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# **Patient Safety:** ***“From Noun to Verb”*** **Charting Queensland** **Health’s Progress in Patient** **Safety**

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**Change Champions – Cairns**  
**22nd March 2007**

h e a l t h   •   c a r e   •   p e o p l e

# Presentation Outline

- What is Patient Safety anyway?
- What is Queensland Health doing about it?
- Current status?
- Finish with a story!

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# Understanding the Patient Safety problem: What is Patient Safety?



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# Safety - definition

- Safety: *“A state in which risk has been reduced to an acceptable level”*
  - *Acceptable to whom?*
  - *How do I know?*

# Can patient safety be measured?

## 2 dimensions of patient safety

1. **Patient experience (Stories):** Do they feel safe? What proxies exist to measure this? (also “*n of 1*” patient harm)
2. **Extent of harm (Statistics):** This is actual harm experienced and is a statistical concept. (Wilson, 1995; Jackson et al., 2006)

*Note: Incident reporting NOT measure of actual harm*

# First Dimension - Stories

- *“I feel safe – I am safe”*
- Consider this:

“Human behaviour is governed more by stories than statistics”

# Let's test the theory....



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# *How does the community know that their health service provider is 'safe'?*

- It's like flying – It's all about perception and feelings “If I feel safe....I am safe”.
- US data – Patients choose doctors and hospitals on reputation – only 1% patients change provider based on accessing information (AHRQ, 2004).
- Sharyn and Scotty – Townsville “What made you feel safe?” answer: “Seemed to know what they were doing. They were calm and reassuring”.

...Stories  
affect how  
safe patients  
*feel....*

The Courier-Mail Monday, March 24, 2003+

# Hospital care among worst in the nation

WHERE TO BE WARY

Queensland's Error-Prone Hospitals

Australia's Error-Prone Hospitals

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# Perspectives – *perception vs. reality*

- One rogue surgeon, 13 preventable deaths and associated publicity and political fall out led to additional \$6.4 billion over 5 years;
- The community, politicians and media believe that healthcare would be safe if we just weed out the bad doctors, nurses and bureaucrats.
- Despite little action after 10 years of evidence that 1:6 hospital patients suffer harm and 18000 patients die per year, largely due to **good people that make mistakes**. (Wilson et al 1995);

# Dimension 2 – Technical Safety

## 1995 – Quality Australian Health Care Study (QAHCS)\*

16.6% of admissions had Adverse Events

- 50% preventable
- 5% associated with death
- 75% as a result of human error

## Australia-wide (annually)\*

- 50,000 with a permanent disability
- 18,000 deaths
- \$4.17 billion – total economic burden

# The Drivers for Reform in Queensland

## ➤ Political & Media:

- Bundaberg – Davies and Forster

## ➤ Regulatory:

- Qld. Healthcare Quality and Complaints Commission

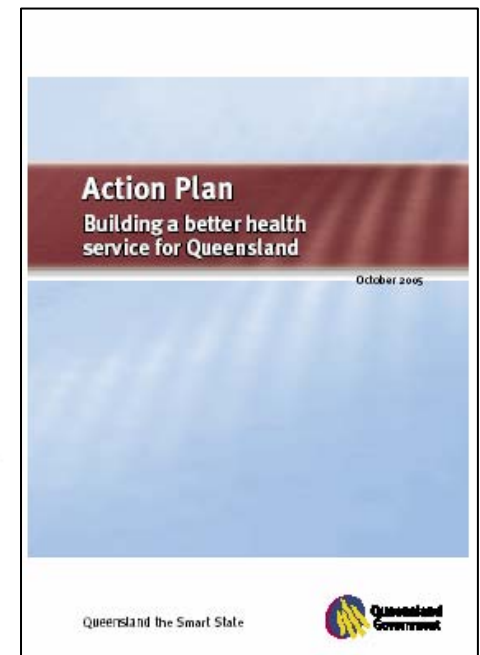
## ➤ Policy:

