

The RCGP Quality Practice Award for Practice Teams

a practical guide for nurses & midwives
working towards the Quality Practice Award



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The Quality Practice Award has proved itself as a driver for change in general practice across the UK.

It links discretely with clinical governance, focusing the attention of practice teams on quality issues. It encourages teamwork and multidisciplinary planning and delivery of services. It sets benchmarks for professional development of staff. And most important, it sets in train changes in practice which result in better care for patients.

Nurses, midwives and health visitors are key members of practice teams and as such are instrumental in meeting the quality criteria contained within the QPA. Their active participation in the QPA process is therefore essential and, to some extent, determines how successful a practice's QPA submission will be.

This practical guide has been written to offer you advice on how to make those vital contributions to the QPA final submission document as informative and clear as possible, with a view to successfully meeting the QPA criteria and boosting the likelihood of your practice team achieving the award.

It sets out the key elements you need to consider when planning and writing the submission document, based on the experience of many nurses, midwives and health visitors who have been through the process or have acted as nurse assessors. It also shows how you can get maximum professional development benefit from your contribution to QPA.

I am delighted to commend this practical guide to you, and feel sure it will be a great source of support as you and your colleagues work through the QPA process.

Michael Proctor
Primary Care Development Manager/Nursing Officer
Scottish Executive Health Department
May 2002

What does this practical guide aim to do?

The guide aims to give you advice and ideas on meeting the Quality Practice Award (QPA) criteria that relate to nurses and midwives.

The guide will help you to:

- *complete your written evidence effectively*
- *structure clinical audits*
- *compile case studies*
- *produce a high quality QPA submission document*
- *maximise your personal learning from participation in the initiative.*

It complements the advice available in the *QPA Manual: the application process, criteria and user's guide*, published by the Royal College of General Practitioners (Scotland) (RCGP(S)), and can also be augmented with advice from local advisors, where available.

Examples of audit, personal learning and case studies used in the guide concentrate on specific disciplines and areas of practice. The general rules governing their design, however, relate to all disciplines and areas of practice.

You will also find a chapter on frequently asked QPA questions (Chapter 8), but the guide can't answer all your questions, or solve all your problems. It will work best if it is used in conjunction with the specialist sources of support available in your area and the resources listed at the back of the guide.

Although developed in Scotland, nurses and midwives employed in England and Wales should find much of value in this guide to help them work towards the QPA. There are differences in service configuration and delivery among these countries, but the key principles for successfully meeting the QPA criteria are applicable across the whole UK.

The guide is not designed to be read in a single sitting, or to be worked through chapter by chapter. Rather, it offers a selection of pieces of information, advice and examples from which you can 'pick and choose' to help you meet your own needs. We do recommend, however, that if you are just starting out on QPA for the first time, you read Chapters 2, 3 and the Frequently Asked Questions to begin the process.

Finally, as QPA relies on the collaboration and equal participation of all disciplines in the wider primary care team, the guide has been developed to be useful for the whole nursing and midwifery team. As such, it is a resource to be shared.

What is the QPA?

The QPA is a UK initiative designed to assure the quality of care provided by practice teams². It was initially developed in 1995 by the North-East Faculty of the RCGP(S), and is now supported by many nursing and midwifery organisations, some of which are listed in Box 1.

Box 1. Nursing and midwifery organisations supporting QPA

- Nursing and Midwifery Practice Development Unit, NHSScotland (NMPDU)
- Queen's Nursing Institute, Scotland (QNI(S))
- Royal College of Nursing (RCN)
- Royal College of Midwives (RCM)
- Community and District Nursing Association (CDNA)
- Community Practitioners' and Health Visitors' Association (CPHVA)
- Scottish Health Visitors' Association/Unison (SHVA/Unison)
- Scottish Nurse Practitioner Group (SNPG)
- Scottish Practice Nurses' Association (SPNA)

QPA is one of two quality assurance systems devised by the RCGP for practice teams (the other is the Practice Accreditation award or its equivalent in England and Wales, Quality Team Development). Both aim to raise quality within practice teams by concentrating on key aspects of practice, but QPA focuses on the issues in more depth and particularly emphasises educational and clinical development of the team. Practice teams are being encouraged to work towards these (or similar) quality systems as part of clinical governance.

QPA is an example of a 'quality accreditation process'. This sounds like an interesting concept, but what does it mean in practice?

The Clinical Standards Board for Scotland has come up with a clear working definition. They define a quality accreditation process as:

a system of external peer review, using written standards, designed to assess the quality of an activity, service or organisation (CSBS, 2001).

The QPA meets this definition in every respect.

² The practice team, as defined in this guide, includes the GP, practice manager and other staff employed by or attached to the general practice, both clinical and non-clinical.

The QPA process

The process starts with the agreement of the team as a whole, then usually a GP or practice manager will notify the RCGP(S) of the practice team's intention to work towards achieving the award.

Practice teams undertaking QPA have to meet certain quality criteria to become accredited with the award. Several sets of criteria cover general topics such as clinical care, communication, continuity of care and health promotion. Specific criteria relate to nurses and midwives working in practice teams, both practice-attached and practice-employed. For an example of a QPA criterion, see Figure 1.

The team must submit an extensive portfolio of written evidence recording how *all* of the quality criteria contained within the QPA Manual have been met. The portfolio will include a variety of different kinds of evidence, including:

- personal profiles
- practice leaflets
- practice policies
- case studies
- clinical audits.

When complete, an external assessment team critically reviews the portfolio against the QPA quality criteria. The team is likely to consist of:

- a GP
- a practice manager
- a nurse with a primary care background
- a lay person.

One of them will be appointed the lead assessor.

A few weeks before the assessment visit, the assessors read and critically review their copy of the QPA submission portfolio. At this stage, the practice team may be asked for clarification or additional written information prior to the visit commencing. The assessors meet on the evening before the assessment visit to discuss the portfolio of evidence, the process of the visit and to identify any specific issues they want to follow up.

On the day of the visit, the external assessors interview all members of the team and some patient³ representatives to further assess practice performance against the quality criteria. They review specific aspects of the practice, including medical records and the premises. At the end, the assessors give the practice team verbal feedback about the outcome of the QPA assessment process.

A written report is then sent to the practice at a later date, setting out the team's strengths and suggesting ways of further improving the services they offer. If the review of the written evidence and the assessment visit are satisfactory, the practice team is awarded the Quality Practice Award. QPA accreditation lasts for five years; if a team wishes to remain accredited after that period, they need to repeat the QPA process.

³ The word 'patient' is used for convenience throughout this practical guide to refer generally to patients, clients and women accessing or receiving maternity care.

Figure 1. Example of a QPA criterion

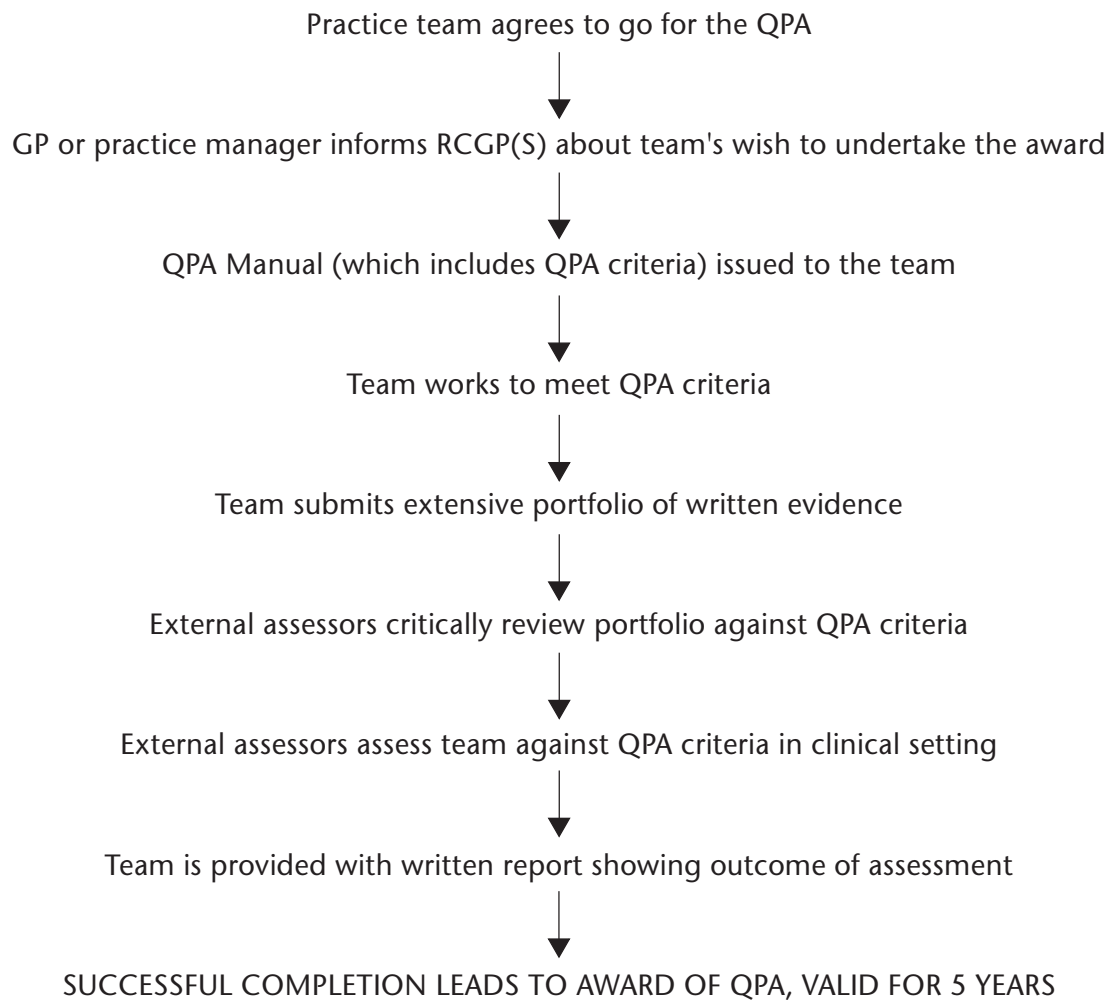
This example has been taken from Section 11⁴, Version 5 of the QPA Manual.

