APPROVED DOCUMENT

Quality Management &Patient Safety Directorate

Document Title	Guideline for Auditing in Health Care Settings	
Document Type	Guideline	
Directorate/Institution	Directorate General of Khawla Hospital (DGKH)	
Targeted Group	Health-Care Professionals Working At DGKH	
Document Author	Ms. Khaloud Al Zadjali	Ms. Khaleej ALSubhi
Designation	General Nurse B	Senior Staff Nurse A
Document Reviewer	Reviewers' Names in the Next Page	
Release Date	January 2026	
Review Frequency	Every Three Years	

Validated by		**Approved by**	
Name	Ms Huda AL Abri	Name	Dr. Ahmed AL Mandhari
Designation	Head of Accreditation Department	Designation	Acting Director General
Signature		Signature	
Date	11/01/2026	Date	11/01/2026

سلطنة عمان - وزارة الصحة
المديرية العامة لمستشفى خولة
مكتب المدير العام
D G Office
DIRECTORATE GENERAL OF KHOULA HOSPITAL
SULTANATE OF OMAN- MINISTRY OF HEALTH

Acknowledgments

I would like to extend my gratitude to the following health-care professionals for their valuable revision and feedback of this document:

1.Ms. Salwa Al Abri – HoD (Quality Service Evaluation Department)

2.Ms. Safa Al Raqqadi – General Nurse A, Accreditation Department (QM&PSD)

Content

Acronyms

DGKH	Directorate General of Khoula Hospital
DGANH	Directorate General of AL Nahdha Hospital
MOH	Ministry of Health
HCP	Health Care Provider
AD	Auditee Department
PN	Policy Number
AN	Audit Number
DQM&PSD	Director of Quality Management & Patient Safety Directorate
QSED	Quality Service Evaluation Department
DG	Director General
DQT	Departmental Quality Team
NC	Non conformance
HoD	Head of Department
PDSA	Plan, Do, Study, Act

1.Definitions

1.1 Clinical Audit: Is a systematic evaluation of a specific practice, typically within a healthcare or professional setting, to assess its effectiveness, efficiency and adherence to the established standards or guidelines.

1.2 Compliance Audit: Is an examination of an organizations adherence to regulatory guidelines, internal policies and external laws.

1.3 Khoula Hospital's Auditors: Is a health – care professional (DQT members), responsible for the development of audit within their departments and participating with the Quality Service Evaluation Department (QSED) in the hospital internal audits whenever requested.

1.4 Quality Auditors: Is a health – care professional (QM&PSD staffs) including both Khoula & Al Nahdha Hospital, who examine and evaluate accuracy, compliance, system or processes within DGKH to assess how effectively the quality goals are being met based on the topics raised from both hospitals.

1.5 Auditee: is an individual, organization, or department that is subject to an audit.

1.6 Service users: Patients.

1.7 Nonconformity: is non fulfillment or failure to adhere to established standards, rules, or expectation.

Chapter One

2. Introduction

An audit is a fundamental in any quality improvement process, it plays an important role in providing assurances about the quality of services provided. The audit is a systematic review of healthcare services against explicit criteria, aimed at improving patient care and outcomes.it involves measuring the quality of care provided, identifying areas for improvement, and implementing changes based on the findings. The process typically includes setting standards, collecting data, analyzing result, and making recommendations for practice changes.

3.Purposes

The purposes of this guideline are to:

3.1 Evaluate and improve the quality of patient care, and to measure healthcare practices against established clinical standard, identify areas for improvement and enhanced patient outcomes.

3.2 Provide guidance for all staff participating in audit activities.

3.3 Ensure all audits are registered, approved and audit results are reported and acted upon.

3.4 Ensure that all clinicians and other relevant staff conducting and/or managing audits are given appropriate time, knowledge and skills to facilitate the successful completion of the audit cycle.

3.5 Ensure that all audits are undertaken, completed and reported in a systematic manner that is implemented and monitored.

4. Scope

This guideline of DGKH applies to health-care professionals working at DGKH.

