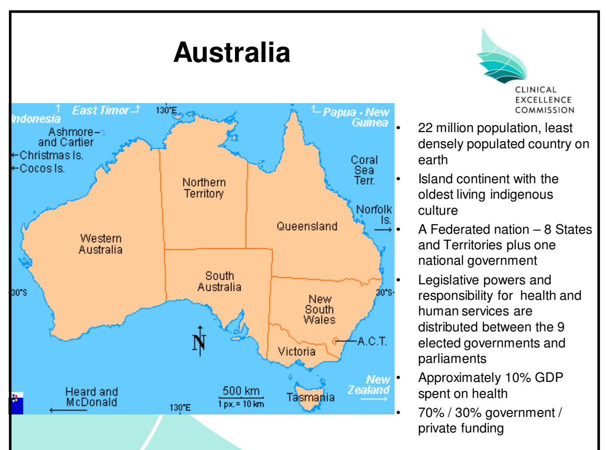


What started the national response for patient safety?

- "Quality in Australian Healthcare Study" 1995
  - Wilson, Runciman et al Medical Journal of Australia 1995 163:459
- 5 years of reviews and reports
- Australian Council for Safety and Quality in Health Care commenced in January 2000, focused on reducing the likelihood and effects of error. $55 million AUD over 6 years

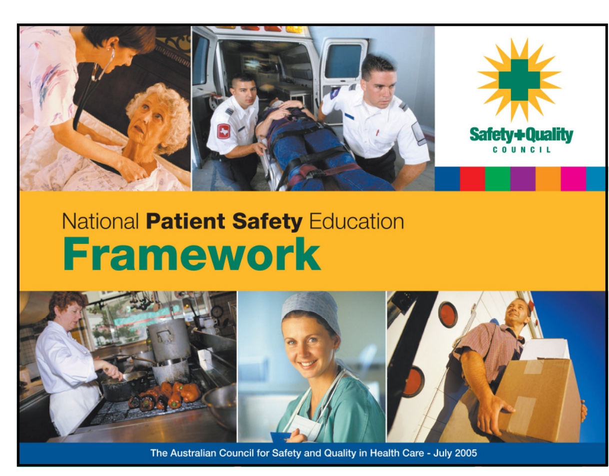
Adverse Events -International information

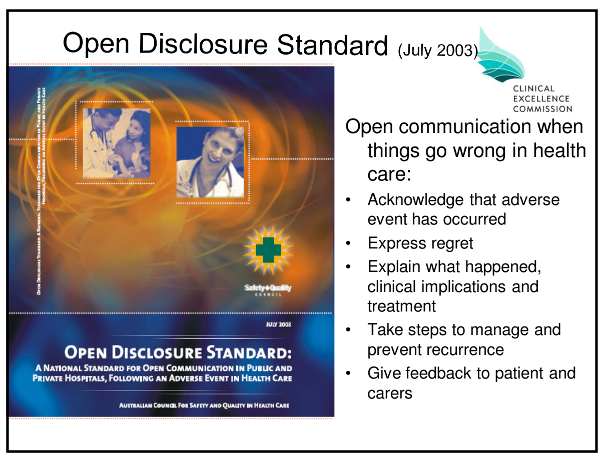
	AE's	Preventable
Baker et al,Canada 2000	7.5%	36%
Thomas etal, Utah Colorado1992	2.9%	--
Wilson et al* Australia, 1995	16.6%	51%
Thomas et al 2000, reworked 1995 Australian paper	10.6%	--
Brennan et al, Leape et al, New York 1984	3.7%	--
Vincent et al, London 1999,2000	10.8%	48%
Davis et al*, New Zealand 1998	12.9%	37%

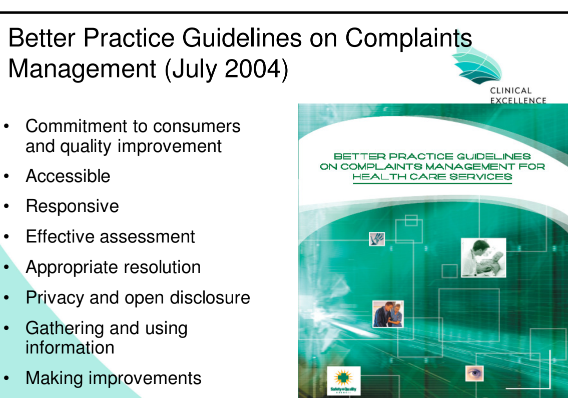
* Slight to modest evidence of healthcare management causation = 2 out of 6 scale, other papers management causation more certain:- 4 out of 6 scale

