

# Achieving quality assurance through clinical audit

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## Summary

Audit is a crucial component of improvements to the quality of patient care. Clinical audits are undertaken to help ensure that patients can be given safe, reliable and dignified care, and to encourage them to self-direct their recovery. Such audits are undertaken also to help reduce lengths of patient stay in hospital, readmission rates and delays in discharge. This article describes the stages of clinical audit and the support required to achieve organisational core values.

## Aims and intended learning outcomes

The aim of this article is to explore the context and need for audit, and the standards and criteria used to define what represents quality in healthcare provision. The steps undertaken by nurses during audits are summarised.

After reading this article and completing the time out activities you should be able to:

- Understand the roles of the Care Quality Commission and the Healthcare Quality Improvement Partnership.
- Describe the relationship between audit, quality and clinical governance.
- Define audit and discuss the stages of audit.
- Distinguish between criteria and standards in the development of clinical audits.
- Identify the most important stakeholders in the planning of audits.
- Review the nurse's role in audits with reference to the Essence of Care benchmarking toolkit.
- Discuss the ethics of clinical audits.

## Introduction

The quality of health care is important to patients and the government, which funds health services. They want to be assured of the quality of health care and require evidence that high standards are maintained.

Audits of services are needed to ensure that healthcare services are co-ordinated and fit for purpose, and that staff adhere to professional standards.

As healthcare providers and patient advocates, nurses are involved in clinical audits (Cooper and Hewison 2002, National Institute for Health and

Clinical Excellence (NICE) 2002, Department of Health (DH) 2008). Such audits must be organised carefully and must be meaningful, both to those who undertake them and to those who receive the results. Where the purpose of audits is ambiguous, contributing to them can be burdensome.

Knowing how the data are to be collected is crucial when planning the audit tool with key stakeholders.

One of the first people to recognise the importance of data collection, analysis and presentation was Florence Nightingale. The statistics and charts she published in her book, *Notes on Matters Affecting the Health, Efficiency and Hospital Administration of the British Army* (Nightingale 1858), helped to convince military and government leaders to make revolutionary changes to military healthcare services that improved the care of wounded soldiers (Schmelzer 2008).

The DH document *High Quality Care for All* (2008) describes how NHS organisations should work towards three quality domains:

- Patient safety. Practitioners must manage risk and reduce threats associated with health care to ensure patient safety. Nurses charged with, for example, infection role determine to a large extent what constitutes safe practice.
- Patient experience. Patients are the appropriate authorities for determining whether their experiences of health care have been good. Audits can therefore alert healthcare practitioners to shortfalls in care.
- Effectiveness of care. This can be assessed by professionals and patients together, for example in relation to quality of life and patient independence.

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## Keywords

**Audit, best practice, criteria, standards, quality**

*These keywords are based on the subject headings from the British Nursing Index. This article has been subject to double-blind review. For related articles visit our online archive and search using the keywords*

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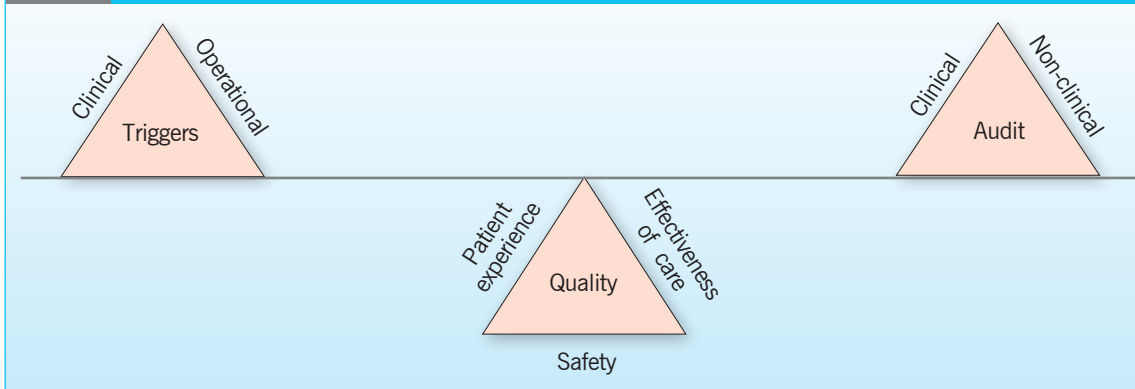
## Acknowledgement

