Clinical Audit and Research Service - annual report 2001

Midland Health Board
Board Slainte Lár Tire

Clinical Audit & Research Service

Annual Report

2001

Iniúchadh Cliniciúil agus Taighde

Tuarascáil Bhliantúil

2001

Contents

Foreword

It is my pleasure to introduce the Clinical Audit & Research Annual Report 2001.

In 2001, the Board launched its Quality Strategy highlighting the adoption of a Continuous Quality Improvement Approach to Healthcare services. The Strategy states that Clinical Audit and Research are key elements in the provision of Quality healthcare.

The Midland Health Board seeks to promote and continuously improve the quality of healthcare and health related services across the continuum of care and improve outcomes valued by the population served by the Board. The Clinical Audit and Research team provides advice, support and professional guidance to all healthcare staff in addition to carrying out specific pieces of research and audits.

This professional and dynamic team of people is now part of the Corporate Fitness group within the Midland Health Board and is an essential resource in our implementation of the goals of the National Health Strategy Quality & Fairness (2001).

I urge you to read this report and hope that it will give you encouragement to continue on your road to 'doing the right things right'! (Quality Strategy 2001).

Mary Culliton,
Director of Corporate Fitness.

Introduction

The year 2001 has been a very active year for the newly established Clinical Audit & Research Service. Highlights of the year included the recruitment of six researchers to support clinical audit and research across the following care groups:

Acute Hospitals
Mental Health
Older Persons
Primary Care
Children & Families
Health Promotion.

The latter three staff commenced employment in November 2001.

The year also saw the team move into its newly refurbished premises on William Street in Tullamore. The premises were officially opened in November of 2001. Presently the offices accommodate 15 staff comprising of Clinical Audit and Research personnel, The Cardiovascular Strategy Co-ordinator and Research staff and a Qualitative Researcher from the Department of Public Health. This centrally based research and audit function facilitates information sharing, co-ordinate training and team building thus strengthening the research and audit capabilities within the board.

Early in 2001 the management structure of the Midland Health Board went through a period of organisational change, leading to the creation of the new post of Director of Corporate Fitness. Ms Mary Culliton took up the position. 'Her role will be to ensure that organisational structures remain relevant to the current tasks and that information, communications, decision and delivery systems are aligned with and supportive of the service strategy plans and operations'. (MHB News, April 2001). In support of this function, Clinical Audit & Research are now part of this directorate together with the following areas: Communication, Internal Audit, Library Services, Irish language, Freedom of Information, Comment, Enquiry, Complaint and Appeal system, Health and Safety, Occupational Health, Risk Management and Health Promoting Hospitals.

Finally, the Clinical Audit & Research Staff look forward to working with this team in 2002 to deliver a high quality and responsive service consistent with patients and service users needs.

Role of the Clinical Audit & Research Service.

The Clinical Audit and Research Service was established in 2000 with the appointment of the Clinical Audit Officer, followed by the appointment of Research Assistants in 2001. The role of the Clinical Audit Team is to support frontline staff and service managers in audit and research projects within their service.

Clinical audit is "the systematic, critical analysis of the quality of care, including the procedures used for diagnosis and treatment, the use of resources and the resultant outcome and quality of life for the patient" ("Quality and Fairness – A Health System for You", Department of Health and Children, 2001)

With the development of services, and the increased emphasis on quality and clinical excellence, enhancement of the research and audit capacity across all care groups is a priority.

Service Provided

The Clinical Audit & Research team provides the following services to healthcare workers in the Midland Health Board:

- Advice on Audit & Research Project Methodologies
  - Quantitative and Qualitative Methods
- Uni-disciplinary & Multi-disciplinary Group Facilitation to provide guidance and reach consensus on audit topic selection
- Project Management Skills
- Literature Searches
- Data Collection
- Data Analysis
- Report and feedback
- Compiling Action Plans
- Re-Audits
- Links strategically with Care Group Managers and the newly established Corporate Fitness Function in the Midland Health Board
- Submission of completed projects for publication and presentation at conferences, on behalf of teams involved in projects
- Networking with Public Health Departments, Research and Audit functions in other Boards

Strategic Development.

Staffing:

Due to increased funding from the Acute Hospitals sector for 2002, there are plans to recruit a further two Clinical Audit Facilitators for acute hospitals. This will increase the present complement to three clinical audit facilitators and it is planned that there will be one located at each of the three acute hospital sites. Initially it is planned to train these new personnel in qualitative and quantitative research methods using a combination of in-house trainers and external providers.

Clinicians in Management:

The year 2002 will see the establishment of the Units of Management within the different specialties across the three acute hospitals. Each unit will consist of a

Clinical Director (Consultant), Unit Nursing Officer and a Business Manager. Accountability for the provision of quality services will lie within this management structure of each unit. The Clinical Audit Officer proposes that a Quality Improvement Team (QIT) will operate within each unit of management. Their remit will be to develop a Quality Improvement Programme (QIP) for the year 2002. Such a programme will identify one audit topic for that unit. Clinical Audit Facilitators within the hospital will facilitate and advise this process as well as supporting the clinical audit project itself.
Clinical Audit training will be provided for project leaders by the facilitator in each hospital. This will be on going as project leaders may change with different audit projects.

Quality Strategy:
The Midland Health Board Quality Strategy was launched in May 2001. The values or hallmarks of quality are:
Equity, Accessibility, Effectiveness, Efficiency, Appropriateness, Responsiveness, Dignity, Farsightedness.
When prioritising topics suitable for audit, the QIT's will use self-selected performance indicators for each of the hallmarks of quality. In this way audit projects will link with the strategic objectives of the Quality Strategy and become a process by which services can be improved on a continuous basis.e.g. Accessibility.

Hallmark	Subset	Definitions	Examples of key performance indicators	Data Sources
Access	Timeliness	The capacity of individuals to obtain the same quality service and to have equitable access to the required service according to patients needs	• Waiting lists, no's of patients, no's of procedures. • Outpatient clinic waiting times • Triage times in A/E • Delay in transfer to other care e.g. nursing home beds	• Medical records Dept. • OPD • A/E database • Discharge planning documentation

(Ryan K. 1999.)

Risk Management:
In 2001 the Healthcare Risk Manager and two clinical risk managers were appointed to the Midland Health Board. This is important to the CQI process outlined in the Quality Strategy. It is planned that Clinical Audit and Risk Management will be an integrated function. Clinical Audit will be:
- Used to monitor the impact of and adherence to risk management programmes.
- Used to ensure that lessons are learned from complaints, near misses, incident reports and mistakes.
- Used to monitor and evaluate the Risk Management function itself.

Training:
A training package for clinical audit facilitators will be developed and piloted in the Midland Health Board in conjunction with the Irish Society for Quality in Healthcare (ISQH). This will be evaluated.
The training objective is to provide a 'train the trainers' package so that audit training would then be cascaded down to frontline staff involved in service delivery. As stated previously training would commence with personnel who become involved as project leaders.

Committee Structures:
In light of developments named above i.e. Clinicians in management, Risk Management, it is planned that present committee membership be reviewed in consultation with the Director of Corporate Fitness. The aim of any joint committee structure is to reduce duplication of effort while affording a transparent, equitable and accountable process for managing the clinical audit / research / risk management workload.
Appendix A contains the present list of committee members. This report would like to commend the support and commitment of the committee that saw the Clinical Audit Service through its first year.

Dissemination of Clinical Audits/ research work.

Annual Report:
The Annual report of the Clinical Audit And Research team will be used as a means of sharing the knowledge gained and improvements made in patient care by using Clinical Audit and Research in day to day practice. The report contains abstracts of all projects completed during the year 2001 and also some that have been commenced in the latter part of the year. It is envisaged that by seeing quality at work using practical examples, other staff members will see opportunities for quality improvements in their own work areas.
It is also testament to the hard work and dedication of all staff who participated in projects throughout 2001. Without their support, initiative and enthusiasm the work could not have been carried out. Their quality orientation has been an example to us all and we look forward to undertaking more quality initiatives with them in the future.

Clinical Audit & Risk Management Open Day:
On March 26th 2002, it is planned to have a joint information day for Clinical Audit & Risk Management. Project leaders from 2001 will be invited to attend and present their projects (assisted by the Clinical Audit & Research team) either in oral or poster format. This will provide a forum for sharing Best Practice and learning from the work carried out in year 2001.

Clinical Audit Newsletter:
The Clinical Audit & Research committee proposed that a newsletter from the team / committee be circulated throughout the board. In 2001, five newsletters were circulated. The Clinical Audit Committee first ratifies each one. This has provided a valuable communication mechanism for the group. The Circulation list has grown to

almost 500. This has been very effective, raising staff awareness of what Clinical Audit is about, types of projects carried out. Staff realise this service is available for all staff and several audit proposals have ensued as a result.

Clinical Audit & Research Manual:
This manual provides a step by step guide to carrying out clinical audit projects as well as giving practical audit examples applicable to different care groups. This will be circulated through out the board in 2002.

Lectures:
The Clinical Audit Officer has been involved in delivering lectures to post graduate students on the topic of Clinical Audit. To date these have been delivered to students on a course ran by the Irish Health Services Management Institute and the Extra Mural Diploma in Management, held at the Athlone Institute of Technology. As the students on the latter course must complete a project as part of their course requirements, some students may chose to carry out a clinical audit project therefore benefiting themselves and the organisation in terms of quality improvement initiatives. It also bridges the gap between theoretical learning and practical application in the workplace.
Education and teaching sessions are also delivered on an on-going basis to frontline staff in the MHB as required.

Other Activities of the Office.
The team strives to accommodate all frontline staff as well as service managers, requiring clinical audit or research advice. This can be on a one to one basis or to small groups of staff. It is the interest of us all to foster ways of sharing knowledge and experience and to make this accessible to all.
The team also supported and led Clinical Audit & Research work from within the Department of Public Health. This has been a two way process and the team would like to acknowledge the many hours of support and advice given by the staff working within the Department of Public Health, MHB in 2001. These close links will be maintained in 2002.

Community and Mental Health Based Audit and Research Projects.

FOLLOW UP RESEARCH OF PATIENTS TRANSFERRED TO ACCIDENT AND EMERGENCY AT LONGFORD/WESTMEATH GENERAL HOSPITAL

Aim

To complete a follow up study to track patients who were referred to Longford Westmeath General Hospital (LWGH) from St. Joseph's Hospital, Longford. This research was conducted as part of the Review of the Longford GP Practitioner Unit, St. Joseph's Hospital, Longford, which was written by Ms Carmel Brennan and Dr Annette Rhatigan.