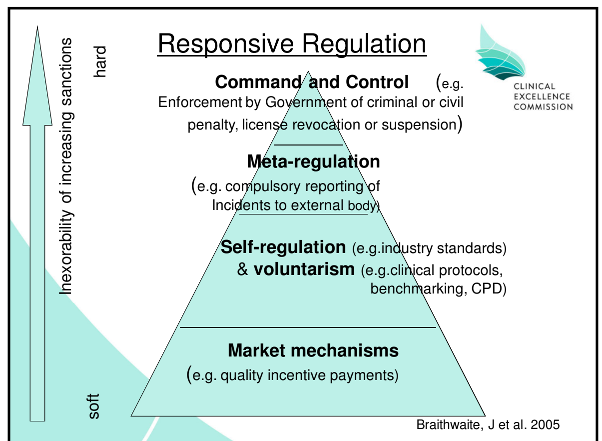
Initial actions of Council

- Commenced research and inquiry to support policy changes
- Established strong consumer input
- Priorities including
  - Raising awareness
  - Promoting a culture of safety
- Establishing building blocks for implementation of safety and quality agenda









Reforms led by the Australian Council for Safety and Quality in Health Care, 2000-2005

All hospitals to:

- Report all sentinel events
- Adopt a specific "correct patient, correct site, correct procedure" protocol
- Provide all patients with a "10 tips" consumer booklet prior to admission
- Have in place a patient safety risk management plan

Reforms led by the Australian Council for Safety and Quality in Health Care, 2000-2005

All States and Territories to agree to:

- National report on sentinel events
- Progressively implement the national "Open Disclosure" standard
- Address performance management, including issues of corporate and clinical governance, supervision and staffing levels
- Data collection – national data sets for safety and quality improvement
- External review – participation of services in processes of assessment (accreditation)

Other work addressed by ACSQHC in Australia

- Health care associated infections
- Credentialling and defining scope of practice
- Root cause analysis training
- Workforce education in safety and quality and human factors science

Australian Commission on Safety and Quality in Health Care

Established January 2006

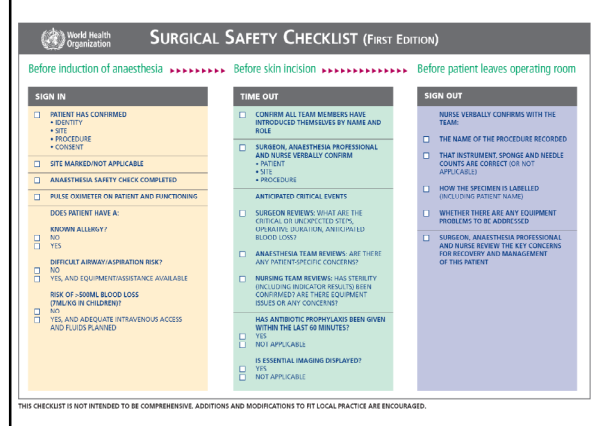
Role in relation to safety & quality

- Lead and coordinate improvements by identifying issues and policy directions and priorities
- Disseminate knowledge
- Report publically on performance against national standards
- Recommend national data sets
- Provide strategic advice to ministers
- Recommend national standards for safety and quality

Australian Commission on Safety and Quality in Health Care

Work programme

- Accreditation
- Australian Charter of Health Care Rights
- Clinical handover
- Falls prevention guidelines
- Health care associated infection
- Information strategy (evidence based safety and quality)
- Medication safety
- Open disclosure
- Patient identification
- Recognising and responding to clinical deterioration



World Health Organization

SURGICAL SAFETY CHECKLIST (FIRST EDITION)

Before induction of anaesthesia ▸▸▸ Before skin incision ▸▸▸ Before patient leaves operating room

SIGN IN

- ☐ PATIENT HAS CONFIRMED
  - IDENTITY
  - SITE
  - PROCEDURE
  - CONSENT
- ☐ SITE MARKED/NOT APPLICABLE
- ☐ ANAESTHESIA SAFETY CHECK COMPLETED
- ☐ PULSE OXIMETER ON PATIENT AND FUNCTIONING

DOES PATIENT HAVE A:

KNOWN ALLERGY?
- ☐ NO
- ☐ YES

DIFFICULT AIRWAY/ASPIRATION RISK?
- ☐ NO
- ☐ YES, AND EQUIPMENT/ASSISTANCE AVAILABLE

RISK OF >500ML BLOOD LOSS (7ML/KG IN CHILDREN)?
- ☐ NO
- ☐ YES, AND ADEQUATE INTRAVENOUS ACCESS AND FLUIDS PLANNED

TIME OUT

- ☐ CONFIRM ALL TEAM MEMBERS HAVE INTRODUCED THEMSELVES BY NAME AND ROLE
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE VERBALLY CONFIRM
  - PATIENT
  - SITE
  - PROCEDURE

ANTICIPATED CRITICAL EVENTS
- ☐ SURGEON REVIEWS: WHAT ARE THE CRITICAL OR UNEXPECTED STEPS, OPERATIVE DURATION, ANTICIPATED BLOOD LOSS?
- ☐ ANAESTHESIA TEAM REVIEWS: ARE THERE ANY PATIENT-SPECIFIC CONCERNS?
- ☐ NURSING TEAM REVIEWS: HAS STERILITY (INCLUDING INDICATOR RESULTS) BEEN CONFIRMED? ARE THERE EQUIPMENT ISSUES OR ANY CONCERNS?

