NSW HEALTH

Patient Safety and Clinical Quality Program

Second report on incident management in the NSW public health system 2004–2005

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Foreword

NSW Health is committed to providing safe and effective health care but recognises that in any complex health care system sometimes things go wrong. Equipment can fail, systems may prove inadequate and occasionally errors of judgment are made. In relatively few cases there is serious harm to the patient.

Strategies adapted from high risk industries, such as aviation and nuclear power generation have been applied to the management of health care delivery. This approach relies on gathering information on any incident that might affect safety, analysing the factors that contributed to the incident and making changes to the way things are done. Such an approach recognises that the vast majority of errors are due to flaws in a chain of events, not the actions of an individual.

NSW Health is recognised nationally and internationally as a leader in this area. Policies and programs to continually monitor and improve patient care have been in development since 1999[1].

In 2004 the NSW Government made $55 million available to establish the NSW Patient Safety and Clinical Quality Program. This initiative builds on past expertise and is unique in its scope as it provides structures and processes to support and encourage **all** staff working in health care delivery to report **any** incident that might have the potential to create a safety risk. As a result safety issues are being identified **before** an incident can occur.

In 2004 the Clinical Excellence Commission (CEC) was also established. This body is responsible for taking a wider look at trends in patient safety and clinical quality and ensuring lessons learned are communicated throughout the State.

This is the second progress report on the NSW Patient Safety and Clinical Quality Program. It describes the systems, structures and processes that have been put in place to foster and support a culture of increased reporting. It is expected that within this improved safety framework, the reporting of incidents in NSW health care facilities will increase. This is a good thing. Larger numbers of reported incidents do not mean the health system is failing. It means that skills in the identification of risks have improved and that the safety culture is robust.

I congratulate the hard work of all employees within the NSW health service for their commitment in developing the program to this point. I also recognise the contribution of the community in providing important feedback that will lead to ongoing improvements in clinical quality throughout NSW.

Robyn Kruk
Director-General

[1] (1999) A Framework for Managing the Quality of Health Services in NSW. The Safety Improvement Program was developed in 2001. Components of this project have been further developed as part of the NSW Patient Safety and Clinical Quality Program.

Executive summary

The NSW health system is among the most advanced in the world. Sophisticated diagnostic equipment, surgical procedures and drug treatments have given us the ability to treat conditions that would have meant certain death in the past. This sophistication presents new challenges, as clinicians and managers work to ensure the coordination of service delivery throughout the system.

In the last reporting year there were over 1.5 million admissions to hospitals and other health facilities in NSW and over 24 million interactions with patients not admitted. During that period 429 serious incidents were reported. While this figure represents less than 0.03 per cent of total admissions, it is recognised that any incident resulting in harm to a patient is unacceptable. All such incidents must be recognised as such and thoroughly reviewed to prevent them happening again.

The NSW Patient Safety and Clinical Quality Program ensures patient safety is at the centre of all health care delivery throughout the state. During the second year of implementation much work has been spent on bedding down reporting systems and structures, and improving collaboration and communication between supporting bodies.

The new electronic Incident Information Management System (IIMS), foreshadowed in the last report, was implemented in all Area Health Services (AHS). All employees of NSW Health have been made aware of this system. Thirty thousand employees have received training in managing incidents and over 2,500 have been specifically trained in an investigative technique known as Root Cause Analysis (RCA).

Clinical Governance Units (CGUs) have been established in all AHS to oversee the collection of data and the management of incidents. These teams are made up of health professionals led by an experienced clinician and report directly to the Chief-Executive of the AHS. CGUs are responsible for implementing the NSW Patient Safety and Clinical Quality Program and ensuring that concerns and complaints raised by the community are taken seriously and investigated. CGUs act as an important interface between the front line and supporting bodies.

The CEC, also established in August 2004, promotes and supports improvement in clinical quality and safety across the system. This year the CEC launched a "train the trainer" model for RCA and a toolkit to improve patient access to acute care services.

In NSW, all adverse incidents must be reported to management and, depending on their severity, to the AHS and the NSW Department of Health. These incidents are classified within a Severity Assessment Code (SAC) that takes into account the seriousness of the event's consequences and the likelihood of it happening again.

This report provides information on the most serious events SAC 1 occuring between July 2004 to June 2005 and compares it with last year's data. SAC 1 events are defined as being in the highest catergory and requiring immediate action. All SAC 1 events must be reported to the Department of Health. These incidents are thoroughly reviewed to capture all relevant information, explore the contributing factors, and make recommendations to prevent them happening again.

Following the introduction of IIMS earlier this year, there has been a steady increase in incident reporting, as was predicted in last year's report. Early analysis of the data suggests serious adverse events represent less than 1 per cent of these incidents. In the 2004/05 reporting period there were 429 SAC 1 incidents. In the previous year there were 452. This represents a slight drop in serious events despite the increased use of the reporting process. In other words, while employees are becoming more skilled in recognising potential risks and reporting them, the majority of reports relate to relatively minor incidents. Such incidents are also being investigated so that changes can be made to prevent a more serious event developing in the future.

