Clinical Audit Application Guide for External Providers

Introduction

This application guide is intended to assist external providers of clinical audit in:

- Preparation and planning (sections 1-6).
- Ophthalmologists' needs analysis (section 7).
- Identification of standards (section 8).
- Data collection and analysis (section 9).
- Follow-up of results and application to future practice (section 10).
- Reporting requirements (section 11).

External providers are required to apply prospectively (at least six weeks prior to activity commencement) to the CPD Secretariat for accreditation by the CPD Committee using the Clinical Audit Provider Application Form.

Preparation and Planning

1. Description

1.1. Provide a description of this clinical audit and what it involves, for example:

- A summary of what the Clinical audit is all about.
- What element/s of ophthalmic practice is/are being analysed, e.g. diagnosis, treatment, laser outcomes, surgery outcomes.
- Will data be collected prospectively or retrospectively?

1.2. Provide a summary of the steps involved for participating Ophthalmologists.

2. Statement of Ophthalmologist Learning Needs

The statement of ophthalmologist learning needs assists Ophthalmologists to think about why they are doing a particular clinical audit. Ophthalmologists should avoid repeating the same clinical audit (e.g. cataract visual outcomes) simply because they feel comfortable with its format. This statement should prompt Ophthalmologists to consider the following:

- What motivated them to participate in the clinical audit?
- What do they expect to learn by participating?
- Does the audit address an area in which the Ophthalmologist's performance may not be meeting clinical guidelines for best practice?
- Does the audit address an area that the Ophthalmologist has recognised as a learning priority?
- Does the audit address an area that was identified in their Personal Development Plan?

3. Patient Selection and Patient Numbers

The minimum number of patients selected for a clinical audit depends on a number of factors, including the topic selected, the prevalence of the condition to be audited, the clinical audit time frame, the 'depth' of the data collection, and the potential for Ophthalmologists to learn from the clinical audit. Some clinical audits may require large numbers of patients and others may only require a small number.

Activity providers should specify both the patient selection criteria and minimum number of patients that each Ophthalmologist will audit. The number of CPD points allocated is at the discretion of the CPD Committee and will be claimable in Category 1 Clinical Expertise Level 2.

4. Stakeholder details

Ensure all stakeholder details are recorded, including the applicant's name, the activity developers, other persons or organisations involved in the development of the audit and those who have a financial interest (funding sources).

5. Privacy, confidentiality and consent

All Privacy legislation must be complied with. Activity developers and providers must ensure patients and Ophthalmologist participants know exactly how the health data they provide will be used and who will have access to any collated data.

5.1. Who will collect the data and have access to the data?

Audit developers should ensure that the data collection method protects the individual identities of the patients whose records are audited. The person collecting the data must ensure that those who are collating the data should not be able to identify individual patients on the basis of the information collected. This is commonly done by ensuring the Ophthalmologist who collects the data also undertakes the initial collation.

In some situations audit developers will be asked by the CPD Secretariat to submit their audit to the RANZCO Ethics Committee (e.g. large, ongoing clinical audits and those which may have commercial interest or application). Applicants are to allow for up to six weeks between submission and an initial decision.

5.2. Patient Consent and De-identification.

Informed patient consent must be obtained if personal health data is to be collected or collated. A sample form is located on the Human Research Ethics Committee (HREC) page of our website. Personal health information should be de-identified.

5.3. Aggregate Data Report.

Activity developers must be clear about how aggregate data will be used. In particular, participating Ophthalmologists must be made aware of who `owns' the data, and all the intended uses of the aggregate data.

5.4. List all Intended Users.

Ensure that all intended users of the collated data, third parties or organisations are clearly and fully listed.

6. Clinical Audit Timeline

6.1. The Continuous Clinical audit.

Ophthalmologists need to collect data on a specified number of patients over an unrestricted time frame.

6.2. The Fixed Timeline Clinical audit.

This is delivered within a specified time period. Ophthalmologists will begin and complete the Clinical audit together. For example, data will be collected on all patients seen within a specific time frame such as one week.

Step 1 of Clinical Audit

7. Needs Assessment

7.1. Clinical audits should reflect valid educational needs.

Clinical audits should reflect valid educational needs in a relevant area of clinical practice. Activity developers need to consider if:

- the audit involves a condition or preventive activity that can be clearly defined,
- the audit involves a condition or preventive activity that affects patients who consult Ophthalmologists,
- Ophthalmologists see enough cases to complete the audit within a reasonable timeframe,
- research is available to develop standards for good care.

Once the topic has been selected, activity developers should write one or more specific question/s that will be answered by the data collection and analysis of the clinical audit.

Activity developers should provide a brief, referenced argument as to why this is an important area for Ophthalmologists to review their clinical practice.

7.2. Clinical audit Learning Objectives.

A Clinical audit is more effective if specific Learning Objectives have been identified (Dixon 1990). In setting the learning objectives, one should consider what participating Ophthalmologists need to know about the quality of patient care.

7.3. List References.

All references used during the needs assessment should be listed appropriately.

Step 2 of Clinical Audit

8. Identify Standards

8.1. List each best practice guideline that will be compared to the clinical audit data.

Guidelines are 'systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances' (Steven et al 1996). A guideline describes best practice and specifies what and how patient care should be provided.

