How clinical governance can enhance care for older people

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This article suggests that nurses can use clinical governance continually to update and improve the quality of care offered to older people. Although nurses have made great efforts to improve care over the past 25 years and have succeeded in creating isolated areas of excellence, many older people continue to experience suboptimal care. Health care providers now recognise that older people require teams with specialist knowledge to ensure that they are provided with the best possible treatment.

The issue of inadequate care for older patients was highlighted more than two decades ago by Wells (1980), who observed that geriatric nurses were very busy and worked very hard – but the problem was that they were busy doing the wrong things.

Today, older people continue to experience suboptimal care; for example, patients who have had strokes may be catheterised unnecessarily, or catheters that should be removed are left in situ in those who are immobile after orthopaedic surgery. When there is a shortage of physiotherapy time, again it is older people who suffer.

Older people are still not rehabilitated effectively in many care settings and they are more vulnerable to the effects of inappropriate and poor-quality care than any other group of adults. Providing effective research-based high-quality care is vital – and clinical governance can help us achieve that goal.

The policy agenda

In the past, quality issues were not considered a priority in the NHS (Gray and Donaldson, 1996), but this has now changed. The government has introduced national policy changes aimed at improving care quality (Department of Health, 1998; 1997), which involve delivering improvements using a concept called clinical governance. Although this encompasses elements such as clinical audit that have been employed for many years, the concept has an underlying framework and incorporates coherent scrutiny of organisations – both of which are new elements (Lugon and Secker-Walker, 2001).

Clinical governance aims to address underperformance, learn lessons from excellent organisations and improve quality of care (Scally and Donaldson, 1998). It indicates a move from viewing patients as passive recipients of care to seeing them as partners in care. The concept requires high-level management skills and major changes in NHS culture (Cook, 2001); it also expects the reconciliation of management and learning objectives (Ferguson and Lim, 2001), and the resolution of tensions between a centralised command-control culture and a localised culture that is innovative and responsive to local needs.

Quality in the care of older people

Concerns about the quality of care older people receive have been voiced since the foundation of the NHS (Wells, 1980; Norton et al, 1962). Half a century later, Health

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**REFERENCES**


Advisory Service 2000 (1998) identified eight major issues affecting the care of older people (Box 1). Yet, six years after the publication of the HAS report, older people continue to experience poor-quality care (Help the Aged, 2002) (Box 2).

Older people have greater difficulty accessing NHS services than younger people. Some services have explicit age restrictions, while others are unofficially restricted. For example, a survey of GPs undertaken by Age Concern (2000) found age limits on procedures, including coronary artery bypass grafting and renal dialysis. Although high-dependency care is often clinically indicated postoperatively for people over the age of 90, only 4 per cent are admitted to high-dependency units (National Confidential Enquiry into Perioperative Deaths, 1999).

Clinical governance and older people

Introducing the internal market into the NHS prevented multi-agency cooperation and led to inequity of access (Robinson and Le Grand, 1994). Modernisation has meant that the NHS has had to become more responsive to the people it serves but bureaucratic and formal structures are ill-suited to this approach. Within clinical governance there are tensions over the need for central targets, such as those set out in the national service frameworks, and the need for services that are sensitive to local needs.

If the NHS is to deliver a high-quality service it must ensure that all older people, its major user group, receive excellent care. The health service is currently a reactive service: in 1999 two-thirds of patients were admitted as emergencies (DoH, 2001a). The health service is currently a reactive service: in 1999 two-thirds of patients were admitted as emergencies (DoH, 2001b). They are vulnerable to deconditioning; for example, the loss of muscle strength and the ability to carry out their normal activities if clinical care is not of the highest quality (Covinsky et al, 2003) (Box 3).

The report An Organisation With a Memory (DoH, 2000) acknowledges that adverse events occur in about 10 per cent of admissions and that service failures can have serious consequences for patients. Older people may become confused because of their illness and are vulnerable to service failures. Confused older people may not realise that they are receiving the wrong medication or an incorrect dosage, or treatment that is not appropriate for them.

If the NHS is to deliver high-quality care, it must become a proactive service. There has been progress over the decades but it is difficult to determine its extent because trusts use different calculation methods (National Audit Office, 2003).

Clinical governance differs from previously used systems – that have all failed – because it is a coherent framework; it is not a series of unrelated initiatives. It requires commitment from all levels of the organisation and a change in focus from a service that is largely reactive to one that is proactive and effective. If clinical governance is to succeed, those of us delivering clinical care at the bedside need to lead change.

Addressing quality issues

We can use a clinical governance cycle (Fig 1) to address and find solutions to the following issues:

- Ageism and inequitable access to care and rehabilitation services;
- Poor standards of care;
- Unprofessional conduct, such as rudeness and neglect;
- Poor understanding of the needs of older people;
- Lack of expertise in the care of older people;
- Lack of involvement in care, and discharge planning that is poor.

Standards in the care of older people

We now have evidence-based guidance on many interventions and treatments. The challenge is to incorporate the evidence into everyday practice so that the older person who has had a stroke, for example, is encouraged and enabled to regain mobility, continence and life skills.

Clinical governance aims to set standards to enable clinicians to use effective treatments and to enable managers to develop a coherent system where excellence can flourish. To support this process, a set of national service frameworks (NSFs) have been devised, which are a set of evidence-based standards that organisations must meet. The National Service Framework for Older People...

**Keywords**

Management, Older people, Clinical governance

**References**


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The care of older people is plagued by images of disability and death, rather than ones of rehabilitation, rebirth or palliative care that can improve quality of life. These perceptions have impeded the delivery of high-quality services for decades and, until recently, there has been little recognition of the specialist skills and knowledge that is required to care for older people (McCormack and Ford, 1999).

