

Uk healthcare services quality management



Clinical audits have been defined as the process of assessment performed using evidence based criteria. Audit currently forms the standardised method for assessing and evaluating quality measures for healthcare in the UK. Audit has been referred as the critical evaluation and an overview to the clinical performance done over a specified period of time which is aimed at generating detailed insights for the healthcare professionals regarding the quality assessments so that they are able to derive the rationale for adjusting their performance (Flottorp et al. 2010). The purpose of using clinical audits for policies in hospitals and care homes is for stimulating and support utilisation of interventions that are applied both nationally and locally for improvement. Re-auditing is further performed for assessing the impacts of such interventions (Department of Health 2009a). The purpose of this paper is to discuss quality and to examine how it is measured within the UK healthcare service with a particular focus on the use of audit. Moreover, the paper aims to assess the benefits and challenges for implementing audits as a measure of quality in the health care. A local clinical policy has been examined to demonstrate the use of audit for measuring quality in healthcare and to determine the extent the policy has proven to be successful. The paper will focus on falls prevention policy. In accordance with the Nursing and Midwifery Council's code of conduct (NMC, 2015) confidentiality will be maintained throughout the essay.

One major cause of disability among patients is falls which also constitute a leading cause of death among patients above 75 years. Fall prevention remains a pertinent challenge for NHS since they have been reported the most common incidents that breach patient safety measures. There have

been more than 240, 000 cases (for each year) reported in the mental health trusts and acute hospitals across England and Wales (Healey and Darowski 2012). Even the falls that do not lead patients to face injuries cause them and their families to bear stress and anxiety. Patients who are weak and frail cannot tolerate even the slightest injuries that may result from fall and undergo significant disabilities in physical functioning as such hip injuries which are estimated to be 3000 each year (Healey and Darowski 2012).

Prevention of falls is expensive yet prolongs the stay of patients in the hospital. In 2007, the total cost that falls imposed on trusts was £15 million which have significantly increased now (Royal College of Physicians 2015). It constitutes an increasingly challenging issue to tackle falls in hospital and care homes. It is also important to note that there has been no standard intervention which is applied uniformly for reducing falls. Researches however have identified a number of different interventions that multidisciplinary team's tailors and perform individually; the strategy is viable to reduce falls among patients by 20-30% (NICE 2013). Quality audits remain the major paradigm used across England and Wales for assessing the policies for fall prevention. Audit is applied for assessing the fall prevention strategies across England and Wales. Primarily, audit was introduced to provide guidance upon assessing fall preventions as per the NICE guidelines (Collins 2014).

Quality has been defined as the level to which healthcare services rendered to the population may viably lead to the desired healthcare outcomes and how consistently it embraces the concepts of professional and contemporary knowledge (Phillips et al. 2010). Primary objective of measuring quality in <https://assignbuster.com/uk-healthcare-services-quality-management/>

healthcare is to assure the services provided are capable to optimise the health of population as well as capable enough to facilitate growth in services to reach the desired goal. Audit subsequently helps in enhancing the performance level of professionals by providing them a systematic way of assessing performance rendered over a specified period of time (Jamtvedt et al. 2007). The system of audit dominates healthcare sector in the UK. The Department of Health in the UK has endorsed auditing as a successive strategic measure and yet a significant way to rationally measure of quality in healthcare (Yorston and Wormald 2010). Audits prove to be a helpful way of employing policies in a strategic manner. Audits are applied for determining the level of adherence that staff shows toward fall prevention strategies, use of the prescribed tools for preventing falls, and utilisation of evidence based care processes for preventing falls. Dissemination of fall data is also done through quality audits. Quality audits also help in conducting the risk assessments through integrating them with the electronic health records (Hempel et al. 2013). Quality remains high over quality agendas and policy makers are often indulged in ruling out the factors that effectively can mediate the policy outcomes (Flottorp et al. 2010). The spectrum is much broader and covers a number of important schemes rendered by the governmental bodies as well as the voluntary initiatives taken by the professionals. Audit therefore incorporate a wider number of measures including evaluations for multi-faceted interventions and the combined educational activities (Nouraei et al. 2009). One important factor that underpins quality measurement is the level of behavioural changes the policies may likely give rise to. Behavioural changes form an effective mediating environment in clinical practices enabling healthcare professionals

to gain generous insights towards the gravity of outcomes (Yorston and Wormald 2010).

