Clinical governance: what foundation doctors need to know

Introduction

The recently published curriculum for the foundation years put patient safety and care within the framework of clinical governance at its centre. It not only included clinical skills, but also formalized the development of generic skills, such as communication and team working. This article defines clinical governance and discusses its components in relation to the foundation years curriculum.

Clinical governance

This has been defined as:

> **'a framework through which NHS organizations 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' (Scally and Donaldson, 1998).**

It is the umbrella for a group of activities brought together in the 'seven pillar' framework which includes: risk management, clinical audit, staffing and staff management, clinical effectiveness, patient and public involvement and experience, use of information, and continuing education and training.

Foundation training has been designed to instill attitudes of lifelong learning to underpin continuing professional and career development. The curriculum (Academy of Medical Royal Colleges, 2005) puts quality of care and patient safety at the centre of clinical practice and includes the skills, attitudes, values and behaviours defined in *Good Medical Practice* (General Medical Council, 2003) as core competencies in its syllabus. It stresses the need for doctors to make patient safety a priority in their clinical practice and understand the importance of good team working with colleagues and patients.

Risk management

This involves organizational systems or processes which aim to improve quality of health care, and create and maintain safe systems of care. It addresses the various activities of an organization by identifying the risks that exist, assessing them for potential, frequency and severity, eliminating those risks that can be eliminated, and reducing the effect of those risks that cannot be eliminated (Walshe, 2001). There are many components including organizational culture, risk assessment, training, induction programmes, guidelines, communication, audit, learning from adverse incidents, claims and complaints.

The systems approach to error

Human beings are fallible and errors are to be expected. Active failures are the immediate causes of adverse events. They are the mistakes made by frontline staff such as doctors. Latent failures are the result of decisions made higher up the organization. They create local conditions that make errors more likely.

To be successful the focus should be on factors influencing errors including patient, task, individual, team, work environment and organizational factors. Actions must be aimed at these. The systems approach is different to a person-centred view where there is individual responsibility and blame, and action aimed at changing individuals' behaviours. There are often multiple factors. Identifying and dealing with these will result in safer systems. Targeting individuals only will not allow learning within the organization, and is likely to result in the same mistake being made by others in the future.

Types of error

Slips and lapses are unintentional and occur where there is a failure of recognition, attention or selection. Mistakes are intentional and occur where a course of action which is incorrect is selected, and therefore does not have the desired result. These are rule based or knowledge based. Violations are an intentional deviation from safe practice. They are categorized into routine reasoned, reckless and malicious violations (Reason, 2001).

Dr Helen Scholefield *is Consultant Obstetrician, Liverpool Women's Hospital, Liverpool L8 7SS*

Patient safety incidents

These are any unintended or unexpected incidents that could have or did lead to harm for one or more persons receiving health care. They occur in about 11% of hospital admissions in this country and half are thought to be preventable (Vincent et al, 2001). This has a huge impact on the lives of patients. The effect on health professionals should not be underestimated either, with depression and difficulty in carrying on at work being common (Department of Health, 2003).

It must be made clear that the purpose of incident reporting is for the organization to learn from mistakes, and make changes that will reduce the risk of similar events occurring in the future, not for punishment or disciplinary action of individuals. A fair blame culture must be developed. Failure to achieve this will compromise the success of incident reporting (Department of Health, 2000).

Near misses should also be included. These are events which could potentially lead to a serious adverse outcome, but for some reason did not. Identifying what avoided harm from occurring can allow changes to be implemented that will reduce the chance of the near miss event actually occurring in the future.

Reported incidents are analysed for numbers and trends. Many will just need recording for statistics, but a number will need looking into further, and a few serious ones will need a formal in-depth investigation to find out exactly what happened and why.

Investigation involves the collection of information about what happened. Information will also be needed on workload, staffing, skill mix, training records, and equipment checking records. A root cause analysis is then done using a number of techniques to find the underlying contributory factors involved in the incident. Action plans need to be developed to deal with these root causes to allow implementation of changes that need to be made to avoid future similar events (Stanhope et al, 1997).

The National Patient Safety Agency has been set up to allow learning across the whole NHS. A national system for incident reporting is being rolled out. This should provide more information by facilitating detection of issues that might not be picked up locally because of the lack of numbers.

The principles of medical ethics

These cover the principles of autonomy (personal independence), justice, doing good and doing no harm. The legal framework for medical practice includes disciplinary and legal action if doctors fail to achieve necessary standards of practice and care. Patient confidentiality is covered in the Caldicott report *Report on the review of patient-identifiable information* (Department of Health, 1997) and the Data Protection Act. There are limits to confidentiality to protect the public in criminal cases.

