

- 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 service benchmarks 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. If “improvement of health care performance hinges on changing the day-to-day decisions of doctors, nurses and other staff”, then it is important that each individual’s role in achieving this is clearly delineated, supported and acknowledged.

A more detailed explanation of the Framework elements and roles, including examples of how it may be applied in your organisation can be found in the full “Better Quality, Better Health Care” Framework document.

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Better Quality, Better Health Care

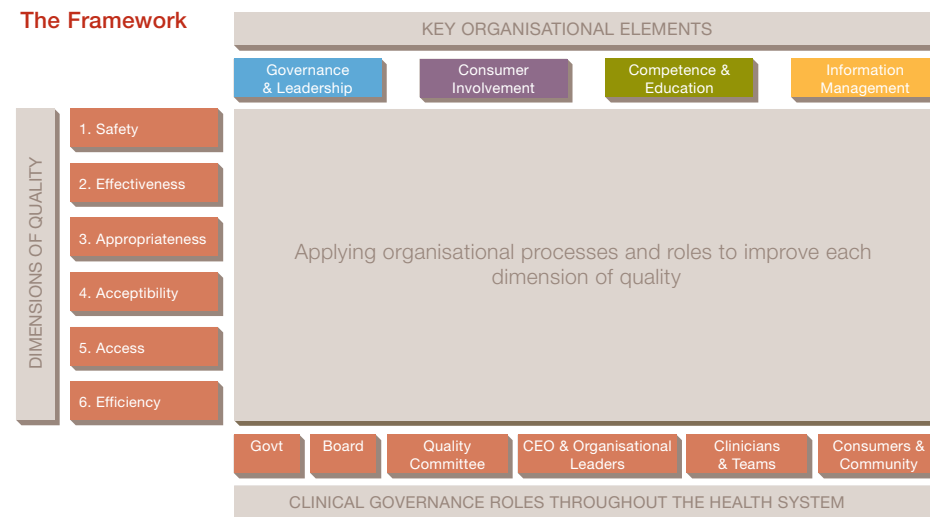
Executive Summary

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 defined by ACHS as “the system by which managers and clinicians share responsibility and are held accountable for patient care, minimising risks, and for continuously monitoring and improving the quality of clinical care”. This 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



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.

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.

Framework Fundamentals

Whatever approach is taken, 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 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
- there is a clear and transparent process for the review of deaths and reporting and responding to sentinel and adverse events