AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

Safety and Quality in Health Care

An Australian Context

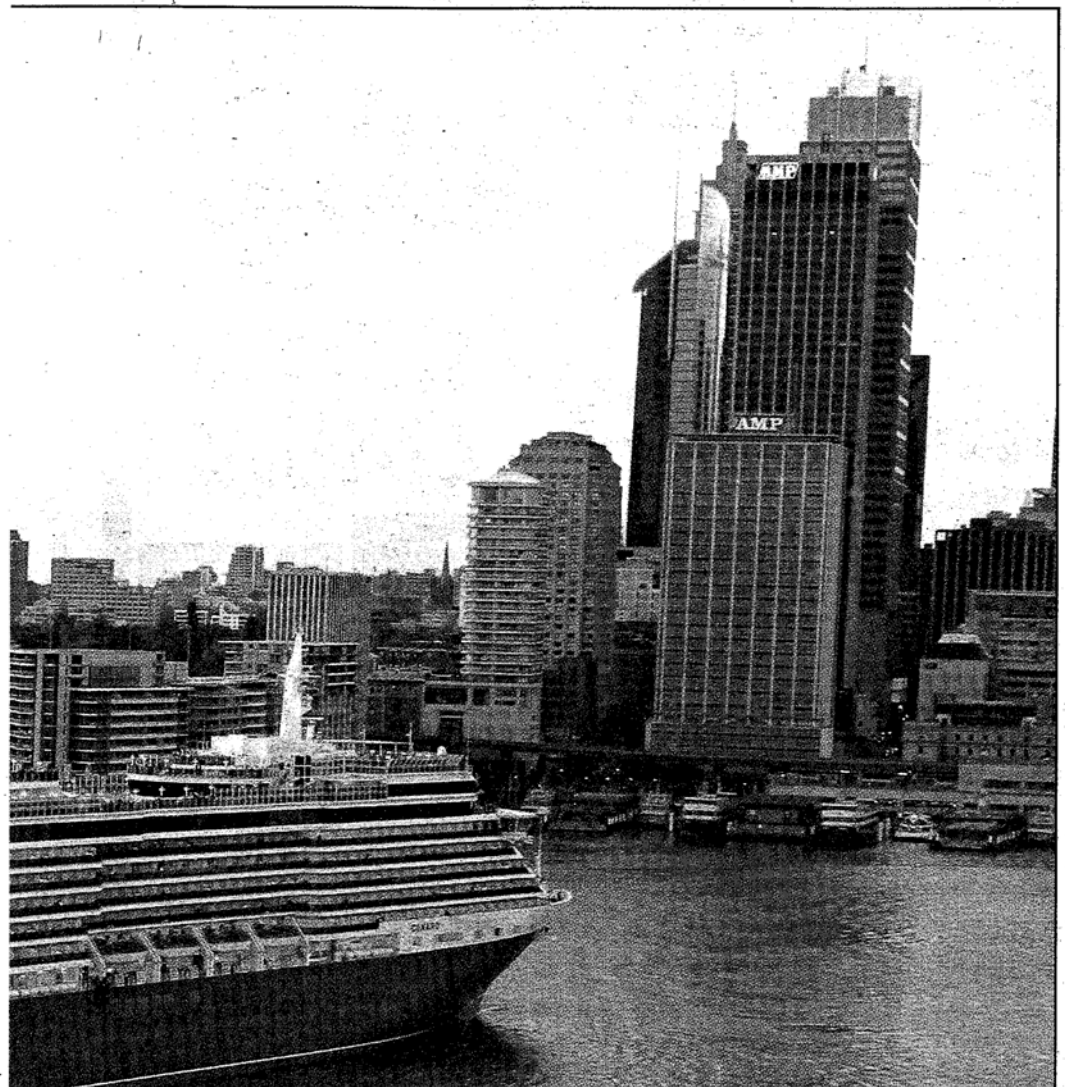
AHIA Conference

Chris Baggoley

8 October 2008

Could QANTAS help?

Sun Herald – 'simple jab'



Simple jab can cut blood-clot deaths

By LOUISE HALL
HEALTH REPORTER

TENS of thousands of patients in NSW hospitals are to be given a mandatory injection in a bid to prevent unnecessary deaths through blood clotting.

