Clinical quality improvement and risk management nursing essay

ASSIGN BUSTER

Clinical governance has been described as: " A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish"(Scally & Donaldson, 1998)

Clinical governance is not just a requirement for NHS organisations as stated above but also a practical collection of practice management principles integral to a successful business of dentistry.

To me it is a tool that I can use to improve my professional performance and sustain it to a high standard. It can also help me define the standard whereby I can measure myself and my practice. It allows for proof of what has been achieved and guidance on areas that need to be developed either personally or as a practice. It therefore answers the question: is my practice safe and effective?

The Department of Health has published the following 7 pillars of clinical governance for health care providers(DOH, 2004)

1. Patient, user & carer involvement

2. Risk management

3. Clinical audit

4. Research & effectiveness

5. Staffing & staff management

6. Education, training & development

7. Use of information

These 7 pillars was further adapted into twelve themes by the NHS Primary Care Contracting Service more specifically for general dental practice (NHS, 2006)

Theme 1: Infection control

Theme 2: Child protection

Theme 3: Dental radiography

Theme 4: Staff, Patient, Public and Environmental Safety

Theme 5: Evidence based Practice and Research

Theme 6: Prevention and Public Health

Theme 7: Clinical records, patient privacy and confidentiality

Theme 8: Staff involvement and development (for all staff)

Theme 9: Clinical staff requirements and developments

Theme 10: Patient information and involvement

Theme 11: Fair and accessible care

Theme 12: Clinical Audit and Peer Review

I will aim to explore the meaning of the term “ clinical governance” by expanding on these twelve themes.

More recently all providers of primary dental care have to register and comply with the Care Quality Commission’s Essential Standards of Quality and Safety. These standards consist of 28 regulations that are found under both the Health and Social care Act 2008, Regulations 2010 and CQC Regulations 2009.

Theme 1: Infection control

This theme is an integral part of clinical governance and aims at ensuring a safe environment for patients and workers. Dental care is subject to legislation under the Health and Safety at Work Act (1974) and the Control of Substances Hazardous to Health Regulations 1999 (COSHH). The cornerstone of implementing this into practice is an infection control policy. Every member of staff should be trained to comply with this policy. It is the team leader and dentist’s responsibility to ensure that the infection control policy is realistic and fully complies with current regulation and that all members are trained and capable to comply with it. This compliance should be regularly checked by risk assessment, observation, practice audits, workgroups etc.

The Department of health published the Health Technical Memorandum 01-05: Decontamination in primary care dental practice (2009) and a self-assessment audit tool to ensure the necessary action can be taken to comply with “ essential quality requirements” of this memorandum. An action plan working towards achieving “ best practice” should also be drawn up.

Theme 2: Child protection

The Department for Education and Skills (Working Together to Safeguard Children) states: “ All health professionals working directly with children should ensure that safeguarding and promoting their welfare forms an integral part of all stages of the care they offer”

This theme help safeguard children in a dental practice environment by having the needed knowledge, policies and responsible staffing to ensure that concerns are appropriately shared and managed. This can be implemented into dental practice by a Child Protection Policy that clearly states what is expected from staff when working with children and steps to be taken when a child protection issue arises.

Theme 3: Dental radiography

Dental radiography is regulated by two regulations; the Ionising Radiations Regulations 1999 (IRR99) which deals with radiation equipment, the protection of the public and healthcare workers and the Ionising Radiation(Medical Exposure) Regulations 2000 (IR(ME)R2000 which mainly deals with the protection of the patient. The “ legal person” is a clearly defined individual or body corporate that has been appointed to take

responsibility to implement and manage these regulations. This include assuring that the quality of diagnostic information is adequate and assessed through regular clinical audits; staff are trained on the safe and effective use of radiation equipment and the maintenance of equipment are up to date.