Criterion	Written evidence
<p>11D. Nurses and midwives linked to the practice team will provide evidence-based practice in at least two areas of their care per discipline, e.g. care could be based upon national clinical guidelines for the management of leg ulcers, continence, palliative care, post-natal depression, cardiac rehabilitation and/or childhood immunisation. Nurses and midwives linked to the practice team will also have audited their clinical practice against at least two clinical guidelines per discipline during the last three years.</p>	<p>(i) Brief descriptions of at least two areas of care per discipline provided by the nurses and midwives linked to the practice team which is evidence-based. These descriptions should include references for the evidence used, e.g. national or local guidelines.</p> <p>(ii) Summaries of at least two audits from each discipline linked to the practice team, e.g. two from health visiting, two from district nursing. Audit summaries should highlight the main issues, i.e. standards or criteria audited, key results and changes made to practice as well as who participated in the audit. (Full audit reports, including data collection tools, should be available during the assessment visit).</p>

⁴Section 11 applies to nursing and midwifery staff linked to practice teams.

The whole QPA accreditation process is set out diagrammatically in Figure 2 below.

Figure 2. The QPA process



Further details about the QPA process can be found in the QPA Manual sent to all participating general practices.

QPA annual updates

A multi-professional working group reviews the content of the QPA Manual each year and produces an updated version. This guide is based on *Version 5* (which covers August 2001 - July 2002), the most recent version at the time of writing. *It's important to stress, however, that while there may be some differences in the content of the different QPA Manual versions, the main principles (as outlined in this guide) remain consistent.*

Nursing and midwifery participation in QPA

QPA has benefits for *all* members of the practice team who participate in the process. As a result of going through the process as a team, staff who have successfully completed QPA report:

- better team working
- improved communication
- reduced duplication of effort
- increased understanding of each others' roles.

All nurses and midwives attached to or employed by general practices participating in QPA have an active role to play in the accreditation process, both collectively and individually.

Collective participation

Effective team-working must be in place for successful QPA accreditation, and external assessors will search for evidence of strong team-working both in their review of the portfolio and their visit to the practice.

Nurses and midwives are expected to show how they have worked with other disciplines within the team to meet the QPA criteria. For example, Criterion 8A (QPA Version 5) asks practices to provide details of evidence-based health promotion. If a team chooses the promotion of breastfeeding as their example, assessors will expect the supporting documents to refer to activities by all relevant and locally appropriate personnel such as health visitors (HVs), midwives, GPs, practice nurses (PNs) and perhaps nursery nurses or health visitor assistants.



Action points

Ensure all relevant disciplines within the wider practice team are included when preparing QPA written evidence. Remember to include practice-employed and practice-attached staff, trained and untrained healthcare staff, and clinical and non-clinical personnel.



Make sure responsibility for production of the written evidence is shared appropriately among the different team members and between the different disciplines. Everyone within the practice team should be committed to playing their part in producing the necessary portfolio.



Adopt an agreed format for presenting the documents when evidence for a criterion has to be provided by many or all team members.

Individual participation

QPA encourages team-work, but there are also criteria relating specifically to individuals. For instance, individual team members must complete the section on 'personal learning'.

QPA and PREP

Post-Registration Education and Practice (PREP) is a set of United Kingdom Central Council (UKCC)⁵ standards and guidance points designed to help nurses and midwives provide the best possible care for patients and to assure the public that practitioners are safe, competent and professionally up-to-date (UKCC, 2001).

As part of the PREP criteria for renewing periodic registration, nurses and midwives must show evidence of having undertaken a minimum of five days study relevant to their area of practice every three years. They must build a personal profile detailing their continuing professional development activity and how it has enhanced their practice.

Work undertaken by nurses and midwives as part of the QPA process - literature searches and compiling case studies, for instance - can be used to meet these PREP requirements. See Chapter 7, *QPA as a personal learning process*, for more information on QPA and PREP.

Action points



Reflect on how the work you are undertaking in the QPA process is helping your professional development.



Record your development in your personal profile.

⁵The United Kingdom Central Council was replaced by the Nursing and Midwifery Council on 1 April 2002.

Planning and presenting your QPA written evidence

Please note: information in this and the following chapters is presented only as a guide; the content is not meant to be prescriptive. Readers are advised to seek more detailed advice and guidance from specialist staff and educational resources, where appropriate.

Planning the written evidence

Quality written evidence is based on:

- *good organisation*
- *good action planning, with identification of who is responsible for which parts of the document and clearly defined time scales for completion*
- *participation of all relevant team members.*

Action points



Ensure all relevant staff are invited to QPA planning meetings.



Produce a brief action plan at the end of each planning meeting, setting out:

- what needs to be done before the next meeting
- by whom
- by when.



Ensure those unable to attend planning meetings are subsequently informed of the outcomes, especially the details and deadlines of any work identified for them.



Appoint someone to take the lead in ensuring the work is done on time for each criterion, and is shared between team members.



As soon as possible during the planning stage, liaise with local staff who can help you with your submission. For instance, some practice teams undergoing QPA have a local advisor; Trust or Local Health Care Co-operative (LHCC) clinical effectiveness and/or clinical governance staff may be able to help; and local practice development staff might be a potential source of support.

Meeting the criteria

Practice teams must submit a portfolio of written evidence detailing how they have met *all* the criteria contained within the QPA Manual to complete QPA successfully and become accredited.

You must ensure you provide a written response for each relevant criterion and that the information you give meets the criterion in full. Failure to do so could result in you having to submit additional evidence prior to the assessment visit; it also increases the possibility of your team not achieving the QPA.



Action points

Check you have met *all* the criteria and that you have provided the appropriate written evidence *in full* and as requested in the QPA Manual *before* the portfolio of written evidence is forwarded to the assessors.



Be critical with your written work; if you feel it is hard to be objective, ask someone you trust to critique it for you and provide feedback.

Proof-reading

QPA is a prestigious award, and a lot of time and effort is required to complete the portfolio. Your final submission should therefore reflect the importance of the process and the efforts of the team in the quality of its appearance and content. A portfolio of evidence that contains numerous spelling and typographical errors creates a bad impression about even the best practices!



Action point

Closely read your final document for errors before it leaves the practice team.



Ask someone you trust to closely read it on your behalf.

Clinical audit, case studies and personal learning have all been identified as areas where nurses and midwives may require additional support and guidance when preparing their QPA submissions. The following three chapters set out some of the key principles you need to adopt to present your information clearly and coherently and achieve maximum personal and professional benefits from the QPA process.

Presenting information on clinical audit

Clinical audit

Clinical audit is primarily aimed at demonstrating and improving the quality of care provided, but there are also educational benefits to staff from participating in the process⁶.

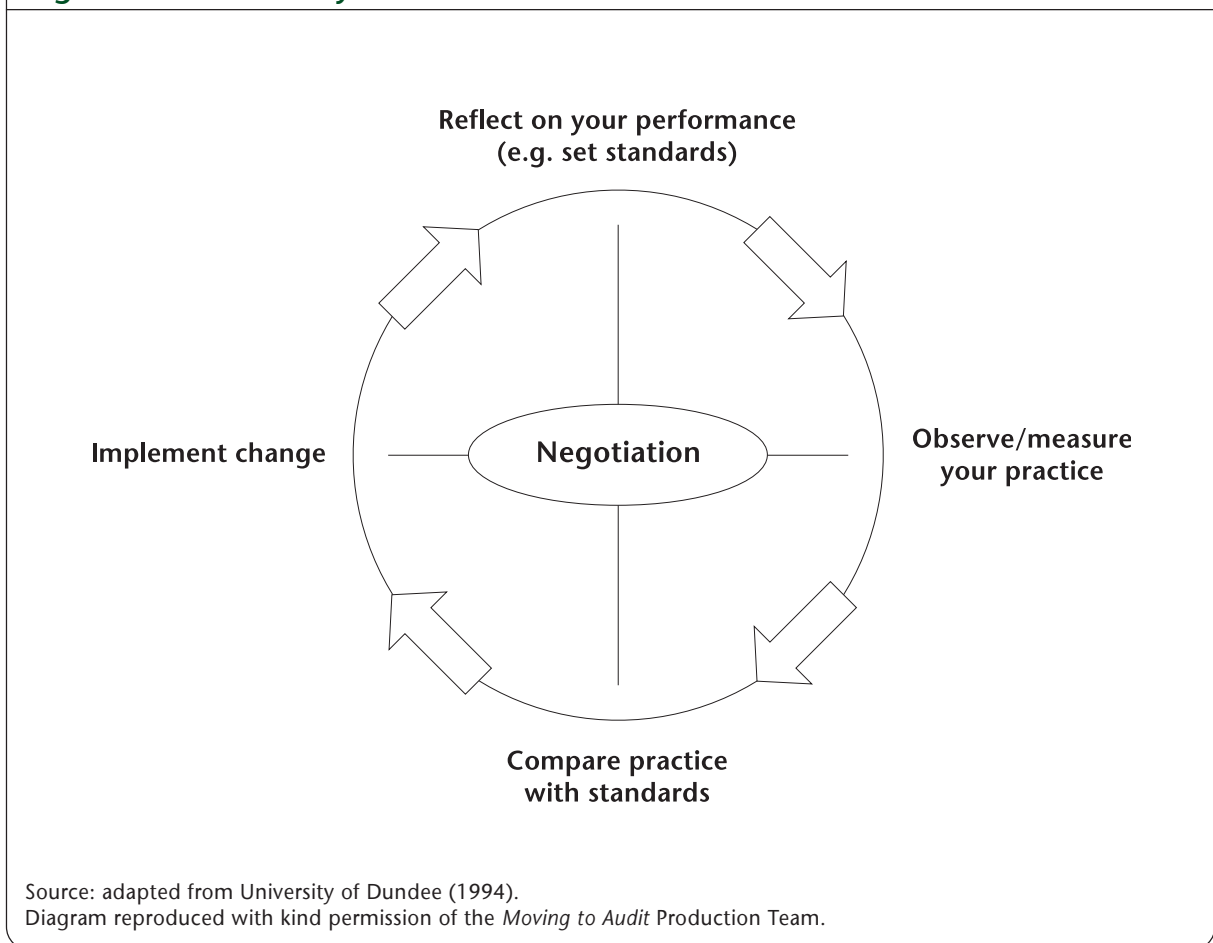
Clinical audit is about:

- setting standards
- measuring practice to see if the standards are currently being met
- if they are not, taking steps to improve practice and the quality of care.