The author would like to thank director of postgraduate programmes in advancing healthcare practice Bob Price for helping to redraft the article before publication.

Audit criteria are available in a Microsoft Word template that can be integrated into local audit systems from [www.nice.org.uk/auditcriteria](http://www.nice.org.uk/auditcriteria)

Further information on the Healthcare Quality Improvement Partnership is available at [www.hqip.org.uk](http://www.hqip.org.uk) and the Quality Accounts toolkit can be accessed from the Department of Health website at [www.dh.gov.uk](http://www.dh.gov.uk)

**Figure 1** The relationship between the events that can trigger audits, the audits undertaken, and the three quality domains in the quality assurance programme



If healthcare organisations strike a balance between the clinical and non-clinical events that can trigger quality-improvement initiatives and the audits undertaken as a result, they can achieve the three quality domains and raise quality of care (Figure 1).

Professionals also need good leadership skills and a vision of excellence to ensure high quality healthcare services. Furthermore, all providers of acute, mental health, learning disability and ambulance services are required to produce quality accounts (DH 2010), which are annual, public reports from organisations that provide NHS services. They describe what service improvements are needed, the priorities for improvement, and how service users can be encouraged to support the quality priorities.

Now do time out 1.

## 1 Vision of excellence

Time out

Audits can be difficult to undertake where there is no vision of excellence. Make a note of three areas of practice in your local clinical setting that can be improved. Ask yourself why these areas require your attention and summarise what optimal care would be like in them. Then identify the one that you think requires closest examination.

## Quality regulations

On April 1 2009 the Care Quality Commission (CQC) took over from the Healthcare Commission to become the independent regulator for health and adult social care in the UK, charged with assessing the performance of NHS organisations and ensuring that quality and safety standards are maintained.

The aims of the CQC, set out in the document *Guidance about Compliance: Essential Standards of Quality and Safety* (CQC 2009a), are to ensure that health services meet people's needs, to improve these services, to ensure value for money and to make

information about the quality and safety of these services available so that people can choose their healthcare services (CQC 2009b, DH 2010).

According to the registration system for healthcare service providers in the UK implemented on April 1 2010, NHS trusts are required by law to meet the standards set out by the government and to be registered with the CQC (CQC 2010).

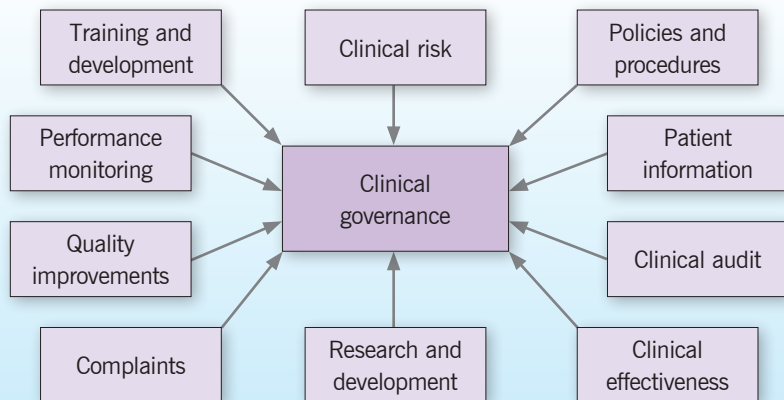
In 2008, the Healthcare Quality Improvement Partnership (HQIP), which is led by a consortium of the Academy of Medical Royal Colleges, Royal College of Nursing and National Voices, was formed to promote engagement in clinical audit, provide audit support and promote links between national and local audit. The HQIP took over management of the National Clinical Audit and Patient Outcomes Programme in England and Wales from the Healthcare Commission.

