Clinical governance: the Challenges and opportunities of supervisory system

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Abstract: The purpose of this study was to explore the perceptions and attitudes of senior managers and clinical staff concerning the supervisory system of clinical governance in Iranian hospitals. An in-depth qualitative method using semi-structured interviews and document reviewing was employed. The purposeful samples of 38 people from six Iranian public hospitals were recruited. The interview and document data analysis disclosed six themes including the assessment approaches, the assessment teams, the pros and cons of internal and external assessment, the current supervisory system, effective supervision, and the indicators to evaluate clinical governance. The participants generally expressed concerns regarding the assessment system of clinical governance. They insisted on establishing a multidisciplinary assessment system consisted of relevant stakeholders interested in clinical governance development in hospitals. The supervisory approach offered in this study could expand the concept of effective supervision by emphasizing on participatory aspect in term of how stakeholders could play their roles.
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1. Introduction

The hospitals are supposed to deliver high quality and safe cares to patients. Following the wave of reforms in health care systems, the quality improvement initiatives have been valued more seriously than before. Clinical governance (CG) as a relatively new approach to improve the quality and safety of health care services has been recently emerged in some countries, pioneering by National Health System of England. Iranian ministry of health has promoted CG as a framework for safeguarding quality and safety in all hospitals since 2009 (Heyrani et al., 2012, Ravaghi et al., in press).

The specific CG model developed in Iran consists of seven inter-locking components, namely the Seven Pillars model (Nicholls et al., 2000). This address a range of managerial and clinical practice, including clinical audit, clinical effectiveness, risk management, patient and public involvement, staff and staff management, education and training, and use of information. Factors including systems awareness, leadership, teamwork, ownership, and communication are considered as a foundation of this model.

Monitoring and evaluation are important to assess whether the relevant inputs to implement CG are actually provided; whether the major defined activities are implemented as intended; and whether the outputs and targets are achieved using the indicators. On the other hand, the policy makers would like to track progress and demonstrate the impact of CG; and to respond the challenges faced the development of this policy among hospitals (Ravaghi and Mohaghegh, 2013). In the context of Iran, the supervisory system for CG is conducted at two-tiered including medical universities and health ministry levels. The medical universities have regular visits to the hospitals; and the health ministry team assesses the development of CG across the hospitals annually and announces best hospitals in a national festival.

The literature has shown that the supportive supervision that includes problem-solving, recording review, observing clinical practice, and giving constructive feedback has had a moderate to marked effect in improving the clinical services' quality (Rowe et al., 2005, Suh et al., 2007, Bosch-Capblanch and Garner, 2008, Mogasale et al., 2010).

About two years after the introduction of clinical governance to Iranian hospitals, on the best knowledge of research team there is no research regarding the challenges of CG supervisory system from the supervisees' views. This study was a part of a larger study designed to investigate the CG implementation challenges and opportunities. Specific objectives included generating evidence on the perceptions and attitudes of senior managers and clinical staff concerning the supervisory system of CG in hospital settings.

2. Material and Methods

A qualitative design using semi-structured interviews and documentation review was employed. This multi-case study was conducted in six public acute hospitals affiliated with the Tehran University of Medical Sciences from October 2011 to March 2012.

Sampling and recruitment

Six out of 25 hospitals were selected purposefully to reflect a range of common characteristics of general hospitals in terms of varied bed sizes, teaching status, and whether they had a board of trustees. The cases selected for inclusion comprised of four teaching and two non-teaching general hospitals located in Tehran. In each hospital, a purposive sample of staff with a range of managerial and clinical responsibilities was selected in order to maximize the sample diversity and provide a rounded view and perspective of CG supervisory system. Three main groups consisting of senior managers, medical consultants, and nurses with responsibility for the implementation of CG at various levels of the organizational hierarchy were targeted. A total of 42 people agreed to participate. Sampling continued until data saturation was achieved. An invitation letter and a participant information sheet were sent by email or mail. Finally, 38 participants including six senior managers, 11 clinical consultants, and 18 nurses, and three lab supervisors were interviewed.

Data gathering and analysis

Data were gathered through a combination of semi-structured interviews and a review of internal documents and reports. Ethics approval was obtained from the Local Research Ethics Committee of the Tehran University of Medical Sciences. One of the researchers visited hospitals and undertook face-to-face interviews. The participants were identified using the organizational chart for the hospitals.

The used topic guide in the process of interviewing included subjects such as the participants' perception about the challenges and opportunities of current supervisory system, and potential effective indicators needed to be considered in monitoring and evaluation of CG.

