



Is audit research? The relationships between clinical audit and social research

Is audit research?

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Abstract

Purpose – Quality has an established history in health care. Audit, as a means of quality assessment, is well understood and the existing literature has identified links between audit and research processes. This paper reviews the relationships between audit and research processes, highlighting how audit can be improved through the principles and practice of social research.

Design/methodology/approach – The review begins by defining the audit process. It goes on to explore salient relationships between clinical audit and research, grouped into the following broad themes: ethical considerations, highlighting responsibilities towards others and the need for ethical review for audit; asking questions and using appropriate methods, emphasising transparency in audit methods; conceptual issues, including identifying problematic concepts, such as “satisfaction”, and the importance of reflexivity within audit; emphasising research in context, highlighting the benefits of vignettes and action research; complementary methods, demonstrating improvements for the quality of findings; and training and multidisciplinary working, suggesting the need for closer relationships between researchers and clinical practitioners.

Findings – Audit processes cannot be considered research. Both audit and research processes serve distinct purposes.

Originality/value – Attention to the principles of research when conducting audit are necessary to improve the quality of audit and, in turn, the quality of health care.

Keywords Quality, Clinical audit, Health services, Research methods

Paper type Literature review

1. Introduction

Quality and its assessment within health care has a long history (Cabot, 1912; Reed and Clark, 1941; Sheps, 1955; Makover, 1951; Donabedian, 1996a, b). Internationally, quality is an important component of health care policy and some countries legislate for quality assessment and improvement (Pollitt, 1993a; Øvretveit, 1994; Sluijs *et al.*, 2001).

A host of methods and approaches towards understanding health care quality as well as mechanisms to effect change to improve health care exist. Audit is one established approach that serves towards understanding and improving health care quality (National Institute for Clinical Excellence, 2002). Pollitt (1993b) describes how the 1970s saw quality and audit packages being introduced from North America to nurses in the United Kingdom (UK). In the UK, as health policy increasingly emphasised quality and audit in the 1980s, nursing in particular was reasonably familiar with such measures and equipped to implement quality improvement measures according to health care policies.

Thanks are due to Nerys Anthony and Bee Peel for helpful discussions when writing this paper, and to the journal's referees for constructive comments on an earlier draft.



The relationships between audit and research have been given some, but not a great deal of attention within health (Closs and Cheater, 1996; Scott and Pinnock, 1997; Carr, 1999; Wilson *et al.*, 1999; Warlow and Al-Shahi, 2000). This paper reviews the relationships between audit and research processes. The distinct focus is on the improvement of audit through the application of the principles of social research. Research into clinical practice focuses on constructing questions, specifying people or problems to be addressed and any clinical interventions or outcomes. Methods for data collection and analysis must then be applied that are suitable to the topics under investigation (Strauss and Sackett, 1998). As will be discussed in this paper, important issues that may impede the successful implementation of audit have been identified (Baker *et al.*, 1995; Berger, 1998a, b; Cheater and Keane, 1998; Sutton *et al.*, 1998; Hearnshaw *et al.*, 2003; Hughes *et al.*, 2003, 2004). These problems are not irresolvable (Cooper and Hewison, 2002), especially when the principles of research are applied to audit. However, as Power (2003) notes, many studies of audit are by products of other projects and may, therefore, be inadequately focused.

2. Defining audit

Shaw (1989, p. 11) defines audit in three stages:

The first stage is to define expectations, the second to compare these with observed reality, and the third to bring about appropriate change in clinical practice.

Links can be made between audit and research, as both represent forms of inquiry. Research questions (defining expectations) underpin the adoption of particular research methods (observing). Once research has been undertaken it is important for the results to be fed back (to bring about change). Answering research questions is informed by the theoretical positing of research, the kinds of information required and how best this information can be obtained with regards to practical and ethical considerations (Denzin, 1970). These guiding principles of research are also reflected in quality improvement, as Sheps (1955, p. 977) exemplifies:

The methods and standards selected must be related to the particular purposes for which they are being applied

The audit process can therefore be conceptualised as:

- the identification of elements of care for examination and setting questions, issues for exploration, standard setting or review criteria;
- the choice and application of methods to appraise care, including rigorous analysis of data; and
- the feedback of results to affect direct service improvements.

