

CLINICAL

AUDIT

FOREWORD TO CLINICAL AUDIT

WHY AUDIT?

Audit is the utilisation of proven techniques to improve services to patients. Improving services to patients enhances the overall success of the practice. Audit is not about coercion.; it should not be seen as threatening. Audit should be seen instead as an opportunity.

Clinical audit is widely used within the Health Service to identify how successful or appropriate clinical systems are in delivering a high level of patient care. Increasingly optometry will be expected to demonstrate that clinical audit is in place. It should be a standard procedure in all co-management schemes, but has a wider role in measuring practice “performance” in a patient centred way against pre-set targets. This will identify areas where care systems can be improved.

WHAT IS AUDIT?

“ Clinical audit is a clinically-led initiative which seeks to improve the quality and outcome of patient care through structured peer review whereby clinicians examine their practices against agreed explicit standards and modify their practice where indicated ”

NHS Executive, 1996

WHAT TO AUDIT?

The enclosed audit programmes are designed to help the optometrist or practice to improve the care of the patient. Not all of the programmes can be defined strictly as “clinical audit”, but all are designed to assist in the delivery of a uniformly high standard of patient care within the practice. The practice can audit many other functions, and some

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of these may more appropriately be termed structural audit. It is intended that other programmes will be added to this pack in due course.

HOW TO AUDIT

Audit needs to involve the whole practice team, and should be structured in such a way that the information required can be gathered in a straight forward manner, with least disruption to the day-to-day activities of the practice. There may be some aspects of the practice which could be seen to impinge on patient care, but which cannot easily be audited. Only items which are relevant and measurable should be audited.

DOES THE PROCESS END WITH THE AUDIT RESULTS?

No- there is no point in starting an audit unless the intention is to remedy any defective systems, or to improve the service to the patient. The results of the audit should therefore be analysed in such a way that improvements can be identified and put into place.

WHY RE-AUDIT?

If the purpose of the audit is to identify ways in which patient care can be improved, then the only way of checking that changes have had the desired effect is to re-audit. Further audits on the same topic may be necessary at intervals.

More information on audit is given in the introduction.

AN INTRODUCTION TO CLINICAL AUDIT

SETTING STANDARDS

- ❑ Standards are a formal statement of how patients should be managed, with the understanding that this level of care should be as high as resources allow.
- ❑ The Department of Health is keen to see the further development and maintenance of clinical standards across the entire family of health care providers. They see the development of clinical standards as a means of focusing attention on quality issues, stimulating discussion, detecting & eliminating problems, motivating change and providing a crucial link with clinical effectiveness.
- ❑ It is considered crucial that the clinical standards should meet the following criteria:
 - Be measurable & capable of being monitored
 - Realistic & attainable within existing resources
 - Be based on evidence of best practice
 - Are real & important indicators of quality
 - Be expressed clearly & unambiguously
 - Be set in conjunction with the people who will be asked to achieve them
- ❑ The responsibility for setting standards lies with
 - The College of Optometrists and the Royal Colleges
 - Health Authorities (including Primary Care Trusts)
 - The Cochrane Database (*The databases produced by the Cochrane Collaboration aim "to prepare, maintain and disseminate systematic reviews of the effects of health care".*)
 - Clinical journals,
 - National Centre for Audit,
 - National Institute for Clinical Excellence
 - Other DoH bodies
 - local shared care protocols
 - In extreme circumstances, the courts.

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- Other sources might include
 - patients' charters,
 - patient surveys
 - healthcare bulletins.
- The method by which the effectiveness of standards can be measured is the Clinical Audit.

AUDIT PROGRAMMES

- The Government and the DoH are keen to establish audit programmes in all aspects of healthcare in both the secondary and the primary care sectors.
- Such schemes are well established in most hospitals to monitor the efficacy of various clinical and surgical procedures.
- The same approach has been introduced in primary health care, most notably in GP's practices and more recently to dental surgeries and pharmacy outlets.
- Many Health Authorities and Health Boards in the country are investigating methods for introducing audit into optometric practice as well.
- The Optometric profession is fully committed to clinical audit; many practitioners have been exposed to audit programmes in the past as part of their involvement in multi-disciplinary shared care schemes.

THE DEFINITION OF AUDIT

- Medical audit has been described as:

“ The systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome for the patient ”

The Government in its White Paper “ Working for Patients ” (1989)

- And as:

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“ Quality of clinical care, by all those who contribute to care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient ”

DoH, 1994.

- ❑ A later definition is:

“ Clinical audit is a clinically-led initiative which seeks to improve the quality and outcome of patient care through structured peer review whereby clinicians examine their practices against agreed explicit standards and modify their practice where indicated ”

NHS Executive, 1996

- ❑ The change in definition is the inclusion of explicit standards against which clinical practices are examined. What this essentially means is that the days of ‘counting heads’ and ‘number crunching’ have given way to clinical audit, which relies on standards derived from effective evidence based practice.
- ❑ There are many other definitions of clinical audit but all should address the following points:
 - The main person to benefit from the audit is the patient
 - The person responsible for the audit is a clearly identifiable practitioner or group of practitioners
 - The audit is in relation to the clinician’s own patients
 - The results, where indicated, lead to positive change in the care of patients.
- ❑ If change has been indicated from the audit results, or indeed in any case of change in practice to improve clinical effectiveness, in order to confirm that changes are being implemented there is need for feedback. Feedback is again supplied from the audit process, therefore audit is not just a single event but a continuous one.

THE USES OF AUDIT

- ❑ Areas that could be covered by the use of clinical audit might include:
 - Reduction of risk

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- Effectiveness of care
 - Improvement of diagnosis
 - Timing of care
 - Better use of resources
 - Consumer (patient) satisfaction
 - Access to care
 - Documentation and records
 - Education
- As a good guide, audits should address areas of ‘ high risk, high volume, high cost ’.

THE BENEFITS OF AUDIT

- The benefits of a good, reliable structured audit are numerous and include the following:
- Substantial improvements in the quality of service to patients / users
 - Facilitates improved communication between disciplines, professions and at the primary / secondary care interface
 - Can be a valuable educational tool
 - Helps to highlight and prioritise key issues & problems
 - Prevents problems re-occurring
 - Better overall utilisation of resources
 - Improves morale
- The evidence of these benefits would be better management, improved clinical regimes, new guidelines (as appropriate) and the development of new clinical protocols.
- It is therefore clear that clinical audit cannot address optometric practice as a whole, rather it deals with small areas of practice and individual questions raised in practice. Many audits may therefore be required to build into a larger picture.

