NURSING AUDIT

PREPAREDBY

MRS.AMUDHA.G

ASST.PROF

ICON

MEANING

Quality - a judgment of what constitutes good or bad.

Audit - a systematic and critical examination to examine or verify.

DEFINITION

Nursing audit -

(a) It is the assessment of the quality of nursing care

(b) Uses a record as an aid in evaluating the quality of patient care.

- Nursing audit is defined as the evaluation of nursing care in retrospect through analysis of nursing records.
- It is a systematic format and written appraisal by nurses of the quality of content and the process of nursing service from the nursing records of the discharged patient.

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According to Elison

"Nursing audit refers to assessment of the quality of clinical nursing".

TYPES OF AUDIT

1. **INTERNAL AUDITING**: Internal auditing is a control technique performed by an external auditor who is an employee of the organization. Manager makes an independent appraisal policies, plans and points the deficits in the policies or plans and give suggestion for eliminating deficits.

- **2. External auditing:** It is an independent appraisal of the organizations financial account and statements. The external auditor is a qualified person who has to certify the annual profit and loss account and prepare a balance street after careful examination of the relevant books of accounts and documents.

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- **3. Financial audit**: It is a historically oriented, independent evaluation performed for the purpose of attesting to the fairness, accuracy, and reliability of financial data.

- **4. Operational Audit**: It is a future-oriented, systematic, and independent evaluation of organizational activities. Financial data may be used, but the primary sources of evidence are the operational policies and achievements related to organizational objectives.

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5. **Department Review**: It is a current period analysis of administrative functions, to evaluate the adequacy of controls, safeguarding of assets, efficient use of resources, compliance with related laws, regulations and University policy and integrity of financial information.

6. **Integrated Audit**: It is a combination of an operational audit, department review, and audit application controls review. This type of review allows for a very comprehensive examination of a functional operation within the University.

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7. **Investigative Audit**: It is an audit that takes place as a result of a report of unusual or suspicious activity on the part of an individual or a department. It is usually focused on specific aspects of the work of a department or individual.

8. **Follow-up Audit**: These are audits conducted approximately six months after an internal or external audit report has been issued. They are designed to evaluate corrective action that has been taken on the audit issues reported in the original report. When these follow-up audits are done on external auditors' reports, the results of the follow-up may be reported to those external auditors.

BRIEF HISTORY OF NURSING AUDIT

* Before 1915- very little was known about the concept.
* 1918- industrial concern introduced for the beginning of medical audit.
* George Groword- introduced the term physician for the first time medical audit.
*Ten years later Thomas R Pondon MD established a method of medical audit based on procedures used by financial account.
* He evaluated the medical care by reviewing the medical records.

PURPOSES OF NURSING AUDIT

* Evaluating nursing care given
* Achieves deserved and feasible quality of nursing care
* Verification: stimulant to better records
* Focuses on care provided and on care provider
* Contributes to research
* Review of professional work or in other words the quality of nursing care ie, we try to see how far the nurses have confirmed to the norms and standards of nursing practice while taking care of patients.

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* 1955- First report of nursing audit of the hospital published
* Next 15 years, nursing audit is reported from study or record.
* The program is reviewed for record nursing plan, nurses' notes, patient condition, nursing care.

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* It encourages followers to be actively involved in the quality control process and better records.
* It clearly communicates standards of care to subordinates.
* Facilitates more efficient use of health resources.
* Helps in designing response orientation and in-service education programme.

Methods of Nursing Audit

There are three methods:

a. Retrospective review

b. The concurrent review

c. Peer review

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- **1. Retrospective review** - this refers to an in-depth assessment of the quality after the patient has been discharged, have the patients chart to the source of data.

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- **2. The concurrent review** - this refers to the evaluations conducted on behalf of patients who are still undergoing care. It includes assessing the patient at the bedside in relation to pre-determined criteria, interviewing the staff responsible for this care and reviewing the patients record and care plan.

3. Peer review

In nurse peer review nurses functioning in the same capacity that is peer's appraise the quality of care or practice performed by others equally qualified nurses. The peer review is based on pre-established standards or criteria. There are two types of peer reviews. Individual and nursing audit

a) Individual peer review: focuses on the performance of an individual nurse

b) Nursing audit: focuses on evaluating nursing care through the review of records.

