

Eliminate compliance challenges and costs of quality improvement in hospitals

Systematic risk mitigation and quality improvement should not be a burden on Australia's healthcare system

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Many Australians have access to safe and high-quality healthcare and skilled clinicians committed to meeting their patients' needs¹.

According to a [2019 report](#) by the Australian Commission on Safety and Quality in Health Care (ACSQHC), significant improvements over the previous decade resulted in reduced healthcare-associated infections and preventable in-hospital cardiac arrests, as well as improved patient experience and outcomes, and better clinical care governance.

The report also acknowledged that safety and quality risks existed along the patient journey due to system failures between the intricate network of health services.

Financial costs of healthcare variation

Lapses in safety and quality, and unwarranted health care variation across Australia have substantial costs on people's lives and the healthcare system.

**12% -
16.5%**

of total hospital activity and expenditure was the direct result of adverse events **in 2013**

**Est
\$4.1 billion**

(8.9% of total hospital expenditure) public sector cost for HACs admissions **in 2017-18 financial year**

Australian Commission on Safety and Quality in Health Care. The state of patient safety and quality in Australian hospitals 2019. Sydney; ACSQHC, 2019.



Identify and mitigate risks

Australia's approach to safety and quality has been to identify and mitigate systemic risks to patients and improve patient outcomes through clinically appropriate risk management responses,² including robust clinical governance, national standards, meaningful consumer partnerships, measurement and reporting.

Since 2011, all hospitals have been required to align their patient safety and quality improvement programs using the [National Safety and Quality Health Service \(NSQHS\) Standards](#) framework. They are also required to identify links across the eight Standards to ensure safety and quality systems are integrated to reduce duplication.

These standards guide the delivery of quality care and reduce unwarranted variation by embedding evidence-based approaches in policies, practices, systems and governance³ to:

- Improve patient outcomes
- Incentivise the system to provide the right care, in the right place, at the right time
- Decrease avoidable demand for public hospital services
- Signal to the health system the need to reduce instances of preventable poor-quality patient care, while supporting improvements in data quality and information available to inform clinicians' practice.

Responsibility for improving the safety and quality of health care is no longer seen to rest solely with frontline clinicians.

Australian Commission on Safety and Quality in Health Care. The state of patient safety and quality in Australian hospitals 2019.



Streamlined safety and quality improvement

According to the ACSQHC, safety and quality systems are most effective when they are integrated and inform each other.

“For example, processes (such as collecting outcomes data, distributing reports and developing recommendations) from a risk management system should inform policy and training systems, and the incident management system should inform the risk management system.

“Information on the connectedness of systems can be used to understand how effectively an organisation uses their learnings about safety and quality to improve care and improve the effectiveness of its safety and quality processes.”⁴

Questions hospitals should ask about their safety and quality improvement efforts include:

- Is there a simple, centralised way for executives and project leaders to see all past, current, and proposed projects in real-time?
- Can safety and quality teams easily access and customise standardised workflow templates?
- Can team members effectively collaborate on projects and track their evolution?
- Does the literature available for search offer full-text articles most relevant to the identified safety and quality problem?
- Does critical appraisal result in valuable, substantiated recommendations?
- Are projects prioritised and completed on time, with findings rapidly disseminated?

Identifying how technology can enhance a hospital’s safety and quality processes can ensure that evidence-based approaches are embedded into the policies, practices, systems and governance that guide everyday care.

The organisation’s safety and quality systems should ensure that patient safety and quality incidents are recognised, reported and analysed, and used to improve the care provided. It is important that these systems are integrated with governance processes to enable health service organisations to actively manage risk, and to improve the safety and quality of care.

National Safety and Quality Health Service Standards: Guide for Hospitals

Improve compliance with NSQHS Standards

Ovid® Synthesis Clinical Evidence Manager is a workflow management solution that organises, standardises, and accelerates quality improvement, evidence-based practice, and research projects across the hospital.

This solution creates transparency and reduces duplication across teams while fostering collaboration by streamlining the literature search, appraisal process, implementation and dissemination.

Key benefits

- Promotes project alignment to strategic plan and goals
- High-level view reduces duplication
- Easy to use interface engages team members of all skill levels
- Collaboration across teams eliminates silos
- Easily access projects for regulatory and accreditation requirements

Learn more:
wltrsklwr.com/ovid-synthesis



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References

- ¹ The state of patient safety and quality in Australian hospitals 2019.
- ² Ibid.
- ³ Ibid.
- ⁴ [Fact Sheet 12: Assessment Framework for Safety and Quality Systems.](#)