HAS ANTIBIOTIC PROPHYLAXIS BEEN GIVEN WITHIN THE LAST 60 MINUTES?
- ☐ YES
- ☐ NOT APPLICABLE

IS ESSENTIAL IMAGING DISPLAYED?
- ☐ YES
- ☐ NOT APPLICABLE

SIGN OUT

NURSE VERBALLY CONFIRMS WITH THE TEAM:
- ☐ THE NAME OF THE PROCEDURE RECORDED
- ☐ THAT INSTRUMENT, SPONGE AND NEEDLE COUNTS ARE CORRECT (OR NOT APPLICABLE)
- ☐ HOW THE SPECIMEN IS LABELLED (INCLUDING PATIENT NAME)
- ☐ WHETHER THERE ARE ANY EQUIPMENT PROBLEMS TO BE ADDRESSED
- ☐ SURGEON, ANAESTHESIA PROFESSIONAL AND NURSE REVIEW THE KEY CONCERNS FOR RECOVERY AND MANAGEMENT OF THIS PATIENT

THIS CHECKLIST IS NOT INTENDED TO BE COMPREHENSIVE. ADDITIONS AND MODIFICATIONS TO FIT LOCAL PRACTICE ARE ENCOURAGED.

AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.

2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.

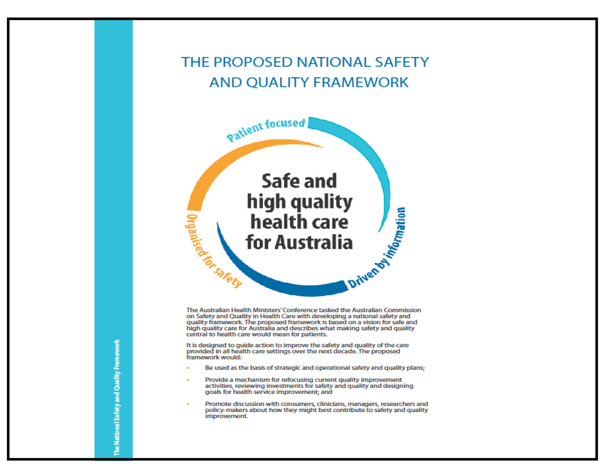
3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.

What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
Access	
I have a right to health care.	I can access services to address my healthcare needs.
Safety	
I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
Respect	
I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
Communication	
I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
Participation	
I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
Privacy	
I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
Comment	
I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

For further information please visit www.safetyandquality.gov.au

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE



The National Safety and Quality Framework

THE PROPOSED NATIONAL SAFETY AND QUALITY FRAMEWORK

The Australian Health Ministers' Conference tasked the Australian Commission on Safety and Quality in Health Care with developing a national safety and quality framework. The proposed framework is based on a vision for safe and high quality care for Australia and describes what making safety and quality central to health care would mean for patients.

It is designed to guide action to improve the safety and quality of the care provided in all health care settings over the next decade. The proposed framework would:

- Be used as the basis of strategic and operational safety and quality plans;
- Provide a mechanism for refocusing current quality improvement activities, reviewing investments for safety and quality and designing goals for health service improvement; and
- Promote discussion with consumers, clinicians, managers, researchers and policy-makers about how they might best contribute to safety and quality improvement.

SAFE AND HIGH QUALITY HEALTH CARE FOR AUSTRALIA

Safe, high quality health care is always:	What it means for me as a patient or consumer:	Strategies for action by health systems and providers:
1. Patient focused This means providing care that is respectful of and responsive to individual preferences, needs and values. It means a partnership between consumers, family, carers and their healthcare providers. Processes of care are designed to optimise the patient experience.	**I can access high quality care when I need it.**	• Develop service models which improve access to health care for patients.
	I can obtain and understand health information, so that I can make decisions about my own care and participate in ensuring my safety.	• Increase health literacy. • Involve patients so that they can make decisions about their care and plan their lives. • Provide care that is culturally safe[1].
	My health care is co-ordinated because people and systems work in partnership with me.	• Enhance continuity of care. • Minimise risks at handover. • Provide case management for complex care. • Facilitate patient-centered service models.
	I know my healthcare rights[2].	• Promote healthcare rights.
	If I am harmed during health care, it is dealt with fairly. I will get an apology and a full explanation of what happened.	• Inform and support patients who are harmed during health care.
2. Driven by information This means enhancing knowledge and evidence about safety and quality. Safety and quality data are collected, analysed and fed back for improvement. Action is taken to reduce unjustified variation in standards of care, and to improve patients' experiences and clinical outcomes.	**My care is based on the best knowledge and evidence.**	• Reduce unjustified variation in standards of care. • Collect and use data to improve safety and quality.
	My clinical outcomes and experiences are used to build the evidence base for care and for strategies designed to improve care.	• Learn from patients' and carers' experiences. • Encourage and apply research that will improve safety and quality. • Continually monitor the effects of healthcare interventions.
3. Organised for safety This means that safety is a high priority in the design of health care. Organisational structures, work processes and funding models recognise and reward taking responsibility for safety.	**I know that governments, healthcare managers and healthcare staff take responsibility for my safety.**	• Clinicians recognise their responsibilities for safety. • Managers recognise their responsibilities for safety. • Governments recognise their responsibilities for safety.
	Our money funds a safe and efficient health system.	• Restructure funding models to support safe, appropriate care. • Support and implement e-health. • Design facilities, equipment and work processes for safety.
	I know that when something goes wrong, actions are taken to prevent it happening to someone else.	• Take action to prevent or minimise harm from healthcare errors.