QUALITY OF AUDIT

- ❑ The quality aspects of audit are considered equally important. The principal considerations being:

Access	being able to obtain care reasonably, conveniently and promptly
Appropriate	getting the right care, the correct treatment & the proper decisions made for the patient involving the patient in the decision making process
Effective	having the agreed care provided in the correct way using the most up to date knowledge, equipment & technology
Efficacy	experiencing the right outcome of treatment, i.e. seeing the benefit of care which the treatment is supposed to provide
Acceptable	everybody involved in the process has performed correctly, i.e. being satisfied with the care that was delivered.

THE AUDIT CYCLE

- ❑ The actual process of audit is a well-defined process. All of the stages in the cycle should be completed in order that the audit is a productive piece of work.

- ❑ The stages are as follows

1 Choose topic

2 Set objectives

- o The reason(s) why the audit is being carried out should be specific and well defined.

3 Set standards

- o “ *The standards of practice and the way they are converted to measures used in clinical audit should be based on evidence of good practice from research and / or expert opinion* ”

(NHS Executive)

- o The setting of a standard involves the selection of indicators, an indicator being an element of practice capable of being measured or defined and more importantly changed by the practitioner carrying out the clinical audit. Selecting criteria or the measures by which the indicators are appraised and finally selecting the level of performance which is the extent to which the criteria are met.

4 Choose sample

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- o Decisions have to be made as to who will be included and excluded from the audit and whether data collection is retrospective, concurrent or prospective. It must always be borne in mind that the data collected should be valid and accurate.
 - 5 Collect data
 - o The data must be readily available although if it proves difficult to find or is not available this in itself may indicate a problem in record keeping and requires further scrutiny.
 - 6 Analysis and interpretation
 - 7 Provide feedback to practitioners involved
 - 8 Introduce change in practice
 - o A number of papers have reported that this can prove to be the most difficult part of any audit.
 - o There is no magic wand that insures that change will happen, consequently, there are many strategies to change and how and when they are likely to work varies.
 - o Simple feedback may work in the situation where practitioners have direct control over the promotion of change, but cannot be relied upon in all cases.
 - o An example of promoting change in clinical practice is the educational materials produced by the College of Optometrists.
 - 9 Re-audit
 - o *“ The (audit) process is repeated until the evidence of day to day practice shows that agreed good practice is being implemented routinely ”*
(NHS Executive)
- ❑ It is wise that once stages 1 through 4 are completed, before proceeding further, the audit objectives are tested. The following points should be fulfilled
- Relevant
 - Understandable
 - Fellow colleagues should be able to determine specifically what is being audited and hopefully will accept and ultimately act on the results
 - Measurable

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- As previously stated the data must be available
 - Behavioural
 - The end result is to bring changes in patient care
 - Achievable
- This concerns both the technical aspects of the audit as well as whether the objectives are achievable in terms of resources.
- Clinical audit is not about money but it is not inconceivable that the end result(s) in changing practice could cost more than present practice, money that may not be available.
- Audit subject matter can vary considerably but normally fall into one of the following categories:
- Assessing the frequency or volume of service
 - Risk associated aspects of a service
 - Problem associated aspects of a service
 - Effectiveness associated aspects of a service
 - Cost aspects of a service

WIDER ISSUES OF AUDIT

- In some instances the audit may need to address the wider issues of the delivery of patient care. Therefore, the following may also need to be considered:
- Structure e.g. Premises, staffing, access to support services, diagnostic equipment, and furniture.
- Process e.g. Waiting times, patient recall, investigations, diagnosis, treatment (if any), record keeping, communication.
- Outcome e.g. Therapy, improvements, adverse events.
- The quality of the audit outcome will in some respect be dependent on the type of audit objective.
- To simply count objects as an audit objective leads to a weak and sometimes meaningless outcome.

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- ❑ On the other hand, if the objective is to compare procedures or even change the structure or delivery in some way then the outcome will be much stronger as some attempt is being made to :
 - assess whether or not standards are being met / improve standards
 - indicate level of compliance / improve compliance if possible
 - improve clinical effectiveness
 - change current practice as necessary.

AUDIT OF PRACTICE FACILITIES AND EQUIPMENT

REASONS FOR AUDIT

- To monitor standards of practice facilities and equipment

OBJECTIVES

- To ensure all patients have access to the premises
- To raise standards within the practice
- To ensure the practice equipment is appropriate and well maintained
- Improved services for patients

STANDARD SETTING

- 100% of patients have access to premises
- 100% of criteria identified for checking to be of satisfactory standard
- Practice has 100% of necessary equipment
- 100% of equipment regularly serviced and calibrated

AUDIT TEAM

- An audit coordinator, taking responsibility for the appointment of designated staff and their roles and responsibilities
- An audit team leader to take overall responsibility for data collection and correlation
- A member of staff at each practice to take ultimate responsibility for collection of data on a daily basis

Some of these persons may have more than one role within the audit cycle

Ensure that all practice staff are aware of the aims and reasons for undertaking the audit and that all team members are fully involved in all stages and regularly updated on the progress of the audit.

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METHODOLOGY AND DATA COLLECTION

- Ensure that all members of staff are aware of the aims and reasons for the audit
- Use data collection sheet provided
- Check information against data sheet, by going around the practice on a random day of the week
- Set target date to review equipment /facilities

ANALYSIS AND PRESENTATION.

- Look at the findings
- Decide which areas need addressing
- A simple way to present the findings is to:
 - 1 Add up the number of items checked on the data collection sheet
 - 2 Count the number not completed to standard
 - Present the results as a percentage (2 expressed as % of 1)

ANALYSIS OF FINDINGS AND DEFINING OPTIONS.

- Compare the results with the standards set
- Discuss the results with the team
- Look at data and decide where changes need to be made
- List the *possible* changes that could be made to improve the practice facilities and equipment

IMPLEMENT CHANGE

- List the changes that it is intended to put into action with a time frame
- Make sure everyone in the team knows what is to happen and their role in implementing the changes
- Set date to re-collect the data

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RE-EVALUATE.

- Repeat data collection and assessment to complete the cycle. This is very important to show that improvements have actually occurred as a result of the changes that have been made.
- Recollect data as before
- Compare both sets of results
- Have the changes improved the facilities and equipment?
- Has the standard set been met?
- Have the objectives been met?

CONCLUSION

- Write a brief conclusion to sum up the findings
- Are there still areas where improvements could be made?
- Write a short summary in bullet point form
- Consider when re-audit will be required

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PRACTICE DETAILS

PRACTICE TITLE: TRADING NAME	PRACTICE TEL. NO.
PRACTICE ADDRESS:	PRACTICE FAX NO.
PRACTICE E-MAIL:	
PRACTICE HOURS	
Monday	Tuesday
Wednesday	Thursday
Friday	Saturday
Sunday	

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CRITERIA	AUDIT RESULT	ACTION/ COMMENT	TARGET DATE	RE-AUDIT RESULT	COMMENT
ACCESS					
Are practice services accessible by:-					
The physically handicapped	Y/N			Y/N	
The visually impaired	Y/N			Y/N	
The hearing impaired	Y/N			Y/N	
The speech impaired	Y/N			Y/N	
People for whom English is not 1 st language	Y/N			Y/N	
MAINTENANCE					
Are the premises maintained in a good state of repair?	Y/N			Y/N	
Are the premises clean and tidy?	Y/N			Y/N	
Have provisions been made for inspection of electrical equipment?	Y/N			Y/N	
FACILITIES					
Is there a waiting area with appropriate seating?	Y/N			Y/N	
Are there toilet facilities for patients?	Y/N			Y/N	
If so are they suitable for the disabled?	Y/N				
MANUAL RECORDS					
Are manual records stored in a confidential and secure manner?	Y/N			Y/N	
How long are records kept for?					

