

Exploring the boundaries of risk within and between NHS organisations

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Dr Jeffrey McIlwain aims to start a debate about boundary risk management, which he argues is important but overlooked because of the concern of organisations with internal standards and public image.

Since April 1991, the internal market has created divisions between primary and secondary care delivery and so also, indirectly, created organisational compartments. A division by its existence creates a boundary between organisation X and organisation Y. The concept of micro-management through budgetary and other controls has further exaggerated the division. This may then develop into clinical boundary disputes when care provision becomes the victim of territorial turf-wars or uncertain concepts of how to deliver local care and service standards. What may be seen as satisfactory in one clinical "parish" (according to local needs and perspectives) may not be seen as such by other care-service provision agencies. Managing the boundary between organisations and departments within an organisation is the next step towards achieving a risk Utopia.

Many organisations and departments strive, usually through policies and procedures within a governance framework, to achieve a standard as set down and agreed under national and local frameworks of care and service, perhaps even achieving reward or gain in quality control internally. However, what happens when a patient transfers between departments or between organisations? Does he or she become a transferable commodity subject to the rules and regulations of the receiving entity?

Boundary risk scenarios

Some of the scenarios outlined below are hypothetical and others are based on fact.

Scenario 1: the DNR order

Patient A is terminally ill and is under the care of trust 1 and consultant X. A "do not resuscitate" (DNR) order has been properly invoked by this consultant X at trust 1. However, patient A, in agreement with the consultant, wishes to transfer to a hospice facility at trust 3 where the consultant has admitting

rights. Is the DNR order invoked in trust 1 effective in trust 3? The short answer is likely to be no. While consultant X may be employed by each trust, trust 3 remains a different organisation with differing rules. The professional's DNR may not be managerially transferable.

Scenario 2: resuscitation given

As scenario 1. However, a proper written agreement is now in place between trust 1 and trust 3 that satisfies consultant X, patient A and the carers. The DNR order will remain in place and active when the patient reaches trust 3.

The patient is transferred (with active DNR order) from trust 1 to trust 3 by trust 2, an ambulance trust. The patient suffers a cardiac arrest in the ambulance en route, and so the ambulance diverts to the nearest hospital emergency department at trust 4 where full cardio-respiratory resuscitation is attempted, yet the patient dies. Aside from waving an advance directive in the air, could this have been avoided by trust 2?

Scenario 3: missing records

Patient B in trust 5 is under the emergency care of consultant Y for a serious infection. A care package is invoked under consultant Y's supervision and drug C (an antibiotic) is commenced. The patient is severely allergic to drug P (a different antibiotic). The drug Kardex is correctly written up and the allergy noted on the Kardex and case record. The following day on the ward round the patient is deemed to be slightly better and transferred to the care of specialist consultant Z, whose team is more familiar with this type of infection. The patient is drowsy.

The drug Kardex is at the pharmacy across the site at the time of transfer as it has been accidentally lifted with other patients' Kardexes. Despite the absence of the Kardex, the patient is transferred. The clinical records are placed under the patient's pillow on the trolley by the porter and forgotten about. The patient is received without the Kardex and case record. As drug P is the preferred antibiotic of consultant Z for this infection, the patient is placed on this drug with a new Kardex, as this dose is now due. The patient suffers a serious allergic reaction and is successfully resuscitated. The allergy to drug P is later discovered when the nursing documentation is read. Later still, the porter reappears with the missing clinical record and the pharmacy returns the original Kardex – although this is returned to the patient's original ward.

Scenario 4: the pregnant drug addict

Patient C is a drug addict. She attends a community drug rehabilitation centre (trust 6). She prefers buprenorphine to methadone to alleviate her addiction to opiates. She becomes

KEY POINTS

- Managing the boundary between organisations, and between departments within organisations, is essential in reducing risks to patients.
- Agreements in writing between different organisations can help ensure smooth care transfers.
- In transfers between departments within an organisation, complete and accurate transfer of information about patients is essential.
- Organisations must look beyond internal measurements and their own reputation in order to address risks at "parish boundaries".

pregnant. Trust 7 obstetric unit does not carry buprenorphine within its prescribing remit. Trust 7 asks the community drug rehabilitation team of trust 6 to consider prescribing methadone, which is permissible in trust 7. The community drug rehabilitation team does not respond to queries from the obstetric unit except to say that they stand by the prescription of buprenorphine, but it is up to the obstetric unit to decide what drug to use. The patient is adamant that she does not want to convert from buprenorphine to methadone because of the side-effects of methadone. How does trust 7 manage the boundaries between the patient, the community drug rehabilitation team reaction and the advice from its own pharmacy about prescribing in pregnancy?

