

Incident Management in the NSW Public Health System 2007 January to June

NSW DEPARTMENT OF HEALTH

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Foreword

The New South Wales public health system is committed to providing safe and effective patient care. We also recognise that as health care continues to advance, so the system that supports the delivery of such care becomes more complex. As a result we have adapted strategies from high risk industries. 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.

In 2004 we launched the NSW Patient Safety and Clinical Quality Program. This program is led by the Quality and Safety Branch within the NSW Department of Health and the Clinical Excellence Commission (CEC). Clinical Governance Units within each area health service are responsible for making sure the aims of the program are achieved at a local level.

Over the last three years we have built the structures, systems and processes that support staff in notifying and managing incidents. Insights gained from analysing incident information are continually used to improve patient care. This process is supported by an electronic Incident Information Management System (IIMS).

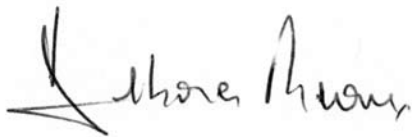
In the six-months period covered by this report there has been a 17 per cent increase in the number of notifications overall with no significant increase in the number of serious incidents. An increase in the notification of minor incidents demonstrates that staff are becoming more aware of safety issues. Managers are also demonstrating increased confidence and capability in using IIMS data to assess their facilities for safety risks and to put prevention measures in place.

We now have a robust collection of data that we are using to identify themes and trends around particular areas of patient care. This is allowing the development of all-inclusive strategies that can be applied and measured throughout the entire health care system.

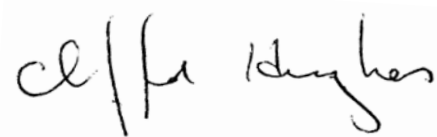
We will now release public reports every six months rather than annually. More frequent reporting is an important part of creating an informed community that understands the processes of health care and the priorities that must be addressed to support improvement.

Addressing safety and clinical quality is an ongoing process which requires vigilance as health services evolve. Consumers of health care can take an active role in this process by making themselves familiar with the issues outlined in this report. They can also become aware of processes and protocols being implemented in their health care system to continually improve patient care.

We are indebted to all those who have contributed to advancing the vision of the NSW Patient Safety and Clinical Quality Program during this reporting period. Their dedication to evidence-based best practice is the foundation upon which continual improvements in patient safety and clinical quality will be made.



Professor Debora Picone, AM
Director-General
NSW Department of Health



Professor Clifford Hughes, AO
Chief Executive Officer
Clinical Excellence Commission

Key messages in this report

New South Wales has a Statewide system to support the notification and management of any incident that could result in patient harm. Incidents are analysed and their causes identified. This information is used to develop prevention measures at both the local and strategic level.

The outcomes of improvement strategies are measured and strategies are revised on an on-going basis to achieve the best possible outcome.

This process is supported by the electronic Incident Information Management System (IIMS). The data collected in IIMS allows the identification of themes and system issues that should be addressed across the State, or to alert the entire system to a particular concern that may affect all health facilities.

These initiatives fall under the umbrella of the NSW Patient Safety and Clinical Quality Program, launched in 2004. Since that time the NSW Department of Health has released annual public reports on the management of serious incidents. In 2006 the CEC released a public report on the first full year of all data collected in IIMS. This information will now be combined and reports released every six months. This is the first six-monthly report and covers the time period between January 1 and June 30, 2007.

During this period there was an increase in the number of incidents notified, without a significant increase in the number of serious incidents. This demonstrates the ongoing willingness of staff to notify and manage incidents, and the development of a strong safety culture.

Serious incidents represent approximately 0.03 per cent of occasions of patient care. This is a small percentage but each of these incidents has an enormous effect on the lives of the patients involved and their families. The NSW public health system will continue to focus on gathering information on incidents, researching effective prevention strategies and putting them in place to improve patient safety and clinical care.

There have been improvements in issues identified in previous reports, such as the reduction in wrong patient/wrong site/wrong procedure incidents occurring in operating theatres.

In this reporting period there are three significant areas where we are focussing efforts. These include:

- The recognition and management of the patient whose condition unexpectedly and rapidly gets worse
- Methods for the correct identification of patients as they move between facilities and teams.
- A comprehensive approach to tackling infection in hospital

Getting the most out of this report

In order to grasp the implications of this report, readers should have some understanding of how the NSW Patient Safety and Clinical Quality Program gathers, classifies and analyses the causes of incidents.

Collecting information in IIMS

An important part of the NSW Patient Safety and Clinical Quality Program is an electronic Incident Information Management System (IIMS) that is available in all facilities in the public health system. IIMS supports the notification of incidents and groups them in ways that allow managers and clinicians to identify hot spots and trends. The result is increased understanding of the causes of incidents and the ability to develop effective strategies to make sure they do not happen again.

All employees of the NSW public health system are able to notify incidents into IIMS. The word “incident” refers to any situation that has, or might, cause patient harm.

IIMS stores information about a range of incidents, including those involving property. This report, however, is concerned with those incidents related to patient care. These are defined as “clinical incidents”.

Incidents entered into IIMS are rated against a Severity Assessment Code (SAC) that plots the consequence of the incident against the risk of it happening again. There are four SAC ratings with SAC1 incidents being the most serious. IIMS also stores information on the contributing factors to incidents. Gathering information on contributing factors assists analysis and provides insights into themes. For instance, lack of communication may not be rated as the first and foremost contributor in every incident, but if it is seen as a contributing factor across a range of incidents, it can be identified as a very important theme to address overall.

Notifying all incidents, including those that did not result in patient harm, is the process by which clinicians and managers continually monitor safety and clinical quality.

