ENHANCING CARE TOGETHER

Regional Outcome Review Initiative

JOINT REVIEW TOOLKIT

This Implementation Toolkit provides a road map to implementing Joint Reviews. It includes the background of the project and an overview of key activities with accompanying tools to support implementation.

Originally set up for mental health, alcohol and other drugs, and suicide prevention services, Joint Reviews can be implemented in other health settings.

Contents

A note about language

This document will broadly use the term "**consumer**" to refer to people with Lived and Living Experience of mental illness, mental ill health or recovery. Similarly, the term "**families and support people**" will refer to carers, parents, siblings, spouses, friends, neighbours, nominated persons, and natural occurring supports.

While "**incidents**" are labelled differently across the sector, this document will use the term "**incident**" to mean any event or circumstance which could have or did lead to an unintended, unnecessary, undesirable, or unexpected harm to a person receiving care.

Defining what constitutes a "**Joint Review**" takes time, as each organisation may approach the criteria differently. This flexibility is intentional. Organisations are encouraged to adopt the principle of Joint Reviews which is to review incidents with relevant stakeholders who were involved with the consumers care around the time of the incident. While the exact process will vary, the commitment to learn together underpins the process.

Forword

The Regional Outcome Review Initiative, 'Enhancing Care Together', is a long-awaited development in the sector and one which we anticipate will be applauded by consumers and families and support people. The project promotes collaborative joint incident reviews amongst mental health, alcohol and other drugs (AOD) and suicide prevention services, so that learnings are shared, and harm is reduced. We know that when there's collaboration and integration between services, the consumer and their family are better supported, incidents are reduced, the consumer's treatment is more effective, and recovery can be a real possibility.

But so often, consumers and their families experience "things going wrong, horribly wrong", and there seems to be no appropriate redress. Or, if there is, it's disjointed, gets no traction, and the improvements identified fall by the wayside. When services "get on the same page", working together to create common processes, the consumer can receive quality, safe care, and confusion is reduced. Examples of excellence emerge from this, and these examples, too, are important learnings. The insights achieved in Joint Reviews, and Collective Learning Forums, can enhance collective learning and reveal system strengths and weaknesses. That understanding is crucial.

The Enhancing Care Together: Regional Outcome Review Initiative is a remarkable step forward in local mental health reform, providing a very real opportunity to build consumer and family confidence in the system.

Lynda and Denise
Lived Experience Representatives

Background

The North East Metro Health Service Partnership (NEM HSP) in collaboration with mental health, AOD and suicide prevention services in the eastern and north-eastern region of metro Melbourne, developed the Regional Outcome Review Initiative (RORI). Commencing in November 2022, RORI is our response to the question, how can we improve our ability to learn from incident reviews?

Five hospitals and seven community health services, and one non-governmental organisation, along with people with Lived Experience, Eastern Melbourne Primary Health Network have united in this important process of improvement, reform, and cultural change in our region's health system.

Drawing on principles from the Royal Commission into Victoria's Mental Health System and Safer Care Victoria, the shared principles ensure RORI provides safe learning environments, is connected and collaborative, and organised for safety and quality.

Participating organisations have piloted three key actions that have led to improvements in quality, safety, and clinical governance in integrated care. These are Joint Reviews, Collective Learning Forums, and a Panel Pool.

This Toolkit is to support you to implement Joint Reviews in your region. Other Toolkits and resources are available on the RORI website**:** **www.austin.org.au/rori/**.

Joint Review Implementation Toolkit

What?

When more than one service was involved with the consumer at the time of an incident a Joint Review is indicated. The involvement could have been either consecutive or concurrent. A Joint Review occurs when the service organising the incident review invites other stakeholders involved in the care to participate in the review rather than completing the review by themselves. This includes contributing to the timeline and contributing to the discussion as panel members.

Why?

