Clinical governance in nursing

Introduction

The health sector today is very different from what used exist in the past quarter of a century. Patients who are more aware of their rights and hospital or clinical staffs who have responded quite well to the demands posed by the public have brought this about. The legal systems and their punitive measures have also played a significant role in the transformation of the health sector.

Clinical governance is defined as a system set up to improve the standards of clinical practice (Finkelman 2006). As such, the system hopes that clinicians will go beyond their traditional role in health care provision and provide support to patients as they seek to improve the quality of care offered in health institutions. McSherry and others (2002) state that clinical governance is a complex system that contains diverse themes and processes, aimed at increasing the clinical quality for individuals and organizations (p. 34).

Risk management on the other hand is simply defined as the system that seeks to develop good and responsible practice among clinicians in order to avoid or reduce the occurrence of adverse or harmful incidences (McSherry et al 2002, p. 34). Risk management therefore reduces clinicians' chances of incurring loss and the possibility of the practice having a bad outcome. Risk management is part of clinical governance, which deals with policies, procedures and systems that the clinicians should uphold. Other key components of clinical governance include information, accountability, performance management and quality-improvement programs (McSherry et

al 2002, p. 35). This paper will explain the responsibilities of a nurse leader in upholding clinical governance and managing risks. It will also highlight the challenges that the nurse leader faces in Hospital X as she does her duties.

Literature review

Clinical governance was a fairly new concept in the late 1990s. As such, governments and players in the private sector have all tried to shed some light into this concept. What most writers seem to agree is that the concept has the capacity to transform the health sector for the better. Reading the literature available in this concept, one notes that some authors are skeptical about the practicability of the concept.

McSherry and others (2002) explain that clinical governance is more about risk management than anything else. According to them, health care professionals are perpetually managing risks both at personal and corporate levels. These authors define clinical risk as a variance from the planned treatment, therapy, care or diagnostic. Clinical risks according to these authors may involve problematic clinical outcomes or not.

In the book, " Clinical governance: A guide to implementation for healthcare professionals," McSherry and others (2002) state that most health institutions fail in implementing clinical governance because individual clinicians view the risk management in relation to their own professions and positions, thus neglecting the holistic risk management. As a result, risk management in a sizeable number of health facilities is only partial.

In the book ' Effective Healthcare Leadership' Jasper and Jumaa (2005) states that there are four main features in clinical governance. The two authors

state these features are combined political, societal and professional forces that initially introduced clinical governance, integrated features from all stakeholders, appropriate leadership styles and frameworks developed by the government and other stakeholder in the health sector in order to harmonize clinical governance across health organizations (p. 73).

Hewison (2004) on the other hand examines the management trends that have contributed to the development of good management systems in the healthcare sector. He bases his arguments on the National Health Service (NHS) declaration that states that all patients are entitled to high standards of health care (p. 40). In his book, Hewison (2004) contends that defining quality in the healthcare sector is not an easy thing to do (p. 41). Because of this, the author, he suggests a few pointers that the public health providers would incorporate to expand the definition of quality.

Finkelman (2006) takes a different approach to the clinical governance concept, by reviewing the how NHS proposes to enact the standards proposed in the concept (p. 103). Her book reviews the systems, clinical audits, and the regulatory bodies that oversee the implementation of the concept. McKinnon (2007) on the other hand writes about the concept in an advisory manner. The author states that the best way to enact clinical governance is by encouraging clinicians to incorporate the governance activities into their daily roles in the healthcare sector.

In some authors' minds, there is no doubt that clinical governance is a concept that should be enacted all through. One such author is Lugon and Secker-Walker (1999), whose book proposes ways of making clinical

governance work. Under risk management, this author proposes that medical staff thought to have gone against the principles of clinical governance should be investigated and the necessary disciplinary measures taken against them. Journal article writers have also written volumes of materials to expound on the clinical governance concept. Their work will also be used as reference resources for the practice application section.

Practice application

I work for hospital X as a nurse leader. My roles involve ensuring that individual patients who seek the hospital's services receive maximum care and support. As such, I have to double as a nurse educator to ensure that the nurses and clinicians under me know the best way to handle patients. I also brief my superiors as well as tell them about the equipment and resources that my unit needs in order to provide quality care. My work requires me to be clinically competent, physically able, emotionally fit and technologically savvy.

Any organization, be it in the health sector or not needs aligned structures in order to perform well. According to Porter (1998), health facilities must have a good organization structure that has clear roles, which foster accountability amongst the staff members (p. 20). The organization structures must also have manageable means through which they can be controlled. Managerial responsibilities, clinical leadership, decision-making and strategic planning are some of the focal considerations that healthcare providers make when formulating quality structures (Porter 1998, p. 20).

Accordingly, it is my belief that for a healthcare facility to succeed in implementing the clinical governance concept, and especially where risk management is concerned, people responsible for designing structures in specific healthcare facilities must be able to design the structures and roles around people who can handle the roles well. For example, while scouting for a nurse leader, hospital X considered my clinical qualifications and my leadership qualities. Alternatively, the structures' design should focus on performance, whereby the roles are only assigned to people who prove that they can actually handle them well.

