



QI TALK TIME

Building an Irish Network of Quality Improvers

**Healthcare Audit for Understanding &
Improving
5th June 2018**

Connect

Improve

Innovate

Speaker

Speaker: Cora McCaughan MSc (Hons), BSc (Hons), Dip Project Management (With Distinction).

- Member of the Chartered Institute of Ergonomics and Human Factors (UK) and a Member of the Irish Ergonomics Society.
- Assistant National Director for Healthcare Audit within the Quality Assurance and Verification Division of the HSE.
- Chartered Physiotherapist, but she has worked in the area of human factors and system safety for the last 25 years in healthcare and other industries in Ireland, the UK, and in Africa.
- teaches in the areas of systems safety, human factors, and healthcare audit on the RCSI Masters in Human Factors and Patient Safety; and on the RCPI QI Module – “Essential Leadership Skills for New Consultants”.
- recently submitted her PhD at the Centre for Innovative Human Systems within the School of Psychology at Trinity College Dublin.



Healthcare Audit for understanding and improving

QI Talktime Webinar 5th of June 2018

Cora McCaughan

Assistant National Director

Healthcare Audit

Quality and Assurance and Verification Division



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Overview

1. Introduction to Healthcare Audit
2. Healthcare Audit in the context of the overall healthcare system
3. Healthcare Audit for understanding system performance
4. Healthcare Audit for driving system improvement



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1. Introduction to Healthcare Audit



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HSE Healthcare Audit

- Established 2010
- Office of the CEO → QCCD → QPS → QID → QAVD
- 17 people
- Audit schedule informed by risk information



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HSE Healthcare Audit

- 2018/19 operational plan include audits spanning acute and community services and relate to key safety issues
- Provides assurance/triggers quality improvement
- Key role in assurance framework



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HSE Healthcare Audit

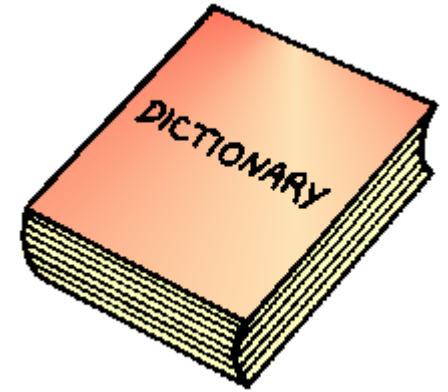
- Identifies good practice for sharing across system.
- Tests the effectiveness of internal controls.
- Provides evidence for signing the statement of internal control.



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Assurance



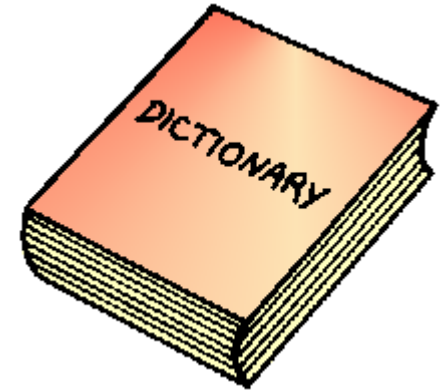
Confidence that controls are in place based on sufficient evidence and are operating efficiently and that the objectives are being met.



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Assurance Audit



An objective examination of evidence for the purpose of providing an independent assessment on governance, accountability, risk management and control processes within an organisation. Examples may include compliance with a national standard, policy or guideline.



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HSE Healthcare Audit

What we do:

We audit compliance against clinical and non-clinical standards in both acute and community services.



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HSE Healthcare Audit

What we DON'T do:

- We do not audit compliance against financial standards
- We are not clinical audit

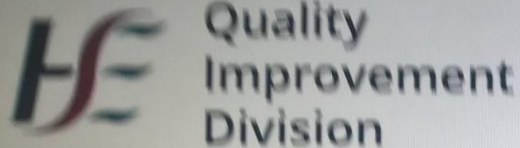


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About Clinical Audit

Share:



What is clinical audit?

Clinical audit is the systematic review and evaluation of current practice against research based standards with a view to improving clinical care for service users.

Why clinical audit?

The Health Service Executive recognises clinical audit as a reliable method of:

Proactively measuring the effectiveness and performance of healthcare against agreed standards for high quality.

2. Healthcare Audit in the context of the overall healthcare system



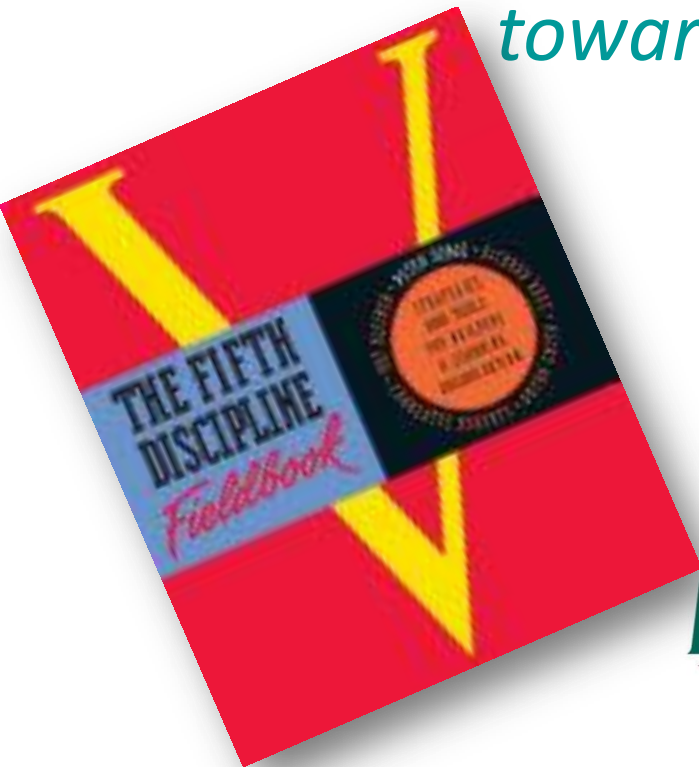
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A System