Some safety improvements are made at a State level but most work is conducted by individual hospitals in response to situations arising in their own setting. This process ensures a bottom up/top down approach to improvement.

The majority of SAC 1 incidents discussed in this report are categorised under *Clinical Management*. These are complex situations that generally involve very ill patients and many attending staff, often from different disciplines. Cases are carefully analysed to determine any deficiencies in clinical care and to identify strategies to prevent the incident occurring again. A major role of the CEC is to investigate the range of factors associated with these events and to make recommendations as to the best ways to improve patient care.

Overview of the NSW Patient Safety and Clinical Quality Program

The NSW Patient Safety and Clinical Quality Program is the culmination of years of development. It builds on previous policies, frameworks and strategies already in operation within the NSW health system to create what is potentially one of the greatest ever systemic improvements to clinical quality and safety.

There are five key components.

1. A system for managing incidents and identifying risks both locally and statewide that ensures steps are swiftly taken to prevent the incident occurring again.
2. A new electronic IIMS that supports centralised reporting and the recording of information.
3. The establishment of CGUs in each AHS to implement the NSW Patient Safety and Clinical Quality Program at the local level.
4. The development of a Quality Systems Assessment Program, conducted by an external agency, to assess quality and safety systems within all public health organisations and determine whether everything is in place and working well.
5. A CEC that provides advice to the Minister for Health and the Director-General of Health on ways of improving patient safety and clinical quality throughout the NSW health system.

The program works within a spirit of open communication and ensures that anyone who has a concern about patient care will have his or her concerns heard and addressed.

Supporting Bodies

Communication and collaboration between the bodies that support the NSW Patient Safety and Clinical Quality Program is fundamental to its success. These bodies include:

NSW Department of Health and the Quality and Safety Branch

Responsible for:

- developing standards and policies
- helping to create governing structures (such as the CGUs)
- installing and managing the IIMS in each AHS
- monitoring and analysing clinical incidents that are classified as serious and taking appropriate action statewide

- providing advice about safety issues and distributing warnings about adverse incidents to the entire health system
- helping to establish and oversee the work of the CGUs located in AHS
- overseeing the implementation of the NSW Patient Safety and Clinical Quality Program in all AHS.

Clinical Governance Units (CGUs)

CGUs are teams made up of health professionals and led by an experienced clinician. They report directly to the Chief-Executive of the AHS. CGUs are responsible for implementing the NSW Patient Safety and Clinical Quality Program and ensure that concerns and complaints raised by the community are taken seriously and investigated.

Key responsibilities include:

- making staff aware of the electronic IIMS and how to file a report
- managing the implementation and support for IIMS in the AHS
- ensuring all clinical incidents are appropriately reported and investigated
- managing the RCA investigation of serious incidents
- identifying safety managers in clinical areas and supporting their training
- creating specialised teams, when required, to investigate serious incidents
- ensuring the implementation of changes within AHS facilities that will reduce identified risks and prevent incidents happening again
- providing regular reports to the Chief-Executive on the safety and quality of services in the AHS.

CGUs are a vital link between health care workers, patients and supporting government bodies. They interface with the Department of Health, the Coroner, the Health Care Complaints Commission (HCCC) and the CEC.

Clinical Excellence Commission (CEC)

The CEC is a statutory health corporation established under the *Health Services Act*. One of CEC's responsibilities includes taking a wider look at trends in patient safety and clinical quality, and providing education and advice. To fulfil this role it consults with, and gathers information from, a wide range of sources. These include IIMS, the Department of Health, CGUs, Coroner's findings, Special Committee and Expert Committee reports, research articles and other sources as required.

The CEC provides advice to the Minister for Health and the Director-General of Health on ways of improving patient safety and clinical quality performance throughout the NSW health system. It supports the NSW Patient Safety and Clinical Quality Program by:

- analysing information from a range of sources on adverse events to identify trends, causes and relevant strategies
- managing external Quality System Assessments on public health organisations
- conducting special reviews for the Director-General of Health when required
- developing training and communication programs that support the aims of the NSW Patient Safety and Clinical Quality Program
- participating in Health Priority Taskforces, established by the Minister for Health and other organisations and groups, to promote patient safety and clinical quality.

Health Care Complaints Commission (HCCC)

The New South Wales HCCC is an independent statutory body that receives, assesses and investigates serious complaints about individual practitioners. While HCCC investigations relate to individual conduct sometimes these investigations can disclose systemic problems as well. In these cases, the systems deficiencies are communicated to the Department of Health, which in turn, may notify the CEC.

All parties to a complaint are treated fairly and the HCCC operates independently of health service providers. Although it consults with registration boards the processes of the HCCC are autonomous.

Gathering information and managing incidents

Some people will become increasingly unwell in a health setting despite the very best care. Not all illness can be cured. However, no one should become ill as a result of incidents that affect treatment and care. The term "incident" refers to an unplanned event that either results or has the potential to result in injury, damage or other loss. Such preventable errors must be separated from the natural progression of disease.