- National Commission (Council)
- Queensland Health Action Plan

## ➤ Accreditation:

- ACHS Mandatory Criteria

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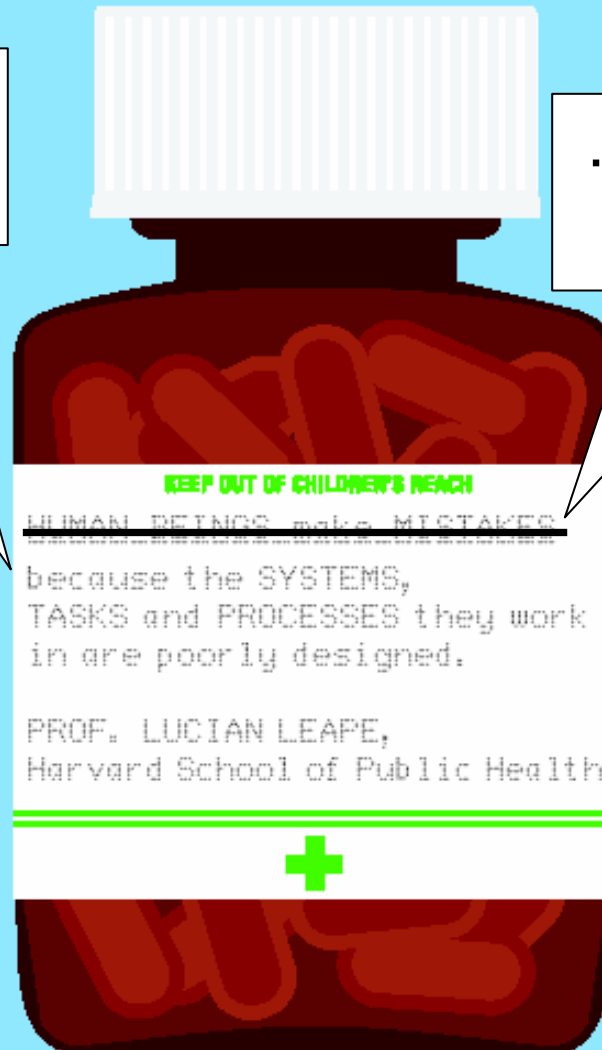
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# Why do patients get harmed by healthcare?

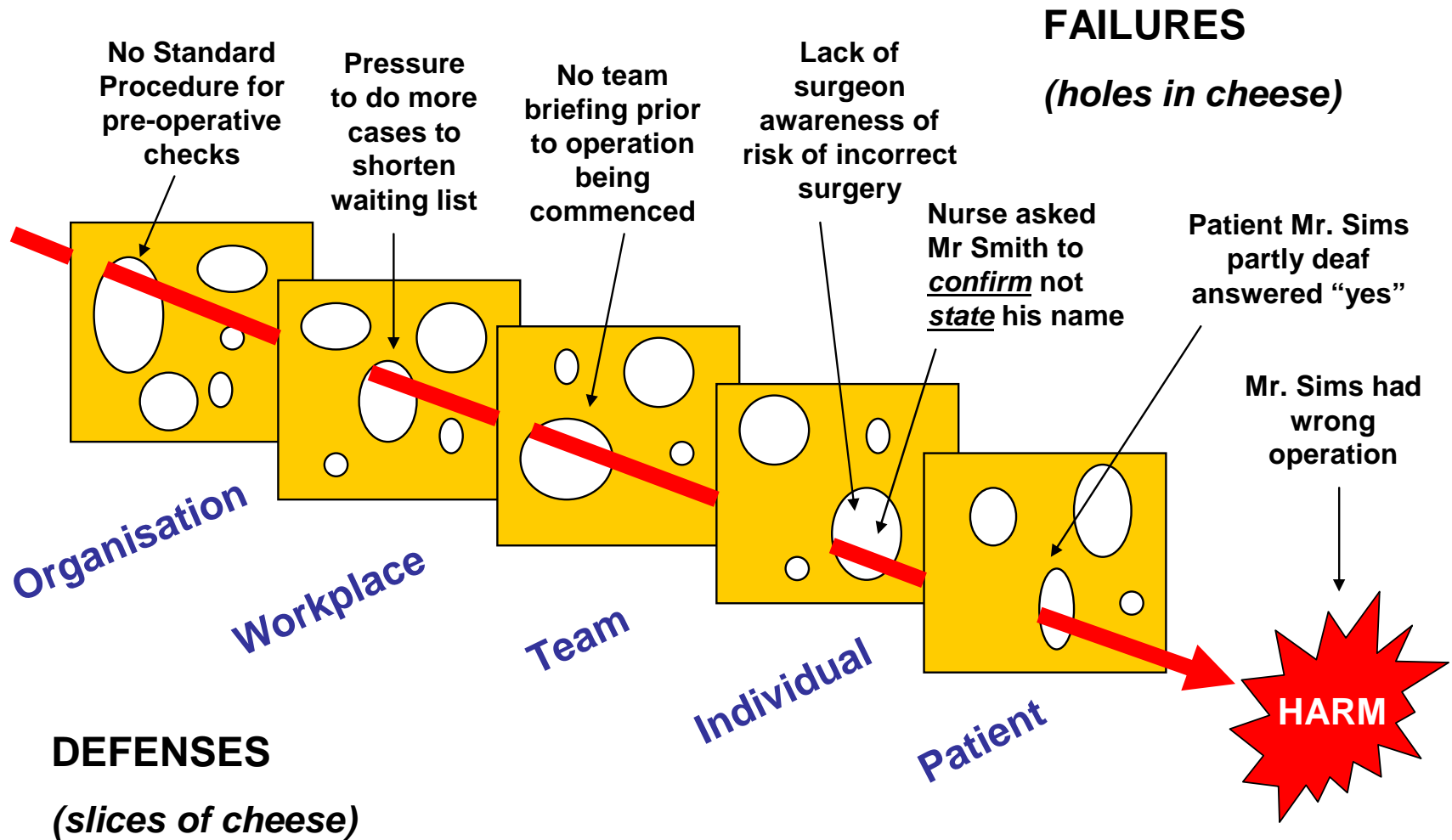
# Why are we in this situation?

