**Audit Data Collection Tool for Nurse/Midwife Referral for Radiological Procedures**

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| **Part 1: Demographic Details** |
| **Name of Nurse /Midwife Referrer for Radiological Procedures:** |
|  |  |
| Work Address: |  |
|  |  |
| Area of Practice: |  |
|  |  |
| Date of Audit: |  |
|  |  |
| Audited by: |  |
|  |  |
| Source of Data Collection:  | (Please Tick) |
| * Health Care Records
 |  |
| * National Data Collection System
 |  |
| * Incident Forms
 |  |
| * Referral Forms
 |  |
| * Other (Detail)
 |  |
| Comment: |

|  |
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| **Part 2: Data Collection Tool** |
| **Name of Nurse/ Midwife Referrer for Radiological Procedures:** |
|  | Yes  | No | Evidence |
| An assessment of the patients/service users’ needs has been recorded by the nurse/midwife referrer  |  |  |  |
| Physical examination |  |  |  |
| Patient/service user history |  |  |  |
| Clinical findings are documented |  |  |  |
| **For handwritten referrals:** |
| The referral is legible |  |  |  |
| The referral is in ink/indelible |  |  |  |
| The referral is signed by the Nurse/Midwife referrer |  |  |  |
| **For handwritten and electronic referrals:** |
| The name of the nurse/midwife is stated on the referral |  |  |  |
| The name of the patient’s Consultant is on the referral |  |  |  |
| Clinical indication/rationale for decision to refer for radiological Procedure |  |  |  |
| Clinical impression correlates with the imaging procedure requested |  |  |  |
| The ward / clinical area is stated on the referral |  |  |  |
| The referral is dated and timed (24-hour clock) |  |  |  |
| The full name of the patient/service user is on the referral |  |  |  |
| The address of the patient/service user is on the referral |  |  |  |
| The patient/service user date of birth is stated |  |  |  |
| The type of radiological procedure requested is clear  |  |  |  |
| The anatomical site requested for imaging is clear |  |  |  |
| Limb side correlates with the notes |  |  |  |
| Pregnancy status is documented as appropriate |  |  |  |
| If pregnancy is documented is this specified in the notes and the referral |  |  |  |
| If pregnancy is documented is it specified in the notes and the referral regarding the identification of the registrar /consultant with whom it was discussed? |  |  |  |

**Clinical Audit Report for Nurse/Midwife Referral forRadiological Procedures**

**Clinical Audit Report Template**

|  |  |
| --- | --- |
| Submitted by:  | Date: |
| Submitted to:  | Date: |

**Participants in Audit**

|  |  |  |
| --- | --- | --- |
| **Name**  | **Job Title** | **Department Job Title**  |
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| Title of Audit: |

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| Objectives of the Audit: (Patient Safety) |

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| --- |
| Standards: |

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| --- |
| Methodology*:* |

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| --- |
| Findings: |

|  |
| --- |
| Were there any Risk Management issues involved? YES/ NOIf yes, please elaborate: |

|  |
| --- |
| Conclusion: |

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| --- |
| Recommendations: |

|  |
| --- |
| Proposed Re-Audit Date: |

**Quality Improvement Plan for Nurse/Midwife Referral for Radiological Procedures**

Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Problem Identified**  | **Root cause of****Problem** | **Required Actions** | **Timeframe** | **Identified****Person(s) Responsible** | **Evidence of****Completion** | **Review Dates**  | **Outcome** |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
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*Source: Office of the Nursing Services Director, Health Service Executive, Version Feb 2022.*