# IQIPS Accreditation – Clinical


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This is our fifth and final article in the series on IQIPS accreditation, and we turn our attention now to the Clinical domain. As ever, we aim to give some practical advice on how to approach compliance with the requirements and some ideas for the sort of evidence you will need to keep as you work your way through the standards.

The purpose of this domain is to "promote the service's role in rapid and accurate diagnosis and treatment. This is achieved through administrative and clinical practices appropriate to the patient population, effective management of risk, and the review of existing and new clinical practice to develop and improve the service."

This is the largest domain with 9 sections and covers:

- Service delivery from referral to discharge/follow-up
- The quality of the diagnostic test
- The quality of the results and how they are communicated
- The quality of treatments and interventional procedures
- Management of drugs and contrast media
- Management of risks and errors arising from clinical activities
- Management of clinical records
- The review and implementation of emerging/new practice as appropriate
- Management of service (in this case vascular) specific risks.

Arguably, this is the domain that we are most familiar with. It encompasses our day-to-day function of organising clinics, making diagnoses and appropriately acting on the results, so should be the most straight forward domain to satisfy. Not all of the sections will apply to all services, so you may find that it is not as onerous a domain to satisfy as first appears. As always, the emphasis for UKAS, is on continuous improvement of systems – so where you have good systems in place, audit and monitoring are the essential finishing touches.

### Where do we start with fulfilling IQIPS requirements?

Please take a look back at the Spring 2018 Newsletter for detailed information as this was covered in our first article, but a good place to start is in:

- checking your organisational and departmental policies are up to date
- writing any local policies that are required
- considering how you might monitor your systems so that you can identify those things that are working well and where improvement might be needed

Some examples of monitoring methods for **CL**:

| **System/Procedure** | **Monitoring** |
|---|---|
| Collaborative approach to service delivery | Survey your Surgeons/DVT clinic etc |
| Management of DNAs | Regular analysis of DNA rates |
| Quality of results | Regular audits with improvement actions |
| Incident/Error Management | Departmental log, team discussion, documentation of learning points |
| MSK/WRULD risk management | Up-to-date Risk Assessments |

Here is a more detailed look at each of the 9 Clinical sub-domains:

**CL1 – Ensuring delivery of the service from referral to discharge, including follow-ups.**

To satisfy the requirements of this domain, we need to ensure we work collaboratively with colleagues to agree and deliver appropriate patient pathways.

As we might expect from the domains we are already familiar with – we will be required to show that we have defined roles and responsibilities. Some of these will be covered in job descriptions, but you may also need to ensure your local policies cover such things as referral vetting and prioritisation (who is authorised to do this?), management of “red flags” or incidental findings and waiting list management.

Some questions that you might ask yourself:

- Do you check your referrals to make sure all required information is included?
- Is there a policy stating who can vet referrals? Would it be appropriate for admin staff to vet for sufficient patent ID information? and Vascular scientists to vet for appropriate clinical indication?
- How do you manage inappropriate referrals?
- Where possible, do you liaise with other hospital departments to minimise hospital attendances?
- Are your patient pathways grounded in current good practice?
- Do you meet with relevant multidisciplinary teams and tailor your service, as required?

So firstly you need to design systems. Do you have comprehensive policies which include: Referral Management; Report Issuing and DNA management? Do you allow other clinics (e.g. TIA/DVT) to book directly into your clinic lists? Are all of these referrals appropriate? Do you monitor this? Do you report back to the referrers and discuss with the rest of your team? Can you improve things? Do you engage with your clinical colleagues to ensure pathways are appropriate? These are the sort of questions that assessors will be asking as they look through your evidence and it is useful to follow their train of thought as you design and adapt your own departmental systems.

Then think about the key objective of the IQIPS process: "to show continuous monitoring and improvement". How are you going to do this?

Here is a suggested method to monitor and manage DNAs:

- Include DNA management in a departmental policy so you have clear guidance that follows your Trust/organisational policy. You could consult your Radiology department to ensure consistency across services.
- Perhaps your Receptionist could keep a list of DNAs each month,
- Analyse whether some patient groups/times of day have higher DNA rates,
- Discuss at your Team meeting,
- Suggest ways to address (maybe telephoning elderly patients the day before as they may not have mobile phones or get automatic hospital appointment text alerts).
- Implement your suggestions
- Then you could analyse and re-discuss at the next Team meeting,
- You may notice that your actions have had an impact, need to amend your departmental policy and you could then make this a regular audit, and agenda item for your Team meetings

You have very simply developed a mechanism of audit, action, surveillance and a continuous improvement tool.

CL1 is one of the standards that results in a significant number of non-compliances at assessment. So it is worth ensuring you have robust mechanisms to meet this standard.

## CL2 – Systems to ensure the quality of the diagnostic test.

This is our bread-and-butter, so should be a relatively easy standard to satisfy!

