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BUNDABERG HEALTH SERVICE DISTRICT

POSITION DESCRIPTION

POSITION TITLE	Manager – Clinical Benchmarking Unit
VACANCY REFERENCE NO.	BB00/08/8
LATTICE POSITION NO.	101349
LOCATION	Bundaberg Base Hospital
CLASSIFICATION LEVEL	AO6
REPORTS TO	Director of Medical Services
AWARD	District Health Services Employees' Award - State
REVIEW DATE	August 2000

PURPOSE OF POSITION

The position is responsible for ensuring that the Districts' Clinical information resources add value to the planning, performance monitoring and decision-making processes. Initially the position will be responsible for the project management of Transition II Clinical Benchmarking System at Bundaberg Base Hospital as per the Queensland Health Corporate Project. The incumbent is expected to identify opportunities for the improved use of clinical information resources and provide leadership in attaining advantage for the District through the application of available information, including clinical, resource or financial data as it pertains to potential and current clinical activity.

ORGANISATIONAL UNIT

The Clinical benchmarking Unit is responsible for driving the District's clinical benchmarking system, ensuring data integrity, appropriate systems and policy development and promotion of the resultant information for informed planning and decision-making by clinicians and management. A key objective of the area is to ensure that the needs of clients for Casemix / Clinical Benchmarking data are met. The unit will facilitate the assessment of the District's performance against clinical benchmarks identified through Enterprise Bargaining Agreements and external benchmarking organisations. The success of the area will be evidenced by the Teams' reputation for providing an efficient and effective clinical information function.

ORGANISATIONAL ENVIRONMENT

The Bundaberg Health Service District provides comprehensive Hospital and Community based health care. The District consists of Bundaberg City and surrounding coastal towns from Burnett Heads to Woodgate, the towns of Childers, Gin Gin and Mount Perry. There are Hospitals at Bundaberg, Childers and Gin Gin and a Community Health Centre at Mount Perry.

The Bundaberg Hospital campus is a 140 bed facility. The Hospital provides medical, surgical, paediatrics, emergency, intensive/coronary care, day surgery, renal, orthopaedics,

diabetes, gynaecology/obstetrics, medical oncology, rehabilitation, allied health and mental health services for the District population.

Community Health Services provided by the District comprises Community Mental Health, Alcohol and Drug, Child & Youth Mental Health, Child Health, BreastScreen, Oral Health and Indigenous Health.

Bundaberg Health Service District has approximately 850 employees.

REPORTING RELATIONSHIPS

The position reports directly to the Sponsor of Clinical Benchmarking – the Director of Medical Services. It is expected that this position will have significant interaction with all members of the Hospital Executive as to the performance and progress of planned initiatives. In addition the position is expected to have significant contact and collaboration with Business Managers, Nurse Practice Coordinators, and Clinical Directors in relation to performance measures and progress of planned initiatives within their respective departments.

A Clinical Benchmarking – Support Officer reports to this position.

Internal and External Communication Requirements

The position's primary internal communication is with the Director of Medical Services. Continual contact will also be maintained with the Director of Corporate Services. The position will communicate with a wide range of staff including Finance, Health Information Managers, Clinicians, and Departmental Heads.

Externally, the position confers with Queensland Health Corporate Office, Central Zone, other district health services staff, and External Consultants.

PRIMARY DUTIES/RESPONSIBILITIES

- Manage the operations and functions of the Clinical Benchmarking Information System to ensure the design and operation of the Clinical Benchmarking information systems are such that they are able to provide reliable, valid and accurate reporting of patient costing information.
- Manage and evaluate the implementation and refinement of Clinical Benchmarking information systems for Bundaberg Health Service District and develop recommendations to meet future data requirements and analysis needs.
- Provide specialist advice to District Executive, senior and middle management and other work units and committees on the development and availability of Clinical Benchmarking related management information.
- Participate in the improvement of data collection systems and manage the integration of new feeder systems to Transition II liaising with the Information Systems Unit, Queensland Health Clinical Benchmarking Project, Allegiance Systems Pty Ltd, and other external vendors as required.
- Manage basic technical aspects of the Clinical Benchmarking system and liaise with internal information systems support and external vendors as required.
- Conduct regular quality audits of the information used for decision purposes within the system and its' feeder systems. Supervise all end of month transactions to ensure an accurate and reliable Clinical Benchmarking System. Report data accuracy problems to the relevant personnel.

- Ensure the delivery of monthly reports that detail progress in relation to base activity targets in accordance with Service Agreements. Provide advice on the analysis and use of these

reports. Provide activity and costing reports to managers and clinicians on a regular basis so that strategic organisational planning processes can be developed and implemented.

- Analyse and promote the utilisation of Clinical Benchmarking information for the purposes of improving the organisation's understanding of:
    - the cost of products within the hospital's service delivery;
    - improved definition of responsibility of cost centre budgets;
    - development of improved budgetary management for activity and cost centre budgets;
    - measurement of the hospital's performance against best practice standards and peer hospitals.
- Coordinate the benchmarking of the hospital's data with peer institutions to highlight potential areas of improvement.
- Participate in the development of all policy and procedures that relate to the Clinical Benchmarking Unit.
- Develop and provide training to primary and secondary on-line users of Transition II and appropriate education and training in Clinical Benchmarking Data Analysis to Hospital and Clinical Managers.
- Participate in the Performance Planning and Review process.
- Participate in Quality Management activities, as appropriate.
- Supervise and manage staff in line with quality human resource management practices including Workplace Health and Safety, Employment Equity, Anti-Discrimination and ethical behaviour.

QUALIFICATIONS

- There are no formal qualifications required for this position although it is essential that the successful applicant possess experience in health service provision and highly developed computer skills.
- A qualification in a financial or health related field would be well regarded.

Skills, Knowledge and Abilities

Experience in management of activity data at senior management and executive level.

Management ability to plan, organise, implement, monitor and evaluate projects.

Ability to present patient activity data, costing data and reports for hospital management.

Skilled with health related information management systems and other software including database packages.

Demonstrated ability to establish and prioritise activities for self and others to accomplish specific goals in line with set deadlines and available resources.

Proven ability to actively influence events to achieve corporate and organisational goals and objectives.

Demonstrated ability to develop alternate courses of action and make decisions which are based on logical assumptions and available information.

Proven ability to compare and critically analyse data from different sources, identify relevant issues and make appropriate recommendations.

High level of interpersonal, negotiation, and communication skills.

Demonstrated ability to provide leadership and team development skills at a senior level within a complex organisation.

Additional Factors

Personal qualities of sound judgement, discretion, tact and attention to detail.

OTHER INFORMATION

Queensland Health is a "smoke free" employer. Smoking is not permitted in any Queensland Health facility except where specifically defined.

The Bundaberg Health Service District requires all employees to adopt appropriate and recognised measures to minimise the risk of infection and workplace injury to themselves, other staff and clients and to adhere to the Districts Infection Control Policy Manual and Workplace Health and Safety policies and practices.

A Bundaberg Health Service District *Confidential Agreement* is to be signed upon appointment.

Applicants must address each selection criterion.

SELECTION CRITERIA

SC1 Demonstrated ability to implement, maintain and evaluate complex information systems, particularly health-related systems in a health-related discipline.

SC2 Demonstrated knowledge of Clinical Benchmarking and the Clinical Benchmarking System (Transition II)

SC3 Demonstrated high level consultative, interpersonal, communication and negotiation skills at a senior level.

SC4 Demonstrated skills in the implementation of organisational change initiatives, including capacity to motivate and lead in an evolving environment engendering high performance and team cohesion.

SC5 Ability to prepare and present reports and submissions of a complex and substantial nature and negotiate their recommendations to clinical and other staff.

SC6 Demonstrated ability to supervise and manage staff in line with quality human resource management practices including workplace health and safety, employment equity, anti-discrimination and ethical behaviour.

ORGANISATIONAL CHART

- As per attachment.

The Bundaberg Health Service District is an Equal Employment Opportunity Employer

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QUEENSLAND HEALTH

BUNDABERG HEALTH SERVICE DISTRICT
JOB DESCRIPTION

POSITION TITLE	**District Quality and Decision Support Unit** Manager
VACANCY REFERENCE NO.	
LATTICE POSITION NO.	101349
LOCATION	District Quality & Decision Support Unit Bundaberg Health Service District
CLASSIFICATION LEVEL	AO6
SALARY LEVEL	[illegible] per annum
REPORTS TO	Director of Corporate Services
AWARD	District Health Services Employees' Award – State 2003
REVIEW DATE	September 2004

PURPOSE OF POSITION

The position is responsible for ensuring that the Districts' Clinical information resources add value to the planning, performance monitoring and decision-making processes. The position will be responsible for the management of Transition II Clinical Benchmarking System at Bundaberg Base Hospital as per the Queensland Health Corporate Project. The incumbent is expected to identify opportunities for the improved use of clinical information resources and provide leadership in attaining advantage for the District through the application of available information, including clinical, resource or financial data as it pertains to potential and current clinical activity.

