



NSW HEALTH

Incident Management in the NSW Public Health System 2007

July to December

NSW DEPARTMENT OF HEALTH

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Foreword

The NSW community can be assured that the quality of healthcare they receive is among the best in the world. No complex system is perfect however; both here and in other developed countries sometimes things go wrong:

- a system for delivering a particular treatment may prove inadequate
- a piece of equipment may be faulty
- an individual may make an error in judgement.

The NSW Department of Health has adapted strategies used in other high-risk industries, such as aviation and nuclear power generation, and applied them to the management of healthcare delivery. This approach relies on gathering information on any incident that might affect safety, even if the incident did not result in harm. Contributing factors to the incident are determined and analysed, and the information used to make changes to the way things are done. Such an approach recognises that the vast majority of incidents are due to flaws in a chain of events, not the actions of an individual.

Organisations with the best safety records are usually those with the best incident notification systems in place. It means that people in the organisation are always on the lookout for anything that might represent a risk.

The NSW Department of Health has applied this approach to the management of healthcare delivery. The NSW Patient Safety and Clinical Quality Program (PS&CQP), established in 2004, provides structures and processes to support and encourage all staff working in healthcare delivery to notify incidents involving patient safety, including those that did not result in patient harm.

Since the launch of the PS&CQP and the implementation of the electronic Incident Information Management System (IIMS), the number of notifications has continued to rise. The vast majority have been about minor events where there was little or no harm to the patient. Staff confidence in using the system is improving and our culture of safety is becoming more robust. All these incidents are managed and the contributing factors addressed.

We now have a much larger pool of information about our health system. This allows us to find common threads and develop 'whole-of-system' solutions that not only address specific safety concerns, but make overall improvements to the quality of patient care.

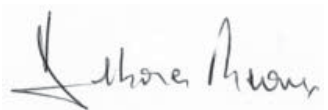
In this six month reporting period, July 1 to December 31, 2007, we began three important 'whole-of-system' projects:

- The Between the Flags Program addresses factors contributing to incidents involving a patient whose condition unexpectedly and rapidly becomes worse in an acute ward setting
- The Healthcare Associated Infection (HAI) prevention program aims to reduce dramatically the possibility of any patient developing an infection while in hospital
- The Patient Identification Project is in its planning stages and will develop improved methods to identify patients correctly as they move between different teams and attend different facilities such as X-ray, pathology and other diagnostic and treatment speciality areas.

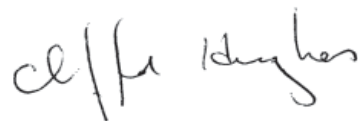
These projects combine clinical expertise with management know-how to ensure that quality changes are embedded into the way things are done.

In this reporting period results are presented from the first Statewide Patient Survey. We learned that the majority of patients are happy with public health services in terms of clinical care, but that we are not always meeting emotional needs or supplying people with enough information about the treatment they are receiving. The Patient Survey is one of several strategies being used by the NSW Department of Health to gain a complete picture of patient and carer experience and to link this feedback with service improvement.

All the projects in this report require hard work and dedication by our staff. We are indebted to them for their enormous contribution. We also acknowledge the important feedback we receive from the community that helps broaden our perspective of what quality care involves.



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



Professor Clifford Hughes, AO
Chief Executive Officer
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Key messages

These six-monthly reports keep the community up-to-date with incidents occurring in the NSW health system and what is being done about them. They are produced by the Clinical Excellence Commission and the Quality and Safety Branch of the NSW Department of Health. The word 'incident' refers to any event that either causes, or has the potential to cause patient harm.

These reports are part of the NSW Patient Safety and Clinical Quality Program established in 2004. This program builds on previous systems, structures and knowledge to place patient safety at the centre of all healthcare delivery. It incorporates a Statewide electronic Incident Information Management System (IIMS).

Incidents notified in IIMS are rated against a Severity Assessment Code (SAC) that has four ratings. SAC1 is the most serious. The NSW Department of Health uses a very broad definition for SAC1 incidents to ensure that they are all captured and investigated. SAC1 notifications also include incidents that do not result in patient harm, but which indicate the possibility of a systems error that could result in serious harm.

There has been a steady increase in the number of notifications about incidents since the NSW PS&CQP began. The increase in notifications has consistently been among incidents classified as SAC3 and SAC4. These categories capture events and situations where there has been minimal or no harm to the patient, but where the staff member identified risk. SAC1 incidents continue to represent well under one per cent of all notifications made. The increase in the number of SAC3 and SAC4 notifications, without a corresponding rise in the number of SAC1, indicates that staff are becoming increasingly aware of safety issues and comfortable with notifying them.

In the six-month period from July 1 to December 31, 2007 there were 753,938 admissions to hospitals and other health facilities, 1,348,265 operations performed, 969,887 emergency department attendances, and 10,662,490 interactions with patients who were not admitted (out-patient and other services). During that period 57,808 incidents were reported, of which 294 were classified as SAC1. While the number of incidents represents a very low proportion of total admissions and other types of care, this in no way diminishes the impact they have on individual lives. Every possible step is being taken to learn from them and prevent their re-occurrence.

IIMS enables the management of incidents to be tracked and to assist in determining themes and trends. The most common themes are communication and the correct identification of patients. The incident categories with the highest number of notifications are:

- Falls
- Medication
- Clinical management.

This report contains information about all the incidents notified in IIMS which focus on the top three Principal Incident Types. More specific detail is provided on all SAC1 incidents under particular categories of care.

Incidents occurring in the NSW health system are analysed and the contributing factors addressed. They are managed in the environment where they occurred and where appropriate. Lessons learned are used to develop and inform projects and programs at a Statewide level. This process cultivates system-wide learning and drives quality improvement at both local and strategic levels.

New projects started in this reporting period include:

- the 'Between the Flags' Program that addresses incidents involving the recognition and management of the patient whose condition unexpectedly and rapidly becomes worse
- methods to support the management of people arriving at hospital with symptoms of a possible heart attack
- planning for an electronic Medication Management system that will link medications with other patient records, provide clear communication between health teams and assist in medication reconciliation
- the rollout of the Healthcare Associated Infection (HAI) prevention program to reduce dramatically the possibility of any patient developing an infection while in hospital
- a collaborative project with the Australian Commission for Safety and Quality in Health Care (ACSQHC) that focuses on technological solutions and best-practice models in the area of patient identification.

Projects that started in the previous reporting period are progressing and others are being refined by insights gained through notifications made in this reporting period.

Examples include:

- the implementation of a computer-based training program on fetal welfare assessment and the interpretation of fetal heart rate monitoring results to all NSW hospitals responsible for providing maternity care
- further rollout of the Rural Critical Care Services Program into four rural and regional Area Health Services. This program aims to increase the capacity of rural hospitals to provide rapid round-the-clock specialty care for people who have mental health problems and are at risk of harming themselves
- strategies used to prevent falls are being further refined to suit the needs of a variety of healthcare settings, with over 150 hospitals implementing protocols and guidelines
- further refinement of the National Inpatient Medication Chart (NIMC) to incorporate changes to the way Warfarin (a medication to prevent blood clots) is recorded.

Special reviews have been conducted on the use of medications to treat Attention Deficit Hyperactivity Disorder (ADHD) and on complication rates associated with surgery to implant permanent pacemakers. The reviews found that NSW is overall, in keeping with best practice regarding the prescription of ADHD medications and that the State's performance in surgery to implant pacemakers is in line with international outcomes. Recommendations were made to improve the provision and co-ordination of services for children and adolescents with ADHD and to standardise the credentials required by cardiology medical specialists and cardiothoracic surgeons who undertake pacemaker surgery.