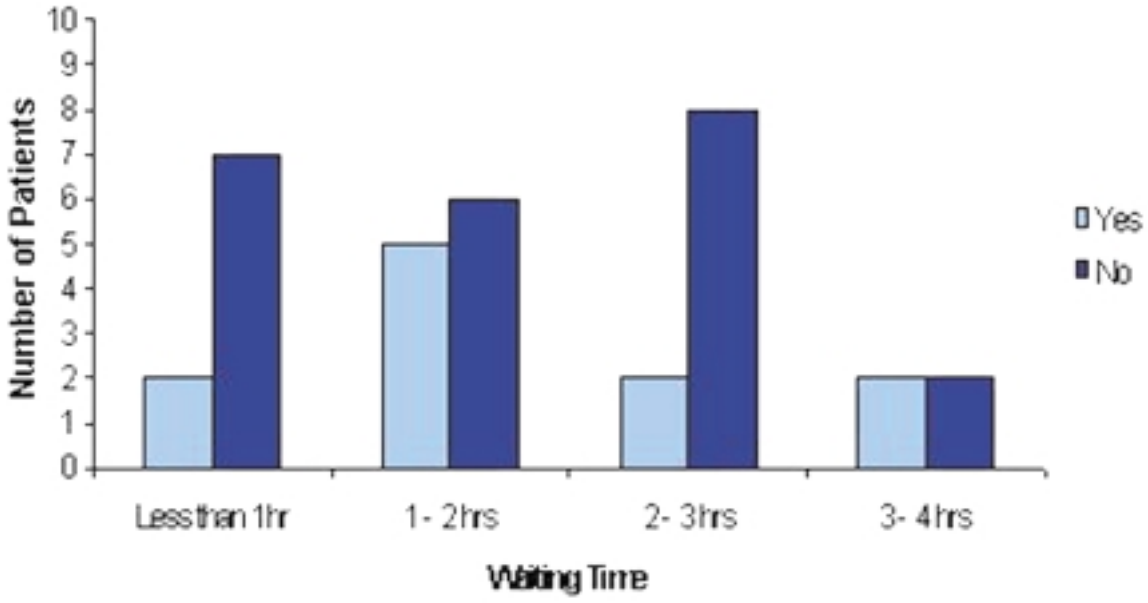
Methodology

Patient details were collected from the casualty register and the patient casualty cards. All data was analysed using SPSS.

Results

It was found that 3 people were admitted straight to hospital and 42 people attended A&E. Of the 42 who attended A&E, 15(35.7%) were admitted and 27 (64.3%) were discharged.

An analysis of waiting times in A&E by admission status are illustrated below.



A copy of the full report can be obtained from Public Health.

PRIMARY HEALTH CARE PROJECT

Summary

This initiative is a pilot project in the region and is based on the Tullamore Travellers Movement. Previous research on the health status of Traveller's, has documented their low life expectancy, high infant mortality rates and the high rates of morbidity. Traveller health status as an ethnic minority group, has been identified as a very complex issue. It relates not only to material socio-economic conditions but also to concepts of cultural validity and to issues of discrimination, marginalisation and their effects. It is hoped that a community response involving Travellers as Trained Community Health Workers, as part of a larger, overall strategy will help to address some of the issues. This project is at a pre-intervention stage and eight women are in training to become Community Health Workers.

Working relationship

Tullamore Travellers Movement (T.T.M.), Midland Health Board (M.H.B.), FAS, Technical Advisors and Course Participants

Overall Objectives

- The development in consultation with Traveller, FAS, the Midland Health Board and the Tullamore Traveller Movement of a Primary Health Care Project aimed specifically at Travellers.

- To increase Traveller awareness and knowledge of health.

- To facilitate the development of work-related skills and to provide practical assistance in identifying future income generating possibilities.

- To increase dialogue and communication between Travellers and health service providers.

- To pilot the training of Traveller women as community health workers.

Phases

Phase One: Capacity Building
Phase Two: Pre-Training Phase

Aims

1. To enable Traveller women to build on their existing awareness, knowledge and skills in child-care and health promotion work.

2. To offer a wide range of opportunities for women to gain control over their own health needs.

3. To develop work-related skills and to provide practical assistance in identifying future income generating possibilities.

Phase Three: Pre-Employment Phase and Employment Phase

Evaluation Process

Aims of evaluation process:

1. To assess the extent to which the objectives of the pre-training phase are being met through the workings of the project.

2. How the work being conducted in the pre-training phase will go towards meeting the objectives of the Primary Health Care Project.

3. Assess extent to which expectations of the Primary Health Care Project for each of the partners T.T.M., FAS and M.H.B. are being met in the first year of the project.

4. Assess the extent to which expectations of evaluation for each of the partners T.T.M., FAS and M.H.B.

Objectives of Evaluation of Pre-Training Phase

1. What are the self-identified needs of the trainees on the Primary Health Care Project in order to become Primary Health Care workers?

2. To what extent are these needs being met on the Primary Health Care project and particularly in the Pre-Training Phase?

3. Details what new skills have the women on the course acquired as a result of the course to date.

4. Identify successes/failures of course to date according to participants/tutors/health care worker.

5. Identify successes/failures of partnership between T.T.M., FAS and M.H.B?

6. Successes/failures of Steering Group which oversaw the operation of the Primary Health Care Project.

Evaluation summary to date

- Evaluation framework was designed and presented to Steering Group April 1999

- Interim evaluation report on the Pre-Training Phase completed and presented to Steering Group April 2000.

- Pre-Training phase evaluation report complete and presented to Steering Group Jan 2001.
  The Pre-Training Phase, aims and objectives of each quarter were designed by Steering Group Health Worker and achievement of these were assessed through the evaluation process.

Methods

Comparison, were made with previously stated norms, standards or intended results. Weekly evaluations were carried out.

Quarterly evaluation were performed as follows:

- Private semi-structured interviews with each of the participants on the course
- Group discussion
- Semi-structured interviews with staff were held but are now discontinued due to repetitiveness with group discussions.

Record of Certified components of the course.

Current stage of project.
Phase two: year two.

- Health Intervention Phase: Evaluation issues

Health intervention phase evaluation to proceed by determining if aims/objectives of each module are achieved by assessment of Trainee/Tutor evaluation forms completed by Trainee/Tutor at end of each module. The aims/objectives of each module were set out at the beginning, by the tutor. In many cases these were drawn up in consultation with the Health Worker and/or trainees.

Evaluation plan for Phase two: year two.

- The Steering Group requires monitoring to assess if Terms of Reference are being adhered to (similar to Pre-Training Phase)
- Evaluation of Partnership (Similar to Pre-Training Phase Evaluation Method)
- Baseline survey analysis
- Evaluation of Consultation Process

Baseline Survey and Maps: Primary Healthcare Project

Tutor and Trainee Assessment
Course Evaluation by Trainers
Course Evaluation by Trainees
Course Content Evaluation
Baseline survey

Skills development for survey
All are currently being analysed.
Consultations with the Travellers, Health Service Providers and a joint consultation are planned for early 2002.
Results will be analysed using Microsoft Access and Epi-Info (Database and statistical packages respectively).

Future plan
Finalise analysis and to prepare focus group 4-5 key question suggestions.

AUDIT OF THE PILOT SPEECH AND LANGUAGE THERAPY INTERVENTION FOR TRAVELLER CHILDREN: LONGFORD/WESTMEATH

Summary
Speech and Language Therapy Services identified an apparent low level of uptake of available services by Traveller families. A significant number of children were presenting with difficulties and these children would benefit from attendance at regular speech and language therapy. During 2000, Teachers in Mullingar expressed their concerns regarding the speech and language skills of a number of Traveller children, which were contributing to an educational disadvantage. Although these children had been referred to the therapy services in place, they were discharged due to their failure to attend regular appointments. The normal route of clinical assessment and regular contacts with the children speech and language therapy appointments at specially organised clinics were identified as a type of intervention unsuitable for the majority of families within the Traveller Community. Alternatively school based intervention has been seen as an effective way of providing therapy to some of the children who had difficulty in attending for regular community appointments.

Aim
To audit speech and language therapy delivery to Traveller children (in a manner acceptable to the Traveller families and in a Traveller friendly environment) and the outcomes.

Objectives
To highlight, in consultation with the Traveller families, the barriers and the gaps in the delivery of Speech and Language Therapy Services for Traveller Children in Longford/Westmeath.

To develop a model for the delivery of culturally appropriate and acceptable Speech and Language Therapy services to the children of the travelling community to ensure a high up-take of the provided services by Traveller families.

Methods
This is an audit of the process of delivery of speech and language therapy to Traveller children in schools and the outcome will be compared to that achieved at local clinics.

Those who participated included the following:
1. Speech and Language Services, Longford/Westmeath.

2. Longford-Westmeath Schools

3. Traveller families (Longford and Westmeath)

4. Traveller Community Health Workers

5. Health Promotion Unit, Midland Health Board

- Focus group methodology is the most suitable tool to collect qualitative data in this instance.

1. Focus groups facilitated by Health Board Personnel and Traveller Community Health workers, have been planned and are expected to take place early 2002:

2. To explore Traveller beliefs and perceptions of Speech and Language Services, plus the reasons for low uptake of these services within the Health Centre settings.

3. Parents “views” of this service being delivered in a school setting, pre and post intervention.

- Questionnaires have been prepared and will be administered to Teachers within the schools (pre- and post-intervention), to assist in measuring the broader outcomes of the pilot intervention.

- Outcome measurements of the therapy have been developed by the Speech and Language Services using appropriate measurement/evaluation tools/methods to evaluate the project.

Data Collection Stage

The focus groups and therapy sessions are planned to be carried out early 2002. Data will be collected prior to and post intervention Spring 2002.

Results

Quantitative results will be analysed using Microsoft Access and Epi-Info (Database and statistical packages respectively).

EVALUATION OF THE COMMUNITY REHABILITATION UNIT, MIDLAND HEALTH BOARD

Objectives

To critically appraise the Community Rehabilitation Unit (CRU) currently operating in the Tullamore and Birr regions of the Midland Health Board.

Methodology

The audit aims to evaluate the CRU from three aspects:

- questionnaires to obtain views of all stakeholders involved with or affected by the unit (excluding patients)

- an analysis of patient records

- an analysis of the number of interventions carried out by the CRU crew in the specified time period.

Stakeholders identified are General Practitioners, Public Health Nurses, Ward Sisters, Consultants, Physiotherapists, Occupational Therapists, Speech and Language Therapists, and the crew of the CRU. Stakeholders were first contacted by post, with a follow up call to administer the questionnaire.

Patient details were supplied by the CRU administrator, and interventions numbers have been submitted by each member of the crew.

Data will be analysed using Microsoft Access and Epi-info.

Results

Available by January 2002.

CARER STRATEGY

A Carer Strategy is currently being written by Anna de Siún, Researcher for Older Persons, Marian Delaney-Hynes, Carer Co-ordinator Longford/Westmeath and Paula Brophy, Carer Co-ordinator Laois/Offaly, in conjunction with Liam O'Callaghan, General Manager Laois/Offaly and Pat O'Dowd, General Manager Longford/Westmeath.

In order to prepare a strategy to deal with the needs of informal carers in the Midlands region, it was first necessary to identify those needs. This was done by running information fora specifically for carers, where their views could be canvassed and recorded. These fora, which were organised and run by the Carer Co-ordinators were held across all four counties and ran from February to June 2001.

