Audit of delays in CT scans after stroke

# Introduction

Most hospitals fail to meet the current guidelines for CT scanning after stroke. National performance figures are collected by central audit staff. Audit performed by the imaging staff stimulated change and improvement in performance in our hospital.

# Method

Prior to the study there had been little change in the performance of CT scanning for stroke patients. An independent departmental audit study undertaken by radiologists and radiographers stimulated analysis of the patient request pathway and process mapping. Following the study period, the results were discussed with imaging, clerical, nursing and medical staff to bring about change in practice and procedure.

# Results

The mean delay from admission to request received by the radiology department fell from 30 hours to 24 hours and the proportion of patients waiting more than 48 hours from receipt of request to scan fell from 35% to 4%.

# Discussion

Delay to scan was reduced by implementing a number of changes:

* Facilitating a telephoned request instead of waiting for a written card
* Nursing staff were allowed to request scans following a protocol instead of request by medical staff only
* Involvement of radiographers in the audit stimulated a change in attitude and an awareness of the need for early imaging
* Introduction of a staffed second CT scanner

# Conclusions

* Changes in procedure can reduce waiting times
* Involvement of imaging staff in audit changes attitudes, generates ownership and desire to improve performance.
* Audit funding should be available at departmental level.