A new policy to assess patients at risk will be implemented throughout the state to combat the 10,000 deaths each year in hospitals from venous thromboembolism (VTE). This is despite the availability of simple, cost-effective preventative measures such as blood-thinning injections and compression stockings.

The condition, which refers to deep vein thrombosis (DVT) and pulmon-

deaths, lifelong complications from VTE, such as leg ulcers, cost the health system an estimated $200 million a year from re-admissions.

NSW Health director of surgery Professor Donald MacLellan said the new policy to make VTE risk assessment a compulsory part of every hospital visit would be implemented in all NSW hospitals throughout this year.

"Many hospitals have their own policy but, unless its mandated across the whole state and clinicians are supported, not every patient is going to get what they should have," he said.

Chairman of the Australian and New Zealand Working Party on the Prevention and Management of VTE Professor John Fletcher called for a

Health care organisations are *complex adaptive systems…*

They deal with people's lives – within a complex mix of staffing, funding, technology, expectations and demand

It is not easy to produce consistently safe and high quality care in this environment

Other high risk industries have many lessons for us, eg mining, aviation, oil rigs have taught us the value of a systems approach and a low tolerance for safety

But the area that comes closest to us in terms of complexity, risk and variables is?...

Health care and traffic systems, a useful analogy…

- Both are high risk, highly stressed, highly public, complex environments – and experience constant contextual change (strategically and operationally)

- The environment is subject to uncontrolled and unanticipated change at short notice – and this must be responded to quickly and appropriately by individuals and by the system, to remain safe

- A wide range of factors impact safety: both have numerous standards, rules and systems in place to reduce risk, and technology is playing a key role in improving safety – and simultaneously creating other unanticipated problems

- Both have 'policing' functions built in – to varying effect

- Ultimately, both rely heavily on the behaviour and decisions of independent, fallible human beings, acting alone, and interacting with each other, for safety

Health care and traffic systems, a useful analogy…

- Accidents that cause harm can result from individuals choosing to override the system or one fallible human being making a mistake; or an unexpected impact of the interaction between people, other factors and systems; or the systems failing and letting the people down

- In both cases, 'trying harder' and 'being more aware' have a role, but are of limited usefulness, in improving safety

- Both require extraordinary levels of expenditure to develop, maintain and improve, within a competitive funding environment – and are therefore highly political

- We expect to be safe in both environments, and appear to have a level of tolerance for risk, unsafe practice and the consequences, that does not help drive the safety agenda – until there is a catastrophe.

Organisational Factors

Organisational intervention to improvement in patient care : a structured review of reviews

“There is growing evidence base of rigorous evaluations of organisational strategies, but the evidence underlying some strategies is limited and for no strategies can the effects be predicted with high certainty.”

Wensing M, Wollersheim H & Grol R Implementation Science, 2006

www.implementationscience.com/content/1/1/2

Organisational Factors

Organisational interventions to improvement in patient care : a structured review of reviews

Revision of professional roles

Focus	Main results
Nurse practitioners in primary care (13 trials)	Improved: laboratory testing, resolution of pathology conditions, patient satisfaction No change: quality of care, prescribing functional status, consultation rates, use of emergency service
Nurse practitioners in primary care (13 trials)	Improved: patient satisfaction Increased: consultation length, investigations No change: health status
Mental health workers in primary care (38 trials)	Replacement role: did not consistently change psychotropic prescribing, consultation rates or mental health referrals
Enlargement of the role of the public pharmacist (16 trials)	Changed: use of health care services, improved patient outcomes No change: quality of life
Outreach nursing for COPD (4 trials)	Increased: hospital service use No change: mortality, lung function, health related quality of life

Organisational Factors

Organisational interventions to improvement in patient care : a structured review of reviews

Integrated care services

Focus	Main results
Stroke Units (19 trials)	Reduced: mortality, dependency, institutionalisation, length of hospital stay
In-hospital pathways for stroke (10 trials)	Fewer: UTIs, readmissions More: CT brain scans, carotid duplex Reduced: patient satisfaction, quality of life No change: mortality, dependency, discharge destination
Disease management for heart failure in patients discharged from hospital (11 trials)	Decreased: hospital use, costs No change: all-cause mortality

Organisational Factors

Organisational interventions to improvement in patient care : a structured review of reviews

