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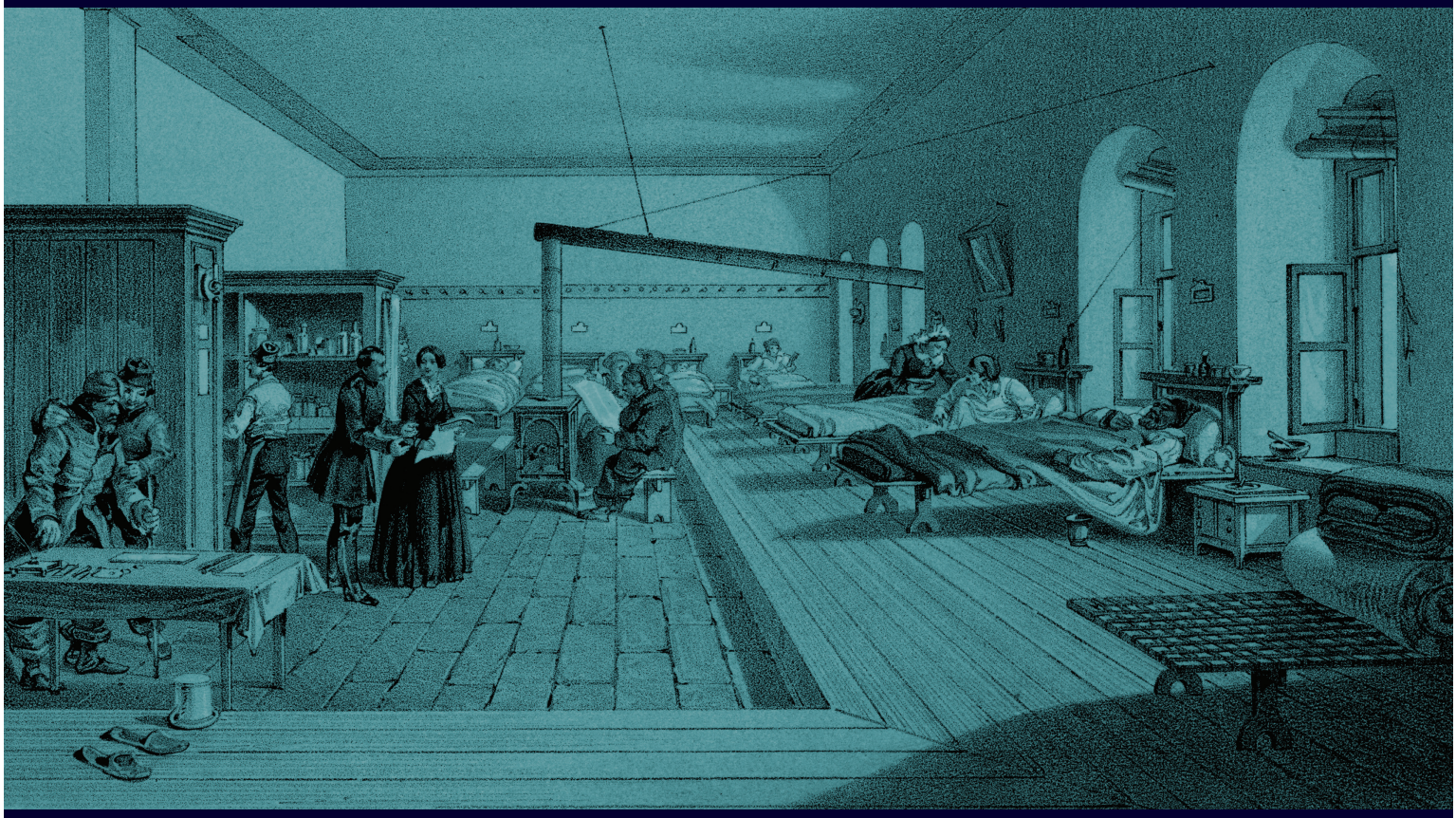
Healthcare Quality
Improvement Partnership



Clinical Audit

A Manual for Lay Members of the Clinical Audit Team

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INTRODUCTION

The purpose of this manual is to provide an overview of the basic clinical audit process for the use of non-clinician members of the clinical audit team.

