RCSI

PCS Audit User Guide

1 INTRODUCTION

The Medical Practitioners act of 2007 placed the legal duty on Doctors to maintain their professional competence. A framework under the act has been set out by the regulatory body, the Irish Medical Council, mandating not only the collection of 50 credits (internal and external) per year, but also the completion of a clinical audit every year. Since May 2011, the act has come into force meaning those enrolled on the specialist and general registers have to attain the standard 50 credits as well as performing 1 audit per year. The accounting year runs from May- April. Points must be collected during the relevant year, but maybe registered to that year, even after the year end.

The Medical Council suggest that an audit represents 12 hours of work. It may be shared providing that an active part has been taken by the doctor using it for credit.

When submitting evidence of Audit for the Professional Competence Scheme, in addition to meeting the criteria, the Audit must be either published (abstract / paper) – the published source outlined and or attach a scanned copy ***OR*** Audit evidence must be signed / verified by a consultant supervisor, clinical director or other appropriate clinician other than the registrant.

2 CLINICAL AUDIT

The RCSI has prepared these notes to aid in the preparation of your audit- it should not be considered an exhaustive review of audits, more information can be found on relevant websites including:

a. www.medical council.ie (information for doctors on PCS)

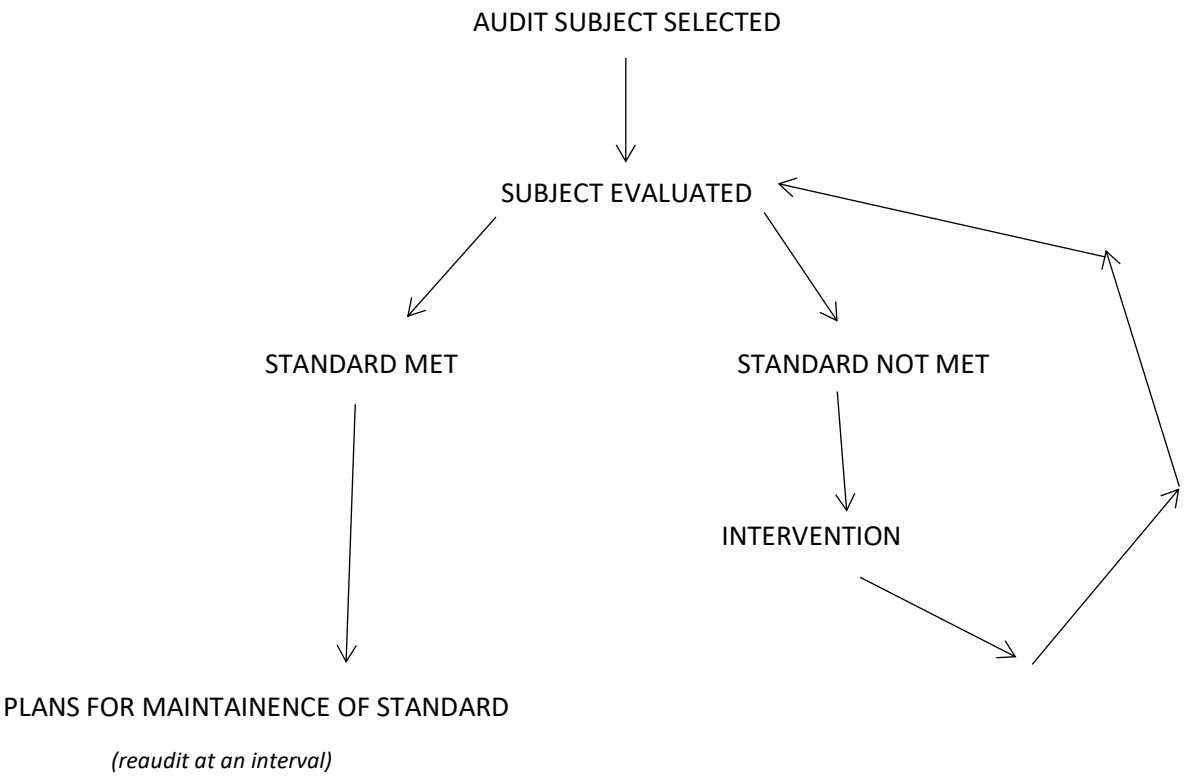
b. http://www.pdqa.gov.hk/english/qa/methodology/method_ca_audit.php

c. http://www.sign.ac.uk/guidelines/audit/index.html

d. http://www.rcsi.ie/retired-doctors

Various definitions of Clinical audit exist, all variations on the same theme. Early definitions such as the English Department of Health's ''Clinical Audit involves systematically looking at the procedures used for diagnosis, care and treatment, examining how associated resources are used and investigating the effect care has on the outcome and quality of life for the patient" (1993) are equally valid today. The Irish Medical Council asks that audits are mainly concentrated on the doctor's practice rather than processes in general, but obviously there is considerable overlap between hospital or surgery systems and individual practices.