The interviews were conducted at the workplace of the interviewees, in a quiet area. All interviews (except two) were audio-taped.

The qualitative data were analyzed using the 'framework analysis' approach (Ritchie and Spencer, 1994) with the assistance of the Atlas-Ti, a qualitative data analysis package.

The validation process was carried out with member checks to approve the transcripts by presenting them to all participants (Belk et al., 1988). Based on Mays' recommendations (2000), to improve the trustworthiness of the analysis and interpretation of data a brief report of the results was sent to participants to get their feedback and incorporate into the study findings.

3. Results

The interview and document data analysis disclosed six themes including the assessment approaches, the assessment teams, effective supervision, the pros and cons of internal and external assessment, the current supervisory system, and the indicators to evaluate CG in hospitals.

The assessment approaches

Three forms of assessing including external, internal, and inter-hospitals approaches were proposed by participants to guide the development of CG in hospitals. In external assessment, medical universities and the ministry of health are the key bodies to monitor and evaluate the CG implementation across the hospitals. Some interviewees suggested a participatory approach to assess the CG development by involving different parties such as health insurance organizations, medical professional bodies, social welfare organizations, and community NGOs. An interviewed manager stated that participation of different stakeholders with varied interests in assessing process is important. Some interviewees believed that patients could be the potential external assessors for quality of services.

"Assessment should include internal as well as external, even a third part, NGOs." [S8M]

A nurse pointed out to an inter-hospital approach for evaluating CG implementation where the peer professional groups from hospitals could assess the performance of each other. For instance, the nursing services of a hospital might be assessed by matron from other hospitals.

A medical consultant proposed a 360-degree approach for internal assessing of CG implementation. In this method the performance of hospitals' departments are assessed through vertical and horizontal directions. Some participants emphasized on carrying out self-assessment approach at departmental and hospital levels. A medical specialist placed emphasis on bottom-up approach, which subordinates assess the performance of higher managerial levels.

The assessment teams

Some respondents indicated that an assessment team that comprised of senior managers such as hospital manager, the head of CG, matron, and all departments' heads could be appropriate to assess the implementation of CG. Some nurses emphasized on peer-group assessment teams at department levels. For example, a group included head nurse of other wards could assess the nursing performance of a ward.

Regarding the external teams, the respondents offered a multidisciplinary assessing team that includes members from nursing, medicine, and managerial professionals. They stated that this team should be more knowledgeable and experienced than the supervisees (i.e. the hospitals' people).

"Team of assessors should be consisted of multi professional members; they could not be limited to a distinct group." [F3Nm]

In contrast, some interviewees pointed out to the necessity of establishing an internal assessing team comprised multidisciplinary members. They stated that this team needs to be organized formally in term of organizational positions with well-defined roles and tasks. The suggested roles for internal assessment team were guidance and directing all assessment activities within hospitals.

Effective supervision

Interviewees provided a range of views in regard with effective supervision approach. The majority of respondents believed that the external supervisors, during the on-site assessments, should provide solutions to the found problems and deficits.

"We expect supervisors, in case of finding any performance deficits, provide solutions that are suitable to the underlying problems." [Sh14N]

The other features desired for an effective supervisory system were focus of supervisors on outcomes and comparing the progress of CG development in regular periods. Some participants highlighted using consistently collection methods and clearly defined criteria by supervisors to assess CG implementation level at hospitals. Few respondents supposed a promotional role for an effective supervision in term of enhancing the performance and motivation of staff.

In viewpoint of some interviewees, the types of hospitals (whether they are teaching or non-teaching, and general or specialty hospitals) need to be taken into consideration when external assessors evaluate and compare the CG implementation level.

The pros and cons of internal and external assessment

Some interviewees preferred external assessment rather than internal mode, and vice versa; however, an integrated approach including both were emphasized by most of them. This variation in participants' opinion appeared in term of citing some advantages and disadvantages for each of these assessment approaches.

The supporters for external assessment cited some potential advantages such as it could be an encouraging factor to pursue for conducting internal assessments among hospitals; and it could enable comparison and benchmarking between different providers. Some participants stated that the problems found by external assessment could inform the development of quality improvement plans of hospitals.

