



Monitoring and reviewing Policies, Procedures and Protocol and Guidelines

In line with the requirements of the various Accreditation/Inspection systems that we are participating in, we require Policies, Procedures, Protocols and Guidelines (PPPGs) to support and guide us in the day to day processes that we use to carry out our jobs.

However, it is also necessary to demonstrate to ourselves, to our customers, our colleagues and to the accreditation/Inspection bodies that our PPPGs are being implemented, that they are achieving the outcomes they were designed to achieve and that changes are being made to the PPPGs when required.

There are 2 levels of monitoring the implementation of the PPPGs.

1. Routine measurement of the Policy, Procedure, Protocol and Guideline.
2. 3 yearly formal review of the Policy, Procedure, Protocol and Guideline.

1. Routine measurement of the implementation of the Policy/Procedure/Protocol/Guideline

Section 2: Stages 6 & 7 (pgs 20-21) of the HSE National Framework for developing PPPGs (2016) outlines five specific standards required for monitoring, audit, evaluation and revision when developing PPPGs

In meeting these standards it is required upon the completion of the Policy, Procedure, Protocol or Guideline to identify how it is they will routinely monitor the implementation of the PPPG to ensure that it is being adhered to and that the outcomes being achieved are those that are desired for the process/intervention being described within the PPPG.

Staff must identify data that they will collect and the frequency of the data collection. Depending on the process described in the PPPG, the frequency of that data collection can be daily, weekly, monthly etc. the key to this is that whatever data is collected and the frequency of the data collection, that staff feel confident that the data that they collect can demonstrate to managers, staff, service users and the accreditation inspection bodies that the PPPG is working, is being implemented and that the desired outcomes are being achieved. It is a process of on-going assessment for staff to assess their performance against the agreed processes and the outcomes to be delivered.

Example

For example, if a service develops a procedure in relation to the allocation of appointments to patients and the procedure states that the appointment date will be given to the patient within 3 days of referral, then the outcome is that a patient will receive an appointment within 3 days of receipt of referral.

To show this, staff needs to carry out a routine check – perhaps weekly – of a random selection of a number of referrals received and the % of those for which an appointment date was sent to the patient within 3 days of receipt of the referral.



Staff may decide that they will select sample size e.g. 10 referrals received each week will be selected at random and measured – or perhaps they may track all referrals. The sample size is dependent on the total number of referrals) so that it can be reflective of what is actually happening) and is also dependent on the level of measurement that is manageable by the service. The sample number chosen should be adequate to provide assurance to the service while not being too unwieldy for staff to undertake in addition to their day to day duties.

2. Formal Review of PPPGs:

A formal review of the Policy, Procedure, Protocol or Guideline is carried out to check that the content, processes and recommendations in these documents are current and correct and that it is still in line with current evidence based healthcare and local consensus.

The frequency of the review will be determined by the rate at which new developments are being introduced to the service and the regularity of changes to profession practice, evidence based best practice, guiding principles, standards etc.

It is recommended that the frequency of the review will be at least every three years – or more frequently at the discretion of the line manager.

The questions to be asked by the reviewer(s) include:

- Are the processes/standards/required behaviours etc. described in the Policy, Procedure and/or Guideline correct?
- Are they still in line with current best practice?
- Are staff compliant with the requirements of the PPPGs?
- Are the desired outcomes being achieved through the implementation of the PPPG?
- If not, why?
- Are there any changes/additions required?

When carrying out a review staff may find it beneficial to look at the PPPG from a Structure-Process-Outcome perspective to ensure that all aspects of the process is examined.

The data collected through the routine monitoring process should be used to inform the review process.

In addition, the data obtained from the routine monitoring may indicate that a review of the PPPG is required sooner than planned if desired outcomes are not being achieved through the implementation of the PPPG.

A review of the PPPG may also be required sooner than planned if an incident has occurred/near miss etc. and assurances are required that the PPPG is adequate to prevent such incidents/near misses etc. happen again.

If a review is carried out sooner than the planned review date, then this becomes the new review date and the next review is one/two years from the new review date.



Sample Questions for PPPG review:

Structure

e.g. Staff, equipment, facilities – physical structure to enable the process to be carried out.

Are all staff aware of PPPG?

How do you ensure staff awareness?

Is PPPG in a location to facilitate ease of access by staff?

Is there availability of appropriate equipment to meet needs of PPPG?

Are all relevant staff available to meet needs of PPPG?

Are there log books/database/computer/check sheets etc., for collection of data?

Are all staff trained in meeting the requirements of the PPPG?

How are training needs identified?

Is the work environment appropriate?

Does the PPPG involve all relevant staff – or are there staff outside the PPPG involved in the process?

What standards are used to inform the processes described/recommendations made?

Process

i.e., the actual steps to be followed in carrying out a task

Is the process still in line with current evidence based best practice?

Would the process pass the “Test of Peers?”

Are all staff doing as PPPG states?

How do you know?

Is responsibility clear for all parts of the process?

What data are you collecting to ensure all staff are compliant with the described processes?

What are your processes if you determine non-conformance of staff with the PPPG?

What data are you collecting to demonstrate ongoing compliance to be PPPG?

Outcome

The results/end product obtained through putting the PPPG in to place

What data are you collecting to demonstrate ongoing achievement of the desired outcomes?

Are there standards being adhered to? Are these referenced?

Is PPPG in line with evidence based best practice? Is this evidence referenced?

Do you know if this PPPG is meeting the needs of the patient/customer?

How do you measure customer satisfaction?

How do you know if changes/improvements to the PPPG are being implanted?

Are desired results being achieved for?

A. Staff?

B. Customers?

Are there clear outcomes identified in the PPPG?

What is being done with the results of the measurement of the performance indicators?



3. Healthcare Audit of PPPGs:

Healthcare Audit is audit of current practice against standards in any aspect of healthcare and includes both clinical and non-clinical audit. Clinical audit is specifically about audit of actual practice against evidenced based clinical standards of care.

Healthcare Audit involves measuring the current clinical practice, using quantitative or qualitative measurement tools, against relevant standards. The standards against which the practice is measured should be set out in the Policies, Procedures, Protocols or Guidelines developed for the service. The standards may be contained in one PPPG or a number of PPPGs depending on the scope and scale of the audit.

While all PPPGs must be monitored and reviewed on a routine basis, not all individual PPPGs require a clinical audit.

A Healthcare Audit is required where it is identified that current processes are hazardous or high risk, processes and standards are not being adhered to by staff, or if poor outcomes are being obtained. An audit may also be carried out on processes that are identified by staff or service users as being an area of concern, or about which complaints have been made or where a serious incident/near miss has occurred or a series of incidents or near misses have occurred. Another indicator for Audit may be where processes are proving to be high cost and there exists uncertainty in relation to the value for money of such processes.

In such instances, an Audit is required to identify where the issues exist, to what extent the issues exist, where standards are not being met and where changes for improvement are required.

A Clinical Audit may also be carried out on a Care Programme such as Diabetes, which will involve a number of PPPGs to ensure that the Care Programme is being implemented satisfactorily. This is particularly the case if the care programmes are national priority and the HSE is requesting information on the performance of each location against the standards set out in the care programme.

It is in cases such as the above that an audit of the systems may be carried out and part of that audit will involve checking all relevant PPPGs, comparing current practice to the PPPGs and comparing current practice and the PPPGs to current and nationally/internationally accepted evidence based best practice/standards to determine deficiencies and gaps in the current system. Recommendations for improvement will be determined and implemented to bridge such gaps or to eliminate deficiencies. Changes may include the updating and improving of the relevant PPPGs.