ORGANISATIONAL ENVIRONMENT AND KEY RELATIONSHIPS

The Bundaberg Health Service District provides comprehensive Hospital and Community based health care. The District extends from Miriam Vale Shire in the north to Isis Shire in the south, and includes Town of 1770 and Agnes Water, Bundaberg City and surrounding coastal towns from Moore Park Beach to Woodgate, the towns of Childers, Gin Gin and Mount Perry. The District services a population of 82,211. The Bundaberg Health Service District maintains a 136 bed hospital in Bundaberg, a 17 bed hospital in Gin Gin, an 18 bed hospital in Childers, and Health Centre in Mount Perry.

The Bundaberg Base Hospital is a Level 4 hospital, and provides services including accident and emergency; surgery; orthopaedics; obstetrics and gynaecology; paediatrics; medicine; intensive care/coronary care; theatre and anaesthetics; rehabilitation; palliative care; renal dialysis; ambulatory services/specialist outpatients; medical imaging; pathology; mental health services; and allied health services. Community health services provided by the District include oral health; BreastScreen Queensland; social work; indigenous health; Alcohol Tobacco & other Drug Services; health promotion; aged care assessment; home medical aids; palliative care; sexual health; Transition to School Developmental Assessment

team; Home and Community care; diabetes education; stomaltherapy; community & family health.

Bundaberg Health Service District has approximately 600 full time equivalent employees.

ROLE OF THE DEPARTMENT

The Decision Support Unit is responsible for providing the District with financial and clinical information to support decisions at both an Executive and Clinical Management level. Decision Support Services, encompasses both the finance and clinical benchmarking departments. The Unit is responsible for ensuring data integrity, appropriate systems and policy development and promotion of the resultant information for informed planning and decision-making by clinicians and management.

A key objective of the area is to ensure that the needs of clients for Financial / Casemix / Clinical Benchmarking data are met. The unit will facilitate the assessment of the District's performance against clinical benchmarks identified through Enterprise Bargaining Agreements and external benchmarking organisations.

The success of the area will be evidenced by the Teams' reputation for providing an efficient and effective financial & clinical information function.

REPORTING RELATIONSHIPS

The position reports directly to the Director of Corporate Services. It is expected that this position will have significant interaction with all members of the Hospital Executive as to the performance and progress of planned initiatives. In addition the position is expected to have significant contact and collaboration Medical Clinical Directors and Nurse Practice Coordinators in relation to performance measures and progress of planned initiatives within their respective departments.

The Finance Manager and Clinical Benchmarking Support Officer reports to this position.

Internal and External Communication Requirements

The position's primary internal communication is with the Director of Corporate Services. The position will communicate with a wide range of staff including District Manager, Executive Directors, Finance, Health Information Managers, Clinicians, and Departmental Heads.

Externally, the position confers with Queensland Health Corporate Office, Central Zone, other district health services staff, and External Consultants.

ORGANISATIONAL CHART

Attached.

POSITION REQUIREMENTS

Queensland Health is committed to achieving its mission to improve the health and well-being of all Queenslanders. To sustain the trust of the people of Queensland in fulfilling this mission, and for staff to achieve their full potential, four core values are shared across the organisation. These are quality and recognition, professionalism, teamwork and performance accountability. Implementation of these values in the workplace requires the commitment of management and staff. The primary duties and assessment criteria outlined in this job description reflect the commitment to core values which is required by this position.

PRIMARY DUTIES/RESPONSIBILITIES

- Leadership and management of the District Quality & Decision Support Unit

- Manage the operations and functions of the Clinical Benchmarking Information System to ensure the design and operation of the systems are such that they are able to provide reliable, valid and accurate reporting of patient costing information.
- Manage and evaluate the implementation and refinement of information management systems for Bundaberg Health Service District and develop recommendations to meet future data requirements and analysis needs.
- Provide specialist advice to District Executive, senior and middle management and other work units and committees on the development and availability of Clinical Benchmarking related management information.
- Participate in the improvement of data collection systems and manage the integration of new feeder systems to Transition II liaising with the Information Systems Unit, Pricing Strategy Unit, Central Zone, and other external vendors as required.
- Manage basic technical aspects of the Clinical Benchmarking system and liaise with internal information systems support and external vendors as required.
- Conduct regular quality audits of the information used for decision purposes within the system and its' feeder systems. Supervise all end of month transactions to ensure an accurate and reliable information management system. Report data accuracy problems to the relevant personnel.
- Ensure the delivery of monthly reports that detail progress in relation to base activity targets in accordance with Service Agreements. Provide advice on the analysis and use of these reports.
- Provide activity and costing reports to managers and clinicians on a regular basis so that strategic organisational planning processes can be developed and implemented.
- Analyse and promote the utilisation of financial & activity information for the purposes of improving the organisation's understanding of:
    - the cost of products within the hospital's service delivery;
    - improved definition of responsibility of cost centre budgets;
    - development of improved budgetary management for activity and cost centre budgets;
    - measurement of the hospital's performance against best practice standards and peer hospitals.
- Coordinate the benchmarking of the hospital's data with peer institutions to highlight potential areas of improvement.
- Participate in the development of all policy and procedures that relate to the Decision Support Unit.
- Develop and provide training to primary and secondary on-line users of Transition II and appropriate education and training in management/health informatics data analysis to Hospital and Clinical Managers.
- Participate in Performance Appraisal and Development process.
- Participate in Quality Management activities, as appropriate.
- Supervise and manage staff in line with quality human resource management practices including Workplace Health and Safety, Employment Equity, Anti-Discrimination and ethical behaviour.

PRIMARY DELEGATIONS AND ACCOUNTABILITIES

This position is accountable for the ongoing management of activity data at senior management and executive level. Ability to plan, organise, implement, monitor and evaluate projects, present patient activity data, costing data and reports for hospital management.

MANDATORY CRITERIA

There are no mandatory qualifications for this position; however skills and abilities relevant to the position would be expected.

ADDITIONAL FACTORS

Queensland Health is a "smoke free" employer. Smoking is not permitted in any Queensland Health facility except where specifically defined.

There are no formal qualifications required for this position although it is essential that the successful applicant possess experience in health service provision and highly developed computer skills.

A qualification in a financial or health related field would be well regarded.

The Queensland Health Code of Conduct explains the acceptable standard of behaviour required of all staff. The Code consists of five (5) principles: Respect for the Law and System of Government, Respect for People, Integrity, Diligence, Economy and Efficiency.

Clinical Services Networks (CSNs) are being developed in the Zone in a range of medical specialities as the vehicle of efficient and equitable service delivery, quality improvement, education and professional accreditation. The appointee will be required to provide services to the Bundaberg Health Service District and may be asked to provide services in other hospitals within Central Zone as part of CSNs at times and places to be specified.

PROBATION

All new permanent employees to Queensland Health will be required to undertake a period of probation upon commencement of duty. This period will be three (3) months in length with a possible 3 (three) month extension if performance objectives are not met.

PRE – EMPLOYMENT CHECKS

This position may be subject to pre-employment history checks including a working with children suitability check (Blue Card), criminal history, identity or previous disciplinary history checks for the preferred applicant.

HEPATITIS B VACCINATION

Health care workers in Queensland Health whose occupation poses a potential risk of exposure to blood or body fluids must be immunised against Hepatitis B according to the National Health and Medical Research Council Australian Immunisation Handbook 7th Edition and the Queensland Health Infection Control Guidelines.

Hepatitis B immunisation is a condition of employment for Health Care Workers in Queensland Health who have direct patient contact (eg medical Officers, nurses and allied health staff), as well as those staff who, in the course of their work, may be exposed to blood or body fluids, for example by exposure to contaminated sharps eg (but not confined to) plumbers.

Proof of vaccination must be provided to prior to appointment. Proof of vaccination can be provided via a letter from a General Practitioner, infection control or occupational health department.

ASSESSMENT CRITERIA

Applicants should address each assessment criteria in a written application.

Assessment criteria weighting is indicated.

The written application weighting is 25 %. Short-listed applicants will be interviewed. Interview weighting will be 75 %.

AC1 Demonstrated ability to implement, maintain and evaluate complex information systems, particularly health-related systems in a health-related discipline.

Weight 8

AC2 Demonstrated knowledge of Clinical Benchmarking and the Clinical Benchmarking System (Transition II).

Weight 10

AC3 Demonstrated high level consultative, interpersonal, communication and negotiation skills at a senior level.

Weight 8

AC4 Demonstrated skills in the implementation of organisational change initiatives, including capacity to motivate and lead in an evolving environment engendering high performance and team cohesion.

Weight 7

AC5 Ability to prepare and present reports and submissions of a complex and substantial nature and negotiate their recommendations to clinical and other staff.

Weight 10

AC6 Demonstrated ability to supervise and manage staff in line with quality human resource management practices including workplace health and safety, employment equity, anti-discrimination and ethical behaviour.

