Clinical Governance and the District Nurse

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Author details:

Peter Zeh, BSc Nursing Studies, RGN (Critical Care Nurse), University Hospitals, Coventry & Warwickshire NHS Trust and also Part-time Masters Student in Applied Health Studies, University of Warwick

Introduction

The NHS guidance document 'First Class Service' (1998) regards clinical governance as a central plank of health service that develops, delivers and monitors the standards of health care. Thus working in conjunction with the principle of lifelong learning and the necessity for professional self-regulation, clinical governance is seen as the most crucial change in professional culture for many years in the NHS - a change that district nurses accept as a way forward for overall health care provision; in continuing professional development, evidence-based practice, complaints, risk management, and clinical audit.

The purpose of this article from the literature reviewed is therefore to discuss the virtues of clinical governance as a way forward for health care by explicitly looking at the role of the district nurses within clinical governance in primary health care in relation to the local population. It will focus on the meaning of clinical governance and its requirement by district nurses. The article will also demonstrate how effective self-regulation and continuing professional development as advocated by clinical governance can help these nurses to bring about quality improvement activities (evidence based practice, complaints and risk management, and clinical audit), to address a range of performances. It will conclude and give recommendations for the future.

Clinical governance

The government's definition of clinical governance is built on an idea first put forward by the World Health Organization, where clinical quality is described as: professional management (technical quality), resource use (efficiency), risk management (including the risk of injuries or illness associated from service provided), and satisfaction of the patients with the service provided (Swage, 2000). The White Paper: A First Class Service (1998), defines it as a framework through which the NHS organisation is accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which clinical care will flourish. In essence, clinical governance is a framework that helps practitioners of all professional groups (health authorities, acute, community and mental health trust, primary care groups/trusts) to maintain and improve

high standards of patient care. It is inter-linked with and supported by professional self-regulation and continuing professional development.

As a framework, it brings together existing quality assurance and audit processes under one umbrella. The challenge is to ensure that PCGs/PCTs develop a culture, systems and new ways of working that will ensure that quality of care is at the heart of the whole organisation. At the top of the framework is the chief executive who is principally accountable for the quality of care delivered within his/her organisation in much the same way as for financial issues. A lead clinician for clinical governance, on behalf of the chief executive, ensures that the framework is robust to enable the co-ordination of quality improvement activities and monitors its continued effectiveness.

In the literature reviewed (Zwanenberg & Harrison, 2000), the quality in primary care as in secondary or other specialities varies. This implies that district nurses need a way of reducing inappropriate variation in care and minimising the risk that care may not be beneficial. Generally speaking, clinical governance as an organisation-wide initiative requires the support and commitment of all health care practitioners for significant, sustained improvement to occur. A shift in culture away from blame and punitive action, towards an open, questioning, participative culture which encourages multi-disciplinary activities like team work, learning and research at all levels of the organisation is essential to bring about an environment conducive to the development of clinical excellence. This may not develop if the chief executive and lead clinician for clinical governance do not establish a good working rapport with the community nurses. They need to encourage these nurses to learn from past mistakes rather blaming them so as to produce standards for a high quality service.

Clinical governance recognises that district nurses are part of public services (DoH, 1998), and gives them the lead in planning how to provide the best care. Consequently, they have to be accountable to the UKCC as well as to the public for what they do. However, they are already familiar with quality improvement activities such as risk management, standard setting and monitoring, clinical audit, evidence-based-practice, clinical supervision and so on. It would appear that the UKCC believes that clinical governance will assist in co-ordinating these activities to produce a programme of quality initiatives with patient/client as the central focus. This requires district nurses of high standards who are self-regulating.

Self-regulation

The practice of professional self-regulation requires registered practitioners to ensure that their acts and omissions in practice have, as their core focus, the interests and safety of the patients (UKCC, 1992; 1996). Evidently, this practice contributes to patient's experience and perception of the quality of service they receive from these nurses and the organisation in general. This is the face of professional self-regulation from the public perspective. Like many other recent policy initiatives clinical governance places safe, high quality care at the top of the health and political agenda - a position that is congruent with expectations of

both the public and the UKCC. Clinical governance makes it a requirement for district nurses and other practitioners to be involved in local professional self-regulation (DoH, 1999). This implies that practitioners must adhere to professional standards and ensure that poor performance is dealt with in a constructive manner.

