

## British Association of Otolaryngologists Head and Neck Surgeons Summer Meeting, 7–8 September 2005, Edinburgh, Scotland, UK: audit abstracts

### Oxford regional audit of ENT short stay surgery

D Costello, P Brown

From the Milton Keynes General Hospital, Milton Keynes, UK

#### Standards

A 1995 Royal College of Surgeons of England (RCS (Eng)) national comparative audit found that only 31 per cent of ENT surgery was being performed as day surgery.<sup>1</sup> At that time, the RCS (Eng) *Guidelines for Day Surgery*<sup>2</sup> suggested that a proportion of 50 per cent was achievable overall. Now, the Audit Commission has published benchmark day surgery percentage rates for five ENT procedures, included within a group of 25 procedures from all surgical specialties.<sup>3</sup> Against this background of rapidly moving standards 'goal posts', we wanted to know if we were keeping up and whether there were variations within the region covered by the Oxford Professional Group.

#### Evaluation of practice

In 1992, an audit was undertaken to establish the rates of ENT day surgery being performed in the Oxford region (mean rate, 27 per cent; range, 20–44 per cent).<sup>4</sup> This audit examined only those procedures booked as day cases. Amongst other things, this cycle of the audit found that patients undergoing multiple procedures were significantly less likely to be discharged on the same day than those undergoing just a single procedure.

#### Change in practice

A working party was set up to address the recommendations needed to close the gap between benchmarks and practice; it issued its report in 1995.<sup>5</sup> The report suggested a 'basket' of cases that could reasonably be expected to be performed as day cases and set percentage rates. It also suggested that tonsillectomy should not be recommended as a day surgery procedure until there was more evidence on the safety of this.

#### Re-evaluation

The present audit (2005) re-examined the original criteria but also assessed more parameters and was expanded to include 'short stay surgery' (i.e. admissions under 36 hours) in order to take account of changes in practice since 1992. Overall, day surgery rates as a proportion of total surgical procedures had increased since 1992 to 43 per cent. This was less than the overall target, but the rates for the Audit Commission index procedures of grommets insertion, septoplasty, fractured nasal bone manipulation under anaesthesia and tonsillectomy were either achieved or exceeded. There was still a wide range of variation between units, and this comparative data will be separately presented in the future. More information was available in this cycle about potential reasons for variations in day surgery rates (e.g. the effect

of American Society of Anesthesiologists grade on day surgery rate).

#### Further recommendations for changes in practice

We recommend that further changes to practice be made.

#### References

- 1 Brown PM, Fowler S, Ryan R, Rivron R. ENT Day Surgery in England and Wales – an Audit by the RCS (Eng) Comparative Audit Service. *J Laryngol Otol* 1998;**112**:161–5
- 2 Royal College of Surgeons of England. *Guidelines for Day Surgery*, revised edn. London: Royal College of Surgeons of England, 1992
- 3 Department of Health. *Day Surgery: Operational Guide. Aug 2002 Annex A*. London: The Stationery Office, 2002
- 4 Brown P, Legg F. *Audit of Ear, Nose and Throat Day Surgery Across the Oxford Region*. Oxford: Oxford Regional Health Authority, 1993
- 5 Brown P, Lee R, Marks N. *Day Case Surgery in the Oxford Region – a Review and Recommendations*. Oxford: Oxford Regional Health Authority, 1995

### An audit loop of doctor signatures in out-patient clinic notes

I Gianopoulos, E Blenke, G Kelly

From the ENT Department, Leeds General Infirmary, Leeds, UK

#### Aim

To audit case-note entry identification, implement changes for improvement and then re-audit.

#### Standard

The General Medical Council and the Royal College of Surgeons of England have both published guidelines<sup>1,2</sup> that require doctors' case-note entries to be legibly signed. We set a criterion that at least 95 per cent of our out-patient notes should comply.

#### Evaluation of practice and comparison against standard

Of 70 randomly selected clinic notes, only 16 (23 per cent; 95 per cent confidence intervals (CI), 15–34 per cent) identified the doctor with a legible name, three contained an illegible name, eight contained no identification and in 33 the doctor was unidentified except for a short, hasty signature. Therefore, the absence of the doctor's name rather than its legibility was the main problem.

#### Change in practice

We purchased a rubber stamp with blank spaces for the doctor's name, grade and contact number. The clinic clerk, before making the case-notes available to doctors, stamped and dated the page allocated for the out-patient record. Doctors filled in the blank fields and wrote their notes in the area under the stamp. Therefore, the stamp prompted doctors to sign legibly at the beginning of their notes.

