Nottingham University Hospitals NHS
NHS Trust

Audiology

Procedure

Quality Monitoring

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Target audience:	All Audiology Staff
Lead Executive:	Head of Audiology
Author(s):	Craig Tilt – Project Facilitator Kevin Hole – Quality lead, Children's Audiology Naomi Oglesby - Quality lead, Adult Audiology
Consultation with:	Claire Benton, Head of Audiology Richard Nicholson, Clinical Lead – Adult Audiology Jennifer Parker-George, Clinical Lead – Diagnostic Audiology Karen Willis, Clinical Lead – Paediatric Audiology

Contents

1. Introduction

Quality Monitoring Activity (QMA) forms an essential part of Quality throughout the Audiology Service. This document details the Service's approach, requirements & recommendations for any current or prospective QMA Audits.

2. Executive Summary

Whilst the contents of this document are to be applied to all QMA types used within the service, there is additional detail provided for clinical QMA's to ensure they conform to the requirements of the Trust's CET (Clinical Effectiveness Team), including the requirement that they be registered on the Trust's intranet.
The contents of this document is intended to be applicable to the majority of QMAs undertaken within the department, however it is noted that its entirety will not apply to certain QMAs i.e. Service evaluations.

3. Procedure Statement

To comply with national recommended procedures and guidance, Audiology staff must meet the responsibilities of their individual roles as defined in Section 5 (Roles & Responsibilities), and must adhere to the practices defined in Section 6 and associated documents defined in Section 11 (References).

4. Definitions

Term	Definition
QMA	Quality Monitoring Activity
CAPA	Corrective and Preventative Actions

5. Roles and Responsibilities

5.1. Senior Leadership Team/Lead Executive

The Senior Leadership Team (SLT) or Lead Executive are responsible for approving this document and ensuring that it is reviewed in line with Trust Policy.

5.2. Audiology Staff

Audiology staff are responsible for accessing, reading, understanding and following this document where it applies to their job role.

6. Procedure

6.1. Identification of QMA need

There are three main routes to identify the need for a QMA:

- The CAPA team identify a need based on route cause analysis of a corrective action. This is raised with the relevant service clinical lead. A QMA lead is identified and the proposed QMA allocated to and discussed with them. The CAPA team may also identify the need in response to concerns raised through Preventative actions.
- A clinical lead identifies a need. A QMA lead is identified and the proposed audit allocated to and discussed with them.
- A member of staff identifies a need. This is discussed with the appropriate clinical lead.

Additionally, following the review of an existing QMA, a gap may be found in our quality assurance and an additional QMA is required to fill it.

6.2. Developing a QMA

Before a QMA is proposed & formally put into action, it is vital that time is taken to develop it.

The following questions should be considered:

- What is the QMA's scope?
- Are there any current QMA's that cover the same scope?
- What other QMA's are on the QMA schedule?
- How frequently will the QMA be carried out? (please note that all QMA's are expected to adhere to the financial year)
- What will the QMA methodology be?
- What will the QMA's questions be and can they be easily understood?
- If there are identified KPI criteria, what are they?

Additionally, when questions have been agreed upon, it is important to consider what their individual target pass rate should be (section 6.2.2).

6.2.1. QMA methodologies

- **Audits:** Audits are a formal documented examination of the quality or condition of an area or service. Audits can be broken down into 2 different types:

    - **Vertical Audit:** This examines more than one element in a process.

    - **Horizontal Audit (also includes Baseline Audits):** This examines one element in a process across the service (For example, this could examine real ear measurements carried out throughout the department).
      The first time a Horizontal Audit is completed it can be used as a baseline audit. A baseline audit measures the current status, the results of which would provide a baseline marker for improvement.

- **Clinical Audit:** Defined by the Healthcare Quality Improvement Partnership (HQIP, 2002) 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". In essence, clinical audits investigate and discover if health care is being provided in line with standards. Such audits enable care providers and patients to highlight where their service is doing well, and where there could be improvements. Clinical audits can be either Horizontal or Vertical. Where an audit is deemed to match the above criteria, it must be registered on the Trusts intranet as per section 6.3.

- **Patient Surveys:** Used to gain specific feedback on the experience of people receiving care and treatment within NUH. Collected via various methods, including surveys, focus groups and one-to-one interviews.

- **Service Evaluation:** A method of evaluating the effectiveness and/or efficiency of a specific service by assessing the aims, objectives, activities, outcomes and costs.

6.2.2. QMA Traffic light system.

QMA's are subject to the Traffic light system. Consideration should always be given as to what constitutes a desired target, a cause for concern and what requires immediate action. Percentages attributed to these targets are to be developed by the audit owner then ratified by a member of the SLT(typically this will also be the audit sponsor). The following percentages are for guidance only.