Audit is a cyclic process, whereby the feedback of results should lead to the identification of new areas of inquiry in much the same way as research findings can lead to the identification of further research questions.

This is an ideal-type conceptualization of audit. The cyclic process is a blueprint, and in practice these stages, particularly stage three, are not always completed. Furthermore, ideal-type audit practice tends to focus on these cyclic stages in order to satisfy external pressures rather than on the integrity of self-observation and

regulation itself, which lies at the heart of audit (Power, 1999, 2000). For example, Is audit research? Power (2000, p. 114) exemplifies some of the complexities at work:

... the design of accounting reports, and of the performance measures by which organizations can be judged, is greatly influenced by the imperative of “making them auditable”, and that this has much to do with agendas for control of these organizations. It follows that many audit processes are not neutral acts of verification but actively shape the design and interpretation of “auditable performance”.

There is, therefore, a case to examine audit. The principles and practice of research provides one useful framework for doing so.

3. Ethical considerations

In formulating high-quality research questions and choosing methods, attention is paid to the ethical sensitivities of involving participants (Bulmer, 1982; Homan, 1991). Equally it is important to consider researchers' obligations to themselves, their funders and their colleagues (Social Research Association, 1994). These broader ethical issues in social research help to position audit within a socially responsible inquiry approach. Evidence suggests that the effects of audit on professional relationships are often overlooked, and tensions between professionals conducting audit may arise (Cheater and Keane, 1998; Hearnshaw *et al.*, 2003). For example, Cheater and Keane (1998) used qualitative focus groups and interviews to explore perceptions of nurses' involvement in audit and impediments to nurses' involvement within multidisciplinary teams. They found that some doctors resisted attempts to involve nurses and maintained medical leadership of audit groups, which resulted in hierarchical audit practices. One participant in Cheater and Keane's (1998) study, for example, remarked:

... the caring profession within the trust itself ... their voice at present isn't heard, it's not listened to at all. If you bring in that voice it does threaten the hierarchy. Those most under threat are medical staff ... who previously have enjoyed God-like status, the consultant who tells everyone what to do. That attitude is going to have to be changed somehow (p. 33).

The inclusion or exclusion of professionals in the audit process raises important ethical issues, not least in terms of representation and the promotion of fair working practices. It is important for audit to be conducted in ways that maximise professionals' obligations towards one another, and in doing so, may improve the quality of audit. What is required is a move away from hierarchical working structures in audit towards devolved responsibility for quality improvement that is supported by management with appropriate resourcing (Harvey and Kitson, 1996).

There are also important ethical obligations to participants, including patients, when conducting audit (Carr, 1999; Low-Beer, 2001; Talbot, 2001). Carr (1999) examines the ethical issues pertaining to patients during an audit of post-operative pain within a hospital. The audit employed discharge surveys and follow-up telephone interviews with patients. The ethical issues arising in this study, for example consent, privacy and freedom from harm, were the same as if the work had been conducted as “research”. In the UK, the Royal College of Physicians (cited in Carr, 1999) sets out that audit need not necessarily be subject to ethical review. Any form of inquiry raises ethical issues (Homan, 1991) and it is important for audit to be seen, and therefore reviewed, in the same manner as research.

Research is not value-free and has to be conducted with attention to social responsibility (Shaw, 2000). Similarly, audit is not value-free and tensions can arise between the different groups that audit serves. Low-Beer (2000, p. 72) argues for ethical review of audit on these grounds:

Audit cannot be value free. The audit process is set to predetermined standards for any given healthcare activity. Best practice is bound to set priorities, and conflicts will arise between benefit to individual patients and demands of management, or perceptions of what is best for the community. Staff shortages, finally officially recognised, have forced the health service to make compromises, which in turn influence the determination of standard setting. These compromises clearly involve value judgements.

