Pacific Heads of Nursing & Midwifery Meeting

Réunion des chefs des soins infirmiers et obstétricaux du Pacifique

AICG

Australasian Institute of Clinical Governance

Pacific Heads of Nursing & Midwifery Meeting

Wednesday, 15 November 2023

Beverley Sutton

The global impact of clinical governance

We know that internationally:

▪ Length of hospital stay is inversely correlated with good Clinical Governance Quotient.[1] Hospital Acquired Complications increases the average length of hospital stay from 4.7 to 18.8 days (16.2 in private settings)[2]

▪ $2 billion saved over 5 years (to 2016) through supply chain and treatment efficiencies[3]

▪ Patient Safety First (nation-wide UK initiative) resulted in[4]:

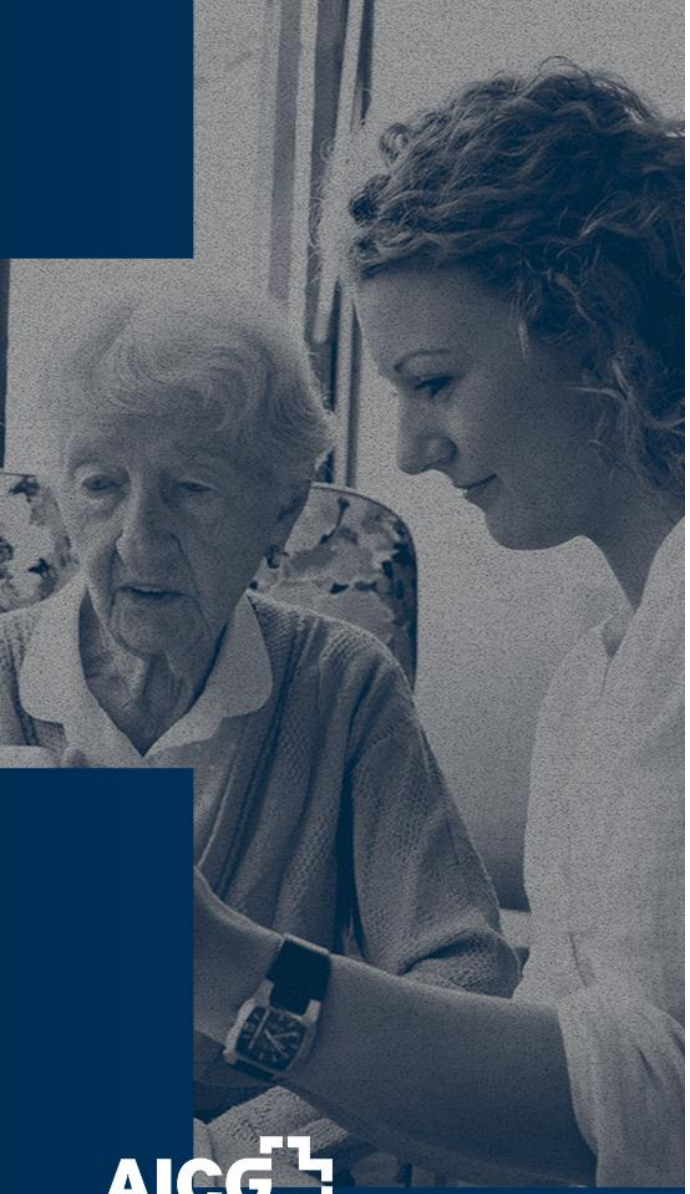
- Complete compliance in the implementation of the Surgical Safety Checklists (100% compared to usual 50%)
- Reduced cardiac arrest calls
- Improved use of Rapid Response Teams (preventing further patient deterioration)
- Increased compliance with ventilation care
- Increased compliance with pre-operation antibiotic administration

1 Specchia *et al*. *BMC Health Services Research* (2015) 15:142 DOI 10.1186/s12913-015-0795-2
2 Australia's Hospitals at a Glance, Australian Institute of Health and Welfare (Jul 22 update), accessed 21 Nov 2022
3 Intermountain Healthcare, *Reducing Costs by Improving Quality,* accessed 21 Nov 2022
4 Patient Safety first (2008 – 2010), *The Campaign Review*, March 2011

The Current Landscape (In Australia)

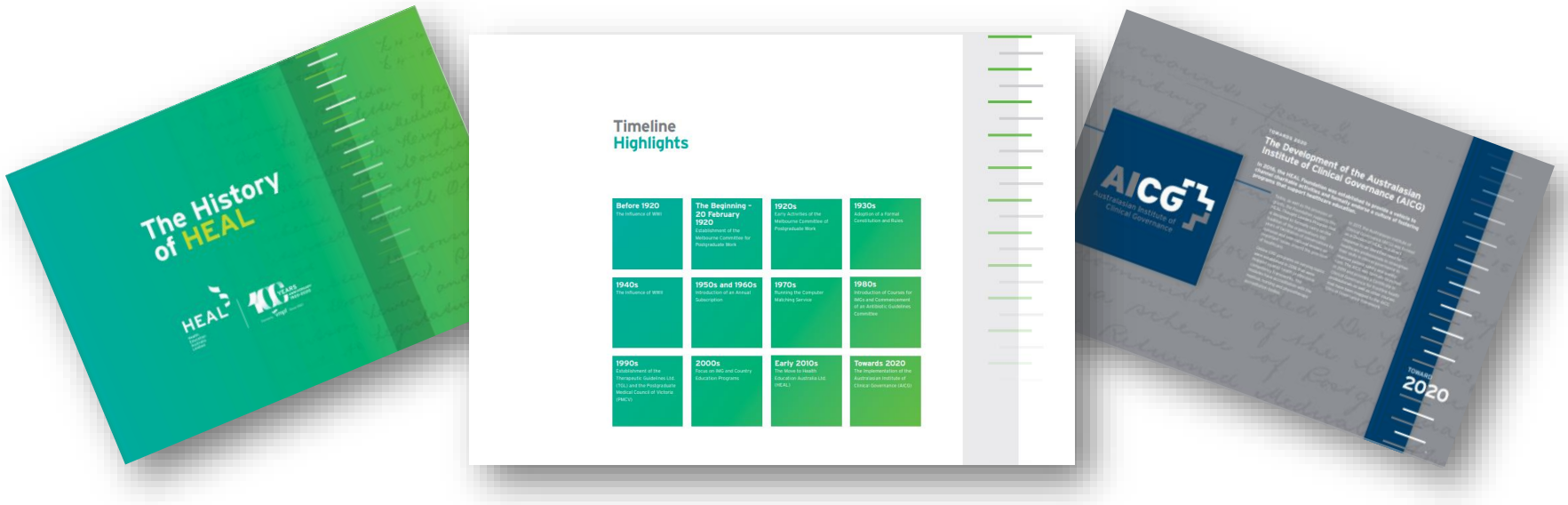
- Despite national standards and accreditation processes, patient safety and quality care lapses continue to plague our health system. In fact, almost every significant safety failure in recent decades happened in a hospital that passed its accreditation with flying colours[1].
- 1 in 9 patients in Australian hospitals suffers a complication. 1 in 4 if the patient stays overnight[1].
- Patient complications are costing $4 billion a year for public hospitals and more than $1 billion a year for private hospitals[1]
- Variation in care continues to exist.
- **Globally, the light is shining on clinical governance.**

