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Achieving Safety and Quality Improvements In Health Care

Sixth Report to the Australian Health Ministers' Conference

Summary



28 July 2005

Disclaimer

The views expressed in this document do not necessarily represent the views of the Australian Government, Department of Health and Ageing or its contractors.

Acknowledgements

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The Australian Council for Safety and Quality in Health Care was established in January 2000 by the Australian Government Health Minister with the support of all Australian Health Ministers to lead national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error. The Council reports annually to Health Ministers.

Achieving Safety and Quality Improvements In Health Care is Council's sixth annual report to Health Ministers and this document is a summary of the main report.

Copies of the main report, this summary, standalone documents and further information on the work of Council can be found at www.safetyandquality.org or by contacting the Office of the Safety and Quality Council on telephone: +61 2 6289 4244 or email to: safetyandquality@health.gov.au.

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About this summary report

This summary report provides the key content and recommendations of the Australian Council for Safety and Quality in Health Care's Sixth Report to the Australian Health Ministers' Conference, titled *Achieving Safety and Quality Improvements in Health Care*. It contains an introduction, recommendations made to Health Ministers, Statement from the Chair, Professor Bruce Barraclough, and achievements from the full Report.

It reports against Council's key themes:

- building capacity of the workforce to deliver safer patient outcomes;
- improving the use of data and performance information to promote care;
- promoting consumer and community involvements in improvements in health care;
- leading practice improvements in areas of harm;
- influencing safer design of equipment, processes, environment and improved information technology for health;
- building awareness and understanding of safety and quality issues;
- increasing effective safety and quality governance and investment; and
- developing strategic partnerships and future directions.

A number of stand-alone documents accompany the sixth report:

- *Partnerships for health in action: promoting consumer and community involvement in health care improvement*
Showcases the powerful role that consumer engagement can play in the health sector by highlighting achievements in consumer focussed approaches to improving safety and quality.
- *State and Territory Highlights: Improving Patient safety*
This publication reports on achievements and activity being undertaken by states and territories to improve quality outcomes and patient safety in health care.
- *National Patient Safety Education Framework and Bibliography*
The Framework identifies the skills, knowledge, behaviours and attitudes required by all health care workers in relation to patient safety.

- *Preventing Falls and Harm from Falls in Older People*

This suite of resources includes *Preventing falls and harm from falls in older people, best practice guidelines for Australian hospitals and residential aged care facilities* as well as a quick reference guide, short film on DVD, hospital brochure, residential aged care brochure, fact sheets, poster and indigenous resources.

- *Governance of Health Safety and Quality*

This discussion paper (by Professor John Braithwaite, Dr Judith Healy and Dr Kathryn Dwan) is intended to stimulate debate on how to improve the governance of health care safety and quality in Australia. It illustrates their ideas by drawing on other regulatory initiatives and considers emerging approaches to health sector regulation.

Introduction

This sixth report is the last formal report to Health Ministers as the Australian Council for Safety and Quality in Health Care's (Council) agreed extended term will finish in June 2006 prior to that year's mid-year Health Ministers' meeting. It is set against a background of the Ministerial *Review of future governance arrangements for safety and quality in health care*. Ministers clearly see safety and quality as important and have had the foresight to plan to take this agenda forward before the Council's term ends. The Council has taken a strong interest in informing this Review, and listening to stakeholders who have made their views known through this Review, to inform Council's directions for its remaining term and the broader landscape of safety and quality in the future.

In this context, this report builds on all five previous reports to Australian Health Ministers, provides a summary of achievements since Council's inception in 2000 and identifies the foundation for future directions in safety and quality in Australia that has been built with the active support of many stakeholders.

The central achievement of the Council over this time has been to set a national agenda and achieve widespread understanding and acceptance of that agenda among policy makers, administrators, clinicians and consumers. It has established credibility as a national leader, with jurisdictions and other health sectors adapting the agenda to suit local conditions and now implementing that agenda. Effective working partnerships have been established and a range of tools and resources developed to support safety and quality improvement. Together, these have built a foundation for widespread systemic change.

There remains, however, much to be done, to build on and benefit from the body of work that has started – to strengthen and extend partnerships, identify ownership of the safety and quality agenda, ensure funding into the future, and achieve national implementation by those with the responsibility, authority and resources to achieve this.

A more strategic approach is now needed to ensure that the national consensus achieved in developing best practice approaches to safety and quality is translated into widespread change on the ground. Safety and quality in health care remains a major and urgent challenge – but one that is unequivocally worth addressing. Council's work to date indicates that it could be addressed effectively with strong commitment, adequate resources and an integrated governance structure and the appropriate agreed accountabilities by all involved.

