

## Clinical Leadership in Clinical Governance

### Abstract Word

This project undertakes a medication administration audit aiming to embed a clinical governance model at the point-of-care. Adolescent Health (AH) has undergone significant organisational change with a shift to an adult procedural-context. The clinical context is a custodial environment for young people aged 10-21 years. Healthcare service involves multiple partner agencies with divergent philosophies for care. AH services are not 24-hours, reliant upon on effective continuity of care (CoC). The short length-of-stay relies on effective monitoring of pharmacotherapy interventions across CoC. The project has successfully embedded a clinical governance model, with a subsequent downward trend in medication errors. Future work will broaden measures to patient outcome and workforce development. The work is transferable to other NSW youth health settings.

### Aim

To undertake a medication administration audit within Adolescent Health with the aim of embedding a clinical governance model at the point of care

### Nature Of The Problem

AH has had significant organisational change moving from the governance of the Department of Juvenile Justice (DJJ) to Justice Health (JH). This shift brought a system of clinical governance and an adult procedural context. As AH services are not 24-hours, to maintain continuity of care (CoC) after hours medications are administered by non-health partner agencies. IIMS medication incidents and risky practice inconsistencies were evident across sites.

Medication administration policy review and practice development was required to ensure responsive reform. Clinical governance implementation was also underway requiring significant clinical leadership to embed an effective model at the point of care.

### Extent Of The Problem

All AH services within DJJ Centres across NSW and the Youth Drug Court were reviewed in terms of medication administration procedures. Methods included file/chart audits, staff focus groups, process- mapping, and patient-journey exercises. Medication administration procedures, key management, hand-over of duty-of-care to after hours staff (DJJ/DCS) medication effect monitoring, nurse initiated medication procedures, the preparation and pre-positioning of medications and clinical management processes were audited against legislation and policy.

Review of current practice / procedure identified several improvement areas specifically legislative non-compliance, dated policy directions and the impact of divergent interagency philosophies of care. Table1 highlights significant issues, which impacted on maintaining CoC with subsequent risks to patient outcomes. Retrospective chart, file audit, and IIMS analysis identified procedural errors indicating joint organisational accountabilities such as

medication packaging for later administration and charting errors (Table 2). Clinical governance was limited to IIMS reporting with an absence of responsive practice development.

**Table 1 – Nature of the problem – Affinity Diagram**

Clinical Redesign	Learning &Development	Procedural Issues	Performance Management
Timing /coordination of activities between JH & DJJ	No formal Change management in place	Partner agencies health not core business	Non-compliance with current procedures
No structured local procedures	Changes to accountability for practices	Changes to Legal requirements	No formal process for managing poor performance
Procedural variations	Therapeutic & adverse effect monitoring absent	Risky medication procedures for delivering / administering	

