

# CLINICAL GOVERNANCE FRAMEWORK

## Definition of Clinical Governance in Relation to Hafan Wen

A framework through which NHS organisations are accountable for continuously improving the quality of its services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish (Donaldson, L. Gray, J. 1998).

The Clinical Governance Framework for Hafan Wen will be written and developed locally and will consider the following:

- Roles and Responsibilities of key personnel to include lines of accountability.
- Required skills knowledge.
- Training needs.
- Resources to implement Clinical Governance.
- Required outcomes of the implementation.

There are a number of key principles that will underpin the implementation of the Clinical Governance Framework:

- ***Change Management:*** Change is managed in a systematic demonstrable way, moving away from a culture of “blame” to one of learning so that quality infuses all aspects of Hafan Wen work.
- ***Patient focussed:*** All elements of clinical governance must be focussed on improving the quality of patient care.
- ***Partnerships:*** Clinical Governance demands partnerships between clinicians (nurses, doctors, etc), between clinicians and manager, and clinicians and patients.
- ***Patient/User Involvement:*** The involvement of patients is essential to effective clinical governance.
- ***Nurses’ Involvement:*** Nurses have a key role to play in implementing all aspects of clinical governance at Hafan Wen and maximum use should be made of their skills and expertise around improving quality.
- ***Culture:*** An improvement based approach to quality in health care needs to create an enabling culture which celebrates success and learns from mistakes, rather than seeking to attribute blame.
- ***Openness:*** Clinical Governance applies to all Hafan Wen staff and must be defined and communicated clearly so that all staff understands its relevance to their work.

**CLINICAL GOVERNANCE**

**ANNUAL REPORT 2007-2008**

QUESTION	ACTION TO DATE	RESULTS	FURTHER ACTION PLANNED
<p><b>1. <u>Quality Improvements</u></b></p> <ul style="list-style-type: none"> <li>• Are nominated individuals responsible for Quality Improvements?</li> <li>• Is there a framework in place to ensure all key aspects of Quality Improvements are implemented and influence daily practice?</li> </ul> <p>a) <b><u>Audit</u></b></p> <p>Are key individuals responsible for each priority Audit?</p> <p>Is there an Audit programme in place?</p>	<ul style="list-style-type: none"> <li>• Quality Improvement Committee now expanded to company level, via Quality Improvement Team.</li> <li>• Quality Improvement Framework underpins all areas of Review within Hafan Wen.</li> <li>• <b>YES</b>, key individuals are nominated and responsible for initiating and reporting of results.</li> <li>• <b>YES</b>. Areas agreed for Priority Audit.</li> </ul> <p>1. Clinic Audit</p>	<p>Service Framework Document completed.</p> <p>Hafan Wen Feedback Loop Process developed.</p> <p>• Reported as part of Hafan Wen Feedback Loop Process.</p> <p>Completed quarterly</p>	<p>Continuous update and review of Framework.</p> <p>Implemented Hafan Wen Feedback Loop Process (see appendix 1). Format of communication loop changed and implemented.</p> <p>On-going</p>

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<p>Is there an Audit programme in place?</p>	<p>2. Catering Audit</p> <p>3. Nursing Process (Case Note)</p> <p>4. Care Planning- processes and implementation</p> <p>5. Cleanliness Audit</p>	<ul style="list-style-type: none"> <li>• Catering service provision reviewed and new processes implemented in May 2006</li> <li>• Format changed to live case-note audit</li> <li>• Key-working and care planning process changed</li> <li>• Improvements recorded since implementation, via case-note audit and Service User feedback Questionnaire (appendix 2)</li> <li>• Bi-annual Audit of cleanliness of Hafan Wen, carried out by Domestic Services Supervisor, (appendix 3)</li> </ul>	<ul style="list-style-type: none"> <li>• Re-Audit completed, overall feedback via Service User Satisfaction questionnaire (appendix 2)</li> <li>• Continue live audit</li> <li>• Clinical Manager to lead on implementing audit of current practice.</li> <li>• Continue with audit.</li> </ul>

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<p>b) <b><u>Change Management</u></b></p> <p>Is change managed effectively, making use of Change Management Tools?</p> <p>Is change managed as an open, inclusive process for staff and patients?</p>	<ul style="list-style-type: none"> <li>• <b>YES</b>, Policies and Procedures reviewed and changed using appropriate tools, processes and involvement: <ul style="list-style-type: none"> <li>▪ Visiting Policy</li> <li>▪ Unescorted Leave Policy</li> <li>▪ Therapeutic programme</li> <li>▪ Urine Testing Procedures</li> <li>▪ Key-working and care planning processes.</li> </ul> </li>   <li>• Implemented Hafan Wen Feedback Loop Process <ul style="list-style-type: none"> <li>○ Team meetings held monthly</li> <li>○ Patient/staff meetings held weekly</li> <li>○ Service user forum held monthly</li> </ul> </li> </ul>		<ul style="list-style-type: none"> <li>• Reviews completed following implementation policy changes maintained: <ul style="list-style-type: none"> <li>○ Therapeutic programme</li> <li>○ Unescorted Leave Policy</li> <li>○ Urine testing procedures</li> <li>○ Visiting Policy</li> </ul> </li>   <li>Continue with Implementation of Hafan Wen Communication Loop Process</li> </ul>