It asks us questions around:

- Protocols – do you have them?; are they evidence based and referenced?; who is responsible for reviewing, updating and disseminating any changes to staff? Could one of your team be the 'protocol lead'?
- Have staff read the protocol? Do you record this?
- Do your staff follow the protocol? Would you know if they didn't?
- If you use locums, do you allocate time for local induction to ensure they also follow your protocols? Do you check?
- Do you allocate time for Peer Observation of staff in clinic?
- Do you save images for later analysis/QA?

- Who is responsible for addressing any quality issues?
- Are staff aware of any limitations? Do you know the axial resolution of your probes? Do staff always use the most appropriate probe and round measurements to an appropriate level of accuracy?
- Do your reports meet the requirements of your referrers and follow departmental policy?

And in terms of monitoring, these are some suggestions:

- Peer observation of staff in clinic. You could combine observation of protocol adherence, image acquisition and labelling and reporting with hand washing, checking patient ID, obtaining consent etc. Designed well, peer observation can easily provide evidence across many IQIPS standards. Design a simple checklist form to evidence your observations. You may also need a space to record any required actions and evidence that improvements have been discussed. Then re-audit and hopefully show improved compliance……..you are now 'monitoring' and this is resulting in 'continuous improvement'.
- Quality and Audit. Could you ask one of your team to take responsibility for this important area? Perhaps monthly audit meetings could be squeezed in for an hour before clinic starts. You could discuss any discrepancies with other imaging methods which came up at recent MDT meetings. You could focus on quality of carotid images one month, randomise some recent scans, present the images and ask the team to score them against your agreed departmental standards. Document the results, re-audit in 6 months and see if there's been any improvement. Just the thought that your images may come up in a future audit may be enough to reset the acceptable baseline within your team!

This is one of those standards where assessors will probably glean a great deal of information from being on-site, but protocols, policies and audit results will go a long way to provide evidence for the web-based tool. If you don't currently have complete systems for audit, there may seem a lot to address. Remember that accreditation isn't dependent on the final all singing, all dancing product, if you are working towards a robust system, evidence of your journey towards your final goal will often be sufficient. You could set up one robust audit process prior to accreditation and inform the assessors of future planned audits with anticipated timescales – this provides evidence that there are processes in place with plans for future development. The accreditation cycle requires continuous improvement, so no-one expects it to be perfect at the beginning.

## CL3 - Systems to assure the quality of results including reporting and communication

This standard ensures that you have locally agreed methods of reporting, that reporting formats are appropriate and results are disseminated in a clinically relevant time frame.

Your reporting methods and timeframes may be different for different tests, e.g. for a routine arterial Duplex or a 'one-stop' Duplex for a critically ischemic limb. Do you have departmental policies around this, do staff comply, and does anyone check that processes are being followed? Would reporting templates save time and ensure consistency within the team?

You may also want to think about how you handle any discrepancies. Do you attend MDT to find out how your results are interpreted or used by the clinicians? Do you have a process of recording discrepancies and following them up within your team?

And how do you manage inaccuracies or mistakes in reports? Do you have a process for amending and recalling reports? Are all reporting staff aware of this? Do you have evidence of this process?

Do you audit your results against other diagnostic tests such as angiography or CT or audit the results of new technology, such as intervention with drug-eluting balloons? Could one of your trainees undertake a short project to look at this and report back to the multi-disciplinary team? This could also fulfil some of CL1's requirements.

## CL4 – Systems to assure the quality of treatments and interventions

This standard may be applied where services are involved in e.g. varicose vein treatments or where contrast agents are used. It will not apply to all services, so if it doesn't apply, you can skip this section.

Where it does apply, you will need to evidence that you have processes in place, staff are trained and competent, risks are defined and managed and you have facilities to manage complications. You will also need to ensure that you have processes to assess outcomes. Bear in mind that this standard is another of those with a high percentage of non-compliances at accreditation, so make sure you have robust processes.

Some examples of evidence you could provide for this section, if this standard applies to your services, are:

- Training logs and competency documentation for staff involved in delivering treatments/interventions
- Audit trail documentation for any drugs/contrast used and associated literature used as an evidence base to validate the use of any particular drug or contrast agent
- Feedback from any clinicians involved in the treatments you support
- Clearly defined roles and responsibilities of staff involved – e.g. flow map of staff and their individual responsibilities

## CL5 – Systems to manage drugs and contrast media

Again, it may appear that this standard does not apply, however, remember that oxygen is classed as a drug, so you will need robust processes in place for your patients who require oxygen whilst in your department.

Where you use contrast agents, you will need processes to manage the purchase, storage, administration and response to any adverse reactions.