Weight 5

RESPONSIBLE OFFICER

Name: Peter Heath
Director Corporate Services

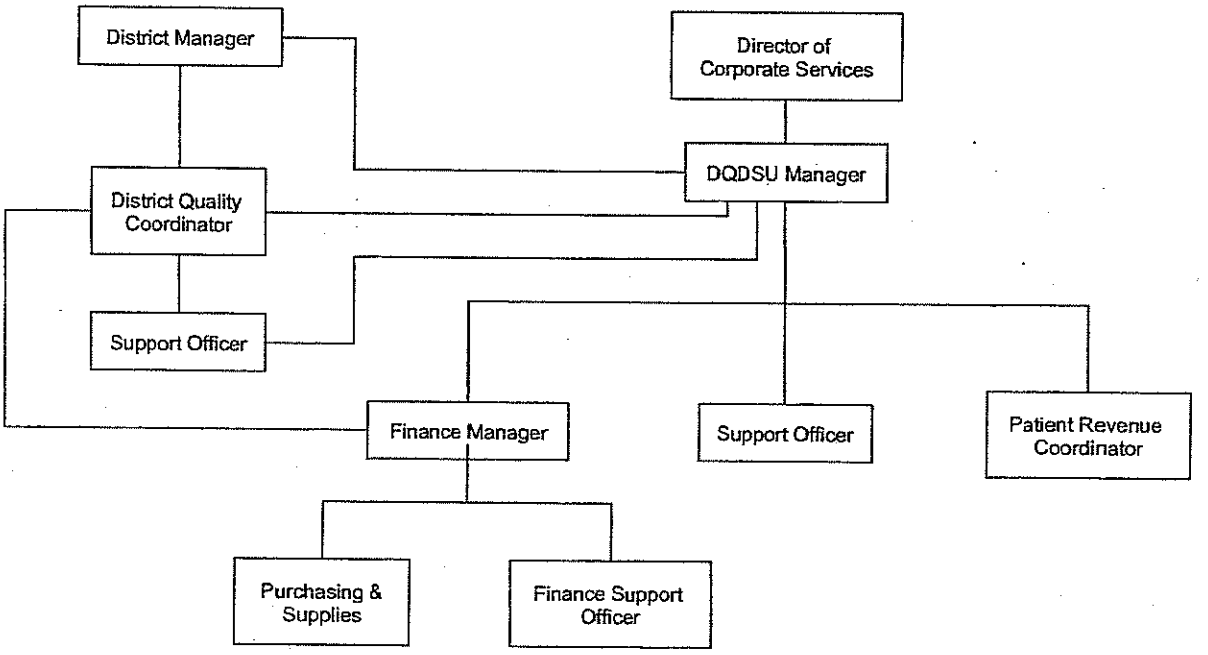
Signature:

Date:

Organisational Chart

Bundaberg Health Service District

DISTRICT QUALITY & DECISION SUPPORT UNIT



Clinical Audit Process

Wed. 18 June 2003 from 1500 hrs
(duration: approx. 2 hrs)

Venue: Seminar Rm, 3rd Floor, Link Building

Attention all interested Clinicians

Yes, everything that you ever wanted to know about.... **Clinical Audits**!!!!

Forget complex statistics.....This session will be a simple, practical application of the Clinical Audit Process.

Topics that will be covered are...

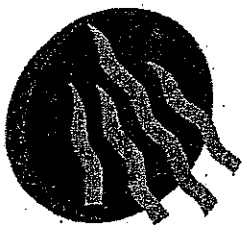
- What is a Clinical Audit?
- How to apply the Clinical Audit process in my area?
- Identifying clinical achievements and those areas of opportunity

Please register your attendance by phoning the Ed Centre on ext. 2280

VK3

Clinical Audit

Guide for Clinicians



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An Introduction to Clinical Audit

What clinical audit IS

Clinical audit has been described as..

"...a quality improvement process that seeks to **improve patient care** and outcomes through **systematic review** of care against **explicit criteria** and the **implementation of change.**" Aspects of the structure, processes and outcomes of care are selected and **systematically** evaluated against explicit criteria. Where indicated **changes are implemented** at an individual, team or service level and **further monitoring is used to confirm improvement."**

(National Institute for Clinical Excellence 2002)

This particular definition highlights some important features of clinical audit, which are worth further discussion.

1. Clinical audit is a process designed to **improve patient care.**
   - Focuses on the clinical aspects of care, rather than administrative or financial aspects of patient care.
   - Large-scale clinical audits may include measures such as waiting times or costs of services, but these are usually secondary to the measures of actual clinical care.

2. Clinical audit is a **systematic** process, often described as a cycle.

3. Clinical audit involves the measurement of current practice against explicit **criteria.**
   - Criteria are at the heart of the clinical audit process
   - Criteria form the benchmark against which practice will be measured and compared
   - Criteria should be based on best practice whenever possible.

4. Clinical audit should **lead to change.**
   - When reviewing practice clinicians often focus on the collection and analysis of data, but although these are important stages in the clinical audit cycle they are not in themselves clinical audit.
   - There is an expectation that data will be used to influence and bring about change.
   - Without a commitment to introduce change there is little point in collecting the data.

5. Having introduced change **reaudit** should be used to confirm that an improvement has been achieved.

What clinical audit ISN'T

It might be also useful to dispel a few myths and misconceptions about clinical audit at this stage.

1. Clinical audit is **not** a fault finding or blame process.
   Clinical audit **is** a learning process and should be viewed positively.

2. Clinical audit is **not research.**
   Both processes may involve sampling, collecting data and data analysis.
   - Research is essentially about the creation of new knowledge – about what works and what doesn't.
   - Clinical audit asks whether the result of this new knowledge is being put into practice.

- Research may involve experimentation and patients being allocated to different treatment groups.
- Clinical audit never involves anything being done to patients beyond accepted clinical management and never involves the allocation of patients to different treatment groups.

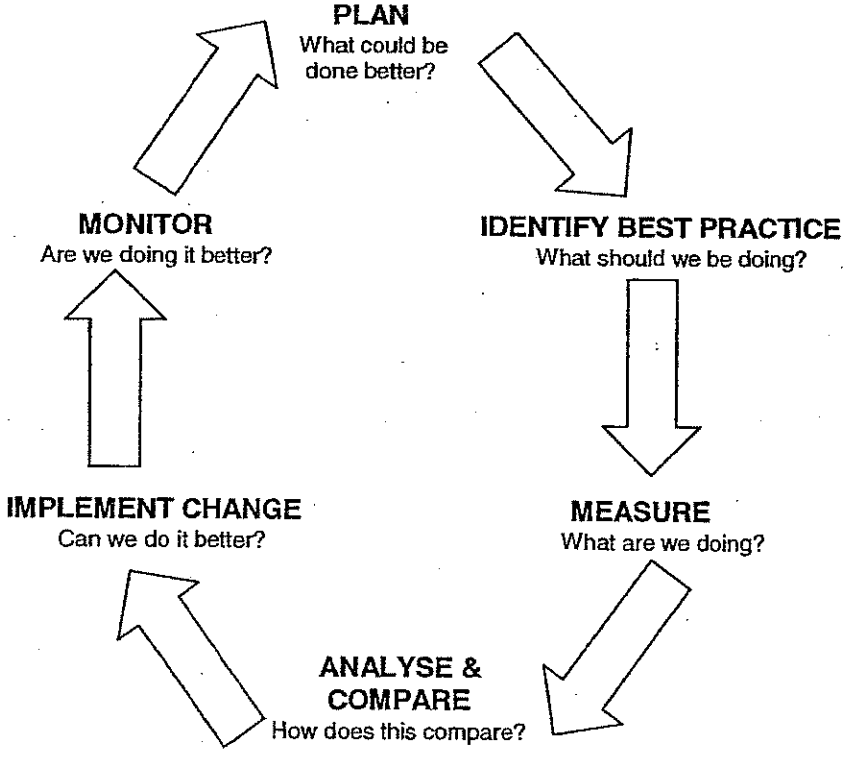
3. Clinical audit is **not** about routine data collection.
   - Clinical audit involves the collection of data and may make use of routinely collected data. Collection of data in itself is not clinical audit.
   - Only when data is compared to explicit criteria and the results of this comparison used to influence change does it become clinical audit.

The Clinical Audit Cycle

The literature highlights many variations of the audit cycle but essentially they all describe a sequence of key activities which drive the process forwards towards the ultimate objective of improving patient care. Failure to complete all the key activities will reduce the likelihood of the audit leading to improvements in patient care.

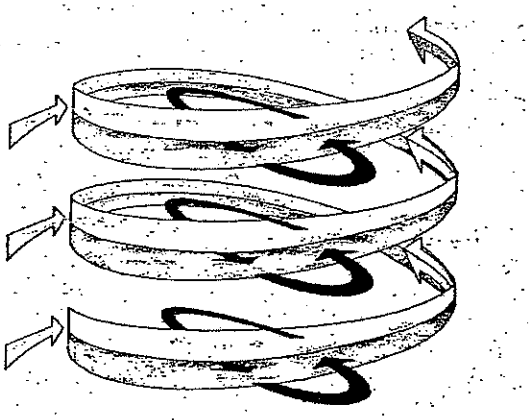
This version of the audit cycle features 6 stages. It may help to think of each stage of the cycle as addressing a question. Answering that question may involve a series of activities.

Figure One: The clinical audit cycle



The clinical audit cycle encourages you to repeat the cycle as often as you deem necessary giving you the opportunity to set progressively higher standards and thus creating a spiral of continuos improvement.

Figure Two: Clinical Audit as a Spiral of Continuous Improvement



What does clinical audit achieve?

