The College's view on How to do Audits, extracted from a Sept 2016 OSCE Station

Clinical audit is considered an integral part of clinical governance within the health service. In addition to measuring quality, there must be a commitment to change practice where the results of the audit show that improvements should be made. The key component of clinical audit is that performance is reviewed (audited) to ensure that what should be done is being done; assesses the gap between what we know and what we do exists, and it then provides a framework to enable improvements to be made.

A clinical audit may ask one or more of the following questions:

1. Is what should have happened actually happened?
2. What is the standard?
3. Does what is actually happening meet or exceed agreed standards?
4. Is current practice following published guidelines?
5. Is current clinical practice applying up to date knowledge?
6. Is current evidence is being applied in the particular situation under review?

In clinical governance the most commonly known audit process is the PDSA/PDCA Cycle. In 1924 Walter A. Shewhart introduced a Plan, Do, and See method for quality control to which W. Edwards Deming then applied a statistical process control method which led to the development of the well-known Plan, Do, Check, Act Cycle. The **Deming Cycle, or PDSA/PDCA Cycle** consists of a sequence of four repetitive steps for continuous improvement and learning: Plan, Do, Check (Study) and Act. It is also known as the Deming wheel of continuous improvement spiral.

PDCA cycle is made up of four key activities:

PLAN:	plan ahead for change. Analyse and predict the results.
DO:	execute the plan, taking small steps in controlled circumstances.
CHECK:	check, study the results.
ACT:	take action to standardise or improve the process.

The PDCA cycle should be repeated again and again for continuous improvement.

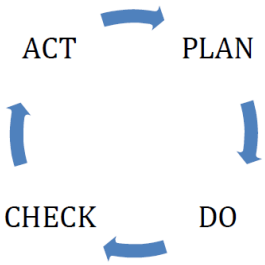
Clinical audit

Clinical governance is a systematic approach to maintaining and improving the quality of patient care within a health system and originates from within the United Kingdom NHS, with its most widely cited formal definition describes it as: *A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish* (G. Scally and L. J. Donaldson, *Clinical governance and the drive for quality improvement in the new NHS in England* BMJ (4 July 1998): 61-65).

As services become more focussed on patient-centred care and improved outcomes there is a need for clinical professionals to develop knowledge and skills to monitor and develop quality. Quality assurance is any systematic process of checking to see if a service is meeting specific requirements and clinical audit is one of the key tools applied in the coordinated approach to the assessment of the quality of services delivered.

Clinical audit is considered to be a continuous quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. The aim of clinical audit is to improve care by improving professional practice and the general quality of patient care delivered.

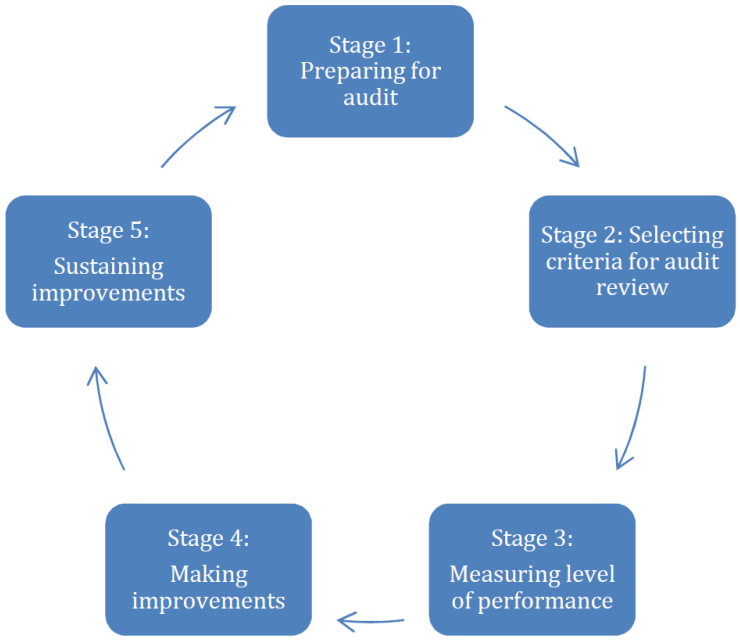
This is achieved by healthcare professionals reviewing patient care against agreed standards/criteria and making changes to meet those standards then repeating the audit to see if the changes have been implemented and the quality of patient care improved. Therefore, standards-based audit is a cycle which involves defining standards, collecting data to measure current practice against those standards, and implementing any changes deemed necessary.



