Explaining the pitfalls and challenges of auditing

Most healthcare staff working in clinical practice will be aware of the numerous and ongoing audits that take place on what seems like a daily basis in their place of work.

Most will also agree that audit is a necessity. However, it is why we audit that seems to have become somewhat lost to many of us. I challenge you to ask yourself the question - have we become so caught up in getting the audits done that we have lost sight of the whole reason for the audits in the first place?

The Medical Council states that 'Clinical Audit can be defined as assessing, evaluating and improving the care of patients in a systematic way. Setting of standards, measurement of practice compared to the 'gold standard', identification of deficiencies and addressing deficiencies (closing the loop) is an accepted model of clinical audit'(Medical Council 2010).

National Institute of Clinical Excellence (NICE, 2002) definition of 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' is widely accepted and quoted within healthcare (HQIP, 2012; Pasquale Esposito, Antonio Dal Canton World J Nephrol. 2014; HIQA, 2017).

And yet we find that it is often just the act of completing the audit itself that has become the goal. In this era of constant demand for audit data from quality departments, Trust boards and accreditation bodies are we focusing on getting 100 per cent of the audits done as the target for our quality programme instead of focusing on the data we have collected and what it is collected for?

This I feel is the first challenge of auditing – Keeping the focus on WHY we are auditing. If we focus on WHY we audit, we will know that we must analyse the data collected to identify risks, patterns, trends and noncompliance for action so we can then identify what is needed to improve practice.

And here in lies challenge number two – Ensuring the audit data is meaningful.

One of the pitfalls facing us in healthcare is that auditing is not consistent. The standard of audit depends on the experience of the auditor. An experienced auditor will know instinctively just the right question to ask or the place to look for evidence of compliance while those inexperienced in this process will often miss non-compliances or possible risks.

Standardised, Consistent Auditing

And of course, this points to another pitfall of auditing, the fact that compliance and what is considered necessary to meet required standards, is often based on the auditor's opinion rather than specific measurable, quantifiable standards. This, of course, is not something that is unique to healthcare. This is challenge number three – Ensuring compliance is based on specific measurable standards and not the auditor's opinion.

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Indeed, I only have to look to my own opinion of a tidy bedroom (all clothes hung up neatly in the wardrobe), and compare that to my teenage son's opinion (a month's worth of clothes, both clean and dirty, piled high on a chair or, depending on the time of day, piled high on the bed) to know our opinion of the standard required to be considered 'tidy' is different. So what can we do to avoid these pitfalls and challenges of auditing?

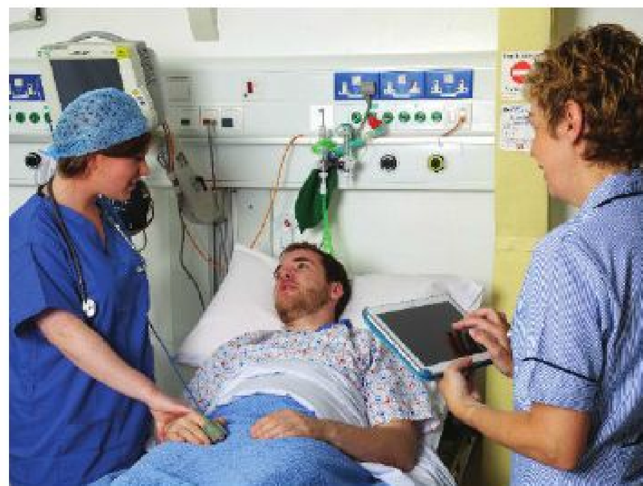
Clear Audit Questions

It would certainly make audit data more accurate if we could provide clear check lists for the auditor. Often the questions in an audit tool are ambiguous and left to the auditor to decide how to evidence compliance. For example, the question in the audit is worded, 'Staff are trained in Infection Prevention and Control (IPC)' rather than the more specific 'All staff working in the department have had training in IPC in the past 12 months – ask to see records'.

