UKMi

Audit standards and toolkit

**for measuring quality in NHS Medicines Information Services**

Data collection/

Audit report

This document contains guidance notes and factors to consider during audit. It is to be used as a data gathering document and a basis for the final report.

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| **Centre:** |  |
| **Medicines Information manager:** |  |
| **Auditor:** |  |
| **Date of audit:** |  |

**Template version: January 2018 v1.1**

**Produced by the QRMG on behalf of UKMi**

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| **Background and guidance notes** |

# The UKMi audit standards

The objective of the UKMi audit process is to ensure that NHS Medicines Information services are provided to a defined standard, which is consistent with the provision of advice and information that impacts positively on patient care and outcomes. In addition, the UKMi audit process seeks to identify and encourage innovative practice that adds value to pharmacy services and the wider organisation. The process also seeks to encourage learning from critical incidents and encourages good practice in training and staff development. The general principles are:

* Focus on self assessment with external validation
* Focus on risk assessment and incorporate critical incident learning
* Include impact on patient outcome and safety
* Incorporate peer review and support for action planning
* Provide a streamlined process, proportional to need and include a mechanism to review progress against recommendations in a timely manner
* Identify innovative practice and value to pharmacy and wider organisation
* Be applicable UK wide

All MI services should be externally audited against UKMi standards at least every three years. However, if significant risks are identified the timeframe for a follow-up visit should be reduced to ensure factors that affect patient safety are addressed.

# What areas are covered in an audit?

The standards are set out under seven areas:

1. Enquiry answering process and patient outcome\*
2. Risk management and governance\*
3. Service management\*
4. Training and staff development\*
5. Publications and proactive information†
6. Specialist services†
7. Actions from previous audits\*

\*Compulsory for all centres, † Only where applicable.

In each area there are several standards to be met which are designed to improve the quality of the service delivered. The process focuses on what the service is delivering for patients and healthcare professionals. MI pharmacists individually and the MI network as a whole are accountable for how well the standards are being achieved to ensure delivery of a high quality service which meets the needs of its users.

The standards are broad-ranging, subjective and not always easily measurable. However, this is necessary to accommodate the wide range of service profiles that exist in the network and is designed to be reflective of and responsive to the needs of different service users. It is the responsibility of the auditor to decide at what level the service meets the standard being assessed taking account of limitations. However, limitations should be incorporated into the risk assessment of the service if considered appropriate. An audit should be viewed as enabling and as a lever for service improvement.

Following published work (IJPP Practice 2013: 21(6);393–404, EJHP 2014; 21(4): 222-228) rating scales to assess impact of MI enquiries on patient outcomes and safety have been developed. Each enquiry in the sample selected for audit will be scored using these rating scales.

# What happens during an audit, what are the timelines and how to use this template? \*\**Delete all cream highlighted guidance notes such as this to produce the audit report\*\**

The following is only for guidance, auditees and auditors should always liaise about appropriate timelines. Auditors will provide support if requested about how to approach an audit.