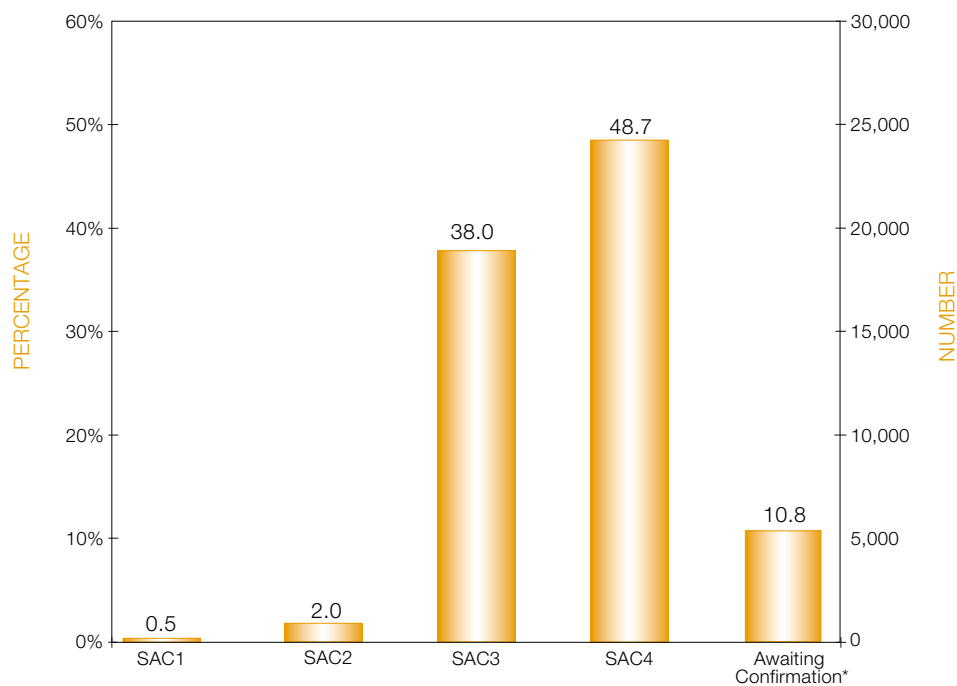
The NSW Patient Safety and Clinical Quality Program provides structures and processes to support and encourage all staff working in health care delivery to notify any incident that has the potential to create a safety risk.

The Severity Assessment Code (SAC) has four ratings. SAC1 incidents are the most serious. The complete SAC matrix can be viewed at:
http://www.health.nsw.gov.au/pubs/2005/sac_matrix.html

Classifying incidents

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

Figure 1. Clinical Incidents across SAC categories



*Modifications have been made to IIMS to ensure all incidents will have a SAC score in the future.

Analysing Incidents

Notifying all incidents, including those that did not result in patient harm is the process by which clinicians and managers continually monitor safety and clinical quality.

All incidents are analysed and the same three questions asked. What happened? How did it happen? How do we prevent it from happening again? SAC ratings simply escalate the level of management and the depth of analysis involved.

SAC1 incidents undergo a very thorough analysis process known as Root Cause Analysis that helps managers at a local level understand all of the contributing factors to the incident and to take action. Reports on serious incidents are reviewed by the Department of Health and the CEC to identify system issues that should be addressed across all facilities throughout the State.

Managers at each level of health care can use incident information, stored in IIMS, to review their hospital, health facility or department for any similar risks and put prevention strategies in place. (IIMS has information removed that might identify particular patients and staff.)

It is important to note that while IIMS is an important tool that supports patient safety and clinical quality improvements, other mechanisms are in place. These include many specialist committees and review programs that gather information and develop projects to target specific areas of health care.

Safety Alert Broadcast System

The Safety Alert Broadcast System (SABS) is a communication tool used by the NSW Department of Health for rapid and effective distribution and management of important information. SABS provides health services with early warnings about safety issues. There are three levels of warning.



Safety Alert: Requires immediate action, designates who is responsible and calls for mandatory reporting of the steps taken to address the risk.



Safety Notice: Alerts designated managers to important issues. Managers must review or develop processes and protocols to ensure that the issue is managed for any safety risk.



Safety Information: Provides information on safety issues.

Open Disclosure Policy

Open Disclosure is telling patients, carers and families involved in an incident what we know about the event and saying we are sorry for the distress caused. Last year a policy was released to provide guidance for all staff in this process. This year education programs and workshops are in progress to develop the communication skills of all staff, up to and including chief executive officers, in conducting these conversations.

Open Disclosure also provides patients and their families with the outcomes of the analysis of the incident and the steps that are being taken to ensure that it does not happen again.

“Safety is part of everyday work, where once it was only something we thought about now and again.”

Comment from an area health service staff member at a feedback session on the Patient Safety and Clinical Quality Program.

Falls

Entering hospital requires careful attention for older people. They are entering an unfamiliar environment, often when they are weak and frail.

The risk of falling must be assessed and strategies put in place to reduce the likelihood of incidents occurring.

As our population ages, falls-related injuries are rising. Most at risk are the elderly. Preventing these injuries requires a multifaceted approach that includes:

- programs that encourage flexibility, balance and muscle strength
- attention to environmental hazards in spaces used by the frail and elderly
- putting risk management strategies in place
- assessing the risk of individuals falling.