### Re-evaluation

Five months later, 70 clinic notes were randomly sampled. Sixty-two (89 per cent; 95 per cent CI, 79–94 per cent) were signed legibly.

### Discussion

Further effort is required to attain the required standard; however, the introduction of a rubber stamp led to an extra 66 per cent (95 per cent CI, 51–76 per cent) of case notes being appropriately signed. In the reality of busy clinics, signing at the end of the record, instead of the beginning, results in inadequate identification of the consulting doctor.

### References

- 1 General Medical Council. *Good Medical Practice*. London: The Council, 1998
- 2 Royal College of Surgeons of England. *Good Surgical Practice*. London: The College, 2002

### Audit of the effect of organizational change on day-case ENT surgery

R J Glore, M Kadarsha, P A Harkness

From the ENT Department, Rotherham General Hospital, Rotherham, UK

### Standards

Day-case surgery can represent 31 per cent of total ENT procedures in British hospitals.<sup>1</sup> According to The British Association for Day Surgery, the case mix for ENT day cases should include pinnaplasty, tonsillectomy in children, and half of all rhinoplasties, tympanoplasties, partial thyroidectomies and superficial parotidectomies.<sup>2</sup> The unexpected admission rate may be approximately 2 to 3 per cent.<sup>1,3</sup>

### Evaluation of practice (1 July 1999 – 31 December 1999)

We conducted a retrospective case note audit. Prior to 2000, there were in-patient ENT beds at the base hospital. Day surgery was carried out from the ward and from the day-case unit, with the safeguard of having an overnight ENT bed. During this first six-month study period, there were 449 intended day cases. This represented a day surgery rate of 50.1 per cent. Procedures performed as day cases included septal procedures, grommets insertion and adenoidectomies. Eight-three patients (18.5 per cent) required an unplanned overnight stay.<sup>4</sup>

### Change in practice

Network reorganization meant that in-patient ENT beds were transferred to a neighbouring hospital. This triggered certain non-specific changes in surgical and anaesthetic practice. The anaesthetic changes included: a switch to multimodal and pre-emptive analgesia, particularly the use of non-steroidal anti-inflammatory drugs on induction; pre-emptive antiemesis, especially the use of intra-operative 5-HT<sub>3</sub> antagonists; transdermal hyoscine patches; and modern anaesthetic techniques such as administration of intravenous anaesthetic agents on induction and throughout the surgery (e.g. propofol).<sup>5</sup> The surgical changes included: better patient selection; morning-only theatre lists; wider use of vasoconstrictors; and local anaesthetic techniques.<sup>6,7,8</sup>

### Re-evaluation of practice (1 July 2003 – 31 December 2003)

During the second six-month period, 372 patients underwent day-case surgery, representing a day-case rate of 51.3 per cent. Procedures commonly performed as day

cases now included ??, ??, rhinoplasty, stapedectomy, mastoidectomy, tympanoplasty and pinnaplasty. Ten patients (2.7 per cent) required an unplanned overnight transfer.

### Conclusions

Far from reducing the case mix, the variety and complexity of procedures performed as day cases increased and, paradoxically, the unplanned transfer rate for admission decreased.

### References

- 1 Brown P, Fowler S, Ryan R. ENT day surgery in England and Wales – an audit by the Royal College of Surgeons (Eng) Comparative Audit Service. *J Laryngol Otol* 1998;**112**:161–5
- 2 The Royal College of Surgeons of England. *Guidelines for Day Case Surgery*, revised edn. London: The Royal College of Surgeons of England, 1992
- 3 Basket cases and trolley – day surgery proposals for the millennium (revised). <http://www.bads.co.uk>
- 4 Ganesan S, Prior A, Rubin J. Unexpected overnight admissions following day-case surgery: an analysis of a dedicated ENT day care unit. *Ann R Coll Surg Engl* 2000;**82**:327–30
- 5 Honkavaara P, Saarnivaara L, Klemola UM. Prevention of nausea and vomiting with transdermal hyoscine in adults after middle ear surgery during general anaesthesia. *Br J Anaesth* 1994;**73**:763–6
- 6 Sun R, Klein KW, White PF. The effect of timing of ondansetron administration in outpatients undergoing otolaryngologic surgery. *Anaesth Analg* 1997;**84**:331–6
- 7 Tramer MR, Moore RA, Reynolds DJ, McQuay HJ. A quantitative systemic review of ondansetron in treatment of established postoperative nausea and vomiting. *BMJ* 1997;**314**:1088–92
- 8 Honkavaara P. Effect of ondansetron on nausea and vomiting after middle ear surgery during anaesthesia. *Br J Anaesth* 1996;**76**:316–18

### Audit of patient information on the ENTUK website: is the information we give to patients readable?

D D Pothier

From the Gloucester Royal Hospital, Gloucester, UK

### Standards for readability

A large proportion of the UK population has limited literacy skills. The average adult reading age has been estimated to be around nine to 11 years.<sup>1,2</sup> Forty-five to 56 per cent of the UK population have literacy levels below that appropriate for schooling level 3, the level required for functioning in a modern working environment. Patient information should conform to the readability parameters defined by Flesch<sup>3</sup> in order to be readable by the majority of the population (i.e. a Flesch readability ease score of >65 and a UK reading age of >11 years).

