

Clinical Audit

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The concept of clinical audit exploded in 1980s. It employed the quality management approach used in commercial management and applied that to the health care. The "Quality Initiative" was launched by the Royal College of General Practitioners in 1983 and it sounded very much like an audit, to define specific objectives for patient care and monitor the extent to which those objectives are met. The National Institute for health and Clinical Excellence (NICE) published the paper "Principles for Best Practice in Clinical Audit", which defines clinical audit as "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, 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 in health care delivery".

The clinical audit is a cycle and it is the heart of clinical governance. There are five stages in the cycle [1]. The cycle should be completed until success then followed with regularly monitoring the performance. Through these five stages and a good environment of audit, the clinical audit seeks to improve the quality of health care. The five stages are: 1) preparing for audit, 2) select criteria, 3) measuring performance, 4) making improvement, 5) sustain improvement.

How About the Effectiveness of Clinical Audit?

Walshe pointed out that the clinical audits sometimes did work and sometimes did not work and many times depended on who did it and how it was done [2]. Maxwell indicated that the clinical audit can be dangerous [3]. Clinicians may spend excessive time and effort on the audit instead of on their patients. There may be too much in the line of centrally led targets, service standards, penalty, data and budget discipline if the clinical audit operates poorly. Clinicians and service provider organization could be dealing with distortion, excessive time consumption and game playing such as giving false data to satisfy the auditors. Quite often data were submitted as a chore. The data could be distorted and extra time will be needed to write up some rhetorical

reports. Some clinical audit was done simply in order to survive in the health care business.

Despite over ten years investment in clinical audit by National Health Service (NHS), the NICE (National Institute for Clinical Excellence) reported a "mixed record" and list its flaws and shortcomings as the poor track record including poor project design, inadequate data, bad project management, lack of commitment, poor support and patchy follow up [2]. Nevertheless, there are many significant successes for clinical audit. Clinical teams in many local projects can deliver improvement in patient care because of the clinical audit. Some of the national projects played an important role in service-wide change and created improved access and quality of care throughout the country (the well-known national audit of stroke care, NICE, 2002, ix) [1]. Another example, the prevalence of pressure sores was 19% of the patient population in the initial audit of 1992. By 1997, it dramatically dropped to only 3% [4].

In summary, the clinical audit is a quality improvement process through systematic review of care against explicit criteria and with implementation of change to improve health care. It is a cycle; the repetition of the process is to sustain improvement in the health care. The efficacy of clinical audit in practice was reported as "mix record". There were some flaws as well as some successes. Future approach should focus more on how, who and why in clinical audits with more emphasis on professional commitment rather than on the excessive measurements of effectiveness.

References

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Received June 28, 2012; Accepted June 29, 2012; Published July 03, 2012

Citation: Chen M (2012) Clinical Audit. J Clin Exp Ophthalmol 3:e107. doi:10.4172/2155-9570.1000e107

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