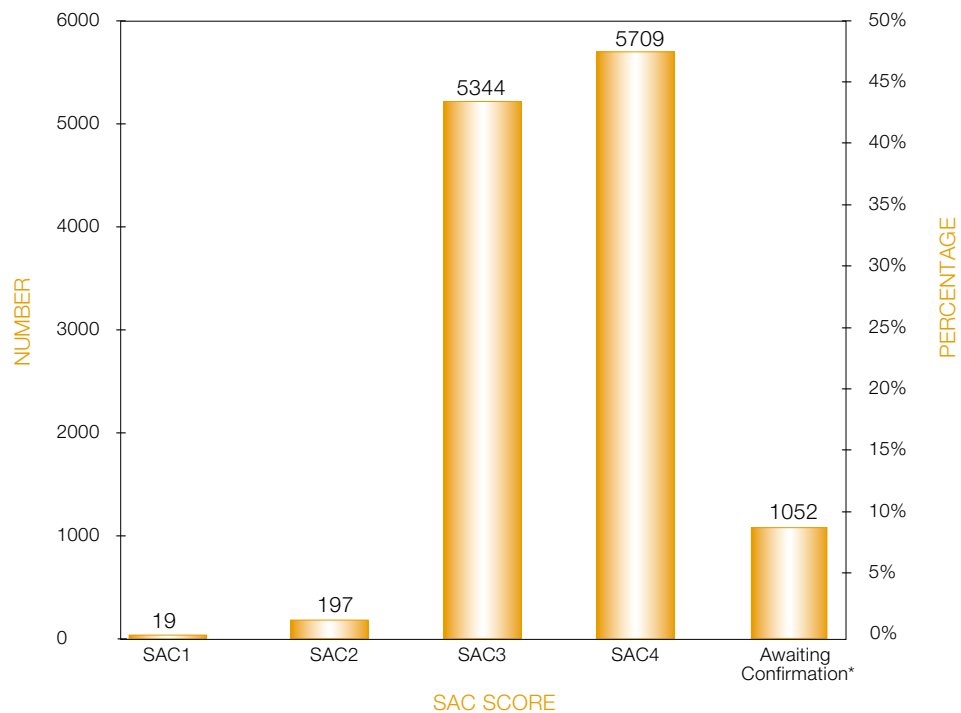
With this in mind careful attention must be paid to older people entering hospital. They are coming to an unfamiliar environment, often when they are weak and frail. They may have mobility, hearing and vision problems. They may also be taking medication that makes them dizzy.

Falls represent the greatest number of notifications made in IIMS. Continually providing notifications about any incident involving a fall in hospital provides managers with information to put targeted prevention strategies in place.

Notifications

In the January 1 to June 30, 2007 reporting period, 12,321 fall notifications were made. Nineteen of these incidents were classified as severe or SAC1. The spread of incidents within SAC categories can be seen in Figure 2.

Figure 2. Falls Incidents across SAC categories



*Modifications have been made to IIMS to ensure all incidents will have a SAC score in the future.

Lessons Learned

Many fall injuries occur in aged care rehabilitation facilities, where elderly people are regaining mobility and function after an operation or illness. Getting elderly people up and about so that they can enjoy a fuller life presents specific risks that must be carefully monitored. Other hospital areas where falls occurred more frequently were stroke wards, oncology and haematology. Most of these incidents involved patients 65 years and over.

There are often multiple causes for a fall and it is sometimes difficult to determine whether the patient slipped, lost his or her balance, or had a medical condition that caused a collapse.

Analysis of incidents revealed contributing factors to a fall included:

- the use of medications that affect the central nervous system
- mental confusion or impulsive behaviour brought about by medical conditions
- a change in environment, as a result of a move to a new ward or hospital, where the patient was in unfamiliar surroundings

Almost half of the falls were associated with the task of going to the toilet.

Action Taken

The Falls Prevention Program

The CEC is overseeing the roll-out of a Statewide Falls Prevention Program. As part of this program, Falls Co-ordinators have been appointed in each area health service. Falls management committees have also been established to support the implementation of strategies at a local level. This includes the Australian Safety and Quality Commission's (formerly Council) Best Practice Guidelines for Australian hospitals.

In this reporting period area-wide policies governing the prevention of falls in hospitals were implemented. These include a post-fall management protocol to ensure that anyone who does fall is carefully assessed and any injury appropriately managed.

Area health services have established working groups within hospitals, individual facilities and departments to support the implementation of Best Practice Guidelines within all areas of health care. The CEC has also developed a quick reference guide with good practice tips to support the program.

The Falls Prevention Program

The CEC is overseeing the roll-out of a statewide Falls Prevention Program.

There are Falls Coordinators in each area health service and area falls management committees support the implementation of strategies at a local level.

Information provided through IIMS assists in the continual refinement of strategies to reduce falls incidents.

Specific strategies being undertaken as part of the Falls Prevention Program include:

Screening

All hospitals are now implementing a recommended screening tool to identify patients at risk of falling. Systems are also being put in place to support managers in making a more comprehensive assessment of the risk of patients falling in their areas and to take steps to manage these risks.

Identification

Methods are being put in place to identify patients at risk of falling and ensure they are carefully monitored. These methods include: placing falls risk alerts in patient records and by the patient's bed; placing at-risk patients in one area so they can be monitored as a group; and moving at-risk patients closer to nursing stations. Beds that can be lowered to almost ground level are also being purchased for confused older patients.

Sharing expertise

To ensure expertise on falls prevention was shared to facilities in more remote areas, the CEC piloted a rural telehealth education session. Experts provided information on how to reduce falls incidents through a video conference. The session was recorded and a DVD distributed across the State.

April Falls Day

The best ideas implemented in hospitals were showcased as part of the CEC "April Falls Day" so that models of good practice could be shared across the State. This will be an annual event.

Managing outcomes

Performance agreements for area health service chief executives now include a measurement of falls injuries to ensure that implementation and compliance with fall prevention strategies are well managed.



Sharing expertise: April Falls Day

More information on falls prevention for patients and their carers can be found at:
[http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/C06811AD746228E9CA2571C600835DBB/\\$File/fallprevbrochure.pdf](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/C06811AD746228E9CA2571C600835DBB/$File/fallprevbrochure.pdf)

Medication and IV Fluid Incidents

There are many different types of medication and many ways of giving them to patients. Managing safety requires careful co-ordination between prescribing doctors, pharmacists and those who are giving the medication to the patient.

A National Inpatient Medication Chart (NIMC), based on best practice principles, has been designed for use across all hospitals in Australia. This project provides standardised methods and training about prescribing, dispensing and administering medications.