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<p>c) <b><u>Clinical Effectiveness/ Standards</u></b></p> <p>Are individuals responsible for the setting of Clinical Standards and Reviewing Clinical Effectiveness?</p> <p>How are Clinical Standards set?</p> <p>Is there a review plan for measuring Clinical Effectiveness?</p>	<ul style="list-style-type: none"> <li>• <b>YES</b>, Clinical Manager leads in all aspects of Clinical Management in conjunction with Quality Standards Committee.</li> <li>• Quality Improvement Team established in CAIS to include setting of standards.</li> <li>• Guidance from National Service Framework.</li> <li>• Reviewed by Clinical Governance committee.</li> </ul>		

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<p>d) <b><u>Benchmarking</u></b></p> <p>Is benchmarking used actively to measure service delivery with the appropriate services?</p> <p>e) <b><u>Evidence Based Practice</u></b></p> <p>Do all Clinicians have access to appropriate databases to underpin effective, safe practice?</p> <p>Do all Clinicians have access to internet facilities for research and academic use?</p> <p>Do all Clinicians have access to local resources within the Unit?</p> <p>Do all Clinicians have access to Library facilities?</p>	<ul style="list-style-type: none"> <li>• <b>YES,</b> Benchmarking used successfully in the change management process when reviewing: <ul style="list-style-type: none"> <li>▪ Therapeutic programme</li> <li>▪ Visiting policy</li> <li>▪ Changes to Unit rules</li> <li>▪ Unescorted Leave Policy</li> <li>▪ Key-working</li> </ul> </li> <li>• <b>YES,</b> all Clinicians have access to computers at Hafan Wen.</li> <li>• All Clinicians offered training from accessing database.</li> <li>• All Clinicians now have access to computer with internet facility at Hafan Wen.</li> <li>• Unit resource facility/library established.</li> <li>• Resources increased</li> <li>• <b>YES,</b> in-house Library</li> <li>• College Library.</li> </ul>	<p>Changes to Policies/Procedures</p>	<p>Review all policies every 12 months</p> <p>Unit Manager and Clinical Manager to develop proposal to present to CAIS Re development of process for accessing further knowledge base such as Athens and Howis.</p> <ul style="list-style-type: none"> <li>▪ Library catalogue made available via CAIS intranet 2006.</li> </ul>

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<p>1. e) Is evidence of effectiveness and good practice implemented in local clinical protocols?</p> <p>2. <b><u>Risk Management</u></b></p> <ul style="list-style-type: none"> <li>• Are individuals responsible for all aspects of Risk Management?</li> <li>• Is Risk Management systematically analysed so change can be made to working practice?</li> </ul>	<ul style="list-style-type: none"> <li>• Service Framework complete.</li> <li>• Hospital Manager carries overall responsibility and accountability for Health &amp; Safety.</li> <li>• Health &amp; Safety Committee established.</li> <li>• Critical Incident/Near Miss Policy &amp; Procedure developed, including Incident Review Panel, Process and Reporting.</li> <li>• Review Panel/Committee meet Bi-annually.</li> <li>• Reports produced on a bi-annual basis and fed into Annual Clinical Governance Report.</li> </ul>	<ul style="list-style-type: none"> <li>• Therapeutic programme reviewed and established.</li> <li>• Staffing structure changed to employ specific trained Group Worker.</li> <li>• Bi-annual Reports produced</li> </ul>	<ul style="list-style-type: none"> <li>• Evaluate program every 6 months</li> <li>• Provide group work feedback report annually (appendix 4)</li> </ul> <p>Annual Report to include overall Data and Statistics for 4 Quarters. (see appendix 5)</p>

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<p>3. <b><u>Workplace Planning</u></b></p> <ul style="list-style-type: none"> <li>• Are all staff given the opportunity to reflect on practice with a more experienced practitioner?</li>   <li>• Is there an induction process in place for new starters and students?</li> </ul>	<ul style="list-style-type: none"> <li>• New Supervision and Appraisal Framework established, and working effectively</li> <li>• Peer/group supervision carried out informally on daily basis – issues raised brought up in Clinical or Management Supervision as appropriate.</li>   <li>• CAIS Induction Day now in place.</li> <li>• CAIS Induction Pack and Hafan Wen induction packs now implemented</li> </ul>	<p>Implemented with current Nurse Student placements</p>	<p>Review Annually</p>

