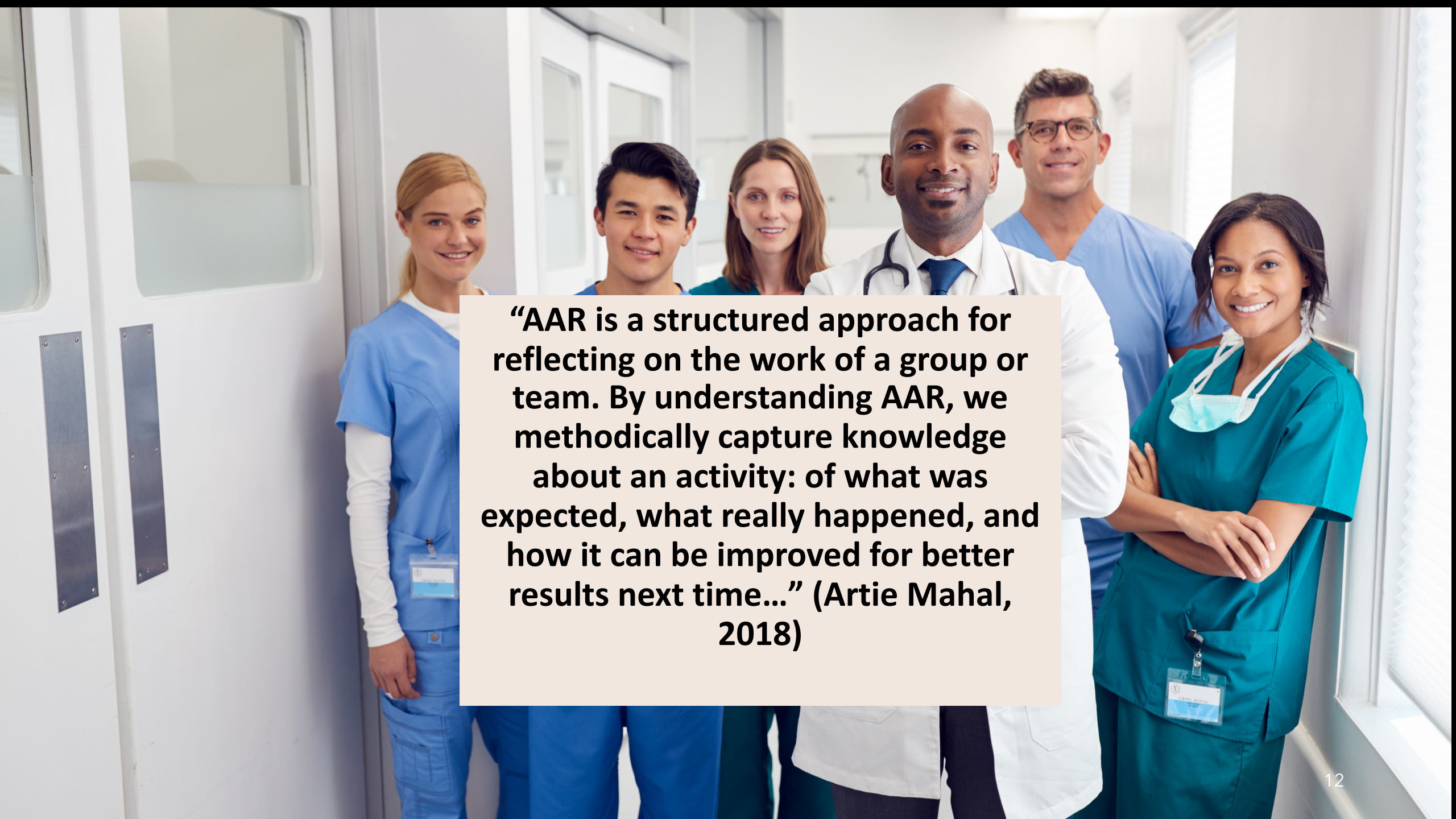
- Organisation joined up approach to audit and QI =

➢ Audit and QI committee – clinical and non-clinical reps

➢ Clinical Audit Awareness Week #CAAW24 – activities – get the whole organisation involved.


Analyse data
Understand issues
Develop ideas
Inspire change
Transform practice

After Action Review



“AAR is a structured approach for reflecting on the work of a group or team. By understanding AAR, we methodically capture knowledge about an activity: of what was expected, what really happened, and how it can be improved for better results next time…” (Artie Mahal, 2018)

Why use AAR?