The benefits of clinical audit are multiple. The principle benefits relate to its potential to assure or improve patient care, but patients are not the only beneficiaries of the process.

You and your team benefit from
- feedback on performance
- enhanced teamwork
- development of knowledge
- identification/minimisation of problems

The organisation benefits from
- achieving cost benefits through the application of best evidence
- having accurate information about performance and being able to
- demonstrate high quality services
- identification/ minimisation of risks

Patients benefit from
- being reassured that the quality of care is monitored
- improved patient care

Is clinical audit the right approach?

Of all the quality tools available clinical audit offers perhaps the greatest potential for routinely assessing and improving clinical care. However it's not the only approach and it may not be the most appropriate in all circumstances.

Example: Using the right approach for the problem

PROBLEM	APPROACH
You have heard about a new treatment approach for the management of venous leg ulcers and want to compare this new treatment to the treatment you currently use to see which is better.	The most appropriate approach is a research project. Research creates new knowledge about what works and what does not. However clinical audit may be used to check if recommendations from research are being put into practice

PROBLEM	APPROACH
You become aware of a body of evidence that indicates that enforced bed rest following a lumbar puncture has no benefit. You know that currently all your patients who have a lumbar puncture are restricted to lying flat on their back for 12 hours after the procedure.	The most appropriate approach is likely to involve the dissemination of best practice information to colleagues and the development of a local clinical guideline or protocol. A clinical audit project is unnecessary at this stage, as you are already aware that best practice isn't being followed. However, having introduced new guidelines you may then wish to conduct a clinical audit to ensure that the new approach is being followed consistently.

Stage 1 of the Audit Cycle: PLAN

Good planning is critical to the success of an audit project. Many projects start with great enthusiasm, but flounder as a result of poor project design.

Common problems include:

- choosing topics which are of limited significance and hence fail to attract the interest or support of others
- failure to consider who should be involved in the project
- failure to define the topic adequately, leading to inadequate or inappropriate data collection.

1. Identifing and prioritising topics for clinical audit

The time and resources clinicians have available for audit are limited, so it is important to focus your effort on areas which offer the greatest potential. This means identifying areas which are of some clinical significance and which are best suited to clinical audit.

Areas which might indicate that an aspect of care may be of significance include:

- areas of high volume – things which are done frequently
- areas of high cost – things which are complex or costly to undertake
- areas of high risk – things which involve significant risk to patients, staff or the organisation
- areas of concern to service providers – these might include priority areas identified at national, state or local level
- areas of concern to service users – these might be raised as complaints or identified through patient surveys

Clinical audit projects are most effective when there is

- good evidence available about what constitutes best practice
- observed variation in current practice
- potential to introduce change to bring about improvement

Activity One: Identify three aspects of care which you think should be audited and state why.

1. _____

_____

2. _____

_____

3. _____

_____

How can I Prioritorise my topic?

You are likely to be able to identify a number of potential topics for audit and may have to prioritise these. You can prioritise topics by scoring each on a range of criteria. The example below illustrates how some of the criteria discussed might be used to prioritise potential topics.

Example : Use of a criteria matrix to prioritise topics for audit

Topic	Clinical Concern	User concern	High volume	High cost	High risk	Evidence of best practice	Potential for change	Total
Chest pain management	6/10	8/10	7/10	5/10	9/10	9/10	6/10	50
Wound care Management	5/10	5/10	8/10	8/10	7/10	7/10	8/10	38

Activity Two : Use this matrix to score the audit topics you identified in Activity One.

Topic	Clinical Concern	User concern	High volume	High cost	High risk	Evidence of best practice	Potential for change	Total

2. Consider who should be involved

The provision of clinical care is generally a multi disciplinary activity and it follows that the greatest improvements to care are likely when all members of the team are involved in reviewing that care. Decide who should be involved and involve everyone as early as possible.

Remember that the audit may lead to changes in practice and people are generally more amenable to change if they are involved at the outset. You don't need to include every member of staff, from every area affected by the audit, but it does mean that key staff groups should be represented or consulted.

Take measures to ensure that you have the support of key people for whom the project might have implications or who will support the undertaking of the project. So consider discussing your plans with your:

- manager (s) – whose support you may need if any changes are recommended as a result of the audit
- local clinical audit department, local clinical audit committee or quality coordinator – who may be able to provide advice or support in setting up your audit project
- information services area – for advice on the best possible way of collecting data

3. Define the purpose of the audit

The next step is to define what it is you want the project to achieve – this is the aim of your project. The aim is usually a broad statement of intent, but will focus on a specific aspect or aspects of your topic of choice.

Example: Defining the aims and objectives of an audit project

Topic	Aim	Objective
Acute chest pain	To improve the management of patients attending the emergency department with chest pain	To improve the timeliness of treatment for those patients attending the emergency department with chest pain
Anxiety management	To improve the management of patients being prescribed benzodiazepines	To ensure that prescriptions for benzodiazepines are appropriate.

Activity Three: Defining the aims and objectives for your audit

Topic	Aim	Objective

Keep your audit small and focussed. This will ensure the most efficient use of time and resources and increase the likelihood that you will successfully complete your project.

Stage 2 of the Audit Cycle: DEFINING BEST PRACTICE

This stage of the audit cycle is about defining best practice for your area of clinical interest and using this knowledge to develop criteria which can be used to assess the quality of care currently being provided.

1. Where to look for evidence and what to look for...

Your first task is to consider and critically appraise the evidence available for the topic concerned. This requires several important skills, which include knowing where to look for information about evidence-based practice and how to appraise the information you find.

Sources of evidence include databases and journals, particularly those which focus on evidence based material. The information you might find will include:

- Research findings
- Systematic reviews
- Clinical guidelines

Research findings

- Can provide good evidence, but it must be critically appraised to ensure it is of sufficient quality and current enough to be valid and reliable as a basis for practice.
- You will be able to make informed decisions about effective practice when substantial research exists.
- To locate and appraise the research available on the topic of interest will take time and effort.

Systematic reviews

- Constructed so that the evidence has already been located and appraised, systematic reviews make your task much more straightforward.
- The Cochrane Database of Systematic Reviews, is available to Queensland Health staff on QHEPS. It is widely recognised and should be your starting point.

Clinical Guidelines

- The recommendations from good quality **clinical guidelines**, based on good evidence, can also be used to form the criteria against which practice can be.
- Good quality guidelines are available, but again, it is important to appraise these.

Evidence Based Practice Online Learning Program

- More detailed information about looking for and appraising evidence can be found on the on QHEPS, accessed through the Clinician Development site.

2. Consider local circumstances including patient preferences

However good the evidence you have to consider the practical application of research or guidelines to the particular circumstances in which you work. For example, what might work well in a tertiary hospital in the city, where specialists are on hand, may not be practical or appropriate in a rural and remote setting. You should also consider things from the users perspective. Research may indicate that a particular treatment is an effective one, some patients may consider the treatment inappropriate, for example for cultural reasons.

If you decide that recommendations from research or guidelines need to be adapted for local use, take care not to completely undermine the research evidence on which they are based.

In the absence of research or clinical guidelines for your specific area of interest you may need to consider alternative means of establishing a measure against which current practice can be compared. These might include:

Criteria based on consensus of opinion.

- There may be a current or accepted consensus of opinion based on the consideration of a multi-professional panel of experts, that has been published. Where this does not exist you may have to determine best practice through a process of local consensus.

Clinical indicators and benchmarking.

- You might consider national indicators such as ACHS or statewide indicators, such as those developed through the Measured Quality Program.

3. Develop valid criteria based on the evidence

The next step is to develop the criteria against which current practice will be measured. Criteria are explicit statements that define what is being measured. They should be defined locally; based on evidence of best practice; and be considerate of local circumstances and patient perspectives. When setting criteria keep in mind that they should be:

- Relevant – to the achievement of your project aim
- Evidence based – founded on the evidence of best practice
- Achievable – reasonably achieved within current resources
- Measurable - current practice can be measured against it

Having developed your criteria you can then specify an expected level of compliance with the criteria, which will turn your criteria into a standard.

Example: Using evidence of best practice to develop criteria

Audit Aim	Evidence of Best Practice	Criteria	Standard
To improve the management of patients being prescribed benzodiazepines.	Benzodiazepines are indicated for the short-term relief (2-4 weeks) of acute anxiety or insomnia.	1. New prescriptions for benzodiazepines should be for the relief of anxiety or insomnia only. 2. New prescriptions for benzodiazepines should be issued for no longer than four weeks.	1. 100% of all new prescriptions for benzodiazepines should be for the relief of acute anxiety or insomnia. 2. 90% of all new prescriptions for benzodiazepines should be issued for no longer than 4 weeks.

Audit Aim	Evidence of Best Practice	Criteria	Standard
To improve the management of women undergoing caesarean section.	The use of prophylactic antibiotics in women undergoing caesarean section substantially reduces the incidence of fever, endometritis, wound infection, urinary tract infection and serious infection after caesarean section.	Women undergoing caesarean section should be offered prophylactic antibiotics unless contraindicated.	90% of women undergoing caesarean section should be offered prophylactic antibiotics unless these are contraindicated.

