

**A GUIDELINE FOR CLINICAL AUDIT IN**

**PUBLIC HEALTH FACILITIES**

**(DRAFT)**

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PREAMBLE

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1. **INTRODUCTION**

In the South African public health sector, the important role clinical audit as process has to play in improving patient care is acknowledged, hence its inclusion as a policy directive in the *Policy on Quality in Health Care for South Africa*, *February 2001* as well as the abbreviated April 2007 version of the said policy (see Annexure D). The Policy requires that all health professionals in health facilities participate in Clinical Audit. However, the findings of national core standards performance appraisals that are being conducted in public health facilities and information extracted from provincial quarterly reports continuously demonstrate that clinical audits are either not done at facility level at all or such audit are only being done in some of the priority health programmes and not in all priority health programmes. This subsequently leads to an obvious lack of quality improvement projects that are based on the results of clinical audits. These guidelines serve as a quick reference to get started with clinical audit, thus enabling health facilities to comply with the said Policy and with the specific standard contained in the national set of core standards for health establishments in South Africa, and in so doing, further improve on the clinical quality of care the public sector provides.

**2.** **DEFINITION OF CLINICAL AUDIT**

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit standards/ criteria and the implementation of change. Aspects of structure (input), processes and outcomes of care are selected and systematically evaluated against explicit standards. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in health care delivery.

Clinical audit should be an integral part of clinical practice and preferably a multi-professional activity. It informs health care providers whether they are providing care that will, (i) yield improved outcomes for patients, (ii) bring about efficiency gains, and (iii) raise patient satisfaction to higher levels.

Clinical audit is not research. Research is about obtaining new knowledge, thus finding out about what best practice is. For example, the research question might be, “What is the most effective way of treating pressure sores?” Clinical audit is about quality, i.e. finding out if agreed best practice is being followed. In this instance the question would be, “How are we treating pressure sores and how does this compare with acceptable best practice?” Although clinical audit is not research, similarities do exist between them. Both aim to answer a specific question relating to quality of care, both can be carried out either retrospectively (looking at historical data) or prospectively (collecting data as care is given), and both involve careful sampling, questionnaire design and analysis of findings.

Figure 1 below schematically illustrates the difference between Clinical audit and research:

Process

 Inputs Output and outcome

 **Audit**

 (Applying acquired knowledge to improve care)

 **Research**

(Determine most effective treatment)

 ***Figure 1: The difference between research and clinical audit***

1. **RATIONALE FOR CLINICAL AUDIT**

The underlying purpose or motive of conducting a clinical audit that seeks to improve patient care is as follows:

* 1. To enable health care workers and health care users to measure and evaluate clinical practice against set standards.
	2. To identify factors impeding successful implementation and adherence to the set standards.
	3. To identify those areas that requires changes in human resources, technical knowledge and in skills.
	4. To identify and meet further development and training needs of clinicians.
	5. To advocate for patient safety
1. **PRINCIPLES OF CLINICAL AUDIT**

 When clinical audits are conducted, certain principles do apply. These principles are as follows:

* 1. **Confidentiality** should at all times be respected. No information regarding the health status, treatment or stay of a patient in a health facility is to be divulged verbally or in writing without the necessary prior consent. Furthermore, patient data entered into any computer (database) should be protected by a password, access to such computers should be limited to authorised personnel only, and all relevant documentation and material related to the clinical audit must be locked away when not attended to or not in use. Making information anonymous before it is used in audit could also be considered.
	2. The **organisational environment** must be supportive towards clinical audit. In practice this means that those who are managing our facilities should ensure policies and procedures are in place to safeguard patient care and they should encourage professional self-regulation, and lifelong learning.
	3. A **non-judgemental** working environment should exist, i.e. the search should be for error only. The results that are produced when searching for a deviation from agreed good practices should not be used to denigrate and condemn health care providers.
	4. Clinical audit is **data driven**. Clinical audit can only be undertaken if enough data is available to ensure credible results are produced. It is therefore essential that a strong relationship be established between the Health Information system and the Clinical Audit project.
	5. Clinical audit should be part ofa **structured programme** to improve quality of care within a facility.
	6. Clinical audit is **participatory** in nature. It involves multidisciplinary teams that comprise of health care workers and service users at any level or tier of the health care system. Working in teams ensures that appropriate skills are pooled together from the outset.

