

**CareSafe** NSW  **HEALTH**

*putting the patient first*

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# Challenges and Barriers

- Staffing issues
- Skills, Competency, Local Knowledge
- Limited patient data on initial presentation
- Ebb and Flow of patient demand
- Resources
- Increasing demand on the system
- Information system
- Unwieldy Administration and Bureaucracy
- Lack of recognition from the Community

# What is the Patient Experience?

- What **patients** tell us
  - Almost **90% patients say that their care is good or better** but ***40% would not recommend the service to friends or family***
  - we do not adequately discuss anxieties and fears
  - we are not available to talk
  - we do not answer questions and explain results adequately

# Royal North Shore Report

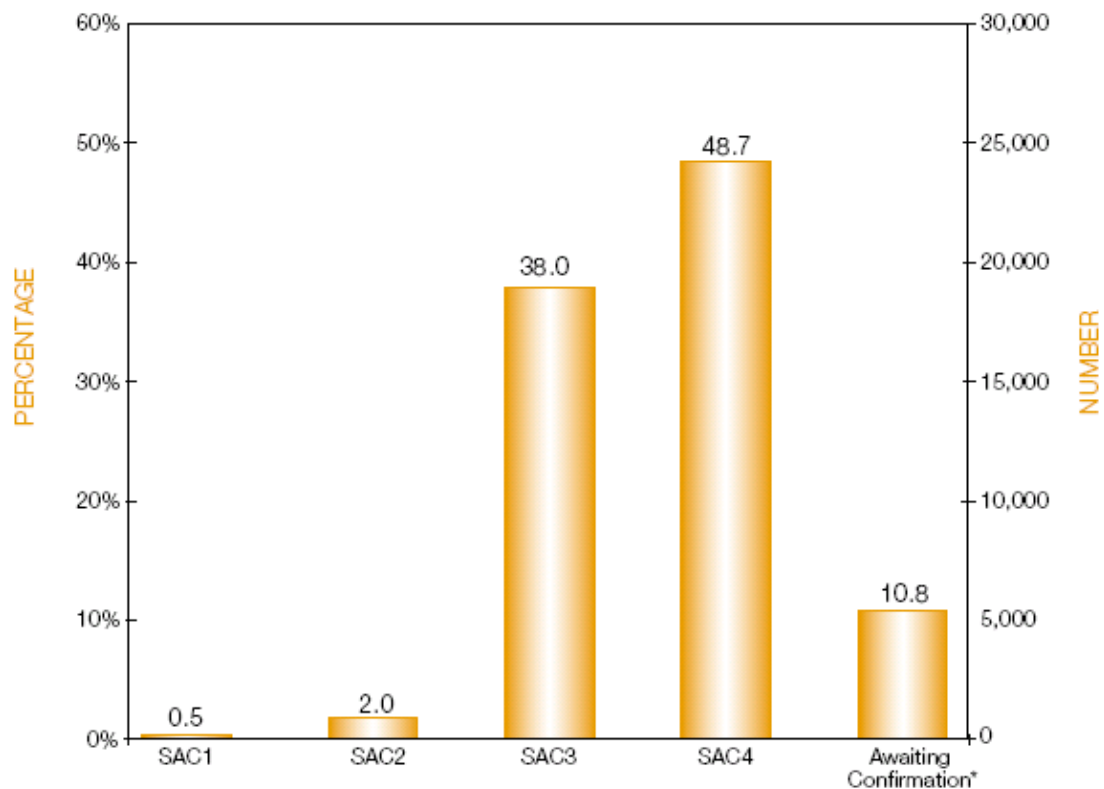
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- Patient Experience is a key challenge
- How do we communicate the service standards so that patients have well informed expectations?
- How do staff relate and communicate to patients and each other?
- How do we design hospitals to reduce remove the physical barriers to patient engagement?

# Incident Events

There were 53,817 clinical incident notifications made in the January 1 to June 30, 2007 period. The spread of incidents within SAC categories can be seen in Figure 1.

**Figure 1. Clinical Incidents across SAC categories**



# Error Estimates

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In the USA the Institute of Medicine (IOM) reports on two studies estimating the **hospital deaths due to medical errors at 44,000 to 98,000 annually**, which would place **medical errors in the top ten causes of death in the USA**.

Starfield's article in JAMA places the estimates even higher, citing a total of **225,000 deaths due to iatrogenic causes**, which would place health-caused deaths as the 3rd leading cause of death in the USA.

Holland et al (1997) estimates as many as **1 million patients are injured** while in the hospital and approximately **180,000 die as a result**, with the majority due to medication adverse reactions.