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| 1-2 months pre audit | * The centre being audited will gather appropriate evidence to support the standards being assessed. The focus will be on the MI manager providing evidence of how they meet the standards rather than having a standard set of documents and practices. Use this document to collate the evidence electronically. Once people are familiar with this approach, they should be encouraged to collate evidence on an ongoing basis rather than immediately prior to audit. * The ‘Factors to consider’ questions will help focus and direct you to the type of evidence to submit. These are posed as a series of questions to prompt thought processes. A simple yes/no may be sufficient but if there is further evidence to demonstrate the standard is met include that; use the process to highlight areas of excellence rather than just meeting the standard. There may be other factors/evidence not mentioned that could be used to support the statements. For example, if you have undertaken an audit of processes using LEAN methodology, this evidence can be used to demonstrate the service is run efficiently. * The amount of evidence needed will vary with the standard and the individual centre. The auditor will assess the evidence on its quality rather than quantity. |
| 1-3 weeks pre audit | * Auditor requests sample of enquiries (see appendix 1). Time period covered by sample is between 6 months and a year depending on number of enquiries the centre receives. |
| Audit day | * MI manager should be present and ideally, their line manager available for preliminary feedback. * The auditor will gather evidence in a number of ways including using completed pre-visit paperwork, observing processes, questioning and posing scenarios, testing systems, processes and procedures. Having a written standard operating procedure (SOP) on a particular process does not mean in itself that the service has the right systems in place to keep patients safe. The auditor may want to assess how processes and policies work in practice and may question other members of the team. * The auditor will use the evidence provided by the auditee, together with any additional evidence obtained at the audit visit to make a reasoned judgement and rate (see guidance below) whether the standard has been met. If evidence shows that a standard has not been fully met but it is an isolated issue and could simply and easily be rectified and, most importantly, that there is not a significant risk posed to patient safety, this will be an ‘acceptable tolerance’ and the standard will be met. * The centre being audited should be encouraged to self-rate prior to the audit visit and this can be used as basis for discussion with the auditor who will have a wider experience of standards operating at other centres. However, the auditor will make the final decision on the rating applied for each section and any subsequent recommendations. |
| Post audit | * This documentation forms the basis of the final report. Sections that are included as process guidance are deleted for the final report. * Draft audit report sent to MI manager within 2 months of audit date. * Comments returned to auditor * Final report sent to MI manager and line manager within 3 months of audit date. |
| Follow up | * It is the responsibility of the MI manager in liaison with their line manager to implement the action plan. The auditor will only provide support if requested. |

***Guidance on application of green / amber / red ratings for standards:***

*Auditor: For each standard aspects of the service will be green, others amber or red; use this classification to focus action plan*

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| *Comments, advice, commendations:* | * the service meets or exceeds standards * evidence of continual improvement in standards * innovative practice demonstrated that others can learn from |
| *Comments, advice where appropriate:* | * there is room for improvement but concerns are not serious and do not affect patient safety |
| *Comments, advice where appropriate:* | * no or insufficient evidence submitted to enable assessment * standard has not been met, there are major concerns that require immediate improvement * standard has been partially met but there are serious concerns |
| *Action plan and review dates where appropriate:* | *Auditor note:* Copy this section from each of the standards assessed into the action plan summary of the report separated according to short, medium and longer term actions. |

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| **Executive summary** |
| ***How this audit is undertaken***  The audit is split into several overarching themes, within which a number of service standards are outlined. The centre undergoing audit provides evidence that these standards have been met (using guidance notes with questions to focus evidence to be produced). The auditor rates the evidence (red/amber/green) and suggests an action plan to address areas of deficiency.  Below are the key points raised during the audit, further detail is available in the body of the report.  **Auditor note: Keep brief. List areas of excellence and areas of deficiencies (delete for report).**   * Keep brief |

|  |  |
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| **Action plan summary** | |
| *Action plan for* ***immediate*** *implementation:* |  |
| *Action plan for implementation in* ***medium term****:* |  |
| *Action plan for implementation in* ***longer term****:* |  |

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| Service outline | | | |
| **Service profile** | | | | |
| Service hours | |  | | |
| Service users for enquiries (Trust, primary care etc) | |  | | |
| Details of proactive service provision | |  | | |
| Specialist trust (e.g. mental health, paediatric) OR  Specialist service (e.g. drugs in pregnancy)? | |  | | |
| **Staffing** | | | | |
| **Staff** | **No. WTE** | | **Other roles** e.g. medicines management, trials, clinical, dispensary | |
|  |  | |  | |
|  |  | |  | |
| **Background enquiry answering service statistics (double click on embedded spreadsheet below)** | | | | |
|  | | | | |
| **Reasons for significant changes in activity:** | | | | |

