Better Quality, Better Health Care

A Safety and Quality Improvement Framework for Victorian Health Services
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A safety and quality improvement framework for Victorian health services is an initiative of the Victorian Quality Council (VQC). It was developed as one component of a strategic approach to improving the safety and quality of patient care in Victoria across five areas: Establish a Safety and Quality Framework, Provide Improved Access to Better Data, Involve Consumers in Improving Safety and Quality, Educate on Safety and Quality and Respond to Known Problems and Risks.

The VQC Safety and Quality Framework is a strategic overview of the key principles and practices necessary for the effective monitoring, management and improvement of health services. Whilst the framework is applicable to health services of all sizes and types, its usefulness depends on the extent to which organisational and clinical leaders adapt it to local structures, environments and needs. The framework is built on a foundation of clinical governance, which clearly delineates the board responsibility for ensuring that service and care quality is addressed with the same rigor as financial governance, and ensures that corresponding accountabilities are delegated throughout the organisation.

The intent of this framework is that it is applied to best benefit each individual organisation in improving the safety and quality of care and services. Depending on the quality maturity and program progress of an individual health service, it may be applied as a model, a reference, a plan, a source of ideas or a benchmark to review progress and identify quality improvement (QI) program gaps. Where specific examples of activities, structures and processes are given, these should be considered in terms of their relevance to your organisation. The key to the usefulness of the framework is that it is applied to add value to health service safety and quality programs.
The framework describes the intersection between four critical organisational processes essential for quality improvement and each of the six dimensions of quality, as well as exploring related roles and responsibilities throughout the health system as seen above in figure 1.0.

Access and efficiency have traditionally attracted the majority of the health care quality focus. Whilst these are important quality components, this framework emphasises the other four equally significant dimensions and offers examples of how these might be measured and improved, and how the clinical governance component of the board corporate governance role can best be fulfilled.

The relevant literature clearly demonstrates that a strong and unwavering commitment to safety and quality results in demonstrable benefits, not only for patients, but for the organisation, including less complications and deaths, lower costs, greater efficiency and improved clinical outcomes. A quality program is only as successful as the culture within which it is implemented, however. It is the responsibility of the board and senior management to promulgate a culture wherein openness, mutual respect and teamwork are encouraged and rewarded. This should provide the foundation for a planned approach to quality and safety that encompasses staff and patients’ values, identifies clear priorities, allocates resources, provides education, addresses risk, illustrates the QI methodology in use and outlines the supporting committee and reporting structures.

Developing a comprehensive approach to safety and quality improvement takes time and can be achieved via a staged approach. Quality programs are iterative and require constant development by the organisation to meet changing internal and external contexts, expectations and stakeholder needs. Health service quality approaches also comprise many external components such as: accreditation standards and reviews, funding and policy imperatives and tools from the Department of Human Services (DHS), national initiatives from bodies such as the Australian Council on Safety and Quality in Healthcare and ideas from programs in other countries. This framework is consistent with external requirements for safety and quality improvement programs and has also drawn on quality and safety research to integrate best practice in safety and quality program development and implementation.
Whatever approach is taken, however, a clinical governance based model of safety and quality improvement will demonstrate some standard features across all organisations. As a minimum requirement, boards should ensure that safety and quality management receives the same emphasis as financial management, and is linked to strategic and business planning processes. An effective quality program requires a planned approach, which enables boards to provide evidence that:

- there are appropriate organisational structures, processes and resources in place to monitor, manage and improve the safety of care and services and the service delivery environment
- the objectives of the quality program are clear and staff at all levels understand their related roles and responsibilities
- staff have access to appropriate safety and quality technical support and information to enable their effective participation in improving care and services
- consumers and carers are involved in safety and quality improvement in a variety of ways including through feedback, complaints and improvement activities
- key areas of risk are identified, prioritised, managed and regularly reported
- there is a strategy for managing those internationally recognised problem areas in patient safety and quality such as health service acquired infection, medication errors, pressure ulcers, falls, use of blood and blood products and pain management, including regular reporting, action and follow up (a more comprehensive list of suggested data collection and reporting is found in the “Information management and reporting” section of each dimension of quality in Appendix A)
- there is a clear and transparent process for the review of deaths and reporting and responding to sentinel and adverse events
- patient care is based on best available evidence and delivered by properly credentialed and trained staff
- external reviews, such as accreditation, are used as positive opportunities to review compliance with standards
- the health services benchmark with other like organisations on key areas of care and safety to facilitate learning and improvement
- there is ongoing development of an organisational culture wherein participation and leadership in safety and quality improvement are resourced, supported, recognised and rewarded.
On an operational level, it is up to the CEO and senior managers to make it easier for staff at all levels of the organisation to do the right thing in the provision and improvement of quality care and services than not. Research has shown that there are three key predictors of staff involvement in safety and quality activities: the extent of support from their direct line manager; a belief that the organisation will experience outcomes of value from the activities; and training in the tools of change and improvement. Thus, embedding the improvement program in an organisation will require engaging and building leaders and innovators at all levels, from “board to bedside”. Information flow should ensure that the board, managers and committees receive regular reports on relevant issues, that these are considered and acted upon and that feedback flows to those affected by and providing the information.

Evidence of improvements should be widely circulated and celebrated and staff should have access to training that equips them to participate in quality improvement activities. This framework discusses each of these key requirements in detail, both theoretically, in the body of the document, and practically, by offering ideas for implementation and data reporting in Appendix A. An example of how the framework might be applied to the management of a sentinel event is described in Section 4, and a checklist for organisational self-assessment against the framework elements is found in Appendix C.

If “improvement of health care performance hinges on changing the day-to-day decisions of doctors, nurses and other staff”\textsuperscript{7}, then it is important that each individual’s role in achieving this is clearly delineated. To this end, the framework identifies generic clinical governance roles at six levels of the health system that can be adapted to individual organisations (see Appendix B).
The Victorian Safety and Quality Improvement Framework builds on the salient NSW Health (1999) document “A Framework for Managing the Quality of Health Services in NSW”¹ and also sources material from the safety and quality literature, the Victorian Department of Human Services (DHS), and other relevant material such as hospital review reports and discussion papers.

The Framework is a generic strategic and principles-based document, which should be applicable to health services of any size. Whilst it is primarily hospital-focused, the principles and framework elements, particularly those concerning clinical governance and leadership, are applicable more broadly across all aspects of service provision and care. Organisational safety and quality improvement is illustrated using a matrix approach. Each of six dimensions of quality is explored within health service roles and organisational environment.

Section 1, the Executive Summary and Section 2, the Overview, summarise the framework. The Executive Summary reads as a stand-alone document and can be used as a condensed reference to the framework. Section 3 explores the organisational elements and their application to safety and quality in more detail. Section 4 gives an example of how the framework might be applied to a sentinel event. Appendix A shows the dimensions of quality/organisational elements matrix in table form and gives examples and ideas of how they might be applied, and suggests areas for data collection and reporting. Appendix B lists clinical governance roles and responsibilities at a number of different levels in the health system. A checklist to assist with organisational self-assessment and review is found in Appendix C.
The Framework for Managing the Safety and Quality of Health Services in Victoria:

- focuses on the safety and quality of clinical care
- promotes leadership and accountability for the safety and quality of health care with a systemic orientation
- focuses on the principles for managing the safety and quality of health services
- provides an organisational focus for quality activities and reporting, recognising the essential role played by leaders, consumers and all health service staff in quality improvement
- recognises the essential cultural requirements of quality and safety improvement.

For the purposes of this framework, quality care is defined as “the extent to which a health care service or product produces a desired outcome”.\(^2\)

Quality improvement is defined as “the continuous improvement of all processes and the products and services that are the outcomes of those processes”.\(^13\)

Clinical Governance is defined using the Australian Council on Healthcare Standards (ACHS) definition: “the system by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risks to consumers, and for continuously monitoring and improving the quality of clinical care.”\(^14\)

Safety is defined as “a state in which risk (measured in terms of consequences and likelihood) has been reduced to an acceptable level”.\(^2\)

This framework is consistent with, and should be considered in conjunction with, relevant DHS policies, statutory and insurance processes and reporting requirements, and relevant professional, industry and accreditation standards and protocols.
2A The Principles Underpinning the Framework

The principles that underpin the delivery of safe and high quality health care have been developed from a variety of sources, including published literature and relevant reports from Australia and other countries.

A quality oriented health service will reflect the following characteristics: 1, 4, 5:

- the health consumer as the primary focus of any model of health care quality management
- the board, CEO and executive taking responsibility for creating and maintaining a structure, culture and policies for managing the safety and quality of health care
- the health service board creating an open and honest culture wherein responsibility for the quality of the health care provided to consumers is clearly articulated and enacted at all levels
- a systematic and system-wide approach to continuous improvement of the quality of care delivered
- an emphasis on preventing adverse outcomes through simplifying and improving the processes of care
- those practising within the system taking appropriate responsibility for the standard of their own practice and sharing responsibility for creating and maintaining a system which provides safe, high quality health care
- consumers being enabled and encouraged to participate effectively in both their own care and treatment and the planning, delivery and evaluation of health services
- consumers having ready access to effective systems of complaint and compliment
- an emphasis on the development of partnerships of care with consumers, staff within the organisation and health workers in the community
- a robust advisory and reporting structure designed to promote the improvement of health services and to provide regular information to the health service board on the quality and safety of services provided
- health treatment and care based on the best available evidence
- the quality of health care measured systematically with a focus on the minimisation of inappropriate variation in practice
- all health care providers having access to information about the outcomes of the care they provide and the systems within which they work
- a system driven by performance in the six primary dimensions of quality of health care
- quality and safety information used in planning and resource allocation decisions within health services
- the quality framework supported by high quality organisational structures and processes that have been evaluated by a recognised external accrediting body.
The framework describes the dimensions of quality and the cross dimensional organisational elements that underpin effective safety and quality improvement.

