

“What on earth is clinical governance?”

In the first of a series of articles on clinical governance, Catherine Dewsbury, the Royal Pharmaceutical Society's clinical governance pharmacist, debunks some myths

In the five months since I came into post as the Society's clinical governance pharmacist I have learnt many things. One of them is that there are a number of misunderstandings about clinical governance and what it means for pharmacists and for pharmacy practice. I hope to counter these misconceptions and fuel a debate on how we might address clinical governance in the profession. This article is based on questions and comments I have received.

“Clinical governance is just a fad and if we ignore it, it will pass.” This is a myth. Clinical governance has been with us for a long time and should be at the heart of all professional practice. So pause for a moment to think about the Society's Royal Charter, which requires it “to promote pharmaceutical education and the application of pharmaceutical knowledge”.

How does the Society do this? It has worked with pharmacy educators and students, monitored schools of pharmacy and increased the levels of educational attainment required to meet the requirements to be registered as a pharmacist. The Society has promoted audit, continuing education and continuing professional development. Its inspectors monitor standards and practice. In addition, pharmacists have a Code of Ethics which requires them to keep up to date and act in the interests of patients. In its section on key responsibilities of the pharmacist, the code says: “Pharmacists in professional practice use their knowledge for the well-being and safety of patients and the public.”

So clinical governance is not the latest fad. It concerns the regulation of professionals, their professional education and knowledge and the application of that knowledge in practice in the interests of patients and the public.

“Clinical governance is just another excuse to blame us when something goes wrong.” This is one of the big misunderstandings. Clinical governance is about creating an open culture in which people can learn from each other. It requires an understanding that incidents and errors happen for all sorts of reasons, not just because of people. Of course, pharmacists need to have the knowledge and skills to undertake the roles required of them and keep up to date with development, but environmental factors such as working practices, systems and workload all contribute to incidents.

The fact that clinical governance at the Society is a responsibility of the Professional Development Directorate rather than the Professional Standards Directorate gives an indication that the Society wants to pro-

mote an open, “no blame” culture, where errors and incidents are taken seriously. It wants people to understand how incidents occur and share those lessons with the profession so that all pharmacists can learn from the analysis and minimise future risks to patients.

“When are you going to start your clinical governance inspections?” I am not an inspector. Clinical governance is not about inspection. It is a professional commitment to quality. It necessitates setting standards and reviewing them, wanting to improve, being willing to learn from others and using



tools to demonstrate that one is improving. As for monitoring standards, the Society already has inspectors who do that.

“Clinical governance is the new name for audit, isn't it?” This is another common misunderstanding. Audit is one of the tools for measuring performance against standards. It helps in identifying the priorities for improvement. Audit also highlights those areas where people can pat themselves on the back and say well done, before setting higher standards and starting the cycle again.

“The community pharmacy baseline assessment tool report is completed, so that's it. We've done clinical governance, haven't we?” There is more to clinical governance than the baseline assessment for community pharmacy. The word “baseline” is the clue. The assessment is a tool for getting started. It provides a structured way of looking at practice and services to get pharmacists thinking about their strengths and weaknesses.

The assessment tool is not perfect, but many pharmacists have used parts of it and developed other areas themselves. Many have already completed it and are working on action plans they have developed from the results. Some people have done this for

their own pharmacies, but in some areas the local pharmaceutical committee or other local body has produced reports for a locality.

The Society is looking at how the tool might be improved. But that should not stop pharmacists from using the baseline assessment. Changes to the tool are inevitable because Society staff are already adopting the principles of clinical governance and reviewing their own practice.

“Who is going to do clinical governance to me?” No one. Much of clinical governance must come from within. It is about looking at one's own practice, considering how it might be improved, and then changing practice, implementing the changes and finding out if the changes work. This can be summed up in the well-known mantra of the pioneer of autosuggestion, Émile Coué (who happened to be a pharmacist too): “Every day in every way I am getting better and better.”

Other people may be able to suggest alternatives to try, but there is no one model for pharmacists to buy or rent because they practise in different ways and every pharmacy is different. No other person can “do” clinical governance to you. As Coué told his patients: “The power is within yourself.”

