

### Editorial: Safeguarding patients – the fifth report from the Shipman Inquiry

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In the last issue of the *Bulletin*, details of the General Medical Council's new procedures on fitness to practise were described. Since then the fifth report of the Shipman Inquiry has been published and it is critical of the General Medical Council (GMC). The report, entitled *Safeguarding Patients: Lessons from the Past – Proposals for the Future*, examines the performance of statutory organisations responsible for monitoring primary care and makes a series of recommendations aimed at protecting patients. This editorial does not aim to give a comprehensive account of these recommendations but rather to give a flavour of what they contain, which include proposals for:

- a more streamlined and accessible complaints process in primary care;
- the development of standards against which complaints can be assessed;
- policy for raising concerns in general practice and the private sector;
- greater support for single-handed GPs;
- a review of recruitment procedures for GPs.

Although the main focus of the report is on primary care, it is likely that the recommendations will affect the regulation of hospital doctors and the way the GMC conducts its business. By far the most radical recommendations relate to the employment of doctors.

A proposal is made for a single central database containing comprehensive information about doctors. It is suggested that the database should contain information held by the GMC, the Criminal Records Bureau and the NHS Counter Fraud and Security Management Service, as well as records of disciplinary action by employers, adverse reports, findings reported by the Healthcare Commission and Ombudsman, and findings in clinical negligence actions.

In addition, the report suggests that the GMC should have a policy of 'tiered disclosure'. The first level of the tier should contain information relevant to current registration status and past information about fitness to practise (FTP), and should be made available on the Internet. The second tier is an alert that old information is available and will be disclosed to anybody requesting information about a doctor. When conditions are imposed on a GP's registration, patients should be informed by the primary care trust, so that patients have the opportunity to request an appointment with another practitioner.

Other recommendations relating to the GMC could be considered a challenge to medical professionalism in the UK:

- a change in the GMC's constitution to avoid an overall medical majority, the appointment of members both lay and medical following open competition and the GMC's accountability to Parliament;

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- the adoption of clear, objective tests to be used at the investigation and adjudication stage of the FTP procedure, to ensure consistency;
- 'deficient clinical practice' to be introduced to cover cases which do not amount to gross professional misconduct but where incidents of negligence or poor clinical practice apply;
- a review of the standards of proof to be applied by FTP panels;
- the GMC to monitor those doctors

- who have registration restrictions to ensure their compliance with the conditions imposed;
- an objective assessment of every aspect of FTP before restoring the doctor to the register;
- pilot use of legally qualified chairs in more complex FTP hearings;
- audit of the various aspects of the GMC's procedures.

These recommendations have implications for all statutory bodies

mentioned in the report and all medical practitioners. The changes that will result from the review of the report will need not only to reassure the public but also to have the confidence of the doctors who will live with these procedures during their professional lives.

The full report and recommendations are available online at [www.the-shipman-inquiry.org.uk](http://www.the-shipman-inquiry.org.uk).

## A template for clinical pathway design based on international evidence

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- Clinical pathways are well known as a potentially powerful tool with which to organise and manage patient care. They are used in health-care organisations around the world.
- They have many benefits, such as decreasing length of stay, reducing clinical variation and costs, and improving patient outcomes.
- Much attention has been given to the development and implementation of clinical pathways, but there has been less focus on the crucial components and design features.
- We analysed 176 clinical pathways drawn from a range of settings in three countries and developed a set of criteria that identifies essential components in their design.
- This set of criteria enables health-care staff and clinical pathway developers to place the clinical and technical content of pathways into a workable template. The template may support others in critically reviewing their existing pathways and help planners to understand the essential elements of clinical pathways.

A clinical pathway is a tool with which to support the development of structures and processes to manage clinical work while at the same time optimising resource use.

Clinical pathways are employed for a wide range of purposes – as a budgeting tool, as a care planning and review tool, as a teaching tool as well as a patient management and education tool. They can

strengthen coordination of care and identify accountability for patient outcomes, and they can promote multidisciplinary collaboration and communication. A range of studies show that clinical pathways, if used

### Box 1. Features of an ideal clinical pathway – a laparoscopic cholecystectomy clinical pathway from a metropolitan hospital in Australia

This pathway is characterised by the following features:

- It provides an instruction page on how to complete the pathway and explains the occurrence of positive and negative variances and the reporting process.
- There is a signature identification page that all health-care professionals making an entry into the clinical pathway are required to complete. This allows for unequivocal identification.
- The pathway shows how nurses, medical officers, dieticians and pharmacists work together towards the care of patients undergoing a laparoscopic cholecystectomy, indicating clear multidisciplinary cooperation.
- Patient outcomes, including activity and mobility status, and quality indicators are checked along the way.
- Risk identification consists of an alert box for nurses to contact a nominated doctor if something untoward occurs.
- The pathway is structured using an accessible table format and bullet points and allows for spaces to write in.
- Variances can be coded using four categories: 'patient', 'clinical', 'hospital' and 'community/family'. These categories are further refined. For instance, in the category 'patient' there are options such as 'non-compliance with treatment', 'infection' and 'early mobilisation'. In the 'hospital' category various specifications are allowed, such as 'cancellation of procedure' and 'delay in test results'.
- For each variance an action plan is required.

well, can reduce length of stay and clinical variation in terms of diagnostic and therapeutic prescriptions, without compromising the quality of care<sup>1,2</sup>.