In August 2005, the Department of Health released a formal policy to ensure a consistent, systematic and coordinated approach to incident management in all NSW hospitals. The *Incident Management Policy* outlines the seven steps that clinicians and managers must follow to respond effectively.

1. **Identification**
   The first step of the incident management process is for all staff to be able to recognise actual incidents and risks, and to take immediate action to ensure safety in the short-term.

2. **Notification**
   All staff are responsible for making notification on incidents as soon as possible, preferably by the end of the working day. Patients and their family or carers are able to make notification through the treating hospital's complaint process. All reported incidents have identifying details removed and are stored centrally within IIMS so that comparisons can be made across the entire NSW health system. The centralisation of data allows "clusters" of incidents to be recognised so that trends can be addressed statewide.

3. **Prioritisation**
   Reported incidents are prioritised according to a SAC. This code is a matrix that takes into account both the consequences of the incident and the likelihood of it happening again. A numerical score is applied, which prioritises the response and guides the level of investigation.

4. **Investigation**
   All incidents are investigated and a RCA is conducted on all those classified as SAC 1 (Serious incidents). This technique explores the chain of events leading up to an event to find the "root cause" and the factors that are within management's control to fix. More than 2,500 employees within the NSW health system have been trained in RCA. Centralised training has now shifted to an ongoing *Train the Trainer* program in local areas.

5. **Classification**
   Information about the incident is gathered from a range of perspectives to ensure all contributory factors are documented and understood. This information is entered in IIMS, where it can be collated with data on similar incidents and trends identified. This process assists managers to understand potential risks in their areas and to develop prevention strategies.

6. **Analysis and Action**

   All information is reviewed to find out how and why an incident occurred and to identify ways of preventing it happening again. Recommendations are signed off by the Chief-Executive of the relevant AHS. Features in the IIMS track the progress of incidents and an electronic audit feature prevents the deletion of information. Reports on incidents cannot be lost, deleted or ignored.

Incident management in action

A report entered into IIMS with a SAC 1 rating, generates an email to the responsible safety officer within 15 minutes. A report on the incident must reach the Department of Health within 24 hours. The Chief-Executive of the AHS where the incident has occurred is responsible for assembling a specialist investigative team trained in RCA. This team's final report and their recommendations must reach the Department within 65 days.

IIMS also allows managers to regularly gather information on all incidents in their area, no matter how serious, rather than waiting for statistical reports from other sources. Such detail provides a clear picture of what is going on in a ward or unit and allows staff to focus on specific changes to improve safety.

For instance, an investigation of fall incidents in one hospital revealed that these events occurred when nurses met to handover a shift. Other safety incidents occurred at this time because patients were left unattended. As a result of this knowledge, handovers are now conducted at patients' bedsides.

By returning knowledge and accountability for safety management to the local clinical area, the Patient Safety and Clinical Quality Program is empowering those in the front line to make small changes that make big differences in the end.

7. **Feedback**

   Patients, carers and/or families are provided with information of the outcome of an investigation in a timely manner and staff involved in the incident are informed of the recommendations.

More general feedback on safety issues is also provided through IIMS. Managers can collate data on all incidents occurring in their area and present this information at staff meetings for further review. By providing accessible information to managers, IIMS returns knowledge to the front line where small safety changes create a large difference overall.

Issues concerning individual clinicians

While investigations of incidents seek to identify shortcomings in a sequence of events, there are some situations where concerns are raised regarding a clinician. Any concern which is raised about any staff member is fully investigated. The Department of Health policy, *Managing a Concern or Complaint about a Clinician*, first released in 2001, addresses the process. The policy has been renewed and improved, and will be reissued in 2005. Depending on the nature of the incident, the response may include reporting the clinician to the relevant professional registration board or other authorities.

National reporting

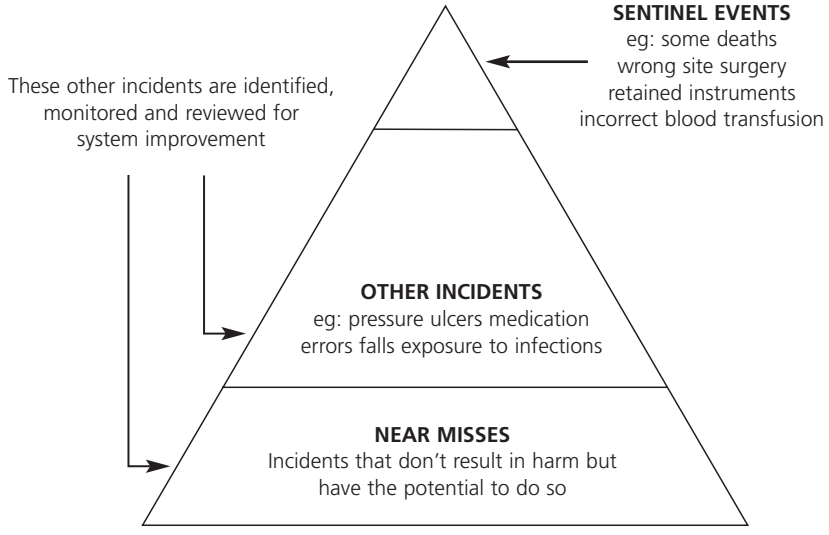
In January 2000, The Australian Council for Safety and Quality in Health Care was established to lead national efforts to improve the safety and quality of health care. This body gained agreement from all States and Territories to a common definition system of "core sentinel events". These eight event categories are agreed indicators of system problems. A national report that will identify trends across Australia is in the process of development.