The strategy is a response to the many issues raised at the fora, and a guide to show clearly the steps the Midland Health Board intends to take in the future to address those needs.

UTILISATION OF LONGSTAY BEDS FOR THE ELDERLY, 2001

Aim

In order to facilitate the drafting of a strategic development plan which is evidence based, the statistical information collected in March 2000 relating to longstay beds was updated, and data was collected on waiting lists in each of the long stay facilities for older people within the Board's area.

Methodology

The Directors of Nursing of each of the longstay units were contacted by phone and asked to give the number of beds currently available in their nursing homes. Reasons for changes from the 2000 figures were also sought.

Results

- Two new private nursing homes have been built and registered since March 2000.
- The Aged Care Unit in General Hospital Tullamore is no longer a long stay facility.
- In the Laois/Offaly area, one bed was lost due to the building of an oratory and one bed was made available by converting a visitor's room to a bedroom.
- In Longford/Westmeath area, 7 beds were lost following a recommendation from the fire officer to reduce the numbers of beds in each ward.

A full report is available from Clinical Audit and Research.

DATA COLLECTION ON HOME HELP STATISTICS FOR LAOIS/OFFALY

Background
An in depth research report on the home help service in Longford/Westmeath was completed in 2001. In order to ensure that the recommendations in that report were applicable for the Laois/Offaly home help service, it was decided to collect corresponding statistics for the Laois/Offaly area.

Objective
To collect statistics on the home help service in Laois/Offaly from 1996 – 2000.

Methodology
Information on all home helps and recipients is kept in a hand written ledger. This information was analysed using Microsoft Access to ensure that duplicate counting did not occur and for ease of analysis.

Information on refusals was collected from both patient charts and a separate applications/refusals ledger.

Information on population statistics was provided by the Central Statistics Office.

Results
- Statistics were collected on the following

- Number of Home Helps Laois/Offaly

- Number of Home Help Recipients Laois/Offaly

- Client Categories Laois – 2000

- Client Categories Offaly – 2000

- Service Analysis

- Analysis of Applications Laois/Offaly

- Analysis of Refusals Laois/Offaly

- Population Statistics

Since the collection of these statistics, it has been decided to form a working group to review the recommendations and the initial report and discuss the best methods of implementing these recommendation in both community care areas which in turn will lead to a more standardised system within the board.

AN AUDIT OF CARE PLANS IN ADULT PSYCHIATRY – Co. OFFALY

Objectives

The Community Mental Health Services, Tullamore introduced the care planning process to their service in 2000. All acute patients, living in the community, attending Dr O'Hanlon have been care planned and a Health of the Nation Outcome Scale providing a score for the level of overall severity of functioning for each patient was also completed. Collectively, these care plans would provide a base-line recording of the level of functioning and support needed by each patient against which future care-plans and severity of functioning could be compared. A subcommittee was formed in April 2001 and agreed the following objectives for the audit.

- To provide the first full needs assessment of a full psychiatric population in one sector of the Midland Health Board.
- To assess the unmet needs of acute patients in the community.
- To assess risk in the population.
- To provide data upon which operation plans can be established
- To establish the baseline level of functioning for each patient.
- To examine the overall effectiveness of the care planning approach.

Methods

Clinical Audit and Research audited the data from the care plans to obtain the following information concerning the group of patients: -

- Demographic Information – age, sex, residential area, employment status, hobbies, martial status.
- Primary, secondary and tertiary psychiatric diagnosis.
- Allocation to a key worker.
- Medical illness.
- Degree of risk in the patient population – suicidal ideas, acts, non-compliance, harm to others and property.
- Services required, the availability of these services, frequency and location of attendance.
- Presence of patient at the care plan meeting and agreement to the care planning process.
- Patient's social supports.

Results & Conclusion

A large number of variables were analysed for the results and the audit has provided a baseline level of functioning and information regarding the services required by the patients in Dr O'Hanlon's care. The results show that this aim has been met and a wide range of information had been obtained from the care plans. The following recommendations relate to service provision:-

1. A psychiatric social worker is needed for 20% of the patients in this sample, it is recommended that a psychiatric social worker is employed to meet the needs of these patients.

2. 147/400 patients required family intervention, it is recommended that a family therapist is recruited to meet the needs of these patients.

3. A small number of patients require child psychiatry services to assist in family interventions (3/400). It is recommended that a child psychiatrist be contracted into the board on a sessional basis.

4. Other services required by patients that are not accessible as yet are:-
   Out of hours crisis service
   Out of hours appointments service
   Psychiatric beds in Tullamore General Hospital
   Respite provision
   Recreational facilities

It is recommended that these facilities are put into place within the Board to meet the unmet needs of patients.

The care plans were generally well completed, but for the ease of future audit, it is recommended that they become computerised. This will ensure that information is standardised and more accessible for audit. In order for comparisons to be made with the results of this audit, it is vital that the patients are care planned again as soon as possible as it is now 9 months since the last care plans were completed.

AUDIT OF INTEGRATED CARE PATHWAYS IN PSYCHIATRY OF LATER LIFE

Objectives

The Psychiatry of Later Life Services in Laois/Offaly introduced Care Pathways in 2001 for all new patients entering the service. Dr Lorcan Martin, in consultation with his multi-professional team designed the care pathway form and structure. The team felt that a single set of multidisciplinary case notes were required to reduce duplication of information in case notes. A care pathway would best meet this need. The pathways would assure standardised delivery of care and would monitor waiting time in the service, correspondance and communication within the team and to outside agencies. Initially the care pathways were designed as a 3-month pilot project and would be evaluated following the results of this audit and evaluating the feedback received from the professionals who use the pathways on a day to day basis.

Standards were locally agreed by all multi-disciplinary staff for the following key areas of service delivery:

1. Pre-assessment

2. Assessment

3. Community Follow-up

4. Day Hospital

5. Admission Unit

6. Discharge

A number of steps are listed for each of the service areas. Staff were requested to sign off each step as it was completed. Where variances from the agreed steps have occurred eg medical examination could not be completed as patient would not co-operate, then these are recorded using a designated coding system and are signed off by staff. When a group of steps have been completed then the outcome for that group can be signed and staff can see of they have completed the steps within the designated time allotted on the pathway.

The Clinical Audit Department were asked to audit the care pathways completed before the end of August 2001 so that the service could determine to what degree they had met the outcomes listed on the pathways and to record the variances from the designated pathway. This retrospective audit would also allow the service providers to look at the targets and standards they have set locally and to ensure that these are realistic.

Method

Completed care pathways were posted to the Clinical Audit Department by the secretary from the Psychiatry of Later Life Services. 39 care pathways were received in total. An SPSS (Statistical Package for Social Sciences, Version 10) spreadsheet was set up and each care pathway was entered onto the spreadsheet. The variables corresponded with each step of the pathway and were recorded as

“yes” if achieved and where a variance occurred, the code for the variance was recorded as listed on the care pathway. Once the 39 care pathways were coded and entered onto SPSS, the analysis was carried out. Once the report is finalised, the results will be fed back to the multi-disciplinary team.

Results and Conclusions

The care pathways were well completed and were signed off consistently by all staff members. Any variances from the pathway were generally well recorded and there was little information that was missing for analysis. There were occasions however, when the outcome boxes had been ticked that, for example, all steps of the pre-assessment had been completed within 5 working days of receipt of referral when in actual fact this had been achieved 6 or 7 working days later. As a result, the overall outcome percentages are lower than might be expected.

The report presents the overall percentage of completion for each step of the pathway and an overall one for each section. It can be seen that the percentages achieved varies from step to step and across outcomes and a further audit would be necessary to see if these variations are consistent.

A list of all possible variances and the number of times they were identified on the care pathway are presented in the report. Many of the variances are out of the control of the service provider eg. patient becomes unco-operative or is unavailable for an appointment and therefore a particular part of the pathway is incomplete. These variances will effect the overall outcome scores but there are many variances that can be eliminated if the service provision becomes more streamlined and more staff are made available. The recommendations below are based on the variance that have arisen as a result of inadequate service provision:-

- Further secretarial support is required – to cover annual leave/sickness.

- Further medical staff required to carry out assessments.

- Extra OT provision is required.

- To provide a Day Hospital in Offaly.

- Further availability of ECG and X-Ray required in conjunction with PGH.

From the literature gathered on care pathways, it would be recommended that a patient or carer comment form is attached to each care pathway and it should be considered that the documents are available for patients to look at when required. The department, should care pathways continue to feature in their service, should also examine electronic means of recording the pathways.

This is essentially an audit of the Integrated Care Pathways Process. All inputs to the process of care are documented and variances are highlighted. However the pathway in itself does not act as an outcome measure. Further outcome audits of indicators such as length of contact within a service, patient satisfaction, health outcome measures etc would need to be addressed to assess the overall effectiveness of the service. However, the ICP does provide a useful tool and allows staff to monitor variances in the process of care on an ongoing basis. If the inputs are in place in terms of service provision there is a higher chance that end goals/outcomes are being reached.

AUDIT OF ALCOHOL ADMISSIONS IN ST FINTAN'S AND ST LOMAN'S HOSPITAL

Objectives

The admission rate of patients with alcohol related problems to both St Fintans and St Lomans is very high, as is readmission. The objectives of the audit were to:

- Collect the data for the first 60 alcohol related admissions and re-admissions into both hospitals from October 1st 2001- January 2002.

- To identify current practice relating to referring patients with alcohol use to community services.

- To identify gaps in service provision at present.

- To identify the characteristics of service users.

- To improve protocols for the management of clients diagnosed with alcohol misuse on admission to hospital with an aim to reducing readmission.

Method

A data collection sheet was designed by Clinical Audit in conjunction with the staff from the 2 hospitals. This was piloted by collecting data on previous admissions using the form. A few minor changes were made, and the forms were sent to the admission units, both male and female in the 2 hospitals. The nursing and medical staff completed the questionnaires about any admission that was alcohol related and completed forms were returned to Clinical Audit. Letters were then sent to alcohol counsellors informing them of the audit and were then contacted by telephone to establish whether the patients attended counselling following discharge.

The data was entered onto an SPSS spreadsheet and will be analysed in January 2002.

AUDIT OF OCCUPATIONAL THERAPY STATISTICS COLLECTED FOR PATIENTS WITH MENTAL HEALTH PROBLEMS ATTENDING THE OT SERVICE WITHIN THE MIDLAND HEALTH BOARD

Objectives

The Occupational Therapists complete a form for each patient attending the OT service. There is a large amount of data on these forms, which are paper based, and it would be of benefit to audit their contents to establish the profile of paitents using the service, their waiting time for appointments, levels of DNAs and CNAs, patients progression through the service and investigate patient outcomes. It is uncertain how useful the information currently collected is and an audit of the forms would highlight any areas where data collection could be enhanced. After audit, the forms may be updated and possibly computerised to make future audit easier.

