Nursing Conference Papers

School of Nursing

2008

Perceptions of External Stakeholders Regarding the Development of Clinical Governance: A Western Australian Perspective

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I would like to thank the organising committee for a fantastic program so far and for the opportunity to present some early findings from my current study you and welcome.

In my presentation today, I will give some background to my research topic. This will lead onto the research question. I will then discuss briefly the methodology the challenges in undertaking the study, the strategies to overcome these challenges and then finally I will present some early findings from the study. That is the external participants' perceptions of changes that have occurred.

Please feel free to ask questions at the end of the presentation if there are areas that require clarification

The current context of healthcare delivery is one that emphasises patient safety and high quality care This focus on patient safety within the health industry has lead to the widespread adoption of the term clinical governance. Clinical governance has two aspects. Firstly, this term describes the systems and processes that a health agency has in place to detail accountability and responsibility for patient safety. Secondly, the term clinical governance also encompasses the mechanisms used to monitor and measure patient outcomes to ensure optimum quality care (Balding, 2005).

The growing awareness of the vulnerability of patients to safety related incidents was highlighted in an Australian study by Wilson and colleagues in 1995. This study retrospectively audited patients' notes to identify the incidence of patient events that occur because of errors in care. Because of this study, they estimated that 18,000 deaths and 17,000 permanent disabilities occur each year to patients in Australian hospitals because of preventable errors. This study focused political attention on the issue of patient safety and increased pressure on health care agencies to demonstrate processes that protected patients

In 2000, the Australian Commonwealth and State Health Ministers established the Australian Council for Safety and Quality in Health Care (ACSQHC). This group took a lead role in the development of research initiatives in areas such as medication safety, open disclosure of incidents, accident and incident monitoring systems and consumer education improvements.

Despite this activity and the progress that has occurred since the Wilson study, there continues to be exposés of health system failures that have resulted in poor patient outcomes This has led to the establishment of high profile Inquiries such as the King Edward Inquiry in Western Australia (2001), the Campbelltown and Camden Inquiry in New South Wales (2003), the, the Bundaberg Inquiry in Queensland and most recently the Royal North shore inquiry (2005). The continued need for these Inquiries

challenges the credibility of claims that there has been significant improvement in patient safety

The final reports of all of these inquiries identified that each of the organisations had been collecting information that indicated there were problems with patient safety. So they had some sort of clinical governance framework in terms of a monitoring system. However, there seemed to be insurmountable barriers that prevented the implementation of strategies and improvements in the clinical governance structures of the organisations concerned that would remedy or prevent failures of care.

Inquiries such as those just mentioned, are highly visible to the community and can undermine the public's trust in the health system

The establishment of inquiries can be seen as politically motivated to apportion responsibility and culpability for errors of commission and omission. However, the potential personal and professional impact on those involved in an Inquiry can be extremely distressing and harmful. These negative impacts can only be justified if there is sustained and positive change that occurs as an outcome of the lessons identified at the Inquiry

There is much written about the lessons that need to be learnt from Inquiries. Common factors identified in Inquiry reports include a lack of review of clinician's performance, inadequate or weak leadership, inadequate record keeping and disempowered staff and patients.

There is also a large body of literature dealing with change management, but there is a dearth of literature specifically looking at change management and clinical governance systems.

In order to learn from inquiries into health system failures, several areas require further investigation. Firstly, we need to be able to identify if the inquiry process affects reform of clinical governance systems and processes. Secondly, we need to identify how the conduct or inquiry process influences the reform (Duckett, 2003; Hindle, 2003; Walshe & Higgins, 2002).

The proposed study will identify if there have been any changes in the clinical governance systems and processes at one hospital, (KEMH). To do this, the researcher will draw upon Lewin's (1951) model of change, in order to identify if there were any factors within the conduct or process of the Inquiry which positively or negatively influenced these changes

The central research question for this study is "did the KEMH Inquiry have any impact in reforming the hospital's clinical governance systems and processes And if so why?