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| 1. Enquiry answering process and patient outcomes | | |
| ***Standard 1.1:*** *Enquiry answers are of high quality.* | | | |
| **Delete for report** | ***Notes and supporting documentation:***  Prior to the audit visit the auditor will contact the centre being audited to obtain a sample of 30 enquiries for assessment. The time frame from which the sample is taken is negotiable and will be reflective of the service profile of the centre; however, a time frame of 6 to 12 months prior to the audit date is usual.  Appendix 1 outlines the process for selecting the enquiry sample from MiDatabank and contains a spreadsheet for collation of comments and scores to assess whether minimum standards have been met for overall quality in terms of documentation, analysis, search coverage, answer. The spreadsheet automatically calculates relevant data which can be copied into the evidence section for this standard.  Supporting references: [Enquiries to document](http://www.ukmi.nhs.uk/filestore/ukmiacg/EnquiriestodocumentSept2013.doc), [Guidance notes for ranking enquiries](http://www.ukmi.nhs.uk/filestore/ukmiacg/Enquirylevelguidance-quickreference_2.doc), [Criteria for grading answers to enquiries](http://www.ukmi.nhs.uk/filestore/ukmiacg/Criteriaforgradinganswerstoenquiries.docx), [Peer Review Good Practice Guidance](http://www.ukmi.nhs.uk/filestore/ukmiacg/PeerReviewGoodPracticeGuidance-final.doc), [Ensuring Quality in enquiry answering](http://www.ukmi.nhs.uk/filestore/ukmiacg/EnsuringQualityinenquiryansweringMar20051.doc)  The impact of enquiry answering on patient care and outcomes is assessed on each of the enquiries sampled in the audit.  ***Factors to consider during assessment:***   * Does the sample of enquiries assessed meet minimum standards for overall quality in terms of documentation, analysis, search coverage, answer (see appendix 1) * Do all enquiries sampled meet the minimum standard score of 15/20 (75%)? * What is the impact of enquiry answering on patient care and outcomes? (see [Patient Outcome Impact Rating Scale for Enquiries](http://www.ukmi.nhs.uk/filestore/ukmiacg/Patient%20Outcome%20Impact%20Rating%20Scale%20for%20Enquiries.docx) ) Are there any negative impact scores? * What is the impact of enquiry answering on patient safety? (see [Patient Outcome Impact Rating Scale for Enquiries](http://www.ukmi.nhs.uk/filestore/ukmiacg/Patient%20Outcome%20Impact%20Rating%20Scale%20for%20Enquiries.docx)) Are there any negative impact scores? * How are enquiry answering standards maintained or improved? * Is peer review of enquiries undertaken? | | |
| ***Evidence:*** | | | |
| ***Data obtained from enquiry assessment (further details in appendix 1):*** | | | |
| *Auditor: Copy stats calculations from bottom of spreadsheet in appendix 1 (outlined in red box) into this box to provide a summary* | | | |
| *Comments, advice, commendations:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Action plan and review dates where appropriate:* | |  | |

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| ***Standard 1.2:*** *Enquiry answering service meets the needs of its users and patients.* | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Is a patient helpline in place? Are the patient helpline standards used (see [Medicines Helpline (for patients) Standards](http://www.ukmi.nhs.uk/filestore/ukmiacg/MedicinesHelplineStandardsvn3_2.pdf))? * Is the UKMi recommended survey tool, number of users surveyed and frequency of survey implemented? (see [User survey guidance](http://www.ukmi.nhs.uk/filestore/ukmiacg/UKMiusersurveyguidanceJan2013.doc)) * What is the mean user survey score achieved for the previous 12 months (or appropriate time period)? Are there any individual scores less than 4 (collected from KPI data)? * What percentage of enquiries were answered within agreed timescale over the previous 12 months (obtained from MiDatabank on day of audit). Minimum standard >95%. * Are other KPIs collected? If so what are they? Who are the results reported to, how often and are there any individual targets set? * Is there a range of categories of enquirer, or are service users predominantly of one type? * Is there a process for stakeholder input to service. Describe. What reporting mechanisms to stakeholders are in place (attach any relevant). | |
| ***Evidence:*** | | |
| *Comments, advice, commendations:* | |  |
| *Comments, advice where appropriate:* | |  |
| *Comments, advice where appropriate:* | |  |
| *Action plan and review dates where appropriate:* | |  |