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CRITERIA	AUDIT RESULT	ACTION/ COMMENT	TARGET DATE	RE-AUDIT RESULT	COMMENT
Is the practice registered under the Data Protection Act?	Y/N			Y/N	
COMPUTER SYSTEM					
Does the computer system have different levels of access for different categories of staff?	Y/N			Y/N	
Are backup data files maintained?	Y/N			Y/N	
COMPLAINTS HANDLING					
Does the practice have a complaints procedure?	Y/N			Y/N	
Is there a member of staff with responsibility for the management of complaints?	Y/N			Y/N	
INFORMATION					
Is there information on NHS services clearly visible?	Y/N			Y/N	
Is there a current certificate of employers liability insurance displayed?	Y/N			Y/N	
DISPENSING SERVICE					
Equipment for verifying prescription lenses	Y/N			Y/N	
Frame ruler	Y/N			Y/N	
P.D. Gauge	Y/N			Y/N	
Equipment for locating and marking optical centres	Y/N			Y/N	
Sample lenses (bifocal types, tints etc.)	Y/N			Y/N	
Frame screwdrivers	Y/N			Y/N	

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CRITERIA	AUDIT RESULT	ACTION/ COMMENT	TARGET DATE	RE-AUDIT RESULT	COMMENT
Frame pliers	Y/N			Y/N	
Frame files	Y/N			Y/N	
Frame heater	Y/N			Y/N	
CONSULTING ROOM SERVICE					
Distance test chart	Y/N			Y/N	
Vision chart suitable for child	Y/N			Y/N	
Trial lenses and accessories	Y/N			Y/N	
Trial frame	Y/N			Y/N	
Refractor head	Y/N			Y/N	
Retinoscope	Y/N			Y/N	
Direct ophthalmoscope	Y/N			Y/N	
Indirect ophthalmoscope	Y/N			Y/N	
Reading tests for adults	Y/N			Y/N	
Reading tests for children	Y/N			Y/N	
Colour vision test	Y/N			Y/N	
Test for distance oculo-motor balance	Y/N			Y/N	
Test for near oculo-motor balance	Y/N			Y/N	
Test for stereopsis	Y/N			Y/N	
Tonometer	Y/N			Y/N	
Amsler chart	Y/N			Y/N	
Central visual field test	Y/N			Y/N	
Peripheral visual field test	Y/N			Y/N	
Slit lamp	Y/N			Y/N	
Camera attachment for slit lamp	Y/N			Y/N	
Lens for slit lamp ophthalmoscopy	Y/N			Y/N	
Keratometer	Y/N			Y/N	

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CRITERIA	AUDIT RESULT	ACTION/ COMMENT	TARGET DATE	RE-AUDIT RESULT	COMMENT
Is the equipment regularly serviced?	Y/N			Y/N	
Is the consulting room constructed to provide a suitable degree of confidentiality?	Y/N			Y/N	
Is there a suitable patient's chair?	Y/N			Y/N	
Is there a suitable practitioner's chair?	Y/N			Y/N	
Is there an occasional chair (for an escort)?	Y/N			Y/N	
Is there suitable and controlled room lighting?	Y/N			Y/N	
Is the room of suitable size and set up for a six meter testing distance?	Y/N			Y/N	
Is the consulting room suitably heated and ventilated to prevent temperature excesses?	Y/N			Y/N	
Are there hand-washing facilities easily accessible to the consulting room?	Y/N			Y/N	
Is the drug stock within the use by date?	Y/N			Y/N	
Is the drug stock suitably stored?	Y/N			Y/N	

AUDIT OF EXAMINATION PROCEDURES

REASONS FOR AUDIT

- To compare routine eye examination procedures against the College Of Optometrists' guidelines for different categories of patients
- To establish actual clinical practice for different categories of patients
- To identify examination techniques that are not routinely undertaken for different categories of patients

OBJECTIVES

- To establish and maintain "best practice" guidelines for the eye examination according to different categories of patients
- To establish an optimum examination for patients according to individual needs
- To suggest and encourage improvements in clinical practice
- To ensure that all optometrists in the practice team carry out examinations to the same standard

STANDARD SETTING

- To suggest a "minimum acceptable" and "optimum" standard of clinical practice for different categories of patients

AUDIT TEAM

- An audit coordinator, taking responsibility for the appointment of designated staff and their roles and responsibilities
- An audit team leader to take overall responsibility for data collection and correlation
- A member of staff at each practice to take ultimate responsibility for collection of data on a daily basis

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Some of these persons may have more than one role within the audit cycle

Ensure that all practice staff are aware of the aims and reasons for undertaking the audit and that all team members are fully involved in all stages and regularly updated on the progress of the audit

METHODOLOGY AND DATA COLLECTION

- During the audit information is gathered regarding the examination techniques undertaken according to patient categories and recorded in the audit data collection pack
- Examination techniques undertaken in a routine eye examination are considered for the following patient categories:
 - Under 1 year old
 - 1 to 5 years old
 - 6-11 years old
 - 11-18 years old
 - 19-25 years old
 - 26-40 years old
 - 41-60 years old
 - 61-80 years old
 - Over 80
- Optometrists will record those examination techniques, which would form part of a routine eye examination for each category of patient.:
 - History and symptoms
 - Unaided vision
 - Aided vision with current spectacles
 - Cover test
 - Ocular motility assessment

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- Near point of convergence
 - External examination
 - Internal examination
 - Pupillary distance
 - Retinoscopy
 - Autorefractor
 - Subjective refraction
 - Binocular balancing
 - Distance oculomotor assessment
 - Near oculomotor assessment
 - Amplitude of accommodation
 - Gross visual field screening, e.g. Confrontation test
 - IOP measurement
 - Pupil dilation
 - Visual field screening
 - Other, please specify
- Optometrists will record for each technique and patient category whether the technique would be used:
- On all patients
 - On most patients
 - On some patients
 - Never

DATA ANALYSIS AND PRESENTATION.

