Can clinical governance act as a cultural barometer?

Health professionals need to identify and act on the essential factors that influence quality care to create a safe and compassionate culture.

In this article...

- What is clinical governance
- How to identify where cultural change is needed
- How to implement changes to the culture

Keywords: Culture/Mid Staffordshire/Health check

5 key points

1. Clinical governance involves adopting a culture of shared accountability.
2. Shared culture, learning, effort and information are key to high productivity and quality in organisations.
3. Creating a safe, caring and compassionate culture in which excellent nursing practice occurs involves numerous organisations, departments and people.
4. Escalation should be considered part of nurses’ professional accountability.
5. The core principles of caring, compassion and person-centred care underpin all aspects of nursing practice.

Teams need to adopt a shared culture of accountability.

The report of the public inquiry into failings at Mid Staffordshire Foundation Trust stated that problems at the trust were systemic, that they may also occur more widely across the NHS, and that cultural change is needed to make the service more patient focused (Francis, 2013).

It said NHS organisations need a “cultural barometer” that can quickly gauge the temperature or atmosphere within a given clinical team, department or organisation. Similarly, Willis (2012) recommended “the culture of healthcare provider organisations should be routinely assessed, building on ongoing work to develop and standardise a cultural barometer that will help boards ensure that practice settings are suitable learning environments”. Clinical governance has the potential to be used as a cultural barometer.

The term “clinical governance” has been defined as “a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish” (Department of Health, 1997). McSherry and Pearce (2011) argue that it involves acknowledging the importance of adopting a culture of shared accountability, and using this to sustain and improve the quality of services and outcomes for both patients and staff. However, not all NHS organisations, regulators, commissioners, professional bodies or practitioners achieve the intended outcome and principles of clinical governance in practice (Box 1).

The principles of clinical governance and associated frameworks should support the delivery of safe, compassionate quality care as suggested in the chief nursing officer’s strategy for nursing (Department of Health, 2012) and the Energise for Excellence (E4E) initiative (NHS Institute for Innovation and Improvement, 2013). However, the reality for the majority of NHS organisations needs to be addressed.

The Francis report into failings at the Mid Staffordshire Foundation Trust highlighted systemic failures across the NHS, with major stakeholders failing to intervene. Nursing organisations, along with all nurse leaders, managers and nurses themselves, need to make changes in accordance with the report’s findings and recommendations.

We suggest that the last thing the profession needs now is another campaign to change the “system” or “systems of care delivery”. This article highlights the importance of nurses sharing and learning from the Francis report and illustrates how clinical governance offers a framework for gauging and measuring the healthcare culture and caring environments using the “cultural health check”.

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Abstract

McSherry R et al (2013) Can clinical governance act as a cultural barometer? Nursing Times; 109: 19, 12-15. The Francis report into failings at the Mid Staffordshire Foundation Trust highlighted systemic failures across the NHS, with major stakeholders failing to intervene. Nursing organisations, along with all nurse leaders, managers and nurses themselves, need to make changes in accordance with the report’s findings and recommendations.

Clinical governance offers a framework for gauging and measuring the healthcare culture and caring environments using the “cultural health check”.

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of frontline nurses is that the organisations in which they work do not focus on creating a culture that values people and quality over finance and performance targets. This is in opposition to the intended outcome of clinical governance to foster a culture where excellence can flourish and patients are fundamentally the central focus.

Developing a safe and caring culture
The starting point for developing a safe, caring and compassionate culture is to establish the current culture of the organisation or team. Francis (2013) and Edwards (2013) identify several types of culture including: blame, bureaucratic, mistrust, reactive and proactive. Of these, the latter is preferable as it encourages learning and development and, importantly, encourages learning from mistakes and celebrating success.