Where action has been undertaken to improve care, *re-audit* is required to ensure that the standards are now being met.

This process is known as the *audit cycle*, as shown in Figure 3.

Figure 3. The audit cycle



⁶This chapter is based on recommendations on clinical audit issued by the Clinical Resource and Audit Group (CRAG).

Clinical audits can assess the *process* (what you *do* to the patient, such as diagnosis and treatment) and the *outcomes* of care (what was the *result* of those interventions for the patient?).

What's audit, and what's not?

Although audit is a straightforward process, it can be confusing. Healthcare staff often have difficulty in differentiating between clinical audit, research, surveys and monitoring. Table 1 gives brief details of some of the differences between clinical audit and these other processes.

Table 1. Clinical audit - what it is, and what it is not	
Clinical audit is about:	Clinical audit is not about:
<ul style="list-style-type: none"> • finding out what is <i>currently</i> happening in an area of practice • seeing if standards based on best available evidence are being met or exceeded • changing practice; the underlying principle of clinical audit is improving the quality of care when audit results indicate that current practice is not as good as expected • having a commitment to completing the full audit cycle and, where changes have been made to practice, re-auditing to find out whether those changes have resulted in standards being met. 	<ul style="list-style-type: none"> • finding out what <i>future</i> practice should be; finding new evidence on which to base future best practice is <i>research</i> • simply collecting and presenting data; isolated lists or tables of data not linked to standards are <i>survey</i> or <i>monitoring</i> information rather than clinical audit • collecting data without using them to show whether standards are being met or not; collecting and presenting data without comparing them to standards is a common reason for an audit cycle being considered incomplete. Without changes being made, where necessary, the audit cycle hasn't been completed.

One of the most common reasons for a poor-quality QPA audit is the presentation of data in survey or monitoring format, rather than as an audit. Staff simply provide detailed lists or tables of data, but make no attempt to link the information to their standards. This leaves assessors asking, '*so what? How did this audit improve patient care?*'

It's interesting to read about the number of patients who attended and defaulted for 'flu vaccination, and which nurses administered the vaccine. But that kind of description is *not* audit; in an audit, you will also state whether standards on 'flu vaccination have been met and, if not, what action has been taken to improve current performance.

Getting started with your audit

The following information highlights some of the areas you should address when completing your clinical audits for QPA. However, it is only possible to provide a broad overview of the clinical audit process within this guide; you may find you need to seek out the expertise of others to help you complete the cycle.



Action point

You are advised to contact clinical audit staff (or equivalent) within your Trust or LHCC and to read relevant resource information (see the Resources section of this guide).

Defining the audit topic

Audit requires a lot of time and effort. The topic you choose to audit should therefore be considered a priority for your practice team.

State in the introduction of your audit summary why the topic was considered a priority. Your practice may have been participating in the SPICE project, for example, and the results from this benchmarking initiative might have indicated a need to review diabetic care in your practice in more detail. Or a cancer patient may have complained about his pain relief, prompting the practice to audit its palliative care pain control procedures.

Be specific, clearly define your audit topic, and be realistic about the scope of the project.

Keep your audit simple and focused

Where audit is concerned, less can definitely be more! Cardiac rehabilitation may be a priority within the practice, but it may not be feasible for you to simultaneously audit drug therapy, lifestyle advice and management of hypertension. It's far better to successfully carry out a small audit focusing on a specific area of practice (such as aspirin usage post-myocardial infarction (MI)) and show how it has been used to improve patient care than to attempt an audit of all aspects of cardiac rehabilitation which can't easily be completed and therefore has no effect on service quality.

Getting the audit team together

Consider who should be involved at the planning stage and ask for their support. An audit of leg ulcers will probably include district and practice nurses, but it might also be appropriate to include non-clinical practice staff, patients and/or carers. But remember to get their consent to being involved in the project - auditing the work of others without their knowledge isn't good for developing a team-working ethos!

Sharing the load

If, for example, there are two practice nurses in a practice, the workload of the audit can be shared. Rather than each separately auditing the care of patients with diabetes and those with asthma, one could lead the audit of all diabetic patients while the other leads the audit of the care of all asthmatic patients. Audit results can then be presented in two ways - the overall results for both practice nurses, and the individual results for each. The identity of each nurse need not be disclosed; it is acceptable to present audit results using initials, numbers or identifiers such as 'PN1' and 'PN2'.

Audits initiated outwith your primary care team

Increasingly, audits are being carried out on an LHCC or Trust-wide basis. The circumstances under which you can submit an example of these audits in your portfolio of evidence is shown in Box 2.

Box 2. Using LHCC and Trust-wide audits

- The LHCC or Trust-wide audit should have included you and/or your patients.
- Only one example of an LHCC or Trust-wide audit can be submitted for each nursing or midwifery discipline. That is, if health visitors are submitting two audits for QPA, one could be an LHCC audit, but the other one must have been prepared by the health visitors themselves and be specific to their practice.
- You must not simply submit the entire LHCC or Trust-wide audit report. Write a two - three page summary of the project from your practice perspective. Explain, for example, why participation in this audit was a priority, which patients were included and how data were collected. Focus on the results for your practice and compare them to those for the LHCC or Trust as a whole. Specify any action taken within your practice to improve services as a result of the audit.

Writing your audit standards

The use of standards is the 'hallmark' of clinical audit (Crombie et al, 1995), but there is often confusion about what standards mean in practice.

Standards are statements of professionally agreed levels of performance that are:

- objective
- achievable
- desirable
- measurable (RCN, 1986).

As such, standards are 'used as a reference point against which comparisons can be made' (Marr and Giebing, 1994).

Standards consist of a *criterion* and a *target* (Difford, 1990; Crombie et al, 1995). A *criterion* is the aspect of care being measured, such as whether 'flu vaccinations have been carried out. The *target* is the percentage or number of times you expect the criterion to be fulfilled. Basically, standard setting is the process of reaching agreement about your criteria and targets (Difford, 1990)⁷.

Details of how to write audit standards can be found in sources such as *Moving to Audit* (University of Dundee, 1994) and *The Audit Handbook* (Crombie et al, 1995), but you can use national standards that have been written on a range of topics.

The standards need to be relevant to the area of practice being audited. For instance, if your audit focuses on patients newly diagnosed with asthma, you may need to set standards that include assessment of inhaler technique and the provision of written asthma information at the time of diagnosis.

⁷ Other definitions of standards may be used in health care; it is advisable when doing multidisciplinary audit to clarify definitions at the planning stage.

Your standards should also be achievable. What is a realistic level of performance (or target) for the aspect of care you are auditing? In the audit summary in Appendix 1, the practice nurse expects to meet each criterion in 100% of cases, a figure she considers achievable for her practice. Another practice nurse, working under different circumstances, might see a target of 90% as being a more realistic figure.

Where possible, standards should be based on sound evidence such as national clinical guidelines⁸, national standards and best practice statements. Highlight the evidence you've used to set standards in your audit and include appropriate references. An audit on leg ulcer care, for example, may have been based on standards within an LHCC guideline, which in turn may have been based on a national clinical guideline.



Action points

Make sure the standards are right from the outset. Check out draft standards with someone experienced in standard setting before collecting any data, as this often saves time later in the audit cycle.

Refer to relevant audit textbooks and articles when drafting your standards.

Set standards that are achievable and realistic for your area of practice.

Measuring practice

Defining the audit sample

Once you've decided on your audit topic, you need to consider whether you should use an audit *sample*. First, you should identify your patient *population*, which is the overall group to whom the audit applies - all patients with diabetes, all patients with leg ulcers or all breast-feeding women, for instance. The *sample* is a smaller group of patients chosen from the population who will be included in your study.

How and whether you sample will depend on the size of the audit population, what is feasible in the time and resources available to you, and ethical constraints. For example, if your audit population is small (less than 50 patients), you should consider including all of them in your audit. If your population is 250 and too large for you to audit feasibly, you will need to use a sample. And remember, if your audit involves getting feedback from patients about their treatment, you will need to consider ethical issues. Some patients, such as those who are very ill, may have to be excluded as it could be inappropriate to ask them to participate.

There are several sampling techniques that can be used. Details of these can be found in the materials listed in the Resources section at the back of the guide.



Action point

Check your ideas for sampling with someone experienced in this area before you start collecting any data.

⁸ Examples of national clinical guidelines include those produced by SIGN, NICE, RCN and the RCM.

Setting audit time frames

The length of time taken to complete an audit cycle varies, depending on the nature of the project. Take, for example, an audit of pain control in palliative care patients and one involving diabetic patients attending practice follow-up clinics.

The *palliative pain control project* might involve collecting data as you go along (concurrent data collection). It may take several months before you can gather enough patient information for a satisfactory audit.

The *diabetic patients audit*, however, may involve extracting data already documented in patient records (retrospective data collection). These audit data could therefore be collected in a matter of hours or days.