**5.** **CLINICAL AUDIT** **CRITERIA**

To ensure successful clinical audit, the following criteria should be adhered to:

5.1 Topics chosen for clinical audit should preferably cover aspects of care that are of high risk, high volume or high cost.

5.2 The standards/ criteria, against which the systematic review of care will take place, should be derived from nationally and provincially endorsed guidelines, approved guidelines developed by clinical societies or from good local quality guidelines.

* 1. The sample size chosen should be adequate to produce credible results.

5.4 To be successful, clinical audit should lead to action. An assessment of the input, process and outcome of care should therefore always culminate in embarking on agreed upon action.

5.5 The required action will be guided by action plans that address the local barriers to change and identify those responsible for service improvement.

* 1. Managers should be actively involved in audit and in particular in the development of the action plans.
	2. The outcome of action plans should be monitored to ascertain whether improvements in care have been implemented as a result of clinical audit.
	3. Systems, structures and specific mechanisms should be made available to monitor service improvements once the audit cycle has been completed.
	4. Each clinical audit should have a local lead (leading official) to ensure accountability.

**6. THE CLINICAL AUDIT PROCESS**

In clinical audit the overarching questions posed, are: “What are we trying to achieve? Are we achieving it? Why are we not achieving it?”; and “Have we made things better?” These questions correspond with the same questions asked in problem solving and can also be viewed as a cycle (see Figure 2).

**What are we trying to achieve?**

**Have we made things better?**

**Are we achieving it?**

**Why are we not achieving it?**

**Doing something to make things better**

***Figure 2: The clinical audit cycle***

From the above cycle it is clear that finding answers to these questions, requires a supportive environment and a broad range of specific methods and skills, such as benchmarking, process analysis and re-design, questionnaire design, data analysis, continuous quality improvement, facilitation, system analysis and root-cause analyses. It is therefore imperative that these skills are acquired by as many possible members of the multidisciplinary clinical audit team(s) and the methodologies become embedded and routine (institutionalised) amongst these teams. Skills development and training should in this regard become part ofthe health establishment’s structured programme to improve quality of care within a facility (as mentioned in section 4.5 above).

Within the above cycle there are very distinct **stages** that follow a systematic process of establishing best practice, measuring care against criteria, taking action to improve care, and monitoring to sustain improvement (*see* Figure 3). It goes without saying that the cycle suggests that as the process continues, each cycle strives towards attaining a higher level of quality

# STAGE ONE

# Preparing for audit

# STAGE TWO

**Selecting criteria**

 **Using various Creating the**

# STAGE THREE

Measuring performance

 **methods environment**

# STAGE FOUR

**Making improvements**

# STAGE FIVE

**Sustaining improvement**

*Figure 2. The stages of clinical audit*

* 1. **STAGE ONE: PREPARING FOR AUDIT**

Preparing for audit can be broken down into five elements.

* + 1. **Involving users**

The focus of a clinical audit should always be on those receiving treatment in a health facility or using a health service. Thus, involving users to identify problems with the care they receive becomes imperative. The most commonly used method of identifying these problems is through user satisfaction surveys. Other sources of user information could also include letters of complaint/ comment, adverse incident reports and feedback from hospital boards/ clinic committees.

5.1.2 **Selecting a topic**

Clinical topics firstly need to be prioritised in order to be able to select the ‘right’ topic for audit. Useful questions clinical teams can ask in this regard are –

* Is the topic concerned of high cost, volume, or risk to staff or users?
* Is there evidence of a serious quality problem?
* Is good evidence available to inform standards, e.g. national and/ or provincial clinical guidelines?
* Is the problem concerned amenable to change?
* Is the topic pertinent to national/ provincial policy initiatives?
* Is the topic a priority for the health facility?

