Communique | Meeting 1 2019

The Victorian Clinical Council (the council) met on Thursday 21 March 2019 to discuss communicating for safety.

In the morning we heard from Kym Peake Secretary of the Department of Health and Human Services, Terry Symonds Deputy Secretary Health and Wellbeing, and Lance Emerson CEO Victorian Agency for Health Information. They provided feedback on previous council advice and updates on current activities.

Terry spoke about recent advice on cultural safety and diversity and the need for further resources and funding for particular activities, such as cultural safety training across the sector. He noted that the department is well equipped to help strengthen the governance of specific requirements and programs around cultural safety and diversity with the boards of our healthcare organisations.

He also spoke about the department’s response to the advice on ‘Integration of care and value-based healthcare’. Terry identified some key groups that would benefit from improvements in integration of care including children and families, those with chronic disease and the frail elderly.

Lance gave an update on the Victorian Agency for Health Information’s (VAHI) key actions in response to the council’s variation in care recommendations. This includes:

* the development of the VAHI interactive data portal (VHSP)
* the development of a minimum set of agreed indicators
* accessing data registry data
* the development of a public reporting process.

The meeting coincided with national Close the Gap day and Kym invited the council to use this opportunity to reflect on how to improve health outcomes for Aboriginal and Torres Strait Islander Australians.

Kym provided an overview of the key priorities for the incoming government and the Minister’s commitment to real reform in the health sector, noting the important role that council will play in informing this. Emerging directions for the new term include a stronger emphasis on prevention and early intervention and a greater focus on the health of children and young people. She also spoke about the Royal Commission into Victoria’s Mental Health System.

Kym encouraged council members to consider the following in their discussions about communicating for safety:

* strengthening the safety, quality, performance and design of our systems
* how we embrace our patients, clients as partners in their own care – particularly vulnerable people
* how we equip our staff to deliver better outcomes and strengthen our internal systems that support them to do this.

## Communicating for safety

### Purpose

The purpose of this meeting was to:

* provide members with an update regarding implementation of previous advice
* change the culture of communication within the health sector to improve patient safety by
  + advising on changing communication to meet the needs of the consumer
  + advising on changing how clinicians communicate with each other.

### Discussion

The council heard from

* Hon John Olle, Victorian State Coroner
* Prof Richard Osborne, Distinguished Professor of Health Sciences, Swinburne University
* Prof Harvey Newnham, Professor and Director of General Medicine, and Clinical Program Director of Emergency and Acute Medicine at Alfred Health / Professor of General Medicine, Central Clinical School, Monash University.

John Olle spoke about the coroner’s court perspective on the role of communication in adverse events in Victoria. Providing a system level perspective, John spoke about the need to have well designed communication systems including electronic medical record systems to support clinicians to provide safe care and avoid harm. He described a well-designed system as one that:

* is easy to navigate and access by all clinicians
* can transfer information from one computer program to another
* accounts for inevitable human error
* is transparent to the patient and gives the patient the tools to engage with the system directly.

Richard Osborne spoke about the importance of having systems in place to understand the health literacy levels of patient populations and to promote better understanding of healthcare for all patients. Richard described the components of effective communication. Consumers using the teach-back method is shown to improve participation in patient decision-making and informed consent, medication adherence, and self-management of chronic disease.

Harvey Newnham spoke about using quality interdisciplinary communication (QuIC) rounds at the Alfred including the outcomes of reduced patient complaints and improved quality of care, with effects on readmission rates, mortality, and length of stay not yet demonstrated.

The session concluded with a panel discussion featuring Richard, Harvey, and Louise McKinlay, Director, Consumers as Partners, Safer Care Victoria.

### Workshops

Council members participated in two afternoon workshops:

Workshop 1: Changing the culture of communication within the health sector to improve patient safety

Workshop 2: Prioritisation activity

Using a case study from the coroner’s court and the presentations from the morning session to guide discussions, members were challenged to think about:

* What are the system barriers to an improved culture of communication to improve safety?
* Where should a focus for culture change for communication be?

A second panel followed the workshops to share early themes that came out of the discussions. Terry Symonds and Professor Euan Wallace (CEO, SCV) provided feedback to the council on implementing some of their ideas.

## CONCLUSION

Outputs from the workshops will be used to develop formal advice which will include recommendations for the department, Safer Care Victoria and the Victorian Agency for Health Information (VAHI).

The next council meeting will be held Thursday 6 June 2019 in partnership with VAHI.

## RESOURCES

* [Case study from the Coroners Court](https://www.coronerscourt.vic.gov.au/sites/default/files/2018-12/mettalokamalindahalwala_585715.pdf)
* Brewster, D J, & Waxman, B P 2018, ‘[Adding kindness at handover to improve our collegiality: the K-ISBAR tool](https://www.mja.com.au/system/files/issues/209_11/10.5694mja18.00755.pdf)’, *The Medical Journal of Australia*, *209*(11), pp. 482-483.
* O’Halloran, R 2019, *Patients with a communication disability,* La Trobe University
* Australian Commission on Safety and Quality in Healthcare, [Communicating for safety portal](https://www.c4sportal.safetyandquality.gov.au/)  Accessed 20 February 2019
* Safer Care Victoria 2019, [Partnering in healthcare framework](https://bettersafercare.vic.gov.au/sites/default/files/2019-02/Partnering%20in%20healthcare%20framework%202019_WEB.pdf)
* Sammer, C E., et al. 2010, ‘[What is patient safety culture? A review of the literature.’](https://sigmapubs.onlinelibrary.wiley.com/doi/full/10.1111/j.1547-5069.2009.01330.x)*Journal of Nursing Scholarship* 42.2, pp. 156-165.

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