The Blood Watch Program continues to conduct research and develop strategies to improve the safety and use of this valuable resource.

The first Statewide Patient Survey was undertaken. Approximately 75,000 people completed the questionnaires, with 88.1 per cent rating the delivery of healthcare services in the good/very good and the very good/excellent categories. The healthcare system performed best in patient preferences, access to care, co-ordination of care and physical comfort. There is room for improvement in the involvement of family and friends in patient care, the provision of emotional support, continuity of care, and the supply of information and education on treatment issues.

The results of the survey will provide focus for improvements that will complement what is being done in other areas of the NSW Patient Safety and Clinical Quality Program.

Understanding this report

This report provides the community with information on incidents relating to patient care and what is being done about them. The word 'incident' refers to any event that either causes, or has the potential to cause, patient harm.

These reports are compiled twice a year and include:

- an examination of notifications received through the electronic Incident Information Management System (IIMS)
- lessons learned from analysing individual incidents
- the results of special reviews into patient safety and quality issues
- the actions taken within the reporting period to make improvements
- information about complaints and our response.

These reports are one of the ways in which the community receives information on the activities of the NSW Patient Safety and Clinical Quality Program. Production is overseen by the Clinical Excellence Commission (CEC) and the Quality and Safety Branch (QSB) of the NSW Department of Health.

The CEC is an independent statutory body that looks at patient safety and clinical quality issues in terms of how the NSW health system works as a whole. It also conducts reviews on safety topics nationally and internationally identified to see how well we are responding to particular health concerns. Its job is to advise on improvement strategies of a more global nature.

The Quality and Safety Branch is part of the NSW Department of Health. It is responsible for:

- setting safety and quality standards
- developing related policies
- measuring how well the policies are working
- gathering information on serious incidents and their analysis
- taking preventative action
- overseeing the management of safety and quality in Area Health Services so that measures to prevent incidents are put into practice.

The Patient Safety and Clinical Quality Program provides a framework for making significant improvements to clinical quality in our public health system.

More about the Patient Safety and Clinical Quality Program can be found at www.health.nsw.gov.au/policies/pd/2005/pdf/PD2005_608.pdf

Information is gathered and used to achieve safety and quality improvements

An important part of the NSW Patient Safety and Clinical Quality Program is the electronic Incident Information Management System (IIMS) 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 increases understanding of the causes of incidents and the ability to develop effective strategies to make sure they do not happen again.

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

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 being the most serious. IIMS also stores information on factors contributing 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.

Analysing Incidents and Taking Action

Incidents occurring in the NSW health system are reviewed and the same three questions asked:

- *What happened?*
- *How did it happen?*
- *How do we prevent it from happening again?*

The SAC ratings guide the steps to be taken to address the incident.

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

Analysis of incidents and resultant action requires a systems approach. This means looking at the steps in a process used for undertaking a procedure and identifying any issues that could compromise the best outcome. 'What system do we have in place to make sure that a person coming to hospital with a very serious illness is diagnosed quickly?' or 'What system do we have in place to make sure that no-one

is ever given the wrong medicine?’ Insights gained from the analysis of incidents are used to make changes to policies, provide further education, review work environments and so on. Each improvement must be thoroughly tested, embedded in practice and monitored, to check if it is having the desired effect.

IIMS plays a valuable role in ensuring that all agreed actions are signed-off by the responsible manager.

Managers at each level of healthcare can also use IIMS to review their hospital, health facility or department for any similar risks and to put prevention strategies in place. The Falls Prevention Program on page 16 illustrates this approach.

Project teams in the Clinical Excellence Commission and the NSW Department of Health also use information in IIMS to inform the development of programs implemented across the healthcare system. Examples include:

- ‘Between the Flags’ program
- Health Care Associated Infection (HAI) prevention program
- Blood Watch program.

Details of these and other projects are contained throughout this report.

Safety Alert Broadcast System

While system improvement programs can take time, it is important that the health system is alerted to any concerns as rapidly as possible. The NSW Department of Health has developed the Safety Alert Broadcast System (SABS) for this purpose. SABS provides health services with early warnings about safety issues and indicates who is responsible for taking action. Anecdotal responses from health professionals indicate that the system is proving to be effective.

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

Notifies designated managers about important issues. Managers should review or develop processes and protocols to ensure that the issue is managed for any safety risk.



Safety Information

Provides information on safety issues.

A Safety Alert relating to fetal heart rate monitoring is noted on page 29 of this report.

Special reviews

While IIMS is an important tool supporting patient safety and clinical quality improvements, there are other mechanisms in place. A safety issue may be identified by a member of the community, or may come to light as a result of a serious incident that has implications for the wider NSW health system. A special review may be set up to conduct an in-depth review of how NSW Health is handling the concern and any action that may be required.

Special review: Pacemaker Safety

The Clinical Excellence Commission conducted a review of surgery used to implant permanent pacemakers. This was in response to concerns that complication rates following the procedure were too high.

Pacemakers can be implanted by medical specialists in cardiology and by cardiothoracic surgeons. The review looked at:

- individual hospital requirements regarding the credentials of those approved to implant pacemakers
- systems used by hospitals to collect and review the outcome of this procedure
- the extent to which information on patient outcomes was being used towards improving systems that applied to this procedure.

The review found that NSW did not have a higher rate of complications relating to this surgery than the international figures and that there was little evidence to show that complication rates differed between cardiology medical specialists and cardiothoracic surgeons. The review did find however, that there were no clear and consistent requirements regarding the credentials of those approved by individual hospitals to perform the procedure.

The review also found that while hospitals do collect some information on complications, the amount and type of this information was inconsistent.

In light of these findings the review recommended that:

- standards be developed on the credentials required to implant pacemakers
- those approved to implant pacemakers meet the required credentials and receive regular performance reviews
- follow-up systems be established to review all patients approximately three months after a pacemaker is implanted
- hospitals gather information on early and late complications and use this to make improvements to the systems that apply to this procedure
- standardised complication definitions be developed and a Central Pacemaker Registry established to collect and analyse information, with the aim of making continual improvements across all hospitals.

Open Disclosure Policy

An important part of quality patient care is open disclosure. This means telling patients, carers and families when a mistake has been made and saying sorry for the distress caused. Open disclosure also provides patients and their families with information on why an incident happened and the steps that are being taken to ensure that it does not happen again.

The NSW Department of Health has developed an *Open Disclosure Policy and Guideline* – based on the Australian National Standard to provide guidance in this process. An ongoing training program provides information and education on open disclosure, and fosters the communication skills of all staff, including senior managers. Evaluation shows that participants felt their communication skills had improved and that they felt confident in conducting sensitive conversations with patients and families.

Health facilities are developing and implementing local guidelines and procedures to support the ongoing implementation of the *Open Disclosure Policy*. Ensuring local protocols are in place is an essential part of increasing staff confidence in the open disclosure process and fostering a culture of openness.