“A system is a perceived whole, whose elements hang together because they continuously affect each other over time, and they work towards a common purpose”

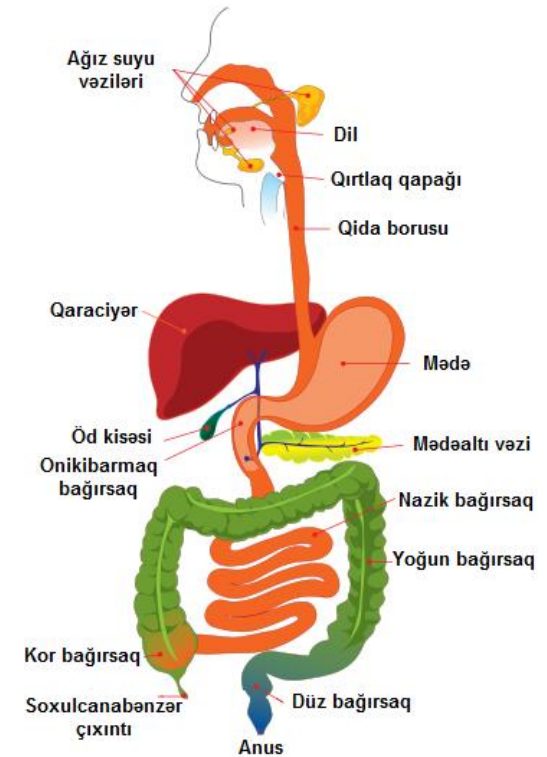
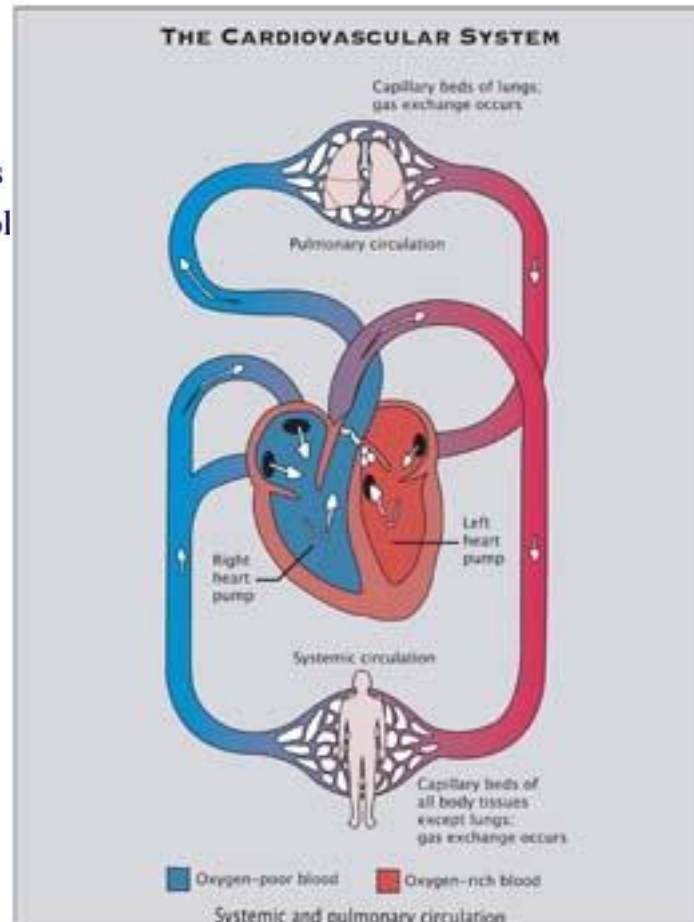
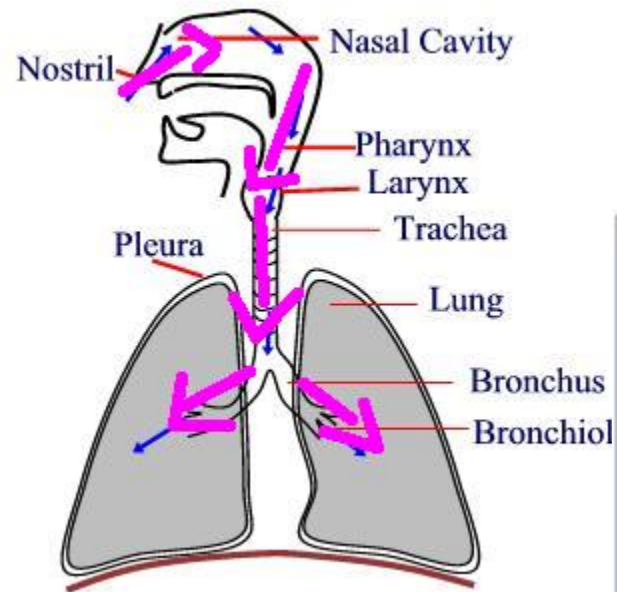
Senge *et al.*, (1994)



