An Stiúrthóireacht um Ardchaighdeáin agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil

National Quality and Patient Safety Directorate
Office of the Chief Clinical Officer

HSE National Centre for Clinical Audit

Nomenclature

A Glossary of Terms for Clinical Audit

HSE National Centre for Clinical Audit

Reader Information

Title:	HSE National Centre for Clinical Audit Nomenclature - Glossary of Terms for Clinical Audit
Purpose:	The purpose of this Nomenclature document is to provide a glossary of agreed terms including a standard definition for clinical audit to be adopted across all healthcare services and clinical audit service providers
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Nomenclature

1. Introduction

We are very pleased to present the Nomenclature for clinical audit, which contains an agreed glossary of terms produced as part of the National Review of Clinical Audit (2019). The nomenclature should be adopted by the HSE and become the national standard for nomenclature for all agencies involved in clinical audit.

The National Review of Clinical Audit found that there have been inconsistencies in the language used across the Irish healthcare system in the area of clinical audit, quality improvement, research, and day-to-day care of patients.

The National Review extensively reviewed existing literature and subsequently agreed a glossary of agreed terms including a standard definition for clinical audit to be adopted across all healthcare services.

The consultation process carried out as part of the National Review highlighted that there is much confusion in relation to clinical audit in the Irish healthcare system. Much of the confusion was around what is and is not a clinical audit. The consultation process highlighted that the terms clinical audit, registries, and research are often confused. Across many sites where the focus groups were facilitated, many participants used the terms clinical audit and research interchangeably. This confusion with research may result in the misapplication of the strict General Data Protection Regulation (GDPR) interpretation from the Health Research Regulations 2018 to clinical audit, to detrimental effect. The National Review also highlighted a number of national registries that have been incorrectly identified as National Clinical Audits (NCAs). These are to be excluded from any published list of NCAs.

The controversy relating to the CervicalCheck Screening Programme in 2018 caused further confusion. The controversy arose from conduct associated with a number of look-back reviews. However, those look-back reviews were repeatedly misidentified as clinical audit, which has had a negative effect on the work of clinical audit. A definition for look-back reviews, consistent with the HSE Incident Management Framework (HSE, 2020), has been included to provide clarity.

Finally, the consultation process found that the terms ‘healthcare audit’ and ‘clinical audit’ are not widely understood as distinct activities by many staff in health service provider organisations. Healthcare audits can include both clinical and non-clinical audits, which further confused some of those consulted. For this reason, a definition of healthcare audit, provided by the HSE Quality Assurance and Verification Division (QAVD) is also included in this document.

There are also a number of different definitions for clinical audit across the healthcare system, resulting in confusion around clinical audit design. The definitions contained in this document aim to provide clarity with the clinical audit cycle.

This agreed list of definitions in the nomenclature should be adopted by all HSE staff and become the national standard for nomenclature for all agencies involved in clinical audit. This guidance is intended to strengthen clinical audit in Ireland and assist those carrying out clinical audits across Ireland through the provision of an agreed glossary of terms.

2. Agreed nomenclature

The agreed glossary of terms in this document, produced as a result of the National Review of Clinical Audit, should be adopted by the HSE, and become the national standard for nomenclature for all agencies involved in clinical audit.

2.1 What is clinical audit?

"Clinical audit is a clinically-led quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and acting to improve care when standards are not met. The process involves the selection of aspects of the structure, processes and outcomes of care which are then systematically evaluated against explicit criteria. If required, improvements should be implemented at an individual, team or organisation level and then the care re-evaluated to confirm improvements."

DOHC (2008, p. 152)

Clinically-led includes the breadth of clinical professionals working in health and social care services.

2.2 What is service evaluation?

"Service evaluation seeks to assess how well a service is achieving its intended aims. It is undertaken to benefit the people using a particular healthcare service and is designed and conducted with the sole purpose of defining or judging the current service."

Twycross and Shorten (2014, p. 65)

Unlike clinical audit, it does not compare the service to a predefined standard.

2.3 What is a registry?

"A clinical registry is described as a system which collects a defined minimum data set from patients undergoing a particular procedure or therapy, diagnosed with a disease or using a healthcare resource."

Hoque et al. (2019)

2.4 What is research?

"Research is designed and conducted to generate new generalisable or transferable knowledge. It includes both quantitative and qualitative studies that aim to generate new hypotheses as well as studies that aim to test existing or new hypotheses."

Health Research Board (2018)

2.5 What is a healthcare audit?

"Healthcare audit, in line with the design and practice of Internal Audit, is an independent, objective assurance activity designed to add value and improve an organisation's operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes."

HSE (2019a, p. 2)

"Under the HSE's Code of Governance, Healthcare Audit sits alongside and mirrors the organisation's Internal Audit function by providing 'third line of defence' assurance in relation to risks and controls in care related activities in both clinical and non-clinical settings. The HSE's Healthcare auditors are members of the Chartered Institute of Internal Auditors (CIIA) and are required to comply with the professional and general standards set by the CIIA."

