## APPENDIX 5:
Audit topics approved by the Faculty of Intensive Care Medicine and the Intensive Care Society

### National ICM Audit Recipe Book

Chapter 10 of the 3rd edition of The Royal College of Anaesthetists *Audit Recipe Book*\(^\text{19}\) contains a list of 16 audits relating to Intensive Care Medicine. However, the Faculty is working with the Intensive Care Society (ICS) to produce the first national *ICM Audit Recipe Book*.

Whilst numerous audit topics might be included both the FICM and ICS want to focus the attention of colleagues upon core audits which are underpinned by an evidence base that shows a positive effect on patient outcome, to which end we surveyed colleagues in the Autumn of 2013 regarding audits that met this criterion. The result of the survey was published in *Critical Eye*\(^\text{20}\) and the top 5 suggestions are summarised in the table below:

<table>
<thead>
<tr>
<th>Audit title</th>
<th>Reason for audit</th>
<th>Suggested measures/indicators</th>
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| **Tracheostomy in the ICU** | Not many tracheostomies are done each year in individual units. In order to highlight any problems with the kit or post-op complications at an earlier stage, pooling of data from as many units across the country will help. | • What techniques are used?  
• Is capnography routine?  
• Is USS neck routine?  
• Is bronchoscopy routine?  
• What proportion is percutaneous vs surgical?  
• Complications - early and late |
| **Central Venous Catheter Insertion and Management** | Frequently performed procedure on ICU | • Audit of insertion practice based on recommendations from Department of Health and other professional bodies  
• Audit of ongoing management  
• Complication rates  
• Rate of catheter-related bloodstream infections |
| **ARDSnet ventilation compliance** | There are very few strategies or drugs used in critical care that have been proven to improve patient outcome. Lung protective ventilation is one of them. | Audit of ventilator parameters in intensive care patients, either prospectively or retrospectively. Data may be collected at 4 pre-defined times over a 24 hour period.  
Standards and data to be collected:  
• Ideal body weight calculated and recorded for 100% of ventilated patients.  
• Delivered tidal volume no more than 8 ml/kg ideal body weight at all times  
• Plateau airway pressure maintained below 30 cmH2O at all times |

\(^\text{19}\) Royal College of Anaesthetists’ *Audit Recipe Book*, 3rd Edition.  
Evaluation of the long term risks of percutaneous tracheostomy, i.e. stenosis

Despite the large number of procedures performed there is little hard data on long term risks.

The frequency of symptomatic and asymptomatic airway problems after tracheostomy.

Renal Replacement Therapy Dosage on ICU

Is Renal Replacement Therapy Dosage on ICU matching the standard unit prescription?

- Patient identification details
- Ideal body weight
- Duration of RRT dependency
- Hours receiving RRT during period of dependency
- Hourly exchange achieved (in mls)
- Reasons for interruption of RRT

Outcomes and targets:
- Demographics of RRT provision N/A
- Average exchange dose delivered during dependency period 20-35 ml/kg/hour
- Average exchange dose delivered during first 12 hours of each RRT session 35 ml/kg/hr
- Average exchange dose delivered during continuous RRT 35 ml/kg/hr

The recipe book will be a compendium of audits with the relevant background information and research, suggested methodology and the relevant references provided in a standard format. In time, each pack will also have the relevant data analysis tools to permit inter unit and possibly collaboration. An example of such a template will be included.

Trainee networks such as those established in the specialties of anaesthesia and surgery could play a crucial role in the process. Such groups include representatives working at all of the trusts in a given region and make it possible to co-ordinate activity across a much wider geographical area. Representative trainees from each trust are given the responsibility of leading the audit process within that trust and of getting the approval of the local anaesthetic and critical care department.

Clinical audit is at the heart of good clinical governance. It ensures that we are delivering the best possible care to all patients at all times and highlights areas of excellence as well as revealing areas that require improvement. It forms the basis of quality improvement projects supported by new knowledge gained from clinical research. The ultimate goal of the audit recipe book is to provide a framework for clinical audit that maximises local enthusiasm and commitment to high-quality patient care.