

# Comparative Audit Group Meeting at the Royal College of Surgeons of England 25 September 2003

## Audit of ward round standards

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## Standard

The GMC document *The Duties of a Doctor* sets out nationally agreed standards of practice.<sup>1</sup> This study assessed whether patients felt that the traditional style ward round conformed to these standards. The authors planned to use the information to improve ward round practice.

## Evaluation

From the GMC document, seven areas of care that were relevant to the ward round were identified. The following statements encompassed these.

- (1) My health care was the doctors' first concern.
- (2) I was treated politely and considerately.
- (3) My dignity and privacy was respected.
- (4) My views were listened to and respected.
- (5) Information was given to me in a way I could understand.
- (6) I was involved in decisions about my healthcare.
- (7) I had all of my questions answered.

One further element of care that we considered essential was stated as:

'I was aware of the identity of all of the people on the ward round.'

An anonymous questionnaire with these eight statements and a Lickert scale from strongly agree to strongly disagree was used.

The questionnaire was handed to each patient by one researcher, before the ward round. Patients excluded were children, day-case patients and those unable to complete the questionnaire.

## Results

After 50 patients had completed the questionnaires the results were collated. We considered a patient indicating that they agreed or strongly agreed with the statement, equated with high quality care. Marking disagree or strongly disagree indicated low quality care. A 90 per cent rating of care as high, was deemed an acceptable target. One hundred per cent of responders rated their care as high quality for six per cent of the eight areas audited. In the area of identifying ourselves clearly, 73.9 per cent rated their care as high quality. In the area of making the patient feel involved in their healthcare 81.9 per cent rated their care as high quality. These both fell short of the 90 per cent target.

## Change in practice

A new style 'private' ward round was implemented. All medical staff and the lead nurse would meet in a private

room with the notes to discuss the cases. A preliminary plan was made for each patient. Then one SpR and one SHO, with the nurse, would visit each patient in turn to discuss their care and finalize the plan. A further 50 patients were audited in the same manner, with the same questionnaire as before.

## Results of Re-audit

Again in six of the eight areas of care, 100 per cent of the patients rated their care high quality.

For identifying ourselves clearly, 81.3 per cent considered their care high quality, 91.7 per cent of patients perceived that their healthcare was the doctor's first concern. Therefore the new ward round structure met our targets of greater than 90 per cent in seven of the eight areas. This was an improvement over the traditional ward round.

## Reference

The Duties of a Doctor, General Medical Council; 28 Aug 2002; [www.gmc-uk.org/standards/doad.htm](http://www.gmc-uk.org/standards/doad.htm)

## Audit of one-stop facial skin lesions clinic

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## Standard

The NHS plan states that by 2005, the waiting time for outpatient appointments should not exceed three months. In addition, the services should be patient centred.<sup>1</sup> In a one-stop clinic, the total waiting time from initial referral to surgery should be no more than three months (90 days).

## Evaluation

The average waiting time between initial GP referral and surgery for facial skin lesions, in the ENT department was 121 days prior to September 2001. The average waiting time for patients originally referred to the plastic surgery department was 498 days for the initial appointment and 250 days for treatment (total 748 days). This clearly fell short of the agreed standard.

## Change in practice

Encouraged by the Action on ENT programme, a one-stop see and treat clinic for facial skin lesions was set up in the community in September 2001. All referrals for facial skin lesions were sent by GPs in the normal manner to the ENT department. Additional referrals for all facial skin lesions sent to the plastic surgery department were also forwarded to the ENT department. The referral letters were reviewed and prioritized by two ENT consultants. All referrals deemed suitable for the one-stop clinic were added to the

clinic list. The lesions considered unsuitable for ENT were returned to the plastic surgery team.

The clinics were held in a minor surgery unit of a centrally located GP practice. There were three sessions a month, with a capacity of six patients a session. The clinics were held in the afternoon and evening.

The patients on the clinic list were telephoned by the ENT booking clerk to choose and agree a time and date for an appointment. Patients were seen, assessed and if the facial lesion considered amenable to excision under local anaesthetic, the patient was consented and the procedure carried out immediately. A letter detailing the histology result was sent to the patient and the GP by the consultant concerned.