HSE (2019a, p. 2)

2.6 What is the Maternal Death Enquiry (MDE) Confidential Enquiry?

In 2009, Ireland launched the Maternal Death Enquiry (MDE) Ireland. MDE Ireland was developed with the support of the Institute of Obstetricians and Gynaecologists, the HSE, the DOH, and the State Claims Agency. MDE Ireland is a stand-alone office, based in the National Perinatal Epidemiology Centre (NPEC) UK, and funded by the HSE. It uses the validated UK confidential enquiry methodology.

"A confidential enquiry is a systematic process of multi-disciplinary, anonymous review of all or a sample of defined cases occurring in a defined geographical area during a defined period of time. Where the numbers of a specific type of condition are few, for example maternal deaths, it is possible and generally necessary to review all the cases. Where numbers are large it is usual to take a sample of cases for review. The review can take place either by individual or paired reviewers or during a panel process. Comparisons of care are made against guidelines or best practice where guidelines have not been developed. The review aim is to assess the quality of care provided in each case so as to inform future practice and improvements in care which may make a difference to future outcomes."

National Perinatal Epidemiology Unit UK (2018)

2.7 What is a Healthcare Record Review?

A healthcare record review is where pre-recorded and person-centred data are used to answer one or more questions. The review is not part of direct patient care. It may be carried out for a number of purposes, including clinical audit, research, or incident review. The purpose will dictate the governance structures to be followed. It can also be referred to as a chart review or case review.

A healthcare record review for the purposes of audit collects pre-agreed datasets from a cohort of charts without reviewing the overall care or looking at the context of that care. These datasets are used as inputs to a clinical audit which aims to provide learning and subsequent quality improvement.

2.8 What is an Incident Review?

An incident review takes place after an individual patient safety incident has occurred. It involves

"a structured analysis and is conducted using best practice methods, to determine what happened, how it happened, why it happened, and whether there are learning points for the service, wider organisation, or nationally."

(HSE 2020, p. 3)

2.9 What is a Look-Back Review?

"A look-back review is a process that is initiated where it has been determined that a number of people have been exposed to a specific hazard. The process seeks to identify if any of those exposed to the hazard have been harmed and what needs to be done to ameliorate the harm. This process consists of three key stages: preliminary risk assessment, audit and recall."

(HSE 2020, p. 4)

2.10 What is Peer Review?

"Peer review is the professional assessment against standards, of the organisation of healthcare processes and quality of work, with the objective of facilitating its improvement."

McCormick (2012, p. 8)

2.11 What is a standard in healthcare?

"A standard is a definable measure against which existing structures, processes or outcomes can be compared."

NCEC/HIQA (2015, p. 9)

2.12 What is a clinical guideline?

"Clinical guidelines are systematically developed statements, based on a thorough evaluation of the evidence, to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances, across the entire clinical spectrum."

NCEC/HIQA (2015, p. 7)

2.13 What is quality assurance?

"Quality assurance is defined as all those planned and systematic actions necessary to provide adequate confidence that a structure, system, component or procedure will perform satisfactorily and comply with agreed standards."

HSE (2019b)

2.14 What is quality improvement?

"Quality improvement (QI) is the combined and unceasing efforts of everyone - healthcare professionals, patients and their families, researchers, commissioners, providers and educators — to make the changes that will lead to:

- **better patient outcomes**
- **better experience of care**
- **continued development and supporting of staff in delivering quality care."**

HSE (2016b, p. 4)

"All methods highlight the importance of accessing the unique knowledge that frontline staff possess and involving them in any change and improvement process. Improving the quality of care and sustaining it, requires all programmes to have a theory of change that is based on the application of improvement science."

HSE (2016b, p. 15)

3. Distinguishing clinical audit from other processes

There are a number of processes that are similar to clinical audit which can lead to confusion about which governance structures and guidance to follow. This section aims to provide clarity and highlight the key differences of these processes to clinical audit in tabular form and by using the Irish Hip Fracture Database (IHFD) as an example.

3.1 Differentiating clinical audit from other processes

Table 3.1 highlights the key differences of processes such as service evaluation, research, and registries to clinical audit.

