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SIMULATED INTERACTIVE MANAGEMENT SERIES

Article 8. Quality assurance, clinical governance, and a patient wants to die

S McCormick, J Wardrope, C Perez Avila

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This article in a series on management within the emergency department investigates the issues surrounding clinical governance, quality assurance, and the rights of patients who wish to die.



To understand this article fully you must read the extra information on the journal internet site, www.emjonline.com

FEEDBACK**Head injury and warfarin**

Have any of you had problems in keeping guidelines up to date? St Jude's has had such difficulties and this has caused a significant incident. The changes to the guidelines on head injuries and warfarin mentioned in the last article (St Jude's diary.emjonline.com/sims7) did not take place. An elderly lady on warfarin was sent home after a minor head injury and died.

The coroner has finished her inquest and as expected made no direct accusations against anyone involved in the case. She did, however, comment on the near miss that occurred with a similar case the previous month, indicating that such an experience should have led to a review of departmental policies and procedures. These comments cannot go unheeded and so Dr York has asked Rebecca Devon to review the head injury guidelines at St Jude's. The process of constant review of practice against appropriate standards is audit and is part of the responsibility to improve and maintain the quality of health care that is through clinical governance. This issue is discussed in the time out.

Case of possible mismanagement of paediatric case

Mr London has had a formal interview with the registrar Jacob Ireland who was the subject of complaints about his handling of a paediatric resuscitation case (emjonline.com/sims7). Jacob did not see any reason for complaint. He was happy that he reacted to a difficult situation appropriately. A file note of the interview is included in the in tray this month. What action should be taken?

St Jude's budget

This shows that the department is overspent. The major overspends are on radiographs, laboratory tests, drugs, and temporary staff both medical and nursing. How did you explain this to the chief executive and finance director? You have been given a task of breaking even at the year end in April and you must produce a balanced budget for next year. Another of this month's tasks.

The junior doctor with short notice sick leave

This is a perennial problem with all staff in A&E. Temporary staff costs are one of the main reasons

for the current over spend. In real life such staff costs can be huge. Recently up to £1000 has been charged by an agency for a single 12 hour shift for an A&E nurse. As managers we all know that doctors and nurses will get sick at some time, often at short notice and so we should plan for this situation. Most departments will have lists of staff who they know and have either worked in the department in the past or have previously worked as locums. It is obviously preferable to call on some one known to the department but it can take a lot of time to contact these doctors and the list might be long. This is a job that no one likes doing but is an essential part of staffing procedures. When employing nurses it is preferable to use "bank nurses". These are usually local nurses who are prepared to work overtime. Locum agencies and nursing agencies can be expensive but most Trusts have preferred suppliers and they are usually under contract to the Trust. Internal cover is often seen as a last resort but it can sometimes be impossible to cover shifts other than by some rota re-organisation in the department.

The recording of short-term sick leave is often haphazard but should be routine. What procedures does your department have for the recording of sick leave? Do you routinely interview doctors after sick leave?

The unconscious patient who has taken an overdose and has an advanced directive

The case is discussed with the general practitioner who confirms a copy of the advanced directive is in his notes, the patient's husband who confirms his understanding of the situation, and with the clinical director. You make a decision that no further treatment should be given, that the patient should be admitted to an appropriate ward and should be given all nursing care but no active medical intervention.

However, the next morning she wakes up and says that she still wishes to die. What action do you take now?

The issues surrounding advanced directives are complex but are discussed in the time out below.

TIME OUT—QUALITY ASSURANCE AND CLINICAL GOVERNANCE**What is clinical governance?**

The failure to learn from the error in the care of patients with head injuries who are taking warfarin represents a failure of clinical governance within St Jude's. The objective of clinical governance is to ensure the highest possible quality of clinical care for patients. NHS organisations are accountable for maintaining and improving standards,¹ by ensuring that staff have the right

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Box 1

Clinical governance is the structure that has been established for the maintenance and improvement in the standards of care in the NHS.

skills and environment to deliver high quality care and to check that these standards are being met. In addition clinical governance seeks to continuously improve standards, by reviewing old standards, by the reporting of incidents, by the implementation of new guidance, and by encouraging innovation in all staff groups.^{2,3}

The Department of Health web site contains full details of the NHS structures (www.doh.gov.uk/clinicalgovernance).