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Without whom this manual would never have come into being
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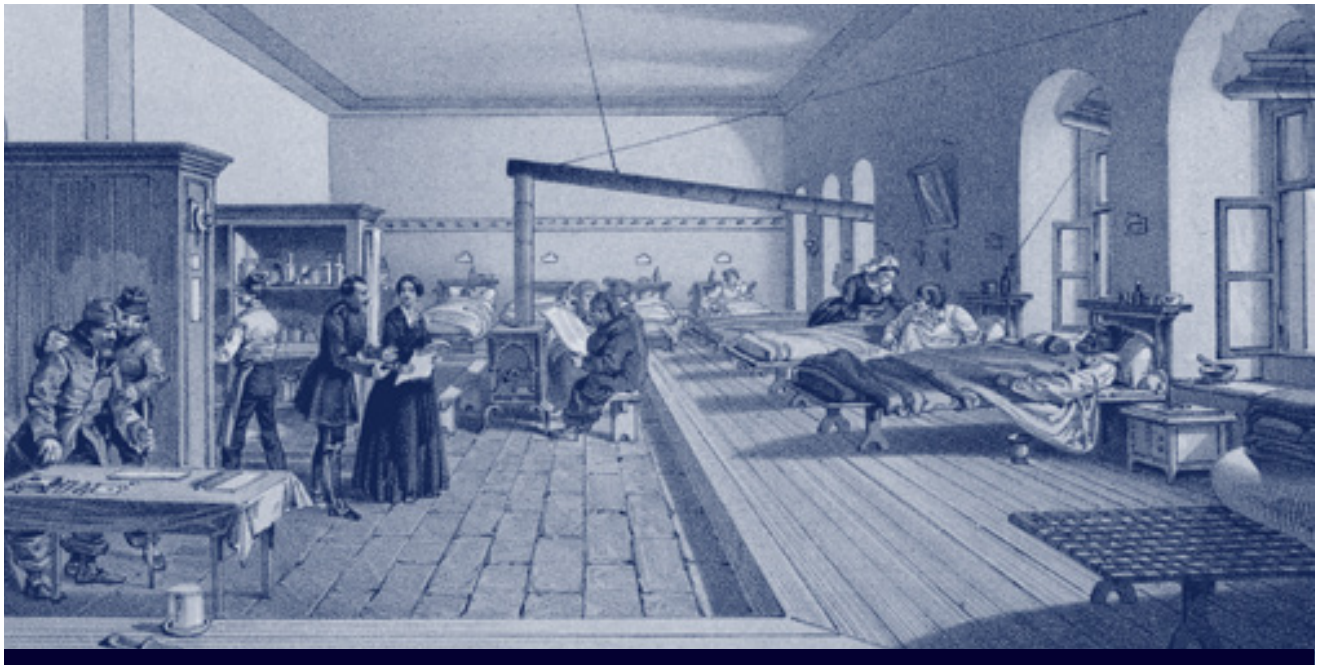


One of the wards of the Hospital at Scutari

BACKGROUND TO CLINICAL AUDIT

One of the first clinical audits ever undertaken was during the Crimean War of 1853-1855. Florence Nightingale was appalled at the unsanitary conditions and the high mortality rates of soldiers in the hospital at Scutari. She and her team of 38 nurses applied strict sanitary routines and standards of hygiene to the hospital and equipment. Miss Nightingale, who had a gift for mathematics and statistics, began to keep meticulous records of the mortality rates amongst the hospital patients.

Following the change of regime the mortality rates fell from 40% to 2% and were instrumental in getting Florence's procedures accepted by the Officers and Doctors. Her methodical approach, as well as the emphasis on uniformity and comparability of results of healthcare, is recognised as one of the earliest programmes of outcomes management.

Another famous advocate of clinical audit was Ernest Codman, (1869-1940); Codman was recognised as the first true medical auditor following his work in 1912 on monitoring surgical outcomes. Although his work is often neglected in the history of healthcare assessment, Codman's work anticipated contemporary approaches to quality monitoring and assurance, establishing accountability and allocating and managing resources efficiently. Whilst Codman's *clinical approach* is in contrast with Nightingales more *epidemiological* audits, these two methods serve to highlight the different methodologies that can be used in the process of improvements to patient care.

Despite the successes of Florence Nightingale and Ernest Codman, clinical audit was slow to catch on. Only a small minority of healthcare staff embraced the process as a means of measuring the quality of care delivered to patients for the next 130 years.