Knowledge management

Focus	Main results
Computerized information services in different settings A. Provider prompt B. Provider feedback C. Computerized medical record D. Assisted treatment planning E. Computerized patient education (100 trials)	Improved: test ordering/prevention in A, B & C Improved: drug prescription in D Improved: patient knowledge in E
Nursing record systems (8 trials)	No change: patient care, patient outcomes Some: administrative benefits

Literature

On the Trail of Safety and Quality in Healthcare

Richard Grol, Donald Berwick, Michael Wensing BMJ 336 (2008) 74-76

Major problems persist to improve the quality and safety of healthcare

Factors include:

- Resistance to change among health professionals
- Organisational structures that block improvements
- Dysfunctional financial incentives

Research agenda topics suggested

Literature

On the Trail of Safety and Quality in Healthcare

Richard Grol, Donald Berwick, Michael Wensing BMJ 336 (2008) 74-76

Research agenda topics suggested include:

- **How to achieve sustained change in normal care**
- **How to guide clinicians towards scientifically correct and safe practice**
- **How to provide new evidence at the point of care**
- **How to create a culture of change and continuous improvement in the ward or practice**

ACSQHC

The Australian Commission on Safety and Quality in Health Care

- Established by Health Ministers in 2005, commenced in 2006
- Reports to all Health Ministers
- Commissioners diversity and strength
- Committee structure:
  - *IJC, PHSC, PCC, ISC*
- Stakeholders / Colleagues include:
  - *Consumers*
  - *Professional organisations*
  - *Health Service Executives*
  - *Safety and Quality organisations*

ACSQHC

Health Ministers Established ACSQHC to:

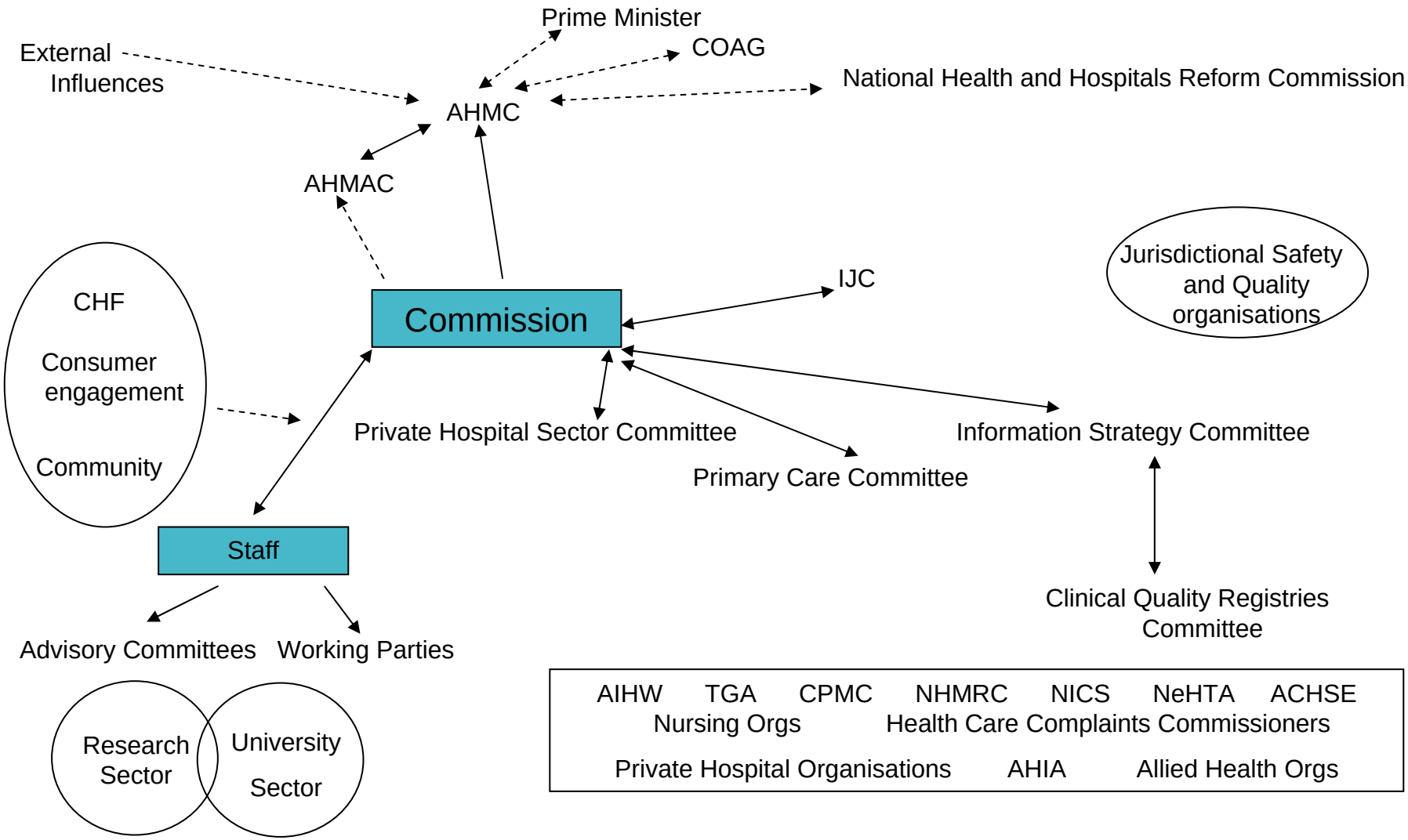
1. **Lead and coordinate safety and quality in health care**
2. **Disseminate knowledge and advocate for safety and quality**
3. **Report publicly**
4. **Recommend national data sets**
5. **Provide strategic advice to Health Ministers**
6. **Recommend nationally agreed standards**