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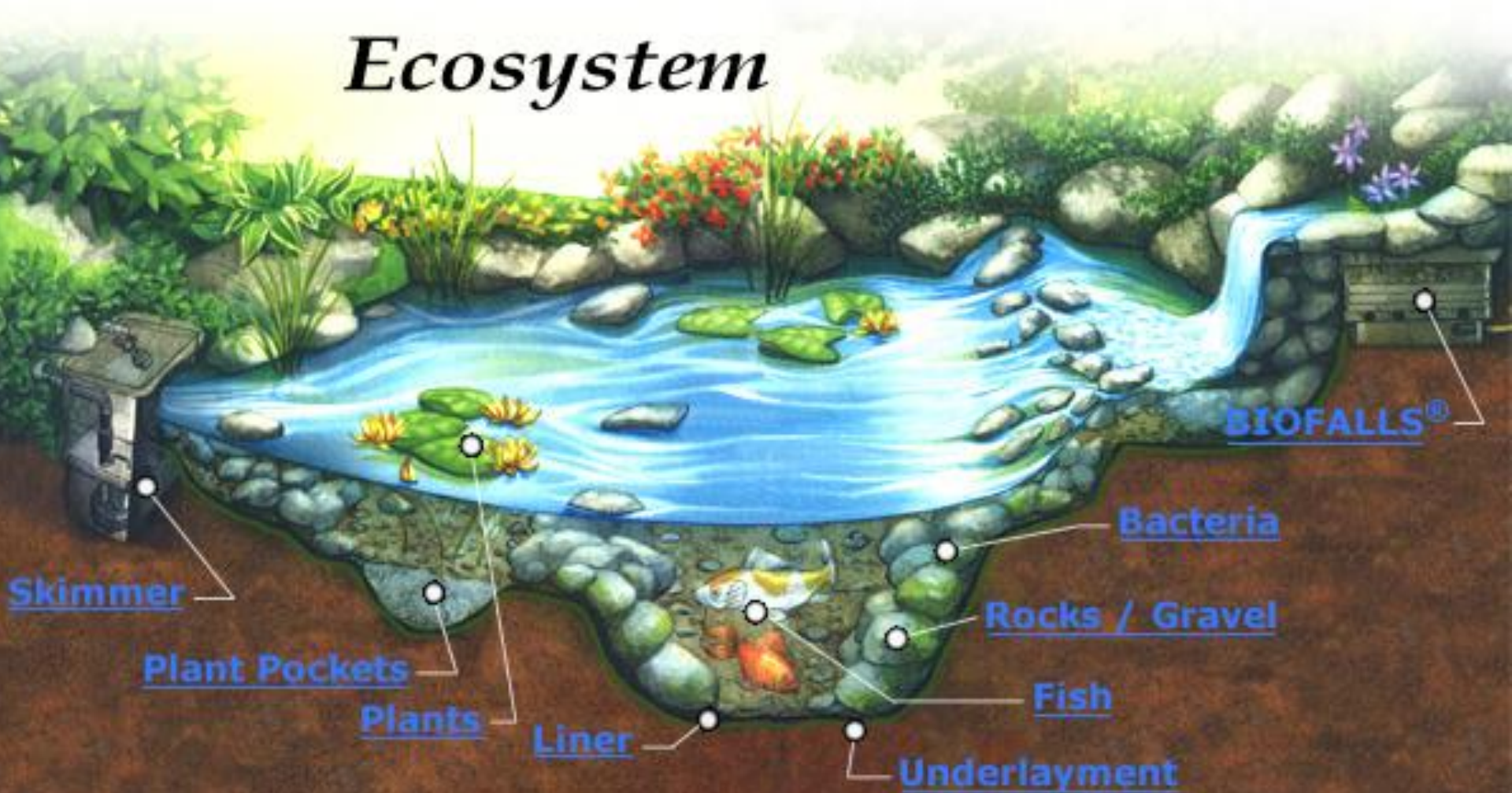
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Examples of Systems