As concepts of clinical audit have developed so have the definitions used to describe the idea. The changes generally reflect the movement away from the *medico-centric* views of the mid-twentieth century to the more multi-disciplinary approach used in modern healthcare, which has seen the focus moved from a medical-professional centred view of health provision to that of a patient-centred approach. These changes can be seen in the following definitions:

"Working for Patients, 1989" – This White Paper defined medical audit, (as it was then known), as "**the systematic critical analysis of the quality of medical care including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome and quality of life for the patient.**"

Medical audit later evolved into clinical audit and a revised definition was announced, "**clinical audit is the systematic analysis of the quality of healthcare, including the procedures for diagnosis, treatment and care, the use of resources and resulting outcome and quality of life for the patient.**" *(NHS Executive 1993)*

An article in the British Medical Journal, (BMJ), (4 July 1998), provides further explanation:
"**Clinical Audit forms an integral part of the Clinical Governance of a healthcare system and Clinical Governance is the framework through which NHS organisations are accountable for continually improving the quality of services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.**"

The National Institute for Health and Clinical Excellence, (NICE), published *"The Principles for Best Practice in Clinical Audit* in 2002, which defined clinical audit as, "**a quality improvement process that seeks to improve patient care and outcomes through a 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 to healthcare delivery.**"

Although NICE provided an excellent technical definition of clinical audit, it is an overly long and complicated explanation and although the language may have changed over time, the 1989 White Paper provides a much clearer description of what is required: "**Audit involves improving the quality of patient care by looking at current practice and modifying where necessary.**"

Nevertheless all these definitions are intended to embody three key attributes:

- Recognisably high standards of care
- Transparent responsibility and accountability for those standards and
- A constant dynamic of improvement

Patient involvement in clinical audit is relatively new and is still growing. Iain Thomas, Myocardial Ischaemia Audit Project, (MINAP), Lay Representative is quoted as saying, "**clinical audit must include patients. They, as well as the clinicians, are the true professionals in illness. The Doctor may be highly qualified to diagnose and give treatment, however only the patient truly knows the pain, physical and psychological, and the stress of living with an illness. The patient's voice is an invaluable part of audit.**"

PART ONE

WHAT IS CLINICAL AUDIT?

"Clinical audit can be described as a quality improvement cycle that involves measurement of the effectiveness of healthcare against agreed and proven standards for high quality, and taking action to bring practice in line with these standards so as to improve the quality of care and health outcomes."[1]

Clinical Audit forms the system for improving standards of clinical practice. Aspects of patient care are evaluated against expected standards of care and where necessary, changes are made at an individual, team or service level. A re-audit can then be used to confirm that improvements have been effective.

Topics for clinical audit should reflect national and/or local priorities of areas of concern, for example, national priorities might include Cancer Services or National Service Frameworks, (NSFs), whereas local priorities might include focusing on issues identified through local incident reporting or the introduction of best practice into local services.

Why is Clinical Audit Important?

Clinical Audit provides the framework to improve the quality of patient care in a collaborative and systematic way. When clinical audit is conducted well it enables the quality of care to be reviewed objectively within an approach which is supportive, developmental and focused on improvement. Benefits of clinical audit include:

- Promotes and enables expected practice
- Provides opportunities for education and training
- Builds relationships between clinicians, clinical teams, managers and patients
- Leads to improvements in service delivery and patient outcomes

Who should be involved in Clinical Audit?

Everyone who is involved in the care a patient receives and anyone who might be affected by the results, such as those who might be asked to change practice. If the audit has implications on professionals or disciplines in other areas, these should be consulted at the planning stages.

[1] Burgess, R. (ed), 2011. New Principles of Best Practice in Clinical Audit. 2nd ed. Radcliffe Publishing Limited

Furthermore it is important that clinical audit is supported by those who have the authority and commitment to see changes put into practice. It is now recognised that services cannot be improved unless patients are involved. In the words of the White Paper, *"Liberating the NHS",* (2010), "**nothing about me without me**". It is a requirement, based in legislation, that the NHS has a duty to involve patients and that Patient and Public Involvement is embedded in core business.

Some areas of the NHS are better than others in involving patients and their representatives. Until recently Clinical Audit has been the sole domain of clinicians and other health professionals. This is about to change.

What is the Audit Cycle?

The Audit Cycle demonstrates the steps involved in a complete audit. When a clinical audit reveals the need for improvements to a service it is important that a re-audit takes place following implementation of changes. Sometimes it will take several re-audits to improve a service and "close the loop".

STAGE 1 - PREPARATION:

Choose a topic:

- Preferably one which is a high priority for the organisation
- This may involve areas in which there is a high volume of work, high risks or high costs of care, or an area identified as a priority by patients

Identify available resources, e.g.:

- The organisation may have a local Audit Lead or office
- There will be existing guidelines defining desired standards for the area chosen

Select the criteria:

- Define the criteria **-** this should be in the form of a statement, e.g. All patients with hypertension who smoke should be offered smoking cessation advice
- Define the standard **-** usually a target (percentage) this may be a minimum standard or an optimal one, depending on the scenario.