Council has worked with a range of individuals and groups to involve and support them in understanding the importance of safety and quality improvements in care, the benefits, how to achieve them and what the rewards are for patients, organisations, clinicians and the community.

The Council is honoured by the trust placed in it by Health Ministers. It is grateful for being encouraged, supported and guided through the first phase of a concerted national activity to improve patient safety and quality. It has every confidence that the platform that its work has built will be taken forward and will continue to be built upon by further national activity to improve health outcomes for all Australians.

Recommendations to Health Ministers

These recommendations have been framed to build on the work of the Council and the State Quality Officials Forum and to progress the work already agreed to by Health Ministers as part of the safety and quality reform agenda.

This is Council's last formal report to Australian Health Ministers. The Council has reviewed its progress and this report sets out what will be achieved by the end of Council's term (30 June 2006).

Ministers are asked to agree:

- that the Council's annual report and accompanying stand-alone reports are released publicly;

Ministers are asked to note:

- Council's achievements to date and expected achievements till the end of its term – 30 June 2006.

Council believes that it has set an agenda for change and that continued work on improving safety and quality of care for all Australians continues to be urgent and important work that must be carried forward beyond the planned and agreed term of Council.

Ministers are therefore asked to agree to:

- reaffirm their commitment to improving the safety and quality of health care.

Statement from Chair




Chair of Council,
Professor Bruce Barraclough AO

As the Australian Council for Safety and Quality in Health Care completes its term of activity prior to the next meeting of Health Ministers in mid 2006, I as Chair, the Members of Council and Australian Government Officers who are the staff of the Office of the Safety and Quality Council, wish to take this opportunity of thanking Ministers for their encouragement, trust and support. Ministers have, on an annual basis, since 2000, approved the Council's activities and work plan, endorsed its recommendations and publicly praised and published its reports. We are very grateful for this active support.

Council is proud of the work it has led and that key stakeholders are now keenly aware of the importance of safety and quality issues and that future priorities can now be further developed and implemented by those with the responsibility and authority to do so across the system. They will be building on the solid platform of achievement and on the enthusiasm engendered in the system by the work of Council.

There are some key achievements of the past five years that I wish to highlight, not only to recognise the achievements of Council and the very many health care staff and managers who have worked with us, but also to recognise the great commitment of all involved. The issues that I wish to highlight are the issues that are now being accepted as a normal part of health care delivery, but that also embed a quality improvement and a patient safety focus across our diverse and complex health system. I refer to the fact that there is now a national system for collection, analysis, reporting and correcting the causes of severe adverse events. These events could erode public confidence if not dealt with effectively. All States and Territories are also actively rolling out consistent incident monitoring and management systems. These two health system wide programs will dramatically increase our understanding of the vulnerabilities that exist in our system and will lead to continuous and satisfactory improvements.

Work has commenced on developing a national data set for patient safety and it is planned to publish a report on the current level of safety of the system prior to Council's completion in mid 2006, using currently collected data sets many of which were not available at the time when the health care system was previously measured between 1992 and 1995. It is expected that the functional end product of all this work will not only be greater understanding of and improvements in care, but also ability to measure and provide spot checks of the system in an ongoing way.



Tools have been provided to allow the health care workforce to be better supported while providing high level care. A National Strategic Plan to reduce healthcare associated infection has been developed and accepted by key stakeholders. A number of different programs have supported improvement in medication safety, with the National Medication Safety Breakthrough Collaborative involving teams from 100 hospitals. This was one of the largest and most successful of such collaborative activities across the world with this result being achieved using the expertise of the Department of Human Services in Victoria.

A Toolkit has been developed to allow sustainability and spread of the lessons learnt and Ministers have agreed, on behalf of all States and Territories, to a single National Medication Chart which has just been trialled. A Toolkit and organisational support package will be disseminated to reduce the incidence of falls, not only in acute health care but also in the aged care environment.

National Standards have been produced, and endorsed by Ministers, in relation to Open Disclosure and to Credentialling and defining the scope of practice, for senior clinicians. This work is gradually being implemented across the system at a pace that is achievable by those who have responsibility for managing our health systems. Both these National Standards will have a significant influence in driving cultural change about openness, about in-depth analysis of adverse events when they occur and with a commitment to fix the problems identified. They also support the move towards a culture of accountability, with performance being reviewed and managed appropriately in an open and just culture.

Engagement with key consumer bodies has been achieved with great help and support being given by the consumer groups for the development of the open disclosure standard, the production and distribution of the "10 tips" booklet and the development of guidelines for best practice in handling complaints.

