Ramsay Health Care Australia

Patient safety and clinical quality framework

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Ramsay Health Care Australia is focussed on the delivery of high quality, safe, and effective clinical care. As an organisation striving for high reliability, we aim to create an environment in which risks and issues are anticipated, identified early, and responded to rapidly. Our Framework consists of five key areas designed to produce reliable, safe, and effective outcomes:

People

Safety

Structure

Culture

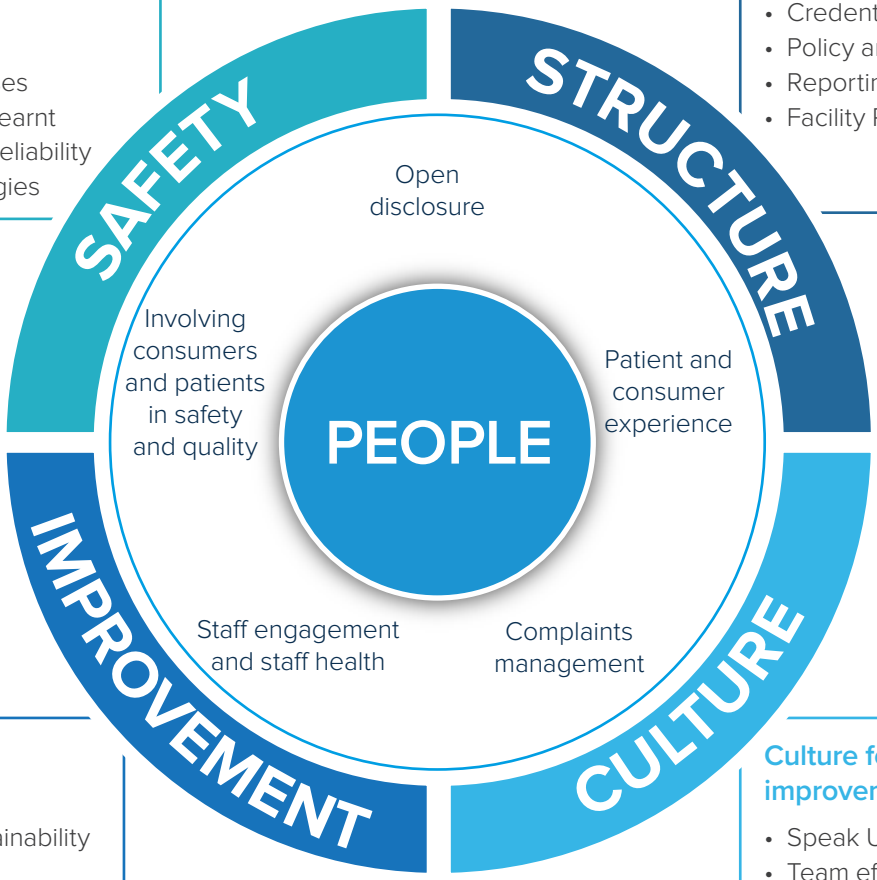
Improvement

Minimising harm and preventable mortality

- Effective clinical incident management
- Morbidity and Mortality processes
- Sharing lessons learnt
- Building system reliability
- Health Technologies

Structure and process for clinical safety

- Accreditation
- Credentialing
- Policy and procedures
- Reporting for clinical safety
- Facility Rules



Continuous improvement

- Spread and sustainability of best practice
- Data for improvement
- Human factors design
- Improvement initiatives

Culture for safety and improvement

- Speak Up Program
- Team effectiveness
- Leadership
- Building workforce capability

People caring for people

Ramsay Health Care Australia is centred on people caring for people. Our framework reflects the central role that our staff, credentialed clinicians, consumers, patients, carers and families, play in the provision of high-quality clinical care.

1. Patient and consumer experience

The organisation routinely collects and publishes data on patient and consumer experience and develops action plans based on this experience. These action plans are developed to address feedback, and strategic and business plans. Shared decision making is demonstrated through discussing values, goals and preferences when planning current and future care.