Implementing clinical governance

For clinical governance to be successful there must be a willingness from all staff to make it work. The NHS has an image of centrally driven performance management but it is the A&E department staff who will know the major problems facing the department and often have creative ways of improving the situation. Capturing this knowledge and drive is essential to success. When dealing with highly trained professionals, self motivation is always more effective than a command and control type of structure. A clinical governance group should meet regularly, led by a senior clinician with representatives from all types and grades of staff. This should be regarded as any other management meeting with minutes and action points. It is easy for this type of group to be an ineffective "talking shop". However, with careful leadership it can be a major team building force within the department and an opportunity to raise standards.

"Performance management" and "incident reporting" are sometimes thought as the mainstays of clinical governance. These are important and failures in local systems need to be recognised but this should be in a spirit of constructive criticism rather than viewed as an opportunity to apportion blame. These systems represent a small part of clinical governance. The structures involved in clinical governance are summarised in the internet section (www.emjonline/SIMS8). The full picture is represented in figure 1. Figure 1A represents the ideal department with a strong underlying structure and good staffing levels. The structure provides a stable platform for quality improvement, staff appraisal, and good clinical quality. Figure 1B is a more realistic picture. There are just enough staff to keep the department going but it may rely more heavily on inpatient support, policies and procedures to maintain quality. Quality improvement is still possible. Figure 1C shows a structure that is unstable. The basic foundations are not strong enough to support quality improvements. Trying to impose quality improvements at the top in this structure will fail. Attention to firm foundations of structure and processes are the essential first step to building a coherent policy structure.

The implementation of clinical governance can be a daunting task. The first steps for the multidisciplinary clinical governance group should be an examination of the current situation, a *baseline assessment* of the building blocks on the first two levels. This will identify gaps in the current service. It is possible to work on all the levels, one should not wait until the structures are perfect before exploring quality improvement. However, in practice quality improvement often requires changes to structure and process.

Structure

The bed rock of any A&E unit are the structural parts of the service, the physical lay out, equipment and staffing arrangements, the supporting specialties within the hospital, numbers and skill mix of staff, and staff training and education.

Standards for these elements are extensively described in documents such as Hospital Accreditation⁴ BAEM,⁵ and others.⁶ These are the foundations of a good A&E service. Trying to build a clinical governance framework on shaky foundations is not going to work in the long term. Training education standards for medical staff are published for junior medical staff.⁷ These are formally assessed by educational approval visits and as part of the normal feedback process.

Process**Policy and procedures**

Clinical guidelines, policies and procedures provide the standards for the process care of individual conditions. The problem is that there are so many clinical guidelines that managing them all is a very significant part of clinical governance. The example of the head injury and warfarin shows the importance of updating guidelines quickly and accurately. This is a time consuming and often a boring task. Dissemination and training in the changes is another major managerial task. This will be a major part of the work of the clinical governance group.

Supervision

This is often omitted in clinical governance frameworks but is an increasingly important part of modern A&E practice. The model of the unsupported SHO is increasingly difficult to justify. The NHS Modernisation programme states that more care will be delivered by fully trained staff. This is impossible with current staffing profiles but in many departments middle and senior supervision of care is becoming the norm. One of the tasks of the clinical governance group will be to champion the cause of increased levels of supervision.

Process measures

There are many process standards for A&E practice. The only standards that *must* be assessed at present are the waiting time, department time, and time to thrombolysis. These form part of the National Plan for the NHS and require that by 2004 75% of patients leave the department within four hours of arrival. They also state that by 2004, the average waiting time for all patients attending A&E departments in the UK will be 75 minutes.⁸ This seems a simple enough standard that should be easy to collect and monitor. However, 14% of A&E departments do not have a computerised administration system.⁹ There is lack of clarity about when a patient "arrives" and when they "leave". It can also be argued that for some patients a prolonged department stay represents good care if they require extensive investigation or a period of observation.