More information on open disclosure can be found at www.health.nsw.gov.au/quality/opensdisc/links.html

Explain

Apologise

Reassure

Open Disclosure is a frank discussion with a patient and/or their support person about an incident that resulted in harm or injury to the patient. The principles are:

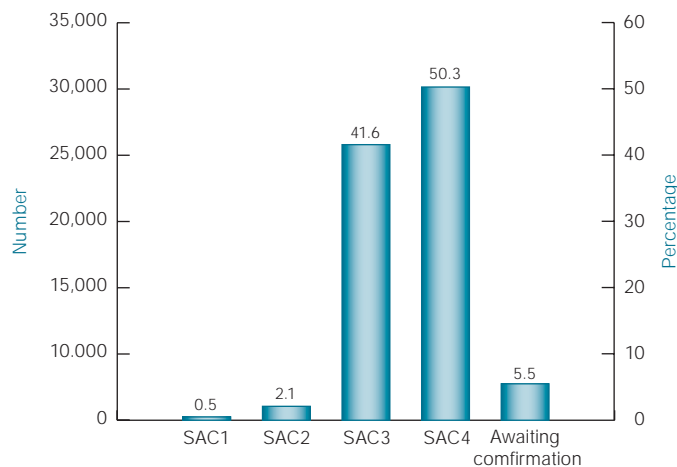
- Open and timely communication
- Acknowledging the incident
- Recognition of the patient's expectations
- Saying 'sorry'
- Supporting staff
- Confidentiality.

An overview of information contained in the Incident Information Management System (IIMS)

IIMS is used to collect and store information about a range of incidents, including those involving property. This report is however, concerned with those incidents related to patient care. These are defined as 'clinical incidents'.

There were 57,808 clinical incident notifications in the July 1 to December 31, 2007 period – and 53,817 in the previous reporting period. The majority of these notifications were classified as SAC3 or SAC4. The increase in the number of SAC3 and SAC4 notifications, without a corresponding rise in the number of SAC1 and SAC2 is evidence that staff are becoming increasingly aware of safety, issues and more likely to notify any incident involving safety, even if it does not result in patient harm. The spread of incidents within SAC categories can be seen in Figure 1.

Figure 1. Clinical incidents across SAC categories July to December 2007



Note. Modifications have been made to IIMS to ensure that all incidents have a SAC rating, following confirmation by a manager. This has resulted in a significant decrease in the number of incidents awaiting confirmation, compared to the previous reporting period.

Principal Incident Types

There are 19 Principal Incident Types. These cover infection, medical equipment, documentation, falls and other areas that may have been involved in the safety risk. 'Was the main reason the patient was at risk of harm due to a failure in our documentation system or because they slipped and fell, or because they developed an infection?' and so on.

Further analysis of Principal Incident Types provides insight into underlying contributing factors like communication issues, training, the need for policies and other support structures. Falls, Medications and Clinical Management (a broad area that takes in all aspects of patient care, including diagnosis of a condition and treatment) are the top three most notified Principal Incident Types.

Collecting information about incidents in IIMS allows managers and clinicians to identify common themes from incidents and to develop whole-of-system approaches to improving healthcare.

Common themes among Incidents

Analysis of notifications in IIMS has identified the most common themes:

Communication

This includes, how well we:

- communicate with one another when we are handing over the care of a patient to another specialist or facility
- how quickly we tell senior doctors and nurses when we are concerned that a patient's condition may have become worse
- explain to patients, their families and carers what we are doing to treat them and what they need to understand when they continue that care at home
- communicate with pharmacists, specialists, nurses, patients, families and carers about medications that are required.

The World Health Organisation (WHO) has targeted communication during patient handover as a priority. Major teaching hospitals in NSW are collaborating on an international project to address this issue. Standardised tools will be developed to measure handover practices and to ensure that they are effective in all situations.

Additional strategies to address communication issues are discussed in more detail in separate sections of this report.

Patient Identification

Correctly identifying patients remains a system-wide issue, contributing to a number of incident types. The NSW Department of Health, in collaboration with the Australian Commission for Safety and Quality in Health Care (ACSQHC), has begun work on a major project to address this issue. There are three areas of focus:

- standardising patient identification bands
- developing patient identification best-practice models
- investigating technological solutions.

The following pages in this report look at the themes in the top three Principal Incident Types in more detail. Separate sections provide information on healthcare infections and complaints.

Falls

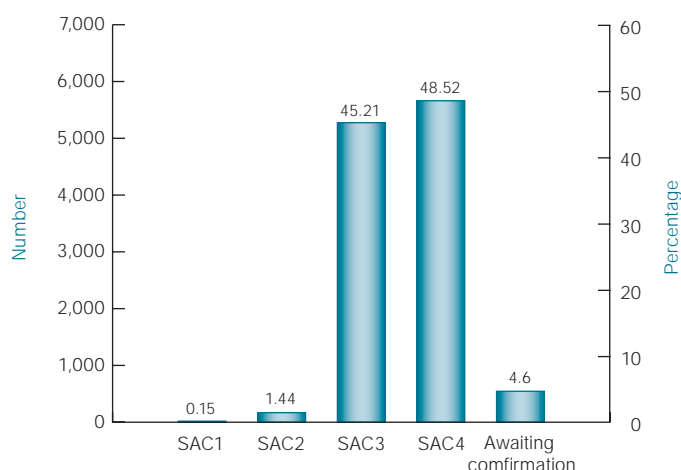
Falls-related injuries are rising as our population ages. Most at risk are the elderly. While this report is concerned with providing information on those falls that occur in a healthcare setting, it also recognises that action taken to reduce these incidents will overlap with strategies being used to tackle the issue in the wider community. These strategies include:

- 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.

Notifications

In the July 1 to December 31, 2007 reporting period there were 13,284 fall notifications. In the previous reporting period the figure was 12,321. Figure 2 shows the SAC categories for fall notifications against the last reporting period. Twenty of these incidents were classified as severe, or SAC1. In the previous six months there were 19. The greatest rise in numbers of notifications has been in the SAC3 and SAC4 categories. There is a greater awareness of falls incidents and a willingness to notify any situation involving a fall, or potential fall, regardless of whether it has caused patient harm.

Figure 2. Falls incidents across SAC categories July to December 2007



Lessons learned and action taken

Falls in hospital happen most frequently among people who have more than one long-term chronic condition, are taking many medications, have impaired thinking – such as dementia and delirium-impaired mobility and/or a disability. In the general community, the risk of falling increases with age. This situation is mirrored in hospital settings with fall incidents more common among people over 80 years.

Difficulties remain in determining the precise cause of some falls. People who are very old and sick may collapse. It is difficult to determine whether the fall was the result of the natural progression of their failing health, or an external factor.

We should not, however, dismiss falls in this group as inevitable. More work must be done to ensure that all staff working in hospitals recognise fall prevention as a serious issue. Environmental risks must be continually identified. Assessing patients for risk and monitoring must be seen as an important component of clinical care.

Issues highlighted by IIMS notifications include:

- the admission of older people to other wards when speciality aged care beds are not available. Staff in other wards are not always familiar with the special needs of elderly patients and their risk of falling
- communication issues regarding risk of falling when patients are transferred between points of care
- recognition that moving older patients frequently for tests or to other accommodation in busy hospital environments can add to their confusion
- timely availability of occupational therapists and physiotherapists to assist in falls prevention among those at risk
- availability of Hi-Lo and Lo-Lo (adjustable height) beds for patients at high-risk of falling out of bed, and other devices that would assist – such as bed and chair alarms
- the availability of staff to monitor and supervise patients who are confused and/or disturbed.

Analysis of notifications in IIMS also highlighted the need to identify those incidents that involve people who fall repeatedly.

The NSW Falls Prevention Program

The NSW Falls Prevention Program, outlined in the last report, continues to be integrated into Area Health Services across NSW. Area Falls Prevention Co-ordinators work to put in place strategies aimed to reduce the likelihood of falls occurring in a variety of settings. Complementary goals include:

- putting post-fall management protocols in place to ensure that anyone who falls is carefully assessed and any injury appropriately managed
- the use of a recommended screening tool to identify patients at risk of falling
- developing systems that support managers in making a more comprehensive assessment of the risk of falling in their areas, and the preventative steps to be taken.