The length of time taken to carry out one audit cycle will determine whether it will be possible to include re-audit results within your QPA portfolio of evidence. If there isn't time for you to include re-audit results before the portfolio is sent to the assessors, make sure your documents explain what changes were made after the initial audit and state that re-audit is planned or on-going, preferably giving completion dates. Re-audit results that emerge after the QPA portfolio has been completed and submitted to the assessors can be made available for them to review during the visit.

Collecting and analysing audit data

Providing information about how to collect and analyse audit data is outwith the scope of this guide. This phase of the audit cycle is usually the most time-consuming stage, but appropriate planning and preparation time can help save time and effort.

Action points



Read appropriate audit reference material and/or contact your local clinical audit or clinical effectiveness staff before proceeding to the data collection stage of the audit cycle.



Before you start collecting any data, first check out your audit plans including your data collection tools (such as questionnaires and proformas) and methods of data analysis with someone experienced in audit.



Remember always to respect the confidential nature of audit data.

Presenting audit summaries for QPA portfolios

Completed portfolios of QPA submission material are large and space is at a premium. Instead of submitting your full audit report, you should include a two-to-three page summary within the portfolio, detailing:

- reason(s) for the audit (why it was considered a priority)
- who led the project
- which disciplines were involved

- when the audit was carried out
- population and sample size
- standards used
- how data were collected
- the main results
- how the results compared with standards
- details of any actions taken
- where possible, re-audit results
- how you shared your audit results with others - at a practice meeting or through the practice newsletter, for instance.

This looks like a lot for a summary, but it's acceptable to set out the key points in note form or as bullet points (as shown in Appendix 1). You should make sure, however, that the summary is not so brief that the reader is unclear about what you did!



Action point

Ask someone not involved in your audit to read the audit summary before it is submitted. In particular, ask him or her to identify if you have missed something out that, if included, would assist the assessor in understanding your audit project. Have you actually completed the audit cycle, for instance?

Results included in the summary (and full report) should always protect the identity of patients and, if preferred, staff. Remember, submission documentation will be seen by all members of your practice team and by the assessment team.

The full report of the audit - including detailed results, charts, graphs, audit tools etc. - should be available during the assessment visit.

Taking action on audit results

Simply collecting data does not mean the audit cycle is completed. Any data collected by the practice team during the audit should be used to assess whether the relevant standards have been met. If results indicate that standards are not being met, the team should take action to improve the patient care provided. In such cases, audit should result in changes to practice.

One of the most frequent comments from QPA assessors is that audits summarised within the portfolio of evidence have not completed the audit cycle. In practice, this usually means that where audit data show that standards have not been met, the team has apparently not made any changes to improve practice. Usually, this is due to staff *failing to record changes made to practice* within their audit summary.



Action point

Where change is needed after an audit, you must ensure that your audit summary submitted as part of your QPA portfolio clearly states what action was taken or planned.

Developing solutions in response to audit results

When audit results were not as good as expected, it's important to take a close look at your standards before setting out to make changes to clinical practice. Perhaps the 'problem' lies with the standard, rather than with the actual care. Re-negotiating standards is part of the change process associated with audit (University of Dundee, 1992), but staff often overlook this activity.

Take, for example, a written standard stating that '*all newly diagnosed adult asthmatic patients will be **given** written information about their condition.*' Seems reasonable enough, but what about those patients who refuse to accept written information? It might be better to re-write the standard to say that '*all newly diagnosed adult asthmatic patients will be **offered** written information about their condition.*'

Where audit results indicate that one team member is performing less well than his or her colleagues, the audit summary should indicate what has been done in response. For example, a practice's overall rate of unsatisfactory cervical smear tests might be small and decreasing, but the audit may flag up that one individual is responsible for most of the unsatisfactory smear results.

In this instance, the audit summary (and main report) will need to set out:

- what happened?
- was this a new practice nurse who was learning to take smears?
- if so, how did the nursing and practice team support her?
- was further training provided?
- did she have a period of clinical supervision?
- has a re-audit been done, or when is one planned?
- does this case highlight issues about staff support generally? If so, what is being done?

Dealing with 'bad' results

Clinical audit has been designed to improve patient care by enabling healthcare staff to learn more about their practice. Results which show scope for improving practice are therefore to be expected. Practices won't be 'marked down' for 'bad' audit results, but they will get lots of praise for showing the assessment team what they did to improve the situation.

Re-audit is needed to show whether changes resulted in improved patient care which (hopefully) allowed standards to be met, but there may not be sufficient time to complete a re-audit before the assessment visit. You can note in your audit summary when re-audit is planned; where re-audit is already underway, you can provide the assessors with interim rather than full re-audit results.

Action points



Ensure your audit summary describes what has been done to improve patient care where audit results indicated that care was not as good as expected.



If there is not time to implement the necessary action before the QPA documentation is submitted, make sure your audit summary details what change is planned or proposed.



During the assessment visit, be prepared to update assessors about these changes and progress since you prepared the summary.

Presenting information as case studies

Case studies⁹ are an integral part of QPA. They help healthcare professionals to:

- critically review the care they provide
- learn lessons from current practice
- apply their learning to improve future practice.

There is no defined style for producing a case study as part of your QPA portfolio of evidence, but the following general points are important.

Choice of case study

Practice teams are requested to submit case studies for different QPA criteria. The number of case studies you have to submit will be stated in the version of the QPA Manual you are using. Some criteria (such as Clinical Care, Section 3, Version 5) specifically define the case studies to be submitted, such as examples of recent hospital admissions and patient deaths from cancer. Other criteria (those in the nursing and midwifery Sections 11 and 12, Version 5) are not prescriptive on which patients should be included, but ask for case studies showing:

- evidence of autonomy
- evidence of team-working
- how lessons learned from the case have translated into changes in practice with beneficial effects for patients.



Action point

Follow the guidance given within the criteria and the user's guide (contained within the QPA Manual) and submit the appropriate case studies for each section.

Case studies should be based on significant events, but it is up to you to define 'significant' and how the case demonstrates new learning that feeds into your practice. You might want to illustrate a complaint against the practice that involved you, or how attendance at a study day made you aware that you could have managed a particular patient's problems more effectively. And remember that a case study can be based on a positive event, a situation where something has worked well and you want to replicate the success in future.



Action point

Use case studies as opportunities to reflect on your practice and improve the way that you and, where appropriate, your colleagues deliver care. This applies regardless of whether you are able to choose your own case study topic or it is chosen for you within the criteria.

⁹ Within the QPA process, case studies are also known as case reports.

Maintaining confidentiality

Protecting the identity of patients is, of course, paramount, and there are a number of ways of ensuring their confidentiality is maintained. For instance, you can:

- give patients and carers fictitious names
- refer to patients and carers by alternative initials or terms such as 'Patient 1'
- refer to an age-group rather than a specific age or date of birth.

But even so, some patients can be identified from case studies. Don't use patient identification numbers issued by the practice, and be careful with the social and demographic information you use to describe your patients. For example, someone's occupation could identify them to your practice team and, if his or her job was particularly unusual, possibly among the assessors. It is better to be cautious; a health visitor citing a client with post-natal depression as her case study subject could describe her as: *'Mrs A., in her late twenties, married with three children, in part-time employment with family support locally.'*

Action point



Ensure the confidentiality of patients is maintained by referring to them by a fictitious name or numeral code.



Be vigilant that you don't inadvertently give clues to the patient's identity by citing specific details about occupation, family or social circumstances.

Content

Don't write a book! Your case study need be no more than one - two pages in length. But the crucial considerations are that it achieves its purpose, and that it meets the criteria set for QPA. Here are some key points to help you:

- If a patient has multiple problems but only two or three are relevant to the case study, concentrate on the main problems.
- If a particular criterion asks for a case study demonstrating team-working, you must specifically mention within the text active processes such as liaison, discussion and meetings. It is not enough to simply mention that you referred a patient to a GP or nursing colleague.
- If your case study provides an example of evidence-based care, you need to specify within the text what the evidence was, such as a national clinical guideline; you can't assume the assessor will know.

Take, for example, a G-grade district nurse's case study which focuses on a 60 year-old patient who had a stroke at home. On initial assessment, she finds the patient has very poor mobility and slurred speech. The focus of this case study is the patient's mobility, which is his main difficulty. As the patient's speech problem resolves spontaneously, the DN only briefly refers to it within the case study. His hearing problems, however, receive more attention because of difficulties in giving information to the patient about his condition. Such a case study would also refer to relevant national guidelines for stroke care and rehabilitation.



Action point

Ask someone you trust to critique your case study and provide feedback. Have you missed anything out?

Style

There are several different ways of writing a case study. For example,

- use a diary or case-note style, summarising events chronologically
- present the case in brief, 'themed' sections such as 'background', 'history', and 'management'; this style is especially appropriate if the patient has a long and/or complicated history.

Examples of these two different styles are shown in the following case study examples.



Action point

Pick a writing style that feels right for you and the case.

Case study example 1: diary or case note style

HV Jane Jones: Continence Assessment

Patient details Mrs J is in her 80s and had a stroke in January 2001. She made a good recovery although she now requires a walking stick. She lives in a bungalow, has good family support and is otherwise well.

2nd June 2001 Mrs J discharged from hospital. Agreed within the team that I should visit her post-discharge and undertake the over-75 assessment.

4th June 2001 Phoned Mrs J to arrange home visit. Mrs J reported that she was managing and asked for the visit to take place later in the month to give her time to get used to being back home and to find out what additional assistance she might require.

19th June 2001 Visited Mrs J, completed the over-75 assessment. Overall, she was coping well on her return home. Equipment and aids were in place/on order. Home help 3 days per week. Physiotherapy fortnightly. Weekly day care. She was managing well with all activities of daily living. She was also managing the raised toilet seat and commode, but occasionally got 'caught short' when out with family or on the bus going to/from day care. Discussed the use of continence pads during these outdoor visits. Mrs J agreed to these, so I arranged for a one-month trial supply of small absorbent pads for light incontinence to be delivered.