Time to thrombolysis is probably a good process measure of how the department reacts to time sensitive medical problems. There are a number of problems with this measure but at least it is a "clinical" measure that may have a relation to mortality.

Having measured performance it is useful to compare this against other units. The District Audit reports⁹ give this opportunity, as do involvement in bench marking groups. Peer review of a department is a powerful tool to assess performance but is time consuming and relies upon colleagues from other units having the time to spend in the process.

The British Association for A&E Medicine have recently published a list of audit standards for A&E departments.¹⁰ Most of these are process measures for individual clinical conditions. These suggestions might help the clinical governance group decide on the audit programme for the department but it is essential that other aspects of clinical care are also considered, especially nursing.

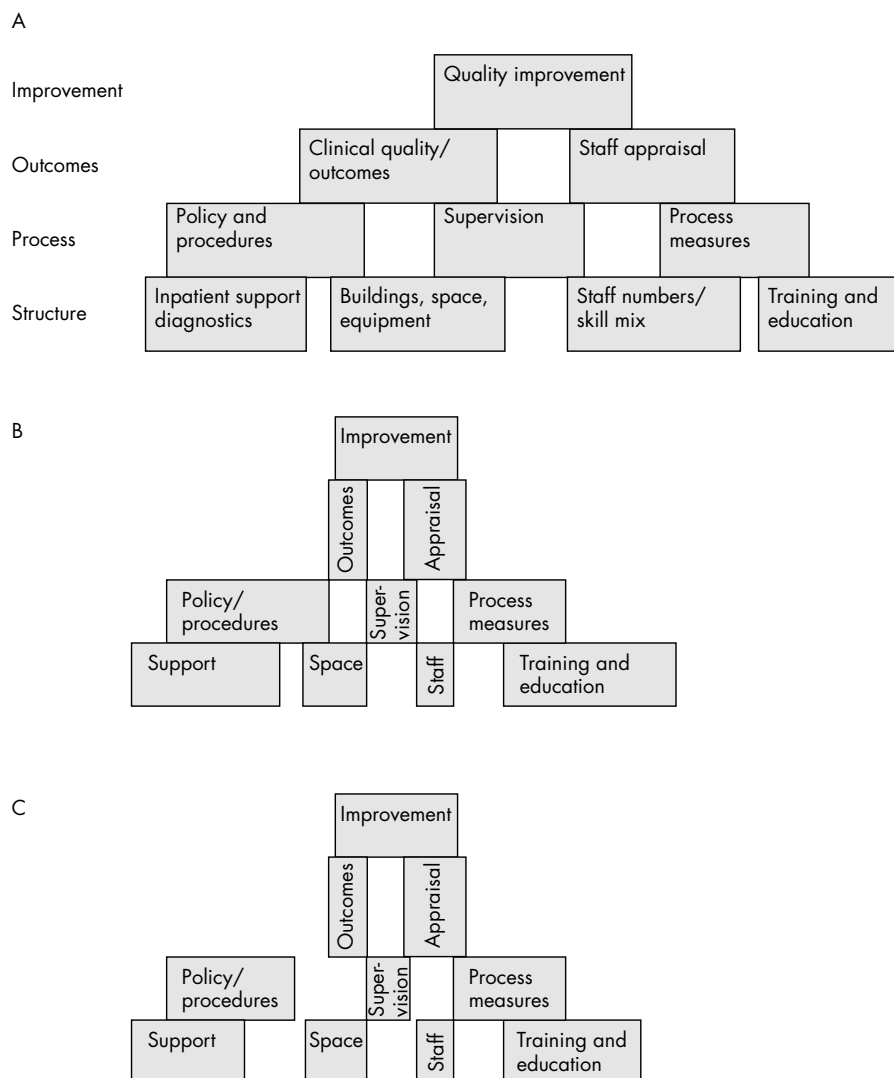


Figure 1 One view of the essential elements of providing a quality service. (A) The ideal department that is strong in all elements; (B) a realistic structure that in which some of the blocks are less than ideal but maintain clinical quality most of the time; (C) is a failing structure. Quality improvements imposed from the top will only further destabilise it.

