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Research papers

The feasibility and potential of organisational peer review audit in community nursing: an example of record keeping

Paul Bowie BA PGDip
Associate Adviser, NHS Education for Scotland, West of Scotland Region, Glasgow, Scotland, UK

Anna Sweeney BSc
Clinical Standards Review Facilitator

June Beattie
Clinical Audit Assistant

Eileen Burns SRN, SCM, HV, BA (Health Studies)
Deputy Director of Nursing

Greater Glasgow Primary Care Trust, Scotland, UK

ABSTRACT

Introduction The record-keeping practices of community nurses is an important clinical governance issue. Good quality record keeping helps to promote high standards of clinical care, enhance patient safety and minimise healthcare risk. In Scotland, NHS trusts must provide verifiable evidence that patients' records are regularly audited to comply with NHS Quality Improvement Scotland Generic Standards (NHS QIS). The main aim of this study was to monitor compliance with the Nursing and Midwifery Council's (NMC's) guidance on record keeping in order to fully satisfy the relevant NHS QIS generic standard for community nursing in our trust. A further aim was to simultaneously develop and test a peer review method of audit, which could be applied by nurses across the organisation.

Design Criterion-based audit involving retrospective case note review by a neutral nursing peer.

Setting Sixteen local health care co-operatives (LHCCs) in Greater Glasgow Primary Care Trust.

Participants Caseload-holding health visitors and district nurses in each LHCC.

Sample size A convenience sample of five records was randomly selected for each caseload holder.

Results 271 community nurse practitioners audited 1239 records during the first audit data collection, with 366 reviewing 1835 records for the repeat audit. The initial audit findings were disseminated across the organisation and a number of record-keeping practices were identified for improvement. Change interventions were agreed and implemented by local nurse practitioners under the guidance and leadership of senior nursing staff at LHCC level. The second audit data collection demonstrated that record-keeping practices had improved considerably, for example in the increased recording of next of kin details ($P < 0.001$), the reduced use of jargon or abbreviations ($P < 0.001$), greater documentary evidence of nursing assessment ($P < 0.001$), care planning ($P < 0.001$) and decision making ($P < 0.001$), and the recording of a review date for patients ($P < 0.001$).

Conclusions Overall compliance with the NMC guidelines has been improved and the requirement to comply with the NHS QIS generic standard satisfied. By adopting a planned and rigorous approach to peer review audit we have demonstrated that an important clinical governance issue can be monitored and improved with the effective use of existing organisational structures and strong professional leadership.

Keywords: community nursing, criterion audit, leadership, peer review

Introduction

The nursing record is a key source of personal, social and clinical information relating to an individual patient requiring specific nursing care. In addition to serially documenting the care process and interventions performed by nurse practitioners, the record should contain clearly presented and sufficient details of all nursing decisions that are made and the rationale behind these courses of action. The Nursing and Midwifery Council's (NMC's) guidance on nursing documentation states that record keeping should be an integral part of patient care and should not be viewed as being external to this process or an optional extra. Furthermore, good quality record keeping helps to promote high standards of clinical care and is an important indicator of the standard of nursing professionalism.[1]

Accurate, complete and up-to-date records are therefore vitally important for a number of organisational, professional and legal reasons.[2–4] For example, poor or incomplete record keeping can impact on the effectiveness of communication between healthcare professionals, the continuity and consistency of the patient care process, and the potential for unsafe practices.[5–7] Against this background, the quality of record keeping is a highly important clinical governance issue and should, therefore, be an organisational audit priority in terms of monitoring and improving nursing practice, patient care and safety, and managing healthcare risk in this area.[8]

In Scotland, NHS trusts must provide verifiable evidence of the regular and systematic audit of nursing records being undertaken as part of the periodic visits by NHS Quality Improvement Scotland (NHS QIS), formerly the Clinical Standards Board for Scotland (CSBS), to monitor compliance with their Generic Clinical Governance Standards.[9] During an initial CSBS visit to our primary care organisation (PCO), it was highlighted that compliance with this particular generic standard in community nursing could be improved across the trust as a whole.