ACSQHC

Our Programs

1. **Australian Charter of Healthcare Rights**
2. **Open Disclosure**
3. **Basic Care Issues**
    - **Healthcare Associated Infection**
    - **Patient Identification**
    - **Medication Safety**
    - **Clinical Handover**
    - **Patient at risk**
    - **Falls Guidelines**
4. **Tools**
    - **Accreditation and credentialing**
    - **Information Strategy**

Effecting Change



ACSQHC

PATIENT CHARTER

I have a right to safe and high quality care

This means:

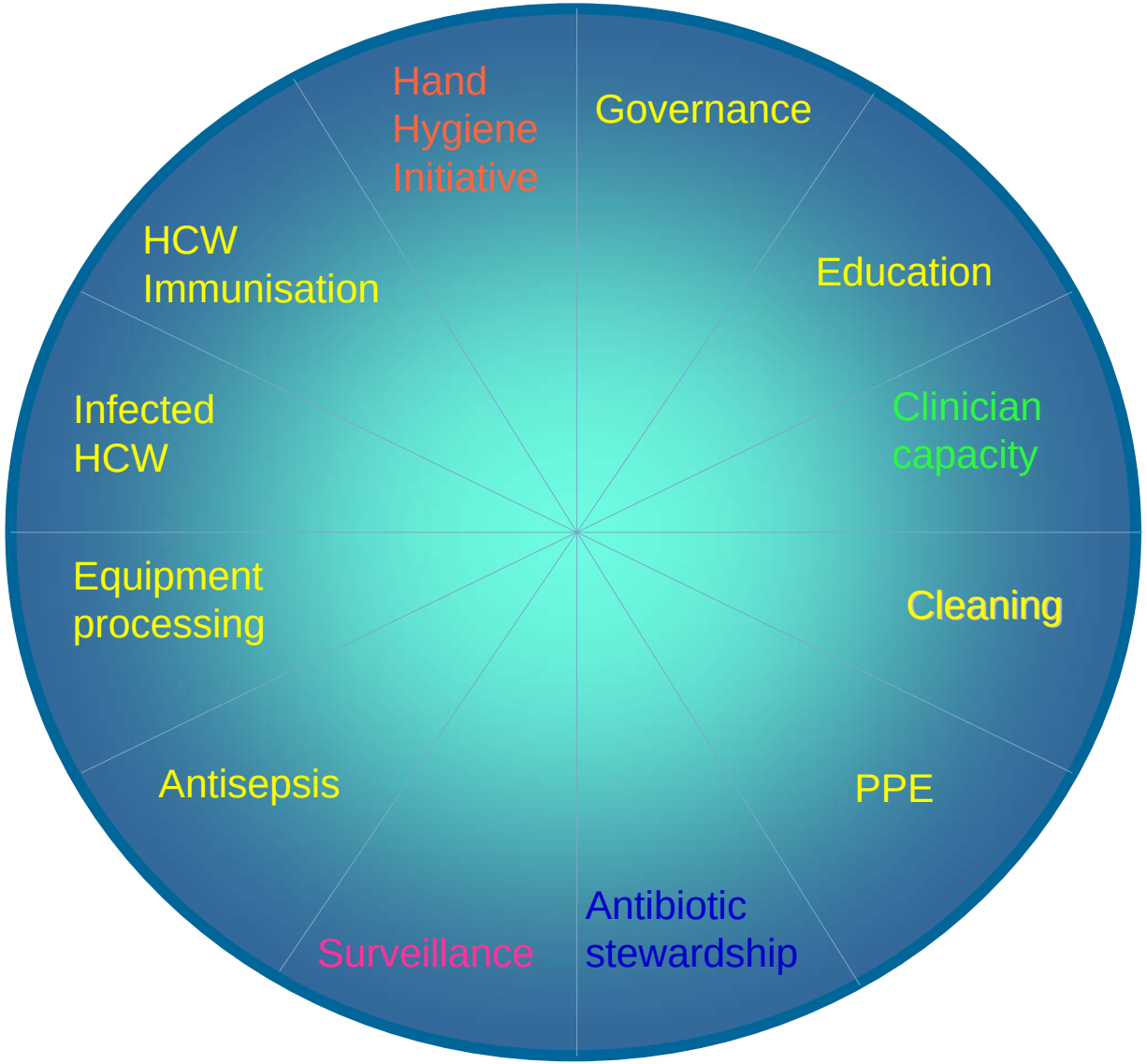
- To be free of being infected by my hospital or health worker
- To be free of medication mishap
- To be assessed for the risk of VTE
- To have the correct procedure, operation, test, x-ray
- To be rescued if my condition unexpectedly deteriorates