As with every other high risk, but reliable industry, the understanding of risk and the development of plans to deal with risk is something that is now being understood across the health system. Ministers have agreed that there should be patient safety risk management plans in all public hospitals, and Council has produced a support package to encourage this.

Many other projects and programs, both local and health system wide in all sectors, have been undertaken in order to drive change. Under the guidance of Council, the State Quality Officials' Forum has become an effective body to co-ordinate quality activities being undertaken by all States and Territories.

The private health system has taken a keen interest in the agenda over a period of time, with a number of private hospitals picking up the same issues as the public system and now there is a keen interest being expressed by the major health insurance funds in supporting safety and quality activities. The Royal Australasian College of General Practitioners is currently working with Council to customise at least 5 major areas of Council's work for office and community practice and this engagement with the private sector is very much welcomed.

Two projects that will have continuing and long term benefit to the community need to be recognised and one of those is the development of a National Centre for Research Excellence in Patient Safety which has been developed, with the help of the National Health and Medical Research Council, with a consortium lead by Monash University being awarded this project. Better answers to our problems will be the end product of this initiative. The development of a National Patient Safety Education Framework is a major achievement produced with the assistance of the University of Sydney and the Centre for Innovation in Professional Health Education. We believe this is the first example of such a Framework across the world. It will be presented to Ministers with this Report and is expected to be enthusiastically taken up by the vocational education and training sector, University, Medical and Nursing schools, Specialist Colleges and employing authorities.

There is already significant interest across these sectors and there is also great interest from international organisations which are picking up this Framework as a guide for their work to improve safety and quality. The Framework defines the competencies necessary for people working at different levels in the system in order to meet the issues identified in the safety and quality agenda. This will be one of the most valuable legacies from Council's work and University of Sydney and the Centre for Innovation and Professional Health Education have our grateful thanks for the enthusiasm and commitment they have shown in producing this product. These are just a small example of the total amount of Council initiated work undertaken and supported by many in the health system.

Council has provided a focus for national efforts in safety and quality, raising awareness, building consensus, and clarifying priority action. At a Government level it is essential that following Council's term, new governance arrangements for safety and quality need to link directly with those who have the authority and resources to implement and administer initiatives. The complexity and variability of governance arrangements is a strong justification for a continuing national body which has the task of developing strategies that will achieve uniform high quality, accountable performance across the vast range of providers and settings in which health care is delivered. The 'levers for change' available to Council were leadership, persuasion, advice and example, with the ability to develop strategies, frameworks, standards, tools and guidelines. Any future governance arrangement for safety and quality will need to be able to access additional levers for change to make more rapid and lasting improvements.

In my view every clinician goes to work to do good, otherwise they wouldn't be there, they would be doing something less stressful, less dangerous and for more money. Our clinicians are top people, doing a top job in one of the better of the world's advanced health systems. To move from good to even better is not easy. A great start has been made. Further efforts will be needed to build in even more systems changes in order to help up to half-a-million health care workers provide care through approximately 6.4 million hospital visits, about 115 million doctor visits and about 220 million Medicare items of service each year. The complexity is enormous.

The necessary first step with any national effort in Australia is to draw the efforts of nine sovereign governments together and at the same time influence the private system in all sectors. Not an easy or simple task!

Sir Ernest Shackleton of Antarctic fame, a renowned leader, said

"Optimism is true moral courage".

Making change in complex systems requires a continued sense of hope and optimism as transformational change cannot be achieved overnight but takes significant commitment and time.

There are many in health care who lack hope and who will vent their frustration at not being supported effectively to do more to help their patients. We as a nation need to strive to rebuild their hope and optimism by providing appropriate resources and support to take this agenda forward.



Professor Bruce Barraclough AO

Chair

Australian Council for Safety and Quality in Health Care

July 2005

What has the Council achieved?

As this is Council's last formal report to Ministers the following provides some highlights of achievements since its inception in 2000, many of these provide building blocks for the future. Last year, the Council reviewed its work in its report to Health Ministers: *Maximising National Effectiveness to Reduce Harm and Improve Care, July 2004*, and the *Review of Future Governance Arrangements for Safety and Quality in Health Care*, has also reviewed the work of Council, so this report does not analyse these achievements further.

A key achievement of the Council has been gaining awareness and acceptance of the need for a national safety and quality agenda. Council has shaped the national agenda to address identified priorities and there is now a clear acknowledgement, among Health Ministers, health professionals, health managers and consumers, that safety is an important issue that needs to be addressed. More importantly, there is readiness to change and even some frustration among health professionals with the slow processes of Government and private bureaucracies.