The National Radiological Protection Board has published guidelines for dental practitioners which can be used to comply with the requirements of IRR99 and IR(ME)R2000

Theme 4: Staff, Patient, Public and Environmental Safety

Patients have a right to clean and safe treatment wherever and whenever they are treated by a healthcare professional, this is an essential element of every procedure so that patients have the confidence they need in the care they receive. The Health and Safety at Work Act 1974 is the basis of keeping the workplace safe for patients and workers. This Acts sets out the responsibilities that an employer have towards the public and employees. The act encourages employers to look at risks at the workplace and take sensible measures to address them.

The Health and Safety Executive has published a short guide to health and safety regulation:

Management of Health and Safety at Work Regulations 1999: require employers to carry out risk assessments, make arrangements to implement necessary measures, appoint competent people and arrange for appropriate information and training.

Workplace (Health, Safety and Welfare) Regulations 1992: cover a wide range of basic health, safety and welfare issues such as ventilation, heating, lighting, workstations, seating and welfare facilities.

Health and Safety (Display Screen Equipment) Regulations 1992: set out requirements for work with Visual Display Units (VDUs).

Personal Protective Equipment at Work Regulations 1992: require employers to provide appropriate protective clothing and equipment for their employees.

Provision and Use of Work Equipment Regulations 1998: require that equipment provided for use at work, including machinery, is safe.

Manual Handling Operations Regulations 1992: cover the moving of objects by hand or bodily force.

Health and Safety (First Aid) Regulations 1981: cover requirements for first aid.

The Health and Safety Information for Employees Regulations 1989: require employers to display a poster telling employees what they need to know about health and safety.

Employers’ Liability (Compulsory Insurance) Act 1969: require employers to take out insurance against accidents and ill health to their employees.

Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR): require employers to notify certain occupational injuries, diseases and dangerous events.

Electricity at Work Regulations 1989: require people in control of electrical systems to ensure they are safe to use and maintained in a safe condition.

Control of Substances Hazardous to Health Regulations 2002 (COSHH): require employers to assess the risks from hazardous substances and take appropriate precautions.

Hazardous waste regulations 2005 and the management of waste amalgam/mercury

Compliance with Carriage of Dangerous Goods and Use of Transferable Pressure Equipment (Amendment) Regulations, 2005

Theme 5: Evidence based Practice and Research

" The aim of evidence based health care is to provide the means by which current best evidence from research can be judiciously and conscientiously applied in the prevention, detection, and care of health disorders"(Sackett et al, 2007). Any new clinical techniques or procedures should be safe and effective and in line with the NICE Interventional Procedures requirements.

Dental practices should keep up to date with guidelines and new research and be able to effectively introduce it into daily practice. Independent organisations like the National Institute for Clinical Excellence (NICE), Scottish Intercollegiate Guidelines Network (SIGN), Faculty of Dental Surgery,

Scottish Dental Clinical Effectiveness Programme (SDcep), the British Dental Association (BDA) and many more provide valuable guidelines on clinical decision making and guidelines should be known and followed by members of staff.

Continued professional development (CPD) is a combination of approaches, ideas and techniques that are a vital source of evidence based practice.

Theme 6: Prevention and Public Health

Under the Health and Social Care (community Health and Standards) Act 2003 health services should assess local oral health needs and address these specific needs by commissioning appropriate services to reduce long standing oral health inequalities. Dental practices should therefore have their own oral health policy that is consistent with both local and national priorities. All members of staff should be familiar with this policy and be ready to give advice on smoking cessation, healthy eating habits, oral hygiene etc. Getting involved with schemes like " Brushing for Health" and the national healthy school standard can promote oral health in a community

Information on local health services should be part of the practice health policy and readily available

Guidelines found in the publication: Choosing Better Oral Health: An Oral Health Plan for England (Department of health 2005)

Theme 7: Clinical records, patient privacy and confidentiality

The view of the General Dental Council is:

“ The dentist-patient relationship is founded on trust and a dentist should not disclose to a third party information about a patient acquired in a professional capacity without the permission of the patient”(GDC, revised 2001)

The Data Protection Act 1998 regulates the protection and handling of personal data in the U. K. All dental practices should comply with these regulations regarding storage and handling of patient information. This can be implemented by identifying a person to draw up a confidentiality policy. This policy should describe procedures that ensure secure storage of information on paper or on a computer. The appointed person is responsible for educating staff on its contents and applications and ensuring adherence thereof.