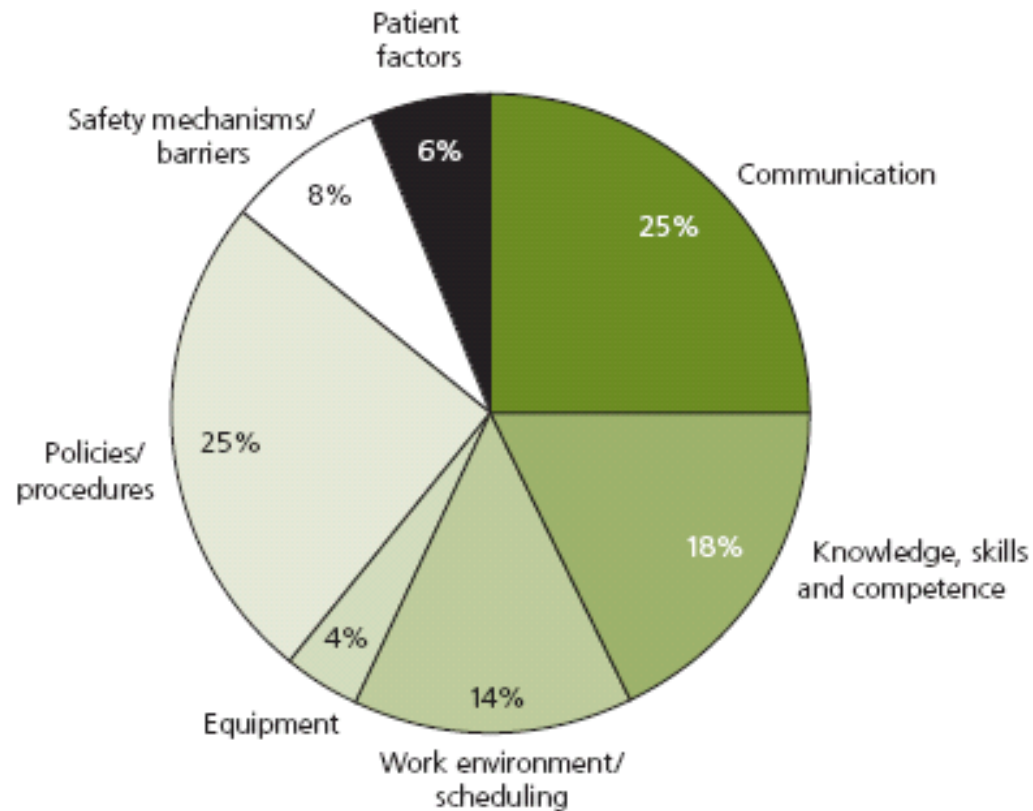
# Adverse Events

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- International Benchmark is that there will be a adverse event for every 16 Hospital admissions, In NSW the rate has been assessed at 1 in 10 to 1 in 15
- Up to 3.6 million hospital admissions in Australia are related to medication error

# SAC1 Factors

Factors contributing to incidents 2005–2006



*Whatever it was that got you where you are today is not sufficient to keep you there*

Improvement comes with evolution



# Quality and Safety Drivers

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- **Patient Satisfaction** – Manage the experience
- **Staff Satisfaction** – Teamwork, communication, support
- **Patient Outcomes** – prevent adverse events
- Harness and Replicate **Innovation**
- System and Procedure **Compliance** – reliable and sustainable practice models that are not personality dependent



# The Next Phase

- Systems Thinking Approach
- Understand and building processes that drive patient satisfaction
- Build Cross Functional teams and a team culture
- Building a systems model that has “Freedom within a Framework”
  - Decision Support
  - Clinical Protocols – where do they fit?