Council has achieved national consensus on best practice approaches to priority areas (for example, infection, medication, open disclosure, credentialling and the like). The Council has identified and fostered a potentially powerful mechanism, through the Australian Health Ministers' Conference (AHMC), the State Quality Officials Forum (SQOF) and the jurisdictions, for stimulating national change in the public sector. It has, however, been very difficult to identify manageable mechanisms for change in the private hospital sector and the community sector, although after much persuasion there is now action in these areas through activities of health funds at one level and the Royal Australasian College of General Practitioners at another.

Acceptance of Council's agenda is evident in the support by all Health Ministers and intentional effort by jurisdictions for a range of Council initiatives that will substantially improve patient safety.

For example, in April 2004, Ministers agreed to eight Council recommendations to accelerate improvements in safety and quality in public hospitals and all jurisdictions have made significant progress in putting these into action. Table 1A-F on pages 11-16 sets out achievements to date across Australia in actioning Ministers' decisions.

Table 1A. Achievements across Australia in actioning Ministers April 2004 Decisions - 'Incident management'

Progress Against Ministers' Decisions from AHMC April 2004 – As at June 2005

Ministers decision at AHMC April 2004	Jurisdictional action
<p><i>All public hospitals will have an 'incident management' system in place by January 2005, incorporating incident management, monitoring, investigation, analysis and action arising</i></p>	<ul style="list-style-type: none"> • ACT Health has introduced a clinical governance framework and clinical risk management system to oversee its incident management system. ACT Health uses Advanced Incident Management System (AIMS) as its incident monitoring system. • In New South Wales a state-wide electronic 'Incident Information Management System' (IIMS) has been implemented. Full deployment to 108,000 users in the health workforce has been completed. • Northern Territory hospitals have utilised the AIMS system since 1998. In January 2005, the system was upgraded to AIMS Version 3.1. Access is available across the NT hospital network. An education and roll-out process is in progress. • Queensland has an Audit of Surgical Mortality under development. Human Error and Patient Safety (HEAPS) education and training for clinical and non-clinical staff and deployment of a Clinical Incident Information System (PRIME) progressing across the State. There is further development and revision of the Queensland Health Incident Management Policy and a coronial data management project is progressing with the piloting of a medical summary to facilitate communication between coroners and facilities. • In South Australia the AIMS is now functional electronically in all public hospitals for state-wide central reporting. Call centre capacity has been increased to facilitate clinician reporting from more health services. A new anaesthetic specialty reporting section has been added to the reporting system. A Risk Register is now available to all public health services to assist in the management of risk. • In Tasmania there have been some delays in progressing this initiative but a project officer and steering committee are now in place with a view to proceeding as rapidly as possible with the implementation of a system following a tendering process. It is expected that implementation will commence in the second half of this year (2005). • In Victoria all public hospitals have an electronic incident management reporting system in place. Requirements are in place to review all sentinel events and manage and monitor other events. • In Western Australia the Australian Incident Management System has been in place in all Western Australian public hospitals and health services since 2001 and there is a state-wide Incident Reporting and Management policy to facilitate improved management of near misses and adverse events. Data is analysed and results fed back to organisations on a quarterly basis. Further information about the WA Incident Reporting and Management system are available from the WA Australian Incident Management System Users Website at: http://www.health.wa.gov.au/safetyandquality/programs/aims/about/index.cfm

Table 1B. Achievements across Australia in actioning Ministers' April 2004 Decisions - '5 step right patient, right site, right procedure' protocol