Joint Reviews offer a comprehensive understanding of incidents and promote a holistic approach to addressing challenges and improving service delivery. Completing Joint Reviews fosters a culture of learning, collaboration, and continuous system improvement. Joint Reviews also improve consumer, family, and carer confidence that their journey has been seen as a whole.

How?

Any service can embed Joint Reviews within their processes and policies. Exactly how this process looks will differ from organisation to organisation. The principles of collaborative review of incidents, fostering a Just Culture – which emphasises learning and accountability rather than blame – and focusing on system improvement can be adopted by any service.

Further to updating processes, organisations can embed within their partnership agreements, a clear process regarding how incidents will be reviewed together. This paves the way for streamlined processes and clear expectations.

Our Learnings

Joint Reviews have strengthened our ability to learn from incidents, address shared challenges, enhance communication and trust between services, develop comprehensive findings and recommendations, enhance clinical governance and safety, increase consumer confidence, and improve closure for consumers, families and support people. Together, the RORI services have fostered a more comprehensive, collaborative, and effective approach to incident reviews.

"Joint Reviews will bring more closure to families"
Lived Experience member

"We have seen Joint Reviews undertaken in different states… …as a direct result of the focus and importance placed on Joint Reviews through the RORI initiative"
Steering Committee member

"Improved collaboration with other agencies will work to reduce incidents occurring at points of care transfer"
Steering Committee member

Decision making flow chart: Do I do a Joint Review?

