

Title	BADGER QUARTERLY CLINICAL AUDIT CLINICIANS, HEALTHCARE SUPPORT WORKERS AND CALL HANDLERS			Number	CL10
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Version Control

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16.02.18	???	????
22.05.19	Reviewed, no changes	SMcD
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1 Introduction

- 1.1 Clinical audit is an essential component of governance arrangements and enables BADGER to demonstrate a commitment to improving quality of practice. Clinicians receive a personal quarterly audit report, carried out by an experienced peer auditor and based on information recorded on Aadastra. The clinical audit procedure was comprehensively reviewed and amended in 2011 particularly to include a new marking template and to provide an explicit statement of expected standards.
- 1.2 From October 2013 Health Care Support Workers (HCSW) are included in the quarterly clinical audit. HCSWs are an essential component of the workforce, providing valuable support to the clinicians and the wider multidisciplinary team, The HCSW audit supports essential components of the governance framework and enables BADGER to demonstrate its ongoing commitment to continually improving quality of practice.
- 1.3 Clinician audit is carried out in the context of the National Quality Requirements for out-of-hours services:
http://webarchive.nationalarchives.gov.uk/+www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4091215.pdf

The audit programme takes account of the recommendations of the RCGP clinical audit toolkit and the recommendations of the joint publication by the RCGP, Royal College of Paediatrics and Child Health and the College of Emergency Medicine.

2 AUDIT PROCESS FOR CLINICIANS

2.1 Calls are sampled from all out-of-hours patient consultations carried out by GPs, Advanced Practitioners and Nurse Practitioners. They are marked by senior clinicians including and under the supervision of an Associate Medical Director

2.2 A sample of Adastra calls is identified randomly for each clinician. Where clinicians carry out different types of calls, those sampled are selected to represent the different types carried out by the individual clinician. The auditor will review the case records and any other appropriate information.

2.3 Audit criteria and marking.

2.3.1 The principle of marking is:

Fully meets criteria	= 2
Partially meets criteria	= 1
Does not meet criteria	= 0

2.3.2 Triage Call - Maximum 18 marks

Telephone consultation before face-to-face consultation

- Caller identification: max 2 marks for identification of the caller by name and relationship if indicated. e.g. one mark for “brother” while two marks for “brother Tom” / one mark for “carer” and two for “Sarah Smith - carer”.
- Caller’s concerns detailed: max 2 marks for clarity about why the service has been contacted.
- Dispatch / next stage intervention: max 2 marks for clear documentation e.g. recording that a primary care centre (PCC) appointment is made; 1 mark if implied and 2 if clearly stated.
- Rationale for next intervention: max 2 marks for clear documentation of why the clinician should have decided upon a course of action. e.g. “?chest infection, needs examination ?medication”
- History:
 - Record made of the history of presenting complaint (HPC) – max 2 marks
 - Record made of the duration of the presenting complaint – max 2 marks
 - Record made of previous medical history (PMH): max 2 marks
 - Record made of drug history (DH) ; max 2 marks
 - Record made of allergies: max 2 marks

Clinicians should confine themselves to the “history” field only in a triage call, leaving other fields clear for the following clinician who has face to face contact with the patient.

2.3.3 Advice Call – Maximum 20 marks

Telephone consultation completing call as final intervention

- Caller identification: max 2 marks
- Caller’s concerns identified: max 2 marks
- History taking as above, to include HPC/PMH/DH/allergies: max 10 marks

- Diagnosis / formulation recorded in diagnosis field and consistent with clinical information: max 2 marks. NB: Recording symptoms in the diagnosis field is not sufficient eg. “abdo pain & rash” is not a diagnosis, while “shingles” is. The use of unusual acronyms or abbreviations is discouraged.
- Management plan recorded in treatment field and consistent with clinical information: max 2 marks – it is important to detail the advice given.
- Safety net advice recorded in treatment field and specific to the problem: max 2 marks eg “see again if needed” = partially will gain one mark, but “call 999 if abdominal pain worsens or vomits blood” will gain two marks.