Progress Against Ministers' Decisions from AHMC April 2004 – As at June 2005

Ministers decision at AHMC April 2004	Jurisdictional action
<p><i>All public hospitals adopt the '5 step right patient, right site, right procedure' protocol' for verifying the site of surgery and other procedures to reduce the risk of wrong site procedures by the end of September 2004</i></p>	<ul style="list-style-type: none"> • ACT Health has introduced a policy to support implementation of the procedure. An evaluation plan and audit tools are being developed. • A Northern Territory specific policy was developed for the Hospital Network and shared with other service divisions and the private sector. There has been wide consultation and advice to both medical and nursing staff across the Hospital Network to support implementation. NT Medical staff are being formally notified by mail. A benchmark, pre-implementation of the policy has been established to facilitate performance measurement. Policy became effective as of 1 March 2005. • Zonal forums have been held across Queensland to develop implementation plans for specific hospitals. Implementation kits have been produced. They include a video of the steps or protocol in policy, posters, brochures, and an audit tool to check on compliance. A detailed plan has been developed to ensure all peri-operative staff are aware of and trained in the protocol. The <i>Ensuring Intended Surgery</i> policy has been approved by the Queensland Health Safety & Quality Board. • In New South Wales the protocol has been launched along with tools and strategies to support implementation, and NSW Health has developed posters and a video, and circulated them widely to key stakeholders such as the medical colleges and specialist nursing groups. • In Victoria the protocol was circulated to all hospitals undertaking surgery in August 2004 for implementation. An audit undertaken in December 2004/January 2005 revealed the majority had implemented the procedure with all hospitals being on track to have completed the process by June 2005. • In South Australia The Correct Patient, Correct Site, Correct Procedure Protocol was launched on 1 October 2004 by the Hon Lea Stevens, Minister for Health and Minister Assisting the Premier in Social Inclusion. The protocol is in various stages of implementation in SA hospitals both public and private. A working group with representation of health service staff responsible for protocol implementation, surgeons and anaesthetists is supporting the implementation of the Correct Patient, Correct Site, Correct Procedure Protocol. • This protocol has been implemented in a number of areas across the public hospitals in Tasmania. For example the Royal Hobart Hospital's blood transfusion policy has used this protocol as the basis of its policy as follows: Right Reason; Right Blood; Right Patient; and Right Time Right Documentation. • The Western Australian Council for Safety and Quality in Health Care and Office of Safety and Quality in Health Care have jointly developed a 'correct patient, correct site and correct procedure' policy and guidelines to reduce the risk of wrong site surgical, medical, radiology and oncology procedures in WA health services. This policy and guideline is consistent with the national '5 step right patient, right site, right procedure' protocol and the Royal Australasian College of Surgeons' 'correct patient, correct site, correct procedure' guidelines. Copies of the policy and guideline and resource materials developed by the Australian Council for Safety and Quality in Health Care have been issued to Area Health Services for distribution to relevant clinical units.

Table 1C. Achievements across Australia in actioning Ministers April 2004 Decisions - '10 tips for safer health care: what everyone needs to know', consumer booklet

Progress Against Ministers' Decisions from AHMC April 2004 – As at June 2005	
Ministers decision at AHMC April 2004	Jurisdictional action
<p>All public hospitals will provide each hospital patient with a copy of the consumer booklet "10 tips for safer health care: what everyone needs to know" at or before the time of admission</p>	<ul style="list-style-type: none"> The <i>10 tips for safer health care</i> has been widely promoted throughout ACT Health. Information has been included in the Healthy Territory Newsletter and the ACT Health Quality and Safety website. Information is being distributed to General Practitioners and Visiting Medical Officers and promoted at clinical staff orientation sessions. When the <i>10 tips</i> was first released in 2003 it was distributed to all health services. NSW is now developing a sustainable strategy including other modes of communication as well as written text. Northern Territory Hospitals have located a laminated copy of a <i>10 tips</i> Poster in each patient locker and issue booklets opportunistically. A significant percentage of the Northern Territory's patient population is Aboriginal and these people often come from rural and remote areas. Literacy rates vary greatly. To accommodate this, the Acute Care Division is currently considering available options for developing the booklet as a culturally appropriate resource. In Queensland, <i>10 tips</i> materials to meet the demands of a year's admissions, have been delivered to all Health Service Districts. Booklets, pamphlets and summary sheets are available in Arabic, Cantonese, Croatian, Filipino, German, Greek, Hindi, Italian, Macedonian, Mandarin, Polish, Serbian, Spanish, Turkish, Vietnamese, Bosnian, Dutch, Hmong, Laotian, Samoan, Torres Strait Creole and are available on the website: www.health.qld.gov.au/quality/10_tips. In addition, a version of these resources has been customised for Aboriginal peoples. In South Australia the <i>10 tips for safer health care</i> information has been distributed to all health services to provide to all public patients. The <i>10 tips</i> are incorporated into patient information in health services through a variety of mediums including patient meal tray placemats, posters, and admission information brochures. In Tasmania each of the public hospitals has been distributing this document and it has been well received. Links to the information will be available to the public via the Departments internet site. Information will also be available through departmental publications eg Community Chat (a newsletter for Housing Tasmania for its public housing clients). In Victoria a print ready CD in 15 community languages was distributed to all public hospitals, community health centres, GP Divisions and non-government organisations in September 2004. Examples of innovative ways of distribution of this information have been reported in some Quality of Care Reports. The Western Australian Department of Health has distributed over 13,000 copies of the <i>10 tips for safer health care: what everyone needs to know</i> booklet to Area Health Services.

