



British Geriatrics Society Best Practice Guide

Clinical Governance and Older People (Good Practice Guide 1.5 published May 2008)

1. Clinical governance and older people in 2008

1.1 The British Geriatrics Society (BGS) believes that all specialists working in older people's health care are in a key position to improve and to monitor quality of care.

1.2 Clinical governance can be defined as *"A framework through which NHS organisations are accountable for improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish"*¹.

1.3 The BGS pioneered work on clinical governance in the late 1990s² and this was followed by a policy statement - Standards of Medical Care for Older People; Expectations and Recommendations³.

1.4 In 2001, the national service framework (NSF) for older people⁴ set out eight standards to improve experience of older people and their carers who use health, social care, and other services. A standard on medicines management followed later. More developed NSFs in the devolved Nations have followed e.g. Wales⁵ which again help set standards.

1.5 The Royal College of Physicians (RCP), London developed Good Medical Practice for Physicians in 2004 which suggested evidence and contained two standards for Physicians in Geriatric Medicine⁶. These could be used routinely to collect information about the quality of older people's services. Consultant appraisal is now well established and coupled with the clinical excellence award process can be positively used to enhance quality of clinical services.

1.6 The Chief Medical Officer report Good doctors, safer patients⁷, was published in July 2006 and set the direction for medical regulation and all aspects of clinical governance that go with it. The subsequent 2007 White Paper, Trust, Assurance and Safety - The Regulation of Health Professionals in the 21st Century⁸ and the subsequent legislation in the Health and Social Care Bill presently going through UK Parliament, will change the regulation of doctors forever.

1.7 It is therefore timely to review the BGS approach to clinical governance and the care of older people.

2. Defining quality of older people's services

2.1 Specialists caring for older people who carry out comprehensive assessments both in hospital and the community regularly come into contact with frail older people and should lead clinical governance processes. Clinical governance is about good practice and will help overcome the difficulties of working with multiple agencies, develop true partnerships and encourage team working.

2.2 Individual specialists are responsible for their own practice and should maintain high standards of care. A Physician's first responsibility must be to the patient and their safety and they must promote this within the broader multidisciplinary team.

2.3 Standards of care abound and there are many ways of collecting evidence on their achievement. Statutory bodies such as the Health Care Commission monitor these and patient and carer views are increasingly taken into account.

2.4 Bernard Isaacs described the "giants" of geriatrics: incontinence, immobility, impaired intellect and instability⁹. He asserted that if you look closely enough, all common problems with older people relate back to one of these giants. The approach to quality should particularly focus on these problems and be based on sound clinical audit, learning lessons from reviews of individual cases or the service as a whole and being up to date.

2.5 The BGS fully supports listening to patients and carers as an important "voice" when improving patient experience.

2.6 The BGS fully endorses the ongoing emphasis on improving patient safety and learning from things that go wrong. Documents such as Safety First¹⁰ and An Organisation with a Memory¹¹ are useful.

3. Responsibility of the individual clinician

3.1 Individual clinicians have a professional responsibility to keep up to date, undergo annual appraisal and to collect evidence of good medical practice. This applies equally to those who practice as consultants and to doctors in training. It is increasingly certain that appraisal and other necessary assessments of practice will be essential to relicensing as part of revalidation. The new guidance from the Royal College of Physicians of London on Appraisal and Revalidation is very useful in this regard¹².

3.2 Individuals should ensure they have evidence of continuing professional development (CPD) e.g. participate and achieve the requisite annual and five year cycle level of credits in Royal College of Physicians CPD schemes and follow the broad CME curriculum of the BGS. Over time individuals will need to demonstrate learning has occurred rather than simple attendance at meetings e.g. post event knowledge assessment, e-learning and knowledge based assessment.

3.3 Clinicians should participate meaningfully in high quality clinical audit (see section 5). At its best this should be truly multidisciplinary, should contain repeated audit cycles and ensure service or individual practice change.

3.4 Clinicians should routinely collect evidence of good team working e.g. multi-source or 360 degree feedback and be cognisant of patient and carer views e.g. patient satisfaction, learning from complaints, risk management profiles etc.

3.5 Those involved in teaching and training in the care of older people should be up to date and have knowledge of the latest assessments and seek regular feedback and peer review. Teaching the broader multidisciplinary team is to be encouraged. Individuals involved in research must maintain high standards of probity and ethics.

3.6 Clinicians should avoid potential conflicts of interest e.g. nursing home ownership and should consider probity and health issues as defined by the General Medical Council.