The normal data collection and monitoring systems of the facility should identify the problems and/ or differences that are experienced in the facility. These problems and/ or differences between current and desired performance should provide the required topics for Clinical Audit.

5.1.3 **Defining the purpose of the audit**

The clear aims of the audit must be defined. Verbs such as, ‘to improve’, ‘to enhance’, ‘to ensure’ and ‘to change’ may be useful in this regard. Examples of using these verbs are –

* To ensure every HIV positive pregnant mother with a CD4 count of more than 200 cells/ml. starts to receive AZT before 28 weeks.
* To improve the waiting time of patients at the pharmacy who are collecting their chronic medication per repeat prescription.

When planning for the audit, it is also important to document the audit method, the criteria and target levels of performance, the data requirements and the data collection tool.

* + 1. **Providing the necessary structure(s)**

Clinical audit as quality improvement tool, becomes truly beneficial to the health facility when –

* A structured audit programme is in place, i.e. there is a committee structure, feedback mechanisms exist and regular audit meetings are being held.
* Funds are provided for audit and appropriately used when responding to the findings of clinical audit.
* Protected time is allocated to all staff members who will be involved in investigating the audit topic, collecting and analysing data, and who will be responsible for completing the audit cycle.
	+ 1. **Identifying the skills and people needed to conduct the audit, and training them and encouraging them to participate**

Clinical audit projects require a wide range of skills. The specific audit project will determine the necessary skills needed and these skills should, if possible, be spread amongst the team members of the audit project team. Typical skills required are as follows:

* Project leadership, project organisation, project management.
* Clinical, managerial and other service delivery input and leadership.
* Audit method expertise.
* Change management skills.
* Data collection and data analysis skills.
* Facilitation skills.

However, all audit project team members should have –

* A basic understanding of clinical audit.
* An understanding of and commitment to the aims and plans of the audit project.
* An understanding of what is expected of the audit project team. These expectations could be formulated into a *Terms of Reference* document when planning for the audit.

It is also vital that Management of a health facility understands the aims of clinical audit and supports clinical audit project teams. This could be done by, (i) showing individuals the relevance of involvement in clinical audit to their personal development, (ii) tapping into the existing knowledge pool within the facility, i.e. identifying those who have already been trained on for example, project management, change management and facilitation, (iii) approving focussed training to increase the required skills base and, (iv) encouraging staff by demonstrating to them the improved clinical outcomes, efficiency gains and improved user satisfaction attained through their clinical audit efforts.

* 1. **STAGE TWO: SELECTING CRITERIA**

The *National Core Standards for Health Facilities in South Africa (2008)* defines a criterion as a rule or test on which a judgement or decision regarding the achievement of a standard can be assessed and it defines a standard as the degree of excellence required for a particular purpose. When conducting clinical audit, criteria are used to assess the quality of care provided by an individual, a team, or a health facility. It is therefore imperative that the criteria being selected are (i) explicit statements that define exactly what is going to be measured and, (ii) represent elements of care that can be measured objectively. Valid criteria must be selected. To be valid and lead to improvements in care, criteria need to be:

* Based on evidence.
* Related to important aspects of care.
* Measurable.

Criteria can be classified into three categories:

* **Structure criteria**: refer to resources required such as the number of staff and skill mix, provision of equipment, availability of physical space and organisational arrangements.
* **Process criteria**: refer to the actions and decisions health care providers and users respectively or jointly take during care processes. These actions may include assessment, communication, documentation, education, evaluation, prescribing, and surgical and other therapeutic interventions. The importance of process criteria is determined by the extent to which the criteria influence outcome.
* **Outcome (of care) criteria**: are the measures of the physical or behaviour response to an intervention, reported health status, and level of knowledge and satisfaction. Sometimes intermediate or proxy outcome criteria are selected, i.e. criteria are used that are closely linked to eventual outcome, e.g. the intermediate outcome of cholesterol control in people with high cholesterol blood levels, instead of eventual morbidity due to related conditions. Often audits do not include formal criteria, but focus specifically on outcomes instead, especially when outcome are easily measurable and occur soon after the delivery of care as well as when the outcome is also of major importance to users, for example postoperative complications. In these instances data about the outcomes of care are collected. It should however be borne in mind that using outcome measures alone sometimes provides insufficient information for developing an action plan for improving clinical practice.