1 When care is culturally safe, clinicians provide care within the framework of recognising and respecting the differences of any individual. Cultural safety goes beyond cultural appropriateness to describe care that improves safety by creating better partnerships with people of different backgrounds.

2 Refer to the Australian Charter of Healthcare Rights available at www.safetyandquality.gov.au

What does all this mean?

- Australian Commission coordinates and provides direction and support
- Each State / Territory has own programme for safety and quality improvement consistent with national agenda
- Reform agenda from National Health and Hospitals Reform Commission
- Health IT needs developed through National e-Health Transition Authority
- Commonwealth Government – requiring increased reporting of performance with increasing control through funding

A Framework for Safety and Quality in Australia: -The NSW Perspective

Professor Cliff Hughes
ISQua
Dublin October 2009

Vanessa Anderson

- Special Commission of Inquiry
- Acute Care Services in NSW Public Hospitals
- 27 November 2008
- Mr Peter Garling SC

NSW: A typical Day?

- Emergency 000 call every 30 seconds
- 6,000 patients arriving at Emergency Departments
- 4,900 admissions
- 17,000 in patients
- 7,000 procedures
- $34 million spent

"On the Brink"

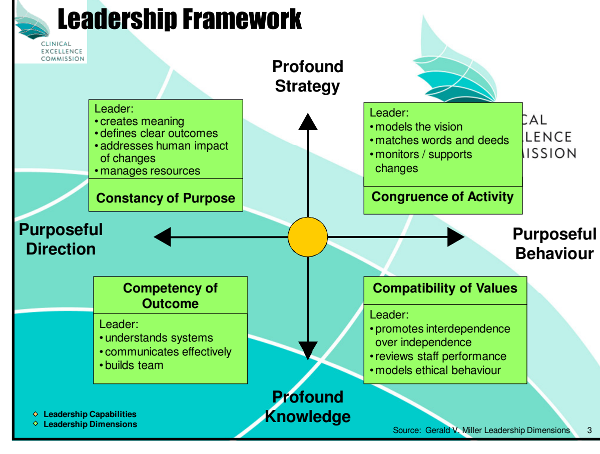
- -Patients
- 2006-2007: 1 in 3 patients were over 65
- 2008: 45% were over 65
- -Population: 13.5% are over 65
- -Nurses: 22% qualify for retirement in 2011
-

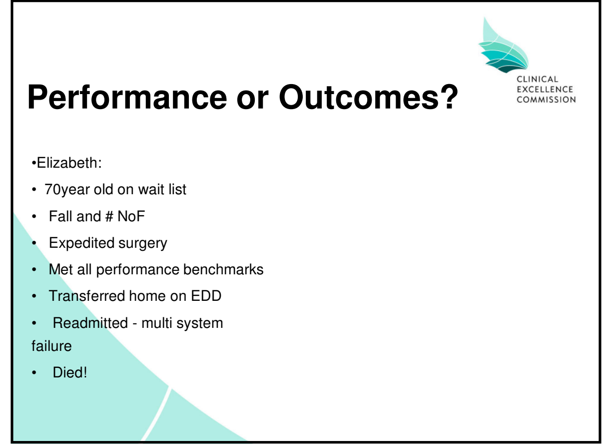
Caring together:
Executive summary

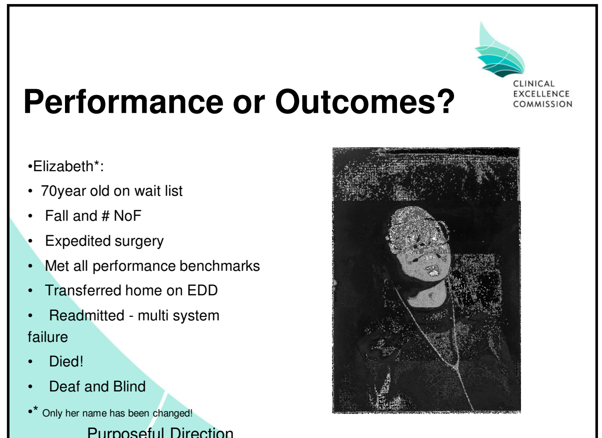
- 139 Recommendations
- 135 “accepted”
- Nurse in Charge
- Clinical Executive director
- Healthcare acquired Infections
- Three phases

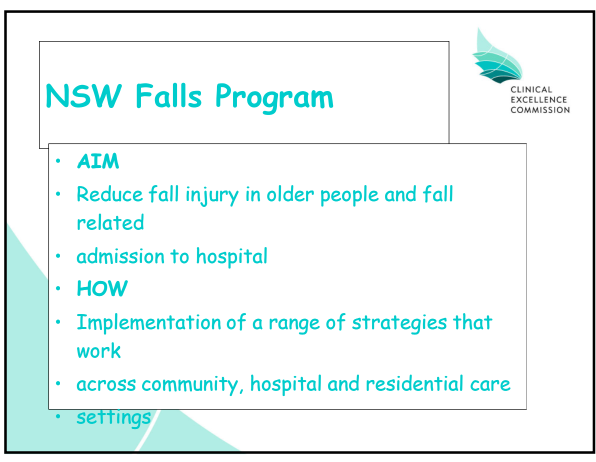
Our Mission:

- To build confidence in health care in NSW by making it demonstrably better and safer for patients and a more rewarding workplace









NSW Falls Program

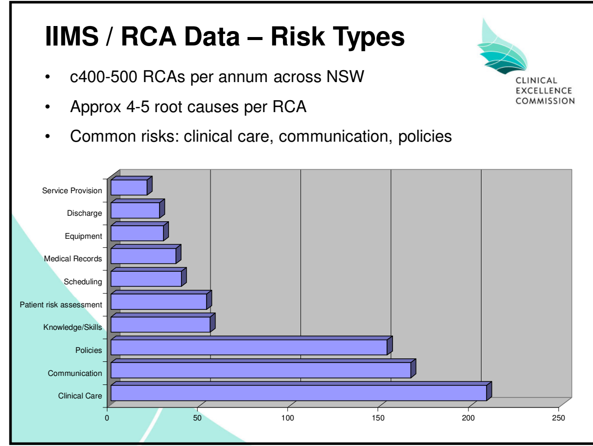
- **AIM**
- Reduce fall injury in older people and fall related
- admission to hospital
- **HOW**
- Implementation of a range of strategies that work
- across community, hospital and residential care
- settings

IIMS

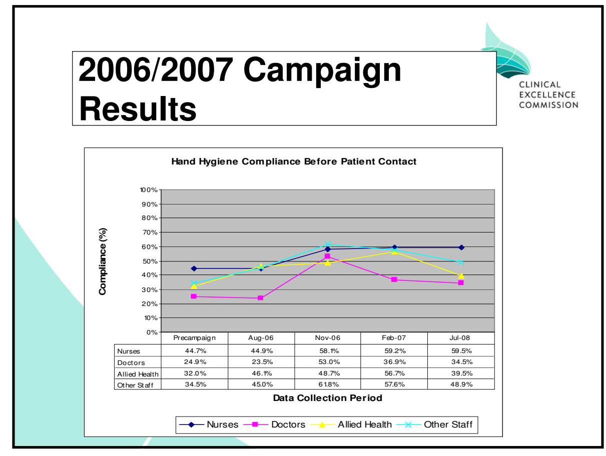
- Available to all staff in NSW health system (c100,000)
- 16,000 notifications per month
- 70% completed on clinical form
- Majority are of minor or minimum impact (SAC 3 or 4). Less than 1% SAC 1.
- Top 3 Principal Incident Types: falls, medications / IV fluids, clinical management
- IIMS Bi Annual Report 2008 released May 2009. 2nd 2008 Biannual report to be released imminently.

IIMS / RCA Data – Risk Types

- c400-500 RCAs per annum across NSW
- Approx 4-5 root causes per RCA
- Common risks: clinical care, communication, policies

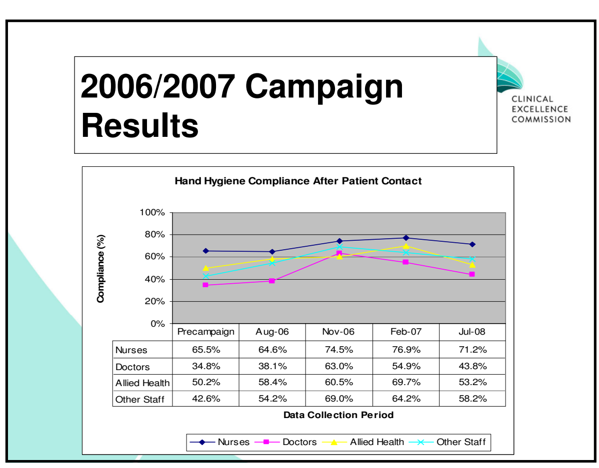


2006/2007 Campaign Results



	Precampaign	Aug-06	Nov-06	Feb-07	Jul-08
Nurses	44.7%	44.9%	58.1%	59.2%	59.5%
Doctors	24.9%	23.5%	53.0%	36.9%	34.5%
Allied Health	32.0%	46.1%	48.7%	56.7%	39.5%
Other Staff	34.5%	45.0%	61.8%	57.6%	48.9%

2006/2007 Campaign Results



	Precampaign	Aug-06	Nov-06	Feb-07	Jul-08
Nurses	65.5%	64.6%	74.5%	76.9%	71.2%
Doctors	34.8%	38.1%	63.0%	54.9%	43.8%
Allied Health	50.2%	58.4%	60.5%	69.7%	53.2%
Other Staff	42.6%	54.2%	69.0%	64.2%	58.2%

Why important for AHSs?