- Once the audit period has finished, a data analysis sheet is completed before submission of final results to the audit team leader

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- For each patient category analyse how frequently each examination technique is undertaken. This can be expressed as a percentage of the overall response for each technique
- Results can be tabulated for each category of patient and each examination technique

ANALYSIS OF FINDINGS AND DATA PRESENTATION

- Have the standards and objectives of the audit been met?
- Consider and list possible changes which could be made to the eye examinations in order to meet the standards and objectives
- Does data collection need to be modified to exclude or include information?
- Identify any difficulties in collecting data, e.g. Record Cards not completed adequately

IMPLEMENT CHANGE

- Conclude whether changes are possible and that they can be implemented practically
- Decide which changes can be implemented immediately
- Plan a suitable time before re-auditing. This should allow sufficient time for the changes to take effect

RE-EVALUATE

- Collect data as previously, apart from any alterations considered necessary after the preliminary analysis
- Analyse the data as previously and make a comparison of results
- Have objectives and standards been met this time?

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CONCLUSION

- ❑ Compile a final summary to establish which examination techniques are considered to form an integral part of the routine eye examination for each category of patient and which are mostly, rarely or never used.
- ❑ For each category of patient, list those techniques which would be undertaken on either all or most patients by at least 60 % of optometrists
- ❑ For each category of patient, list those techniques which would be undertaken only rarely or never by at least 60 % of optometrists

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PATIENT CATEGORY:

UNDER 1 YEAR

Please record how often you would undertake each test for this category of patient. If there are other tests you would routinely undertake on this category of patient, please record this after other and specify the particular technique.

	All patients	Most patients	Some patients	Never
History and symptoms				
Unaided Vision				
Aided Vision with current spectacles				
Cover test				
Ocular Motility assessment				
Near Point of convergence				
External examination				
Internal examination				
Pupillary Distance				
Retinoscopy				
Autorefractor				
Subjective Refraction				
Binocular balancing				
Distance oculomotor assessment				
Near oculomotor assessment				
Amplitude of accommodation				
Gross Visual Field screening				
IOP measurement				
Pupil dilation				
Visual Field screening				
Other, please specify				

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PATIENT CATEGORY:

1-5 YEARS

Please record how often you would undertake each test for this category of patient. If there are other tests you would routinely undertake on this category of patient, please record this after other and specify the particular technique.

	All patients	Most patients	Some patients	Never
History and symptoms				
Unaided Vision				
Aided Vision with current spectacles				
Cover test				
Ocular Motility assessment				
Near Point of convergence				
External examination				
Internal examination				
Pupillary Distance				
Retinoscopy				
Autorefractor				
Subjective Refraction				
Binocular balancing				
Distance oculomotor assessment				
Near oculomotor assessment				
Amplitude of accommodation				
Gross Visual Field screening				
IOP measurement				
Pupil dilation				
Visual Field screening				
Other, please specify				

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PATIENT CATEGORY:

6-11 YEARS

Please record how often you would undertake each test for this category of patient. If there are other tests you would routinely undertake on this category of patient, please record this after other and specify the particular technique.

	All patients	Most patients	Some patients	Never
History and symptoms				
Unaided Vision				
Aided Vision with current spectacles				
Cover test				
Ocular Motility assessment				
Near Point of convergence				
External examination				
Internal examination				
Pupillary Distance				
Retinoscopy				
Autorefractor				
Subjective Refraction				
Binocular balancing				
Distance oculomotor assessment				
Near oculomotor assessment				
Amplitude of accommodation				
Gross Visual Field screening				
IOP measurement				
Pupil dilation				
Visual Field screening				
Other, please specify				

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PATIENT CATEGORY:

12-18 YEARS

Please record how often you would undertake each test for this category of patient. If there are other tests you would routinely undertake on this category of patient, please record this after other and specify the particular technique.

	All patients	Most patients	Some patients	Never
History and symptoms				
Unaided Vision				
Aided Vision with current spectacles				
Cover test				
Ocular Motility assessment				
Near Point of convergence				
External examination				
Internal examination				
Pupillary Distance				
Retinoscopy				
Autorefractor				
Subjective Refraction				
Binocular balancing				
Distance oculomotor assessment				
Near oculomotor assessment				
Amplitude of accommodation				
Gross Visual Field screening				
IOP measurement				
Pupil dilation				
Visual Field screening				
Other, please specify				

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PATIENT CATEGORY:

19-25 YEARS

Please record how often you would undertake each test for this category of patient. If there are other tests you would routinely undertake on this category of patient, please record this after other and specify the particular technique.

	All patients	Most patients	Some patients	Never
History and symptoms				
Unaided Vision				
Aided Vision with current spectacles				
Cover test				
Ocular Motility assessment				
Near Point of convergence				
External examination				
Internal examination				
Pupillary Distance				
Retinoscopy				
Autorefractor				
Subjective Refraction				
Binocular balancing				
Distance oculomotor assessment				
Near oculomotor assessment				
Amplitude of accommodation				
Gross Visual Field screening				
IOP measurement				
Pupil dilation				
Visual Field screening				
Other, please specify				

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PATIENT CATEGORY:

26-40 YEARS

Please record how often you would undertake each test for this category of patient. If there are other tests you would routinely undertake on this category of patient, please record this after other and specify the particular technique.

	All patients	Most patients	Some patients	Never
History and symptoms				
Unaided Vision				
Aided Vision with current spectacles				
Cover test				
Ocular Motility assessment				
Near Point of convergence				
External examination				
Internal examination				
Pupillary Distance				
Retinoscopy				
Autorefractor				
Subjective Refraction				
Binocular balancing				
Distance oculomotor assessment				
Near oculomotor assessment				
Amplitude of accommodation				
Gross Visual Field screening				
IOP measurement				
Pupil dilation				
Visual Field screening				
Other, please specify				

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PATIENT CATEGORY:

41-60 YEARS

Please record how often you would undertake each test for this category of patient. If there are other tests you would routinely undertake on this category of patient, please record this after other and specify the particular technique.

	All patients	Most patients	Some patients	Never
History and symptoms				
Unaided Vision				
Aided Vision with current spectacles				
Cover test				
Ocular Motility assessment				
Near Point of convergence				
External examination				
Internal examination				
Pupillary Distance				
Retinoscopy				
Autorefractor				
Subjective Refraction				
Binocular balancing				
Distance oculomotor assessment				
Near oculomotor assessment				
Amplitude of accommodation				
Gross Visual Field screening				
IOP measurement				
Pupil dilation				
Visual Field screening				
Other, please specify				

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PATIENT CATEGORY:

61-80 YEARS

Please record how often you would undertake each test for this category of patient. If there are other tests you would routinely undertake on this category of patient, please record this after other and specify the particular technique.

