

Quality, Safety Healthcare and Clinical Governance



Learning objectives

By the end of this lecture, you should be able to:

- Identify various definitions of quality healthcare.
- Discuss the dimensions of quality in health care.
- Identify key concepts including clinical governance and risk management
- Describe the elements and types of activities commonly included in models of clinical governance.



Quality Healthcare

- *The Oxford English Dictionary (1988)* defined quality as “the degree or grade of excellence”.
- Agency for health care research and quality defined quality as “the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”

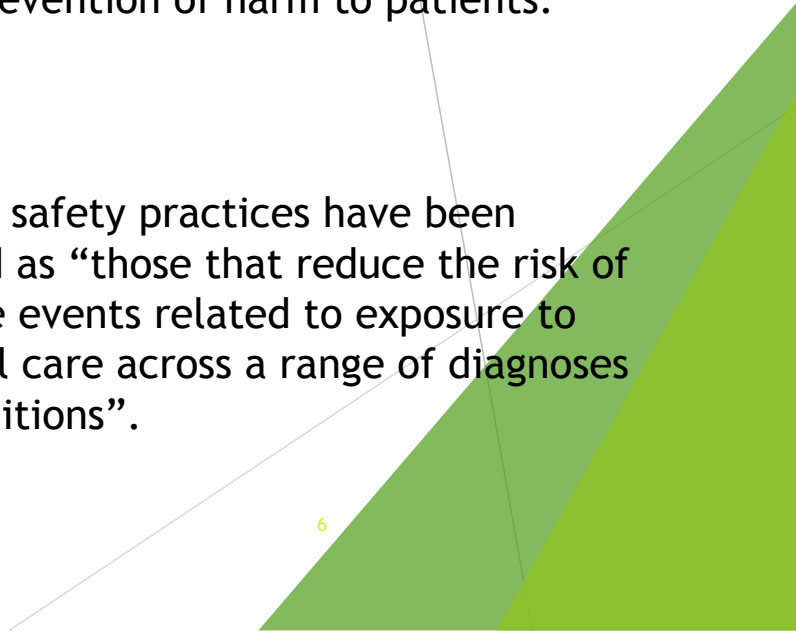
Table 1.1 Selected definitions of quality, 1980–2018

Donabedian (1980) In: <i>“Explorations in quality assessment and monitoring. The definition of quality and approaches to its assessment”</i>	Quality of care is the kind of care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts. [More generally, quality in this work is “the ability to achieve desirable objectives using legitimate means”.]
Institute of Medicine, IOM (1990) In: <i>“Medicare: A Strategy for Quality Assurance”</i>	Quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Council of Europe (1997) In: <i>“The development and implementation of quality improvement systems (QIS) in health care. Recommendation No. R (97) 17”</i>	Quality of care is the degree to which the treatment dispensed increases the patient’s chances of achieving the desired results and diminishes the chances of undesirable results, having regard to the current state of knowledge.
European Commission (2010) In: <i>“Quality of Health care: policy actions at EU level. Reflection paper for the European Council”</i>	[Good quality care is] health care that is effective, safe and responds to the needs and preference of patients. The Paper also notes that “Other dimensions of quality of care, such as efficiency, access and equity, are seen as being part of a wider debate and are being addressed in other fora.”
WHO (2018) In: <i>“Handbook for national quality policy and strategy”</i>	Quality health services across the world should be: • Effective: providing evidence-based health care services to those who need them. • Safe: avoiding harm to people for whom the care is intended. • People-centred: providing care that responds to individual preferences, needs and values. In order to realize the benefits of quality health care, health services must be timely [...], equitable [...], integrated [...], and efficient [...]

Dimensions of Quality in Health care

- **Quality dimensions are:**

1. Safe: avoiding injuries to patients from the care that is intended to help them
2. Effective: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
3. Patient-centred: providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
4. Timely: reducing waits and sometimes harmful delays for both those who receive and those who give care
5. Efficient: avoiding waste, including waste of equipment, supplies, ideas and energy
6. Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status



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Patient safety is a serious global public health issue

- There is now growing recognition that patient safety and quality is a critical dimension of universal health coverage.
- Since the launch of the WHO Patient Safety Programme in 2004, over 140 countries have worked to address the challenges of unsafe care.

