Thirteen things to make patient care better and indirectly clinical governance better

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I will be brief. These are in general my personal opinions based on 20 plus years of hospital experience

1. **Outcomes Focus**

   Accreditation and other quality activities are often process focused. As a result, organisations have passed measures of quality without measuring their outcomes
   Measures such as HSMR do provide some guidance on hospital outcomes but need to be refined. There is significant possibility to use routinely connected data to measure outcomes (eg Coded complications, return to theatre, readmissions, transfers, transfer deaths etc etc)

2. **Adverse events**

   Large amounts of data about adverse events are collected, collated and referred to DHHS. Little is done with this data. Previously analysis of adverse events statewide has seen improvements. For example, withdrawl of potassium and methotrexate from ward stock has saved lives.

3. **Use of casemix and other data usage across the system**

   On a similar theme, large amount s of data remain untapped. While this gradually improving ,a concerted effort would see health services better placed to judge performance. Example include DRG mortality, LOS, transfer to another facility etc

4. **Capability Framework development**

   By defining what you can and should do through a capability framework, it allows you to measure your compliance and performance for your defined role and put in place arrangements for other services to fill the gaps.
   Also when services change in capacity (grow) the capability of the service needs to be revisisted

5. **Policy development across the system (state-wide or nationally)**

   Organisations have traditionally developed their own policies, procedures and guidelines. Most of the variation has been fairly random with the core content being consisitent. With the development of PROMPT there has been greater sharing of these documents but the excess burden of development has largely remained. This should be addressed.
   In the urgent care space, the Primary Care Clinical Manual from Queensland has eliminated the need for local protocols.

6. **Presentation of information in form that is digestible to clinicians**

   Recently a 78 page guideline was produced on highly resistant organisms. Rather than adding to existing protocols and frameworks, it started from scratch and devised a new system for CRE. This approach is completely unhelpful to the average clinician. Given the enormous amounts of useful data, greater attention needs to be paid to its simple and straight forward presentation

7. **Central control of information systems to allow standardisation of communication and data**

   Recently Dr Tim Baker (an ED physician from Warrnambool) and I attempted to look at the outcome of UCC transfers in Victoria) Given the different data collection systems of different hospitals it was impossible to get an overview of outcomes

8. **Relaxation of inter agency privacy control to allow transfer follow up**

   Unwell patients are often transferred from smaller hospitals to larger ones. Follow up of these patients are often blocked by staff expressing privacy concerns. This needs resolution

9. **Training of boards in relation to clinical governance**

   Training a board member de novo in clinical governance is a long winded and sometimes unsuccessful task. Boards should rather recruit individuals with appropriate experience who may require some top up training.

10. **Development of clinical internal audit of services**

    The audit process trialled by VMIA, an accounting firm and clinicians has great potential. The UCC audit at Seymour was affordable, practical and helpful. It would appropriate for each major service to be reviewed on a rotation basis in say a three to four year cycle.

11. **Review of the role of accreditation and the National Safety and Quality standards**

    The evolution of the EQUIP to the national standards does not seem to ensure quality service provision in health services. The pass fail approach seems unhelpful and many consider the process to be tick box Clinicians are generally unimpressed and uninvolved in the process. A complete review should be undertaken

12. **Partnerships**

    As an extension to the concept of capability frameworks, smaller services who cannot deal with a particular patient need partnerships with larger health service to accept their patients. This can be achieved through local arrangements or state-wide services such as ARV

13. **Doctors and nurses must have peer groups**

    Isolated practitioners or those who are divergent from standard practice are often brought into line by involvement in a peer group. Personally, my experience is that this has greater effect than continuing education. The isolated practitioner may be OK but the risk of deviant practice is increased. This has in recent times been put in place with the regional radiotherapy services after the commonwealth SMU trials

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