Patient harm occurs....

....because they are human!



# Swiss Cheese Model



*Adapted from Reason, 1990*

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# What is Queensland Health doing about it?

# The focus of reform in QH

**Right  
Person  
Doing The  
Right Job**



**With The  
Right Skills**

**Supported By  
Effective  
Organisational  
Systems**

**Working In  
High  
Performance  
Teams**

# Key units driving Patient Safety reform in Queensland Health

- Patient Safety Centre (PSC)
- Area Clinical Governance Units (ACGUs)
- Safe Medication Practice Unit (SMPU)
- Clinical Practice Improvement Centre (CPIC)
- Centre for Healthcare Related Infection and Surveillance Program (CHRISP)
- Skills Development Centre (SDC)

# Why a Patient Safety Centre?

The Queensland Health Patient Safety Centre (PSC) was formed in early 2005 to take a lead role in:

Planning; Implementing; Managing; & Evaluating.....

patient safety initiatives and programs as part of a broader system to **prevent and address patient harm.**

# Who are we?

- Part of Reform and Development Division
- Led by Senior Director (Doctor) and Nursing Director
- 25 staff **plus** 38 *Patient Safety Officers* (27.5FTE) located in districts
- Located at Royal Brisbane Hospital
- Funded from Commonwealth \$ under AHCA
- *Based on modified US Veterans Health Administration model*

# Current status

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# **Built comprehensive, integrated clinical incident management system:**