Outcome

Clinical outcomes/quality

Outcome based audit is the gold standard of clinical quality control. These should be criterion based and allow comparison between departments. This type of audit is time consuming and technically demanding, and sometimes difficult to interpret. The national trauma audit (UKTARN), provides a good example of outcome audit. It is based on a definite outcome (dead or alive), allows for variations in case mix by using methodology that is internationally accepted and provides information on how one unit is performing over time or against other departments. However, the method is time consuming and the system requires significant resource. In a recent exhaustive review of possible outcomes measures for A&E¹¹ the trauma audit and the rate of recall for missed fractures were the only true outcome measures in a list of many possible measures.

Staff outcomes—appraisal

Staff performance

The performance of staff is pivotal to the quality of service provided. Assessment and appraisal are meant to be part of the culture of all organisations. However, it is notoriously difficult to measure staff performance. At a crude level one could take the

numbers of new patients seen as an indicator of the work carried out by medical staff or nurse practitioners. However, this does not allow for case mix seen, amount of teaching and supervision given or the time spent “on the floor” Equally the numbers of complaints or errors may seem to be a measure of quality. It is often the hardest working doctors that make more errors as they see more patients. Often it is only by working with staff that the real assessment of quality of care is assessed. This has been formalised in the “Teaching One to One” system that is being piloted as a formal system to assess SpRs.

The quality of care provided by consultant staff is even harder to assess. The role of a consultant working in a department with only one other colleague is going to be very different from a large multi-consultant department. There are no readily available criteria against which one can be judged. The process of annual appraisal is active in some hospitals but not others.

Formal appraisal is becoming much more common in nursing practice and in other staff groups such as administrative staff.

QUALITY IMPROVEMENT

Improving standards

Once improvements are identified it is essential that the process of change is monitored closely to ensure that there has

been a gain in quality. This will mean that resources are used more effectively and give weight to requests for continued or increased funding of quality issues. The level of existing care is monitored and a programme of rolling audits are often used to allow many different areas of practice to be examined regularly.

New guidelines, new evidence

The practice of emergency medicine is changing rapidly. We must establish adequate mechanisms for sifting the literature and new guidelines. These should be critically appraised, costed and plans made for local implementation.

Patient surveys

Patient views on the service are important. We exist to provide a service to patients. General surveys tend to show high levels of satisfaction with clinical care but less satisfaction with waiting times and environment. It is probably better to target questions about specific aspects of the service and even to use semi-structured interviews on smaller numbers or patients than a large questionnaire survey.

Incident reporting

Perhaps one of the hardest parts of clinical governance to implement is the monitoring of adverse outcomes. To make an error is one of the most powerful teachers in medicine. We can all profit from a culture that is open about error, where everyone can learn the lesson and, if needed, policy and guidelines can be changed. Unfortunately, within the NHS there has been a culture of either covering up errors or attempting to blame someone for them. This has led to reluctance for errors to be openly discussed and individual or system problems are not properly tackled. In such a climate, prevention of future episodes becomes difficult. The challenge for quality monitoring is changing the culture of blame and creating a culture of learning from our mistakes. This is especially difficult, as outside of the NHS there is an opposing rise in the blame culture and medical litigation.

If clinical governance meetings are to be successful then they need to be led by senior staff, who must be prepared to admit to their own mistakes and encourage their juniors to openly discuss their errors. There is little evidence that this approach actually reduces error rates but it is now an accepted part of a clinical governance framework and has to be in place. All the trends we see at present imply a greatly increasing error rate, much of this may be attributable to increased reporting.