5.Structure

This is the guideline of DGKH designed to assist healthcare staff in comprehending the stages of the audit cycle, to promote best practices in clinical audit, and to enhance awareness of the audit as a vital and integral aspect of clinical practice. There are seven stages of the audit cycle:

5.1 Stage (1): Select topic

a. **Involving stakeholders:** All individuals engaged in delivering or receiving care may be regarded as stakeholders in the audit. Common strategies for engaging clients in the audit process include:

i. Collecting feedback from service clients, such as letters of complaint or compliments.
ii. Analysing comments made during service client discussions.
iii. Interviews with service clients.
iv. Surveys of service clients.
v. Focus groups.
vi. Expert client teams.
vii. Analysing critical incidents.

b. **Determining the audit topic:** The audit topics should be chosen to enhance the quality or safety of care and service delivery. The classification system of structure, process, and outcome can be adopted to concentrate on certain areas of practice from which a topic may be chosen:

i. Structure:

- Resources required to deliver care.
- Environment in which care is delivered.
- Equipment made available.
- Documentation of policies, procedures, protocols and guidelines

ii. **Process:** The guideline, policy and procedure, protocols and methodologies employed by healthcare providers in the delivery, administration, and assessment of care.

iii. **Outcome:** It is the impact of care received by service clients due to healthcare delivery and the related cost required by the service in providing care, such as the outcomes of clinical interventions.

c. **Planning the delivery of the Audit:** The aim of the audit must be outlined in the form of goals and objectives and should be defined through the use of verbs, such as improve, increase

enhance, ensure or change. The auditing is a quality improvement process therefore audit objectives need to show the intension to improve. For example, verbs along with quality features can be used for the purpose of designing the audit and the audit should be safe, effective, patient- centered, timely, efficient and equitable.

d.Identifying the skills and people needed to carry out the audit. For the audit to be successful and achieve its aim and purpose, it needs to involve the right people with the right skills from the outset. Therefore, the identification of skills required and of individuals possessing these skills should be a priority. Examples of skills required for the audit process.

i.Leadership, organizational and management skills.
ii.Clinical, managerial and other service input and leadership.
iii.Project management skills
iv.Change management skills
v.Audit methodology expertise
vi.Understanding of data protection requirements
vii.Data collection and data analysis skills
viii.Facilitation skills
ix.Communication skills
x.Interpersonal skills

e.Providing the Necessary Structures. Appropriate structures and processes should be in place prior to the initiating of the audit work. The audit team should complete the audit proposal or request. This ensures that every elements of the proposed audit have been considered and that audit will be robust and of high quality. However, completed forms along with supporting standards, the audit tool(s) and other documentation should be submitted to the appropriate responsible clinical lead.

5.2 Stage (2): Set Criteria and Standards

The following crucial phase involves examining the available evidence to identify the standards and audit criteria that will guide audit process. The useful source for standards include: local standards, in the form of evidence-based guidelines, nationally endorsed clinical guidelines, standards and clinical guidelines from relevant quality and safety programs, clinical care programs, professional bodies, and clinical guideline development organizations such as NICE, SIGN, NCEC. In the absence of national or local guidelines, a literature review can be carried out to identify the best and most up to date evidence from which audit standards and criteria may be generated. For the standards to be valid and lead to improvements in care, they should adhere

to SMART criteria, specific (clear statements, not open to interpretation), Measurable, Achievable (of a level of acceptable performance agreed with stakeholder), Relevant (related to important aspects of care), and theoretically sound or timely (evidence based).

a.Set the target/level of performance

Three factors should be considered and assessed when setting targets. These factors are clinical importance, practicality, and acceptability. The expected level of performance or target can range from 0% (the criterion is something that must never be done) to 100% (the criterion is something that must always be adhered to). A defined level or degree of expected compliance with the audit criteria may be expressed as a percentage or proportion of case.

b. Consider inclusion / exclusion criteria

To ensure that the audit sample is representative of the target population and that the collected data is fit for purpose, it is necessary to define what information should be collected and what information should not be collected. Inclusion criteria define areas included in the remit of the clinical guideline/standard, and exclusion criteria define areas outside the remit of the clinical guideline/standard.

c.Consider exceptions

There may be a justifiable reason why some cases from the identified sample may not comply with specific clinical audit criteria. The data analysis does not include these cases; they are considered exceptions in the clinical audit.