Most hospitals have a director of medical affairs at the top most position of leadership. Under him are coordinators for things such as policy, governance, administration and other projects. The nurses, people handling clinical affairs, ambulance-care service providers and the supplementary operators are then placed in the same order in the hierarchy. Under these groups of people are the human resources department, the financial department and the quality improvement department. At the bottom of the hierarchy is the compliance officer, the medical information officer and the associate director, all who are placed at the same level. The people who bear the burden of care are the clinicians. They include the physicians, head nurses, nurses, and paramedical staff members. Others staff members who are equally responsible for a patients' well being include the housekeepers and food service providers.

A conventional quality management structure has the physician as the main person responsible for diagnostics; the head nurse ensures that problems in patient care units or nurse units are handled well, while the nurse's main

responsibility is ensuring that the patients are provided the medication, and care necessary for their recovery.

My main contention with this conventional organization structure is that it rarely provides for consultation amongst the people in different hierarchies. Some of the successful implementations of clinical governance and risk management have included different people working in a health facility, working together to come up with an ideal structure of improving care. In my case, I strive to work with nurses and clinicians to work out a plan of care in my unit. Involving them opens communication between me as a nurse leader to them, and intercommunication between the nurses.

In a case study published by the American college of Medical Quality (2009), when clinicians and administrators are involved in the active design of a governance structure, there are higher probabilities of success because everyone who was part of the decision-making wants to make the structure succeed (p. 36). Clinicians feel the need to uphold the process of care as stated in the structure, while the administrators take an active role in ensuring that the quality and cost measures are upheld.

The conventional structure also fails to involve other stakeholders like the patients and their relatives or friends. According to McKinnon (2007), the seven domains that make up effective clinical governance are clinical audit, involving patients and public, risk management, clinical standards, staff management, professional development of staff through training and the use of technology (p. 124). Public involvement means that the clinicians and the entire health sector staff accepts that, being the recipients of clinical

services, patients could have feedback or suggestions that would improve the quality of care in most health care services. Some of the ideal ways of involving patients' participation as suggested by McKinnon (2007) include surveys or engaging patients in long-tem care in programs where they can voice their opinions about care and support that they receive from the healthcare facility.

The conventional quality management structure also leaves out nutritional support and house keeping personnel without proper briefing on the importance of quality of care. This in many cases could lead to poor service provision since every staff member, despite attending to similar patients on different times, may fail to harmonize their services to satisfy the patient's need for care fully.

As a nurse leader, one has to satisfy the demands of patients, while ensuring that the nurses are able to work in a good environment. According to Rowland (1997), a nurse leader has three basic roles, namely leading a multi-disciplinary team of care providers, managing cases related to resources in hospital units and provision of physician care in the absence of a fully qualified physician (p. 151). This seems like too much work for one person.

Depending on the size of the unit that the head nurse is overseeing, chances are that she or he would have difficulties addressing each issue comprehensively considering the other roles awaiting his or her attention. The head nurse is also responsible for evaluating other nurse's performances, recommending them for promotion to the executive nurse or

proposing disciplinary measures for the poor or negligent performers. In addition, to top it all, the head nurse is supposed to act as a role model to the other nurses (Rowland 1997, p. 151).

Clinical governance seeks to provide quality care to patients at all times. As such it advocates for effective, acceptable, efficient and accessible care. In addition, clinical governance states that patients should be treated fairly, equitably and given relevant care (Hewison 2004, p. 42). With all the responsibilities resting on the head nurse, he or she would have challenges keeping up with all the values advocated for in clinical governance. More to this, the head nurse would have to contend with three different concerns; on one hand, she has to submit to standards set up by higher authorities, who often demand efficient or productive use of clinical resources. The demands of professionalism would also be waiting for his attention. Such includes checking whether the approaches and services provided by the nurses under him meet the patient's needs. The third demand on his attention comes from the patients, the patient's friends or relatives (Hewison 2004, p. 43).

Driscoll (2006) states that any clinician who practices clinical supervision like the nurse leader does has to deal with three very vital aspects of such a responsibility (p. 16). The first is the formative function of constant learning. Because the nurse leader supervises different personnel, he needs to learn the skills needed to handle different people. By doing so, he is able to communicate to them more efficiently and therefore improve their levels of service provision to the patient.

