COLLEGE OF ANAESTHESIOLOGISTS OF IRELAND
Professional Competence Scheme (PCS)

Standards for Acceptable Clinical Audit Activity

within the Professional Competence Scheme

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PURPOSE OF THIS DOCUMENT
This guidance document establishes the minimum acceptable standards for clinical audit activity submitted for Practice Review credit within the Professional Competence Scheme (PCS) of the College of Anaesthesiologists of Ireland. It provides a framework for doctors, verifiers, and governance leads to ensure that audit activity represents genuine, structured engagement with quality improvement, patient safety, and reflective professional practice. This document supersedes informal guidance previously issued by the College.

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1. Scope and Principles

Clinical audit is the systematic process by which healthcare professionals review their practice against defined standards, identify shortfalls, implement corrective action, and re-measure to confirm improvement. It is a cornerstone of clinical governance and a professional obligation for all practising anaesthesiologists.

Within the PCS, audit activity must demonstrate substantive engagement with quality and safety — not merely the completion of an administrative task. The following principles underpin all standards in this document:

- Relevance: the audit addresses a clinically meaningful aspect of anaesthesia or peri-operative care.
- Standards-based: practice is measured against recognised national or international benchmarks.
- Systematic: data collection, analysis, and comparison are conducted in a structured and reproducible manner.
- Reflective: findings generate genuine learning and professional development.
- Improvement-oriented: the process drives measurable, documented change in practice.
- Governed: the activity occurs within or is sanctioned by an appropriate clinical governance framework.
- Verified: an independent senior clinician confirms the authenticity and quality of the activity.

> **Scope**
> This document applies to all doctors enrolled in the Professional Competence Scheme administered by the College of Anaesthesiologists of Ireland. It covers audit submitted for the Practice Review component of PCS requirements. It does not govern research, service evaluation, or non-clinical QI projects, except where these activities satisfy the conditions set out in Section 7.

2. The Clinical Audit Cycle

A high-quality audit follows a defined, iterative cycle. The College expects submissions to demonstrate engagement with as many stages of the cycle as feasible, with re-audit representing the completion of the cycle and the highest standard of evidence for improvement.

Stage	Name	Description and Expectations
1	**Identify the Problem**	Select a topic of clinical relevance; articulate why the area warrants scrutiny (e.g. known variation, adverse event, national guideline). Justify the choice with reference to available evidence or local data.
2	**Set Standards / Criteria**	Define explicit, measurable criteria against recognised guidelines (AAGBI, NICE, HSE, RCoA, SIGN, or equivalent). Standards should be SMART: Specific, Measurable, Achievable, Relevant, and Time-bound.
3	**Collect Data**	Design a data collection tool; determine sample size (minimum n=20 for most local audits, or justified sample for specialist areas); document timeframe; collect data systematically with attention to completeness and accuracy.
4	**Analyse and Compare**	Compare findings against standards; calculate compliance rates; identify patterns, outliers, and root causes of non-compliance. Present data clearly using appropriate tables or charts.
5	**Implement Change**	Develop an action plan with SMART objectives; assign responsibility; set target timeline; communicate findings and proposed changes to the relevant team.

Stage	Name	Description and Expectations
6	**Re-Audit**	Repeat data collection using identical methodology after a defined interval (typically 6–18 months). Compare results against the original findings and the standard to confirm improvement.

Academic Note — SMART Standards

Standards should be SMART. For example: 'Pre-operative fasting instructions should be documented in 100% of anaesthetic records for elective cases, in accordance with the AAGBI 2010 guideline, within the audit period January–June 2025.' Vague standards such as "patients should be fasted" are insufficient: they cannot generate a meaningful compliance rate and do not permit comparison across audit cycles.

3. Essential Components of an Acceptable Audit Submission

Every audit submitted for PCS Practice Review credit must contain all of the following components. Absence of any element may result in the submission being returned or declined. Verifiers should satisfy themselves that each component is adequately addressed before signing.