The Department of Trade and Industry (1997) suggested that effective organisations recognise that shared culture, shared learning, shared effort and shared information are key to high productivity and quality. If clinical governance is to become a reality for healthcare organisations, and the nurses working in them, the major cultural inhibitors must be addressed. These include:

- Lack of openness;
- Mistrust between employee and employers;
- Staff being undervalued;
- Staff being inadequately rewarded;
- Innovation being stifled;
- Lack of transparency.

After the publication of the Francis report (2013) and other highly critical reports over the past three years, such as those by the Health Service Ombudsman (2011) and the Care Quality Commission (2011), public confidence in the nursing profession needs to be restored. There is also a need to restore public confidence in nurses themselves by ensuring they have the knowledge, skills, competence and capability to develop and deliver care in a safe, caring and compassionate way.

It will take time to review and reflect upon the findings and recommendations from the Francis report and look at how these can influence the delivery of the Department of Health’s (2012) 6Cs: care, compassion, competence, communication, courage and commitment.

Implementing the 6Cs requires action at all levels from board to ward. This should involve executives, senior managers and leaders of healthcare organisations encouraging and empowering frontline staff and users to review and revise existing nursing strategies. They should focus on creating a safe, caring and compassionate culture that prides innovation. Patients and carers should not be an addendum, but integral partners in the care team.

In order to raise frontline nurses’ awareness of the principles of clinical governance and the NHS constitution (2013) rights, pledges and responsibilities, these should be included in codes of professional conduct and contracts of employment. These will be a difficult “cultural inhibitor” to resolve as clinical governance involves advocating and protecting standards in a supportive, educational atmosphere and working environment. (Haslock, 1999).

Cultural health check tool
The task of creating a safe, caring and compassionate culture in which excellent nursing practice occurs is highly challenging and complex (McSherry et al, 2012). It involves numerous organisational and departmental systems and processes, but more fundamentally it requires people. People, not systems, are critical in ensuring patient safety, and in safeguarding quality and governance, so it is crucial to understand individual nurses’ attitudes, behaviours and actions or inactions towards the maintenance of patient safety and quality. Similarly, avoiding and managing risks and dealing with inadequate performance means the management of people and systems are essential indicators of quality and excellence. Essentially the major components of clinical governance can be applied in developing a “cultural health check” that can be used to address some of the major culturally inhibiting factors (CIF) identified by Francis (2013) (Box 2).

However, some frontline nurses find it difficult to see the role of clinical governance in enhancing practice and celebrating excellence in care. Essentially, clinical governance offers a potential cultural health check based on six themes deemed crucial for enhancing and demonstrating excellence in practice (Teesside University, 2011; McSherry and Warr, 2010; 2008). Several culturally enabling and inhibiting factors also play a critical role in creating and sustaining a safe, caring and compassionate culture for patients and staff working in practice (Table 1).

Table 1 identifies six cultural themes and 20 culturally enabling and inhibiting factors that have the potential to help health professionals to deliver and sustain patient safety and quality, and to create a safe, caring and compassionate culture. Either singly or collectively these factors should be regarded as a gauge, flag, alarm or warning. Answering “yes” to any of the

BOX 1. PRINCIPLES OF CLINICAL GOVERNANCE

- To re-establish the NHS as a national service for all patients throughout the country to receive high-quality care regardless of age, gender or culture
- To establish national standards based on best practices, which will be influenced and delivered locally by health professionals taking into account the needs of the local population
- Collaborative working partnerships between hospital, community services and local authorities, with the patient as the central focus
- Ensuring services are delivering high-quality care and providing value for money
- To establish an internal culture with clinical quality guaranteed for all patients
- To enhance public confidence in the NHS

BOX 2. THE CULTURAL HEALTH CHECK IN PRACTICE

The cultural health check:
- Is designed to foster, safeguard and protect the quality and standards of nursing and provide a safe, caring culture in healthcare settings or working environments
- Identifies culturally enabling and inhibiting factors that have a potential to directly impact on patient safety, quality and governance
- Offers indicators and measures of priority that require action, rather than inaction, from nurses, nurse managers and leaders
- Highlights key cultural factors for sustaining a safe, caring and quality culture in the future
- Provides a quality-assurance framework for ongoing assessment, monitoring and evaluation of the nursing culture
- Offers benchmarks for sharing and learning within practice

