Q: Critically evaluate the following statement:

Comprehensive clinician accountability and clinical governance reduces the likelihood of errors being committed in the delivery of health care.

Clinical governance and clinician accountability are integral concepts in today’s modern healthcare sector. The purpose of this paper is to critically evaluate the statement that comprehensive clinician accountability and clinical governance reduces the likelihood of errors being committed in the delivery of health care. After key definitions are initially identified, the concepts of comprehensive clinician accountability, clinical governance and the link between the two are then explored in the context of their effects on the potential for, and incidence of, clinical error with reference to current literature.

Contemporary definitions of safe healthcare have revolved around the provision of care free from the occurrence of preventable harm and avoidable adverse client outcomes [Institute of Medicine, 1999; Isaac et al., 2010]. Early Australian research suggested that individual, technical and organisational factors could all contribute to adverse events and that up to half of all such events may be potentially preventable [Wilson et al., 1995]. Several common risk factors for the occurrence of adverse client outcomes and clinical error have been identified including clinician misjudgement, interpersonal interaction shortcomings, insufficient policy, inadequate clinical practice frameworks and support systems and the existence of clinical systems with vulnerabilities related to deliberate misuse behaviours [Chang et al., 2005; Lingard et al., 2004; Patel & Cohen, 2008]. The relevance of such risk and causative factors to client safety may remain consistent regardless of the severity of the outcomes of clinical error [Bartlett et al., 2008].

The topic of error in the healthcare environment has been the subject of considerable focus. Although the identification of a precise definition of error applicable to all healthcare settings has proved somewhat nebulous, common themes have emerged which may prove useful in outlining the concept with regard to human factors. Error committed in the processes of care delivery may be broadly defined as any individual or group action or inaction which represents a deviation from planned or accepted normal practice [Patel & Cohen, 2008]. Errors may be classified across a wide variety factors including the severity of their effects, their ability to be anticipated and prevented, the awareness of the healthcare providers in the process of error occurrence, the specific settings and practice aspects of error occurrence and number and profession of individuals involved [Catchpole et al., 2007; Ghaleb et al., 2005; Lingard et al., 2004].

Comments annotated by David Sotir, HELPS
While very few clinical errors are considered to have been committed with the intention of causing client harm, some clinical errors are deliberately committed in awareness of the associated deviation from required practice. Known as work-around behaviour, this may often be due to clinicians acting autonomously in the absence of robust practice guidance systems having independently assessed the risk associated with such practice deviations as acceptable and/or the effort of following the required practice as excessive (Vogelsmeier et al., 2008). This behaviour generally occurs in the absence of robust practice guidance systems which require mandatory actions or in the presence of systems which have not been completely accepted by clinicians (Bartlett et al., 2008).

The concept of comprehensive clinician accountability may hold considerable depth of meaning. Traditionally, clinician accountability has been associated with examples of healthcare workers assuming responsibility for their decisions and the consequences of those decisions (Morden et al., 2013). However, this definition has expanded considerably in the contemporary healthcare environment. Accountable clinicians are now expected to participate in organisational initiatives, accept and adopt new systems, drive interdisciplinary collaboration and align with current evidence-based practice (Ansell & Gash, 2008; Jeffs et al., 2012). The concept of comprehensive clinician accountability may also include an obligation to report errors and near misses (Waring, 2005). Clinicians failing to act with accountability have been described as acting autonomously, especially in the context of teamwork and communication failures (Lingard et al., 2004).

Clinical governance may be defined as the frameworks and processes by which an organisation drives continuous improvement across all aspects of healthcare operations (Som, 2004). Client safety has long been recognised as a core aspect of health service quality (Institute of Medicine, 1999). A significant proportion of clinical governance may therefore be considered to be related to improving client safety, with reduction in clinical error being a key aspect of this goal (Patel & Cohen, 2008). In that respect, effective clinical governance may involve the development and implementation of systems and practices designed to reduce the risk for error along with the analysis of the causes and contributing factors of clinical errors with a view to enhancing systems and safeguards to reduce the risk of the recurrence of similar errors (Braithwaite et al., 2006; Jeffs et al., 2012). The involvement of all levels of management within health care organisations right up to the board may be required for clinical governance to achieve high levels of effect, consistency, accessibility and continuity (Conway, 2008). This may also include the identification and provision of appropriate levels of service and resource availability, both of which contribute to client safety and outcomes (Thrall, 2004).
The Australian Commission on Safety and Quality in Healthcare implemented the National Safety and Quality Health Service Standards in 2012. These standards were designed to provide guidelines aimed at increasing safety and quality across specific practice areas, with clinical governance identified as an overarching core aspect of health service safety and quality (Australian Commission on Safety and Quality in Healthcare, 2012). The evidence-based nature of these standards reflects the requirement for clinical governance initiatives to be founded upon research and prior learning (Thrall, 2004). The widespread belief that clinical governance supports client safety may be further substantiated by the existence of independent organisations such as the Clinical Excellence Commission (2012) dedicated to the identification and implementation of safe and appropriate evidence-based practice.