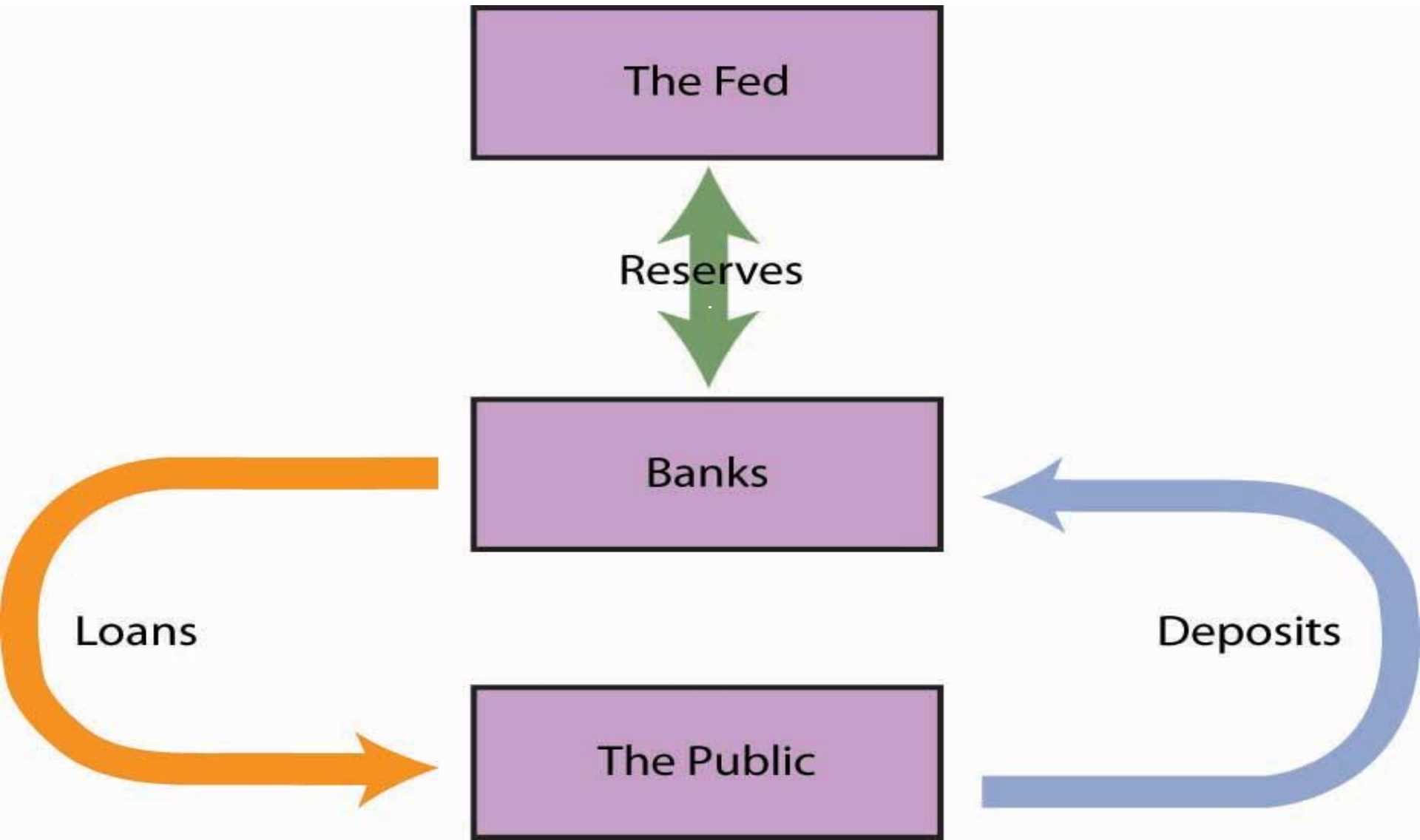


Examples of Systems

Ecosystem

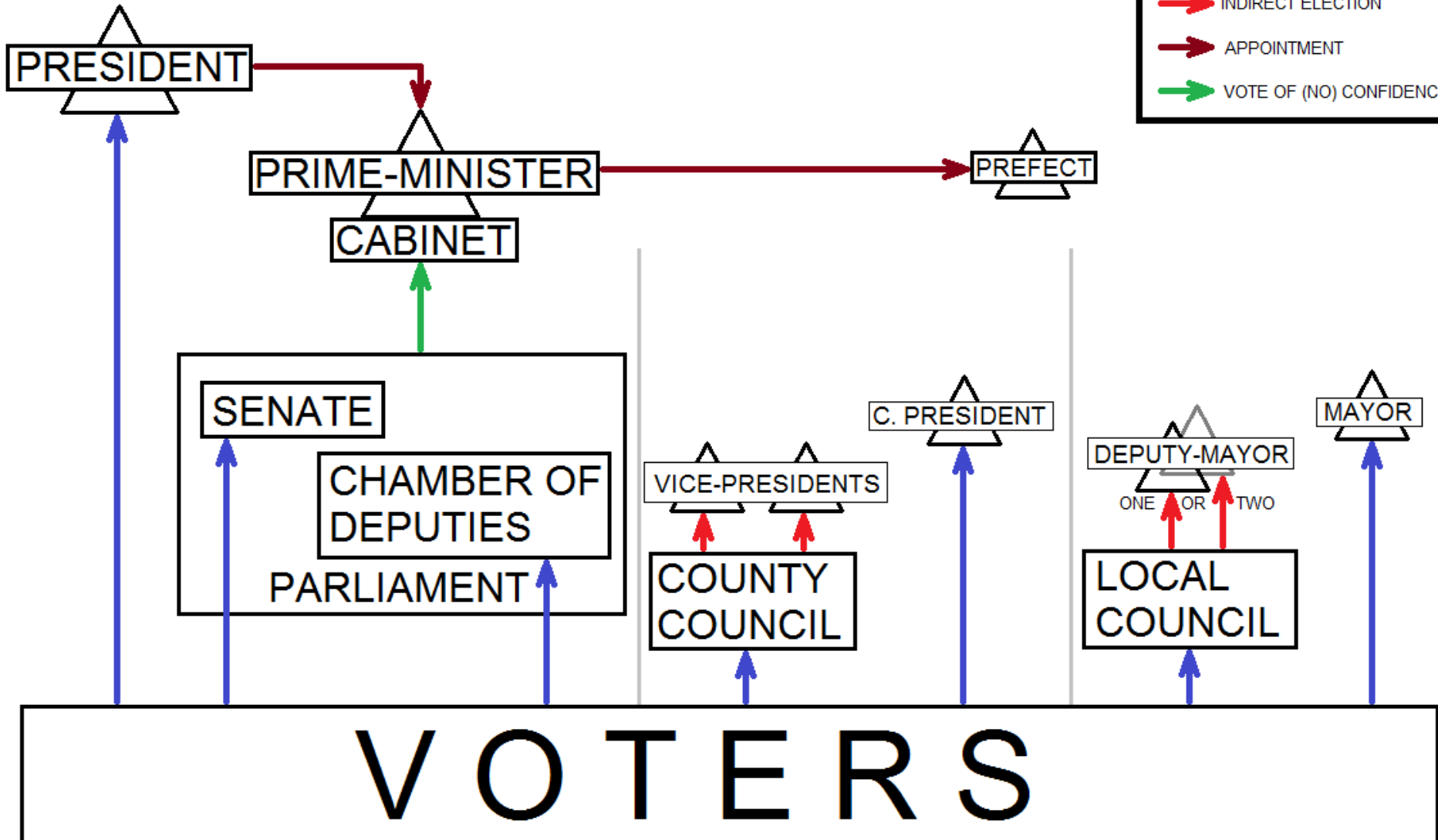


Examples of Systems

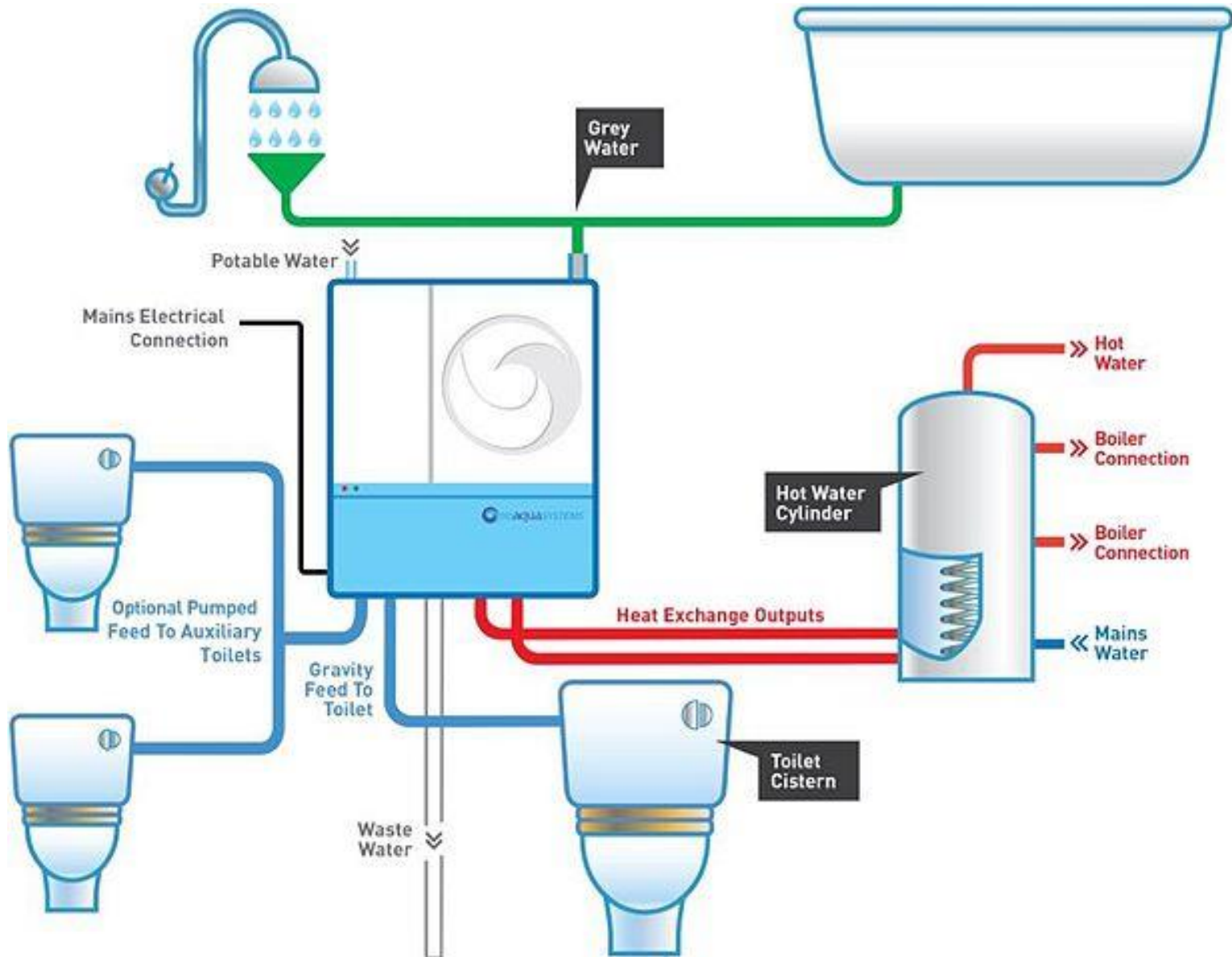


Examples of Systems

- DIRECT ELECTION
- INDIRECT ELECTION
- APPOINTMENT
- VOTE OF (NO) CONFIDENCE



Examples of Systems



Some characteristics of systems

- A system is only as strong as its weakest link