Standard four

This seeks to address a number of issues in general hospital care. These include poor physical environment, mixed-sex wards and issues regarding patients’ privacy and dignity. It also seeks to address the central issue in the care of older people – that of having the right care delivered by people with the appropriate knowledge and skill to deliver it.

People

Although the clinical governance framework provides clear standards, it is important to remember that all standards have their limitations and can even be potentially harmful (Woof et al, 1999). For example, standards may be inappropriate for individual patients as case study 2 illustrates (Box 4).

Clinical practice is informed by research and innovation, and changes over time. If the evidence is interpreted inappropriately or if it is flawed in the first instance, patients may experience suboptimal, ineffective or inappropriate care. However, there is a danger of stifling rather than encouraging innovation when standards are introduced too rigidly. The challenge is to continue to encourage innovative practice within the framework of the standards.

Professional qualities

Modernisation requires staff to improve their skills and to work consistently and coherently in multidisciplinary teams. Organisations need to carry out baseline audits of staff qualifications and skill levels, and to analyse staff appraisal and development plans to determine what education and training is needed. Nurses may need support and dedicated non-clinical time to enable them to carry out robust staff appraisals.

Monitoring

Donabedian (1980) identifies three approaches to the evaluation of quality of care: assessment of structure, processes or outcomes.

● Structural assessment focuses on settings where care takes place and includes staffing levels, staff qualifications, facilities and administrative support. The assumption is that if the setting is good, quality of care will inevitably follow;

● Process of care is concerned with technical competence and humanitarian aspects. This is the medical-audit approach and involves the development of criteria by a panel of experts. It inevitably excludes consumers, who

BOX 4. CASE STUDY 2: BALANCING TARGETS WITH A PATIENT’S WISHES

Annette Walsh is a fit and active 82-year-old who works for the League of Friends at her local hospital. After taking the trolley shop around the medical wards she left for home around 2pm. At home, she cooked a meal for herself and her husband, washed up and started to feel unwell. She developed severe diarrhoea and vomiting and, within four hours, she had collapsed with dehydration.

In A&E, Ms Walsh was administered intravenous fluids and medication to stop her vomiting. She had no wish to be admitted, so she was given oral fluids and medication to stop her vomiting. She had collapsed with dehydration.

In A&E, Ms Walsh was administered intravenous fluids and medication to stop her vomiting. She had no wish to be admitted, so she was given oral fluids and monitored by staff. When she had been rehydrated and was able to take oral fluids without vomiting, her IV infusion was discontinued and she returned home.

This process took six hours. However, on paper, the organisation had failed to meet the four-hour national target designed to improve quality of care for patients in A&E.
are presumed to be technically incompetent. Since the NSFs have been formulated using this approach, it could be argued that the inclusion of users’ groups on the reference group is tokenistic; Outcome assessment focuses on patient outcomes such as death, disease, disability, discomfort and dissatisfaction. The assumption is that increased or improved care reduces the incidence of unfavourable outcomes. The indicators that are used to determine star ratings are outcome measures.

Clinical audit is an integral part of clinical governance and aims to help organisations identify problems and develop solutions (Reilly, 2001). It is not an end in itself but a means to an end and, if it is to be worthwhile, practitioners must develop change management skills to enable them to move practice forward (Onion and Walley, 1998).

**Change management**

In the past, the primary role of managers was control: they dealt with issues such as controlling sickness absence, budgets and minimising complaints. Clinical governance demands a different management style — it requires staff to innovate and improve, something to which traditional management styles do not lend themselves (Drucker, 1996).

Today, nurses at all levels manage others and, if they are to enable colleagues to change, they must change the way they manage. Change is unpredictable, complex, cumulative and subtle. Theories and techniques abound on how to change organisations. These are based on successes and failures of individuals who have introduced change in a particular organisation at a particular time with a certain set of people. The assumption is that others can learn from these triumphs and tribulations but the underlying premise is flawed because change never repeats itself in the same way. It is always related to its time, the people experiencing it and the culture of the organisation. So how can we move clinical governance forward?

Nurses who wish to prove themselves may be tempted to use their position to force through change. This is an ill-judged approach that fails to recognise the reality of power in organisations. Foucault (1972) explains that power is not a commodity but a relationship that is exercised in a particular context. Staff have the power to block change and will use this power if change is not handled sensitively.

O'Toole (1996) comments that creating change using dictatorial, manipulative or paternalistic methods is outdated. He advocates a values-based approach and states that the leader who has the welfare of followers at heart will achieve the best results. Leaders can create an organisation that encourages both change and self-re-evaluation, as well as fostering an atmosphere of open-mindedness and new thinking.

Bennis et al (1985) state that change programmes involve a set of core values that must be reflected in the overall strategy. An essential value is reciprocity and recognition that change is a two-way process.

Sometimes, well-intentioned actions lead to the introduction of unforeseen and unwelcome changes. Moss Kanter (1996) defines exceptional leaders as deep thinkers who are smart enough to see new possibilities and who are mentally agile enough to know when they need to change course. Leaders must work with staff, be sensitive to their fears and aspirations, and be open and honest with them.

**Conclusion**

As nurses, we have not travelled far in our efforts to ensure that older people consistently receive high-quality care. No nurse goes to work to provide poor-quality care yet nurses continue to deliver care that falls short of the quality they would wish their relatives to receive. This is not because nurses do not care but because they lack knowledge and may not consider fully the consequences of their action or inaction.

Clinical governance provides us with a framework to begin transforming care. Nurses now have standards that provide guidance on how to achieve the best possible care. They are at last recognising that older people require teams with appropriate specialist knowledge. The challenge is to put clinical governance into action at the bedside and to confine ageist attitudes and poor-quality care to history.