* 1. **STAGE THREE: MEASURING PERFORMANCE**

Data collection must be precise and only essential data collected, i.e. only the minimum data required by the objectives of the audit. It is strongly recommended that data that already exists be used. To ensure only essential data are being collected, certain details about what is to be audited must be established from the outset. These details include the following:

* + 1. **User group**

The service users must be identified and the user group then clearly defined. Examples of statements (inclusion criteria) that define specific populations for the purpose of particular audits are as follows:

* All pregnant women receiving ARV treatment.
* All epileptic inpatients in a mental health institution.
* All children under the age of 12 years diagnosed with well-established periodontitis.
* All patients at the pharmacy who are collecting their chronic medication per repeat prescription.

In instances where it is not practical or feasible to include each and every user, a representative sample is usually chosen. Sample size is determined by the degree of confidence wanted in the findings and by resource constraints, e.g. time, access to data and costs.

* + 1. **The range and reliability of information**

To further assist the audit team in deciding what data is really needed, they should consult with all staff involved in the care process that is to be audited, because these staff members will in all probability know the range and reliability of existing paper-based and electronic information.

* + 1. **The time period over which the criteria apply**

Time periods are often specified to enable data collectors to gather a representative number of cases to monitor performance. These time periods depend on the number of cases treated on a daily basis and the number needed to make a confident judgement of care being provided.

 The analysis of all the data collected should be performed and comparisons drawn with the existing criteria & standards. It is the responsibility of the clinical audit team to draw conclusions on how well the standards were met or not, identify the root causes of problems and disseminate the findings. Data analysis tools, such as bar charts, run charts and Pareto diagrams, should be utilized to identify and display information. The clinical audit team should present this data in as many ways possible to ensure the maximum knowledge and understanding of the clinical audit project is achieved throughout the facility.

* 1. **STAGE FOUR: MAKING IMPROVEMENTS**

Change does not necessarily culminate in improvement, but making improvements does require change. This change can occur at organisational, group, or individual level, and to implement change at each level requires careful planning and systematic management. In this regard, the following five principal steps need to be taken:

1. The required change is clearly defined, based on evidence, and presented in a way that staff can easily understand.
2. The barriers to change as they relate to health professionals and to the health facility are identified. This can be done in several ways, but generally the simplest and most practical method should be used. If implementation at the first attempt fails, a more detailed investigation of the obstacles may be needed. Some methods of identifying barriers to change are as follows:
* Interviews of key staff and/ or users.
* Discussion at team meetings, using brainstorming or fishbone diagrams.
* Observation of patterns of work.
* Identification of the care pathway (the patient’s course/ passage through the health facility from beginning to end).
1. Implementation methods are chosen that are appropriate to the particular circumstances, the change itself, and the obstacles to be overcome. Many interventions are available for implementing change, but no single method is always effective. Thus, a diagnostic analysis should be undertaken to identify factors that will influence the likelihood of change before selecting the most appropriate strategies for implementing change.
2. An integrated plan is developed for coordinating delivery and monitoring of the interventions. The plan should describe the sequence in which interventions will be made, the staff and resources required to make them, and the target groups.
3. The plan is carried out, and progress is evaluated, with modifications to the plan or additional interventions being used as required.