Despite their popularity, little is known about the use of clinical pathways in an international context. Hale<sup>3</sup> argues that clinical pathways are under-conceptualised and that they are being developed and implemented with very little understanding of what exactly it is that is being implemented. We know what clinical pathways are by definition, and we know locally what people use them for, but do we know what they look like from an international perspective? What are the essential elements of clinical pathways that 'make' them pathways? In order to answer these

questions, we analysed a sample of clinical pathways drawn from various settings in three countries.

### The study

We gathered 176 clinical pathway documents from different health-care organisations in Australia, Canada and the United States. These were found via exchange of email and Internet searches. The sample consisted of varied types of pathways, from surgical, medical and women's and children's health settings. Twenty criteria were developed from this sample, using grounded theory<sup>4</sup>. This is a theory that permits the development of core categories from complex data, in this case a sample of written clinical pathways.

The data suggested we consider the sample of pathways from two angles. First, one set of criteria identified those components of clinical pathways that are essential for clinical, technical and managerial purposes. Second, another set of criteria addressed the overall quality and design of pathways as an administrative and documentary device. These criteria are generic and can be used to develop all kinds of clinical pathways.

### The template

The template consists of 20 criteria organised in five domains. These are:

- *Basic requirements*, which are the necessary elements of any clinical pathway.

**Table 1.** Elements of clinical pathways: template design criteria

Domain	Criterion	Task for designer or assessor of pathway
Basic requirements	Patient identifier	Uniquely identify the patient by name or medical record number
	Exclusion/inclusion criteria	Refer to patient characteristics, e.g. risk factors or co-morbidities, that may exclude the patient from or include the patient in the pathway
	Length of stay	Include the total number of patient-days in hospital
	Case type	Describe the type of patient for which the pathway can be applied in the form of a narrative or code (the 'name' of the clinical pathway)
Organisation	Identification of clinicians	Ensure the identification of all health professionals involved, in the form of a signature, designation and/or initials
	Care elements	Refer to four elements of the care process: episode, diagnosis, therapy and patient education
	Care sequence	Assign responsible staff (group) and 'what is to be done' (the action) for each care element; include timing information
Orientation	Multidisciplinary team	Reflect the multidisciplinary nature of the pathway by including tasks and responsibility for all disciplines involved
	Quality indicators	Include quality indicators to be checked along the way. Quality refers here to technical quality, e.g. infections or wound care
	Risk identification	Provide risk identification in form of nursing alerts, risk factors or risk assessment
	Outcome indicators	Indicate what kind of outcomes can be expected throughout different stages of the pathway
Variance	Discharge criteria	Define a set of criteria that the patient has to fulfil before discharge
	Variance coding	Code reasons for variances according to a standard classification
	Space for recording variances	Allow room for recording variances on a separate variances sheet as well as in a column on the pathway itself
	Variance categories	Categorise into groups (e.g. those relating to hospital, patient, clinician, family/community) the reasons why a variance occurred
	Variance subcategories	Refine the broad categories into subcategories; use a number of subcategories for each main category
Design	Action plan	Record in some detail what was done after the variances occurred
	Format	Use a table format with shading, and highlight key points
	Layout	Print the pathway on one side of a page; if possible make sure that a single day of care does not exceed one page and that the format is accessible
	Readability	Do not overload the pathway with too much information; use bullets or lines to differentiate between tasks and at least 12-point type

- **Organisation**, which relates to the way in which a pathway document purports to organise and map the care process.
- **Orientation**, which highlights the extent to which a pathway is patient or task oriented.
- **Variance**, which deals with whether a pathway incorporates different features in order to ensure that the care process is reviewed. This domain ensures that the pathway is a 'living' document and not reduced to a simple checklist.
- **Design**, which focuses on the format, layout and readability of the pathway. This domain addresses the way the information is presented.

Table 1 lists the domains and the corresponding 20 criteria that would be met by an ideal pathway. In essence this provides a template for consideration when planning a pathway or for assessing an existing pathway.

In Boxes 1 and 2, we provide summaries of two examples from the Australian section of our clinical pathway database. If we were to place all our pathways on a continuum, the first example would be towards the ideal end of the spectrum and the second would be towards the mediocre end. Boxes 1 and 2 highlight some key features vis-à-vis our clinical pathway template.

## Discussion

This study has emphasised the need to attend to various criteria in designing clinical pathways. However, developing a clinical pathway according to the set of criteria does not automatically ensure that a pathway will work. This requires productive negotiation, agreement, a good design and collaborative effort by various stakeholders.