Last year the medication chart was introduced into all NSW public hospitals in conjunction with a comprehensive education campaign. This was followed by a review to assess how well the chart was being used. This was repeated in March 2007. The results indicated that staff were using the chart, but that improvements could be made to its structure. These improvements have been made.

The National Inpatient Medication Chart (NIMC)

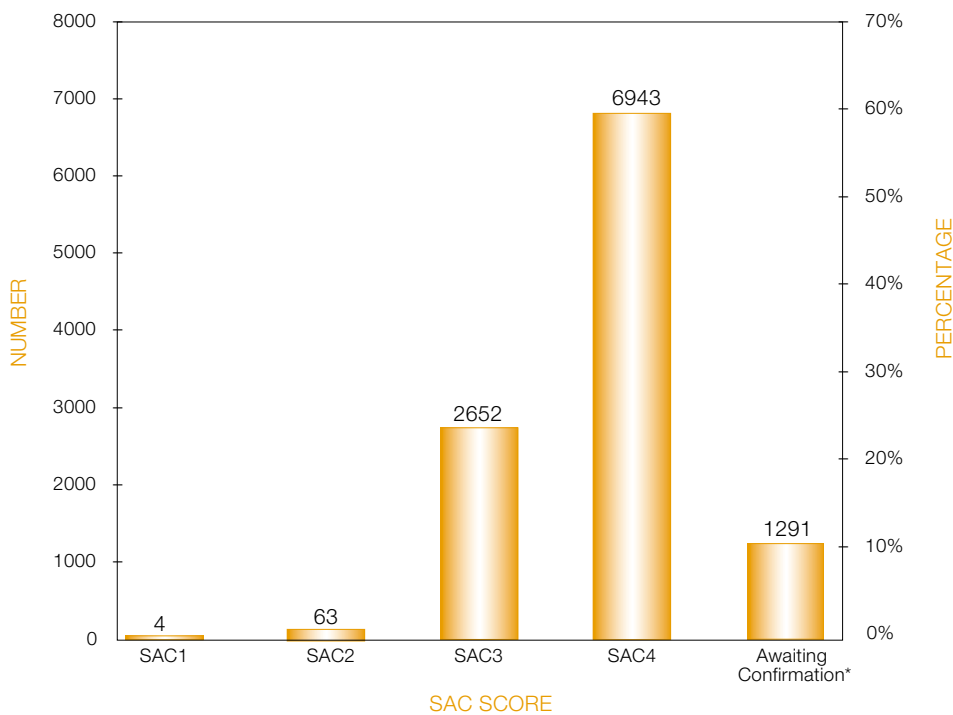
The National Inpatient Medication Chart was developed to provide consistency in the prescription, dispensing and administration of medications across health facilities throughout Australia.

Notifications

In the January 1 to June 30, 2007 reporting period, 10,953 medication/IV fluid notifications were made. Four of these incidents were classified as SAC1.

The spread of notifications within SAC categories can be seen in Figure 3.

Figure 3. Medication/IV Fluid incidents across SAC categories



*Modifications have been made to IIMS to ensure all incidents will have a SAC score in the future.

Lessons Learned

Morphine, Warfarin (a medication to prevent blood clots) and paracetamol (e.g., Panadol) were the medications most commonly recorded in notifications. Incidents related to all steps in the medication process. Issues associated with giving the medication to the patient ranked first, followed by incidents involving prescribing and dispensing medicines.

Action Taken

NIMC revisions

All states and territories worked together to make improvements to the Medication Chart. The revised version was made available as this report was going to press.

The chart forms part of the system for monitoring correct prescribing and administration of medication to patients in hospital. Area health services will continue to perform reviews on the use of the chart, to benchmark compliance with safe practices in medication and identify any areas for improvement.

Medication Safety Self Assessment Program (MSSA)

The CEC, in collaboration with national and international medication safety organisations is developing a suite of complementary tools to promote medication safety and the quality use of medicines in Australian hospitals. The first step of the project is to gather information on the systems and processes that NSW hospitals use to manage medication safety and to compare these strategies against results.

The project will analyse which measures have been the most successful and how they may be adapted to improve medication safety Statewide.

At the time this report was going to press, over 80 hospitals had undertaken the survey. Complete information will be available for analysis by the end of the year.



A Safety Alert: requires immediate action and a report back to the Department of Health.

Warfarin Safety Alert Broadcast

In response to the high rate of incidents related to Warfarin, a Safety Alert was released in April 2007. The alert contains guidelines for prescribing, dispensing and administering the medication.

Clinical Management

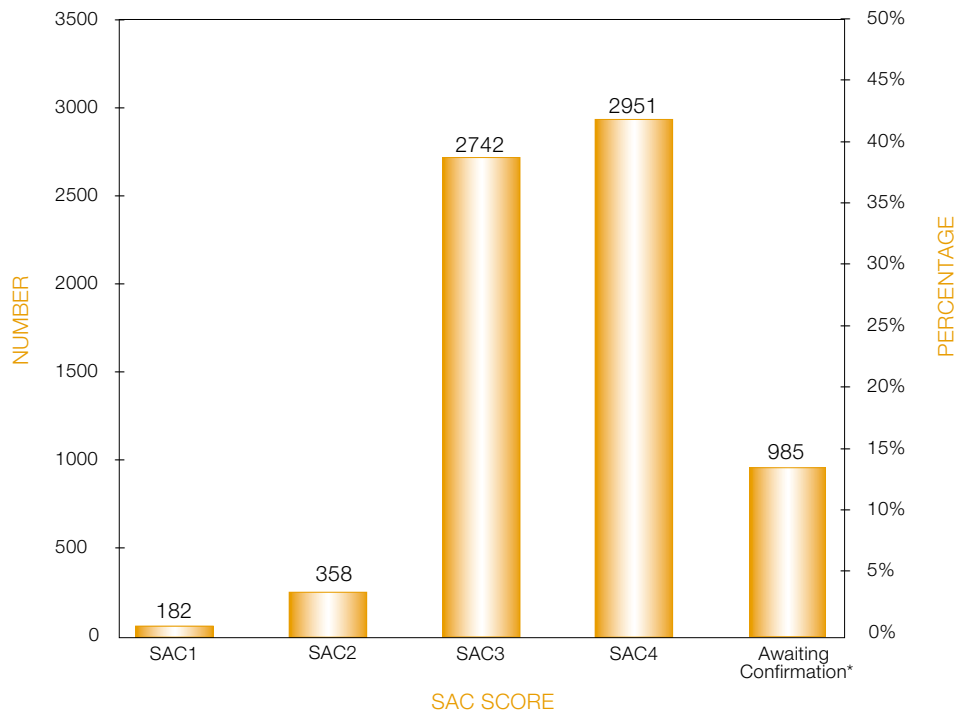
Incidents classified under the category of Clinical Management refer to the range of services that are used to treat illness and injury, such as:

- The diagnosis of the disease or condition, including investigations such as X-rays and scans
- Treating the patient, including any surgery or other procedures
- Monitoring the patient to ensure he or she is responding to treatment and getting better
- Ensuring the safe transfer of the patient to home or other facilities for further care

Notifications

In the January 1 to June 30, 2007 reporting period, 7,218 clinical management notifications were made. One hundred and eighty-two of these incidents were classified as SAC1. The spread of notifications within SAC categories can be seen in Figure 4.

Figure 4. Clinical Management incidents across SAC categories



* Modifications have been made to IIMS to ensure all incidents will have a SAC score in the future.

Clinical management subcategories

Clinical Management is a broad category that takes in many areas of health care. Notifications in this category take into account all steps of the patient journey and include incidents involving retained instruments and the transfusion of blood.

To provide focus in this area we are reporting on those clinical incidents classified as SAC1 or very serious.

Retained instruments

There were six incidents involving retained instruments. All such incidents are classified as SAC1 because they may be an indication of a system failure that could result in serious patient harm. Several of these incidents related to equipment that had removable parts, such as a cannula tip. These incidents were referred to the Therapeutic Goods Administration.

All retained incident notifications, which included items such as a drain and needle, were removed in the ward and did not require the use of surgery. The facilities involved have reviewed processes regarding the removal of “accountable items” and put strategies in place to support staff in complying at all times.

Blood products

There were two incidents involving the safe use of blood products. While these do not represent a significant part of the notifications covered in this report, the availability of this scarce resource, and its appropriate and safe use, is a significant issue throughout Australia.

The CEC has established the Blood Watch Program which will focus on:

- Identifying those situations where a blood transfusion is appropriate
- Ensuring that blood transfusion practices are properly governed, including forming area health service transfusion committees and appointing project officers to oversee data collection, reviews, education and liaison.
- Educating junior medical officers in transfusion medicine
- Ensuring any incidents related to transfusions are notified in IIMS
- Supporting communication between area health services, the Department of Health and the National Blood Authority
- Developing accurate costing models for the use of blood products

All other SAC1 Clinical Incidents

The remaining SAC1 incidents have been grouped under the following subtitles and appear in their own sections in the next pages of this report.

General

This category includes those SAC1 clinical management incidents that are not specific to a particular area of practice or procedure.

Maternal and perinatal

Wrong patient/site/procedure

Suicides

General Clinical Management

In the January 1 to June 30, 2007 reporting period there were 91 SAC1 incidents that have been classified as Clinical Management: General. These have been subdivided under the patient care journey as per the categories below.

Diagnosis (delayed and/or missed diagnosis)	34
Investigations (delayed, not ordered or actioned)	3
Treatment (delayed and/or inadequate)	16
Complication (not the desired treatment outcome)	21
Observations (not performed and/or significance not recognised)	12
Transfer of care (delayed or inadequate planning)	4
Interhospital retrieval/transfer (inadequate stabilisation)	1

Lessons learned

Analysis of these incidents shows that ineffective communication remains an important contributing factor, particularly when there are several clinical teams and services involved in treating a patient. Communication issues can also arise when the care of a patient is transferred between facilities in the health system and/or when the patient is transferred home.

Action taken

Leadership development

All aspects of clinical care are enhanced by strong clinical leadership capabilities. To develop these capabilities, the CEC is running two Clinical Leadership Programs. The first began in February 2007 and is being held in area health services. It aims to enhance the capacity of doctors and nurses to lead sustainable system improvement and patient safety initiatives; to work more effectively with available clinical information and resources; and to develop a culture of patient-centred care.

The second program has begun. It focuses on enhancing understanding of the workings of the NSW health system; developing knowledge of contemporary approaches to patient safety and clinical quality systems; improving communication, conflict resolution and team leadership skills; and increasing clinician ability to influence the direction of health policy.

Identifying and managing the patient whose condition unexpectedly becomes worse

The CEC, in partnership with the Quality and Safety Branch of the NSW Department of Health, is developing a project to improve the recognition and management of a patient in hospital whose condition unexpectedly becomes worse.

An associated issue includes improving communication between groups of clinicians at critical transition points in patient care.

Ambulance transfers

IIMS data has allowed ambulance services to identify clinical incidents relating to patients who are not transported to hospital and subsequently became increasingly ill. Guidelines were developed to help officers clearly communicate risks to the patient and to ensure documentation of any situation where the patient is not transferred.

Patients who decide not to go to hospital are provided with a clinical advice card containing information on signs and symptoms that would indicate the need to contact health care services should they feel increasingly unwell. A patient health care record detailing the observations and the reasons for the patient not attending hospital can be aligned with dispatch records to keep track of patients. A review of this project has shown a compliance rate of 97 per cent.