Specific strategies that support these goals include:

- the distribution of falls prevention good-practice tips and post-fall management guidelines to hospitals and clinics throughout the State
- encouraging the establishment of working groups to review and analyse IIMS data at a ward level to reflect what falls incident information means to their practice and the changes required
- providing resources to assist with this task.

Over 150 healthcare facilities across NSW are implementing falls policy and falls prevention guidelines. Making significant changes in a wide range of healthcare environments is a complex task that involves engaging and supporting staff, patients, families and carers in prevention strategies. There is further work required to support the implementation of this program, including the provision of ongoing falls prevention education to staff.

Area Health Services are ensuring that individual approaches to falls prevention are highlighted and shared. Opportunities to showcase projects continue. These include the gazetted April Falls Day as a regular event in NSW Health Calendar on April 1. Chief Executives have been part of these activities, demonstrating their support for the goals.

The NSW Falls Prevention Network distributes a bi-monthly newsletter with the latest research evidence and continues to hold regular meetings to ensure that falls prevention remains a focus for improvement.

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. Area Falls Management committees have also been established to support the implementation of strategies at a local level. This includes implementation of the Australian Commission for Safety and Quality in Health Care (formerly Council) *Falls Prevention Best Practice Guidelines for Australian Hospitals*.

Falls in hospital are common

Health care providers are working to reduce your risk of falling while you are in hospital by:

- Helping you to settle in, keeping your surroundings safe and providing you with fall-prevention information.
- Assessing your risk of falling and discussing the results with you to develop and implement a care plan.

What YOU can do:

- Bring to hospital any equipment you normally use, such as spectacles and walking aids.
- If you have a walking aid, make sure it is in good condition and that you use it, rather than using furniture or walls for balance.
- If you have spectacles, only wear your distance ones when walking. Take special care when using bi-focal or multi-focal glasses.
- Wear comfortable clothing that is not too long or loose. Wear comfortable, low-heeled and non-slip shoes that fit you well rather than slippers.
- Use your call bell when you require assistance and keep it in easy reach.
- Take your time when getting up from sitting or lying down.
- Let staff know if you feel unwell or unsteady on your feet.
- If staff recommend that you need assistance or supervision when moving, please ask them for this assistance and wait until they come to help you.
- Familiarise yourself with your room, its furniture and bathroom. Look out for hazards such as spills and clutter that may cause a fall and tell staff about them promptly.
- Make sure you drink plenty of water.
- Please ask staff for assistance to go to the toilet if feeling unsteady.

These tips have been adapted from *Preventing Falls and Harm from Falls in Older People. Best practice guidelines for Australian hospitals and residential aged care facilities* developed by the former Australian Council for Safety and Quality in Health Care (2005).

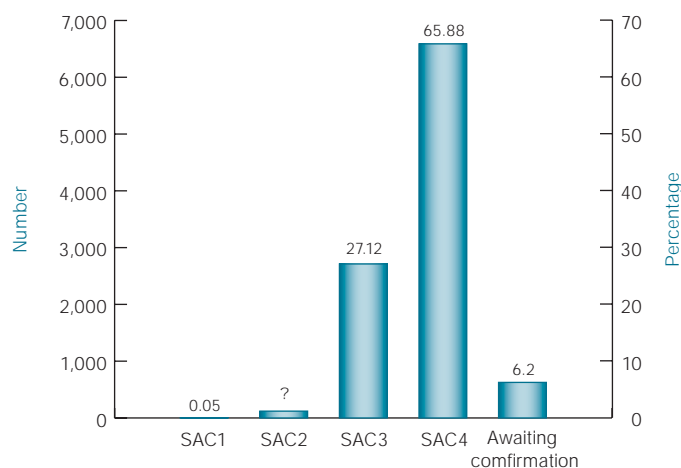
Medication and intravenous fluid incidents

Managing medication safety involves identifying risk factors associated with particular medicines and ensuring co-ordination between prescribing doctors, pharmacists and those giving the medication to the patient.

Notifications

In the July 1 to December 31, 2007 reporting period there were 9,966 Medication/IV fluid notifications. In the previous reporting period the figure was 10,953. Figure 3 shows the SAC categories for Medication/IV fluid notifications. Five incidents were classified as SAC1. There were four in the previous reporting period.

Figure 3. Medication/IV fluid incidents across SAC categories July to December 2007



The most commonly cited drugs in Medication/IV fluid incidents were morphine and its derivatives, paracetamol (eg Panadol) and Warfarin (a medication to prevent blood clots). The risk factors surrounding individual drugs differ. Some are used frequently and regularly. As a result the opportunity for error is increased. Others have very specific dose requirements that vary from patient to patient and must be monitored carefully. Other drugs have legal requirements. Any incident related to supply must be reported.

Lessons learned and action taken

As in the last report, medication notifications continued to span the entire management pathway with incidents occurring during prescribing, dispensing, supplying, storing and giving medication to the patient.

Medication Safety Self Assessment® for Australian Hospitals (MSSA)

The Medication Safety Self Assessment® (MSSA) program is being conducted by the Clinical Excellence Commission in collaboration with national and international medication safety organisations. The project is developing a suite of complementary tools to promote medication safety and quality use of medicines in Australian hospitals. The first step was the collection of information on the systems and processes NSW hospitals use to manage medication safety and to use this information to identify areas where incidents may occur.

Eighty-four public hospitals undertook the survey. Emerging themes for quality improvement include:

- how drug orders are communicated
- information technology that links pharmacy with other hospital information systems
- access to, and use of, approved abbreviations
- access to, and use of, information to inform decision-making about medications
- formal processes for reconciling the medications being used for treating a patient
- formalised high-risk drug lists
- ongoing education in medication safety.

These issues are informing the development of specific projects.

Electronic Medication Management

The NSW Department of Health is committed to developing an electronic medication management system. The project is in the pilot phase. When complete it will deliver a computerised system for placing medication orders linked to other hospital information systems and the patient's record. The computerised system will also contain the latest information on drug risks and prompts to support decision-making relative to the patient's condition and treatment.

National Inpatient Medication Chart (NIMC) revisions

The National Inpatient Medication Chart (NIMC) was developed to provide consistency throughout Australia in prescribing, dispensing and giving medications to patients. It forms part of the system for monitoring all aspects of the medication process and is continually reviewed. Following a number of incidents where prescribed Warfarin (a medication to prevent blood clots) was not given to the patient, the NIMC was revised to incorporate changes in the way this medication is recorded. All hospitals were provided with the new version.

Special Review: ADHD medications

The Clinical Excellence Commission conducted a Special Review into the diagnosis and treatment of Attention Deficit Hyperactivity Disorder (ADHD). The review was prompted by concerns that doctors were over-prescribing stimulant medications to treat this condition.

The review was based on:

- a survey of current practice among a representative sample of doctors approved under the *Poisons and Therapeutic Goods Act* to write prescriptions for such drugs
- an audit of a representative sample of medical files on children receiving medication
- information gathered on NSW and national prescription rates.

The Review found that there was no significant difference between the prescription of stimulant drugs to children and adolescents with ADHD in NSW than in Australia generally. On average, five out of 100 patients diagnosed with the condition are prescribed medication.