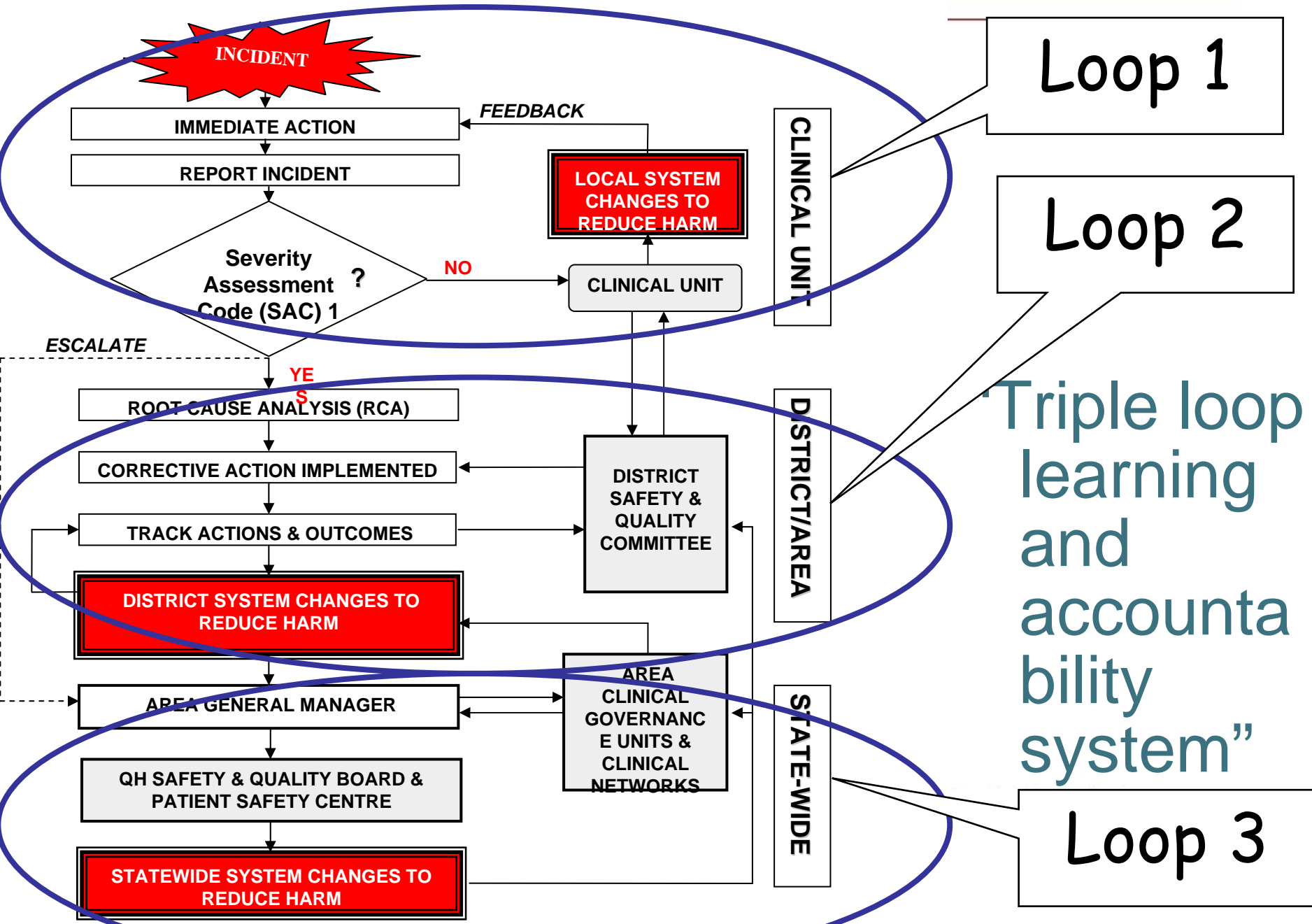
- Developed and implemented statewide clinical incident management information system
- Clinical Incident Policy and Standard June 2006
- Legislation to support Root Cause Analysis (Bill before parliament)
- Standardised processes for RCA's, quality assurance, coding, aggregation and reporting
- Coronial and medical litigation systems



**CLINICAL INCIDENT MANAGEMENT**  
**IMPLEMENTATION STANDARD**

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# Clinical Incident Management Implementation Standard



# Building District Capacity:

- Trained and deployed 38 Patient Safety Officers: One in every District Health Service;
- Maintained a network of PSO's and provided on-line and on-site support;
- Developed comprehensive training modules in RCA, basic systems analysis, leadership for patient safety;
- On-site training to over 1200 staff in all Districts completed August 2006.



# Raised risk awareness and promoted safe and 'just' culture:

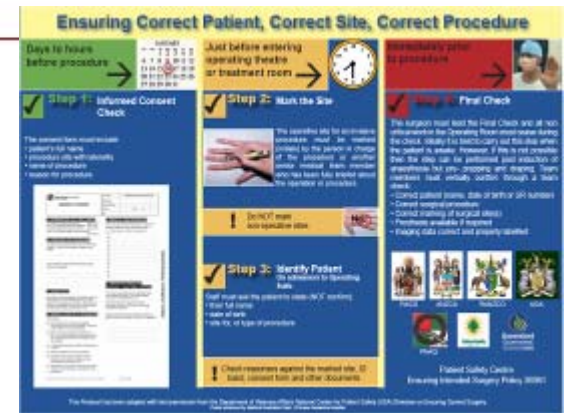
- Decision support to assist in determination of individual vs system response
- HEAPS course delivered to over 6000 staff (since 2003) **Minister for Health trained!**
- Safe Doctors: Fair Process Paper published
- Patient Safety curriculum being developed for undergraduate and post-graduate training of health professionals and managers

# Focus on high risk areas of harm:

- Mental Health Sentinel Event Program
- Falls Injury Prevention collaborative
- Pressure Ulcer Prevention collaborative
- Medicines/Infection (separate but linked programs)

# Specific state-wide safety interventions:

- Open Disclosure national pilot – 90 clinicians trained – state-wide roll-out 2007.
- Ensuring Intended Surgery Program
- Clinical Handover pilots
- Patient Identification programs – blood
- Team and communication training (curriculum piloting)



# Creating Networks and sharing lessons learnt:

- Monthly Newsletter
- Alerts and Advisories
- Quarterly PSO workshops/training
- District/Area and State Reporting