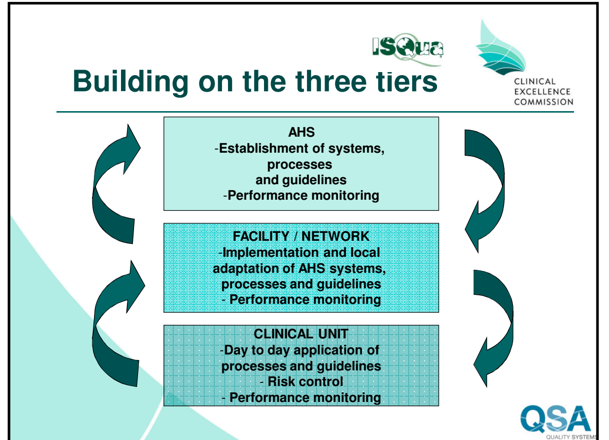
- •Significant problem in all AHSs
- •1344 *S. aureus* bloodstream infections
- •in 2008 (NSW total)
- •$27,148,800 lost annually (based on $20,200 per SAB infection)
- •Excess LOS per case – 11.5 -13 days

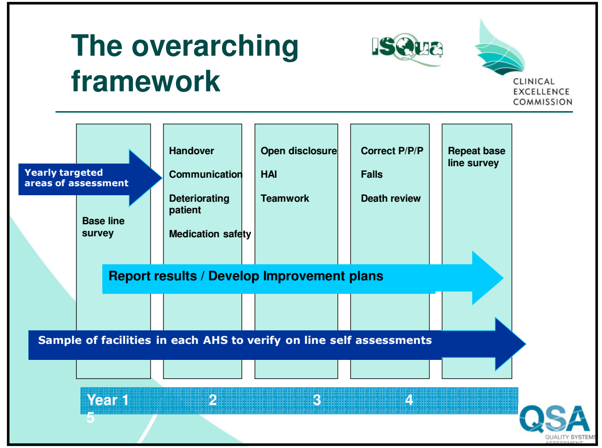
Special Reviews

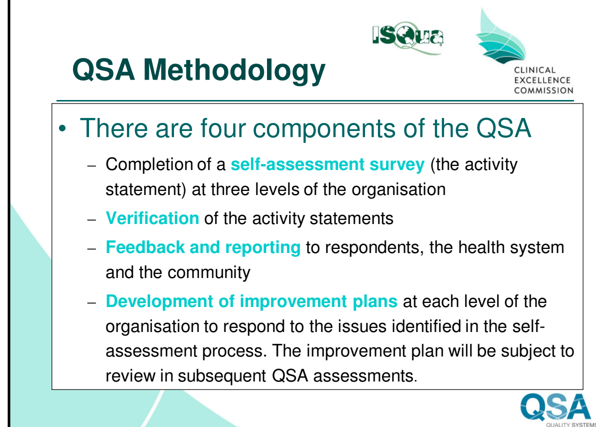
CLINICAL EXCELLENCE COMMISSION

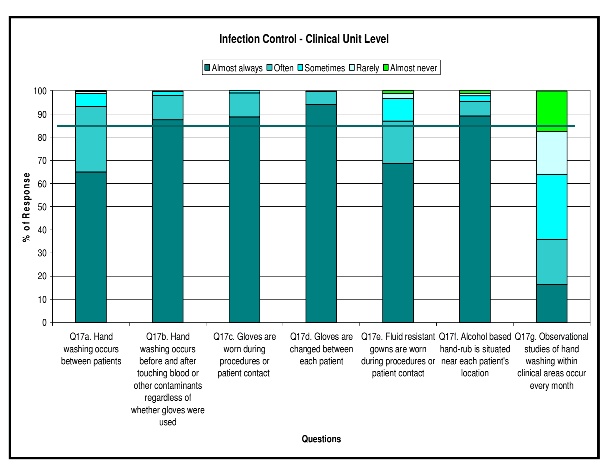
Legislative Framework

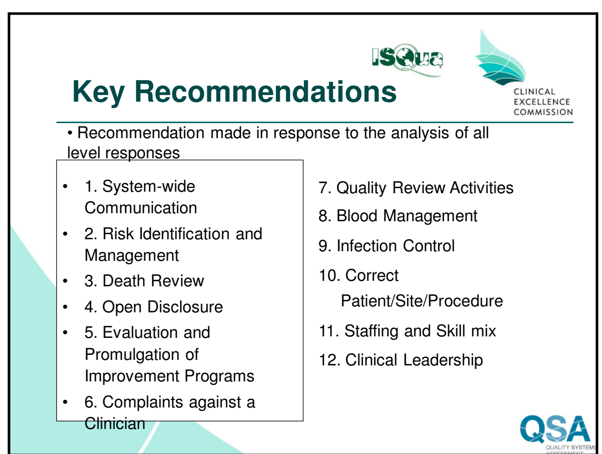
The Director General has the authority under the Health Administration Act 1997 to commission special reviews in the public health system.