27th June 2001 Visited Mrs J to review trial of continence pads. She reported they were working well and she felt reassured to have them when going out, so I set up a regular delivery to her home. Agreed I'd visit next year for over-75 assessment. Mrs J to contact me directly if she required an earlier visit (contact details given).

1st July 2001 Attended a continence update by the local continence advisor. Although this consolidated what I knew about continence products, it helped me realise that I should not have given Mrs J the continence pads without ensuring her incontinence had been properly assessed. As Mrs J developed continence problems as a result of her stroke, she may have underlying bladder problems that need attention. Trust policy is that such patients should be referred to the local continence service or to specially trained district nurses or health visitors. I hadn't been aware of this policy.

2nd July 2001 Phoned Mrs J and asked to visit her that day. During the visit, I explained what I had learned at the update and asked if I could refer her to the local continence service for bladder assessment. After gaining her permission, I made the referral that day. She was very understanding about my earlier omission.

9th July 2001 Continence advisor visited Mrs J at home and carried out a bladder assessment. This showed that she had some urinary retention and a urinary tract infection. Appropriate treatment was started as soon as possible and Mrs J continues to be reviewed by the continence service. She continues to receive her supply of pads.

Lessons learned

Since attending the in-house training day, I am now aware that in this Trust all patients developing continence problems, especially after stroke, should have a bladder assessment. Now when I identify new patients with continence problems, I refer them to the continence advisory service as well as giving them an initial supply of pads, if required, until the continence advisor is able to visit.

While the pads gave Mrs J reassurance when going outside the home and were the right pads for this patient, they only treated her continence symptoms and not her underlying problems. If I hadn't attended the study day, Mrs J would still have had some urinary retention and an infection. The urinary retention could have resulted in further infections and possible renal damage due to reflux.

I presented this case study at a practice clinical team meeting. Other members of staff who had not attended the study day were also unaware of the local requirements for all patients presenting with continence problems to be properly assessed at the time of initial presentation. All nursing, midwifery and health visiting staff in the practice have now adopted this Trust practice and standards have been set. I will lead a practice audit on the topic later in the year. Additionally, as there was no nurse in our area specially trained in continence assessment, one of the district nurses in the practice who has a special interest in the topic has volunteered to undergo such training later in the year (this is supported by our nurse manager and the practice).

Case study example 2: 'themed' sections

DN Pat Percival: Leg ulcer management

Background

Mrs A is a housewife in her 60s. She lives with her husband who is retired and in poor health. They have a daughter who lives at home and works in the nearby town.

History

Mrs A has been hypothyroid since 1986 and is on thyroxine. She also has hypertension, osteoporosis and rheumatoid arthritis. In 1998 she was admitted to hospital having fractured her right hip and in 1999 she had a right total knee replacement and also fractured her right inferior pubic ramus.

Management

GP referred Mrs A to the community staff in January 2001 as she had a small leg ulcer and was unable to attend the practice nurse. Following a wound assessment, Doppler ultrasound assessment and assessment of ankle brachial pressure index (as per SIGN guideline¹), I was able to confirm that the ulcer was arterial, probably associated with her rheumatoid arthritis. Compression bandage was therefore not suitable and the ulcer was treated with a povidone iodine-based dressing and a polyurethane foam film dressing. The ulcer finally healed in 6 months.

Six months after her leg ulcer healed, Mrs A was admitted to hospital after she fractured her left hip (December 2001). When she was discharged home from hospital, her mobility was poor so home care was arranged twice a day, to get her up in the morning and to put her to bed. The community physiotherapist came twice a week and the OT arranged for the necessary changes to be made to her toilet, shower and bedroom. Mrs A had also developed an ulcer on her right anterior aspect of her foot which had been assessed by the tissue viability nurse while she was in hospital. The tissue viability nurse decided to try alginate dressings on alternate days. The community nursing team changed the dressing once Mrs A was discharged. This dressing was very successful and the ulcer responded rapidly.

Case selection

I chose this case because it has had considerable effect on my subsequent nursing practice. Also as most of the multidisciplinary team were involved in the care of Mrs A, communication in the team was usually very good considering the number of different people involved.

Learning points

On reflection, I should have involved the tissue viability nurse earlier, as I found her very

knowledgeable and very helpful. She made several suggestions for treating Mrs A's ulcer, all very useful. As she also gave me detailed information about different types of dressing, I am now aware that the povidone iodine-based dressing was inappropriate for this patient because of her medical history. She also suggested that I refer any future patients I have difficulty with to her out-patient clinic for assessment. I feel the tissue viability nurse is a very useful resource and perhaps, had I consulted her earlier, the patient's healing time could have been reduced and community nursing time could have been saved in the management of this patient.

I presented my case study at a practice clinical team meeting. As others in the team were also uncertain about the role of the tissue viability nurse, we have invited the specialist nurse to a future clinical team meeting (May 2002) to tell us about her role and update us on recent developments in tissue viability. (March 2002)

(1) SIGN publication No 26:, Care of Patients with Chronic Leg Ulcer (7/98)

You may also find it useful to use a *reflective learning cycle*, such as the one shown in Figure 4, as the format for your case study. This can help you systematically review your case study and maximise your learning by providing structure to the reflection process and ensuring that your thoughts are sufficiently focused and critical.

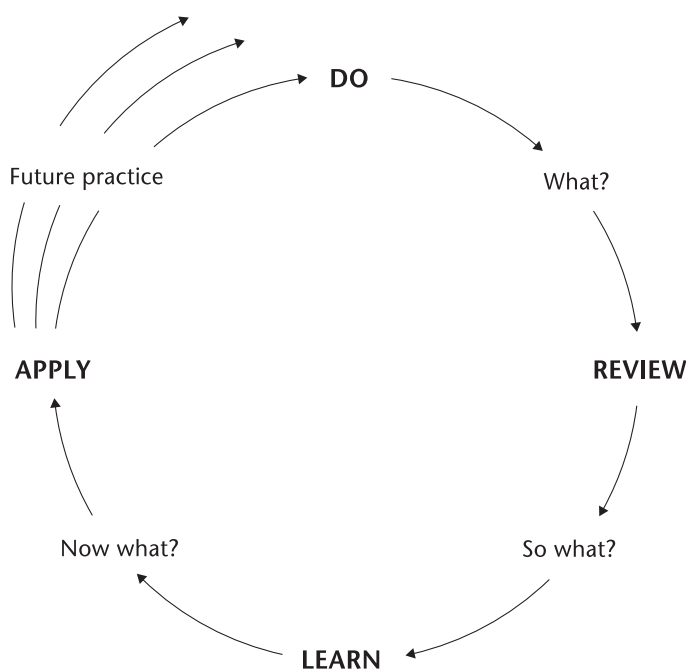
Lessons learned from practice

The purpose of QPA case studies is to critically reflect on past practice in order to improve future practice. Case studies *must* set out the lessons learned - they must demonstrate what you and the team have done (or are doing now) as a result of reflecting on this case. For instance:

- Perhaps your case study identified that you weren't always implementing best practice in the management of newly diagnosed asthma patients. As a result, you developed a proforma, based on national clinical guidelines, for use when seeing new patients, and you have been auditing implementation of this since.
- Your case study may have indicated lack of awareness about the role of a specialist nurse, which resulted in duplication of work. As part of your work towards fulfilling PREP requirements, you arranged a meeting with this nurse to find out more about her role.

Practices won't be 'marked down' for submitting case studies that show care was not as good as expected. They will instead receive lots of credit for showing assessors how they learned from the case study and how it has pointed the way towards delivery of improved care. And it's important that lessons you learn are shared with the rest of the team; assessors will be specifically checking for this within the 'lessons learned' section of your case studies.

Figure 4. Reflective learning cycle



? WHAT (returning to the situation)

- is the purpose of returning to this situation?
- exactly occurred in your words?
- did you see? did you do?
- was your reaction?
- did other people do eg colleague, patient, visitor?
- do you see as key aspects of this situation?

? SO WHAT (understanding the context)

- were your feelings at the time?
- are your feelings now? Are there differences? - why?
- were the effects of what you did (or did not do)?
- 'good' emerged from the situation, eg self/others?
- troubles you? (If anything)
- were your experiences in comparison to your colleagues, etc?
- are the main reasons for feeling differently from your colleagues, etc?

? NOW WHAT (modifying future outcomes)

- are the implications for you, your colleagues, the patient, etc?
- needs to happen to alter the situation?
- are you going to do about the situation?
- happens if you decide not to alter anything?
- might you do differently if faced with a similar situation again?
- information do you need to face a similar situation again?
- are your best ways of getting further information about the situation should it arise again?

Source: Driscoll, J. (1994)
Reproduced with kind permission of the RCN Publishing Company.

QPA as a personal learning process

The focus of QPA is on the quality of patient services, but it also has a role in the educational and clinical development of team members. While this isn't required as part of the submission portfolio, you may want to reflect on what you have learned during your QPA experience and record it in your personal profile to help you meet PREP requirements.

An evaluation form has been inserted in this guide (Appendix 2) to enable you to assess your personal learning and development gained through the QPA process. The form has been adapted from a tool previously developed by the RCGP(S), NBS, and the Scottish Centre for Post-qualification Pharmaceutical Education (SCPPE) (RCGP(S) et al, 2000). It will help you to assess your knowledge and confidence in relation to the key aspects of QPA both at the beginning and end of the accreditation process.

Examples of personal learning

The QPA Manual will have criteria asking nurses and midwives employed by or attached to general practices to list examples of recent learning and state how these learning opportunities influenced their practice.

You don't have to submit a large number of pages to fulfil these criteria. It is perfectly acceptable for you to list only the main points of your learning.