The CQC, which can be characterised as an organisation sponsored by governments, and HQIP, which can be characterised as an organisation sponsored by the healthcare professions, have roles in maintaining quality assurance in health care, with audit being placed at the centre of their relationships (Figure 2).

**Figure 2** Relationships between quality assurance regulators



**Figure 3 The chief components of clinical governance**



(Adapted from Valentine and Smith 2000)

Those who undertake audits must evaluate their findings against the standards of health care expected by patients, irrespective of where they live and which services they access.

Without guidance, healthcare professionals can develop many different standards, some of which may be misunderstood by members of the public. A robust clinical governance system is needed, therefore, to ensure that standards are accurate and consistent, and to promote clinical audit (DH 2007).

### Clinical governance and audit

Clinical governance ensures that NHS organisations become accountable for continuously improving their services and safeguarding standards of care 'by creating an environment in which excellence in clinical care will flourish' (Scully and Donaldson 1998). It was introduced by the NHS in England in response to the Bristol Royal Infirmary Inquiry (2001). The chief components of clinical governance are shown in Figure 3.

One of the most important elements of clinical governance is clinical audit (NICE 2002), which has been defined as 'a quality improvement process that seeks to improve patient care and outcomes through systematic review against explicit criteria and the implementation of change'.

'Aspects of the structure, processes, and outcomes of care are selected and systematically evaluated against explicit criteria. Where indicated, changes are implemented at an individual, team, or service level and further monitoring is used to confirm improvement in healthcare delivery' (NICE 2002).

Ghosh (2009), meanwhile, defines the clinical audit process as 'clinical quality assurance achieved by comparison of one's own practice with a recognised standard, subsequent identification of any deficits in practice, recognition of the causes of these deficits, and rectification educational strategies'.

Clinical audits are cycles of activities that are intended to lead to improvements in clinical practice and service provision (Hughes 2008, Aazh *et al* 2009).

Each of these cycles comprises five stages (Figure 4):

- Preparation for the audit.
- Selection of audit criteria.
- Measurement.
- Implementation of changes.
- Re-audit.

During each cycle, current practice is reviewed, problems are identified, solutions are developed, appropriate changes to clinical practice are made and outcomes are assessed. The cycle is then repeated to ensure that service improvements are sustained.

Because audits can take a long time, and can require much effort and money, they should be undertaken carefully. They can be initiated by concerns about whether, for example, staff are working to best effect or current care suits patients' changing needs (DH 2008).

Clinical audits have also been undertaken to reduce appointment and treatment waiting times (Aazh *et al* 2009), and to gather information on the pace, immediacy and the manner or experience of care delivery (HQIP 2010).

Healthcare organisations have different priorities for clinical audit. Some may be undertaken, for example, to confirm the impression that standards are being met or exceeded. Others may be undertaken in response to assessments by external assessors such as the NHS Litigation Authority (NHSLA), which helps to ensure that risk management is cost effective (NHSLA 2010).

In addition, audits can be undertaken to celebrate and promulgate best practice.

In all of these circumstances, stakeholders must be consulted before audits are undertaken to ensure that the appropriate standards and criteria have been selected for audit (Ghosh 2009).

Hospital audit committees are often challenged to meet targets and obtain favourable CQC ratings so, unsurprisingly, they often focus on local health priorities that reflect national targets in, for example cancer, diabetes or mental health services.

Now do time out 2.

## 2 Auditing areas of practice

**Time out** Referring to the area of practice you chose in time out 1, ask a local risk manager to provide a list of relevant adverse incidents that can justify your choice. Then, investigate the standards and criteria that apply to your chosen area. Remember that these criteria may have been set nationally or locally, after consultations with local patient groups.