	All patients	Most patients	Some patients	Never
History and symptoms				
Unaided Vision				
Aided Vision with current spectacles				
Cover test				
Ocular Motility assessment				
Near Point of convergence				
External examination				
Internal examination				
Pupillary Distance				
Retinoscopy				
Autorefractor				
Subjective Refraction				
Binocular balancing				
Distance oculomotor assessment				
Near oculomotor assessment				
Amplitude of accommodation				
Gross Visual Field screening				
IOP measurement				
Pupil dilation				
Visual Field screening				
Other, please specify				

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PATIENT CATEGORY:

OVER 80 YEARS

Please record how often you would undertake each test for this category of patient. If there are other tests you would routinely undertake on this category of patient, please record this after other and specify the particular technique.

	All patients	Most patients	Some patients	Never
History and symptoms				
Unaided Vision				
Aided Vision with current spectacles				
Cover test				
Ocular Motility assessment				
Near Point of convergence				
External examination				
Internal examination				
Pupillary Distance				
Retinoscopy				
Autorefractor				
Subjective Refraction				
Binocular balancing				
Distance oculomotor assessment				
Near oculomotor assessment				
Amplitude of accommodation				
Gross Visual Field screening				
IOP measurement				
Pupil dilation				
Visual Field screening				
Other, please specify				

PATIENT RECORDS

BACKGROUND

- ❑ The keeping of good patient records is essential:
 - To ensure that patients receive a continuing service of high quality
 - For the protection of the practitioner; patient records completed at the time of the examination may be used in defence against an allegation of negligence or professional misconduct
 - To provide a reliable statistical base for research and general information
- ❑ Patient records should provide an on-going picture of each patient's needs for visual care (both sight and health) as identified by regular eye examinations,
 - of how those needs were met, and
 - of all subsequent services provided.
- ❑ They should also provide a record of signs of any general injury, disease or abnormality which the eye examination may have revealed and a note of any referrals to a medical practitioner. Writing NAD or ticks on pre-printed record cards are *not* considered sufficient evidence of that part of the examination having been carried out.

PATIENTS' ACCESS TO HEALTH RECORDS

- ❑ The Data Protection Act 1998 has replaced the Access To Health Records Act 1990 apart from its application to deceased patients. The Act applies to patient records held manually and on computer. Patients are allowed access to all their health records. This also applies to an applicant acting on behalf of a patient:
 - The parent of a child patient
 - Someone authorised in writing by the patient

CLINICAL AUDIT

- A person appointed by the court to manage the affairs of patients incapable of doing so for themselves
- Access is partially excluded if health professionals consider that any information disclosed by them might be seriously damaging to the physical or mental health of the patient.

REASONS FOR AUDIT

- To improve record keeping
- To ensure that records are kept consistently by various members of the practice team

OBJECTIVES

- To ensure adequate clinical, dispensing and contact lens records are kept for all relevant patients
- To ensure these records are adequate to be used for defence purposes in the event of legal action for negligence
- To improve standards of patient care

STANDARD SETTING

- 100% of records kept on every patient whose eyes are examined, spectacles dispensed or repaired, or contact lenses supplied
- 100% of records fully completed and adequate for defence in the event of legal action for negligence

AUDIT TEAM

- An audit coordinator, taking responsibility for the appointment of designated staff and their roles and responsibilities
- An audit team leader to take overall responsibility for data collection and correlation

CLINICAL AUDIT

- A member of staff at each practice to take ultimate responsibility for collection of data

Some of these persons may have more than one role within the audit cycle

Ensure that all practice staff are aware of the aims and reasons for undertaking the audit and that all team members are fully involved in all stages and regularly updated on the progress of the audit.

METHODOLOGY AND DATA COLLECTION

- Ensure all staff are aware of the aims and reasons for the audit
- There are data collection sheets for each part of the audit
 - Examination records
 - Dispensing Records
- Set up a system to identify patient records included in the audit
- Collect data on 30 patient records chosen at random from the practice files
- These records will form the base group for the first part of the audit
- You may need to audit each optometrist individually

DATA ANALYSIS AND PRESENTATION.

- Complete attached data analysis sheet
- Briefly outline the results of the initial data collection

ANALYSIS OF FINDINGS AND DEFINING OPTIONS.

- Have the standards and objectives of the audit been met?
- List the possible changes that could be made to improve record keeping to meet the standards and objectives
- Does the data collection need to be modified to exclude or include information?
- Identify any difficulties in collecting data

CLINICAL AUDIT

IMPLEMENT CHANGE

- Decide which changes to put into action
- Decide which changes can be implemented immediately
- Plan a suitable time delay before re-auditing. This should allow sufficient time for the changes to take effect
- Ensure all team members are involved

RE-EVALUATE.

- Repeat data collection and assessment to complete the cycle. This is very important to show that improvements have actually occurred as a result of the changes that have been made.
- Randomly select 30 records from the next two months examinations
- Re-collect data as before
- Compare both sets of results
- Have the changes improved the record keeping?
- Has the standard set been met?
- Have the objectives been met?

CONCLUSION

- Write a brief conclusion to sum up the findings
- Are there still areas where improvements could be made?
- Write a short summary in bullet point form
- Is it intended to re-audit this topic and if so when?

CLINICAL AUDIT

AUDIT OF PATIENT RECORDS

Enter Patient Record ID, then Y in each box if information is recorded adequately. This sheet will therefore be sufficient for 10 patients.

Optometric record									
Enter Patient Record ID									
Full name									
Full address									
Contact details									
Examination: NHS / Private / Other									
Date of Birth									
GP's name and address									
Driving licence held									
Type of work									
Hobbies and interests									
Dates of visits									
Reminders									
Current spectacle Rx									
Ocular history									
Family history									
General health									
Medication									
Symptoms									
Aided / unaided vision									
Ocular motility									
Convergence									
Pupil reflexes									
External eye examination									
Media									
Fundus + vessels									
Macula									
Discs colour + CD									
IOPs + method									
Visual fields									
Refraction									
Visual Acuity									
Reading addition									
Intermediate addition									
Size of near print read									
Advice and recommendations									
Examination performed by (person)									
Fee Paid									

CLINICAL AUDIT

Dispensing record									
Enter Patient Record ID									
Full name									
Spec. Rx dispensed									
Name of frame									
Colour									
Size									
Lens type									
Lens centration									
Measurements for multifocals									
Tint/coat									
PD									
Order number									
Manufacturer/supplier									
Details of repairs									
Spectacles ordered by (person)									
Rx verified by (person)									
Spectacles fitted by (person)									
Charges/fees									
Payments									

AUDIT OF APPOINTMENT NON-ATTENDANCE

REASONS FOR AUDIT

- Patients failing to attend booked appointments reduce the profitability of a practice and take up time that could be used on other patients, some of whom may have more pressing needs
- Awareness of dissatisfaction with, or a poor perception of, the practice will assist with future planning and management
- Sometimes, patients may not attend for reasons which could have been avoided

OBJECTIVES

- To reduce the number of failed appointments
- To reduce the cost to the practice of failed appointments
- To reduce the waiting times for patients to access optometric services
- To improve services to patients

STANDARD SETTING

- To find the percentage of patients who do not attend booked appointments currently
- To determine an acceptable level of non-attendance, taking into account that there may be genuine reasons for non-attendance that cannot be avoided

AUDIT TEAM

- An audit co-ordinator, taking responsibility for the appointment of designated staff and their roles and responsibilities
- An audit team leader to take overall responsibility for data collection and correlation
- A member of staff (at each practice) to take ultimate responsibility for collection of data on a daily basis

CLINICAL AUDIT

Some of these persons may have more than one role within the audit cycle

Ensure that all practice staff are aware of the aims and reasons for undertaking the audit and that all team members are fully involved in all stages and regularly updated on the progress of the audit.