ESSENTIAL CHARACTERISTICS OF NURSING AUDIT

There should be:

* Written standards of care against which to evaluate nursing care.
* Evidence that actual practice was measured against such standards, sharing a a percent conformance rate.
* Examination and analysis of findings.
* Evidence of corrective action being taken.
* Evidence of effectiveness of corrective action.
* Appropriate reporting of the audit programme.

TRAINING FOR AUDITORS SHOULD EVALUATE THE FOLLOWING

a) A group discussion to see how the group rates the care received using the notes of a patient who has been discharge these should be anonymous and should reflect a total period of care not exceeding two weeks in length

b) Each individual auditor should then under take same exercise as followed by a meeting of the whole committee who compare and discuss its finding and finally reach a components

PROCESS OF NURSING AUDIT

A) Set the key criteria (item): It should be measurable against identifiable values, set standard and in terms of desired patient outcome. Methods to develop criteria are:

Define patient population

Identify a time frame work for measuring outcomes of care.

Identify commonly recurring problems presented by the defined patient population.

State patient outcome criteria.

State acceptable degree of goal achievement.

Specify the source of information.

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B) Prepare Audit Protocol:

keeping in mind audit objectives, target groups, methods of information gathering (by asking, observing, checking records), criterion are measuring, identifying the time framework for measuring outcome of care, identify commonly recurring nursing problems, state acceptable of goal achievement.

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C) Design The Type Of Tool:

Quality assurance must be a priority.

Those responsible must implement a program not only a tool not only a tool.

Roles and responsibilities must be delivered.

Nurses must be informed about the process and the results of the program.

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Data must be reliable.

Adequate orientation of data collection is essential.

Quality data should be analyzed and used by nursing personnel at all levels.

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D) Plan and implement the tool:

What is to be evaluated? Who is going to collect the information? How many sample in the target group? Time period?

E) Recording/ Analysis, concluding:

Record the information, analyze the information, make a summary, and compare with set standard, conclusion.

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F) Using Results:

The result aid to modify nursing care plan and nursing care process, including

* discharge planning,
* for selected patient outcome
* implementing a program for improving documentation of nursing care through improved charity policies, methodologies and forms,
* focusing of nursing rounds
* team conferences.