Green – pass/desired outcome (suggested 90% compliance & above)

Amber – Failure/cause for concern (Suggested 80%-90% compliance)

Red – Drastic Failure/Immediate action required (suggested below 80% compliance)

6.3. Registration of QMA

With the above actions completed & considerations taken into account, a QMA Registration form should be completed and submitted to a Service lead (if not the sponsor) or SLT for final approval.

Separate forms exist for standalone QMA's and those due to take place regularly/monthly.

- Standalone: Form – Standalone Audit Registration and Report
- Monthly/regular: Form – Regular QMA registration and review

6.3.1. Registration of clinical audits

In line with current NUH Policy and Procedure, the following clinical audits can be registered with the Trust CET: clinical and baseline audits, patient surveys, service evaluation, and quality improvement projects (QIP). QMA's that directly relate to national KPI's should be registered on the CET database.

QMA's which fall under the criteria for clinical audit registration, must have final sign-off by the clinical lead during their development process.

Once signed-off, the contents of the QMA Proposal Form are used by the QMA lead to complete the NUH audit online registration form (available from the Clinical Audit page of the NUH Intranet site).

6.4. Master Quality monitoring Database & Quality monitoring Audit tool

The Master Quality monitoring database is maintained to provide an overview of all QMA activity throughout the department, including current result percentages and the actual frequency QMA's are conducted.

All QMA's should be recorded on the Master Quality monitoring database, this includes the following information:

- QMA title
- The area of the service the QMA covers
- The methodology
- The frequency
- Traffic light trigger points
- The schedule
- The target sample size
- The QMA sponsor
- Who will carry out the QMA

Where applicable, The QMA's questions and target percentages must also be added to the Master Quality monitoring databases question bank.

After registration on the Master Quality monitoring Database, the QMA's questions can be transferred to the Quality monitoring Audit tool. A copy can then be made & configured to the relevant QMA.

All QMA's should have a folder created on the shared drive. This folder should contain all documentation relating to the QMA (i.e. its registration form) and its configured copy of the quality monitoring Audit tool.

QMA's that happen regularly cannot have their questions amended once an audit cycle starts.

6.5. Completing a QMA

QMA's should be completed using the QMA template sheet wherever possible. Agreed sample group sizes & time scales should also be followed, where it is not possible to adhere to these, it should be documented as to why, for example there may be enough samples to fill the target group size.

If a QMA cannot be completed in line with its schedule this should also be documented, in addition a CAPA should be raised.

6.6. QMA Results

6.6.1. Dissemination of results

Regardless of the QMA outcome, the results should always be shared with colleagues as appropriate. Results against each QMA's questions should be communicated along with any notes on areas for potential improvement.

The latest overall result of a QMA must be communicated to the Project facilitator for addition to the Quality monitoring database.

QMA's which are standalone should have a report (found within the registration form) completed once finalised.

QMA's which happen regularly should have their results shared via email after each month has been completed.

6.6.2. Response to Results

The following actions are suggested as a response to each result in the traffic light system.

- Green – Suggested actions: Share results. Consider if target percentage could be narrowed at next QMA review & if any improvements could be implemented into the system.
- Amber – Suggested actions: Share results, Complete RCA, consider if result is genuine or due to unclear questions, if there are 3 or more Amber results in a row approach as a red result. Escalate results to relevant Clinical lead
- Red – Suggested actions: Share results, Complete RCA, escalate results to relevant clinical lead & SLT for immediate action.

6.6.3. QMA support and monitoring

QMA's should be undertaken with support and guidance from the clinical lead, and where deemed appropriate, performed in collaboration with other staff members.

The Audiology Quality group will monitor the overall QMA status of the entire service & escalate any concerns to the SLT when necessary.

6.7. Reviews of regular QMA's

Regular QMA's should be reviewed once a year following the completion of a full audit cycle. During these reviews the following should be considered:

- Has the QMA provided useful information?
- Are the QMA's questions still suitable?
- Have RCA's been completed for any drops in quality?
- Can the target percentages be adjusted to be more suitable?
- Has the QMA's schedule been suitable?
- Is the target sample group size suitable for the time available to complete the QMA?
- Are the individual question target percentages suitable?
- Is there a need to continue the QMA?

QMA reviews should be held between the QMA sponsor and clinical lead to consider the above. Anything of note should be recorded on the QMA's review form and saved in its relevant folder.

Changes to questions & target percentages should then be amended in the Master Quality monitoring Database. This must be done prior to the new QMA cycle in the coming financial year.

If a QMA is no longer required, the questions should be removed from the Master Quality monitoring Database & the relevant QMA's folder amended to include the text 'No longer active'.

7. Training and Implementation

7.1. Training

Staff undertaking audit are will be given training by peer auditors, typically this will the quality lead for their respective area. Training will involve:

- An explanation of basic audit principles and expectations
- Familiarisation with audit tools
- Shadowing/observation of an audit in process

Additional training from the Trusts clinical audit team can be undertaken as required.