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| 2. Risk management and governance | | |
| ***Standard 2.1:*** *The service is organised with a view to maximising safety* | | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Are the latest editions of appropriate core resources (as outlined in the latest UKMi resource list) available to MI staff and appropriate resources accessible out of hours? If not, are there justifiable reasons for this? (see [ResourcesforPurchase](http://www.ukmi.nhs.uk/filestore/ukmiacg/FINALResourcesforPurchase_Feb15v2.docx), [Resources with Free Access](http://www.ukmi.nhs.uk/filestore/ukmiacg/FINALResourceswithFreeAccess_Feb15.docx), [Resources for oncall pharmacists](http://www.ukmi.nhs.uk/filestore/ukmiacg/Resourcesforoncallpharmacists2014_3.doc)) * Are SOPs in place that cover departmental working practices to ensure service safety e.g. second checking policy, and to address business continuity e.g. management in the absence of MI pharmacist? (see [Second checking guidance South West](http://www.ukmi.nhs.uk/filestore/ukmiacg/SecondcheckingMIenquiriesfinalOct2010.doc), [Second Checking Guidance-NorthWest](http://www.ukmi.nhs.uk/filestore/ukmiacg/SecondCheckingGuidance-NorthWestLondon.doc)) * How are IRMIS reports utilised? See [UKMi IRMIS reports and guidance](http://www.ukmi.nhs.uk/activities/clinicalGovernance/default.asp?pageRef=8) * Is there adequate supervision of trainees? * Is there adequate supervision of MI technicians and is there evidence of reaccreditation where applicable? | | |
| ***Evidence:*** | | | |
| *Comments, advice, commendations:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Action plan and review dates where appropriate:* | |  | |
| ***Standard 2.2:*** *Risks are identified and managed accordingly* | | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Has a service risk assessment been undertaken using UKMi or appropriate local tool (see [Risk management Policy](http://www.ukmi.nhs.uk/filestore/ukmiacg/RiskmanagementPolicyv4.doc))? * Is there a risk management plan in place to address identified risks? * How are risk assessment plans monitored, escalated and communicated? * Is there a service business continuity plan? * Are there any environmental issues that have an impact on service delivery? * Are there any personnel issues that have an impact on service delivery? | | |
| ***Evidence:*** | | | |
| *Comments, advice, commendations:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Action plan and review dates where appropriate:* | |  | |
| ***Standard 2.3:*** *The service contributes to initiatives to improve patient safety* | | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Are Yellow Cards submitted (see [Midatabank yellow card submissions](http://www.midatabank.com/ADRs/UsefulResources.aspx))? * Are IRMIS entries (UKMI incident reporting system) made (see [UKMi IRMIS reports and guidance](http://www.ukmi.nhs.uk/activities/clinicalGovernance/default.asp?pageRef=8))? * Are issues identified through MI enquiries (individual or trends) fed back to the relevant pharmacists/ pharmacy departments and/or the relevant wards/ trust departments or committees in order to address issues and improve practice/safety in the department and/or trust? * Have any initiatives been implemented in response to patient safety issues that have come to light through the enquiry answering service? * Does the service contribute to any national patient safety work? | | |
| ***Evidence:*** | | | |
| *Comments, advice, commendations:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Action plan and review dates where appropriate:* | |  | |