Safety Alerts

Safety Alert broadcasts were issued on:

- Taking immediate steps to ensure the rapid communication between hospitals, senior doctors and other on-call staff regarding patient care
- Taking immediate steps to ensure that fine bore feeding tubes were inserted correctly.

The Safety Alert Broadcast System provides health services with early warnings about safety issues. There are three levels of warning Safety Alert, Safety Notice and Safety Information. A Safety Alert: requires immediate action and a report back to the Department of Health.

Maternal and Perinatal

In the January 1 to June 30, 2007 reporting period there were 36 SAC1 incidents classified as Maternal and Perinatal.

These incidents have been subdivided under the care journey of mother and baby in the categories below:

Antenatal care	5
Labour and birthing	24
Postnatal/antenatal period	7

Ineffective communication has been recognised as a contributing factor in maternal and perinatal incidents.

The management of pregnant women is an area where communication between health care professionals, and between these professionals and families, is paramount, there are often several clinical teams and services involved. Communication issues can also arise when the care of mothers and their babies is transferred between facilities in the health system and/or when they are transferred home.

Accurate assessment of foetal welfare has also been identified as a contributing factor. The monitoring of the health and welfare of the unborn baby forms an important part of the clinical assessment of pregnant women in labour.

Further analysis has shown that variation in practice, in relating to policies and procedures, is a potential risk factor in the care of patients. The NSW Department of Health supports consistent, evidence-based practice, which promotes the safety of mothers and babies and reduces the potential for error in clinical care.

Action taken

Improving communication

The Maternal and Perinatal Health Priorities Task Force (M&P HPT) is developing a standardised Statewide antenatal record to replace the current yellow antenatal card. The intention is that this record will be held by the mother and taken to each GP, antenatal clinic or hospital visit. This will improve communication between maternity care providers and ensure that complete information on mother and baby is transferred at all critical points in care.

Foetal welfare assessment

A Statewide project is near completion and will be provided in three stages to maternity care providers in the NSW health system during 2008:

- Stage 1 – introduction of an online foetal surveillance education
- Stage 2 – education program regarding foetal welfare assessment
- Stage 3 – education program regarding maternity emergency management and neonatal resuscitation

Safety Notice Broadcast

A Safety Notice Broadcast on the use of Electronic Fetal Heart Rate Monitoring was issued by the NSW Department of Health in May 2007.

Induction and augmentation of labour

A Statewide review of practices used to induce and augment labour, and the use of related drugs, is nearing completion. The review will examine variations in policy and practice across NSW, with the aim of promoting evidence-based care that maximises safety for mothers and babies.

The Safety Alert Broadcast System provides health services with early warnings about safety issues. There are three levels of warning: Safety Alert, Safety Notice and Safety Information.

N *Safety Notice: identified managers must review processes and protocols on a specific risk.*

Wrong patient/site/procedure

The Correct Patient, Correct Procedure, Correct Site Policy provides clinicians with processes and protocols to ensure the safety in this area. Following its release, there has been a reduction in such incidents in operating suites.

Further information is available on the website at: <http://www.health.nsw.gov.au/quality/correct/index.html>

In the January 1 to June 30, 2007 reporting period there were 45 SAC1 incidents classified as wrong patient/site/procedure.

These notifications refer to incidents where the patient's identity was incorrect; where the wrong procedure was attempted or was about to be attempted; and/or where the procedure was performed or about to be performed, on the wrong body part. These incidents are always classified as SAC1 regardless of the outcome, because they are an indication of a system failure that could result in serious harm.

The clinical areas where these incidents occurred are listed below:

Operating suites	3
Dental	1
Diagnostic tests (such as X-rays and scans)	32
Radiotherapy	2
Other hospital areas (such as wards, labs)	7

Lessons learned

Since the release of the "Correct Patient, Correct Procedure, Correct Site" Policy incidents in operating theatres have been reduced by 50 per cent.

Issues identified in previous reporting periods have led to the development of the Correct Patient, Correct Procedure, Correct Site Policy, which provides clinicians with processes and protocols to ensure patient safety. Since the release of the policy and the implementation of a comprehensive education program, there has been a 50 per cent reduction in incidents in operating suites.

Following the effectiveness of this project, attention in 2007 was directed at reducing these incidents in diagnostic testing areas such as X-rays. An increase in notifications in these areas is in part due to increased awareness and vigilance in providing notifications.

Action taken

Revised strategies

The Correct Patient, Correct Procedure, Correct Site Policy has been revised by specialist working groups to suit the particular environments of diagnostic testing, dental suites and other health care areas. Toolkits to assist in complying with protocols were produced for each specialist area. The kits contain posters to remind clinicians of the key steps to follow to ensure implementation of the Correct Patient, Correct Procedure, and Correct Site Policy in their area of practice.

A poster titled, “Why do we keep asking you who you are?” has been produced for waiting rooms. The poster lets patients know that repeated requests for identification are part of protocols for ensuring safety.



Suicides

Suicide is never the result of a single factor or event. It is usually caused by a complex interaction of many factors such as mental and physical illness, substance abuse, family disturbances, interpersonal conflicts and other events that cause stress. Mental health patients and those who have recently been discharged into the community can be vulnerable. The NSW health system takes its responsibility to protect this group very seriously. While it is encouraging that there has been a consistent decline in the overall suicide rate in NSW over the last decade, there is still much work that needs to be done.

This report includes those incidents involving a suspected suicide of a person who was either an inpatient or where the suspected suicide occurred within seven days of the person's last contact with a public health facility.

Notifications

In the January 1 to June 30, 2007 reporting period there were seven suspected suicides where the patient was an inpatient. During the same period there were fifty suspected suicides in the community involving people who had contact with a public health facility within seven days before the event. This figure includes three patients who had absconded or were missing from care at the time of death and three patients who were on planned leave.

Lessons learned

Analysis of these incidents indicates that continuing attention must be given to ensuring the coordination of the patient journey in and out of hospital, community services and home.

