OFFICE OF THE HEALTH OMBUDSMAN

Health service investigation—snapshot report

Investigation focus: care provided to patients; completion of patient records; infection control; and clinical incident management (June 2024).

Wider learnings and recommendations for service improvements

The investigation highlights the opportunity for health services to:

a) continuously review, improve and embed changes within their governance systems, maintain oversight of the impact of the changes on service provision and patient outcomes through robust auditing and feedback schedules;

b) explore and implement processes and methods to ensure transparent and meaningful feedback of quality and safety data to patients and staff at all clinical levels; and

c) review processes related to Enduring Power Of Attorney to ensure easy identification and documentation of alternative decision makers.

Background

The Health Ombudsman commenced a systemic investigation into a health service after a review of documents provided for individual practitioner notifications at the health service identified several possible systemic concern that may have been impacting on the provision of safe and effective care.

Issues investigated

The Health Ombudsman conducted the investigation to identify potential health service issues and provide opportunities for improvement in the systems and processes within the health service.

Identified concerns were grouped according to the National Safety and Quality Health Service Standards and included:

- Clinical Governance—reporting and management of clinical incidents, practitioner roles, responsibilities and scope of practice;
- Partnering with Consumers—obtaining informed patient consent and identification of alternative decision makers;
- Preventing and Controlling Infections—hand hygiene and surgical site infection surveillance; and
- Recognising and Responding to Acute Deterioration—identification of patients who are acutely deteriorating.

Key findings

At the commencement of the investigation, the OHO met with the health service to discuss the OHO's analysis of the notification material; the possible systemic issues identified; the actions undertaken since the notification; and any plans or actions that are waiting to be implemented.

The health service identified that significant improvements had been made to address the concerns identified by the OHO, with a comprehensive policy and procedure framework and audit schedule to measure the quality and safety of care provided to patients and consumers.

During an OHO site visit, the health service was able to demonstrate a commitment to patient safety, evidenced through the monitoring and continuous improvement in patient safety and clinical governance systems.