Quality Improvement Activity

For the purposes of revalidation you are required to demonstrate that you regularly participate in activities that evaluate the quality and improvement of your work. Examples of quality improvement activities:

- Clinical audit - measures the quality of care individual doctors are involved in;
- Review of clinical outcomes - this could include review of morbidity or mortality data, minor surgery data or commissioning information;
- Case review or discussion - this could be peer review of an interesting or challenging case. This would include significant event reviews. It is important to reflect on the discussion, detail what has been learnt and what will change in your clinical practice as a result of the discussion;
- Audit and monitor the effectiveness of a new system, process or teaching programme;
- Evaluate the impact - this could be a new service developed and implemented. For practices the move to named GPs for the vulnerable elderly and the case management that will be required for the new DES for admissions avoidance would be a useful area to consider;

The RCGP consider significant event review and clinical audit as being core elements to quality improvement but are happy to accept other appropriate quality improvement activities that you can demonstrate have had a positive impact on your care of patients.

It is important to remember that the GMC does not require doctors to undertake clinical audit, if there are other more appropriate methods of delivering quality improvement of your clinical care.

Each year at your appraisal you will need to demonstrate that you have been involved in quality improvement activities.

The LMC’s advice is to undertake a variety of quality improvement activities and ensure that, over the five year cycle, some of these enable you to provide evidence that demonstrates the impact and change this activity has had on your clinical practice.

Practice based audits are acceptable so long as you reflect on the outcomes personally, and this impacts your clinical practice and you detail your role in the audit.

QoF is a simple way to audit quality but simply recorded and comparing 2 years results is not acceptable, you need to discuss the outcomes in one year, suggest and implement change and evaluate the impact at a later date.

Quality improvement activities should be robust, systematic and relevant to your work. They should include an element of evaluation and action, and where possible, demonstrate an outcome or change.
In the past GPs were told that once in every 5 year they would need to complete a full clinical audit. This is now not a requirement as defined by the GMC, the RCGP suggests that GPs should use this as part of their quality improvement activity.

At each appraisal you need to demonstrate that you are engaged in quality improvement activities and provide supporting information for this.

**Case review or discussion:** A documented account of interesting or challenging cases that a doctor has discussed with a peer, another specialist, or within a multi-disciplinary team. You must record an outcome, only need one line but, will this discussion change your clinical practice for the better?

**Significant event review:** All practices discuss significant events, use these as quality improvement activities. What appraisers are looking for is your reflection and then any action that has been taken which will improve the quality and safety of care in your practice.

**Review of clinical outcomes:** Where robust, attributable and validated data is available. This could include morbidity and mortality statistics or complication rates where these are routinely recorded for local or national reports.

For example in general practice you could look at the outcomes of joint injection at 3 months. Again ensure you record the reflections and actions taken.

**Audit and monitor:** For example the effectiveness of a teaching programme.

**Clinical audit:** Evidence of effective participation in clinical audit, or an equivalent quality improvement exercise, that measures the care with which an individual doctor has been directly involved.

There are many examples of audits currently undertaken in most practices including:

- Minor surgery
- Cervical smears
- Monitoring of DMARDs
- End of life care
- Cancer diagnosis
- Referrals and admissions
- Hypertension management
- Leg ulcer care
- Investigations and imaging

It may be more difficult for locums or OOHs GPs to participate in audit, but you could audit your referrals, or look at the next 50 prescriptions for antibiotics, look at avoiding those that can cause clostridia (Co-amoxiclav, ciprofloxacin, cephlosporines and clindamycin).
Nigel Watson has produced a helpful LMC Podcast: Revalidation, Quality Improvement Activity (seems to be unavailable now)

Northern Deanery advice for sessional doctors

Examples of “Quality improvement activities” appropriate for Sessional Doctors

Examples from RCGP revalidation guide Version 6
1) A locum or out-of-hours doctor may undertake an ‘action audit’ in which the care of presenting cases of a defined nature are continually reviewed against pre-set criteria and standards with continuous reflection and improvement recorded.
2) One example might be keeping a log of all referrals and patients causing concern, and then on return to the practice or clinic following the patient up, learning lessons from the outcomes
3) A doctor may undertake a random case analysis, in which clinical decision making, record keeping and standards of care in 20 consecutive consultations are reviewed, using a standardised format, with an appropriately skilled and experienced colleague or colleagues; reflection occurs, and improvements agreed and demonstrated

Other Examples

Records audit
Audit your record keeping on a series of consultations highlighting key elements of information which you feel you might need to improve. These might be: whether you have entered:
- patients account (history)
- examination
- plan
- safety netting
- documentation of consent
- chaperone offered
- patient advice and use of PILS
- red flags
- REAd coded problem
- presence of carer or guardian

Condition based review
Pick a clinical area which you feel may merit improvement for which there are good (preferably) evidence based guidelines and which you see a reasonable number of cases of e.g. UTIs, depression, copd, asthma, anxiety, -carry out a prospective collection of encounters printing off (anonymised) the consultation and patient summary and meds
- once you have collected at least 10, look carefully at how you have managed these in the context of the guidelines you have found and see whether there are any patterns or themes or learning points as to aspects of diagnosis or care which you have omitted or need to improve.
- identify key changes which you need to make in your personal practice
- repeat the exercise
## Review of Referrals (adapted from SOAR)