The main impetus for this study, therefore, was to test and implement a peer review method for auditing community nurse record-keeping practices, which could be routinely applied across the organisation to successfully meet both internal and external clinical governance requirements.

Audit aims

The main audit aims were:

- to monitor and, where appropriate, improve compliance with the NMC good practice guidance on nursing documentation and record keeping
- to satisfy the requirements of the NHS QIS Generic Clinical Governance Standards on the regular and systematic audit of nursing documentation
- to establish the potential and feasibility of undertaking large-scale, peer review audit on an organisation-wide basis.

Criteria and standards

The audit criteria to be measured were mainly adapted from the aforementioned NMC guideline recommendations on nursing and midwifery record-keeping practices. Additional criteria were added to satisfy NHS QIS requirements and specific local concerns. Overall, agreement was reached on a total of 28 criteria to be audited against, which covered three main areas of nursing practice and record keeping (see Table 1). It was acknowledged that this was a large number of audit criteria and that there may be difficulty with collecting associated data and in implementing any changes as a consequence. Consideration was given to dividing the audit up into sections over a period of time. However, the consensus viewpoint amongst those who participated in the pilot, and senior nursing representatives, was that it could be undertaken with proper planning and tight project management linked to the use of an audit calendar to guide activities with care.[10]

There is a lack of relevant published evidence on community nurse record-keeping practices with which to inform and compare appropriate standard levels associated with individual criteria. A professional consensus was agreed on the optimal standard level that should therefore be attained for each criterion (see Table 1).

Methods

Pilot study

A pilot audit study was undertaken in Eastern Glasgow Local Health Care Co-operative (LHCC) to test the audit method and data collection proforma. A few minor improvements were subsequently made to the proforma, based on feedback from participants, which mainly concerned clarifying the wording of specific audit criteria. Participants also estimated that it took them between one and two hours to complete the audit and there was general agreement that it was not an overly onerous or complex task.

Table 1 Full list of record-keeping audit criteria by section

Section	Audit criteria	Standards %
Section A	Personal and contact details	95
A1	Patient's full name is recorded	
A2	Patient's date of birth is recorded	
A3	Patient's gender is recorded	
A4	Patient's full postal address is recorded	
A5	Full contact details of next of kin are recorded	
A6	General practitioner's name and address are recorded	
Section B	Record-keeping entries	90
B1	All entries into the record are legible	
B2	All entries into the record are consecutive	
B3	Retrospective entries have been highlighted as such	
B4	All entries are written in black ink	
B5	The record contains clear evidence that it was written with either patient or carer involvement	
B6	All entries show the date of contact	
B7	All entries show the time of contact	
B8	All entries are signed	
B9	The practitioner's name is PRINTED alongside the first entry	
B10	All entries are written without jargon or abbreviations	
B11	All entries are written without irrelevant or offensive speculation	
Section C	Assessment, care plan and goal setting	80
C1	The record contains a full nursing assessment	
C2	The record shows that the assessment process considers the patient's needs and preferences	
C3	The record shows that information has been provided to the patient or carer on the care proposed and the expected results of this care (e.g. information leaflets/materials)	
C4	The record shows that the needs of carers, where appropriate, have been identified	
C5	The record shows that where interventions have been identified, there is evidence that action has been taken for each one	
C6	The record shows clear evidence of care planning	
C7	The record shows clear evidence of decisions being taken	
C8	The record shows clear evidence of patient goals being set	
C9	The record shows that patient goals contain a time-span	
C10	The record shows that a review date is recorded	
C11	The record shows that details of the discharge process have been documented	

Setting

The primary care division of Greater Glasgow Primary Care Trust (PCT) is divided, on a geographical basis, into 16 LHCCs, all of which participated in the audit. Responsibility for promoting and co-ordinating the audit at individual LHCC level rested with those senior nursing staff accountable for clinical governance (lead nurse – LN) and professional nursing (practice development nurse – PDN) issues.