#	Component	Minimum Standard	Evidence Required
1	**Defined Audit Topic**	Clearly articulated question relevant to anaesthesia or peri-operative practice; not a vague or aspirational statement.	*Audit title and background rationale in the report.*
2	**Standards / Benchmarks**	Specific, measurable criteria drawn from named national or international guidelines or agreed departmental protocols.	*Reference list; copy of guideline section if not publicly accessible.*
3	**Governance Approval**	Documented endorsement from departmental audit committee, governance lead, or equivalent body.	*Registration number; approval letter or email; signed form.*
4	**Structured Methodology**	Explicit objectives; defined sample (with justification if n<20); data collection instrument; specified timeframe.	*Methodology section of report; data collection tool.*
5	**Presentation of Results**	Data presented against each standard; compliance rates calculated; shortfalls and their magnitude clearly identified.	*Results tables/charts in report or presentation slides.*
6	**Root Cause Analysis**	Identified reasons for non-compliance with standards, informed by data and team reflection.	*Discussion section or M&M documentation.*
7	**Quality Improvement Plan**	Specific, time-bound actions; named individual(s) responsible; target date for implementation.	*Action plan table within report or minutes of meeting.*
8	**Dissemination**	Formal presentation to peers at departmental, hospital, regional, or national level.	*Meeting programme, presentation slides, or signed confirmation.*
9	**Re-Audit (where feasible)**	Repeat measurement after implementation; comparison of before/after compliance rates.	*Re-audit data and comparative analysis.*

4. Governance Framework and Acceptable Audit Types

Clinical audit should be conducted within a recognised governance structure. This ensures that audit activity is properly sanctioned, that findings are acted upon at an organisational level, and that accountability for quality improvement is maintained.

4.1 Accepted Audit Categories

The following categories are fully acceptable for PCS Practice Review credit, subject to all essential components being present:

- Personal clinical audit with documented methodology, governance acknowledgement, and reflective outcome.
- Departmental audit with evidence of group participation and governance oversight.
- Hospital or health system quality improvement projects linked to measurable, documented outcomes.
- Audit against national standards or clinical guidelines (e.g. RCoA, AAGBI, NICE, HSE National Clinical Guidelines).
- Audit of departmental outcomes against recognised benchmarks (e.g. national complication rates, NCEPOD standards).
- Critical incident or significant event review conducted using a structured audit methodology with documented analysis.
- Mortality and morbidity (M&M) reviews: structured, documented, with learning points and action plans recorded.
- National or international audit programmes (e.g. NAP projects, CPOC Perioperative Quality Improvement Programme, ICNARC).

4.2 Conditionally Accepted Activities

The following activities may qualify for PCS audit credit only where they are embedded within a structured audit or quality improvement methodology and satisfy all essential component requirements:

Activity	Condition for Acceptance	Reason for Conditional Status
Patient satisfaction surveys	Validated standardised instrument; findings acted upon with documented QI response; comparison against benchmark.	*Risk of subjective data; low academic validity without standardisation.*
Multisource feedback (MSF)	Integrated within formal appraisal or PDP framework; linked to specific development actions.	*MSF alone is performance appraisal, not quality improvement audit.*
Compliments and complaints review	Systematic categorisation; trend analysis; documented learning and service response.	*Anecdotal review without analysis does not meet audit methodology criteria.*
Practice visits / peer review	Structured against agreed standards; written report with findings and recommendations.	*Informal visits without a structured output do not constitute audit.*

5. Verification Requirements

Independent verification is mandatory for all PCS audit submissions. The purpose of verification is to provide the College with reasonable assurance that the audit was genuinely conducted, that the doctor participated actively, and that the activity meets the standards set out in this document.

5.1 Acceptable Verifiers

The verifier must be a senior clinician or governance lead independent of the submitting doctor in the sense that the verifier is not the doctor themselves. Acceptable verifiers include:

- Department Chairperson or Head of Department
- College Tutor for the department
- Clinical Director
- Designated Audit Lead or Quality Improvement Lead
- Supervising Consultant (for doctors in fellowship or training posts)
- National Audit Programme Co-ordinator (for national programme submissions)

5.2 Verifier Responsibilities

By signing the PCS Clinical Audit Submission and Verification Form, the verifier confirms all of the following:

1. The named doctor actively participated in the audit process described.
2. The audit was conducted within an appropriate clinical governance framework.
3. The activity represents a genuine practice review and quality improvement exercise.
4. The supporting documentation submitted is authentic and accurately represents the work described.
5. The verifier has no conflict of interest that would compromise the independence of their verification.

> **Important — Unsigned Submissions**
> Unsigned or unverified submissions will not be accepted for PCS audit credit. Submissions where the verifier cannot be contacted for confirmation, or where the verifier disavows knowledge of the audit, will be referred for further review. The College reserves the right to request additional supporting evidence or to conduct a verification interview during PCS audit processes.

6. Audit Quality Scoring Rubric

To support consistent evaluation of audit submissions, the College has developed a quality scoring rubric. This rubric may be used by verifiers, College assessors, and doctors undertaking self-assessment prior to submission. It is not intended to replace professional judgement but to provide transparent, reproducible criteria for evaluating audit quality.