5.3 Stage (3): Design Audit Tool & Collect Data:

a.Develop Audit Tool

The following principles are applied to designing a data collection sheet:

i. The data to be collected should be relevant to the objectives and criteria for the clinical audit and the expected performance levels. There are three methods for data collection in the audit: which are retrospective, concurrent and prospective.

- Retrospective data is collected after completion of treatment/care to service users (patients).
- Concurrent data is collected while treatment / care is being provided.
- Prospective data is collected if the data required is not routinely recorded, a prospective clinical audit must be undertaken.

ii. Acronyms, jargon, and technical terms should be avoided.

iii. Definition of terms used should be included where necessary.

iv. There should be space to record exceptions.

v. Questions should be episode-specific; they relate to a specific episode of care.

vi. Closed questions should be used; these should be clearly worded and contain no ambiguity to clarify the format for the answer (for example, date: day/month/year).

vii. Limit the use of free text or open questions to audits with qualitative elements, as free text is difficult to code and analysis is very time-consuming.

viii. Data items should be presented in a logical order. The tool should not require the person collecting or analyzing the data to skip backward and forward.

b. Data Collection Process:

It is important that data collected in the course of any audit is precise and relevant to the audit being performed. To ensure that data is collected appropriately, there are a number of details which need to be established at the outset:

i. The population or sample to be included, with inclusion/exclusion criteria should be defined.

ii. The consent is required to access the population or sample information.

iii. The healthcare professionals are involved in the service user's / patient's care.

iv. The time period over which the criteria is applied.

v. The analysis to be performed. Resources should be used effectively to collect the minimum amount of data necessary to achieve the audit objectives.

c. Planning Data Collection:

Prior to the initiation of data collection, a structured approach should be taken to the identification of relevant data and to ensuring that the data collection process is efficient, effective, accurate and understandable.

d. Sources of Data

The source of data for the audit should be specified and agreed by the audit team. The source specified should provide the most accurate and complete data as readily as possible.

e. Sample selection methods

Numerous sampling methods exist, with random sampling and convenience sampling being the most common. The simplest form of random sampling involves selecting service users at random from an overall population listing. Convenience sampling is sometimes used as a simple and effective way of carrying out a sample survey. It involves choosing the nearest and most convenient individuals to act as respondents; it therefore does not produce findings that can be taken to be representative. Moreover, a specific time period often determines interval sampling. For instance, a specific timeframe encompasses all cases. The sample size should be sufficient to generate meaningful results.

f. Piloting the Data Collection Tool

Piloting a data collection tool and its methodology can provide evidence as to whether the proposed methodology is practical.

g. Timeframe for Data Collection

It influenced by the sample (size and population), inclusion and exclusion criteria, and target date for the audit completion

h. Ensuring Data Quality

Data is considered to be of high quality when it meets its intended purpose. There should be a clear definitions for each data item to be collected to ensure that data collectors have a good understanding of what, how and when data needs to be collected. There should also be routine data quality assessments to reduce the incidence of reporting and input errors.

5.4 Stage (4): Analyze data and compare results with standards

a. Data analysis: The basic aim of data analysis is to convert a collection of facts (data) into useful information. The main aim of data analysis is to answer the question posted by the audit objectives; highlighting areas of good practice and areas that require particular attention or improvement.

b. Calculating compliance with audit criteria: The basic requirement of the audit is to identify whether or not required performance levels have been reached. This requires working out the percentage of cases that have met each audit criterion. In order to calculate the percentage, it is necessary to identify both the total number of applicable cases for a criterion (the denominator) and the total number within the sample that met the criterion (the numerator). The percentage is then calculated by dividing the numerator by the denominator and multiplying the answer by 100. To facilitate the

drawing of conclusions from analyzed data, the data should be displayed in the simplest, clearest, and most effective way possible.