2. Staff engagement and staff health

The organisation routinely collects data on staff engagement, action plans are developed to address feedback, and strategic and business plans are informed by staff feedback. The organisation has a coordinated approach to, and ongoing support for, a comprehensive staff health program, including vaccination and occupational exposure support and management.

3. Involving consumers and patients in safety and quality

Consumers, patients, and their families, are actively engaged in the planning and evaluation of quality and safety processes including participation in quality improvement initiatives and service planning; their lived experience and active engagement in committees and advisory panels is sought and encouraged.

4. Open disclosure

Following an adverse event, consumers and patients are supported, provided an apology and openly informed of what occurred. The organisation ensures that staff and credentialed clinicians are effectively educated on, and supported to, participate in the open disclosure process.

5. Complaints management

Consumer and patient complaints are acknowledged and managed in a timely and effective manner to ensure resolution. Information from the complaints management processes is utilised to inform organisational improvement strategies.

Safety: Minimising harm and preventable mortality

Ramsay Health Care Australia recognises that on rare occasions adverse events occur; we aim to build a high reliability system through the comprehensive analysis of incidents, sharing of lessons learnt, establishment of robust Morbidity and Mortality reviews and implementation of evidence-based care to mitigate patient risk.

1. Effective clinical incident management

Recognition and reporting of all clinical incidents and near misses is encouraged. Timely notification, escalation, assessment, and investigation of incidents to identify root causes, contributing factors, and system improvement opportunities occurs. Risks identified in the analysis of incidents are monitored in the risk management system.

Systems are established to ensure recommendations arising from incident investigations are implemented and their effectiveness monitored. Consumers, patients, staff and credentialed clinicians are informed of the outcomes of incident investigation processes.

2. Morbidity and mortality processes

All consumer and patient morbidity and mortality, and outcomes of clinical care, are subject to critical analysis by the multidisciplinary clinical team with an emphasis on the identification of system improvement opportunities. Actions to address any issues identified are developed and monitored.

3. Sharing lessons learnt

Learning from both high performance and where opportunities for improvement exist are equally important. Identification of internal and external key clinical risks, issues, and resulting strategies for improving the safety of the system, are systematically shared across the organisation. The identification of factors leading to high performance and outstanding clinical outcomes are also shared across the organisation to ensure the dissemination of best practice occurs.

4. Building system reliability

The development, implementation, and monitoring of evidence-based care, care bundles, and patient safety processes are supported across the organisation to minimise unwarranted clinical variation and clinical risk. Monitoring occurs through a robust clinical auditing system process.

5. Creating integrated clinical safety within health technologies

We recognise that health technologies that support our clinical care, require seamless and clinically safe experiences. Clinical Decision Support tools are embedded within electronic workflows and interoperability is prioritised. The potential impacts of any changes to our systems are recognised and investigated to minimise potential impact on related and connected systems, alternate parts of the system, clinical workflows and patient care processes. Our health technology eco-system is designed incorporating human factors, is evaluated, and aligns to evidence-based practice, ensuring clinical risk is minimised.

Structure: Structure and processes for clinical safety

Ramsay Health Care Australia has established robust structures and processes for the establishment and monitoring of clinical governance processes across the organisation.

1. Accreditation

All Ramsay facilities undergo formal accreditation processes against the National Standards for Safety and Quality in Health Care. Action plans to address any identified gaps are developed and implemented. Lessons learned at a site level are shared more broadly across the organisation.

2. Credentialing

All applicable clinicians are subject to formal credentialing processes. The scope of practice for individual clinicians is aligned to recognised skills, experience, mandatory training and College requirements where applicable, facility licenses, and organisational service capability.

3. Policy, guidelines and procedures

An informed and systematic approach to the development and implementation of policy, guidelines and procedure is applied. All policies and guidelines and procedures are based on best available evidence to ensure safe, consistent, and effective clinical care. Their effectiveness in guiding practice and outcomes is monitored.

4. Reporting for clinical safety

An effective committee structure ensures reporting on patient safety and clinical quality occurs at the highest level of organisational governance, including to the Australian Risk Management Committee and Board.