Domain	Developing (1)	Meets Standard (2)	Exceeds Standard (3)
Topic and Rationale	Topic stated but rationale absent or weak.	Topic clearly defined; rationale provided with reference to clinical context.	Rationale includes epidemiological or safety data; problem quantified locally.
Standards Used	No recognised standard cited; criteria vague.	Named guideline cited; criterion measurable.	Multiple criteria; SMART standard stated with threshold compliance level.
Methodology	Sample undocumented; timeframe absent.	Sample size, timeframe, and data source documented.	Sampling strategy justified; data collection

Domain	Developing (1)	Meets Standard (2)	Exceeds Standard (3)
			tool appended; reliability addressed.
Analysis and Comparison	Results stated without comparison to standard.	Compliance rates calculated; gap between actual and standard identified.	Stratified analysis; root cause analysis; statistical description where appropriate.
Quality Improvement	No action plan; learning unclear.	Actions identified; responsibility assigned.	SMART action plan; timeline set; implementation confirmed; rationale for each action.
Dissemination	No evidence of presentation.	Presented at departmental level; evidence provided.	Presented at hospital, regional, or national level; abstract or publication.
Re-Audit	No re-audit; no plan.	Re-audit planned with target date.	Re-audit completed; improvement demonstrated with comparative data.

Scoring Guidance

Maximum possible score: 21 points (7 domains × 3). A submission scoring 14 or above (67%) across all domains will ordinarily be considered acceptable. Submissions scoring below 10 (48%) will ordinarily be returned. Scores between 10 and 13 will be reviewed on a case-by-case basis, with particular attention to whether the audit cycle has been substantively completed and whether patient safety learning is evident.

7. Activities That Will Not Be Accepted

The following activities do not meet the standards required for PCS audit credit. Submission of these activities without additional components demonstrating a structured audit process will be declined. Repeated submission of declined material, or submission of materially identical audit activity across consecutive PCS cycles, will be treated as a serious professional concern.

Activity	Why It Is Insufficient	What Would Make It Acceptable
Simple narrative summary (Word document)	Lacks systematic methodology, standards comparison, and governance framework.	Add: defined standards, data collection, comparison against criteria, and governance sign-off.
Case report or case series	Descriptive only; no comparison against standard; no quality improvement process.	Could form the basis of a critical incident review if structured methodology and action plan are added.
Literature review	Reviews published evidence but does not examine local practice or generate improvement actions.	Acceptable only as the 'standard-setting' stage; must be paired with data collection and comparison.
Reflective notes without evidence	Subjective; not reproducible; no objective measurement of practice.	Reflection is valuable but must be supported by objective data and governance documentation.

Activity	Why It Is Insufficient	What Would Make It Acceptable
Data collection without standards comparison	Generates numbers but no quality improvement conclusion; incomplete audit cycle.	Must compare collected data against a defined standard and document actions arising.
Presentation slides alone	Evidence of dissemination but not of the underlying audit process or governance.	Slides should accompany — not replace — a full audit report.
Repeated identical submission	Does not demonstrate ongoing engagement or learning; no new improvement cycle.	Re-submit as a re-audit with new data, updated analysis, and evidence of sustained improvement.

8. Academic and Professional Standards

This section situates the College's audit requirements within the wider landscape of postgraduate medical education, clinical governance, and patient safety science.

8.1 Regulatory and Professional Framework

The requirement to engage in clinical audit is grounded in Irish medical regulation and international professional standards. The following frameworks are directly relevant:

Framework / Body	Relevance to PCS Audit
Medical Council of Ireland Guide to Professional Conduct & Ethics, 9th Ed. (2024)	Mandates participation in clinical audit and quality improvement as a duty of the registered doctor. Relevant paragraphs: 2.2 (Competence), 14.1–14.4 (Quality and Safety).
Health Act 2007 / HIQA National Standards	Establishes the statutory framework for clinical governance in Irish health services; audit is a named requirement under Standard 2.8.
RCoA / AAGBI Professional Standards	Provide specialty-specific benchmarks against which anaesthesia audit standards are set; referenced throughout this document.
NICE — Principles for Best Practice in Clinical Audit (2002; updated)	The foundational methodological reference for clinical audit in the UK and Ireland; defines the audit cycle, criteria setting, and re-audit requirements.
Institute for Healthcare Improvement (IHI)	Model for Improvement and PDSA methodology; applicable to QI projects submitted under Section 4.
World Federation of Societies of Anaesthesiologists (WFSA)	International standards for anaesthesia quality and safety; relevant for doctors working across jurisdictions.

