Safe Care Framework 2020-2024

Our vision

Patient Safety is our focus – together we will promote person centred care and support evidence-based practice and innovation.

Health service values

Respect
Integrity
Empower people
Be courageous
Unleash potential
Ideas into action
Customers first
Compassion

Our values matter

Queensland Public Service values

Values wheel adapted from the values base leadership program.

Our purpose

The Safety, Quality and Innovation Unit (SQIU) supports an integrated approach in meeting the organisation's clinical governance agenda. The SQIU provides expertise and support and works in collaboration with the Directorates and Facilities in the delivery of safe, high quality services. Collectively the team engage and support clinicians and service groups across the HHS to:

- Promote and support safe quality patient care, through meaningful collaboration with patients, staff and the community.
- Promote and support evidence-based person-centred care
- Monitor, analyse and evaluate clinical practice to improve the patient outcomes and experience.
- Identify and support quality improvements

Alignment with SCHHS Strategic Plan 2020-2024

Our objectives and activity align with the SCHHS Strategic Plan 2020-2024:

- We support a network of health services responsive to the needs of our population/ region.
- We are committed to strengthening partnerships with our consumers
- We are committed to inspiring a workplace where staff thrive and know they are valued
- We lead and embed an education and research culture
- We leverage digital and technological advances in health care
- We champion health equity and advocate for Closing the Gap initiatives.

Our commitment to staff and consumers

- We actively engage and collaborate with our consumers and community in the delivery of safe care
- We acknowledge staff at all levels are all responsible for safe and high-quality health care
- We identify opportunities to continually improve our performance
- We support ongoing staff development
- We commit to providing safe care as set out by national, state and other bodies.

Speak up for *Safe Care.*

See it, say it, fix it •

Sunshine Coast
Hospital and Health Service
Exceptional people. Exceptional healthcare.

Queensland Government

Safe Care Framework 2020-2024

	Responsibilities to deliver safe clinical care				
	Patients/consumers—partnering in safe clinical care	Everyone—leading self in safe clinical care	Managers—leading others in the delivery of safe clinical care	Senior leaders—leading leaders in the delivery of safe clinical care	Strategic leaders—leading organisation in the delivery of safe clinical care
Governance, leadership and culture	• Identify opportunities for improvement and communicate these to relevant individuals and/or the health service. • Consider taking an active role in the HHS when opportunities exist.	• Report incidents and near misses - 'Speak up' for patient and staff safety 'See it, Say it, Fix it'. • Model professional conduct that is consistent with a commitment to deliver safe clinical care. • Be accountable for the delivery of safe clinical care.	• Respond when staff Speak up' for patient and staff safety 'See it, Say it, Fix it'. • Create opportunities for staff to learn about safety and quality. • Encourage identified opportunities for improvement. • Implement business plans, strategic plans and organisational policies and procedures relevant to the delivery of safe care. • Actively monitor culture, identify improvement opportunities and ensure they are acted on.	• Support the 'SCHHS Safe Care' Framework and strategy. • Ensure the review and implementation of contemporary 'Models of Care' in place in your area. • Actively communicate the commitment of the delivery of safe clinical care in your area. • Ensure that your area has an operational plan, strategies and policies that support safe clinical care. • Ensure all leaders have learning opportunities for training in safety and quality improvement systems. • Actively monitor culture and identify improvement opportunities and ensure they are acted on.	• Actively communicate the commitment of the Board and Executive to the delivery of safe care. • Lead the SCHHS towards achieving a just, accountable and learning culture. • Ensure the SCHHS has a suite of plans, strategies and policies that support safe care. • Create learning opportunities for training in safety and quality improvement systems. • Monitor organisational culture and identify and capture improvement opportunities and ensure they are acted on.