STAGE 3 - MEASURING LEVEL OF PERFORMANCE:

Collect the data:

- May be from computerised records, manual collection, or both
- May be retrospective or prospective

Analyse the data collected:

- Compare actual performance with the set standard
- Discuss how well the standards were met
- If the standards were not met, note the reasons for this (if known).

STAGE 4 – MAKING IMPROVEMENTS:

- Present the results and discuss them with the relevant teams in the organisation
- The results should be used to develop an action plan, specifying what needs to be done, how it will be done, who is going to do it and by when.

STAGE 5 - MAINTAINING IMPROVEMENTS:

- This follows up the previous stages of the audit, to determine whether the actions taken have been effective, or whether further improvements are needed
- It involves repeating the audit (i.e. targets, results, discussion); hence the terms “audit cycle”.

Differences between Audit, Research & Service Evaluation

Studies have demonstrated that research, and clinical audit or quality improvement studies cannot be distinguished in a reliable or valid way. Research is about creating new knowledge and helps answer the question "**what is best practice?**". Clinical audit asks whether we are doing things we have agreed and should answer the question "**are we following agreed best practice?**".

In the past it was accepted that clinical audit did not require ethical review whilst research always did. This is no longer the basis for deciding whether or not an activity requires ethical review.

The table below outlines the main differences between research, audit and service evaluation.

CLINICAL AUDIT	RESEARCH	SERVICE EVALUATION
Based on facts, (standards)	Aims to establish what expected practice is	Designed and conducted solely to define or judge current care
Aims to evaluate how close practice is to expected practice	Is often a one off study	Identifies the standards that the service achieves
Is specific & local to one particular patient group, (results are not transferable to other settings)	Is designed so it can be replicated and results generalised to other similar groups	Measures current service without reference to a standard
Aims to improve services	Aims to generate new knowledge or increase the sum of knowledge	Usually involves analysis of existing data, but may include administration of simple interview or questionnaire
Is practice based	Is usually initiated by researchers	-
Never involves a new treatment	Is theory driven	-
-	Is usually testing a hypothesis and follows a protocol	-
May require Ethical review	Requires Ethical review	-

Do you want to measure current practice against evidence based clinical standards?
If the answer is yes – It is probably **Clinical Audit**

Do you want to investigate the effect of a new or existing treatment or technique on patients/carers? If the answer is yes – It is probably **Research**

Do you want to evaluate the effectiveness and/or efficiency of current practice or service?
If the answer is yes – It is probably **Service Evaluation**

Standards

Clinical Audit is the process whereby actual practice is compared against explicit standards of good practice. Once a topic has been chosen, valid standards must be selected which must be based on evidence, related to important aspects of care, and measurable. These standards describe the level of care we expect patients to receive.

Recommendations from clinical practice guidelines such as NICE guidance and National Service Frameworks (NSF) can be used to develop standards. Other sources of information on best practice can be obtained from literature such as peer-reviewed journals or expert opinion such as Royal Colleges or other professional bodies. If no evidence exists then local consensus of expected practice is acceptable. Identifying areas of expected practice are crucial to the audit as they form the standards against which we can audit.

Standards or Criteria

When drawing up standards the following needs to be considered:

- What we should look for to tell us if we are providing quality - **the evidence**
- How frequently we should expect to find the "evidence" if we are providing quality – **the percentage or proportion expected to meet the standard, (or target)**
- If there are cases or times the evidence might not be followed but it would clinically justified – **the exceptions**
- How we will define the evidence and exceptions for data collection – **definitions and instructions for data collection**

A standard is an explicit statement describing the area of care that is being measured:

It must relate to a specific area of care and should give unambiguous specific boundaries

- It must be possible to physically measure aspects of the standard to allow comparison
- There is no point auditing against standards that are not achievable either due to resource or clinical limitations
- They should be evidence based
- Standards must be timely and should reflect current practice rather that what was done two years ago.

Standards can also be classified into those concerned with:

Structure	-	What you need
Process	-	What you do
Outcome of Care	-	What you expect

Targets

The aim should be to achieve 100% compliance with standards at all times.

Example 1

STANDARD	TARGET	EXCEPTIONS
Patient's full name and hospital number must be on each sheet of health record	100%	None

However for various reasons, e.g. patient choice or the introduction of a new procedure, it may not always be possible to meet this level of performance. It is therefore acceptable to set lower standards of achievement in some areas.

Example 2

STANDARD	TARGET	EXCEPTIONS
Patients seen within 20 minutes of appointment time.	80%	None

Incremental increases in target levels are often used as a way of demonstrating continual improvement and progress towards a 100% target.