Clinical Governance Bulletin  
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## Box 2. Features of a mediocre clinical pathway – an asthma clinical pathway from a metropolitan teaching hospital in Australia

This pathway is characterised by the following features:

- The pathway has been poorly designed and structured. It is difficult for a busy clinician to read quickly through the document and readily locate important information.
- There are no spaces to write in text if needed.
- The pathway fails to require identification of clinicians and the provision of a patient identifier.
- There is no option to record variances. Without this option a pathway is a 'dead' rather than a 'living' document and is unlikely to be reviewed or updated.
- Tasks outlined cover one discipline, namely nursing; thus multidisciplinary communication and collaborative approaches are neither envisaged nor encouraged.
- There are no discharge or quality indicators.
- The focus seems to be on a small set of tasks rather than the patient.
- This pathway in essence is a simple checklist that fails to capture the complexity of the patient trajectory, the multidisciplinary nature of care and the range of elements that can be written into a well conceptualised pathway.

Despite the purported benefits of clinical pathways, it is clear that there is resistance to their use in some quarters. For instance, there are concerns among some clinicians about the loss of autonomy that pathways may represent, and individual patient differences may impede the systematisation and standardisation of care that clinical pathways imply. Moreover, the absence of organisational processes to review performance in terms of improved costs and quality is also a barrier to the effectiveness of clinical pathways. Other possible barriers to their uptake are poorly designed or deficient pathways.

Our study suggested that if a pathway failed to meet any of the 20 criteria it might fail in its objective of facilitating the care process. For example, how can pathways be regarded as a communication tool that brings together different disciplines when the design does not promote multidisciplinary? Fiddes *et al.* reported that reasons for not conducting variance analysis include a pathway design that does not allow for variance recording<sup>5</sup>. As long as pathways lack essential elements such as these they are unlikely to realise their promise.

## Conclusion

This study drew on many clinical pathways in three countries, and

identified a comprehensive set of pathway elements across 20 criteria, over five broad domains. We would argue that it is beneficial to use a template like this in order to design robust clinical pathways. The two examples of clinical pathways we provide here (Boxes 1 and 2) highlight some key features of relatively well designed and relatively poorly designed pathways.

Without a good design template, pathways are likely to fall short of the ideal and are likely not to meet users' needs. Our template presents fundamental criteria in good pathway design. Its use may shorten the journey some would otherwise travel in creating better pathways.

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# Being open with patients and their carers following patient safety incidents

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- Patients will forgive medical errors when they are disclosed promptly, fully and compassionately. Being open also decreases the trauma felt by patients following a patient safety incident. However, patients and doctors have different beliefs about what should be communicated following an incident.
- The National Patient Safety Agency (NPSA) has developed a 'Being Open' policy for health-care organisations in England and Wales; this outlines how they should set in place an infrastructure to facilitate openness between their staff and patients and carers following an incident.
- The policy differentiates between the levels of response required for incidents that led to moderate harm, severe harm or death, as well as between these and incidents that were prevented (i.e. near misses) or which did not harm the patient.
- It is relevant to acute, primary care, mental health and ambulance trusts providing NHS-funded care in England and Wales.
- It is accompanied by a Safer Practice Notice on being open – this is aimed at health-care professionals and outlines the key 'do's and 'don't's in planning where, when and how to be open with patients and their carers.
- The NPSA is also developing two forms of training: an e-learning programme on being open and a video-based training workshop.

Being open involves apologising and explaining to the patients and carers involved what happened in a patient safety incident (i.e. an adverse event or near miss). Patient safety incidents can have devastating physical and emotional consequences for patients and carers.

For health-care staff too, incidents can be distressing, leading to them becoming demoralised and disaffected. Following incidents, health-care professionals often feel unclear about what to communicate

to patients and their carers, when and how. There is also a widely held belief among health-care professionals that saying sorry to a patient or carer is an admission of legal liability. This is a false assumption but nevertheless an important barrier to openness.

Research has shown that patients will forgive medical errors when they are disclosed promptly, fully and compassionately<sup>1</sup>. Being open also decreases the trauma felt by patients following a patient safety incident<sup>2</sup>. However, patients and doctors have different beliefs about what should be communicated following an incident: whereas doctors are reluctant to use the word 'error' and are afraid to apologise (because of fears of litigation), patients want an apology and an explanation of what happened, why it happened and how the health-care organisation will ensure it does not happen to another patient<sup>3</sup>.

These results were supported by the findings of the Australian Open Disclosure Project, in which there was consultation with a wide range of consumers and their representatives<sup>4,5</sup>. In this project, patients reported that they would like:

- to be told about patient safety incidents that affect them;
- acknowledgement of the distress that the incident caused;
- a sincere and compassionate statement of regret for the distress that they are experiencing;
- a factual explanation of what happened;
- a clear statement of what is going to happen from then onwards;
- a plan about what can be done medically to repair or redress the harm done.

In England, a MORI survey was commissioned for the Department of Health's consultation document *Making Amends*<sup>6</sup>. Of the 8000 people interviewed, 400 reported that they had suffered a medical error. They wanted an apology, an explanation of

what happened and an in-depth incident investigation, as well as support in coping with the emotional and physical consequences. These factors were more important to most people than pursuing financial compensation or disciplinary action against staff.