As much as the environment is important for audits to take place, the nature of the environment for implementing change is even more important. Aspects of an environment that promote clinical audit can be summarised as follows:

|  |  |  |
| --- | --- | --- |
| **Individuals** | **Teams** | **Organisations** |
| ***Structure***TimePersonal development plansAccess to advice about  change managementAccess to a system for reporting concernsOccupational health services available***Culture*** Positive attitude to audit and improvementLack of fear – of change and of confronting less than desired or even poor performance | LeadershipClear and shared objectivesEffective communicationTraining in improvement methodsOpportunities for the team to meet to share ideas and develop plansOpen to new ideasFocus on the user’s experienceInterpersonal respect and cooperation | Explicit commitment to clinical  audit within the organisationClear system for managing a clinical governance(1) programmeStaff with responsibility for audit fully trained and encouraged to develop new solutions to old problemsGood systems to understand the views of usersGood communication with other external stakeholders in health and social servicesUsers’ perspectives genuinely regarded as the focus of quality improvement Open to interest from external agencies in quality of performance, and not afraid of ‘inspection’‘No blame’ approach to errorsAudit given a high priority |

*Table 1*. *Aspects of an environment that promote clinical audit*

 Clinical governance(1) : Clinical governance is an initiative to ensure health facilities have in place a system to support continuous improvement in the quality of care. This includes having policies and procedures to safeguard patient care and, importantly, promoting an organisational culture that encourages patients, visitors and staff to report any concerns they may have or make suggestions for improvement. In addition, the clinical governance system should include, (i) fully functional procedures for professional development, (ii) appraisals, (iii) effective team management and, (iv) adverse incident reporting system(s).

* 1. **STAGE FIVE: SUSTAINING IMPROVEMENT**

As the primary objective of audit is to improve health care delivery, sustaining any such improvement is as important. Thus, any systematic approach to changing professional practice should include plans to monitor and evaluate the change in practice and plans to maintain and reinforce the change.

* + 1. **Monitoring and evaluating changes**

Collecting data for a second time, after changes have been introduced, is central to both assessing and maintaining the improvements made during clinical audit. The same procedures of sample selection, information collection, and analysis (see 5.3 above) should be used throughout the process, to ensure that the data are valid and comparable with each other. If performance targets were not reached during implementation, modifications to the plan or additional interventions will be needed.

Systems for long-term monitoring of indicators should be set up and only the minimum number of essential indicators should be included. Data collection can be minimised if monitoring is based on routinely available or easily collected indicators. However, if no data source is available and the performance indicator is a key measure, systems for providing data must be created. For example, should health facilities not routinely monitor the proportion of people on ARV therapy who have been advised about the possible side effects of the drugs they are using, they will have to develop a monitoring system for *inter alia* this indicator as well. Whenever possible, authoritative, evidence-based sources of guidance on selecting performance indicators and advice on audit criteria should be used. When local indicators are required and subsequently developed, care should be taken to ensure these indicators are valid and reliable. It is important to ensure that data are collected accurately and analysed and interpreted appropriately when performance indicators are used to monitor sustained improvement. Findings should be reviewed regularly and any decline in performance should be investigated through more detailed audits. The subsequent results should inform the development and implementation of new improvement strategies. By so doing, monitoring is linked to an overall quality strategy, thus making it a routine part of managing the service.

Other sources of information, such as errors, adverse incidents, mortality and morbidity reviews, and comments from users can also be included for continued monitoring of performance, but these mechanisms depend largely on a non-judgemental environment.

* + 1. **Maintaining and reinforcing improvement**

To ensure improvement is maintained and reinforced, the following common factors should always be kept in mind:

1. Maintaining and reinforcing improvement over time is complex.
2. Management need to build motivating factors into the clinical governance system to support the continual cycle of quality improvement.
3. Clinical audit must be integrated into the facility’s wider quality improvement systems.
4. Strong leadership is required.
5. A culture is needed that supports the concept of planned audit activity, leading to improvements in quality of which everyone in the organisation is aware and supportive.
6. The shared values and beliefs of the organisation must support the ideas of quality improvement.
7. Appropriate structures are needed to support and implement the changes that are suggested. These structures should be able to coordinate and monitor quality improvement activities quickly and effectively.
8. IT processes should be in place to provide accurate information about the organisation and patients, allowing sensible decisions to be made about where audit is needed and whether changes have had the desired effects.
9. Achievable plans of quality improvement must be developed.
10. Adequate training must be offered so that staff can gather and analyse data accurately.