The key points you should consider when making submissions to those parts of the portfolio are:

- State why the particular study day, training course or learning experience was a priority for you, giving reasons to support your choice. For instance, you might explain that:
 - there is an annual requirement for nurses and midwives to attend anaphylaxis updates within your Trust
 - a significant event occurred during an immunisation clinic in your practice which prompted you to find out more about anaphylaxis
 - diabetic foot care is an LHCC priority and you felt you needed to update your knowledge
 - you are expanding your role to meet a practice health need and you required additional training on the management of diabetes.
- Show how your personal development related to the needs of your practice and patients, rather than how it related to your personal interests.
- Describe briefly the type of learning. For example, you shadowed a specialist nurse, attended a diabetic study day and/or carried out a literature search.
- Detail your new learning. For example, the study day refreshed what you already knew about the diagnosis and management of diabetes, but you also learned about a new diabetic drug, including when to use it and side-effects.

- Set out benefits (actual and potential) of your new learning to patients and/or the practice team. How has your learning improved care for patients? How have your colleagues in the practice team benefited?

Examples of how nurses and midwives might describe their personal learning through the QPA process are set out in the boxes below.

Name:

Anaphylaxis training

Date of training June 2001.

Type of training/learning Attended an annual in-house anaphylaxis update (half-day).

Reason for training/learning Attendance is a Trust requirement for all nursing staff.

What I learned

- I learned about administration of adrenaline and appropriate nursing interventions.
- I was reminded about the signs and symptoms of anaphylaxis. This was important as I realised I had forgotten some of them. I am now more aware about what to look for in at-risk patients.
- I learned about the storage conditions for adrenaline. This made me realise that we need to check the storage conditions of adrenaline more often within the practice.

How this has benefited me, my patients and the practice

- The DN sister and practice nurse have now agreed I will check the stored adrenaline once a month, as advised during the update, and record the outcome of this check on a specially designed form. This should ensure that if any patient requires adrenaline within the practice, the drug should have its effectiveness maximised through being stored in optimum conditions.

Name:

Doppler assessment

Date of training September 2001.

Type of training/learning Attended a half-day workshop on Doppler assessment given by the tissue viability nurse at the local hospital .

Reason for training/learning My role has recently extended to include assessment of leg ulcers (this development is part of the practice development plan). As the assessment of leg ulcers using Doppler is a recommendation of the SIGN guideline, learning how to use this equipment was a priority for me.

What I learned

- The theory behind the use of Doppler in assessment was explained.
- I was taught how to use Doppler equipment in the assessment of leg ulcers (theory and practical session) and how to calculate ankle brachial pressure index.

How this has benefited me, my patients and the practice

I am now carrying out leg ulcer assessments under supervision from the district sister. Once I'm competent, this will mean patients in the practice will have improved access to Doppler assessment within the practice. In particular, this should provide better continuity of care when the district sister is on leave; at the moment, patients have to wait until a nurse from the neighbouring practice can come and assess them. I will audit this new development at a later date.

Name:

Clinical audit training

Date of training June and September 2001.

Type of training/learning Attended a two- day course on clinical audit provided by the Trust clinical governance department (one day in June, one in September).

Reason for training/learning To learn how to carry out clinical audits properly. I needed this knowledge to participate in the QPA process with the rest of the practice team and to participate in the clinical governance process.

Benefits to self

- I learned about the audit cycle in theory, including how to set standards, sample, analyse data and report results.
- I had to carry out a first audit cycle of an area of my practice and present my audit project at the September study day.

Benefits to women and/or the practice team

- I am now able to personally audit my work and have used that information to improve the service I provide. For example, the HV and I audited the support given to breastfeeding women within the practice and I audited the service provided to clients attending the practice's pre-conceptual clinic. Both audits resulted in changes to practice (see audit summaries submitted within the QPA portfolio).
- I have also been able to help other members of the practice team with their QPA audits. Colleagues now report feeling more confident about undertaking their own audits.

Name:

Post-natal depression and puerperal psychosis

Date of training September 2001.

Type of training/learning Attended the SIGN national event on post-natal depression (PND) and puerperal psychosis (full day event).

Reason for training/learning The screening and management of PND is an LHCC and practice priority. I needed to update my knowledge about this subject from a midwifery perspective. The SIGN national event not only gave me more information on the topic, but also gave me an opportunity to comment on the relevant draft SIGN guideline.

Benefits to self

- Through hearing about the latest research in this area, I was able to update my knowledge on PND generally.
- My knowledge about puerperal psychosis was increased - in particular, I discovered that although rare, decreased length of stay in post-natal wards means this condition is likely to present following a woman's discharge home from maternity care. This has enhanced my awareness of this condition among the women I work with.

Benefits to women, the practice team and/or the profession

- As the team HV also attended the SIGN meeting, we jointly reviewed the service we provided in this area in collaboration with one of the GPs and improved our practice system for communicating about women we considered at risk of developing PND or puerperal psychosis. We will audit these changes at a later date.
- The HV and I updated other members of the practice team at a clinical meeting focusing on what we had learned at the SIGN national event. We also informed them about the changes to our system for communicating about women at risk.
- I was also able to comment on the draft SIGN guideline; these comments should strengthen this guideline from a midwifery perspective.

Frequently asked questions about QPA

Q: There are health care assistants and a nursery nurse working with the district nurses and health visitors. Should they be taking part in QPA?

A: Yes, they are members of the nursing team. QPA is a quality initiative for the whole practice team, which includes clinical and non-clinical staff, professionally trained and untrained staff. Some staff may, however, need additional support and assistance with the QPA process.

Q: How does QPA help improve patient care?

A: It encourages staff within the practice team to look critically at the care they provide to see if it could be improved in any way. Teams are expected to take steps to improve the quality of care when indications for improvement in current services are found. QPA also promotes a culture within the practice team in which the quality of care is considered to be an integral part of practice, rather than an optional extra.

Q: I am a mental health nurse specialising in substance misuse. I am linked to a practice undertaking QPA and visit the team once a week. Should I be taking part in their QPA application?

A: All healthcare disciplines have a professional responsibility through clinical governance to assure and improve the quality of care. As QPA is one means of achieving this, all nurses and midwives should actively participate in this initiative. QPA has been designed to acknowledge the wider practice team, which includes midwives, mental health and learning disability nurses, pharmacists and allied health professionals. You should therefore speak to the practice manager and/or nursing colleagues as soon as possible about your participation in the process.

Q: Practice accreditation is a priority for my LHCC. Will my team, which is currently undergoing QPA, need to do this as well?

A: Practice Accreditation (PA) and QPA have both been developed by the RCGP(S) as quality accreditation schemes for practice teams. QPA is a more comprehensive process, with greater emphasis on the educational and clinical development of team members. As such, it is considered to be a higher-level quality award than PA; consequently, practices who have completed QPA will not be expected to complete PA.

Q: Will my practice team fail QPA if I describe an example of bad practice within my case study?

A: QPA is all about learning from current or past practice to improve future practice and therefore patient care. A team will not fail QPA if you submit a case study showing that

care was not as good as you expected it to be. What is *essential* is that your case study then documents what you subsequently did (or plan to do) to improve the care provided. When assessors are reviewing the portfolios of evidence, they will be looking to see what changes you have made to your practice as a result of critical reflection through your case study. A case study showing that care was not as good as expected but which then sets out what was done to improve the situation will receive praise from the assessors.

Q: What if the results of an initial audit show that a standard I'd set wasn't achievable or measurable?

A: Don't worry. Hopefully, your audit data should give you some indication about how you could rectify it for future audits. Perhaps the wording of your standard needs to be amended to exclude patients who fail to attend or comply. Alternatively, your standard may be fine, but your data collection tool (such as a proforma or checklist) didn't allow you to gather all the data you needed to measure it. If so, you should amend your data collection tool accordingly and audit again.

Be honest about any standards that weren't achievable or measurable in your audit summary. Mention any subsequent changes you made to them or the data collection tool. Learning from experience is part of the audit process. And remember, you can greatly reduce the risk of setting standards that aren't achievable or measurable by asking local clinical audit staff (or equivalent) to critique your draft standards before you start collecting data.

Q: I haven't got experience of writing essays or case studies. Will that mean I'll have difficulty completing the QPA submission material?

A: No. The QPA criteria have been devised to be of relevance to all members of the practice team. Much of the work required for QPA, such as clinical audit and case studies, is relatively straightforward and should be achievable by all team members. If you follow the guidance within the QPA user's guide (in the QPA Manual) issued to all practices participating in QPA, as well as the advice contained within this guide, you should be able to produce documents that will satisfy the assessors. Remember, QPA is about learning from what you do to improve practice. You will see from the examples included within this guide that QPA is not about submitting academic essays, but showing that you've been reflecting on what you do and acting on those reflections to improve the quality of care.

Q: I have a very busy caseload. Why should I participate in QPA?

A: All healthcare professionals participating in QPA have clinical commitments which have to be met. But since the introduction of clinical governance, they also have a personal duty to assure and improve the quality of the care they provide. QPA is one means of meeting clinical governance responsibilities. Participation in QPA or other quality systems is time-consuming, but it also brings considerable benefits to all professionals through improved team-working and communication, which facilitate greater personal effectiveness and improved standards of care.

Q: I am a health visitor attached to, but not employed by, the practice undergoing QPA. I want to participate in this process. Will my line manager approve of my participation?

A: Your line manager is likely to approve of your participation in QPA because of its clinical governance and PREP implications. Work done to fulfil the QPA criteria can be used to demonstrate that you are assuring and improving the quality of your care and keeping up-to-date professionally, simultaneously meeting your clinical governance responsibilities and PREP requirements.

Q: Nursing and midwifery staff are based in separate buildings in my practice team. Will this affect our ability to work towards QPA?

A: No. Many teams in similar circumstances have successfully completed QPA. Good team-working is central to the QPA process and while it may be easier for teams based in the same building to communicate and work together effectively, it can still be achieved by teams working across different sites. Your team should objectively review existing communication systems at the start of the QPA process, and strengthen them as necessary. The external assessment team may want to visit all sites.