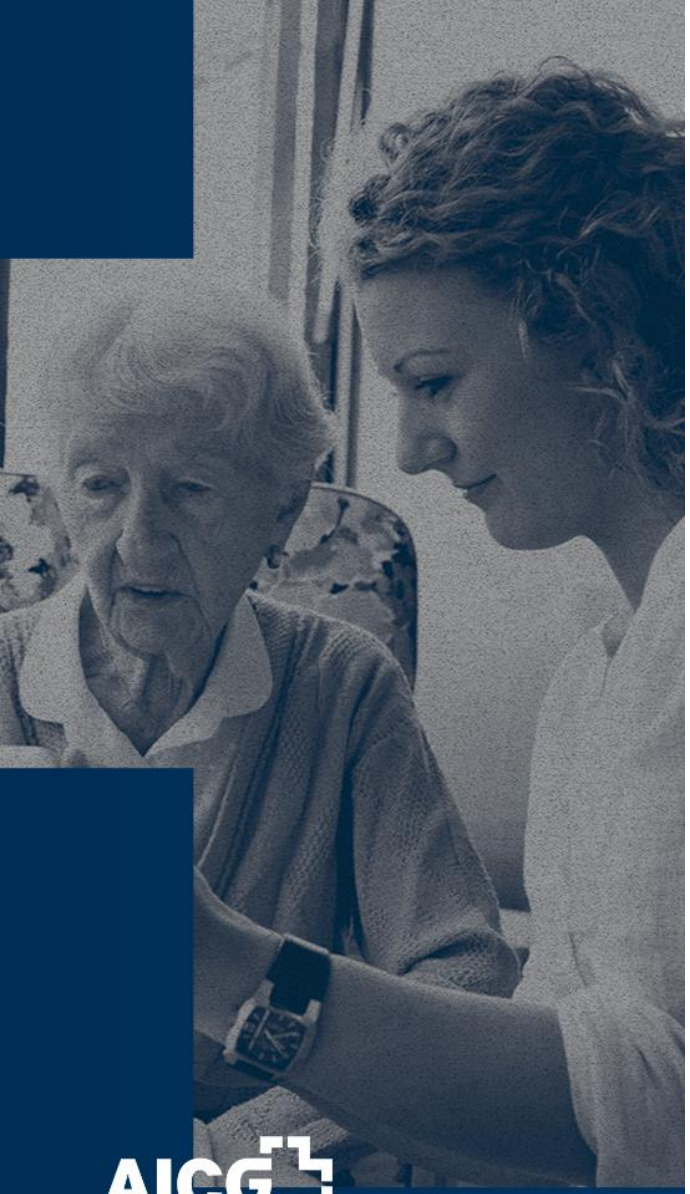
1. Duckett, S., Jorm, C., Moran, G., and Parsonage, H. (2018). Safer care saves money: How to improve patient care and save public money at the same time. Grattan Institute



AICG
Australasian Institute of Clinical Governance

Who are we?





The AICG

Vision

Safe and quality care through excellence in clinical governance.

Purpose

By empowering healthcare providers through clinical governance education, we improve safety and quality of patient and consumer care.

AICG Clinical Governance Competency Framework

Who is responsible?

Boards and/or Governing Body

Set the culture and expectation for safe and quality care with the Executive using the Clinical Governance (CG) framework as the vehicle.

Executives

Empower change and operationalise the CG framework by enabling people and systems. They foster the desired culture and mindset. The Executive lead, support, monitor and improve.