One potentially powerful and widely used method of quality improvement involves establishing the extent to which clinical practice complies with criteria identified for audit. The findings of NHSLA audits are important because of their influence on trusts' insurance costs.

Hearnshaw *et al* (2002) define criteria as 'systematically developed statements that can be used to assess the appropriateness of specific healthcare decisions, services and outcomes'.

When several or all such criteria are satisfied, a standard can be said to have been met, and auditors can refer to full or partial compliance with specific standards, which can be defined as written statements of best practice that have been agreed by healthcare professionals in the light of research and changing healthcare priorities (Guinness 2009).

Thus, an audit criterion defines an outcome to be measured, while a standard is a written statement of professionally agreed, evidence-based levels of performance and service delivery. Thus, if the criterion is that written patient records are recorded in black ink, a standard may be that 100 per cent of written patient records are presented in this way.

Healthcare professionals have a vested interest in their practices being audited with reference to the appropriate criteria (Collis 2006). Clinical auditors should spend time verifying criteria and standards, and explaining their significance to staff. The more that nurses are involved in setting standards and criteria, and the better they recognise their relevance, the more authentic the audits.

Identifying the appropriate audit criteria helps healthcare professionals and organisations to make baseline assessments and monitor any subsequent activities. By completing baseline assessments of practices at given dates auditors can review how practices have changed.

Standards must be reviewed periodically if they are to remain valid, and if the commitment of healthcare organisations and staff is to be secured.

## Benchmarking

The concept of benchmarking was developed by the office equipment company Xerox and is defined as 'the search for industry best practices that lead to superior performance' (Camp 1989).

In clinical practice, benchmarking is referred to as 'the best possible achievable practice by professional consensus, having considered all the available evidence' (Ellis 2000).

Benchmarking has been cited as one way in which members of the nursing, midwifery and health visiting professions can focus on the fundamental and essential aspects of care (Badham *et al* 2006), thereby improving patient experience.

The Essence of Care benchmarking toolkit identifies 11 'fundamental aspects of care', each with its own set of benchmarks (DH 2003a). These are:

- Continence, and bladder and bowel care.
- Personal and oral hygiene.
- Food and nutrition.
- Pressure ulcers.
- Privacy and dignity.
- Record keeping.
- Safety of clients with mental health needs in acute mental health and general hospital settings.
- Principles of self-care.
- Communication.
- Health promotion.
- Care environment.

Essence of Care benchmarks continue to be developed by focus groups of stakeholders. For example, a focus group made up of carers, patients and professionals has proposed a new benchmark for pain management (DH 2009b).

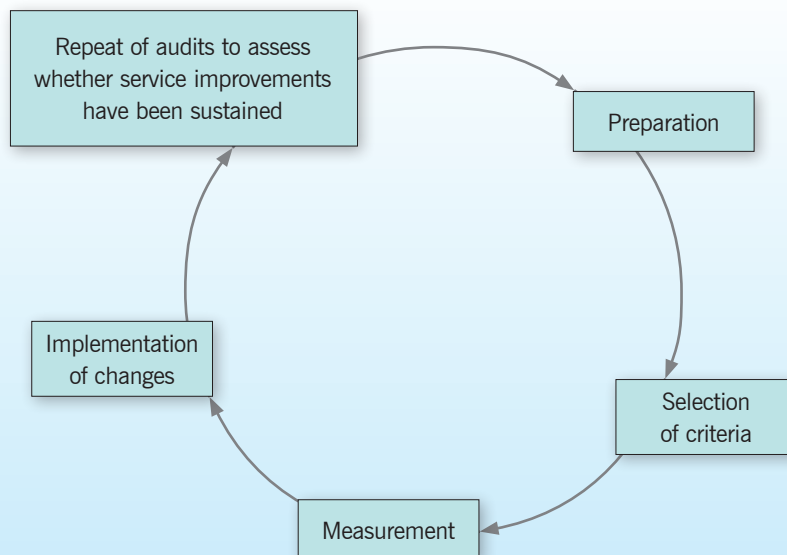
Because clinical audits are clinically led initiatives that involve services provided by more than one profession, a collaborative approach to undertaking them is usually required (Dinakara Babu *et al* 2001).

