A review of the literature on the nurse role in clinical audit

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Delivering quality in the NHS is not a new concept. However, the recent focus on clinical governance has resulted in the need for effective methods of systematically reviewing quality. Clinical audit is a tool that has been created for this purpose. This literature review assesses the benefits of clinical audit and critiques the nurse’s role in the process, addressing any barriers to their involvement.

The belief that clinical staff should be continuously seeking to improve patient care is almost as old as the professions themselves (Morrell and Harvey, 1999). In terms of nursing practice, the phrase quality assurance was used to describe this process with the emphasis on setting standards, comparing practice and taking action (Pearson, 1987). However, the recent focus on quality in NHS policy (Department of Health, 1998) has resulted in a determination to produce transparent quality standards and adopt a systematic and critical approach to measuring practice (Kinn, 1995) usable by each of the clinical professions. Clinical audit, or as Quinn (1998) prefers, patient care audit, is just one tool that is seen as essential in ensuring quality patient care.

This literature review will first address how and why the concept of clinical governance emerged, then focus on clinical audit as it developed from within the clinical governance framework. Several electronic databases were searched to examine alternative terminology (Box 1). Other literature, such as DH publications and general management texts, was used. A lack of studies about nurses’ views on clinical audit and the barriers to its implementation was noted, which may be an indication of its low priority in UK nursing.

**Context**

Quality in the NHS has been a political priority for many years (Thomas, 2000). However, the emergence of a clinical governance framework following the 1997 general election (Stephens and Bick, 2002) has refocused attention on the need for quality. The Labour government emphasised the importance of evidence-based clinical practice (DH, 1999a) to ensure interventions were proven to be effective, that staff were up to date with research and that costs could be justified (Muir Gray, 2001).

The white paper The New NHS: Modern, Dependable made it clear that clinical judgements must be linked with set national standards. Two further documents published by the DH, A First Class Service (1998) and Clinical Governance (1999) developed this concept. The need for quality improvements had been established and the three main elements were defined as:

- Setting clear national standards;
- Ensuring local delivery;
- Monitoring the delivery.

The NHS Modernisation Agency was set up to support clinical audit initiatives (NHS Modernisation Agency, 2003).

**National evidence-based standards**

National clinical practice standards are increasingly being accepted throughout the NHS. These are a result of research and systematic reviews and make evidence available nationwide (NICE, 2002).

The DH has developed two main strategies for the creation of national standards: those compiled by NICE, which draws on systematically reviewed research to produce guidelines for safe, quality treatments; and national service frameworks (NSFs), which are guidelines offering evidence of effective interventions.

However, NICE has particular areas of priority and NSFs only target specific populations, so there is still a need for local standard setting. One method of achieving this is by benchmarking as in the Essence of Care document (NHS Modernisation Agency, 2003).

**Defining clinical audit**

Clinical governance is an umbrella term for any strategy that ensures local delivery of care is continuously improved (DH, 1998). One of these strategies is clinical audit (Heard, 1998), which has been defined by Currie (2003) as: ‘a process to improve patient care through the regular review of care against clear standards, and the implementation of change’.

This is similar to the notion of quality assurance mentioned previously but within clinical governance improvements must be continuous. So clinical audit should not be viewed as a single exercise but as a cyclical process (NICE, 2002; Hallett and Thompson, 1999).
The nurse’s role

The information produced by audit will only be useful if it is carried out correctly and the data collected is only as good as the tool used (Murphy-Black, 2000). Since nurses constitute the majority of ward staff, clinical audit that does not involve nurses cannot truly represent patient care.

In order for nurses to be involved in audit, nurse managers must utilise the many tools and strategies available to simplify the process while ensuring it remains systematic and effective. Morrell and Harvey (1999) believe that ‘change agents’ are needed if this change is to be truly achieved. The first change agent is a nurse manager who empowers, encourages and enables staff to undertake audit by providing the necessary support and resources.

The second change agent is an opinion leader. Staff rarely change their behaviour as a result of a memo or written instruction but are more likely to change as a result of a conversation with an opinion leader, a respected colleague or specialist, who has convinced them of its merits (Lomas, 1991).

The third change agent is a facilitator – a professional who is external to the ward. They may be part of the trust’s clinical governance department or just have expertise in audit. An example of this is buying the services of a benchmarking coordinator who can assist in standard-setting and comparing practices (Stark, 2002).

The fourth agent is an innovator. Put simply, this is a member of ward staff who is happy to embrace change. Often their enthusiasm encourages peers to do the same. If these four change agents are available and utilised, Morrell and Harvey (1999) believe nurse-led clinical audit becomes achievable.

Essence of care

The NHS Modernisation Agency (2003) has produced a revised Essence of Care toolkit to aid local clinical audit. This can be utilised by nurse managers to enable staff to benchmark good practice effectively and subsequently audit their own ward practice. However, nurse managers must have the confidence to adapt Essence of Care documentation to fit local needs and not be restricted by the areas benchmarked in the toolkit (Stark, 2002). In fact, if areas are chosen that are ward-specific priorities (Morrell and Harvey, 1999), a sense of local ownership may develop, which is an important factor for success (Anthony and Brooks, 2001).