Professional self-regulation is a privilege for district nurses rather than a right of the profession. It is a contract between the public and the nursing profession and requires district nurses to monitor themselves at the point of practice. It places on them an obligation to practise within professional ethical codes and to ensure that they not only 'do no harm', to patients/clients, but that they are concerned to 'do good'. However, this self-regulation according to Swage (2000), and Making a Difference, (DoH, 1999), require district nurses, as individuals, to go beyond 'policing' activities and be proactive in delivering good quality service. Therefore, district nurses should share effective practice (eg pressure sores prevention), with colleagues, while failures in performance need to be acknowledged and addressed.

The White Paper, A First Class Service (1998), envisages continuing professional development (CPD) or lifelong learning, as an essential component in the development of clinical governance and is therefore seen as one method of support quality improvement in practice. In order for district nurses to provide effective care, they need to make sure that their own skills, knowledge and expertise are up-to-date. Many commentators in the field have reported that there had been a fair amount of CPD activity in a number of professions prior to the establishment of clinical governance, few links were made between this and clinical effectiveness and research and development. Continuing professional development aims to match the legitimate aspirations of individual practitioners and to respond to service development and patient expectations. The essential process is that this should be developed at a local level ranging from formal classroom - based courses to one-to-one learning through the systems of mentorship, precetorship and clinical supervision.

Swage (2000), looks at CPD as an individual practitioner taking responsibility for development of his/her own career by systematically analysing development needs, identifying and using appropriate methods to meet these needs and regularly reviewing achievement compared against personal and career objectives. However, for CPD to work effectively for an individual, clinical governance expects that there be a clear understanding of the way in which that individual learns and develops most effectively. Continuing professional development recognises the need for district nurses, in the interests of patients/ clients, to maintain and improve their knowledge and skills throughout their career. Fortunately, the UKCC (1997) continuing professional development system, provides a simple, cost-effective and realistic means for all registrants to achieve this and has, as its focus, the development of the individual practitioner. UKCC has implemented PREP, framework relating to CPD, as a means to maintain and improve the standards of knowledge and competence achieved at the point of initial registration in order to promote higher

standards of patient/ client care and ensure that district nurses are safe to practise in a rapidly and constantly changing health care environment. However, Hare (1999) argues that this PREP is not working as yet because its requirements have not had a desired effect of ensuring that these nurses provide appropriate evidence to demonstrate their fitness to practise. Also, there is no obligation on employing organisations to support PREP implementation and the framework has not defined, the standards and outcomes needed to maintain competence. However, it must be acknowledged that it is the responsibility of the registered nurses to maintain their standards and remain accountable for their actions. Clinical governance would require employers to ensure that their staff is up to the job by providing them with the necessary resources to ease this process. This may necessitate a lot of comprises. However, the author believes that PREP encourages and facilitates reflection and by so doing, it promotes good standards of patient/client care through hands-on-delivery or management. It is for this reason that clinical governance expects the district nurses to provide evidence-based quality health care.

Evidence-based practice

Evidence-based practice is a critical component within the clinical governance framework that has been welcomed by district nurses as well as other health care practitioners (McSharry & Haddock, 1999). In order to guarantee quality service to patients and achieve effectiveness, the government in 'Making a Difference' (1999), believes in the process of evidence-based practice. It occurs through the integration of clinical expertise with the best available external evidence from systematic research, Sackett et al. (1997), and offers confidence to practitioners that their interventions (clinical, educational and managerial), are informed by appropriate up-to-date knowledge base. Zwanenberg & Harrison (2000), define it as a process of conscientiously and systematically finding, appraising and using contemporaneous research findings as the basis for clinical decisions.