Sharing a benchmarking toolkit such as Essence of Care has many advantages, not least that different professionals audit to collaborative ends.

Other benefits of using the toolkit include its:

- Ability to co-ordinate improvements in clinical environments that address local and national priorities.
- Emphasis on patient journeys and the contributions of care to these.
- Usefulness in different contexts.

**Figure 4** Stages in the audit cycle



(Adapted from National Institute for Health and Clinical Excellence 2002)

**Table 1** Audit feasibility scoring grid

Question	Answers (scores)		
	Yes (2 points)	Not sure (1 point)	No (0 points)
■ Does the audit address a problem that is relevant to patient care?			
■ Is addressing this problem a priority?			
■ Can audit data be collected quickly?			
■ Will this data be reliable?			
■ Can changes recommended by the audit be implemented?			

### Scoring

If the score is 5 or less, the audit will probably fail.

If the score is 6 or 7, the audit may succeed.

If the score is 8 or more, the audit will probably succeed.

(Adapted from Baker *et al* 1998)

Now do time out 3.

### 3 Consulting on audits

**Time out** Referring to the area of practice you chose in time out 1, consider who you would need to consult regarding your prospective audit. Make a list and then prioritise who needs to be contacted first.

### Involving stakeholders

Determining the stakeholders in audit processes and obtaining their involvement are critical to secure the correct inputs for audits (Gustin 2005).

Clinical audits usually involve people who either experience, deliver or provide resources for healthcare services. Such audits can also involve the designers of bespoke and local services. Examples of the stakeholders who may be approached include:

- Patients.
- Medical directors.
- Nurses.
- Consultant doctors or nurses.
- Medical secretaries.
- GPs.
- Directors of quality and service improvement.
- Service leads.
- Audit facilitators.
- Educational facilitators.
- Governance facilitators.

- Information team members.
- Medical-record team members.

Doctors or nurses often take the lead in these consultations but audit facilitators are responsible for co-ordinating the audit processes.

Once areas of practice have been selected for audit, and relevant criteria have been chosen, the feasibility of the audit should be checked to ensure that all aspects of care may remain open to measurement and, therefore, audit, and that recent changes to patient needs or care provision have not made the criteria irrelevant. If the criteria have changed in these ways, policy or protocol reviews may be required instead of audit.

One way to check the feasibility of prospective audits is to use a grid such as that presented in Table 1. These feasibility checks are important, especially if extra resources or time are needed to complete audits.

Now do time out 4.

### 4 Feasibility check

**Time out** Referring to the area of practice you chose in time out 1, conduct a feasibility check. This will help you to make a clear and reasoned case if you propose the audit to managers who typically determine the allocation of resources and time for audits.

### Audit enquiries

Clinical audits involve series of enquiries in which data, for example on infection rates, are gathered, healthcare professionals and patients are interviewed, and practice observed.

The questions asked during these enquiries depend on the nature of the audits, but they must be formulated to elicit accurate descriptions of healthcare services as they are experienced and delivered, and as they are intended to be experienced and delivered.

This distinction between achievements and perceptions is crucial, and practitioners' perceptions of the care they deliver are often less important to audits than patient perceptions of the care they receive. Professional intentions express philosophies and goals, but the care received, understood and interpreted by recipients will define much of what has been achieved.

Obtaining patients' views is essential in the promotion of quality services and provision of effective health care (Avis 1997), and involves asking the 'why' and 'how' questions rather than the 'how many' and 'how much' questions.