3.7 Clinicians should ensure that they and their Departments meet the recommended standards for medicine for older people defined by the BGS and set by the Royal College of Physicians. It is likely that this will be better defined over the next two to three years as the methods of medical regulation become clearer. Those involved in the acute medical take will also need to take into account standards for acute care.

3.8 The BGS recognises the need for defined sessions to carry out all these activities and strongly recommends the provision of adequate time for such supporting activities within consultant job plans.

4. Responsibility of the Department of Geriatric Medicine

4.1 The BGS recommends that all Departments have clear arrangements to deliver clinical governance with an identified leader and appropriate management and administrative support. If they are a Consultant or Clinical Director, he or she must be given time within the Job Plan to develop such an approach. Wide multidisciplinary involvement with the broader team e.g. nursing staff, pharmacists and therapists should be encouraged.

4.2 Departments should have regular clinical governance meetings in the form of CPD sessions (case presentation, guest speaker), clinical audit sessions and meetings to learn from incidents or complaints. These should become part of the everyday education and training activities and be attended by all grades of doctor and open to the wider multidisciplinary team. Action notes should be made of such meetings and registers of attendance should be retained. Demonstration of attendance and participation in meetings are key components of “supporting professional activities”.

4.3 Departments should have annual clinical audit programmes which cover the “geriatric giants” and meet standards for audit set out by the BGS and Royal College of Physicians Clinical Effectiveness Unit or SIGN Guidelines. Audit activities should be focused on National themes e.g. Sentinel Stroke Audit or Scottish Stroke Care Audit and Departments will require effective clinical management support. Junior doctors should undertake audits to complete the cycle after intervention rather than develop “one off” projects. Guidance about these can be found on the Clinical Practice Evaluation Committee section of the BGS website ¹³ in addition to hosting clinical guidelines on common problems of old age.

4.4 Regular “lessons learned” sessions from a review of incidents, medication errors, near misses and complaints should be held on at least a quarterly basis. Mortality review meetings with a focus on end of life care, palliative care and coroner referrals are important in this group of patients. Such sessions will require managerial and administrative support to both provide information and develop suitable service change.

5. Clinical audit and clinical effectiveness

5.1 The BGS has a track record of work in this area with the Clinical Practice and Effectiveness Committee delivering clinical guidelines and being instrumental in working with the RCP on National audits. Examples of guidelines would be those developed on delirium ¹⁴ and National audits on stroke, falls and continence ¹⁵.

5.2 Clinical audit should cover the key “geriatric giants” and many of these quality indicators are highlighted in Standards of Medical Care for Older People; Expectations and Recommendations ³.

- Mental health – assessment of cognitive function, mental capacity and issues such as power of attorney, use of antidepressants and major tranquilisers, use of delirium guidelines
- Falls - assessment, prevention, e.g. % of patients discharged on osteoporosis treatment after a fracture
- Continence - documented assessment and treatment plans for patients with continence problems, catheterisation rates in various ward settings
- End of life care - CPR, use of guidelines and documentation such as the Liverpool Care Pathway¹⁶, communication with carers, withdrawing and withholding artificial feeding and fluids, advanced directives
- Stroke - at a minimum participation in National sentinel stroke audit

- Medication review - number of patients discharged on more than four drugs, prescription chart audit, use of controlled drugs
- Infection – incidence of clostridium difficile and MRSA in clinical settings, hand hygiene audits, adherence to antibiotic policies
- Discharge arrangements – comprehensive geriatric assessment for all discharges, readmissions surveys

5.3 BGS encourages all Departments to have a rolling or annual programme for audit that all grades of doctor participate in. This would contribute to allowing the positive assertion to be made of meeting the standards expected of specialists in this area.

5.4 BGS with the RCP will work to produce standardised audits in these domains with for example standard databases for data collection. This should enable a move from high quality audit being the remit of enthusiasts to it becoming an every day part of the service. Clearly NHS resources and time will be required.

5.5 Guidance from bodies such as National Institute for Clinical excellence (NICE) or the Scottish Intercollegiate Guidelines Network (SIGN) should be used to inform practice and appropriate audits to ensure implementation is carried out. Key recent guidance relevant to older people would include clinical guidelines on Dementia ¹⁷, Head Injury ¹⁸, and the Management of Chronic Heart Failure ¹⁹.

6. Conclusion

6.1 The BGS strongly supports all attempts to raise the profile of clinical governance to improve the quality and safety of care delivered to patients. Geriatricians should continue to champion the issue which will improve care of older people and ensure high standards of professional practice.

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