Q: How will the midwifery documentation be assessed?

A: Following discussions with the RCM (Scotland), it has been agreed that prior to the portfolio of evidence being submitted to the RCGP(S), midwifery documentation such as case studies, clinical audits and learning examples will be reviewed by the relevant supervisor of midwives. This review should therefore ensure that the midwifery care documented for the purposes of QPA is satisfactory from a clinical perspective. Subsequent review of the midwifery documentation by the QPA assessors would therefore be from a generic quality perspective rather than from a specific clinical or technical viewpoint. Prior to starting their QPA documentation, midwives should inform their supervisor of their intention to participate in QPA.

Q: I am a treatment room nurse working with two practice teams. Both are currently working towards QPA. Will I have a lot of extra documentation to do?

A: If you plan your work well, you should not have too much extra work preparing for both practice submissions. You can submit the same learning examples for both practices, although you may need to adapt them to suit the different practices accordingly - the date and type of training, reasons for learning and benefits to self are likely to be the same for both practices, but the benefits to patients may differ. This section of your learning example would consequently be different between the two submissions.

Regarding clinical audits, it is possible to audit a particular aspect of your work but present the results separately for the two practices. For example, when auditing your standards for venepuncture, you could collect the data for patients from both practices at the same time, but present your results per practice. Your audit summaries (see Chapter 5) for Practices A and B would contain similar material such as who led the project, what standards were used and how the data were collected. The changes made as a result of the audit, however, would probably be different between the two practice teams. This element of your audit summaries would therefore be different in each of your submissions.

Alternatively, rather than carrying out your own audits, you could participate in a practice audit. You could, for example, collaborate with PN and GP colleagues to audit a topic that affected you all.

Where case studies are concerned, however, it is preferable for you to submit separate case studies for each practice based on their own patients.

Q. What should we expect on the day of the QPA visit?

A. Assessors want to keep disruption to patients to a minimum so, where possible, it will be business as usual for team members. On arrival, the assessment team will confirm the programme for the day, including details on when different groups of staff will be interviewed. Assessors often meet some or all of the team members informally at lunchtime. Although the assessment visit is a tiring day, it is usually an enjoyable experience for everyone. The assessment team work hard to emphasise where the practice team is working well, and also offer suggestions on how the practice might improve its performance. At the end of the day, the assessors meet the whole team to give verbal feedback on the visit. Then the team's celebrations usually begin!

Appendix 1: Example of an audit summary

Summary of an audit of newly diagnosed adult patients (aged 16 years and over) with asthma attending the Practice Nurse Asthma Clinic.

Reason for audit An LHCC health needs assessment identified lung disease, especially asthma, as a local priority. This practice audit is in response to this identified priority.

Audit leader Anne Andrews (Practice Nurse)

Audit team Anne Andrews, Bette Barclay (GP), Chris Carper (Administration Assistant).

Date first audit cycle initiated: June 2000.

Audit standards (NB. these were based on the 2000 national guidelines for asthma care)

Standard 1: All newly diagnosed adult patients with asthma able and willing to use an inhaler will have their inhaler technique assessed by the practice nurse (PN) and the outcome of this assessment will be documented.

Standard 2: All newly diagnosed adult asthmatic patients will be offered written asthma information and this will be documented.

Data collection

Audit data were gathered through computer search of all patients receiving asthma drugs between 1 October 00 - 31 March 01. The search was then narrowed to identify all those receiving first prescriptions of asthma drugs. Patients identified were then cross-checked with the appointment diary for the PN asthma clinic for the same period. Twelve patients were identified for inclusion in the audit.

Audit Results

Month	New adult asthma patients	Number seen by PN	Inhaler technique assessed and outcome recorded	Written information documented as offered
October	0	0	0	0
November	0	0	0	0
December	1	1	1	1
January	1	1	1	1
February	4	4	2	2
March	6	6	3	3
Total	12	12	7	7

Comparing audit data with standards

- The PN saw all twelve of the adult patients newly diagnosed as having asthma between 1 October 2000 and 31 March 2001.
- Although all twelve were able and willing to use an inhaler, only seven were recorded as having had their technique assessed and having written information offered.
- Neither Standards 1 nor 2 have therefore been met on this occasion.

Action taken

- Results were presented at the May 2001 practice team meeting. Anne reported that the standards she had written were achievable in that she routinely assesses the inhaler technique of all new patients and offers them written information. However, the audit showed that her documentation in these areas was not as good as expected and should be improved.
- Anne, with support from Bette and Chris, drafted an assessment sheet for newly diagnosed asthmatic patients. This proforma asks staff if a patient is able and willing to use an inhaler, the date of the inhaler technique assessment, the outcome of that assessment and which information leaflets were offered to the patient. The proforma, which uses free text and tick boxes, will be used primarily by Anne but also by other team members during her absence.
- Staff were made aware of the proforma at a subsequent team meeting. The proforma is currently being piloted for 3 months (June - August 2001). Initial feedback about its use is positive.
- The re-audit cycle will start in September 2001.

If a re-audit had also been carried out, the following additional information should be included within the summary.

Date re-audit cycle initiated: September 2001.

Re-audit standards

Standard 1: All newly diagnosed adult patients with asthma will have a New Asthma Patient Proforma contained within their medical records.

Standard 2: All newly diagnosed adult patients with asthma able and willing to use an inhaler will have their inhaler technique assessed by the PN and the outcome of this assessment will be documented on the proforma.

Standard 3: All newly diagnosed adult asthmatic patients will be offered written asthma information and this will be documented on the proforma.

Data collection Re-audit data were gathered using a similar method to the first audit cycle. Data were collected between 1 October 2001 and 31 March 2002.

Re-audit Results

Month	New adult asthma patients	Number seen by PN	Number with asthma proforma in records	Inhaler technique assessed and outcome recorded	Written information documented as offered
October	1	1	1	1	1
November	2	2	2	2	2
December	4	4	2	2	2
January	1	1	1	1	1
February	0	0	0	0	0
March	1	1	1	1	1
Total	9	9	7	7	7

Comparing audit data with standards

- Results indicated that the proforma had not been used by the locum PN during Anne’s Christmas holidays. Standard 1 had therefore not been met.
- Although there had been an increase in the number of times Standards 2 and 3 had been met, the target of 100% had not been achieved within this re-audit.
- The audit team noted that when the proforma had been used, Standards 2 and 3 had been met because documentation had improved.

Action taken

- Re-audit results were presented at the April 2002 practice team meeting. Anne reported that her standards for inhaler assessment and written information were still achievable, if the proforma was used. She also reported that results had made her aware that the locum PN had not known of the new proforma or the asthma standards. Anne and Bette both reported finding the proforma helpful at follow-up clinics, especially the information about inhaler technique. The team agreed that use of the asthma proforma should continue at the clinic.
- Anne met the locum PN to discuss the proforma and asthma standards. During this discussion, the locum also reported difficulty in finding the patient information leaflets for newly diagnosed asthma patients.
- Anne has now made up a file for the asthma clinic to assist the locum PN. This folder which includes copies of the proforma and patient information leaflets will be stored in Anne’s consulting room. The locum PN has been made aware of this.
- Re-audit to see whether changes mean the 100% standards are achievable is due October 2002.

NB. Space restrictions in the audit summary mean it is not possible to provide more than two examples of initial standards or more than six months of data. In practice, such an audit and re-audit would usually require more standards and the period of data collection would need to be extended to include more patients.

Appendix 2: Evaluation of personal learning gained through participation in QPA

This form has been adapted from a developed tool (RCGP(S) et al, 2000). It will help you to assess your knowledge and confidence in relation to the key aspects of QPA at the beginning and end of the accreditation process. **Please feel free to photocopy additional copies of the form for personal use or use by colleagues as required.**

The aim of the form is to help you evaluate your knowledge and confidence in relation to each of the subject areas set out below, *at the beginning* and again *at the end* of the QPA process. Remember, this is entirely for your own use.

How knowledgeable/confident am I in relation to:

Clinical audit

1. Planning and undertaking a complete audit cycle:

Start of QPA (tick box that applies)

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA (tick box that applies)

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

2. Setting standards:

Start of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

3. Writing an audit summary:

Start of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

Case studies

1. Identifying and critically reflecting on a significant event :

Start of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

2. Learning lessons from significant event analysis and applying them to practice:

Start of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

Clinical effectiveness and clinical governance issues

1. Understanding the QPA process:

Start of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

2. Awareness of national clinical guidelines and how to access them:

Start of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

3. Implementing and evaluating clinical guidelines in practice:

Start of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

4. Awareness of national initiatives and bodies promoting quality in health care:

Start of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

Personal skills

1. Clear understanding of the roles of *all* members of the primary care team (clinical and non-clinical):

Start of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

2. Ability to work in a team to meet the specific QPA criteria:

Start of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

3. Information technology:

Start of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

End of QPA

very knowledgeable/confident	knowledgeable/confident	quite knowledgeable/confident	not knowledgeable/confident

Now that you have completed the QPA process, list below three areas of personal learning you have gained from QPA:

1. _____
2. _____
3. _____

List below any unmet training needs you have identified as a result of going through QPA. (You should now discuss these with your line or practice manager).

Congratulations on all your hard work completing the QPA process.

RESOURCES

Please note: there are many textbooks and articles that will be useful to you during the production of your QPA portfolio; the list below is only an example of the type of resources you could use.

Literature

Clinical audit

Adams, C. (2000) *Clinical Effectiveness: a practical guide for the community nurse* London: Community Practitioners' & Health Visitors' Association.

Crombie, I.K., Davies, H.T.O., Abraham, S.C.S., Florey, C.V. (1995) *The Audit Handbook: improving healthcare through clinical audit* Chichester: John Wiley & Sons.

Davis, J.P.L., Crombie, I.K., Davies, H.T.O. (2001) Understanding sampling: representativeness matters. *Hospital Doctor* 62: 4, 237-239.