Table 1D. Achievements across Australia in actioning Ministers April 2004 Decisions - 'patient safety risk management plan'

Progress Against Ministers' Decisions from AHMC April 2004 – As at June 2005

Ministers decision at AHMC April 2004	Jurisdictional action
<p>All public hospitals will have in place a patient safety risk management plan by the end of 2005</p>	<ul style="list-style-type: none"> • ACT Health has established a comprehensive clinical risk management framework that includes patient safety which is being implemented by all public hospitals. • The NSW Government has established the NSW Patient Safety and Clinical Quality Program. The five key components of the program are: <ol style="list-style-type: none"> 1. The systematic management of incidents and risks both locally and statewide to identify remedial action and systemic reforms. 2. The Incident Information Management System (IIMS) to facilitate the timely notification of incidents, track the investigation and analysis of health care incidents, enable the reporting about incidents, particularly the provision of trended information by incident type, and to understand the lessons learned. 3. The establishment of Clinical Governance Units (CGU) in each Area Health Service (AHS) to implement the NSW Patient Safety and Clinical Quality Program including where relevant, initiatives such as the Clinical Risk Management Program for Rural GPs. 4. The development of a Quality Systems Assessment (OSA) Program for all public health organisations undertaken by an external agency, to determine whether the above components are in place and working well. The focus of the assessments is on AHS patient safety and clinical quality systems. 5. A Clinical Excellence Commission (CEC) to promote and support better clinical quality and to advise the Minister for Health on where systemic improvements can be made. • In the Northern Territory this is an agenda item of the Acute Care Quality Committee. An implementation process is currently under consideration. • The Patient Safety Risk Management Plan / Checklist developed by the Council is being considered by the Integrated Risk Management Team in conjunction with the Patient Safety Centre as a potential component of the assessment of a safety culture across Queensland Health. • The Patient Safety Framework is the plan for South Australian Public Health Services to operationalise within its services as required in state health service agreements. A specific plan for incorporating risk registers and monitoring of risk is under development. • The focus within Tasmania to date has been to develop clinical risk management frameworks and the next stage will be to address the development of patient safety risk management plans. • Victorian hospitals were required to undertake a clinical risk management (CRM) plan and report against it to the Department of Human Services (DHS) in 2001/02 and 2002/03. During 2004/05 plans formed part of a strategic approach and did not require DHS sign off. During 2005/06 a framework to provide a minimum standard for a patient safety risk management plan will be developed to ensure organisations build on their CRM strategies in a consistent way. • The Department of Health Care in Western Australia has developed <i>Clinical Risk Management Guidelines for Western Australian Health Services</i> to assist Health Service Executives, Clinicians, Risk Management and Quality Co-ordinators to meet their Clinical Risk Management responsibilities through the identification and management of clinical risk areas in a consistent and systematic way in accordance with State and local priorities. The Guidelines are consistent with the Department of Health's <i>Health Risk Management Framework and Health Risk Management General Procedures Manual</i>, which provides a structured approach for incorporating clinical risk management into the broader risk management process of Health Services.

Table 1E. Achievements across Australia in actioning Ministers April 2004 Decisions - 'sentinel events reporting'


Progress Against Ministers' Decisions from AHMC April 2004 – As at June 2005

Ministers decision at AHMC April 2004	Jurisdictional action
<p><i>All public hospitals to report all sentinel events either to the State department or to an agreed third party; and all States and Territories will contribute to a national report on sentinel events</i></p>	<ul style="list-style-type: none"> • All jurisdictions are contributing to a national sentinel events report. • ACT Health has introduced a policy on Mandatory Reporting of Sentinel Events. Sentinel Events are reported to the Chief Executive and Deputy Chief Executive within 5 working days of the event occurring. Preparation for contribution to the national report is underway. • New South Wales released its first <i>Patient Safety and Clinical Quality Program Report</i> in January 2005. The report provides an overview of the implementation of the Safety Improvement Program and the serious incidents (Severity Assessment Code 1) reported to NSW Health. The report also provides an overview of the risk mitigation strategies implemented following analysis of the reported incidents. • The Northern Territory Department of Health and Community Services has developed a sentinel events policy and is awaiting final endorsement from the Executive. Although in the preliminary stage, data reports regarding the number of Sentinel Events occurring across the department have been commenced. This will enable the NT to contribute to the national report before the end of 2005. • In Queensland, the development of root cause analysis training packages, based on the US Veterans Health Administration model, support the analysis of sentinel events across the state and facilitate a focus on system lessons. • In South Australia a system for reporting sentinel and serious adverse events is operational. Root Cause Analysis (RCA) of serious adverse events are reported centrally and analysed. RCA training continues with six, two-day courses offered this year (2005). • In Tasmania the 3 main public hospitals have in place through the Clinical Risk Management Framework a process for the investigation and reporting of sentinel events. Using a Reportable Incident Brief as the basis, Hospital CEOs ensure that practices are reviewed and recommended changes implemented. At the same time sentinel events are discussed by the Hospitals and Ambulance Executive Committee and these will be reported nationally. • Victoria has been collecting sentinel events since 1 July 2001 and produced two public reports for 2002/03 and 2003/04. Sentinel events are reported to the Department of Human Services within 15 working days and a root cause analysis and risk reduction plan is required within 60 days. Victoria will contribute 2004/05 data to the national report. • Western Australia implemented a statewide Sentinel Event Reporting Policy in October 2003. This policy requires both public and licensed private hospitals to report sentinel events to the Chief Medical Officer within 7 working days. WA has adopted the 8 nationally agreed categories of sentinel events plus an 'other' category which continues to be refined as additional data becomes available. A clinical incident investigation must be undertaken following a sentinel event to identify the root causes and contributing factors. The investigation findings, including recommendations, must be forwarded to the Sentinel Events Officer within 45 working days of initial notification. Hospitals and health services are notified of relevant findings and recommendations arising from Sentinel event investigations, by way of 'The Sentinel', a quarterly publication which describes de-identified incidents and the recommendations which have been implemented in order to reduce the occurrence of similar errors in the future. Chief Executives are also advised of all sentinel events via a confidential quarterly report. Further information about Sentinel Event Reporting and Investigation is available from: http://www.health.wa.gov.au/safetyandquality/sentinel/index.cfm