Recommendations on how such information must be handled can be found in the Calidicott report (The Calidicott Guardian Manual 2010)

Theme 9: Clinical staff requirements and developments

The employer in a dental practice has the responsibility to meet the requirements of the law and the GDC regarding the management staff. This includes appointing staff with the necessary qualifications and registration with authorities. The supervision and continual development of staff, handling of complaints and whistle blowing are part of clinical governance under this theme. This can be introduced into practice with an extensive Human Resources file that includes portfolios of staff, training received, poor performance etc. Clinical staff needs supervision and constant monitoring to ensure training can be tailored to their specific needs.

Theme 10: Patient information and involvement

To successfully implement this theme patients need to know that they can take ownership of decisions involving their care. They should therefore be fully aware of what treatments are available to meet their needs. Listening to patients concerns and experiences and responding to these concerns should be executed promptly and recorded to show that the practice take the view of the public seriously.

A practice information leaflet should therefore be designed to introduce the practice facilities, services, team members, treatments available. A suggestions box and a formal compliant procedure should be visible and in place and be reported and acted upon.

Theme 11: Fair and accessible care

This theme governs dental practices to provide care that is delivered promptly and gives patients a choice to services and treatments. It is mainly governed by the Race Relations (Amendment) Act 2000, Human Rights Act 1998 and the Disability Discrimination Act 1995

The Race Relations Act promotes race equality and promotes equal opportunities and good relations between people of different racial groups. This involves having access to interpreting services to help patients of different ethnicities to make use of and fully understand the local dental services available. The Human Rights Act covers a range of political and civil rights and the Disability discrimination act makes it unlawful to discriminate against a person on the grounds of disability in the areas of employment,

facilities and services. An access audit should be carried out by a third party to assess current compliance under this act and to introduce improvements in access to disable patients.

Theme 12: Clinical Audit and Peer Review

Audits are a great tool to test and proof the presence of the clinical governance themes as described above. An audit has been defined as:” The method used by health professionals to assess, evaluate and improve the care of patients in a systematic way, to enhance their health and quality of life(Irvine & Irvine, 1991)

The audit cycle has been proposed as follows(Rattan et al, 2002)

“ Describe the criteria and standards that you are trying to achieve

Measure your current performance with regard to how well you are providing care or services in an objective way

Compare your performance against criteria and standards

Identify the need for change – to performance, adjustment of criteria or standards, resources, available data

Make any required changes as necessary, and re-audit later”

All evidence that is gathered internally will have to be externally validated to be of use.

Quality initiatives in a hierarchical model has been proposed by Birch(Birch et al, 2000)

This model is based on a hierarchy with a minimum requirement of statutory quality measures being in place and validated by the health authority. This will be the essential requirements met. A practice can then also be validated by being involved in national recognised schemes such as the BDA good practice scheme or have an external accreditation through the Fellowship by Assessment from the FGDP or Investors in People or ISO 9000

The evidence that is internally gathered can be initiated through a self audit or an audit by an external party. The NHS has produced a workbook and a clinical governance framework that can be utilised to build up a portfolio of evidence.

Recording activities, reflection and appropriate actions taken in a learning log provides evidence to the outcomes that need to be achieved under these themes. These records can include

Patient reviews

Continual professional development portfolio

Reflective practice logs

Any adverse incidents and following response

Compliments

Peer review relates to a comparing an area of work with that of another individual and can lead to improvement in the quality of care provided

Applying these themes into a dental practice will firstly involve a self audit against the required standards of the General Dental council and the General Dental Services Regulations and more recently the Care Quality Commission. These assessments are ideally done by an external person that can be more objective.