## The National Patient Safety Agency's work on being open

So in the USA, Australia and England there is some consensus among patients about how they would like the health-care team to respond after a patient safety incident. With this in mind, the National Patient Safety Agency (NPSA) has developed a 'Being Open' policy for health-care organisations in England and Wales; this was launched in February 2005. A listening exercise was carried out on a draft version of the policy, which was amended following feedback from three patient and public focus groups, health-care professionals, other government agencies and professional bodies.

The Being Open policy outlines how health-care organisations should set in place an infrastructure to facilitate openness between their staff and patients and carers following an incident. It differentiates between the levels of response required for incidents that led to moderate harm, severe harm or death, as well as between these and incidents that were prevented (i.e. near misses) or that did not harm the patient. The policy is relevant to acute, primary care, mental health and ambulance trusts providing NHS-funded care in England and Wales. It is accompanied by a Safer Practice Notice on being open – this is aimed at health-care professionals and outlines the key 'do's and 'don't's in planning where, when and how to be open with patients and their carers. The Safer Practice Notice is being launched alongside the Being Open policy by the NPSA in February 2005.

The NPSA is also developing two forms of training to help health-care professionals learn key skills needed to hold Being Open discussions with patients and their carers: an e-learning programme on being open and a video-based training workshop. Both these training tools will be available to the NHS in 2005.

## Conclusion

By launching the Being Open policy, Safer Practice Notice and training tools the NPSA can help health-care professionals improve the way they communicate with patients and carers following an incident. The Being Open work programme will break down barriers on a difficult and challenging subject and allow both patients and staff to share their experiences. It will ensure that the NHS is developing a consistent approach to handling communications following patient safety incidents.

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# Preventing infection in hospital – should patient involvement be central to current hand hygiene strategies?

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- Patient involvement in hand hygiene improvement has not formed a core part of hand hygiene strategies across the NHS.
- There is evidence that empowering patients to ask staff about hand hygiene can improve it and reduce infection.
- The National Patient Safety Agency has worked with patients and their relatives and carers in the pilot of its 'cleanyourhands campaign' and the learning from the

pilot informed the next stage of the campaign's development, with a national launch across the NHS in 2004.

In July 2002 the National Patient Safety Agency (NPSA) initiated a project to reduce health-care-associated infections (HCAIs) by improving hand hygiene among NHS staff. The project attempted to incorporate learning from the Oxford Radcliffe Hospitals, where patient

empowerment in hand hygiene improvement had been tested<sup>1</sup> in the Partners in Your Care programme, which suggested that empowering patients with responsibility for their care and actively encouraging them to ask staff 'Did you clean your hands?' would result in a marked improvement in compliance with hand hygiene. Overall, however, there is limited research available relating to patient involvement in efforts to reduce HCAI in the UK.

The empowerment of patients in relation to hand hygiene has received recent impetus from the Health Secretary, who emphasised that patients must not be inhibited in asking NHS staff whether they have washed their hands<sup>2</sup>.

## Purpose of the patient involvement work

The purpose of the work was to create opportunities to ensure that patients and the public could contribute towards the NPSA's patient safety agenda. In particular, the NPSA wanted to identify a diverse range of patient perceptions of staff hand hygiene compliance and how this might influence a future campaign.

## Methodology of the pilot of the campaign

The Communications Team at the NPSA developed the 'cleanyourhands campaign' and an associated toolkit with the aim of improving hand hygiene. One key element of the campaign was that alcohol hand rubs should be placed at the point of care, that is, near to patients.

A campaign toolkit was developed, which included:

- an implementation guide;
- posters aimed at changing staff behaviour (these changed every two weeks);
- posters designed to invite patient involvement using a simple approach based on four key words – 'It's okay to ask';
- leaflets for patients designed to invite their involvement using a simple approach based on those four key words;
- badges stating 'It's okay to ask';
- template local press releases and staff magazine articles.

The patient elements of the toolkit were designed to create an environment in which patients would feel comfortable asking about hand washing and specifically feel encouraged to ask staff 'Have you cleaned your hands?' Staff would also be satisfactorily prepared for patients to ask. The patient poster was intended to stimulate discussion between staff and patients and to act as a reminder to staff of patients' role within the campaign. The patient leaflet had three key aims:

- to raise awareness of the campaign among patients;
- to raise awareness of HCAIs among patients;
- to encourage patients to feel comfortable asking staff about hand washing.

Patient information in the pilot was made available in languages other than English and in accessible formats.

The NPSA identified six pilot sites in which to test the prototype campaign and toolkit, and in these a patient survey (see Figure 1) was undertaken by the patient advice and liaison services (PALS; within the NHS in Wales these are known as patient representatives). The

PALS used the patient leaflet to create awareness of the campaign. Patient involvement testing was then extended to a further three NHS trusts, but these did not have the benefit of the toolkit; the survey was again used to obtain feedback. One trust undertook a focus group to facilitate sampling of the views of patients. Staff were surveyed twice in the pilot study.

## The role of PALS in engaging patients

Participation in the campaign provided an opportunity to support PALS locally by raising their profile within each trust. The Patient

**Patient Evaluation Form**

The Healthcare Team caring for you has been chosen by the National Patient Safety Agency (NPSA) to take part in a campaign to remind staff about the importance of clean hands when caring for patients. The NPSA and the staff in your hospital want to know what you think about the cleanyourhands campaign and how you would like to be involved in helping to keep your hospital safe.