Activity Four: Try to develop at least one criterion for your audit topic of interest

Audit Aim	Evidence of Best Practice	Criteria	Standard

Stage 3 of the Audit Cycle:
MEASURING CURRENT PRACTICE

This stage of the audit cycle is concerned with collecting data. However before you can begin to collect data there are a number of things you need to consider.

1. Identify patient population

The entire set of people to whom your project applies is called the **target population.** It is important to define this group accurately by specifying any inclusion or exclusion criteria.

Example: Defining your target population

Aim	Criteria	Target Population
To improve the management of patients being prescribed benzodiazepines.	New benzodiazepines prescriptions for the relief of severe anxiety or insomnia should be issued for no longer than four weeks.	All patients attending their GP whom are given a first prescription for benzodiazepines for the relief of anxiety or insomnia.
To improve the management of women undergoing caesarean section.	Women undergoing caesarean section should be offered prophylactic antibiotics unless contraindicated.	All women undergoing elective or emergency caesarean section for whom antibiotics are not contraindicated.

You also need a means of identifying this population – a source that will identify all the patients who match the inclusion criteria of your target population. Sources might include

- HBCIS
- Local clinical databases
- Patient registers

Activity Five: Try to identify the patient population to whom your audit relates and at least one source of information on your target population.

2. Calculate a sample size

Once you have defined your target population and found a means of identifying this population, you will need to consider how many of the patients who match the inclusion criteria for your audit you are going to review. It may not be practical to include each and every patient from your target population, in which case you will need to identify a representative sample from which inferences about the total population can be made.

In deciding how many patients to review, you will take into account:

Practical considerations
- time available
- access to data
- cost

Epidemiological considerations
- frequency and season of events

Statistical considerations
- degree of statistical confidence wanted in the findings

Typically, a larger sample size will take longer and cost more, but is be more likely to represent the population from which it was drawn and allow you a greater degree of confidence about the results.

The following is a very rough guide to determining a sample size. If you are in any doubt and need to be very confident about your results consult some with statistical expertise.

TARGET POPULATION	SUGGESTED SAMPLE SIZE
100	75 or 100
200	125
300	175
400	200
500	220

TARGET POPULATION	SUGGESTED SAMPLE SIZE
600	240
800	260
1000	275
2000	325
3000	350

At the end of the day there is no easy answer to the question of how big a sample should be. The most practical advice we can offer is that your sample should be a size to convince people to act on the results. You should agree in advance on a sample size that if the results suggest you would all be prepared to change practice, if necessary.

3. Deciding a sampling method

Equally important is the way in which the sample is chosen to avoid bias and ensure that your sample is representative of the population. There are 2 main approaches.

Consecutive sampling

- Choose a point in time to commence and include every patient from that point forward until you achieve your sample size.
- It is important to ask yourself if there is any reason to suspect that the timeframe might not be representative of what happens all the time.

Random sampling

- More robust approach
- Each case in the target population is allocated a number and a sample is selected from this randomly.
- Random numbers can be taken from a published random numbers table or be generated from commonly used software such as Microsoft Excel or from more complex statistical programs.

4. Develop the audit tool and method of data collection

The next issue to consider is what data to collect. The data you may wish to collect is likely to include:

- Basic Demographic Data
    - age and sex - can help you to demonstrate that your sample is representative of your target population
- Data which relates to your clinical question and which will help you to answer that question

The criteria you set form the basis of your audit. It can be helpful to think of them as a series of questions that your audit will address as this will help to focus your attention on the data you will need to collect.

Example: Using your audit criteria to identify the data to be collected

Criteria	Focussed Clinical Question	Data to be collected
New prescriptions for benzodiazepines, for the relief of anxiety or insomnia, should be issued for no longer than four weeks.	Are new benzodiazepine prescriptions, for the relief of anxiety or insomnia, issued for 4 weeks or less?	Initial or repeat prescription. The indication for the prescription. The period of time covered by the prescription.

Avoid the temptation to collect too much data. It's tempting to collect data because "it might be useful" or "it would be interesting to know", but the reality is that this wastes valuable time. So if it does not have a bearing on the question(s) that you are trying to answer, don't collect it.

Now you need to think about where you might find the data that you need. In an ideal world, all the necessary data items for an aspect of clinical care important enough to be audited would be routinely collected and readily accessible. The reality is that our information management systems are not yet that sophisticated.

Some of the data items you require may be available from your hospital information management systems, but it is likely that you will have to consider other sources of data too. These might include other databases and paper record, particularly patient charts.

Some of the data you require may not be collected routinely at all and you may have to devise a means of capturing this data. This might involve creating a record sheet on which clinicians record clinical data at the time of consultation with the patient, or developing a questionnaire or interview schedule to obtain information from staff or patients.

Activity Six: Identify the data items you might need to collect for your audit project and their likely source.

The availability of data may influence the type of audit you undertake. Clinical audits may be

- Retrospective – care has already been provided and the data required exists
- Prospective – care has yet to be provided and data is collected as care is provided or following care provision

The example below illustrates the pros and cons of each approach. Sometimes a combination of the two approaches is required.

Example: The advantages and disadvantages of two types of audit

Timing of Audit	Application/Advantages	Disadvantages
Retrospective	Useful when the data you require has already been collected. Generally, a quick and low cost method.	You may discover data is incomplete, as it was not collected specifically for your purpose. If you need to track patients following discharge this may be difficult.
Prospective	Useful when the data you require is not routinely collected. Tracking of patients is easier allowing follow-up post-discharge.	Data collection may take longer as it may be undertaken over a period of months.

The three main methods of collecting data are:

- Data abstraction
- Interviews
- Questionnaires

Each method has advantages and disadvantages however you will be influenced by the source of the data you require. Aspects of clinical care provision are most commonly collected by means of data abstraction sheets, while the knowledge or views of staff or patients are more usually collected by means of questionnaire or interview.

Data being collected **retrospectively** is most likely to involve a source such as a patient record. This will be entered directly into a database or, more commonly, a data abstraction form. Data being collected **prospectively** usually involves data being entered at the time of a consultation with a patient or soon after. Data abstract sheets should specify precisely the data that is to be recorded. They should allow for data being recorded in a logical sequence as the consultation progresses. In all cases the better you design your method of collecting data the more complete and accurate your data will be.

It is always a good idea to pilot the tool to allow any problems with it to be identified and rectified.

5. Decide who will collect the data

To determine the most appropriate and reliable person/persons to collect the data consider:

- their understanding of the audit and its aims
- their familiarity with the source of data, such as patient charts
- any need for specialist knowledge of clinical conditions or care processes

Stage 4 of the Audit Cycle: ANALYSE AND COMPARE

Having collected your data the next stage involves collating and analysing. You will make a comparison of the results with your preset criteria or benchmark and identify the best means of displaying your results.

1. Collating and analysing data

How you collate and analyse your data depends on a number of factors including:

- the type of data you have collected, its volume and complexity
- whether your audit involved the collection of data from the whole of your target population or a sample

Quantitative analysis

- Concerned with numerical data – probably the more common form of data used in audit. Such analysis strikes fear in a lot of people who worry that a good knowledge of statistics is required. This is not necessarily the case as very often straightforward counts and the calculation of percentages is all that is required.
- If your audit involved a sample of your target population it is recommended that you calculate the confidence intervals of your results. Simple statistical packages, such as Epi Info can do this for you. This is a free epidemiological system that is available on the Internet. If more complex statistical methods need to be applied then seek help.

Qualitative analysis

- Concerned with words rather than numbers and is most commonly used to analyse comments made in questionnaires, the transcripts of interviews or focus groups. Although this can be a time consuming process, it is an effective means of assimilating what can be a very rich source of information.

Essentially the process involves summarising data and grouping it into categories or themes. Begin by reading and re-reading the data to familiarise yourself. As you read it is likely that a number of themes will emerge which can become your starting point. Then start to pick out data on different themes. Two practical ways of doing this are to:

- use different coloured highlight pens to identify narrative on particular themes
- cut narrative up and rearrange into themes using either scissors and glue with print or cut and paste on a computer

When you have grouped together comments on the same theme you will find that a number of sub-themes emerge, which you may be able to quantify in terms of the number of comments made.

The following example uses extracts from questionnaires in which postnatal women were asked a number of questions about their postnatal stay. One of the themes to emerge concerned the support they received with breastfeeding while in hospital.

Example: Identification of themes in narrative

Comments on the theme of breastfeeding	Sub theme & number of comments on this theme
"The emphasis the nurses placed on breastfeeding made those of us who chose not to feel very uncomfortable." "I felt pressured to breastfeed when I didn't really want to."	Pressure to breastfeed (2 comments)
"The midwives spent a lot of time helping me breastfeed my baby - I felt much more confident by the time I went home." "The midwives were very reassuring and gave excellent advice and help, which led to me breastfeeding successfully" "The assistance the midwives gave with breastfeeding was first class." "The midwives were so patient helping me to breastfeed when I had difficulty – without their support I would have given up."	Good support given (4 comments)
"I found I was given a lot of differing advice on breastfeeding." "There were too many different people, with too many different ideas about breastfeeding." "There was a lot of conflicting advice on breastfeeding - each change of shift brought another point of view." "I got so confused with all the different advice I was given on breastfeeding I decided to go home early and rely on my instincts."	Conflicting advice given (4 comments)
"I felt more information on breastfeeding was required, especially advice specific to any problems you might be having, rather than just general advice." "I was disappointed not to get more advice about breastfeeding – I left hospital with a lot of unanswered questions"	Insufficient advice given (2 comments)

2. Comparison of results with preset criteria or benchmark

It is this comparison which provides you with the means of measuring your performance. That is identifying how good or bad your results are.