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| 3. Service management standards | | | | | | | | | | | | |
| ***Standard 3.1:*** *Service is accessible and efficient.* | | | | | | | | | | | | |
| **Delete for report** | | ***Factors to consider during assessment:***   * How do customers access the service? Is there dedicated access by telephone for internal and external callers, during the advertised opening hours of the service, including answerphone & bleep if no MI staff available to answer the phone. Do MI service hours reflect departmental service hours? What happens in the absence of an MI pharmacist (short and long term)? * How is the service advertised? * Are incoming enquiries handled promptly? Post, telephone, email, web (tested prior to audit where relevant). Is there a generic e-mail address? How often are messages (e-mail & ansaphone) picked up? * Are acknowledgment procedures and means for negotiating deadlines in place? * Are adequate procedures in place for handling and prioritising workload? * What procedures are in place for records management (see [Records management](http://www.ukmi.nhs.uk/filestore/ukmiacg/RecordsmanagementV112.doc))? Is the latest version of Midatabank in use? Is there suitable back up facilities? Are there appropriate procedures in place to ensure enquiry records meet organisation standards for length of storage? Is MiDatabank accessible in absence of an MI pharmacist or event of MI centre closure for legal purposes? * Are completed enquiries appropriately dealt with? How many are pending in MiDatabank? Is there appropriate follow up with clinical pharmacists etc? * Are completed enquiries available outside MI? Are enquiries available to non-MI staff in the Pharmacy? * Are enquiries shared with other centres? | | | | | | | | | | |
| ***Evidence:*** | | | | | | | | | | | | |
| Telephone number: | | | | | | | | | | | |
| Date | | | Number of rings | Is an MI Pharmacist or MI technician available? | | | If No, or time >5mins is another pharmacist available? | | Answer machine.  Bleep number available? | | Time to reply to answer machine/ bleep |
|  | | |  |  | | |  | |  | |  |
|  | | |  |  | | |  | |  | |  |
| E-mail address: | | | | | | | | | | | | |
| Date sent: | | | | | | Time sent: | | Date acknowledged: | | Response time: | | |
|  | | | | | |  | |  | |  | | |
|  | | | | | |  | |  | |  | | |
| *Comments, advice, commendations:* | | | | |  | | | | | | | |
| *Comments, advice where appropriate:* | | | | |  | | | | | | | |
| *Comments, advice where appropriate:* | | | | |  | | | | | | | |
| *Action plan and review dates where appropriate:* | | | | |  | | | | | | | |
| ***Standard 3.2:*** *Service is responsive to highlighted problems* | | | | | | | | | | | | |
| **Delete for report** | | ***Factors to consider during assessment:***   * How are complaints handled? How is criticism and praise handled? What positive comments have been received? How are concerns dealt with? Is there a procedure for dealing with concerns/complaints? * What action is taken to negative feedback on user survey? (scores of less than 4) * What procedures are in place for recording errors that arise from enquiry answering? Are incidents reported to IRMIS and local incident reporting system? Are negative impact ratings reported to IRMIS and local incident reporting system? | | | | | | | | | | |
| ***Evidence:*** | | | | | | | | | | | | |
| *Comments, advice, commendations:* | | | | | |  | | | | | | |
| *Comments, advice where appropriate:* | | | | | |  | | | | | | |
| *Comments, advice where appropriate:* | | | | | |  | | | | | | |
| *Action plan and review dates where appropriate:* | | | | | |  | | | | | | |
| ***Standard 3.3: Service is integrated with wider pharmacy services*** | | | | | | | | | | | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Is the MI manger involved in wider management of the pharmacy service? * Do MI staff have appropriate additional roles that utilise MI skills e.g. formulary, pathway development? * Is the MI manager involved in ensuring quality in responses to enquiries dealt with by non-MI staff at ward level? * Does the MI manager attend non-MI meetings? | | | | | | | | | | | |
| ***Evidence:*** | | | | | | | | | | | | |
| *Comments, advice, commendations:* | | | |  | | | | | | | | |
| *Comments, advice where appropriate:* | | | |  | | | | | | | | |
| *Comments, advice where appropriate:* | | | |  | | | | | | | | |
| *Action plan and review dates where appropriate:* | | | |  | | | | | | | | |
| ***Standard 3.4:*** *Staff are appropriately managed* | | | | | | | | | | | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Is the service pharmacist led? * Are PDPs and objective setting exercises undertaken for all staff? * How is poor performance handled? | | | | | | | | | | | |
| ***Evidence:*** | | | | | | | | | | | | |
| *Comments, advice, commendations:* | | | |  | | | | | | | | |
| *Comments, advice where appropriate:* | | | |  | | | | | | | | |
| *Comments, advice where appropriate:* | | | |  | | | | | | | | |
| *Action plan and review dates where appropriate:* | | | |  | | | | | | | | |
| ***Standard 3.5:*** *Development plans are in place for the service* | | | | | | | | | | | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Is a service delivery plan aligned to national and organisational strategy in place? * What long term plans (even if aspirational) are in place for the service? * Is an annual report produced? * Has the centre or its staff been involved in audits, quality improvement, service development or research projects. If so have they been published? | | | | | | | | | | | |
| ***Evidence:*** | | | | | | | | | | | | |
| *Comments, advice, commendations:* | | | |  | | | | | | | | |
| *Comments, advice where appropriate:* | | | |  | | | | | | | | |
| *Comments, advice where appropriate:* | | | |  | | | | | | | | |
| *Action plan and review dates where appropriate:* | | | |  | | | | | | | | |