It has been identified that all organisations working in the healthcare sector in the UK employs a fall prevention policy. A large portion of these policies (94%) is based upon the guidelines generated by NPSA and NICE for preventing falls in hospitals (Royal College of Physicians 2015).

Contrastingly, it is also evident that a portion of these policies (32%) do not match with the related policies. These mainly involve prevention of falls for patients with bone health, delirium, and dementia (Royal College of Physicians 2015). The audit policy applies to all the staff irrespective of their profession and designation. The policy is to manage falls in a hospital care setting. Audit is applied for measuring the adherence of staff towards the safety guidance processes and procedures applied for preventing falls. The audit is undertaken at an organisational level and can be differentiated into three sections that are maintained at both the health board level and the hospital trust. The section one covers organisation's background details including the number of occupied beds and number of days each patient spend on the bed and the subsequent number of falls. The section two comprises of protocols, policies, and paperwork. In the section three are contained the guidelines for service and leadership provision. Though the local organisation implements a fall prevention policy; it seems to relevantly cover all the major areas of preventing falls in the premises. Audit data retrieved locally provides information regarding association between what is included in the policies and assessments done that either the patient received care after getting admitted to the hospital. Multidisciplinary

approach is followed locally for preventing falls among patients. Despite there have been different elements that collectively form a part to routine fall care among patients, the policy emphasises upon improving patient culture. Audit in the given policy provides GPs and clinicians with the optimal potential to assess the level of quality of routine basis (Dawda et al. 2010). The reasonability of clinical audits can be determined from the fact that almost all the GPs practicing in the UK acquire skills for incorporating the conventional medical audits for quality assurance. It, however, has been argued that training does not form a consistent part of auditing that causes it face inconsistencies the improvement measurements (Raleigh and Foot 2010). The local organisation has been consistent in emphasising upon the significance of establishing fall prevention facility program. The key element the program underpins is the assessment of risk, risk reduction, educating the staff, caregivers, and family members regarding fall prevention. A comprehensive program is necessarily required for fall prevention to conduct audits or otherwise an organisation is unable to evaluate and improve its existing actions and programs (Swonnell 2010). Planning involves selection of the key staff members such as nurse managers to formulate Fall Committee that specifically has been dedicated to facilitate the planning process. Members that ideally are considered to include in planning are the nursing representatives, nursing directors, MDS, and the Quality Assurance departments. Goal setting however is done by the committee specifically formed for developing the procedures and policies which must be followed and paradigms for rendering information for staff. Forms are used for implementing fall preventing programs which are also made by the committee. Evaluation refers to ensuring compliance with the procedures

and policies for fall prevention. Assessments are done on frequent basis to mitigate the problems accordingly. A Fall Committee member is designated to overview the change arrangements applied across each are for assuring a follow-through. The committee members are responsible for examining the effectiveness of measures and for designing interventions as per the requirements. Committee undertake meetings on monthly and sometimes weekly basis to assure the processes are being followed continuously.

Both the policy and audit are interconnected in that they contain integrated sets of activities. They are interconnected in a way that outputs from one activity formulate an input to the other. Policies are required to regulate the process of auditing and the associated subsequent activities (Russell, 2007). According to Raleigh and Foot (2010), issues that are central to the quality measurement includes the purpose of incorporating and introducing newer policy frameworks for quality assurance and improvements. Quality measurement forms an essential need in the context of policy development. Use of auditing as part of policy development for preventing falls is beneficial since it leads to state the clear objectives that are conceptually aligned and can easily be incorporated with the evaluative mechanisms. Without a comprehensive policy, it becomes increasingly difficult to ascertain whether the staff can viably meet policy objectives for falls prevention (Hempel et al., 2013; Leather et al., 2010). Clinical audits nationally constitute an enriched source of information for policy development (Bullivant and Corbett-Nolan, 2010). However, critiques have highlighted inadequacies in the functionality of clinical audits when applied apart from policies. Auditing in healthcare, when is regulated by a comprehensive policy, provides an effective clinical

measure to assess the prospective outcomes against interventions for fall prevention. It is beneficial since it utilises a well-defined criteria and a standardised set of principle regarding use of evidence-based clinical measures (Jamtvedt et al., 2007). The impact it lays on quality of care is to underline the discrepancies encountered in usual practices and deviate professionals from following a standard way of practice. Another impact that auditing create is enable the professionals to identify and channelize the changes required to improve the quality of care (Ivers et al., 2012).