Scenario 5: child-adult services

Patient D has had several serious operations for congenital heart defects in a children's hospital trust (trust 8) and is well known to the paediatric cardiac surgery and paediatric cardiology teams. D is now 18 and has great faith in trust 8's teams. However, trust 8 cannot admit patients over 18 as it has no adult facilities. Trust 8 wants to transfer D to trust 9, which has adult cardiac surgery and cardiology teams. D does not want to go, as all his care has been with trust 8's teams, but he is now an adult and needs ongoing adult clinical care. How does trust 8 successfully transfer a child, now an adult, to a service that he knows nothing about and which knows nothing of his anxiety? While arrangements are being put in place, D suffers a severe cardiac event and requires an intensive care bed. The only bed available is in trust 10, 80 miles away, where staff know nothing of trust 8's previous care. D has a prolonged stay. How should these boundaries be managed?

Analysis

In scenarios 1 and 2 the clear route to improvement is a definitive agreement in writing between the various organisations, concerning continuation of care quality across the boundary. This must allow for a smooth transition, focused upon the patient, not internal organisational management and liability. The concept of planned discharge (returning a patient from secondary care to primary care) is well defined within vertical care integration. However, standards of care can crumble during transfer between secondary units or between secondary and tertiary settings when lateral integration is absent or poor. This issue has been partially noted within the Clinical Negligence Scheme for Trusts (CNST) standards (April 2005 standards: standard 7.2.2.). But, the focus here is upon staff working in other organisations, not patients being transferred.

In scenario 3, the core issue is proper and complete transfer of important information. Information that goes astray is information that is not available. Organisations owe a duty of care to a patient and also to attendant matters of information transfer. They must acknowledge that the transfer between one department and another is one of the weakest links crossing internal boundaries. Proper and appropriate document management and checklists must be in place and adhered to. Further, a checklist is only useful when the questions do not offer the word "no" as an option. The wording of a checklist can be as follows: "Is the Kardex with the patient?", with only "yes" being the permitted answer. "No" should not be a checklist option as it means that the task has not been done at the appropriate pre-boundary stage, but has instead been dumped at the receiving (post-boundary) stage.

Scenario 4 describes a difficult scenario that can deteriorate when each department limits its care provision to internal arrangements. The core issue is a drug imported across a boundary where the importing organisation is a) unfamiliar with that drug and b) has difficulty with liability issues when prescribing that drug outside its drug licence. An agreement in writing between the community drug rehabilitation team psychiatrist, the obstetrician

and the senior pharmacist can facilitate a smooth transition of care between the community and secondary care as regards areas of liability, accountability and responsibility.

Scenario 5 illustrates how a specific transfer problem may escalate dangerously when clinical care conditions deteriorate and the boundary is then exposed.

Discussion

As trusts improve their internal care and risk standards they drive up quality that can be measured in risk management terms through CNST standard achievements or Healthcare Commission inspection under core standards C1, C3, C4, C7c, C13b and C16¹. However, only core standards C18 and C22a reflect issues about boundary risk management, which is otherwise largely considered developmental (D1, D2c, D4, D5, D10 and D11). Internal departmental accountability and responsibility systems can be effective, but their effectiveness is only as strong as the education and training and will that supports the policies and guidelines in place. Such policies and guidelines must be fit for purpose and have quality, and not be simply imported to lie dormant.

However, despite evidence of good internal systems within healthcare organisations, it is what happens outside those organisations that can generate concern. Internal vigilance can be strong enough to prevent error or harm within a department, yet can be confounded when the clinical care is exported over departmental boundaries. Poor communication and absent, or lax, control systems can fundamentally damage care packages. Managing risk internally is understood and established fairly well within the NHS. However, when a boundary between departments is crossed one cannot necessarily attest to systems strong enough to provide equitable patient protection.

Boundary risk management can be implemented by:

- the identification and analysis of boundaries;
- putting robust control systems in place to manage boundaries; or
- creating a seamless agreed care provision that is acceptable, understood and uniform to both organisations.

The last point cries out for joined-up thinking and the abolition of territorial attitudes. This can be difficult to achieve in an environment of public liability and accountability and between competitive organisations seeking to secure and maintain their public integrity, probity and record.

Conclusion

The concept of boundary risk management is not new but has somehow fallen off the map in recent times. While there are examples of good interdepartmental clinical management, an ingrained attitude of "get it right locally first" seems to remain. Internal care standards are important, but must transfer seamlessly across boundaries between departments or organisations to show effective management of risks at the boundary. When public image takes precedence for an organisation then the importance of boundary risk management can be lost and the patient may suffer as a consequence.

Boundary risk management needs to be brought into line with established risk management protocols and strategic thinking. The patient must come first, above all things. HCRB

The views expressed above are the personal views of the author and represent no organisation nor cause.

References

1. Department of Health (2004), *Standards for Better Health*, London: DH. Accessible at <http://www.dh.gov.uk/assetRoot/04/08/66/66/040866666.pdf>.