In order to facilitate and support district nursing in having the required knowledge and skills to deliver evidence-based practice, it would be essential that their employing organisations (PCTs/PCTs) encourage their approach. They need to focus on forging links between theory and practice at both pre- and post-registration levels. Understandably, patients have the right to expect that they receive the highest quality and clinically effective care. In essence, the adequate provision of programmes to develop their skills of research and appraisal and literature searching would promote evidence-based practice as well as the development of multi-professional integrated care pathways. However, it would appear that some PCTs have in the past become more concerned with ensuring 'financial governance' (balancing the books), that other important issues integral to patient care (eg clinical risk, quality and patient outcome), have taken second place (DoH, 1997). Consequently, clinical governance can be seen as an ambitious shift of focus in moving away from finance to quality. However, the problem with clinical governance is defining what it actually means for district nurses delivering health care interventions at clinical level. They need to decipher the meaning behind the guidance so that clinical governance can become a framework to perform

evidence-based health care. It must be noted that clinical governance is also intended to instil confidence in both the public and nurses by providing a safe clinical environment on which to accommodate rising patient dependency and shorter hospital stays attributed to the ageing population (DoH, 1997). Needless to say that patients acknowledge the important values/elements of the district nursing role such as the management of leg ulcers, continence and nutritional needs, which must be research-based. Unfortunately, reports by the Health Advisory Service have highlighted variations in the delivery of such core elements of community nursing care (Moores, 1999). Making a Difference (DoH, 1999), makes clear the intention of district nurses to tackle such variation by exploring the benefits of bench marking to examine whether it provides the best means of supporting the vision to refocus on fundamental and essential aspect of care (McSherry, 1999).

As for 'A Vision for the Future' (NHSME, 1993), there are many examples of excellent and innovative practice; clinical supervision, including cross-disciplinary supervision for clinical areas such as prescribing (Moores, 1999). District nurses need to develop more evaluation measures to assess the impact of supervision on their practice. They also need to establish a system for accessing, implementing, monitoring, supporting and disseminating research findings to ensure that clinical practices and patient care are based upon the most recent and best scientific evidence. It would be essential if they establish clinical risk and audit to evaluate the effectiveness and quality of treatment, intervention or care offered to patient (eg pressure sores management or wound care). In order for these nurses to be more effective within a clinical governance context, they need good leadership, service support and resources to equip themselves with the appraisal skills required to rationalise the risk and benefits of care and to critique research evidence. This can be done through effective communication between the district nurses and other practitioners. It is hoped that it will promote an organisational culture that proactively develops infrastructure (eg education, research and training), and nurtures professional and practice development in the pursuit of clinical excellence.

Cost-effectiveness

The National Institute for Clinical Excellence (NICE) has been developed to give a new coherence and prominence to information about clinical and cost effectiveness. NICE, together with the National Electronic Library for Health is intended to make access to evidence-based guideline easier. Where evidence is not available, clinical governance expects district nurses to base their care on consensus opinion of best practice.

However, the fundamental problem district nurses are facing is in obtaining relevant information or research evidence to critically appraise the process. Swage (1998), reported that many nurses stumble at the first hurdle because they are not confident about understanding research and reviews. Having had the required education and training to critically appraise research, clinical governance expects nurses to move practice away from tradition or rituals to evidence-based care. Despite attempts to implement research-

evidence to support practice, these nurses continue to experience difficulty in ensuring that the treatment they provide is effectively evaluated. It would be important for them to continue to evaluate the quality, standard and effectiveness of their interventions to minimise complaints from the public.

Generally speaking, most patients, their families and carers have considerable trust in services provided by the PCGs/PCTs and the NHS in general. Hobbs (1999), believes that the majority of the patients receive high quality care but where they perceive a drop in standards, they have the right to be heard and for their complaints to be dealt with promptly, efficiently and politely. They have different reasons for complaining and this was stressed in the Wilson Report (1994) that complainants want to be taken seriously. It is for this reason that a practice-based complaint procedure was introduced in 1996. Consequently, if a complaint made against a district nurse, and it is not resolved by the complaints manager, it can be referred to the Health Authority's Independence Review Procedure. It must be acknowledged that when patients and/or their families experience a failure in health care, it can be distressing for them, but can also be very difficult for the nurse and the team. From the literature reviewed, some nurses are defensive about complaints, consequently, they fail to respond to the complaint in a way that recognises the complainant's distress. Complaints can be seen as an important indicator of problems associated with the care given by primary care teams. Therefore, complaints systems are an important element of clinical governance, and if effective, will respond positively and constructively. However, if a complaint reveals a case of negligence, or if it is thought that there is a likelihood of legal action, then this becomes a risk management matter (Swages, 2000), and is referred to the person responsible for dealing with it. For example, a case that was closed by the UKCC Professional Conduct Complaints Committee (PCC), concerned the delegation by a nurse to a care assistance to administer an insulin injection which was prima facie wrong. The issue considered by the PPC was not whether the care assistant could give the injection but rather if she/he was competent to carry out the task. This was concluded as an issue about supervision, the appropriateness of the delegation. This further explains the importance of clinical supervision in clinical governance.