The survey of current practice showed that the vast majority of the doctors sampled complied with prescribing criteria based on internationally recognised guidelines for the use of medication. These drugs were used with caution and the doctors recognised the importance of using other approaches such as speech and language therapy, behavioural management, occupational therapy, and family therapy.

The review recommended that:

- interagency collaboration, particularly in health, education and training, be formalised to develop comprehensive services for these patients
- medical practice in diagnosing and treating the condition be enhanced through ongoing professional development and by encouraging research
- health promotion material be produced to inform the community, professionals and the media regarding best practice in the management of ADHD
- the use of medications to treat ADHD be continually monitored and guidelines updated based on solid research evidence.

Clinical Management

Clinical Management is a broad incident category that covers many areas of healthcare. Notifications take into account all steps of the patient journey and include specific services, such as maternal and mental health. They also include incidents involving the transfusion of blood, instruments that are retained during surgery and procedures that are performed on the wrong body part or person. More detail about these specific issues is contained in subsections within this report.

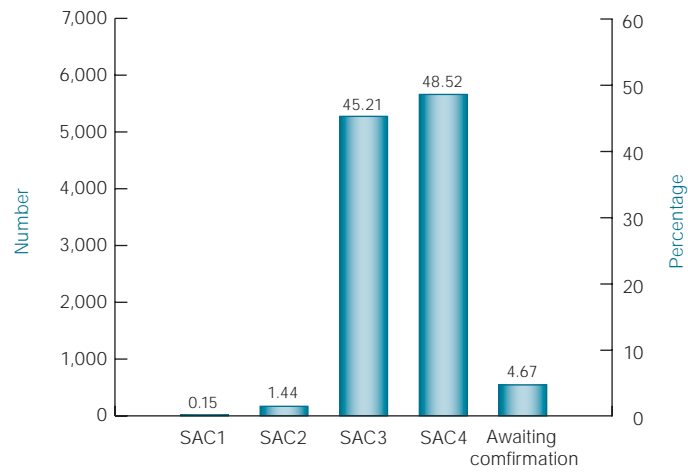
In this overview section we refer to all services used to treat a patient. These include:

- 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/she is responding to treatment and improving
- ensuring the safe transfer of the patient to home or other facilities for further care.

Notifications

From July 1 to December 31, 2007 there were 8,112 Clinical Management notifications (7,218 in the previous period). Two-hundred and ninety-four were classified as SAC1. These incidents include 64 suicides. More information on suicides is contained on page 32. In the previous reporting period, 182 SAC1 incidents were classified under Clinical Management. Suicide numbers were listed on a separate page as they fall under a different category during the review process. For the purposes of this report, however, and because suicides are captured under Clinical Management in IIMS, the figures have been combined. The spread of notifications within SAC categories can be seen in Figure 4.

Figure 4. Clinical Management Incidents across SAC categories
July to December 2007



Note that caution must be taken in interpreting the meaning of small fluctuations in numbers within any incident category from one reporting period to the next. For further information see appendix on page 22.

The following pages provide more detailed information on SAC1 (serious incidents) occurring within specific incident categories of Clinical Management.

Clinical Management – General

This category includes those SAC1 Clinical Management Incidents that are not specific to a particular area of practice, procedure or other Principal Incident Type, such as 'Fall' or 'Medications/IV Fluids'.

In the July 1 to December 31, 2007 reporting period there were 123 SAC1 incidents classified as Clinical Management: General. There were 91 in the previous reporting period. These incidents have been subdivided under categories in the patient care journey and shown against the last reporting period in Table 1.

Table 1. Clinical Management: General SAC1 Incidents
– according to category of care (2007)

Category of care	January/June	July/December
Diagnosis missed or delayed	34	37
Investigation delayed, not ordered, put into action and/or reviewed	3	5
Treatment delayed and/or inadequate	16	33
Complication not the desired treatment outcome	21	15
Observations not performed and/or significance not recognised	12	20
Transfer of care delayed or inadequate planning	4	2
Interhospital retrieval/transfer inadequate stabilisation	1	2
Non-preventable deaths *		9

Note that caution must be taken in interpreting the meaning of small fluctuations in numbers within any incident category from one reporting period to the next. For further information see appendix on page 45.

* NSW Department of Health uses a very broad definition for SAC1 incidents to ensure they are all captured and investigated. Any unexpected death must be reported as a SAC1. Investigations into some incidents reveal that no medical intervention would have prevented the death and that they were not the result of any failure in health care. These incidents have been included in the figures presented in this reporting period.

Lessons learned and action taken

There have been more incidents recorded under the observation and treatment categories of Clinical Management: General in this reporting period. This is in part due to increased vigilance among staff in ensuring that incidents are notified and correctly classified. There are themes that have been identified and programs developed to address these incidents.

The 'Between the Flags' program, outlined below, aims to achieve improvement in the category of 'observations'. Analysis of incidents in the treatment category also revealed emerging themes relating to patients with abdominal or chest pain. The NSW Department of Health is in the process of developing approaches to address the management of these conditions.

Between the Flags Program

The recognition and management of a patient whose condition unexpectedly and rapidly becomes worse in an acute hospital ward was identified in our last report as a contributing factor to many incidents. While it is an issue that affects health systems world-wide there is no easy solution. Many aspects of care must be addressed in a 'whole-of-system' approach.

Key issues involved include:

- processes for taking regular patient observations and the obstacles (workforce issues etc) that might interfere
- how observations are communicated
- identifying which early warning symptoms indicate the patient might be deteriorating
- processes for escalating concerns to more senior doctors
- processes for contacting the appropriate person for a timely review.

The CEC is developing a long-term project in this area.

It will consist of four phases:

- diagnosing the extent of the problem and the contributing factors
- designing solutions to address these areas
- testing and evaluation
- making recommendations for Statewide implementation.

Spotlight on preventing VTE

National and international studies have shown that many patients who develop blood clots in their veins could have avoided this potentially fatal condition.

Pulmonary embolism (blood clots in the lungs) and other blood clots such as deep vein thrombosis (DVT) fall under the collective heading of venous thromboembolism or VTE. VTE can be avoided by adequate risk assessment followed by the use of medications to prevent blood clots and other measures, such as compression stockings, where appropriate.

The Australia and New Zealand Working Party for the Prevention and Management of Venous Thromboembolism has recently released the fourth edition of its best practice guidelines designed to prevent this condition developing. These guidelines provide advice on how to assess the risk of a patient developing blood clots and the appropriate preventive treatment required.

The NSW Department of Health is preparing a policy directive based on these guidelines to mandate that all public hospital patients be assessed for the risk of blood clots. Healthcare professionals will be provided with education and tools to facilitate the implementation of the policy.

Clinical Management: General sub-categories

To provide a deeper understanding of the issues involved in the category of Clinical Management: General, SAC1 (serious) incidents have been further subdivided into specific services and procedures where possible. Table 2 shows the number of SAC1 incidents occurring in each sub-category against the previous reporting period. Details regarding the lessons learned and action taken within these categories are contained in the sections that follow.

Table 2. Clinical Management: General SAC1 Incidents – according to service or procedure (2007)

Service or procedure	January/June	July/December
Retained instruments	6	9
Blood products	2	1
Maternal and perinatal	36	25
Wrong patient/site/procedure	40	42
Suicides (mental health) inpatient	7	3
Suicides in the community	50	61

Note that caution must be taken in interpreting the meaning of small fluctuations in numbers within any incident category from one reporting period to the next. For further information see appendix on page 45.

Retained Instruments

Any retained piece of material is classified as SAC1 because it indicates the possibility of a system error that could result in serious harm.