- Elements are interconnected
- The relationship at the boundaries of elements is both challenging and important
- Variation is sometimes good and sometimes bad
- Has the knowledge to solve system problems
- The sum of the whole is greater than the sum of the parts



Purpose of the HSE

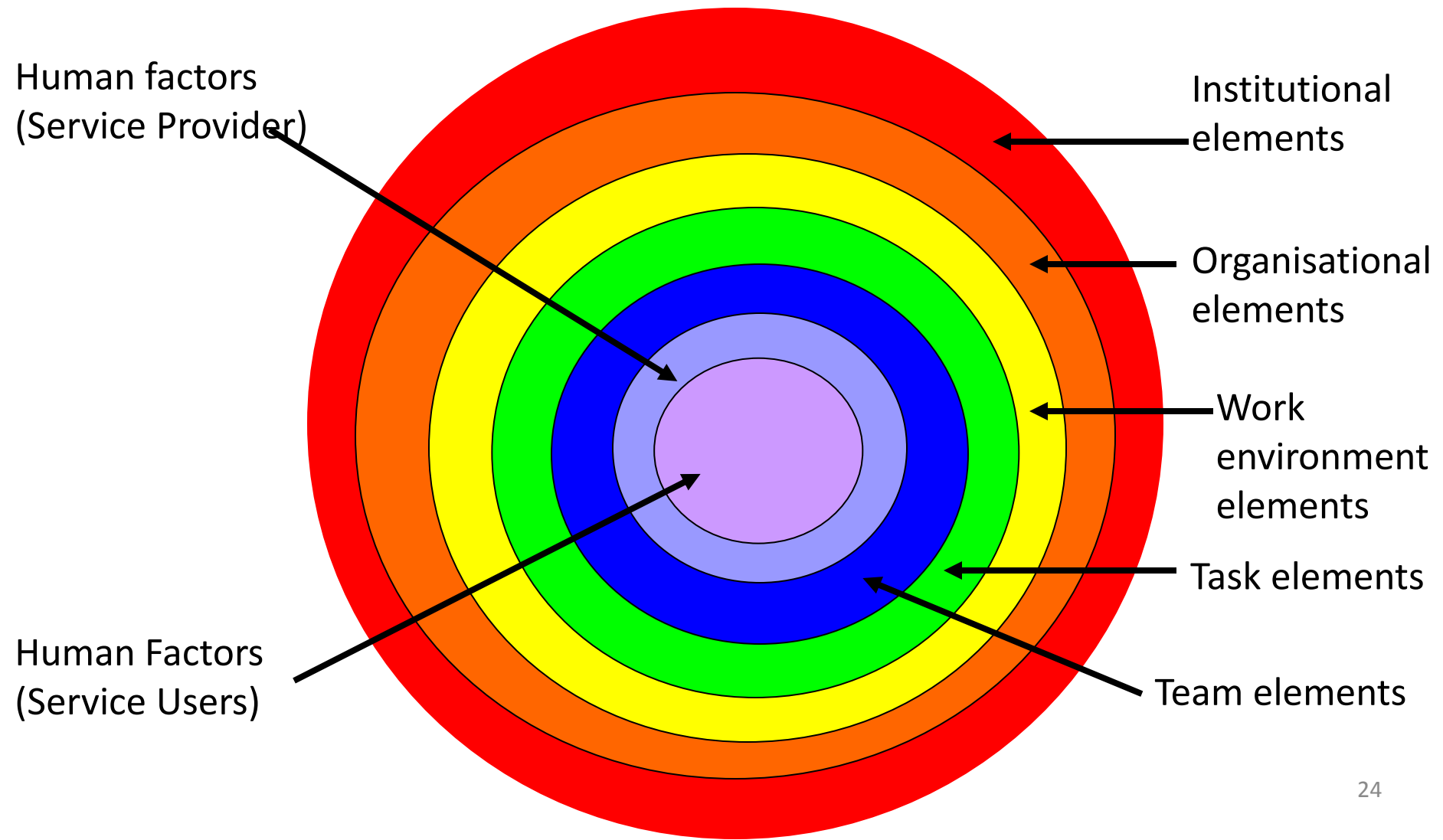
“A healthier Ireland with a high quality health service valued by all”