- It can be used to analyse the results of any activity within an organisation
- It can be conducted during the activity or at the conclusion
- It is a tool for continuous improvement
- It is conducted with the group or activity participants; asking them to reflect on and acknowledge what was planned, what actually happened and what could be improved upon next time
- It allows group members to find out for themselves what happened and why
- Can be formal or informal.

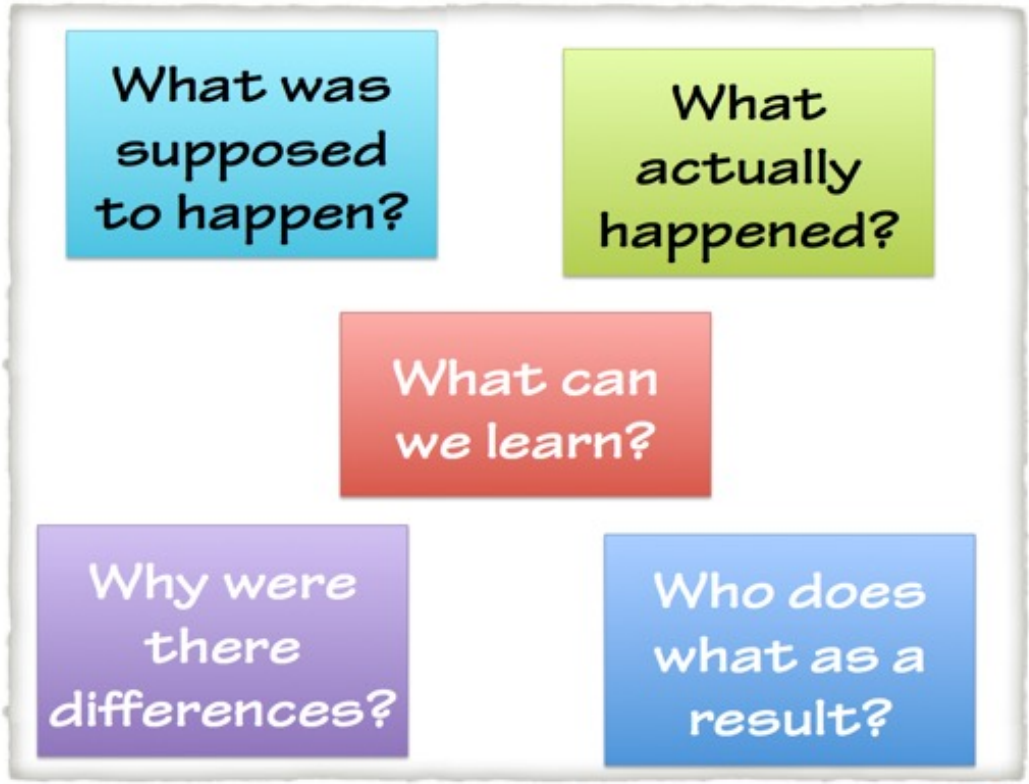
When to use AAR…

- Immediately after a significant activity, incident, event or project concludes
- When a professional discussion around a specific activity would be beneficial for capturing and sharing for future improvement.

4 main questions:

- What was expected to happen?
- What actually happened?
- What went well and why?
- What can be improved upon and how? (What have we learned?)

After Action Review



7 Steps to Significant Event Audit

1) Awareness and Prioritisation of a significant event
2) Information Gathering
3) The Facilitated team-based meeting
4) Analysis of the significant event: What happened? Why did it happen? What has been learned? What has been changed or actioned? Possible outcomes
5) Agree, Implement and monitor change
6) Write it up
7) Report, Share and review

After Action Review v Significant Event Audit

AAR	SEA
Immediate: Prioritise completion – no more than 2 weeks	Planned: after the event
Can be ad hoc without too much pre-work	More in depth look at a specific event
Compares intended results with what actually happened	Retrospective look at the event and learning
Applied to all recurring and repeating events and activities as well as those that pose a challenge	Applied to specific selected often deleterious significant events/incidents.
Based on theory that Improvement cannot be realised without an understanding of what went well.	Can look at what went well to replicate in the future, however perhaps more of a look at what happened in a "what went wrong" way

AAR Case Studies

- Symptom management stay
- Recruitment event
- High profile patient stay
- Catering provision over New Year.

