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Is Clinical Audit Action Research?

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ABSTRACT Since 1991 clinical audit has become an essential part of Health Service practice with local funding for projects in the United Kingdom. The process seems to be very similar to action research as it is based upon 'the systematic peer evaluation of the quality of patient care'. This paper sets out to compare and contrast terms used in health and education to explore similarities that may provide opportunities for multiprofessional dialogue.

Background

I work in the mainstream schools in a defined geographical area in East Suffolk, which includes five high schools and their feeder schools, and one special school, my remit is to:

1. Assess and advise on any environmental difficulties relating to access and circulation around a school for children with mobility problems.
2. Assess and advise on any special equipment which might be necessary, for example, for seating or writing, for a child with physical difficulties.
3. Assess and advise when a child is having fine-motor, perceptual or coordination difficulties, when their learning difficulties are not accountable through lack of intellect or opportunities.

More and more of my time is now being spent with children in this last group.

When I first started this work in 1986, I was told by my manager that it was "All common sense", so why, I wondered, did the schools need me? It is through a form of action research, further training, reflection and experience that I have begun to understand the difficulties these children face, both practical (everything they touch gets messed up) and personal (always the last to be chosen for a team), and the contribution occupational therapists can make. In medical publications and in the public media, many possible theoretical explanations for these difficulties have been offered over the

years, some more far-fetched than others; each have had their own remedies and disciples, each fashionable for a time or in certain contexts. Treatment techniques have largely focused on teaching 'splinter skills', e.g. dressing, writing, using cutlery, tying shoelaces. Although these tasks may be achieved in the context of the practice they may not become generalised or accessible to the child in other circumstances. What I needed was (a) an assessment to identify the signs of 'sensory-motor dysfunction' and (b) a treatment that supported the development of such a child's motor control so that they could in the general context of their lives, sit firmly on a chair, scan the pages of a book or write. This is my contribution to the child's education.

While I was working at the American Airforce base school in Woodbridge in the late 1980s I was introduced to the work of occupational therapist Dr Jean Ayres and her sensory integration therapy.

> *Through her research, Dr Ayres (1920–1988) made the discovery that [some] children had a neural disorder that resulted in inefficient organisation of sensory input received by the nervous system. She developed diagnostic tools for identifying the disorder and proposed a therapeutic approach that transformed pediatric occupational therapy. (Sensory Integration International, 1991)*

I have completed two of the three parts of this training and use the techniques extensively, in parallel with others, to provide assessment, intervention or advice at the child's school or home. In this article I argue that my enquiry techniques are similar to action research. At first I did not document my thought processes; however the British Association of Occupational Therapists Code of Practice includes:

> *15. Professional development.*
> *d. Occupational therapists have a responsibility to the continuing development of the profession by critical evaluation and research.*

Hence, to fulfil this requirement I embarked on the MA Applied Research in Education at the Centre for Applied Research in Education (CARE), University of East Anglia in 1991. A very important personal development began when I started to keep a professional journal at the beginning of the course. In an editorial published two years later in the *British Journal of Occupational Therapy* in June 1993, I wrote:

> *In these days of standards and contracts, how do we record our 'experience'? One way to begin is to start keeping a professional journal. Not a diary of facts and figures but free writing, using the page as a mirror in which to reflect thoughts and feelings as we explore alternative solutions, make decisions and document how these were reached ... Once things are visible they become concrete, we may look at them later and be amused or amazed, but they are there to reflect upon, criticise, use or abuse ... By documenting the thought processes as well as the facts and the*

sources we can examine our unique professional development and provide others with evidence of our experience and expertise.

Comparing Action Research and Clinical Audit

This journal is about action research. Is it possible that we could become professions isolated by our own jargon, when we have much experience to share? Until I went to CARE, action research to me was a charity who funded research into crippling diseases in children. To quote from one of their current leaflets 'Clumsiness in Children':

DOES YOUR CHILD ...
Look awkward when running or jumping?
Have difficulty catching a ball?
Get in a muddle when fastening buttons or tying shoelaces?
Find handwriting very difficult?
At action research our priority is to safeguard health. We are one of the United Kingdom's leading medical research charities, committed to improving the quality of life for everyone.

There is no confusion, just two groups who, although unknown to each other, are using the same name for different things. Similarly, are we perhaps confusing each other by using different names for the same things?