3. Presenting your results

You may wish to develop a simple report. This could form the basis of a report on the project at a later stage or the basis of a publication. Alternatively you may just find it a useful means of putting together all the information about the project about which you may be asked questions when you begin to share the results with others. A simple format for this report would include

- rationale – why you chose to audit this particular topic
- evidence base – the evidence on which you based your criteria
- criteria and standards – those which you developed to compare practice against
- methods – sample size, sampling methods, data collection methods and tools
- results – summary of the data analysis
- involvement and costs – details of those involved and any direct costs of the project to date
- references - for the evidence presented

Most people respond best to visual displays of results so consider displaying your results in simple graphical formats such as, pie charts and bar graphs.

Stage 5 of the Audit Cycle: IMPLEMENTING CHANGE

This stage of the audit cycle is concerned with sharing the results of your audit, deciding whether change is warranted and, if it is, planning and introducing change. People have a tendency to dislike change. Implementing change is often the most difficult phase of the audit process and the point at which the project may lose momentum or stall altogether. However an understanding of the change process can help you.

1. Share your results

All those clinicians involved in the audit need to be given the opportunity to review the results; contribute to their interpretation and the decision making about any action that may be required.

When presenting your results the following points are important to remember:

- All patient data should be de-identified to assure patient confidentiality
- Results should be presented as an aggregate. Demonstrating team outcomes, rather than as a comparison of individual results, unless there has been prior agreement to do otherwise.
- Results should be presented objectively and should highlight both areas of good practice and areas where further work may be required

2. Decide if change is warranted

What happens next depends on the results. You may be satisfied with the level of performance suggested by your results, in which case you may simply wish to reflect on what has contributed to this success. Celebrate the achievement and go on to look at another aspect of care. Alternatively you may feel the results reflect a level of performance where there is scope for improvement. If this is the case the same effort which went into planning the initial stage of your audit needs to be applied to planning and bringing about change.

Do not make the mistake of assuming that simply feeding back the results of an audit to those concerned will in itself, bring about change This is rarely the case.

3. Explore the situation fully, identify the causes of the problem and establish some solutions

Once you have decide that change is warranted you will need to explore why your results were not as good as you might have wished. It is important to involve all those for whom there is a likelihood of change - people are more likely to be willing to implement change if they have been involved in the decision making. Start by thinking about the 'who', 'what', 'where', 'why' and 'when' of the situation. When you have a fuller picture of the situation you can begin to tease out the root cause or causes of the problem. Tools which might assist you include:

- Brainstorming
- Flow charts or other process diagrams
- Cause and effect diagrams
- Data collection

Thinking broadly about the situation or problem helps to prevent the implementation of quick fixes to problems, which address only the symptoms rather than the causes. When you have a good understanding of the problems you can start to consider the solutions. This involves identifying possible solutions and selecting the most appropriate for implementation.
Tools, which might assist you, include:

- Brainstorming
- Criteria for decision making

It can be beneficial to ask someone who is not involved in the delivery of the service you are reviewing, to facilitate your meetings, particularly if there are some contentious issues.

4. Develop an action plan

Putting you proposed solutions into action needs some further planning. In particular you will need to identify

- What the solutions entail – ie a list of actions
- Named person responsible for each action
- Time scale for each action

While you are drawing up this action plan it is worth trying to foresee any potential barriers there might be to your introducing the changes and to include in your plan strategies for overcoming these.

Example: Developing strategies for overcoming barriers to change

POSSIBLE BARRIERS	POTENTIAL STRATEGIES
Resource implications	Provide managers with a cost/ benefit analysis or suggestions as to where efficiencies might be made elsewhere
Strong resistance from one or more individuals	Engage the support of others. For example, in most organisations there are identifiable opinion leaders - those clinical experts who are well respected, influential and known for their ability to lead by example. Such individuals may well be able to sell your changes to those who are doubtful.

5. Implementation of change

A good action plan should be straightforward to implement. However try to time the introduction of any changes so as not to coincide with any other activities which might detract interest away from what you are doing.

Stage 6 of the Audit Cycle: MONITOR

The final stage of the audit cycle involves monitoring. It is only by completing this important stage that you can determine whether the changes you implemented were effective in improving care. Essentially it involves reauditing by measuring practice and comparing this to your preset criteria a second time.

1. Reaudit

There is no definitive answer to the question of when you should reaudit. The guiding principle is that you need to leave sufficient time for change to have been effected and for sufficient patients in your target population to experience the changed conditions.

You should use the same strategies as you did in the initial audit, ie the same sample size and sampling methods, data collection tools and analysis.

If the results of the reaudit suggests improvement has been achieved - well done! You may decide that there is further room for improvement. Set yourself a higher standard, introduce further change and re-audit again. Alternatively you may feel satisfied with your achievement and decide to start the audit cycle again with a different aspect of care.

If reaudit suggests improvement has not been achieved or is limited you may need to review the work you did on implementing change. You may need to undo some of the changes you introduced or reinforce these with additional changes. You may need to consider some of the solutions you came up with and did not use or find completely new solutions.

2. Take steps to maintain and sustain change

When the results of your reaudit suggest that the changes you have implemented have been successful don't take your eye off the ball completely. It is very common, over time, for people to drift back to old ways. Be vigilant to ensure that the changes you made remain in place and if necessary consider some strategies for reinforcing them eg reminders, updated policies reflecting the changes etc.

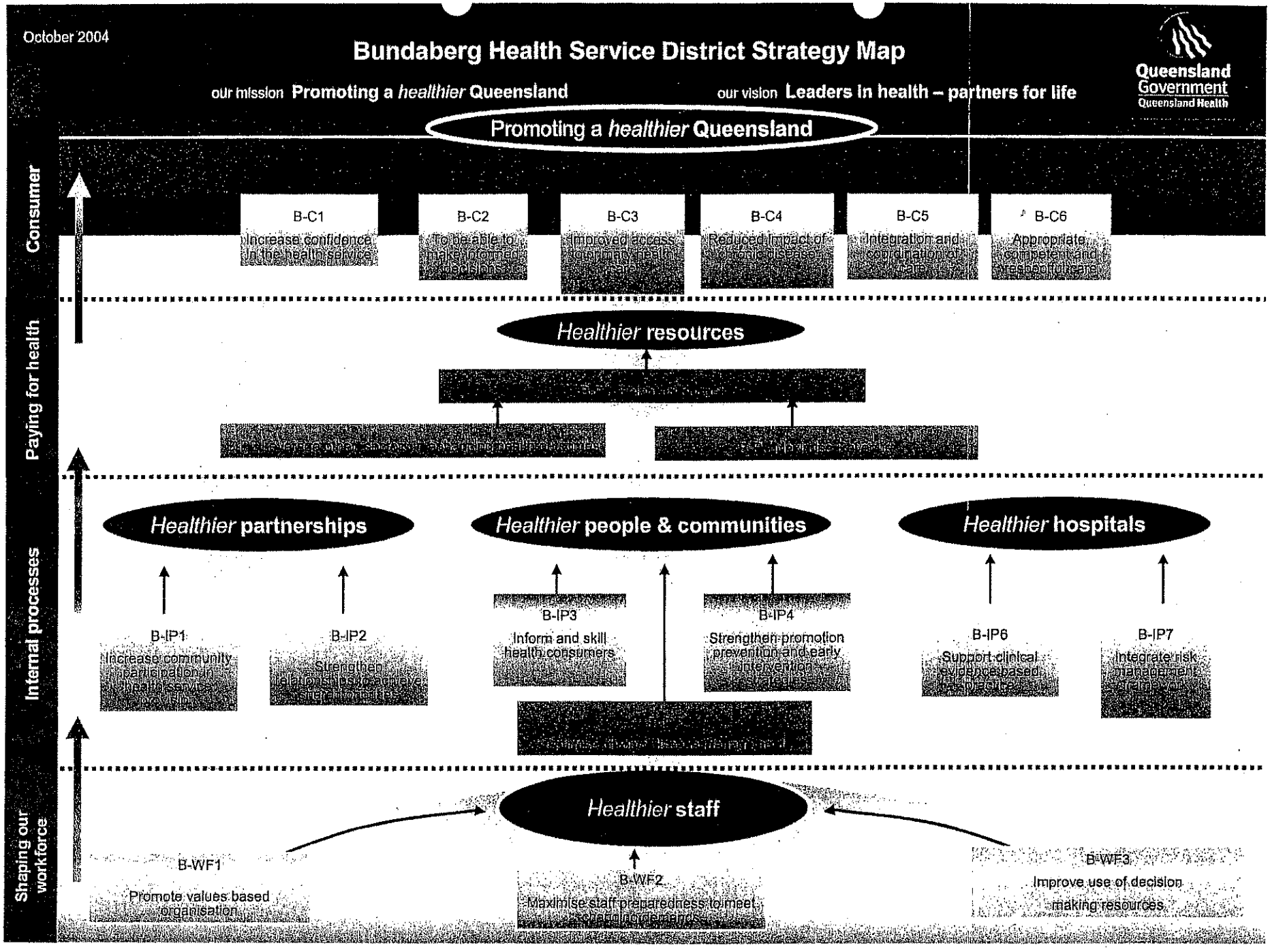
Providing people with evidence of the positive impact of change can encourage and sustain change. Be sure to draw attention to, and emphasise the results of, any reaudit that indicates improvement.