“So what you are saying is that clinical governance is yet another new role for pharmacists?” No. That is another myth. Clinical governance is a new name for a group of existing functions. Pharmacists will carry out these functions more formally than in the past because they will be recording more of what they do so that they can demonstrate it to others. That is no bad thing. Pharmacists all know that they do much more than stick labels on boxes and offer advice on over-the-counter medicines, but that is the public face of pharmacy in most settings. Pharmacists cannot expect other people to understand and value what they do it if they cannot explain it or measure it. Clinical governance gives them that opportunity.

AND FINALLY . . .

Be positive. Clinical governance is good for us. Clinical governance will help pharmacists as they continue to improve and to enhance their reputation as experts in medicines, managing risks and improving quality in the interests of patients and the public.

Let me know what you think about clinical governance and send me copies of your examples of good practice (Royal Pharmaceutical Society, 1 Lambeth High Street, London SE1 7JN; fax 020 7572 2501; e-mail cdewsbury@rpsgb.org.uk).

A BRIEF GUIDE TO CLINICAL GOVERNANCE

Making sense of clinical governance

In the second of a series of articles, Catherine Dewsbury, the Royal Pharmaceutical Society's clinical governance pharmacist, explains how clinical governance, far from introducing new requirements, reflects much of the Society's Code of Ethics

I hold the belief that clinical governance is not new to pharmacy, because its individual components all have links with the Society's Code of Ethics and Standards. Clinical governance should therefore be a part of everyday practice.

The history of clinical governance in the National Health Service begins in 1998, when the Department of Health published "A first class service: quality in the NHS", setting out for the first time the Government's policy for raising quality for NHS patients and services. The policy involved setting standards through the National Institute for Clinical Excellence and the national service frameworks, and monitoring standards through the Commission for Health Improvement, patient forums and national patient satisfaction surveys. Central to this process would be delivering higher quality services through better self-regulation and through clinical governance. "A first class service" gave a complex definition of clinical governance: "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".

The Society was quick off the mark with its policy document "Achieving excellence in pharmacy through clinical governance" (1999) in which it welcomed clinical governance and set a framework through which pharmacists might deliver clinical governance. Since that time much work has been done in pharmacy by both local groups and individuals. There is, however, evidence that much more work is needed if pharmacists are to participate fully in clinical governance.

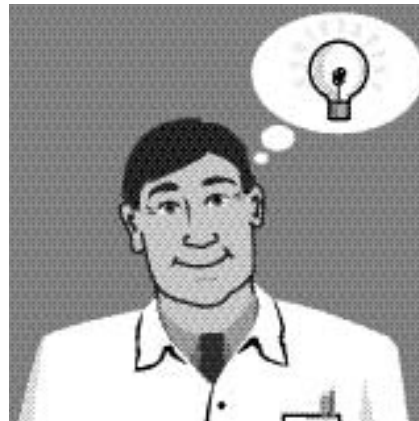
Since "Achieving excellence", the focus of clinical governance has changed significantly in the light of reports such as "Organisation with a memory" (1999), the Kennedy report on Bristol children's hospital (2001), the Toft report on intrathecal chemotherapy (2001) and "Building a safer NHS for patients" (2001). These, and the launch of the National Patient Safety Agency in September, have mapped out the quality agenda in terms of the NHS plan's objective of a patient-centred NHS. In addition, the new National Health Service Reform and Health Care Professionals Bill spells out even more clearly that in future regulatory bodies such as the Society will have to focus on improving their systems to involve more lay people and re-emphasise their role in protecting patients and the public.

WHERE ARE WE NOW?

Although the Government's wordy definition of clinical governance does not exactly trip off the tongue, its commitment to

improvements and excellence is clear. What helps us understand what is required of us as individuals, and in our workplaces, is to consider the component processes of clinical governance. These processes help us to build the links between clinical governance and the Society's Code of Ethics.

Clinical governance consists of a series of processes for improving quality and ensuring that professionals are accountable for their practice. These processes have been identified as continuing professional development, evidence-based practice, audit, dealing with poor performance, managing risk, monitoring clinical care and patient involvement.



Let us consider each clinical governance process in turn.

CPD One of the key responsibilities of a pharmacist is to keep up to date. Part 2 of the Code, which sets out standards of professional practice, states that pharmacists must ensure that "they undertake continuing professional development relevant to their professional duties".

Evidence-based practice The need for evidence-based practice is highlighted in the Code's "key responsibilities of a pharmacist", which state: "Pharmacists must ensure that their knowledge, skills and performance are of a high quality, up to date, evidence based and relevant to their field of practice."