A case study strategy was chosen for this study

The case study strategy has a number of pertinent advantages for undertaking this study. The case (The inquiry conduct and KEMH) is bounded in time and space. The research question requires an in depth analysis using multiple sources of data, with the analysis involving multiple units of analysis as well as the development of themes describing the impact of the Inquiry on changes at KEMH.

The KEMH Inquiry is a significant case. This is because it relates to a high profile and public event documenting KEMH organisational failure. Therefore, the impact on KEMH and any reform of clinical governance systems can be isolated and considered independent of other factors.

Although the findings from a case study may not be generalisable, the term Transferability can be used to describe the applicability of finding s between the case being studied and others to which the findings might apply.

In this case, KEMH as a public sector acute tertiary metropolitan hospital has many similarities with other public sector hospitals. The areas of similarity are particularly in terms of workforce context, consumer/patient expectations, resource constraints, public sector/community accountability and the need to work within a political context. Therefore, findings from this research study may have transferability to other similar public hospitals.

Although I feel passionate about this study and firmly believe that it is an important study in terms of what it will contribute to our understanding of how to bring about positive changes in clinical governance systems, not everyone feels the same way!

There have been several challenges along the way. The first was in terms of the shear number of recommendations that arose from the Inquiry. Given the time and the resources, it was an impossibility to try and investigate the changes for all recommendations

The second and third dot points are really part of the same phenomenon. That is an institutional, organisational and professional aversion to bringing up "the topic" again! From all levels explanations and justification for undertaking the study have been demanded in terms of possible negative findings impacting on the organisation, the staff and the general public just when "things are starting to settle down"

This in turn has impacted on the access to data and criticism in some quarters of the nature of qualitative research and the value of this type of research to add knowledge about the study topic.

Finally, my challenge has been in ensuring the confidentiality and non-identification of participants to make certain that they are not identified.

The strategies to overcome these challenges included:
Limiting the study to two areas that were highlighted by the final Inquiry report as requiring reform. These are those that deal with:
the involvement of consumers in the maintenance of improvement at KEMH; and medical credentialing and performance management.
These were chosen for several reasons:
Credentialing and performance review processes are excellent examples of administrative functions that are important for patient safety, easily measured in terms of structure, process and outcome and require cultural change from medical staff. Yet it is an area that is highlighted in not only the Douglas report but also in the others as a significant deficiency.
Involvement of consumers is more difficult to measure objectively in terms of structure, process and outcome and requires a large amount of cultural change by all

clinicians. Yet, in terms of what is valued by patients and families, it is of great importance and in terms of the Douglas Inquiry was an area of major focus.

In regards of the negativity, I have focused on clear objective explanations of the study purpose. This seems to have dispelled some pessimism about motives and outcome.

In regards to access to data, I have become an expert at FOI and the pedantic and finicky descriptors to describe what I am seeking. I will say tho' that once the requests have been approved the people involved in providing the data have at all times been extremely helpful, Although I am currently sitting on 2 FOIs which don't seem to be moving quite as well.

Finally, in terms of the participants. I am using external participants and I am very cognisant of the need for de identification and limiting details in my write up.

The interview sample is purposive sample of five drawn from senior members or officers of clinical, professional, regulatory and consumer representative organisations. In order to obtain a diverse range of perceptions there will be a limit of one participant per organisation. The organisations identified were chosen as they either have direct interactions with clinicians or consumers where they provide advocacy or policy advice, or, they have a role in the registration or accreditation of clinicians.

The senior officers of these organisations are in the unique position of having knowledge and experience of the clinical governance systems and processes in place at KEMH. This knowledge is gained through their interactions with patients, families, clinical staff or management of KEMH. These senior officers however, have no vested interest in the image of KEMH and as such will provide a more objective view. The decision to limit the size and sample pool to senior members from these organisations was made on the basis of the specialised knowledge that this group will have of how organisations function at a system level. It was felt that this understanding will inform the research to ensure an in depth analysis and understanding of the topic being investigated.

