

Nursing Audit

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Nursing Audit is an important component of medical audit. Increase in the public awareness of their rights of safety and high cost of medical treatment necessitate that the nurses should become more accountable for care they deliver. Hence the nursing process has become a legal document in many countries.

The word "Audit" today is specifically concerned with the checking and endorsing of financial accounts. It is a control to improve the quality of patient care. Auditing is done on some expected set standards.

The seven functions of professional nursing are used as the framework for an audit. These functions are:

- (1) Nursing care of the patient.
- (2) Care given by other professionals.
- (3) Observation of signs, symptoms and reaction.
- (4) Application and execution of nursing procedures and techniques.
- (5) Promotion of physical and emotional health by direction and teaching.
- (6) Reporting and recording.
- (7) Application and execution of physician's legal orders.

Definition : According to Elison, "Nursing audit refers to assessment of the quality of clinical nursing". According to Goster

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Walfer, (i) Nursing audit is an exercise to find out whether good nursing practices are followed and (ii) The audit is a means by which nurses by themselves can define standards from their point of view and describe the actual practice of nursing.

Nursing audit is the process of analysing data about the nursing process of patient's outcome to evaluate the effectiveness of nursing intervention.

Purpose of Nursing Audit

It evaluates the nursing care given by nurses.

CB Jorvell (a PhD student) developed an audit instrument that measures the extent to which patient records describe important aspects of nursing care. Twenty records from each of three hospital wards were collected and audited. The auditors were registered nurses with the knowledge of nursing documentation in accordance with the VIP model – a model designed to structure nursing documentation (VIPS is an acronym formed from the Swedish words for well being, integrity, prevention and security).

Bell & Solieri stated that audit and associated subsequent work have resulted in direct improvement to burn patient care and health outcomes. Authors concluded that there is great value in developing protocols particularly those involving nurses, because they spend more time with patients whilst they are in hospital than any other professional group.

It teaches nursing staff to prioritise and analyse problem
Younger (2000) said, the audit was designed not only to measure the quality of care but to identify where improvement in care practice was necessary.

Butler-Williams et al (2005) showed the significance of increasing staff awareness in managing respiratory rate. Auditing of records of vital signs for intensive care unit showed that although recording respiratory is a simple basic bed side observation, yet for some reasons it is not seen as a "vital". Based on this, education and training was provided and again a second audit was done which demonstrated 54 percent improvements.

It stimulates better recording, as nurses understand the value of documentation.

Chatopadhyay (2003) revealed that standardised abbreviations were used in almost 95 percent of intake and output charts. Errors including illegibility, incomplete entries, entries in inappropriate space were found. Walker (2006) developed an audit tool for off-duty standards. The duty rosters were used to do auditing 21 surgical wards. The results showed that amendments to the off duty were not dated and signed which would make it very difficult, should the records need to be scrutinised in the future. Details of sickness and absence were not recorded properly.

Nursing audit is done to evaluate the care given according to

the set standards

- The audit determines the systematic collection of facts for a particular problem. Again it gives rise to new strategies for planning to improve the nursing care. It evaluates the course of action and also evaluates the outcome of a particular action.
- It contributes to research, and it evaluates the kind of trends for a particular type of care and the theories on which the care was based.

The Audit Process

According to Lancaster (1988) there are six steps to conduct an audit.

1) Selection of a topic for audit

- Before the auditing is done one needs to identify the aspect of care which is to be audited.

2) Selection of explicit criteria for quality care

- The criteria for assessing the quality care has to be decided. Any type of audit needs to have particular criteria on the basis of which auditing will be done. Each criterion should be clearly phrased in numerical, descriptive or behavioural terms.

3) **Review of records** - If the retrospective kind of auditing is to be done the auditor needs to decide in what particular time he/she wants to review the charts.

4) **Peer reviews of all cases that do not meet criteria for quality care** - If the criterion set for auditing is not met then peer review is done to find the reasons.

5) **Recommendations to correct deficiencies** - Specific recommendations are given to correct deficiencies like staff devel-

opment programme - in-service education, etc.

6) Follow-up of the topic

- After giving recommendations, one needs to do a follow-up to assess whether problems are eliminated or not and again another audit can be conducted.

Audit Cycle

Audit cycle gives series of actualities which when followed eliminate any confusions.

Setting of standards: Minimum standards are set for structure, process and outcome audit.

Observes practice: In observing practice directing a concurrent auditing is done where direct care is given by the care giver whereas records are observed after the patient is discharged.

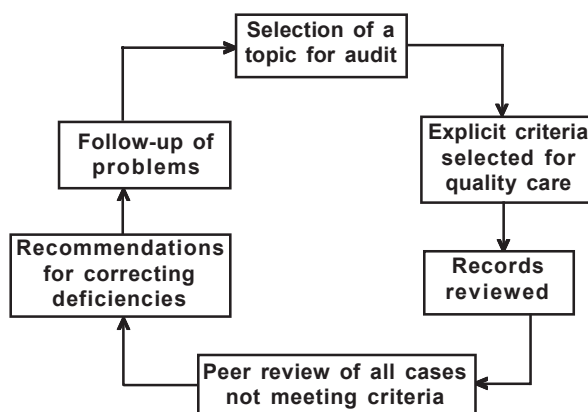
Compare with standards: All observations whether ongoing or given in the past, are compared with the set.

Implement change: After observing the deficiencies, motivation and education is given to the care givers. So a change can be implemented and again reauditing can be done to evaluate the quality of care.

Types of Audit

Two types of audits are used in nursing peer review: Concurrent and Retrospective.

Concurrent Audit - It is a



method of evaluating quality of ongoing care through appraisal of the nursing process.