3. Reflect on how the audit was done

This is a good time to reflect on what you learnt from doing the audit. What was done well? What could have been done better? Put this learning into practice when you do your next audit.

Appendix: Online resources for clinical audit (last accessed May 2003)

Education and advice on conducting clinical audit	National Institute For Clinical Excellence Principles for Best Practice in Clinical Audit Radcliffe Medical Press 2002	http://www.nice.org.uk/docref.asp
	Ministry of Health Towards Clinical Excellence New Zealand Ministry of Health2002	http://www.moh.govt.nz
	United Bristol Healthcare NHS Trust A Practical Guide To Clinical Audit (Online)	http://www.ubht.org.uk
Systematic reviews and other critically appraised topics	The Cochrane Library	http://www.cochrane.org.au/
	Centre for Reviews and Dissemination	http://www.york.ac.uk/inst/crd
	Health Evidence Bulletins	http://www.uwcm.ac.uk/uwcm/lb/pep
Clinical guidelines	National Institute for Clinical Excellence (NICE) guidelines	http://www.nice.org.uk
	Scottish Intercollegiate Guideline Network (SIGN) guidelines	http://www.sign.ac.uk
	National Guideline Clearing House	http://www.guideline.gov/index.asp
	New Zealand Guideline Group	http://www.nzgg.org.nz
	National Health and Medical Research Council Clinical Practice Guidelines	http://www.health.gov.au/nhmrc/publications/cphome.htm
Clinical Indicators	Australian Council on HealthCare Standards (ACHS) Clinical Indicator Data	http://www.achs.org.au


October 2004
Bundaberg Health Service District Strategy Map
our mission Promoting a healthier Queensland
our vision Leaders in health – partners for life
Queensland Government
Queensland Health
Promoting a healthier Queensland
Consumer
B-C1
Increase confidence in the health service
B-C2
To be able to make informed decisions
B-C3
Improved access to primary health care
B-C4
Reduced impact of chronic disease
B-C5
Integration and coordination of care
B-C6
Appropriate, competent and responsive care
Paying for health
Healthier resources
Internal processes
Healthier partnerships
Healthier people & communities
Healthier hospitals
B-IP1
Increase community participation in health service planning
B-IP2
Strengthen relationships to achieve health outcomes
B-IP3
Inform and skill health consumers
B-IP4
Strengthen promotion, prevention and early intervention
B-IP6
Support clinical evidence-based practice
B-IP7
Integrate risk management systems
Shaping our workforce
Healthier staff
B-WF1
Promote values based organisation
B-WF2
Maximise staff preparedness to meet changing demands
B-WF3
Improve use of decision making resources

UK4

VR5

Queensland Government
Queensland Health

Report Criteria

Bundaberg Health Service District

Patients with diagnosis of Disruption of Operation Wound (T81.3) discharged from Surgical Ward between 01/01/2003 and 30/04/2004

Confidentiality Statement

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Variations between this report and other reports of similar content may occur due to selection criteria or timing differences.
If you have any further enquiries please contact DQDSU on Extensions 2208, 2207 or 2277.

Data as at 14/12/2004

Encounter Number	Length of Stay	Discharge Date	Principal Diagnosis	ICD_SHORT_DESC
000009-7	42	05/10/2003	K45.0	Oth sp abdo hernia w obs
000910-2	70	16/03/2004	K57.82	Diverlitis intest NOS w perf abs wo haem
012769-3	9	04/06/2003	C18.7	Mal neo of sigmoid colon
030054-5	10	24/02/2003	T81.3	Disrupt operation wound
047475-6	7	16/04/2004	T81.3	Disrupt operation wound
049114-2	19	03/05/2003	D12.6	Ben neo of colon unspec
058347-4	3	11/04/2004	T81.41	Wnd infect foll proc
093077-5	16	04/02/2003	K57.21	Divertic large intest w haem perf & abs
09[illegible]3-10	4	13/07/2003	T81.3	Disrupt operation wound
095623-8	43	25/04/2003	T81.41	Wnd infect foll proc
124584-2	15	07/10/2003	I72.3	Aneurysm of iliac artery
128142-2	4	07/07/2003	T81.3	Disrupt operation wound
133338-4	44	28/04/2004	T81.3	Disrupt operation wound

Queensland Government
Queensland Health

Bundaberg Health Service District

Wound Dehiscence

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Data as at 15/12/2004

106934-3

Admission Date	25/03/2003
Discharge Date	25/03/2003
Admission Status	2 - Elective Admission
DRG and Desc	G44C - Other Colonoscopy, Sameday
State ALOS	
Hospital LOS	1
Age	48

Proc Code

1.00	32090-00	Fibreoptic colonoscopy to caecum

Surgery Date	Surgeon	Theatre Minutes
25/03/2003	FAI	38

Principal/Secondary Flag	Diagnosis Code & Description	
P	K57.30	Diverticulosis of large intestine without perforation, abscess or mention of haemorrhage

Queensland Government
Queensland Health

Bundaberg Health Service District

Wound Dehiscence

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Data as at 15/12/2004

106934-5

Admission Date	30/05/2003
Discharge Date	04/06/2003
Admission Status	1 - Emergency Admission
DRG and Desc	T61B - Postoperative & Post-Traumatic Infections Age<55 W/O Catastr or Severe CC
State ALOS	
Hospital LOS	5
Age	48

Proc Code

1.00	95550-01	Allied health intervention, social work

Surgery Date	Surgeon	Theatre Minutes

Principal/Secondary Flag		Diagnosis Code & Description
P	T81.41	Wound infection following a procedure
P	Y83.6	Removal of other organ (partial) (total)
P	Y92.22	Health service area
S	Z63.0	Problems in relationship with spouse or partner
S	Z72.0	Tobacco use, current

VKO

Queensland Government
Queensland Health

Report Criteria

{Enctr.Discharge Fiscal Period} in {?StartFiscalPeriod} to {?EndFiscalPeriod} and {Enctr.Inout Code} = "I" and {Enctr.Facility Code} = "00062" and {Enctr.Discharge Fiscal Year} = {?FiscalYear} and {R_ICD_DIAG.ICD_VERSION} = "43" and {R_ICD_PROC.Code_Block} in ["858", "859", "860", "872", "875", "876", "877", "878", "879", "880", "881", "883", "887", "895", "896", "897", "907", "913", "914", "915", "916", "917", "918", "934", "936", "976", "978", "979", "980", "985", "986"] and {R_ICD_PROC.ICD_VERSION} = "43"

Bundaberg Health Service District

Wound Dehiscence Indicator

Displaying Months between July, 2002 and June, 2003

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Data as at 17/06/2005

Discharge Month	No. of Wound Dehiscence	Number of Abdominal Operations	Index %
July	0	7	0.00
August	2	9	22.22
September	0	3	0.00
October	0	5	0.00
November	0	10	0.00
December	0	8	0.00
January	0	7	0.00
February	1	9	11.11
March	0	9	0.00
April	0	7	0.00
May	1	10	10.00
June	3	15	20.00
TOTAL	**7**	**99**	**7.07**

Wound dehiscence identified from ICD-10 Code T81.3

Queensland Government
Queensland Health

Report Criteria

{Enctr.Discharge Fiscal Period} in {?StartFiscalPeriod} to {?EndFiscalPeriod} and {Enctr.Inout Code} = "I" and {Enctr.Facility Code} = "00062" and {Enctr.Discharge Fiscal Year} = {?FiscalYear} and {R_ICD_DIAG.ICD_VERSION} = "43" and {R_ICD_PROC.Code_Block} in ["858", "859", "860", "872", "875", "876", "877", "878", "879", "880", "881", "883", "887", "895", "896", "897", "907", "913", "914", "915", "916", "917", "918", "934", "936", "976", "978", "979", "980", "985", "986"] and {R_ICD_PROC.ICD_VERSION} = "43"

Bundaberg Health Service District

Wound Dehiscence Indicator

Displaying Months between July, 2003 and June, 2004

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Data as at 17/06/2005

Discharge Month	No of Wound Dehiscence	Sum Number of Abdominal Operations	Index %
July	1	19	5.26
August	0	15	0.00
September	0	10	0.00
October	1	12	8.33
November	0	11	0.00
December	0	11	0.00
January	0	8	0.00
February	0	8	0.00
March	1	11	9.09
April	0	15	0.00
May	1	11	9.09
June	0	11	0.00
TOTAL	**4**	**142**	**2.82**