# If a patient was a computer



# If a patient was a parcel



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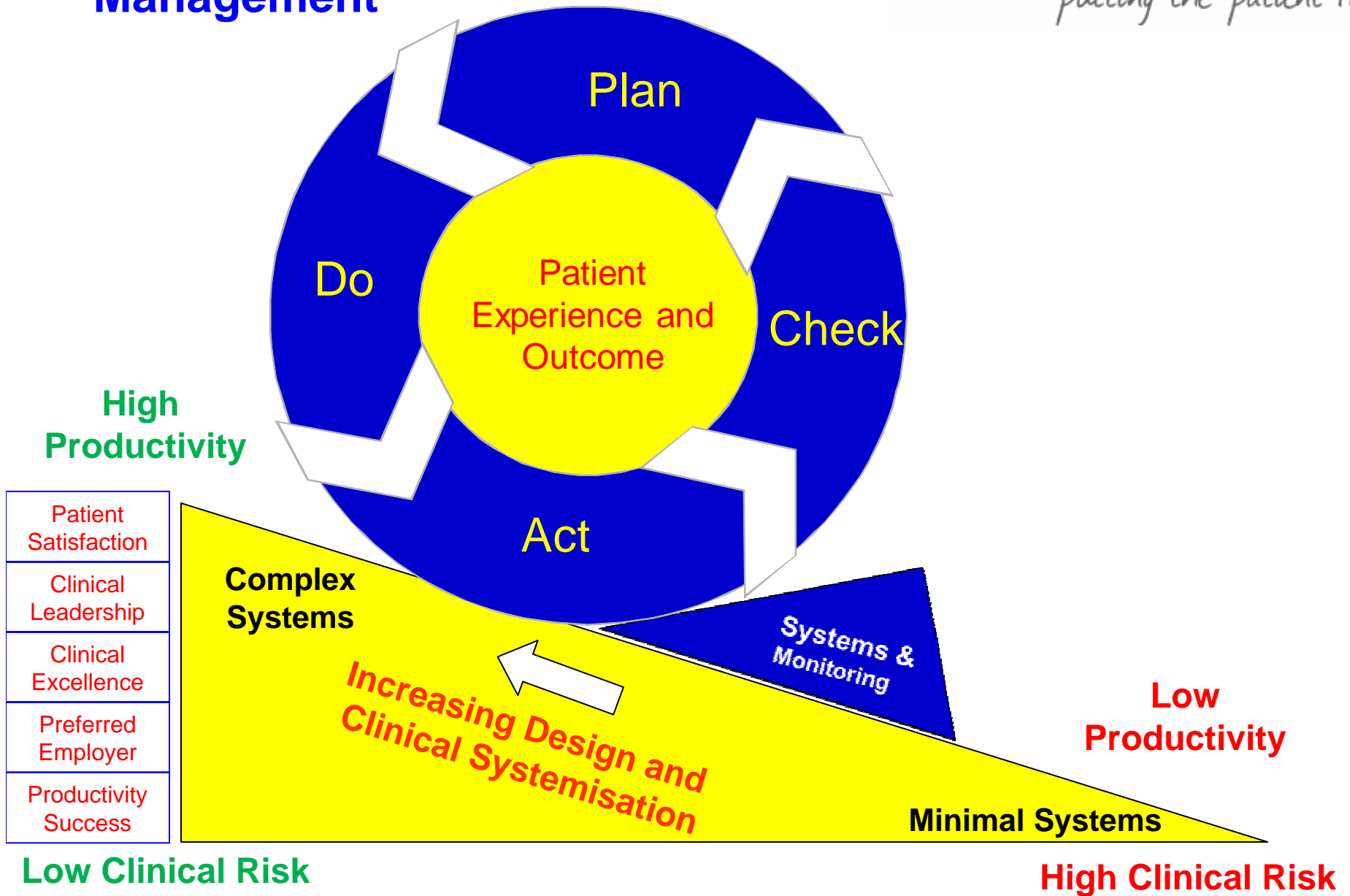
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# Clinical System Management



# Clinical Protocols

Clinical protocols are a key feature of system redesign.

They are used to inform, direct and record the patient's clinical pathway, admission and discharge. Clinical protocols can streamline patient care processes and support the quality and safety of clinical management of the patient.

## ■ **Features of a clinical protocol**

- Require endorsement by all relevant clinicians from the appropriate surgical specialty
- Reflect best practice
- Must be dynamic and adaptable to local conditions
- Must be regularly reviewed to ensure latest knowledge is adapted

# Why is Decision Support Required

- Why do we need this tool?
- – According to a 2003 *JAMA review of autopsy studies*, misdiagnoses occur between 8% and 24% of the time
- – A 2005 AHRQ study found that diagnosis errors far outnumber medication errors as a cause of claims
- – Almost 75 percent of all mortality attributable to patient safety incidents was caused in part by failure to diagnose and treat in time
- A 2006 study showed that failures in judgment (79%), vigilance or memory (59%), and knowledge (48%) were the leading factors contributing to misdiagnoses.

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# The Clinical Questions

- How do we get protocols to work?
- How do we enhance the clinical decision making process without impeding clinical freedom?
- Where are the points to apply decision support?

# The Path to Improving Flow

- Focus on Patient Engagement and Satisfaction
- Build Cross Functional Teams
- Listen to engage all staff
- Develop evolving Systems
- Use Design Standards
- Building workable protocols and frameworks and Standard Operating Procedures

# What Does the Future Look Like?

- <http://www.youtube.com/watch?v=V35Kv6-ZNGA>

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# Thank you for your attention

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- Kelvin Genn
  - Director Quality and Safety NSW Health