Within A&E the value of learning from previous mistakes has been known about for years. With the constant turnover of medical and nursing staff dealing with such a variety of conditions the potential for error is high. To tackle this problem most A&E departments have well established guidelines for staff, easily available as handbooks or on computer. Unfortunately, as has happened at St Jude's, these guidelines need to be constantly updated or out of date practices will be perpetuated.

Learning from our own mistakes is essential but it would be better if we could also learn from the mistakes of others as well. Creating a health service with a collective memory would be of benefit in ensuring quality and safety as is demonstrated by the tragic repetition of intrathecal injection of Vincristine. This only ever happens once in a hospital but has happened too many times within the health service to continue to be tolerated.

SUMMARY

Quality assurance is a major responsibility of all managers and clinical governance is the structure developed by the NHS to deliver this objective. We should support this as it is a great opportunity to improve the service we provide to patients.

Assessment of these systems will be a major part of the external monitoring of a department's performance by bodies such as the Commission for Health Improvement (CHI). The CHI is responsible for the dissemination of clinical governance principles and has the authority to investigate problem areas where there is seen to be a serious failure of a service or a persistent problem. When CHI comes calling, you will want to be sure that you have good clinical governance structures in place.

TIME OUT—LIVING WILLS (ADVANCE DIRECTIVES)

The rights of patients and the duties of doctors

From time to time you will be confronted with a serious dilemma when a patient arrives in the A&E department with a "living will". Your Trust and department should have a policy on such "end of life decisions". This situation runs against the main ethos of A&E, that of saving lives. The principle "if in doubt, treat and resuscitate" is still the best policy in most cases but a well constructed advance directive leaves little doubt about the wishes of the patient. Such clear statements of intent made by a competent person should be respected. Advanced directives are clear instructions from a patient to a clinician outlining the actions to be taken in the event of a serious medical problem that would normally require active medical treatment.

The Voluntary Euthanasia Society has provided a comprehensive pack containing so called "living wills" that have, if properly filled, legal validity.¹²

The legal, moral, and professional issues of such documents are increasingly agreed.¹³⁻¹⁷ The essential elements of a "living will" are a declaration by the patient of a series of circumstances, which will validate the will, followed by a clear definition and set of parameters, which need to be followed by the carers of the patient. It includes a series of statements that absolve the medical profession of any wrongdoing. An essential part of the directive is a clear schedule of the conditions that would activate the directive. The "will" also has a nominated person or persons who need to be contacted to corroborate the "will" if there is any doubt or concern about a special case outside the directive's schedule. The "will" also contains details of the patient's general practitioner. All advance directives must have the dated signatures of the patient and two witnesses. The directive must have a sentence at the end listing when the directive was reviewed and updated by the patient. An example of such a document is given in the internet section.

In *Introduction to medical law* the section "Capacity to consent to or to refuse treatment", discusses the issue of advance directives.¹⁶ It describes the conditions that make such a directive binding of the profession. (1) Directives must be made by someone with the necessary capacity, applicable to the circumstances that arise at the time the directive was drawn. (2) The patient must fully understand and appreciate the significance of their refusal to such treatment and (3) the whole process must be done under no duress.

When considering if a directive is effective the clinician should consider the points in box 2.

You must be absolutely happy that the advance directive is a clear and an unambiguous desire of the patient to refuse treatments or management that would prolong life. All such difficult ethical decisions merit discussion with a senior colleague or possibly the Trust's legal representative. Medical insurance companies also provide 24 hour access to legal advice. However, some one has to make a "clinical decision", and that is likely to be the A&E consultant. Properly and sensitively handled this can be a positive experience for those involved.