Many resources are available that can be used as a reference. Once areas are identified that does not fully comply with the set standard an action plan can be drawn up to implement changes, introduce policies, procedures, new layouts or equipment as needed In a dental practice environment the practice owner is responsible to introduce a systematic plan, to train those involved and to monitor progress and response.

A progress report on the improvements achieved by clinical governance by NHS trusts stated that about three quarters of trusts identified specific improvements in care due to the implementation of this strategy(Bourn, 2003a; Bourn, 2003b)

The Care Quality Commission have initiated a “ Regulating for better care” series whereby views of patients and healthcare workers on the improvement of care following action by the commission and a positive response have been shown.

Once an aspect of service delivery that needs to be improved is recognised it is important to have a clear strategy of change will be implemented. This can

be a difficult task if it involves a worker and not a system or piece of equipment.

The National Institute for Health and Clinical Excellence has published a guide: “ How to change Practice” (NICE, 2007) that can be used as a tool to help change behaviour. It states that when implementing change into a practice environment it is important to understand barriers that might prevent change. This can be a lack of knowledge, awareness or motivation of an individual but can also be a practical barrier like the lack of a needed skill, resources available etc. Once the barriers are identified by gathering information an action plan can be initiated to overcome them. This plan will be highly specific to each barrier and target audience. Strategies such as clinical audits with feedback; structured and planned continual professional development, information leaflets and practice meetings can used to initiate a change in behaviour. Budgeting and resource management will also play an important role to keep goals realistic.

Contemporary Record keeping

“ Good records are at the heart of professional practice. Moreover, good healthcare delivery, best use of healthcare resources, and delivery of a cohesive service that satisfies an increasingly demanding population can be achieved only with good communications and a shared clinical perception of a patient’s problems and needs-seamless care is difficult to achieve without seamless information”.(Drazen et al, 1995)

The statement good record keeping shows good clinical is true. Good record keeping is vital for patient safety and therefore a priority to ensure patient

records are correctly managed. It is vital in litigations but more importantly to provide quality care. Good dental records show that the healthcare professional has been thorough in using all available information to make a correct diagnosis, treatment plan and management of the patient. It also shows that the patient was given enough correct information to make a decision on the treatment proposed. Once treatment is commenced details are important to improve follow up care and maintenance.

From a third part perspective if not recorded it is seen as not done.

Record keeping in dental practice should be internally audited regularly and compared to best practice standards. The Faculty of General dental Practitioners have published good practice guidelines on Dental examination and record keeping. An audit can be drawn from the standard set out in this guide and repeated annually.

A dental record should be clear, legible and accurate and made at the same time as the actual events that are being recorded or as soon as possible afterwards.

Dental patients have the right of access to their own Health Records under the Data Protection Act 1998; it can also be produced as evidence during legal proceedings or misconduct hearings.

To following is a description of a good dental record (Adapted from Merseyside NHS: Guide to good record keeping)

Be factual, consistent and accurate.

Be written in black ink.

Be written as soon as possible after an event has occurred, providing current information on the care and condition of the service user (if the date and time differs from that of when the records are written up, this should be clearly noted under the signature, printed name and position/grade).

Be written clearly, legibly and in such a manner they cannot be erased.

Erasers, liquid paper, or any other obliterating agents should not be used to cancel errors. A single line should be used to cross out and cancel mistakes or errors and this should be signed and dated by the person who has made the amendment.

Be accurately dated, timed and signed with the signature being printed alongside the first entry.

The use of abbreviations should be kept to a minimum.

Be written, wherever possible, with the involvement of the service user or carer and in terms that the service user or carer will be able to understand.

Be consecutive.

Be bound and stored so that loss of documentation is minimised.

Be relevant and useful

Identify problems that have arisen and the action taken to rectify them.

Provide evidence of the care planned, the decisions made, the care delivered and the information shared.

Provide evidence of actions agreed with the service user (including consent to treatment and/or consent to share).

Include Clinical observations: examinations, tests, diagnoses, prognoses, prescriptions, other treatments.