Healthcare Associated Infection

What is the problem?

- Each year
  - 200,000 patients diagnosed with HAI
  - 7,000 Staph aureus BSIs reported (4,500 hospital acquired)
  - 12,000 patients with hospital acquired BSIs (25% death rate)
  - 2 million extra bed days due to HAI
  - $20M expenditure on post discharge SSIs

Healthcare Associated Infection



Healthcare Associated Infection

AHMC November 2008

“ A national approach to the prevention of Staphylococcus aureus and other virulent micro-organisms in hospital settings.”

Healthcare Associated Infection

Who prevents?

- Hospitals
  - Surveillance
  - Case review
  - Implement Infection Control Guidelines
  - Hand hygiene initiatives, IV cannula programs, Surgical Site Infection program
  - CE and clinical director leadership and accountability

Healthcare Associated Infection

Who prevents?

- Jurisdictions
  - Surveillance data collation, analysis, feedback
  - Expert advice
  - CE/DG leadership and accountability

Healthcare Associated Infection

Who prevents?

- National
  - Surveillance data collation, analysis, feedback
  - Private sector involvement
  - National leadership and accountability

Submission to NHHRC

Safety and quality design principle

“There should be effective systems of clinical governance at all levels of the health system to ensure continuous improvement in the safety and quality of health care.

Good clinical governance makes certain that there is accountability and creates a ‘just’ culture that is able to embrace reporting and support improvement.

Consumers are central to identifying safety and quality issues and the solutions that need to be implemented.”

Submission to NHHRC

Safety and quality design principle

“For improvement to occur information is critical: of the gaps between care recommended and care received and of the occurrence of adverse events and complications.

In addition to ensuring safe practices and that consumers receive effective and appropriate healthcare, attention to both access and efficiency of service provision is also essential for good quality care”

The future for safety and quality in healthcare in Australia

Submission to NHHRC: 2020 Vision

1. Patient Centred Health Care
2. Systemisation of evidence base health practice
3. Build a culture so ‘safety is how we do business’
4. Performance measurement that supports patient safety and quality

A framework for improving safety and quality

Patient centred health care

- Consumers know their healthcare rights
- Data collection supports comprehensive patient care
- Funding models support continuity of care
- There is case management for complex care
- Electronic health records are available
- Patients have access to trusted information
- Patients are routinely involved in system improvement

Health Literacy

Australian Bureau of Statistics Report: 25 June 2008

Definition

‘the degree to which individuals have the capacity to obtain process and understand basic health information and services needed to make appropriate health decisions.’