2.3.4 Face-to-face contact – Maximum 18 marks

Consultation at primary care centre

- Diagnosis – as above: max 2 marks
- Examination: max 10 marks
 - Case specific: max 2 marks –e.g. a case involving cough and shortness of breath has record of a respiratory examination
 - Pulse/ HR: max 2 marks when indicated.
 - Blood pressure: max 2 marks when indicated. In a young child or baby, capillary refill time (CRT) should be recorded instead. Comments such as “well perfused” or “pink” in children, may earn 1 mark.
 - Temperature: max 2 marks when indicated. The comment “apyrexial” may earn 1 mark.
 - Oxygen saturation: max 2 marks. If not recorded, there should be a comment made about the patient’s general condition or absence of cyanosis.
- Prescription consistent with clinical findings, national and local guidance, details recorded in the treatment field: max 2 marks. The drug name, strength, frequency and quantity prescribed should be recorded. This occurs automatically if the item is printed from Adastral and does not need to be repeated. In the case of items handwritten or dispensed from cars the prescription should be written on Adastral and recorded as “hand written”. If computer access is not available, no Adastral prescription is written and so a free text record is required. In the event that prescribing is not clinically indicated and does not take place, the marks are allocated by default.
- Treatment / management plan consistent with clinical information and entered in the treatment field: max 2 marks
Specific safety net advice must be recorded as above: max 2 marks

2.3.5 Face-to-face contact – Maximum 18 marks

Consultation at home visit

- Diagnosis – as above: max 2 marks
- Examination – as above: max 10 marks
- Prescription – as above: max 2 marks
- Management plan – as above: max 2 marks
- Safety net – as above: max 2 marks

Note – in the case of consultations without computer access (eg home visits undertaken from a standby car), clinicians may handwrite findings for later transcription by admin staff. Marks will be lost by clinicians whose entries are sparse and / or illegible.

2.4 Summary of call marking

Scoring template

X = criterion applies

	Triage	Advice	PCC	HV
Identify caller	x	x		
Caller's concerns identified	x	x		
History taking	x See below	x See below		
Despatch	x			
Rationale	x			
Diagnosis		x	x	x
Appropriate prescribing			x	x
Management plan		x	x	x
Safety net		x	x	x
Examination findings			x See below	x See below
Maximum marks	18	20	18	18

ID 0 - not mentioned, 1 – Implied 2 – Fully documented
Concerns 0 – not mentioned 1 – Implied 2 – Identified

History

History of Presenting Complaint 2 marks
Duration 2 marks
Previous Medical History 2 marks
Drug History 2 marks
Allergies 2 marks

Marks scored by default if history component is not indicated by the nature of the call. e.g. expected death, prison call or some other call where information is either not disclosed or is not available – clinicians should document in such cases e.g. “patient declined to disclose PMH”, “Caller no access to medication for DH”

Despatch	0 - not documented	1- implied	2 - clearly documented
Rationale	0 - not documented	1 - implied	2 - clearly documented
Diagnosis	0 - not documented	1 - symptoms only / incorrect field	3 – correctly documented
Prescribing	0 - not documented	1- partially [Where prescribing not indicated, 2 marks by default.]	2 - full and appropriate
Plan	0 - not documented	1- implied	2 - recorded fully
Safety Net	0 - not documented	1- general terms	2 - specifics documented
Examination			
Case specific	2 marks		
Pulse	2 marks		
BP	2 marks		
Temp	2 marks		
Oxygen Sats	2 marks		

Marks scored by default where a reason is given why a component was not available or recorded e.g. “baby moving too much for Sats to be recorded”

3 AUDIT PROCESS FOR HEALTHCARE SUPPORT WORKERS

- 3.1 Calls are sampled from all out-of-hours patient consultations carried out by the HCSW. They are marked by the Audit Assistant including and under the supervision of the Clinical Audit Manager
- 3.2 A sample of Aadastra calls is identified randomly for each HCSW. The auditor will review the case records and any other appropriate information.
- 3.3 HCSWs receive a quarterly audit report based on information recorded on Aadastra. Any concerns relating to the audit findings are shared with the Lead Nurse and an appropriate training/supervision/monitoring action plan for the respective HCSW is implemented.