Table 1F. Achievements across Australia in actioning Ministers' April 2004 Decisions - 'common medication chart' and 'pharmaceutical review'

Progress Against Ministers' Decisions from AHMC April 2004 – As at June 2005

Ministers decision at AHMC April 2004	Jurisdictional action
<p><i>All public hospitals in Australia will be using a common medication chart by June 2006</i></p>	<ul style="list-style-type: none"> All jurisdictions have participated in the national inpatient medication chart pilot involving 31 public and private facilities from metropolitan, regional and rural/remote areas. An evaluation of the pilot is underway and precedes a national rollout of this initiative.
<p><i>All public hospitals will have in place a process of pharmaceutical review of medication prescribing, dispensing, administration and documenting processes for the use of medicines by the end of 2006</i></p>	<ul style="list-style-type: none"> An expert group is progressing this initiative on behalf of all jurisdictions by considering what building blocks are necessary for national implementation.



Some other key areas where Health Ministers have agreed to Council initiatives which are being developed across the health system to improve safety and quality of care include:

- a national trial of open disclosure of adverse events including 40 hospitals across 5 jurisdictions and the private sector;
- guidelines for administering qualified privilege schemes;
- a national strategy to reduce Health Care Associated Infection;
- a national credentialling standard for medical practitioners in public and private hospitals, to ensure that clinicians have the knowledge, skills and local resources to deliver safe care; and
- scoping the development of a data set for safety and quality of care.

Council has also developed a range of products and tools to assist jurisdictions, clinicians, consumers and health care managers to implement change. A report against Council's strategic plan is in Part B of this report. It provides detail of progress and future directions for each priority area.

A snapshot of Council achievements since 2000, is listed in Table 2 on the following page.

Table 2. A snapshot of Council's Achievements 2000 - 2005

Supporting the workforce

- Produced the *National Report on Qualified Privilege*, consulted with jurisdictions and developed guidelines for improved administration of qualified privilege schemes, to help achieve a balance between clinician participation in quality assurance activities and public access to health information.
- Developed the *National Patient Safety Education Framework* which sets out the required skills, knowledge and behaviour in respect to patient safety. It recognises education as a foundation element for redesigning systems and facilitating a sustainable culture of safety and quality in health care. Already there is great interest from universities, the vocational education and training sector as well as from international organisations.
- Developed an agreed approach to credentialling through the *National Standard for Credentialling and defining the scope of clinical practice of medical practitioners, for use in public and private hospitals*, which was supported by Health Ministers in July 2004. Support materials to assist in implementation have been developed and distributed.

Measurement for Improvement

Council has gained national agreement on a need for standardised measurement of safety and quality and transparent reporting. For example through:

- A *national core set of sentinel events* has been agreed with jurisdictions and a national report is being developed to measure and learn from events that cause death or serious harm to patients;
- *Charting the Safety and Quality of Health Care in Australia*, based on that developed by the US Commonwealth Fund, assembled data to provide health care providers, policy makers and consumers with a comprehensive overview of what is known about the safety and quality of the Australian health care system;
- Development of the *measurement for improvement toolkit* which aims to produce a practical toolkit of ways to measure the safety and quality of clinical services;
- Supporting the continuation of the National Breast Cancer Surgical Audit which is a standardised collection instrument to measure surgical practice and treatment of people with breast cancer; and
- Conducted national workshops to instruct Australian trainers from all jurisdictions on root cause analysis methodology, which identifies factors contributing to adverse incidents.