Method

The forms were copied and sent to Clinical Audit and Research. An SPSS spreadsheet was set up and the data for each patient was recorded.

Results

Will be available in January 2002.

HEALTH NEEDS ASSESSMENT OF THE ADULT HOMELESS POPULATION IN THE MIDLAND HEALTH BOARD AREA

Objective

- To estimate the scale of homelessness in the Midland Health Board area.

- To make evidence-based recommendations for optimal health care of the homeless population by documenting details of their health status, lifestyle and health care access in the Midland Health Bard area.

Methods

The following methodology is to be put forward for consideration and approval by the health forum on homelessness in the new-year. In order to complete a profile of the homeless population it is proposed that a survey be carried out of homeless individuals and their families who have contact with any of the services, statutory or voluntary, in the region, during a specified week. This survey would seek basic demographic information, and information on duration and type of homelessness. A unique identifier of initials, date of birth and gender can be used to minimise double counting. An important element of this methodology is that as many of the agencies in the area as possible, both statutory and voluntary, take part in the survey.

On completion of the profile of the homeless population, it is proposed that a second more detailed questionnaire be administered to a representative sample of the homeless population. This questionnaire would seek information on Health Status, Lifestyle, and experience of current Health Services, suggestions for future developments etc. Given that this questionnaire would be much longer and more detailed it would be appropriate for it to be administered by the researcher, in consultation with service providers.

Another proposed element of this methodology would be to complete a postal survey of health service providers in the area. This survey to include GP's in the area, A&E staff, Out Patient Department staff, staff in Psychiatric Services. Topics to be covered in this survey would include, definition of homelessness; perceptions of problems associated with treating homeless people, if any; support required by staff in the care and treatment of homeless people; knowledge of services available to homeless people; responsibilities for helping homeless people access health service, perceptions of the numbers of homeless people who attend their service.

Results

Not available.

“TWO YEAR DEVELOPMENTAL CHECK” AUDIT

Objective

To ensure that all children in the 22 to 28 month category are being assessed and that the checks offered by all PHN’s are standardised.

To provide baseline information on the current practice in the MHB regarding the “Two Year Developmental Check” in relation to checks carried out at the “18 month check” and the “24 month check”, and consequent referral to specialist services

Methodology

The sample included all babies born in the month of July 1999 in the Longford/Westmeath Community Care Area. An audit questionnaire was developed by the audit department in consultation with the Director of Public Health Nursing and the Assistant Director of Public Health Nursing. The Child Health Service Pre-School/School Card for each child in the sample was checked retrospectively by the area PHN’s. These cards contain information for the 18 month and 24 month Developmental Check and the audit questionnaire was filled out using the information on the cards. The questionnaires were returned to the audit department An SPSS (Statistical Package for Social Sciences, Version 10) spreadsheet was set up and the questionnaires are currently being entered.

Results

Available March 2002.

EARLY IDENTIFICATION, PREVENTION, AND MANAGEMENT OF POSTNATAL DEPRESSION

Introduction

Postnatal Depression affects around 10% of women in the weeks after giving birth (A. McCarthy, 1998). Although it is a common disorder, only half of those affected seek medical help. Postnatal depression is a distressing disorder, more prolonged than the "blues" (which occur in the first week of delivery) but less severe than pneurperal psychosis. The mother may suffer insomnia, fatique and lethargy, tearfulness, depression, despondency, feelings of inadequacy, resentment and an inability to cope. These mothers may cope with their baby and with household tasks, but their enjoyment of life is seriously affected and it is possible that there are long-term affects on the family. The Edinburgh Postnatal Depression Scale (EPDS) has been developed to assist primary care health professionals. It is a self-rated instrument that has been used to screen for postnatal depression in practices throughout Europe, New Zealand and Australia (C. Epperson, 1999). The EPDS consists of ten short statements. The mother underlines which of the four possible responses, scored from 0-3, is closest to how she has been feeling during the past week. The score on individual statements are added together. A total of 12+ indicates the likelihood of depression and the need for further assessment two weeks later (Cox et al., 1987). The scale can be completed, without difficulty, in less than five minutes.

Aim

The aim of this study was to find out the prevalence of postnatal depression for all mothers who deliver between 1st July 2000 and 30th June 2001, in the Edenderry, Granard and Delvin Health Board areas. A retrospective study for all mothers, who gave birth between 1st July 1999 to 30th June 2000, in the above Health Board areas, will determine any history of postnatal depression and treatment received.

Objectives

- To give an estimate of the prevalence of postnatal depression in the Health Board areas selected.

- To measure the effectiveness of the Public Health Nurse's intervention for mothers with depression.

Method

The prevalence of postnatal depression for all mothers who delivered between 1st July 2000 and 30th June 2001, in the Edenderry, Granard and Delvin Health Board areas was calculated using the EPDS. EPDS statements are scored from 0-3; the normal response scores 0 and the 'severe' response scores 3. The score on individual statements are added together. Women scoring 12 or above were further assessed before deciding on treatment. A retrospective study for all mothers, who gave birth between 1st July 1999 to 30th June 2000, in the above Health Board areas, determined any history of postnatal depression and treatment received. The data was analysed in the Clinical Audit and Research Department using SPSS version 10.1.

Results

A total of 205 mothers gave birth between 1st July 2000 and 30th June 2001, in the Edenderry, Granard and Delvin Health Board areas. 13.7% (28/205) of these were considered to be suffering from postnatal depression (EPDS score of ≥ 12). 60.7% of these improved after home visits. For the retrospective study, 1st July 1999 to 30th June 2000, a total of 172 women gave birth. 33.1% of these mothers considered themselves to have suffered from postnatal depression.

Discussion

A total of 205 mothers gave birth between 1st July 2000 and 30th June 2001, in the Edenderry, Granard and Delvin Health Board areas. 13.7% (28/205) of these were considered to be suffering from postnatal depression (EPDS score of ≥ 12). This figure is comparable to findings by McCarthy, 1998, who states that postnatal depression affects 10% of women in the weeks after giving birth. Studies carried out in the UK (50 women) and Taiwan (101 women) gave results of 18% and 19%, respectively, suffering from postnatal depression.

Of the 28 women reported to be suffering from depression, 60.7% improved after home visits from the Public Health Nurse and were considered to be no longer suffering from postnatal depression. A study of over 200 women, mainly of Caucasian origin, demonstrated that with the use of the EPDS not only is identification of women at risk possible, but that increased intervention can significantly reduce the risk factor of post natal depression (Sheldrake et al., 1996).

For the retrospective study, 1st July 1999 to 30th June 2000, a total of 172 women gave birth. 33.1% of these mothers considered themselves to have suffered from postnatal depression. This figure, 33.1%, is relatively higher than that found in previous studies. This high figure may be due to self-diagnosed depression. The EPDS avoids such common postparum changes as fatique, poor appetite, and altered sleep patterns as evidence of depression

FAMILY PLANNING SERVICES IN THE MIDLAND HEALTH BOARD REGION

Introduction

The 1992 Health Family Planning Act and the Health (Family Planning) Regulations obliges Health Boards to make available services for their regions. In March 1995 the Department of Health issued "Family Planning Policy: Guidelines for Health Boards". This stated that "The Health Boards should ensure equitable, accessible and comprehensive family planning services. The role of General Practitioners in providing family planning services is recognised and this role will be developed and strengthened".

Objective

The objective of this study is to establish the range and extent of family planning services provided by GP's in the region.

Method

There are 110 GP's with GMS contracts in the Board region. Each GP was forwarded a questionnaire in May 2001. Further contact was made by telephone, during the period November 2001 to date, and individual visits to some practices were carried out to ensure the return of the questionnaires. The data will be analysed in the Clinical Audit and Research Department using SPSS version 10.1.

Results

Results are currently being analysed and will be available on the day of presentation.

Discussion

It is planned that the outcome of the study would inform service providers and the Health Board about any gaps in existing services and plan for the future. These results will be compared to data from the 1996 Lansdowne Market Research Family Planning Survey.

Clinical Audit Projects – Acute Hospitals

GUIDELINE DEVELOPMENT FOR THE MANAGEMENT OF PERCUTANEOUS ENDOSCOPIC GASTROSTOMY (PEG) TUBES – A MULTIDISCIPLINARY, CROSS-CARE GROUP QUALITY INITIATIVE

Objective

To improve the quality of care received by patients who require a PEG tube, from the time the tube is inserted through to the long term management of PEG tube patients.

Methods

An audit of numbers of patients with PEG tubes and the numbers of patients re-admitted for PEG tube re-insertions was Proposed by the Clinical Placement co-ordinator.

A multi-disciplinary working group from the Acute Hospital and the Long Stay Older Persons' homes was established to review the results.

The group identified that there was a problem managing PEG tube patients due to lack of a clear research based protocol.

The working group subdivided into four groups who each took responsibility for different parts of the protocol depending on their area of expertise.

Results

A preliminary audit at LWGH revealed that 42 patients from 29.09.00- 29.09.01 had a PEG tube inserted. 16% of these patients had to re-attend the hospital for re-insertion and these were performed as emergency procedures in the Causality Department. One patient attended 5 times for re-insertion.

The four sub groups devised the guideline under the following heading having researched Best Practice in PEG tube management in Ireland and the UK:

- Referral Procedure for PEG tube insertion / re-insertion
- Multi-Disciplinary team (MDT) Assessment
- Surgical Protocol for tube insertion
- Follow up and long term care of Patients with PEG tubes.

Conclusion

A protocol for the management of PEG tubes has been agreed. The next stage is to ensure effective dissemination and implementation. It was felt education would be one of the most important aspects of any dissemination strategy.

Care will now be standardised, access to services in the acute hospitals more streamlined leading to improved quality of care for patients requiring PEG tubes.

Re-audit will be carried out in one year following implementation to measure effectiveness and use of the protocol.

AUDIT OF USAGE OF SARSTEDT NEEDLE PROTECTORS, PORTLAOISE GENERAL HOSPITAL AND GENERAL HOSPITAL TULLAMORE

Aim

To evaluate the new Sarstedt Needle Protector system which was introduced into Portlaoise General Hospital (PGH) and General Hospital Tullamore (GHT) in January 2001.

Objectives

To measure awareness and usage of the Sarstedt Needle Protector.
To assess how user friendly staff found the system.