All patients were given a patient satisfaction questionnaire to fill out immediately after the surgery on the same day.

### Re-evaluation

All patients booked into the one-stop clinic between September 2001 and September 2002 were included in the audit. One hundred and seventy-five patients were booked into the clinic over this period, 163 patients attended giving an attendance rate of 96 per cent. The average waiting time between initial GP referral and surgery in the ENT department was reduced from 121 to 45 days. The average waiting time for patients originally referred to the plastic surgery department was reduced from 748 days to 121 days by March 2002. Once the backlog was cleared, this was reduced further to 47 days by September 2002.

The patient satisfaction survey was completed and returned by 158 of 163 patients (97 per cent). All the patients rated the experience of the one-stop clinic as good (12 per cent) or excellent (100 per cent).

### Conclusion

Our audit shows that the aims of reducing waiting time and improving patient care were achieved. The patient satisfaction rate was very high. Hence, the one stop see and treat facial lesions clinic was continued and is now an integral part of the service provided by the Ear, Nose and Throat department at Ipswich Hospital.

### Reference

1 Department of Health. The NHS Plan: A Plan for investment, a plan for reform. 2000

### Beneficial effects of a tumour map at panendoscopy on the staging of head and neck cancer

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### Standard

The benefits of staging squamous cell carcinoma of the head and neck are well documented. The BAOHNS' guidelines<sup>1</sup> state that 'quality management requires universal, accurate TNM staging which must be clearly documented in the notes at diagnosis'. Furthermore, all tumours should have axial, sagittal and coronal views illustrated using the recommended tumour maps.

### Evaluation

Initial practice was reviewed by a retrospective analysis of case notes of all newly diagnosed squamous cell carcinomas of the larynx, pharynx and tongue base at St. George's

Hospital over an 18-month period (n = 37). At primary endoscopy, the surgeon may have TNM staged the tumour and documented the appearance of the tumour using a free hand drawing in the operation note. Only 68 per cent of new cases were TNM staged at panendoscopy. Diagrammatic representations of the disease in all planes (sagittal, axial and coronal) were documented in none of the cases, with 38 per cent having axial views, 0 per cent sagittal views and only five per cent having coronal views (Figure 1).

### Change in practice

A pre-printed proforma on which to document findings at endoscopy was introduced. This included all three anatomical planes and a space to clearly document the tumour's stage with details of TNM classification on the reverse for easy reference.

A prospective investigation was carried out for a period of 18 months following the introduction of the standardized tumour map proformas. This change in practice increased the percentage of tumours that were TNM staged at diagnosis from 68 per cent to 92 per cent. Rates of axial, sagittal, and coronal representations improved to 69 per cent, 54 per cent and 69 per cent respectively, and half of all tumours had complete three-dimensional representations compared to none previously (Figure 1). Following this assessment, the use of panendoscopy tumour maps was established as permanent practice within our department.

### Re-evaluation

We carried out a re-evaluation period for a further 18 months, which demonstrated that the improvements in practice had been maintained. Eight-nine per cent of newly diagnosed cancers were still being TNM staged at primary endoscopy. Diagrammatic representations of the disease with all three views together remained at 51 per cent. The rates of axial, sagittal and coronal representations were maintained at 89 per cent, 64 per cent and 61 per cent respectively at re-evaluation (Figure 1).

### Conclusion

With a standardized tumour map more cases are TNM staged at panendoscopy. Multiplanar representation is also more common with tumour maps, allowing more accurate staging and better multidisciplinary team discussion of patient management. Furthermore, it is possible to maintain this improvement in practice as demonstrated by our audit re-evaluation period.