### Evaluation of practice and comparison with standards

An audit was undertaken of the readability of patient information leaflets and web pages available on the ENTUK website (<http://www.entuk.org>). The Flesch reading ease score and the Flesch–Kincaid reading grade level were used to assess the readability of the web pages. From these scores, the UK reading age was calculated. The reading age scores of the 10 downloadable leaflets ranged from 8.4 to 11.8 years, with a mean of 9.83 years (standard deviation (SD) = 1.11). Reading age scores for the 20 web pages ranged from 13.9 to 17 years, with a mean of 16.01 years (SD = 1.06), i.e. significantly higher ( $p < 0.001$ ). Eighty per cent of the Flesch reading ease scores for the leaflets were classified as readable by the majority of the UK population. Despite the technical accuracy of the web pages, none of those containing patient information could be classified as easily readable.

### *Change in practice*

The text of ENTUK website information pages was reviewed. Simple guidelines on improving readability, obtained from the Plain English Campaign,<sup>4</sup> were applied. Changes to the style of word usage and sentence structure were made, and standard techniques to improve readability were applied. No significant change to core content was made, and the online versions were not altered.

### *Re-evaluation*

The Flesch reading ease score and the Flesch–Kincaid reading grade level test were re-applied to the revised documents. The revised versions had UK reading age scores ranging from 8.1 to 15.3 years, with a mean of 11.32 years (SD = 2.14), representing a mean reduction of 4.69 years ( $p = 0.022$ ).

### *Further changes*

Only standard changes were made to the documents. If other changes can be made, including some minor content alterations, it will be possible to produce patient information pages on the ENTUK website that are even more readable by the UK public.

### *References*

- 1 Chestnutt IG. Internet-derived patient information on common oral pathologies: is it readable? *Prim Dent Care* 2004;**11**:51–4
- 2 Boulos MNK. Readability of internet diabetes information. *Diabetes Technology and Therapeutics* 2005;**7**:528–35
- 3 Flesch RF. *The Art of Readable Writing*. New York: Harper & Row, 1973
- 4 Plain English Campaign. <http://www.plainenglish.co.uk/plainenglishguide.html> [1 May 2005]

### **Optimizing opportunities for training: an audit**

J Wasson, N Jacobsen, D Bowdler, C Hopkins

From the Department of Otolaryngology, University Hospital Lewisham, London, UK

Mr Wasson's abstract was the prize winner. The full paper will be published in JLO7.

### *Introduction*

A number of government initiatives have sequentially reduced working hours and training opportunities for surgical trainees. The European working time directive (EWTD) will reduce the working week to 48 hours by August 2009.<sup>1</sup> In addition to this, planned changes to surgical training will drive the need for junior surgeons to be trained over a shorter period of time, but to the same standard as current consultant surgeons. The impact of the reduction in hours on training has been well documented.<sup>2</sup> Surgery is a craft specialty in which both quality and quantity of training are important. There is concern that the latter may be lacking in current training programmes. We undertook a departmental audit to identify in which areas opportunities for training were being lost, so that appropriate timetable changes could be made to optimize exposure to suitable cases.

### *Standard*

Taking into account planned absences, our department concluded that junior surgeons should aim to attend 50 per cent of all theatre sessions and surgical cases performed.

### *Evaluation of practice*

A two-week, prospective audit was undertaken. Attendance at theatre lists and level of participation of trainees was recorded. The higher surgical training syllabus was

used to determine the potential suitability of cases for senior house officers (SHOs) and specialist registrars (SRs). Reasons for non-attendance were recorded, as well as non-participation in potentially suitable cases.