Audit Pharmacists' participation in audit is outlined in the Code's standards for professional competence: "Pharmacists must continually review the skills and knowledge required for their field of practice, identifying those skills or knowledge most in need of development or improvement and audit their performance as part of the review."

Dealing with poor performance Identifying poor practice and remedying it is inherent in the Code's section on personal responsibilities of a pharmacist, which begins: "Pharma-

cists' prime concern must be for the well-being and safety of patients and the public.

Risk management In terms of managing risk, the introduction to the Code's standards for personal responsibilities says: "Pharmacists must ensure their own working practices are safe and effective." There are additional responsibilities for superintendents and chief pharmacists in hospitals and pharmacy owners who "must ensure that procedures designed to minimise risk are formulated and applied" in the workplace.

Monitoring clinical care The key to monitoring clinical care is the way in which pharmacists manage and use the information they have about patients. Guidance on these responsibilities is given in the Code in the service specification for patient medication records. The requirements for adequate records is repeated in specifications for diagnostic services, advice to nursing and residential homes and domiciliary oxygen services.

Patient involvement Part of the Code's key responsibilities of a pharmacist is that: "Pharmacists must respect patients' rights to participate in decisions about their care and must provide information in a way in which it can be understood."

ACCOUNTABILITY

Above all these processes is the requirement for professionals to be accountable for their work, as is made clear in "Building a safer NHS for patients", the Kennedy report and "A first class service". The Society takes this requirement seriously. Part 1 of the Code, which covers pharmacists' ethics, requires that "when faced with ethical dilemmas pharmacists are expected to use their professional judgement in deciding the most appropriate course of action. They must be able to justify their decisions to their peers, and to any person or organisation which may be affected by their actions, including individual patients, the public, the NHS, their employers, and other healthcare professionals. Pharmacists may be accountable to any of these".

A NEW YEAR'S RESOLUTION

At this time of year many of us review the past year and consider our actions for the coming year. I hope that, having read this article, readers will now agree that participation in clinical governance is a substantive part of good professional practice. Let us make 2002 the year in which we resolve to do the right things right, to the right people, in the right way and at the right time, and to take responsibility for doing it.

What it means for community pharmacy

In the third of a series of articles on aspects of clinical governance, Catherine Dewsbury, the Royal Pharmaceutical Society's clinical governance pharmacist, analyses a new Department of Health document on clinical governance in community pharmacy

Clinical governance is defined as: "A framework through which National Health Service 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." From this month there is no excuse for community pharmacists to say that the NHS is ignoring their role and potential in clinical governance. Throughout England, letterboxes have been rattling to announce the arrival of the Department of Health document "Clinical governance in community pharmacy: guidelines for good practice for the NHS" (see p81).

The document has been written by Professor Alison Blenkinsopp (regional pharmaceutical adviser, West Midlands), Professor Jennifer Tann (University of Birmingham) and Jeannette Howe (deputy chief pharmacist for England). The guidelines have been tested by many individuals and organisations involved in quality and in pharmacy, including the Royal Pharmaceutical Society, the Pharmaceutical Services Negotiating Committee and the National Pharmaceutical Association. The guidelines provide a clear reminder to chief executives of primary care organisations that clinical governance must extend to all NHS activities, including community pharmacy.

The guidelines list initial actions for primary care trusts (or health authorities where PCTs do not yet exist) to carry out by April and elements on which to build an action plan for integrating community pharmacy into wider clinical governance plans in future.

With the Vice-President (Dr Gill Hawksworth) and the head of professional ethics (Helen Darracott), I was involved in preparing the document. The Society supports the objective of clinical governance, and it encourages all pharmacists in the community — whether contractors, superintendents, managers or locums — to participate fully so as to maximise their contribution to the health and safety of patient and the public.

WHAT NEEDS TO BE DONE?

There is work for all in this document, with the emphasis on PCTs and community pharmacists and their staff. Chapter 3 of the guidelines acknowledges that PCTs may be at different stages in terms of pharmacy and clinical governance. Some areas have done considerable work, as demonstrated in the numerous examples of good practice. Others have either ignored community pharmacy or have not prioritised it. This is worrying when one considers that about 15 per cent of NHS expenditure is on medicines. The aim for the months until April is to get all PCTs off the starting blocks.

