

289: THE FRAMEWORK FOR PATIENT SAFETY IN SOUTH AUSTRALIAN METROPOLITAN PUBLIC HOSPITALS

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Objective:

To develop and implement a robust and comprehensive framework for patient safety improvement with the South Australian health system.

Methods:

This framework is underpinned by a common clinical information system that allows transfer of the clinical record across the whole system through a network that provides for clinical display, and a number of decision making aids that assist with clinical practice and clinical safety. The OACIS system also provides for clinical orders management for pharmaceutical prescribing and diagnostic test ordering, as well as an automatic e-mail event summary to referring general practitioners at the time of discharge. The clinical reporting repository features of the OACIS system also allow for the automatic production of clinical performance parameters such as unplanned re-admission and unplanned return to theatre. The infection control module allows for automatic reporting of continuous quality improvement for antibiotic resistant infections, the identification of patients at risk and the documentation of antibiotic prescribing patterns as well as identification of antibiotic resistant organisms.

South Australia has also incorporated a patient safety reporting system as an integral component of the framework. The system includes the voluntary reporting of adverse events and 'close calls' using software developed by the Australian Patient Safety Foundation. The challenge of developing a system for root cause analysis, has been facilitated by the adoption of the patient safety approaches of the US Veterans Affairs 'National Centre for Patient Safety (NCPS) which includes severity assessment, the use of multidisciplinary teams for root cause analysis and a focus on systems rather than an individual 'fault finding' response to adverse events. The safety framework also provides for aggregate and continuous analysis of major issues such as infection control, medication errors, falls, suicide and missing persons.

The framework also identifies the need for a separation of corporate risk management from patient safety activities. The need to clearly identify issues/events that should be addressed through an administrative review process (such as intentionally unsafe acts, negligence or criminal acts) was regarded as a critical factor in the success of the system. The Root Cause Analysis process has been determined as an appropriate activity to be undertaken under the umbrella of qualified privilege. This allows for full and free participation of all clinicians in an environment that is actively pursuing a culture of 'no blame' however recognises that this functionally does not exist at present. The patient safety framework has been implemented during 2003 and is being supported by extensive education and training programs.

Results:

The success of the framework is not, and should not be measured, in terms of a reduction in adverse events. Rather the success of the system will result in an increased number of both actual events and 'near miss' incidents being reported.

Success will also be determined through a gradual change in the culture of organisations with regard to patient safety and this may not be evident and indeed identifiable for many years.

Conclusions:

A system wide systems approach to patient safety that seeks to embed a culture of safety by all staff has been implemented in South Australia during 2003. The effects of this program should be demonstrable in 2004.