A planned approach to safety and quality by key organisational elements:

- Governance, Leadership and Culture
- Consumer and Community Involvement
- Competence and Education
- Information Management and Reporting

To monitor, manage and improve each dimension of quality:

1. Safety
2. Effectiveness
3. Appropriateness
4. Acceptability
5. Access
6. Efficiency

At each level of the organisation:

- Government
- Board
- Quality Committee structure
- CEO and Senior Clinicians and Managers
- Clinicians and Teams
- Consumer and Community
This framework distils and discusses four key organisational elements necessary for the effective improvement of the quality of health care: Governance, Leadership and Culture; Community and Consumer Involvement; Competence and Education; Information Management and Reporting.

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<thead>
<tr>
<th>Governance, Leadership and Culture</th>
<th>Competence of, and Education to Support, Health Care Providers</th>
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<tr>
<td>Corporate governance describes the structures and processes put in place by boards to fulfil their strategic, statutory and financial obligations. Clinical governance is a critical element of the corporate governance of health services. Clinical governance refers to boards’ accountability for ensuring that a framework and rigorous systems are established so health care safety and quality is monitored and supported, evaluated and continuously improved.</td>
<td>Competence is an overarching issue and a major priority for review and action in health services. This includes the competence of the organisation, the competence of multi-disciplinary care teams and the competence of the individuals who deliver care and services.</td>
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<tr>
<th>Consumer and Community Involvement</th>
<th>Information Management and Reporting</th>
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<tr>
<td>Consumer involvement in health care is critical to effective service planning and evaluation and to the achievement of optimum care outcomes. There are many differing definitions of ‘consumers’ in healthcare. For the purposes of this document, the term consumer refers to people who either directly or indirectly make use of health services. This includes individuals receiving, or who have received, health care services, whether individuals or in groups according to similar backgrounds or health states. It also includes family and carers of those receiving health care. Community is described in this framework as the population served by the health service, including future users and the wider community that benefits from health care services.</td>
<td>Information management refers to the collection of data, the technology required to do so, including the software and hardware, the reliability and validity of the data and how data are reported and converted into information to be used in practice. To support these processes, data and information should be available, accurate, timely and relevant. Ensuring this includes review of coding accuracy, robust data definitions and collection systems, and transparent analysis and reporting processes.</td>
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Dimensions of quality in health care are variously described in the literature with a number of different dimensions and definitions available.

For the purposes of this framework, the dimensions of quality are described as follows:

**Safety** of health care: A major objective of any health care system should be the safe progress of consumers through all parts of the system. Harm arising from care, by omission or commission, as well as from the environment in which it is carried out, must be avoided and risk minimised in care delivery processes.

**Effectiveness** of health care: Consumers of health services should be able to expect that the treatment they receive will produce measurable benefit. The effectiveness of health care relates to the extent to which a treatment, intervention or service achieves the desired outcome.

**Appropriateness** of care: It is essential that the interventions that are performed for the treatment of a particular condition are selected based on the likelihood that the intervention will produce the desired outcome for each patient. This means that the expected health benefit exceeds the expected negative consequences by a sufficiently wide margin that the procedure is worth doing. Essentially, the appropriateness of health care is about using evidence to do the right thing to the right patient, at the right time, avoiding over and under utilisation.

**Acceptability** of care: Opportunities must be provided for health consumers to participate collaboratively with health organisations and service providers in health service planning, delivery, monitoring and evaluation at all levels in a dynamic and responsive way. Consumer and community participation should enhance the level of acceptability of services, which is the degree to which a service meets or exceeds the expectations of informed consumers.

**Access** to services: Health Services should offer equitable access to health services for the population they serve on the basis of need, irrespective of geography, socio-economic group, ethnicity, age or sex. This includes availability of services, such as waiting times for services and processes involved in accessing services, physical and information access. The Victorian public health system, like others in Australia and internationally, is experiencing unprecedented and sustained increases in demand. The issue of access to all health services is a critical one.

**Efficiency** of service provision: Health services must ensure that resources are utilised to achieve value for money. This can be achieved by focussing on minimising the cost combination of resource inputs in the production of a particular service as well as the allocation of resources to those services to provide the greatest benefit to consumers. Allocative efficiency informs decisions on what services or treatments to deliver, whereas technical efficiency is concerned with reducing costs and minimisation of waste.

This classification system for quality recognises that each dimension is not a completely separate entity. Each should be considered when developing and implementing a system to improve the quality of care and services. There is significant overlap and interdependence between them, however.
2E Roles and Responsibilities

(These are explored in more detail in Appendix B.)

1. Government (Department of Human Services) Role
   DHS lays the foundation for clinical governance in legislative, policy and funding frameworks.

2. The Board Role
   The board has ultimate responsibility for the clinical governance of a health service, and attention to this must be as rigorous as that given to other corporate board responsibilities.

3. The Quality Committee Role
   The Quality Committee is the peak patient safety and quality committee in the organisation, however named, and takes an active safety and quality planning, monitoring and evaluation role on behalf of the board.

4. CEO and Senior Clinician and Management Role
   The CEO and managers are central to operationalising clinical governance.

5. Clinician and Team Roles
   Whilst the board, CEO and managers provide the principles, systems and resources for good clinical governance, it is the staff delivering services who implement and monitor these systems day to day.

6. Consumer/Community Role
   Consumers want assurance that their care is safe, effective and appropriate. The wider community is becoming increasingly knowledgeable about health care delivery and want to be active participants in this process. The challenge is to involve these groups in a meaningful and positive way for both the consumers and health services.
An Organisation-wide Approach to Safety and Quality Improvement

In this section, the principles of the organisational elements of the framework and their application are discussed in more detail:

A. Governance, Leadership and Culture
B. Consumer Involvement
C. Competence and Education
D. Information Management and Reporting

An example of an organisational approach to an element of safety and quality is given at the end of this section. Examples of activities that relate to each element for each dimension of quality are found in the matrix in Appendix A.
Clinical governance emphasises the importance of boards governing clinical safety and quality with the same rigour as applies to corporate governance. Boards and executive staff should regularly audit their knowledge and performance to identify gaps and develop appropriate orientation and education process to enable the governance role to be effectively undertaken. Strong support should be given to the organisation pursuing valid external assessment via an accreditation or certification program.5

A (i) GOVERNANCE

As a minimum, boards should work with the CEO, clinicians and management to develop a quality plan that ensures key areas of risk are prioritised, monitored and regularly reported and that there is a clear and transparent process for responding to sentinel and major adverse events. Staff should be equipped and supported to engage in improving the safety and quality of patient care. Boards should be confident that there is a process in place to monitor the safety of the environment, ensuring that patient care is carried out by properly credentialed and trained staff, that external reviews, such as accreditation, are used as opportunities to review compliance with standards and that consumers are involved in safety and quality improvement.

The four principles of effective clinical governance arising from the literature are:

- build a culture of trust and honesty through open disclosure in partnership with consumers and community
- foster organisational commitment to continuous improvement
- establish rigorous monitoring, reporting and response systems
- evaluate and respond to key aspects of organisational performance.4
Building the right culture involves, among other things, creating a non-punitive environment where blame is the exception rather than the rule, where the principles of open disclosure are embedded in everyday practice, and where staff willingly report and learn from problems and adverse events.

Fostering organisational commitment to continuous improvement includes assigning clear responsibility to the CEO for leading a planned approach to safety and quality and monitoring key aspects of organisational safety and quality performance. The CEO, in turn, builds an organisational environment wherein safety and quality are reviewed and improved through sound planning, committee, leadership, reporting and evaluation structures at every level.

Monitoring, reporting and response systems must be planned, robust and the focus of health care organisations should go beyond meeting minimum standards. The measures reviewed by the board and subsequent improvements should be based on knowledge of key health care quality and risk issues and sound safety principles. The focus should be on systems improvement, while supporting and encouraging the application of evidence-based practice by individual clinicians. Boards and executives should have in place a process for responding to adverse events and clinical governance issues that is clear, transparent and consistent.