5. Facility Rules

A comprehensive set of Facility Rules are applied to new and existing credentialed clinicians and disseminated widely to ensure the roles and responsibilities of both the clinicians and Ramsay Health Care are explicit.

Culture: Culture for safety and improvement

Ramsay Health Care Australia recognises a positive safety culture and maintains that a concentrated focus on effective teamwork and resilience can reduce adverse events and improve clinical outcomes. To ensure high quality, safe and effective care, Ramsay Health Care Australia promotes a culture that encourages and supports : the reporting of, and learning from, incidents; building effective leaders and clinical teams; and staff and credentialed clinicians to speak up for patient safety.

1. Speak Up Program

A culture and framework that supports all staff, clinical and non-clinical, and credentialed clinicians to speak up when then they perceive or observe a patient to be at risk, or identify any safety concern, is encouraged and promoted.

Our Speak Up Program contains two fundamental elements:

- Speak Up Now utilising the principles of Graded Assertiveness and Human factors understanding to maintain patient safety in the moment, and, Speak Up Later via a dedicated electronic reporting platform for situations where Graded Assertiveness has been successful and a positive outcome achieved or to report an incident where Graded Assertiveness was not successful or perceived to be unsafe, and/or to report behaviours that are detrimental to our patient safety culture.
- The Speak Up Later component of our Speak Up Program and Framework was originally based in part on the Vanderbilt University Medical Centre model for Promoting Professional Accountability and is integral to our two parts Speak Up Framework. All patient facing staff are provided with training to ensure the ability to speak up when necessary is embedded in everyday clinical practice to support the Ramsay Way and Ramsay's patient safety culture.

2. Team effectiveness

The implementation of team-based improvement initiatives are encouraged. The organisation supports openness, transparency, and analysis of incidents to provide team-based learning opportunities. Practices to support effective teamwork are encouraged including team based bedside clinical handover, active patient rounding, and the implementation of safety huddles.

3. Leadership

The development of effective clinical leaders, and identification of emerging clinical leaders, is promoted across the organisation. Leadership training is tailored to leaders' experience and promotes practices of effective leadership. Executive walk rounds and active listening are encouraged to support leaders to connect with their teams.

4. Building workforce capability

The training and development of the workforce in patient safety clinical quality initiatives and digital literacy is recognised as essential, and is supported across the organisation. The roles and responsibilities for the workforce in relation to patient safety and clinical quality are well defined in role descriptions.

Improvement: Continuous improvement

Ramsay Health Care Australia recognises the requirement for continuous improvement to ensure safe and effective clinical outcomes. The encouragement of local improvement initiatives, identification and dissemination of best practice, use of data for improvement, and consideration of human factors are supported across the organisation.

1. Spread and sustainability of best practice

The identification and dissemination of best practice is encouraged across the organisation. The promotion of policy, procedures, care pathways, and models of care which ensure high quality, safe and effective outcomes for patients is supported to reduce variation and ensure the consistent application of best practice.

2. Data for improvement

The use of qualitative and quantitative data to identify high performance and opportunities for improvement is encouraged. Transparency in reporting is embedded across the organisation, and reported patient safety and clinical quality data includes reliability measures, both process and outcome measures, and is appropriately benchmarked wherever possible. Understanding the key drivers to outcomes is fundamental and this inquisitiveness for system learning is actively encouraged.

Feedback is regularly sought from patients and carers about their experiences and outcomes of care, and is used to improve the safety and quality of care provided.

3. Human factors design

Human Factors is recognised in system design and redesign, and capital changes to minimise the impact on system safety. Education and training of the workforce in human factors design is available. Human factors design is considered in the implementation of changes to clinical and organisational practice and embedded in culture across the organisation.

4. Improvement initiatives

The workforce is encouraged to identify the opportunity for, development and implementation of, local improvement initiatives. Support for improvement initiatives is provided, including the provision of education and training in improvement science. Quality improvement initiatives are recognised across the organisation.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