Managers

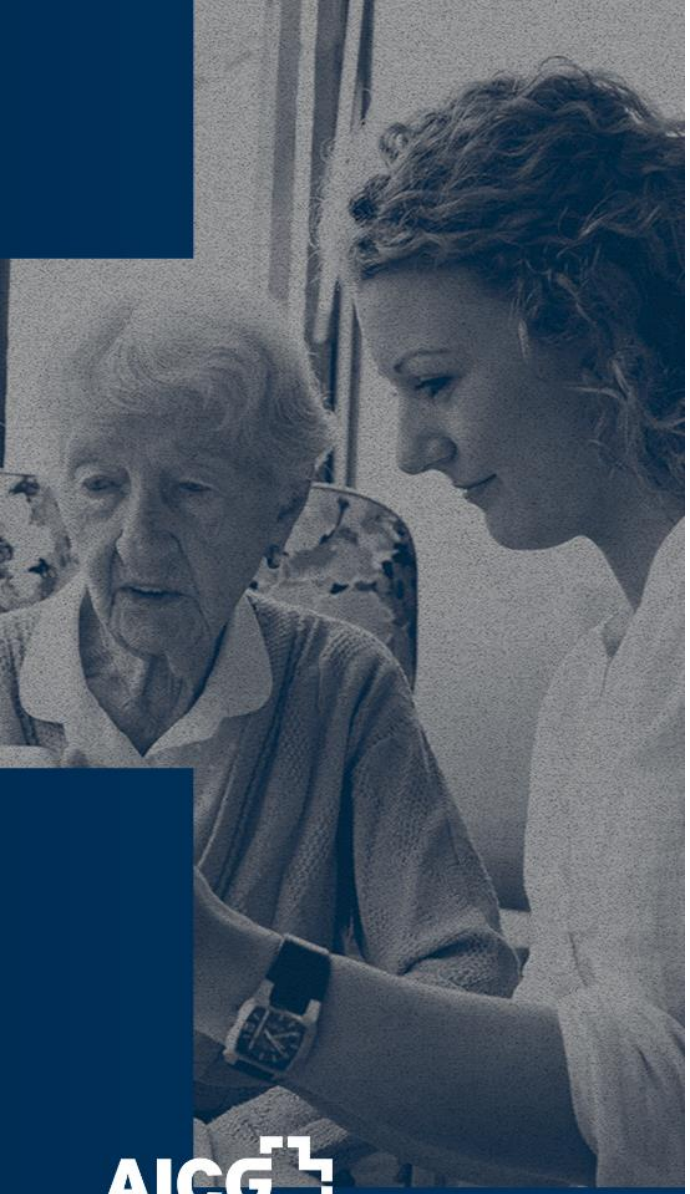
Create the environment for change. They support, organise and develop staff to create safe and quality care with the use of guidance tool such as standards and systems.

Frontline clinicians and care staff

Enact the change. They create the point of care experience through their behaviour and skills and by monitoring and improving the care experience.

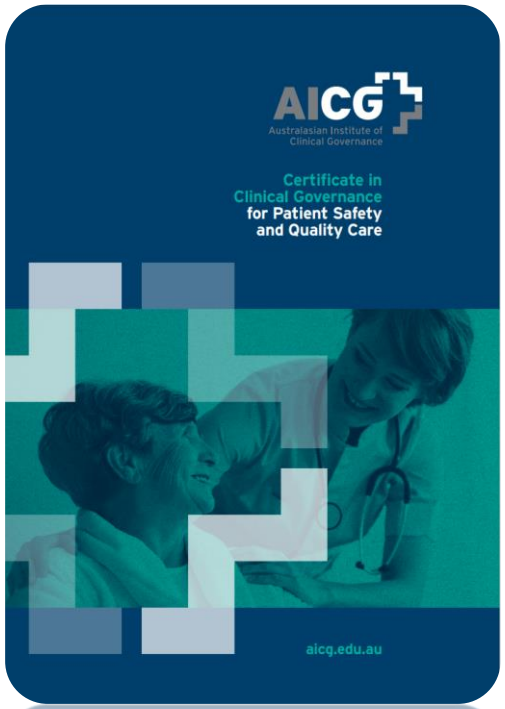
Non-clinical/care workforce

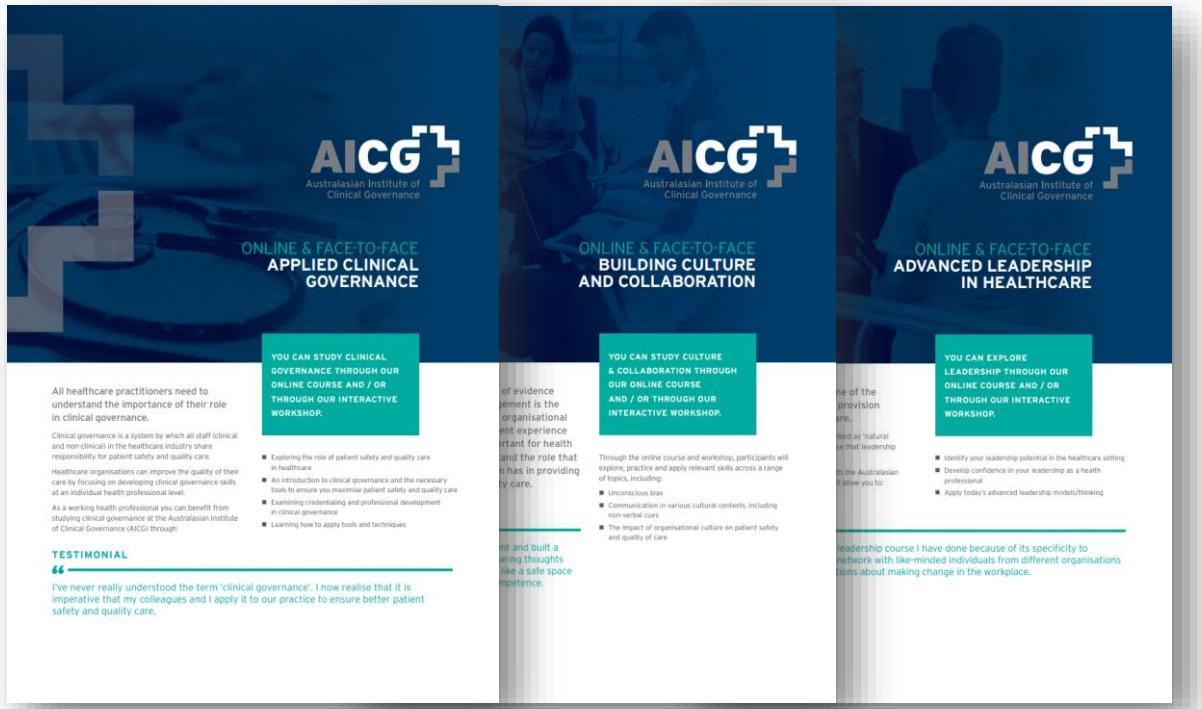
Support frontline clinicians and care staff to create a quality experience.