There were nine such incidents in this reporting period, with two incidents relating to guide wires. Guide wires are used to assist the insertion of intravenous central lines used to deliver treatment such as antibiotics into larger veins in the body. Work is in progress to develop consistent guidelines for the use of this equipment.

Several incidents related to pieces of equipment with small removable tips that can easily detach. One was referred to the Therapeutic Goods Administration (TGA). The TGA carries out a range of assessment and monitoring activities to ensure therapeutic goods available in Australia are of an acceptable standard. More information on the TGA and its duties can be found at www.tga.gov.au/

All items involved in these incidents were removed without further complication to the patient.

The Blood Watch program

The availability of blood products and their safe use is a significant issue throughout Australia. The CEC has established a Statewide Blood Watch program aimed at improving the safety and quality of fresh blood product transfusion in all NSW public hospitals. The focus is on:

- identifying when a blood transfusion is the appropriate therapy
- reporting undesirable reactions to a transfusion
- accurate costing of transfusion medicine
- putting management measures in place to govern the use of blood products
- ongoing education of healthcare professionals
- communicating new policies that address supply and demand issues.

Research

Information on the use of blood products was gathered through a review of IIMS notifications during a 12-month period; a sample audit of patients receiving transfusions; a comparison of blood usage among hospitals and a survey of prescribing practices.

Mis-labelled specimens, storage, wastage and transport issues were the most common incidents notified in IIMS in the sample period.

The sample audit of patients receiving transfusions in large hospitals found that the majority had haemoglobin (red cell) counts above the level the National Health and Medical Research Guidelines specified as indicating a transfusion was required. Many medical records did not contain recorded evidence demonstrating a need for blood transfusion therapy. Some patients had low red cell counts that could have been treated prior to surgery.

The audit showed that the standard dose was two units of blood products, with no intervening assessment. Current expert advice is that the patient should be assessed after one unit of blood is transfused to determine whether a second unit is necessary.

There is a wide variation in the use of blood products, with some hospitals prescribing well above the State average. Those hospitals with more prudent prescribing practices had quality systems in place to manage blood transfusions. These include:

- restrictive thresholds for ordering blood products (above which clear evidence of need must be provided)
- management structures governing the use of blood product transfusion therapy
- feedback to specialists on the results of monitoring programs
- ongoing education.

The survey of prescribing practices found that senior consultants were reluctant to change prescribing habits even in the face of new evidence recommending more cautious use of this therapy.

Project teams across the State have used the following methods to address the findings of the above research:

- spreading information and providing education using tools that support decision-making on use of this therapy. These include an e-learning education package, broadcast videos and the learning guide, *Appropriate Use of Red Cell Transfusion*
- implementing restrictive thresholds for ordering blood products, above which clear evidence of need must be provided
- developing and circulating a series of *Myth Buster* posters to inform specialists that blood product transfusion is not always the best therapy to use and has significant safety considerations
- putting a variety of approaches in place to address labelling, storage, wastage and transport issues.

Maternal and Perinatal

In the July 1 to December 31, 2007 reporting period, 25 SAC1 incidents were classified as Maternal and Perinatal.

These incidents have been subdivided under the care journey of mother and baby in Table 3 and shown against the last reporting period.

Table 3. Maternal and perinatal SAC1 incidents according to care journey (2007)

	January/June	July/December
Antenatal care	5	5
Labour and birthing	24	13
Postnatal	7	7
Total	36	25

Note that caution must be taken in interpreting the meaning of small fluctuations in numbers within any incident category from one reporting period to the next. For further information see appendix on page 45.

Lessons learned and action taken

Communication

Good communication is essential to providing maternal and perinatal care and includes sharing information verbally or in writing, and ensuring that fail-proof communication systems and policies are in place. To this end, work has progressed on the standardised Statewide antenatal record announced in the last report. It is anticipated this project will be completed within one year. This record will improve communication between maternity care providers and ensure complete information on mother and baby is transferred at all critical points of care.

Assessment of fetal wellbeing

Accurate assessment and monitoring of the unborn child has been identified as an issue. The Statewide Fetal Welfare and Obstetric Emergency/Neonatal Resuscitation Education Program (FONT) project addresses this area. It has three stages:

- Stage 1** Statewide rollout of computer-based training regarding fetal welfare assessment and the interpretation of fetal heart rate monitoring results to all NSW hospitals responsible for providing maternity care.
- Stage 2** development and provision of a train-the-trainer education program on fetal welfare assessment, both before and during birth, and the use of fetal heart rate monitoring results.
- Stage 3** development and provision of a train-the-trainer education program on maternity emergency management and neonatal resuscitation.

An information bulletin was released to advise Area Health Services of the start of the FONT program. The bulletin also provided information on the educational levels required of obstetricians, midwives and student midwives after the release of the policy directive.

Safety Alert Broadcast System



The Safety Notice on the use of electronic fetal heart rate monitoring was upgraded and released as a Safety Alert (see www.health.nsw.gov.au/quality/sabs/index.html).

Shoulder Dystocia

Some incidents were associated with shoulder dystocia. This is a rare situation where the baby's shoulders are a tight fit with the mother's pelvis and create a difficult birth.

The FONT program provides education and training in the management of common maternity emergencies, including shoulder dystocia. Simulation models to provide on-going training in management of this emergency have been purchased for each birthing facility. Simulation models allow health professionals to gain experience and develop skills in a safe and controlled learning environment that is comparable to reality.

Breast milk identification

Policies and practice relating to the correct identification of babies prior to feeding breast milk remains an issue.

The policy directive in this area is being amended to include new identification procedures for babies and the action to be taken in the event of exposure to incorrect breast milk. It will be issued to all Area Health Services.

Wrong patient/site/procedure

In the July 1 to December 31, 2007 reporting period there were 42 SAC1 incidents classified as Wrong patient/site/procedure.

These notifications refer to incidents where the:

- procedure was performed, or about to be performed on the wrong patient
- wrong procedure was attempted or was about to be attempted
- 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.

Table 4 divides these incidents into the areas in which they occurred and shown against figures in the last reporting period.

Table 4. Wrong patient/site/procedure SAC1 incidents – according to procedural area (2007)

Department	January/June	July/December
Operating suite	3	7
Dental	1	0
Imaging/nuclear medicine	32	29
Radiotherapy	2	0
Wards and other areas	7	6
Total	45	42

Note that caution must be taken in interpreting the meaning of small fluctuations in numbers within any incident category from one reporting period to the next. For further information see appendix on page 45.

Lessons learned and action taken

Four incidents involved implanting an intra-ocular lens of incorrect size and strength. These are being further investigated to determine the reasons and the changes can ensure it does not happen again.

Common themes identified from analysing all incidents include:

Patient identification

Patient identification was a consistent theme in 20 of these incidents. As mentioned earlier in this report, correctly identifying patients is a system-wide issue contributing to a number of incident types. The NSW Department of Health, in collaboration with the Australian Commission for Safety and Quality in Health Care, has begun work on a major project to address this issue. There are three areas of focus:

- standardising patient identification bands
- developing patient identification best-practice models
- investigating technological solutions.

Compliance

Compliance with the *Correct Patient, Correct Procedure, Correct Site* Policy is essential. This policy contains a 'Time Out' step where the team undertakes a final safety check before starting a procedure. A 'Time Out' checklist for surgical procedures has been developed to guide teams through the process and document the completion of this step. Audits to review compliance with this protocol have commenced.

A safety toolkit for radiologists, dentists, radiation therapists and nuclear medicine technologists was distributed to NSW public health facilities in December 2007.