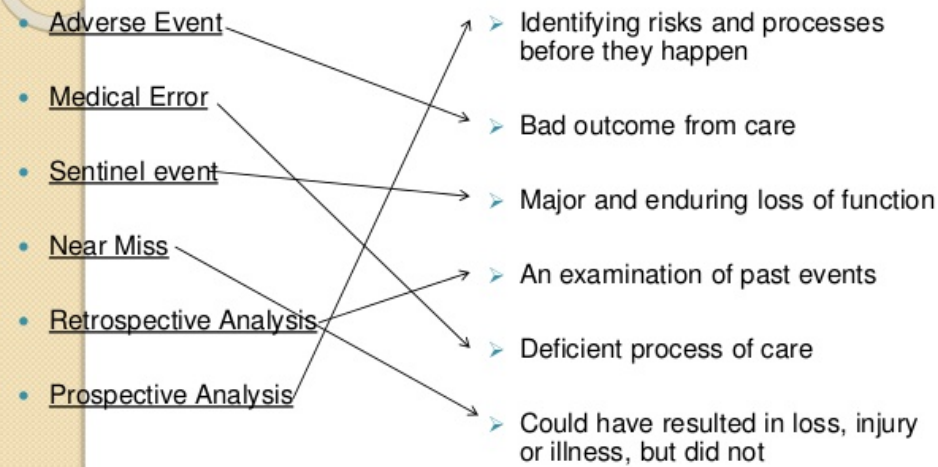


One in 10 patients may be harmed while in hospital



- Estimates show that in developed countries as many as 1 in 10 patients is harmed while receiving hospital care.
- The harm can be caused by a range of errors or adverse events.

Patient Safety Terms



Clinical Governance

- The concept of clinical governance was introduced to the UK National Health Service (NHS).
- Clinical governance came into general use as a concept in the late 1990s, following the exposure of high-profile cases of failures within the NHS: scandals such as Bristol Royal Infirmary, with babies dying at high rates after cardiac surgery.
- These cases highlighted to both the public as well as health professionals that clinical care was not always of the highest possible standard and that patients were being placed in serious danger.
- These failings have been put right, but as we are constantly reminded in the media, other failings in care delivery continue today, making clinical governance an issue that both individuals and organisations need to embrace and fully implement

Clinical Governance

- The concept of clinical governance has evolved from the need to significantly improve organisational management of the quality of health care.
- Historically, the quality of clinical care was the province of clinicians, professional bodies and external regulatory and disciplinary authorities.
- Managers and governing bodies saw their role asappointing the clinicians and providing a safe physical environment for patients, staff, and visitors.

Clinical Governance

- The ability to produce effective change such that high quality care can be achieved.
- Change is at the heart of Clinical Governance
- “If you always do what you always did, you always get what you always got”

Mark Twain

What does clinical governance mean in practice?

- The essentials of clinical governance for practising clinicians can be summarized as being able to:
 - demonstrate that we are doing things right;
 - demonstrate that we are up to date and fit to practise;
 - demonstrate continuous improvement in the quality of clinical services.

demonstrate that we are doing things right;

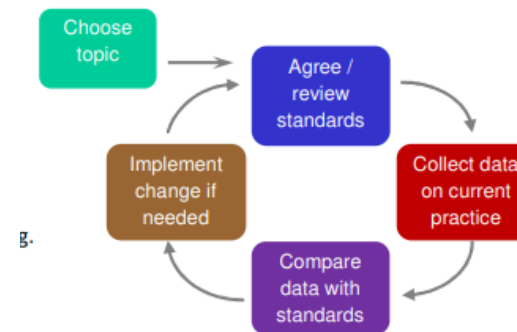
- Doing things right implies both that the right (i.e. appropriate, clinically effective and evidence based) things are being carried out, and that they are actually being carried out rather than just talked about.
- Demonstrating this will mean participating in appropriate clinical audit activities, which may be locally or nationally organized.