# What are we learning?

## **PATIENT SAFETY: FROM LEARNING TO ACTION**



### **FIRST QUEENSLAND HEALTH REPORT ON CLINICAL INCIDENTS AND SENTINEL EVENTS**

**November 2006**

Prepared by: Dr J Wakefield  
Senior Director  
Queensland Health Patient Safety Centre

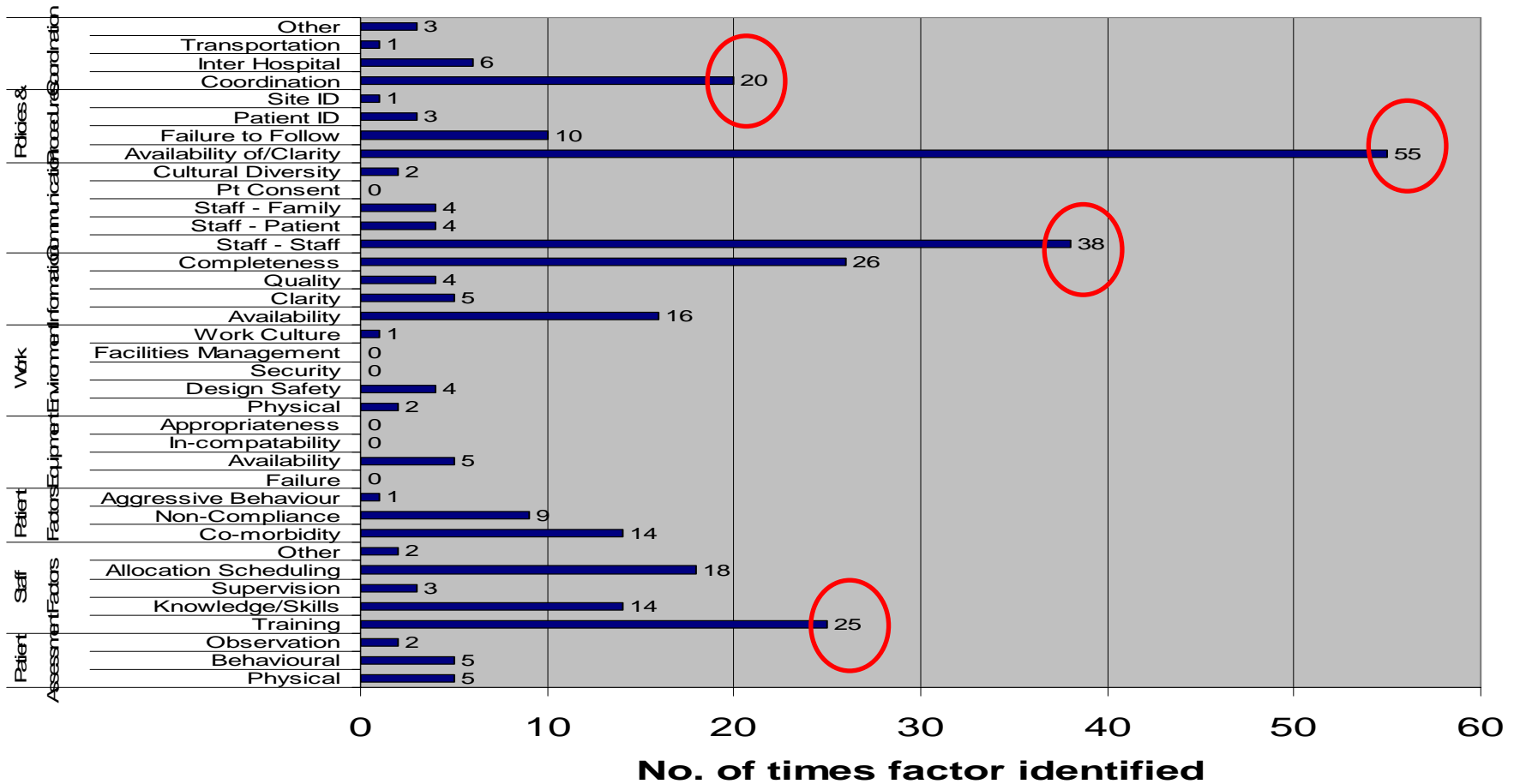
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# Sentinel Event data 2005/6