One way you can help us is fill in this form and the diversity and ethic monitoring form. This will let us know what the patients and the public think about the cleanyourhands campaign and help us find out the views of the diverse communities we live in.

To make sure the information you give us is anonymous we will not ask for your name or address. These forms will be sent to the NPSA and held confidentially. The information will be used to help improve patient safety in hospitals in the future.

**Q1 In the last 24 hours have you seen staff clean their hands?**  
 Yes  No  Sometimes  Don't know   
 Any other comments

**Q2 How useful have you found the patient posters, leaflets and stickers?**  
 Very useful  Quite useful   
 Not very useful  Not at all useful   
 Comments

**Q3 Do you think patients and the public should be involved in helping staff improve hand hygiene in hospitals?**  
 If yes please explain  
 If no please explain

**Q4 What would you do if you thought a member of staff had not cleaned their hands?**  
 a. nothing   
 b. tell the member of staff directly   
 c. tell the PALS officer   
 d. tell your visitor/ family member   
 e. contact an advice line   
 f. other please explain

**Q5 Would you ask a member of staff if they had washed their hands before they have direct contact with you?**  
 Yes  No  Not sure

**Q6 What else do you think staff, patients and visitors can do to improve hand cleaning in your hospital?**

Please indicate if you are a:  
 Patient   
 Relative   
 Carer   
 Other

*Thank you for taking the time to complete this form. Your feedback is very valuable and will help to inform future projects.*

Figure 1. Patient survey.

Experience and Public Involvement Team at the NPSA was available for additional support, if required. PALS leads were supported by PALS assistants, volunteers and rehabilitation assistants.

The NPSA also worked with a further two patients with direct experiences of health-care services, who were engaged to support the development of some of the patient products for the campaign.

## Results

A range of views were expressed by patients, with some enthusiastic about the idea of asking staff, others expressing no interest and some expressing outright dissatisfaction with the concept. Over 70% of the entire sample of 265 patients thought that patients should be involved in helping staff improve hand hygiene. One of the patients interviewed summed up a commonly repeated theme by stating: 'To improve hygiene, let's work together'.

Some patients reported that they felt staff were often too busy and they did not want to be perceived as a nuisance by asking questions. However, patients reported a positive response to seeing staff wash their hands, stating that they felt more confident in the care they were receiving.

By the end of the pilot, around 40% of the 123 staff who responded to a survey reported that they had been asked at least once by patients about hand hygiene. Of the 231 staff who responded to the two pilot surveys, 97% stated they felt comfortable being asked. When staff reacted positively to patients asking 'Have you cleaned your hands?', patients felt more able to ask staff questions about their health-care in general.

In the three trusts that did not have the benefit of the toolkit, many patients noted that they did not feel comfortable to ask them to clean their hands as they feared being treated unfavourably, even though they had no evidence of negative staff responses.

A range of other issues were raised by patients, including:

- a need to know when and how to ask staff to wash their hands;
- staff wearing protective gloves at all times;
- lack of opportunities for patients to clean their hands;

## Contributing to CGB

The audience is predominantly practising clinicians and managers, so please make your article as practical and relevant to everyday practice as possible.

**Length:** 500–800 words plus a maximum of five references in Vancouver (numerical) style.

**Illustrations:** where appropriate, use tables, charts, summary boxes etc. to present information, and to break up the text.

**Web links:** where possible, provide web and/or email addresses for further information – e.g. Department of Health reports or circulars, publications, societies, etc.

**Presentation and submission:** On the first page include the article title and author names and addresses (including email addresses); please also indicate which author is responsible for correspondence about the article and proofs. Start the article with three to five brief bullet points summarising the key lessons learned. Use plain, unjustified text throughout, with subheadings in bold upper and lower case.

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- poor standards of hygiene generally in hospital.

All these were addressed as part of the preparation for the launch of a national campaign.

## Conclusion

The pilot illustrates the important role staff can play to ensure patients, carers and relatives feel comfortable asking questions about their health-care, including hand hygiene. The following points have been taken forward as part of the national launch of the cleanyourhands campaign:

- Staff have been made aware of the importance of the role of the patient in hand hygiene improvement and of the need to be open to being asked about hand washing, without feeling undermined or criticised. Getting this message right is vital to the success of patient participation in the national campaign.
- Patients are being informed about HCAI and when to ask staff to wash their hands.
- Patient information conveys clear messages and advice. The NPSA acknowledges that leaflets cannot replace creating the right atmosphere for patients to ask about their health-care.

- Carers and relatives are being encouraged to ask about hand hygiene in situations in which staff are relaying patient information.
- The benefits for staff and patients in adopting the campaign have been clarified and promoted as a broad component of clinical governance. It is important that staff across the NHS are made aware of the positive effect on staff morale that can result from the campaign.

