

9. The universal protocol for preventing wrong site, wrong procedure, wrong person surgery is part of the National Patients Safety Goals® chapter of the Joint Commission accreditation manual [consultado 12 Ene 2020]. Disponible en: <https://www.jointcommission.org/standards/universal-protocol/>
10. Berg D, Berg K, Riesenber LA, Weber D, King D, Mealey K, et al. The development of a validated checklist for thoracentesis: preliminary results. *Am J Med Qual.* 2013;28:220–6, <http://dx.doi.org/10.1177/1062860612459881>.
11. See KC, Jamil K, Chua AP, Phua J, Khoo KL, Lim TK. Effect of a pleural checklist on patient safety in the ultrasound era. *Respirology.* 2013;18:534–9, <http://dx.doi.org/10.1111/resp.12033>.
12. DeBiasi EM, Puchalski J. Thoracentesis: state-of-the-art in procedural safety, patient outcomes, and physiologic impact. *Pleura.* 2016;3:1–10, <http://dx.doi.org/10.1177/2373997516646554>.
13. Making Health Care Safer II (AHRQ) [consultado 12 Ene 2020]. Disponible en: <https://www.ahrq.gov/research/findings/evidence-based-reports/ptsafetyuptp.html>
14. Listados de verificación. Agencia de Calidad Sanitaria. Junta de Andalucía. Observatorio de Seguridad del Paciente

[consultado 12 Ene 2020]. Disponible en: <https://www.sspa.juntadeandalucia.es/agenciadecalidadsanitaria/observatorioseguridadpaciente/gestor/sites/PortalObservatorio/cirugiasegura/>

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An audit of audits – A never ending loop



Una auditoría de auditorías - Un bucle sin fin

Dear Editor,

The National Institute for Health and Clinical Excellence (NICE) have defined audit as “a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change”.¹ As such it plays an integral role in ensuring the delivery of high-quality patient care and forms a cornerstone of clinical governance within surgery, with the General Medical Council (GMC) advising all doctors ‘must take part in regular and systematic medical and clinical audit’.² There has been criticism of the practice of audit within hospitals. To investigate the efficacy of clinical audit we analysed the audit practices within the orthopaedic department of Wythenshawe Hospital, a large teaching hospital in the North West deanery UK, over a 5-year period.

Clinical audit is formed of six prescript stages, making up the audit cycle. These stages are: (1) identifying a problem, (2) identifying set standards, (3) measuring current practice, (4) comparing current practice against set standards, (5) implementing change, (6) re-measuring practice.¹

Implementing change necessitates presenting findings and agreeing recommendations. Recommendations should meet the SMART criteria, being Specific, Measurable, Achievable, Relevant and Time-Bound.³ Meeting SMART criteria provides a framework to reach clearly defined audit goals. An effective audit must show completion of the audit cycle, allowing for demonstration of change to practice.⁴ Completing this cycle has previously demonstrated positive results in orthopaedics.⁵ Demonstrating sustainability relies upon repeating the audit cycle at regular intervals.

There has been criticism of the practice of audit within hospitals. Previous papers have suggested that many do not have clear objectives, are not set against recognised standards and that the proportion of completed audit cycles falls far below the recommended 100%.^{6–8} Furthermore, it is thought that clinician time and hospital funding committed to the process often has a negative impact on doctor’s clinical time and does not always show improvement to the standard of patient care.⁹

We retrospectively reviewed all Trauma and Orthopaedic projects registered with the audit department at Wythenshawe Hospital between 2013 and 2018. Projects that satisfied a minimum of 3/6 stages of the audit cycle were included, with presented work that did not meet the criteria excluded. Audit meeting minutes and audit presentations were scrutinised. Audits were categorised into ‘partial’ (satisfying 3/6 stages of audit cycle), ‘full’ (satisfying 5/6 stages) or ‘re-audit’ (satisfying 6/6 stages).⁸ We reviewed the audit action plans, assessed their quality against the SMART objective setting criteria and determined departmental trends for re-audit.

Over a 5-year period there were 129 projects presented at the quarterly audit meetings. 36 were excluded, as they failed to meet the definition of clinical audit. These included case reports, research projects and teaching sessions. The most common category for audit was ‘neck of femur fractures’ and ‘other’ (18% each), with ‘spine’ having the lowest number (4%). Of the 93 audits reviewed (see Fig. 1):

- 15 (16%) were only partially completed, either failing to make comparison between the identified standards and observed practice or failing to agree recommendations for change to clinical practice.
- 55 (59%) were ‘full’ audits, making recommendations and yet failing to demonstrate a change to clinical practice. Only 18 (33%) of these audits made recommendations that met the criteria for SMART objective setting, with a clear plan to re-audit in the future.