METHODOLOGY AND DATA COLLECTION

- During the audit period information is gathered regarding every incident of non-attendance and recorded in the audit data collection pack as it occurs (Data Sheet A)
- Each day a total of attenders is calculated (Data Sheet B)
- The following data is collected individually for each failed appointment, and as a daily total for each person attending except those marked *:
 - * Date of appointment
 - Day of week (include all days that practice is open)
 - Time of appointment (Morning, Midday, Afternoon, Evening)
 - Type of appointment, i.e. Refraction, contact lens, patient recheck , follow up appointment (e.g. repeat fields, IOP etc.), [*co-management appointments (diabetic, glaucoma, pre-or post surgical cataract), LVA etc can be added as appropriate to practice*]
 - Age of patient (in bands <16, 16-25, 26-40, 41-60, 61-80, >80)
 - Employment status (Employed, Self Employed, Unemployed, Homemaker, Retired, Student/ School/ Pre-School)
 - Funding of visit (Private, NHS, Co-Management fee or No-charge)
 - Patient attending was last examined at this practice, has been seen elsewhere or has never had a previous eye examination
 - * Whether the appointment was rebooked

CLINICAL AUDIT

- Data to be collected overweeks (*8 weeks suggested*)
 - Start date .../.../...
 - Finish date .../.../...

DATA ANALYSIS AND PRESENTATION.

- Once the audit period has finished, the data analysis sheet (C) is completed before submission of final results to the audit team leader
 - Transfer to sheet C the number of attenders in each category, and the number of non-attenders in each category;
 - Calculate the percentage of non-attenders in each category as a percentage of the total booked;
$$\% \text{ non attending} = \frac{\text{number non-attending} \times 100}{\text{number non-attending} + \text{number attending}}$$
 - Calculate the total non-attenders as a percentage of the total patients;
 - Calculate the number of non-attenders who rebooked the appointment
- A brief presentation of the main results and preliminary findings is necessary at this stage

ANALYSIS OF FINDINGS AND DEFINING OPTIONS.

- Have the standards and objectives of the audit been met?
- Consider and list possible changes which could be made to the appointment system in order to meet the standards and objectives
- Does the data collection need to be modified to include or exclude information?
- Identify any difficulties in collecting data, e.g. Non-compliance, patient not available

CLINICAL AUDIT

IMPLEMENT CHANGE

- Conclude whether changes are possible and that they can be implemented practically
- Decide which changes can be implemented immediately
- Plan a suitable time before re-auditing. This should allow sufficient time for the changes to take effect

RE-EVALUATE

- Collect data as previously, apart from any alterations considered necessary after the preliminary analysis
- Analyse the data as previously
- Have objectives and standards been met this time?
- Make a comparison of results using data analysis sheet (D)

CONCLUSION

- Compile a final summary to include:
 - The audit and re-audit results
 - Changes identified
 - Changes implemented
 - Whether implemented changes were considered to lead to improvements
 - New changes for further consideration
 - Discussion and comments from participants
- Consider when future re-audit will be required

CLINICAL AUDIT

DATA COLLECTION PART B - ATTENDERS									
PRACTICE NAME				AUDIT PERIOD					
	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7	Week 8	Total
DAY OF WEEK									
MONDAY									
TUESDAY									
WEDNESDAY									
THURSDAY									
FRIDAY									
SATURDAY									
SUNDAY									
TIME OF DAY									
AM									
MD									
PM									
EV									
TYPE OF APPOINTMENT									
REFRACTION									
CONTACT LENS									
RECHECK									
FOLLOW UP									
AGE OF PATIENT									
A (<16)									
B(16-25)									
C (26-40)									
D (41-60)									
E (61-80))									
F (>80)									
EMPLOYMENT STATUS									
EMPLOYED									
SELF EMPLOYED									
UNEMPLOYED									
HOMEMAKER									
RETIRED									
STUDENT/SCHOOL									
FUNDING OF VISIT									
N (NHS)									
P (PRIVATE)									
CO (CO-MANAGEMENT)									
NC (NO CHARGE)									
PREVIOUSLY SEEN?									
OLD PATIENT									
NO PREVIOUS EXAMINATION									
SEEN ELSEWHERE BEFORE									

CLINICAL AUDIT

DATA COLLECTION PART C - ANALYSIS			
PRACTICE NAME		AUDIT PERIOD	
	ATTENDERS	NON ATTENDERS	% NON ATTENDING
DAY OF WEEK			
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			
SUNDAY			
TIME OF DAY			
AM			
MD			
PM			
EV			
TYPE OF APPOINTMENT			
REFRACTION			
CONTACT LENS			
RECHECK			
FOLLOW UP			
AGE OF PATIENT			
A (<16)			
B(16-25)			
C (26-40)			
D (41-60)			
E (60-80)			
F (>80)			
EMPLOYMENT STATUS			
EMPLOYED			
UNEMPLOYED			
SELF EMPLOYED			
RETIRED			
STUDENT/SCHOOL			
HOMEMAKER			
FUNDING OF VISIT			
N (NHS)			
P (PRIVATE)			
NC (NO CHARGE)			
PREVIOUSLY SEEN IN THIS PRACTICE?			
OLD PATIENT			
NO PREVIOUS EXAMINATION			
SEEN ELSEWHERE PREVIOUS EXAM			
ANALYSIS			
TOTAL			
REBOOKED			

