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In-depth reviews of health services 2020–23

Learnings to improve the system of healthcare

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# Executive summary

Safer Care Victoria (SCV) undertakes reviews of health services and multiple agencies with the purpose of improving the quality and safety of healthcare. We worked in partnership with 12 health services between January 2020 to February 2023. There were five reviews of acute health services provided by hospitals and ambulance services, one review of community services, three reviews of health programs, and three multi-service reviews.

This document summarises the key findings of the reviews and makes recommendations to improve safety and quality using the learning from good practises and errors in the healthcare system.

The findings and recommendations align with the Victorian Clinical Governance Framework[[1]](#footnote-1).

1. Leadership and culture
2. Consumer partnership
3. Risk management
4. Workforce
5. Clinical practice

# Common themes from in-depth reviews

## Leadership and culture

Insights from the 12 reviews demonstrated an opportunity for Board, CEO, and Executive to improve their understanding of clinical governance and assurance of good clinical governance. In addition to developing clinical governance capability, there is a need to establish role clarity amongst Board, CEO and Executives. Supporting strong clinical governance requires more than a single training session at induction. This will require a bespoke program of clinical governance training that adapts to support strong governance in a continuously changing healthcare environment.

Boards, CEOs, and Executives are accountable for ensuring that there is a strong patient safety culture at all levels and amongst all staff groups in their organisation. This review highlighted the need for organisation-wide safety culture assessment and improvement programs. This includes ensuring cultural safety for Aboriginal and Torres Strait Islander people as well as those from culturally and linguistically diverse backgrounds.

## Consumer partnership

Developing and maintaining consumer partnership in governance is critical to ensure strong patient safety culture. People with lived experience contributing to strategic discussions ensure that staff and leaders maintain their connection with the ‘why’ of service delivery. Consumer representation provides insights otherwise not considered in decision making. When the organisation engages those with lived experience, decision-making is more effective.

## Risk management

Organisations with robust incident management systems are more likely to learn from and prevent future harm from occurring. Key to learning is providing feedback to those who raised concerns, which includes the actions taken and their evaluation and monitoring.

## Workforce

Developing and maintaining a capable and resourced workforce is key to the delivery of safe, high quality healthcare. Organisations that have a strategy to anticipate workforce requirements for high-quality service delivery have reduced harm arising from adverse events. Moreover, when adverse events occur, such organisations are able to learn and improve. The quality of teamwork is a strong predictor of safe systems of care. Comprehensive workforce planning ensures that staff have individual and team goals that are aligned with organisational priorities and receive regular feedback on their performance and an annual development plan.

## Clinical practice

Clinical guidance and process for escalation of care is a feature of good clinical governance. Organisations provide a culture of psychological safety where escalation of concerns and availability of capable decision makers with authority to respond are embedded in the system. This includes valuing interdisciplinary and cross department input into issues and clinical practice reviews such as morbidity and mortality meetings. Continuous reflection and learning in a psychologically safe environment are key to delivering safe, high quality clinical practise.

# Recommendations for improvement to health services

Practical steps can be taken by health services to improve clinical governance. We are committed to partnering with health services to improve their clinical governance effectiveness to deliver safer care for Victorians. Always. We believe that reflection and learning from what went well and what did not go well in the past is key to improvement.

## Leadership

* Have an up-to-date organisational chart that clearly describes roles and responsibilities, including those for clinical governance.
* Ensure leadership roles and responsibilities are communicated to staff and consumers.
* Increase the visibility and accessibility of the CEO and Executive to all staff.
* Provide ongoing and comprehensive management and leadership training for all managers of staff, including clinical leaders, especially around challenging conversations and performance improvement.
* All health service Board members, CEOs, and Executives complete general governance and clinical governance capability development consistent with the Victorian Clinical Governance Framework.
* Provide guidance to support managers to implement the clinical governance framework consistently across the organisation.
* Roles, reporting, and responsibilities of clinical governance committees must be well outlined in a clinical governance plan.
* Develop and widely publicise and promote a clinical governance plan.
* Ensure the separation of clinical governance and operational committees.