Working with consumers

- Produced, launched and distributed more than 100,000 copies of *10 tips for safer health care* to help consumers understand health care safety and become more actively involved in their health care. It has been translated into 15 languages, and agreed by Health Ministers that all public patients will receive a copy of the booklet at or before the time of admission. It has also been adopted by some private insurers.
- The *Open Disclosure Standard: A National Standard for open communication in public and private hospitals* was endorsed by Health Ministers as a national standard in July 2003. It aims to encourage greater openness about adverse events through acknowledging when things go wrong and providing reassurance to patients and their carers that lessons will be learned. A national trial is underway and many individuals and organisations are using the Standard prior to trial completion.
- The *Consumer Adverse Medicine Events (AME) Line*, a national system for consumers to report adverse events, was launched nationally in October 2003 as an initial 18-month trial. This is an important way of identifying common adverse drug events enabling learning and preventative action.

Table 2. A snapshot of Council's Achievements 2000 - 2005

<p>Practice Improvements</p>	<ul style="list-style-type: none"> • <i>Medication Safety Innovations Awards Program</i> provided funding of more than \$1.3 million to 16 local level projects testing innovative interventions to reduce harm from medication use and look at ways for sustainable improvement to be applied more widely. • Conducted a national workshop and gained endorsement by Health Ministers of a <i>National Strategy to Reduce Health Care Associated Infection (HCAI)</i>, one of the leading causes of adverse events. There is national agreement to key HCAI definitions, surveillance templates and production of clinical guides for health professionals to reduce health care associated infection. • In the <i>Medication Safety Breakthrough Collaborative</i>, 100 clinical teams from across Australia participated in two waves of collaborative action to reduce harm from medication use by 50% in participating facilities. A showcase workshop held in June 2005 provided the impetus and tools for wider improvements across the system. This is one of the largest and most successful of such projects worldwide. • Provided funding of around \$3 million for over 175 local projects to improve patient safety across Australia in three rounds of the <i>Safety Innovations in Practice (SIIP)</i> program to foster innovation in safety and quality improvement at the local level. • Produced the <i>Ensuring Correct Patient, Correct Site, Correct Procedure Protocol</i> to help prevent procedures being carried out on the wrong patient or body part, an event that can cause serious harm and distress to patients. This is an evidence based tool that is being widely used and supported by the Royal Australasian College of Surgeons. • The first <i>High-Risk Medication Alert</i> on Intravenous Potassium Chloride was released in October 2003 with another alert on Vincristine due to be released by October 2005, so that action is taken on known hazards with potentially catastrophic patient outcomes.
<p>Redesign and IT</p>	<ul style="list-style-type: none"> • Trialled and evaluated A <i>National Common Inpatient Medication Chart</i> in 31 sites across Australia, to reduce medication error, one of the most common causes of unintended harm to patients. Tools to assist with national rollout have been developed and made widely available.
<p>Building Awareness</p>	<ul style="list-style-type: none"> • Helped spread the safety and quality message by sponsoring the <i>Australasian Conference on Safety and Quality in Health Care</i> in Perth in 2003, Canberra in 2004, and Adelaide 2005 including support for international patient safety experts to speak at the Conferences and 29 scholarships for health workers and consumers to attend. • Organised the world class <i>1st Asia Pacific Forum on Quality Improvement in Health Care</i> and provided scholarships for the 2nd and 3rd Asia Pacific Forums in Singapore and New Zealand. • Council members delivered hundreds of <i>patient safety presentations</i> to thousands of people throughout Australia, contributing to wider safety and quality knowledge. • Advice from Council Chair sought by Canadian Health Ministers prior to setting up the Canadian Patient Safety Institute. High level safety and quality bodies in the USA and UK also sought advice. Council Members are working with the World Health Organization on the <i>World Alliance for Patient Safety</i> and Council has provided funding (together with the UK) to support a performance manager for the Alliance.
<p>Governance and Investment</p>	<ul style="list-style-type: none"> • Forged a partnership with the National Health and Medical Research Centre resulting in a <i>Centre for Research Excellence (CRE) in Patient Safety</i>, located at Monash University in Victoria. Council is investing \$2 million over 5 years into this Centre to build a body of knowledge on what works in health care in order to build capacity for this type of health services research. • Developed a <i>Patient Safety Management</i> checklist to enable people to identify areas for improvement in their organisation to encourage development of Patient Safety Risk Management plans.



The full annual report and all stand-alone documents are available by contacting:

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