### *Comparison with the standard*

During the initial cycle, 30 theatre sessions, with a total of 124 surgical cases, were undertaken in the department. Fifty-eight per cent were thought to be potentially suitable for SHOs to undertake with supervision or assistance, and all but one of the remaining cases were thought suitable for SRs. Only 30 per cent of the theatre sessions and 27 per cent of the total theatre cases were attended by SHOs. Of the cases attended, only 18 (15 per cent of the total) were deemed suitable for SHO training. Seventy-three per cent of all cases were unattended by SHOs, of which 54 (43 per cent) were suitable for SHOs. The EWTD, dictating a day off following on-call work, resulted in four missed theatre sessions. However, the major cause of missed opportunity was that SHOs were not timetabled to attend the most suitable lists, which were often undertaken in the day surgery unit. Specialist registrars were found to be already attending those lists most suitable for their level of training.

### *Change in practice*

The results were presented at departmental meetings. Within the constraints of SHO numbers (six SHOs; one post-take, two away on annual leave or study leave each day), some simple changes were made which increased the flexibility in the timetable. The new system involved allocating SHOs to theatre sessions on a weekly basis and accommodating for absences, changes to lists and the suitability of cases. Senior house officers attended day-case lists when possible.

### *Re-evaluation*

The second prospective audit cycle demonstrated an improvement in the utilization of training opportunities, with more operating sessions being attended and a greater number of cases being participated in. The increased flexibility allowed SHOs to attend 46 per cent of theatre sessions (13 out of 28 sessions) and to actively participate in 48 per cent of cases (55 out of 115 cases).

### *Conclusions*

Simple timetable changes allowed an increase in the opportunities for training junior surgeons, almost achieving the standard set. We identified further possible means of improvement, but these require a more radical change to the provision of services (e.g. nurse-led pre-admission clinics) and therefore need further discussion and planning. We will repeat a further audit cycle to demonstrate continued improvement.

### *References*

- 1 Pickersgill T. The European Working Time Directive for doctors in training. *BMJ* 2001;**323**:1266
- 2 Carr S. Education of senior house officers: current challenges. *Postgrad Med J* 2003;**79**:622–6

### **Medical note-keeping within the ENT department, using the CRABEL score**

D Wong, S Lo, J Knight

From the Department of Otolaryngology, St George's Hospital, London, UK

### *Standard*

The Royal College of Surgeons of England has given clear guidance<sup>1</sup> on the details that are required in hospital case-

notes. Notes should be legible, unambiguous, signed, dated and timed, and the patient should be correctly identified on each sheet. These points form the basis of the CRABEL score,<sup>2</sup> a quick, easy and standardized method for the assessment of medical note-keeping. For each set of notes, a score is given out of 50, divided into four sections: initial clerking (10), subsequent entries (30), consent (5) and discharge (5).

#### *Evaluation*

Medical note-keeping within the department was reviewed via a retrospective analysis of 30 random sets of notes. Fifteen of these were for elective cases and the remaining 15 were emergency cases. The CRABEL score was applied to each set of notes. The total score ranged from 28 to 48 out of 50 points, with an average of 39. The average total score for elective case notes was 40 out of 50, and the average total score for emergency case notes was 38 out of 50. The average subtotal for initial clerking was 5.5 out of 10, the average subtotal for subsequent entries was 24.4 out of 30, the average subtotal for consent was 4.9 out of 5 and the average subtotal for discharge summary was 4.5 out of 5.

#### *Change in practice*

The above findings were presented at the departmental audit meeting, and areas were identified in which note-keeping could be improved. Copies of the CRABEL scoring system were distributed to all doctors within the department so that they were aware of all the points that were required in keeping good medical notes.

#### *Re-evaluation*

Re-evaluation was carried out in 30 randomly selected case notes (15 elective procedures and 15 emergency cases) after a three-month interval. The total score ranged from 36 to 49 out of 50 points, with an average of 44. The average total score for elective case notes was 44 out of 50, and the average total score for emergency case notes was 43 out of 50. The average subtotal for initial clerking was 7.8 out of 10, the average subtotal for subsequent entries was 26.2 out of 30, the average subtotal for consent was 4.9 out of 5 and the average subtotal for discharge summary was 4.9 out of 5.

#### *Conclusion*

Raising staff awareness of the importance of good medical note-keeping and of what points should be included resulted in an overall improvement in note documentation. Repeating this audit at regular intervals will help to maintain good note-keeping. This audit also highlights the fact that the CRABEL score can potentially be used by all hospital departments in order to improve and to maintain good medical note documentation.

#### *References*

- 1 The Royal College of Surgeons of England. *Guidelines for Clinicians on Medical Records and Notes*. London: The Royal College of Surgeons, 1990
- 2 Crawford JR, Beresford TP, Lafferty KL. The CRABEL score – a method for auditing medical records. *Ann R Coll Surg Engl* 2001;**83**:65–8