There will be some crossover with the evidence from CL4 that can be provided in this standard. But in addition, you could perhaps think about how you could evidence any communication with other departments or services in the process of developing and maintaining these systems, such as:

- Contact with Pharmacy in developing a Patient Specific Direction or Group Specific Direction for administration of contrast

- Local protocols pertaining to the safe use and renewal of gas supplies
- Risk assessments developed alongside health and safety representatives
- Training and audit/competency records from any cannulation and drug administration courses

## CL6 – Systems to manage risks and errors

Services should have and maintain risk assessments. The way you do this will be up to your service and should be in accordance with your local Trust/organisational policy. Risk assessments should be regularly reviewed, and this process should be recorded somewhere on the document.

You may want to have an overarching departmental risk assessment including all risks or you may want to divide it up into individual assessments for e.g. clinic rooms, health and safety, manual handling, staffing etc.

Make sure you think about everything which posses a potential risk. When thinking about clinic room risks you may want to include:

- Infection control – cleaning, hand hygiene
- High BMI patients – risks to staff, diagnostic quality, couch safe working loads
- Violence and aggression
- Manual handling, including arrangements to assist pregnant staff
- Slips, trips and falls
- Electrical safety
- Ultrasound machines – breakdown, timely replacement, probe problems, ergonomics when purchasing
- WRULD
- Scans for children

This list is by no means exhaustive but will get you thinking about what you require and what the assessors are looking for.

If you are not familiar with completing risk assessments, you could see if there is any available training within your Trust/organisation. Or perhaps contact any other IQIPS accredited departments that your organisation has, to see how they have addressed this.

This standard also covers your Incident reporting procedures.

## CL7 – Systems to manage clinical records

This standard covers your departmental processes for ensuring that staff are aware of their data protection and information governance responsibilities and will include evidence of essential training. The assessors will also seek assurance that clinical records (paper or electronic) are secure in their creation, storage and transmission. If you have multiple sites, you may need to think about use of encrypted devices. You should also consider e mail communication of results.

Observation at your site visit will be required to assess whether you meet this standard, but prior to this you should evidence that you have policies and procedures in place by uploading these to the web tool.

You could also conduct audits to assure that staff follow your policies:

- Walk round the department – have staff locked their computers if unattended?
- Are medical records secure?
- Are any computer screens visible to patients in the waiting room?
- Do you have any lists of patients (paper of white boards) which are visible to visitors etc either during clinic operation or when the department is closed?
- Have staff kept up-to-date with Information governance training? – could you audit this at annual appraisal?

## CL8 – Systems for implementation of emerging clinical practice

You will need to review emerging developments in clinical practice and ensure your own service implements these where appropriate. Hopefully your staff are given the opportunity to attend scientific conferences, take part in research and are keen to keep abreast of developments in vascular diagnostics.

Could you include a requirement for reporting back on learning prior to granting approval for conference attendance? Perhaps you could start a journal club and take it in turns to talk the team through a newly released paper (you could start with some of the 'Bubbles' articles from back issues of the SVT Newsletter), or perhaps revisit some of the old established key articles and see if your practices are in line with these generally accepted techniques. Is your stenosis classification criterion consistent with recent work and publications? Do you have a research department in your organisation, they will be aware of nationally funded studies which you may be able to join? Do you have any trainees (STP or 'in-house') who have received research methodology training and could lead in this area?
Do you know about the Elsevier Journal e mail alerts e.g. for the Journal of Vascular and Endovascular Surgery?

In terms of implementation of emerging clinical practice, you will need to demonstrate a collaborative approach, ensure that training and competency are maintained, and that you use and learn from appropriate audit.

## CL9 – Management of discipline specific risks

You will be aware that the IQIPS standard is applicable to all of the Physiological disciplines, so this final standard is designed to cover any discipline specific risks which may not have been included elsewhere in the standards.

For Vascular, it includes assurance that rooms and equipment are suitable for vascular diagnostics and includes consideration of WRULD.

You may want to consider:

- Staff awareness of WRULD – could you audit this? maybe ask your Occupational Health department to do a WRULD workshop?
- Do you provide trainees with access to a Backcare advisor? – they could be invited to watch a clinic and provide preventative advice before bad habits have set in. If WRULD is prevalent for established staff, this could be a regular thing.
- Do you consider ergonomics when procuring ultrasound machines?
- Do you schedule clinics to provide a mix of scans and thereby minimise WRULD risks?
- Are staff aware of TI and MI and is it displayed on your machines?

This is the last in our series of articles, we hope that they have been helpful and as ever, we would be very pleased to receive any feedback.

Abbreviations:
DNA = Did not attend
DVT = Deep vein thrombosis
IQIPS = Improving Quality in Physiological Services
MI = Mechanical Index
MDT = Multi-disciplinary team
QA – Quality assurance
STP – Scientist training programme
SVT – Society for Vascular Technology
TI = Thermal Index
TIA = Transient ischemic attack
UKAS = United Kingdom Accreditation Service
WRULD = Work related upper limb disorder