Nursing audit

Outline:-

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- ❖ Steps to problem Solving Process in Planning Care
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Objectives

- ❖ Define Nursing Audit
- ❖ Enumerate purposes of Nursing Audit
- ❖ Identify difference between Audit and research
- ❖ List methods of Nursing Audit
- ❖ List steps to problem Solving Process in Planning Care
- ❖ Enumerate advantages of Nursing Audit
- ❖ Know disadvantages of the Nursing Audit

Nursing Audit

Introduction

Nursing audit is a review of the patient record designed to identify, examine, or verify the performance of certain specified aspects of nursing care by using established criteria.

Nursing audit is the process of collecting information from nursing reports and other documented evidence about patient care and assessing the quality of care by the use of quality assurance programs.

Nursing audit is a detailed review and evaluation of selected clinical records by qualified professional personnel for evaluating quality of nursing care.

A concurrent nursing audit is performed during ongoing nursing care.

A retrospective nursing audit is performed after discharge from the care facility, using the patient's record.

Meaning:

1. **Quality** - a judgment of what constitutes good or bad.

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

3. **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.

4. **Medical audit** - the systematic, critical analysis of the quality of medical care, including the procedures for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient.

Definition:

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

II. According to Goster Walfer

a. **Nursing Audit** is an exercise to find out whether good nursing practices are followed.

b. **The audit is** a means by which nurses they can define standards from their point of view and describe the actual practice of nursing.

Nursing audit is defined as: part of the cycle of quality assurance. It incorporates the systematic and critical analysis by nurses, midwives and health visitors, in conjunction with other staff, of the planning, delivery and evaluation of nursing and midwifery care, in terms of their use of resources and the outcomes for patients/clients, and introduces appropriate change in response to that analysis (NHS ME, 1991 Framework for Audit for Nursing Services).

History of Nursing Audit:

- Nursing audit is an evaluation of nursing service. Before 1955 very little was known about the concept. It was introduced by the industrial concern and the year 1918 was the beginning of medical audit.
- George Groword, pronounced 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.
- First report of nursing audit of the hospital published in 1955. For the next 15 years, nursing audit is reported from study or record on the last decade. The program is reviewed from record nursing plan, nurses' notes, patient condition, nursing care.

Purposes of Nursing Audit

1. Evaluating Nursing care given,
2. Achieves deserved and feasible quality of nursing care,
3. Stimulant to better records,
4. Focuses on care provided and not on care provider,
5. Contributes to research.

Difference between Audit and research

Audit	Research
Is not randomized	May be randomised
ares actual performance against stan	ifies the best approach, and thus the sets the sta

nducted by those providing the servit	necessarily provided by those providing the ser
Usually led by service providers	Usually initiated by researchers
Does not involve investigation of newves comparators between new treatments and pl treatments, t evaluates the use of current treatme	
ves review of records by those entitl	uires access by those not normally entitled to ac access them them
Ethical consent not normally required	Must have ethical consent
Results usually not transferable	Results may be generalisable
ypothesis used to generate the standa	Testable hypothesis generated
npares performance against the stanc	Presents clear conclusions

Methods of Nursing Audit

There are two methods:

a. Retrospective view - 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.

Retrospective audit is a method for evaluating the quality of nursing care by examining the nursing care as it is reflected in the patient care records for discharged patients. In this type of audit specific behaviors are described then they are converted into questions and the examiner looks for answers in the record. For example the examiner looks through the patient's records and asks:

a. Was the problem solving process used in planning nursing care?

b. Whether patient data collected in a systematic manner?

c. Was a description of patient's pre-hospital routines included?

d. Laboratory test results used in planning care?

e. Did the nurse perform physical assessment? How was information used?

f. Were nursing diagnosis stated?

g. Did nurse write nursing orders? And so on.

b. 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.

Method to Develop Criteria:

1. Define patient population.

2. Identify a time framework for measuring outcomes of care,

3. Identify commonly recurring nursing problems presented by the defined patient population,

4. State patient outcome criteria,

5. State acceptable degree of goal achievement,

6. Specify the source of information.

7. Design and type of tool

Points to be remembered:

a. Quality assurance must be a priority,

b. Those responsible must implement a programme not only a tool,

c. A co-coordinator should develop and evaluate quality assurance activities,

d. Roles and responsibilities must be delivered,

e. Nurses must be informed about the process and the results of the programme,

f. Data must be reliable,

g. Adequate orientation of data collection is essential,

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

Audit Committee:

Before carrying out an audit, an audit committee should be formed, comprising of a minimum of five members who are interested in quality assurance, are clinically competent and able to work together in a group. 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 minutes. If there are less than 50 discharges per month, then all the records may be audited, if there are large number of records to be audited, then an auditor may select 10 per cent of discharges.

Training for auditors should include the following:

a. A detailed discussion of the seven components.

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

c. Each individual auditor should then undertake the same exercise as above. This is followed by a meeting of whole committees who compare and discusses its findings, and finally reach a consensus of opinion on each of the components.

Steps to problem Solving Process in Planning Care:

a. Collects patient data in a systematic manner,

1. includes description of patient's 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.

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,

Audit as a Tool for Quality Control

An audit is a systematic and official examination of a record, process or account to evaluate performance. Auditing in health care organization provide managers with a means of applying control process to determine the quality of service rendered. Nursing audit is the process of analyzing data about the nursing process of patient outcomes to evaluate the effectiveness of nursing interventions. The audits most frequently used in quality control include outcome, process and structure audits.

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.

2. Process audit

Process audits are used to measure the process of care or how the care was carried out. Process audit is tasks 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.

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.

For the effective quality control, the nurse manager has to play following roles and functions.

Advantages of Nursing Audit:

1. Can be used as a method of measurement in all areas of nursing.
2. Seven functions are easily understood,
3. Scoring system is fairly simple,
4. Results easily understood,
5. Assesses the work of all those involved in recording care,

6. May be a useful tool as part of a quality assurance program in areas where accurate records of care are kept.

Disadvantages of the 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,
5. deals with a large amount of information,
6. Only evaluates record keeping. It only serves to improve documentation, not nursing care

Conclusion

A profession concerns for the quality of its service constitutes the heart of its responsibility to the public. An audit helps to ensure that the quality of nursing care desired and feasible is achieved. This concept is often referred to as quality assurance.