This month, Saima Begum Naroo applies the five-step audit process to a dispensing situation

CPD PART 5

Audit in action

In CPD Part 4, 'What is a clinical audit?' (*Dispensing Optics, April 2019*), we discussed that an audit is not just a data collection exercise; in fact, it holds great purpose when a practice or individual is looking to: improve a service, procedure and user outcome; monitor its performance; and monitor the quality of its products.

Last month's article also introduced the five-step audit process used by many healthcare professionals. This process is easy to implement without being too onerous, and works in almost every scenario. It allows you the flexibility to delve deep into a situation or to keep it succinct.

In this article, the five-step audit process has been applied to a dispensing situation. This is an area not usually exposed to scrutiny, but rather quick reviews to reach the source of an issue – often resulting in no real gain.

In this example, the five-step audit process is used to improve a dispensing service and prevent unnecessary financial loss. For the purpose of this article, enough detail will be given to form an idea of the process, but lengthy discussions will not take place.

The practice in question encountered an issue in quarter one of the financial year. It was apparent that remaking of spectacle orders had increased to a substantial level, resulting in unmet targets and a lot of unhappy patients. The practice was also experiencing increases in: spectacle turnover time; patient trips to practice; patient complaints due to unsuitable spectacles; time consumed by resolving patient complaints; and financial loss.

STEP 1: IDENTIFYING THE AUDIT TOPIC

The increased number of spectacle remakes was costing the practice more than anticipated financially, in time and in patient loyalty. A decision was made to investigate all remakes to get some direction on the main source of this issue. All the spectacle remakes were analysed and the reason for the second or third remake was noted. A decision was made to ignore the one-off errors and concentrate on the reoccurring reasons for remaking spectacles. **Figure 1** shows the two main reasons responsible for the majority of the remakes in quarter one of the financial year.

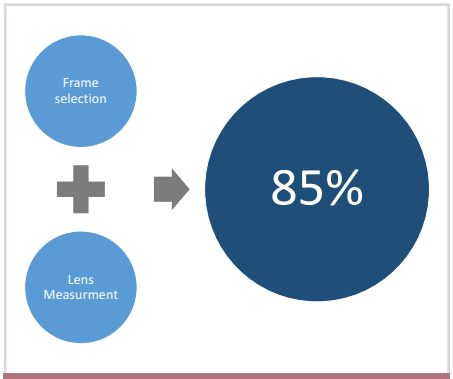

Figure 1: Top two reasons for the majority of remakes over three months

A previous action plan to tackle this issue was re-visited, which showed that all the issues were addressed in the practice's morning team briefings. Staff had been reminded to: monitor input information; double check all the information and measurements before sending orders; and write everything down with reference to frame and lens selection.

However, the issues addressed were not the main cause of the spectacle remakes, therefore, another reminder to control input errors wouldn't bring the desired results.

REFLECTION

Collecting information on previous plans to tackle an issue is crucial to ensure that implemented steps are not repeated, and for learning purposes. This can be compared to the literature review in a clinical audit where you collect existing data from peer-reviewed research to take learnings and then plan your next step.

It is important to limit your action plan. Trying to tackle all the reasons behind remakes can be onerous and pull the team in different directions. The key is to keep it simple and tackle areas that will have the greatest impact first.

STEP 2: SETTING STANDARDS

Looking at ABDO guidelines to set standards, Section two: Ophthalmic Dispensing 2.21 and 2.2.3 provide specific advice on lens and frame measurements, spectacle fitting and who should be involved in these procedures[1].

For this audit, ABDO's guidelines were used as they are detailed and the team can relate to them. The practice budget report was used to extract the percentage for remake costs, to allow for human error, accidents and goodwill, in this case 3% maximum of overall sales.

The four standards set were:

1. Spectacle remakes three per cent or below.
2. Facial, frame and other appropriate measurements are taken as necessary and recorded prior to ordering spectacles.
3. The finished spectacles are checked on the patient for fit, function and comfort.
4. Wide frame selection available in different sizes.

REFLECTION

The standards can also include NHS contracts, NICE guidelines, GOC standards

MONTH	PLASTIC FRAME – SLIPPING	PLASTIC FRAME – PINCHING	PLASTIC FRAME – UNCOMFORTABLE OR HURTING	LENS MEASUREMENT – INCORRECT HEIGHTS	LENS MEASUREMENT – INCORRECT PUPILLARY DISTANCE
1	6	4	5	5	4
2	5	5	4	7	3
3	8	5	9	6	5

Figure 2. Total number of remakes each month for one quarter

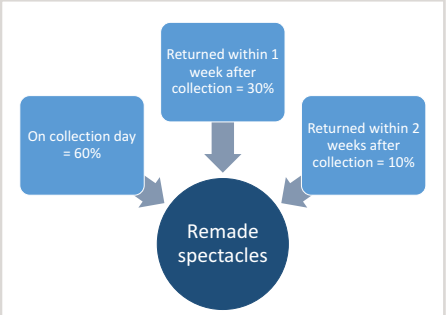

Figure 3: When the remake went through on the system

and the Opticians Act 1989. These standards were set using ABDO's guidelines with agreement from the team leaders, as it was apparent that these four areas needed improvement to lead to any desired results.