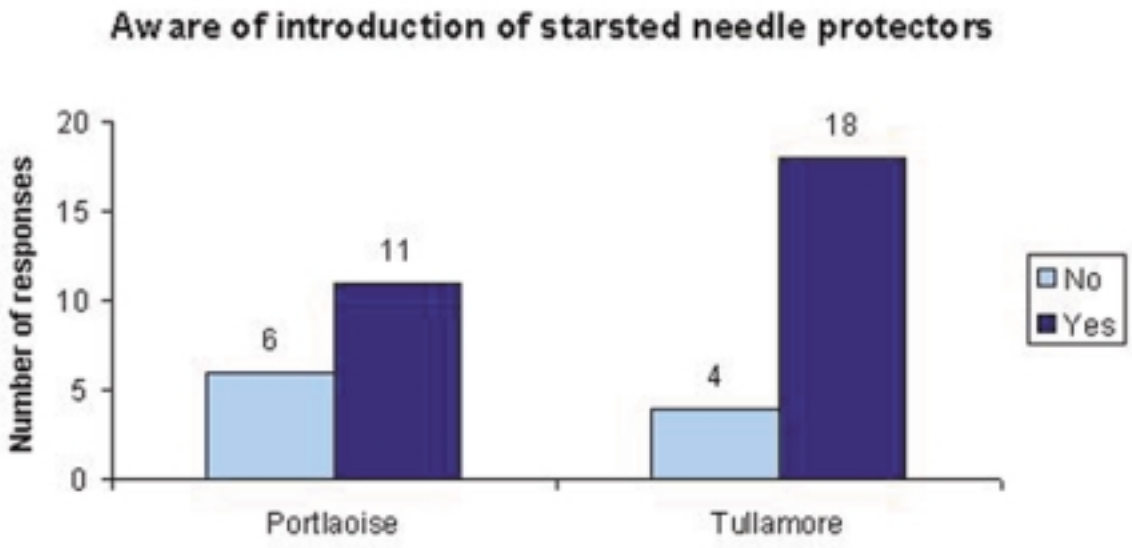
Methodology

A questionnaire was designed by Clinical Audit and Research in conjunction with Occupational Health to evaluate awareness, uptake and training of the system.

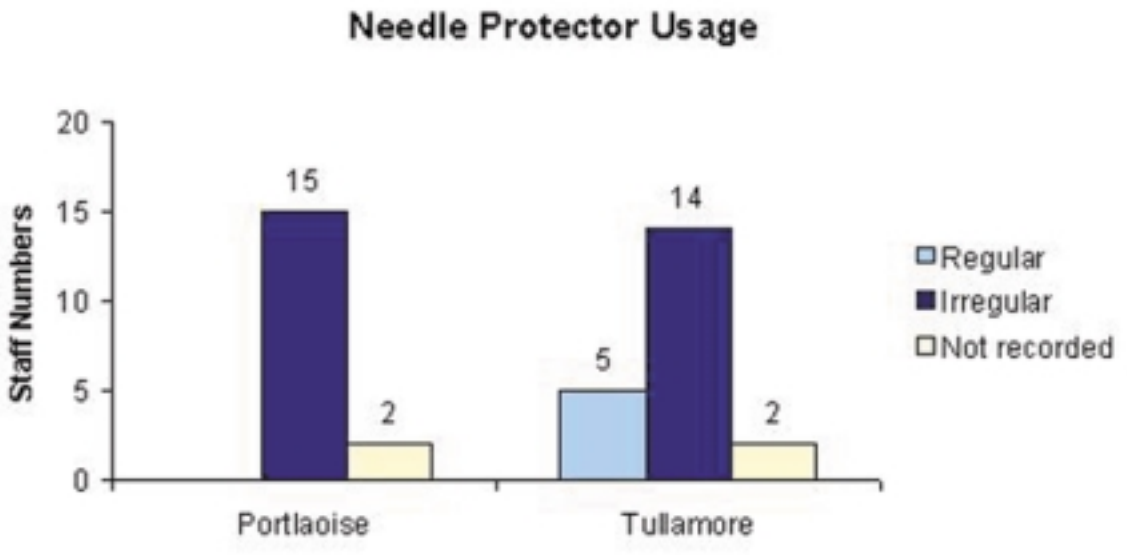
The questionnaire was pre-tested, and then administered in GHT and PGH. A total of 22 questionnaires were collected from GHT and 18 from PGH. Questionnaires were analysed using Microsoft Access and Excel.

Results

Some of the results are illustrated below.



Overall, a total of 29 staff (74%) were aware of the new system, leaving 10 staff (26%) unaware of the system.



Overall, 5 members of staff (13%) regularly used a needle protector while 29 (74%) used a needle protector irregularly.

Recommendations

- Seek staff views on which needle protector system they would be most comfortable using.
- Devise a training programme, which could be incorporated into doctor's induction day every six months.
- In order to improve quality of training, an evaluation questionnaire should be devised in order to identify strengths and weaknesses of training programme.
- In hospital promotion/information on the reasons why needle protectors should be used.
- An analysis of needlestick accident report forms to identify areas where needlestick injuries occur most frequently.
- Devising a comprehensive prevention strategy, including administrative changes, safety education and awareness, feedback on safety improvements and actions taken on continuing problems.

Action

Responsibility for action taken by the Occupational Health Department.

ANALYSIS OF SURGICAL ADMISSIONS FROM THE DAY WARD IN LONGFORD WESTMEATH GENERAL HOSPITAL

Aim

To complete an analysis of number and reasons for admission to the surgical ward from the day ward in Longford Westmeath General Hospital (LWGH).

Methodology

It was decided to analyse admissions which occurred during the first four months of 2001. Patient details were collected from the Day Ward ledger and patient charts. All data was analysed using Microsoft Access.

Results

It was found that out of a total of 778 day cases, 34 people were admitted, accounting for 4% of cases. An analysis of corresponding statistics for 2000 showed that 4% of cases were admitted during the first four months of 2000.

Reasons for Admission

Admission Category	Surgeon 1	Surgeon 2	Surgeon 3	Total
age/social reasons	2	1		3
late surgery	2		1	3
pain control/observation	2	2	5	9
planned admission	3			3
post procedure complications	1			1
surgery needed following exploratory procedure	2	2		4
underlying condition	1		1	2
uneventful post op	4		1	5
unknown	2	2		4
Total	19	7	8	34

A full copy of results is available from Clinical Audit and Research.

EARLY PREGNANCY UNIT DATABASE

An Early Pregnancy Unit is to be launched by the Obstetric Department at the Midland Regional Hospital, Mullingar on January , 2002. In order to facilitate the smooth running of this service, and ease of future audit, a database was designed in consultation with the multidisciplinary team. All patient data relevant to their visit is stored on the database.

This database is designed to record patient details, laboratory results and ultrasound results, to print appointment slips and GP letters. Regular audit of clinical and administrative data can be carried out by staff themselves and audit reports printed. This will facilitate collation of Performance Indicators for the service.

A database has also been designed for a Home Enteral Feed Register which is to launched in 2002. Anna has also been available in an advisory capacity for other Access database designs.

AUDIT OF BREAST-FEEDING RATES IN PORTLAOISE MATERNITY UNIT

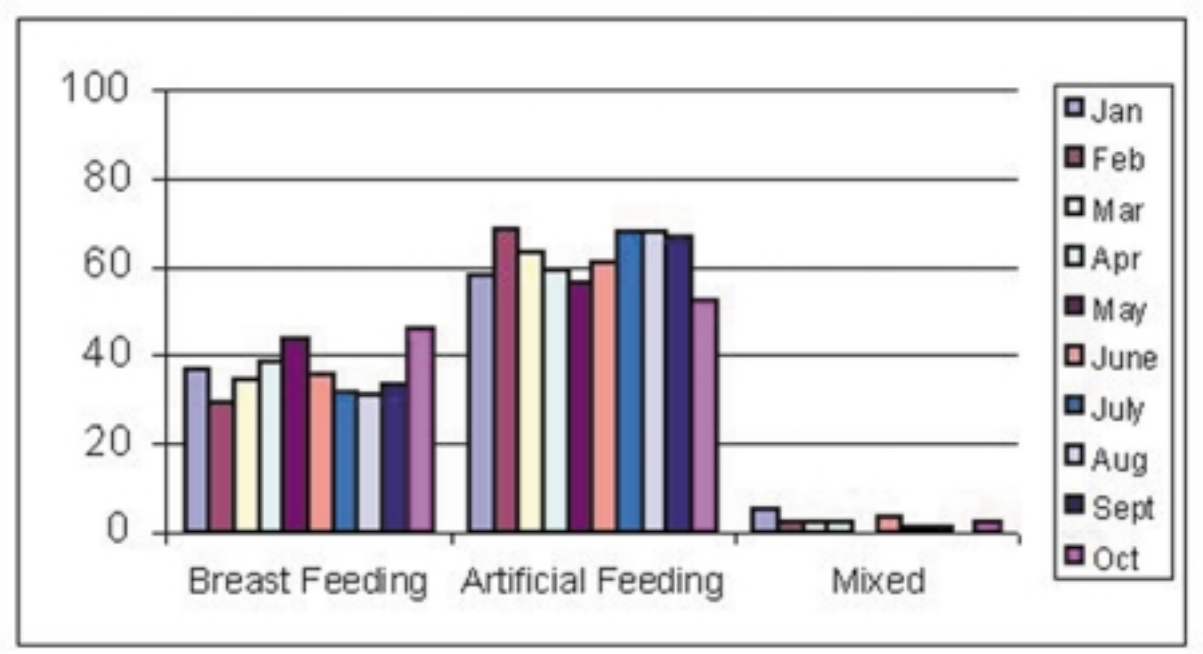
Objectives

To obtain an accurate monthly record of breast-feeding rates at the birth and discharge of each baby born in the Maternity Unit, Portlaoise General Hospital. This information is required in the breast feeding policy published by the Midland Health Board in 2000. It was also identified as an action for 2001 for the Baby Friendly Hospital Initiative.

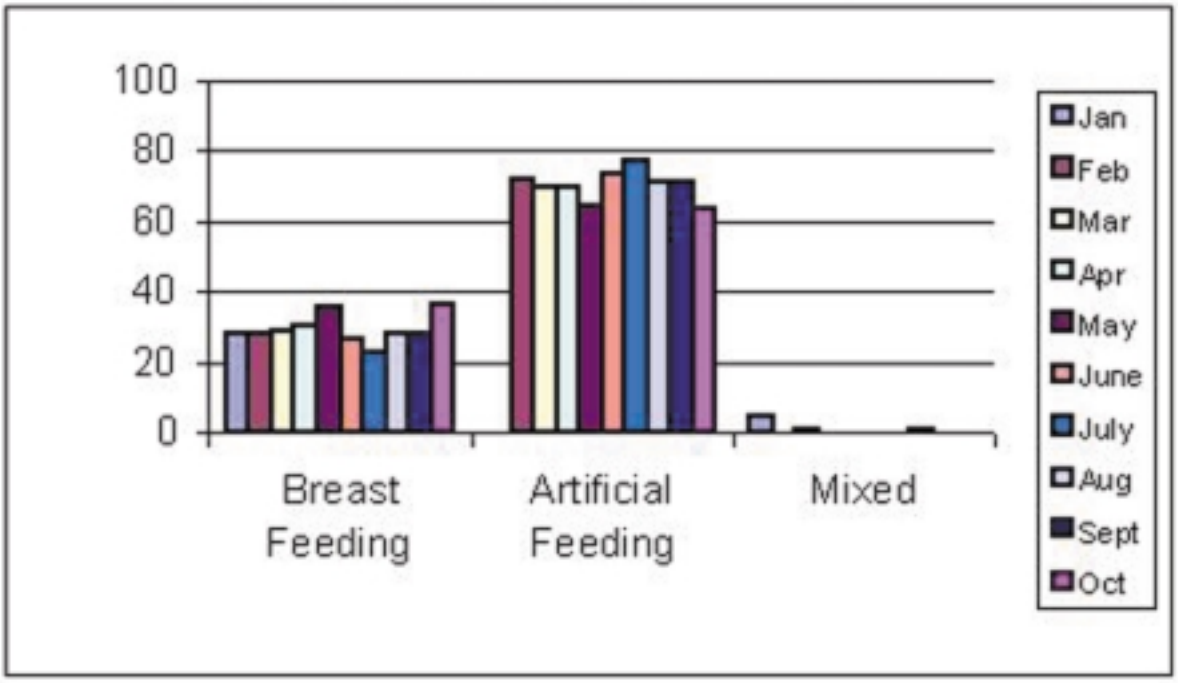
Methods

A data collection sheet was designed for staff to record the feeding methods of each baby on a daily basis from the day of birth to discharge. The sheet was designed by Clinical Audit in conjunction with the staff on the maternity unit. The data collected included, the place of this baby in the family, the method of feeding – breast, bottle or mixed and a section for comments. The data was collected from the unit on a monthly basis and was analysed using SPSS. A monthly report was written, as well as a 6 and 12 month summary document and the results were presented by a researcher to the unit staff on a quarterly basis.