Evaluation and response to key aspects of organisational performance should be approached with a strong focus on systems issues and systems improvements, as well as supporting and encouraging the application of evidence-based practice. Other related considerations include:

- ensuring a range of qualitative and quantitative methods is used to monitor performance
- defining and streamlining the reporting process and structure to prevent information overload and ensure appropriate feedback
- ensuring the health care service responds in a planned way to important safety and quality matters;
- approving policies and changes enabling the organisation to manage and reduce risks
- delegating safety and quality improvement and reporting accountabilities throughout the organisation
- benchmarking and comparing organisational performance
- sharing lessons learned on safety and quality across the health care industry
- evaluating the board’s clinical governance performance regularly.
Lead a Culture of Improvement

Boards and senior managers must lead a culture of improvement. This includes supporting and implementing relevant policies such as open disclosure, consumer and community involvement and identifying, analysing and learning from errors and problems. Improvements and change efforts must involve individuals and teams and encourage inter-departmental and inter-disciplinary communication. Developing a culture of improvement will require that boards, CEOs and managers at all levels are seen to be involved in developing, supporting and rewarding staff involvement. It may also involve identifying, encouraging and resourcing opinion leaders at all levels to involve staff in various ways.

Empower and Resource Managers at all Levels

Boards and senior managers should empower and resource managers at all levels (both clinical and non-clinical) to be involved in improving safety and quality. This includes tangible assistance such as funding administration time, backfilling staff, increasing incentives and removing perverse incentives. It also requires the CEO and senior managers to clearly delineate all managers’ responsibilities for improving safety and quality as part of position descriptions and performance reviews, and for managers to make a reciprocal commitment to fulfil those responsibilities.

Managers will be most open to full participation in the QI program when they feel supported by senior managers, are clear about the QI goals and their role and responsibilities for achieving them, trained in the skills they need to fulfil their role and trusted to fulfil those responsibilities. Another important role for senior managers in assisting this process is the creation of organisational slack, or space, for managers and staff to use the quality program to plan, implement and evaluate innovative approaches to improvement.

Develop an Organisational Quality Improvement Plan

One of the most critical contributions a CEO can make to an organisational safety and quality program is to lead the development of the organisational quality improvement plan, which should map out the why, what, who and how of safety and quality monitoring and improvement in the organisation.

Developing the Plan

This plan should be developed in conjunction with other senior and middle managers, clinicians and consumers, and importantly, incorporate organisational, consumer and staff professional values. This places the safety and quality program in the broader context of contributing to the strategic direction, assists in setting priorities, and helps engage staff by recognising and incorporating the values of those who will implement the program. A key element of this is the translation of the strategic vision for the organisation into operational priorities and implications for safety and quality.
A quality improvement plan can be structured in many different ways, for example, safety and quality improvement activities may be planned on the basis of the dimensions of quality, health service strategic priorities, safety and quality priorities, organisational structures, accreditation frameworks or a combination of these. Each organisation should develop an approach that best fits their structure and culture for maximum QI program effectiveness.

The quality improvement plan will facilitate reporting and analysing errors and problems without blame or negative consequence and outline the process for investigating, managing and reducing their occurrence. It will demonstrate that areas of risk are prioritised, monitored and minimised, professional, statutory and external standards are met and key areas of care and service delivery are routinely monitored and improved. Responsibility and accountability of all levels of the organisation should be clearly delineated at individual, team and committee levels. The policy on issues such as qualified privilege and associated use of identified data should be explained. The board should understand and endorse the QI plan and be able to supply documentary evidence of its implementation and outcomes to external evaluators.

Quality Improvement Methodology
The quality and safety process, whether embedded in strategic and operational plans, or a separate, but linked process, should be built on a simple improvement methodology that is relevant to the organisational context. The key to continuous improvement is the feedback loop, where data and information collected are analysed, acted upon, the results of action reviewed for effectiveness and all parties concerned kept informed of progress. Common improvement methodologies include: Plan, Do, Study, Act; Monitoring, Assessment, Action, Evaluation; Breakthrough Collaborative; Assess, Diagnose, Review, Implement and Six-Sigma.

Whatever methodology is chosen, effective planning, change management approaches, information sharing and leadership are fundamental to success.

Any methodology will encompass a number of common improvement tools and techniques including:

- diagnostic, monitoring and priority-setting activities such as identifying and managing risk via clinical risk management systems; clinical and performance indicators; peer review; audit; morbidity and mortality review; improvement teams; practice review against evidence and standards (internal and external) and benchmarking

- quantitative and qualitative data collection, analysis and presentation tools such as checksheets; pareto charts; cause and effect diagrams; brainstorming; process mapping; interviews and questionnaires

- skills for enhancing the effectiveness of communication, discussion and decision-making such as team dynamics; communication and negotiation skills; meeting processes; presentation skills and problem-solving techniques.

Improvements can be made, evaluated and embedded in an organisation’s process and outcomes in many ways, including:

- developing and implementing new standards, policies and procedures
- changing processes and practices
- systems redesign
- education and training
- physical and equipment changes
- strategic and operational plan review.

All changes should involve those impacted: staff, consumers and the community and other stakeholders. An effective change management methodology that considers both the people and business sides of change is critical to quality program success and should be built into the quality plan.

Whatever method is used, it is critical that the QI process doesn’t overwhelm the quality program objectives: “cynicism comes when the pursuit of the program is more important than the pursuit of quality”.11
Encourage and Facilitate Staff Participation at all Levels

Quality improvement is often perceived by staff as “the top telling the middle what to do at the bottom.” Encouraging and facilitating the organisation-wide participation of staff in the safety and quality program is critical to its effectiveness and relies on a number of leaders, both clinical and non-clinical, working together throughout the organisation. This requires an organisational culture that encourages effective vertical and horizontal communication across professional boundaries and within hierarchies.

Studies of staff involvement in QI in the literature indicate some key predictors of middle management and staff involvement in improvement activities, including:

- the extent of support from their direct senior manager
- a belief that the organisation will experience outcomes of value from the activities
- training in the tools of change and improvement.

Responsibility for staff participation cannot, therefore, lie with the quality manager and other associated personnel. The quality manager can and should assist with encouraging staff involvement as a technical expert, for example, ensuring staff are trained and equipped to participate, setting up appropriate monitoring and reporting systems and providing guidance with planning, executing and evaluating activities. But the responsibility for staff participation in ensuring safe and high quality care requires the commitment and development of formal and informal leaders throughout the organisation.

Leadership development in safety and quality comprises a number of elements:

a) A clear understanding of what leadership in safety and quality means within a particular organisation, for example:
   - setting the safety and quality agenda
   - determining priorities
   - acting as champions
   - initiating activities.

b) Provision of incentives to take on a safety and quality leadership role such as time, resources, education, data, influence, research and publication opportunities and supportive organisational structures and processes.

c) Specific training to equip leaders including:
   - managing change
   - leadership in health care
   - team building and motivation
   - safety and quality tools and techniques
   - meeting skills
   - negotiation and conflict management
   - communication and delegation
   - project planning and management
   - principles of adult learning.

Training and education should be implemented using a variety of media:

- short courses
- mentorship
- case studies and discussion
- information presented by respected peers
- literature, from peer-reviewed journals
- action learning.

d) Changes to governance structures and roles to embed safety and quality leadership.
Culture is often referred to as ‘the way we do things around here’. Health care is said to have a distinctive culture, departments and professions within health care have discrete cultures and each health care organisation has its own unique culture. This is one of the reasons that quality improvement programs will be most effective if QI frameworks, principles and practices are applied in a way that is acceptable and appropriate to each organisation.

Culture is created from the top of the organisation and maintained at all levels. The culture of health care organisations is particularly complex due to the nature of health care itself, the organisations in which it takes place and the broad range of professions involved. Organisational culture may be a primary source of resistance or a force for major improvement, depending on the initiative.

A health service culture wherein safety and quality are key to core business requires clear and consistent leadership from boards, CEOs and senior managers. This can only be achieved if addressed in a variety of ways, including being embedded in organisational structures and governance, part of the accountabilities of staff at all levels; actively encouraged and rewarded; and the consumer voice strengthened.4,5

Not everyone will embrace a move towards a culture based on clinical governance. Start with those who want to be involved (the innovators and opinion leaders) and demonstrate improvements to encourage others to follow. The cultural change required in the move towards clinical governance should be values-based, with the organisational and professional values of those involved used as the cultural foundation. In health care, a widely held value is “the desire to help people by offering a high standard of service in a timely and courteous manner”.7 QI programs are more likely to foster involvement if both formal and informal opinion leaders are seen to practically support this goal.

It is the responsibility of the board and CEO to create and lead a culture, within which it is easier for staff to do the right thing than not, at an individual, team and organisational level. This requires a culture wherein safety and quality improvement are encouraged and rewarded, and supported by structures and processes to facilitate involvement.
B. Consumer and Community Involvement

Consumer involvement in quality and safety improvement can enhance and guide the organisational QI program by:

- providing a basis for dialogue between health services and consumers about improving services
- improving the safety, effectiveness, appropriateness and acceptability of individual care episodes
- providing information to health services about their impact on consumers
- identifying priorities, expectations and needs
- providing information about short and long term outcomes of health care treatment
- developing a culture of consumer and health service partnership
- improving information quality and availability and consent processes
- engendering consumer and community support for health services
- developing an understanding of the social view of health and health of communities.

To achieve this, consumer participation should be facilitated at all levels of the organisation, including individual care episodes, information development, strategic and service planning, staff and consumer education and quality review and improvement. Such participation will necessitate the development of structures, polices and protocols that embed consumer involvement at all levels of the organisation.