Study participants

Individual caseload-holding district nurses and health visitors in each of the 16 LHCCs took part.

Study design

Data were collected by retrospective case note review by a neutral nursing peer from either nursing discipline using a predesigned proforma. Completed proformas were then passed to the local PDN who collated the data forms and sent them on to the clinical audit department for analysis. Identifiable personal data were not collected and anonymity was guaranteed.

Sample size

The nurse auditor for each individual caseload holder randomly selected a convenience sample of five records. The sample size is small, but was chosen to reflect the number of audit criteria being measured against and the time and resources available to support the audit. The audit numbers would be large when collated for each nursing discipline and this was the basis on which the findings would be interpreted.

Timescales

Study participants were provided with a six-week period during both data collection periods in which to conduct the audit. The first data collection took place during August and September 2002, and the repeat audit during February and March 2003.

Audit calendar

A calendar outlining the various stages of the audit cycle and when they should take place was agreed upon before the pilot study, to guide everyone concerned in the audit project.

Data analysis and statistical tests

Data were stored and analysed using Microsoft Access and Minitab v.13.0 software. Analysis of the data consisted of simple counts (yes, no or not applicable) to determine the level of compliance with each individual criterion. In addition, 95% confidence intervals were calculated to measure any proportional differences between the results generated by the first and second data collections.

Results

In total, 271 nurse practitioners were identified as having audited 1239 patient records during the first data collection, with 366 reviewing 1835 records during the second data collection. The difference in the numbers of participants and records audited can be attributed to two PDNs not being in post during the first data collection and an associated communication problem resulting in some practitioners from specific bases in these LHCCs failing to fully participate. A few practitioners also audited less than five records.

First data collection

The main audit results for 531 district nursing records and 708 health visitor records are outlined in Tables 2 and 3, respectively. The findings show that, although there were some successes in meeting or even surpassing the optimal standard levels for each criterion previously set, many were below the figures agreed upon.

For district nursing records, of the six standards in audit section A, a total of four were below the agreed level. Of the 11 in sections B and C, six and nine respectively were also below the levels agreed upon. In terms of the health visitor records, one standard was not reached in section A, seven in each of sections B and C.

Agreement and implementation of change

In line with the audit calendar requirements, the initial audit results were presented at a specially convened meeting of senior nursing representatives from all LHCCs and trust headquarters. There was general agreement, based on the initial findings, that record-keeping practices were reasonable, but it was clear that many pre-set standards were not being reached and there was still much room for improvement. The group was made aware that there is some evidence from previous nurse-led record-keeping audits to suggest that failing to implement change after the first data collection is a common problem.[11,12] The main reasoning behind this suggests that although

Table 2 District nursing records: proportion compliant with individual audit criteria