Action taken

Working with Families Program

The Working with Families program is being implemented across area health mental health services to help clinicians work effectively with families and carers, particularly during assessment and in planning for the patient's discharge.

Environmental factors

A Safety Notice focusing on environmental safety, and in particular the implementation of collapsible curtains and shower rails, has been issued.

New Directions Package

As part of the New Directions package, over \$41 million has been committed to community rehabilitation services. The program aims to facilitate access to housing, education and employment for people with a mental illness, in order to maximise their potential and minimise or avoid the trauma of relapse.

Psychiatric Emergency Care Centres (PECCs)

PECCs are located within emergency departments and provide round-the-clock specialist mental health assessment, with the capacity to admit mental health patients for observation and immediate care for 48 hours. Seven of the nine hospitals nominated as PECC sites are now providing 24-hour, seven-day-a-week specialist mental health assessment and all nine have dedicated inpatient care co-located in emergency departments.

Rural care

A rural critical care services model is being implemented to support emergency departments to manage mental health presentations. The aim is to provide rapid access to specialist mental health assessment and to establish clear roles and resources for inter-hospital transport and to avoid unnecessary use of Police services.

N *Safety Notice:*
identified managers must
review processes and
protocols
on a specific risk

Infection Control

Clean Hands Campaign

The Clean Hands campaign conducted last year resulted in an increased understanding of the importance of hygiene. It provided alcohol rubs to make the task of hand cleaning easier.

Multi-resistant organism (MRO) data collected during the Clean Hands campaign showed a reduction of MRO infections in Intensive Care Unit sterile sites from 5.28 to 3.92 infections per 100,000 occupied bed days.

New South Wales is committed to reducing the chance of patients getting an infection during a stay in hospital. A Statewide approach is being implemented and focuses on five key areas:

Hand hygiene

Ensuring all staff comply with hand cleaning practices.

Preventing contact with infections

The most common way to spread micro-organisms is through contact. Patients with infections should be isolated and staff should wear protective clothing, such as gloves and gowns.

Keeping the hospital environment clean

Infections can live on surfaces. All equipment and furnishings should be cleaned systematically and regularly.

Correct antibiotic use

The inappropriate and over-use of antibiotics has been linked to the development of multi-resistant organisms. This part of the infection control strategy will focus on ensuring the appropriate use of antibiotics.

Adhering to central line insertion guidelines

Central lines are intravenous lines used to deliver treatments such as antibiotics and other medicines. These lines account for up to 40 per cent of bloodstream infections. Ensuring compliance with insertion guidelines will reduce the incidence of these infections.

Infection rates

Snapshot surveys conducted during the first half of 2007 and comparison with figures collected in the second half of 2006 indicate:

- a reduction in superficial infections occurring in hip, knee, heart and chest operations
- a reduction in deep surgery infections
- a reduction in MRO infections in sterile surgical sites.

Specific Projects

Clean Hands Campaign

A Statewide Clean Hands campaign was launched in March 2006. Project officers were appointed in each area health service to co-ordinate the effort, which included distributing campaign material and introducing alcohol-based rub to assist busy staff in cleaning their hands before and after each patient contact.

The campaign resulted in:

- 15.1 per cent improvement in hand washing among all professional groups in NSW Health facilities
- 70 per cent improvement in the availability of alcohol rubs beside acute beds
- 17.9 per cent increase in staff confidence in using alcohol rubs and a general increase in staff understanding and knowledge of the importance of hand washing.

Multi-resistant organism (MRO) data collected during the campaign showed a reduction of MRO infections in Intensive Care Unit sterile sites from 5.28 to 3.92 infections per 100,000 occupied bed days. Although at this stage it is difficult to ascribe a direct link to the campaign, the results are promising.

Elements of the campaign will be continually applied, reviewed and expanded to ensure that the gains made are sustained and inform other aspects of infection control.

Reducing Central-Line Associated Bacteraemia (CLAB) in Intensive Care Units (ICU)

A campaign to reduce central venous catheter blood stream infections in Intensive Care Units (ICUs) was launched in March 2007. The campaign aims for a 20 per cent reduction in infection rates across all ICUs in NSW by January 2008, with a further reduction of 80 per cent by January 2010.

Agreed guidelines for the insertion and management of central lines based on best practice are being developed, taking into account the working environments within ICUs in NSW hospitals. These will be implemented and an easy-to-use data collection system will be created to monitor success.

Preventing any infection in the intravenous lines used to administer some medicines is an important strategy being implemented in ICUs across the State.

Complaints

In 2006 a Complaint Management Policy was introduced to ensure that patients with complaints have their concerns resolved effectively and in a timely manner. All complaints, risks, issues and resolutions are recorded in IIMS. Such systematic recording provides valuable information that complements incident notifications.