8.2 Audit vs. Research vs. Service Evaluation

Doctors must correctly classify their activity before commencing. Misclassification — particularly treating research as audit to avoid ethical approval — is a professional misconduct issue. The following distinctions apply:

Criterion	Clinical Audit	Service Evaluation	Research
Purpose	Improve care against a standard	Describe current service	Generate new knowledge

Criterion	Clinical Audit	Service Evaluation	Research
Question type	Are we meeting standard X?	What is the current state of service Y?	What is the effect of intervention Z?
Comparison	Against defined standard	No comparator required	Between groups or time points
Ethics approval	Not required	Not required	Required (Research Ethics Committee)
Patient consent	Not required (usually)	Not required (usually)	Usually required
Counts as PCS audit	Yes (if criteria met)	Only if structured as QI (Section 4.2)	No

8.3 Quality Improvement Methodologies

Quality improvement (QI) projects that employ recognised structured methodologies may be accepted under Section 4 where they satisfy all essential component criteria. Recognised methodologies include:

- Plan-Do-Study-Act (PDSA) cycles — the standard IHI model for iterative improvement; requires a defined change theory and measurement plan.
- Lean methodology — focused on eliminating waste and improving flow; requires process mapping and measurable outcome metrics.
- Six Sigma (DMAIC) — data-driven approach to reducing variation; requires statistical analysis of a defined process.
- Model for Improvement (MFI) — combines PDSA with three fundamental questions: What are we trying to accomplish? How will we know if change is an improvement? What change can we make?

> **Distinction from Audit**
> QI projects should be clearly identified as such on the submission form. They differ from audit in that they may not measure against a pre-existing external standard, but they must demonstrate: a defined aim, a measurement strategy, a tested change, and evidence of improvement. Projects that lack any measurement component will not be accepted.

9. Worked Example of an Acceptable Audit

The following example illustrates a submission that meets the standards set out in this document. It is provided to assist doctors in understanding the expected level of detail and structure. It is not a template to be reproduced verbatim.

> **Illustrative Example Only**
> The figures and findings in this example are fictitious and are provided solely for educational purposes. They do not represent data from any named institution.

Worked Example — Pre-operative Fasting Documentation Audit	
Audit Title	Pre-operative Fasting Documentation in Elective Surgical Patients: Audit Against AAGBI 2010 Guidelines
Audit Type	Departmental Audit (with personal lead)

Standard Used	AAGBI 2010: 'Pre-operative fasting instructions should be documented in the anaesthetic record for 100% of elective cases.' (Standard: 100% compliance)
Objective	To determine the proportion of elective anaesthetic records in which pre-operative fasting instructions were documented, and to implement improvement where gaps exist.
Methodology	Retrospective review of 50 consecutive elective anaesthetic records from January 2025. Data collected using a structured proforma. Exclusions: emergency cases, paediatric cases (separate audit).
Results	Fasting instructions documented in 31/50 records (62%). Inadequate documentation most common for afternoon list patients (only 48% compliance). No cases of aspiration in this cohort.
Root Cause Analysis	Identified causes: inconsistent theatre team briefing; no standard section on anaesthetic record form; instructions given verbally without documentation.
Actions Implemented	(1) New anaesthetic record form with mandatory fasting documentation field — implemented March 2025. (2) Laminated prompt card added to each anaesthetic machine — implemented February 2025. (3) Department education session — February 2025. Responsible: Dr [Name] and Audit Lead.
Dissemination	Presented at Departmental Audit Meeting, 14 February 2025. Presented at Hospital Quality & Safety Committee, 6 March 2025.
Re-Audit	Planned: August 2025. Preliminary data (n=25): compliance 96%. Full re-audit report to be submitted with next PCS cycle.
Scoring (Rubric, Section 6)	Topic & Rationale: 3 | Standards: 3 | Methodology: 2 | Analysis: 2 | QI Plan: 3 | Dissemination: 3 | Re-Audit: 2 | TOTAL: 18/21 — Exceeds Standard

10. Evidence Required for PCS Submission

All supporting evidence must be submitted alongside the completed PCS Clinical Audit Submission and Verification Form. Incomplete submissions will be returned without credit. Doctors are advised to maintain an ongoing audit portfolio to facilitate straightforward PCS submission.