Audit criteria	District nursing		Difference % (95% confidence intervals)	*P* value
	First data collection ($n = 531$) *n* (%)	Second data collection ($n = 840$) *n* (%)		
Section A				
A1	530 (99.8)	836 (99.5)	0.3 (–0.3 to 0.8)	$P = 0.34$
A2	519 (97.7)	833 (99.1)	1.4 (0.02 to 2.8)	$P = 0.05$
A3	282 (53.1)	659 (78.4)	25.3 (20.3 to 30.4)	$P < 0.001$
A4	233 (43.9)	552 (65.7)	21.8 (16.5 to 27.1)	$P < 0.001$
A5	390 (73.4)	686 (81.7)	8.2 (3.6 to 12.8)	$P < 0.001$
A6	488 (91.9)	801 (95.3)	3.4 (0.7 to 6.2)	$P = 0.01$
Section B				
B1	506 (95.3)	806 (96.0)	0.7 (–1.5 to 2.9)	$P = 0.56$
B2	517 (97.4)	834 (99.3)	1.9 (–0.4 to 3.4)	$P = 0.11$
B3*	66/109 (60.5)	40/40 (100)	39.4 (30.3 to 48.6)	$P < 0.001$
B4	437 (82.3)	769 (91.5)	9.2 (5.5 to 13.0)	$P = 0.001$
B5	400 (75.3)	654 (77.8)	2.5 (2.1 to 7.1)	$P = 0.28$
B6	519 (97.7)	831 (98.9)	1.2 (0.2 to 2.6)	$P = 0.11$
B7	13 (2.4)	262 (31.1)	28.7 (25.3 to 32.1)	$P < 0.001$
B8	517 (97.4)	817 (97.3)	0.1 (–1.6 to 1.8)	$P = 0.91$
B9	41 (7.7)	285 (33.9)	26.2 (22.3 to 30.1)	$P < 0.001$
B10	272 (51.2)	553 (65.8)	14.6 (9.3 to 19.9)	$P < 0.001$
B11	501 (94.4)	819 (97.5)	3.1 (0.9 to 19.9)	$P < 0.001$
Section C				
C1	262 (49.3)	666 (79.3)	30.0 (24.9 to 35.0)	$P < 0.001$
C2	363 (68.4)	636 (75.7)	7.3 (2.4 to 12.3)	$P < 0.05$
C3	274 (51.6)	616 (73.3)	21.7 (16.5 to 26.9)	$P < 0.001$
C4*	185/302 (61.3)	408/567 (71.9)	10.7 (4.1 to 17.3)	$P < 0.05$
C5*	442/491 (90.0)	732/791 (92.5)	2.5 (0.7 to 5.7)	$P = 0.125$
C6	342 (64.4)	673 (80.1)	15.7 (10.8 to 20.6)	$P < 0.001$
C7	443 (83.4)	743 (88.4)	5.0 (1.2 to 8.9)	$P = 0.01$
C8	211 (39.7)	507 (60.3)	20.6 (15.3 to 25.9)	$P < 0.001$
C9	90 (16.9)	320 (38.0)	21.1 (16.6 to 25.7)	$P < 0.001$
C10*	226/473 (47.8)	554/791 (65.9)	22.3 (16.7 to 27.8)	$P < 0.001$
C11	370 (69.7)	608 (72.4)	2.7 (2.2 to 7.6)	$P = 0.28$

*Not applicable option available

Table 3 Health visitor records: proportion compliant with individual audit criteria