Ensuring that questions are open and flexible encourages patients to provide their own narratives



and helps practitioners to understand what patients understand of the events they describe. Time invested in question selection and formulation is therefore valuable.

For example, when auditing patient education, it is important to ask about patients' perceptions of roles as well as what they have been taught, and whether they expected to be learners rather than passive care recipients.

Now do time out 5.

**5 The 'effort quotient'**

**Time out** Referring to the area of practice you chose in time out 1, try to anticipate your means of enquiry and review that will help you to conduct a coherent, fair and rigorous audit. At first, you will want as complete an understanding of the issues as possible. Later, you may want to return to some of your informants to clarify what they have told you. Estimate how much effort must be expended by you and others to complete the audit. This 'effort quotient' is important if thorough audits are to be undertaken.

### Auditing tools

Audits can be prospective or retrospective. Prospective audits are undertaken when, for example, healthcare professionals and patients have identified the satisfactory outcomes of new services, and have responsibilities for the final outcomes.

Retrospective audits are undertaken when services have been delivered and healthcare professionals must ascertain whether they can still respond to care requirements (Hughes 2008).

Healthcare professionals should use the appropriate outcome measurement tools for prospective or retrospective audits.

If practitioners are auditing pain management, for example, or improvements to life before death, the appropriate tool to use is the Support Team Assessment Schedule (Cooper and Hewison 2002), which was designed to assess the clinical and intermediate outcomes of palliative care.

Audits typically produce a mass of qualitative and quantitative information, and auditors need to work with their colleagues to interpret its meaning.

Some audit findings may be unambiguous, for example showing that targets have not been met, while others may show that services are 'good in parts'. In such cases, auditors must consider whether achievements should be accepted or rejected.

One important factor in successful audits is the implementation of change, and audits must include references to the different possible outcomes of strategies and the changes needed if these outcomes are poor. The more that is understood about the consequences of action or inaction, therefore, the easier the design of effective health services becomes.

The changes prompted by audit can be uncomfortable to some stakeholders (NICE 2002). Every time a new strategy is introduced, one or more groups of stakeholders will be required to act or to interact differently, and some may question or resist the strategy's implementation.

Leadership is also important in implementing change and the identification of people to lead change in their areas of practice is often part of audit processes.

A simple example of an audit action plan with criteria for monitoring outcomes is shown in Table 2.

The more transparent and consultative audits have been, therefore, the easier it becomes for stakeholders to support new strategies. Identifying those who resist change, for example because they have vested interests in keeping services as they are, can also be part of audit processes.

If audits highlight problems, changes to practice may be needed and these become easier to accept by staff if they benefit patients and nurses. Nurses must also be assured that their skills are used fully.

### Ethical considerations

The ethical issues associated with clinical audits can have far-reaching consequences for clinicians, patients and healthcare providers (Kinn 1997). Nurses are bound by a code of conduct, for example to ensure that patient data remain confidential, outlined by the Nursing and Midwifery Council.

**Table 2 Example of an audit action plan**

Desired change	Method	Criteria and standards	Lead person	Time taken for change
To raise staff awareness of the importance of record keeping	Introduction of local training programmes	Compliance with hospital policy on record keeping	Ward manager	Three months

The code (NMC 2008) states that nurses should:

- Respect people's right to confidentiality.
- Ensure people are informed about how and why information is shared.

Asking patients to comment on services when they are dependent on the goodwill of staff who provide these services requires that patient confidentiality is maintained.

Clinical audits must adhere to the Data Protection Act 1998, therefore, and patients must be unidentifiable and made aware that the information they give may be recorded or shared to support service improvement initiatives and the monitoring of care (DH 2003b).

Now do time out 6.

## 6 Ethical issues

**Time out** Referring to the area of practice you chose in time out 1, consider what ethical issues are raised. What are your duties of confidentiality? Ensure that you address these issues in any proposal for an audit that you make to your employer.