RANZCO guidelines are detailed on our website and the NHMRC has a clinical practice guidelines portal which has been developed to help Australian clinicians and policy-makers access clinical practice guidelines via a single entry point.

8.2. Develop clinical audit criteria from these guidelines:
Clinical audit criteria are brief statements that specify what and how patient care should be audited. The clinical audit criteria determine the data to be collected (Dixon 1990).

Clinical audit criteria should be:

- Specific, measurable, easy to define, and amenable to improvement by medical care.
- Based on evidence from research.
- Amenable to simple yes/no decisions.

For example, in a clinical audit of diabetic eye screening, the criterion is that all adult diabetic patients should have an eye examination each 2 years.

8.3. Identify standards.
Once the clinical audit criteria have been identified, standards need to be set. When identifying clinical audit standards, the following might be employed:

- Adapt existing guidelines for best practice for local relevance.
- Conduct a literature review and develop new guidelines for best practice.
- Bring together a group of Ophthalmologists to develop consensus guidelines.

Table 1 Example of comparing criterion, standard and data to be collected.

Clinical audit criterion	Standard	Data to be collected
All adult diabetic patients should have an eye examination every 2 years.	Ideal: 100% patients are up to date with eye examinations. Acceptable: 80% patients are up to date with eye examinations.	Age Type of diabetes Whether the patient has been screened in the last 2 years.

8.4. List References

Include the following:

- Referenced guidelines.
- A list of both Clinical audit Criteria and Standards against which Ophthalmologist performance will be evaluated.

Step 3 of Clinical Audit

9. Data Collection and Analysis

9.1. Data Collection.

The following questions may help to decide the best method for data collection:

- What information is needed?
- Who will collect the data?
- Is this data relevant to the standards and objectives of the clinical audit activity?
- Should it be collected prospectively or retrospectively?
- If prospective, will this be during or after a consultation, by separate interview, or by patient administered questionnaire?
- If retrospective, will this be by record review, patient follow-up questionnaire, phone call, or review of routine data?

Audit developers should:

- Record how the data to be collected relates to the clinical audit criteria and standards.
- Record data to be collected against the standard that is being used for comparison (see example in Table 1 above).
- Attach a copy of the data collection instrument.

9.2. Data Collation and Standards Comparison.

Once the data has been collected a comparative analysis can be performed between collated (aggregate) data and the standards:

- Indicate who will collate and analyse the data.

- Do the audit results fall short of the recommended standards? If so, what changes are indicated by the results, e.g. clinical practice, practice organisation?
- Can the Ophthalmologist identify barriers to achieving best practice? If so, what are they, and how can they be overcome?
- What else does the Ophthalmologist need to know in this area?
- How might these learning needs be met - academic detailing, peer group workshops, printed materials, other?
- Did the Clinical audit meet the learning needs identified in their Personal Development plan? (If they have prepared one).
- What worked about the Clinical audit process and/or what didn't work?
- What could be done differently during the clinical audit process next time, could the Clinical audit be improved?

Table 2 Example of how Ophthalmologist Feedback could be formatted

Standard	**Individual Ophthalmologist**	**Peer Group Result**
Ideal: 100% of diabetic patients are up to date with eye screening. Acceptable: 85% of diabetic patients are up to date with eye screening.	For Dr Ophthalmologist: 75 patients audited. Of these, 70 patients were eligible for eye screening. 52 patient (74% of eligible patients) were up to date with eye screening.	17 Ophthalmologists participated. 1,241 patients audited. Of these, 1,085 were eligible for eye screening. 749 patients (69% of eligible patients) were up to date with eye screening.

10.3. Attach a copy of the Activity Evaluation pro-forma.

Post Audit Reporting

11. Report

11.1. Report to CPD Secretariat.
A report must be submitted to the CPD Secretariat and should include:

- A summary of the activity.
- The number of Ophthalmologists who completed the full audit.
- The number of patients audited.
- Identified barriers to implementing change in clinical practice.
- Other resources needed by Ophthalmologists to achieve best practice.
- The overall responses to the audit.
- Suggestions for improvements to the clinical audit.

11.2. Ophthalmologist Record of Participation.
All participating Ophthalmologists should receive a record of participation. This should include:

- The Ophthalmologist's name.
- The activity title.
- The name and contact details for the organisation providing the clinical audit.
- Dates of the activity.

DECLARATION

Ensure Declaration is completed and signed. Forward all documents to:
The CPD Secretariat, RANZCO
94 Chalmers St, Surry Hills 2010 NSW
ranzco@ranzco.edu

REFERENCES

- Baker R, Fraser R Development of review criteria: Linking guidelines and assessment of quality BMJ 1995; 311: 370
- Berwick DA A primer on leading the improvement of systems BMJ 1996; 312: 619
- Dixon N Practical principles of medical audit Postgrad Med 1990: 66 (suppl 3): S17
- Johnston G, Crombie IK, Davies HTO, Alder EM, Millard A Reviewing audit: barriers and facilitating factors for effective clinical audit Qual Health Care 2000; 9: 23
- Steven ID, Coffey GA, Burgess TA, Bishop K, Mudge P Development of consensus guidelines for conditions commonly managed in general practice Aust Fam Phys 1996; 25: Suppl 2

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