



Surgical Audit and Peer Review

INTRODUCTION

Surgical audit is an educational exercise that is grounded in everyday practice. Research shows that audit and feedback is an effective educational strategy and helps participants analyse their performance and plan effective responses to improve their performance¹. Only by looking objectively at our own practice of surgery will we be able to compare our current performance and derive information which may help us consider how to improve what we do for the benefit of our patients.

Surgical Audit and Peer Review is a mandatory requirement for all surgeons participating in the RACS CPD Program.

DEFINITION

Surgical audit is a systematic, critical analysis of the quality of surgical care that is reviewed by peers against explicit criteria or recognised standards, and then used to further inform and improve surgical practice with the ultimate goal of improving the quality of care for patients.

The purpose of audit is to examine assumptions about practice, and whether current performance meets recognised standards.

A surgical audit involves:

- Collection and measurement of clinical activities and outcomes
- Analysis and comparison using standards, performance indicators an outcome parametres and
- A peer review process with a feedback mechanism to redress problems.

In addition to ensuring compliance with registration and recency of practice standards relevant to their jurisdiction, RACS recommends that all surgeons in operative practice undertake at least 10 weeks of operative practice per annum to maintain competence and dexterity.

TYPES OF AUDIT

Surgical audit may take the form of a personal surgical audit (total/ practice/ selected) or a group/hospital/specialty audit (focused or generic).

- *Total Practice or Workload Audit:* This is an audit that covers all the surgical operations performed. While total practice audit is a goal, it is recognised that in some circumstances it is unrealistic. A total practice audit enables you to identify patterns and trends in your practice by observing changes in throughput (caseload), procedures performed and outcomes. One period needs to be compared with another and needs to be long enough to accrue sufficient cases.
- *Selected Audit from Surgical Practice:* This is an audit that covers all patients who undergo a selected procedure, or an audit that covers all procedures conducted within a selected time-frame.
- *A Clinical Unit Audit:* This is an audit conducted by a clinical unit in which a small number of individual surgeons may participate.
- *Group or Specialty Audit:* This is an audit conducted by or under the auspices of a group or Specialty Society e.g. ANZSVS Bi-National Audit, BreastSurgANZ, Australasian Vascular Audit (AVA), Bi-National Colorectal Audit, Breast Implant Registry, Australian and New Zealand Gastric and Oesophageal Surgical Association (ANZGOSA)

¹ Thomson M, Oxman A, Davis D, Haynes R, Freemantle N, & Harvey E (2000) Audit and feedback to improve health professional practice and health care outcomes (Cochrane Review). In: The Cochrane Library, issue 3, part 2. Oxford: Update Software, 1997.

- *A Focused Audit:* A focused audit collects data on the process or outcome indicators such as those recommended by departments of health which may influence it: e.g. what is the wound infection rate after large bowel surgery - emergency/elective procedure, type of surgery, antibiotic prophylaxis blood loss, etc.
- *Locum logbook:* Fellows whose surgical practice type is 'locum' are required to maintain a logbook of surgical procedures, for review by the Locum Evaluation and Peer Review Committee.
- *Peer review of reports (non-operative surgeons only):* Fellows in non-operative (consulting only) practice are required to undertake a peer reviewed audit of their practice each year (e.g. peer review of three reports).

THE SURGICAL AUDIT CYCLE

The Surgical Audit Cycle Surgical audit activities are based on a five-step cycle:

- **Step 1: Determine scope:** A thoughtful decision about which area(s) of surgical practice to review.
- **Step 2: Select standards:** A clear description of what is good practice in this area against which the results of the audit will be compared.
- **Step 3: Collect data:** The collection of relevant data.
- **Step 4: Present and interpret results including peer review:** Comparison of results to standards and/or those of peers, discussion with peers, decision about what changes may lead to improvement e.g. learning new skills, changes in practice, systems etc.
- **Step 5: Make changes and monitor progress:** Alteration or confirmation of practice in accord with the results of analysis and consultation with peers, then checking that improvement has occurred.

MINIMUM STANDARD OF AUDIT FOR CPD

For CPD purposes, an audit must comply with the following minimum standard:

1. The participation in audit/s accurately reflects the surgeon's scope of practice
2. Can be one of the following:
 - a. total practice audit
 - b. selected audit (must include at least 10 weeks of surgical data)
 - c. clinical unit audit
 - d. group or specialty audit
 - e. a focused audit
 - f. locum logbook
 - g. peer review of reports (non-operative surgeons only)
3. Be benchmarked against minimum standards, guidelines or relevant research for that procedure/s (e.g. [Colonoscopy Clinical Care Standard](#))
4. The audit must incorporate data that meets the RACS minimum dataset standard. Guideline for minimum standards are included in Appendix 1 of the "Surgical Audit and Peer Review Guide" available here: <https://www.surgeons.org/research-audit/my-audits>
5. The audit be submitted for peer review.
6. Where an outlier is identified, the surgeon must take steps to identify the reasons and if necessary change their practice and monitor progress.

ASSOCIATED DOCUMENTS

[Surgical Audit and Peer Review Guide](#)