Example 3

STANDARD	TARGET	EXCEPTIONS
Patients seen in six weeks. Patients seen in six weeks Patients seen in six weeks	80% Yr 1 90% Yr 2 100% Yr 3	None

PART TWO

HOW TO SET OBJECTIVES

Why set objectives?

To audit successfully and in order to stay focused, it is necessary to decide why there is a need to carry out the audit and what is going to be achieved by doing it - that is the objective of an audit.

Objectives are specific statements which describe which aspects of quality are going to be measured in order to show that the purpose of the audit has been met. It is not uncommon for an audit to have more than one objective.

Clearly stated audit objectives give the audit project team:

- A specification of the purpose and the scope of the audit
- A shared understanding of what the audit is to achieve
- A way of informing others about the purpose and scope of an audit
- A basis for keeping the audit focused and preventing it from losing direction or becoming too big
- A consensus on what is realistic and achievable
- A means by which to judge the success of an audit
- A focus for writing the audit report.

How to construct an objective

Objectives demonstrate the aspects of service or delivery of care to be audited. Verbs such as “determine”, “ensure”, or “assess” are commonly used in setting objectives. These verbs convey the intention to measure the current practice and hence identify where improvement may be needed.

Objectives can also include an indication of the feature of quality that is going to be measured. For example this may be whether the service or delivery of care is appropriate or timely. It is vital to make objectives clear and unambiguous. Any abbreviations or acronyms must be defined. This will ensure that there is no confusion over the intention and focus of the audit project.

Example:

Taken from an audit of consent to treatment:

- To assess whether consent forms are appropriately completed
- To determine whether patients are being offered their copy of the consent form
- To establish that consent is obtained by a healthcare professional who is entitled to do so.

What if there are a large number of objectives?

Be aware that there needs to be a careful balance between setting objectives to cover all aspects of care where assurance of quality is needed, whilst keeping the project manageable. Audits frequently lead to improvements in practice. The more objectives there are, the wider the scope of the audit, and hence the more improvements that may be needed. If a project has a large number of objectives, it is worth considering whether the scope is too large for one project. It may be preferable to divide the objectives into two or three smaller audits. Undertake one audit, then implement any changes, give time for these changes to become embedded in practice and then go onto the next objective.

PART THREE

HOW TO SELECT AN AUDIT SAMPLE

Populations and Samples

Clinical audit involves comparing some aspect of patient care against an agreed standard. The patients who have received this aspect of care are known as your "**Audit Population**".

Ideally a clinical audit should include all patients but this can be impractical due to resource or time constraints. To make the audit more manageable, we need to select a smaller sample of this population whilst ensuring that the sample is representative of the whole population.

What is an appropriate sample size?

Clinical audit is not research; a research study often needs large numbers of subjects to show which intervention is best, clinical audit only needs to determine if practice complies with standards. You can usually get the information you need from smaller sample sizes.

However, there is no magic number as to exactly how many subjects should be included and it will depend on the area being evaluated, the amount of information being collected, how easy it will be to obtain that information and the resources available for data collection.

How to choose a sample?

Random sampling methods will return a sample which is more representative of the overall population and assumes that this population remains the same throughout the period being audited. There are a number of ways to choose a random sample:-

1. **Simple random sampling** – Cases are selected in a random way which ensures that each case has an equal chance of being selected e.g. by using a computerised random number list or drawing random numbers out of a hat.

2. **Stratified random sampling** – The population is divided into groups depending on characteristics they share in common e.g. diagnosis, age, gender, ethnicity. A random sample is then selected from each group.

3. **Interval random sampling** – The population is arranged in order and the first case is then selected at random. The rest of the cases are then selected at pre-defined intervals, e.g. every 3rd or every 5th patient.

4. **Rapid-cycle sampling** – This method can be used when it is known there may be a problem and the results are needed as quickly as possible. Here you carry out the audit with a relatively small sample group, implement changes and then re-audit using another small sample to determine whether improvements have been made. This method uses lots of small data sets to monitor care and can make the change cycle quicker to complete.

Other sampling methods

There are other ways of choosing an audit sample. However, care should be taken when using these as audit samples may end up less representative of the audit population:

5. **Purposive sampling** – Cases are selected specifically because they share particular characteristics, for example, diagnosis, age, gender, ethnicity

6. **Convenience sampling** – Cases are selected for inclusion in the sample because they can be accessed relatively easily, for example, patients visiting heart clinic for a BP check on a specific day

7. **Quota sampling** – Similar to convenience sampling, steps are taken to ensure that subgroups of the audit population are represented in particular proportions, for example diagnosis, age, gender, ethnicity

8. **Consecutive sampling** – Samples are included from an agreed start date, for example all new heart patients from 1st September.