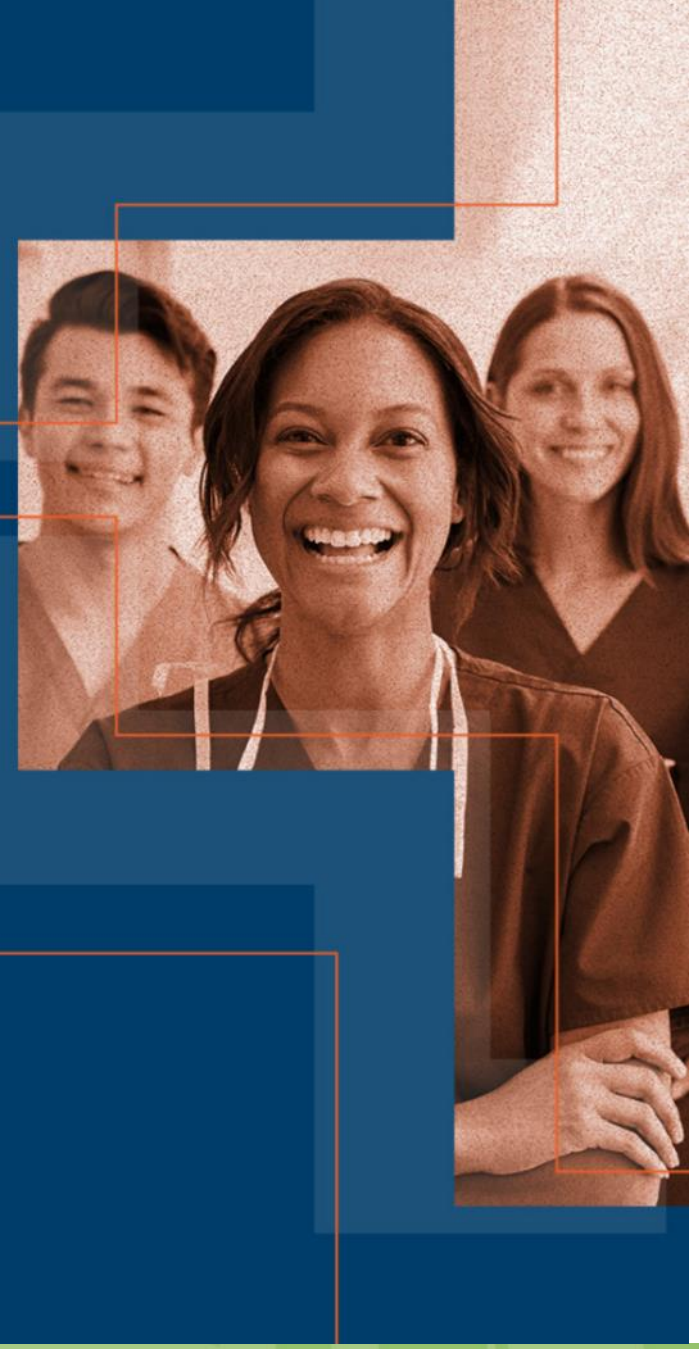


What do we do?

Courses in Clinical Governance competencies for the Board and Executive, for frontline professionals, middle to senior managers. We are developing a course for service providers. Our flagship course is our Certificate in Clinical Governance.







AICG Membership

Articles and blogs

Exclusive access to all AICG articles and blogs written by clinical governance experts

Post nominal

AICG Members will be able to proudly display their AICGM post-nominal.

Monthly webinars

Members have free access to our monthly webinars, where experts present on a particular topic relating to clinical governance. A database of past event recordings is also available exclusively to members.

Community of practice

Everyone wants to feel like they are part of a community, and the AICG membership does just that. Members are invited to join this social group to engage in discussion with like-minded peers and share success stories.

Course discounts

Members are eligible to receive a discount on the Certificate in Clinical Governance.

Event discounts

AICG members receive generous discounts on AICG annual events and conferences.

So what is Clinical Governance?

Clinical governance is the set of relationships and responsibilities established by a healthcare service between regulators and funders, managers, owners and governing bodies (where relevant), healthcare providers, the workforce, patients, consumers and other stakeholders to ensure optimal clinical outcomes.[1] It ensures that:

- The community can be confident there are systems in place to deliver safe and high-quality health care
- There is a commitment to continuously improve services

Everyone is accountable to patients and the community for ensuring the delivery of safe, effective and high-quality health care. This includes healthcare providers, other members of the workforce and managers, owners and governing bodies (where they exist). Depending on the size of the healthcare service, multiple roles may be carried out by the same individual.[1]

1 Australian Commission on Safety and Quality in Health Care. National Model Clinical Governance Framework. Sydney: ACSQHC; 2017.

Key principles of effective clinical governance

Consumer/patient centred care, engagement and participation

Organisational capacity and capability

Open and transparent culturally safe care for patients/consumers and staff

All staff actively participate (and partner) in clinical governance

Continuous quality improvement focus

Leadership, managerial and clinical competence

Promotion of evidence-based practice

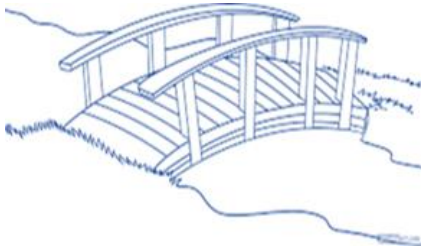
Transparency and open information systems

