Clinical governance impact on occupational therapy

This paper aims to understand how clinical governance affects Occupational Therapists (OTs) and how an OT could implement a clinical governance initiative in an in-patient ward within an adult orthopaedic department.

The right to high-quality care is the first item on the paper ‘ A First Class Service’ (Department of Health, 1998). It aims to deliver this care through clinical governance. The paper describes clinical governance as “ a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”. Clinical governance influences how an occupational therapist (OT) works to ensure that the patient receives the safest, most effective care possible.

Clinical governance was created as a tool to support staff and develop all health organisations so that they are able to deliver quality care (Department of Health, 1999). The responsibility for the quality of care lies with local NHS Trusts, which use clinical governance to ensure that a patient receives good quality care. Recent developments within the NHS have meant that the government is introducing ‘ best practice tariffs’ – payments for good quality care (Department of Health, 2009). Providing good quality care has also been one of the key priorities, as trusts now need to prove that they are providing this good quality care in order to get the money.

Clinical governance is made up of key initiatives: risk management, supervision, staff appraisal, continuing professional development, evidence-based practice, research and development, quality assurance, clinical audit

and patient and public involvement. These are taken from the pillars in the ‘ Seven Pillars of Clinical Governance’ model, providing good quality care is at the top of the model. Beneath the pillars are the foundation stones; systems awareness, teamwork, communication, ownership and leadership This is a model to show how all areas are related, and when all seven are in place, with the foundation stones, then good clinical governance is considered to have been achieved (Swage, 2001). If one of the pillars or foundation stones is removed, then the apex – good clinical governance – will not be achieved. Kennedy (citied in Currie, Morell & Scrivener, 2003), discussing the Bristol baby scandal, states that the lack of openness, concerns not being discussed, absence of a monitoring process and no learning from untoward events all led to the scandal, highlighting the effect that if parts of the structure are not in place, then it won’t remain standing, and this can have an effect on the quality of care and safety that a patient receives.

Clinical governance affects all health care professionals, including OTs, OT assistants and OT students. An OT needs to be aware of the clinical governance initiatives, and that they are needed to achieve an ‘ environment where clinical care will flourish’ (Department of Health, 1998). Clarke (2000) states that an OT would not just look at risk management to ensure safe practice, as s/he would need to consider the other initiatives such as basing their practice on evidence and keeping up to date with the most recent approaches. If one initiative is missing then a client may not receive the highest standard of care. OTs are responsible for their own interventions – even if there is a committee or similar for clinical governance within the Trust – so the individual needs to make sure all aspects of clinical

governance are used in their interventions to ensure that they are practicing in the safest way possible (COT, 1999). Furthermore quality assurance schemes, such as comparing outcomes to make sure there are no unwanted results, mean that the OT would be working towards the best outcome for the patient.

Occupational therapists are regulated by the Health Professions Council. Clinical governance does not replace regulation: registration with the HPC (obtaining and maintaining registration) and clinical governance are linked, and the paper ‘ Clinical Governance Quality in the new NHS’ describes the relationship between clinical governance and regulation by the profession’s governing body as one in which the two aspects ‘ complement each other’ (Department of Health, 1999). An OT needs to ensure that s/he is working towards all of the clinical governance components: doing this will help the OT to meet the criteria in order to maintain registration and will ensure that patients are receiving the best care possible.

For clinical governance to be most effective, the OT (or any healthcare practitioner) should take part in developing and promoting it (Clarke 2000). Sealey (1999) states that staff should identify areas of concern and act on them, under the guidance of more senior staff members. The concept of individuals taking responsibility for improving services is echoed by Murray (2004). Some OTs may be prevented from doing this, and from taking steps to develop their department, because of environments where staff fear reprisal if they raise problems – good leadership can help to overcome this (Kavanagh and Cowan, 2004). Other team members (OTs, support staff and multi-disciplinary team members) need to follow and support the planning

and implementation of clinical governance; therefore, effective leadership is essential (Sealey, 1999). Ladrum et al (cited in Stewart, 2007) state that good leaders are needed to implement change, as leaders are able to make changes and to shape services. Stewart goes on to say that a leadership style that designates one person as a leader and one as a follower (or more senior and junior members of staff) is likely to be ineffective, as the follower will be less likely to engage in the process. A more effective style of leadership is one that empowers staff, and thus ‘ allows them to be more effective in their contribution to the organisation’ (Stewart, 2007), such as transformational leadership.

In relation to the case study, the band 6 OT takes the lead in implementing a clinical governance initiative; this initiative could be identified by the band 6 or in collaboration with other staff. The initiative could be limited to the OT staff or within the wider multi disciplinary team (MDT).

The idea that ‘ providing healthcare is a risky business’ is a concept that has been echoed by different authors (Starey, 2001 and Clarke, 2000). Risk management is part of clinical governance; it is a proactive approach to manage or reduce risk that could lead to an untoward incident (Clarke, 2000, (Wright & Hill, 2003), and reducing these risks will ensure quality and safety (Currie, Morell & Scrivener, 2003).

Furthermore, the need for risk management has been highlighted in the NHS Operating Framework (Department of Health, 2009) by the introduction of ‘ best practice tariffs’ – payments for good quality care. Therefore, the need to reduce the chances of untoward events is reinforced, so that the Trust can

benefit from these payments. As well as the loss of payments, such as the ‘ best practice tariff’, an untoward incident may have a further financial impact in terms of the patient having to stay in hospital longer, compensation claims and damage the reputation of the hospital.