Sampling Bias

If you do not choose your audit sample carefully it can skew your audit results and give inaccurate information. It is important that you choose the most appropriate method of sampling for the given situation, ensuring that the audit is as robust as possible.

PART FOUR

CLINICAL AUDIT CONFIDENTIALITY AND ETHICS

Ethics

Clinical audit by definition does not involve anything being done to patients other than their normal clinical management. Therefore it does not usually require formal ethical approval unlike research. This does however mean that it is essential that projects undertaken in the name of clinical audit are not in fact research.

All clinical audits must be conducted within an ethical framework. In practice this means that consideration should be given to such issues as confidentiality and disclosure of audit results.

Data Protection Act

All personal identifiable data relating to a living individual is subject to the conditions of the Data Protection Act 1998. This Act requires that the data collected for a clinical audit project must:

- Be accurate, relevant to the project's objectives and must not be excessive in quantity.
- Not be used for any other purpose than the audit.
- Not be kept any longer than is necessary.
- Be kept secure at all times. This includes information on paper, and data held on computers, discs, & USB pens.

Caldicott Principles

The *Caldicott Principles* state that patient identifiable information must only be transferred for "justifiable purposes" and on a "need to know" basis. Please take advice from the *Caldicott Guardian* in your organisation before sharing any patient **identifiable** data with another health care sector or organisation.

Duty of Confidentiality

All NHS staff and volunteers are bound by a duty of confidentiality. If a person not employed by the Trust needs to access identifiable patient data, they must be issued with a contract by the Trust involved, which includes a confidentiality agreement.

Protecting Patient & Staff Confidentiality

Ideally a unique identification, (ID), code should be used to identify individual patients or staff included in an audit. This unique ID code should be used on data collection sheets, spreadsheets and databases. The key to these ID codes must be kept separately in a secure place; for example it should not be kept in the same folder as the data collection sheets. The key should be destroyed once the audit is reported.

Patient or staff identifiable data

Always consider whether you really need data to identify patients or staff. You must keep all patient and staff **identifiable** information secure at all times. This can be achieved by:

- Ensuring paper documents with patient or staff identifiable data are held in a secure environment, for example in a locked room or drawer at your place of work
- Ensuring sensitive documents are not left on display at any time, for example left on a desk whilst you take a break
- Ensuring sensitive documents are not removed from your place of work
- Ensuring that data is disposed of in a secure manner once the audit report is written
- Ensuring electronic data is password protected
- Ensuring electronic data is stored in a secure area on a server, not on a computer hard drive
- Ensuring data is not sent to an email address outside your place of work
- Ensuring information is deleted as soon as it is no longer essential
- Ensuring patient identifiable information is not removed from the workplace, for example on a USB or lap top computer
- Ensuring patients and staff are not identifiable in reports and presentations.

Under the Freedom of Information Act, anyone is entitled to apply for information relating to clinical audit.

PART FIVE

COMPARING PERFORMANCE AGAINST CRITERIA AND STANDARDS

This is the analysis stage, whereby the results of the data collection are compared against the criteria and standard. The end stage of analysis is concluding how well the standards are met and, if applicable, identifying reasons why the standards were not met in all cases.

In theory, any case where the standard was not met in 100% of cases suggests a potential for improvement in care. In practice, where standard results are close to 100% it might be agreed that any further improvement will be difficult to obtain and that other standards, with greater levels of non-compliance are a priorities for action. This decision will depend on the topic area, in some areas nothing less than 100% will be acceptable.

Analysing audit data

The basic aim of data analysis is to convert data into useful figures. Patterns in the data will tell you how well the area complies with the audit standards. It is important to identify how the data will be analysed before collecting it – this ensures that only relevant information is collected.

The main aim of data analysis is to answer the questions posed by the audit objectives. If the right data has been collected it will be easy to analyse and obtain the information needed.

Remember – Objectives are specific, achievable and measurable

Example:

Objective: To determine the number of patients referred inappropriately according to the Selection Guidelines.

Data Collection: Information relating to patient referrals and peer review to determine which referrals were inappropriate

Analysis: Compare the number of referrals against the number identified as inappropriate and calculate as simple average or percentage. In some areas more sophisticated statistical techniques may be required, particularly where large sample sizes are used.

Remember – Keep it as simple as possible

Although statistical techniques can be useful, it is important that the reader understands what the information means. If the results of audit are to improve practice and performance, the results and the analysis must be simple enough for **everyone** in the care process to understand.