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| 4. Training and staff development standards | | | | |
| ***Standard 4.1:*** *Service provides high quality training* | | | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Are sufficient facilities available for trainees? * Are appropriate UKMi training tools/support materials used for various staff groups trained? E.g MiCal, workbook? (see [Training Database Template](http://www.ukmi.nhs.uk/filestore/ukmiacg/MITrainingDatabaseTemplatefinal.xls)) * Are learning outcomes clearly defined for all staff groups trained? * Is feedback from trainees formally collected? How are identified issues acted on? * Is there a record of all staff trained and an assessment of whether the learning outcomes have been achieved? | | | |
| ***Evidence:*** | | | | |
| *Comments, advice, commendations:* | |  | | |
| *Comments, advice where appropriate:* | |  | | |
| *Comments, advice where appropriate:* | |  | | |
| *Action plan and review dates where appropriate:* | |  | | |
| ***Standard 4.2:*** *Staff providing the service are adequately trained* | | | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Are individual staff training needs identified? * Have all relevant staff attended the UKMi national training course? * Are there any problems accessing appropriate training? * Is there an MI technician in post? If so have they undergone accreditation/reaccreditation as appropriate? | | | |
| ***Evidence:*** | | | | |
| *Comments, advice, commendations:* | |  | | |
| *Comments, advice where appropriate:* | |  | | |
| *Comments, advice where appropriate:* | |  | | |
| *Action plan and review dates where appropriate:* | |  | | |
| 5. Publications and proactive information standards | | |
| ***Standard 5.1:*** *Adequate systems are in place to ensure quality* | | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Are procedures in place to guide production? * Is the ‘Project’ facility in MiDatabank used for publications and other proactive work? * Is all proactive information checked for readability and grammar? * Is all proactive information checked for accuracy? * Is documentation retained identifying authors and checkers? | | | |
| ***Evidence:*** | | | |
| *Comments, advice, commendations:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Action plan and review dates where appropriate:* | |  | |
| ***Standard 5.2:*** *Proactive information meets the needs of the target audience* | | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Has the target audience had the opportunity to comment on whether the publication meets their needs? (It may not be possible to assess this if you are contributing rather than leading on the workstream). * Is there a stakeholder group that contributes to content of publication? Stakeholders may include primary care, secondary care, SLA holders, commissioners. * Is there a stakeholder group that addresses organisation needs in terms of proactive publications? | | | |
| ***Evidence:*** | | | |
| *Comments, advice, commendations:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Action plan and review dates where appropriate:* | |  | |
| **6. Specialist service standards** | | |
| ***Standard 6.1: High quality specialist service is provided*** | | | |
| **Delete for report** | ***Factors to consider during assessment:***   * Is the specialist service adequately resourced in terms of access to specialist texts etc? * Do newly appointed staff have specific training in provision of specialist service? * Does the service have sufficient trained staff to ensure service continuity? * Does the specialist service contribute to national UKMi agenda in terms of outputs? * Is the specialist service proactive in terms of sharing their expertise? * Is there external clinician input/support that can be accessed by the specialist service? | | | |
| ***Evidence:*** | | | |
| *Comments, advice, commendations:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Comments, advice where appropriate:* | |  | |
| *Action plan and review dates where appropriate:* | |  | |