**Table 2 – Practice Error Analysis, Planning, and implementing solutions**

Practice errors	Pre-conditions/contributing factors	Practice Solutions
<p>Medication Administration Errors</p> <ul style="list-style-type: none"> <li>▪ Fundamental errors i.e. wrong drug, wrong patient, wrong dose and wrong route of administration</li> <li>▪ Patient diversion of medication to another young person</li> </ul>	<p>Absence of medication chart when preparing and administering medications</p> <ul style="list-style-type: none"> <li>▪ Poor work practice whilst administering medications on units</li> <li>▪ Insufficient supervision of detainees by DJJ/DCS</li> </ul>	<p>Standardising medication procedures across all sites. Risk analysis guided prioritisation</p> <ul style="list-style-type: none"> <li>▪ Performance management strategies</li> <li>▪ Learning and development strategies</li> <li>▪ Interagency security procedure review</li> </ul>
<p>Partner-agency Medication Administration Errors</p> <ul style="list-style-type: none"> <li>▪ Wrong patient</li> <li>▪ Drug diversion activities</li> <li>▪ Medications not given</li> </ul>	<p>Insufficient training of DJJ staff Organisational change delayed DJJ procedural review despite change in process</p> <ul style="list-style-type: none"> <li>▪ No agreed frameworks for practice within partner agencies</li> <li>▪ A lapse in security procedures related to supporting AH nurses in medication administration</li> <li>▪ Joint Clinical Governance still under development with no clear link to partner operations meetings</li> </ul>	<p>Joint interagency clinical governance process</p> <ul style="list-style-type: none"> <li>▪ Joint policy development</li> <li>▪ Joint learning and development activities</li> <li>▪ Joint process-mapping activities</li> <li>▪ Invitation to review learning modules and participate in teaching programs</li> </ul>
<p>AH Procedural Errors</p> <ul style="list-style-type: none"> <li>▪ Risky transport of medications</li> <li>▪ Incorrect charting (no allergies noted or wrong charts used)</li> <li>▪ Non-approved Nurse Initiated medications used</li> <li>▪ Off JH formulary medication used</li> <li>▪ Incorrect use of drug registers according JH policy</li> </ul>	<p>Organisational change required and delayed multiple policy reviews</p> <ul style="list-style-type: none"> <li>▪ Absence of safe work practices</li> <li>▪ Slow uptake and adherence to new