Audit criteria	Health visiting		Difference % (95% confidence intervals)	*P* value
	First data collection ($n = 708$) *n* (%)	Second data collection ($n = 995$) *n* (%)		
Section A				
A1	702 (99.2)	986 (99.1)	0.06 (–0.08 to 0.09)	$P = 0.9$
A2	705 (99.6)	985 (99.0)	0.6 (0.2 to 0.1)	$P = 15$
A3	688 (97.2)	967 (97.2)	0 (–1.6 to 1.5)	$P = 0.99$
A4	674 (95.2)	963 (96.8)	1.6 (0.3 to 3.5)	$P = 0.1$
A5	652 (92.1)	933 (93.8)	1.7 (0.8 to 4.2)	$P = 0.2$
A6	684 (96.6)	962 (96.7)	0.1 (–1.8 to 1.6)	$P = 0.9$
Section B				
B1	664 (93.8)	976 (98.1)	4.3 (2.3 to 6.3)	$P < 0.001$
B2	688 (97.2)	983 (98.8)	1.6 (–0.2 to 3.0)	$P = 0.02$
B3*	162/199 (81.4)	72/81 (88.9)	7.5 (1.2 to 16.2)	$P = 0.09$
B4	548 (77.4)	906 (91.0)	13.6 (10.1 to 17.2)	$P < 0.001$
B5	566 (79.9)	931 (93.5)	13.6 (10.3 to 16.9)	$P < 0.001$
B6	699 (98.7)	986 (99.1)	0.4 (–1.3 to 0.6)	$P = 0.5$
B7	71 (10.0)	415 (41.7)	31.7 (27.9 to 35.4)	$P < 0.001$
B8	668 (94.4)	950 (95.5)	1.1 (1.0 to 3.3)	$P = 0.3$
B9	104 (14.7)	639 (64.2)	49.5 (45.6 to 53.5)	$P < 0.001$
B10	352 (49.7)	726 (72.9)	23.2 (18.6 to 27.8)	$P < 0.001$
B11	625 (88.3)	977 (98.2)	9.9 (7.4 to 12.4)	$P < 0.001$
Section C				
C1	451 (63.1)	805 (80.9)	17.2 (12.9 to 17.5)	$P < 0.001$
C2	537 (75.8)	906 (91.0)	15.2 (11.6 to 18.8)	$P < 0.001$
C3	572 (80.8)	900 (90.4)	9.6 (6.2 to 13.1)	$P < 0.001$
C4*	557/629 (88.6)	914/963 (94.9)	6.3 (3.5 to 9.2)	$P < 0.001$
C5*	571/667 (85.6)	880/945 (93.1)	7.5 (4.4 to 10.6)	$P < 0.001$
C6	476 (67.2)	851 (85.5)	18.3 (14.2 to 22.4)	$P < 0.001$
C7	580 (81.9)	902 (90.6)	18.3 (5.4 to 12.1)	$P < 0.001$
C8	419 (59.2)	727 (73.1)	13.9 (9.3 to 18.4)	$P < 0.001$
C9	320 (45.2)	621 (62.4)	17.2 (12.5 to 22.0)	$P < 0.001$
C10*	364/659 (55.2)	715/970 (73.7)	18.5 (13.8 to 23.2)	$P < 0.001$
C11	51 (7.2)	186 (18.7)	11.5 (8.4 to 14.6)	$P < 0.001$

*Not applicable option available

individual nurses tend to be made aware of the results of audit, they are then denied the opportunity to explore the findings with their peers and so gain a working knowledge of what is required. Simple dissemination is not enough – practitioners must be engaged at all stages of the audit process so that a sense of ownership is developed. Ideas for change and how to action them must be generated by staff or the motivation to participate in any interventions may be lacking.[12]

After some group work to consider the findings, identify the deficient areas and suggest improvements, a series of recommendations was made:

- a detailed interim report of the results was drafted and distributed to all staff involved in co-ordinating and leading the audit
- an A4 'flyer' outlining the main findings and recommendations was disseminated immediately to all nurse practitioners. The results were also repeated in the trust clinical governance newsletter
- individual PDNs were responsible for presenting the data results at established monthly meetings and then engaging staff in how best to improve record-keeping practices at a local level within the agreed timescale
- areas for improvement, potential solutions and interventions were agreed, co-ordinated and implemented locally by nurse practitioners in each LHCC.

Second data collection

The results of the second data collection for both nursing disciplines can also be viewed in Tables 2 and 3, respectively. For district nursing records, of the six standards in section A, three were still below the agreed level, while of the 11 in sections B and C, four and eight respectively were now below the levels set. The results for health visitor records showed that one standard in section A was not being met, with four each in sections B and C, respectively not meeting the optimal levels.

Discussion

In terms of the main aims of this large-scale peer review study, it is clear that overall compliance with the NMC guidelines has been greatly improved through the successful implementation of change and subsequent re-evaluation required of a completed audit cycle. Importantly, our organisational requirement to satisfy the NHS QIS generic standard on record keeping has also been successfully achieved. However, a number of standard levels have yet to be attained for both the nursing disciplines which took part. It is recognised by these practitioners, however, that there is still room for improvement in record-keeping practices and that this is an area that will require regular monitoring. Audit, especially on this scale, is a progressive activity and so it can take time for pre-set standards and goals to be successfully achieved.