Suicides

Death by suicide is a tragedy for the person involved and has profound emotional, social and economic effects on families, friends and the wider community. It is rarely the result of a single issue or event, but rather a complex interaction of contributing factors such as mental illness, substance abuse and stressful situations. Determining that a death is the result of suicide, and not another factor, is made by the NSW Coroner. Preventing suicides is a government priority.

Both suicide deaths and non-fatal suicide attempts occur among those who have had contact with the healthcare system and among those who have not. This report is concerned with specific strategies aimed at making safety and quality improvements in the health system as it cares for this vulnerable group. There are other services and programs operating in the community to address the needs of people in mental distress.

Notifications

Healthcare associated suicides are defined as those involving people who were inpatients at the time, or who had contact with a public health facility within seven days of the event. All suicides are referred to as 'suspected suicides' until the actual cause of death is confirmed by the coroner.

In the July 1 to December 31, 2007 reporting period there were three suspected suicides where the patient was an inpatient of a public health facility. During the same period there were 62 suspected suicides in the community, involving people who had contact with the public health system within seven days prior to the event. This figure includes 11 cases where the actual cause of death could not be determined, despite thorough analysis of all factors decreased contributing to the incident.

Suicides among inpatients have decreased since the last reporting period (from seven to three) and have increased among those having contact with the health system within seven days prior to the event (from 50 to 62). Neither situation is a sign of success or failure. As stated elsewhere in this report, caution must be taken in interpreting the meaning of fluctuations in numbers within any incident category from one reporting period to the next. Readers should refer to the appendix concerning small numbers on page 45. Instead, the focus must remain on reviewing every incident and identifying gaps in care to be addressed.

Lessons learned and action taken

The Mental Health Sentinel Events Review Committee provides an independent analysis of incidents involving deaths by suicide where the person involved is a client of public mental health services. The committee has made three reports to the Minister for Health to date: *Tracking Tragedy (2003)*, *Tracking Tragedy (2005)* and *Tracking Tragedy (2007)*. Key themes of the 2007 *Tracking Tragedy* report are:

- the assessment and management of mental health patients at risk of violence to themselves and others
- standards of care provided to mental health patients referred for depressive disorders.

Sixteen specific recommendations relating to these themes that can be viewed at www.health.nsw.gov.au/pubs/2007/response_ttragedy.html

Many of the recommendations of the *Tracking Tragedy* reports overlap with issues raised through the analysis of incidents notified in IIMS. They help guide systemic improvements relating to the care, management and control of people suffering from a mental illness.

Analysis of notifications in IIMS covering the July 1 to December 31, 2007 period highlights the following issues:

- continuity of care throughout the patient journey, particularly at points of transition between the hospital and return to the community
- effective communication and co-ordination between healthcare professionals and the home and community support services to minimise the possibility of gaps in care
- the provision of resources that support the recognition, assessment and timely care of patients in an emergency department, who may be showing signs of mental illness.

Projects covered in our last report that are part of a comprehensive approach are progressing and showing signs of success. They include:

Discharge Planning Policy for Adult Mental Health Inpatient Services

The NSW Department of Health has released a new *Discharge Planning Policy for Adult Mental Health Inpatient Services* to support the safe and successful transition between inpatient environments, and from mental health inpatient units into the community. The structured approach aims to:

- improve patient, family, carer and community safety
- improve continuity of care between the health system and the community

- improve communication between clinicians, the consumer, the family/carer and community agencies involved in the individual's ongoing care and support
- provide better access to community mental healthcare, primary healthcare and community support services.

Mental health services throughout NSW are reviewing their existing local discharge protocols and practices to ensure consistency with the Statewide policy. They will also undertake local training activities as required, and monitor and report on measures taken to ensure that the policy is in place and working effectively.

Rural Care

The implementation of the Rural Critical Care Services Program continues. The model includes initiatives to:

- build capacity of large rural hospitals to provide rapid round-the-clock specialist mental healthcare
- develop flexible service models for regional and rural hospitals to provide rapid mental healthcare locally
- improve the collaboration and capacity of emergency services to respond to people with mental health problems who attend hospital.

The Rural Critical Care Services Program is now in place in all four rural and regional Area Health Services (North Coast, Hunter New England, Greater Western and Greater Southern). The model provides support for smaller rural emergency departments by:

- teleconferencing to centres for rapid access to specialist mental health assessment
- providing resources for inter-hospital transportation for those people who need more intensive specialist mental healthcare.

Psychiatric Emergency Care Centres (PECCs)

PECCs are now operating alongside nine major metropolitan emergency departments to provide round-the-clock specialist mental health services. During the first 12 months of operation 8,200 people were seen in seven PECCs. The first evaluation of their operation has shown that the model:

- is successful and sustainable
- reduces the pressure in hospital emergency departments by diverting people presenting with mental health problems to specialist clinicians
- reduces delays in accessing care
- delivers better treatment for patients.

Overall PECCs appear to be a sustainable and effective service model for some general hospital settings where substantial numbers of people present with mental health problems.

NSW Family and Carers Mental Health Program

This program provides funding to non-government organisations and mental health services for the education and support of those who care for people with mental illnesses and disorders. Important aims are to:

- reduce the stress, tension and isolation often associated with caring for a person with a mental illness
- reduce the rate of hospital admissions, re-admissions and psychotic symptoms for people with a mental illness
- provide families and carers with the skills to help people with a mental illness live and be integrated into their community.

Funding has also been allocated to train doctors, nurses and other healthcare professionals to work more effectively with those who care for mental health patients. This includes engaging them in making decisions around treatment plans and patient progress. The program is the first of its kind in Australia.

NSW Healthcare associated infection (HAI) prevention program

The NSW Department of Health had developed a comprehensive Statewide program to prevent patients getting an infection while in hospital. The Healthcare Associated Infections (HAI) prevention program is an integrated and system-wide approach. It combines the expertise of infection control specialists with the knowledge of clinical line managers to ensure that quality improvements are delivered and embedded into all areas of patient care in every healthcare facility.

The focus is on reducing:

- bloodstream infections caused by *Staphylococcus aureus*
- surgical site infections in patients undergoing coronary artery bypass grafts and hip and knee joint replacements
- the spread of the multi-resistant organisms – *methicillin-resistant staphylococcus aureus (MRSA)* and *multi-resistant acinetobacter baumannii (MRAB)* in intensive care units.

Performance will be measured against a reduction in infection rates.

Strategies include:

- compliance with hand cleaning practices and supporting this requirement with bed-side hand hygiene products and facilities
- isolating patients with infections and using protective gowns and gloves
- ensuring that guidelines for inserting intravenous lines are followed
- systematically cleaning all hospital surfaces and equipment
- correct use of antibiotics. The over-use of antibiotics has been linked with the development of organisms that are resistant to antibiotics.

These strategies require a management approach that:

- clearly assigns responsibility to line managers for implementing the HAI prevention program
- puts in place systems to regularly monitor, review and take corrective action within individual hospitals and departments
- conducts regular performance reviews and recognises excellence.

Monitoring infection rates

It is important that information on infection rates is gathered on a Statewide basis, so that progress can be compared from one period to the next and between health facilities. A comprehensive data collection process is being developed as part of the HAI prevention program. Figures from this collection process will appear in the next report.

The CLAB project (central-line associated bacteraemia)

A specific project to reduce central venous catheter blood stream infections in Intensive Care Units (ICUs) was launched in 2007. Central lines are intravenous lines used to deliver treatment such as antibiotics into large veins in the body. Infections can result when micro-organisms enter the blood at the time the line is inserted.