There is a range of material available on strategies for community and consumer participation that will not be repeated here, except to stress that effective community and consumer involvement will require education and training for both health services staff and the consumer and community members involved. This can help alleviate some of the difficulties that can be found in this collaboration and may include meeting procedures, orientation to hospital structures and health service decision-making processes for the consumers; and communication, consultation and participative decision-making skills for health services staff.

Boards, senior managers and committees with a consumer focus such as Community Advisory Committees, or other consumer oriented groups in the health service, can monitor the extent of consumer participation by receiving information on areas such as: demonstrated evidence of consumer involvement in assessment of feedback about service delivery; changes as a result of complaints and feedback; numbers of consumers involved in strategic and service planning and consumer response to new or updated treatment or service information.
C. Competence of, and Education to Support, Health Care Providers

Assessing, achieving and maintaining a high level of staff competence at all levels to ensure the safe and effective delivery of health care is both a corporate and personal responsibility. Achieving this requires close attention to recruitment, credentialing, peer review, skills assessment, clinical supervision, recertification and continuing education.5,10

Credentialing should be considered by the organisation on the basis of:
- eligibility for professional registration held and current entitlement to practice
- qualifications and training including undergraduate, postgraduate and special training with respect to privileges requested
- clinical experience, competence and integrity in the field of expertise in which privileges are sought
- whether the candidates have involved themselves, and will continue to participate in, and subject the results of clinical work to, quality review mechanisms including clinical audit, peer review and risk management processes
- commitment to past and continuing professional education
- satisfactory professional referee reports including peer comments
- acceptable and safe practice as evidenced by personal history of patient complaints, professional body investigations, indemnity and legal records
- communication skills as demonstrated with patients/families/communities/health care team
- collaboration skills as demonstrated by effective interdisciplinary team activities
- management skills as demonstrated by cost effective and efficient resource utilisation
- advocacy skills
- academic and/or research skills including continuing education aimed at the attainment of best practice models and practices.10

Targeted continuing education is a fundamental component of competence and professional development. Education and training is consistently identified in the literature as a key element of successful quality improvement, whether it be for an organisation wide program or a specific practice improvement activity. This includes technical education and training to update and improve patient care as well as training in improvement tools and techniques. Education and training can take many forms, and a combination approach has been shown to be the most effective method for encouraging uptake including6:
- mentorship
- short courses/workshops
- case studies
- experiential learning opportunities
- didactic information presented by respected peers
- literature from peer reviewed journals
- supervision of junior staff.

Key areas of knowledge for improving quality, specifically, include9:
- quality improvement tools and techniques
- professional/technical knowledge of best practice
- understanding of the profile and needs of consumers
- leading and making change in health care
- collaboration in single and multi-disciplinary teams
- health care processes and systems
- human factors
- social context and accountability.
D. Information Management and Reporting

Information management should assist in monitoring and evaluation of areas of risk for the board and senior managers, support effective clinical decision making for health care practitioners, inform the planning, delivery and improvement of effective and appropriate services and inform and involve consumers and the community. The issue of public reporting of safety and quality information is topical, and Victorian health services are currently being encouraged to report publicly via Quality of Care reports.

Data collected for safety and quality should contribute to improvements in the care delivered to patients and to the outcomes of that care. If the results of data collection and analysis are not fed back to those providing and receiving services and to those who collected it, meaningful change and improvement are unlikely to occur. Involving clinicians in decisions about data collection purpose, method and presentation may improve reliability, validity and use of the information.¹

Medical record documentation is critical to safety and quality, both to assist in care delivery and to inform reviews of the quality of the care provided. Clear, accurate and timely documentation should be encouraged and rewarded.

Boards and senior managers will need to allocate resources to the collection and analysis of timely, valid and reliable data. Data needs will be linked to the strategic priorities of the safety and quality program, part of which will encompass a reporting schedule of key data for boards, senior managers and key committees, in much the same way, from a board perspective particularly, that financial information is reported, discussed and acted upon.

Information management also includes benchmarking and sourcing and implementing standards and evidence-based practice; in short, anything that involves the collection and application of information to inform and improve safety and quality.

The suggestions for data collection listed in the matrix in Appendix A should be read in conjunction with other internal and external reporting requirements such as those for DHS, funding and accreditation.
Example of an Organisational Approach to Safety and Quality Improvement
Organisational Elements and Roles:

A. Governance, Leadership and Culture

A transparent process for identifying, reporting and responding to sentinel events has been developed by relevant staff working in high-risk areas in conjunction with the relevant patient safety-related committee and senior management, approved by the board via the Quality Committee, or equivalent committee that oversees and reports quality and safety issues to the board, and is documented in the organisational safety and quality plan. It is clear, when a sentinel event occurs, how it will be managed at the local and organisational levels, to whom it will be reported and how.

The board, managers and staff are clear about their roles and responsibilities in reporting and managing the event, and organisational and local leaders are trained and equipped to lead the local management of the event and its consequences. The board and senior management provide positive feedback and support to those involved.

The organisation has implemented an open disclosure policy and procedure. Staff have received training in this and are clear about their obligations in relation to dealing with the patient and carers involved in the event.

B. Consumer and Community Involvement

The organisation’s open disclosure policy clearly describes staff and patient rights and responsibilities in relation to an adverse event occurring. Patients have been made aware of this in hospital and ward orientation, but once an event has occurred, this is reiterated to the patient and carers by the relevant senior clinician with appropriate high-level support as planned. All steps in the event management process are explained to the patient and carers as per the policy and they are kept informed of progress as it occurs, including the period after discharge.

C. Competency and Education

The extent to which the sentinel event in question involves issues of competence and/or necessitates follow-up education will depend on the event itself. Most sentinel events will occur as a result of systems breakdown, where the competency of an individual or team will not be an issue. The clinical risk manager, in conjunction with the staff and committees involved, may decide that education and training is a necessary part of the response to the event.

Education and training may be used to assist staff to respond appropriately to the current event (or more appropriately to the next one) or to equip staff to manage and investigate the event via root cause analysis, systems review, and team and communication skills.

If competency or skill is found to be a contributing factor to the event, however, the quality plan should describe the process for the individual or team to be supported through an appropriate education and training process. Other staff involved in the area or clinical care in which the event occurred may also receive the training. If the event is related to a wider concern about an individual or team competence, this then becomes a professional issue, to be managed as per the organisational policy, and is removed from the quality process.

D. Information Reporting and Management

This is a critical aspect of sentinel event management. The process for event identification reporting and review should be clearly described in the quality (or related clinical risk management) plan. Staff at all levels should be aware of their roles and responsibilities in reporting the event. The information should be reported in a timely and appropriate fashion to the patient and carers, relevant local and senior managers, experts and committees (for example, an infection control event would be reported to the infection control consultant and the infection control committee) and the peak quality-related committee and board. The feedback loop should facilitate timely feedback to those involved, incorporating support for the patient and staff involved and clear expectations of follow up and management.

Responsibility for reporting to external organisations as appropriate such as the Department of Human Services, the GP, the Coroner, Consultative Councils and the insurers should be clearly delegated.

Information gathered in the management of the sentinel event should be fed into the broader safety and quality information management system where it can be used at local departmental or committee level to inform ongoing diagnosis and improvement of systems problems.
Conclusion

This framework describes a high quality health care system that has the consumer as the primary focus and facilitates the health care team providing services that are safe, effective, timely and appropriate. In this system, clinicians collaborate to produce the best results and are clear about and committed to their roles and responsibilities for safety and quality. Health care facilities are governed and managed by those with a strong commitment to and responsibility for the quality and safety of the care and services provided and support this commitment through practical strategies. Such a system rejects a punitive approach that blames individuals for poor quality and works continuously to develop staff and improve the systems of care to identify better ways of working, and to facilitate organisational learning for the purpose of better addressing the needs of the population it serves.
Appendix A

The Safety and Quality Matrix
Boards accepts ultimate accountability and responsibility for the safety and quality of services and care and ensure they are fully informed regarding performance in relation to key areas of risk, patient feedback, service delivery, patient outcomes and staff competence.

Boards and executives delegate accountability for safety at all levels of the organisation. This involves creating and supporting opportunities for safety and quality leadership development and participation at all levels of the organisation via provision of succession planning, education, resources, backfilling and incentive systems.

Boards create a culture where open disclosure, reporting and learning from errors and adverse events and clear accountability for and participation in safety improvement are embedded and rewarded.

Boards and executives support this culture by resourcing and encouraging root cause analyses, systems review, implementation of best practice and appropriate education and training.

Boards and executives encourage care and service delivery that is patient-focused, and provide an environment where consumers and the community participate equally with health services in safety improvement.

Boards and executives ensure there is a committee, data collection and reporting structure that facilitates discussion of, and a planned approach to, safety, including resolution of safety and quality problems, and review and improvement of performance.

Executive and senior managers ensure that there is a mechanism in place where standards, policies and procedures for safety are regularly reviewed and updated.

