This month, Saima Begum Naroo looks at reviewing and auditing in clinical practice

CPD PART 4

What is a clinical audit?

Whenever the words clinical audit are uttered people usually think, 'a tick box exercise'. A few individuals might be sceptical, fear stricken and some may have never heard of it; however, at some point in practice everyone has knowingly or unknowingly carried out an audit. Sometimes an audit takes the form of going over the number of rechecks or scrutinising spectacle remakes to try to find a common link. So any activity with the ultimate goal of improving clinical practice or service is a form of audit.

This article will look at the process of a clinical audit in the hope of it seeming less daunting and, instead, being seen as one of the most effective tools for learning and development.

Often times, knowing the origin behind a system amplifies the experience. Going back to the very first clinical audit takes us to the work of Florence Nightingale during the Crimean War (1853)[1]. Using an audit, Florence Nightingale improved hygiene and, in doing so, reduced the death rate at the time. This process was further established in 1912 by Ernest Codman, recognised as the first medical auditor[1].

It wasn't until the 1989 White Paper, *Working for patients*, that a suggestion to standardise clinical audit was made[2]. Four years on, in 1993, clinical audits were introduced within the National Health Service (NHS). By 1997, clinical audits had become a major part of the clinical governance framework[3]. Today, clinical audits are a vital organ of the NHS system. They play an extensive role in the accreditation, quality, safety, peer review and clinical governance process.

'Clinical audit' is used as an umbrella term for any audit conducted by professionals in the healthcare sector. The definition given by the National Institute for Health and Care Excellence (NICE) 20023 is: "*a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Aspects of the structure, process and outcome of care are selected and systematically evaluated against explicit criteria...*" and so on.

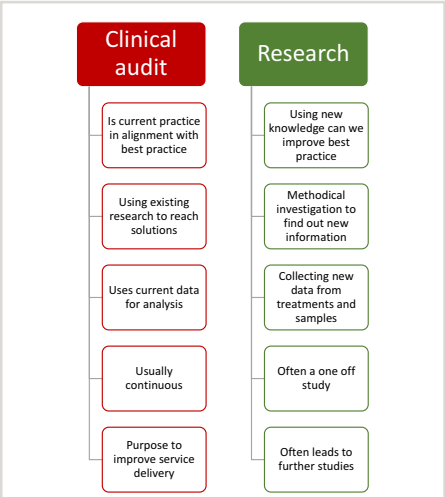

Figure 1: Key differences between a clinical audit and research

This long, detailed definition isn't easy to grasp so a concise version would be as follows: a clinical audit is a simple process of aligning your quality of care to best practice.

Although research and clinical audit are interrelated on a number of levels, it is essential to understand that clinical audit is *not* research. **Figure 1** shows the key differences.

BENEFITS OF A CLINICAL AUDIT

At the core of everyday clinical practice is the commitment to deliver high quality care. How do we know if we are achieving this? Well, this is where clinical audits come in to play. Without some form of a clinical audit, it is challenging to know whether current practice is effective and even more challenging to demonstrate this to others.

This process will allow the service provider to enhance their service delivery and, hence, their service user outcome. This tool can be used to ensure a practice is meeting the requirements stated in the Opticians Act 1989 and help reach best practice.

There are a myriad of reasons that make clinical audit a worthwhile exercise, along with maintaining the highest standards of practice. It is a good tool to highlight and prioritise key issues, plus it identifies opportunities for training and education, as well as showing where standards are being met. A well-constructed audit, that is designed to evaluate the uptake of a new product or service, can often lead to changes that increase the number of uptakes – resulting in economic benefits.

In February's CPD article, Haydn Dobby explored reflective practice as a tool to help individuals improve and develop. This is not that dissimilar to a clinical audit; although the purpose and the process is different, it can sometimes lead to personal development.

SIGNIFICANCE IN DISPENSING

Many practitioners have personally carried out or experienced others auditing the optometrist's clinical records at least twice or maybe several times a year. Yet only some of them experience the same level of auditing activity for dispensing records. Why? A clinical audit is as useful in the dispensing field as it in the optometric.

Dispensing spectacles meticulously is of the utmost importance to ensure patients are receiving the full benefit of their prescription. This lucrative part of the business has room for improvement but for the most part it has been overlooked.