Results



Bar Chart Comparing Feeding Methods at Birth for the First 10 Months of 2001 in Portlaoise Maternity Unit.



Bar Chart Comparing Feeding Methods on Discharge for the First 10 Months of 2001 in Maternity Unit, Portlaoise.

Conclusions

The daily recording sheets completed by the staff for each mother and baby proved to be a successful, accurate method of collecting data regarding feeding methods. The comments section highlighted the experiences of mothers whilst breast feeding their child and allowed a level of understanding to be obtained regarding why a mother may have discontinued breast feeding before discharge.

During the following year, feeding rates will be collected for 4 months of the year – in January, April, August and December.

AUDIT OF BREAST-FEEDING RATES IN LONGFORD-WESTMEATH GENERAL HOSPITAL

Objectives

To obtain an accurate monthly record of breast-feeding rates in Longford-Westmeath General Hospital at the birth and discharge of each baby born.

Method

Due to staff shortages in the Maternity Unit and high workload, the unit staff felt that they would be unable to commit to completing a record sheet of the daily feeding methods of each mother and baby born in the unit. This information is already kept on an ad-hoc basis in the Wrist Band Book and they decided that they would try to keep this more consistently over the year. For the first half of the year 2001 staff from Clinical Audit and Research obtained the data for feeding methods from the wrist band book kept in the Maternity Unit. The ledger, since not designed for the recording of feeding methods, made data access very difficult and feeding data for some babies was missing at birth and discharge. The ledger did not allow any comments about the feeding process to be recorded. Feedback sessions were held with staff regularly, but due to the amount of data missing, it was difficult to report back true feeding rates. It was decided that a data recording sheet could be designed for the mothers to record their own feeding methods on a daily basis. This sheet allowed information about the number of children in the family to be recorded, as well as the method of feeding and any comments about the feeding process. The sheet was piloted in the unit in December 2001 and will be reviewed in January.

Results

Include the results of the pilot.

AUDIT OF STANDARD AND QUALITY OF CHARTS PULLED FOR OPD CLINICS IN TULLAMORE GENERAL HOSPITAL.

Objective

- To measure the accuracy and quality of record management within the chart covers.

- To assess the level of duplication of charts and causes for this.

- To set a standard protocol for the correct management of charts and to ensure compliance with this.

Methods

A questionnaire was designed in consultation with the secretarial staff within the Medical Records Department. The questions addressed the following standards:

1. Chart cover information should be correct in 100% of cases.

2. New labels should be printed for the clinic; no old labels still within the chart.

3. Chart date stamped for the clinic.

4. All relevant contacts, correspondence and results in the chart and in the correct place and order – 100% of cases.

5. Only one chart in use i.e. all relevant information in the most up to date chart e.g. chart 2 of chart 1 or chart 3 of chart 2, and records transferred accordingly.

6. Only one laboratory or x-ray mounting card in use at any one time – 100% of cases.

Data was collected concurrently. The questionnaire was piloted and two sections were removed due to difficulty collecting the information concurrently.

As medical secretaries pulled charts for clinics, a random sample of these charts was selected for the purposes of audit. Data collection took place over one month and a sample of 54 questionnaires was returned. The data was then analysed using Statistical Package for Social Sciences (SPSS) version 10.

Results

Results were compared with the standards set at the start of the audit. Varying levels of compliance with the standards were demonstrated. For example in relation to the standard that chart cover information should be correct in 100% of cases, it was found that it was correct in 46% of cases with reasons for inaccuracies being date of birth missing, chart number illegible, chart number or patient's name too small or hard to read.

In general the results fell below standard by about 25%.

Conclusion:
The audit met the objectives originally set out in the audit proposal. It was felt that the main reason for a failure to meet the standards in all cases was lack of knowledge among staff of what the protocol should be.
A clear written protocol is now in the medical records department and this is used for the induction of all new staff and re-training of staff. It was drawn up in consultation with all staff of the department when the results of the audit were presented.
Random on-going audit of charts is maintained.
Re-audit of a similar sample size is planned in early 2002.

Follow Up:
It is now planned to extend this type of audit work to the Medical Records Department in Longford / Westmeath General Hospital. Preliminary meeting has been held and the Department is undergoing some system reorganisation before the commencement of audit.

AUDIT OF NURSING DOCUMENTATION ON POST-OPERATIVE PATIENTS ON THE REGIONAL ORTHOPAEDIC UNIT, TULLAMORE GENERAL HOSPITAL

Objectives

- To measure current practice against protocols in relation to nursing documentation in the postoperative Orthopaedic patient.

- To identify training needs.

- To perform a baseline study in order to assist in drawing up guidelines and standards in relation to documentation in light of 'Best Evidence' and current findings of the audit.

- To improve documentation.

- To reduce risks of adverse events to patients in the post-operative period.

Methods

A retrospective audit was performed. 28 charts of Orthopaedic patients were randomly selected from November / December 2000 time period.
The Audit Officer and the Practice Development Nurse designed a questionnaire and this was piloted on five charts.
Modifications were made and the questionnaire was used to collect data from the 28 charts. The areas examined were:

1. Section 1: Patient / surgery details.

2. Section II: Documentation of vital signs.

3. Section III: CMS Assessment Chart.

4. Section IV: Fluid Balance Chart

5. Section V: Pressure Care Assessment.

6. Section VI: Pain Controlled Analgesia.

Results

Vital signs were recorded with varying frequencies and though BP and pulse were recorded regularly, respiration was not.
14% of the sample did have a colour, movement and sensory chart. Of the remainder; 50% did not have this information recorded with 32% having this information recorded either in their care plan or the postoperative sheet.
All patients sampled had a Fluid Balance Chart in situ. However, further examination revealed that the protocol in relation to the Fluid Balance Chart e.g.that the chart should be balanced and brought forward daily, 89.3% failed to comply with this.
89.3% of the sample had a pressure sore risk assessment carried out on their return from theatre. However, again there was variation about when the risk assessment

was carried out. 44% had it carried out within the first hour but the remainder ranged from 1 hour up to 72 hours.
14 patients (50%) had a PCA in situ. 92.8% of these had their BP and pulse recorded in the 4 hour, 24 hour and 48 hour period post operatively. However, recording of respiration in the same time period fell below standard.

Conclusions
In reporting the results of this audit, it was difficult to record succinctly the number of times vital signs were recorded, as there was a large range of times apparent on examination of the charts. This is not surprising as there is no written protocol on how frequently vital signs should be recorded in the 4, 24 and 48 hours post operatively.
It was felt on discussion with staff from the unit that failure to comply with standards was due to lack of nursing personnel on the ward and therefore lack of time to record this data regularly.
However, since the audit there has been an increase in the staff complement with the appointment of a second CNM II, a second CNM I and a Divisional Nurse manager. AV impulse machines have also been installed to reduce the risk of DVT's.
Guidelines are presently being completed for the nursing care of patients with THR, fractured neck of femur and discectomy. Re-audit planned for early in 2002.

AUDIT OF THE MANAGEMENT OF PERIPHERAL IV CANNULAS IN THE GENERAL SURGERY DEPARTMENT

Objective

To survey the incidence of occurrence of complications in patients with IV cannulas in the General Surgical Ward. The aim of the audit is to reduce the occurrence of complication in patients with IV cannulas, to improve the quality of service delivered to patients and to reduce unnecessary additional days in hospital.

Methods

This was a multidisciplinary audit of structure, process and outcome in the General Surgery department, General Hospital Tullamore. The members of the audit team consisted of:

- Medical staff of the General Surgical Department
- Nursing staff from the General Surgical Department.
- Clinical Audit Facilitator.

A prospective audit was undertaken and it ran for a period of two weeks to allow for a sample size of 50-60 patients to be collected. The subjects of the audit were any patients who had an IV cannula sited in the surgical ward during the duration of the audit.

The collection of the relevant data was co-ordinated by the Clinical Audit team in the General Hospital Tullamore. Questionnaires were designed by the Clinical Audit team, to be filled out by both the medical and nursing staff in the General Surgery department, to facilitate the recording of all proceedings, precautions, monitoring etc. carried out by the medical and the nursing staff upon siting/resiting the cannula, connection of the giving set and upon the occurrence of a complication. The audit also included observation by a member of the Clinical Audit department.

Results

Data collecting during the audit were analysed using Microsoft Excel and SPSS (Statistical Packages for Social Sciences).

The results provided information on the procedures used by both the medical and nursing staff when siting a cannula or connecting giving sets in the General Surgery Department. The report was constructed under the headings:

- Structure e.g. the number of handbasins per bed;
- Process: e.g. the procedure followed for siting an IV cannula;
- Outcome: the number of complications identified.

Conclusions

A number of areas for improvement were highlighted as a result of the audit

- Guidelines for the siting of an IV cannula need to be documented and implemented.
- Improved documentation and management of giving sets for the Nursing staff.

The information obtained in from the audit will assist in decreasing the occurrence of complications to patients with IV cannulas

AUDIT OF DNAS IN THE OUT-PATIENT DEPARTMENT IN GENERAL HOSPITAL, TULLAMORE

Objective

To investigate the occurrences of DNA's (Did Not Attend) in General Hospital Tullamore, to put recommendations in place to reduce the numbers of patients who do not attend for appointments and to ensure the standard procedures are put in place to deal with DNA patients.