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Morell, G., Harvey, G. (1999) *The Clinical Audit Handbook; improving the quality of healthcare* London: Bailliere Tindall.

Morris, M. (1998) *Midwifery Audit Good Practice Guide*. London: RCM.

Scottish Audit Network (1990) *Getting Started in Clinical Audit* Edinburgh: CRAG.

Solieri, A. (2001) How to complete a successful clinical audit. *Nursing Times* 97: 44,37.

University of Dundee (1994) *Moving to audit: an educational package for nurses, midwives and health visitors* Dundee: University of Dundee and CRAG.

Clinical Effectiveness and clinical governance

Baker, N. (1999) Clinical governance within primary care. *Practice Nursing* 10: 1, 18-19.

Chambers, R. (1998) *Clinical Effectiveness Made Easy - first thoughts on clinical governance* Oxford: Radcliffe Medical Press.

Charnock, A. (2001) Who's afraid of clinical governance? *Nursing Times* 97: 50, 34 -35.

Hamer, S. (2000) *Clinical Governance - 1* London: Nursing Times Monographs.

Marr, H. (2000) Quality and clinical effectiveness. In: Lawton, S et al (Eds.) *District Nursing: providing care in a supportive context* Edinburgh: Churchill Livingstone.

McSherry, R., Haddock, J. (1999) Evidence-based healthcare: its place within clinical governance. *British Journal of Nursing* 8: 2, 113-117.

Royal College of General Practitioners (Scotland), National Board for Nursing, Midwifery and Health Visiting for Scotland, Scottish Centre for Post-qualification Pharmaceutical Education (2000) *Practical Clinical Effectiveness: a 2-day course for primary healthcare professionals promoting the clinical governance agenda in LHCCs* Edinburgh: RCGP(S), NBS, SCPPE.

RCN (2000) *Clinical Governance Resource Pack* London: RCN.

QPA

RCGP (Scotland) (2000) *RCGP Quality Practice Award: the application, process and criteria and user's guide (Version 5)* Edinburgh: RCGP (Scotland).

Reflective practice

Driscoll, J. (1994) Reflective practice for practise. *Senior Nurse* 13: 7, 47-50.

Haddock, J. (2002) Reflective practice and decision-making related to research implementation. In: McSherry, R. et al (Eds). *Evidence-informed Nursing: a guide for clinical nurses* London: Routledge.

RCN Scotland (2000) *Personal Professional Portfolio* Edinburgh: RCN (Scotland).

Websites

NB: The following information was correct at the time of going to print. However, some of the national bodies listed below are undergoing re-organisation during 2002/03. As a result, some of these web addresses are also expected to change.

organisation or site	web address
CDNA:	www.cdna.tvu.ac.uk
CHI:	www.chi.nhs.uk
CPHVA:	www.msfcphva.org
CRAG:	www.show.scot.nhs.uk/crag
CSBS:	www.clinicalstandards.org
HTBS:	www.htbs.co.uk
NES:	www.nes.scot.nhs.uk
NICE:	www.nice.org.uk
NMC:	www.nmc-uk.org
NMPDU:	www.nmpdu.org
Nurse Practitioners (UK)	www.nursepractitioner.org.uk
QNI (Scotland):	www.qnis.co.uk
RCGP:	www.rcgp.org.uk
RCM:	www.rcm.org.uk
RCN:	www.rcn.org.uk
RCGP (Scotland):	www.rcgp-scotland.org.uk
Scottish Health on the Web:	www.show.scot.nhs.uk
SIGN:	www.sign.ac.uk
SPNA:	www.show.scot.nhs.uk/spna

Professional contacts

If you require further information about QPA from a nursing or midwifery perspective, the contact details for some QPA nurse assessors can be found on the NMPDU web site at www.nmpdu.org

Acronyms

Acronym	Meaning
CDNA	Community & District Nursing Association
CHI	Commission for Health Improvement
CPHVA	Community Practitioners' & Health Visitors' Association
CRAG	Clinical Resource and Audit Group
CSBS	Clinical Standards Board for Scotland
DN	District Nurse
DoH	Department of Health
GP	General Practitioner
HV	Health Visitor
LHCC	Local Health Care Co-operative
NBS	National Board for Nursing, Midwifery and Health Visiting for Scotland
	From the 1 April 2002, the NBS was incorporated into NHS Education for Scotland (NES).
NES	NHS Education for Scotland
NHSE	National Health Service in England & Wales
NICE	National Institute for Clinical Excellence
NMC	Nursing & Midwifery Council
NMPDU	Nursing & Midwifery Practice Development Unit, NHSScotland
PA	Practice Accreditation
PN	Practice Nurse
PREP	Post-Registration Education and Practice
QNI(S)	Queen's Nursing Institute (Scotland)
QPA	Quality Practice Award
RCGP(S)	Royal College of General Practitioners (Scotland)
RCM	Royal College of Midwives
RCN	Royal College of Nursing
SCPPE	Scottish Centre for Post-qualification Pharmaceutical Education
SEHD	Scottish Executive Health Department
SHVA/Unison	Scottish Health Visitors' Association/Unison
SIGN	Scottish Intercollegiate Guidelines Network
SPICE	Scottish Programme for Improving Clinical Effectiveness in Primary Care
SPNA	Scottish Practice Nurses' Association
SNPG	Scottish Nurse Practitioner Group
UKCC	United Kingdom Central Council for Nursing, Midwifery & Health Visiting
	The UKCC was replaced by the Nursing & Midwifery Council (NMC) on the 1 April 2002.

Glossary

Term

Assessment

Benchmarking

Best Practice Statement

Clinical audit

Clinical Governance

Clinical Resource and Audit Group (CRAG)

Clinical Standards Board for Scotland (CSBS)

Continuing Professional Development

Criteria (plural)/criterion (singular)

Evidence-based

Definition

The process of measuring the quality of an activity, service or organisation (CSBS, 2001).

A means of self-assessing comparative performance and sharing good practice (SEHD, 2001).

A national statement to describe best and achievable practice in a specific area of nursing and midwifery care (NMPDU, 2002).

The systematic, critical analysis of the quality of clinical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the client (DoH, 1989).

Clinical audit should be seen as one of the key instruments for assessing and ensuring quality (Irvine and Irvine, 1997).

A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care can flourish (NHSE, 1998).

An extra dimension that will provide the public with guarantees about standards of clinical performance (SODoH, 1998).

The lead body within the Scottish Executive Health Department promoting clinical effectiveness in Scotland.

It promotes public confidence that the services provided by NHSScotland are safe and meet nationally agreed standards. It also demonstrates that within the resources available, NHSScotland is delivering the highest possible standards of care (CSBS, 2001).

A commitment to learning in various forms, which maintains and enhances professional standards of work and develops the ability to recognise good practice (CSBS, 2001).

The aspect of care being measured to assess quality (University of Dundee, 1992). Criteria are based on clinical observations and measurements which assess the quality of care a patient has received (Crombie et al, 1995).

The process of systematically finding, appraising, and using research findings as the basis of clinical decisions (CSBS, 2001).

Guideline	Systematically developed statements which assist in decision-making about appropriate health care for specific clinical conditions (CSBS, 2001).
Local Health Care Co-operative (LHCC)	A voluntary grouping of GPs in Scotland. LHCCs are operational units within Primary Care Trusts responsible for managing and delivering integrated services across defined areas (SODoH, 1997).
National Institute for Clinical Excellence (NICE)	Its role is to provide guidance to the NHS in England & Wales based on clinical and cost-effectiveness. NICE produces three types of guidance: technology assessments, clinical audit methods and clinical guidelines.
Nursing & Midwifery Practice Development Unit (NMPDU)	This national unit has a broad remit which includes identifying and sharing good practice within nursing and midwifery across Scotland. For example, the development of Best Practice Statements.
Population	The total number of people of interest to the audit team (University of Dundee, 1994).
Post-Registration Education and Practice (PREP)	A standard framework for post-registration education and practice, which contributes to the maintenance and development of professional knowledge and competence leading to improved standards of patient and client care (RCN, 2000).
Practice Accreditation (PA)	A first-level quality assurance scheme for practice teams in Scotland developed by RCGP(S).
Quality accreditation	A system of external peer review using written standards, designed to assess the quality of an activity, service or organisation (CSBS, 2001).
Quality assurance	Improving performance and preventing problems through planned and systematic activities including documentation, training and review (CSBS, 2001).
Quality Practice Award (QPA)	A higher level quality assurance scheme for practice teams which also promotes the clinical and educational development of team members.
Quality Team Development	The equivalent to Practice Accreditation in England and Wales.
Sample	A selection, usually at random, of a number of individuals from the population on the basis that the sample is representative of the population from which it was taken (University of Dundee, 1994).

Scottish Inter-Collegiate Guidelines Network (SIGN)

SIGN is responsible for systematically developing multi-professional national clinical guidelines based on systematic reviews.

Scottish Programme for Improving Clinical Effectiveness in Primary Care (SPICE)

SPICE is a voluntary benchmarking initiative for practice teams in Scotland. There are SPICE criteria sets for different aspects of primary care, such as the management of hypertension. Practices participating in SPICE can benchmark themselves against other practices implementing the same criteria sets.

Standard

Professionally agreed level of performance which is observable, achievable, measurable and desirable (RCN, 1986).
A standard consists of a criterion and target (Difford, 1990; Crombie et al, 1995).

Target

The proportion of times the criteria is expected to be met (Crombie et al, 1995).

References

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- Scottish Office Department of Health (1998) **Clinical Governance:** Management Executive Letter MEL (1998) 75. Edinburgh: SODoH.
- Scottish Executive Health Department (2001) *Rebuilding our National Health Service: guidance to NHS chairs and chief executives on implementing Our National Health, A Plan for Action, A Plan for Change.* Edinburgh: SEHD.
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