<b>Queensland Health Notifiable Sentinel Events 2005/6</b>		
SE 1	Surgery / Procedure on the wrong patient / body part.	6
SE 2	Haemolytic blood transfusion reaction resulting from ABO incompatibility.	1
SE 3	Instrument or other materials inadvertently left in body cavity or operation wound following a procedure.	6
SE 4	Intravascular gas embolism resulting in death or neurological damage.	-
SE 5	Infant discharged to wrong family.	-
SE 6	Death of an employee during the course of their duties.	-
SE 7	Suicide of a patient.	4
SE 8	Death of a patient as a direct and immediate result of a medication error.	1
SE 9	Death of a patient during inter-hospital transfer	5
SE 10	Direct maternal death.	1
SE 11	Sudden and unexpected death of an infant associated with labour or delivery.	15
SE 12	Death of a patient during surgery.	5
SE 13	Unexpected death of a patient.	32
SE 14	The suicide or unexpected death in respect of any patient (inpatient or community) of a mental health service, any person who has been in contact with a mental health service or emergency department within seven(7) days preceding the incident.	81
SE 15	Death of any person through shooting by the Queensland Police Service where the deceased had, or is reasonably suspected to have had, a serious mental illness.	1
SE 16	Death of any other person due to the actions of a person who has, or is reasonably suspected to have, a serious mental illness.	4
<b>TOTAL:</b>		<b>162</b>

# SE Contributing Factors 2005/6

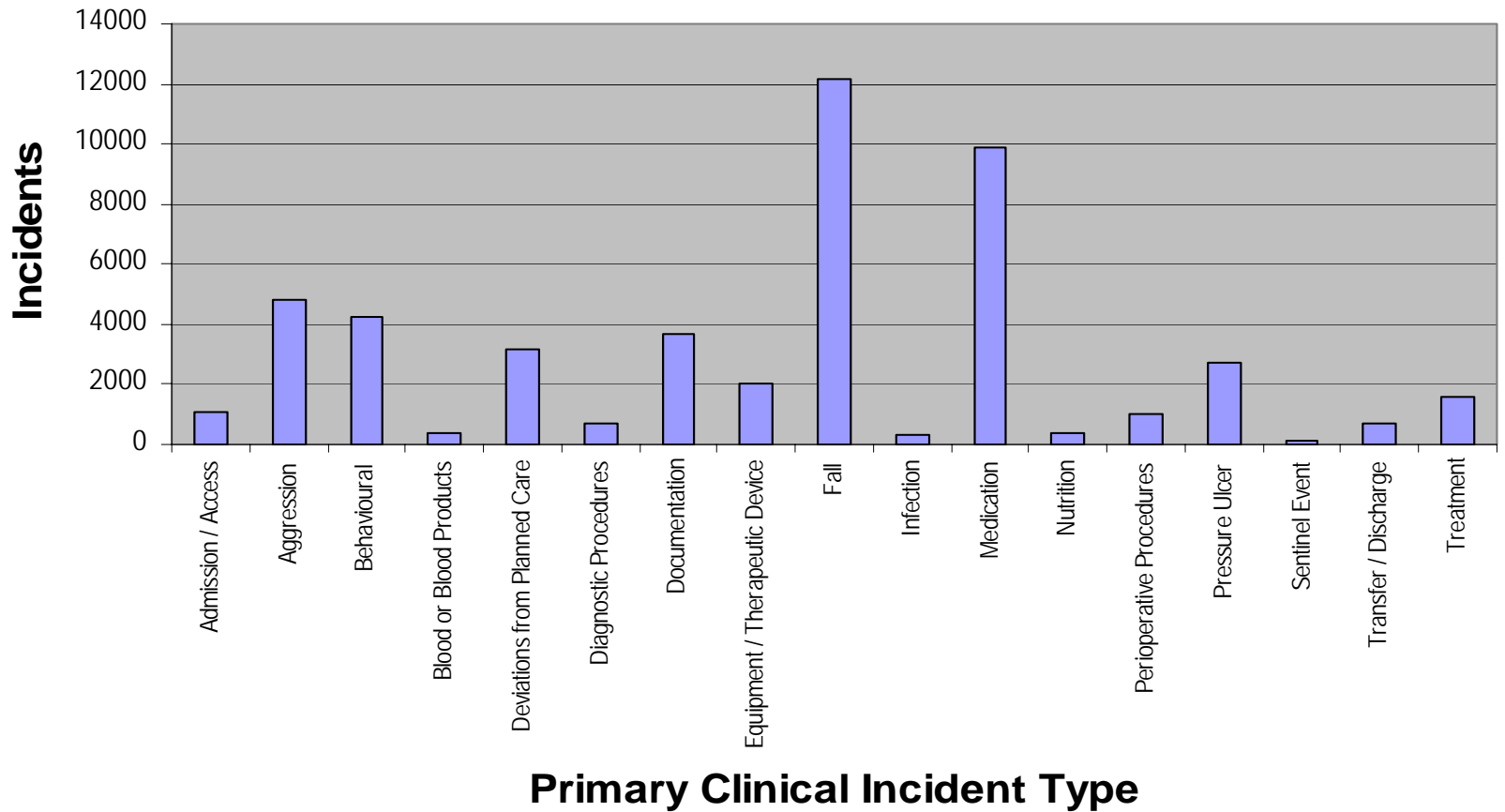
**Classification of Contributing Factors**  
Reported Sentinel Events 2005