It is important to understand sentinel events within the context of all incidents that occur in a public health system. Not all incidents have serious consequences, although they must be taken seriously to prevent a repeat of the incident and the likelihood of harm.

The pyramid below provides an illustration of the spread of incidents in a health care system. Most can be classified as near misses — in other words an event that might have caused a problem. Such incidents represent the bottom of the reporting pyramid.

The second layer of the pyramid relates to those incidents that do result in some patient harm. For example, a patient falls from a bed, is given the wrong medication or develops pressure sores because there has been a lack of communication regarding when she should be turned.

More serious yet, and representing the tip of the reporting pyramid, are those incidents referred to in the national classification as "sentinel events". These incidents include surgery that is conducted on the wrong patient or wrong body part, instruments that are left inside a patient after an operation and incorrect blood transfusions.



The table below lists serious incidents occurring in NSW according to the national definition system and compares figures against last year.

Table 1. National sentinel events in NSW

Sentinel event	2003/04	2004/05
Procedure involving the incorrect patient or body part	13	14
Suicide in hospital	4	8
Retained instruments or other material after surgery	9	5
Medication error resulting in death of a patient	2	2
Intravascular gas embolism resulting in death or neurological damage	0	0
Haemolytic blood transfusion reaction resulting from ABO incompatibility	0	0
Maternal death or serious morbidity associated with labour or delivery EXCLUDING neonates and babies	3	3
Infant discharged to wrong family	0	0
TOTAL	**31**	**32**

NSW report on serious incidents 2004/05

The national classification system of core sentinel events identifies very specific things that can go wrong in a clinical setting. The NSW Patient Safety and Clinical Quality Program is broader in its scope and includes categories such as clinical management, falls, equipment failures and suicides occurring in the community.

As mentioned previously, all incidents are classified using a SAC, which takes into account both the consequences of the incident and the likelihood of it happening again. A numerical score is applied, which prioritises the response and guides the level of investigation.

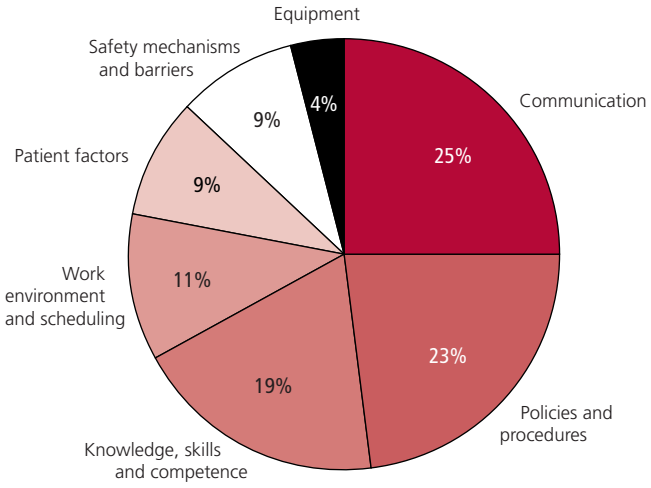
The information contained in the table below covers all SAC 1 incidents reported from July 2004 to June 2005 as per the NSW classification system. These figures include the 32 sentinel events reported in Table 1 and are compared against last year's figures. Analysis of these categories is contained in the following pages.

Table 2. NSW public hospitals — SAC 1 reportable incidents 2004/05

Incident type	2003/04	2004/05
Clinical management problems	157	145
Suicide – in hospital	4	8
Suicide – in the community	128	134
Attempted suicide – in hospital	8	4
Patient at risk absent against medical advice	27	10
Labour or delivery problems	26	29
Falls	22	32
Wrong patient/site/procedure	13	14
Medical devices, equipment failure	11	5
Retained instruments/materials	9	5
Medication or intravenous fluids problems	7	5
Blood and blood products problems	5	5
Other	35	33
TOTAL	**452**	**429**

All reported SAC 1 incidents are investigated using RCA to determine the underlying causes. Many of these cases are highly complex and involve a multitude of contributing factors within a chain of events.

RCA reports of SAC 1 incidents examined by the NSW Department of Health in this reporting year identified contributing factors that have been grouped into the categories below. As most incidents have more than one contributing cause, the categories are presented as percentages of the total list of causes. The breakdown is consistent with similar investigations in other States and overseas.