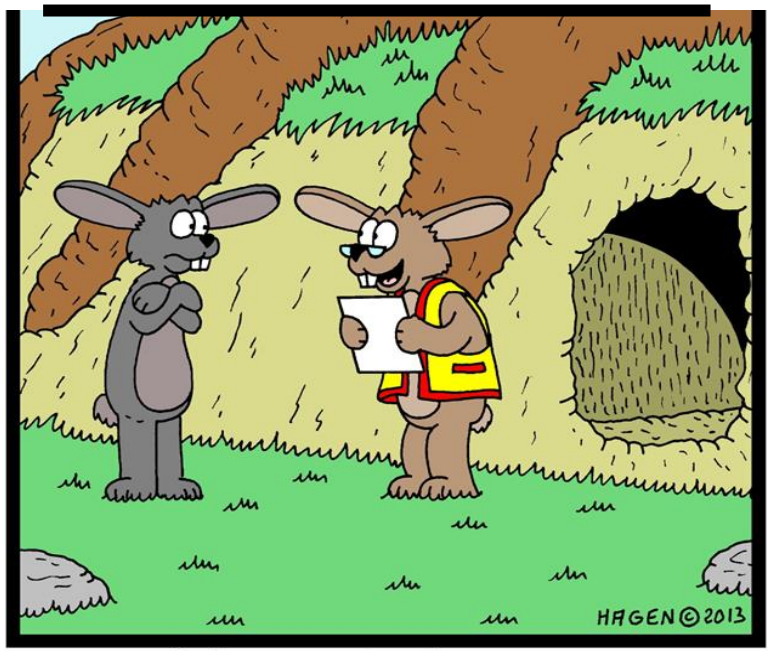
Today: 30 years of lessons learned in 10 mins

Even today, we understand what doesn't work…but we keep doing it anyway

Four rabbit holes:

- Common Clinical Governance traps
- Suggestions for building bridges





Before you enter the warren,
I need to give you a full Safety Induction...

'Four Clinical Governance Rabbit Holes to Avoid' paper available –how you can become a *'Clinical Governance rabbit hole avoidance specialist*'. Note: It was written for the aged care sector from lessons learnt in acute care.

Four ‘rabbit hole’ reasons (of many)

1. Activity without Purpose

2. Process before People

3. Prioritising Passivity

4. Confusing Fads with Foundations

Why these?

- Easy to fall into – hard to escape from
- Align with the literature and public inquiry findings on clinical governance failures and fault lines
- Waste time, energy and $$$
- Avoidable – through committed and focused executive leadership
- Lived experience

1. Activity Without Purpose

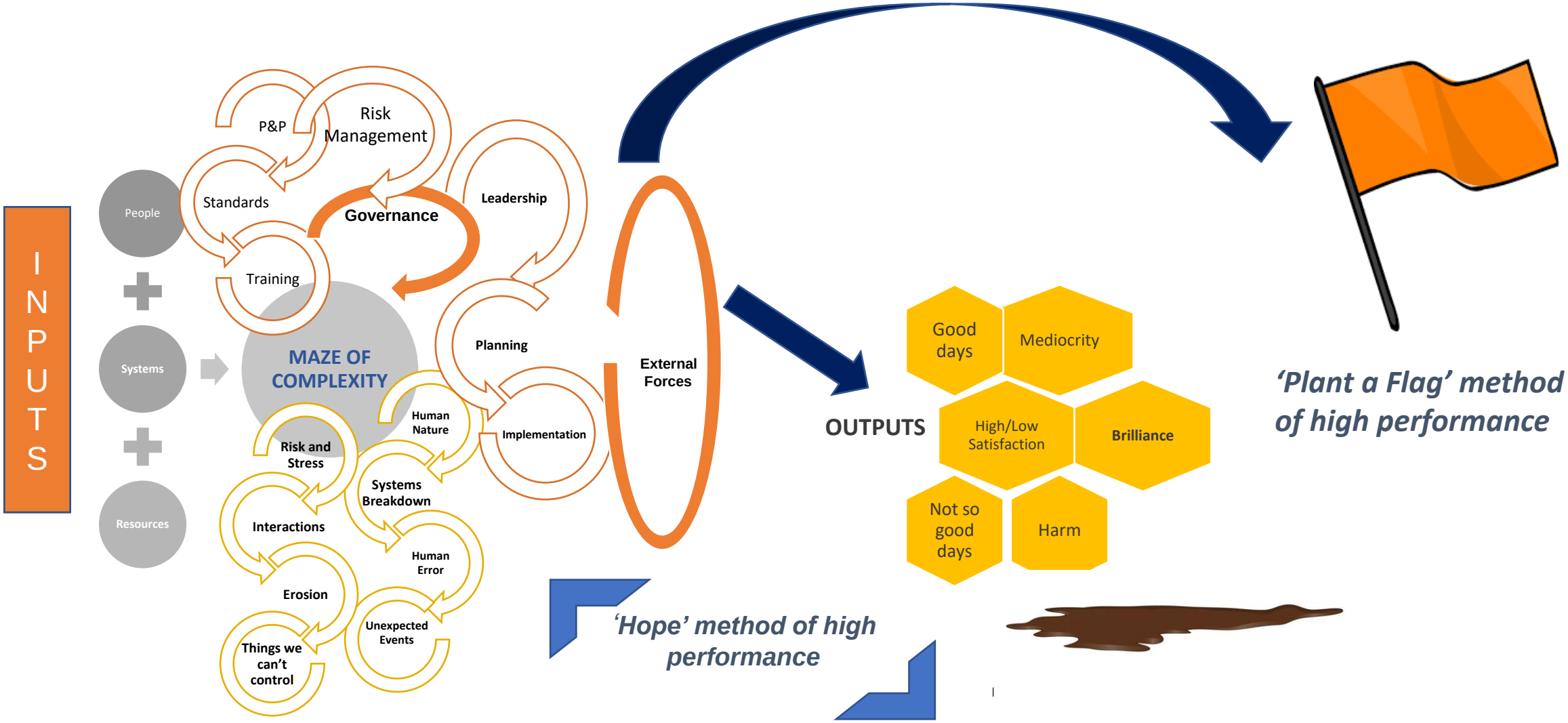
Clinical Governance became all about following directions… and not about the destination

What's the point?