c. Drawing conclusions: After results have been compiled and the data has been analyzed, the final step in the process is to identify if the standard was met or not met. To understand the reasons a standard was not met, the audit team should carefully review all findings to:

i. Clearly identify and agree on areas for improvement identified by the clinical audit.

ii. Analyze the areas for improvement, to identify what underlying, contributory or deep-rooted factors are involved.

iii. Have a clear understanding of the reasons why performance levels are not being reached, to enable development of appropriate and effective solutions.

d. Sharing results: The aim of any presentation of results should be to maximize the impact of the audit on the audience to generate discussion and to stimulate and support action planning. Data graphics are a good way of communicating this information to others, such as infographics. The most commonly used form of data graphics in audit are tables, graphs and charts, using Excel.

5.5 Stage (5): The Audit Report

a. Layout of report:

The audit report should follow a standard of the Audit Report Template include: background, methodology, action plans, conclusion/summary, and recommendation and quality improvement plan.

b. Reflection

5.6 Stage (6): Quality Improvement Plan and Action

a. **Development of a quality improvement plan:** The quality improvement plan is a fundamental part of the audit cycle; without it, the audit is not effective. It is an important change management tool; however, to be effective a QI plan must explicitly contain the following information:

i. Highlight what needs to change (recommendation).

ii. Indicate the action(s) that must be taken in order to achieve change.

iii. Give a deadline by which time the actions must be carried out.

iv. Show who is responsible for making sure that the actions are carried out.

v. Indicate the evidence required to prove that the actions have been implemented.

The audit loop is completed by developing and implementing the QI plan (the QI plan is often referred to as an action plan).

b.**Action**

Priorities for action should be identified and these should be clearly documented. All audits should be accompanied by an improvement plan which should be consistent with SMART guidance and QI Toolkit such as process mapping, the 'Five Whys', Cause and Effect Diagram (Fishbone Diagramming) and the Model for Improvement (MFI), Plan, Do, Study, Act (PDSA) cycles.

5.7 Stage (7): Re-audit

The audit cycle is a continuous process. If the first data collection cycle demonstrates that the required standard was met, the audit does not need to be re-audited. If the audit shows that the standard was not met, completing the audit cycle involves two data collections and a comparison of one with the other, following implementation of change after the first audit completion, to determine whether the desired improvements have made a difference. Further cycles may be necessary if performance still fails to attain the levels set at the outset of the audit. Completion of the audit cycle will usually result in improvements in practice. This should be communicated to all stakeholders.

6.Types of Audit :Audits should be performed by the auditors in three ways:

6.1 Departmental audit:

a. The auditor should set an annual audit plan for selected audit title from the approved polices or practices within their department.

b. Departmental audit annual plan should be developed and agreed from beginning of the year and submitted to quality service evaluations department.

c. Auditor should submit a written report to QM&PSD on biannually basis (every 6 months) regarding the status of the auditing system in their department. The status of the auditing system should include the following:

i. Total number of audits conducted.

ii. Any major non-conformity (NC) in the last three months.

iii. Total number of follow-ups planned to be conducted.

d. The audit should be done for all new polices after 6-12 months from the approved date.

e. All audits should be registered with the in-charge of audit in QM&PSD and has a unique serial number for easy reference.

f. Prior to any audit, auditors are responsible to ensure that all audit are registered and approved by QM&PSD.

g. If any changes or update of auditors names from departments, the new names should be submitted to QM&PSD

6.2 Hospital audit

a. The auditors (DQT members) shall participate in the hospital internal audits with the QM&PSD whenever requested.

b. The annual plan for the hospital audits should be lead and scheduled by the in-charge of audit in QM&PSD.

c. Annual plan for hospital audit should be submitted annually to Director of Quality management and patient safety directorate by Quality Service Evaluations Department.

d. Auditor should ensure that audit title proposed can measure the clinical practice against approved standard of best practice (National / Khoula hospital standards).

e. Audit's due date for follow up should be considered at the same day of conducting hospital audit.

