National Council for NCOR Osteopathic Research

Evidence-based practice tutorial – Clinical Governance for Practising Osteopaths

Many osteopaths have recently received communications from health insurers requesting information on their clinical governance policy. Clinical governance may not be as familiar to osteopaths in private practice as it is to those osteopaths who work in the NHS.

The arrival of clinical governance is a public recognition of the fact that quality, accountability, transparency and continuous improvement are vital aspects of the life of any health care professional. The establishment of good practice management, patient management and care pathways all help to facilitate the many facets of clinical governance. "Clinical Governance encourages a culture of excellence, partnership and accountability." [1] It is an important aspect of clinical governance to learn from successes as well as recognise areas where improvements in standards and performance are required. The key areas to consider with clinical governance are:

- Standards of professional performance (technical quality).
- Resource use (efficiency with which the practice runs and the patients are treated).
- Risk management (the risk of injury or illness associated with the services delivered).
- Patients' satisfaction with the service(s) provided.

Many publications focus on key criteria that are an implicit part of clinical governance: a number of these are considered in turn:

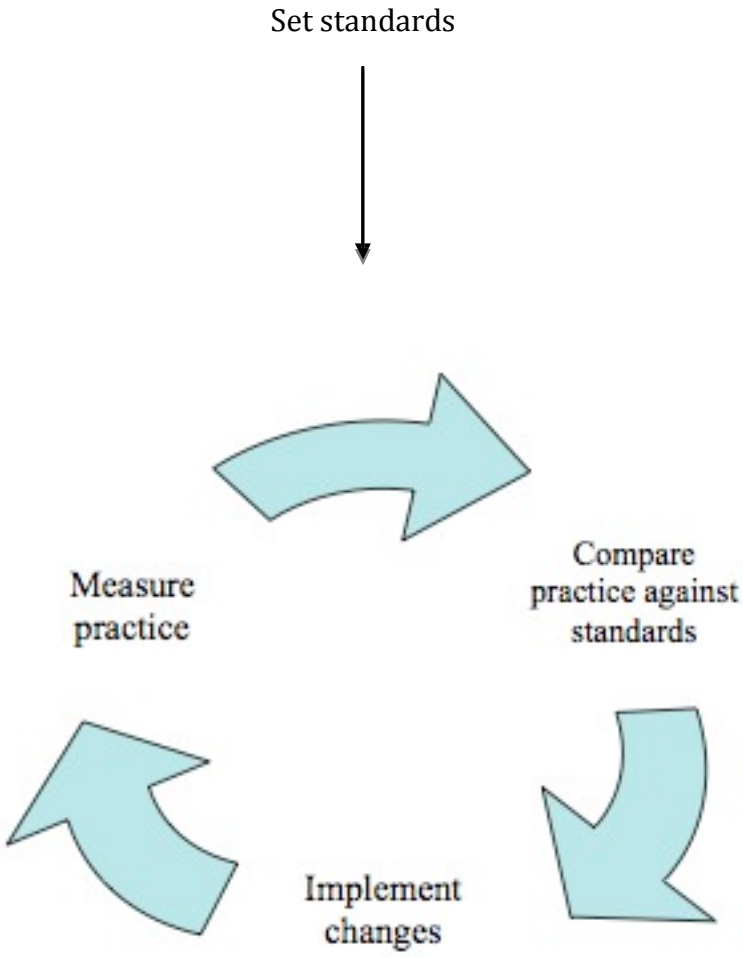
1. Quality improvement processes e.g. clinical audit.

Quality improvement remains at the heart of the clinical governance. A number of strategies need to be in place to facilitate this process. There must be:

- The creation of a culture of awareness of the importance of quality improvement.

- The introduction of systems to identify obstacles to quality and quality improvement.
- Development of strategies to overcome the obstacles identified.
- Focussing on identified deficiencies in care and monitoring changes.

Clinical audit is a cyclical process and can be the starting point to address quality monitoring and improvement monitoring.



The Audit Cycle

A number of obstacles can exist to making changes to improve quality; these can include:

- Lack of knowledge, time or skills
- Lack of awareness of the need for change
- Unconvinced of the need for and value of change
- Poor communication about what the change will involve

- Conflicting objectives between practitioners
- Limited resources
- Lack of leadership within the practice setting

Identifying the obstacles to change can be carried out in a number of ways e.g. questionnaires, interviews, practice meetings or feedback from patients. Once the obstacles have been identified appropriate workable strategies can be developed to overcome the obstacles.