# clinical incident data 2005/6

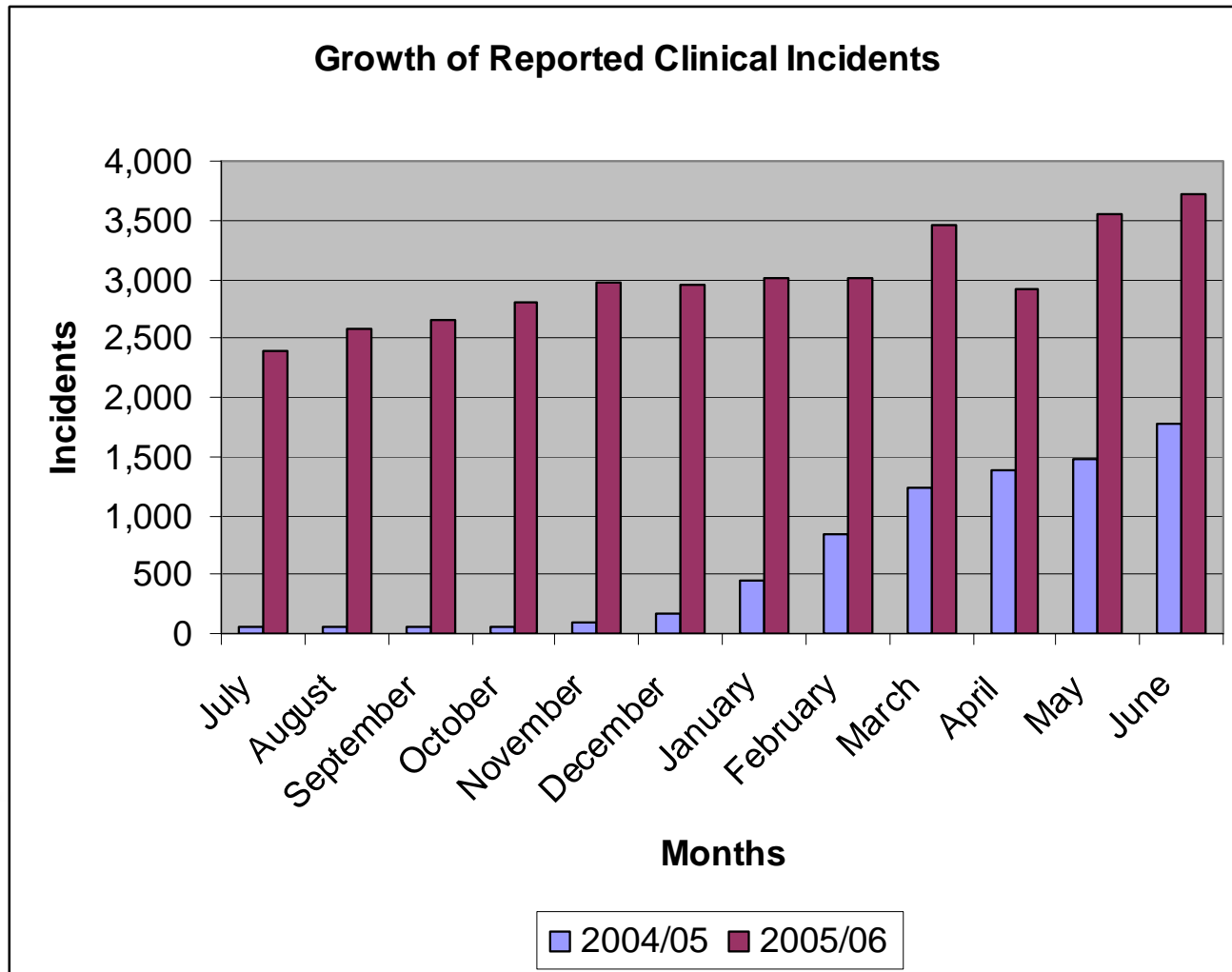
# clinical incidents 05/06 (n=33,321)