Questions for community pharmacists

For community pharmacists the following questions may serve to emphasise the relevance of clinical governance to their professional and business practice:

- 1 How am I/my staff/my pharmacy doing? Which clinical and service standards are we meeting and where do we need to take action to improve?
- 1 What must we do to meet the expected standards of practice?

- 1 What difference will this make to patient care?
- 1 What can I do that will have the biggest impact on patient care?
- 1 What near "misses" have I had and how can I learn from these?
- 1 How can I share my experiences with my colleagues?
- 1 Where can I get help/support in understanding the issues?

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The first steps are to:

- 1 Identify someone at the PCT who will take the lead on integrating community pharmacy into local clinical governance frameworks
- 1 Appoint a community pharmacy facilitator for clinical governance
- 1 Include community pharmacy in PCT clinical governance committees
- 1 Set up local communication networks
- 1 Undertake a baseline assessment
- 1 Provide training on clinical governance and to build on earlier training
- 1 Ensure that services commissioned locally, whether new services or existing ones such as advice to residential homes, have clinical governance arrangements
- 1 Include community pharmacy in plans for 2002-03
- 1 Develop a strategy for implementing community pharmacy clinical governance in a multidisciplinary framework

We know that many community pharmacists have done baseline assessments and are working to establish local networks, and some local facilitators have already visited more than 100 pharmacies. But do not sit back thinking you have nothing else to do. Remember that clinical governance is not a one-off event. We can always improve. Look at the questions in the panel and be honest with yourself and your staff. You might take the opportunity to ask your customers similar questions. Remember that involving patients is an important part of clinical governance.

Where local pharmaceutical committees and PCTs have agreed a strategy for clinical governance in community pharmacy, it should be tested against the guidelines. The guidelines include a whole section (Chapter 4) on formulating a development plan. This offers useful advice on such diverse topics as confidentiality, handling complaints, reporting adverse incidents, continuing professional development, appraisal and poorly performing pharmacists. Much of this is a useful reminder for employers, superintendents and individual pharmacists.

The Society also receives a steady stream of telephone calls from PCT pharmaceutical advisers seeking tips on writing job descriptions for clinical governance facilitators in community pharmacy. This is made easier for all concerned because the guidelines give a sample job description and person specification for this role (Appendix 3).

For those who are new to clinical governance or who want more information on how it fits into the wider health agenda, Chapter 5 sets out "the wider context". This includes an important update on government initiatives, including improving patient safety by minimising medication errors.

Preventing and reducing medication errors is a subject close to the heart of all community pharmacists and their staff. It may be news to many to learn that England's chief pharmaceutical officer, Dr Jim Smith, is working up a plan to tackle the problem of medicine errors with the aim of hitting the Government's target for reducing serious medication errors. This is a tough task but one that the Society must support if pharmacists are to fulfil their role in risk management and protecting patients.

The document's final section (Chapter 6) consists of examples of good practice, demonstrating the contribution community pharmacists and their staff can make to local quality improvements and clinical governance. These are split under three headings: "Delivering clinical and service standards", "Risk assessment and management" and "Continuing professional development".

In many examples the pharmacist is based in the pharmacy. Other examples highlight the work and support available from the Society, the NPA and the College of Pharmacy Practice. Helpfully, there are contact details for those who wish to follow up particular examples. Most importantly, the examples demonstrate that, with imagination, commitment and local co-operation, pharmacists can participate in local schemes to improve quality of pharmacy services, and wider NHS services, for patients and the public. And if others can do it, so can you.

What do I do when I have tried to do what is right and it still goes wrong?

In this fourth article on aspects of clinical governance, Catherine Dewsbury looks at the way in which clinical governance affects the individual pharmacist and the need for an open approach to investigating the causes of error in the interest of patient safety

In an earlier article in this series (*PJ*, 15 December 2001, p873), I said that clinical governance is about doing the right thing right to the right people at the right time. On millions of occasions every day it is easy for pharmacists to practise in this way.

For example, on receipt of a prescription, the pharmacist reads it and establishes that it is legal, that the dose prescribed is appropriate and that the drug is suitable for the patient. Then someone types the label, assembles the product and the pharmacist checks the product against the prescription. Finally, the medicine is supplied to the patient (or the patient's representative) and there is a short discussion on how to take it. Job done.

At other times it can be more difficult. An example is the patient needing a cocktail of medicines for symptom control in palliative care. Sometimes, although there is little research on whether the drugs can be mixed in the same syringe, the nurses or doctors looking after the patient want to give the drugs together so as to minimise the number of injections.