Risk management is an organisational response to reduce errors and their costs. Hobbs (1999), reported that it is linked with quality improvement programmes, and places a special emphasis on the cost and consequences of poor quality care. In essence, it is a fundamental approach to improve the quality of care, which places special emphasis on occasions in which patients are harmed or disturbed by their treatment or care. In effect, clinical governance recommends a coherent, comprehensive and accessible complaints management policy for the PCGs/PCTs as an essential component of the overall risk management strategy. It is hoped that prompt management of complaints, avoidance of litigation will benefit the complainant, the trusts and its employees. This calls for effective auditing to improve standards.

Clinical audit

The publication of 'A First Class Service' (1998) has re-inforced quality standards central to primary care services (Lugon & Secker-Walker, 1999). This is seen as a remarkable shift in health policy from a primary responsibility for financial performance, to a position where financial and quality performance are equally balanced and given the same priority. It follows that if quality standards are the central means of improving community services, then the mechanism for monitoring and ensuring these are delivered, will undoubtedly be clinical audit, an essential component of clinical governance.

Clinical audit is the systematic and critical analysis of the quality of clinical care, including the procedures for the diagnosis, treatment and care, the associated use of resources and the resulting outcome and quality of life for the patient (Swage, 1999). Within the clinical governance context in primary care, this is implied that clinical departments need to have an overview of all quality improvement initiatives from clinical risk management, complaints and health and safety, professional development to clinical effectiveness. It would be useful if clinical improvement facilitators are employed to work with these services and help the nurses through the process rather than work for a service. This leads the author to believe that less technical skills will be required and competencies such as negotiation, training, planning and conflict management will increase in demand for these facilitators would play vital roles in clinical improvement groups, acting as experts to the group on quality improvement. This is the essence of clinical governance in primary care and the NHS in general.

The Audit Commission (1999), examined the way district nurses managed leg ulcers, which showed less evidence based care subjected to peer review. This was due to the lack of on-going training and understandably, resulted in poor performance. Consequently, if auditing is undertaken effectively as suggested by clinical governance it will improve quality of care by reducing complaints and so benefit patient, staff and the NHS.

Conclusions and recommendations

The role of the district nurse within clinical governance is imperative in the New NHS. Clinical governance in primary care is a powerful, new and comprehensive mechanism for ensuring that high standards of clinical care are maintained and that the quality of services is continuously improved with the chief executive being accountable. It is a framework which comprises functions and values such as professional regulation, strong leadership, communication, patient focus, valuing each other, and continuing professional development, and recognises that district nurses are part of a public service; gives them lead in planning how to provide the best care through quality improvement activities. The UKCC as one of its objectives in promoting high standards of professional practice, supports

clinical governance and consequently, the nursing profession, by setting professional standards and providing guidelines and advice to the district nurses (UKCC, 2001).

The clinical governance quality agenda is a challenging initiative that seems not to have been confronted yet. To maintain and improve quality in health care and create an enabling culture for district nursing, the author recommends:

- A significant shift in organisational culture, strong leadership, and the commitment of all district nurses for an effective implementation of quality agenda,
- Improved recruitment and retention of nurses by providing more facilities (more training places and flexible career pathways) to make working environment safer and reward district nurses for efficiency/excellence and commitment by a system that relies on competency and achievement of identified skills rather than on a grading system that is based on experience,
- IT NHSnet to join communities and hospitals to transfer clinical information electronically across all parts of the NHS, with potential benefits including speed, and access to information as opposed to a paper-based record system; and finally,
- District nurses should identify areas for improvement in patient care, work towards strategies to overcome problems, and actively engage in activities that evaluate contribution to patient outcomes, ensuring that initiatives are shared across the professions through publication, conference papers, networking, and consultation of experts both local and national level.

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