### Reference

1 *The Management of Head and Neck Cancer Consensus Document*, The British Association of Otolaryngologists, Head and Neck Surgeons, 2002

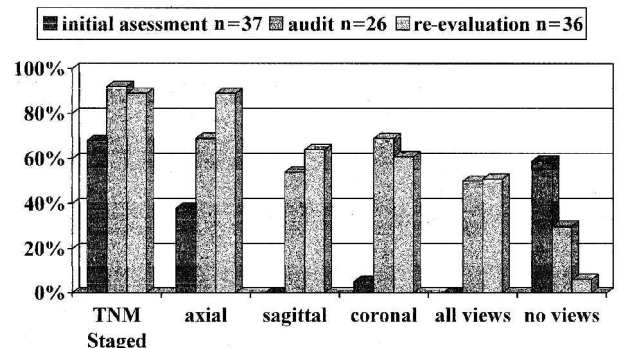


FIG. 1

Diagrammatic representation of the disease.

## Managers, doctors, cancer patients: whose '10-days' rule' is it anyway?

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### Standard setting in Head and Neck cancer

The Welsh Assembly's Cancer Services Co-ordinating Group produced the *All Wales Minimum Standards for Cancer Services and Specialist Palliative Care* document<sup>1</sup> in 2000. These state that urgent patient referrals with a suspected diagnosis of cancer must be seen within 10 working days of receipt by the hospital of the GP referral.

We wished to measure our ENT department's level of '10-days' rule' compliance. Especially we wanted to qualify suspected 'referral-time' discrepancies between that centrally reported to the Welsh Assembly by ENT Directorate managers and the actual time delay to be seen in the ENT clinic.

### Evaluation of current practice and comparison with standard

A prospective audit was done, over three months in 2002, of 102 consecutive GP referral letters than raised suspicion of Head and Neck cancer. Referral letter time-intervals were prospectively recorded from initial GP referral, through receipt by hospital and letter screening by ENT consultant, to the actual date of patient review in clinic.

ENT Directorate managers calculated a 65 per cent compliance with the 10-days' rule.

### Change in practice and re-comparison with standard

ENT doctors discussed and elucidated the proper 10-days' rule calculation method with the Welsh Assembly's Cancer Services Co-ordinating Group. The audit was re-performed on the 102 consecutive GP referral letters.

ENT doctors calculated a 78 per cent compliance with the 10-days' rule.

### Comparison of changes in practice

The variance between *actual* patient referral time to see an ENT specialist and *official* timing data submitted to the Welsh Assembly is statistically significant ( $p = 0.0001$ ).

### Conclusion

To achieve or not achieve the UK government's clinical care targets can influence the standing, development and funding of healthcare departments. It is, therefore, important that management data provided to central government is accurate and complete. Our prospective audit cycles have shown that interpretation of the *same* healthcare data can vary dependent upon who analyses the data. This is perhaps due to either poorer understanding of healthcare processes or to alteration of data for ulterior motives beyond improving patient care. Achieving clinical care targets can be influenced by spurious data submissions.

Data inaccuracies can undermine any potential of 'targets' to benefit patient care.

### Reference

1 Cancer Services Co-ordinating Group (2000) *All Wales Minimum Standards*. CSCG, Wales

## Minimum data documentation for ear surgery

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### Standard

To allow a better peer review of their results, surgeons should record a minimum of data relevant to the procedures they perform. We aim to audit the practice of minimum data documentation for middle-ear surgery at Doncaster Royal Infirmary.

A postal survey amongst the BAO-HNS members identified that only 28 surgeons in the UK had a proforma for ear surgery audit. The Clinical Practice Advisory Group (CPAG) therefore produced and distributed an Otolology Minimum Data Form.

The CPAG Otolology Minimum Data Form was adopted as a standard. Specifically the following data should be recorded:

#### At the time of the operation:

- (1) a clear primary aim of the procedure;
- (2) the operative findings;
- (3) the perforation size as a percentage;
- (4) the perforation site;
- (5) the ossicular chain status.

#### During the post-operative period:

- (6) disease activity;
- (7) tympanic membrane intactness.

Since this is the minimum data required to be documented, the standard was set at 100 per cent.

### Evaluation of practice

From September 2002 to February 2003, there were a total of 44 cases. During that period 22 myringoplastics, 18 modified radical mastoidectomies, two atticotomies and two stapedectomies were performed.

The results are summarized in Table I under 'Before Intervention'. This showed that we were below the standard especially in operative data documentation.