HSE (2018)

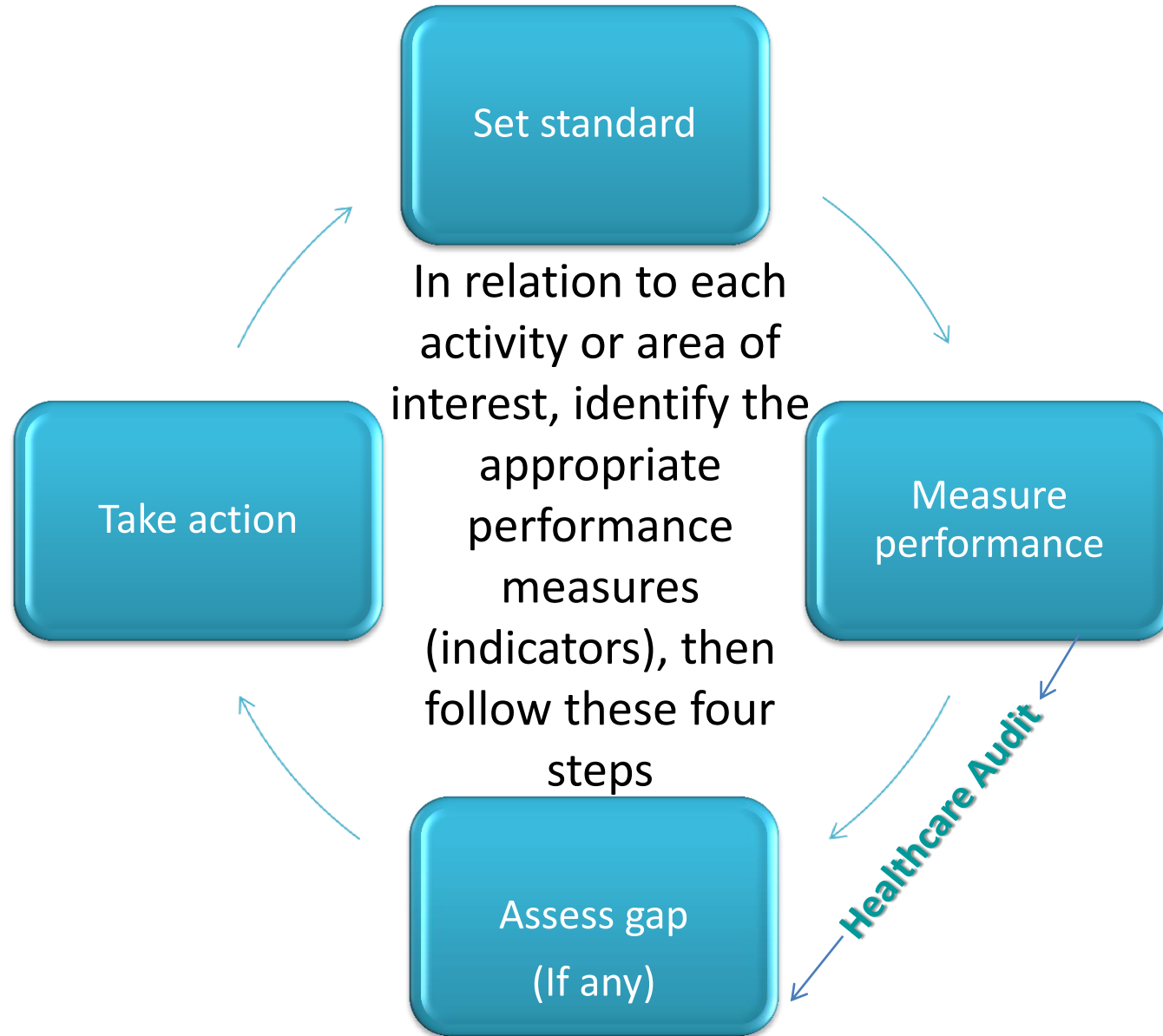




The Health System



Measuring system performance*



3. Healthcare Audit for understanding system performance



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Healthcare Audit Plan 2018/2019