Driscoll (2006) notes that a nurse leader has a restorative function that includes supporting both the patients and the nurses under him (p. 16). Under this, the nurse leader has to consider how other nurses under him react emotionally to work related demands and stress. Often, nurses are overwhelmed by the need to uphold professional ethics, when human nature demands that they do something completely different. Such emotions can affect the overall performance of the affected nurses and could even go against the risk management concept. The third aspect of clinical supervision regards accountability. A nurse leader has to account for the quality and provision of care under his unit. To ensure that they are able to do this, nurse leaders have to devise ways of monitoring the performance of the clinical staff in their departments. While handling all these, the nurse leader must be able to work with the physician to countercheck the instructions issued to nurses. Sometimes, a nurse may approach me with what looks like a solid argument about going against the physician's order when giving care to a patient. A perfect example is when a patient has a restricted sugar diet but craves for the same. In such a case, it is my responsibility as a nurse leader to advise the nurse to stick by the physician's order. I also confer with the physician to see if the craving can be offset by other means.

According to McSherry and Bassett (2002), the nurse leader needs to comprehend effective ways of managing risks in the health care facility (p. 105). Today, patients have higher expectations about health care provision. In addition, a higher number of older people are seeking rehabilitative, long-term care. Moreover, the legal system is responding to different litigations in

a way that encourages the public to learn the rights about healthcare provision. These factors raise the need for risk management in the health sector.

Despite all qualified nurses having studied the code of professional conduct, most of them do need take it seriously until cases related to negligence pop up (McSherry &Basset 2002, p. 107). It is only then that most nurses realize that ideals such as accountability are applicable in practice. Because negligence cases pose a big risk to health institutions, the nurse leader should stress the need for the nurses under him to know that they are responsible for their own actions. In addition to helping the nurses uphold professional integrity, this would also aid the entire health entity to manage its risks. This is because patients may hold the employee of the nurse who acted negligently during care provision accountable too.

Jasper and Jumaa (2005) suggest that leadership qualities affect the kind of clinical governance that each health institution has (p. 71). A nurse leader who has a personal approach to leadership is more likely to implement an open culture in the unit under him. A nurse who sets the direction that nurses and other clinicians should follow on the other hand is more likely to motivate them to improve their care services. One who leads by example sends a clear message that the target for his unit is results. The results in the health sector can only be measured by how contented the patients are about the services offered. Combining the three approaches looks to me like the ideal way of handling clinicians under the nurse leader's supervision.

A nurse leader may have furthered his or her education beyond the four year mandatory training (Rowland 1997, p. 149), but I am of the opinion that to be a leader can be inherent but must also be enhanced through training. As such, a nurse leader needs training in order to provide the intended leadership for the people under him (Jasper & Jumaa 2005, p. 73). Training would not only enhance the quality of care, but would also improve the public's confidence in the healthcare sector. Such would especially be beneficial to the leader nurse who is required by the powers above him in the quality management structure to provide guidance to the nurses and support staff under him on risk management.

The opinion therefore is that making nurses and other service providers fully grasp the concept of risk management is the most complex responsibility that a nurse leader has. According to Pickering and Thompson (2003), risk management involves identifying the patient's needs, and choosing a care provision strategy that will satisfy the needs with no or minimum risk (p. 191). Therefore, in order to ensure that the responsibility of informing the nurses does not weigh too heavily on the nurse leader, the health facility should take a multidisciplinary approach to addressing risk management. By doing this, all staff who handles patients in the line of duty would be informed about it. For example, instead of issuing paper handouts to nurses about risk management, Hospital X can hold nursing workshops where all nurses can learn about the value of risk management. This is a more interactive form doing it than the leaflets, which most of them possibly never read.

Herring (1999)- cited by Pickering and Thompson (2003) states that an interdisciplinary approach aimed at addressing issues in the health sector usually has positive effect since it opens the lines of communication between healthcare providers and as a result, creates an environment where the professionals act because they were involved in the decision making process.

Writing for a medical journal, Antrobus and Kitson (1999) captured the tricky situation that nurse leaders are caught in quite precisely. The authors state that nurse leaders act as translators and interpreters (p. 752). Their role as translators although lacking in official definition mainly involves understanding the contextual ideals in clinical governance and passing them to nurses under their leadership. The role of interpreting is assumed by the nurse leaders when communicating nursing issues to people in the leadership domain with an aim of advancing the nursing practice.

Conclusion

Clinical governance and risk management are issues that are best handled collectively by an institution. This is because as much as individual clinicians may try to hold their end of the bargain, there are bound to be some slip-offs where no collective approach is in place. Whereas clinical governance was a pretty new idea in the early 1990s, this is no longer the case. Any health facility that ignores the need to harmonize clinicians and other support staff to the ideals are just exposing them to risks that may cost them huge amounts of money to settling the cost of negligence to disgruntled patients, or worse still, it may cost a hospital its reputation.

Transformational leadership, whereby a leader seeks to empower people under him is an ideal form of governance in the health sector. Here, the person in the top most position in the hierarchy of clinical governance would take the initiative to understand the concept of clinical governance, which is inclusive of risk management, and would share the same with staff members under his leadership. This type of governance creates an atmosphere where all people work together for the benefit of the institution. If implemented in the health sector, this type of governance would benefit the patient greatly. This would be a metaphoric situation of killing two birds with one stone; patients would enjoy better health care services, while the individual clinicians and the health facility would be exposed to fewer risks.