6.3 Quality audit:

a. The auditors (all quality staffs) should participate in the quality audit as per schedule.

b. The annual plan for the quality audits should be scheduled by quality service evaluation department and submitted to director of quality management and patient safety directorate.

c. The quality audit schedule to be disseminated to all quality auditors.

d. The topics should be raised and selected by the quality auditors.

e. All polices and guidelines should be valid and with availability of audit tool prior to audit.

7. Procedure: The process to conduct an audit from QM&PSD is described by following stages:

7.1 Stage one: Approval Process

a. An audit request form (see appendix I) should be completed for each clinical audit identified by the auditor and submit it to in-charge of audit in QM&PSD.

b. The proposed scope (audit title or topic) for departmental audit should be discussed and approved by HoD/Supervisor of the auditor.

c. All proposals for audits received will be reviewed and approved by QSED and Feedback will be provided within two weeks.

d. Copy of the data collection tool (Audit tool) should be submitted with the request form.

e. Coding of the audit should be done by in-charge of audit in QSED according to the coding system (See appendix 5)

7.2 Stage two: Conducting the Audit

a. Auditor should use corrective action plan form (See appendix 2) to write the audit findings in non-conformance column (NC Description).

b. NC finding should be discussed with the HoD/ In-charge of the Auditee department.

c. Action plans should be specific, measurable, achievable, realistic with time frame (SMART) and be filled by HoD/In-charge of the Auditee department.

d. If audit findings shows that all standards are being met, there will be no need for an action plan.

7.3 Stage three: Follow up Audit

a. Follow up audit should be arranged within the time frame given in the action plan and to be discussed with HOD/ in- charge of the auditee department.

7.4 Stage four: Reporting

a. Completed reports should be sent to the QM&PSD and should include the NC findings and action plan provided by HoD/ In-charge of auditee department once audit and follow up audit is done (see appendix II).

b. The progress of clinical audits reports and action plans should be sent to DQM&PSD every six months by in-charge of audit in QSED.

c. Final annual report will be submitted to DG and a copy to the auditee departments by DQM&PS

Chapter Three

8. Responsibilities:

8.1 Directors/Heads of Departments shall:

8.1.1 Ensure all health care professionals are aware of this guideline.

8.1.2 Ensure implementation of audit guideline in their department by auditor.

8.2 Audit Manager in QM&PSD shall:

8.2.1 Ensure adherence to this guideline.

8.2.2 Ensure approving departmental clinical audit topic.

8.2.3 Monitor and report progress of the clinical audit plan.

8.2.4 Lead and plan for the annual hospital audit.

8.2.5 Send annual report for the hospital, departmental and quality audit to DG and concerned department.

8.3 Khoula Hospital's Auditors shall:

8.3.1 Ensure adherence to this guideline.

8.3.2 Set departmental annual audit plan for selected audit topic from the approved polices related to their practice within their department.

8.3.3 Ensure that all clinical audits are registered and approved by QSED by filling audit request form.

8.3.4 Perform audits for all new polices after 6 months from the approved date.

8.3.5 Develop clinical audit and follow the audit activities in the department.

8.3.6 Participate in the hospital audits with the QSED whenever requested.

8.3.7 Submit a written report to in-charge of audit (QSED) once every six months regarding the status of the auditing system in the department.

Chapter Four

9 Document History and Version Control Table

Version	Description	Name of authors		Review Date
1	Initial Release	Ms. Huda AL Harthi		2018
2	Version two	Ms. Khaloud Al Zadjali	Ms Khaleej ALSubhi	2028

10 References

10.1 Pennine Care NHS Foundation Trust Clinical Audit Policy, 2016
https://www.penninecare.nhs.uk/media/494762/cl89-clinical-audit-policy-v4.pdf

10.2 The Newcastle Upon Tyne Hospitals NHS Foundation Trust, 2017

10.3 HSE (2023). Clinical audit a practical guide 2023 HSE national centre for clinical audit. [online] Available at: https://assets.hse.ie/media/documents/HSE_National_Centre_for_Clinical_Audit_-_A_Practical_Guide.pdf.