Clinical Audit

The main stages of the clinical audit process are:

- 1) Selecting a topic.
- 2) Agreeing standards of best practice (audit criteria).
- 3) Collecting data.
- 4) Analysing data against standards.
- 5) Feeding back results.
- 6) Discussing possible changes.
- 7) Implementing agreed changes.
- 8) Allowing time for changes to embed before re-auditing.
- 9) Collecting a second set of data.
- 10) Analysing the re-audit data.
- 11) Feeding back the re-audit results.
- 12) Discussing whether practice has improved.

- This process is called the Audit Cycle

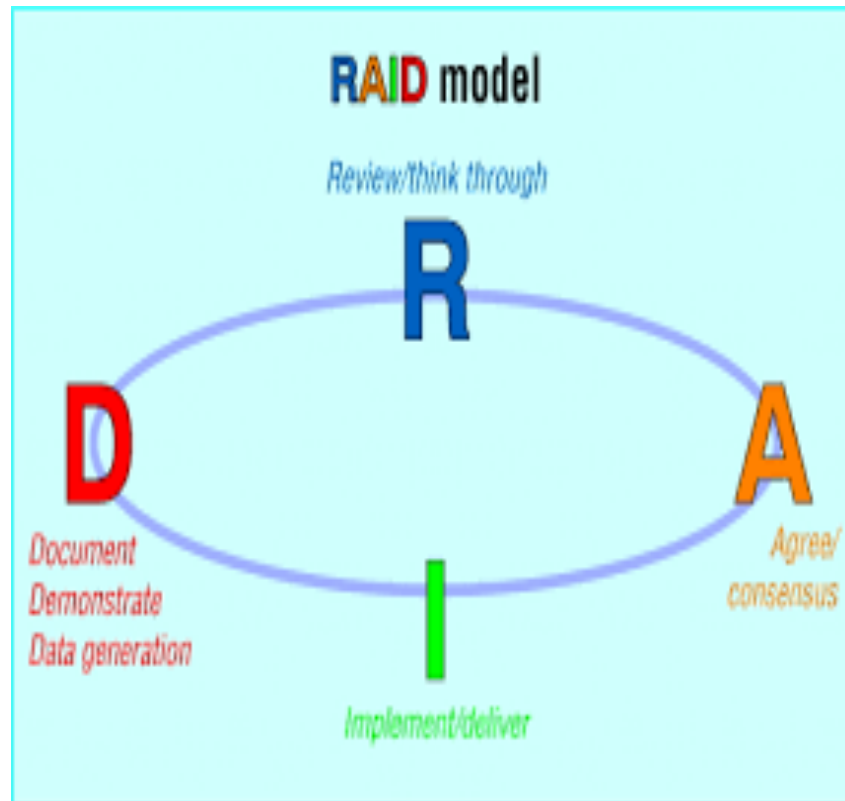


demonstrate that we are up to date and fit to practise;

- Demonstrating that we are up to date and fit to practise means that we can show that we are practising up-to-date medicine, that we are taking steps to keep abreast of advances in our field, that we are developing professionally, that we are healthy in mind and body (and thereby not a danger to ourselves or our patients) and that we are behaving towards our patients and colleagues in a professionally appropriate manner.