3.4 Audit criteria and marking

- 3.3.1 The principle of marking is:

Fully meets criteria	= 2
Partially meets criteria	= 1
Does not meet criteria	= 0

3.3.2 Face-to face contact – Maximum 18 marks

HCSW documents clearly and concisely in the patient’s records:

- Introduction: who the patient attended with, if on their own or accompanied by someone else, e.g. relative, friend, guardian, etc. max 2 marks
- Presenting reason: patient’s concerns detailed. Clarity about reason for attendance, e.g. coughing for five days and has developed fever; max 2 marks

- Medical history: recording of specific conditions and/or long term conditions; max 2 marks
- Medication: recording of any drugs patient is taking or noting not taking any drugs/medication if that is the case; max 2 marks
- Allergies: recording of any allergies or noting no allergies if that is the case; max 2 marks

Observational findings – recording of the following:

- Temperature - max 1 mark
- Pulse - max 1 mark
- Respirations - max 1 mark
- Blood pressure - max 1 mark
- Oxygen saturation level (SATS) - max 1 mark
- Urinalysis (when indicated) - max 1 mark
- Blood glucose (when indicated) - max 1 mark
- Rationale given where an observation could not be recorded, e.g. baby moving too much for SATS to be recorded - max 1 mark

3.4 Summary of marking

Scoring Template for face-to-face contact:

	Maximum Mark:
Introduction	2 marks
Presenting reason	2 marks
Medical history	2 marks
Medication	2 marks
Allergies	2 marks
Observational findings	5 marks
Urinalysis (when indicated)	1 mark
Blood glucose (when indicated)	1 mark
Rationale for not recording an observation	1 mark
Total maximum marks:	18 marks

Marks are awarded by default if the patient or accompanying parent/carer in the case of a child declines to disclose any information – the HCSW should document in such cases, e.g. ‘patient declined to disclose medical history’.

Marks are awarded by default for ‘when indicated’ observations which are not recorded, because the nature of the patient’s presenting reason does not require it.

4 AUDIT PROCESS FOR CALL HANDLERS

- 4.1 Calls are sampled from all GP out-of-hours calls taken by Call Handlers or those acting as such to a significant extent. They are marked by the Audit Assistant under the supervision of the Clinical Audit Manager.
- 4.2 A sample of Aداstra calls is identified randomly for each call handler. The auditor will review the case records
- 4.3 Call Handlers receive a quarterly audit report based on information recorded on Aداstra. Any concerns relating to the audit findings are shared with the Team Leaders and an appropriate action plan for the respective Call Handler is implemented.

4.4 Audit criteria and marking.

- 4.4.1 The principle of marking is:
- | | |
|--------------------------|-----|
| Fully meets criteria | = 2 |
| Partially meets criteria | = 1 |
| Does not meet criteria | = 0 |
- Where there is less detail:
- | | |
|------------------------|-----|
| Meets criteria | = 1 |
| Does not meet criteria | = 0 |

4.4.2 Call Handling – Maximum 23 Marks

Call Handler establishes a rapport with the patient and records the correct information and makes and documents an appropriate prioritisation decision.

Identifies and records the following demographic information correctly:

- | | |
|---|-------------|
| • Name (spelt properly and the right way round) | max 2 marks |
| • Gender | max 1 mark |
| • GP name | max 1 mark |
| • GP surgery | max 1 mark |
| • Date of birth | max 1 mark |
| • Home phone | max 1 mark |
| • Current contact numbers | max 1 mark |
| • Home (registered) address (if not at home) | max 1 mark |
| • Current address with area in line 4 | max 2 marks |
| • Caller details | max 1 mark |
| • Previous record (previous episode or open call) | max 1 mark |

Identifies and records the following information:

- | | |
|---------------------------------|-------------|
| • Reason for call | max 1 mark |
| • Duration and query recurrence | max 2 marks |
| • Self-care / medication | max 1 mark |
| • Own GP / WIC / A&E | max 1 mark |
| • Other medication | max 1 mark |
| • Other medical conditions | max 1 mark |

Condition Specific Questions (where appropriate)	max 2 marks
Appropriate Prioritisation	max 1 mark

Marks are awarded by default, and deducted in the case of clear absence of information or performance or recording of erroneous information.

4.5 Listening to the call recordings:

An audit of a sample of telephone calls are listened to, assessing the professional manner of the call handler to the patient and appropriate questioning to gather standard information and condition specific information.

5 CONCLUSION

Questions should be directed in the first instance to the Clinical Audit Assistant
Confidential advice on personal reports is available via the medical director, the lead nurse for training and quality, or the associate medical directors.

Suggestions for improvement of the procedure are welcome.