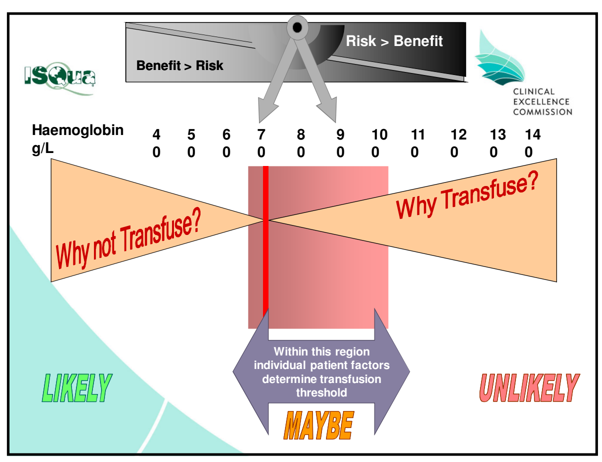


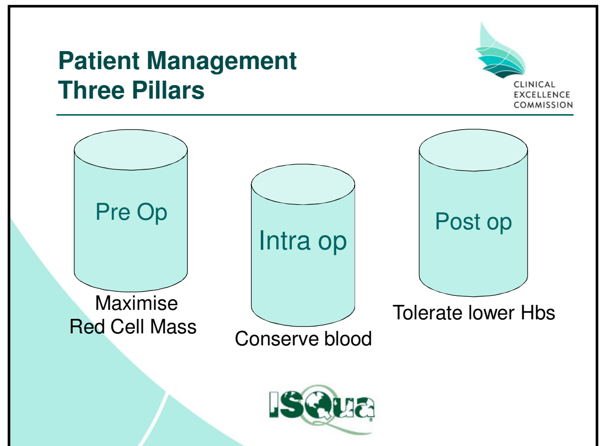


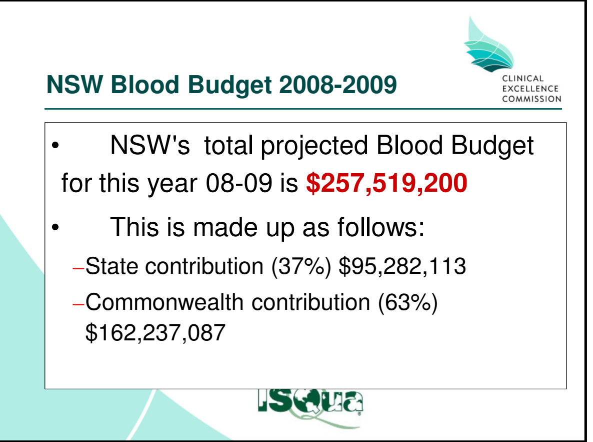


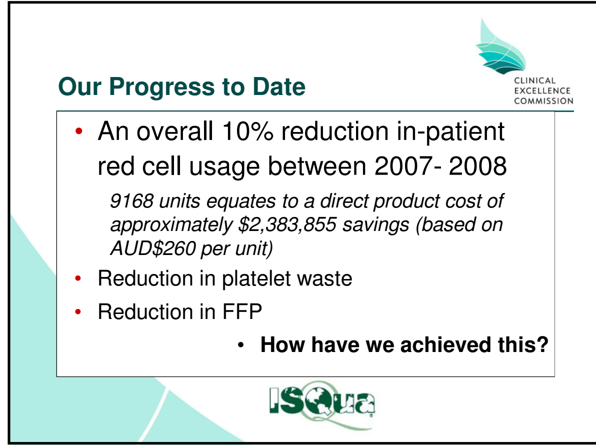



Key Recommendations
• Recommendation made in response to the analysis of all level responses
1. System-wide Communication
2. Risk Identification and Management
3. Death Review
4. Open Disclosure
5. Evaluation and Promulgation of Improvement Programs
6. Complaints against a Clinician
7. Quality Review Activities
8. Blood Management
9. Infection Control
10. Correct Patient/Site/Procedure
11. Staffing and Skill mix
12. Clinical Leadership
CLINICAL EXCELLENCE COMMISSION
QSA

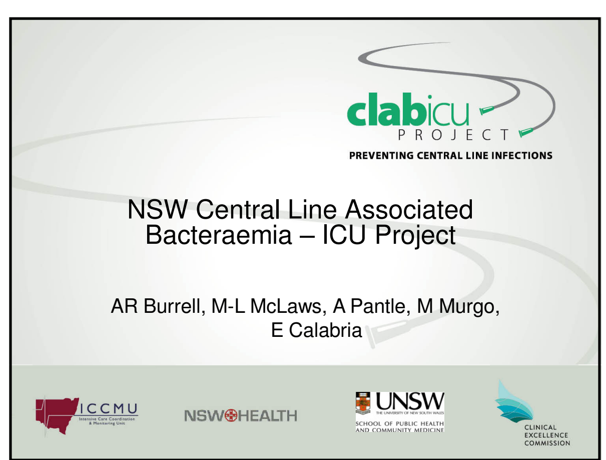

Benefit > Risk
Risk > Benefit
Haemoglobin g/L
40 50 60 70 80 90 100 110 120 130 140
Why not Transfuse?
Why Transfuse?
Within this region individual patient factors determine transfusion threshold
LIKELY
MAYBE
UNLIKELY
CLINICAL EXCELLENCE COMMISSION