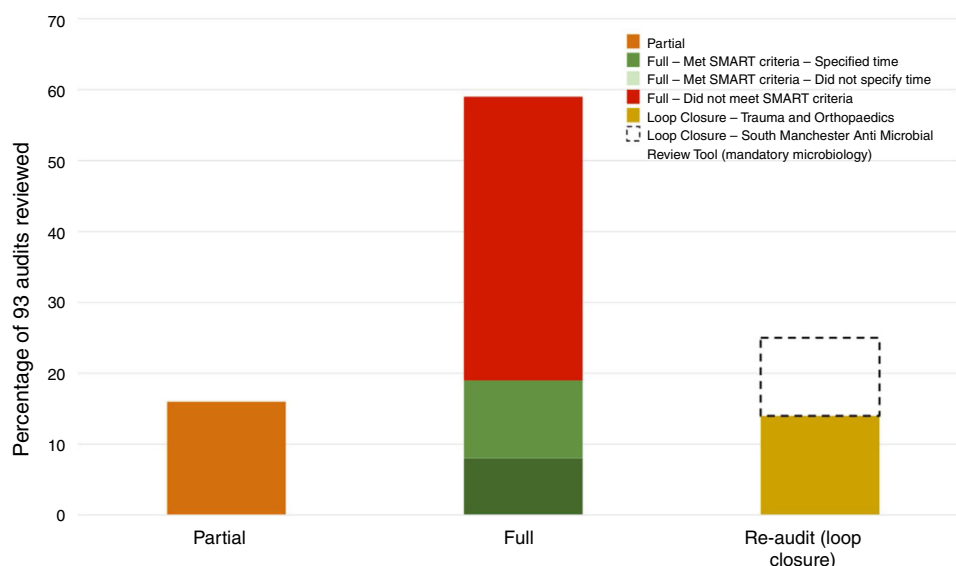


Figure 1 Graph showing distribution of partial, full and re-audit (loop closure).

- 23 (25%) could be classified as 're-audits', completing all six stages. However, of these 23 re-audits, 10 were of the same audit repeated at regular intervals over a three-year period (the South Manchester Antimicrobial Review Tool, which had been completed as part of the microbiology department's mandatory auditing protocol) and of the remaining 13 re-audits only 2 made subsequent recommendation for long-term monitoring.

Our department performed an average of 18.6 audits each year over a 5-year period, higher than that of previously documented studies.^{6,7} We found that of the audits analysed 59% were deemed 'full' audits, again higher than that reported by other groups.⁹ Only 33% made recommendations that met SMART criteria for objective setting. The remainder failed to outline a robust strategy to achieve and monitor change. As such, few of these progressed to loop closure.

The explanation for poor audit practice is multifactorial. With an ever-increasing workload medical staff are often reluctant to commit time to clinical audit, which can be perceived as a tick box exercise. Furthermore, junior staff members feel unsupervised and unsupported, negatively impacting on the quality of audit.¹⁰ Regular rotations and changes of junior staff mean that audit follow-up can be neglected unless new staff members are made aware of what is required of them.

To improve the quality and efficacy of clinical audit all junior staff should be educated on local audit practices upon induction to a new rotation/department.⁹ Doing so will promote early engagement.

Advances in information technology should be utilised such to improve ease of audit registration, as well as provide access to past audits proposals, data collection proformas and recommendations.⁹

Categorising audits in terms of priority will ensure that important clinical concerns are monitored, whilst using the SMART criteria for objective setting to agree an action plan

will clarify how and when this monitoring is to take place. Audit supervisors and departmental audit leads must adopt a more hands-on approach to guide juniors, with previous studies showing projects led by consultants show a higher proportion of audit completion.⁹ Audit departments should be encouraged to audit their outcomes annually, with findings presented and discussed at local directorate meetings.

Audit is an important component of health care service quality control and improvement and if performed well has been shown to improve medical practice.^{4,5} For this benefit to be achieved and monitored it is essential that the audit cycle is completed. We found that in the trauma and orthopaedic department of a large teaching hospital this was often not the case, a finding not isolated to the studied hospital.⁶⁻⁸ We suggest that improvement requires a structured approach, aiming to increase the audit quality and completion rate, improving patient care and ensuring staff time and trust finances are used efficiently.

Bibliografía

1. National Institute for Health and Clinical Excellence (NICE). Principles for best practice in clinical audit. Oxford, UK: Radcliffe Medical Press; 2002. p. 10. Available at: <https://www.nice.org.uk/media/default/About/what-we-do/Into-practice/principles-for-best-practice-in-clinical-audit.pdf> [accessed 15.10.19].
2. General Medical Council (GMC). Leadership and management for all doctors; Maintaining and improving standards of care. Manchester, UK; 2012. p. 25. Available at: <https://www.gmc-uk.org/ethicalguidance/ethical-guidance-for-doctors/leadership-and-management-for-all-doctors/maintaining-and-improving-standards-of-care> [accessed 15.10.19].