There is one method, the clinical audit cycle. The basis is that once the audit subject is decided and evaluated it is then compared to a standard. If the standard is not met then an intervention is planned and re-evaluation occurs at an interval. If the standard is met then plans for maintenance of the standard are generated (Flow diagram).



Flow diagram: Algorithm for audit cycle

3 CLINICAL AUDIT METHODOLOGY

Clinical Audit is comprised of a number of steps, with improvements in aspects of care often achievable. It is therefore important that the audit subject has been selected based on the clinical suspicion and clinical priority assigned by the practitioner.

There are various method steps, the following is a useful template (modified from RCS/ RCP template):

1. Title
2. Reason/ Subject for the audit
3. Criterion or criteria to be measured
4. Standard(s) set / identified
5. Results (and dates of data collection) one (if standards met, skip to number 8)
6. Description of change(s) implemented
7. Results (and dates of data collection) two
8. Future plans for process improvement/ reevaluation

It is very important that the audit subject is clearly defined from the outset. The clearer the question the easier it is to identify relevant standards to compare findings. Where possible, dissemination of the audit should be to all relevant healthcare professional stakeholders.

4 CLINICAL AUDIT EXAMPLES

The recommended time for audit activity is 12 hours per year. This includes preparation time, data collection. Depending on circumstance (e.g. Hospital practice, independent practice, community, practice) this maybe be easily achievable through systems already in place or may require bespoke projects designed and implemented by the doctor.

Here are some examples of the structure of audits around topics. Obviously, audits require to be tailored to individuals practice requirements. It is useful to follow a standard structure and report it in the same way. The medical council can ask for documents related to the audit in selected cases. If enough information is included in your attached files to your audit (e.g. a structured abstract) this is less likely. We recommend that such a file is submitted along with your confirmation of having fulfilled your audit requirements for the year.

Should you have any audits you wish to include in this section as examples, we are delighted to received same, anonymised, to Ms Marie O'Boyle, Manager PCS, RCSI moboyle@rcsi.ie

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EXAMPLE 1: Specific treatment audit

These are the most common audit types. A treatment or a procedure is specifically selected and some part of that pathway is looked at in detail. When designing this type of audit, it is better to have an hour session with those conducting the audit, to make sure all the confounding variables are identified so they can be recorded/ accounted.

Title: Venous thromboembolism prophylaxis adherence.

Reason: To assess compliance of prescribing LMWH thromboprohylaxis among appropriate acute general surgical admissions.

Criteria/ Standard: Patients assessed per local hospital policy guideline 100% in non-trauma, non - haemorrhagic admissions.

Results 1: sample time identified (e.g. 1 month admissions) and data recorded on pre formed audit sheet (e.g. see SIGN audit tools), or retrospective review of 1 month if dataset already available. Confounders such as reason for admission, using other anticoagulants, risk stratification for VTE etc. accounted for a priori.

Standard met: then plan maintenance/ future plans

or

Standard not met: intervention (education of surgical teams and nursing)

Results 2: reevaluate with further sample time (1 month) and report

Future plans: reaudit in 2 years.

EXAMPLE 2: Monthly departmental morbidity and mortality meetings

*Evidenced attendance at regular structured hospital or departmental morbidity and mortality meetings **together** with identifying 1-2 areas each month to examine in greater detail/ and or plan an intervention to optimise care will be considered adequate in meeting the audit requirement. The following is an example is such an enhancement.*

Title: Superficial Surgical Site infection rates for clean-contaminated surgery.

Reason: Perceived increase in SSSI rates among open appendicectomy cases

Criteria/ Standard: International standard of up to 15% rate

Results 1: sample time identified (e.g. over 3 months admissions) and data recorded on pre formed audit sheet, or retrospective review of 1 month if dataset already available. If rate unacceptable, the mining data for confounders.

Standard met: then plan maintenance/ future plans

or

Standard not met: intervention (prophylactic antibiotics, patient warming, tissue handling, move to more use of laparoscopic appendicectomy)

Results 2: reevaluate with further sample time (1 month) and report

Future plans: Plan to reaudit if monthly rates exceed 15%.