<u>QUESTION</u>	<u>ACTION TO DATE</u>	<u>RESULTS</u>	<u>FURTHER ACTION PLANNED</u>
<p>4. <b><u>Management Poor Performance</u></b></p> <ul style="list-style-type: none"> <li>• Is there an individual responsible for management of poor performance?</li> <li>• Does the service routinely monitor the performance of individual key workers?</li> <li>• Does the service routinely monitor the delivery of the therapeutic programme?</li> <li>• Are procedures in place for reporting and acting upon concerns of staff regarding poor performance of colleagues?</li> </ul>	<ul style="list-style-type: none"> <li>• <b>YES</b>, Committee established.</li> <li>• <b>YES</b>, Nursing Process (Case Note) audit developed to return data on individual key worker as well as overall service delivery.</li> <li>• New Therapeutic programme implemented September 2006.</li> <li>• Whistle Blowing Policy now completed with appropriate procedures.</li> </ul>	<ul style="list-style-type: none"> <li>• Reported as part of Hafan Wen Feedback Loop Process to team</li> <li>• Discussed via annual appraisal with individual staff</li> <li>• Monitoring format established</li> <li>• Service user Feedback reviewed as part of Quality Team meeting.</li> </ul>	<p>Report annually (appendix 4)</p>

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<p>5. <b><u>Research &amp; Development</u></b></p> <ul style="list-style-type: none"> <li>• Are individuals responsible for research &amp; development?</li> <li>• Are protocols in place to encourage and support staff to identify research questions?</li> <li>• Are staff involved in their own professional and personal development?</li> <li>• Is there a framework in place to discuss or set Annual Training Plan?</li> </ul> <p>6. <b><u>Complaints &amp; Commendations</u></b></p> <ul style="list-style-type: none"> <li>• Are individuals responsible for dealing with complaints?</li> </ul>	<ul style="list-style-type: none"> <li>• <b>YES</b>, Committee established.</li> <li>• <b>NO</b>, specific protocols at present, staff reluctant unless part of directed study.</li> <li>• <b>YES</b>, Appraisal process and Protocols.</li> <li>• Appraisal process.</li> <li>• Complaints procedure reviewed.</li> </ul>	<p>As advised by Healthcare Inspectorate Wales, All Wales Research Policy adopted.</p> <ul style="list-style-type: none"> <li>• Training plan developed 2008-2009</li> <li>• Internal complaints process agreed with CAIS Complaints Procedure.</li> <li>• Included in Patients Handbook.</li> </ul>	<ul style="list-style-type: none"> <li>• Included in annual report (see appendix 6).</li> </ul>

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<ul style="list-style-type: none"> <li>• Are complaints reviewed in order to highlight service deficiency and influence change?</li> </ul> <p><b>7. <u>Service User Involvement</u></b></p> <ul style="list-style-type: none"> <li>• Does the service use methods to gain feedback from patients?</li> <li>• Does the service use feedback to bring about quality improvements?</li> <li>• Are service users consulted when discussing changes to service provision?</li> </ul>	<ul style="list-style-type: none"> <li>• Complaints and Commendations Review Panel established.</li> <li>• Satisfaction Questionnaire reviewed and re-developed.</li> <li>• Satisfaction Questionnaire results reviewed by Quality Improvement Committee and recommendation made.</li> <li>• Service user forum as part of Hafan Wen Feedback Loop process used to inform policy changes: <ul style="list-style-type: none"> <li>▪ Therapeutic programme</li> <li>▪ Daily management changes</li> <li>▪ Core rule changes</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Review Panel bi-annual reports completed</li> <li>• Improved measurements being produced.</li> <li>• Changes made to relevant policies</li> </ul>	<ul style="list-style-type: none"> <li>• CAIS Complaints Manager Mr J P Williams</li> <li>• Report included in annual report (see appendix 7)</li> <li>• Report to be included in annual report ( see appendix 2)</li> <li>▪ Continue with present forum and processes</li> <li>▪ Service user group established in North Wales, Established partnership working relationship.</li> </ul>

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<p>8. <b><u>Management of Confidential Information</u></b></p> <ul style="list-style-type: none"> <li>• Are individuals responsible for safeguarding confidential information of patients and staff?</li> <li>• Is there a framework in place to review if Policy &amp; Procedures are appropriate and effective?</li> </ul>	<ul style="list-style-type: none"> <li>• Director of CAIs nominated as lead.</li> <li>• CAIS Policy/Procedure Committee established to review and report all policies/procedures annually</li> </ul>	<ul style="list-style-type: none"> <li>• CAIS Caldicott Guardian nominated as member of the board.</li> </ul>	<ul style="list-style-type: none"> <li>• Awaiting first report and first phase of .</li> </ul>