The focus of the interviews was on the Inquiry recommendations for this section of the report. The issue identified in the report was that there had been a lack of formal credentialing and performance management systems in place in the years 1990-2000 (Douglas *et al*, 2001). The recommendations centred on the establishment of processes to address the deficiencies identified. As well, processes for ongoing maintenance and monitoring of compliance with credentialing and performance review policies and procedures for each group of clinical staff were to be developed. In total, the Inquiry made 25 recommendations in this section. 14 concerned with credentialing and 11 concerning performance management and 15 recommendations pertaining to consumer involvement in care

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In all there were 22 references coded to this theme. Participants were very clear that there had been substantial changes and improvements in this area. The comment by these participants are typical of all those who made comments on this category.

> "... (KEMH) have certification and privileging policies in place to clarify scope of practice within the service which is connected to safety and quality care ..."

> "...the credentialing documents that were being produced were very comprehensive... before in the past it was "did you have that qualification?" and then you had a job..."

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Although no participants commented explicitly about the performance management process as described in the policies and procedures all who made comments noted the opportunities and processes in place in terms of performance development. One participant remarked that:

"… accreditation has occurred so the Drs acknowledge what is required and it's been good because there are education opportunities and skill updates available… and that has been provided to them by the Public Health System. So that's been good for them but it is also been good for patients …"

And another commenting of performance review:

" there is a half-way peer revision that now agreed to and acknowledged by the those servicing the area … and it comes from their College … and so their College actually identifies what the practice has been, reviews the practice and, makes recommendations and they are encouraged to comply "

There were seven comments coded to this coding theme. Specific comments were made within similar areas to the coding theme above. These were in the areas noting general improvement, the requirement for regular ongoing and specific competency assessment and finally, the opportunities for ongoing performance development. As one participant commented:

"…Midwives, a similar process but not as involved …all midwives must undergo annual emergency management competency and there, that process is very clear when you articulate it now, that all midwives must do it …staff not being able to work in the labour ward for instance if they hadn't achieved those competencies …"

Four participants made comments that were coded to this coding theme. Several talk in very definite terms of the initial reaction of medical and midwifery staff to the changed processes and expectations in terms of credentialling and performance management. These are encapsulated by the following comments:

"…for I would say the majority it did change their behaviour eventually… initially it was an aggressive …yes I suppose aggression describes the type of behaviour because they were being asked to comply with policies they felt that they had no ownership of or that they didn't develop… "

"…and there were a lot of midwives who were fearful and, there were a lot of midwives that were anal retentive about it and, there were a lot of midwives that didn't care because … they felt it didn't apply to them…"

However, participants went on to comment on reactions as the processes have become bedded down. The comment by this participant describes the changed viewpoint:

"…and midwives were more ready to listen to aspects of care that they might need to change, legal aspects that would cover them and enabled them to provide appropriate care …"

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Six coding themes emerged in this section looking at consumer involvement in care. The coding themes can be divided into two general themes. The first focuses on the positive and is one where generally the participants felt there had been an improvement in the processes that involved consumers in care. Under this general improvement-coding theme three, more particular coding sub themes identified where participants felt there had been specific improvements. These were in the areas of patients' involvement in clinical care decisions, continuity of care, and the management of critical incidents. The second general coding theme focused on the negative. In this coding theme, participants identified that changes in the processes of involving consumers in their care still need to happen. Under this general theme, one more specific coding sub themes were identified. This was labelled patient deafness.

All of the participants who commented in this general theme had a primary role as clinicians and secondary roles as consumer advocates either in an operational or strategic context. They spoke from the perspective of their observations and interactions with patients as external stakeholders in the system. Their comments were broad with no specific examples, but were very definite and positive. As one participant commented:

> *"...I mean ...from that consumer perspective ...the general feel would be that it had improved..."*

Another participant stated:

> *"...what I can say is I don't hear patients talk about King Edward in terms of the Douglas Inquiry or the failures anymore..."*

With another remarking:

"...I must say that of all the people I've seen that have had interactions with King Edward the .., by far .., the vast majority have been positive. The vast majority have been positive in how they have experienced the health care. "

This theme focused on patients and families feeling comfortable to be able to ask questions, be involved in making decisions about their care, and having access to information that gave them the tools to be involved more actively in the care provided.
On participant stated

".. so there are so many parties that people can rightly go to now and they explain to them what, they find out what it is they want and what their concerns are. "

With another

" generally feeling more comfortable at being able to ask questions .. feeling that people were accessible to ask questions ."

