Chapter 2
Better care

Objective: **Striving for better care in Central Queensland**

Our patients are the focus of everything we do.

We owe it to our patients and community to focus on continually improving our standard of care and eliminate avoidable patient harm.

Safe care is the best care.

Eliminating avoidable patient harm is the clear goal of the health service and its employees.

A significant clinical incident in early 2014 was a defining moment for the organisation and has hardened the resolve to become, and be recognised as, a patient safety leader in Queensland and across the country.

Quality, safety and the management of risks across the health service is reaffirmed as the highest priority for the health service. The initial focus was to ensure sustainable systems around the quality, safety and risk management agenda are established to ensure patients are safe.

Integrated into the work around patient safety is preparation for the Australian Council of Healthcare Standards EQuIP national accreditation to be held on 3 to 7 November 2014.

Vanguard Health was contracted to review all outstanding recommendations in a document known as the Vanguard Report. This report became a key focus to ensure quality and safety initiatives were implemented across the health service.

It was identified that a large number of recommendations from internal reviews and coronial inquiries, each with the aim of improving patient safety and reducing patient risk, had not been implemented. The 123 recommendations from the 2012 ACHS EQuIP survey had also not been implemented. At 30 June 2014, 98% of the recommendations had been implemented.

This work has identified opportunities to improve patient safety and the review of safety systems was prioritised to ensure the building blocks were in place to maximise quality and safety.

From this work, the health service:

- Developed and implemented a risk framework.
- Established a quality framework which sets direction for the implementation of quality initiatives across the organisation. This includes a quality improvement operational plan for all business units outlining new initiatives, safety initiatives and an audit program.
- Implemented project teams to maximise opportunities for a multidisciplinary approach to the implementation of innovation.
- Provided extensive training in the management of a Root Cause Analysis (RCA – an internal review resulting from avoidable or unavoidable patient death or serious harm) to create a greater awareness of the management of Severity Assessment Code 1 (SAC1) incidents and RCAs and create greater awareness of the safety systems required to limit the number of SAC1 incidents.
- Initiated a Speaking up for Safety campaign. This campaign included confidential forums with designated groups of clinical staff regarding safety and risk with the intent of gaining insight into safety risks identified by front-line staff. These discussions informed a wider strategy to identify organisation changes that would make it safer for patients and staff. This campaign included staff engagement on safety and safety initiatives with the shared aim of eliminating avoidable patient harm.
- Introduced a monthly Clinical Governance Half Day as a direct result of the Speaking up for Safety meetings. The protected time allows clinical staff to focus on the safety and effectiveness of services across the health service. It also provides a teaching opportunity in a multi-disciplinary setting.
- Developed a communication flow sheet to centralise and formalise quality information from across the health service. A Quality and Safety Operational Governance meeting was implemented to develop a comprehensive and quality system across the health service.

- The Quality and Safety Unit developed an intranet site incorporating alerts and preparedness for accreditation. This site will hold all information relevant to the quality and safety program allowing staff access to information relevant to their application of quality and safety.

The continual monitoring of Nurse Sensitive indicators,including reported incidents on falls, pressure ulcers, medication administration, blood transfusion,nursing skill mix and nursing agency utilisation was introduced to allow the timely development of strategies with the aim of reducing the number of incidents.

A software system called TrendCare, a nursing tool measuring patient acuity, was implemented in all acute services allowing a review of nursing procedures to ensure they are evidence-based and contemporary in their practice.

Clinical governance structures were established for each hospital. The clinical governance framework at Rockhampton Hospital includes a global audit schedule and monthly discussion and oversight of the hospital's clinical care.