Most Trusts are writing policies or guidelines about the treatment and care of patients with advance directives. They are based on the British Medical Association published Code

Box 2 Point to consider when dealing with an advanced directive

- Is there a question about the patient's mental capacity at the time of the decision?
- What are the family's views on the patient's wishes?
- Is there any evidence that the family/individual put pressure on the patient to make a particular decision?
- Was the patient aware of the consequences of the decision and the risks/benefits?
- Do the circumstances that have arisen fit with the circumstances envisaged when the advance directive was made?

of Practice. The Medical Protection Society's pamphlet on Consent gave advice on advance directives.¹⁸ It notes the case of *Airdale NHS Trust v Bland* (the case of a young man with persistent vegetative state following hypoxic brain damage) in which the senior judges established "a requirement to respect the patient's instructions in advance declarations or living wills" providing they previously had expressed such a wish.

Health Service Risks¹⁹ tackles the issues around consent and specifically discusses advance directives. It expands on the previous tenants and gives pointers about how and when to draw an advance directive and the considerations that are needed when acting upon it. It emphasises the importance of competency of the patient when drawing the directive, the need for the clinician to check with relatives or carers the validity of the directive and for the clinician to ensure that the directive is appropriately signed and witnessed.

What is your department's policy on advanced directives? What is your "game plan" for handling the situation when it arises? It is better to have a clear idea about this now than at 3 am one Sunday morning.

TASKS

- What action are you going to take over the SpR with a possible competence problem?
- How would you set a balanced budget when current expenditure exceeds income?
- Review your Trust's sick leave policy. How robust are sick leave procedures in your department.
- What action are you going to take over the patient with the advanced directive who has survived a suicide attempt.
- Review the minutes of the directorate meeting. Outline at least six issues that might need closer examination and some action. Can you identify some "team roles" taken by members of the orthopaedic service?

Web info (emjonline.com/contents/SIMS8)

File note from SpR interview
 Note of previous training assessment
 Example of a living will
 St Jude's diary
 Minutes of the clinical directorate meeting
 Letter from the chief executive
 Disclaimer

- What action do you want to take about the letter from the chief executive?

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REFERENCES

- 1 **NHS Executive**. *Clinical governance: quality in the new NHS*. Health Service Circular, 1999/065.
- 2 **Department of Health**. *An organisation with a memory*. London: Department of Health, 2000.
- 3 **Department of Health**. *Building a safer NHS for patients*. London: Department of Health, 2001.
- 4 **Health Services Accreditation**. *Standards for accident and emergency services*. Battle: HSA, 1997.
- 5 **Royal College of Paediatrics and Child Health**. *Accident and emergency services for children*. London: RCPCH, 1999.
- 6 **British Association for Accident and Emergency Medicine**. *The way ahead*. London: BAEM, 1998.
- 7 **Faculty of Accident and Emergency Medicine**. *Higher specialist training in accident and emergency medicine*. London: Faculty of Accident and Emergency Medicine, 2001.
- 8 **Department of Health**. *The NHS Plan. A plan for investment, a plan for reform*. London, Department of Health, 2000.
- 9 **District Audit**. *A&E services- a follow up*. London: 2001.
- 10 **British Association for Accident and Emergency Medicine**. *Audit standards*. London: BAEM, 2001.
- 11 **Beattie E**. *Report on the Outcomes Project*. London: Faculty of Accident and Emergency Medicine, 2001.
- 12 **The Voluntary Euthanasia Society**, London.
- 13 **British Medical Association**, Resuscitation Council (UK), Royal College of Nursing. *Decisions relating to cardiopulmonary resuscitation*. London: BMA, 2001.
- 14 **British Medical Association**. *Withholding or withdrawing life prolonging treatment*. London: BMA, 1999.
- 15 **Boyle M**. *Health Monitor Issue 4: Living wills*. Wansbroughs Willey Hardgrave Solicitors, 1995.
- 16 **Marquand PM**. *Introduction to medical law*. London: Butterworth Heineman, 2000.
- 17 **General Medical Council**. *Seeking patient's consent: the ethical considerations*. London: GMC, 1998.
- 18 **Medical Protection Society**. *Consent*. Leeds: MPS, 1998.
- 19 **Croner CCH Group**. *Croner's health service risks: management and practice*. Kingston, Surrey: Croner CCH Group, 1996.