Safety is reviewed with regard to the Department of Human Services Clinical Risk Management Program requirements.
## B. CONSUMER AND COMMUNITY INVOLVEMENT

- Health care leaders create and support a culture wherein consumer input into individual care and overall safety improvement is expected, supported by organisational policy and procedure, and respected.
- Consumers avail themselves of opportunities to participate in the monitoring and improvement of health care safety, both on an organisational and personal level.
- Individual consumers inform themselves of the risks of their care and treatment choices by reviewing available information.
- Consumers are informed of adverse events, errors and problems relating to their care and participate in review and corrective action.
- Consumers work with clinicians to improve safety by asking appropriate questions about, and participating in, the care and treatment they are receiving.
- Consumers contribute to the development of consumer information about safety issues such as risks and side effects.
- Consumers take the opportunity to make complaints when dissatisfied, and provide feedback about care, treatment and services.
- Appropriate consent processes are in place to support informed consent.
- Health care organisations regularly seek and review consumer complaints and feedback to identify and address safety issues.

## C. COMPETENCE AND EDUCATION

- Credentialing is critical to delivery of safe care and services. Credentialing procedures are designed to ensure that health professionals practice within the limits of their competence and provide opportunity for regular review and approval of the scope of an individual's practice.
- Board, executive and senior managers should be satisfied that robust credentialing policies and processes are in place for all current clinical staff and that these are supported by appropriate committee and reporting structures.
- Participation in activities that improve the safety of care and services should be considered as an element of the credentialing and privilege process. These will include specific improvement activities as well as daily contributions to patient care quality such as effective teamwork and communication.
### C. COMPETENCE AND EDUCATION (CONT'D)

<table>
<thead>
<tr>
<th>Organisational Element</th>
<th>Dimension of Quality: Safety</th>
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<tbody>
<tr>
<td><strong>Safety</strong></td>
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</table>

1. Board and executive staff should provide sufficient resources to ensure rigorous systems are in place to recruit and retain competent staff. This includes optimum and consistent processes for advertising, shortlisting, interviewing, selection, orientation, staff development and promotion, and performance review and coaching. Education and incentives should be put in place to assist managers to recruit and maintain competent staff.

2. Supervision and mentoring should be provided for new and junior clinical staff. Mechanisms must be established for managers to select and provide appropriate staff and supervision across each shift.

3. All clinicians and technical staff skills should be regularly assessed for safety by a competent peer group to determine competence for performing a particular task or using a new technology. Methods for early detection of problems with performance should be in place.

4. Where certification (both clinical and non-clinical) applies, mechanisms should be in place to ensure these are reviewed and current. Provision should be made for practitioners to update their skills and knowledge as appropriate, and practitioners should commit to fulfilling this responsibility.

5. Monitoring of numbers of procedures performed by both individual clinicians, and the organisation overall, should be undertaken to ensure that sufficient numbers are being done to maximise them being carried out in a safe and effective way.

6. Continuing education regarding safety issues is pivotal. Individual practitioners have a responsibility to undertake continuing education appropriate to their role and speciality, and also in safety related monitoring, management and improvement tools and techniques. Such education may include:
   - the nature of error and its management
   - understanding the impact of culture on safety
   - effective communication, teamwork and conflict resolution
   - problem solving and decision making
   - change management
   - sharing mental models
   - human factors
   - tools and processes for monitoring, analysing and improving safety.
Boards and executives are responsible for planning and resourcing an information system on safety that: identifies risk areas, collects and analyses data and reports and feeds back those data to inform the monitoring, management and improvement of patient safety.

 Provision is made for clinicians to be involved in collection, analysis and discussion of risk-related information via administration time, staff backfilling, easy access to relevant reports and training in appropriate tools. Consumers are involved in discussion and decision-making regarding improvements resulting from data reporting and analysis.

 Safety-related professional, accreditation and industry standards should be widely available and their implementation regularly reviewed against actual practice. Health services should fulfil clinical risk management and safety-related DHS reporting requirements.

 A minimum data set, relevant to the health service, should be developed for reporting to the board, peak quality-related committees, executive, managers and clinician leaders. This should include key areas of risk such as adverse and sentinel events and near-misses, including, but not restricted to:

 a) Medication errors  
b) Patient falls  
c) Infection control  
d) Blood and blood product use  
e) Pressure ulcers  
f) Pain management  
g) Death rates  
h) Cases reported to the coroner  
i) Sentinel events as defined by the Department of Human Services.

 Other areas for review may include:

 - unplanned return to operating room for certain procedures  
 - unexpected admission to ICU  
 - unexpected deaths and severe complications relating to specific procedures relevant to the health service  
 - clinical indicators relating to safety.
Sustained improvement in the quality of health care requires a commitment to health care based on sound scientific principles and evidence, and the effective delivery and communication of that care.

Boards and executives will ensure processes are in place for drawing on the literature and other sources of research and standards to develop guidelines, pathways, policies and protocols based on sound evidence.

Responsibility and accountability for identification, implementation, review, evaluation and communication of evidence-based care should include involvement of clinicians and opinion leaders to ensure effective local adaptation.

Boards create a culture of recognition and reward for effectiveness of care, treatment and communication, for individual and team-delivered care.

Boards and executives are responsible for creating a culture that respects and encourages patient participation in, and contribution to, the effectiveness of the care and services provided, including provision of an environment where there are opportunities for patient input and feedback.

Consumers have a key role to play in the effectiveness of care and services provided. This requires collaboration between consumers and clinicians on at least three levels: in direct care and associated communication; in patient information development; and between the health service and the community in planning, developing and implementing service and care improvement.

Consumers should be involved in developing meaningful information on which to base decisions about their health and to inform participation in their care.

Consumers and clinicians collaborating on individual care episodes should agree on a course of treatment, with both parties fulfilling their obligations to ensure the greatest chance of effectiveness.

Processes for complaints and feedback about care and service effectiveness should be clear, user-friendly and accessible. Such feedback should be responded to in a timely fashion and incorporated into service and case review.
### Organisational Element: C. Competence and Education

<table>
<thead>
<tr>
<th>Dimension of Quality: Effectiveness</th>
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<tbody>
<tr>
<td>Individual and team competence are critical to delivery of effective care and services. Credentialing procedures are designed to ensure that health professionals practice within the limits of their competence and provide opportunity for regular review and approval of the scope of individual practice. Board, executive and senior managers should ensure that robust credentialing policies and processes are in place for all current clinical staff, backed up by appropriate committee and reporting structures.</td>
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<td>All clinicians’ skills should be regularly assessed for effectiveness by a competent peer group to determine competence for performing a particular task, using a new technology and communication with consumers, their carers and the health care team. Methods for early detection of problems with performance should be in place.</td>
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A range of clinical indicators and audit tools is available for the collection of process and outcome data on the effectiveness of care and services and these should be adopted as appropriate.

Processes should be put in place to identify ineffective care and service via monitoring and review processes such as clinical audit, indicators, adverse events and pathway variance analysis.

Information about new technologies and treatments should be made widely available to those involved in their implementation.

There should be a process whereby evidence-based information that has the potential to improve service and care effectiveness is identified, locally evaluated and adapted if appropriate. Reviewing the percentage of eligible clinicians who are involved in development, application and review of guidelines and evidence application, for example, may assist in informing and identifying clinical leaders and reinforcing the seriousness with which the organisation views these activities.

High risk, high volume and high cost areas should be regularly monitored for effectiveness and reports sent to relevant clinician leaders in those areas, and to committees such as credentialing, new technology and innovation, clinical risk and clinical review for action.

These may include:

- % of best practice guidelines in use
- % of patients receiving appropriate treatment within the evidence-based timeline, e.g. prophylactic antibiotics in surgery; stroke admissions having a CAT scan with a certain time of arrival in the Emergency Department
- Screening rates
- Avoidable deaths.

Professional, accreditation and industry standards should be widely available and their implementation regularly compared against actual practice.
Patient centred care is key to appropriate treatment. Appropriateness requires adaptation to each individual patient. This requires patients to participate in their care by providing all information relevant to treatment decisions. The patient must be provided with the means to do so, such as access to interpreters. Patients should be given the opportunity to increase the appropriateness of their care by participating in the planning and delivery of their care. This will require policies and protocols to be implemented to embed this in the routine of wards, theatres and other departments. Consumers and community may be involved in appropriateness by assisting in information development for review of disease-specific care and services.