Arguably the most important aim of the study was to establish the feasibility and potential of undertaking peer review audit in community nursing on an organisational basis. Utilising a peer review approach has a number of potential advantages over self-audit, provided that practitioners are open to this type of evaluation and educational feedback is at the core of the process. From a record-keeping perspective, it may also be more accurate and reliable to have a colleague critically review records against agreed criteria rather than the individual caseload holder. Peer review has been shown to be effective in a number of studies, particularly in implementing change. Practitioners have highlighted various factors, such as being made aware of gaps in their performance and discovering that colleagues have failings too, as being influential in their willingness to change.[13–16] In addition, the potential role of peer review in contributing to personal development, enhancing professional nursing practice and supporting the clinical governance agenda has been well-described.[17]

Prior to this exercise, most nursing audit had been left to LHCCs, healthcare teams and individual practitioners to plan and undertake. Anecdotal evidence strongly suggested that although many caseload-holding community nurses were involved in some form of audit activity, clearly there is an undefined proportion who did not participate or whose involvement was infrequent. In addition to this, it was also clear when reviewing this audit activity that much of it was *ad hoc* and unfocused, leading to predictable problems with the rigour of audit methods adopted, data collection inconsistencies, implementing change and completing the audit cycle. These problems with the audit process are, of course, not unique to our organisation but are common across all health sectors in the NHS.[18–20]

Unfortunately, these avoidable problems can often lead to frustration and even open hostility towards the audit process, while there is also the parallel issue of opportunities to improve patient care and manage risk being missed. Criticisms of this type of 'bottom-up' and unstructured attempt at the audit of healthcare are well-documented.[18,21–23] This explains in part why co-ordinated rolling programmes of core audit activity are strongly promoted as an alternative to the *ad hoc* approach.[24] Additionally it is clear that there is still an education and training issue for many

healthcare professionals with regard to audit. The formal introduction of audit to the NHS was based on the implicit assumption that all healthcare professionals understood audit method and could successfully apply it as part of everyday clinical practice, which is clearly not always the case. Successfully undertaking an audit means being skilled in – amongst other things – teamwork, data collection, project management and implementing change.[18,25] It is fair to say that a majority of healthcare professionals will lack proficiency in many of these areas and so audit advice, leadership and practical support will often be required.

Adopting a carefully planned, co-ordinated, and rigorous approach to audit in a well-managed environment, combined with strong professional leadership has been shown to be more effective in achieving audit objectives. The additional pressure to participate in audit from an external accreditation body has also been promoted as another essential way of focusing attention on the effectiveness of audit.[18,26] To manage the peer review process well, a number of personal and organisational conditions must be fulfilled.[13,14] For example, practitioners must be continually stimulated, motivated and involved in the process and be provided with dedicated time to participate in and attend regular feedback meetings. Careful planning and preparation should be made to ensure all practitioners are aware of their responsibilities, and local leadership is in place to oversee issues of continuity and the successful functioning of the group – all within existing healthcare structures. Our study was modelled on all of these important factors and this is perhaps a pointer to its success in terms of securing the implementation of change and completing the audit cycle, despite the large-scale nature of the project.

Conclusions

Expecting disparate groups of healthcare professionals across an organisation to undertake specifically identified audit projects in a consistently rigorous and successful manner – in isolation and unsupported – is quite probably professionally and organisationally naïve. This is not to suggest healthcare professionals and teams cannot necessarily achieve this on their own, but that from an NHS trust perspective it may be more prudent, reliable and successful to administer and co-ordinate *priority* audit projects on an organisational basis.

Our study has shown that an important quality issue can be successfully monitored and improved by peer review when the existing organisational structures and professional leadership are utilised effectively. We commend this approach as a method for engaging all relevant practitioners in audit, facilitating genuine change and contributing to improved patient care and safety.

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CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Paul Bowie, NHS Education for Scotland, 2 Central Quay, 89 Hydepark Street, Glasgow G3 8BW, UK. Tel: +44 (0)141 223 1463; fax: +44 (0)141 223 1403; email: paul.bowie@nes.scot.nhs.uk

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