Ionad Náisiúnta d'Iniúchadh Cliniciúil
Cáilíocht Náisiúnta agus Sábháilteacht Othar
National Centre for Clinical Audit
National Quality and Patient Safety

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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Contact Details for further information:	HSE National Centre for Clinical Audit E-mail: ncca@hse.ie https://www.hse.ie/eng/about/who/nqpsd/ncca/
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Nomenclature

1. Introduction

We are pleased to present the reviewed and revised Nomenclature for Clinical Audit, which offers a glossary of terms that builds on nomenclature in the National Review of Clinical Audit (2019) and includes updates to align with the Patient Safety Act 2023 and other updated literature. 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 areas 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. This standard definition has been updated since the implementation of the Patient Safety Act 2023 as Part VI-Clinical Audit sets out the definition and criteria for clinical audit.

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 Guidelines for conducting a Lookback Review (HSE, 2022), has been included to provide clarity.

There are 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 and revised in 2025, 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 specific clinical standards or clinical guidelines and acting to improve care when clinical standards or clinical guidelines 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 specific clinical standards or clinical guidelines."

(Patient Safety (Notifiable Incidents and Open Disclosure) Act, 2023)

Following clinical audit, improvements, if required should be implemented at an individual, team or organisation level and then the care re-evaluated to confirm improvements.

(DOHC, 2008)

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

2.2 What is a National Clinical Audit?

The National Clinical Effectiveness Committee (NCEC) defines National Clinical Audit as: "A cyclical process that aims to improve patient care and outcomes by systematic, structured review and evaluation of clinical care against explicit clinical standards conducted on a national basis."

(NCEC, 2015).

In national clinical audits where it is not possible to include all of the population, the sample size should be statistically significant or sufficiently powered to allow meaningful interpretation of the findings.

2.3 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)

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

2.4 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., 2017)

2.5 What is research?

The HSE Action Plan for Health Research 2019–2029, adopted the definition of research as that of "the attempt to derive generalisable or transferable new knowledge to answer or refine relevant questions with scientifically sound methods."

(Terres, 2019 and NHS Health Research Authority, 2017)

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)

2.9 What is a Look-Back Review?

"A review where a number of people may have been exposed to a specific hazard in order to identify if any of those exposed have been harmed and how to take care of them. The Look-back Review process consists of four key steps:

1. **Consideration of the Preliminary Assessment Form (as per the Incident Management Framework) to identify the need for a Look-back Review**
2. **Implementation of a Look-back Review Risk Assessment to identify the need to progress to the Audit and Recall Stages of the Look-back Review Process**
3. **Audit Stage**
4. **Recall Stage."**

(HSE, 2022)

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)

2.11 What is a Clinical Standard in Healthcare?

"Clinical Standard means a statement which —

a. **specifies a level of healthcare outcome that is required to contribute to patient quality and safety,**
b. **sets out the care that patients should, having regard to a specific clinical condition, be offered by, or receive from, a health practitioner or healthcare provider (or both) for—**
   i. such specific clinical condition, or
   ii. the treatment and prevention of different diseases and conditions,
c. **is consistent with current evidence-based best practice, and**
d. **is measurable,**

and includes any such statement that is agreed for use, from time to time, at a national level or in respect of any region or other specific geographical area."

(Patient Safety (Notifiable Incidents and Open Disclosure) Act, 2023)

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)

"Clinical Guideline means a statement relating to clinical care –

a. That is used to assist in making decisions in relation to appropriate health care for specific clinical circumstances by –

i. a health services provider or a health practitioner (or both of them), and

ii. the patient and the health practitioner or the health services provider (or as the cases may be, both of them) where a decision is made in consultation with a patient,

and

b. Which is repeatedly subjected to systematic review and evaluation.

(Patient Safety (Notifiable Incidents and Open Disclosure) Act, 2023)

2.13 What is quality assurance?

"Quality Assurance is all the planned and systematic activities implemented within the quality system that can be demonstrated to provide confidence that a product or service will fulfil requirements for quality."

(American Society for Quality, 2025)

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."**

(Framework for Improving Quality (HSE, 2016) (adapted from Batalden, Davidoff Quality Safety Health Care, 2007))

"QI is a data-driven approach that involves identifying problems, analysing them, and implementing solutions to prevent them from recurring. It involves the use of a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement within a health care setting."

(The Health Foundation, 2021)

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 "the attempt to derive generalisable or transferable new knowledge to answer or refine relevant questions with scientifically sound methods." (NHS Health Research Authority, 2017)	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, 2018).

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 personal, medical, and social repercussions for these patients, as well as financial and capacity implications for the health service (Hughes *et al*., 2019).

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Cáilíocht Náisiúnta agus Sábháilteacht Othar
Oifig an Phríomhoifigigh Cliniciúil
National Quality and Patient Safety
Office of the Chief Clinical Officer

About National Quality and Patient Safety

National Quality and Patient Safety (NQPS) was established in mid-2021 as a result of the HSE Central Reform Review. NQPS is part of the HSE Office of the Chief Clinical Officer, and is led by Dr Orla Healy, National Clinical Lead, Quality and Patient Safety.

Purpose

Our vision for patient safety is that all patients using health and social care services will consistently receive the safest care possible by:

- Building quality and patient safety capacity and capability in practice.
- Using data to inform improvements.
- Developing and monitoring the incident management framework and open disclosure policy and guidance.
- Providing a platform for sharing and learning; reducing common causes of harm and enabling safe systems of care and sustainable improvements.

For further information, please contact:

HSE National Centre for Clinical Audit
Health Service Executive
Dr Steevens Hospital
Dublin D08 W2A8

e: ncca@hse.ie

w: https://www.hse.ie/eng/about/who/nqpsd/ncca/