Different types of data

There are two main types of data, *Quantitative* and *Qualitative.*

Quantitative data is concerned with definitive, numerical, factual and specific data, for example Yes or No; Age; Gender; Blood Pressure; Blood Groups. The analysis of this type of data is performed using mathematical techniques.

Qualitative data is usually descriptive and subjective based on personal values and opinions, for example complaints, and narrative responses to questionnaires. This data needs to be analysed differently and carefully due to the high levels of inference and interpretation that can be applied to the information.

Analysing Quantitative Data

Average is a measure of the "middle" value of the data set. There are three types of average:

- **Mean** – the mathematical average. All values are added and divided by the number in the list

- *Example 1*
- *4; 8; 12; 16*
- *Mean = 10 (The sum of the numbers) ÷ (the number of items in the list)*

  40 *4*

- **Mode** - the most frequently occurring item in a list

Example 2
Male; Female; Male; Female; Female; Female; Male
Mode = Female

The mode has the advantage that it can be used with non-numerical data while other averages cannot.

- **Median** – The median is the middle number of the group when they are ranked in order. (If there are an even number of numbers, the mean of the middle two is taken).

Example 3
1; 7; 3; 15; 13
Median = 7 (reorder the list to read 1; 3; 7; 13; 15. Remove the highest and lowest values until one is left. This is the median)
Example 4
1; 7; 3; 13
Median = 5 (since there are two elements in this remaining list, the median is the mean of these two values - 3 + 7= 10 ÷2 = 5)

- **Standard Deviation** – gives information about the spread of data around the mean. The value of standard deviation is compared relative to the mean. A large standard deviation, when compared to the mean, implies the data is widely spread whereas a small standard deviation implies the data is mainly concentrated around the mean. Standard deviation will influence your conclusions and findings when conducting clinical audits.

Example 5

Patients have a mean age of 32 years with a standard deviation of 1.2 years.
The majority of patients are 32 years and those who are not will be a year or so older or younger.

Example 6

Patients have a mean age of 32 years with a standard deviation of 10.5 years
Whilst the majority of patients will be 32 years, the ages of those who are not is spread across a much wider range, up to 10.5 years older or younger.

- **Confidence Intervals** – unless the audit population is small, a sample of subjects will be used. Confidence intervals indicate whether the information you have collected is the same as would have been collected had the whole subject population been audited. It is used to indicate the reliability of an estimate. (Calculating confidence intervals is a statistical technique and is unlikely to apply to the type of audits being considered here. If further information is required please contact the Audit Lead).

PART SIX

WRITING AN AUDIT REPORT

An audit report outlines the steps taken to complete the audit. It does not have to be lengthy or complex. Always ensure you include the following information:

1. Cover sheet

Include the audit title, service under audit, date of audit, Audit Lead and team and the NHS Trust logo.

2. Introduction

Include a paragraph about the service being audited, identify the target group and its role within the Trust.

The introduction should also provide background information covering the issues that have led to the audit being carried out, such as national interest, local priority, national service framework, NICE guidance or safety issues. Also includes details about why the audit was undertaken and which standards where applied.

3. Aim and Objectives

Aim – the purpose of the audit - what the audit is intended to achieve
Objectives – the objectives breakdown the overall purpose (aim) into more detailed and specific components.

4. Standards

Include a list of the standards of expected practice against which the audit compared current practice.

5. Methodology

Explain how you approached the audit, the steps you took to get your results and a description of the methods used. This section includes details of how you collected your data, such as from clinical notes, computer systems, and individual patients, and the tools used to collect the data, such as questionnaires or telephone interviews. Details of who analysed the data, whether an external agency was used or if the clinical audit team carried out the necessary analysis will also be included. Copies of data collection sheets or questionnaires must be included as annexes.

6. Size and Scope

This section includes:

- Who was involved in the audit
- Sample sizes or exclusions
- Target group of patients
- Time period in which the audit was undertaken.

If questionnaires were involved include the distribution numbers, as a whole and per locality.

7. Results

This section presents the results of the data analysis, often in graph or table form. They should be easy to read with a summary of the analysis under each section if needed. *Response rates* and any deficiencies in the data are highlighted in this section. Data analysis should focus on finding out if the standards have been met, identifying areas for improvement and observing any trends that may assist in implementing improvements.

8. Findings

The findings should be presented in a way that indicates the achievement of each of the listed standards. Under each graph it may be useful to provide in text the key facts that can be drawn from each graph or table. You can also state any areas of improvement for the future.