Include relevant disclosures by the service user – pertinent to understanding cause or effecting cure/treatment.

Records should not include unnecessary abbreviations, jargon, meaningless phrases, irrelevant speculation and offensive statements.

Records should not include Personal opinions regarding the service user (restrict to professional judgements on clinical matters).

Records should not include the name(s) of third parties involved in a serious incident. The name should be included on the separate incident form for cross referencing.

Records should not include correspondence generated from legal papers and complaints

Audit of patient records: My Dental Practice

Clinical audits was introduced into the NHS in The White Paper(DOH, 1989) to review the delivery of healthcare to ensure that best practice is being carried out.

“ Clinical audit is the systematic critical analysis of the quality of dental care, including the procedures and processes used for diagnosis, intervention and treatment; the use of resources and the resulting outcome and quality of life as assessed by both professionals and patients”

The National Institute for Clinical Excellence (NICE) published Principles for best practice in clinical audit which can be used to design an audit in a dental practice environment

Audit reference

Dental Record Audit 2010. 1 (DRA2010. 1)

Aim

To complete an audit of record keeping in a multi-surgery mixed NHS/private general dental practice to establish a baseline of the dental record keeping standard

Objectives

Assess my current standard of record keeping competence and appropriateness compared to known standards

To translate the findings into numeric value for comparison with future audits of same kind

To identify my training needs

To introduce best practice to improve quality of care and communication

To assess current guidelines and protocols and their execution

Methodology

A caseload of 50 patient’s records were randomly chosen by using a range of patient numbers and randomization software

The Crabel scoring system(Dhariwal & Gibbons, 2004) was modified to record keeping

The Faculty of General Dental Practitioners publication of Good record keeping was used to formulate 10 essential requirements of a good dental record and each given a numeric value of 10.

A value of 10 were deducted from the total score if any of the requirements were not adequate(left out or not clear)

Only the last entry in the notes was assessed according to criteria

Only records that relate to the auditor can be included

10 requirements (Adapted from: Faculty of General Dental Practitioners (UK) Clinical Examination and Record-Keeping: Good Practice Guidelines 2nd edition

Personal details (name, address, date of birth, gender, contact number)

Medical history completed and updated including alerts, details of medical practitioner and any current treatment

Dental history(updated charting, current treatment)

Examination of the soft tissue, periodontuim and including cancer screening

Examination of the teeth with reference to occlusion, restorations required, caries, any appliances, radiographs taken with a report

Treatment plan present

Complete records with full details of treatment and drugs used or prescribed

Valid consent sought

Costing

Date and name of operator

Results

Table of results dental record audit 2010. 1

Column1

req1

req2

req3

req4

req5

req6

req7

req8

req9

req10

totals

case 1

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case 2

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case 3

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case 4

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case 5

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case 6

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case 7

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case 8

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case 9

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case 10

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case 11

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case 25

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case 26

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case 27

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60

totals

240

250

180

180

200

200

230

210

190

220

2100

8. 88

9. 25

6. 66

6. 66

7. 40

7. 40

8. 51

7. 77

7. 03

8. 14

77. 7

88. 8

92. 59

66. 66

66. 66

74. 07

74. 07

85. 18

77. 77

70. 3

81. 48

Percentage achieved for each requirement:

Compliance with requirement 1 88. 88%

Compliance with requirement 2 92. 59%

Compliance with requirement 3 66. 66%

Compliance with requirement 4 66. 67%

Compliance with requirement 5 74. 07%

Compliance with requirement 6 74. 07%

Compliance with requirement 7 85. 18%

Compliance with requirement 8 77. 77%

Compliance with requirement 9 70. 37%

Compliance with requirement 10 81. 48%

Mean compliance 77. 77%

Graph 1: Total percentages achieved for 10 essential requirement

Discussion

A self audit of patient records was completed. A total of 50 patient records were randomly selected. From this caseload a sample of 27 record cards could be included in the audit in accordance with the methodology