Clinical Governance- a recap

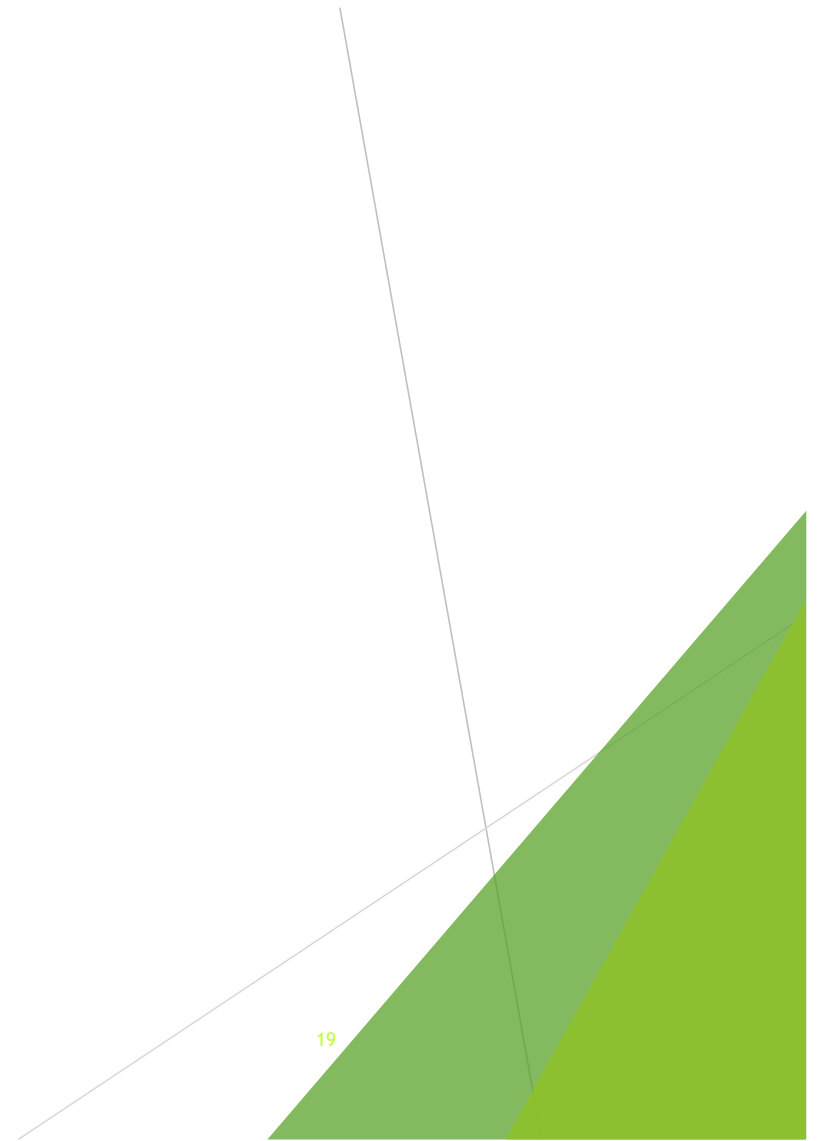
- Quality in health care service and efficiency in health care provision is underwritten by the ability to effect change
- In many health systems, there is a natural inhibition to change
- Clinical Governance is the process involving techniques that make this happen



Putting it into
practice : RAID
model

RAID Model

- Review
- Agree
- Implement
- Demonstrate



Review

- Where are we now
- Gather information
- Listen to clients/staff
- Audits, documentation and process

Carry out a review of the current service

Agree

- Consensus
- Form teams
- Formulate recommendations
- Preparing for implementation
- Shape the future

Gain widespread agreement and commitment to the recommendations and Build an

Implement

- Making it happen
- Measuring success
- Process of implementation
- Identifying achievements
- Motivate and support
- Expect and deal with resistance

Develop and steer a number of project teams as they implement the recommendations

Demonstrate

- Has is made a difference?
- Will these benefits continue?
- Identifying lessons learned?
- Spreading the message?
- Sharing the learning?
- Plan next objectives

Demonstrate success and share the lesson learned



Risk management

Risk Management

- There are risks associated with all episodes of care.
- Risk Management is about minimising risks to patients and staff;
- It is a positive function and central to the quality of care we give to patients
- Risks need to be avoided or controlled;
- We do this by carrying out a Risk Assessment and agreeing the level of seriousness attached to each risk;
- Actions are then taken on the result of the Risk Assessment to ensure everyone's safety.
- Where risks cannot be completely removed we aim to minimise the harm caused by any adverse incidents.

Risk Management is about **"stopping bad things from happening"**

Types of Risk Management

- There are two types of risk management - proactive risk management and reactive risk management.

- **Reactive risk management** involves detecting adverse events that have occurred in the health service. These types of adverse events can be identified through direct observation, legal claims, the patient medical record and direct report from a clinician, other staff or patient/carer.

- **Proactive risk management** involves using information about adverse events that have occurred in other health care services/organisations to identify areas of risk and anticipate hazards within the health care service. Scenario based risk identification can also be used, for example, when developing new services or programs or adopting new treatments.



THANK YOU