The hospital department (in the case study) has been highlighted by its trust as not achieving the hospital acquired infections (HAIs) standards as set by the NHS Operating Framework (Department of Health, 2009). Therefore the band 6 OT has agreed with the multidisciplinary team that she works within that she will take the lead in implementing the risk management aspect of clinical governance to put steps in place to reduce the rates of patients acquiring MRSA and clostridium difficile. The OT is using the Health and Safety Executive’s (HSE) five-step process to identify risks (2006). The risk management process can be used to reduce or manage any problem or risk identified. Identifying hazards is the first step in the HSE process. Other hazards and risks may be identified – such as equipment not being returned to the correct place for staff to find, lack of supervision or continuing professional development, not learning from complaints or untoward incidents – but for the purpose of this paper, the focus is on the risk of patient contracting a HAI. Reducing the rate of HAI, across all departments and Trusts, to 30% is one of the five priorities set by the NHS Operating Framework. HAIs are very costly for the Trust: each case means that the patient spends approximately 11 additional days in hospital and costs the Trust £3154, and in addition, the quality of care received by the patient is reduced (Currie, Morell & Scrivener, 2003). Research has shown that using

alcohol hand rubs reduces HAI and that use of alcohol hand rub increased among patients after education (Currie, Morell & Scrivener, 2003).

The second step suggested by the HSE is to decide who may be harmed and how. The risks of HAIs are to the patient, to staff and to visitors, and in the worst scenario, a HAI could cause death. In addition, high HAI infection levels could damage the Trust's reputation and lead to loss of money and inability to attain Foundation Trust status, which could lead to the Trust being merged with another Trust. Linking back to the first item in the paper ' A First Class Service', the right to high quality care is expected by patients, but patients are not receiving this if they are at risk of getting an HAI.

In the third step, the band six OT would need to evaluate the risks and decide on precautions that could be implemented. The band six OT has identified that certain steps are in place: there are standard posters explaining MRSA around the department, patients who are attending for elective surgery are given a leaflet explaining MRSA at the pre-operation visit, there are the dispensers for hand gel and next to the sinks there are paper towels and soap dispensers, although staff have reported to the band six OT that these are not always refilled. Staff are unsure who to report this issue to, which leads to staff and patients not following the correct procedure, which may increase the spread of HAIs. The band six OT has identified that several further steps could be taken to reduce the risk of patients acquiring HAIs: bottles of alcohol hand rub are to be placed next to every bed and staff desks, everything needs to be refilled daily, staff need access to extra materials if they run out after cleaning staff have left, HAIs are to be discussed with patients on the pre-operation visit, explaining the

steps they and their visitors can take to reduce HAI, and that they can ask if staff have cleaned their hands, staff training is to be implemented and finally the cleaning staff need to ensure that everything is cleaned properly.

The band six OT allows all staff to have input and to give their contributions at a meeting, to empower the staff and allow her to be a more effective leader. After the discussion with all staff, the nursing staff have agreed to continue giving out the leaflet but to also have a discussion around MRSA with each patient. The band five OT has agreed to create new posters saying ‘ Are your hands clean?’ or something similar, and to involve patients, asking them to choose the poster they feel they would take the most notice of, to be printed on the office computer and to be prepared within two weeks. The band five OT suggested asking patients to design the poster but then felt that they might not feel up to it whilst recovering from surgery, but will be open to anyone saying they would like to, such as patients’ family members or patients themselves when they have recovered. The band five OT has also agreed, after discussion with the band six OT, that she will hold thirty-minute sessions that all staff working in the department (cleaners, porters, health care assistants, nurses, physiotherapists, doctors, radiographers, receptionists) have to attend, reinforcing the need to reduce HAIs, their effect on patients and the wider Trust, how to wash hands, how frequently to do it, and why it is necessary to reduce the infection rate (to fit in with the Operating Framework). The sessions are to be offered on Mondays and Fridays for two weeks at the lunchtime change over-to allow all staff a chance to take turns missing the handover to attend the training. The band five OT has also agreed to do two early morning sessions to offer the training

to night staff. These sessions are to be started in one month. The two OTs have discussed this and some resistance is anticipated but the band six OT will discuss this with managers and senior staff and explain that no-one is exempt, and that senior staff need to lead by example. The band six OT has agreed to approach the cleaning staff manager to ensure that the staff are cleaning in line with the Trust's policies and procedures. Throughout the implementation, it is important that no-one feels that they are being blamed – that the nursing staff do not feel that they are being blamed for not giving out more information before, cleaning staff are not made to feel that they were responsible and that no single member of staff is singled out for not cleaning hands correctly. New ways of working need to be adopted to raise the standard of care. The risks have been identified and steps put in place to prevent them, and this should be used for learning, not to assign blame (Wright & Hill, 2003). However, the individual staff members need to take responsibly for their own actions, so that they will follow the learning through. The band five OT, in supervision, said she felt she might not have enough time to implement everything, so the band six OT has reduced her case load for the following month to allow time to design the posters and put together the training. The band five OT feels that this will be a good piece of work for her CPD file, as well as a huge benefit to the department.

The fourth step in the HSE process is to record findings and implement them. The OT has obtained a folder and marked it ' risk assessment': this has been placed in the main office area of the orthopaedic department, on the shelf with the other folders containing documents that staff access. The OT has

decided to use the standard form from the HSE (appendix 1). On this form, the OT has marked down who is doing which job and by when.

The fifth step is to review the items that have been implemented and update them if needed. The OT has decided that this will be done at the first MDT meeting of every month, by comparing the months HAI figures to the previous months, thus ensuring quality, and by reviewing with staff that they are following the hand washing procedure.

From this case study, it is clear that when implementing an initiative from clinical governance, it is not implemented in isolation from the other initiatives. In this case study, the band six OT brings in leadership, audit, training and education, continuing professional development, research and development and patient involvement. To implement risk management without involving parts from these other initiatives would mean that it would be less effective and less likely to achieve the desired outcome of quality care.

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