Should change that was brought about subsequent to a clinical audit culminate in improvements and these improvements are sustained, it becomes very important for the team to celebrate and share their success with other facility staff members and with management. Clinical audits may be used as a means to document and disseminate best practices between different facilities in a province and even amongst provinces.

1. **ROLE PLAYERS IN CLINICAL AUDIT**

Clinical audit is one of the many quality improvement processes that are followed to assure quality. The **Quality Assurance manager/ coordinator** in a facility therefore seems to be the most appropriate member of staff to take overall responsibility for the management of clinical audit in the facility. The Quality Assurance manager’s role with regard to clinical audit could be viewed as follows:

1. Empower health care providers to conduct, plan, implement and sustain a facility-wide clinical audit programme.
2. Ensure clinical audit meetings take place.
3. Encourage, guide and support health care providers in all clinical disciplines on the process and areas for clinical audit.
4. Establish clinical audit teams.
5. Develop links to information sources on quality of care, such as complaints, litigation, critical (adverse) incident reporting and risk management, so that lessons can be learned and clinical audit activity can be refined.
6. Monitor clinical audit processes on a frequent basis.
7. Keep records of clinical audits, its findings, the interventions and the impact thereof.
8. Report to senior management on the clinical audits conducted and the outcome thereof.

The **Manager/ Chief Executive Officer** of the health facility has an important role to play in creating an environment that promotes clinical audit. It is therefore almost imperative that the Manager will be well versed in change management methods and will have extensive knowledge of clinical issues. Consideration should also be given to making quality improvement interventions based on the outcome of clinical audit part of the Manager’s key performance areas. The Manager/ Chief Executive Officer’s role with regard to clinical audit could be viewed as follows:

1. Attend as many clinical audit committee meetings as possible per annum, especially those where the clinical audit topic is of great importance to the facility in terms of care and cost.
2. Avail sufficient funds to ensure all the stages of clinical audit are adequately addressed.
3. Allocate protected time to all staff members who will be involved in investigating the audit topic, collecting and analysing data, and who will be responsible for completing the audit cycle.
4. Ensure the training and development of the relevant health care providers.
5. Create a supportive environment for clinical audit, e.g. setting up a library for reference, providing data capturers and computers with internet access, and buying in expertise when necessary to ensure successful clinical audit takes place.
6. Review on a regular basis, (a) clinical audit data, (b) the proposed quality improvement interventions, (c) the obstacles to the successful implementation of quality improvement interventions and, (d) the training that is conducted to appropriately skill staff members.
7. Report to higher authority on clinical audit activities, using provincial/ national indicators.

The real success of any clinical audit hinges on the commitment, experience and expertise of the **Clinical Manager**. Clinical audit and quality improvement interventions should form part of the key performance areas of all the relevant Clinical Managers in the facility. The clinical manager should attend all clinical audit meetings and present to the health facility’s Quality Assurance committee the following:

1. Information on clinical audit activities taking place in their clinical discipline/ service area.
2. The quality improvement interventions that are recommended and undertaken by the service area.
3. The obstacles that may affect the successful implementation of any quality improvement intervention.

As stated earlier, clinical audit is participatory in nature. It focuses on teamwork and should therefore involve multidisciplinary teams of health care providers. The participation of **every clinician and other relevant health care provider** in clinical audit and in subsequent quality improvement activities is therefore of the utmost importance and should become part of the key performance areas of these cadres of health workers. These health care providers should do the following:

1. Report areas of concern that are to be considered for auditing.
2. Partake in clinical audit activities that relate to their functional ambit.
3. Aspire to attend all the relevant clinical audit meetings as determined by the relevance of the clinical audit topic to their service area, including mortality and morbidity reviews.