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<td>referral sent within recommended time period?</td>
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<td>used local form/proforma?</td>
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<td>PMH and drug history included?</td>
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<td>Alternative pathways not available?</td>
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<td>Driver for referral: diagnostic uncertainty; to access treatment/surgery; patient concerns; to access investigations; other</td>
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<td>Routine/Urgent/fast track?</td>
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<td>Outcome as expected?</td>
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<td>Any lesson learned?</td>
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<td>In retrospect was referral the most appropriate?</td>
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<td>Was the most appropriate method or pathway used?</td>
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<td>Appropriate investigation? (if applicable)</td>
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Examples from SOAR:

**Antibiotic prescribing**

For ten surgeries, note your use of antibiotic prescribing against your chosen set of criteria and standards. You need to consider setting criteria such as:

1. Patients receiving antibiotics should have a recognised condition for which antibiotics are recommended
2. Antibiotics should be used which are in line with local formulary or microbiology laboratory recommendations for first line use, unless clinically contraindicated
3. When appropriate, microbiology sampling should be undertaken to check on organisms and sensitivities
4. All antibiotic prescribing should use the most effective dose and duration of treatment for the identified condition, in line with local formulary guidelines or the BNF.
5. All antibiotic prescribing should be accompanied by a check for known past history of hypersensitivity.
6. All antibiotic prescribing should be accompanied by a check for potential drug interactions.
7. Broad spectrum antibiotics should only be used where clinically indicated.
8. If a second line antibiotic is used, the reason for its use should be documented.
9. All potentially infective lesions or conditions should be subject to local infection control policies.
10. Patients with MRSA should be handled in line with agreed local guidelines.

These are only examples of criteria which you might choose from. You are recommended to use criteria which you can justify, and you will then need to justify the standards that you set for your performance. You might want to consider repeating the exercise for another 10 surgeries at a later date, to complete the “audit cycle”.

**Analgesic prescribing**

For ten surgeries, note your use of analgesic prescribing against your chosen set of criteria and standards. You need to consider setting criteria such as:

1. Patients prescribed analgesics should have a condition or reason clearly recorded in their records.
2. Analgesics should be used which are in line with local formulary recommendations for first line use, unless clinically contraindicated.
3. If a non steroidal anti-inflammatory is used, gastric protection should be considered where appropriate (for example elderly, debilitated patients).
4. Non steroidal anti-inflammatory drugs should generally be avoided in patients with a past history of GORD, ulcer disease or upper G-I haemorrhage.
5. Strong analgesics should be prescribed in relatively small quantities on first presentation (a week?).
6. Patients with chronic pain should have a clear record of any adjustment to their regime.
7. Patients who are prescribed opiates often experience constipation: for elderly patients a laxative should be prescribed or a warning of the risk given to the patient and recorded.
8. All analgesic prescribing should be accompanied by a check for known past history of hypersensitivity.
9. All analgesic prescribing should be accompanied by a check for potential drug interactions.
10. If a second line analgesic is used, the reason for its use should be documented.

**Imaging and investigations**

For ten surgeries, note your use of investigations and imaging requests. You should keep a note of each patient, and at a later date you should

- either contact the practice to find out the result
- or contact the laboratory or X-ray department

You can do the audit against your chosen set of criteria and standards. You need to consider setting criteria such as:

1. A request for a laboratory test should have a clear clinical reason. Can you identify one for each of yours? (For example if checking renal function in hypertension, what reason for also ticking LFTs?)
2. Laboratory samples need to be correctly labelled, in the correct container and to arrive within an appropriate time period.
3. A laboratory investigation should be appropriate. On reflection did you ask for a test that was likely to help with managing the patient’s problem? (For example it is difficult to justify checking TFTs for a young patient who complains of “tiredness all the time” whose TFTs were checked three months ago)
4. Investigations should expect to include a reasonable proportion of abnormal results. (What proportion do you think this should be?)
5. Clear directions should be included on a request form if a telephone report is required. Did you do this?
6. X-rays should only be requested in compliance with the guidelines of the Royal College of Radiologists (to avoid unnecessary exposure to ionising radiation). Do you know what these state or how to find out?
7. Guidelines now suggest alternatives to X-ray investigations in some cases: did you follow all relevant guidelines? (for example SIGN or local guidelines on dyspepsia)
8. Radiologists now have the right to refuse all requests which do not conform to guidelines. All requests for which the referring doctor is uncertain should be discussed before referral. Did you encounter a situation like this?
9. All imaging techniques have limitations. Can you show that your requests take this into account? (For example, an ultrasound scan on a “lump” can only be performed on one that you can definitely palpate)

10. Some imaging investigations can be dangerous or uncomfortable. Do you give patients a clear explanation and explore possible adverse events in advance? (Barium enema or colonoscopy are both uncomfortable and sometimes hazardous; allergy to injected contrast medium may be serious; diabetics who are asked to fast before an examination need special arrangements)

Michael Harris guide to audit

http://gppro.co.uk/contents.htm