7.2. Implementation

Implementation of this procedure is through the readership assurance database.

7.3. Resources

No additional resources are required.

8. Equality Impact Assessment (EQIA) Form

An equality impact assessment has been undertaken on this document and has not indicated that any additional considerations are necessary.

Q1. Date of Assessment: December 2022			
Q2. For the document and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the document or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups experience? i.e. are there any known health inequality or access issues to consider?**	**b) What is already in place in the document or its implementation to address any inequalities or barriers to access including under representation at clinics, screening**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of the document or its implementation being assessed:			
Race and Ethnicity	No issues identified		
Gender	No issues identified		
Age	No issues identified		
Religion	No issues identified		
Disability	No issues identified		
Sexuality	No issues identified		
Pregnancy and Maternity	No issues identified		
Gender Reassignment	No issues identified		
Marriage and Civil Partnership	No issues identified		
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	No issues identified		

Q3. What consultation with protected characteristic groups inc. patient groups have you carried out? None			
Q4. What data or information did you use in support of this EQIA? None			
Q.5 As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments? None			
Q.6 What future actions needed to be undertaken to meet the needs and overcome barriers of the groups identified or to create confidence that the document and its implementation is not discriminating against any groups			
What	**By Whom**	**By When**	**Resources required**
Q7. Review date	Not applicable		

9. Values and Behaviours

The Trust's TEAM NUH Values and Behaviours describe the principals and beliefs of our people and show that 'we listen, we care'. The TEAM NUH Values and Behaviours have been considered in relation to this document.

Please rate each value from 1 – 3 (1 being not at all, 2 being affected and 3 being very affected)

Value	Score (1-3)
1. Polite and Respectful Whatever our role we are polite, welcoming and positive in the face of adversity, and are always respectful of people's individuality, privacy and dignity.	1
2. Communicate and Listen We take the time to listen, asking open questions, to hear what people say; and keep people informed of what's happening; providing smooth handovers.	3
3. Helpful and Kind All of us keep our 'eyes open' for (and don't 'avoid') people who need help; we take ownership of delivering the help and can be relied on.	1
4. Vigilant (patients are safe) Every one of us is vigilant across all aspects of safety, practices hand hygiene & demonstrates attention to detail for a clean and tidy environment everywhere.	1
5. On Stage (patients feel safe) We imagine anywhere that patients could see or hear us as a 'stage'. Whenever we are 'on stage' we look and behave professionally, acting as an ambassador for the Trust, so patients, families and carers feel safe, and are never unduly worried.	1
6. Speak Up (patients stay safe) We are confident to speak up if colleagues don't meet these standards, we are appreciative when they do, and are open to 'positive challenge' by colleagues	1
7. Informative We involve people as partners in their own care, helping them to be clear about their condition, choices, care plan and how they might feel. We answer their questions without jargon. We do the same when delivering services to colleagues.	1
8. Timely We appreciate that other people's time is valuable, and offer a responsive service, to keep waiting to a minimum, with convenient appointments, helping patients get better quicker and spend only appropriate time in hospital.	1

9. Compassionate We understand the important role that patients' and family's feelings play in helping them feel better. We are considerate of patients' pain, and compassionate, gentle and reassuring with patients and colleagues.	1
10. Accountable Take responsibility for our own actions and results	3
11. Best Use of Time and Resources Simplify processes and eliminate waste, while improving quality	3
12. Improve Our best gets better. Working in teams to innovate and to solve patient frustrations	3
TOTAL	20

10. Monitoring Matrix

Minimum requirement to be monitored	Responsible individual/ group/ committee	Process for monitoring e.g. audit	Frequency of monitoring	Responsible individual/ group/ committee for review of results	Responsible individual/ group/ committee for development of action plan	Responsible individual/ group/ committee for monitoring of action plan
Service evaluation/ monitoring audits	SLT All staff	Audits	Various	SLT CAPA team	SLT CAPA team	SLT CAPA team
Adverse Incident Surveillance	SLT Audiology Clinical Governance Lead/CAPA team	Datix incidents/ Non-conformance reporting	Monthly	SLT Audiology Clinical Governance Lead/CAPA team	SLT Audiology Clinical Governance Lead/CAPA team	SLT Audiology Clinical Governance Lead/CAPA team
Peer review	SLT All staff	Peer review	Various	SLT Line manager CAPA team	SLT Line manager CAPA team	SLT Line manager CAPA team

11. References

Local documents:

- (0)004 Policy – Quality
- (0)001 Audiology Quality Manual
- Form - Regular QMA registration and review
- Form - Standalone Audit Registration and Report

Trust documents (available on Trust intranet):

- NUH Policy for Clinical Effectiveness
- NUH Procedure for Clinical Audit

External documents:

- NHS New-born Hearing Screening Programme Standards
- NICE Guidance: Hearing Loss in Adults – Assessment and Management