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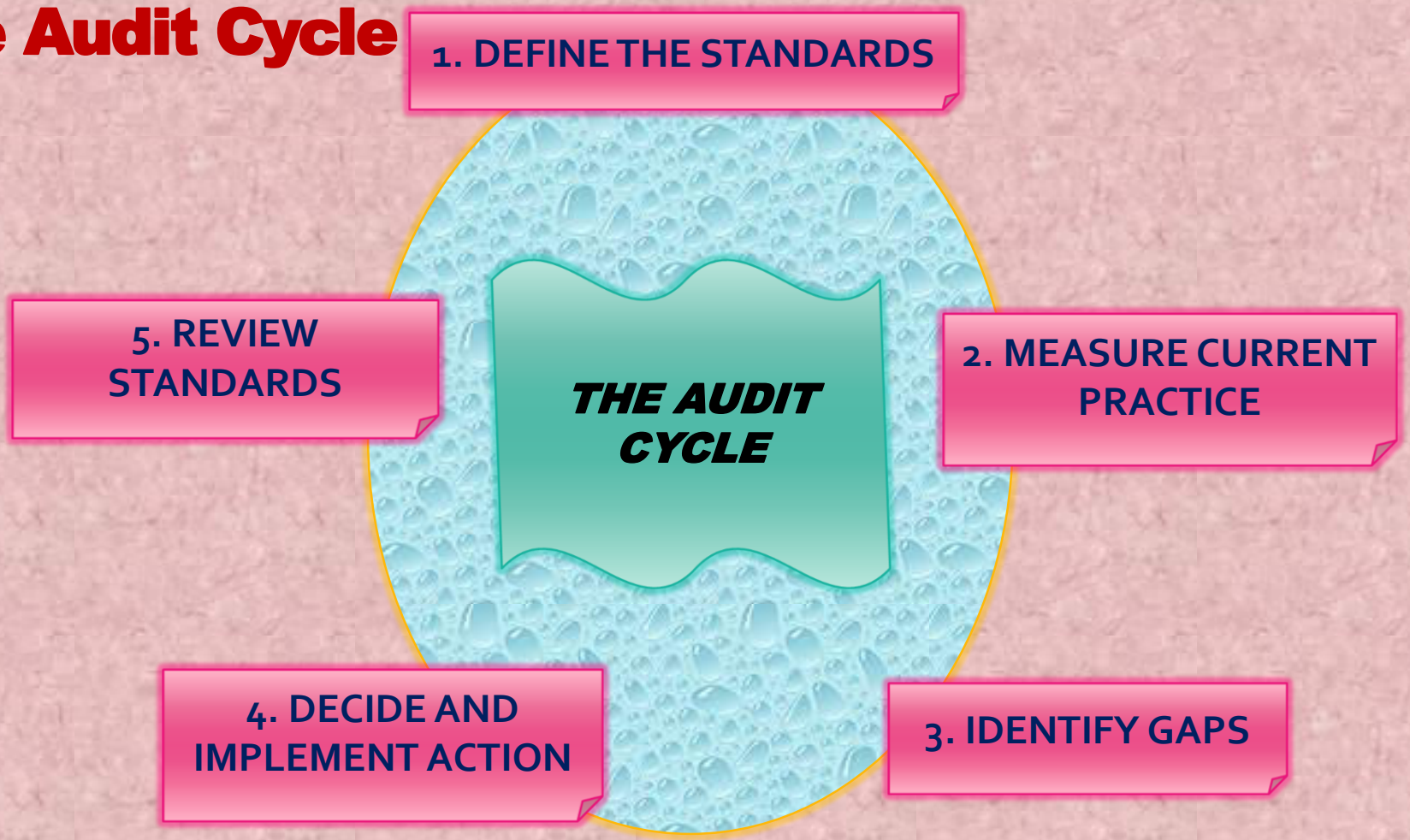
Focusing supervisory attention upon areas of weakness identified such as one particular nursing unit or specific employees.

Designing responsive orientation and in-service education programs.

Gaining administrative support for making changes in resources, including personnel.

The Audit Cycle



AUDIT CYCLE

Step 1: Define the Standard

Standards comprise two elements that define the context for care and a third which shows how care is delivered.

1. *Structure* – environmental elements required to deliver care. E.g. policy, procedures, clinic setting, equipment, record keeping system etc.
2. *Process* – professional elements required to deliver care. E.g. KSF, SIGN guidance,

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3. *Outcome* – measurable elements demonstrating results of care. E.g. Leg ulcer healing time, breast feeding duration, immunization levels, smoking cessation, dying at home, asthma/diabetic stability, pressure ulcer prevalence etc.

The elements contain criteria, which should be **R**eliable, **U**nderstandable, **M**easurable, **B**ehaviourable and **A**cceptable

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Step 2: Measure current practice within the selected topic

A baseline enquiry is carried out to identify problems requiring a solution to improve the quality of patient care.

Step 3: Identify gaps in service provision

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Step 4: Decide and Implement action

* This is the hardest area to address and involves the input from the whole team.
* An action plan needs to be developed.

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Step 5: Review standards

If the standard is easily met, does it need to be raised?
Is the standard too high?
What are the future needs?

Steps to problem Solving Process in Planning Care :

a) Collects patient data in a systematic manner

1. includes description of patients pre-hospital routines,
2. has information about the severity of illness,
3. has information regarding lab tests,
4. has information regarding vital signs,
5. Has information from physical assessment etc.

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b. States nurses diagnosis,

c. Writes nursing orders,

d. Suggests immediate and long term goals,

e. Implements the nursing care plan,

f. Plans health teaching for patients,

g. Evaluates the plan of care,

PREREQUISITES OF NURSING AUDIT:

Audit Committee

* Audit committee consist of members including senior nurses as members to do nursing audit.
* This committee should comprising of a minimum of five member who are interested in quality assurance are clinically competent and able to work together in a group.

