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Review Article

Clinical audit: A simplified approach

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Abstract A clinical audit measures practice against standards and performance. Unlike research which poses the question, "what is the right thing to do?" clinical audit asks are we doing the right thing in the right way? An approach for understanding a clinical audit is provided. A basic clinical audit example of a case note audit is presented. A simplified template to help the beginners is included.

Key words
Clinical audit.

Introduction and steps of clinical audit

Audit is a key component of clinical governance, which aims to ensure that the patients receive high standard and best quality care.[1,2] It is important that health professionals are given protected and adequate time to perform clinical audit.[4,5,6,7] Clinical audit runs in a cycle and aims to bring about incremental improvement in health care. Guidelines and standards are set according to perceived importance and performance is then measured against these standards.[8,9,10].

A clinical audit is NOT the same as research. There are differences (**Table 1**).

A clinical audit usually starts by discussion at an audit team meeting discussing possible topics and prioritising them according to perceived importance applicable to the practice. The golden rule is we should only ever audit our own practice. If for some reason we need to gather data about the practice of others, then we should involve them in the audit and obtain their permission.[11]

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We should determine what we are trying to measure and define gold standards. The next stage is about setting the standards. Criteria are those aspects of care that we wish to examine. Standards are the pre-stated or implicit levels of success that we wish to achieve. The standards are based on the local, national or international guidelines. They should be relevant to our practice. A couple of example of the sources includes National Institute of Clinical Excellence (NICE) and the British Association of Dermatologists (B.A.D) web sites. When setting the standards remember the acronym SMART – Specific, Measurable, Achievable, Relevant and Theoretically sound – based on current research.

Next, methodology should be defined. Who will be involved? Who will collect and analyse data? What will be the sample size? What about the feedback of findings – to whom and how? When will the project begin and end?

The audits and the data collection can be prospective or retrospective (**Table 2**)

The audit once completed is presented at a meeting and recommendations are made with regards to deficiencies found and to identify areas for improvement. The implementation of the changes cannot be over emphasized - What

Table 1 Difference between audit and research.

Research	*Audit*
Generates new knowledge	Knowledge being used to the best effect
Is initiated by the researchers	Usually led by the service providers
Is theory driver (hypothesis based)	Is practice based (standard based)
Is often a one-off study	Is an ongoing process
Large scale, prolonged periods	Usually less so
Lot of statistical analysis	Not much analysis
May involve allocating service users randomly to different treatment groups	Never so
May involve administration of placebo	Never so
Requires approval from ethical committee	No such approval needed

Table 2 Data collection.

Categories	*Retrospective*	*Prospective*
Definition	Data collected by looking back over your practice	Data collected from this point onwards, starting at a future date
When to use	When looking at what has been happening in a chosen topic area	Data currently unavailable Data of poor quality
Advantages	Can be faster Provides a baseline	Avoids using poor quality data. Allows design of a clear and concise data collection sheet
Disadvantages	Past service users do not benefit	Provides no baseline for audit. Can be time-consuming since a no of individuals needed to collect data

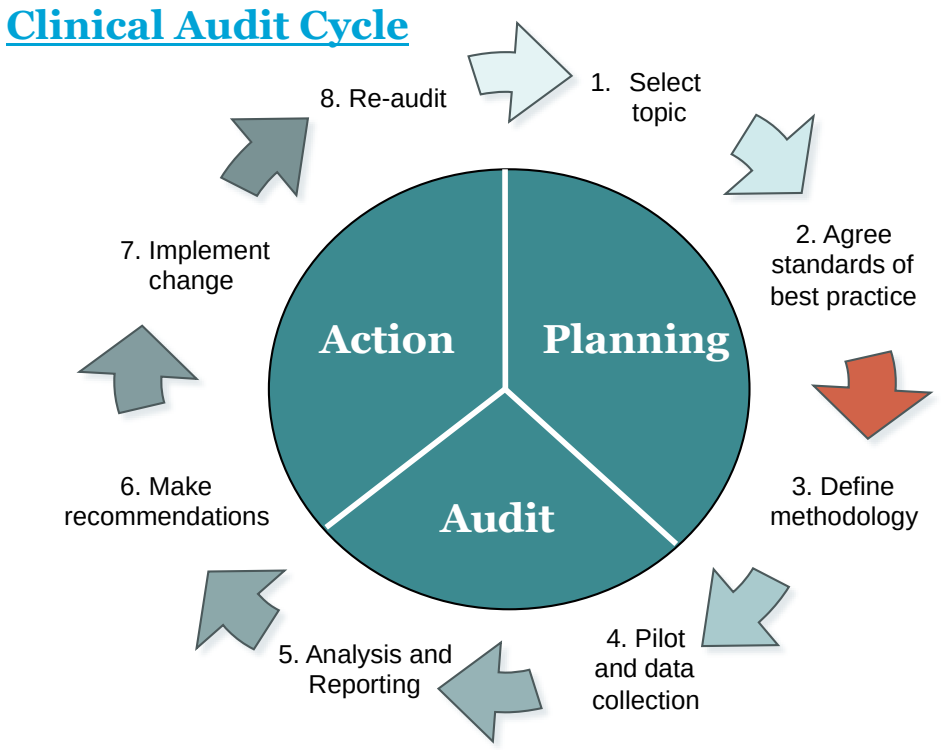

Figure 1 Clinical audit cycle.

needs to change? How change could be achieved – what actions need to be taken? Who needs to take these actions? When will the proposed actions begin? How these actions will be monitored and by whom to achieve the desired outcome and then re-auditing to see if the desired outcome(s) has been achieved.