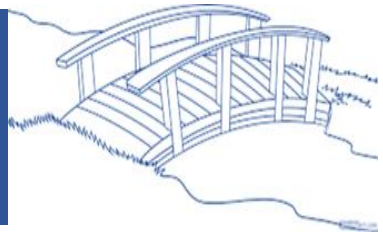
- "A lot of what we do [in quality management] seems to just be done for the doing" (Clinical leaders)
- "I'm so busy trying to meet compliance requirements, I question if what I am doing is actually improving care delivery." (Front line staff)

•*Leggat and Balding, 2018. La Trobe University Strategic Quality System Research 2015-2017.*

It gets worse…at the bottom of the ‘Activity without Purpose’ rabbit hole… lies the ‘swamp of inconsistency’



Avoid 'Activity without Purpose': define a high-quality service experience, and make it an executive priority

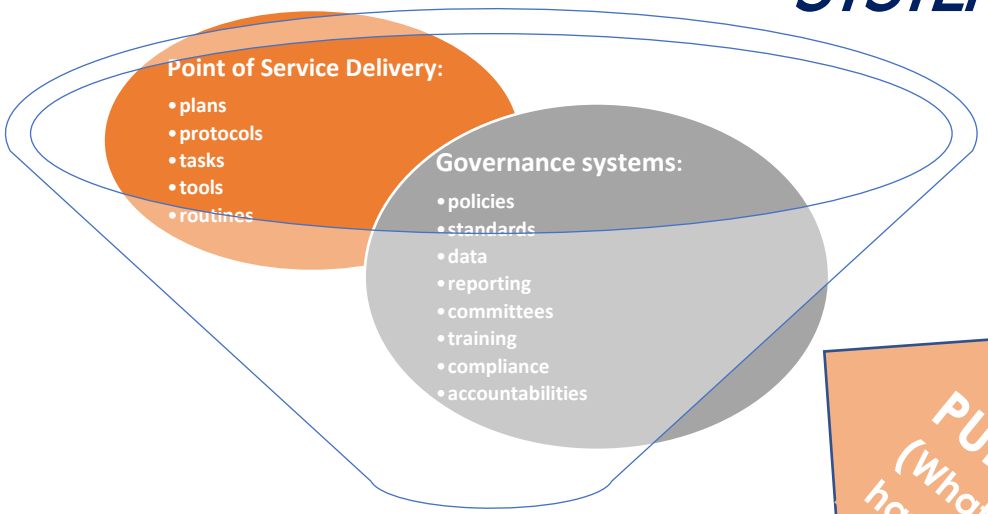


"If you want to be happy, set a goal that commands your thoughts, liberates your energy, and inspires your hopes."
- Andrew Carnegie

What do human beings want from a human service?	
Treat me like a dignified, respected individual and support my goals and needs	**INDIVIDUAL CARE and SERVICES**
Don't harm me or make me worse	**SAFE CARE and SERVICES**
Do the right thing by me that gets the best possible result	**EFFECTIVE CARE and SERVICES**
Don't let me fall through the cracks	**CONNECTED CARE and SERVICES**

2. Process Before People

THE CG SUPPORT SYSTEM



THE QUALITY EXPERIENCE

PURPOSE (What we have to do)

PURPOSE (What we want to do)