Communication – remains the largest issue as the complexity of patient care often involves a variety of specialist teams and facilities. Transferring information between these teams and tracking a patient's pathway through the treatment process requires further development and monitoring.

Policies and procedures – are the second highest category. This definition refers to the guidelines followed by health professionals when carrying out tasks. Incidents can highlight deficiencies in staff orientation, training or compliance with health codes, standards and regulations. Such incidents can also suggest the need for policy improvements at a local and State level.

Knowledge, skills and competence – given ongoing advances in technology, employees require continual education on new ways of treating patients and working with equipment. Knowledge levels must be continually assessed.

Work environment and scheduling – some incidents highlight environmental issues such as the design of an area, temperature and noise factors. Scheduling relates to the ability of staff to rest properly between shifts.

Equipment – it is important to ensure that all equipment used in patient care is designed to properly accomplish the intended purpose. Such equipment must meet current codes and be properly maintained.

Safety mechanisms – this category refers to barriers, such as bed rails, and other control systems that are used when there is a known risk. Incidents can highlight design problems and/or staff awareness.

Patient factors – that might contribute to an incident are also considered as part of the RCA process. These might include an individual's mental state and/or concurrent medical problems.

The following pages provide more detail on SAC 1 incidents and the lessons that have been learned. It should be noted that the full implementation of IIMS began in May 2005 and that the information in this report covers the period July 2004/June 2005. As such, not all of the data presented has been gathered using the new system.

Clinical management: lessons learned

A large number of SAC 1 incidents are captured under the category of clinical management. These incidents refer to cases where there is a serious deterioration of a patient's condition that appear not related to the natural course of an illness and differ from the expected outcome of treatment. Examples of cases where serious events are identified include:

- adequacy of the initial and ongoing assessment, investigations and follow-up
- issues with diagnosis including delay, adequate investigation and correct treatment plan
- clinical judgement regarding decline in a patient's condition that resulted in inappropriate discharge
- misdiagnosis, misinterpretation and/or a failure to review results of diagnostic investigations including x-ray and pathology reports
- delay in referral to a tertiary hospital due to the availability of services, including transport and the capacity of the tertiary hospital to receive the patient.

There were 145 serious clinical management incidents during July 2004 to June 2005. This is a decrease from 157 incidents reported the previous year. Communication remained the most common contributing factor. Forwarding information to the appropriate senior personnel and improving communication when transferring patients between treatment teams and hospitals are issues of particular importance.

Other contributing factors identified through RCA were:

- adequacy of training in policy and procedures
- availability of senior staff
- availability of specialist treatment in unit where patient admitted
- adequacy of orientation to the workplace and workflows
- currency of policies and procedures reflecting best practice
- seriousness of patient condition
- supervision of medical and nursing staff
- environmental considerations, patient supervision and related risk management strategies
- rostering practices, particularly after hours and on public holidays.

Action Taken

Local hospitals are responding to these safety issues through:

- revision and development of guidelines and clinical management strategies
- introduction of new protocols for safe patient transfers between facilities and units
- additional high dependency beds
- deploying staff and equipment to areas of need
- training opportunities so that staff skills are appropriate in specialist areas.

Example: Patient Transfer

Patient safety and clinical quality care issues involving the referral of critically ill patients have been addressed in one area health service through the implementation of a central point of contact at the regional referral hospital for both the rural district hospital and the aeromedical operations centre to facilitate referral.

Information gathered through incident monitoring revealed the need for referral hospitals to have a single point of contact for a clinical pathway to expedite the acceptance of critically ill patients and provide clinical advice.

This approach allows the referring clinicians to focus on the clinical management of the patient while the mode of transport (ambulance or helicopter) is undertaken by the State-wide retrieval services in consultation with the regional referral hospital.

Statewide Response

The NSW Department of Health has identified communication between clinicians, patients and their families as a major factor contributing to clinical management incidents. The NSW Department of Health has asked the CEC to recommend a communication training strategy for NSW Health clinicians.

The *Children's Emergency Care Project* is an initiative being piloted by the CEC to address complex care issues involving young children presenting to hospital. This project will assist Emergency Departments to identify the symptoms of the most common illnesses in children and track diagnosis and treatment. The implementation of this project will be guided and supported by insights gained through the NSW Patient Safety and Clinical Quality Program.

Policies and guidelines have been developed by the Department of Health to address the following issues:

- policy for the Delineation of Clinical Privileges
- policy for the Appointment of Visiting Medical Officers

- policy for the Appointment of Staff Specialists
- guidelines for implementing the National Medication Chart in all health services. This project allows clinicians access to the same chart no matter where the patient is within hospital.

Example: Specialist Services

An incident involving the misreading of a CT scan highlighted the need for radiologist services in smaller hospitals during weekends.

In response a digital imaging network has been established to send CT scans and other images to a major hospital. Senior radiologists or radiologist registrars have been placed on a 24 hour roster to read these images and interpret them. There have been no further incidents since this network was put in place.