3. Smith M, Fereday S. Documenting local clinical audit – a guide to reporting and recording. Healthcare Quality Improvement Partnership (HQIP); 2016. p. 20.
4. Mungford M, Banfield P, O'Hanlon M. Effects of feedback information on clinical practice: a review. *BMJ*. 1991;303:398–402.
5. Merle V, Moret L, Pidhorz L, Dujardin F, Gouin F, Josset V, et al. Does comparison of performance lead to better care? A pilot observational study in patients admitted for hip fracture in three French public hospitals. *Int J Qual Health Care*. 2009;21:321–9.
6. Iqbal HJ, Pidikiti P. Audit of orthopaedic audits in an English Teaching Hospital: are we closing the loop. *Open Orthop J*. 2010;4:188–92.
7. Guryel E, Acton K, Patel S. Auditing orthopaedic audit. *Ann R Coll Surg Engl*. 2008;90:675–8.
8. Gnanalingham J, Gnanalingham M, Gnanalingham K. An audit of audits: are we completing the cycle? *J R Soc Med*. 2001;94:288–9.

9. Johnson G, Crombie I, Davies H, Alder EM, Millard A. Reviewing audit: barriers and facilitating factors for effective clinical audit. *Qual Health Care*. 2000;9:23–6.
10. Nettleton J, Ireland A. Junior doctors' views on clinical audit – has anything changed? *Int J Health Care Qual Assur Inc Leadersh Health Serv*. 2000;13:245–53.

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El argumento «negocial» del consentimiento informado como incentivo para cumplir en la práctica clínica los requisitos de la doctrina ética y jurídica



The business case for medical informed consent as an incentive to meet in the clinical practice the requirements of the ethical and legal doctrine

Sra. Directora:

El consentimiento informado (CI) ha devenido una herramienta «defensiva» que olvida el proceso de información ser el instrumento en el proceso de información al paciente sobre las alternativas terapéuticas y sus consecuencias. Se limita a la firma de un documento para «pseudoproteger» a los profesionales y a las instituciones. Algunos autores han formulado propuestas de revisión del CI para superar el ejercicio defensivo de la medicina mejorando su procedimiento.

Entre las propuestas para su mejora destaca el argumento «negocial» (*business case*) del CI de Marshall Kapp¹ como un impulso adicional para implantar la doctrina en la práctica clínica de forma minuciosa con incentivos económicos, en una aproximación utilitarista que estimula la conducta del proveedor hacia los resultados, en analogía con el argumento «negocial» para la calidad sanitaria (*business case for quality in health care*), y que ha sido poco difundida en España.

Los efectos sinérgicos que tiene implementar esta propuesta son los siguientes: 1) los pacientes participan activa y autónomamente en las decisiones; 2) los proveedores maximizan beneficios, y 3) los profesionales satisfacen el deseo de preservar la reputación profesional. Aspectos que se detallan a continuación:

1. **Reducción de costes.** Cumplir los requisitos de la doctrina legal y ética del CI se justifica por sus beneficios, tanto pragmáticos como prudenciales.
2. **Seguridad del paciente.** Un buen proceso de CI capacita y recluta al paciente como «socio» para prevenir los eventos adversos, frente a la escasa adherencia al tratamiento que compromete el éxito de los resultados clínicos y cuyo resultado insatisfactorio aumenta la posibilidad de demandas.
3. **Defensa legal.** Un proceso de obtención del CI con un proceso estandarizado, adecuado y bien documentado ejerce una función valiosa en la gestión de riesgos legales, pues fortalece la defensa jurídica del profesional ante el advenimiento de eventos adversos y, consecuentemente, reduce las demandas legales ante la ausencia o insuficiencia del CI.
4. **Confianza.** La discusión abierta, honesta y respetuosa con el paciente y/o la familia sobre las alternativas terapéuticas, o el rechazo de estas, mejora la confianza en la relación clínica y la tasa de adherencia del paciente al plan terapéutico propuesto y acordado.
5. **Elección del proveedor.** Cuando la estructura sanitaria permite elegir la provisión asistencial constituye un estímulo para fidelizar o ampliar la cartera de usuarios: 1) los consumidores exigen un servicio de calidad con precio asequible que respete sus derechos; 2) los proveedores compiten frente a una audiencia sofisticada y exigente que valora otros factores, como el respeto a su autonomía, y 3) las instituciones sanitarias procuran mejorar la experiencia del paciente y garantizar la sostenibilidad financiera.
6. **Utilidad económica.** Reducir los eventos adversos disminuye los costes de la defensa legal, el pago de reclamaciones y la necesidad de una atención sanitaria adicional.
7. **Reputación profesional.** El médico tiene un interés en mantener una buena imagen profesional entre sus pacientes y los pares.