'DOING' QUALITY

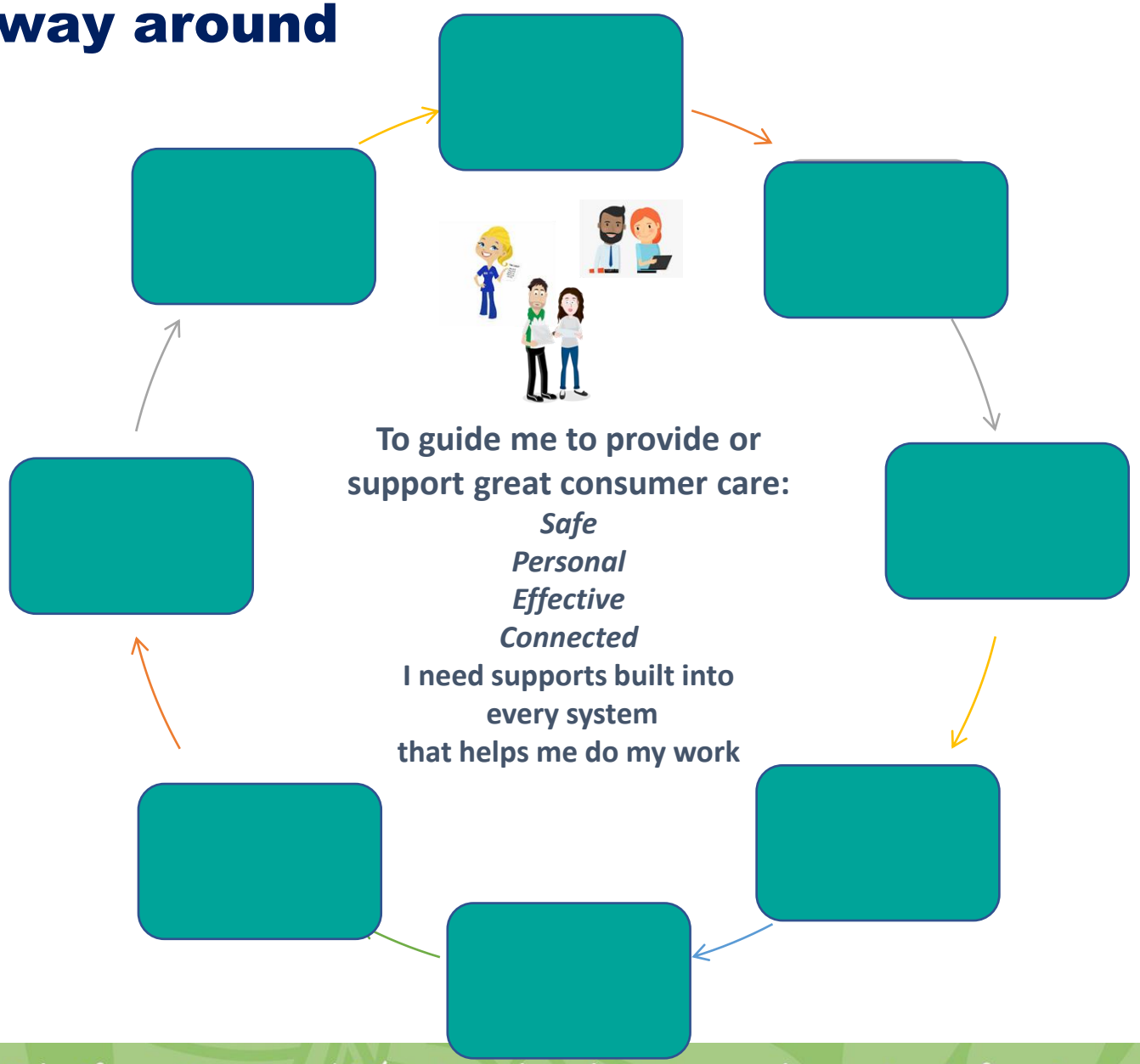
***Embed** in Systems…*

*…to **support** consistently good care*

'CREATING' QUALITY care and services:

- ***Individual***
- ***Safe***
- ***Effective***
- ***Connected***

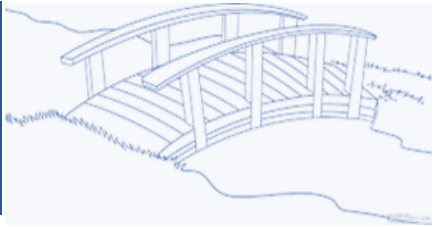
Systems must be implemented to ‘wrap around’ people, not the other way around



3. Prioritising Passivity

Passive (or 'trickle down') clinical governance:
not very useful in complex systems

Avoid ‘Prioritising Passivity’ by understanding what it takes to achieve consistently good care in complex systems - and implement to support line management responsibility



***‘I AM’* RESPONSIBLE**

Consumer

FRONT LINE STAFF

MANAGERS

SENIOR LEADERS

BOARD AND EXEC

A quality services experience with every consumer	
Individual	Safe
Connected	Effective

Committees, Support Services, Quality Team

Governance and Systems ‘Engine Room’ Supports managers and staff to achieve the Quality Goals as BAU	
Planning, Leadership and Culture	Partnering with consumers
Positive People and Practice (incl. standards)	Pursuing High Performance

Measurement and Feedback inform system improvement

4. Fads Before Foundations

Fads are the kiss of death. When the fad goes away, you go with it.
(Conway Twitty)

Effectively implementing clinical governance foundations to support consistently high-quality services requires knowledge, skills and a toolkit

Great tools out there – from our own sectors and other industries:

- Software
- Training
- Templates
- Guidance
- Models
- Methods

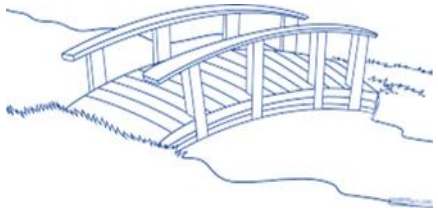
But!...

Without clear intent and purpose, there's been too much 'grab and 'go and not enough 'assess and adapt':

'Studies show that some approaches borrowed from other industries may not be as effective in health care settings for increasing the reliability of outcomes, and that more dynamic and flexible approaches may be needed' (Liberati, Peerally and Dixon-Woods, 2018.)

Tools and methods help – but there are no quick fixes. No single approach 'ensures' quality care (a convenient untruth)

Avoid ‘Fads before Foundations’ by knowing the key CG foundations for great care - and evaluating ‘fads’ for their helpfulness in development and implementation



Ask – will this tool/model/method help use to successfully embed the foundations of quality services (and avoid the rabbit holes?):

A. **Set clear goals for high quality services** and create a shared and practical understanding of what that means in practice with staff and consumers

B. **Create a positive, quality-oriented mindset and culture** that embraces the challenge of creating quality services within the real-world complexity of the environment

C. **Clarify staff roles and responsibilities for point of service quality**, support staff to enact them and to be accountable for their role

D. **Support partnering with consumers** in service improvement

E. **Develop line manager capability** to lead and pursue point of service quality goals

F. **Develop quality managers, leaders and teams** with the knowledge and skills to support line managers and staff to achieve point of service success

G. **Identify and implement the governance and operational infrastructure** required to support quality goal achievement, including the use of **standards to specifically support quality service development**