Clinical audits should be undertaken logically and auditors should be clear about the areas of practice to be examined, the criteria and standards to be applied, and the stakeholders to be involved.

Before auditors present their ideas for audit to employers, they must conduct feasibility checks and identify cogent reasons for auditing and relevant lines of enquiry so that the correct information can be obtained and balanced judgements reached.

Clinical audits are more likely to be approved if they can be seen to contribute to patient safety, a clear understanding of patient experience and the delivery of strategic objectives, especially those linked to healthcare efficiency.

Now do time out 7.

## 7 Practice profile

Now that you have completed this article, you might like to write a practice profile. Guidelines to help you are on page 35.

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# Practice profile

## What do I do now?

- Using the information in section 1 to guide you, write a practice profile of between 750 and 1,000 words – ensuring that you have related it to the article that you have studied. See the examples in section 2.
- Write 'Practice Profile' at the top of your entry followed by your name, the title of the article, which is: **'Achieving quality assurance through clinical audit'**, and the article number, which is **NM383**.
- Complete all of the requirements of the cut-out form provided and attach it securely to your practice profile. Failure to do so will mean that your practice profile cannot be considered for a certificate.
- You are entitled to unlimited free entries.
- Using an A4 envelope, send for your free assessment to: Practice Profile, RCN Publishing Company, Freepost PAM 10155, Harrow, Middlesex HA1 3BR by **May 2011**. Please do not staple your practice profile and cut-out slip – paper-clips are recommended. You can also email practice profiles to [practiceprofile@rcnpublishing.co.uk](mailto:practiceprofile@rcnpublishing.co.uk). You must also provide the same information that is requested on the cut-out form. Type 'Practice Profile' in the email subject field to ensure you are sent a response confirming receipt.
- You will be informed in writing of your result. A certificate is awarded for successful completion of the practice profile.

- Feedback is not provided: a certificate indicates that you have been successful.
- Keep a copy of your practice profile and add this to your professional profile – copies are not returned to you.

## 1. Framework for reflection

- Study the checklist (section 3).
- What have I learnt from this article?
- To what extent were the intended learning outcomes met?
- What do I know, or can I do, now, that I did not/could not before reading the article?
- What can I apply immediately to my practice or client/patient care?
- Is there anything that I did not understand, need to explore or read about further, to clarify my understanding?
- What else do I need to do/know to extend my professional development in this area?
- What other needs have I identified in relation to my professional development?
- How might I achieve the above needs? (It might be helpful to convert these to short/ medium/long-term goals and draw up an action plan.)

## 2. Examples of practice profile entries

- Example 1** After reading a CPD article on 'Communication skills', Jenny, a practice nurse, reflects on her own communication skills and re-arranges her clinic room so

that she will sit next to her patients when talking to them. She makes a conscious decision to pay attention to her own body language, posture and eye contact, and notices that communication with patients improves. This forms the basis of her practice profile.

- Example 2** After reading a CPD article on 'Wound care', Amajit, a senior staff nurse on a surgical ward, approached the nurse manager about her concerns about wound infections on the ward. Following an audit which Amajit undertook, a protocol for dressing wounds was established which led to a reduction in wound infections in her ward and across the directorate. Amajit used this experience for her practice profile and is now taking part in a region-wide research project.

## 3. Portfolio submission

Checklist for submitting your practice profile

- Have you related your practice profile to the article?
- Have you headed your entry with: the title 'Practice Profile'; your name; the title of the article; and the article number?
- Have you written between 750 and 1,000 words?
- Have you kept a copy of the practice profile for your own portfolio?
- Have you completed the cut-out form and attached it to your entry?

## Continuing professional development: practice profile

Please complete this form using a ballpoint pen and CAPITAL letters only, then cut out and send it in an envelope no smaller than 23 x 15cm to:

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**RCN Publishing Company**  
**Freepost PAM 10155**  
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Full title and date of article:

Article number:

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