2. Evidence-based practice with the infrastructure to support it.

Evidence-based practice is one of the key components of clinical governance. It can be described as "the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients, integrating individual clinical expertise with the best available external clinical evidence from systematic research" (Bury & Mead, 1998)2. It requires practitioners to

- Ask questions in a focussed manner
- Locate the evidence to answer the questions
- Critically appraise the available evidence
- Apply the evidence in an appropriate manner
- Evaluate performance(s) based on the application of that evidence.

Asking a question in a focussed manner can be achieved by using four components:

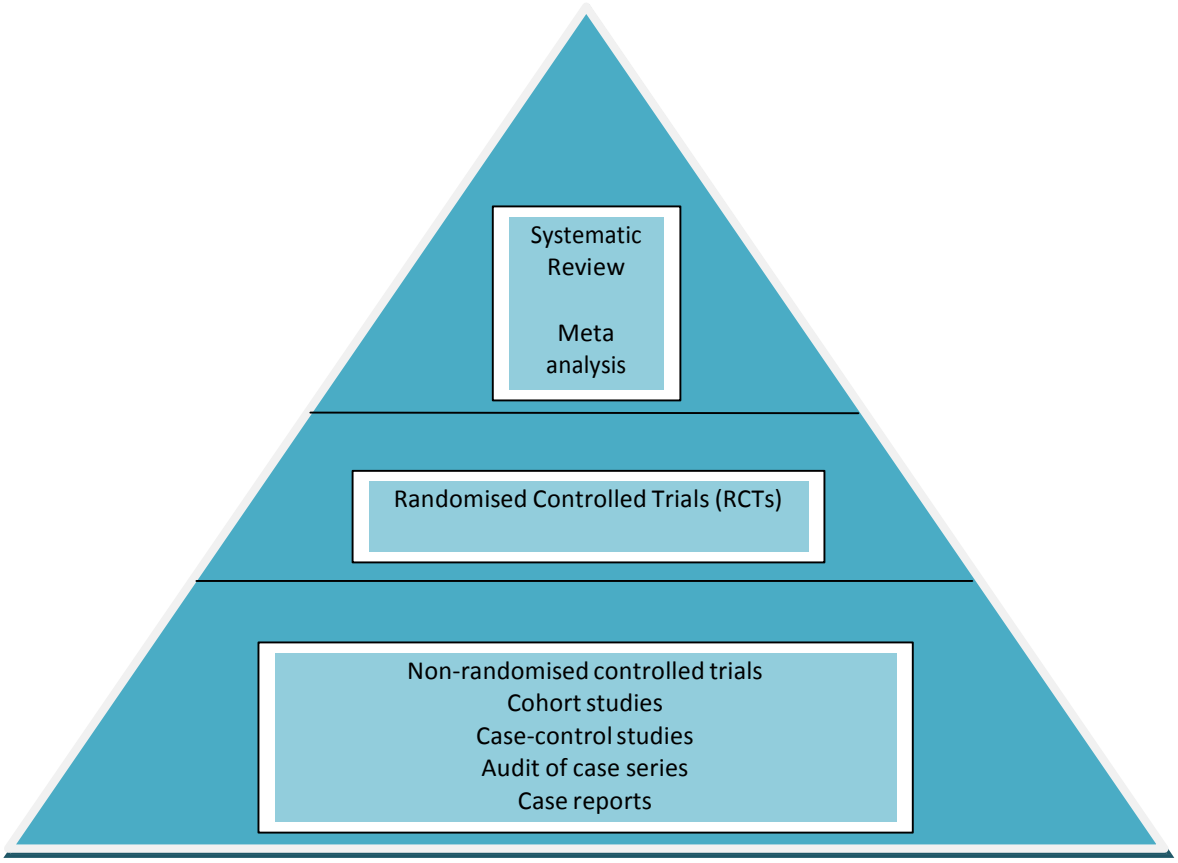
Patient, population or problem

Intervention

Comparison or control intervention (if appropriate)

Outcome(s)

Locating the evidence can be achieved by searching a number of scientific databases. A hierarchy of evidence exists based on the suggested reliability of the evidence:



The categories represented above are explained further in the table below:

Level	Evidence
Ia	Evidence from systematic review and meta-analysis of randomised controlled trials
Ib	Evidence from at least one randomised controlled trial
IIa	Evidence from at least one controlled study without randomisation
IIb	Evidence from at least one other type of quasi-experimental study
III	Evidence from non-experimental descriptive studies, such as comparative studies, correlation studies and case control studies
IV	Evidence from expert committee reports or opinions and/or clinical experience of expected authorities

A number of tools exist to assist with the appraisal of research literature. An example of these can be found at: www.phru.nhs.uk/casp/critical_appraisal_tools.htm.