CLINICAL AUDIT

DATA COLLECTION PART D -COMPARISON ANALYSIS			
PRACTICE NAME		AUDIT PERIOD	
% NON-ATTENDERS	1 st AUDIT	2nd AUDIT	DIFFERENCE
DAY OF WEEK			
MONDAY			
TUESDAY			
WEDNESDAY			
THURSDAY			
FRIDAY			
SATURDAY			
SUNDAY			
TIME OF DAY			
AM			
MD			
PM			
EV			
TYPE OF APPOINTMENT			
REFRACTION			
CONTACT LENS			
RECHECK			
FOLLOW UP			
AGE OF PATIENT			
A (<16)			
B(16-25)			
C (26-40)			
D (41-60)			
E (60-80)			
F (>80)			
EMPLOYMENT STATUS			
EMPLOYED			
UNEMPLOYED			
SELF EMPLOYED			
RETIRED			
STUDENT/SCHOOL			
HOMEMAKER			
FUNDING OF VISIT			
N (NHS)			
P (PRIVATE)			
NC (NO CHARGE)			
PREVIOUSLY SEEN IN THIS PRACTICE?			
OLD PATIENT			
NO PREVIOUS EXAMINATION			
SEEN ELSEWHERE PREVIOUS EXAM			
ANALYSIS			
TOTAL % NON-ATTENDERS			
REBOOKED			

AUDIT OF APPOINTMENT RECALL

REASONS FOR AUDIT

- To find out why patients do not return to the practice after being recalled
- To reduce the cost of repeating recalls and chasing non-responders
- To ensure that patients have regular eye examinations

OBJECTIVES

- To assess the numbers of patients who do not respond to a recall
- To identify groups of patients who do not respond to a recall
- To identify reasons for patients not responding to a recall
- To increase the percentage of patients responding to a recall
- To encourage patients to attend for a regular eye examination

STANDARD SETTING

- To find the percentage level of patients who do not respond to a recall at present
- To set an acceptable percentage level of non-response, taking into account that on occasions there may be genuine reasons for non-response that cannot be avoided

AUDIT TEAM

- An audit coordinator, taking responsibility for the appointment of designated staff and their roles and responsibilities
- An audit team leader to take overall responsibility for data collection and correlation
- A member of staff (at each practice) to take ultimate responsibility for collection of data on a daily basis

Some of these persons may have more than one role within the audit cycle

CLINICAL AUDIT

Ensure that all practice staff are aware of the aims and reasons for undertaking the audit and that all team members are fully involved in all stages and regularly updated on the progress of the audit

METHODOLOGY AND DATA COLLECTION

- During the audit period information is gathered regarding the incidence of non-response to recall and recorded in the audit data collection pack
- The following data is collected over the audit period (Data Sheet A):
 - Date of recalls in the period
 - Number of patients recalled
 - Number of patients who subsequently responded
 - Number of patients who did not respond
 - If recalls are made other than by letter, (e.g. Letter, phone, E-mail, fax, other) then a separate data collection sheet should be used for each method
- On a separate data collection sheet, the number of patients who did not respond to the recall in the period, allowing 2 months response time by category (Data Sheet B):
 - Age of patient (in bands <16, 16-25, 26-40, 41-60, 61-80, >80)
 - Employment status (Employed, Self Employed, Unemployed, Homemaker, Retired, Student/ School/ Pre-School)
 - Funding of last visit (Private, NHS, Co-Management fee or No-charge)
 - Reason for non-response, asking the patient by telephone why they did not respond (financial reason, under HES, moved away, illness, attending another practice, died, other reason, no reason)
- The Data is to be collected over 6 months (*6 months suggested, but data to be collected up to 2 months after final recall date to allow response time*)
 - Start date .../.../...
 - Finish date .../.../...

CLINICAL AUDIT

DATA ANALYSIS AND PRESENTATION.

- Data can be analysed by each component, and by any combination of components
- Submission of final results to the audit team leader
- A brief presentation of the main results and preliminary findings is necessary at this stage

ANALYSIS OF FINDINGS AND DEFINING OPTIONS.

- Have the standards and objectives of the audit been met?
- Consider and list possible changes which could be made to the recall system in order to meet the standards and objectives
- Does data collection need to be modified to exclude or include information?
- Identify any difficulties in collecting data

IMPLEMENT CHANGE

- Conclude whether changes are possible and that they can be practically implemented
- Decide which changes can be implemented immediately
- Plan a suitable time delay before re-auditing. This should allow sufficient time for the changes to take effect

RE-EVALUATE

- Collect data as previously, apart from any alterations considered necessary after the preliminary analysis
- Analyse the data as previously and make a comparison of results
- Have objectives and standards been met this time?

CLINICAL AUDIT

CONCLUSION

- Compile a final summary to include:
 - The audit and re-audit results
 - Changes identified
 - Changes implemented
 - Whether implemented changes were considered to lead to improvements
 - New changes for further consideration
 - Discussion and comments from participants
- Consider when future re-audit will be required

COMPLAINTS PROCEDURE

BACKGROUND

- The AOP and the College recommend that complaints should be dealt with as quickly as possible and if circumstances permit, in an informal manner.
- The majority of complaints are the result of poor service or lack of communication.
- It is important to distinguish between a formal written complaint and an informal oral complaint that is dealt with 'on the spot' to the satisfaction of the patient.
- Those non-NHS complaints that cannot be resolved by the practice may be referred to the Optical Consumers Complaints Service (OCCS) who may be able to negotiate a resolution without the need for the involvement of expensive time-consuming and stressful legal procedures.
- If the complaint specifically states or implies negligence then AOP members should consult the AOP and non-members seek legal advice before attempting to settle the matter or admit liability. This is particularly important if;
 - o The practitioner becomes aware of any circumstance which might give rise to a claim of professional negligence being made against the practitioner
 - o Notice is received from any person of their intention to make a claim
 - o A claim is made against the optometrist by any person

NHS COMPLAINTS PROCEDURE

- All practitioners who are contracted to their local Health Authority for GOS eye examinations have to ensure that there is a practice based complaints procedure in place; this is part of their terms of service.

CLINICAL AUDIT

- Complaints should be resolved rapidly and in practice. If it cannot be resolved in the practice then the Health Authority will instigate an independent review.
- The national criteria for a practice based complaints procedure are as follows: -
 - o Be the responsibility of the practice and be understood by all members of staff
 - o Be administered by a complaints manager; (any appropriate member of staff)
 - o Be publicised; leaflets in the practice or a notice on the wall will suffice
 - o A complaint must normally be acknowledged and resolved within a fixed period
 - o A written complaint and its resolution must be recorded
- Practitioners should do the following; -
 - o Appoint a person to handle complaints
 - o Produce a practice leaflet (The leaflet should also indicate that, in the absence of the named person, the complaint should be lodged with the optometrist in charge)
 - o Send a copy of the complaints procedures to the Health Authority (a copy of the leaflet should suffice)
 - o Ensure that all staff are aware of the procedures
 - o Abide by the time limits
- If in doubt, contact the Health Authority or AOP for advice

TIME LIMITS

- If a patient wishes to make a formal complaint, he or she should complain as soon as practicable and certainly within six months of the event giving rise to the complaint.