This was reiterated by

" going on a number of women I know who have made comments to me there is much better access, and there are people available for them to ask and they are encouraged to ask questions "

And reinforced by

" I do know that women are able to access the medical staff if they have any queries whereas before they may not have been able to . "

This coding theme dealt with the support and services that were available when a patient had a poor outcome. Comments form participants included the following:

" I'm aware that there has been a large change in how people are supported in those extreme circumstances and I guess there a number of layers that that support..."

" there also seems to be genuine multi-disciplinary formal structured processes that people are given access to so that they can have their questions answered and so that they can grieve and make choices about arrangements for, in the case of neonatal death or stillbirth, cremation or burial, or what have you. Whereas before decisions were often made for people and information was often withheld "

" the service for supporting people through grief has improved immensely in the last few years "

This theme focused on an area that was identified as a major area of dissatisfaction for patients in evidence presented at the Inquiry. It was identified that patients wish for some continuity in care from caregivers they recognise. As well, that the treatment and care they receive in one place is communicated to their other caregivers. Comments that illustrated perceptions of improvements included the following:

" and the team midwifery means they are seeing the same people again "

"...there is a King Edward Hospital GP Liaison Office so therefore I see that that person sits at the interface looking to improve the patient journey from the Community into the Hospital and from the Hospital out into the Community and that's the main thing that I hear as a Clinician outside. I can't..., I can't really say about other things except perhaps the Patient Held Record that has been more extensive than before and thirdly, the discharge summary of the Clinicians receiving the patient back into the Community is certainly more comprehensive than it has been before. "

The second general coding theme was one that focused negatively on consumer involvement at KEMH post Inquiry. In this, coding theme participants identified that there was still improvements required in the processes that involved consumers in care. All participants who commented in this area had either primary or secondary roles involving consumer advocacy. The following comments capture the perceptions expressed..."

" . but I've been involved in a few reviews of obstetric cases and practitioners ... and they have been concerned ..(with) problems with communication, or accessing information or accessing practitioners for information ... other people have come out and have tried to access different hospitals because they have not been happy with what was going on I think the numbers, the few numbers going through felt they were not getting the information they needed. Yet...I see that with all the policies that have been put in place from the recommendations that were suggested that this has been followed up and things have been put in place but "

"...could have said to the consumers that it's a caring organisation ...instead they get tromped on by a staff member that is soooo...' important, just too important than the reason they are there So what you have . is a service ethos cultural issue, that's possibly unshakeable . no matter what you do at a high leve.. "

" some of the aboriginal consumers we now talk to through our aboriginal workers, they felt they were treated like shit at King Edward and..."

The theme that was coded to this section described that clinicians were deaf to what the patient really wants and values in their interactions with clinicians.
Examples from this theme:

" the deafness to the patient reports .. (long pause) the deafness language, fleeing from your distressed patient .. it is the other, the mentality of the other .. it is .... you can only do that to a person if you are not seeing them as similar to yourself .. "

In addition, another who was describing patients with whom they came in contact where everything went right BUT ....?

" .. (it) was fine, the birth wasn't bad but ... I hate that hospital. These are the ones you worry about .. the people who still had a good outcome but don't like the hospital because there's something about the cultural dynamic of the service they got... "

And reporting on other interactions with patients

.. you can hear a persons pain, and you know (you have) safety and quality problems .. when they (the staff) say oh they couldn't be having pain from that operation .... and then you later find a nick or they're bleeding or whatever .. because they haven't heard..."

And so, where to from here?

It is very early days in the data analysis. Data analysis to date has been on focusing on whether there have been changes in the clinical governance processes at KEMH post Douglas Inquiry. The next step is to identify factors that may have influenced change. Or, put another way how have the barriers been overcome or what are the driving forces that influenced change.

The goal is the development of a conceptual model of clinical governance change.