Table 3.1 Differentiating clinical audit from other processes

Theme	Clinical audit	Service evaluation	Research	Registry
Definition	Clinical audit is a clinically led quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and acting to improve care when standards are not met	Service evaluation seeks to assess how well a service is achieving its intended aims. It is undertaken to benefit the people using a particular healthcare service and is designed and conducted with the sole purpose of defining or judging the current service	Research is designed and conducted to generate new generalisable or transferrable knowledge. It includes both quantitative and qualitative studies that aim to generate new hypotheses as well as studies that aim to test existing or new hypotheses	Registries are systems which collect a defined minimum dataset from patients with a particular disease, undergoing a particular procedure or therapy, or using a healthcare resource
Answers question	Clinical audit demonstrates whether a predetermined standard is being met	Service evaluation tells how well a service is working	Research demonstrates what should be done	Registries show the details of certain patient groups They can be used to answer both clinical audit and research questions
Purpose	To find out if best practice is being practised for quality assurance and improvement purposes	To evaluate current practices for information purposes. The information can inform management decisions	To generate new knowledge and find out what treatments, interventions or practices are the most effective	To monitor a patient population or healthcare process A registry may have an improvement aim, a cost focus or form an epidemiological database used for research
Context	Carried out at local or national level	Carried out at local level only	Carried out at local or national level	Carried out at national level only
Methods	Measures practice against evidence-based clinical standards	Measures current service without comparison against standards	Has a systematic, quantitative or qualitative approach to investigation	Carries out data collection and analysis
Research Ethics Committee Review	No, but ethical considerations should still be considered	No, but ethical considerations should still be considered	Yes	• Yes, if for research • No, if for others listed

3.2 Example from Irish Hip Fracture Database (IHFD): distinguishing clinical audit, quality improvement and research

Throughout this review, questions relating to the differences between clinical audit, quality improvement, and research have been raised. Clear definitions are now provided for all of these approaches to data collection.

Clinical audit and quality improvement are inexorably linked, in that measuring clinical practice against agreed standards is likely to lead to the identification of areas and aspects of practice that could benefit from quality improvement methodologies. Where clinical audit findings identify a need to pursue new information or to reach a new understanding, which is unrelated to the clinical audit standards, research can be undertaken. Exemplars from the IHFD are used to distinguish these processes.

The following example from the IHFD demonstrates how clinical audit can be used for both quality improvement and research projects, which are not in themselves clinical audit, to provide further clarity.

Clinical audit

The IHFD audit assesses care of hip fracture patients across six standards of care, one of which relates to access to surgery. One of the determinants of early access to surgery is admission to a hospital where hip fracture surgery is carried out.

The IHFD Report showed that 84% of patients with a hip fracture were brought directly to a hospital that could operate on hip fractures in 2014. One clear recommendation coming from the IHFD audit was that all patients with a suspected hip fracture should be brought directly to a hospital where hip fracture surgery is carried out (NOCA, 2015).

Making improvements — clinical audit leading to change

In 2016, the HSE National Clinical Advisor and Group Lead for Acute Hospitals, working with key stakeholders, instituted a national hip fracture bypass policy implementing this recommendation. In 2017, 92% of patients with hip fractures were brought directly to an operating hospital, an improvement of 6% from 2015 (NOCA, 2018b).

Creating new knowledge - research arising from clinical audit

In 2015, an orthopaedic specialist registrar, undertook a research project using data from the IHFD. The aim of the study was to generate new knowledge on the impact of admission route on the time to surgery, length of stay, and pressure ulcer development in patients who sustained a hip fracture in Ireland during 2013—2014. It was found that interhospital transfers predisposed patients to a prolonged length of stay (six days longer than those admitted directly), but did not result in a longer time to surgery or a higher rate of pressure ulcer development. The significantly prolonged length of stay may have both personal, medical, and social repercussions for these patients, as well as financial and capacity implications for the health service (Hughes et al., 2019).

References

For full bibliography and further information, please refer to:

Health Service Executive (HSE) National Review of Clinical Audit, November 2019

https://www.hse.ie/eng/services/publications/national-review-of-clinical-audit-report-2019.pdf

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About the HSE National Centre for Clinical Audit
National Quality and Patient Safety Directorate

The National Quality and Patient Safety Directorate (NQPSD) was established within the Office of the Chief Clinical Officer in Summer 2021, following the HSE Corporate Centre review. It merged a number of functions from the former national Quality Assurance and Verification Division (QAVD) and National Quality Improvement Team (NQIT). National QPSD is anchored in the HSE Patient Safety Strategy 2019-2024. It works to embed a culture of patient safety improvement at every level of the health and social care service. This is achieved through developing a collaborative culture aimed at repeating and improving on positive outcomes and minimizing adverse outcomes.

The HSE National Centre for Clinical Audit (NCCA) established within the QPSD, follows publication of the HSE National Review of Clinical Audit Report in 2019, and will be primarily responsible for implementing the report's recommendations. This step confirms the HSE's commitment to developing clinical audit as an essential quality and patient safety tool in Ireland, promoting improved patient outcomes.

Clinical audit is an integral component of safety in all modern healthcare systems and the programme will ensure delivery of a standardised approach. Establishing the HSE NCCA marks an important step in the HSE's continued efforts to improve the quality and safety of healthcare for patients. This will strengthen the development of an end-to-end process for clinical audit in accordance with the recommendations in the report and meet the needs of clinical audit service providers and multi-disciplinary stakeholders.

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