The cleanyourhands campaign was launched across the NHS in September 2004 and will help trusts to improve patient safety. Its potential to increase the confidence which patients have in their health-care in general cannot be underestimated. Such an approach has been recommended recently by the Secretary of State for Health, who has endorsed the NPSA's plans to involve patients in hand hygiene and who supports the extension of the campaign across the acute NHS<sup>2</sup>.

## References

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# Improving staff understanding of gestational diabetes – use of self-audit

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- There was considerable lack of understanding of the diagnosis of gestational diabetes among midwifery and obstetric staff.
- The introduction of a novel, anonymous, questionnaire-style self-audit was well received by staff and found to be useful.
- The audit resulted in a significant improvement in the understanding of gestational diabetes.

Gestational diabetes mellitus (GDM) is defined as carbohydrate intolerance that begins or is first recognised during pregnancy. There is considerable debate about the value of screening for GDM<sup>1</sup>. From May 2000, we adopted a policy of screening women at high risk for GDM with a 75 g oral glucose tolerance test (OGTT) around the 26–28th week

of gestation. As the incidence of GDM in Southampton was apparently only 1.7% in 2001, we became concerned that we were missing significant numbers of women with the condition. The aim of our audit was to determine whether there was poor adherence to our screening policy because of a poor understanding of GDM among obstetric and midwifery staff.

## Development of the audit tool

We used a self-audit tool that was developed as an anonymous questionnaire (Figure 1). The overall aim was for the tool to be used by staff to improve their own knowledge of GDM and its diagnosis, and to implement best practice. The self-audit tool could also be used to pinpoint

training requirements. The staff were invited to keep copies of the audit tool in their personal development portfolios.

Questions were structured in such a way that they provided the answers to staff. An example is ‘Were you aware that every woman should have her urine tested at each antenatal visit?’, for which staff then ticked ‘Yes’ or ‘No’. This method was used to reduce confusion caused by providing incorrect answers and because it did not encourage guessing. At the end of the questionnaire there was space for comments.

## Audit

The self-audit questionnaires were posted via the internal mail system to all members of staff involved in

Gestational Diabetes & Its Diagnosis - October 2002

This form is designed as a self-audit. It aims to provide you with the opportunity to record your understanding of Gestational Diabetes and its diagnosis. You will then be able to address your own specific training needs. It will also provide us with an idea of the areas where training needs to be improved.

<p>Q1 Were you aware that the definition of gestational diabetes refers only to diabetes that is first detected during pregnancy?</p> <p>Q2 Were you aware that every woman should have her urine tested at each antenatal visit?</p> <p>Q3 Did you know that if a woman has a fasting blood sugar <math>\geq 7.0</math> mmol/L or a random blood sugar <math>&gt; 11.0</math> mmol/L, that she does not need a glucose tolerance test (GTT) because these results are sufficient to make the diagnosis?</p> <p>Q4 Were you aware that the following are all indications for a GTT? Please tick the ones you were aware of</p> <p>Q5 Did you know that for most women the best time for a GTT is between 26–28 weeks of gestation?</p> <p>Q6 Did you know if a woman has had previous gestational diabetes, the GTT should be performed earlier at 16–18 weeks of gestation?</p>	<p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p> <p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p> <p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p> <p>Glycosuria.....<input type="checkbox"/></p> <p>Large for dates (AC&gt;95th centile).....<input type="checkbox"/></p> <p>Polyhydramnios.....<input type="checkbox"/></p> <p>Maternal obesity (BMI &gt;30 or booking weight &gt;100 kg).....<input type="checkbox"/></p> <p>Asian origin.....<input type="checkbox"/></p> <p>Previous IUD/SB of unknown cause.....<input type="checkbox"/></p> <p>Polycystic ovarian syndrome.....<input type="checkbox"/></p> <p>Previous large baby (&gt;4.5 kg or &gt;95th% for gestational age).....<input type="checkbox"/></p> <p>Mother/father/siblings with diabetes.....<input type="checkbox"/></p> <p>Previous gestational diabetes.....<input type="checkbox"/></p> <p>Fasting blood glucose &gt;6.0 mmol/L or random glucose &gt;7.0 mmol/L.....<input type="checkbox"/></p> <p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p> <p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p>	<p>Q7 Did you know that if a woman with previous gestational diabetes has a normal GTT at 16–18 weeks of gestation that it should be repeated at 26 and 32 weeks of gestation?</p> <p>Q8 Have you seen the criteria for performing a glucose tolerance test? (this can be found on the Day Unit)</p> <p>Q9 Were you aware that women must be nil by mouth before a glucose tolerance test but that they may drink water only, in order to quench their thirst?</p> <p>Q10 Were you aware smoking affects the test, and that women should be made aware of this?</p> <p>Q11 Were you aware that a GTT is considered abnormal if the fasting glucose is <math>\geq 7.0</math> mmol/L and 2 hour glucose is <math>\geq 7.8</math> mmol/L?</p> <p>Q12 Would ward-based teaching be of benefit to you?</p> <p>Q13 Would it help you if there were a request form for glucose tolerance testing that included all of the indications for testing, together with information about how the test should be performed?</p> <p>Q14 Please make any comments (particularly about specific learning needs) in the space below:</p>	<p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p> <p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p> <p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p> <p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p> <p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p> <p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p> <p>Yes.....<input type="checkbox"/></p> <p>No.....<input type="checkbox"/></p>
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This audit is intended to be a self-directed audit tool. If you did not know the answer to any of the questions, please consider some revision of this topic or feel free to consult any member of the Diabetes team. We plan to run a diabetes training programme next year and by returning these forms, you will help us to address your needs. We would be grateful if you would return the completed questionnaire to: PENNY CLARKE, DIABETES MIDWIFE, ROOM 4, O.P.D. Princess Anne Hospital EXT.5007 using the envelope provided. Thank you for your time. Please feel free to photocopy this form for your own professional profile. If you would prefer personal feedback please write your name here:

Figure 1. Self-education audit tool.

antenatal care at the beginning of November 2001. Questionnaires were returned anonymously via the internal mail system or to a dedicated posting box by 1 December 2001. The audit was repeated using the same method in November 2002.

## Results

### 2001 audit

This showed that there was a considerable lack of awareness of the risk factors for GDM, in particular for those with non-white European ethnic backgrounds or polycystic ovary syndrome. Less than half the staff knew that the diagnosis could be made by appropriate levels of fasting or random hyperglycaemia without the need for oral glucose tolerance testing. There was also confusion about the scheduled time for screening and only two-thirds could correctly interpret the OGTT. Half the staff had not read our local guidelines and nearly 90% requested further training in this difficult area.

### Feedback on audit tool

At the end of the questionnaire, many members of staff expressed their thanks in the comments box. By virtue of the fact that the questionnaire was presented in a non-confrontational manner, many felt that the audit tool was an excellent learning aid. Other staff were grateful for the opportunity to photocopy the questionnaire to add it to their professional profile for future reference.

### Response to audit

After analysis of the first audit, we developed a specific request form for a glucose tolerance test for use in pregnancy that contained space for the patient's demographic details, a list of indications for testing, instructions to the patient about the protocol for the test and a results section. We also introduced a rolling monthly education programme for all midwifery staff involved in provision of care for diabetic mothers and their babies.

## Subscriptions and enquiries

*Clinical Governance Bulletin* (ISSN 1470-9023) is published by The Royal Society of Medicine Press Limited, London, and is sent free to targeted health-care professionals working in the NHS.

Subscription prices (non-NHS) for Volume 5, 2004/5 (six issues from May), including postage, are:

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This publication is funded by the Department of Health.

### 2002 audit

There was considerable improvement in the understanding of the diagnosis of GDM. In particular, there was much greater awareness that Asian women (72% of staff vs 19% in 2001) and that women with polycystic ovaries (54% vs 19%) are at risk of GDM. Eighty per cent could now correctly interpret OGTT results (65% in 2001) and 21.5% of pregnant women underwent an OGTT in 2002 (17% in 2001). The percentage of positive tests fell in 2002 and the incidence of GDM (1.8% vs 1.9%) was unchanged.

## Discussion

A major success of our audit was the development and use of a non-confrontational audit tool. The self-audit was well received by the staff who took part in the study. In particular, its format was well appreciated and many participants liked its clarity and lack of confrontation. While the relative contributions of the audit tool, request form and ward-based teaching on the improved

understanding of GDM seen in the second audit cannot be determined by this study, we believe that this style of audit, which combines education with clinical effectiveness, is an important step forward. Education of health-care professions can improve the appropriateness of requests for testing<sup>2</sup>.

In conclusion, our study showed that there is confusion among midwifery and obstetric staff concerning the diagnosis and need for screening of GDM. The use of a novel educational audit tool followed by the introduction of a specific request form for pregnant women and ward-based teaching improved knowledge and understanding.

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- 2 Kroenke K, Hanley JF, Copley JB, *et al.* Improving house staff ordering of three common laboratory tests. Reductions in test ordering need not result in underutilization. *Medical Care* 1987;25:928-35

# Performance indicators for primary care dentistry

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- From October 2005, primary care trusts will take responsibility for commissioning and for monitoring primary care dentistry in England, and dentists will receive payment based on a more preventive approach.
- Current plans for ensuring quality dental services across a primary care trust seem limited.
- In South Tyneside, routinely collected data on a range of clinical activities have been used as performance indicators for general medical practice.
- There is an urgent need to devise similar performance indicators for primary care dentistry.

In October 2005, primary care dentistry in England will see the biggest change for 50 years in the way it is run. Primary care trusts (PCTs) will assume responsibility for commissioning and monitoring all primary care dentistry, while dentists will move from a system of payment based on clinical activity to one based on prevention. This will affect every NHS patient and will fundamentally alter the way that £1 billion is spent annually.

Foremost among issues for the transitional period (2005 to 2008) are:

- how PCTs will ensure an agenda of quality in a service more used to dealing with quantity;
- how this will fit within a clinical governance framework;
- how it will be monitored.