(US Dept. Human Services)

Health Literacy

Australian Bureau of Statistics Report: 25 June 2008

Measured against five health-related activities

• Health promotion	–	articles, food labels
• Health protection	–	articles, reports, warnings
• Disease prevention	–	screening, follow up treatment, alerts
• Healthcare maintenance	–	history forms, discharge instruction, booklets, follow medicine label directions
• Systems navigation	–	find facilities, complete forms, understand health packages, charters, informed consent

Health Literacy

Australian Bureau of Statistics Report: 25 June 2008

Scoring system

- *5 tiers*
- Level 1 lowest, Level 5 highest
- Level 3 ‘minimum required for individuals to meet complex demands of everyday life and work’

Health Literacy

Australian Bureau of Statistics Report: 25 June 2008

Results:

- Age: 17% of those 65 – 74 years achieved level 3 or above
- Location: ACT highest score: 56% at Level 3 or above

  Other jurisdictions: 37% - 43% at Level 3 or above

Health Literacy

Australian Bureau of Statistics Report: 25 June 2008

General conclusions

- 40% population cannot handle basic health literacy
- 59% population adults achieve scores lower than optimal
- Lower literacy skills mean less able to navigate health system, eg:

  > present late

  > informed decision making

  > own role in health safety

A framework for improving safety and quality

Systematisation of evidence based health practice

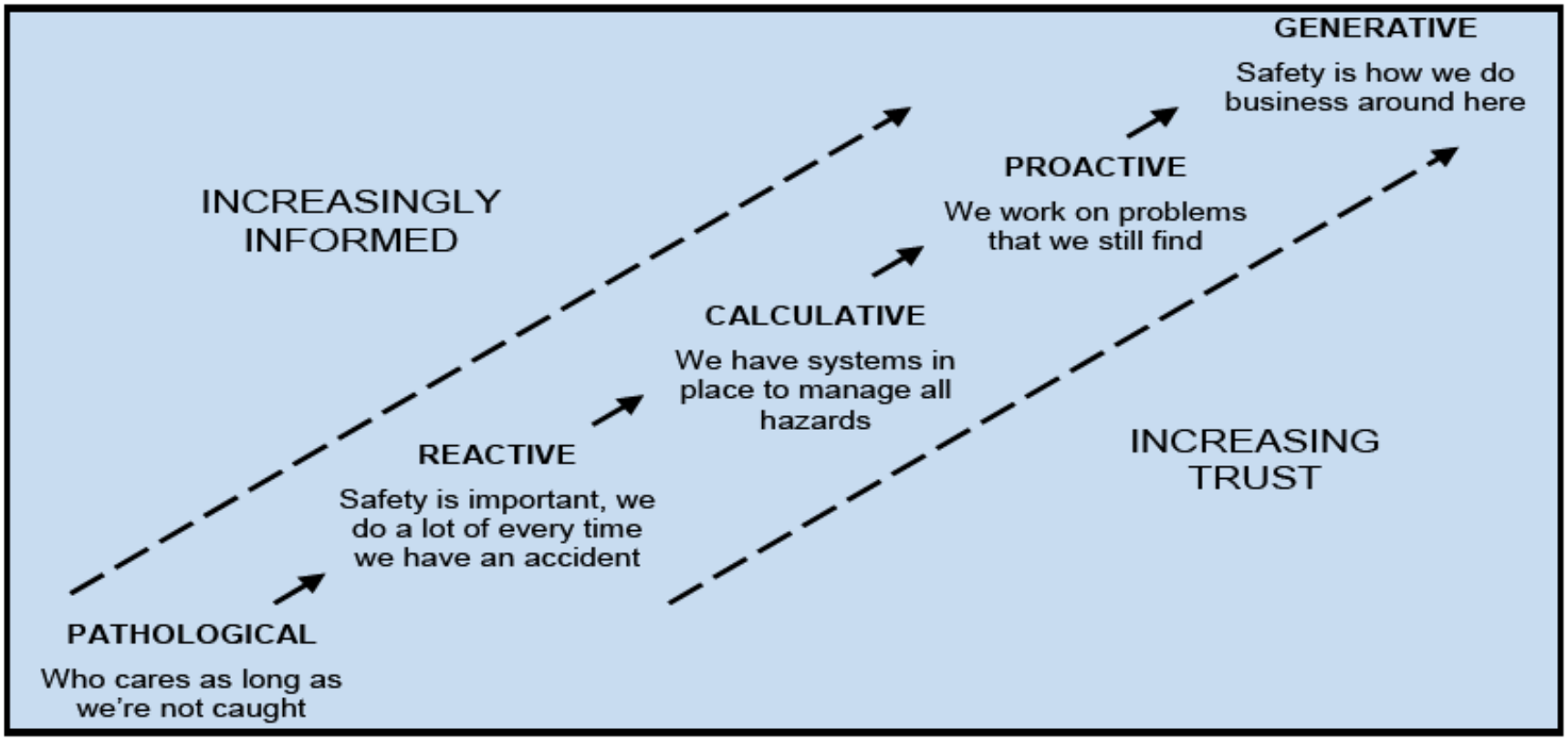
- Evidence is based on the outcomes of Australian patients
- Clinical guidelines are reliable and current
- Information systems support safety and quality
- Primary care data are available and support safety and quality
- Economic information is available to measure the cost of unsafe or poor quality care

