Appendix 10
Guidelines for clinical audit

Description
A clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria. Its objectives are to measure the outcomes of patients against accepted standards, and to recommend changes if the standards are not met. The process may be repeated in a cycle of quality improvement. A clinical audit may involve one specialist or a group of doctors in single or multiple disciplines.

Examples
A comparison of procedures, processes or outcomes of health or patient care in anaesthesia, perioperative medicine or pain medicine, with best practice standards in that domain.

An audit of the outcomes of a department or group of anaesthetists, compared with the state, national or international benchmarks.

An audit of own clinical performance in an area of practice compared with those of peers (department or group of colleagues).

Approach
Any clinical audit can be conducted using the following steps:

1. Decide on a topic or domain that entails anaesthesia/pain or perioperative management.

2. Look into best practice for the topic or domain – research evidence or authoritative opinion (refer to link below).

3. Consider the indicators that may demonstrate performance.

4. For this audit identify the:
   a. Proposed standard or target for best practice.
   b. Selection criteria.
   c. Data to be collected.
   d. Process for collection of data and timeframe.

Audit examples
The Royal College of Anaesthetists (RCoA) has developed a publication titled “Raising the Standard: a compendium of audit recipes for continuous quality improvement in anaesthesia”, which provides examples of achievable audits focused mainly on measurement against defined process standards. ANZCA graciously acknowledges the RCoA willingness to make this document available for our Participants.
ANZCA will develop supporting resources relating to audit, but in the meantime, the RCoA publication can be downloaded via the link below. Refer to Part 2 for the “recipes”:

Audit Recipe Book

For practical information on how a clinician or group carrying out an audit can ensure the right cases are selected for clinical audit, including determination of the sample size, refer to the Health Quality Improvement Partnerships document available via the link below (p8).

Guide to Ensuring Data Quality in Clinical Audits

5. Collect the data.

6. Compare the data against chosen standards.

7. Summarise audit outcomes and discuss with a colleague who can provide meaningful feedback on the findings.

It is recommended that participants complete the “audit loop” by writing a report on outcomes arising, and recommendations and implemented changes if performance falls short of standards. This could include presenting your findings to peers locally and more widely if possible. Additional credits can be accrued by taking these extra steps (two credits per hour).

Recording this CPD activity

Completion of this activity can be recorded in the CPD portfolio system.

Participants will be asked to provide the following information:

- Audit topic.
- Standard data was measured against.
- Name and contact details of the colleague with whom you discussed audit results.

If a participant is selected to be involved in the random audit of CPD activities, they must provide evidence of the review.