## Total Clinical Incidents Reported

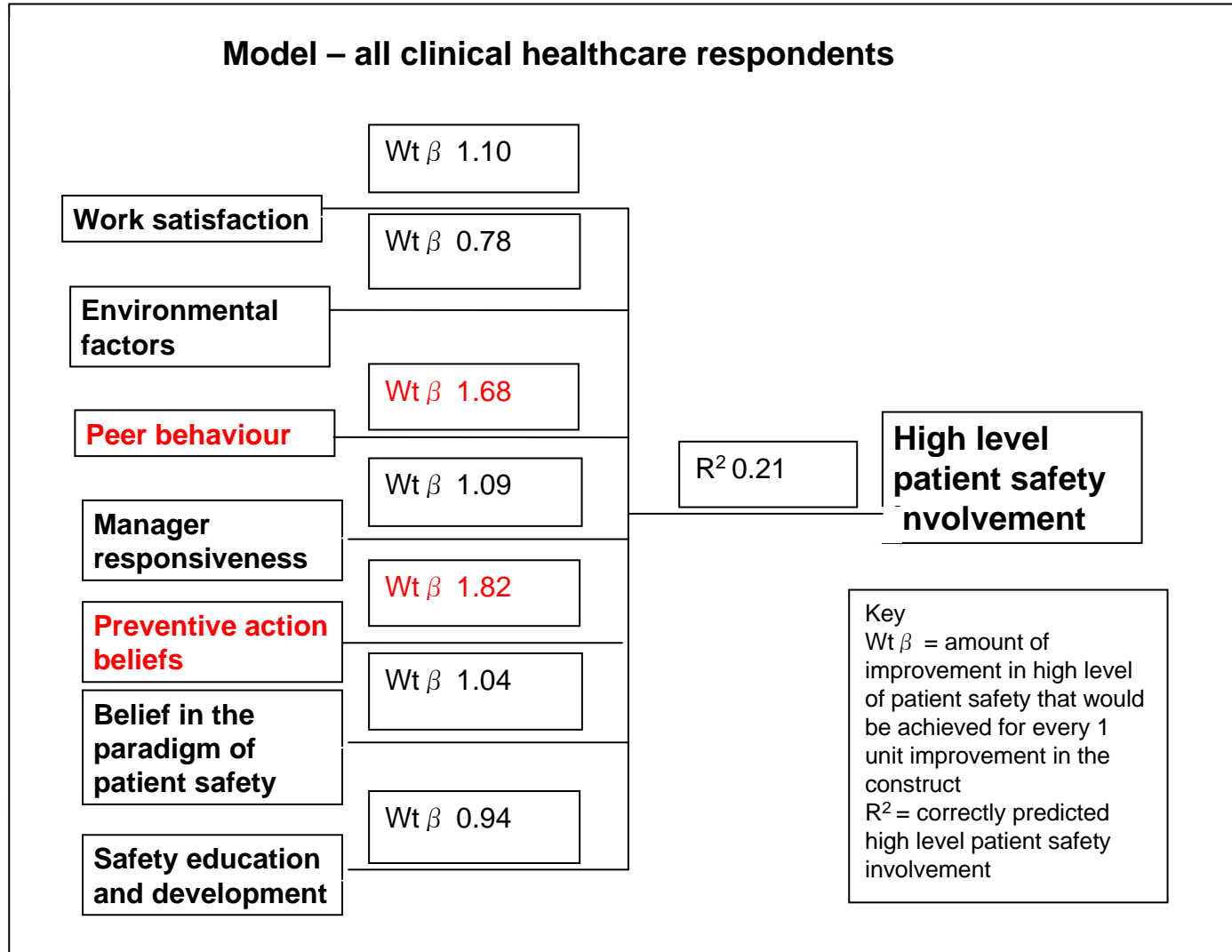


# Implementation of CIMIS

n=56,000



# PS Culture Survey - (n=5300)



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# The future?

# Where to from here?

- Pay for performance
- Public reporting
- Metrics for patient safety – incident reporting and active data collection
- e-Health and patient safety
- Development of clinical patient safety leaders
- Curriculum in patient safety

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# A story to finish.....

# What has pizza got to do with clinical handover?



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If 15 year olds can do  
“readback” for pizza  
orders.....What is it that stops  
highly intelligent healthcare  
professionals from doing it for  
patient care?

# Key Messages

- QH now has robust systems and processes for patient safety.
- Early focus on building local capacity for safety improvement.
- Professional leadership and behaviour modelling is key to moving beyond bureaucracy of safety to real safety improvement.
- Patients view of safety is about how they **feel** rather than statistics.

# Contact us

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