JH guidelines</li> <li>▪ Absence of performance management guidelines for medication errors and some staff resistant to change</li> </ul>	<p>Procedural and practice development</p> <ul style="list-style-type: none"> <li>▪ Development of performance management matrix</li> <li>▪ Joint safe work practices</li> <li>▪ Contribute to JH formulary, nurse-initiated list and medication guideline development (over 150 changes for AH patient care contexts) (including external paediatric expert review)</li> </ul>
<p>Clinical Management/Medication related errors</p>	<ul style="list-style-type: none"> <li>• Absence of clinical management frameworks to link policy to patient outcomes i.e. asthma &amp; allergies &amp; skin rashes</li> <li>• Absence of metabolic effect monitoring procedures</li> </ul>	<p>Identified CoC matters group and establish meetings</p> <ul style="list-style-type: none"> <li>▪ Establish points of agreement and formalise practice development frameworks for staff</li> <li>▪ Develop Clinical Practice Guidelines (CPG) that articulate with partner agency procedures</li> <li>▪ Purchase and train staff on new equipment such ECG and pathology result management</li> <li>▪ Pilot and evaluate allergy &amp; asthma CPGs</li> </ul>
<p>Medical Charting Errors</p>	<p>Absence of medical engagement in clinical governance process Absence of feedback process on errors</p>	<ul style="list-style-type: none"> <li>▪ Medical officers now included in clinical governance and practice development activities</li> <li>▪ Communication channels (electronic and documentation) established with contracted General Practitioners</li> </ul>

### Strategic Importance

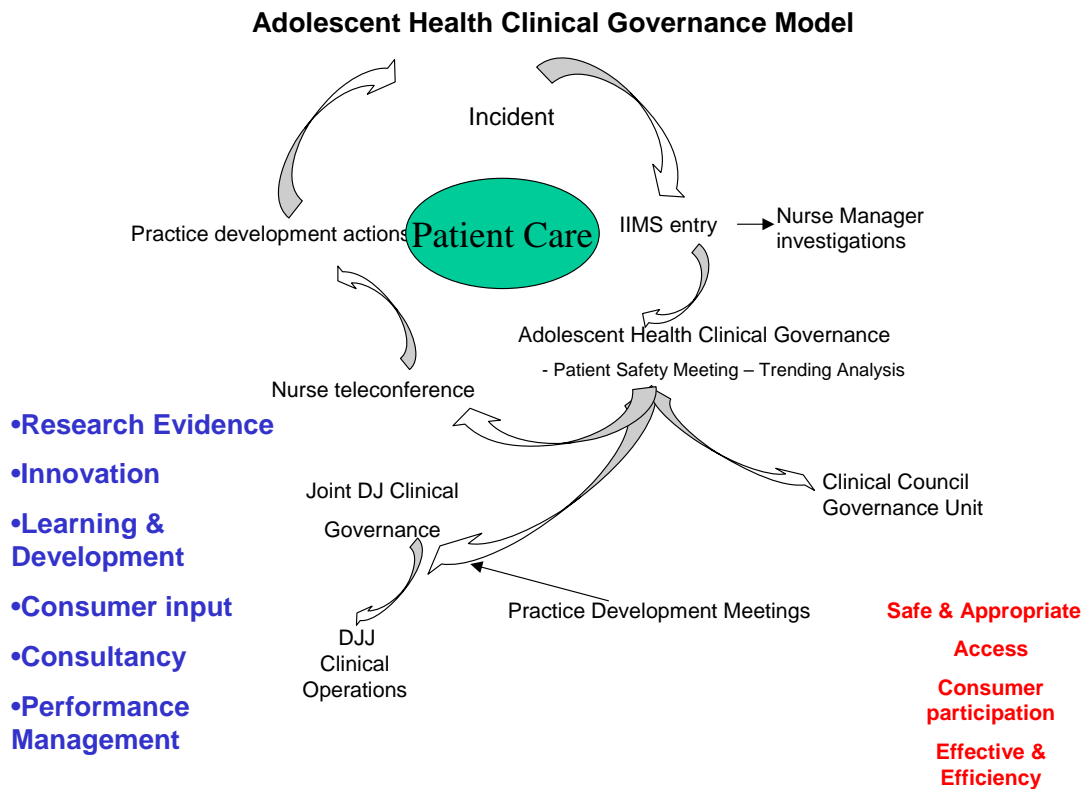
This project links with Strategic Direction 2; creating better experiences for people using health services. The project further links Strategic Directions 1, 3, 4, 6 and 7 by linking IIMS analysis and trending to practice and workforce development, CoC optimising patient outcomes. Project-work will improve the efficacy of pharmacotherapies targeting health drivers of offending behaviour and ameliorate the health impact of risky-behaviours with benefits for the young person and the community. The project links local strategies such as the implementation of clinical governance processes within AH and provides a major contribution to the JH Medication Administration Guidelines development and implementation.