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### TABLE 1: THE CULTURAL HEALTH CHECK

<table>
<thead>
<tr>
<th>Theme</th>
<th>Theme description</th>
<th>Culturally enabling and inhibiting factors</th>
<th>Rationale</th>
<th>Time:</th>
<th>Response</th>
<th>Location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Working in organisations</td>
<td>Concentrates on vision and mission of the team, team development, communication and the sharing of information</td>
<td>1. No involvement in trust-wide multidisciplinary meetings</td>
<td>Good healthcare delivery relies on successful collaborative working. Absence of multidisciplinary working will negatively impact on patient care</td>
<td>As above</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
</tr>
<tr>
<td>2. Collaborative working</td>
<td>Focuses on multidisciplinary working and development as the main issue for achievement of quality improvement</td>
<td>4. Unfilled shifts is higher than 6%</td>
<td>As above</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>3. User-focused care</td>
<td>Transforming and reforming practice must incorporate users’ views/experiences into the development and evaluation of practice. This is a critical factor in highlighting the lived experience and culture of organisations</td>
<td>5. Two or more formal complaints in a month in a ward or clinical area; or three or more in a specialist area or unit; or one or more a high dependency area</td>
<td>Complaints are an indicator that there may be problems relating to the quality of care and patient experience</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>4. Continuous quality improvement</td>
<td>Makes quality part of everyday working practice and individuals accountable as part of their roles and responsibilities</td>
<td>6. No weekly review of key nursing care quality indicators by peers (for example peer review or governance team meetings)</td>
<td>Shows a potential lack of engagement and closed culture that does not seek to continuously improve</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>5. Performance management</td>
<td>Effective management improves performance and user-satisfaction. This theme should concentrate on how this can be achieved in practice</td>
<td>7. No evidence of effective discharge planning leading to increased average lengths of stay</td>
<td>An indicator of a service that is not reviewing its care systems and process, thus missing the opportunities to enhance the efficiency and effectiveness of the care provided</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>6. Measuring efficiency and effectiveness</td>
<td>Demonstrating efficiency and effectiveness in practice is associated with measuring and auditing to illustrate developments and improvements in practice</td>
<td>8. Educational audits not undertaken or undertaken without engagement from the team</td>
<td>A potential lack of understanding of the need to have a sound evidence base for driving care standards</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>7. Product innovation</td>
<td>Includes the development of a new product, process or service</td>
<td>9. Nursing Care Indicators below 80% for one month</td>
<td>Provides evidence that standards are falling and should be used as an early warning and reviewed to understand what is happening</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>8. Quality assurance</td>
<td>Includes all aspects of ensuring standards are being met</td>
<td>10. Cleanliness and hand hygiene audits not performed</td>
<td>A potential indicator of a busy unit, lack of supervision, or possible disengagement or apathy</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>9. Complaints</td>
<td>Includes all aspects of ensuring standards are being met</td>
<td>11. Study leave is cancelled (including clinical supervision, preceptorship, mentorship, mandatory/statutory, safeguarding sessions)</td>
<td>A potential indicator of staff shortage and pressure on a busy unit. This could lead to further problems in the future as staff will not be fully up to date with the required knowledge and skills to provide high-quality care</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>10. Staff retention</td>
<td>Includes all aspects of ensuring standards are being met</td>
<td>12. Planned personal development reviews not performed</td>
<td>Could lead to staff performance issues and frustration as staff could feel undervalued</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>11. Sickness absence</td>
<td>Includes all aspects of ensuring standards are being met</td>
<td>13. Regular use of agency and bank exceeding 3%</td>
<td>Staff who are unfamiliar with local practices and procedures may impact on quality and safety</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>12. Unplanned re-admission</td>
<td>Includes all aspects of ensuring standards are being met</td>
<td>14. Current or ongoing investigations, including disciplinary, root cause analysis (RCA) or infection control RCAs/investigation</td>
<td>An indicator of poor performance and potential systemic problems</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>13. Ward/department untidy</td>
<td>Includes all aspects of ensuring standards are being met</td>
<td>15. Staff retention is low</td>
<td>Indicator of staff satisfaction, which is correlated with good patient care</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>14. Unexpected high number of confirmed cases of MRSA and C difficile</td>
<td>Includes all aspects of ensuring standards are being met</td>
<td>16. Sickness absence higher than 3.5%</td>
<td>Indicator of a busy stressful environment and low staff morale</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>15. First impressions impact on visitors’ perception and may be an indicator of a ward/department under pressure</td>
<td>Includes all aspects of ensuring standards are being met</td>
<td>17. An unexpectedly high number of new confirmed case of MRSA and C difficile over a month</td>
<td>A proxy measure of high-standards of hygiene</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>16. May suggest lack of good discharge planning due to bed pressures and heavy workloads</td>
<td>Includes all aspects of ensuring standards are being met</td>
<td>18. Ward/department is untidy</td>
<td>First impressions impact on visitors’ perception and may be an indicator of a ward/department under pressure</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
<tr>
<td>19. Evidence that important learning is not happening and not being systematically shared. Similar problems may not be prevented and could reoccur in future</td>
<td>Includes all aspects of ensuring standards are being met</td>
<td>20. No evidence of resolution to recurring themes from incidents/complaints</td>
<td>Evidence that important learning is not happening and not being systematically shared. Similar problems may not be prevented and could reoccur in future</td>
<td>✓ Yes × No</td>
<td>✓ Yes × No</td>
<td></td>
</tr>
</tbody>
</table>
identified factors indicates the need to take action.