9. Conclusion/Summary

This section draws together and summarises the findings of the audit. It should comment on the original aim and objectives and whether standards have been reached. It highlights the key findings and the most noteworthy points from which the conclusion can be drawn. Conclusions must be supported by the evidence within the results.

10. Recommendations

Recommendations set out what needs to be done as a result of the audit. This may include for example:

- raising awareness of the findings of the audit
- training and education on best practice
- increasing sample sizes next time.

Recommendations must be realistic. (There is a need to discuss and agree with service managers who need to action the recommendations, as they may have resource implications).

11. References

For any references you may have, use the Harvard style or take direction from the Audit Lead.

12. Appendices

Appendices are usually referenced within the report and can include:

- Additional or more in-depth information to that given in the report
- The project plan
- The guideline or protocol the standards are drawn from
- The data collection sheet/questionnaire.

13. Additional items to include in a re-audit report

Background – information should be provided about the previous audit and the key actions that were implemented as a result

Action plans – previous action plans must be evidenced when later re-audited and an assessment made of the success of any actions taken

Conclusion/summary – a progress report and comparison to the previous audit must be included. This can be contained as a summary or a table. Consider what has changed, either for the better or worse since the previous audit.

PART SEVEN

IMPLEMENTING CHANGE & ACTION PLANS

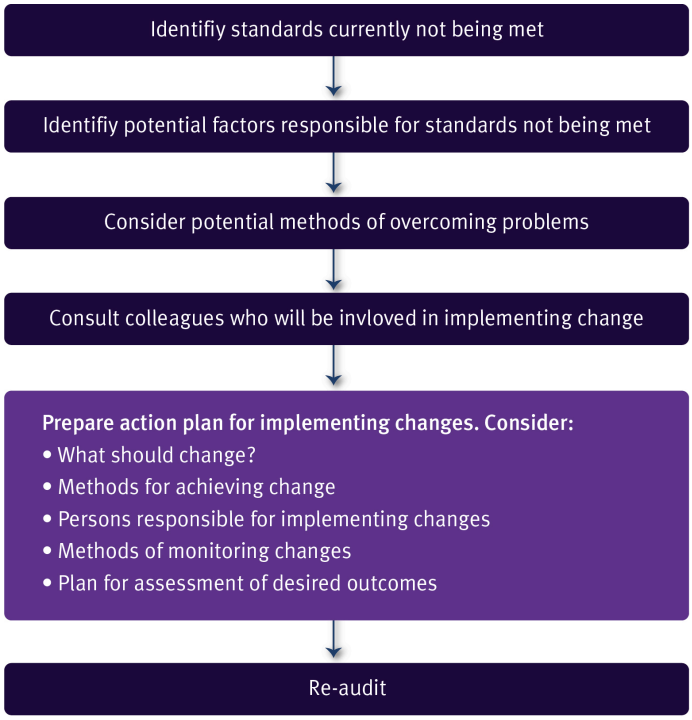
Implementing Change

Recommendations for change can be recorded in an action plan negotiated with the Service Manager.

Once the audit report has been accepted the Service Manager is responsible for implementing any changes to improve the delivery of care.

It is beneficial to have a meeting with all the people involved in the audit and the people tasked with implementing change to discuss the results to gain a full understanding of why improvements are required and where performance needs to improve.

The figure below summarises the stages involved in implementing changes.



Writing an Action Plan

Recommendations for change can be recorded in an action plan. This should include who has agreed to do what and by when. Each point needs to be well defined, with the person responsible named, and an agreed, realistic timescale for its completion.

An action plan is an important change management tool; however, to be effective an action plan must explicitly contain the following information:

1) Highlight what needs to change
2) Indicate the actions that must be taken in order to achieve change
3) Give a deadline by which time the actions must be carried out
4) Show who is responsible for making sure that the actions are carried out
5) Indicate the evidence required to prove that the actions have been implemented.

Action plans are live documents and will need to be updated and reviewed regularly to ensure progress is being made and maintained.

EXAMPLE ACTION PLAN

RECOMMENDATION	ACTION	LEAD/ CONTACT	TIMESCALE	
Share copy of audit results with service	Audit results to be copied to Managers in the area	Auditor	One month	Tick sheet
	Meeting with service staff to discuss results	Auditor Service Managers	One month	Minutes of meeting
Service staff to ensure effective record keeping takes place	Service staff to be given copy of record keeping policy guidance	Service Managers	One week	Staff to sign for their copy
	System of checks to be enforced	Staff and Managers	Two months Ongoing	Included as agenda item at staff meetings Individual performance challenged through staff appraisal system
Service staff to maintain improvements	Re-audit	Auditor	Six months	Audit report