Anyone setting out on any type of research in the health service must have approval from the local medical ethics committee. The chairman said at my interview in 1991 that as long as I stayed in the realms of *audit*, he would have no opposition. So, what is clinical audit? I had only previously heard of audit linked to accountancy. Trying to unravel my confusion I first found some definitions:

Clinical Audit

The systematic peer evaluation of the quality of patient care, based on explicit and measurable indicators of quality, for the purpose of demonstrating and improving the quality of patient care. (East Anglian Regional Clinical Audit Team, 1993)

The development of quality assurance and audit activities ... Within the professions allied to medicine (PAMs, i.e. OT, physio, speech therapy and chiropody) start with defining professional standards. These cover the clinician being properly prepared for interventions, with a clear assessment of the problem, setting achievable and realistic goals, and involving the customers (clients, carers and other professionals) in planning. All are concerned about the effectiveness of the intervention, although this poses many serious

> *measurement problems. All are concerned with the experience of being a patient or client. (Department of Health, 1991)*

Action Research

> *May be broadly defined as research on a social situation which incorporates action and change in the discovery of new knowledge ... a value-laden, moral activity which sets out to bring about improvement through reflection leading to action. (CARE, 1989)*

> *A systematic inquiry by collaborative, self-critical communities of teachers, which takes place in schools. It is pursued out of a desire or need to improve educational knowledge and practices. It is accomplished through a recursive cycle of (1) identifying a problem areas, (2) studying it by gathering data, and (3) reflecting on the data in order to make teaching decisions grounded in evidence rather than in hunches. Action is an integral part of the research and not an event which may – or may not – follow the study's completion. (Watt & Watt, 1991, p. 36)*

> *The fundamental aim of action research is to improve practice rather than to produce knowledge. ... [it] improves practice by developing the practitioner's capacity for discrimination and judgement in particular, complex, human situations. It unifies inquiry, the improvement of performance and the development of person's in their professional role. (Elliott, 1991, p. 49)*

These activities clearly have common elements. I believe action research has a place in many more areas than teaching. What is even more interesting is the comparison of Lewin's 1946 model quoted by Elliott (1991).

> *the basic cycle of activities is: Identifying a general idea, reconnaissance, general planning, developing the first action step, implementing the first action step, evaluation, revising the general plan. (p. 69)*

and the description of 'How audit works' by the East Anglian Regional Clinical Audit Team (1993):

> *Audit offers a means for health professionals to set standards, observe and compare practice with standards, implement change and then re-audit. ... In other words, it's about health professionals looking at what they do and how they do it, and seeing if changes can be made which will lead to measurable improvements in patient care. (p. 4)*

The difference is that audit requires us to set and publish standards then measure performance, although the report to the Department of Health

clearly recognises that there are serious problems. This is the task I set myself for my dissertation (Bennett, 1994).

Doctors in the National Health Service (NHS) have had a contractual obligation to audit their practice since 1989, when it was known as 'medical audit'. Since the Department of Health report in 1991 audit has spread to include all professions and departments and the name has changed to 'clinical audit' to reflect this. For me, learning about audit and learning about action research have occurred at the same time.

Facing Some Common Dilemmas

In common with the dilemmas faced by other professionals when they begin to reflect on their practice, a lot of the recurring difficulties, for me, centred around five main areas.

(1) *Power.* It is very difficult to identify, at the moment, who has power in the health service. We have, on average, over the last eight years, experienced one change every three months. Some are minor, but others have the effect of destabilising the structure of the organisation. For practitioners dealing mainly with the public, many things stay the same, but some *people* move, merge or change their role, making support and information networks very difficult to maintain. This tends to affect action research in one way, since it can be very small in scope and therefore may not need to involve permission from many people. In contrast, audit is public, the region, district and unit will have agreed priorities for audit topics, and funding may be restricted to those topics.

(2) *Control.* It can become very confusing when many people appear to have some form of control over what is happening in the health service, when finding someone who can make a decision is difficult. Before writing the standards for the department, the research involved interviewing the staff in groups or individually, as they chose, and reviewing the literature. We are being encouraged to define our working practices but, in fact, to a large extent this has already been done by a number of different agencies, for example, the Department of Health in the Patient's Charter, the Regional Health Authority, the local Health Authority, Allington NHS Trust in their mission statements and manifestos, and the British Association of Occupational Therapists in their Code of Professional Conduct and their advisory Standards, Policies and Proceedings. These definitions cannot be disregarded and local standards can only be in addition to, not instead of them.