"The external assessment could enforce the hospitals to develop clinical governance; otherwise, the hospitals' enthusiasm is gradually diminished. [Sh13LabM]

In contract, some participants revealed their concerns relating to the external assessments. They, concentrating on external assessment conducted by local medical university, stated that the time that assessors spend to assess the process is usually short; therefore, not all aspects of services could be comprehensively evaluated. Other issue was the perceived low reliability of evaluation results by different external assessors. Some respondents said that the external assessors are mainly focused on reviewing records and documents rather than the outcomes of health services. Interviewees believed that the external supervisors usually do not provide practical solutions and feedbacks to the hospitals. The respondents expected to see assessors as mentors rather than inspectors.

The cited advantages of internal assessment included the assessors being familiar with hospital atmosphere and being more accessible. However, some interviewees believed that the internal assessment approach entails deficits. The internal assessors are more likely to fail to find problems compared to the external counterparts. Furthermore, the assessors from hospitals might not seriously conduct the functions of their colleagues due to close working relationship.

The current supervisory system

Based on interview and field observation of selected hospitals, monitoring of CG in two domains of patient and public involving (e.g. regular survey of patient satisfaction) and risk management (e.g. collecting the events and medical errors) were prominent. Checklists were common tools used in monitoring CG implementation in hospitals. The checklists were prepared by medical university and ministry of health or were developed by hospitals. The main guiding checklist regarding the CG domains criteria in hospitals had been developed by CG office of curative affair department of ministry of health, which it is applied to evaluate all Iranian hospitals to be candidate in an annual festival.

Some interviewees criticized the current system for monitoring and evaluation of CG. They complained that some supervisors conduct assessment as inspectors using a fault-finding approach. Some participants stated that most internal assessment conducted in hospitals are limited to the collecting data; and analyzing the data and preparing feedbacks are rarely happened. On the other hand, the internal monitoring of CG was not regularly supervised by local medical university. This issue resulted in confusing hospitals to know whether they are on track of CG implementation. Some nurses stated that most of supervisions carried out by medical university teams were focused on nursing procedures and the activities in other parts especially medical procedures were neglected.

"No any feedback is being provided to me; I do not know where I am; what are the problems in my performance; I am reluctant that what plan I could design to resolve the faults." [Z21Nm]

The indicators to evaluate CG

In response to the question of what indicators are best to consider in the evaluation of CG implementation among hospitals, interviewees cited a number of indicators that we can group them using Donabedian's model (input, process, and output/outcome).

The indicators relating to the availability of resources included checking the existence of proper and adequate human forces and other resources such as supplies and facilities. The other indicators were about administrative checking of structures, internal policies and protocols needed to successful implementation of CG (i.e. existence of strategic and operational plans, self-assessment, and proper organizing of workforces).

The process indicators noted by participants related to the quality of patients flow in term of reducing delays and cancellations such as operations, the patient safety procedures, and the procedures fulfill the patient rights charter requirements.

The output/outcome indicators were considered in three domains of patients, staff, and organization. The cited indicators relating to the patients included rates of mortality, medical errors, patient satisfaction, and patient loyalty. In level of human resource, two indicators of employees satisfaction and the rate of employee absence or leaving work were noted. Finally, at organization level, the indicators of productivity and efficiency were emphasized.

4. Discussion

The role of assessors in implementing rate of CG considered as an important issue. There were generally some concerns regarding the conducted supervisory visits by medical university team in some circumstances once an inspection and control approach had been used. This has resulted in a distrustful climate that may negatively affect the relationship between them and hospital staff. Similarly, Kilminster and Folly (2000) pointed out that the low quality of relationship between supervisors and hospitals' staff reduces the effectiveness of supervisions. This issue could be against the respondents' beliefs that the supervisory system is important for motivation of workforce (Bosch-Capblanch and Garner, 2008).

The respondents felt that the supervisors at the university and hospital levels lacked sufficient supervisory skills and knowledge to assess the CG implementation, indicating that they are inadequately trained which is consistent with finding of Nicholas et al (1991). Thus, training supervisors should be conducted effectively to improve the supervision practice.

The focus of supervision by external assessors from local medical university was mostly concentrated to the nurses' functions rather than physician's performance that it might be due to their powerful position.

The use of checklists was common in internal assessment of CG performance within hospitals. It may facilitate the assessment process by providing a working guide; however, as Bosch-Capblanch and Garner (2008) mentions this may encourage an inspection and controlling behavior that decreases a mentorship function. Marquez and Kean (2002) also stress that such supportive supervision provide a learning environment that may result in a better problem solving process.