We should also provide clear directions on what to check to ensure every auditor checks the same things before recording a YES or NO against the check list. Using the same example above we would go on to explain:

'IPC training should be specific to the Healthcare worker's role and include the following at a minimum:

- hand hygiene and the five moments
- standard precautions and personal protective equipment
- management of patients with MRSA, VRE, CPE, C Difficile, Influenza etc.
- what to do in the event of a blood exposure incident '



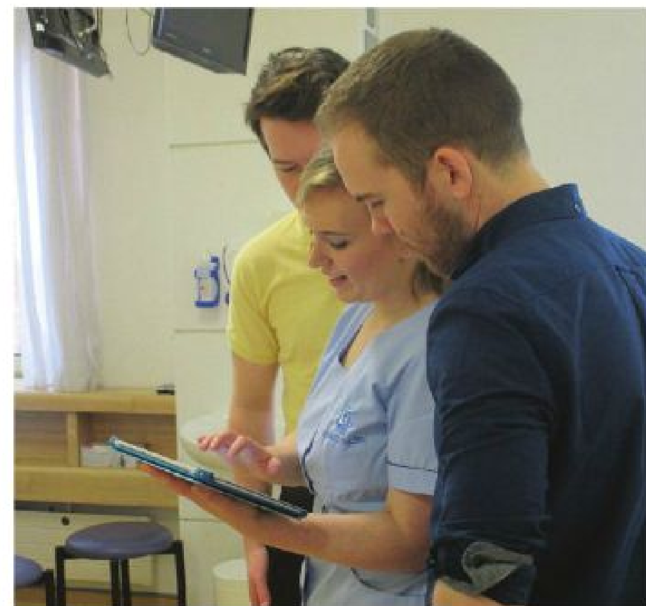
Consistent Hospital Auditing

By providing these clear instructions, step by step, on how to audit each element or standard and if possible some background to the reason for the standard in the first place, we are standardising the auditing process. We can then collect consistent accurate data that reflects the practice being audited, allowing us to compare the true practice against specific standards, regardless of who carries out the audit (NICE, 2002).

Utilising the audit process for quality improvement

Once we know we have dependable, accurate data collected we must tackle challenge number four – Utilising the audit process for quality improvement.

Unfortunately, many auditors do just that, audit. They secretly write down everything they see during the audit and then disappear to write the report and, hopefully, analyse the data. The feedback provided is then often delayed and non-specific. To be powerful, feedback needs to be provided verbally at the time of the audit as well as in written format later (Ivers et al, 2012).



Timely, specific, feedback

Let's use the example of a missed opportunity to clean hands.

If we can stop the person at the time and explain that a moment has been missed we can help them to understand why it was missed. Perhaps, as often happens, gloves were applied too early or hands cleaned before touching the patient's environment instead of immediately before touching the patient. The audit becomes an opportunity to teach and a powerful way to learn, surely better than recording the percentage compliance and walking away?

I ask you, will a puppy learn not to pee on the carpet if you chastise him or her a week after the peeing incident? I hasten to add, I am not for a moment comparing healthcare professionals to puppies… but do we not all need to have a context to understand where and why we have made an error, ifwe are to attempt to change our behaviour?

Safe in the knowledge that we are not only collecting accurate data, but also using the audit process for teaching and improving practice, we must tackle the final challenge of auditing. Yes – challenge number five – Close the audit loop.

Close the audit loop

Closing the loop on the audit process is a necessity - otherwise the same issues will be present on reaudit. If training needs are identified, then ensure they are addressed. It can be at the time of the audit, or an agreed later date, but address them with real examples and explanations as to why it's important. If the issue is process, then spend the time reviewing it with those involved and work together to find a solution.

Remember that closing the audit loop is not just about closing the issue for now… it is about closing the issue for good. What I mean by this is that it is not enough to simply correct the non-compliance. We must analyse why it is occurring, so we can deal with it and be confident it doesn't occur again.

Targeted Training and Education

When we identify a non-compliance during an audit, say for example a glucometer with blood splashes on it, we point out the issue and a healthcare worker cleans and decontaminates it and then we close the related non-compliance. But, because we have not dealt with the REAL issue, the issue that glucometers are not being consistently cleaned after use by everyone because the risks associated with a blood splash on a glucometer are not recognised or understood by staff, a similar non-compliance is identified over and over every time we audit. After all – he or she who complies against their will is of their own opinion still.