STEP 3: DATA COLLECTION

Figure 2 shows the total number of remakes each month for one quarter. It was also important to understand if the spectacles were rejected and remade on the collection day, or whether patients were taking them away and then returning to practice with concerns at a later date.

Figure 3 shows when the remake went through on the system.

REFLECTION

For this audit, conversations with the team involved were necessary to get their input and understanding of the situation. This was especially important with regards to releasing spectacles to the patient after they had made clear their concerns.

STEP 4: ANALYSE THE DATA

A brief summary of the data analysis showed that the overall spectacle remakes were 8% of the total spectacle sales.

Firstly, the 3% target was questioned to ensure it was realistic. The target was the same across all the practices and was being met in other similar practices. The percentage of remakes had crept up over the last quarter and in some cases were having to be remade twice.

Remakes concerning the lens measurement were due to incorrect heights or pupillary distance (PD). In most of the cases, the incorrect PD was selected on the order form. Nevertheless, this was an area that required urgent attention.

There was a mixture of staff responsible for these errors. The majority of errors were carried out by two new optical assistants. There was still a number of errors carried out by experienced staff, indicating a refresher training session on frame selection and lens measurements was necessary.

This analysis led to the conclusion that none of the set standards were consistently met. One could argue that in the end, the patient found a satisfactory spectacle frame even if it was after two remakes; therefore a wide selection was available.

Analysis showed the replacement frames chosen were metal and notes on records indicated plastic frames were either uncomfortable on the bridge, hurting or slipping down the nose. This indicated that the frame selection process was poor, or a broad selection of plastic frames in different sizes was not available.

REFLECTION

Where targets are concerned, it is important to explore if they are realistic and achievable. The practice team would not appreciate being set up for failure. Nothing destroys team motivation faster than unrealistic targets, so it is vital that an approved strategy is used to determine targets.

The data analysis can be a lengthy process depending on the level of information required. For this audit, all the plastic frames were measured, especially the apical radius; as many of the notes indicated, nose fitting was an issue. This step was initiated by the practice frame buyer for future frame purchase direction; it added time to the process but was much needed for future reference.

Once all the results were gathered, they were discussed with the team. The team were invited to give their input on tackling these issues and collectively they assisted and agreed on an action plan. Involving the team is a sensible decision as they are the people who will make the difference.

STEP 5: IMPLEMENT CHANGE

The agreed action plan was to achieve the four standards set in Step 2, and a refresher training programme was devised. This was bespoke to the team to close their gaps in knowledge regarding plastic frame selection, lens measurement and spectacle collection process. The frame selection was increased but no bespoke frame service would be introduced yet.

The practice was tasked with increasing its plastic frame range and sizes. The concept of bespoke frames was discussed. **Figure 4** shows that all these changes were required to reach the goal, and the practice is aiming towards getting it right first time. It was agreed to re-audit three months after the training was completed.

RE-AUDIT

The re-audit results showed remakes were down to 2.5%, and the main reason was no longer frame selection or lens measurements. As there were still some remakes there was an opportunity to analyse and decide if further

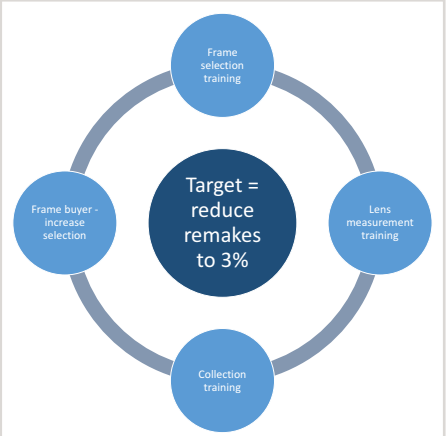

Figure 4: Proposed changes and training

action needed to be taken on reoccurring remake issues.

Reducing the number of remakes was important for patients who put their complete faith in the practice's service. Continuous review of current practice processes will help you grasp more opportunities to make the correct decisions for your practice reputation, team and patients.

This practice did go further and implemented more changes to tackle other areas to reduce avoidable remakes. As the practice progresses and achieves current targets, a continuous service review will help improve other areas to help deliver best practice.

REFLECTION

When an audit is carried out thoroughly, involving all the people who will help implement the necessary changes will have a rapid positive impact on the process, service or service user outcome.

SUMMARY

Personal dispensing audits are important and effective in monitoring individual performance. Dispensing audits should be the norm in everyday practice so that all the patients are given the best products available and an impeccable service.

REFERENCE

1. ABDO Advice and guidelines. Section 2: Ophthalmic Dispensing. 2018. Available at **www.abdo.org.uk/advice-guidelines** (accessed: 20 February 2019).

In CPD Part 6, Haydn Dobby will discuss setting goals for learning and development.

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