H. **Develop both responsive and proactive methods** for managing risk and creating quality services

I. **Help staff to make positive changes** that *stick and scale*

J. **Tell the story of your care and service quality** through valid, reliable, subjective and objective data.

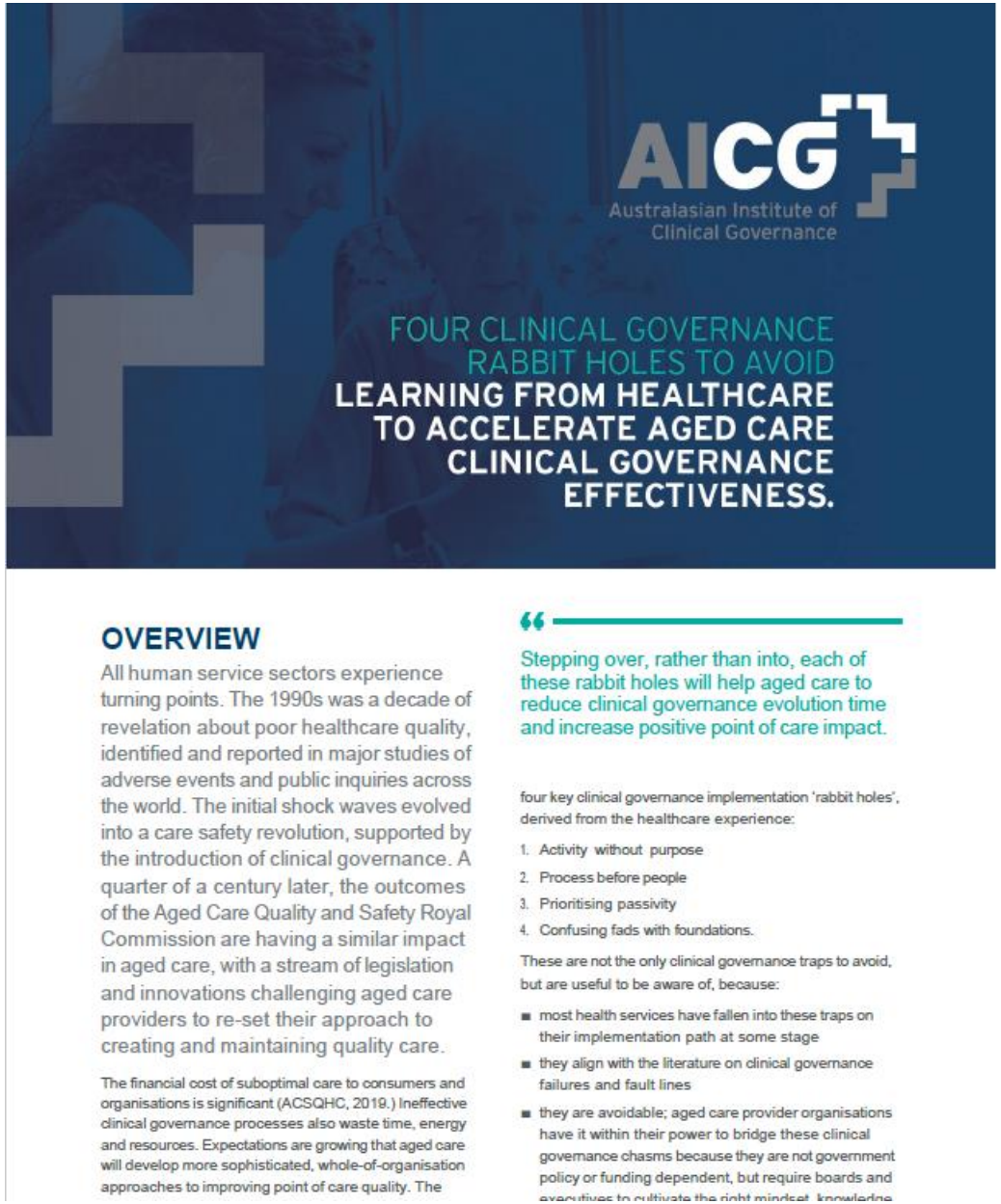
Critical Clinical Governance Questions

- How do we know our care is safe and effective?
- How do we ensure the quality and safety of care?
- Do we know what the red flags are?
- How will we fix what it is that we don't know isn't working?
- What needs to be done to improve the quality and safety of care?
- Do we have the right culture to facilitate continuous improvement in care and safety?
- What do we need to do to ensure patients feel empowered to partner in their care?
- What do we need to do to ensure that intimidating and inappropriate behaviour is not tolerated?
- Do the staff feel supported to create consistently safe, person-centred effective care?
- What must we do to increase support for the staff?
- What must we do to increase the effectiveness of the systems?
- What evidence do we have to show that our patients are better off?
- Do we have a shared understanding of success?

Source: Safer Care Victoria. Delivering high-quality healthcare Victorian clinical governance framework. Melbourne. 2017

Help is at hand! Haul your organisation out of the rabbit holes – or avoid them in the first place!

Get your copy of
'Clinical Governance Rabbit Holes' paper from the Australasian Institute of Clinical Governance (AICG)



AICG
Australasian Institute of Clinical Governance

FOUR CLINICAL GOVERNANCE RABBIT HOLES TO AVOID

LEARNING FROM HEALTHCARE TO ACCELERATE AGED CARE CLINICAL GOVERNANCE EFFECTIVENESS.

OVERVIEW

All human service sectors experience turning points. The 1990s was a decade of revelation about poor healthcare quality, identified and reported in major studies of adverse events and public inquiries across the world. The initial shock waves evolved into a care safety revolution, supported by the introduction of clinical governance. A quarter of a century later, the outcomes of the Aged Care Quality and Safety Royal Commission are having a similar impact in aged care, with a stream of legislation and innovations challenging aged care providers to re-set their approach to creating and maintaining quality care.

The financial cost of suboptimal care to consumers and organisations is significant (ACSQHC, 2019.) Ineffective clinical governance processes also waste time, energy and resources. Expectations are growing that aged care will develop more sophisticated, whole-of-organisation approaches to improving point of care quality. The

> Stepping over, rather than into, each of these rabbit holes will help aged care to reduce clinical governance evolution time and increase positive point of care impact.

four key clinical governance implementation 'rabbit holes', derived from the healthcare experience:

1. Activity without purpose
2. Process before people
3. Prioritising passivity
4. Confusing fads with foundations.

These are not the only clinical governance traps to avoid, but are useful to be aware of, because:

- most health services have fallen into these traps on their implementation path at some stage
- they align with the literature on clinical governance failures and fault lines
- they are avoidable; aged care provider organisations have it within their power to bridge these clinical governance chasms because they are not government policy or funding dependent, but require boards and executives to cultivate the right mindset, knowledge

Thank you

aicg.edu.au