Methods

This was a multidisciplinary retrospective audit of DNA's in the Out-Patient Department, General Hospital Tullamore. The members of the audit team consisted of:

- Medical staff of General Hospital Tullamore
- Nursing staff from the Out-Patient department, Tullamore
- Administration staff/medical secretaries in the Out-Patient department, Tullamore. Clinical Audit Facilitator.

The evaluation consisted of the following

- Group discussion/Semi structured interview with Medical Secretaries and Administration staff in OPD.
- Group discussion with Nursing staff in the OPD.
- Collection of baseline information on the current situation in OPD in relation to DNA's.
- Consultants were invited to express their views on DNA's in OPD and on the procedures used to deal with patients who DNA.

Information collected included the following

- Examination of OPD clinics for the week commencing 1st October to determine the number of DNA's.
- The procedures used to deal with each of these DNA's were investigated.
- This information was compared to protocols already in place to identify if the existing protocols are adequate, and being adhered to.
- 60 randomly selected DNA patients were administered a telephone questionnaire. The aim of which was to investigate the reasons why patients did not attend for their appointment in the OPD and why they did not cancel the appointment prior to the clinic.

Results

Data collecting during the audit were analysed using Microsoft Excel and SPSS (Statistical Packages for Social Sciences). The results indicate that during the week of October 1st to October 5th, the number of DNA patients made up 19% of the total number of appointments for that week. Of this, 81% were return patients and 19% were new patients. The highest numbers of DNA's were observed in the Orthopaedic clinic. The present protocol for DNA's in the OPD required updating with no SOPs in place for many of the consultants. The main reason given for non-attendance was "forgot appointment" or "did not receive appointment". The main reasons for not canceling the appointment was "Forgot to ring" and "unaware of the requirement to ring".

Conclusions

A number of areas for improvement were highlighted as a result of the audit
Updated protocol for dealing with DNA's required for each consultant.
Improved facilities in the OPD.
Increased public awareness about the problem of DNA's in the OPD
Improved overall communication
The information obtained in from the audit will assist in decreasing the occurrence DNA's in the OPD in General Hospital Tullamore

Plan

Re-audit in one year to measure any reduction in the number of DNA's due to changes implemented.

AUDIT OF ANTIBIOTIC PRESCRIBING IN PORTLAOISE GENERAL HOSPITAL

Objective

To investigate the length of time for which antibiotics are prescribed for all patients in Portlaoise General Hospital and to determine if patients are on antibiotics for prolonged or excessive periods of time.

Methods

The evaluation consisted of the following:

- Assessment of the number of patients on antibiotics in Portlaoise General Hospital on October 18th 2001.

- Investigation of drug cardex for each of these patients to assess how long patient was on antibiotic, why patient was on antibiotic and if the prescription was open-ended or for a finite period of time.

- Examination of patient charts to determine how long patient was actually on the antibiotic, if antibiotic was switch from iv to oral and if the patient was still on the antibiotic when released from hospital.

Results

On the date of the audit, there were 32 patients on antibiotics in Portlaoise General Hospital. The antibiotics administered and the conditions being treated were very varied. Of these 32 patients, 30 were on open-ended prescriptions. There was a finite period of time for the administration of antibiotics recorded on two drug cardexes only. The length of time patients were administered antibiotics ranged from 5 days to 23 days. Due to inadequate documentation it was sometimes difficult to determine the total length of time patients were on antibiotics.

Conclusions

A number of areas for improvement were highlighted as a result of the audit

- Guidelines for the prescription of antibiotics required in all areas of PGH

- Improved documentation of antibiotic prescription/completion especially upon discharge of patient

- Definite dates for either completion or review of the administration of antibiotics.

The information obtained from the audit will assist in improving the administration of antibiotics to patients in Portlaoise General Hospital initially and ultimately in all of the acute hospitals in the MHB.

Plan: Monitoring of new Drug Cardex in PGH in the Autumn. Induction days for staff regarding the drug Cardex are being planned by the Pharmacy Services.

AUDIT OF PRE-OPERATIVE FASTING TIMES IN LONGFORD/WESTMEATH GENERAL HOSPITAL

Objectives

To review the evidence base for pre-operative fasting times. To identify the length of time patients are fasting pre-operatively in LWGH. To assess if patients receive comprehensive and adequate information about fasting requirements. To investigate if theatre lists could be organised to allow for more definite theatre schedules for patients as this would allow the possibility of reduced fasting times particularly for those patients who are scheduled for afternoon surgery.

Methods

This was a multidisciplinary prospective audit of pre-operative fasting times in LWGH. The audit was carried out on all elective surgical patients (> 14 years old) in Ward 3, 4, Level 0 and the Day ward who were to undergo a surgical procedure under general anaesthetic. Also included in the audit were patients attending for Day ward Gynaecological procedures or procedures under sedation as these patients were also required to fast pre-operatively.

The members of the multidisciplinary audit team consisted of:

- Surgical staff of LWGH
- Nursing staff from the Surgical wards and the Day ward in LWGH
- Nursing staff from Theatre
- Anesthetists in LWGH
- Catering staff in LWGH
- Clinical Audit Facilitator.

The collection of the relevant data in LWGH was co-ordinated by the Clinical Audit team. Questionnaires were designed by the Clinical Audit team, to be filled out by the nursing staff in each of the surgical wards and Day ward prior to surgical procedure, to record how long each patient was fasting, what their last meal consisted of and if they got adequate information prior to their procedure. The questionnaire also looked at areas such as pre-meds, routine medications, if the patient was administered IV fluids, if the patient was diabetic, the time the patients went in to theatre and solid and fluid intake post-operatively. The audit took place over a 3-week period in May/June 2001 and 60 questionnaires were completed.

Results

Data collecting during the audit were analysed using Microsoft Excel and SPSS (Statistical Packages for Social Sciences). The average age of the patients included in this audit was 51.4 years and 70% of these patients attended the Day ward. The overall findings of the audit were as follows:

- The average length of time patients were fasting from solids was 15.5 hours

- The average length of time patients were fasting from fluids was 12.79 hours

- 85% fasted from solids and 67% fasted from fluids for 12 hours or longer.

- 52% fasted from solids and 22% fasted from fluids for 15 hours or longer.

- Comprehensive information about pre-operative fasting was lacking. A number of patients were unaware of the proper fasting requirements for their procedure.

- Patients on the wards were fasting excessively due to the early evening meal times on the wards.

Conclusions

A number of areas for improvement were highlighted as a result of the audit

- Improved information about pre-operative fasting requirements and pre-surgery requirements to be delivered to the public.

- Separate and colour coded sheets for Local Anasthetic and General Anesthetic fasting requirements.

- Patients on the surgical wards to be given sandwiches in the evening (approx. 8-9pm) so that they are not fasting excessively on the wards.

- Improved liaison and communication between the theatre and the surgical wards and the Day ward.

- Theatre lists to be as structured as possible.

The information obtained in from the audit will assist in decreasing the length of time patients are fasting unnecessarily prior to a surgical procedure in Longford/Westmeath General Hospital.

Plan

Re-audit in one year to show a reduction the length of time patients are fasting pre-operatively due to changes implemented.

AUDIT OF THE EFFECTIVENESS OF FINE NEEDLE ASPIRATIONS ON BEHALF OF THE REGIONAL LABORATORY UNIT OF MANAGEMENT, MIDLAND HEALTH BOARD

Objectives

To measure the number of FNA samples that are adequate for the purpose of diagnosis from January 2000 to December 2000. To assess if any false negative or false positive results with FNA's carried out during this time and to assess the effectiveness of the FNA's on eventual patient diagnosis.

Methods

This was a multidisciplinary retrospective audit of all FNA's carried out in the three acute hospitals in the Midland Health Board, General Hospital Tullamore, Longford/Westmeath General Hospital, and Portlaoise General Hospital from January 2000 – December 2000.

The members of the multidisciplinary audit team consisted of:

- Pathologists in GHT
- Laboratory staff in GHT
- Regional Laboratory unit of Management
- Medical records staff in GHT
- Clinical Audit Facilitator.

A member of the Clinical audit team liaised with the pathologists and the lab supervisor in GHT during this audit.

158 FNAs were carried out from January and December 2000 inclusive. The laboratory reports for each of these FNAs were assessed to determine if the FNA was adequate for the purpose of diagnosis. The charts for each of these FNA patients were reviewed to investigate if the FNA performed on that patient was essential or contributed to the final diagnosis for that patient.

Results

Data collecting during the audit were analysed using Microsoft Excel and SPSS (Statistical Packages for Social Sciences). The results of the audit indicate that of the 158 FNAs carried out:

- 99 (62.7%) were inadequate
- 17 (10.8%) were inconclusive
- A definite diagnosis could only be obtained from 26.6% of the FNA samples
- 73 patient charts were examined. Of the inadequate and inconclusive FNAs, 74% were eventually diagnosed as a benign condition and 20% were diagnosed as a malignant condition. No false positive or false negative FNA results were observed.
- FNAs contributed to 23% of the final patient diagnosis in GHT.

Conclusions

As a result of the audit a number of recommendations for change were made:

The Midland Health Board to employ a Histopathologist with expertise in Cytopathology to perform and report on Fine Needle Aspirates in the three acute hospitals within the Midland Health Board.

Adequate staff to be employed to support the additional pathologist.

FNAs not to be taken by clinicians but where practical to be taken by Cytopathologists.

Clinics, to be set up in each of the three acute hospitals in the MHB and run by the new Cytopathologist / Histopathologist and support staff to cater for all patients requiring the FNA procedure.

The information obtained from the audit will assist in increasing the effectiveness and adequacy of the FNA procedure in the Midland Health Board so that this procedure will contribute more to future final patient diagnosis.

Plan

Re-audit in one year to show an increase of the effectiveness of FNAs in the MHB if and when a histopathologist is employed.

EVALUATION OF THE 18 HOUR BREASTFEEDING MANAGEMENT COURSE

Objective

To evaluate the skills required on the WHO/UNICEF 18-hour Breastfeeding Management course.

Methods

A Breastfeeding Support Skills Tool (BeSST), devised by the Dept. of Midwifery in the University of Lancashire, was utilised to assess the effectiveness of the WHO/UNICEF 18-hour Breastfeeding Management course. This tool consisted of a video in conjunction with a questionnaire which was administered to the course participants on the morning of the first day of the course in May 2001 and approx. 1-2 months post-course. The marks achieved by the course participants pre-course were compared to the marks achieved by these participants post-course to determine if the course significantly increased the breastfeeding management knowledge of the participants.

The audit team consisted of the following:

- The 18hr breastfeeding management course organisers and lecturers.
- The Breastfeeding course participants
- Clinical Audit team.

The participants consisted of representatives from both the hospital and the community.

Results

Data collecting during the audit were analysed using Microsoft Excel and SPSS (Statistical Packages for Social Sciences).

Pre-course: The average overall score for all participants combined was 38.28±11.01. For the community based participants the average score was 36.29±13.71 and the average score for the hospital-based participants was 38.10±8.56.

