

CLINICAL AUDIT REGISTRATION FORM

All audits should be **registered** before they start *whether or not* support is required from the Clinical Audit Team. **Guidance** notes for completing this form are available on **Page 3**

AUDIT TITLE:

REASONS FOR CHOICE OF AUDIT:

- | | | |
|---------------------|--|--------------------------|
| National Priority - | National Service Framework | <input type="checkbox"/> |
| | NICE Guidance | <input type="checkbox"/> |
| | Other National Guidance | <input type="checkbox"/> |
| | Confidential Enquiry | <input type="checkbox"/> |
| | National Audit | <input type="checkbox"/> |
| | Other _____ | <input type="checkbox"/> |
| Regional Priority - | South Central Regional Audit | <input type="checkbox"/> |
| | Other _____ | <input type="checkbox"/> |
| Local Priority - | Affects a large number of patients | <input type="checkbox"/> |
| | Involves a higher than usual risk | <input type="checkbox"/> |
| | Reflects an identified quality concern | <input type="checkbox"/> |
| | Evidence available to inform standards | <input type="checkbox"/> |
| | Potential for improving effectiveness | <input type="checkbox"/> |
| | Considered a costly intervention/service | <input type="checkbox"/> |
| | Established audit project / re-audit | <input type="checkbox"/> |
| | Equality Impact Assessment | <input type="checkbox"/> |
| | Other: _____ | <input type="checkbox"/> |

AUDIT OBJECTIVE/S:

AUDIT STANDARD/S:

(Continue on separate sheet if necessary)

Standard of Care	Target %	Exception/s	Source of Evidence
------------------	----------	-------------	--------------------

AUDIT SUPPORT: Do you need any audit support? (See page 3 for more detail) Yes No

CONSULTATION:

	Yes	No
Will the audit involve direct contact with patients?	<input type="checkbox"/>	<input type="checkbox"/>
Will the audit involve other health professionals?	<input type="checkbox"/>	<input type="checkbox"/>
Will the audit involve other organisations (E.g. PCT, Social Services)?	<input type="checkbox"/>	<input type="checkbox"/>
If yes to any of the above, has their agreement been obtained to carry out the audit?	<input type="checkbox"/>	<input type="checkbox"/>

AUDIT METHOD:

Data collection proforma
Questionnaire
Interview
Other _____
(Please attach a copy where possible)

Data collection: Prospective
Retrospective

Proposed sample size:

Data collection time period:

Proposed completion date of project:

How do you intend to disseminate the audit results?

DATA SOURCE:

Patient records
Computer held information
Patient experience
Staff experience
Observation
Other _____

Patient records required? Yes No

If yes, please complete the Patient Records Request Form on Page 4

Project Lead*

Name:

Post:

Department:

Division:

Tel ext/bleep no:

Signature:

Date:

Line Manager / Supervisor**

Name:

Post:

Signature:

Date:

Please note that by signing this Registration Form you are agreeing to:

***Project Lead:** Ensure this project is completed, the results disseminated, and a report given to the clinical audit team.

****Line Manager/Supervisor:** Give my full support to the audit: ensure the dissemination of audit results and lead on the development and implementation of an action plan (if necessary) in order to obtain improvements in the quality of care provided. Be responsible for ensuring that a re-audit is undertaken if changes are made following the audit

The information on this form will be entered onto the Trust Clinical Audit Database. As Project Lead you will be asked to complete a project outcome summary /action plan form once the results of your audit are known. These will also be entered on the database and together this information will form the basis of your project report and or presentation

**Please return a copy of the completed form to:
The Clinical Audit Team, The ARK Centre, Basingstoke and North Hampshire Hospital**

GUIDANCE NOTES FOR THE COMPLETION OF THE CLINICAL AUDIT REGISTRATION FORM

Please use these notes to help you complete the form. If you require any further assistance, or training, please contact the Clinical Audit Department x3025

- Audit Title:** A short name for the project, that can easily be fitted onto reports and presentations, e.g. "Re-audit of leg ulcer management"
- Reason for Audit:** Explain why the audit subject was selected. Is it a national or local priority? The reasons for undertaking the audit may include areas of high volume, cost or risk; quality problems; evidence on effectiveness; or the potential for significant and achievable quality improvement
- Audit Objectives:** These must be measurable and specific i.e. what are you trying to achieve by undertaking this audit. Clear objectives will enable you to focus the project ("To ensure that...." "To increase...To improve.....To reduce")
- Audit Standards:** A standard is the basis for measurement by which the accuracy or quality of something is judged. Standards and audit are integral to each other: you can't have one without the other. There is little point in measuring something (auditing) without knowing what should be happening and likewise, a standard which cannot be measured is meaningless. Please **list the standards** of care along with any exceptions
- Audit Support:** The Clinical Audit Department can assist with any stage of the audit process including project planning; objective and standard setting; audit design; data analysis and presentation of audit results.
- Consultation:** Indicate whether the audit involve patients, other professionals or organisations. Please show whether the agreement of all such stakeholders has been obtained to carry out this audit. Audits have a greater chance of success if all those likely to be affected by the audit process or the changes identified, are involved from the outset.
- Audit Method:** Indicate the audit method and the data source(s) to be used for the audit. Indicate the proposed sample size or data collection time period, the end date of the audit and specify how you intend to share the results of your audit. Any patient records required can be requested here
- Project Lead:** Name of the person responsible for ensuring the audit is undertaken, completed and presented.
- Line Manager / Supervisor:** Someone who can oversee any changes that the audit may recommend, especially if there are resource implications, and who is responsible for ensuring that a re-audit is undertaken where necessary.

PATIENT RECORDS REQUEST FORM

GUIDANCE:

Before completing the patient records request form below please note the following:

- In order for the request to be processed you need to attach a legible, preferably typed, list of required patient names and hospital numbers
- A member of the clinical audit team will submit the request to the medical records department and should notify you within 7-10 days that your records are ready for collection – *if you have not been notified within this time please contact the audit team on x3025 or email clinicalaudit@bnhft.nhs.uk*
- Once you have received notification you will be responsible for collecting your records from the “audit holding bay” situated within medical records within **2-3 days**
- If you are unable to collect your records within this timeframe please inform us otherwise your records will be returned back to file.
- Once you have collected your records you are responsible for transporting them to the location you have identified below *
- Please ensure that while patient records are in your possession, they are stored safely and securely in line with data protection principles and do not take audit data out of the Trust
- Once you have finished auditing the records please return them to a member of the medical records team to be re-filed. Please do **not** place back in the “audit holding bay” as the medical records team will need to track the notes back to file

Thank you for your cooperation

Do you require – Main hospital records Maternity records

Number of records required:

Date requested:

* Location for records to be tracked to:

Name:

Contact bleep / extension number:

Signature:

FOR CLINICAL AUDIT DEPARTMENT USE ONLY

Request approved

Audit reference No:

Signed _____

Date _____

I confirm I have read and agreed to the above notes

**Please return a copy of the completed form to:
The Clinical Audit Team, The ARK Centre, Basingstoke and North Hampshire Hospital**