Identifying which incident or event to use with AAR

We started with a patient stay that was out of the ordinary and had several Datix incident reports around medicines and clinical incidents / errors.

Decided to look at the whole event / journey to discover what we could learn or do differently in the future.

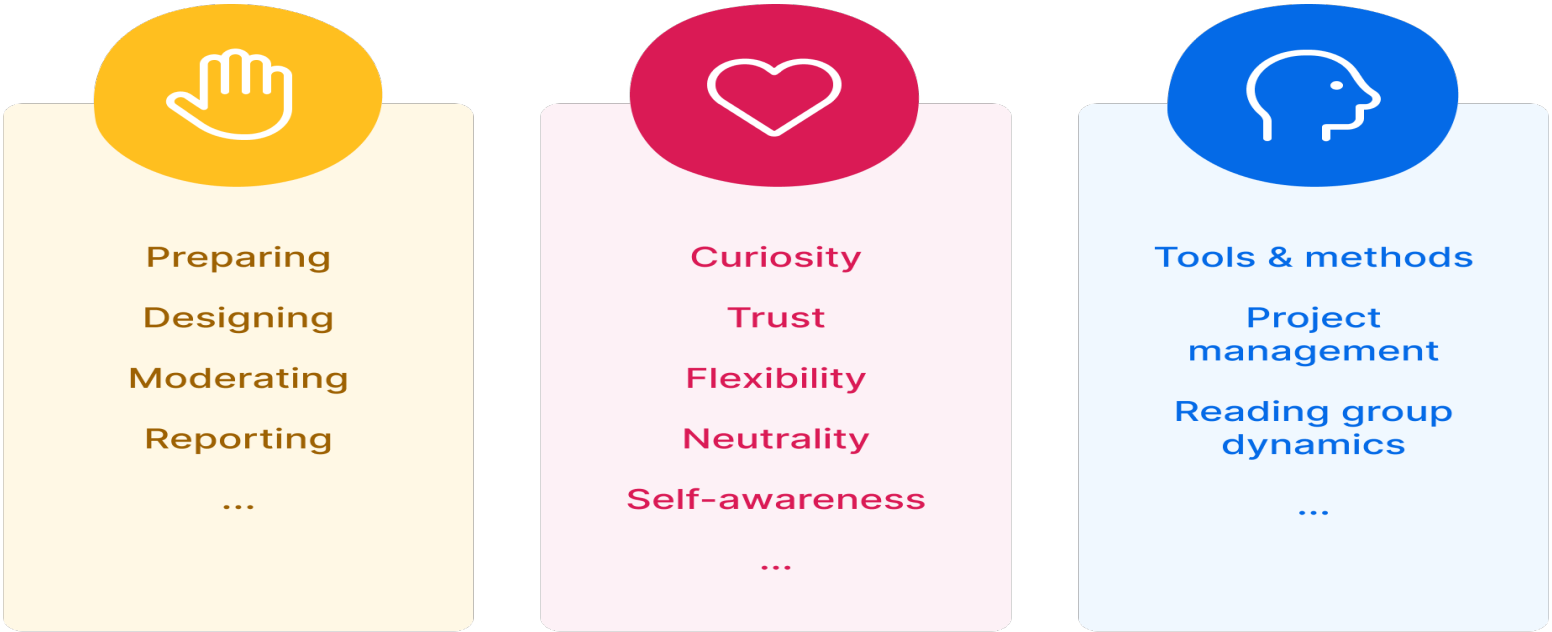
And just gave it a go…..

Top Tips for Successful AARs

- Make it a priority – no more than 2 weeks after the activity
- Consider venue – in-person v virtual? Mix?
- Involve everyone – everyone gets a say. Encourage active participation in the discussion
- Use a neutral skilled facilitator who can keep the discussion on track in a non-threatening, non-judgemental way
- No finger pointing / blame – focus is on learning and improvement – make this clear from the start of the review.
- Highlight what was done well so that it can be repeated again
- Encourage open and honest discussion of what could be done differently with a focus on action in the form of lessons learned.

Facilitating AARs: The AAR Conductor

The hands, heart and head of facilitation skills



Facilitators Mantra

Don't look for trouble -Keep the bigger picture in mind, maintain professional behaviour

Don't let them see you sweat – Demonstrate self-confidence. Handle any situations with honesty, wisely and with integrity of intent.

Keep calm and carry on!

Go for It!

Thank you

Anne-Marie Murkett

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