Wound dehiscence identified from ICD-10 Code T81.3

Queensland Government
Queensland Health

Report Criteria

{Enctr.Discharge Fiscal Period} in {?StartFiscalPeriod} to {?EndFiscalPeriod} and {Enctr.Inout Code} = "I" and {Enctr.Facility Code} = "00062" and {Enctr.Discharge Fiscal Year} = {?FiscalYear} and {R_ICD_DIAG.ICD_VERSION} = "44" and {R_ICD_PROC.Code_Block} in ["858", "859", "860", "872", "875", "876", "877", "878", "879", "880", "881", "883", "887", "895", "896", "897", "907", "913", "914", "915", "916", "917", "918", "934", "936", "976", "978", "979", "980", "985", "986"] and {R_ICD_PROC.ICD_VERSION} = "44"

Bundaberg Health Service District

Wound Dehiscence Indicator

Displaying Months between July, 2004 and June, 2005

Confidentiality Statement

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Data as at 17/06/2005

Discharge Month	No of Wound Dehiscence	Number of Abdominal Operations	Index %
July	0	12	0.00
August	0	13	0.00
September	0	15	0.00
October	0	15	0.00
November	0	17	0.00
December	0	14	0.00
January	0	5	0.00
February	2	17	11.76
March	0	10	0.00
April	0	12	0.00
May	0	5	0.00
TOTAL	**2**	**135**	**1.48**

Wound dehiscence identified from ICD-10 Code T81.3

UKT

BUNDABERG HEALTH SERVICE DISTRICT
MEETING AGENDA

MEETING OF:	ASPIC Clinical Service Forum
MEETING No:	10/04
DATE:	13th October, 2004 (September meeting cancelled – no minutes)
TIME:	1215hrs
VENUE:	HRM Meeting Room (Small Room)

- **Presentation**
- **Apologies**
- **Confirmation of Minutes**
- **Correspondence**

AGENDA

Business Arising

Item No.	EQuIP Function	Topic	Person Responsible
04/04-6	CC	Wound Dehiscence	J. Patel
07/04-5	L & M	Risk Management ASPIC Registrar – Advance Health Directive	G. McDermid
06/04-7	CC	Joint Replacement Pathway	M. Mears and D. Jenkin
07/07-9	SPE	New Guidelines for Risk Management for Procedures	Committee Members/ D. Levings

Standing Agenda

Item No.	EQuIP Function	Topic	Person Responsible
10/04-1	IM	Performance Monitoring – Monthly and Cost centre Reports	Head of Departments
10/04-2	SPE	Infection Control	G. Aylmer
10/04-3	IP	Quality Management	Head of Departments
10/04-4	IM	Theatre Booking Report	K. Smith
10/04-5	L & M	Risk Management	Head of Departments
10/04-6	CC	Clinical Indicators	Head of Departments

New Business

Item No.	EQuIP Function	Topic	Person Responsible
10/040-7		Morbidity / Mortality Subcommittee	M. Carter

Agenda to be compiled and distributed by Chairperson/Minute Taker one week prior to meeting

BUNDABERG HEALTH SERVICE DISTRICT
RECORD OF MEETING

Meeting of: ASPIC Clinical Service Forum

Meeting No: 10/04

Date: 13th October, 2004 **Start Time:** 12.15hrs

Present: Martin Carter, Gwenda McDermid, Jay Patel, Toni Hoffman, Margie Mears, Gail Doherty, Darren Keating, Peter Leck, Dianne Jenkin

Apologies: Jenny Kirby, Leonie Raven, Gail Aylmer, Karen Smith.

Confirmation of Minutes: Martin Carter **Seconded:** Margie Mears

Minute Taker: Toni Hoffman

Correspondence: Nil

Business Arising

Item No	EQuIP Function	Topic	Discussion	Agreed Action & Outcome, Person Responsible, and Time Frame	Open/Closed
04/04-6	C of C	Wound Dehiscence		Jay Patel	Item Closed. Wards will obviously continue to report Wound Dehiscence as adverse event/outcome.
06/04-7	C of C	Joint Replacement Pathway		Di and Margie working on them	Open / Ongoing. Di Jenkin and Margie Mears.
07/04-5	L & M	Risk Management ASPIC Register – Advance Health Directive	Gwenda and Di discussed AHD, not easily found, process in place but not adequate. Risk Register done , but process of finding/tracking AHD is not adequate	Risk rating of medium/ process needs to be addressed properly, Requires further education/discussion.	Di to ask Joanne Elmes to present AHD
07/04-9	SPE	New Guidelines for Risk Management for Procedures	Most of this is supposed to be in place by Jan next year.	Darren will chase up Risk Management procedure	Open. Darren Keating to Follow up and present back to ASPIC.

Standing Agenda					
Item No	**EQuIP Function**	**Topic**	**Discussion**	**Agreed Action & Outcome, Person Responsible, and Time Frame**	**Open/Closed**
10/04--1	IM	Performance monitoring Monthly and Cost centre reports	ICU	Well over budget due to large number of vents and OT required to care for them. Discusssion ensued about ways to change this. Surgical ward over budget due to S/L and increased acuity of patients. Alos the number of patients that required specialling. PAC In budget. OT Over budget due to joints.	Open Ongoing All Staff.
10/04-2	SPE	Infection Control		Apologies from Gail Nil reported	Open
10/04-3	IP	Quality Management	ICU DSU Surgical ward. OT	Completed ACS study, Collecting Aortic data. CI collaborative Continues and our results look very good Updating Chemo package. Survey of staff ongoing redoing of manual. Doing Consent audit.	Open
10/04-4	IM	Theatre booking Report	Slowly long term Cat 2 list rising	Huge influx of cat ones , and loss of anaesthetists.	Open
10/04-5	L & M	Risk Management	AHDs ICU Surgical	 Problem with Blood not being able to be obtained.	Open Martin
10/04-6	C of C	Clinical Indicators	ICU Surgical DSU PAC	Ongoing.AORTIC, Ongoing	Open

New Business					
Item No	**EQuIP Function**	**Topic**	**Discussion**	**Agreed Action & Outcome, Person Responsible, and Time Frame**	**Open/Closed**
10/04-7		Morbidity / Mortality Subcommittee	Discussion ensued about whether The old format of looking at the arrest data in the hospital should be changed to a formal morbidity and mortality meeting, with all involved staff invited	Suggested that Terms of Reference be developed and then represented back to the meeting.	Open. Martin Carter will develop.

Meeting Closed:
Next Meeting: 10.11.04

JK8

Queensland Government
Queensland Health

Selected DRG Report
Surgical Ward
Bundaberg Base Hospital

DRG	Long Description	Total Discharges	Hospital ALOS	State ALOS	Weighted Separations

Displaying Period Between January and March 2002/03

Surgical Ward

H04B	Cholecystectomy-CDE-CSCC	18	2.11	1.51	45.94
J06A	Maj PR malig breast cond	8	3.75	3.43	25.36
H04A	Cholecystectomy-CDE+CSCC	5	6.80	4.95	25.92
J06B	Maj PR n/malig breast dis	2	2.00	1.37	4.83
J07B	Min PR n/malig breast dis	2	4.50	1.05	2.47

Queensland Government
Queensland Health

Top 10 DRG
Bundaberg Base Hospital

Top 10 DRG's by Ward. Reports supports drill down to Episode Level

Displaying Period Between January and March 2002/03

Queensland Government
Queensland Health

Bundaberg Health Service District

Laparoscopic Cholecystectomy

Displaying Months between July, 2003 and December, 2003

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Data as at 16/06/2005

H04A Cholecystectomy W/O Closed CDE W Catastrophic or Severe CC — State ALOS 5.28

30445-00 **Laparoscopic cholecystectomy**

Non-Same Day

Number of Patients	4	ALOS	4.25
Total Actual Cost	$ 19,803	Weighted Separations	10.59
Average Actual Cost/Patient	$ 4,951	Cost per Weighted Seps	$ 6,616

H04B Cholecystectomy W/O Closed CDE W/O Catastrophic or Severe CC — State ALOS 1.19

30445-00 **Laparoscopic cholecystectomy**

Non-Same Day

Number of Patients	45	ALOS	1.73
Total Actual Cost	$ 130,467	Weighted Separations	57.82
Average Actual Cost/Patient	$ 2,899	Cost per Weighted Seps	$ 3,257

30446-00 **Laparoscopic cholecystectomy proceeding to open cholecystectomy**

Non-Same Day

Number of Patients	4	ALOS	4.25
Total Actual Cost	$ 19,191	Weighted Separations	5.21
Average Actual Cost/Patient	$ 4,798	Cost per Weighted Seps	$ 3,257

Report Criteria

{Enctr.Discharge Fiscal Year} = {?FiscalYear} and
{Enctr.Discharge Fiscal Period} in {?StartFiscalPeriod} to {?EndFiscalPeriod} and
{Enctr.Facility Code} = {?Facility} and
{Enctr.Inout Code} = "I" and
{Enctr.Principal Procedure} in ["30449-00", "30448-00", "30446-00", "30445-00"] and
{R_PRINCIPAL_ICD_PROC.ICD_VERSION} = "43" and
{R_ARDRG.ARDRG_VERSION} = "4" and
{R_WEIGHTS.HFM_PHASE} = "8"