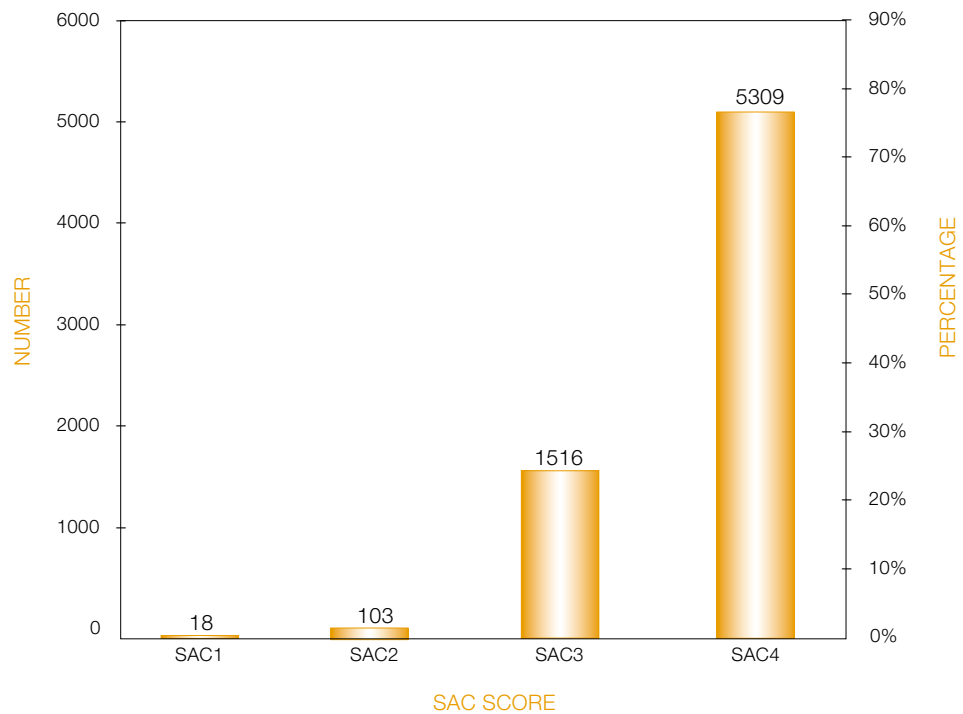
The Complaints Management Policy is underpinned by the following principles:

- Encourage patients and their families to provide feedback
- Acknowledge and respond to complaints quickly and sensitively
- Deal with complaints in a manner that is effective, complete and fair to all parties
- Communicate complaint information openly while protecting confidentiality and privacy.

Notifications

In the January 1 to June 30, 2007 reporting period there were 7207 complaints received. Among these, 6946 had the Severity Assessment Code confirmed locally. The SAC distribution of these incidents is illustrated in Figure 5.

Figure 5: Complaints classified according to SAC categories



Resolving complaints

Forty-six percent of complaints were resolved with an explanation and 35 per cent with an apology, demonstrating the importance of these measures. Most people need to understand the processes of the health system and why things have happened in a particular way. It is also important that they know that the impact of the event on their lives has been understood and the outcome regretted.

Understanding how patients and their families perceive a treatment process is an important part of establishing trust and improving the quality of care.

A benchmark of five calendar days was set to acknowledge formally the receipt of a complaint in writing and to explain the review process.

A second benchmark of 35 calendar days was set for finalising the review and providing information on the outcome to the person who complained. The State has set a benchmark of 80 per cent percent of complaints to be resolved in 35 days. Current performance is at 83 per cent. Some cases, are complex and took longer than the 35 day benchmark.

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What did people complain about?

The top three complaint categories were communication, treatment and access.

Communication

Twenty-eight percent, or 1990 complaints, were classified as “communication”. This category refers to situations where patients saw staff as being unhelpful, lacking compassion or abrupt. This category also includes complaints about the poor provision of information regarding test results and treatment, and how the family should care for the patient at home.

Treatment

Twenty-seven percent, or 1933 complaints, were classified as “treatment”. Complaints in this category related to “clinical” situations relating to diagnosis, infection control, medication and co-ordination of treatment. This category also includes organising the necessary equipment needed to accompany a patient home, and helping the family to plan for this move.

Access

Twenty-three percent, or 1638 complaints, were categorised as “access”. Complaints in this category relate to the availability of specialist services such as speech pathology, the opening hours of clinics, the postponement of surgery, and waiting for a long period in a clinic or emergency department.

How complaint information will be used

It is important that complaints are effectively managed and resolved. Gathering information about them is also an essential part of identifying specific areas and trends running throughout the health system that can be improved.

Complaints also provide clinicians and managers with another perspective on how treatment services are experienced and where changes can be made to enhance quality care.

Consumers can play an active role in their own healthcare. The following are some tips on how you can get involved.

Ten tips for safer health care

1. Be actively involved in your own health care
2. Speak up if you have any questions or concerns
3. Learn more about your condition or treatments by asking your doctor or nurse and by using other reliable sources of information
4. Keep a list of all the medicines you are taking
5. Make sure you understand what the medicines are for and how to use them
6. Get the results of any test or procedure
7. Talk to your doctor or other health care professional about your options if you need to go into hospital
8. Make sure you understand what will happen if you need surgery or a procedure
9. Make sure you, your doctor and your surgeon all agree on exactly what will be done
10. Before you leave hospital, ask your health care professional to explain the treatment plan you will use at home

Find out more at www.health.nsw.gov.au/quality/10tips/

Looking to the Future

Since the establishment of the NSW Patient Safety and Clinical Quality Program in 2004, the NSW Department of Health has published three annual reports on the management of serious incidents in our public health system. In 2006 the CEC published an inaugural report on the first complete year of data collection using IIMS.

The capacity of IIMS, coupled with an infrastructure that supports the analysis of incidents and tracks the steps taken to address safety, has led to the production of six-monthly reports.

It is important that the community receives timely information on the process used to improve patient safety and clinical quality because this knowledge provides a better understanding of the incremental steps required to make effective change. Such steps include: creating a system and culture to gather information on incidents; analysing the causes; identifying common themes; using local, national and international expertise to develop programs; implementing these programs; and continually monitoring the outcomes.

Such an approach can be witnessed in projects such as the National Inpatient Medication Chart and the Correct Patient, Correct Procedure, Correct Site Policy.

In this reporting period we have identified themes and trends around the recognition and management of the patient whose condition unexpectedly and rapidly becomes worse. The CEC and the Quality and Safety Branch within the NSW Department of Health are working on a project to address this issue. A project is also being developed to ensure the correct identification of patients as they move between health care settings, because there are a variety of methods used. Our next report will keep the community abreast of these developments.

We believe it is important that patients and their families are aware of the projects being undertaken and that they understand why health services are delivered in a particular way. This allows us all to make best use of our health system and provide comment as required. Remaining open and responsive to these comments is an ongoing commitment of the NSW Patient Safety and Clinical Quality Program and an important part of ongoing improvement.

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