Consent

Mentally competent adults have the right to refuse treatment, even if that might result in harm to themselves. Competency is judged on the ability to understand and retain the necessary information about the planned procedure. If they are unable to do so, the doctor looking after them must make a decision on their behalf about what is the best for them, and not a relative.

Young people under 16 years of age have the right to make their own decisions on treatment if they are mentally mature and competent enough to do so. Patients must be given enough information about the procedure, its risks, benefits and alternatives in order to make an informed decision. For minor procedures verbal consent is adequate, but should be recorded. This would include many primary care situations. Consent for more invasive procedures should be written, and a note made of the discussions with the patient and any information leaflets given (Medical Protection Society, 2003).

Maintaining good medical practice

The curriculum includes the principle of lifelong learning, and to support this includes appraisal, assessment and planning to address relevant needs, together with the need to recognize errors and mistakes and make serious attempts to learn from them.

Evidence-based medicine

This is stressed in the curriculum for the foundation years, including types of clinical trial, limitations of the evidence base, and the concept of absolute and relative risk.

Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research (Sackett et al, 1996).

Guidelines

These are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances, and can improve quality of care by supplying the knowledge practitioners need to put evidence-based medicine into practice (Foy et al, 2001; Ransom et al, 2003). It is important to recognize that there may be circumstances which do not fit into available guidelines. The foundation programme doctor must seek guidance when required to practice outside these. There are a number of national guidelines produced by the National Institute for Clinical Excellence (NICE). These are recognized standards against which care is judged. The Royal Colleges also have a large number of evidence-based guidelines and others are available from the Scottish Intercollegiate Guidelines Network.

Audit

Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. Where indicated, changes are implemented at an individual, team or service level and further monitoring is used to confirm improvement in health-care delivery. This is called the audit cycle. The curriculum

requires the completion of an audit during the foundation programme.

Partnerships with patients

Good communication skills are one of the most important aspects of patient care (MPS Risk Consulting, 2004) and it is on this basis that patients primarily judge the care they receive. They do not have the knowledge to judge our competence. They are much more likely to be satisfied with their care if communication has been good and if they have received an apology when things have gone wrong.

Patients' expectations are important. They are likely to be dissatisfied with their care and complain or claim, if their expectations are not met. Their expectations may not be realistic or may be misunderstood by doctors. Therefore it is important to check what the patient's expectations are, address them, and explain why they might be unrealistic. It is also vital to check patients' understanding, as misunderstanding is likely to lead to dissatisfaction.

Patient information is another key area. This involves providing both adequate verbal explanation and also written information. Information is needed in different languages and other formats such as Braille and tapes. Patient information leaflets are extremely useful, but must not be used as a replacement for adequate explanation.

Communication problems make patients more likely to claim or complain. There are statutory requirements for dealing with complaints within the NHS Complaints Regulations.

Working with colleagues in teams

It is important that doctors have an understanding of their personal role, that of other team members including their competencies and skills, and the ability to support the team leader. This includes ensuring safe continuing care on handover.

Training and teaching

Inexperience increases the risk of error fourfold and unfamiliarity seventeen fold, therefore training and induction are extremely important in clinical governance. It is important to tailor training needs to individuals. This should form part of the induction, assessment, appraisal and professional development processes. Specific training in resuscitation must be completed in the foundation years.

Doctors have a duty to train and must be aware of the principles of educational methods and undertake teaching of medical trainees and other workers. An understanding of adult learning is needed, with a learner-centred approach (Mackway-Jones and Walker, 1999).

Professional behaviour and probity

Doctors are required to behave with a high degree of professionalism. They must maintain their own health and demonstrate appropriate self care including handling stress and its effects on performance (General Medical Council, 2003).

Conclusions

Patient safety and care are the central features of the curriculum for the foundation years and clinical governance is the framework suggested to achieve these. **BJHM**

Conflict of interest: Dr Scholefield is an Associate Consultant for MPS Risk Consulting.

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KEY POINTS

- The curriculum for the foundation years puts quality of care and patient safety at the centre of clinical practice.
- Clinical governance involves risk management, clinical audit, staffing and staff management, clinical effectiveness, patient and public involvement and experience, and use of information, continuing education and training.
- All humans make mistakes. A systems approach must be adopted to reduce the risk of these inevitable mistakes causing harm.
- Clinical risk management aims to improve the quality of care by creating and maintaining safe systems.
- Maintaining good medical practice involves lifelong learning, evidence-based medicine, use of guidelines, audit, partnerships with patients, team working, teaching and training.