## Indicators in general practice

In South Tyneside PCT, clinical governance addressed these issues for medical practices by developing a series of performance indicators that seek to identify, by practice, variation in performance. These indi-

cators are shared with and between practices in 'away days', so that their relevance and possible causes can be discussed and development plans put in place. While there was initial suspicion of the indicators and discussion of their relevance and validity, they are now accepted and practices focus on what they mean for their performance.

Our indicators for GPs were chosen for the following characteristics:

- They should come from data that were already routinely collected for clinical or administrative reasons.
- They should cover a range of clinical conditions and activities.
- They should cover a range of members and skills in the clinical team.
- They should examine areas of significant clinical impact, in terms of either severity or prevalence.
- The data source should be a robust measure of the indicator.
- There should be agreement that the areas examined (if not the indicators themselves) are non-controversial.

It is important to understand that these are performance *indicators* and not *measures*. They indicate areas where practices may wish to examine their own performance in greater detail.

We now need to develop similar meaningful and practical performance indicators for primary dental care. The aim was to agree a set of indicators of quality for general dental practices to be used by South Tyneside PCT and dental practices to increase the quality of care. These would form part of the information base for PCT-led practice development workshops with each team, in PCT-paid protected time. These

would follow a similar format to our quality workshops for GPs, which have been held over the last four years.

## Methods

A multidisciplinary PCT group was supported by dentists from dental public health and academia. The indicators were derived by a small working group and refined by the full group. They were tested and refined with local dentists and then discussed with the Local Dental Committee and are to be trialled in South Tyneside.

## Chosen indicators for the trial

The indicators are presented in Table 1. The broad areas the indicators seek to examine are presented along with the data source and the rationale for their inclusion.

## Discussion

From October 2005 the move to commissioning dentistry at PCT level will offer an opportunity to demonstrate the high quality of most primary care dentistry and to identify and improve those areas where quality is not as good. If the PCT works with local general dental practitioners as willing participants rather than reluctant conscripts, this change should offer opportunities for coordinated and consistent delivery of dental services tailored to specific local needs. There is already investment in developing an information technology (IT) structure that will link dentists with the rest of the NHS, which will allow data on performance to be collected more easily. We should decide what indicators of dentist performance to use ahead of the IT developments, so they can be incorporated into the IT structure.

**Table 1.** Suggested performance indicators for general dental practice

Area of activity	Indicator	Data source	Rationale
Practice organisation	Number of complaints there have been in the last 12 months	Information from practices already passed to PCT. Maybe increase in year 2 to look at type of complaints	A basic indicator of patient satisfaction which is easily understood and compared. May add patient involvement as separate measure in near future
Access	Current waiting time for routine appointment Current waiting time for emergency appointment	Access facilitator at PCT	A long wait for a routine or emergency appointment may indicate either a successful practice or the need for altered priorities or procedures. Long waiting times should prompt a review of practice priorities
Emergency care	Number of patients/1000 notional list size requiring at out-of-hours care	Information available to PCT via out-of-hours provider	See above. A high demand for out-of-hours care may result from specific treatment strategies within the practice and may prompt internal investigation
Use of investigations	Number of radiographs/1000 notional list size (corrected for age profile)	Information available from the Dental Practice Board for the next 2 years. After that practices may collect this as part of their own internal quality control	Appropriate use of radiographic investigation is important from diagnostic and safety perspectives. Both high and low use should prompt practices to review this area
Prescribing patterns	Number of prescriptions for antibiotics/1000 notional list size	Information available to PCT from the Prescription Pricing Authority via prescribing advisers	Although sometimes necessary, antibiotic use is not effective for long-term treatment of dental infections, nor is it in the public health interest. High rates should be of concern to any dental practice
Restorative and surgical activity	Number of crowns and bridgework/1000 notional list size Number of extractions/1000 notional list size	This is available from Dental Practice Board data now held at the PCT but may then be superseded by patient charge bands	Provision of complex restorative care or extraction that is outside the normal range will often be reasonable and easily explained. Where this is not possible it may prompt reflection or audit
Referral rate	Number of referrals to secondary care and to community dentistry	Currently available via the commissioning department of the PCT	Both high and low referral rates may be of concern, depending on circumstances, but rates that are outside the norm may prompt practices to review their procedures

Those described here are a starting point, based on what is currently possible. With improved IT capabilities and the new arrangements, there will be opportunities to refine and improve the indicators

In a similar exercise with GPs, the PCT ran workshops with each medical practice, examining aspects of quality of care offered and identifying priorities for practice and personal development. These have proved popular: all South Tyneside practices have taken part, and have tied practice development to their clinical governance priorities.

The indicators presented here are a first step in this process for

dentistry. They are not perfect and will be refined with local practices. They should help PCTs to monitor the effectiveness of their commissioning process and the quality of the service they deliver. As well as being locally valuable, the final 'core' indicators will have applications in every PCT in the country.

**Acknowledgements**

The authors would like to thank the dentists involved in the project, especially Matt Gill and Malcolm Bond, and Gateshead and South Tyneside Local Dental Committee.

**Topics for future issues**

- Introducing new procedures safely
- Innovation and quality assurance
- Quality versus quantity
- Providing incentives
- Quality in practice
- Working together
- Patients' perspective

See page 8 for guidance on the submission of contributions.