Document / Evidence	Required / Recommended	Notes
Audit summary or formal report	**Required**	*Must cover all stages of the audit cycle; minimum 1–2 pages.*

Document / Evidence	Required / Recommended	Notes
Standards / guidelines referenced	**Required**	*Full citation; copy of relevant section if guideline not publicly available.*
Data collection instrument	**Recommended**	*Proforma, spreadsheet extract, or database screenshot.*
Governance approval or registration	**Required where available**	*Audit committee email, registration number, or signed approval.*
Presentation evidence	**Required**	*Meeting programme with date; or signed confirmation from Chair.*
Action plan	**Required**	*Table format preferred; named responsible person and timeline.*
Re-audit data	**Required if re-audit completed**	*Comparative table of before/after compliance rates.*
Completed Verification Form	**Required**	*Signed by an acceptable verifier as defined in Section 5.*

Audit Portfolio Recommendation

Doctors are strongly advised to maintain a contemporaneous audit portfolio throughout their PCS cycle. This should include: the original audit proposal or registration; data collection instruments; raw or summary data; action plan with dates of implementation; and any correspondence with governance bodies. A well-maintained portfolio significantly reduces the administrative burden at PCS submission and provides robust evidence in the event of a verification request.

11. Conclusion

Clinical audit is not a bureaucratic exercise — it is a professional commitment to the continuous improvement of patient care. The standards set out in this document reflect what the College considers to be genuinely meaningful engagement with quality improvement, and they are consistent with national regulatory requirements and international professional norms.

Doctors who approach audit with intellectual rigour — setting clear standards, collecting valid data, analysing findings honestly, implementing change, and measuring its impact — will find that the process generates real professional value, independent of its contribution to PCS requirements.

Closing Statement

The emphasis of the PCS audit requirement is on learning, governance, improvement, and measurable impact on clinical care. The College remains committed to supporting members in meeting these requirements through guidance, education, and a proportionate verification process.

Appendix A — Verifier Quality Checklist

This checklist should be completed by the verifier before signing the PCS Clinical Audit Submission and Verification Form. Each item maps to a specific standard in this document. If any item is answered 'No', the verifier should discuss with the submitting doctor before signing.

#	Verification Criterion	Yes	No
1	The audit topic is clearly defined and relevant to anaesthesia or peri-operative practice. (Section 1)	☐	☐
2	The audit is based on named, recognised standards or guidelines. (Section 2, Stage 2)	☐	☐
3	SMART criteria have been defined with explicit compliance thresholds. (Section 2)	☐	☐
4	Governance or departmental approval is documented. (Section 4)	☐	☐
5	The methodology (sample, data collection tool, timeframe) is fully documented. (Section 3)	☐	☐
6	Data have been collected and compared against the defined standards. (Section 3)	☐	☐
7	Root causes of non-compliance have been identified and documented. (Section 3)	☐	☐
8	A SMART action plan with named responsibility and timeline is in place. (Section 3)	☐	☐
9	The audit was formally presented at departmental or wider level. (Section 3)	☐	☐
10	A re-audit has been completed or is formally planned with a target date. (Section 3)	☐	☐
11	The doctor actively participated throughout the audit process. (Section 5)	☐	☐
12	All required supporting documentation accompanies this submission. (Section 10)	☐	☐
13	I have no conflict of interest that would compromise my verification. (Section 5.2)	☐	☐

Name of Doctor	
Verifier Name	
Position	*Department Chair / College Tutor / Clinical Director / Audit Lead*
Signature	
Date	

Appendix B — Glossary of Key Terms

Term	Definition
Audit Criterion	A specific, measurable statement of what should happen in relation to a particular aspect of care, derived from a recognised standard or guideline.
Audit Cycle	The iterative process of setting standards, measuring practice, comparing against standards, implementing change, and re-measuring to confirm improvement.
Benchmark	An agreed reference point — typically derived from national data, published guidelines, or expert consensus — against which local practice is compared.
Clinical Governance	The framework through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.
Compliance Rate	The proportion of cases in which practice meets the defined audit criterion, expressed as a percentage.
PDSA Cycle	Plan-Do-Study-Act: a four-stage iterative improvement model used in quality improvement methodology.
PCS (Professional Competence Scheme)	The statutory scheme administered by the College of Anaesthesiologists of Ireland through which doctors demonstrate ongoing professional competence and engagement with continuing professional development.
Practice Review	The PCS component that encompasses clinical audit, quality improvement, and reflection on practice.
Re-audit	Repetition of the original data collection and analysis, using the same methodology, after corrective actions have been implemented, to confirm whether improvement has occurred.
Root Cause Analysis	A structured method for identifying the underlying causes of a problem or shortfall, rather than addressing surface-level symptoms.
SMART	An acronym for criteria that are Specific, Measurable, Achievable, Relevant, and Time-bound.
Standard	A statement — usually derived from a guideline, regulation, or expert consensus — that defines the expected level of performance or care.
Verifier	A senior clinician or governance lead who independently confirms the authenticity and quality of a submitted audit for PCS purposes.

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