### THE SAFETY & QUALITY MATRIX

**Appropriateness**

<table>
<thead>
<tr>
<th>Organisational Element</th>
<th>Dimension of Quality: Appropriateness</th>
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<tr>
<td><strong>A. GOVERNANCE, LEADERSHIP AND CULTURE</strong></td>
<td></td>
</tr>
<tr>
<td>○ Boards and executives have a responsibility to ensure that their health services provide appropriate care.</td>
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<tr>
<td>○ This requires mechanisms that promote and embed evidence-based practice that involves, and is tailored to, individual patients and is delivered in a timely and correct manner.</td>
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<tr>
<td>○ Boards and executives should delegate accountability for ensuring appropriate care to senior clinicians within an appropriate committee structure.</td>
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<tr>
<td>○ Boards should receive regular reports on appropriateness issues such as overuse, underuse and misuse of care, including utilisation rates for high volume, high cost and high complaint areas.</td>
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<tr>
<td>○ Overuse should be addressed to reduce undue risk related to interventions and associated waste. Measures of underuse will require evidence to demonstrate when a particular intervention should be used, and practice measured against this to ensure all eligible patients are receiving the maximum health benefit.</td>
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<tr>
<td><strong>B. CONSUMER AND COMMUNITY INVOLVEMENT</strong></td>
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<td><strong>C. COMPETENCE AND EDUCATION</strong></td>
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<tr>
<td></td>
<td>Appropriateness of care is a consideration for assessing clinician competence and credentialing. Clinical reviews, adverse events and utilisation rates showing overuse, underuse and misuse by unit and clinician will assist in the review of ongoing privileges and the need for education and training.</td>
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<tr>
<td><strong>D. INFORMATION MANAGEMENT AND REPORTING</strong></td>
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<td></td>
<td>Utilisation rates are central to reviewing appropriateness of care. Relevant complaints, clinical audit, review of new technologies and procedures and quality improvement projects can also be sourced to build a picture of appropriate treatment in particular disease categories.</td>
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<td></td>
<td>High volume, high cost and high complaint areas as relevant to the individual health service should be regularly monitored for appropriateness, eg:</td>
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<td>- caesarean section</td>
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<td>- coronary angioplasty</td>
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<td>- cholecystectomy</td>
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<td>- hysterectomy</td>
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<td>- lens and cataract procedures</td>
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<td>- tonsillectomy</td>
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<td>- colonoscopy</td>
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<td>- transurethral prostatectomy.</td>
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<td>Other measures could include:</td>
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<td>- numbers of tests ordered for specific conditions</td>
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<td>- percentage of patients for which a pain assessment is conducted</td>
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<td>- percentage of specific conditions for which best practice guidelines are applied.</td>
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<td></td>
<td>Professional, accreditation and industry standards should be widely available and their implementation regularly compared against actual practice.</td>
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The community in general and consumers in particular make a salient contribution to acceptability of care. Community participation can provide assistance to boards, executives and staff in health service planning, delivery, monitoring and evaluation at all levels. Individual consumers can provide real-time feedback about acceptability of care and services, and there will need to be a process in place whereby such information is sought, noted and fed into a review mechanism. Consumers should be aware of a clear, accessible complaints process that enables them to make a complaint at any time without fear, favour or prejudice. Complaints should be viewed as a valuable source of safety and quality information. Complaints should be dealt with according to a planned process, developed in conjunction with consumers. This process should be made clear to the complainant, and include investigation, resolution and follow-up of the complaint in collaboration with the complainant as equal partners in the process.

### THE SAFETY & QUALITY MATRIX

#### Acceptability

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<tr>
<td><strong>A. GOVERNANCE, LEADERSHIP AND CULTURE</strong></td>
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<tr>
<td>o Acceptability is the degree to which a service meets or exceeds the expectations of informed consumers.</td>
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<tr>
<td>o Acceptability is key to patient centred care. Boards and executives should develop a clear vision of what this means for the health service, in conjunction with clinical and non-clinical staff, and consumers, and put in place structures and processes for achieving this.</td>
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<tr>
<td>o These may include seeking information from Community Advisory Committees and/or other community and consumer groups regarding acceptability issues; for example, reviewing complaints and satisfaction feedback to identify problems and working with consumers to develop new processes for improving acceptability.</td>
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</tr>
<tr>
<td>o Mechanisms should also be put in place for the collection and application of real-time individual consumer feedback.</td>
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<tr>
<td>o Boards and executives should regularly review and reward practitioners and teams demonstrating high levels of acceptability in their care, and provide education and support to assist all staff to address acceptability in their day-to-day activities.</td>
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<tr>
<td>o Acceptability can form a key part of health service staff performance review and can include feedback from patients and peers.</td>
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<tr>
<td>o The Community Advisory Committee, or other consumer focused committee or group may be empowered to take the lead on acceptability of care with board and executive support.</td>
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Complaints and other feedback should be actively sought as a valuable source of acceptability information. Patient satisfaction, one-to-one interviews and focus groups may be used to elicit information. This information should be channelled into a process that reviews safety and quality data, to help paint a complete picture.

The information should be made available to the staff involved, boards, executives and department heads for the purposes of review, analysis and action planning.

Boards and executives should ensure that identified problems are addressed to the satisfaction of consumers and the community, and that consumers are involved in action planning and follow-up.

Reporting on acceptability issues to consumers and the community should be included in the health service Quality of Care report.

Professional, accreditation and industry standards should be widely available and their implementation regularly compared against actual practice.

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<tr>
<td>• Education and training for staff can be provided in areas such as:</td>
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<tr>
<td>• patient rights and responsibilities</td>
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<td>• patient involvement in their care</td>
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<tr>
<td>• communication and consultation</td>
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<tr>
<td>• a multidisciplinary team approach to acceptability.</td>
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<tr>
<td>• consumers themselves relating their experiences is a powerful educational tool.</td>
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<tr>
<td>• Education of consumers to facilitate participation in their care and organisational improvement may include:</td>
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<tr>
<td>• health service structures and organisation</td>
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<tr>
<td>• disease-specific information</td>
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<tr>
<td>• administrative processes such as admission and discharge procedures</td>
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<tr>
<td>• safety and quality information.</td>
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</table>
Access refers to the extent to which a population or individual can obtain health services. This may include when it is appropriate to seek health care and the ability to geographically, physically and economically seek out appropriate care.

Boards have a responsibility to understand the population they serve and to make sound resource allocation decisions regarding how best to serve that population.

Boards should create and foster a culture where resources are utilised to provide maximum access to the community served.

This includes empowering executives and managers to put in place policies and procedures that streamline admission and discharge procedures and associated decision-making, address population, geographic and physical access, and review utilisation and throughput data.

Consumers on a personal level and the community on a population level can offer valuable input to issues of access.

Consumers on a personal level and the community on a population level can offer valuable input to issues of access.

Individual consumers can comment on their own experience of access to the service whether it be financial, geographic, physical or processes-related such as admissions, discharge and waiting time.

Consumers can help improve and streamline access by availing themselves of relevant information regarding these processes and following instructions for arrival times, making appointments, booking interpreters and discharge procedures.

The community can participate in strategic decisions affecting access, such as resource allocation, reviews of physical access and service planning and process review to streamline access.

Consumers and the community can also inform access to information including: public information about the safety and quality of health services; appropriate use of emergency services; clinical treatment choices and options; interpreter issues; risk areas and general information about health service processes to assist consumers and staff to work together for efficient and effective care.
### THE SAFETY & QUALITY MATRIX

#### Access

<table>
<thead>
<tr>
<th>Organisational Element</th>
<th>Dimension of Quality: Access</th>
</tr>
</thead>
</table>
| **C. COMPETENCE AND EDUCATION** | Maximising access within available resources requires a high level of expertise in all access-related areas: physical, population, processes, prioritisation and resource allocation. Boards and executives should empower managers to recruit, train and retain personnel who can contribute effectively to this area.  
Consumers participating in access-related decisions should be provided with appropriate training to make a considered contribution. |
| **D. INFORMATION MANAGEMENT AND REPORTING** | Valid and reliable information systems are critical to access-related planning and decision-making. Those involved in access decision-making require robust information and training in interpreting and applying the information.  
Regular information should inform the board, executive, clinical and non-clinical managers and consumers and the community of the status of access to their services. This may include:  
- waiting list data by category  
- time to first appointment  
- waiting times for all services  
- triage times in Emergency  
- admission times to various areas of the health services  
- travel times to the health service  
- rural and remote patient access issues  
- access to interpreters  
- access blocks.  
Detailed requirements for access reporting on issues such as hospital demand management reporting are available from DHS.  
Professional, accreditation and industry standards should be widely available and their implementation regularly compared against actual practice. |
Consumers and community members may participate in efficiency-related decisions regarding planning new services or reviewing existing services. It is important that both communities and health services are well informed to make these decisions and that discussions follow a clear and transparent process.

Effective decision-making in this complex area will depend on both the consumers and health service staff involved participating in an informed and collaborative manner. Both parties should be experienced in consumer participation at this level.