A framework for improving safety and quality

Build a culture so 'safety is how we do business'

- Clinicians engaged in organisational safety and quality are supported
- Doctors are actively engaged in organisational safety and quality
- Legal processes facilitate both incident investigation and open disclosure
- There is a clear pathway for public accountability for adverse events
- Health facility design incorporates safety and quality input
- Safety and quality training is embedded in the work of health care
- Providers are able to speak up to keep patients safe

Safety is how we do business



Safety is how we do business

Doctors are actively engaged in organisational safety and quality

- Organisational role
- Medical leadership
- Access to timely data about their performance
- Access to timely data about patient outcomes
- Extensive involvement in standard setting and accreditation

Patient Identification

Correct patient
Correct site
Correct procedure protocol

Five steps

1. Check consent form or procedure request
2. Mark the site
3. Confirm identification with the patient
4. Time out
5. Appropriate and available diagnostic images

Evaluation – 3Cs

I thought it would be easy…

"I thought it would be pretty easy. I just sent the notice out in my hospital that we're going to do it. And then looked at it six months later and nothing had really happened. I found I was the only one doing it."

Director of Surgery

Evaluation – 3Cs

Where's your evidence?

"If you ever try to tackle clinicians on anything, they always ask, where's your evidence? I'm increasingly asking where's yours? That stops them in their tracks. It makes them think about why they keep doing things in a certain way. Often there actually is no evidence for what they are doing."

Hospital CEO

A waste of chocolate

"After we put up the posters, and nothing much happened, we tried bribery. We purchased $200 of Cadbury Timeout bars and said that we would reward each team when the correct site, correct patient, correct procedure was completed correctly and we had a wonderful response while the bars lasted. But as soon as the bars ran out, well people said we no longer have to do it. I said I'm not spending any more money on that. It's not good for the staff, it's not a long term solution, and it's not appropriate so we stopped that."

Director of Surgery, Anaesthetist

Evaluation – 3Cs

Where's the common sense?

"Each of the surgical groups had a different view. In the obs and gynae department, the concept of site marking was an issue. If I do a caesarean section do I have to put a big cross on a belly? Why should I have to do it?"

Hospital S&Q Officer

QANTAS may have some tips for us

"I tell them it is easier to get into an operating theatre as the wrong person, than it is to get on a plane. More checking occurs to make sure that you're the right person on that airplane than the right person for that operation."

State S&Q Coordinator

Evaluation – 3Cs

At QANTAS pilots wear the same risk

“Patients trust us so implicitly and completely that it’s scary. They don’t understand how vulnerable they are.”

State S&Q Coordinator

A framework for improving safety and quality

Performance measurement for safety and quality

- Data collection provides a return on investment through improved safety and quality
- Performance indicators support safety and quality
- Public reporting is used where it has benefits

Performance measurement for safety and quality

Public reporting is used where it has benefits

- Clinical staff will have confidence in and value the information that is publicly reported
- The effects of public reporting on clinical performance will be monitored
- Data presented in a way consumers can understand and are relevant to them

Effecting Change