There are criticisms relating to Essence of Care. The scale used to assess practice against benchmarks in the Essence of Care document relies on subjective judgements, meaning there is no inter-rater reliability (Burns and Grove, 1999). Without such reliability, the results may not correlate with the results from other areas meaning that accuracy and quality cannot be assured.

Potential problems

The first problem identified with nurse-led clinical audit is the additional workload (NICE, 2002). If the notion of change agents is addressed here, it becomes apparent that rather than key members of the team assisting with the audit cycle, the actual result is the onus being on a few skilled individuals (Chambers and Jolly, 2002). To solve this issue would require these few key individuals to have paid time allocated for audit, thus creating another problem.

There is already a lack of resources at ward level, so introducing clinical audit and paying nurses to undertake this process cannot be achieved without extra funds (Chambers and Jolly, 2002; NICE, 2002). It is not possible to justify leaving wards understaffed and underfunded to undertake audit unless instant results are attained (Ellis et al, 2000b), which is unlikely to occur.

Another difficulty relates to giving staff the skills to undertake audit. Varying levels of managerial support are available nationally (Ellis et al, 2000) but without good managers who can specify nurses’ role in audit and offer effective training and expertise, it becomes apparent that rather than key members

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REFERENCES


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audit will not occur (Smith, 2004; NICE, 2002). If audit is carried out incompetently and change is not implemented, then the cycle will be incomplete and will have been wasteful (Smith, 2004; Kinn, 1995). It could also be argued that it is unethical to carry out poor clinical audit as it wastes vital resources and if change is made as a result of the findings, it may be detrimental to patient care rather than beneficial (Morrell and Harvey, 1999).

Benchmarking to set standards for audit relies upon the sharing of ideas and evidence. However, it has been suggested that competition and mistrust remain embedded in the NHS despite the shift away from internal market policies (Ellis, 1995). Without sharing and access to the findings of others, benchmarking is impossible (Smith, 2004). Benchmarking may also disillusions wards and trusts that are consistently performing less well than other areas (Morgan and Murgatroyd, 1994), when they are in need of increased support.

As clinical audit is meant to improve patient care, a poignant criticism is the lack of patient involvement in the process (Smith, 2004). It should be noted that the Essence of Care benchmarks were created with patient involvement but the scoring of ward practice is undertaken only by clinical staff. The recent focus on clinical governance suggests quality can be identified, evaluated and managed (Ellis, 2000). However, not all aspects of quality care are empirically measurable. Essence of Care (NHS Modernisation Agency, 2003) has attempted to address some of these aspects, such as dignity and communication. Nevertheless, the challenge associated with quantifying these softer elements of care may explain why they are often omitted.

Attree (2001) is concerned that the omission of these intangible elements compromises the reliability and validity of clinical audit and fails to represent the multiple aspects of quality patient care. Therefore, only elements of patient care will be improved by clinical audit, not patient care as a whole.

**Discussion**

The cost of clinical audit as a barrier to its success is addressed within the literature (Chambers and Jolly, 2002; NICE, 2002). However, perhaps it should not be a case of ‘trusts cannot afford to undertake nurse-led audit’ but rather ‘trusts cannot afford not to undertake nurse-led clinical audit’.

The administrative costs of handling complaints and dealing with an increase in litigation are much higher than the cost of undertaking audit. An example is provided by Stephens and Bick (2002). They reviewed studies of pressure ulcer prevalence over the past decade and noted that the areas where prevalence was high were also the areas where litigation was on the increase.

Patients are increasingly demanding payments for the pain and suffering caused by inadequate risk assessment, which range between £4,500 and £12,500 per case. Factors contributing to these successful claims include poor communication and insufficient documentation – both areas where auditing is encouraged under Essence of Care.

As litigation becomes commonplace, it would be more cost-effective in the long-term to improve quality through clinical audit rather than pay out compensation claims resulting from poorly monitored standards.

**Conclusion**

Nurses need to demand the funding for time to undertake clinical audit. If other health professionals including medical staff have allocated time for audit, then nurses should expect the same privilege. Responsibility for quality is shared by individuals and organisations (Field and Reid, 2002) and as nurses constitute the majority of ward staff, their involvement is necessary to represent patient care. Without their involvement evidence will remain solely biomedical, resulting in the omission of the multiple aspects of quality patient care.

The introduction of foundation trusts in the UK may result in all trusts autonomously allocating their own budget, which is an ideal time for nurses to lobby for the right to undertake funded audit. However, unless nurses are recognised as key members in the quality improvement agenda, they will remain undervalued in comparison with other members of the multidisciplinary team. As long as nurse involvement remains undervalued, funding to release staff will remain unobtainable.

The apparent lack of literature investigating nurse-led audit, as compared with medic-led audit, suggests it has been given low priority in healthcare. This review recommends that further studies should be undertaken to address nurses’ views on clinical audit, as their lack of understanding or anxiety regarding the process may constitute a barrier to their involvement.