EXAMPLE 3: PATIENT SATISIFACTION BASED AUDIT

There is a vogue for evaluation of your practice by 'stakeholders' including the most important stakeholder, the patient. There is an Irish tool in development but Canadian and UK based tools are searchable online. It maybe that you want to evaluate 1 part of your practice, e.g. your Outpatients. The questionnaire should be designed over time with specific headings in mind. Non directional questions used, ideally with a Likert (1-5, 1 is strongly agree, 5 is strongly disagree) type answers. The more simple and focused the tool the better to answer the specific question.

Title: PATIENT SATISFACTION REGARDING CONFIDENTIALITY AT SURGICAL OPD.

Reason: Examine patients perception of whether their confidentiality is respected at a telemedicine surgical OPD

Criteria/ Standard: None known; can be compared with a conventional OPD sample.

Results 1: Prospective questionnaire given to a two week sample of patients after a telemedicine appointment over the internet. Questions developed around headers such as Confidentiality, Preservation of Dignity and overall satisfaction with their telemedicine appointment.

Standard met: defined by acceptability when compared to conventional OPD.

or

Standard not met: intervention (patient education re concern of doctor regarding confidentiality, safeguards etc.)

Results 2: reevaluate with further sample at an interval (e.g 1 month) and report

Future plans: reaudit as required

EXAMPLE 4: MEDICOLEGAL CASE AUDIT

If your practice involves medicolegal reporting/ being an expert witness, it is reasonable to undertake an audit of the process related indicators such as time to report generation, numbers of solicitor requests for additional reports/ clarification etc.

Title: To evaluate efficiency of Medicolegal practice.

Reason: To assess response time to requests and adequacy of response.

Criteria/ Standard: Issuing report within 4 weeks of assessment (arbitrary standard).

Results 1: sample time identified (e.g. 3 month retrospective cases) and data recorded on pre formed audit sheet, with reasons for failing to issue report within the timeline (e.g. not enough data, awaiting diagnostics, unable to give prognosis, non payment etc)

Standard met: then plan maintenance/ future plans

or

Standard not met: intervention depending on common reasons

Results 2: reevaluate with further sample time (1 month) and report

Future plans: reaudit if delayed submissions are perceived to exceed 25%.

EXAMPLE 5: TEACHING AUDIT

If your practice involves teaching, most university affiliated sites will have some form of teacher based performance assessment. This is where the learners provide feedback to the colleges regarding teachers performance. These are not always shared effectively with the teachers and it is reasonable to ask for data which you can then assemble an audit around. It is important that you ask specific questions relating to specific aspects of your teaching and not just how 'good' you are at teaching. It can be difficult to identify key aspects of your teaching practice to assess, but most universities will be able to give you help in identifying the specific tools you may need.

Title: Evaluating teaching style of doctor.

Reason: To assess learner perception of content at small group tutorials.

Criteria/ Standard: Comparison with university standard or previous personal standard

Results 1: sample time identified (e.g. 1 term of tutorials) and questionnaires delivered (ideally not by teacher) to learners immediately after sessions

Standard met: Unless university has pre-developed standards, the first time you conduct this type of audit you will be developing your own baseline standard for future comparisons.

or

Standard not met: intervention (e.g. go on teaching the teachers course, add novel/ innovative teaching method, organise focus groups, invite independent review of teaching practice etc.)

Results 2: reevaluate with further sample time (1 month) and report

Future plans: plan to reaudit or investigate some other parameter in teaching practice

EXAMPLE 6: PROCESS AUDIT

The Medical Council prefers you to develop audits based on your practice. It is reasonable, if a specific area of concern in your practice exists, it perform a process audit to aid in practice improvement. These audits are best conducted with business intelligence officers/ clerical staff within your organization.

Title: Evaluating doctor outpatient waiting list assignment and length.

Reason: To assess correct assignments of received referrals for OPD. To assess length of waiting list capacity and time.

Criteria/ Standard: HSE standard of assigning urgent (level 1) or routine (level 2) to all outpatient refferals. Percentage aherence to guideline patient treatment list standards (PTLs).

Results 1: sample time identified (e.g. 6 weeks of OPD referrals). Audit of correct assignment based on clinical data presented in referral.

Standard met: Unless university has pre-developed standards, the first time you conduct this type of audit you will be developing your own baseline standard for future comparisons.

or

Standard not met: intervention (e.g. standardised referral form, community education sessions for referrers etc.)

Results 2: reevaluate with further sample time (6 weeks) and report

Future plans: plan to reaudit or investigate some other parameter in practice process