

## Level of Performance

For each criterion you will need to set targets for something you should always do (100%) and / or something that should never happen (0%).

**Example Level of Performance 1:** All donors should have a health check prior to donation (we would expect 100% compliance, it is mandatory for all donors.)



### Example Level of

**Performance 2:** Addressograph labels should **not** be used on transfusion samples. (we would expect 100% compliance – it is something we don't want to see!)

However there may be **acceptable** reasons for not meeting the criteria, either due to unforeseen circumstances or to meet the individual clinical needs of the patient or donor.



**Remember: Exceptions are justifiable reasons and not excuses!**

**Example** Male patients who are group O Rh D negative should receive group O Rh D negative red cells **except when there are low blood stocks or the transfusion episode is greater than 8 units.**

Once you have your explicit audit criteria you can audit against them. Once data has been analysed you will have three groups:

1. Those who conformed to the criteria
2. Those that did not conform, but fitted the exceptions
3. Those who did not conform to the criteria

## Who should write Criteria and Standards?

Recent government publications state that health professionals will be expected to develop standards that measure a wide range of features of quality in healthcare (Department of Health, 2002, NICE, 2002)



**Don't panic!** – standards may already be available from a variety of sources, both national and local. For example:

- National Standards / guidelines – National Institute for Health and Clinical Excellence, National Service Frameworks, Department of Health, British Committee for Standards in Haematology, 'Red Book'
- Organisational Standards – NHSBT or hospital policy
- Professional Standards – Nursing and Midwifery Council, Royal Colleges etc

## What if standards are not available?

You will need to develop and write your own in conjunction with the clinical team.

## Who needs to be involved?

Experts in the field/stakeholders.

You can write standards alone, but if you are going to use them to measure practice other than your own, you must involve the relevant people. These relevant people, known as Stakeholders, include anyone who will be affected by your audit, particularly if the findings indicate a need for change.



**Remember, to be valid, your criteria need to be SMART.**

For more information on standard setting please contact the clinical audit department.

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**NHS**

*Blood and Transplant*

# How to Set and Develop Clinical Audit Standards and Criteria

## Contact Information

**National Manager:** Barbara Stearn 01132148616  
**Regional Transfusion Committees:** Marc Lyon 01132148705  
**London & Southeast:** Samantha Lee-Cooper 02082582987  
**Midlands & Southwest:** Rita Bourn 01179912088  
**North:** Joanne Hill 01142034901

If you recall the definition of clinical audit, it is the process whereby actual practice is compared against explicit standards and criteria. So...

### What are Standards?

Crombie et al (1994) describe standards as:-  
“... a formal statement of how well patients should be managed...”.

A standard describes the level of care we expect patients or donors to receive. Examples of standards could be: -  
*'all donors should have their suitability to donate assessed prior to donation'*  
*'all patients should have the appropriate observations performed during transfusion'*

However, standards tend to be quite general about the level of care and the processes they describe. To be able to measure practice, we need to be more specific.

### Criteria

A criterion is an explicit statement describing the area of care that is being measured. Criteria are the way you should be doing things in an ideal world. Explicit means it should be SMART.



**S**pecific  
**M**easurable  
**A**chievable  
**R**esearch Based  
**T**imely

### Specific

Criteria should relate to a specific area of care and should give specific boundaries. They should be unambiguous.

### Measurable

If criteria are vague how can you compare your practice against them? You need to be

able to physically measure aspects of the criteria to allow comparison.

### Achievable

There is no point writing criteria that are not achievable either due to resource or clinical limitations.

### Research Based

Peer reviewed research evidence will have shown the best available treatment / method for your topic area.

There is a Hierarchy of Evidence, as some research methods are more reliable than others. When looking for research in your topic area you need to start looking for the most reliable forms of evidence, then move down the scale if you have no success.

### Hierarchy of Evidence

Systematic Reviews of Randomised Control Trials  
Single Randomised Control Trial  
Results of non-randomised trials  
Non-Experimental trials  
Expert Opinion (e.g. British Committee for Standards in Haematology)  
(There is training in Hierarchy of Evidence. Contact: Diane Pritchatt on 0121 254 0517)

### Timely

Criteria should reflect current practice not what you thought you did two years ago.

### What can be measured?

There are many methods of defining how well we do things. One model used in health care is **Donabedian's Quality Model**. In this model, healthcare and standards can be classified into 3 distinct areas: **Structure, Process and Outcome.**

### Structure - what you need.

This refers to the resources required, for example, the number of staff and the skills they require, space and equipment.

### Process - what you do.

This refers to actions and decisions taken by practitioners, such as communication, assessment, education, investigations, prescribing, interventions, evaluation and documentation.

### Outcome - what you expect.

This refers to the outcome of interventions such as health levels, patient knowledge or satisfaction.

For example the quality of a blood donor session could be assessed by looking at the following: -

### Structure

Is the venue suitable, is there enough space, heating, water, light, ventilation etc?  
Have we enough staff to run the session?  
Are the staff sufficiently trained to do their jobs?  
Does the team have the required skill mix?

### Process

Are all donors “healthscreened” according to Management Process Documents?  
Are all donors selected appropriately according to the donor selection guidelines?  
Is all documentation completed appropriately?

### Outcome

Has a successful donation been obtained?  
Have any donors suffered from adverse events such as bruises or faints?