GOVERNANCE FOR QUALITY AND SAFETY

INFORMATION LEAFLET

This information leaflet outlines an introduction to Governance for Quality and Safety, designed to assist discussions on this topic. It was been adapted from ***Quality and Patient Safety: Clinical Governance Information Leaflet (February 2012)*** *specifically for residential disability services for adults with intellectual disabilities by the SCD/QID Quality Improvement Enablement Project Team in October 2015.*

INTRODUCTION

Over recent years, the health service has placed an important emphasis on quality and service user safety by developing an infrastructure for integrated quality, safety and risk management with the aim of achieving excellence in governance for quality and safety.

The Quality Improvement Division is building on this. Formalised governance arrangements ensure that everyone working in the health and social care services are aware of their responsibilities, authority and accountability, and work towards achieving improved service user outcomes. Effective governance recognises the inter-dependencies between corporate and care governance across services and integrates them to deliver high quality, safe and reliable healthcare/social care. We are all responsible and together we are creating a safer healthcare system.

WHAT IS GOVERNANCE FOR QUALITY AND SAFETY?

A framework through which healthcare/social care teams are accountable for the quality, safety and experience of people in the care they deliver. For health and social care staff this means: specifying the standards you are going to deliver and showing everyone the measurements you have made to demonstrate that you have done what you set out to do. It is built on the model of the chief executive officer/ chief health officer/general manager or equivalent working in partnership with the clinical director, director of nursing and director of services/professional leads. A key characteristic is a culture and commitment to agreed service levels and quality of care to be provided.

GOVERNANCE FOR QUALITY AND SAFETY VISION

Governance for quality and safety is an integral component of governance arrangements where:

- Each individual, as part of a team, knows the purpose and function of leadership and accountability for good health and social care.
- Each individual, as part of a team, knows their responsibility, level of authority and to whom they are accountable.
- Each individual, as part of a team, understands how the principles of quality and safety can be applied in their diverse practice.
- A culture of trust, openness, respect and caring is evident among managers, staff and service users.
- Each individual, as part of a team, consistently demonstrates a commitment to the principles of quality and safety in decision-making.
- Quality and safety is embedded within the overall corporate governance arrangement for the statutory and voluntary health and personal social services in realising improved outcomes for service users.

BENEFITS OF GOVERNANCE FOR QUALITY AND SAFETY DEVELOPMENT

Governance for quality and safety helps ensure service users receive the care they need in a safe, nurturing, open and just environment arising from corporate accountability for service performance. The benefit of governance for quality and safety rests in improved service user experiences and better health outcomes in terms of quality and safety. This has resulted in governance for quality and safety processes being widely adopted internationally.

GUIDING PRINCIPLES FOR QUALITY AND SAFETY

To assist health service/social care providers a suite of ten principles for quality and safety, in the Irish health context, have been developed with a title and descriptor.

Each decision (at every level) can be tested against the quality and safety principles. A descriptor for each principle is set out below.

Table 1: Quality and Safety Guiding Principles Descriptor

Principle	Descriptor
Service user first	Based on a partnership of care between service users/families, carers and healthcare providers in achieving safe, easily accessible, timely and high quality service across the continuum of care.
Safety	Identification and control of risks to achieve effective, efficient and positive outcomes for service users and staff.
Personal responsibility	Where individuals as members of healthcare/social care teams, service users and members of the population take personal responsibility for their own and others health needs. Where each employee has a current job-description setting out the purpose, responsibilities, accountabilities and standards required in their role.
Defined authority	The scope given to staff at each level of the organisation to carry out their responsibilities. The individual's authority to act, the resources available and the boundaries of the role are confirmed by their direct line manager.
Clear accountability	A system whereby individuals, functions or committees agree accountability to a single individual. Where each person can give an account of their practice and can justify their actions or inactions.
Leadership	Motivating people towards a common goal and driving sustainable change to ensure safe high quality delivery of clinical and social care.
Multi-disciplinary working	Work processes that respect and support the unique contribution of each individual member of a team in the provision of clinical and social care. Multi-disciplinary working focuses on the interdependence between individuals and groups in delivering services. This requires proactive collaboration between all members.
Supporting performance	Managing performance in a supportive way, in a continuous process, taking account of professionalism and autonomy in the organisation setting. Supporting a director/manager in managing the service and employees thereby contributing to the capability and the capacity of the individual and organisation. Measurement of the service user experience being central in performance measurement (as set out in the National Charter, 2010).
Open culture	A culture of trust, openness, respect and caring where achievements are recognised. Open discussion of adverse events are embedded in everyday practice and communicated openly to service users and/or their family. Staff willingly report adverse events and errors, so there can be a focus on learning, research and improvement, and appropriate action taken where there have been failings in the delivery of care.
Continuous quality improvement	A learning environment and system that seeks to improve the provision of services with an emphasis on maintaining quality in the future, not just controlling processes. Once specific expectations and the means to measure them have been established, implementation aims at preventing future failures and involves the setting of goals, education, and the measurement of results so that the improvement is ongoing.