The situation at present, in the UK, whereby audit need not be subject to ethical review, may be partly explained as a product of its development. The introduction of medical audit in the 1980s unearthed considerable “territorial sensitivity” amongst the medical profession (Pollitt, 1993b, p. 162). Voluntary and anonymous internal regulation, not open to sanction from outside bodies, was emphasised throughout the development of medical audit by the medical profession (Pollitt, 1993a, b). In recent years, reports of widely publicised poor medical practice led to political commitment to formalise audit practices (Small and Rhodes, 2000). The result is that in the UK, for example, quality assessment is now a legislative requirement (Her Majesty’s Government, 2001). The history of audit, emphasised as a voluntary activity within the medical profession, may help to explain why ethical review of audit is also a voluntary exercise in many areas of health. There are exceptions, such as the journal *Anaesthesia*, which Scott (2000) notes requires prospective ethical approval when presenting audit studies. Reports of ineffective audit (Cheater and Keane, 1998, Hearnshaw *et al.*, 2003, 2004) have the potential to contribute evidence towards arguments for the inclusion of ethical review of audits in the UK.

4. Asking questions and seeking answers

The earlier definition of audit emphasises the process as cyclic, and each stage of the inquiry needs to be met. However, following the principles of social research, the audit cycle can only be entered at point 1. This understanding serves to ensure clarity in the identification of issues and the choice and application of audit methods. There needs to be transparency in audit design, to allow assessment of its quality. Similarly, social research findings should be presented with greater methodological transparency (Stanley and Wise, 1993).

Hearnshaw *et al.* (2003) conducted a questionnaire survey of NHS Trusts and general practices in England and Wales to measure the extent to which audit methods were systematically selected. The authors expected more rigour within clinical audit, compared with non-clinical audit owing to the stronger clinical evidence base. However, they found methods were not selected systematically in either clinical or non-clinical audit. Furthermore, audit practices did not attempt to minimise demands of the audit on staff, neither did they establish acceptability of the audit amongst service users nor appraise findings within the context of literature (owing to limited access to this literature).

Closs and Cheater (1996) suggest that audit is not generalisable due to its local nature. Research is typically seen as the provenance of large-scale studies generalisable to other settings, whereas audit is understood as small scale and local work that serves to directly improve practice (Balogh, 1996). Reflecting these views, Hearnshaw *et al.* (2003) found that audit was usually conducted at organisational levels, with few

regional or national audits being undertaken. However, audit need not be restricted to a local focus. Attention to sampling during the process of audit design can allow national audits to be undertaken, and improved access to literature, for example, can give results from local audits their necessary wider resonance and generalisability. There is also potential to conduct cross-national comparisons (Pollitt, 1993a; Øvretveit, 1994; Sluijs *et al.*, 2001). At present, however, many audits lack attention to the finer details of research practice. Audit in health must therefore pay close attention to the science of inquiry, just as in health care research more generally (Horsfall, 1995).

5. Conceptual issues

Underpinning research questions and methods are the concepts being investigated. Theory-driven evaluation has potential to develop generalisable findings in audit (Grocott *et al.*, 2002). The concept of “satisfaction” as an indicator of quality in health care, for example, is one of the most popular ways of measuring outcomes in health (Thomas and Bond, 1991). Satisfaction, however, is problematic for assessing quality (Carr-Hill and Dalley, 1992; Avis, 1995; Aspinal *et al.*, 2003). A review of satisfaction literature uncovered poorly defined studies, devoid of theory and methodologically inconsistent:

It appears that the current use of satisfaction to measure quality in palliative care is seriously flawed. Satisfaction remains under-theorized in health, palliative care and nursing debates. Until the concept is less ambiguous and has empirically demonstrable links with service quality satisfaction should not be used to assess service provision in palliative care. Everyone involved with the measurement of satisfaction as an indicator of the quality of palliative care has a responsibility to engage in the discourses surrounding satisfaction and its measurement before decisions can be made on the choice of methods to be used to assess performance (Aspinal *et al.*, 2003, p. 337).