The PDCA cycle is a useful procedure when:

- An opportunity is recognised and a plan for change made - **Plan.**
- A change is trialled/tested. Usually carried out as a small-scale study - **Do.**
- The trial/test is reviewed, results/outcomes are analysed and new learnings are identified – **Check.**
- Action is taken based on what is learned in the check/study step – **Act.**

In general **audit cycles** build on the PDCA cycle as is summarised in the following diagram. It involves a cycle of assessment, implementing a change and reviewing the impact of the change (i.e. re-auditing to close the audit cycle).



Stage 1: **Preparing for audit -** Identify the area/topic i.e. consider the need for change in an area/topic and where you suspect that standard could be improved and/or where the change you expect to recommend is possible.

Stage 2: **Selecting criteria for audit review -** Find the standard, ask the question and find the evidence. May need to do a literature search for the standard in the area/topic chosen. Write a plan for how to do the audit: This should include the rationale for doing the audit, the standard you have chosen, the population to be surveyed, the time frame for collecting the data and the data intend to measure.

Stage 3: **Measuring level of performance -** Collate data and compare the results against the selected audit standard. Then write a summary of the findings, discussing how the differences compare to the standard, possible explanations and remedies.

Stage 4: **Making improvements -** Identify the changes that need to make to achieve the standard and how they will be implemented. Put in place the actions and plans to correct any gap between the actual activity and the selected standard.

Stage 5: **Sustaining improvements -** This stage is critical to the successful outcome of an audit: It measures whether the changes implemented have had an effect and determines whether further improvements are needed to achieve the standard identified in Stage 2.

Audit can also provide information to show others the effectiveness of the service, the efficient use of resources and to ensure its development. It can measure the gap between what we know and what we do, and look for any unwarranted variation in care that is not explained by the clinical circumstances or personal choices of the patient. It also allows for training and education opportunities as well as improving communication and liaison.

In order to meet the standards of this station a candidate should therefore present an outline of a practical plan. They should also recognise the importance of feedback as a critical part of the audit process. Barriers to audit are often lack of resources, lack of expertise or advice in design and analysis, and organisational obstructions. Aspects that will need to be taken into consideration include having access to resources (e.g. time, data, and quality managers/statisticians), any opportunity costs, the need for ethical approval (if required) and utilisation/dissemination of the findings.

Audit differs from research. It aims to evaluate how close practice is to best practice and standards and to identify ways to improve quality of health care, whereas research aims to establish what that best practice is. So research generates new knowledge or increases the current knowledge, while audits focusses more on improving services and is practice based as an ongoing process. Patients are not allocated randomly in audit and it never involves a placebo treatment or a completely new treatment.

Better candidates will be able to recognise that audit is a continuous quality improvement activity assessing whether minimum standards/expected performance are being met and then maintained, and making changes to practice when necessary; and so there needs to be a program that sets regular times for repetition. They may also recognise that clinical care is more complex than just focussing on a set of key criteria that are audited, and that audit and feedback alone only provide moderate effects, whereas if combined with a broader strategy of education and quality improvement audit is more beneficial.

The role of the psychiatrist in clinical audit

It is important for doctors to participate in activities that review and evaluate the quality of their individual practice or the work done by their team. This drive for continuous improvement in healthcare delivery is part of what defines medical professionalism. There is a growing emphasis on medical participation and includes reflection beyond descriptive observation, as any changes that clinicians can make to service delivery should directly improve patient outcomes.

All RANZCP Trainees are expected to undertake a scholarly project as part of their training requirements. One option for Trainees to consider is the undertaking of a clinical audit. As part of the Continuing Professional Development (CPD) program of the RANZCP, the section on Practice Improvement Activities recommends *Practice Development and Review* and *Continuous Quality Improvement* activities like formal clinical audit and quality improvement activities which have furthered the participant's CPD goals. Possible activities could include practice audits, participation in root cause analysis, structured quality improvement and risk management projects.

Despite these expectations there are some perceived disadvantages of audit amongst clinicians; namely of reduced clinical ownership, suspicion of the reviewers, fear of reprisal or litigation, and professional isolation.

When discussing the psychiatrist's role in conducting clinical audit in a multidisciplinary team environment, the candidate is expected to identify the role that psychiatrists play in implementing clinical governance. As the clinical leader of this project they should consider their collegial relationship with other psychiatrists in the service and how to engage them. As part of the preparation, the other psychiatrists should be consulted on how to set up the audit cycle and confirm the key criteria, as well as participating in the feedback on performance and deciding on the actions for any performance improvement. The candidate would be expected to consider ways in which feedback will be given within a no blame environment. When comparing audit results among colleagues, it is important to be sensitive to variations, so candidates may consider the value of anonymising the data presented in group settings.

A better candidate will clearly demonstrate the role of psychiatrists in clinical governance, leadership, managing team dynamics and change management. They may also identify that someone will need to undertake the audit and who will be involved in the review. A better candidate may also consider the value of benchmarking with other services and learning from exemplar teams.