The *Safety Advocate* is a specialist bulletin for health professionals. To date bulletins have been released on:

- sterilisation and disinfection
- medication safety
- falls in health services
- improving the safety of bed rails
- the safe use of infusion pumps
- self inflating resuscitation bags
- the safe management of breast milk
- eliminating retained instruments – abdominal visceral retractor.

Copies of *The Safety Advocate* are available at www.health.nsw.gov.au/quality.

Example: Equipment

Reporting any incident involving equipment identifies future risks. One such report indicated potential problems regarding resuscitation equipment that required disassembly for cleaning.

On one occasion it was discovered that the equipment had not been put back together correctly. The problem was rectified by using another resuscitator but the incident foretold dangers that could arise in the future if the replacement had not been available.

The hospital now purchases disposable resuscitators that do not need to be assembled and has them available in all clinical ward areas. This information was communicated throughout the health system via The Safety Advocate Bulletin.

Suicide: lessons learned

Suicide is a human tragedy, often occurring in circumstances of hopelessness and despair. The contributing factors are many and complex. The most recent available data on suicide deaths in NSW shows a rate of 9.4 deaths per 100,000 people. This rate has decreased gradually since 1997 when the rate was 15.1 per 100,000 people.[2]

Suicides were the second largest category of SAC 1 incidents. There has been a consistent pattern to suicides in hospitals over the past five years with numbers fluctuating between four and eight from year to year.

During the period from July 2004 to June 2005, there were eight suicides and four suicide attempts in public hospitals. During the same period there were 134 suicides in the community involving people who had contact with a mental health service in the four week period prior to the event. There is no single cause and no simple solution to these tragedies. However, it is important to improve staff skills in assessing the risk of suicide and to closely monitor the mental states of individuals, as these mental states are subject to rapid change.

Action Taken

All suicides are reviewed by AHS and reported to NSW Department of Health. The NSW Coroner also reviews these cases.

The NSW Mental Health Sentinel Events Review Committee was established as an independent committee to review and report on Sentinel Events. As part of this brief they also review suicide and homicide among people suffering from a mental illness in the context of public mental health settings. This Committee also overviews suicide statistics and trends, and may review individual cases as part of its role in making recommendations for improvements in the care of people suffering from a mental illness.

Local hospitals and mental health services are responding to these safety issues through:

- improving staff training in suicide risk assessment
- changing staff supervision and communication systems
- improving staffing levels
- changing documentation and communication systems, including developing systems for making community mental health files more accessible to after-hours and emergency department staff

[2] Suicide in New South Wales: We need to know more. The NSW Data Report, NSW Health, 2004 www.health.nsw.gov.au/pubs/2004/suicidedata0504.html

- auditing and making changes to inpatient unit environments to eliminate items a patient might use to inflict self harm
- improving systems for communication and handover between hospital and community settings.

Statewide Response

The NSW Government Response to the first report of the NSW Mental Health Sentinel Events Review Committee was released in December 2004. Fifty one of the 52 recommendations were accepted and the vast majority have been implemented or are scheduled to be implemented within the requested timeframes.

The Mental Health Sentinel Event Review Committee's key recommendations fall under the following broad categories and are currently being addressed:

- enhancements to the quality of clinical suicide risk assessment and management procedures as documented in the Framework for Suicide Risk Assessment and Management for NSW Health Staff, released in December 2004
- safety improvements in the physical environment and resources for mental health inpatients
- action to improve families' access to information
- enhancing communication and documentation to ensure adequate and appropriate mental health assessments, treatment and continuity of care for patients
- recommendations made in relation to Clinical Practice and Care covering a range of clinical situations
- training and education programs to support the implementation of the Sentinel Events Review Committee's recommendations
- response to Suicide Deaths and Homicides including the development of a protocol for AHSs, procedural improvements to facilitate the Coroners access to information, and for the adoption of the Coroner's recommendations.

The NSW Government Response to the second report of the Committee will be released shortly and it is anticipated that all twenty four recommendations will be endorsed. The recommendations relate to:

- improving reporting and review systems
- developing clinical standards and guidelines relating to practice and care, service partnerships and resources
- developing standards and guidelines relating to children, families and carers
- developing guidelines relating to forensic patients.

The *Framework for Suicide Risk Assessment and Management for NSW Health Staff* [3] was also released this year. This document provides specific information on the roles and responsibilities of generalist and mental health service providers in hospitals and in community settings. There is clearer guidance for all staff caring for patients on how to identify and assess suicide risk. The focus is on improving communication, family involvement and recognising how quickly the risk of suicide can change. Training resources to support this document are being developed and implemented.

Psychiatric Emergency Care Centres have been established in two major emergency departments and more are planned over the next twelve months. Extra mental health staff will also be placed in rural hospitals to reduce pressure on generalist Emergency Department staff and increase early access to expert mental health assessment and intervention.

[3] Framework for Suicide Risk Assessment and Management for NSW Health Staff, NSW Health, 2005.