11 Annexes

11.1 Appendix (1): Audit Request Form

Audit Reference Number: ----------

المديرية العامة لمستشفى خولة
Directorate General of Khoula Hospital

Audit Request Form

Section A: Completed by Audit Requester			
Audit title (Scope):			
1. Requester Details			
Name		Date of Request	
Job title		Mobile	
Department		Email	
The Purpose of Request:			
☐ Assess practice (Routine) ☐ Assess policy compliance ☐ Other (specify).....			
2. Audit Information			
Collection Source	☐ Al shifaa system ☐ Patient ☐ Observation ☐ Staff ☐ Other (Specify).....		
Auditee (Department)			
Sample Size			
Auditing Team (names)			
Audit Date			
Follow up Date			
When the final report will be ready?			
HOD signature			
Section B: Completed by in-charge of audit (QM&PSD)			
☐ Approved ☐ Rejected Reason.....			
Comment and Recommendation:			
Name/ signature		Date	

** Please attach the audit tool**

11.2 Appendix (2): Corrective Action Plan

Corrective Action Plan | ***Audit Reference Number:*** _____

المديرية العامة لمستشفى خولة
Directorate General of Khoula Hospital

Ministry of Health
Directorate General of Khoula Hospital
Quality Management and Patient Safety Directorate

Corrective Action Plan

Audit title (Scope)..... Auditee .....

Audit Date:..... Follow-up Date:.....

S. no.	NC Description (Non-Conformance Findings)	Proposed Corrective Actions (Actions to eliminate NC)	Responsible	Timeframe	Follow up Remarks

Auditee Incharge's Name & Signature: ..... **Lead Auditor Name & Signature:** .....

11.3 Appendix (3):Audit template

المديرية العامة لمستشفى خولة
Directorate General of Khoula Hospital

Topic Name

Date/Time: _____ Audited by: _____

Department: _____ Audited Area: _____

S.N.	STRUCTURE	Available	Unavailable	Remarks
1.				
2.				
3.				
4.				
5.				

S.N.	PROCESS	Met	Partially Met	Not Met	NA	Remarks
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						

S.N.	OUTCOME	Yes	No	Remarks
1.				
2.				
3.				
4.				

Auditor's Comments:

_____

_____

_____

_____

_____

Auditor's Name: _____ Signature: _____

Audit tool of (document title)

MoH/DGKH/AT/001/Vers.01

Page 1 of 1

11.4 Appendix (4):Audit template

Barcode

For the policy or guideline

المديرية العامة لمستشفى خولة
Directorate General of Khoula Hospital

Directorate of .....

Audit - Topic

Background:

Scope:

Methodology:

- **Data collection methods**
- **Data Collection Process**
- **Sampling**
- **Data Analysis**

Findings:

Suggestions:

Challenges:

Conclusion:

Recommendations:

Written by:
Reviewed by:
Approved by:

11.5 Appendix (5):Codding of Audit Tool

❖ Khoula Hospital as following:

(MOH/DGKH/Dept./ P&P or Gud or AT/PN/ vers/Year/ AN).

A. **MOH** = Ministry of health

B. **DGKH** = Directorate General of Khoula Hospital

C. **Dept.** = Department of the Auditor

D. **P&P** = Policy & Procedure, Gud = Guideline, AT = Audit Tool

E. **PN** = Policy Number

F. **Vers = Version**

D. **Year** = The year of conducting the audit.

E. **AN**= Refers to the Audit Number.

❖ **AL Nahdha Hospital** as following:

(MOH/DGANH/Dept./ P&P or Gud or AT/PN/ vers/Year/ AN).

A. **MOH** = Ministry of health

B. **DGANH** = Directorate General of Khoula Hospital

C. **Dept.** = Department of the Auditor

D. **P&P** = Policy & Procedure, Gud = Guideline, AT = Audit Tool

E. **PN** = Policy Number

F. **Vers = Version**

D. **Year** = The year of conducting the audit.

E. **AN**= Refers to the Audit Number