During the action research phase of reflecting on current practice, changes were made by individuals and groups. They were able to give time and thought to details, and the process remained under their control. However, once the standards were published in 1993 they became part of the official audit structure of the Trust. So far we have retained control as we prepare to refine our wording and audit for the first time.

(3) *Identity.* Most practitioners are already working very hard and find it difficult to find time to be closely involved with the process of audit, although this is a government requirement. In some locations special auditor posts are being created to overcome this, but inevitably that person is one step removed from the patient/client. To be identified with the process and feel in possession of the results, practitioners need to have maximum input, using the auditor only as a facilitator.

During action research the participants are protected by agreed confidentiality, and quotations may be very personal, descriptive and qualitative. In contrast, we can only audit standards that are written in behavioural terms. By using 'indicators' (e.g. referrals will be acknowledged [standard] *within 3 working days* [indicator]) the result is 'yes' or 'no', and very easy to count, but the personalities and reflective discussion that went on to agree the wording are lost. This offers individuals anonymity by submerging them, into a group identity.

(4) *Responsibility.* The person carrying out the research or audit soon becomes aware of the range of their responsibilities. If information and opinions are given in confidence, that must be maintained, even though at times it may seem impossible. If things are going badly wrong the manager needs to know. Thus there is a responsibility to the manager to inform them, but another responsibility to protect the source of the information. In a small department it is relatively easy to identify who might have been in a position to observe the problem; however, keeping sources secret on the one hand protects them, but on the other hand puts everybody 'in the frame', so decisions about where responsibility lies are very difficult to make.

Action research is initiated by the practitioners alone or in collaborative groups, but we are required to do audit. So far the audit has remained a practitioner-based activity and not a management tool. The managers were participants in the research process, and hence aware of all the dilemmas, although they may or may not have been aware of the sources.

(5) *Security.* There are many aspects to security. The confidential information collected for the study must be kept securely, although this may need no more than a lockable draw or a security code on a computer, partly to protect the source but also to prevent the document 'walking'. People taking part in the study must feel that they are not vulnerable to misuse or misinterpretation of their input. An evaluation can be used to criticise as well as inspire groups of workers, so release and access must be negotiated and strictly controlled. Audit at departmental level is not intended for public information, but several people in authority will expect to be informed of the findings; a summary may satisfy them without leaving the subjects or the researcher vulnerable. It is almost impossible to predict or guarantee the effects of a study, whether it is action research or audit, but every effort has to be made to insure against negative outcomes.

Conclusions

Although action research and clinical audit are not identical, I hope to have shown that they have enough similarities to enable people involved in the two different disciplines to understand, communicate, appreciate and support each other. A British Telecom advertisement says "Man's greatest achievements have come about by talking, and his greatest failures, by not talking". Although we can never expect to know another profession's daily experience, we can talk, listen, try to understand and learn, which will enrich our ability to tackle professional dilemmas and challenges in a professional way.

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References

Action Research (1994) *Clumsiness in Children*, Vincent House, North Parade, Horsham, West Sussex RH12 2DP, United Kingdom.

Bennett, E. (1994) Standards and delivery: a self-evaluation of the Community Occupational Therapy Department of Allington NHS Trust, Suffolk, prior to writing standards, unpublished MA dissertation, CARE, University of East Anglia.

Centre for Applied Research in Education (1989) *Coming to Terms with Research: an introduction to the language for research degree students*. Norwich: University of East Anglia.

Code of Professional Conduct (1985) British Association of Occupational Therapists, 6-8 Marshalsea Road, Southwark, London SE1 1HL, United Kingdom.

Department of Health (1991) *Report on Clinical Audit for Professions Allied to Medicine*, Belfast: Institute of Clinical Science.

East Anglian Regional Clinical Audit Team (1993) *Clinical Audit Workbook*. Cambridge: Addenbrooke's Hospital.

Elliott, J. (1991) *Action Research for Educational Change*. Buckingham: Open University Press.

Sensory Integration International (1991) *A Parent's Guide to Understanding Sensory Integration*, 1402 Cravens Avenue, Torrance, CA 90501-2701, USA.

Watt, M.L. & Watt, D.L. (1993) Teacher research, action research: the logo action research collaborative, *Educational Action Research*, 1, pp. 35-64.