Quality Assurance and Verification Division

1st March 2018

Theme	Audit no.	Audit description	Source of intelligence informing that this is an audit priority					Issue goes across services	Potential to build on local audit work	Service user (or rep) voice input to audit possible	Staff voice input to audit possible	Comment
			Controls assurance process	Theme from analysis of incident investigations	Theme from analysis of complaint data	Theme from National Patient Experience Survey	Themes from risk management /risk register process					
Core quality and patient safety structures and processes	1	Audit of compliance with HSE National Framework for Developing Policies, Procedures, Protocols and Guidelines (PPPGs) (2016)		Yes				Yes	Yes	Yes	Yes	This will be a stand-alone audit. A module related to compliance with this framework will be included in all other audits of compliance with HSE PPPGs which were developed from 2017 onwards.
	2	Audit of compliance with HSE Open Disclosure Policy (2013)		Yes				Yes	Yes	Yes	Yes	This will be designed as a single audit with a small number of key questions related to each of the 4 key national policies/guidelines for local audit - followed by validation audit of a random sample of sites by the Healthcare Audit (HCA) Team.
		Audit of compliance with HSE Integrated Risk Management Framework (2016)	Yes	Yes				Yes	Yes	Yes	Yes	
		Audit of compliance with HSE Quality and Safety Committees Guidance (2016)	Yes	Yes				Yes	Yes	Yes	Yes	
		Audit of compliance with HSE Incident Management Framework (2018)	Yes	Yes				Yes	Yes	Yes	Yes	
Detecting and responding to patient deterioration	3	Audit of compliance with National Clinical Guideline (NCG) No. 1 - National Early Warning Score (2013), and NCG No. 4 - Irish Maternity Early Warning Score (2014)		Yes				Yes	Yes	Yes	Yes	The theme of detecting and responding to patient deterioration was covered in the HCA 2017/2018 schedule. Significant non-compliance was identified. This continues to be a theme identified through analysis of serious incident investigations. Ongoing/repeat audits will be undertaken within this theme.
	4	Audit of compliance with NCG No. 5 - Clinical Handover in Maternity Services (2014), and NCG No. 11 - Clinical Handover in Acute and Children's Hospital Services (2015)		Yes	Yes			Yes	Yes	Yes	Yes	

Healthcare Audit for understanding system performance

1. Compliance/conformance → assurance
2. Non-compliance/non-conformance → focus for quality improvement
3. Identify variation
4. Identify excellence

Measuring system performance*

Strengths	Weaknesses
Can identify problems	
Can identify and acknowledge good performance	
Can significantly help management control	
Can improve management decision-making	
Makes explicit what is often left implicit	

*Source: Lime Tree Management Consulting – www.limetreeconsulting.ie

Measuring system performance*

Strengths	Weaknesses
Can identify problems	Doesn't explain their cause
Can identify and acknowledge good performance	
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Measuring system performance*

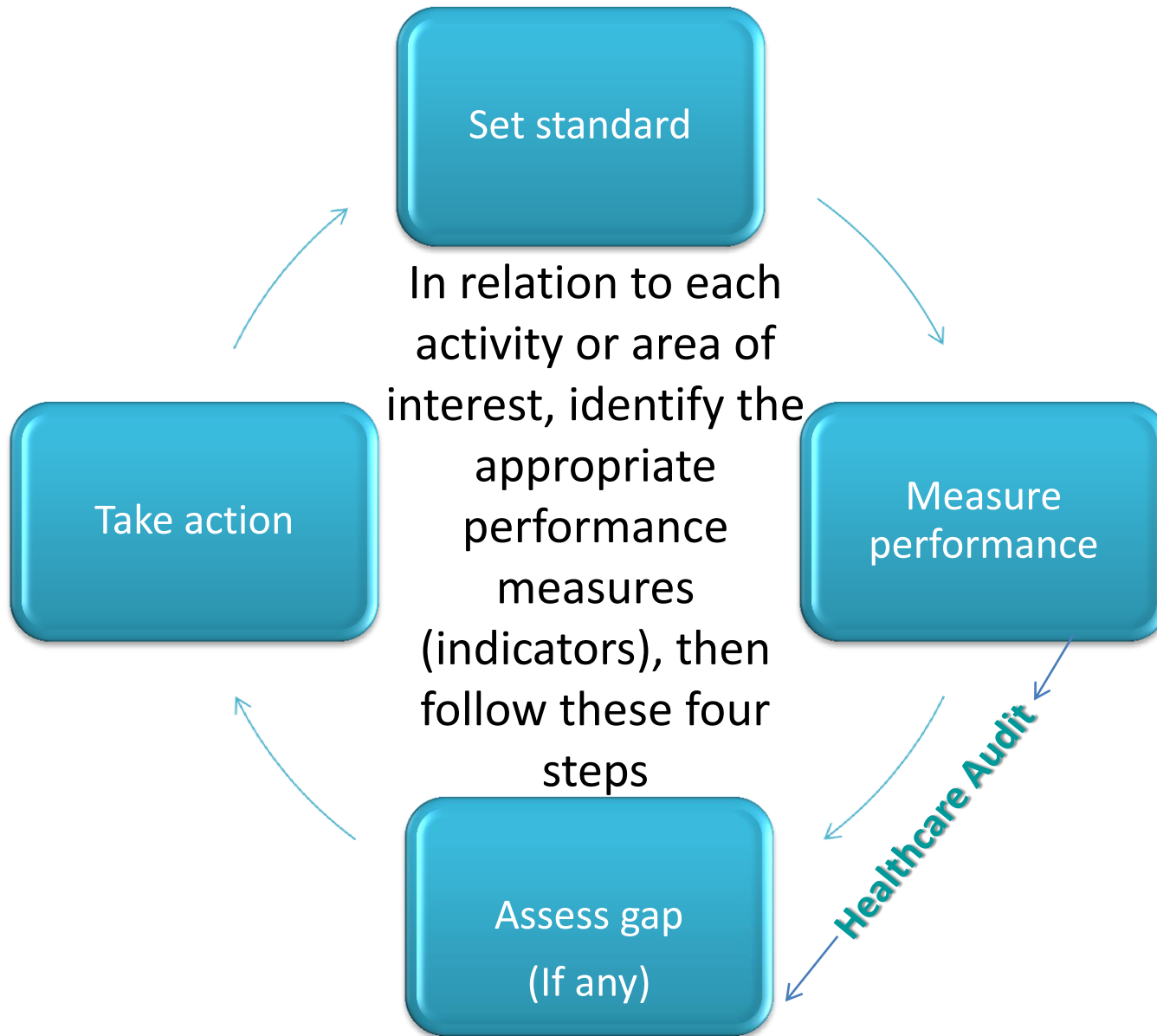
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Can significantly help management control	Risk of emphasis on outputs not outcomes
Can improve management decision-making	Measurement becomes an end in itself
Makes explicit what is often left implicit	Risk of confusion of science with reality