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| 7. Actions from previous audit | | | |
| ***Standard 7.1: Service has responded to recommendations from previous audit*** | | | |
| **Delete for report** | ***Notes:***  The auditor will rate the centre according to progress taking account of external factors that impact on implementing previous recommendations.  ***Factors to consider during assessment:***   * Have key recommendations from previous audits been addressed, especially those that directly impact on patient safety? * If not, and the recommendations are still valid, have barriers to addressing these been explored? * Has implementation been partially addressed but new barriers or issues emerged outwith direct MI control? | | | |
| ***Evidence:*** | | |
| *Comments, advice, commendations:* | |  |
| *Comments, advice where appropriate:* | |  |
| *Comments, advice where appropriate:* | |  |
| *Action plan and review dates where appropriate:* | |  |

# Appendix 1. Quality of enquiry answering.

The embedded spreadsheet below lists details of the enquiries sampled as part of this audit, together with the scores achieved for documentation, analysis, coverage and answer (maximum 5 scores for each section; total 20 scores for each enquiry). The UKMi standard is that all sampled enquiries should achieve a score of 15/20 (75%) or more. Supporting documentation includes: [Guidance notes for ranking enquiries](http://www.ukmi.nhs.uk/filestore/ukmiacg/Enquirylevelguidance-quickreference_2.doc) and [Criteria for grading answers to enquiries](http://www.ukmi.nhs.uk/filestore/ukmiacg/Criteriaforgradinganswerstoenquiries.docx).

Each enquiry is also scored for its potential to impact on patient outcomes and safety. This is not a linear scoring system, the UKMi standard is that there should be no negative impact or safety scores. Further guidance on this is available, see [Patient Outcome Impact Rating Scale for Enquiries](http://www.ukmi.nhs.uk/filestore/ukmiacg/Patient%20Outcome%20Impact%20Rating%20Scale%20for%20Enquiries.docx).

Please note the whole spreadsheet can only be viewed electronically by double clicking into it. If the report is printed only a portion will be visible.

|  |  |
| --- | --- |
| **Delete for report** | **Selecting enquiries for audit from MiDatabank (for auditee)**   1. Go into ‘reporter’ function in MiDatabank. 2. To obtain the percentage of level 1, 2 and 3 enquiries handled by the centre select a time frame of 1 year (or since MiDatabank installation if less than 1 year). Click on ‘Show report’. Note percentage of level 1, 2 and 3 enquiries listed in ‘Workload’ page. 3. Run a second report covering the time frame chosen for the audit. Click on ‘Show report’ then click on ‘Enquiries’ tab at the top of the page. NB. It may take some time to build this report if there are lots of enquiries. If this is the case then it may be worth producing three separate reports by filtering for complexity level. 4. Once the ‘Enquiries’ report has been built click on ‘Save’ tab and save as a Word document. The report will be saved as a table in this format. 5. Delete all columns except enquiry number and complexity level. The table can be highlighted and sorted by complexity level using the ‘sort’ function in Word. 6. This document, together with details of the yearly percentages of enquiry complexity level, should be sent to the auditor to select 30 enquiries that are representative of the enquiries received e.g. if 50% of enquiries are level 1 then 15 level 1 enquiries should be selected for audit.   Sample of enquiries audited = 30. Ensure that proportions of Level 1, 2 and 3 enquiries\* are representative of the mix of level 1, 2 and 3 enquiries answered.  **Use of embedded spreadsheet (for auditor)**  By double clicking in spreadsheet below, you can ***directly enter*** comments and scores for individual enquiries sampled including impact scores for patient outcome and safety.  Once completed the spreadsheet will calculate all relevant parameters at the bottom. Copy the red highlighted section into the evidence section of Standard 1.1 in the section under ‘***Data obtained from enquiry assessment’.*** This can then be used to provide relevant advice. |