The debates surrounding satisfaction highlight widespread need for an improved conceptual positioning of audit. One important issue for the future is the attention given to the values of those individuals, groups and organisations conducting it. The stakeholders involved in quality assurance initiatives will all have different perspectives on quality (Carr-Hill and Dalley, 1992). These stakeholders will therefore emphasise methods and findings in particular ways. Reflexive research practice that brings the “I” into the research process is valuable in this regard (Stanley, 1992; Stanley and Wise, 1993; Shakespeare *et al.*, 1993). Emphasising the “We” within audit teams in health can help to understand the findings and improve future methods of inquiry. Audit is well placed in this respect owing to the reflexive process that underpins the audit cycle. Positioning audit reflexively does well to recognise professionals’ expertise and experience as evidence. As Gerrish (2003, p. 106) argues, professionals’ views are important towards reframing evidence-based practice in health:

... knowing patients, and viewing them as individuals, keeps the recipients of care central and this is fundamental to nursing practice. In conceptualizing evidence-based practice there is a need to recognize that professional expertise is not based solely on case knowledge derived from scientific research, but should incorporate patient and person knowledge.

Post-modern and post-structural approaches provide further opportunities for improvements to health care and research (Jacobson and Jacques, 1997; Cheek, 2000). These approaches allow exploration of taken-for-granted assumptions and look at procedures that are not in vogue as much as those that are. Greater attention to these

conceptual approaches in audit may even lead to practice itself being reconceptualised. The challenge for audit, and health care quality improvement initiatives generally, is to integrate audit methods with suitable social theories to augment understandings of existing health care and its quality:

Postmodern and poststructural approaches offer one way of thinking deeply about nursing and health care. Practical, specific and concrete research outcomes are needed in practice-based disciplines such as nursing, but so are thoughtful practitioners who can influence and change practice. The two need not be mutually exclusive (Cheek, 2000, p. 11).

6. Emphasising audit in context

All forms of inquiry are socially situated and methods and theory are operationalised within the particular contexts of studies and their settings (Denzin, 1970). Within health care quality debates, Donabedian (1996a, p. 402) notes how methods must fit the situation and emphasises 'a study of contexts, and the interventions appropriate to each of these'. Broader conceptualisation of audit, as noted in the previous section of this paper, represents one means of exploring the context of health care quality. The choice of audit methods is also an equally important consideration. Qualitative approaches are more appropriate to address contextual issues than structured forms of data collection (Gerrish, 2003). The qualitative application of vignettes, for example, which represent forms of stimuli – such as written stories of visual images – presented to research participants to respond to have value in this respect (Hughes and Huby, 2002). In social care, Shaw (2000) considers how vignettes, in the form of simulated social work clients, allow the practices of professionals to be explored within defined contexts, including case studies. Social workers will be familiar with the case study approach contained with the vignette approach, and the results can serve to improve the visibility of practice and ways to improve it. The vignette approach also circumvents some of the practical and ethical issues raised when involving service users directly, such as recruiting and interviewing people.

In addition to methods there are indirect situational factors to the audit setting that can impede the success of audit, for example lack of time and resources, "top-down" management styles, insufficient supervision and support, conflicts within interprofessional relationships and negative attitudes associated with the audit process (Black and Thompson, 1993; Baker *et al.*, 1995; Berger, 1998a, b; Sutton *et al.*, 1998; Nettleton and Ireland, 2000; Cheater and Keane, 1998; Hearnshaw *et al.*, 2003; Hughes *et al.*, 2003, 2004). These studies demonstrate the importance for audit to avoid being developed in a vacuum, distant to health care practice. Rather, audit must be informed and shaped by the needs and experiences of individuals within the organisations involved (Hughes *et al.*, 2003). Action research is one approach that is well suited in this respect. Action research is an established research approach within health (Waterman *et al.*, 1995), and has been used to implement audit (Cooper and Hewison, 2002; Dunckley *et al.*, 2004). The value of action research in implementing audit lies in its shared aims towards bringing about positive change that are sensitive to social and organisational contexts. In this way, the principles and practices of audit and action research have close relationships (Closs and Cheater, 1996; Cooper and Hewison, 2002).