Falls: lessons learned

There were 32 serious falls reported during July 2004 to June 2005. Fourteen occurred in the late evening and overnight when staff levels are traditionally lower. Only 4 occurred during the morning shift. Almost half of the patients had decreased mobility and required assistance moving. Twelve were over the age of 80 years. Almost all patients had medical problems and many had a history of falls prior to admission. Some had suffered a heart attack or another serious emergency medical event that brought on the fall. Thirteen cases involved patients falling from bed.

These falls highlight the need to continually review the adequacy of tools used to assess risks in health care facilities. Patient factors that make falls more likely also need to be considered, such as age and existing medical conditions. Ongoing risk assessment should be conducted, particularly when a patient's medical condition may have deteriorated. The treatment of elderly patients must be carefully planned to ensure adequate staffing levels. Falls prevention strategies, such as safety rails, must be consistently used when required.

Action Taken

Local hospitals are responding to these safety issues through:

- reviewing staff knowledge and providing education to staff on fall policies, risk assessment tools and intervention strategies
- developing clinical care pathways for elderly patients to track care and ensure specific needs are met
- establishing competency based clinical risk assessment skills.

Statewide Response

Local responses are being supported by the appointment of a Statewide Falls Program Coordinator to oversee the implementation of the *Management Policy to Reduce Fall Injury Among Older People*. This policy aims to reduce falls in older patients by requiring AHSs to:

- identify patient needs in relation to falls prevention
- implement evidence based, falls prevention strategies
- ensure a comprehensive training program in falls prevention is undertaken
- review falls risk assessment tools
- continually monitor the incidence of falls and their causes
- appoint a Falls Coordinator in each AHS to assist in the planning and implementation of the State policy.

Labour and delivery: lessons learned

There were 29 SAC 1 incidents classified in the category of labour and delivery problems. Analysis of these incidents revealed that the majority were not restricted to the time or place of labour and delivery but occurred during pregnancy (antenatal) or after the birth of the baby in the postnatal period.

Key issues identified include:

- a growing increase both nationally and internationally in postpartum haemorrhage
- inconsistent foetal monitoring or foetal assessment before and during stages of labour
- knowledge regarding safe sleeping practices in situations where mothers and babies are accommodated together
- communication between health professionals directly involved in maternity care and other specialists who provide care outside the maternity setting
- procedures for the storage and labelling of expressed breast milk
- hazards associated with electric cot blankets.

Action Taken

Local hospitals are responding to these safety issues through:

- reviewing and applying existing policy directives on postpartum haemorrhage to assist clinicians managing this condition
- developing strategies to ensure staff knowledge levels regarding foetal monitoring and the consistent use of this technology are of a high standard
- adapting policy directives on safe sleeping to suit the needs of local settings.

Statewide response

- the Maternal and Perinatal Health Priority Taskforce, a multidisciplinary advisory group, responsible for reviewing reportable incidents and providing leadership and direction for the statewide response, is investigating strategies to improve communication among treating clinicians and between separate facilities
- a policy directive has been released to assist staff in identifying risks associated with babies sharing adults' beds. A more specific guideline has been released on Sudden Infant Death Syndrome and the risks associated with positioning babies on their stomach. These guidelines have been prepared in community language so that staff can encourage parents to maintain these practices in hospital and when they return home

- a policy directive, released in August 2004, required the immediate withdrawal of all electric cot blankets in NSW public hospitals. Information was provided on other methods for keeping newborns warm
- the policy directive on the early recognition and management of post partum haemorrhage has been reviewed and re-issued
- a *Safety Advocate* Bulletin was issued to AHS on the prevention and management of breast milk incidents.

Retained instruments or material: lessons learned

There were 5 incidents relating to retained instruments or material during the 2004/05 — a decrease from 9 the previous year. Four of the incidents reported during 2003/04 related to a surgical instrument with problematic design issues. A replacement item, available from another supplier, was recommended for use in October 2004 following a review. There have been no reported incidents relating to these items since November 2004.

Analysis of these incidents identified the following contributing factors:

- inappropriate systems and processes for checking accountable items
- inadequate communication of safety bulletins about design problems related to particular instruments.

Action Taken

Local hospitals are responding to these safety issues through:

- reviewing documented processes for accountable items and incorporating this information into orientation and staff training programs
- creating new communication channels for safety bulletins and alerts
- liaising with manufacturers and clinical product managers to ensure alerts regarding items on Government contracts are communicated
- developing education and training programs on safe work practice guidelines for all staff and students.

Statewide response

- updating and reissuing the policy document, *Standard Procedures for the Handling of Accountable Items in the Operating Suite*
- releasing a *Safety Advocate* bulletin to all NSW hospitals in relation to the item involved in the four incidents that occurred in 2003/2004. Identification of an alternative product with more integrated safety features has been recommended for use throughout the health care system.

Wrong patient/site/procedure: lessons learned

This category captures incidents where surgery or other procedures have been performed on the incorrect patient, the incorrect side of the body or body part, or where the incorrect procedure was performed.

There were 14 incidents reported during 2004/05 compared to 13 during 2003/04. Investigation and analysis of these incidents reveals that most occurred during relatively minor surgical procedures, such as x-ray and dentistry. In four of the incidents the error was discovered before the procedure began.