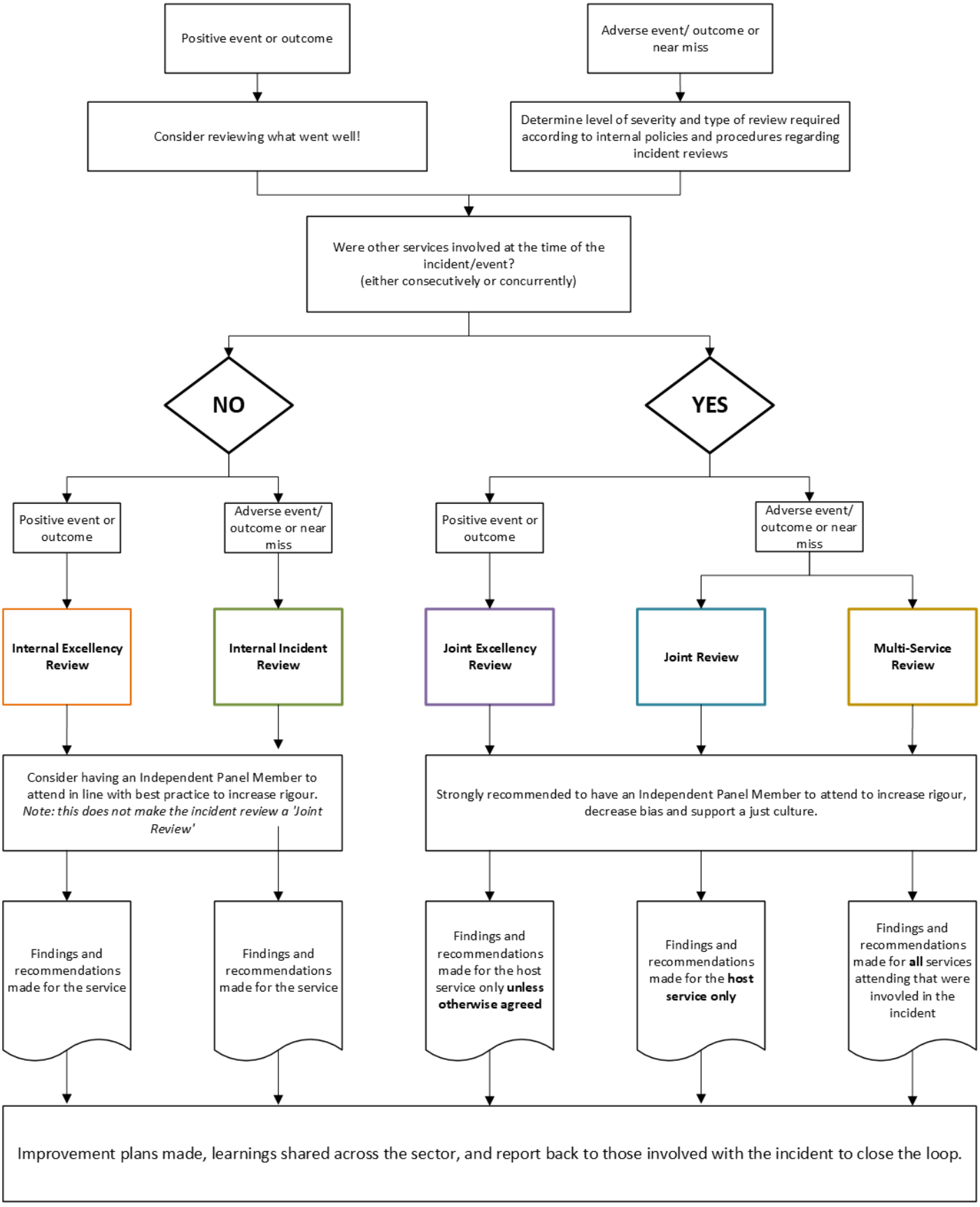

Figure 1: Decision making flow chart: Do I do a Joint Review?