7. The value of complementary methods

There is a distinct tradition with social research that advocates the use of complementary methods or triangulation (Jick, 1979; Fielding and Fielding, 1986). Combining methods, typically including quantitative and qualitative means of data generation, can counterbalance strengths and weakness of methods when used individually. In so doing, the approach:

... can also capture a more complete, *holistic*, and contextual portrayal of the unit(s) under study (Jick, 1979, p. 603; emphasis in original).

Similarly, in the assessment of the effectiveness of quality assurance, Donabedian (1996a, p. 402) recognises that all methods used, to greater or lesser extents, may be effective:

Yet no one method is demonstrably superior in every situation, or in most. One response to this uncertainty is to use a combination of methods, hoping that a cumulative effect, or even a synergy, may emerge.

It is important to recognise that methods and approaches simply represent particular lines of inquiry towards understanding health care quality. Developing complementary approaches in audit represents an important consideration for future work as it can serve to increase the quality of the data obtained. Closely allied to complementary methods is multi-professional team working.

8. Education, training and multi-professional team working

Audit is not something that can be undertaken lightly, and it requires skilled and educated professionals to ask the right questions, choose appropriate methods and undertake the work in a robust yet equally sensitive way. Lindblom (1986, p. 345) exemplifies similar issues with regards to the social sciences:

Only professional social researchers and social scientists have the time, skills, and funds for analyzing larger social problems in society.

Transposing the principles of research into the audit process requires attention to education and training programmes in both pre- and post-registration. Training in research (Taylor *et al.*, 1994), the use of health status outcome measures (Carr and Higginson, 2001), and the process of audit (Nettleton and Ireland, 2000) have been called for.

Education and training issues also reflect wider professional boundaries between audit and research. Researchers undergo research education and training, usually as part of a degree, which provides the foundation for conducting research. In contrast, audit tends to be emphasised as an activity that can be undertaken by anyone wishing to improve clinical practice (Higginson, 1993), and few receive education and training (Nettleton and Ireland, 2000). Clearly, it is not always appropriate or necessary to educate and train clinical practitioners in research, nor researchers in the implementation of findings into clinical practice. Therefore, multidisciplinary synergies in research and audit that can effectively work together are required. In much the same way as complementary audit methods balance strengths and weaknesses, so too do multi-disciplinary audit and research teams within health. This suggestion reflects the principles of researcher triangulation within social research, whereby different researchers are used to explore the same topics, thereby leading to

improved understanding overall (Denzin, 1970). Researchers involved in audit may, for example, benefit from approaches and techniques used to implement findings that could potentially serve to bridge the research-practice gap (Bero *et al.*, 1998; Harries *et al.*, 1999). Equally, those involved in audit will, for example, benefit from sampling techniques in research that can help to improve generalisability.

Understanding further the relationships between audit and research can be achieved by developing links between social research and audit in practice. In so doing the relative merits and disadvantages between audit and research may be elaborated. Underlying this, therefore, is the need for multi-professional team working and ensuring that organisational and multi-professional structures are in place to allow knowledge transfer between researchers and clinical practitioners, for example setting up and maintaining relationships between universities and statutory and non-statutory health care settings. It is also important to recognise that the relationships between audit and research are two-way. The emphasis throughout this paper has been on the areas in which research can influence audit quality. While a fuller discussion of the ways in which audit can influence better quality research is beyond the scope of this paper, it does highlight an important direction for future work.

9. Concluding comment

This paper has reviewed some of the salient considerations surrounding audit and research. Clearly, audit is not research. Audit is insufficiently defined both philosophically and conceptually, and much of current audit practice is not rigorous enough to constitute research. As further studies of audit are undertaken, as called for by Power (2003), and strengths and weaknesses in audit methods and approaches are identified, there is the potential to change ineffective audit practices. However, there are critical unresolved issues, which focus on the balances that need to be achieved between research and audit, notably to:

- pursue audit and achieve greater change in practice but doing so through a weaker evidence base when compared with research approaches; and
- conduct research but recognise it may have limited effects on practice, as characterised by the research-practice gap.

For the future, multi-professional team working between researchers and health care practitioners undertaking audit represent an important step in establishing the necessary synergy needed between audit and research. In this way research and audit together are likely to better serve improvements to the quality of health care.

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