### Planning And Implementing Solutions

The project team included AH staff, partner agencies delegates, and the young people. Planning required finding common-ground with partner agencies for clinical governance and shared medication administration accountabilities. Where possible, consultation occurred with young people in focussed groups or in conversations during patient-journey work. Further planning included thorough incident and practice analysis activities using the quality-cycle (Table 2 above).

Solutions involved imbedding a clinical governance model at the point of care (Table 3) that was responsive to JH and partner organisation accountabilities and, workforce culture needs. The process begins with the entry of an incident into IIMS and subsequent manger investigation. The next step brought the incident to the AH Patient Safety meeting (PSM) for discussion and to identify contributing factors and practice solutions. Further, the PSM undertakes contextual practice analysis to identify contributing factors in order to plan solutions (Table2). The clinical site managers then take back the information to the practice context for discussion and clinical solution planning with front line staff. A second meeting, the statewide teleconference, further involves the front line staff in clinical practice improvement, planning, and evaluation strategies (Table 2) and a third meeting for Joint Clinical Governance for CoC matters with partner agencies. The new clinical governance model was supported and approved by the Director of Adolescent Health (Diagram 1).

Diagram 1 – Adolescent Health Clinical Governance Model

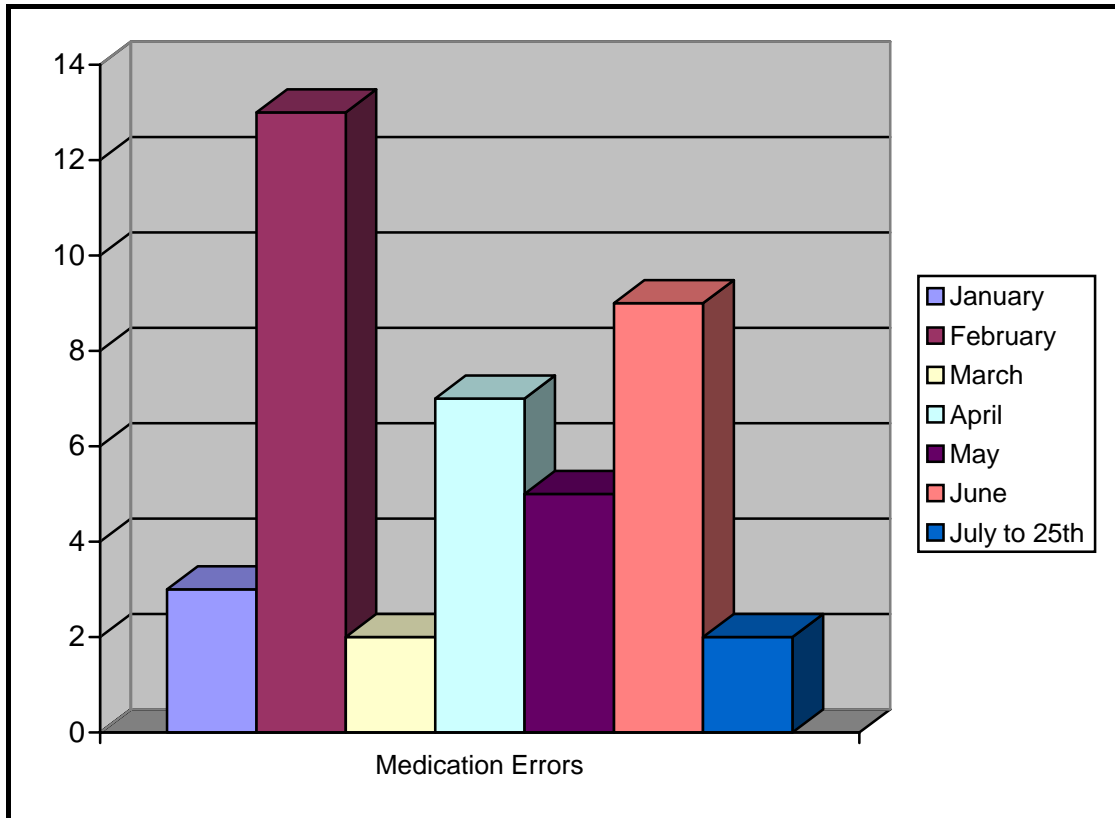


Finally, a practice development framework was required to ensure consistent and evidence based practice. The methodology of clinical practice guideline (CPG) development was selected as an effective approach to practice improvement. The CPG action plan includes all areas where policy is clear but where practice is confusing. Particularly given the AH clinical context of a custodial environment, partner agencies involved in the CoC, a short length of stay making efficient hand-over-of-care (often high risk pharmacotherapies) an imperative in clinical governance and practice development.

#### Outcomes And Evaluation

IIMS incidents and complaints related to these areas are now showing a downward trend (Graph 1) however longer time frames will improve evidence. Learning activities were developed to improve work force skills in valid consent, medication metabolic effect-monitoring, and the use of common pharmacotherapies. AH patient-incident numbers are small but interventions high-risk so broader measures such as patient outcomes and improved recruitment and retention are required.

Graph 1 – IMMS incidents Medication Errors Jan – July 25<sup>th</sup> 2007 – Indicating downward trend – most importantly error reporting increased in February (major changes to AH clinical governance procedures) and continued and still a downward trend



The success of Joint Clinical-Governance is evident in the numerous systems solutions reducing medication errors by partner agencies (Table 2 above). AH has been invited by partner agencies to review all learning modules related to CoC procedures and meetings to discuss CoC matters for procedural agreement such as asthma, allergy and hand-over-care management.

Process-mapping workshops have been undertaken with partner agencies with multiple changes in shared day-to-day healthcare provision such as timing of clinics and medication rounds. Safe work practice development has improved security with greater supervision of young people. An increase in the number of teaching resources at the point-of-care will assist in enhancing workforce skills sets in high-risk aspects of medication administration. A matrix has been developed to further assist Clinical Site managers with performance management at the point of care.

#### Sustaining Change

The ongoing implementation and evaluation of the AH clinical governance model, including joint clinical governance with partner organisations will maintain the quality cycle. Review and evaluation strategies embedded in AH business and clinical plans such as regular audit processes and staff/consumer/partner agency focus groups and broader outcomes such as increased staff retention and workforce-culture measures will be used sustain change. The embedding of clinical governance and practice development at the point-of-care is already showing evidence of sustained with increased

reporting. This work continually re-invest change management strategies and responsive workforce development in order to sustain achievement.

#### Future Scope

Clinical governance is a successful solution-focussed approach to practice improvement and workforce development to ensure evidence-based-practice can optimise patient outcomes. The importance of embedding the model at the point care cannot be understated. Successful Clinical Governance cannot be exclusive top-down prescriptive approach or done without considering workforce-culture, skills-sets, and organisational change. This approach is easily transferable to other NSW Health settings where young people with co morbid health problems frequently move between healthcare services. These transitions are reliant upon the efficacy of healthcare service attention to clinical governance in multiple CoC matters in particular pharmacotherapies in hand-over-of-care procedures between settings.