In November 2004, NSW Health distributed its *Correct Patient/Correct Site/ Correct Procedure Model Policy* to all AHSs. It is the responsibility of AHS to adapt this policy to their particular health care setting. Priority was given to the high risk areas of major surgery and this focus is having a positive effect. However, work still has to be done to ensure a consistent approach in minor procedures.

Analysis of incident reports revealed the following contributing factors:

- inadequate communication between wards/departments when transferring and transporting patients for treatment
- difficulties arising when patients are transferred between treatment teams and hospitals
- pre-admission process — check-in not formalised
- patient's concerns regarding surgery not discussed adequately
- problems in communication with non English speaking patients and non compliance with existing policies for checking patient identity
- correct site surgery guidelines "time out" not followed.

Action Taken

Local hospitals are responding to these safety issues through:

- developing and implementing better pre-admission/pre-procedural identification and checking procedures
- ensuring compliance with the NSW Department of Health's *Correct Patient/ Correct Site/Correct Procedure Model Policy*
- standardisation of procedure booking forms through the AHS.
- educating healthcare professionals on how to respond to patients' queries about a proposed procedure when the patients' understanding differs from their own.

Statewide response

Local hospital initiatives have been supported at a State level by the distribution of the *Correct Patient/Correct Site/Correct Procedure Model Policy* to all AHS. Implementation has been supported with posters, videos and close liaison with relevant professional bodies. The policy is being currently adapted to support minor surgery and procedural areas with progress continually monitored.

Example: Patient identification

An incident involving incorrect patient identification on request forms for tests revealed the wrong set of patient labels had been placed in the patient's chart. It was discovered that the printer used for these labels produced names in a steady stream, thus making it easy to collect more than one set of labels.

This system problem has been rectified by programming the printer to produce blank labels between sets of individual patient labels. This blank label provides a clear division between each set of patient identification labels and ensures the correct labels are entered into each patient chart.

Example: Correct Patient/Correct Site/Correct Procedure Policy

An incident that had the potential to result in a patient undergoing the wrong procedure was rectified by the implementation of the Correct Patient/Correct Site/ Correct Procedure policy.

An error occurred when an incorrect treatment label was affixed to a prepared booking form. The patient was unaware of the technical name for the procedure, signed the consent form and verified the operation.

The Correct Patient/Correct Site/Correct Procedure policy has five stages that include verifying information, marking the site, and then taking time out before the operation to stop all other activity and confirm these details again. As part of the "time out" phase it was discovered that the patient was booked for the wrong procedure and the operation did not proceed.

Summary

This has been a year of ensuring policies and structures are in place and operating correctly. The electronic IIMS has been in operation for several months and already there are early indications that management features in this data collection system are supporting change at the local and State level. More will be done to educate staff, patients and their families about the reporting process.

The Department of Health and the CEC will continue to focus on communication and collaboration. Efforts in this area will focus on creating knowledge management structures and practices to ensure information on effective solutions to safety and clinical quality issues are distributed in a timely manner throughout the health system.

In the year to come IIMS will be used to collect all incident reports. The analysis of this information will continue to drive collaborative action that will ensure the delivery of safe, high quality health care to the people of New South Wales.

Feedback and comments on this report and the NSW Patient Safety and Quality Program are welcomed at quality@doh.health.nsw.gov.au

Glossary

Adverse event	Any event or circumstance leading to avoidable patient harm, which results in admission to hospital, prolonged hospital stay, significant disability at discharge or death.
AHS	**Area Health Service**. There are 8 geographical areas throughout NSW including rural and metropolitan locations.
CEC	**Clinical Excellence Commission**. A statutory health corporation established under the Health Services Act to promote and support improvement in clinical quality and safety in NSW health services.
CGU	**Clinical Governance Unit**. Established within each AHS to oversee the implementation of the NSW Patient Safety and Clinical Quality Program.
IIMS	**Incident Information Management System**. A statewide electronic reporting system designed to underpin the NSW Patient Safety and Clinical Quality Program. IIMS incorporates the Advanced Incident Management System (AIMS) software application as its underlying database.
Incident	An unplanned event resulting in, or having the potential for, injury, damage or other loss.
Sentinel Event	Incidents agreed as key indicators of system failure by all States and Territories and defined by The Australian Council for Safety and Quality in Healthcare as "events in which death or serious harm to a patient has occurred".
RCA	**Root Cause Analysis**. A method used to investigate and analyse a SAC 1 incident to identify the root causes and factors that contributed to the incident and to recommend actions to prevent a similar occurrence.
SAC	**Severity Assessment Code**. A risk matrix used to stratify the consequence and likelihood of an incident to generate a numerical rating from 1 to 4. SAC 1 events always require investigation and notification to the AHS Executive and NSW Health. SAC 2 events require notification to the Area Executive and local assessment as to the level of investigation required. Incidents rated 3 or 4 will be managed locally.

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