---

THE SAFETY & QUALITY MATRIX

Efficiency

<table>
<thead>
<tr>
<th>Organisational Element</th>
<th>Dimension of Quality: Efficiency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. GOVERNANCE, LEADERSHIP AND CULTURE</strong></td>
<td></td>
</tr>
<tr>
<td>Efficiency is an economic concept that implies that choices in health care delivery and treatments should be made to derive the maximum total benefit from available resources.</td>
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<tr>
<td>Setting resource allocation priorities based on economic efficiency requires consideration by boards, executives and Clinicians of the relative costs and benefits (or outcomes) of alternative health care interventions. The two relevant aspects of economic efficiency to be considered are technical and allocative efficiency.</td>
<td></td>
</tr>
<tr>
<td>Technical efficiency is about providing the highest quality services for the lowest cost. This does not provide sufficient information to decide whether or not a particular treatment or service should be undertaken in the first place, or whether one type of treatment is preferable to another.</td>
<td></td>
</tr>
<tr>
<td>Allocative efficiency addresses how to achieve the optimal mix of health care treatments and services to maximise total benefits (outcomes) from available resources. Two aspects of allocative efficiency are relevant to boards, executives and clinical leaders: first, choosing between disease states (eg. should more vascular or orthopaedic surgery be undertaken?) and choosing alternatives within disease states (eg. between prevention initiatives and treatment of lung cancer).</td>
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<tr>
<td>Boards and executives should resource, train and empower clinician, general, finance and IT managers to effectively collaborate in efficiency-related data collection and decisions.</td>
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<tr>
<td>There is a process in place for identifying and eliminating waste across the organisation.</td>
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<tr>
<td><strong>B. CONSUMER AND COMMUNITY INVOLVEMENT</strong></td>
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</tr>
<tr>
<td>Consumers and community members may participate in efficiency-related decisions regarding planning new services or reviewing existing services.</td>
<td></td>
</tr>
<tr>
<td>It is important that both communities and health services are well informed to make these decisions and that discussions follow a clear and transparent process.</td>
<td></td>
</tr>
<tr>
<td>Effective decision-making in this complex area will depend on both the consumers and health service staff involved participating in an informed and collaborative manner. Both parties should be experienced in consumer participation at this level.</td>
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</tbody>
</table>
Both health service personnel and any consumers/community members involved in efficiency decisions should be appropriately educated and trained to do so. Important skills to bring to such discussions include an understanding of resource allocation and economic concepts as well as problem-solving and decision-making skills. Those participating will also need to consider the broader funding and strategic context.

As with all aspects of safety and quality, access to reliable and valid information is critical to effective efficiency decision-making. Efficiency requires that general, clinical, financial managers and IT work together to pool relevant information. Boards and executive staff should adequately resource the collection of efficiency related data to ensure informed decisions are made. This may include:

- average length of stay
- cost per case mix-adjusted separation
- cost per outpatient accession of service
- elective patients admitted on day of surgery
- elective patients cancellations
- cost per treatment alternative.

Professional, accreditation and industry standards should be widely available and their implementation regularly compared against actual practice.
Appendix B
Clinical Governance Roles at Six Health System Levels

There are as many roles in health care safety and quality improvement as there are people involved. This section of the framework proposes six key levels at which responsibilities and accountabilities must be clear and functioning effectively to ensure safe and high quality care and services.
1. Government (Department of Human Services) Role

DHS lays the foundation for clinical governance in legislative, funding and policy frameworks.

They do this by:

- developing and supporting legislation and regulation which promote clinical governance as a key tenet of health service governance
- allocating responsibility for clinical governance to health service boards and clearly communicating the responsibilities and expectations involved
- implementing accountability and reporting mechanisms to ensure clinical governance responsibilities are met
- funding demonstration projects, integrating findings into policy and facilitating the spread of findings across the health system
- supporting health services in managing and reporting quality and safety issues
- coordinating state-wide data collection of key indicator data and providing health services with comparative performance data
- encouraging quality systems development and data collection through funding incentives.
2. The Board Role

The board has ultimate responsibility for patient care safety and quality and attention to this must be as rigorous as that given to all other board corporate responsibilities.

The board provides leadership in this area by:

- sending a strong message through the organisation and to the community via words and deeds that safety and quality are priority issues for the health service
- ensuring the CEO, senior managers and senior clinicians clearly understand and enact their responsibilities and enable clinical governance principles and processes to be applied throughout the health service via appropriate structures, policies, processes and resources
- monitoring the overall state of safety and quality in the health service by seeking, analysing and discussing relevant information, and responding to issues as appropriate
- demonstrating to external and internal review bodies that the board understands and carries out its clinical governance role
- ensuring a culture and practice of partnership with consumers and the community in reporting, discussing and addressing adverse events and safety and quality issues
- ensuring the health service acts in accordance with relevant legislation, regulation and other relevant standards and initiatives, and supporting policies which improve safety and quality
- implementing the four key principles of clinical governance:
  - build a culture of trust and honesty through open disclosure in partnership with consumers and community
  - foster organisational commitment to continuous improvement
  - establish rigorous monitoring, reporting and response systems
  - evaluate and respond to key aspects of organisational performance.
- undertaking regular self assessment as a basis for members’ clinical governance skills and information development.
3. The Quality Committee Role

The Quality Committee, however named, is the peak body responsible for overseeing the quality program in an organisation. Depending on the organisation, this may comprise a suite of committees that address various components of quality, a stand-alone committee, or a regular agenda item on another broader committee. Whatever the structure, the Quality Committee takes an active safety and quality planning, monitoring and evaluation role on behalf of the board.

It does this by:

- working with the CEO and senior managers to determine the best approach to planning, implementing, evaluating and improving safety and quality in the organisation, and monitoring the progress of the approach taken
- translating the strategic direction of the health service into implications for safety and quality
- ensuring the quality plan is related to strategic and business plans, that the CEO is adequately resourcing the plan’s implementation and that an improvement methodology appropriate to the organisation is adopted
- analysis and discussion of safety and quality information and taking action, or delegating action to the CEO, in response to this information
- ensuring quality technical support, education, information and opportunity are provided to assist staff, consumer and community input into planning and improving safety and quality systems
- prioritising and focussing on the key safety and quality issues for the organisation
- reporting data and quality plan progress to the board
- evaluating and recommending the implementation of appropriate data collection, education, communication and information tools to facilitate consumer and staff involvement
- developing information and communication processes for public reporting of safety and quality information
- responding to DHS and other organisations’ safety and quality initiatives and requests.
They do this by:

- espousing and enacting commitment to clinical governance by their attitude to, and involvement in, safety and quality issues
- seeking education and information to equip themselves to lead the safety and quality program
- enabling the development and evaluation of a safety and quality plan and structure which involves consumers and clinical and opinion leaders, to monitor, improve and respond to the safety and quality of care and services
- empowering and holding accountable staff at all levels to be appropriately involved in monitoring and improving care and services
- providing planning, infrastructure and resources that enables the collection, reporting and benchmarking of valid, reliable and relevant safety and quality data
- ensuring systems are in place to facilitate safe, quality care, including the application of best available evidence, learning from problems experienced within the organisation and in other health services and systems
- ensuring all staff are clear about the principles and practices of safety and quality by providing information, education and technical support, and holding senior staff accountable for modelling desired behaviour and practices
- fostering a culture which does not blame, but rather seeks to solve problems and learn from them and supporting staff in this process
- establishing open information exchange with consumers and the wider community, in relation to issues of clinical error, and problems and achievements in service delivery
- acting on recommendations where problems with quality are apparent via events or data monitoring
- ensuring staff are trained and empowered to respond appropriately to adverse events
- providing data and information to the peak quality committee and board relevant to their role, and to DHS and other relevant organisations as appropriate.

4. CEO and Senior Clinician and Management Role

The CEO and managers at all levels are central to operationalising clinical governance. These roles may vary depending on seniority and delegation, but essentially all managers play a critical safety and quality leadership role.
5. Clinician and Team Role

Whilst the board, CEO and managers provide the principles, systems and resources for good clinical governance, it is the staff delivering services who implement and monitor these systems day to day.

They do this by:
- providing safety and quality leadership at professional and team level
- translating high-level quality strategies into operational improvement activities
- participating in the development, implementation and evaluation of quality and safety plans, systems and activities
- openly communicating and reporting safety and quality problems and adverse events, and participating in developing solutions
- adhering to policies and procedures for preventing, reporting and disclosing adverse events
- delivering care and services according to health service protocols and policies
- developing a partnership approach with patients and their carers in individual episodes of care as well as the prevention, treatment and discussion of adverse events
- participating in activities that identify and address areas for improvement from the patient and staff perspective
- participating in a team approach to patient care, quality improvement and problem-solving.
Consumers and the community have a salient role to play by:

- receiving, analysing and responding to information from health services on safety and quality issues in the spirit in which it is offered, that is, as a systems learning and improvement mechanism
- offering constructive feedback, both formal and informal, regarding the safety and quality of health services, both as individual consumers and as a community of stakeholders
- working with health services to improve services, both in response to an individual adverse event and at a systems review level
- feedback to the health service regarding experiences of the care provided
- developing disease-specific and general information to assist other consumers to better navigate care and services
- contributing to safety and quality improvement via involvement in individual episodes of care, information development, education and systems review
- taking responsibility for health service safety by seeking relevant information and asking pertinent questions of both individual health practitioners as consumers and of the organisation as a whole.

6. Consumer/Community Role

Consumers want assurance that their care is safe, effective and appropriate. The wider community is becoming increasingly knowledgeable about health care delivery and want to be active participants in this process. The challenge is to involve these groups in a meaningful and positive way.
Appendix C
Checklist for Reviewing your Safety and Quality Program Against the Framework Elements
This checklist is a tool to assist health services review their safety and quality program against the framework elements. It is not intended as a review of the effectiveness of a quality program, but as a guide to the generic structural and process elements essential to achieving effectiveness.

It may be undertaken as a self-assessment at all levels of the organisation, or as a focus for discussion about the quality program. Where an element is checked as "process established and working effectively", the next question to be answered is "how do we know?"