In these circumstances, what is right pharmaceutically and what is best for the patient? Does the pharmacist have time to ring the manufacturers, to ask colleagues, to contact a few specialist centres or to put a request to a medicines information service? Or, has someone already mixed the medicines and administered the injection? Has something already happened to the patient and the doctor wants to know whether the mixture caused the problem? Are you the central intravenous additive service manager being asked to make up the syringes for storage and use elsewhere?

The answer may depend on the medicines, on the actual question being asked, on the circumstances, on how much time the pharmacist has to look into the research and on what information is available. However, even with plenty of time and all the published information, the pharmacist may still find that there is no answer to the query — so what does he or she say?

IT IS NOT ALWAYS EASY TO BE A PROFESSIONAL

This is what being a professional is all about. It is not always easy. For any query there may be more than one answer or no answer at all. It is up to the pharmacist to give the best advice available and to be accountable for the advice given.

This is clinical governance. Guessing is not an option: people expect and deserve better than that. Clinical governance is about knowing one's limitations and/or the limitations in the research. One will need to be honest with one's colleagues, with the patient and with the patient's family, analysing the risks, minimising them and agreeing a course of action — acting in the interests of patients, as is required by pharmacy's Code of Ethics.

WHAT HAPPENS WHEN SOMETHING GOES WRONG?

According to Department of Health documents, community pharmacies in England dispense more than 550 million prescription items in each year and hospital pharmacies dispense half a million items a day. To these figures one can add the advice community pharmacists give to the two million or so people who consult them every day, the advice each clinical pharmacist in our hospitals provides to professional colleagues about dozens of patients each day, and the day-to-day advice that pharmacists working as pharmaceutical advisers or public health specialists provide to clinicians responsible for providing health services to the nation.

With pharmacists supplying so many medicines and so much advice, it is inevitable that, at some time, in some part of Britain, something will go wrong for a patient or a group of patients. I have yet to meet a pharmacist who has never been involved in such an incident or a near miss. Any practising pharmacist who has never been involved in a near miss or a mistake is extremely lucky, and the rest of us wish to know the secret.

In 2000, a report by the Chief Medical Officer, "An organisation with a memory", found that 10,000 hospital patients each year have serious adverse reactions to medicines and that one-fifth of clinical negligence litigation stems from hospital medicines errors. There are no robust figures for community practice because many — perhaps most — incidents are dealt with at the pharmacy level.

Many hospital pharmacies and pharmacy chains already have systems for collecting information on errors, and are in various stages of developing systems for recording

near misses (see, for example, the paper by Osborne *al*, *PJ*, 26 January, p101). All these systems rely on individual pharmacists or staff members sending reports to head office. Recording incidents and errors is best practice for all pharmacists, including independent contractors and locum pharmacists. However, some professionals are more willing to report incidents than others.

I hypothesise that most of us are afraid of making mistakes. Each time we make a mistake someone could be hurt. Professionals do not as a rule set out to harm people but, like everyone else, they are human and can suffer from illness, stress and even addiction.

Mistakes happen even without human error. Working conditions can and do contribute to errors. No-one can function at their best if they work extended hours without breaks, with insufficient support staff, or in working conditions that are not conducive to minimising risks.

When incidents do occur, it is important to investigate the causes and learn why they happened. This does not override one's responsibility to the person affected by the incident. To get to the bottom of why an incident has occurred needs an open approach. Honest and accurate accounts of what happened, including the working conditions at the time the incident occurred, are vital if similar incidents are to be prevented in the future.

DEVELOPING A NO-BLAME CULTURE

Every major incident is a potential learning experience for professions. This is why all health care providers, including pharmacies, need to develop a no-blame culture when investigating incidents and errors.

This does not mean that professionals who have been careless, negligent or deliberately criminal should get away with it. That would be a blame-free, rather than a no-blame, culture. What it does mean is that professionals who have done everything in their power to do the right thing, who have kept up to date and were working in the interests of their patients, should be encouraged to report and discuss the incident in the interest of protecting future patients. This sort of no-blame approach contributes to future patient safety. It contributes to the memory of the profession (or organisation).

This is clinical governance. It is a brave new world, but it is one that we all need to embrace.

Catherine Dewsbury is the Royal Pharmaceutical Society's clinical governance pharmacist