*Source: Lime Tree Management Consulting – www.limetreeconsulting.ie

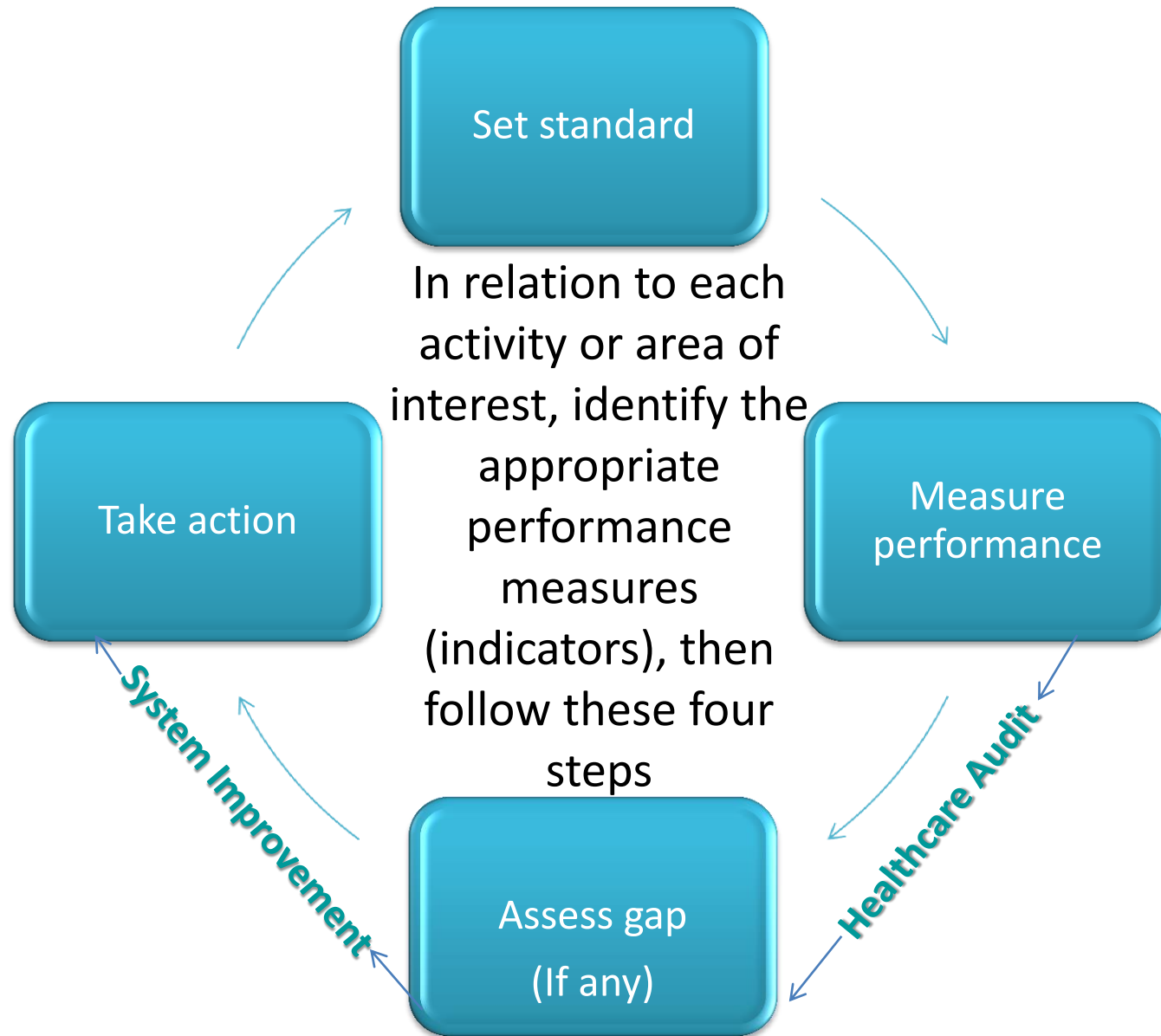


4. Healthcare Audit for driving system improvement



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Healthcare Audit for driving system improvement

1. Re-audit/repeat audit
2. Follow up on implementation of recommendations



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References

- Health Service Executive. (2018). HSE National Service Plan 2018 (pp. 136): Health Service Executive.
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- Senge, P., Kleiner, A., Roberts, C., Ross, R., & Bryan, S. (1994). *The Fifth Discipline Fieldbook*. Great Britain: Nicholas Brealey Publishing

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**Wednesday 20th June: Dr Mark Roberts (Clinical
Director N. Ireland's Safety Forum)**

**Tuesday 3rd July: Professor Lloyd Provost
(Measurement for improvement)**

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