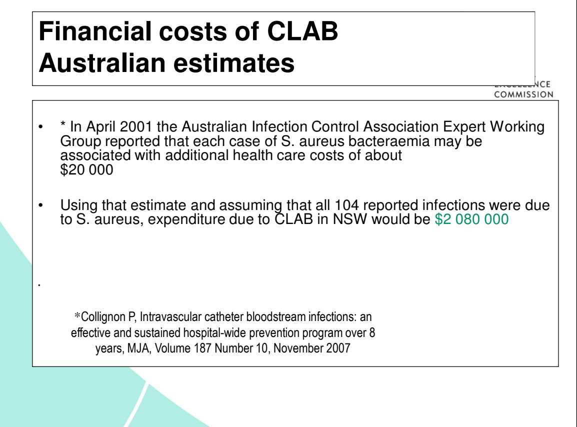

Patient Management Three Pillars
Pre Op
Maximise Red Cell Mass
Intra op
Conserve blood
Post op
Tolerate lower Hbs
CLINICAL EXCELLENCE COMMISSION


NSW Blood Budget 2008-2009
• NSW's total projected Blood Budget for this year 08-09 is $257,519,200
• This is made up as follows:
–State contribution (37%) $95,282,113
–Commonwealth contribution (63%) $162,237,087
CLINICAL EXCELLENCE COMMISSION


Our Progress to Date
• An overall 10% reduction in-patient red cell usage between 2007- 2008
9168 units equates to a direct product cost of approximately $2,383,855 savings (based on AUD$260 per unit)
• Reduction in platelet waste
• Reduction in FFP
• How have we achieved this?
CLINICAL EXCELLENCE COMMISSION

theTransfusionquestion
the debate starts soon
www.thetransfusionquestion.com.au





Financial costs of CLAB Australian estimates

- * In April 2001 the Australian Infection Control Association Expert Working Group reported that each case of S. aureus bacteraemia may be associated with additional health care costs of about $20 000
- Using that estimate and assuming that all 104 reported infections were due to S. aureus, expenditure due to CLAB in NSW would be $2 080 000

*Collignon P, Intravascular catheter bloodstream infections: an effective and sustained hospital-wide prevention program over 8 years, MJA, Volume 187 Number 10, November 2007

Financial costs of CLAB US estimates

- 15 680 lives and $1.3 billion medical costs could be saved annually by reducing the number of CLABS*

  United States House of Representatives Committee on Oversight and Government Reform Staff Report September 2008, Survey of State Hospital Association: Practices to prevent hospital – associated bloodstream infections

- The US Agency for Healthcare Research and Quality recently committed $3 million over 3 years to help reduce the incidence of CLAB

  Health Care Advisory Board, Daily Briefing, 10 February 2008

Results

- Data on 11000 central lines has been collected since June 2007
- 104 infections have been reported
- CLAB rate for the period July 07 to December 08 is 2.2 per 1000 patient line days
- CLAB rate has noticeably decreased in the last six months
- Preliminary analysis suggests that CLAB has been virtually eliminated in the first 72 hours post insertion

Results

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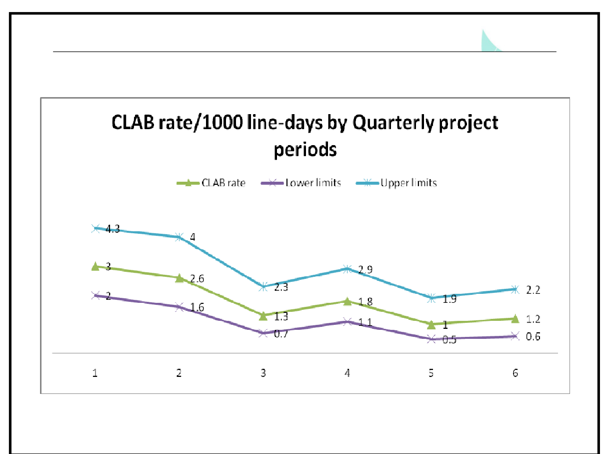

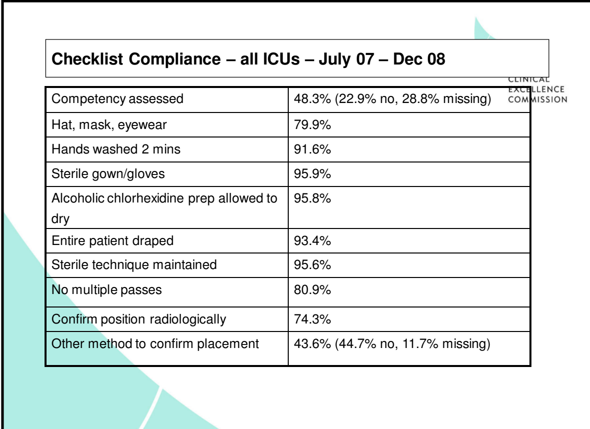

Competency assessed	48.3% (22.9% no, 28.8% missing)
Hat, mask, eyewear	79.9%
Hands washed 2 mins	91.6%
Sterile gown/gloves	95.9%
Alcoholic chlorhexidine prep allowed to dry	95.8%
Entire patient draped	93.4%
Sterile technique maintained	95.6%
No multiple passes	80.9%
Confirm position radiologically	74.3%
Other method to confirm placement	43.6% (44.7% no, 11.7% missing)