Patient safety and quality systems	• Provide feedback to the HHS when appropriate e.g. participate in patient experience surveys.
	• Consider advocating for, or representing, other patients in focus groups.
		• Embrace opportunities to learn about safety and quality.
		• Encourage, mentor and guide colleagues in the delivery of safe clinical care.
		• Ensure contemporary knowledge to deliver safe clinical care.
		• Identifying and acting on opportunities for improvement.
		• Comply with regulatory requirements and code of conduct.
			• Ensure availability of data and information for staff to make informed decisions and support quality assurance and improvement.
			• Review, analyse and monitor actions arising from clinical outcome data and quality performance measures.
			• Understand and take action on clinical risks within their areas.
			• Systematically monitor performance within their areas to ensure the delivery of safe clinical care.
			• Provide feedback to staff on actions taken to reduce identified patient and staff safety risks.
			• Respond to identified concerns and escalation of issues.
			• Engage with staff on all system design issues.
			• Follow through and support open disclosure to patients and families.
				• Enable the delivery of safe clinical care and monitor regularly.
				• Enable the safety and quality audit program embedded in your area.
				• Ensure availability of reliable data and information to support quality assurance and review within your area.
				• Monitor leader performance and opportunities for improvement.
				• Ensure your area has the following programs in place:
				  • Quality improvement and measurement
				  • Risk management
				  • Incident management
				  • Open disclosure
				  • Feedback and complaints management.
					• Actively monitor and review all systems for safe clinical care.
					• Implement a systematic audit of safety and quality systems in the whole-of-organisation program.
					• Ensure availability of reliable data and information to support quality assurance/improvement and review across the HHS.
					• Monitor system performance and opportunities for improvement.
					• Enable the following systems and processes:
					  • Quality improvement and measurement
					  • Risk management
					  • Incident management
					  • Open disclosure
					  • Feedback and complaints management.

Clinical performance and effectiveness	• Consider sharing experiences through patient stories, information sessions, letters, pictures, patient journeys or training sessions for the workforce.	• Maintain professional skills, competence and performance.
		• Ensure that specific performance concerns are reported appropriately.
		• Work constructively and collaboratively within the multidisciplinary teams.
		• Take part in clinical, and safety and quality education and training.
			• Ensure staff in your area are:
			  • Credentialed and working within their scope of practice.
			  • Receive safety and quality education, training and support to do their jobs.
			• Respond in a timely and effective way to indications of clinical underperformance.
			• Work constructively within multidisciplinary teams.
			• Provide appropriate supervision and support to staff when necessary.
				• Ensure the following process are in place and the clinical workforce are subject to periodic performance review including:
				  • Credentialing and defining scope of practice
				  • Clinical education and training
				  • Performance monitoring and management
				  • Whole-of-organisation clinical, and safety and quality education and training.
				• Show leadership and commitment to both the conduct and translation of research to generate new knowledge and apply research findings to clinical care.
					• Ensure the following organisational systems are in place and the clinical workforce are subject to periodic performance review including:
					  • Credentialing and defining scope of practice
					  • Clinical education and training
					  • Performance monitoring and management
					  • Whole-of-organisation clinical, and safety and quality education and training.
					• Show leadership and commitment to both the conduct and translation of research to generate new knowledge and apply research findings to clinical care.

Safe environment for the delivery of care	• Provide feedback about experiences of the environment of the HHS. • Participate in the planning and development of the environment within our health service through participation in Quality Improvement projects.	• Identify opportunities to improve the environment. • Provide clinical care within the parameters of the environment.	• Create an environment that supports delivery of safe reliable care. • Staff have access to equipment to deliver safe clinical care.	• Ensure that the environment of your area promotes safe clinical care. • Provide an environment that is both physically and psychologically safe for staff and consumers including compliance with relevant Australian Standards and Legislation. • Ensure environmental risks are monitored addressed and escalated as appropriate.	• Ensure that the environment of the HHS promotes safe clinical care. • Ensure systems are in place at all levels of the organisation to monitor, escalate and respond to environmental risks. • Provide an environment that is both physically and psychologically safe for staff and consumers including compliance with relevant Australian Standards and Legislation.
Partnering with consumers	• Participate as partners in care to the extent of your choosing eg own care and in organisational design and governance. • Participate in the design, conduct and review of research OR change to organisational design, governance and research.	• Understand how health literacy might affect the way a consumer gains access to, understands and uses health information. • Support patients to share decision making about their own health care, to the extent they choose. • Assist access of consumers to their own health information, as well as complaints and feedback systems.	• Ensure patients have access to high-quality, easy-to-understand information about healthcare. • Collect and review patient experience information as part of quality improvement processes. • Create opportunities for consumer involvement in relevant committees and planning opportunities.	• Show leadership and commitment to partnerships with consumers. • Set up high level policies, procedures and guidelines that support partnerships with consumers. • Ensure your area has an effective system for consumer complaints and open disclosure. • Create opportunities for consumer involvement in your area.	• Show leadership and commitment to partnerships with consumers • Set up high level policies and procedures that support partnerships with consumers • Ensure the HHS has an effective system for consumer complaints and open disclosure. • Create opportunities for consumer involvement in subcommittees of the governing body.