Information within health care is changing at an alarming rate; it can be extremely difficult to become familiar with all of it, but patients will want to discuss the best possible options available to them in terms of currently available treatments. Evaluating

whether performances have changed based on the application of evidence- based practice can be carried out in a formal manner or can be undertaken informally by practitioners.

3. Good practice, ideas and innovations systematically disseminated.

A wide number of interventions can be used to attempt to change clinical behaviour within practice. No single interventions are effective under all circumstances. The maintenance of good standard of practice is of prime importance to all health care practitioners and this is increasingly set against a background of rising accountability. A number of strategies can be used to facilitate the implementation of evidence. These can include **broad strategies** which can include clinical guidelines e.g. RCGP, CSAG guidelines and continuing professional education activities; **specific behaviours** can be targeted which can include targeting specific behaviours e.g. giving focussed reminders concerning advice on posture to patients. **Specific interventions** can also be given which can include disseminating educational materials e.g. information leaflets for patients and practitioners or educational outreach visits e.g. specialists or local opinion leaders giving talks within the practice environment. **Reminder systems**, carried out manually or by computer, can be helpful and could include reminders about research-based strategies giving information concerning the most effective management of particular disorders. Similarly reminders to undertake periodic checks e.g. blood pressure can be helpful. All of these strategies can be employed in isolation or in combination. Research indicates that activities where significant interaction is required are most likely to be effective. Passive dissemination of information is the least effective strategy to facilitate change in behaviour and clinical practice.

4. High-quality data to monitor clinical care.

The quality of data and the quality of its use are two important considerations within clinical governance. The types of data collected and how it is collected will vary between settings e.g. private osteopathic practice and NHS-based osteopathic practice. The type of indicators that need to be collected for data purposes in private osteopathic practice can include e.g.

Area	*Example of indicator*
Access	Time taken to obtain 1st appointment
Patient experience	Number of missed first appointments
Patient experience	Number of missed follow up appointments

5. Clinical risk reduction programmes.

The identification, assessment and management of risk are important components of clinical governance; risks that can be foreseen can potentially be prevented. Patients have the right to expect good standards of clinical practice and care from osteopaths and other health care practitioners. Practitioners are expected to be professionally competent and perform consistently well. In doing so they also have to strike a balance between the potential for doing good and the potential for doing harm.

Non-clinical risks

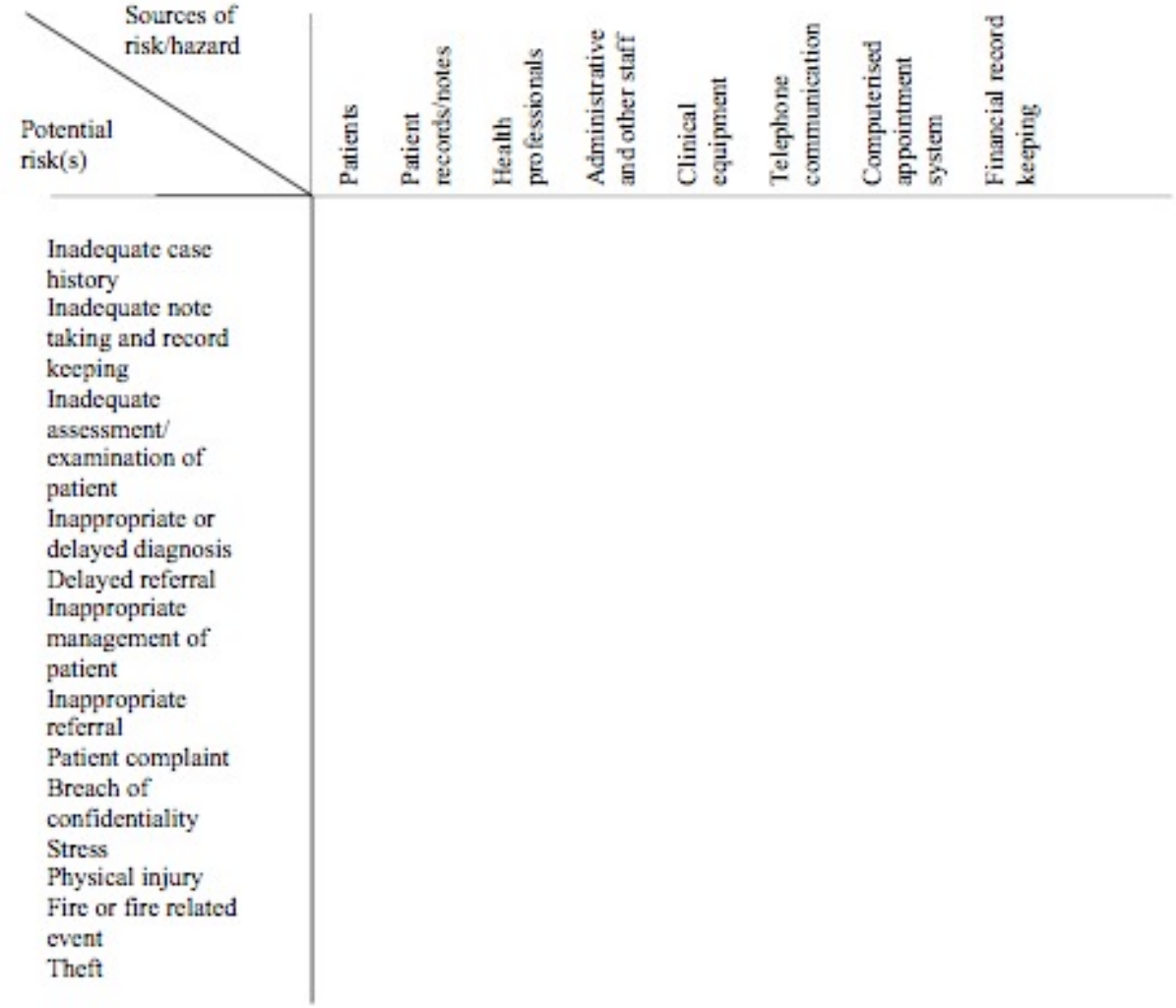
Practice premises can present a variety of risks. The Health and Safety at Work Act (1974) requires any practice with five or more practitioners to have a health and safety policy, and practices should undertake a health and safety assessment to identify potential risks to patients, visitors and staff. Risks can include e.g.:

- stairs and stairwells
- ornamental ponds in grounds surrounding a practice to which patients have access.
- hazardous chemicals e.g. cleaning fluids
- sharps e.g. acupuncture needles
- electrical equipment
- clinical waste e.g. following acupuncture or dry needling treatments.

Other potential hazards can be from working alone or undertaking home visits without suitable mechanisms in place to specify location and times of visiting, and chaperoning.

Risks associated with communication can also occur when patients, experiencing an unexpected reaction to treatment, cannot contact their osteopath for advice and reassurance. Mechanisms can easily be put in place to identify a key person with responsibility for dealing with such eventualities or for attempting to contact the osteopath concerned.

While some risks are easy to identify and deal with, others can be surprising and require significant resources to deal with them. A form of risk assessment is likely to be effective if it is carried out in a systematic and detailed fashion. One of the most straightforward approaches is to try and correlate potential risks or hazards to possible sources. A matrix format can be used to accomplish this; an example is shown overleaf.



Once some of the risks associated with practice have been identified, strategies can be put into place to attempt to deal with those risks.

6. Significant events detected and openly investigated.

Significant events occur in all practices and can be defined as "events that give a good understanding of the care that an individual or team delivers". This is in contrast to an adverse event when something clearly has gone wrong; exactly what has gone wrong must be established, whether the incident was preventable and the type of appropriate response required. The lessons learned from such events must be promptly applied. Following the occurrence of a significant event the following outcomes should be examined:

- Clearly record what occurred and when, who was involved and the actions taken.
- Identify where good practice was demonstrated.
- Identify where practice was less satisfactory.

- Identify areas where further information is required and the potential source of such information e.g. regulator's guidelines, published research literature.
- Read and assimilate this information.
- Identify changes required and implement these appropriately; include all staff in these changes and clearly explain how and why the change is occurring.
- Identify the lessons learned from this situation.
- Monitor practice at a future interval e.g. six months, to ensure that any changes implemented continue to be observed.

7. Problems of poor clinical performance recognised at an early stage and dealt with.

All osteopaths are aware of the need to keep their skills up to date in order to deliver a consistently high standard of care. This principle of maintaining high clinical standards is enshrined in clinical governance. Education can be key to maintaining high standards by refreshing knowledge and further developing or refining skills. Education can take place formally in the guise of post-graduate courses or informally with colleagues or by self study. Some practices may have regular meetings to discuss issues occurring within the running of a clinic or to discuss interesting patients within clinical practice; other practices have established journal clubs to examine current literature related to particular areas of practice and how this relates to the management of patients.

Clinical governance also examines competence of practice as part of quality assurance. The use of appropriate outcome measures can play a significant part in this aspect of care. Examples of outcome measures were given in last month's edition of *The Osteopath*. Further examples of outcome measures can be found at www.csp.org.uk.

References

1. *Clinical Governance in Primary Care*. Eds Zwanenberg T v; Harrison J. Radcliffe Medical Press, 2000

2. *Evidence-based Healthcare.* Bury T and Meade J. Butterworth-Heineman, 1998.

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