



## Service Priorities and Programmes Electronic Presentations

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### **Clinical Audits is a mechanism for gradually improving patient safety**

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#### **Keywords:**

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#### **Introduction**

Clinical audit is a quality improvement process to evaluate and improve health care through review of staff performance against explicit standards and the implementation of change. In particular, “at risk” patient care and outcome are evaluated and improved as required.

#### **Objectives**

1. To examine current practice meets required standards 2. To assess current practice follows published guidelines 3. To explore areas for improvement; 4. To provide data for benchmarking 5. To enhance transparency of quality and safety issues in the hospital

#### **Methodology**

1. To form clinical audit teams which included nursing administrators, clinical frontline staff, physicians and laboratory technicians. 2. To adopt cluster hospital audit forms with minor amendment based on local hospital needs for benchmarking. 3. To decide types of audits to be conducted to evaluate the patient care and outcome 4. To analysis the data and publish reports and post them in the hospital website to enhance transparency of quality and safety issues 5. To disseminate reports to all hospital staff via e-mail and discuss the result in the relevant meeting, such as committee meetings 6. To implement change based on the results of audits

#### **Result**

15 clinical audits were conducted in 4Q 2011 to 4Q 2012, including blood transfusion, post fall incident review, documentation on fall prevention, nursing care plan, pressure ulcer, point prevalence study of pressure ulcer, emergency trolley layout, case note review, bedside procedure safety check, surgical safety check, physical restraint, nursing assessment on admission, specimen reception and ABO-rhesus typing procedure, nursing document. Some improvements were made according to the results of audits. For examples: Audit items Improvement measures Blood transfusion Patient safety alert was published to increase awareness

of the importance of any rash noted before blood transfusion which could be acted as baseline observation. Post Fall incident review Designed a “you are at risk for fall” card to inform patient and carer of their risk for fall. Remind “at risk” patients of “beware of their own ability” . Point prevalence study of pressure ulcer Established a system to investigate hospital acquired pressure ulcer by wound care team as rate of incident increased by 3.9% from 10.8% in 2011 to 14.7% I 2012.