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ANNEXURE A

CHECKLIST TO MONITOR A CLINICAL AUDIT PROGRAMME

The Quality Assurance Manager Coordinator and/ or Chief Executive Officer of the facility may use the following list of criteria to monitor the key components of the clinical audit programme in his/ her facility.

|  |  |  |
| --- | --- | --- |
| **Input** | **Yes** | **No** |
| The organization has a clinical audit team that meets at least monthly. |  |  |
| Every service area / discipline has an identified leader for clinical audit. |  |  |
| All clinical audit teams are multi-professional and include representation from the departments / disciplines that are involved / affected by identified clinical audit topic. |  |  |
| An annual facility-based clinical audit programme is prepared that includes national, provincial, district and facility-based health priorities. |  |  |
| There is a dedicated budget to perform all clinical audit activity. |  |  |
| These clinical audit guidelines are available in all units. |  |  |
| An IT system is available to support all clinical audit activities in the facility. |  |  |
| The database of ongoing and proposed clinical audit projects is up to date. |  |  |
| **Process** |  |  |
| The Quality Assurance manager provides regular feedbacks on clinical audit to other staff members of the facility. |  |  |
| All health care providers are provided training on clinical audit. |  |  |
| Tertiary institutions’ expertise on clinical audit is utilized where available. |  |  |
| Evidence is available that clinical audits are based on available standards / criteria |  |  |
| Improvement plans based on clinical audit outcomes are in place and implemented. |  |  |
| Clinical audits involve appropriate patients and / or carers. |  |  |
| Records are maintained for all staff and service areas that have attended / conducted clinical audit meetings / training events. |  |  |
| **Output** |  |  |
| Input structures are available as required by the expected clinical care. |  |  |
| There is a uniform understanding of quality gaps within clinical service areas. |  |  |
| An increase in the level of knowledge and technical skills amongst clinicians.  |  |  |
| An improvement in staff morale. |  |  |
| A decrease in mortality and morbidity following clinical audit.  |  |  |
| Improved accuracy in adverse events reporting at the health care facility. |  |  |
| Reductions in litigation following implementation of clinical audit recommendations. |  |  |
| Opportunities for further clinical audit processes and / or research are available. |  |  |

**ANNEXURE**

**AN EXTRACT FROM THE POLICY ON QUALITY IN HEALTH CARE FOR SOUTH AFRICA ABBREVIATED VERSION: APRIL 2007**

**Clinical audit**

Clinical audit is essential in patient care as it brings together professional from all divisions of health care to:

* Consider clinical evidence (evidence based health care);
* Promote education and research;
* Develop and implement clinical guidelines;
* Enhance information management skills; and
* Contribute towards better management of resources.

**All health professionals** at all levels of care will participate in clinical audit. Self-assessment needs to take place to accurately assess performance in relation to established standards. Clinical Audit teams will be established to perform the following tasks:

* Determine what aspects of current work are to be considered for auditing;
* Describe and measure present performance and trends
* Develop standards, if these are not available
* Decide what needs to be changed
* Negotiate change;
* Mobilise resources to effect change; and
* Review and renew processes.

**A standardised managerial model** will be developed to prevent the Clinical Audit and peer review process developing into a search for error only, which could lead to the denigration and condemnation of others.

**To enjoy public confidence**, the process of peer review will be:

* Open to public scrutiny;
* Responsive to changing clinical practice and service needs;
* Publicly accountable for nationally set professional standards; and
* Publicly accountable for the action taken to maintain these standards.

Professional bodies will have procedures in place to ensure prompt action when problems occur.

**BIBLIOGRAPHY**

* 1. Copeland, G. A practical Handbook for Clinical Audit. Clinical Governance Support Team, March 2005.
	2. Department of Health. The Policy on Quality in Health Care for South Africa. Abbreviated version, April 2007.
	3. National Audit Office. A safer place for patients: learning to improve patient safety. London: The Stationary Office, 2005.
	4. National Institute for Clinical Excellence (NICE). 2002. Principles for Best Practice in Clinical Audit.