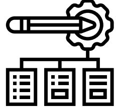
VAGO Clinical governance: health services report

Summary of recommendations

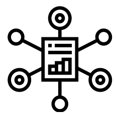
AUSTRALIAN CENTRE FOR HEALTHCARE GOVERNANCE
Quality in governance

Victorian Healthcare Association
Vision • Value • Voice

The VAGO Clinical governance: health services report makes 18 recommendations to one or more of the audited services to improve their clinical governance processes.



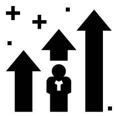
Continue to implement the clinical governance framework by promoting and embedding priority actions to ensure staff have a clear understanding of how they contribute to safe, high-quality care.



Revise the clinical governance framework to ensure it complies with the Victorian Clinical Governance Framework and completes implementing it as a priority to ensure staff have a clear understanding of how they contribute to safe, high-quality care.

Implement initiatives that strengthen staff's skills and confidence in speaking up.

Design and implement targeted initiatives to improve staff's psychological safety.

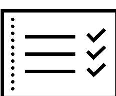


Evaluate initiatives to assess if the service has been effectively improving their patient safety culture and apply learnings for continuous improvement.

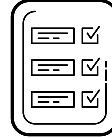
Provide updates on the implementation status of recommendations and actions in response to incidents at each board quality and safety subcommittee meeting.

Analyse common contributing factors to serious and less serious incidents and report findings to their board quality and safety subcommittee at least every six months.

Analyse common contributing factors to less serious incidents and report findings to the board quality and population health subcommittee at least every six months.

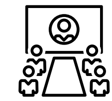


Report the status of serious incident investigations to the board quality and safety subcommittee.

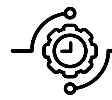


Improve the consistency and quality of regular incident summary reports to the board by clearly indicating the status of ongoing incident investigations, including if there are overdue investigations and reasons for delays.

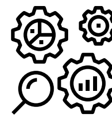
Adopt more statistical approaches to identifying true performance variations, such as using run or control charts (or equivalent statistical approaches), to detect significant changes over time and departures from expected statistical variation.



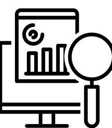
Provide more detailed accounts to boards regarding performance issues.



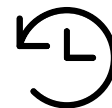
Increase staff capacity and capability to meet timeliness requirements for completing incident investigations.



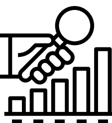
Undertake thematic analyses of less serious incidents every six months at a minimum and include them in clinical incidents themes and trends report to the board quality and population health subcommittee.



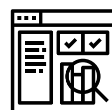
Undertake thematic analyses of serious and less serious incidents at least every six months and report them to the board quality and safety subcommittee.



Identify and address factors contributing to delays in completing serious incident recommendations.



Include impact assessments as a standard requirement of action plans following serious incident investigations and provide guidance to staff on appropriate measures to assess impact.



Report the results of impact assessments in serious incident action plans to the board quality and safety subcommittees so they can be assured that recommendations have been effective.