Types of reviews

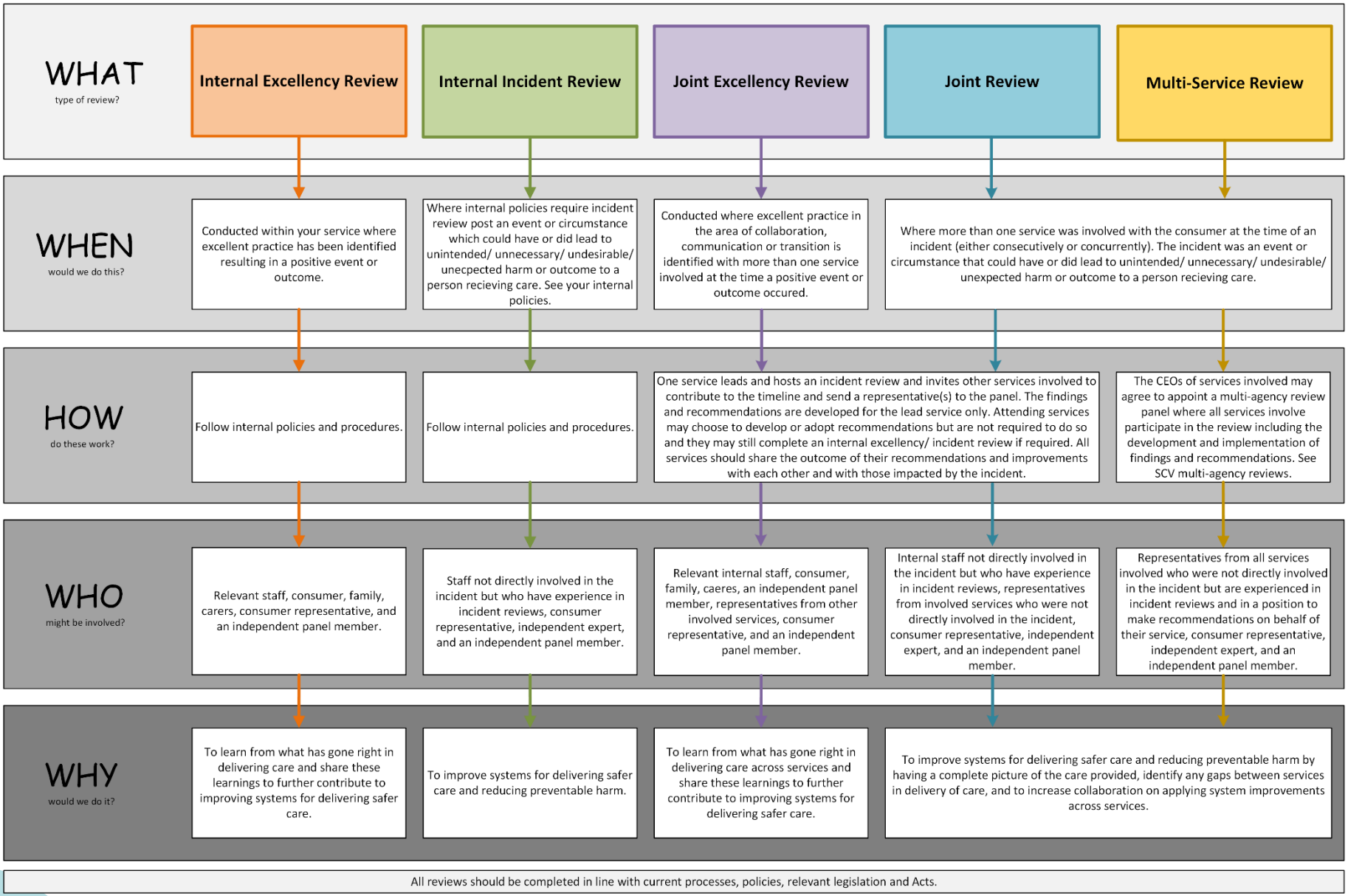

Figure 2: Types of reviews

Administrative tools

Joint Review meeting agenda

1. Welcome and introductions
2. Declaration of conflicts of interest
3. Agreement to investigation principles (see *Figure 4*)
4. Clarify roles and expectations (see *Table 1*)
5. Review (completed according to service processes and methodology)
6. Review timeline of events – is there any additional information required?
7. Agree on incident validity, rating
8. Agree on the problem statement – what is the incident?
9. Identify critical event/s (an event immediately after an action/inaction)
10. Analyse (e.g., systematic review – what should happen – what did happen)
11. Determine findings/ recommendations
12. Identify remedial actions for any findings, support for those involved
13. Post review debrief for all members within the allocated meeting time
14. Plan for communication of learnings in order to close the loop with people involved

Figure 3: Investigation principles

Roles

	Chair/ Method Lead	Leading Service Representatives	Invited Service Representative/s	Lived Experience Representative	Independent Panel Member
Skills	High level incident review and facilitation skills.	Not directly involved in original incident. Experience in incident reviews.	Not directly involved in original incident. Experience in incident reviews.	Experience in incident reviews. Lived Experience of recovery or carer.	High level incident analysis skills. Experience in incident review. Well-developed interpersonal skills.
Pre	Collate timeline. Administrate the review process with admin.	Contribute to the timeline of events.	Contribute to the timeline of events.	Read documents before the review.	Read documents before the review.
At the Joint Review	Facilitate and lead the review process, ensuring fairness, a safe environment, collaboration, and adherence to the review objectives and principles.	Provide expertise and insights into their specific service. Contribute to the development of findings and recommendations for their service.	Provide expertise and insights into their specific service. Contribute to the development of findings and recommendations. *Recommendations made for leading service only (see multi-service review if all services agree to take on recommendations)*	Provide expertise and insights from a Lived Experience perspective during the Joint Review. Contribute to the development of findings and recommendations.	Provide impartial expertise and contribute objectively to the Joint Review discussions, findings, and recommendations.
Post	Share draft findings and recommendations for endorsement. Close the loop with the consumer/ families and support people.	Provide feedback on draft findings and recommendations.	Share with own organisation for development of improvement plans and provide feedback to leading service.	Provide feedback on draft findings and recommendations.	Provide feedback on draft findings and recommendations.

Table 1: Roles for Joint Review panel members

FAQs

How do we know who has been involved with the consumer?