A summary of the stages of clinical audit are presented in the form of audit cycle (**Figure 1**)

Discussion

Clinical audit in simple words means are we doing the right thing in the right way? This is achieved by measuring our practice and performance against standards. Doing regular clinical audits is essential. Audits improve patient care, identify and promote good practice, lead to improvement in service delivery, demonstrate to others that our service is effective, provide opportunities for education and training and encourages teamwork. The overarching aim of clinical audit is to improve service user outcomes by improving professional practice and the general quality of services delivered.[12]

There are three main types of clinical audit:

1. *Structure* (what we need). This includes staffing and facilities.
2. *Process* (what we do). The examples are checklists, protocols, guidelines, record keeping, waiting times, trainee's attendance and treatment.
3. *Outcome* (what we expect) for example satisfaction surveys.

Clinical Governance

A clinical audit is an integral part and key component of clinical governance.[13] Clinical Governance is an umbrella term which encompasses a range of activities in which clinicians should become involved in order to maintain and improve the quality of the care they provide to patients and to ensure full accountability of the system to patients.[14]

There are basically seven pillars of clinical governance:

1. ***Clinical effectiveness*** This means ensuring that everything we do is designed to provide the best outcomes for patients i.e. "doing the right thing to the right person at the right time in the right place". In practice this means an evidence based approach, changing practice if current practice is shown inadequate, developing and implementing new protocols and guidelines, conducting research to develop evidence, CPD, maintaining log books, time management, seeking help where required, patient satisfaction surveys, adequate consultation time, information leaflets etc.
2. ***Clinical audit*** The aim of the audit process is to ensure that clinical practice is continuously monitored and that deficiencies in relation to set standards of care are remedied.[15]
3. ***Risk management*** This involves having robust systems in place to understand, monitor and minimise the risks to patients and staff and to learn from mistakes. When things go wrong in the delivery of care, doctors and other clinical staff should feel safe admitting it and be able to learn and share what they have learnt. In simple terms this means to identify, assess, prioritise and prevent risk.[16]
   Examples of risk management include**:** complying with protocols, learning from mistakes and near-misses, reporting any significant adverse events via incident forms, looking closely at complaints, promoting a blame-free culture.
4. ***Education and training*** This means enabling staff to be competent in doing their jobs and to develop their skills so that they are up to date. This involves attending courses and conferences – CPD activities, taking

Table 3 Clinical audit template.

Project title	Name of the audit
Specialty	Name
Professor/HOD	Name
Project Lead(s)	Name(s)
Staff members involved	Names
Date of presentation	Date
Rationale	Background/Reason for the selected topic
Objective(s)	Insert
Project type	Structure, process or outcome
Basis of proposal	Local, National, International guidelines
Criteria	Insert
Standard(s)	Insert
Sample source	Insert
Sample size	Insert
Data collection/ analysis	Retrospective/ Prospective
Results	Insert
Recommendations/ Areas for improvement	Insert
RE-AUDIT	Date/ Time frame

Table 4 Case notes audit example.

Project title	Case notes audit Re-Audit										
Specialty	Dermatology										
Professor/HOD	Dr. Zafar Iqbal Shaikh										
Project lead(s)	Dr. Mansoor Dilnawaz										
Staff members involved	Dr. Hina Mazhar										
Date of presentation	5 October 2012										
Rationale	Meticulous record keeping is an integral part of patient care										
Objective(s)	1- To assess the quality of patient record 2- To seek incremental improvement										
Project type	Process										
Basis of proposal	Local guidelines										
Criteria	The case notes should contain the relevant demographic and clinical details of the patients										
Sample source	Case notes from the dermatology ward at Military Hospital, Rawalpindi										
Sample size	10 case notes selected at random										
Data collection/analysis	Dr. Mansoor Dilnawaz, Dr. Hina Mazhar										
Standard(s)	1. Is there: a. A hand written record? b. Is the clinician identified? c. Is it legible? 2. Is patient identified on each page (name, personal number, age, disease)? 3. Is there clear diagnosis or clinical problem? 4. Is there a clear management plan?										
Results		1	2	3	4	5	6	7	8	9	10
	1a	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	1b	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	1c	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	2	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	3	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	4	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Recommendations/areas for improvement	1- All the case notes had hand written, legible record of the patients with clear diagnosis and management plan 2- To continue with maintaining good patient record										
Re-audit	6 months										

relevant examinations, regular assessment during training, appraisals, identifying and discussing weaknesses and opportunities for personal development.

5. ***Patient and public involvement*** To ensure the services provided suit patients. This includes patient and public feedback, involvement of patients and public in the service development and local patient feedback questionnaires.
6. ***Staffing and staff management*** This involves: appropriate recruitment and management of staff, ensuring underperformance is identified and addressed, encouraging staff retention by motivation, staff development, good working condition and no bullying and harassment.
7. ***Using information and IT*** Patient data is accurate and up-to-date, confidentiality of patient data is respected, use of data to measure quality of outcome (audits) and to develop services tailored to local needs.

Conclusion

Audit and clinical governance translate into safe, evidence-based and quality care for the patients. Audit is a continuous improvement process. If audit culture is to be successful, then there needs to be a "NO BLAME CULTURE". There should be no "Blame, Name or Shame. Focus should only be on the patient care.

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