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* It is recommended that each member should review not more than 10 patients each month and that the auditor should have the ability to carry out an audit in about 15 minute.
* If there are less than 50 discharge per month, all the records may be audited. If there are a large number of records to be audited, an auditor may select 10% of discharge.
* The impetus must come from the nursing staff themselves, realizing the benefits to the patients and themselves.

Audit as a Tool for Quality Control

1. Outcome audit

Outcomes are the end results of care; the changes in the patients health status and can be attributed to delivery of health care services. Outcome audits determine what results if any occurred as result of specific nursing intervention for clients. These audits assume the outcome accurately and demonstrate the quality of care that was provided. Example of outcomes traditionally used to measure quality of hospital care include mortality, its morbidity, and length of hospital stay.

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2. Process audit

Process audits are used to measure the process of care or how the care was carried out. Process audit is task oriented and focus on whether or not practice standards are being fulfilled. These audits assumed that a relationship exists between the quality of the nurse and quality of care provided.

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- 3. Structure audit

  Structure audit monitors the structure or setting in which patient care occurs, such as the finances, nursing service, medical records and environment. This audit assumes that a relationship exists between quality care and appropriate structure.

  These above audits can occur retrospectively, concurrently and prospectively.

ADVANTAGE OF NURSING AUDIT

1. Can be used as a method of measured in all areas of nursing
2. Scoring system is fairly simple
3. Results easily understood
4. Assess the work of all those involved in recording care
5. May be useful tool as part of a quality assurance programme in areas where accurate records of care are kept

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6) Enables the professional group to highlight the deficiencies and how good they are in giving care.

7) Better planning can be done.

8) Helps in reallocation of resources.

9) Administrators are also sure that patients are getting quality care.

DISADVANTAGE OF NURSING AUDIT

1) Appraises the outcomes of the nursing process, so it is not so useful in areas where the nursing process has not been implemented

2) Many of the components overlap making analysis difficult

3) Is time consuming

4)Requires a team of trained auditors

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5) Deals with a large amount of information.

6) Only evaluates record keeping. It only serves to improve documentation not nursing care.

7) Medical legal importance.

8) The professionals feel that they will be used in court of law as any document can be called for in court of law.

ROLE AND FUNCTIONS OF NURSE MANAGER FOR EFFECTIVE QUALITY CARE:

Roles:

Encourages followers to be actively involved in the quality control process.

Clearly communicates standards of care to subordinates.

Encourages the setting of high standards to maximize quality instead of setting minimum safety standards.

Implement quality control proactively instead reactively.

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Uses control as a method of detraining why goals were not met.

Is positively active in communicating quality control finding.

Acts as a role model for followers in accepting responsibility and accountability for nursing action.

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Functions:

In conjunctions with other personnel in the organization establishes clear cut, measurable standards of care and determines the most appropriate methods for measuring if those standards have been met.

Selects and uses process, outcome and structure audits appropriately as quality control tools.

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Assesses appropriate sources of information in data gathering for quality control tools.

Determines discrepancies between care provided and unit standards and seeks further information regarding why standards were not met.

Uses quality control findings as a measure of employee performance and rewards, coaches, counsels or disciplines employees accordingly.

Keeps abreast of current government and licensing regulations that affect quality control.

RESEARCH STUDY:

A study was conducted to analyze current audit practice and identify improvements for incorporation in the Newcasde Clinical Audit Toolkit for Mental Health. Published material relating to the Central Nottinghamshire Psychiatric Nursing Audit like Psychiatric Nursing Monitor; Standards of Care and Practice; Achievable Standards of Care; Quartz; and Quest are used. The result shows that Five of the systems failed to specify some important elements of the audit process.

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- Conceptually, the six systems can be divided into two main types: 'instrument-like' systems designed along psychometric lines and which emphasize the distance between the subjects of audit and the operators of the systems, and 'tool-like' systems which exploit opportunities for care setting staff to engage in the audit process. A third type of system is the locally-developed system which is offered to a wider audience but which does not make the same level of claim to universal applicability.


THANK YOU….