Advantages: (i) Identification of deficiencies at the time care is given, (ii) Provision of a mechanism for identifying and meeting client needs during the caring process, (iii) Implementation of measures for fulfilling professional responsibilities to the consumer, and (iv) Provision of a mechanism for communicating on behalf of the client.

Disadvantages: It is time consuming and it is more costly to implement than the retrospective audit; and because care is ongoing, it does not present the total picture of care the client will receive (Trussel & Strand, 1978).

Retrospective Audit - It evaluates quality of care through appraisal of the nursing process after the client's discharge from the health care system.

Advantages: (i) it provides for comparison of actual practice to standards of care and analysis of actual practice findings, (ii) it gives a total picture of care given, and (iii) provides more accurate data on which to base corrective action.

Disadvantages: (i) The focus of evaluation is directed away from ongoing care, (ii) client

problems are identified after discharge, when there is no chance to assist that client with the problems, and (iii) corrective action can only be used to improve practice for future clients.

Classification of Audit

The audits most frequently used in quality control include outcome, process and structure audits.

1. Outcome Audit - It determines the results of specific nursing interventions.

2. Process Audit - It is used to measure the process of care or how the care was carried out.

3. Structure Audit - This type of audit monitors the structure or setting in which the patient care occurs. The audit is done for assessing physical facilities, equipments and supplies describe whether they fulfill the set standards or not. Even retrospective studies can be done by reviewing the records which shows the use of equipments and supplies and physical facilities for a particular condition according to set standards.

The audit can be **external audit** i.e. done by outside agency and **internal** i.e. it can be done by health agency staff itself

Audit Committee

An Audit committee is responsible for setting the criteria to assess the nursing care of selected types of patients. It has representatives from each clinical nursing division in the institution. All committee members should be experienced and employed in direct nursing care activities. A capable staff nurse or a clinical specialist will be more suitable as a committee member than a supervisor. A subcommittee can be formed

who practice at bed side so that the work is made clearer.

In conducting nursing audit, the following points are important : Formulation of nursing audit committee consists of chairperson (Senior Nurse) and three to four members (Head Nurses). The Committee should meet once a month to audit records of patients discharged during that time. Chairperson would assign the number of charts each member will audit. Member should be very honest and impartial in their judgment. A confidential note should be sent to the individual if something outstanding has been recorded, and review of audit is done by the members of the committee, compiled and submitted to the authorities.

Uses of Nursing Audit

For Nursing Care Services

It helps in modifying nursing care plans and nursing care process; implementing a programme for improving documentation of nursing care through improved charting policies; focusing attention, weaknesses identified; nursing round and term conferences, and designing responsible orientation and in-service education programme.

For Nursing Administrator:

Providing evaluation of particular programme, such as orientation of personnel or establishment of a patient teaching programme; support for financing a particular programme; serving as basis for planning new programmes; identification of areas of strength and weakness in various settings; determining the influence of varied staffing patterns.

For Supervisors and Head Nurses: Identifying areas of needed patient care improvement; providing basis for in-service education programme, and identifying needs of staff members who gives direct care to patient.

For Staff Nurses: It provides a self examination of care; identifies a particular type of care in which practice may be improved merely by increased attention and identifies types of care on which improvement will depend.

Research Studies in Relevant Areas :

Auditing in health care organizations provides managers with a means of applying control process to determine the quality of service rendered. Thomas (2005) explained that information gained from an audit identifies educational needs, risk management and possible complaints. An audit on hypertension at a clinic found that many patients with raised blood pressure also had a high body mass index. Based on these information obesity clinics was set up to help educate and support the patients.

Kaur et al (2005) used a retrospective approach to access maintenance of 510 intake and output documents. Observation Performa was used for assessment.

Gournay & Bowers (2000) showed that significant use of audit in suicide and self harm patients. Morgan (1994) pointed out that suicide in psychiatric hospital demands a careful evaluation of present day practice.

Limitations of the Auditing: The audit is not designed for evalua-

tion of care, nor the audit is not designed for use in evaluation of nurse performance; the audit is done by going through the records and not the care so it is not a patient care audit. It is not an error-detecting scheme, but audit basically improves the quality of documentation and not the nursing care.

Conclusion

Nursing audit measures the quality of nursing care actually given to patients retrospectively when the cycle care has ended.

Audit findings always suggest for improvement of care and there are ways in which nurses can take the initiative, both unilaterally and in collaboration with others, in developing pattern of care and of health services delivery systems.

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Audit tool for the off-duty standards (Linda Walker, 2006)

Standard	Yes	No	
Are four weeks of duty available?			
Is the nurse in charge of the shift clearly identified?			
Is there is record of when bank requests are made?			
Is there a date of when the off duty was completed?			
Is a copy of the off duty in the bleep folder?			
Is there a system for the authorization of leave?			
Are all amendments signed and dated?			
Is all sickness/absence identified clearly in red ink on the off duty (in hours)?			
Are all absences totaled in hours on the off duty?			
Is the individual scheduled to hold the bleep identified? If not, are there clearly identified alternative arrangements?			
Within the identified desirable staffing level for the ward, is there sufficient staff to meet this requirement over a one-week period?			
If the answer to the above is 'no', what is the total number of shifts that are not covered adequately? How many shifts show a shortfall?	Early	Late	Night
Is there a clearly defined reason for this shortfall?			
Does the number of staff exceed the identified desirable staffing level?			
If 'yes' to the above, how many shifts show an excess of staff?	Early	Late	Night
Is there a clearly defined reason for this excess?			
Do the manageable staff absences (study leave/ maternity leave/ annual leave) on any shift exceed 21% ?			
If 'yes' to the above, is there a clearly defined reason for this excess?			