### 1. GOVERNANCE, LEADERSHIP AND CULTURE

<table>
<thead>
<tr>
<th>The board:</th>
<th>Processes established and working effectively</th>
<th>Processes in place but need enhancement</th>
<th>Processes under development</th>
<th>No processes in place for this element</th>
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<tbody>
<tr>
<td>a. governs clinical safety and quality with the same rigour as applied to corporate governance and reviews this via regular self-assessment</td>
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<tr>
<td>b. discusses and responds to priority safety and quality matters at every board meeting</td>
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<tr>
<td>c. regularly reinforces and demonstrates commitment to safety and quality to all stakeholders</td>
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<td>d. empowers and supports the CEO to take steps to assure and improve safety and quality</td>
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<tr>
<td>e. ensures consumers are informed of, and actively involved in, key improvement initiatives</td>
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<td>f. ensures safety and quality initiatives are consistent with government and quality council priorities and external requirements</td>
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<tr>
<td>g. commits a defined percentage of the annual budget to achieving defined safety and quality goals and monitors expenditure and associated outcomes</td>
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<tr>
<td>h. clarifies the direction and priorities for safety and quality in the strategic plan</td>
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<tr>
<td>i. establishes measurable performance goals and targets</td>
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<tr>
<td>j. establishes clinical safety and quality as core organisational values</td>
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<tr>
<td>k. ensures the organisation benchmarks and compares performance in safety and quality</td>
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</table>
1. **GOVERNANCE, LEADERSHIP AND CULTURE**

The CEO and leaders throughout the organisation:

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>l. actively support and assist the board in the clinical governance role</td>
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<tr>
<td>m. ensures clinician and staff buy-in to help develop and implement safety and quality initiatives</td>
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<tr>
<td>n. focus strongly on reducing preventable errors by improving systems</td>
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<tr>
<td>o. ensure safety and quality risks are proactively identified and managed through effective systems, delegation of accountabilities and properly trained and credentialed staff</td>
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<tr>
<td>p. ensure changes and improvements are sustained beyond the short-term</td>
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<tr>
<td>q. assign sufficient personnel and resources to support the organisation’s safety and quality initiatives</td>
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<tr>
<td>r. establish a non-punitive environment, apportioning blame only in exceptional and appropriate circumstances</td>
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<tr>
<td>s. ensure staff, consumers and other stakeholders are informed about (and actively involved in) the organisation’s safety and quality issues and initiatives</td>
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<tr>
<td>t. encourage and reward safety and quality improvements</td>
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<tr>
<td>u. ensure the organisational values and structures support staff to openly disclose errors</td>
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<tr>
<td>v. support the implementation of an improvement plan and methodology relevant to the organisational structure and culture, based on best available evidence, innovation and systems improvement</td>
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<tr>
<td>w. openly, willingly and regularly report relevant safety and quality issues and improvements to stakeholders, including action taken to address problems</td>
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<tr>
<td>x. respond to and share lessons learned with the wider health care community</td>
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### 2. CONSUMER AND COMMUNITY INVOLVEMENT

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</thead>
<tbody>
<tr>
<td>a.</td>
<td>consumer and community participation in improving safety and quality is an accepted part of the organisation's functioning</td>
<td></td>
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<tr>
<td>b.</td>
<td>consumer and community feedback is regularly sought and is integrated into improvement activities</td>
<td></td>
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<tr>
<td>c.</td>
<td>complaints are managed respectfully and effectively and the information fed into systems improvements</td>
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<tr>
<td>d.</td>
<td>protocols are in place to enable consumers to participate in their care</td>
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<tr>
<td>e.</td>
<td>consumers are made aware of the process for participating in their care</td>
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<tr>
<td>f.</td>
<td>sufficient information and opportunity are provided for consumers to participate meaningfully in their care</td>
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<tr>
<td>g.</td>
<td>health service staff are aware of, and trained in, protocols and procedures for enabling consumer participation in their care, including effective communication</td>
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<tr>
<td>h.</td>
<td>consumers and community members are involved in consumer information development</td>
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<tr>
<td>i.</td>
<td>consumers are invited to relate their health service experiences as part of the safety and quality improvement program</td>
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<tr>
<td>j.</td>
<td>consumers and community members are invited to review and improve current services and assist in planning new ones</td>
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</table>
## 3. COMPETENCE AND EDUCATION

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<tr>
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<tbody>
<tr>
<td>a. robust certification and credentialing policies and procedures are in place for all current clinical staff</td>
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<tr>
<td>b. credentialing responsibilities are clearly delineated to organisational leaders and committees</td>
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<tr>
<td>c. participation in activities that improve the safety and quality of the care delivered is considered as a key element of credentialing</td>
<td>☐</td>
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<tr>
<td>d. there is a policy and procedure in place for supervision and mentoring of new and junior staff, both clinical and non-clinical</td>
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<tr>
<td>e. appropriately trained and qualified staff are rostered across each shift</td>
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<tr>
<td>f. support, education and resources are allocated to assist managers with successful recruitment and retention of staff</td>
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<tr>
<td>g. clinician and technical staff skills are regularly assessed for safety by a competent peer group</td>
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<tr>
<td>h. regular checks are performed to ascertain that clinicians are performing sufficient numbers of procedures to maximise the chances of them being performed safely</td>
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<tr>
<td>i. continuing clinical education is encouraged and supported and clinician responsibility to keep abreast of current knowledge and evidence-based practice is fulfilled</td>
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</tr>
<tr>
<td>j. all staff are trained and equipped to participate effectively in safety and quality improvement activities</td>
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<tr>
<td>k. clinical staff understand safety improvement techniques such as error prevention and management, effective teamwork and communication, and human factor analysis</td>
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4. INFORMATION MANAGEMENT AND REPORTING

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<tbody>
<tr>
<td>a. sufficiently rigorous information systems are in place to identify, monitor and respond to risks and important aspects of care</td>
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<tr>
<td>b. there is an effective information flow for safety and quality matters to and from the board</td>
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<tr>
<td>c. the organisation meets external stakeholder reporting requirements including: DHS, accreditation, insurance and coroner requirements</td>
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<tr>
<td>d. a minimum data set, relevant to the safety and quality priorities of the organisation, is regularly reported to the board, CEO and organisational leaders and committees</td>
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<tr>
<td>e. data reported are discussed, responded to appropriately, including a feedback loop to those who initiated the data collection</td>
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<tr>
<td>f. safety and quality-related professional, accreditation and industry standards are widely available and their implementation regularly reviewed</td>
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<tr>
<td>g. the board, CEO and senior clinicians and managers encourage and reward reporting and learning from errors and adverse events</td>
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<tr>
<td>h. results of improvement activities are widely circulated</td>
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</tr>
<tr>
<td>i. consumers have access to, and contribute to, reliable information about their care and related health care services</td>
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</tr>
<tr>
<td>j. all patients sustaining an adverse event are informed of the event and proposed follow-up in a timely and appropriate manner</td>
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<tr>
<td>k. staff willingness to report adverse events is reviewed and responded to</td>
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Appendix D
Acknowledgements
The Victorian Quality Council thanks all those who contributed to this framework.

**VQC Clinical Governance Working Group**
- Dr Michael Walsh (Chair)
- Professor Peter Choong
- Dr David Hillis
- Dr Jane Hendtlass
- Dr Peter Greenberg
- Dr Christine Walker
- Associate Professor Christine Kilpatrick
- Mrs Kerry Bradley
- Ms Stella Axarlis (up to 16 June 2003)
- Dr Cathy Balding (VQC Manager)

**Health services that provided feedback**
- Austin Health
- Barwon Health
- Bayside Health
- Echuca Regional Health
- Goulburn Valley Health
- Mercy Hospital for Women
- Moyne Health Service
- Peter Mac
- Royal Victorian Eye & Ear Hospital
- St Vincent’s Health
- West Wimmera Health Service

**Department of Human Services**
- Dr Jenny Bartlett (Chief Clinical Advisor)
- Ms Sue Brennan (Manager, Residential Services Unit, Aged Care)

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Written by Cathy Balding on behalf of the VQC Clinical Governance Working Group.

**References**


“One of the difficulties that CEOs face is establishing a connected organisational structure and a safety and quality structure, and this framework allows for a re-assessment of existing structures.”

“The clear message is that there must be total commitment from the top and that means that the Board needs to be educated in their role and makes it clear to the CEO what is expected.”

(Metropolitan health service CEO)

“This document will set the structure, identify the parameters and gain more recognition for clinical governance.”

(Rural hospital DON)

“It makes sense for our organisation and the framework is easy to understand.”

(Metro health service DON)

“I particularly liked the proposed minimum data set.”

(Regional health service CEO)

“We will use this as a benchmark to review our existing quality program and plan for the future.”

(Regional health service medical director)

“The information on roles and responsibilities will be integrated into our staff development program.”

(Metropolitan health service CEO)

“The framework is practical and clear.”

(Specialist health service quality manager)

“It is an easy to read, common sense approach to the implementation of a safety and quality [framework] within health services.”

(Rural health service quality manager)

“We will incorporate the practical examples into our quality plan.”

(Regional health service clinical risk manager)

“Different sections of the framework will be useful for different parts of the organisation.”

(Metropolitan health service quality manager)