The selected local policy and audit relates to national policies and legislation in that it offers clinical governance which formulates the major requirement applied nationally. The selected local policy show adherence to the national policies and legislation since it ratifies the Care Quality Commission's Registration Standards introduced in 2010. NHS imposes important statutory requirements which the healthcare providers are essentially required to incorporate for conducting audits regarding any policy such as falls prevention (Smits et al. 2009). The discussed policy for falls prevention applied locally considers auditing as central to the clinical tenets. It significantly analyses the standards for best practice, assurance and compliance provisions for clinical audits, identification and risk minimisation, prevention of inefficiencies, and quality care improvements for an overall improved patient outcome. The national programme applied is entitled as the ' National Clinical Audit and Patient Outcomes Programme' (NCAPOP). This is a widely recognised national programme managed and commissioned by the HQIP (Healthcare Quality Improvement Partnership).

Service users formulate an effective part of the clinical auditing process. Guidelines rendered by NICE have helped organisations ensure that an effective provision of care can be established if the contributions from service users can be maximised. Contributions from carers and service users contribute to make policies cost effective meanwhile elevating the standards of care they maintain. The Care Quality Commission and Monitor have deemed contribution from service users as essentially important to cater the requirements posed by local commissioners (Bullivant et al., 2012). Service users may effectively contribute to policy development through rendering their feedbacks and taking into account the NICE led guidelines which provides a rational basis of exercising clinical judgements (Raine et al., 2014).

A primary prescription that policy makers and practitioners follow to meet the challenge of effective falls prevention policy development in the context of auditing is to seek help from the multidisciplinary teams. Interaction takes place within more than one line of management in organisations and so is the procedure of policy development. There prevail perceived status differentials and the inter-agency working that causes different professionals to emerge with a different point of view and implications for mediating the organisation led processes of policy development (Reeves and Harris 2016). The systems and structure that healthcare organisations incorporate for effective management and support require enhanced integration between multidisciplinary teams (Hanskamp-Sebregts et al., 2013).

Corporate leadership is found to be vitally important for quality improvement (Raleigh and Foot 2010). The biggest challenge that organisations encounter

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in implementing audits is the poor data management quality. This constitutes a potential deficit in understandings for frontline staff duties. It creates a major loophole for which audit has proven to be ineffective so far for preventing falls (NICE, 2013). Most times, the information collected show inconsistencies and irrelevancies pertaining to patient care. Likewise, the auditors also strive to find the central focus regarding quality of healthcare service delivery from the frontline practitioners. This, therefore, highlights the need of more focused efforts regarding involvement of the clinical staff since their role in using and validating the information produced from audit remains unclear. Auditing constitute a complex healthcare intervention and underpins a number of practice based challenges based on the fact that it underpins a number of parts. Being a multicomponent intervention and because of projecting a wide ranging scope to evaluate the health pyramid including different levels, it does not gain much favour and practical support from the healthcare staff (Zegers and Wollersheim, 2011).

Auditing in health care system is considered as the most important lever of financial mechanisms to objectively assess the state of the health care system and its subjects, the effectiveness of implementation of the state policy in healthcare organisations. The local policy analysed focuses on assessing the risk factors that makes patient vulnerable to falls. Audits are done for analysing the adequacy of interventions provided for preventing falls. Quality improvement for falls prevention is done through the Falls Committee and the multidisciplinary teams. Policy and audit both are complimentary to each other and plays a significant role in ensuring the key national and local drivers have been appropriately contributing to fulfil the

requirements for balancing service/group/trust priorities in the best interest of clinicians.

Findings made in the paper has enabled me understand the significance of incorporating multidisciplinary teams in policy development. As a nursing student, I have gained significant insights the ways how policy development takes place for falls prevention and the significance of auditing in enhancing quality care mechanisms. I can integrate the findings into nursing practice by collaborating with the multidisciplinary teams in course of policy development. Moreover, taking feedbacks from users would further help to gain insights to the quality problems.