Review their file and history to see what services have been involved or if there are formal shared care arrangements in place. Consider if a General Practitioner (GP) has been involved in the consumer's long-term care. Discuss with the clinicians, families, and support people if they are aware of other services involved. Consider if there are any ways to improve how your service gathers and records this information to ensure it is accessible at the time of a review.

How do I invite another service to a Joint Review?

Once you have identified the other services or organisations involved with the consumer, contact the team lead or manager to invite one or two representatives from each organisation to the Joint Review panel. Be mindful of confidentiality. If Joint Reviews are new to this service, be sure to communicate the purpose, expectations, and processes.

Should I invite an Independent Panel Member to a Joint Review?

Yes. The Independent Panel Member's expertise in incident analysis, ability to identify findings and make recommendations, knowledge of a just culture, and strong interpersonal skills make them valuable contributors to the review process. Their independent opinion can provide insights, ensuring a comprehensive and impartial evaluation of the care provided or serious events that occurred. Including an Independent Panel Member in a Joint Review enhances the rigour, objectivity, and overall quality of the review process while maintaining fairness for all parties.

What about privacy and confidentiality for the Joint Review?

To ensure privacy and confidentiality in a Joint Review, it is important for participating organisations to adhere to their existing policies regarding privacy and confidentiality. Additionally, they should comply with relevant acts or laws specific to Victoria, Australia. Organisations may wish to have a confidentiality agreement for Joint Reviews. By following these guidelines, organisations can safeguard the personal information and sensitive data shared during the Joint Review process, maintaining the privacy and confidentiality for individuals involved.

What administrative processes should my organisation consider when embedding Joint Reviews?

Review current incident review processes to ensure staff organising a review consider if it is appropriate for a Joint Review. Ensure staff are aware of the purpose and value of Joint Reviews so the responsibility does not rest with just one person. Use the tools in this Implementation Toolkit to support embedding Joint Reviews into your organisation's BAU. How each service determines the appropriateness for a Joint Review will differ but the principle of collaboratively reviewing incidents with multiple stakeholders is central to all. Like all incident reviews, Joint Reviews should occur in a timely manner. Recognising as early as possible that a Joint Review is indicated is critical.

How do we build Joint Reviews into our partnerships?

If organisation's have existing or are developing new partnerships it is critical to have a formal plan of what you will do if something untoward occurs. Building in a plan for Joint Reviews into your partnership agreement or contract will support this process to occur smoothly and allow for comprehensive review of incidents between partnering organisations.

Tips from RORI members

- It may just take a few times doing a Joint Review to feel comfortable and to be able to ensure policies and processes are re-written clearly to define it and incorporate it.
- Embed RORI principles by incorporating them into whole service local policies and procedures to avoid separate processes for different regions.
- Work out where you are going to store the learnings from Joint Reviews that you are invited to participate in when the incident was not 'owned' by your service. A few suggestions others have used are:
    - Include relevant learnings into your continuous improvement plan. Similar to adopting relevant learnings from coroner's reports or recommendations that do not specifically pertain to the organisation by the learnings can and should be adopted.
    - Include in quarterly or yearly shared learning discussions and/or reports.
    - Take learnings to relevant Quality and Safety Meetings or escalate them up through internal governance committees for discussion and actions.
    - Share the learnings with others in a de-identified report with a summary of the incident, what occurred, what the outcomes and recommendations are.
    - Find a central place to store learnings within your organisation without needing to attach them to the improvement plans of a specific incident.

Acknowledgements

We thank the members of the Regional Outcome Review Initiative Steering Committee and the Implementation Working Group for their valuable contribution to this Initiative. This work is a testament to their commitment to improvement, willingness to be vulnerable, and the openness to building and strengthening relationships.

Thank you to all staff at participating organisations who have adopted the RORI aims and built them into your policies and processes. Because of you, these changes can live on beyond this project and support us to provide better care for those who access our services.

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