HealthManagement
Promoting Management and Leadership

MIR 2015: Clinical Audit Can Maximise Quality, Avoid Harm

Carrying out a clinical audit can be daunting, but help is at hand. Peter Cavanagh, UK, Chairman of the European Society of Radiology (ESR)'s Subcommittee on Audit and Standards explained the role of clinical audit in ensuring a high reliability imaging service, when he spoke at the Management in Radiology (MIR) annual meeting in Barcelona on 8 October.

Clinical audit is defined as:"A systematic examination or review of medical radiological procedures that seeks to improve the quality and outcome of patient care through structured review, whereby medical radiological practices, procedures and results are examined against agreed standards for good medical radiological procedures, with modification of practices, where appropriate, and the application of new standards if necessary."

Clinical audit for radiology will be mandatory in Europe by February 2018 under the terms of the European Directive 2013/59/Euratom. There are several sources of guidance, explained Cavanagh. The European Commission published Guidelines on clinical audit in 2009, which recommend that the objectives of clinical audit should address the practical clinical work by different professionals, and combine internal and external assessments. Audits should be organised in a continuous cycle in six stages:

1. Setting the objectives and identifying the issues to be audited
2. Setting the criteria of good practice
3. Assessing the practice, comparing with criteria
4. Recommendations for improvement
5. Implementation of improvements
6. Re-audit.

High Reliability Imaging Service

Cavanagh noted that there are four elements in a high reliability imaging service

1. Leadership and teamwork

- Make patient safety the service's first priority, including putting safety and quality top of the agenda at management meetings.
- Set high level measurable aims for the service.
- Ensure patient safety is integrated into the operations of the service alongside finance and performance.
- Engaged and committed leadership.
- Develop an open culture, and ensure psychological safety.

Cavanagh observed that the idea of psychological safety is key to the whole process. Staff need to believe that they will not be punished or humiliated for speaking up with ideas, questions, concerns, or mistakes. "A shared sense of psychological safety is critical input to an effective learning system", he said.

2. A monitoring and learning system

- Integrate and learn from past harm
- Ensure feedback mechanism
- Transparency - engage public and patients, present results where people can see them
- Measurement for learning and improvement. This should not be judgmental, and it should be sensitive to operations.

3. Patient-focused and responsive care

- Patient involvement in design of systems
- Hearing the patients' voice
- Understanding the patient experience
- Patient information to inform not instruct

4. Reliability and resilience

- Understanding the human factors involved in system design
- Appraisal, coaching and mentoring
- Developing a training resource to develop and spread improvement skills to staff in the front line.

Structuring an Audit Programme

Five key questions for an audit programme are to ask if the service is:

1. Safe: Are patients, users and staff protected from avoidable harm?
2. Effective: Does the service achieve good outcomes based on the best available evidence?
3. Caring: Do staff involve and care for patients with compassion, kindness, dignity and respect?
4. Responsible: Is the service organised to meet the needs of patients and users?
5. Well led and well organised: Do the leadership, management and governance of the service make sure it is providing high quality care that encourages learning and innovation and that it promotes an open and fair culture.

What to Monitor

1. Structure - This includes staffing levels, equipment and environment
2. Processes - Turnaround times for investigations; Incident reporting; Audits (including peer review)
3. Culture, including surveying the staff safety culture
4. Outcomes, including adverse incidents.

ESR Clinical Audit Tool

The new tool from the ESR will be published shortly. It includes 19 safety standards based on evidence. Each audit will have a template attached to it. Speaking to *HealthManagement,* Cavanagh explained that the subcommittee developed this tool to provide departments that have perhaps struggled with starting an audit programme with a group of standards and templates which will get them on that journey. The tool focuses on safety first of all, particularly radiation protection safety and also MRI, interventional radiology, introduction of contrast agents and infection control. The next level of templates will be launched in March 2016, and will cover other elements of safety, patient focus, effectiveness, responsiveness, well-organised care. These audits will enable department to comply to the Euratom directive.

Peer Review

On peer review Cavanagh reiterated the principles. The potential of peer review is not used to its full advantage. it should be used for feedback, shared learning, better team working and improved performance for patients. Radiologists peer feedback should be part of daily practice. There are a number of ways peer feedback can be carried out in a radiology department in a structured way, including multidisciplinary team meetings, discrepancy meetings and clinical audit. The UK's Royal College of Radiologists has set standards for peer review, and requires that all departments should aim to implement systematic review of 5% of reports by December 2018. Scoring and benchmarking between departments is not advocated, but a single system of categorising discrepancies would help to share learning.

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Published on : Thu, 8 Oct 2015