An optical practice or individuals looking to audit their dispensing records can use the clinical audit process to assess:

- Frame choice and clinical barriers
- Quality of a dispense
- A particular dispensing service
- Patient satisfaction
- Dispensing measurement technique
- Spectacle lens choice
- Frame selection
- Overall dispensing procedure
- Individual performance
- Spectacle turnover time
- Spectacle laboratory process
- Spectacle collection
- Contact lens recommendation

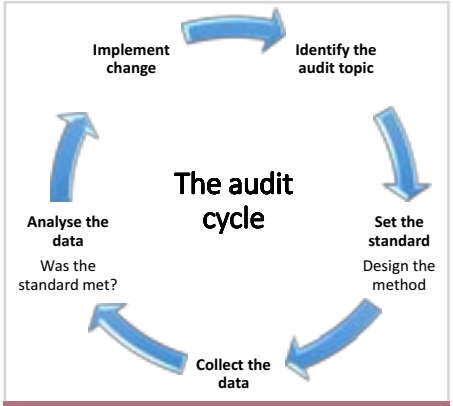

Figure 2: The five stages in the audit wheel[5]

MAINTAINING STANDARDS

The Commission for Health Improvement (CHI) ensures that NHS trusts and primary care organisations carry out clinical audits. Additionally, the Royal Colleges and professional bodies set standards for their members to make auditing a part of their profession.

Focusing on the General Optical Council (GOC) standards of practice, which are the same for both optometrists and dispensing opticians, it states in section five:

- *5.1: Be competent in all aspects of your work, including clinical practice, supervision, teaching, research and management roles, and do not perform any roles in which you are not competent.*
- *5.3: Be aware of current good practice, taking into account relevant developments in clinical research, and apply this to the care you provide.*
- *5.4: Reflect on your practice and seek to improve the quality of your work through activities such as reviews, audits, appraisals or risk assessments. Implement any actions arising from these*[4]

As professionals, we are expected not only to keep up-to-date with the latest research in our field but to carry out audits to improve the quality of our work.

FIVE STEPS TO CLINICAL AUDIT

It can be quite disconcerting at the very beginning of a clinical audit, when you're not sure which audit process (from the long list presented in the Google search engine) will suffice. The audit process used by the majority in the healthcare sector is the five-step audit cycle (**Figure 2**).

Step 1: Identify the audit topic

The aim of the audit must be clear. Establishing what service you want to improve and why is key to a successful audit. Always keep in mind that only relevant, measurable areas and items should be considered for an audit.

At this point, it is vital that you study all similar audits by carrying out a literature review. This is key so that work isn't repeated; instead take a learning from existing audits and possibly build on them.

Step 2: Set the standards

The next step is to set standards. Selecting standards based on expert opinion, best practice guidance, evidence-based research and professional standards will ensure desired outcomes. Using the GOC standards, ABDO guidelines, College of Optometrists' best practice guidance and even the NICE guidelines is a great starting point.

The success of this process depends on the planning and the execution of an audit. All the key participants' clinical or non-clinical staff, including service users if required, need to be involved from the outset. The structure must be non-intrusive to the day-to-day activities of a practice.

Step 3: Data collection

In any audit, time for collecting data varies on the area of analysis. Depending on the service or task, some audits can be completed in a few hours whilst others can take longer. The important factor in all this is the strategy used to produce meaningful data.

Step 4: Analyse the data

Once the data has been collected, it is ready to be measured against the set standards to see if current practice has any discrepancies. Care should be taken when collecting data as it needs to be valid and accurate. If applicable, discuss the results with the team and collectively decide on realistic changes that need to be implemented. An achievable time frame is essential to re-collect the data and re-evaluate. For any change to be successful, everyone involved must know their role in applying them.

Step 5: Implement change

As for the application of these changes is concerned, it is never an easy task and can be time-consuming. If it requires changing habits then allow more than a month for it to become natural behaviour. For any desired results to surface, you need to allow a sufficient time-frame for the changes to be imbedded. Depending on the topic, typically a re-audit should be completed after six months from the initial audit. Never overcomplicate a task as that can impact the delivery hence the results.

Finally, repeat the cycle. Using the initial method and standards, collect data to show if improvements have actually occurred from the changes that were implemented. If not, then another re-audit may be required for the remaining areas to improve. Before the re-audit process, the standards must be reviewed to ensure they are realistic then start from Step 4 and complete Step 5 in due course. The process is repeated until the evidence shows the standards are being met[6].

SUMMARY

The clinical audit has progressed and perfected itself step by step with medical development. It can reduce the chance of litigation or disciplinary action. This five-step process can really benefit a practice when used for the dispensing part of the business. To reap the benefits of an audit, it must be carried out using a reliable structure so that it can prevent issues from re-occurring.

In the next article, we will work through an example of a dispensing clinical audit in practice to support the implementation of this essential tool.

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