## Safety culture

* Improving patient safety culture is one of the most effective actions to reduce preventable harm.
* Board, CEO, and Executive should lead a safety culture assessment and improvement process.
* Ensure awareness and understanding of workplace incivility and its effects on safety and quality of care.
* Develop a consistent organisational approach to embedding psychological safety principles and practices.

## Partnership with consumers

* Develop and widely promote consumer pathways for speaking up and asking for assistance when needed. Embed clinician engagement in the process to ensure consumers are heard and their voices acted on.
* Improve consumer experience when harm occurs by providing training for clinicians in open disclosure and support for delivering the statutory duty of candour.
* Embed processes that routinely engage the consumer in their care planning and decision-making.
* Improve consumer experience of complaint handling. Maximise use of direct contact and improve clinician engagement in responding to complaints.
* Ensure consumer involvement in service improvement and redesign.
* Ensure consumer involvement in strategic governance committees.
* Ensure consumer involvement in appointments of key personnel for the organisation.
* Develop processes to get broader consumer feedback on strategic issues.
* Strengthen the Community Advisory Committee and ensure more diversity. See the committee as partners and use as advisors in organisational decision making.
* Provide detailed orientation and support to enable engagement with the organisation for consumers involved with projects, committees, volunteering, etc.
* Optimise the role and use of consumer support services and personnel that exist within the organisation

## Risk management

* Provide safety and quality team members and clinical leaders with training and development in incident management and quality improvement.
* Use a centralised incident, improvement, and risk management platform to avoid gaps and inconsistencies in learning and improving from clinical incidents.
* Review and use all incidents as an opportunity to remove unwanted variation in practice, to standardise management and incident response and to learn across the system of care.
* Increasingly engage clinical and leadership staff in discussion of ‘near misses’ as a safe topic for improvement.

## Workforce

* Improve awareness of clinical governance structures and roles and responsibilities.
* Include clinical governance responsibilities in position descriptions and contracts. Resource and support staff to undertake these responsibilities.
* Improve workplace safety knowledge and documentation.
* Strengthen workforce planning and align this to the organisation’s strategic and clinical service plans.
* Ensure all staff receive orientation to the organisation and their specific role.
* Improve opportunities to gain staff feedback around their experience of work through pulse surveys, formal exit interviews.
* Provide capability development for staff around management, leadership, and governance to optimise staff retention and succession planning.
* Align work of medical workforce unit and human resources to ensure:
	+ all enterprise agreement requirements are incorporated into work practice
	+ staff related issues are handled in a consistent manner across the organisation.

## Clinical practice

* Monitor and revise systems for escalation of care and response to patients at risk of deterioration.
* Ensure escalation of care procedures include when and how to escalate and to request more assistance.
* Build a safety culture where clinical escalation is seen as and treated as a positive action.
* Where staff infrequently treat critically unwell children, ensure annual training for all staff who may have to respond (including multidisciplinary simulation).
* All resuscitation teams should have visible mechanisms to identify team member roles.
* Ensure guidelines and procedures are easily available to staff at the bedside (consider the use of apps or QR codes).
* Have a dedicated repository for clinical guidance that is easily searchable.
* Ensure there is always a senior decision maker with appropriate clinical experience available. Consider links with other services to provide this remotely if needed.
* Explore digital platforms that allow on call medical staff to have access to required patient information from home.
* Increase multi-disciplinary engagement with clinical care and review, e.g. in management and clinical governance meetings, and in morbidity and mortality reviews.
* Encourage and support interdisciplinary and cross team training and education.
* Maximise understanding and partnerships with community organisations to reduce pressures on acute services.

To engage with Safer Care Victoria in delivering on the recommendations, please contact culture.capability@safercare.vic.gov.au.

1. Safer Care Victoria. (June 2017) *Delivering high-quality healthcare Victorian clinical governance framework.* Victorian Government: Melbourne, Victoria. [↑](#footnote-ref-1)