Post-course: The average overall score for all participants combined was 48.79±11.07. For the community based participants the average score was 43.92±9.2 and the average score for the hospital-based participants was 51.78±11.34.

Conclusions

Although there was an increase in the results, it was decided that for the time and resources given to these Breastfeeding Management courses a larger increase in knowledge would be expected. As a result of this decision, the Breastfeeding management course planned for September 2001 was postponed and measures were taken to ensure that future courses, which are to recommence in 2002, would demonstrate a greater increase in knowledge post-course as a result of improvements to various aspects of the course. Measures for improving the outcome of future Breastfeeding management courses include:

- 3hrs of practical experience / work will be included in the course.

- The experiences of other 18hr Breastfeeding Management course organisers and lecturers both in Ireland and abroad will be used to improve the MHB course.

- The audit tool will also be assessed to ensure that it is obtaining a true reflection of the knowledge gained by the course participants.

- The information obtained in from the audit will assist in increasing the knowledge gained by the WHO/UNICEF 18-hour Breastfeeding Management course participants in the Midland Health Board

Plan

Re-audit in one year to show a greater increase in participant knowledge post-course as compared to pre-course knowledge.

AUDIT OF PATIENT IDENTIFICATION BRACELETS (WRISTBANDS) – THREE ACUTE HOSPITALS

Objectives

- To measure compliance with the present protocol for patient wristbands in the three acute hospitals within the Midland Health Board.

- To review and modify the current protocol in light of current Best Evidence and Risk management to reduce risks of adverse incidents due to incorrect identification of patients.

Methods

Data was collected concurrently using a questionnaire. A sample of 214 patients was included in the audit. This represented 40% of bed numbers in the three acute hospitals and patients were randomly selected from all wards and specilties.
Firstly it was checked that wristbands were on each patient, and then what information was written on the bands. Data was analysed using SPSS version 10.

Results

Out of the 214 patients sampled, 17 patients (7.9%) were not wearing wristbands. There was varying levels of compliance with the protocol for those patients who were wearing wristbands e.g. Was the patients surname present? Yes in 98.5% of cases. The hospital number was only present in 48.5% of patients where this question was asked. This is not surprising, as the present protocol does not require it to be present.

Conclusion

It is imperative that patients wear an identification bracelet at all times. The present protocol has been updated to include that whoever removes an ID bracelet must take responsibility for ensuring it is replaced.
Also from a risk management aspect it is important that the patients chart / hospital number is included on the bracelet. This has raised issues about access to hospital numbers after hours and this is presently being negotiated with the General Managers.
It is also felt that the name of the patients ward no longer needs to be included on the bracelet as patients often move wards during their hospital stay and this information is then obsolete.

AUDIT OF PATIENTS WHO FAIL TO ATTEND FOR OUTPATIENT APPOINTMENTS' EYE CLINIC, LWGH

Objectives

- To identify the reasons why patients do not keep their clinic appointment.
- To identify specific groups with high DNA rates.
- To reduce the failure to attend rates.
- To improve the appointment letter to the patient.
- To devise protocols in relation to patients who 'do not attend'.
- Better utilisation of available resources thereby reducing Ophthalmic Waiting Lists.
- To raise awareness and highlight the problem of 'Do Not Attend' patients.

Methods

It was decided to carry out an audit of all patients who failed to attend the Orthoptic Eye Clinic as this had a high rate of DNA's.

A questionnaire was designed with the input from the multi-disciplinary team of the Eye Department. This was then piloted on five patients who rang to cancel their appointments. Final modifications were made to the questionnaire and prospective data collection started for a period of three months.

26 patients who rang to cancel their appointments had the questionnaire administered by the Eye Secretary over the phone. Permission was sought and confidentiality was assured.

A sample of patients who failed to attend and failed to cancel their appointments were sent the questionnaire by post with a stamped addressed return envelope. 16 participants completed this.

Data was analysed using Statistical Packages for Social Sciences (SPSS) Version 10.1.

Results

During the audit data collection phase, 715 orthoptic eye appointments were sent. Of that 81 (11.3%) of patients 'did not attend' for their appointment. 55 clients (7.1%) contacted the Eye Department to cancel their appointment. Therefore the overall rate was 19.0%.

The main reason for failure to attend were childminding difficulties, unable to get time of work, on holidays either at the time the appointment arrived or when the appointment was due.

25% felt that the notification time for their appointment wasn't adequate. Most patients in the sample received their appointment ten days prior to their appointment date and those patients's were all satisfied with this.

Conclusion

Over the course of the audit itself, due to reorganisation of the management of appointments and patients who ring to cancel their appointment, the DNA rate fell from 33.3% to 19.0%. The Eye secretary now centrally manages appointments for all clinics within the Eye Department and these leads to greater co-ordination of all cancelled appointments and therefore better utilisation of vacant appointment slots. The objectives of the audit were met.

An action plan to further reduce DNA's has been complied and this will be implemented and monitored over 2002.

AUDIT OF NON-ATTENDANCE FOR PHYSIOTHERAPY OUT-PATIENT APPOINTMENTS IN LWGH AUGUST 2001

Introduction

The Physiotherapy Outpatient Department in Longford/Westmeath General Hospital is a facility in which patients can receive physiotherapy treatment as an outpatient. The Department works on an urgent and general waiting list system, whereby a patient is deemed as an urgent referral or in some cases a less urgent – general referral. Patients are referred for treatment either by their GP, Hospital Consultant, or in some cases they may be a self referral.

The audit of the non-attendance at the physiotherapy outpatient department was selected as a priority project due to significant numbers of DNA's (Did Not Attend) and CNA's (Cannot attend) in the department

Objectives

- To catalogue the number of DNA's and cancellations in the department
- To record the reasons for DNA's and cancellations
- To put in place a procedure/protocol to reduce the number of DNA's and cancellations.

Methodology

Following the initial decision on the Audit topic, the Clinical Audit Department designed the questionnaire to record the relevant information from the patients.

A short pilot study began in the Physiotherapy Department on the 2nd April. The questionnaire was administered by Physiotherapy Department staff, when patients rang to cancel their appointments. No amendments were made to the questionnaire. The audit then ran prospectively for 3 months, from the last week of April until the last week of July 2001.

CNA's (Could not attend)

CNA's were patients classified as those who telephoned in advance to cancel their appointment. The questionnaire was administered by phone as patients called to cancel appointments. A sample of 24 patients' details was collected for CNA's. A member of the physiotherapy team who answered the call recorded the details from the patient on to the questionnaire.

DNA's (Did not attend)

DNA patients were classified as those who didn't arrive for appointment or didn't cancel appointment. Questionnaires were sent by post from the Physiotherapy team to those DNA patients with a stamped addressed envelope and an explanatory note of the audit project.

If the questionnaire was not returned within two weeks of post date, a reminder letter was sent from the Audit department asking the patients to forward the completed questionnaire. A total of 22 out of 35 patients returned the DNA questionnaire (response rate of 61%).

The data was analysed using SPSS version 10.1 and the report was produced using Microsoft Word

Results & Findings

From the sample of 46 patients in the audit 24 were ‘cancelled patients’ (Could Not Attend- CNA’s) and 22 were ‘Did Not Attends’ (DNA’s). In total, 30 patients were notified of appointment by a visit to the physiotherapy department, 11 patients were notified by post and 5 were notified of appointment by telephone.

In relation to notification of the appointment, 42 (91%) of the patients felt that the notification was received with adequate notice, 3 (7%) patients felt notice was inadequate and 1 (2%) patient did not record an opinion. A total of 22 (48%) patients were waiting on appointment for less than 10 days, 12 (26%) were waiting between 10 – 30 days, 2 (4%) were waiting for 1-2 months, and 4 (9%) were waiting for over 2 months. This question was not answered by 6 patients. Most of the patients were referred to physiotherapy by a Hospital Consultant - 23 (50%), or by their GP - 16 (35%). Of all the patients in the audit sample 14 were first visit patients and 32 were review visits. Overall 70% of the non-attendance patients were review visits.

There are a number of reasons why patients cancelled or did not attend for their appointment. Of the 46 patients included in the study 14 (30%) reported that they were ill, 8 (17%) had transport difficulties, 5 (11%) forgot their appointment, 4 (9%) had *personal commitments, 3 (7%) were unable to get time of work, 2 (4%) reported child minding difficulties, and 2(4%) no longer required the appointment. Other reasons included holidays (1 patient - 2%), mixed up time of appointment (1 patient - 2%), felt physiotherapy made problem worse (1 patient – 2%). This question was not answered by 4 of the 46 patients.
Incorrect name/address or hospital administration mistakes were not identified as reasons for not attending. 34 of the patients requested a further appointment with the physiotherapy department and 12 did not.

*Personal commitments included; attend funeral, death in family, admitted to other hospital, transport relatives to airport.

Action Plan

Poster designed for the physiotherapy Department to heighten awareness of non-attendance and resultant waste of appointment slots.
Appointment Card to be edited to carry message regarding cancelling appointments.
Physiotherapy staff to review protocols for management of patient on their first visit – emphasis on improved communication.
Good system in place already for dealing with CNA patients. This can be used as an example of best practice for other outpatient clinics.

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APPENDIX A:
MEMBERS OF THE REGIONAL CLINICAL AUDIT COMMITTEE

Dr. John Connaughton – Consultant Physician, Midland Regional Hospital at Portlaoise (Chairperson)

Ms. Mary Culliton – Director of Corporate Fitness

Dr. Gerard Crotty – Consultant Haematologist

Ms. Cora McCaughan – Healthcare Risk Manager

Sr. Jo Daly – CCU Midland Regional Hospital at Tullamore

Mr. Noel Brennan – Laboratory, Midland Regional Hospital at Portlaoise

Mr. Richard Walsh – General Manager, Mental Health Services

Ms. Eileen O'Neill – Project Specialist, Children's and Families

Ms. Breda Crehan Roche – General Manager, Disabilities

Ms. Breda Flynn Murphy – S&LT, Midland Regional Hospital at Tullamore

Mr. John Bulfin – Acute Hospital Services

Mr. Kieran O'Driscoll – Consultant ENT Surgeon

Mr. Pat Marron- Primary Care Manager

Ms. Sharon Longe – Snr Physiotherapist, Midland Regional Hospital at Mullingar

Sr. Eileen Kennedy Dunne – CCU, Midland Regional Hospital at Portlaoise

Sr. Rita Mullins – Surgical Ward, Midland Regional Hospital at Mullingar

Dr. Declan Buckley – Consultant Surgeon, Midland Regional Hospital at Mullingar

Dr. Melissa Canny – Department of Public Health

Ms. Majella Robinson – Clinical Audit Officer

Ms. Anna de Siún – Researcher for Older Persons

Ms. Kathleen Molloy – Researcher for Mental Health

Dr. Eileen Lane – Researcher for Health Promotion

Ms. Eileen Dunphy – Researcher for Primary Care

Ms. Mary Brereton – Researcher for Children and Families

Ms Claire Farrell – Clinical Audit Assistant (Secretary)

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