### Change in practice

Paper copies of the minimum data form were distributed to ENT theatres, wards and pre-assessment unit to be filled by the surgeon/assistant in theatre. Also an electronic database for ear surgery was created.

### Re-evaluation

From April to August 2003, there were a total of 43 cases. Procedures performed during that period were: 13 modified radical mastoidectomies, 12 myringoplastics,

TABLE I

RECORDED DATA USING THE CPAG OTOLOLOGY MINIMUM DATA FORM

	Before intervention	After intervention
Aim of procedure	82%	98%
Operative findings	55%	100%
Perforation size*	0%	46%
Perforation site*	64%	85%
Ossicular chain	61%	80%
Disease activity	74%	88%
Tympanic membrane intactness	87%	92%

\*Applied to myringoplastics only

five combined approach tympanoplasties, three cortical mastoidectomies, three atticotomies, two stapedectomies, two attico-anrostomies, one ossiculoplasty, one tympanoplasty and one myringoplasty and cortical mastoidectomy.

The supplied forms were filled in in only 28 per cent of the cases. The results after comparing to the standard are summarized in Table I under 'After Intervention'.

It illustrates that we are still below the standard but our practice has improved in recording both the operative and post-operative data. This was shown even when the minimum data sheets were not filled.

### Conclusion

The minimum data form has been successful in improving ear surgery data recording. We recommended replacing the currently used paper sheets with an electronic database to be filled in in theatres. We plan to re-audit practice after that intervention takes place to ensure a steady improvement towards the set standards.

### Training for the SHO in the emergency ENT clinic

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### First Cycle

#### Standard

Before commencing autonomous emergency clinic work 100 per cent of ENT SHOs should receive formal training on the use of equipment and the management of common conditions.<sup>1,2</sup>

### Evaluation

Using an operative surgery directory, all the hospitals in England with ENT services were telephoned. The on-call ENT SHO was then asked a series of questions from a pre-prepared questionnaire and the answers logged down.

Out of the 200 hospitals contacted, 50 were included in the audit. The majority of SHOs (56 per cent) start running emergency clinics without any period of training or instruction on the correct use of equipment. Many (40 per cent) have to cope without any help from nursing staff although senior members of staff supervise the vast majority of clinics (88 per cent).

### Comparison

All training grade doctors, particularly junior members, should receive formal training at the commencement of a

new post. At present the majority of ENT departments are falling short of this level and an improvement needs to occur. Only 44 per cent of SHOs are receiving training compared to 100 per cent in the standard.

### Change in practice

In performing this audit we have advertised the shortfall in training. Presentation of the audit's findings on a local, regional and national level was hoped to highlight an area of training which needed to be improved.

Publication of the findings in the *Annals of the Royal College of Surgeons' bulletin* and the fact that the article was highlighted in *Hospital Doctor* were all designed to encourage individual departments to institute either an induction programme or some training structure.

### Re-evaluation and comparison

The audit of the same 50 hospitals was repeated one year later and the results were found to be very similar. Again the majority of SHOs (54 per cent) received no formal training prior to commencing work in the Emergency ENT Clinic. However, the hospital from which the survey was performed improved the training of its SHOs as did four other hospitals. Unfortunately, in four of the other hospitals included, training had actually become worse. Forty-six per cent now received training compared to 100 per cent in the standard.

### Second Cycle

#### Change to improve practice

After re-evaluation it appears some hospitals are still not meeting the set standard for training and so we would like to introduce an induction course.

This would be designed to train any ENT SHO on the use of equipment and to instruct them on the management of common emergency conditions. Our aim would be to have the course conducted at various centres, run twice per year (August and February) and to encourage all departments to allow their SHO's to attend. After the change is introduced then a further audit will be needed.

### References

- 1 Department of Health (2002) Unfinished business—Proposals for reform of the Senior House Officer grade. Sir Liam Donaldson, Department of Health, London.
- 2 *The Manual of Basic Surgical Training. Examples of desirable speciality clinical and practical skills.* The Royal College of Surgeons of England, 1998