The concepts of comprehensive clinician accountability and clinical governance may be considered complementary and interdependent. The effectiveness of clinical governance may be significantly determined by the level of participation and engagement of healthcare workers (Ansell & Gash, 2008). Similarly, the successful participation and engagement of healthcare workers in organisational systems and identified practice requirements may be reliant, to a large extent, on the quality of clinical governance they act under (Sawka et al., 2012). Improvements in client safety may therefore require both clinical governance frameworks and the participation of clinicians through practicing with accountability (Balding, 2005). The presence of both comprehensive clinician accountability and clinical governance may thus be considered to hold greater potential for reducing the likelihood of error in care delivery than the presence of either concept only.

Given the suggestion that up to 50% of errors committed in the delivery of healthcare may be avoidable, the identification and actioning of factors contributing to these errors may be considered imperative (Wilson et al., 1995). For all errors, even those considered unavoidable at the time of occurrence, clinicians acting accountably under effective clinical governance may reduce the likelihood of future recurrences of similar errors through the examination of such factors and the creation of mitigating strategies (Braithwaite et al., 2006; Lingard et al., 2004). Conversely, the absence of clinical governance and the presence of autonomously acting clinicians both hold minimal scope for reducing the risk of error occurrence (Jefls et al., 2012). This may be particularly relevant to the reporting of error and near misses by the clinicians involved, an occurrence which may be much more likely in the presence of clinical governance cultures and frameworks focusing on staff and systems development rather than blame (Waring, 2005).
Comprehensive clinician accountability and clinical governance both shape, and are dependent on, organisational culture. Poor leadership and cultures of blame have been associated with ineffective management of errors and identified risks (Bartlett et al., 2008). It has been suggested that transparency, integration of care and stakeholder engagement are essential values in the development of reliably safer healthcare organisational cultures (Leape et al., 2009). The combination of accountable clinicians and comprehensive high-quality leadership may drive the growth of organisational cultures which are innovative, proactive and dedicated while shifting the focus of error management from blame to root cause analysis, staff support and systems enhancement (Braithwaite et al., 2006; Jeffs et al., 2012; Waring, 2005). Such cultures may further reduce the risk for error occurrence through the reduction of workplace stress, a known contributor to preventable error (Catchpole et al., 2007). Enhancing health professional commitment and organisational culture may also reduce the incidence of work-around behaviours, especially in the presence of increasingly robust systems which prevent such behaviours (Holden, 2010).

Despite over a decade of focus on improvement in client safety, evidence for the actual progress made towards client outcomes has been scant, with results having proven difficult to quantify (Pronovost, 2010). This may be partially due to limitations regarding outcome measures focusing on quality rather than safety (Pronovost et al., 2006). The development and widespread implementation of accurate client safety measures through effective clinical governance may contribute to demonstrated improvements in client safety including reductions in preventable errors (Chang et al., 2005; Patel & Cohen, 2008; Pronovost, 2010).

Comprehensive clinician accountability is a multifaceted concept which includes aspects of transparency and active dedication to expected practices and outcomes. The support and guidance provided by clinical governance may enable clinicians to practice with accountability. In addition, effective clinical governance may drive the ongoing development and implementation of evidence-based practice and safer, appropriately-resourced systems. The combination of both concepts may create a culture of innovation and allow for the consistent mitigation of known risk factors for error. Additionally, this may allow for the application of learnings from the examination of errors and their causes, resulting in achieving reductions in the risk for similar errors recurring. Ideally, in the future, healthcare organisations continue to achieve cultural growth through the combination of comprehensive clinician accountability and clinical governance, thereby reducing the risk for error occurrence while driving the development of both clinical systems and healthcare workers.
References


Institute of Medicine. (1999). To err is human: Building a safer health system. IOM.


Commented [A27]: There is evidence of extensive reading here from both Australian and international current literature. It is also academically reliable, peer-reviewed and from authoritative sources.

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