CLINICAL AUDIT

- The health authority may permit extension of the time limits if there is a reasonable cause for the delay. Practices should acknowledge the written complaint within two working days and respond in full within ten working days

REASONS FOR AUDIT

- To check effectiveness of complaints procedure
- To identify reasons for complaint

OBJECTIVES

- To ensure complaints procedure works
- To assess the nature of complaints
- To minimise the number of complaints
- To improve service to patients

STANDARD SETTING

- What is the ideal level of service?
- What standard is it hoped to achieve (i.e. what is realistically possible)
 - 100% of complaints acknowledged within two working days
 - 100% responded to fully within ten working days
 - 100% of staff aware of complaints procedure

AUDIT TEAM

- An audit co-ordinator, taking responsibility for the appointment of designated staff and their roles and responsibilities
- An audit team leader to take overall responsibility for data collection and correlation
- A member of staff (at each practice) to take ultimate responsibility for collection of data on a daily basis

CLINICAL AUDIT

Some of these persons may have more than one role within the audit cycle

Ensure that all practice staff are aware of the aims and reasons for undertaking the audit and that all team members are fully involved in all stages and regularly updated on the progress of the audit.

METHODOLOGY AND DATA COLLECTION

- Ensure all staff are aware of the aims and reasons for the audit
- During the audit period information is gathered regarding every complaint and recorded in the audit data collection pack as it occurs (Data Sheet)
 - Patient ID
 - Date of complaint
 - NHS or private patient
 - Was complaint written, telephone or in person
 - Reason for complaint
 - Who handled complaint
 - Time taken to acknowledge complaint
 - Time taken for full response
 - Outcome
- the total number of patients seen will need to be identified from start to finish of audit
i.e. 6 months
- Collect data on all complaints in the 6 month period
- You may need to audit each staff member individually
- These complaints will form the base group for the first part of the audit

DATA ANALYSIS AND PRESENTATION.

- Once the audit has finished analyse the number and type of complaints, and the maximum and average response and resolution times

CLINICAL AUDIT

- Briefly outline the results of the initial data collection

ANALYSIS OF FINDINGS AND DEFINING OPTIONS.

- Discuss the results with the team.
 - Compare the actual performance with the standards
 - What are the conclusions?
 - Is it agreed that change is required?
- Have the standards and objectives been met?
- List the possible changes that could be made to improve the practice complaints procedure to meet the standards and objectives
- Use bullet points to keep things clear and simple

IMPLEMENT CHANGE

- Decide when to re-audit to assess if the changes are effective
- Does the data collection need to be modified to include or exclude information?
- Ensure all team members are involved

RE-EVALUATE.

- Repeat data collection and assessment to complete the cycle. This is very important to show that improvements have actually occurred as a result of the changes that have been made.
- Recollect data as before
- Compare both sets of results
- Have the changes improved the practice complaints procedure?
- Have the standards set been met?
- Have the objectives been met?

CLINICAL AUDIT

CONCLUSION

- Has the audit improved the service provided?
- Write a brief conclusion to sum up the findings
- Are there still areas where improvements could be made?
- Write a short summary in bullet point form
- Is it intended to re-audit this topic and if so when?

AUDIT OF ACCURACY AND FEEDBACK OF REFERRALS

REASONS FOR AUDIT

- To identify GP practices and ophthalmologists who do not provide adequate feedback
- To measure accuracy and feedback of referrals based on feedback form GPs and ophthalmologists
- To improve feedback from GP practices and ophthalmologists
- To improve accuracy of optometric referrals

OBJECTIVES

- To assess the feedback from GP practice and ophthalmologists
- To assess the accuracy of referrals

STANDARD SETTING

- To find the numbers of patients referred where there has been no feedback either from the GP or the ophthalmologist
- To identify ophthalmologists or GP practices who are poor at replying
- To set an acceptable percentage level of feedback, taking into account that on occasions there may be genuine reasons for lack of feedback that cannot be avoided
- To set an acceptable level for the accuracy of referrals, (this is likely to be well below 100% but could improve with better feedback)

AUDIT TEAM

- An audit coordinator, taking responsibility for the appointment of designated staff and their roles and responsibilities
- An audit team leader to take overall responsibility for data collection and correlation

CLINICAL AUDIT

- A member of staff at each practice to take ultimate responsibility for collection of data on a daily basis

Some of these persons may have more than one role within the audit cycle

Ensure that all practice staff are aware of the aims and reasons for undertaking the audit and that all team members are fully involved in all stages and regularly updated on the progress of the audit.

METHODOLOGY AND DATA COLLECTION

- You may need to audit each optometrist individually

Phase 1:

- During the Audit Period information is gathered on the total number of patients examined, and the number of these who are referred is recorded on Data Collection sheet A

- Initial data to be collected for each patient referred:

- Patient ID
- Date of examination
- Reason for eye test
- Date of referral
- Reason for referral
- Referral method GOS18/ letter/ telephone/ other
- If letter, sent by post/ hand
- Patient's GP
- Referral indicates Private or NHS referral by GP
- Date response received

Phase 2

- Further data to be collected on response to referral and recorded on Data Collection sheet B

CLINICAL AUDIT

- Time interval since referral
- Responses received from: -
 - o GP practice
 - o Hospital
 - o Patient, opportunistically
 - o Patient, on review
 - o Other, e.g. Relative, carer, guardian
 - o Hospital consultant/clinician

Phase 3

- Further data then collected on each patient on the accuracy of referrals
 - Treatment initiated- none, medical, surgical
 - Continuous monitoring by none, hospital, optometrist, other
 - Validity of referral, accurate/complete, accurate/incomplete, inaccurate, other

ANALYSIS OF FINDINGS AND DEFINING OPTIONS

- Have the standards and objectives of the audit been met?
- Does data collection need to be modified to exclude or include information
- Conclude whether changes are possible and that they can be practically implemented
- Decide which changes can be implemented immediately
- Plan a suitable time delay before re-auditing. This should allow sufficient time for the changes to take effect

RE-EVALUATE

- Collect data as previously on form, apart from any alterations considered necessary after the preliminary analysis
- Analyse the data as previously and make a comparison of results
- Have objectives and standards been met this time?

CLINICAL AUDIT

CONCLUSION

- Compile a final summary to include:
- The audit and re-audit results
- Changes identified
- Changes implemented
- Whether implemented changes were considered to lead to improvements
- New changes for further consideration
- Discussion and comments from participants
- Consider when future re-audit will be required

CLINICAL AUDIT

DATA COLLECTION SHEET A – PATIENTS REFERRED				
Total Number of patients seen in the period		Total Number of patients referred		% Referred

Patient ID	Date of Eye Exam	Reason : For exam	Referral: Date	Reason for referral:	Referred to: (name)	Referral Method:	GOS18/letter sent by:	Response received
		R Routine G GP Referral S Self Referral C Contact lens D Diabetic			GP only Hospital (routine) Hospital (Urgent) Hospital (Casualty)	GOS18 L Letter P Phone O Other	P Post H Hand	