Applying and interpreting the cultural health check
Multidisciplinary teams are essential for the sharing of decisions and information between team members, patients and carers. It is imperative to escalate problems in attending multidisciplinary meetings, or if these meetings are cancelled. Failure to communicate information and share decisions between the various members of the team may lead to ineffective communication, non-application of a specific treatment or intervention, or failure to follow a planned care pathway.

Having insufficient staff on duty also compromises the skill mix, patient safety and the ability of the remaining staff to deliver high-quality care.

If your workplace does not have any of the identified culturally enabling and inhibiting factors it is likely that you are working in a health organisation that fosters a safe, caring, compassionate and person-centred culture. However, having one or more of the factors indicates that you and your department may be at risk of compromising this culture. Our advice is to take action in alerting and escalating concerns, highlighting that your area requires additional support or resources. The escalation should not be regarded as problematic or as a failure on the part of either an individual or team. It should be considered part of your professional accountability and an integral aspect of the clinical governance framework, which is about openness, transparency and honesty. Using this proactive and supportive leadership and management style is a sound indicator of a culture that values safety, quality and care.

Conclusion
The cultural health check is currently being reviewed in a clinical context. However, frontline nurses should familiarise themselves with it and challenge nurse managers and leaders if the culturally inhibiting factors are found to exist on their ward, department or organisation. It is imperative the core principles of caring, compassion and person-centred care underpin all aspects of nursing practice in the future. Sharing and learning from the Francis report (2013) is undoubtedly everyone’s business and responsibility.

Further detailed information about the cultural health check and Excellence in Practice Accreditation Scheme (EPAS) can be obtained from Robert McSherry at Robert.McSherry@tees.ac.uk

 References

Edward B (2013) A Collapse in the culture of care: The Stafford Hospital inquiries. How could all this happen and we not see it? nhsManagers.net. tinyurl.com/Edwards-Stafford
Willis P (2012) Quality with Compassion: The Future of Nursing Education. London: Royal College of Nursing. tinyurl.com/Willis-Commission

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