A broader approach in supervision process emphasizing in our study is consistent with findings of Marquez and Kean study (2002) which highlights using multidisciplinary teams, efficient peer and self-assessments, and more participation of users and communities. As a result, a model of supervision can be developed which involves a range of relevant organizations and people demonstrating in Figure 1. It encompasses officially designated supervisors (e.g. supervisory team from local medical university), patient and community representatives in form of patients and NGOs), and peers (i.e. other hospitals' team). A distinct feature of this model is that the suggested internal supervision mechanism is seen from a 360-degree point of view. The role of peer supervision between hospitals is prominently highlighted in this model and not just restricted within hospitals. This could expand the scope of supportive supervision more by incorporating the stakeholders' input besides of providers'.

In a multidisciplinary approach, effective and efficient communication and collaboration among different members of team and organizations should be seriously taken into account. It is related to the due to the high number of involved people with different kind and level of interests during planning and conducting assessment process. Due to existence of inadequate empirical evidence about assessment process, carrying out such studies to examine the different aspects of assessment process and its effect is crucial.

5. Conclusion

The supervisory approach offered in this study could expand the concept of effective supervision by emphasizing on participatory aspect in term of how stakeholders could play their roles. Besides of Internal evaluation, the mechanisms of self-assessment and peer assessment, as well as patients' input, can be seen as crucial components of a supportive supervision.

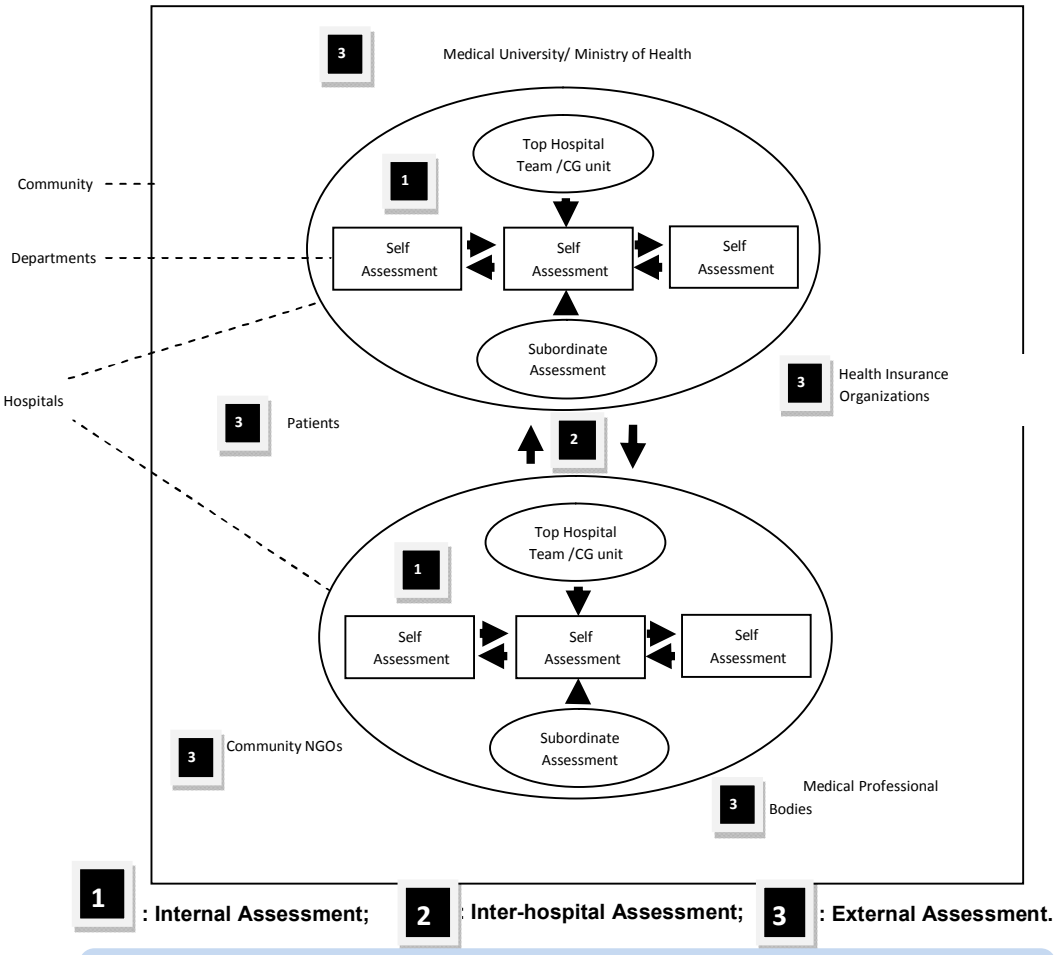

Figure 1: the proposed model for assessing clinical governance in hospitals

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