The CLAB project is a collaborative effort that includes the Clinical Excellence Commission, the Intensive Care Co-ordination and Monitoring Unit (ICCMU), the NSW Department of Health and clinical units within participating hospitals. Thirty-six public ICUs are participating in the project. The first steps include:

Reviewing information in IIMS

Notifications in IIMS entered from July 2006 to June 2007 were reviewed in relation to central lines. The following themes emerged:

- the need for a standardised approach for inserting central lines and the credentials required to undertake the procedure
- ensuring training and supervision
- care of the site after the line is in place and in cases where it may become dislodged
- ensuring that the guide wire used to insert a central line is removed.

Solution steps

Taking action on these issues has involved:

- the development of an improved information collection process to measure infection rates and compliance with infection control practices
- the development by an expert group of a safe central line insertion working policy
- the development of a Teleform™ checklist designed to measure compliance with the safe insertion procedure. This form is now being regularly submitted by the 36 participating ICUs
- engaging multidisciplinary teams at all project sites and conducting monthly teleconferences to discuss progress
- supporting ICUs with regular visits from the CEC to promote the project in individual environments.

Education and training

Steps have begun to train staff on a standard approach to central line insertion. These include:

- the development of a discussion document outlining a standard training framework for central line insertion, using national and international resources
- consultation with specialist medical colleges regarding training requirements.

Improving efficiency: a standardised procedure pack

A standardised procedure pack will be developed and purchased at a Statewide level. This will save money and time. Hospitals will not be required to negotiate with suppliers on an individual basis and healthcare providers will not need to collect individual pieces of equipment at the time of a central line insertion.

Complaints

The NSW Department of Health's *Complaint Management Policy* requires that patient concerns are resolved effectively and in a timely manner. All complaints, and issues and their resolutions, are recorded in IIMS. Systematic recording allows identification of specific trends that can be improved.

The NSW Health Care Complaints Commission (HCCC) is an independent statutory body that receives, assesses and investigates serious complaints about individual practitioners. These are also entered into IIMS when they come to the attention of the NSW Department of Health. As a result, some incidents contained in this reporting period relate to complaints from some time ago. The results of these investigations however, do inform patient safety and clinical quality projects. Further information about the HCCC can be found at www.accc.gov.au/content/index.phtml/itemId/287447

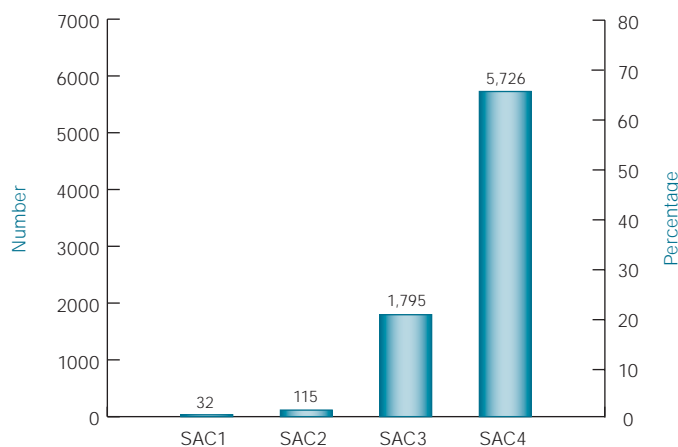
The *Complaint Management Policy* is underpinned by the following principles:

- 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 July 1 to December 31, 2007 reporting period 8,926 complaints were received, compared with 7,207 in the previous six months. Among these, 7,668 had the Severity Assessment Code confirmed locally by the health service. The SAC distribution of these incidents is illustrated in Figure 5.

Figure 5. Complaints classified according to SAC categories



There has been an increase in the number of complaints overall and among those classified as SAC1 compared to the previous reporting period. This reflects heightened awareness among the community regarding the complaint process that encourages individuals to make their concerns heard. The information gathered provides additional insights used in the development of patient safety and clinical quality programs and projects.

What did people complain about?

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

Treatment

There were 28.7 per cent or 2,070 complaints were classified as 'treatment'. Complaints in this category related to clinical situations such as diagnosis, infection control, medication and co-ordination of treatment. It also includes issues related to organising the equipment needed to accompany a patient home, and helping the family plan for this move.

Communication

There were 25.9 per cent or 1,867 complaints were classified as 'communication'. This category refers to situations where patients saw staff as being unhelpful, lacking compassion or abrupt. It also includes complaints about the provision of information regarding test results and treatment, and how the family should care for the patient at home.

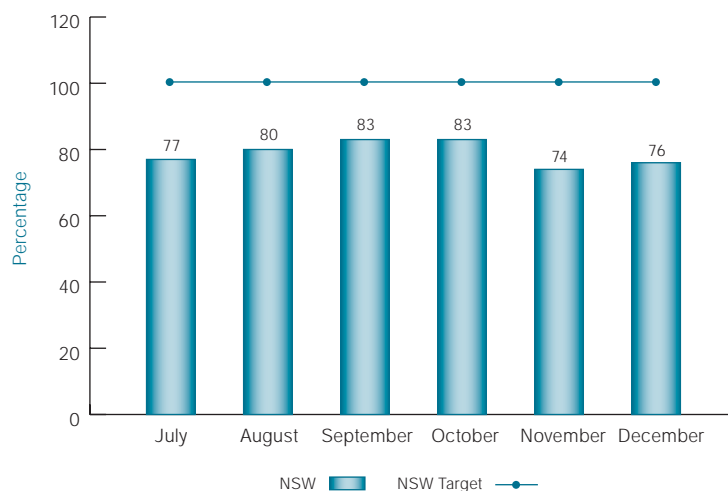
Access

There were 22.2 per cent or 1,596 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.

Resolving complaints

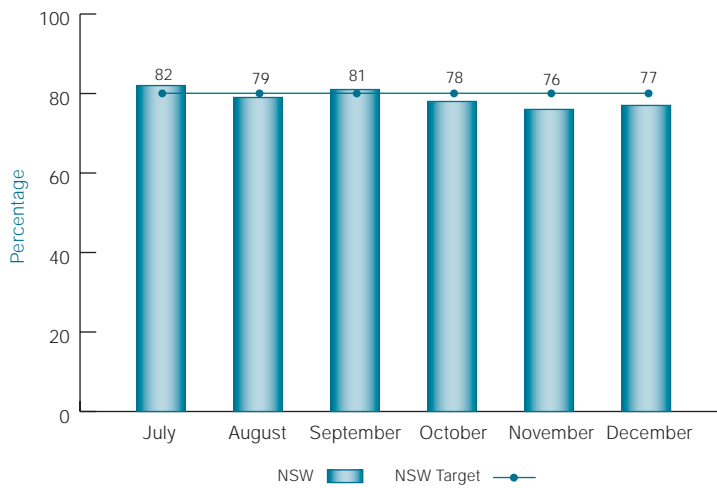
A benchmark of five calendar days was set, where the health services was required to formally acknowledge the receipt of a complaint and to explain the review process. Figure 6 shows the percentage of complaints that achieved that benchmark during the July 1 to December 31, 2007 reporting period.

Figure 6. Percentage of complaints acknowledged in 5 days July to December 2007



A second benchmark of 35 calendar days is set for managing the complaint and providing information on the outcome to the person who complained. A benchmark of 80 per cent of complaints to be resolved in 35 days has been set. Figure 7 shows the percentage of complaints resolved within the 35 day benchmark during the July 1 to December 31, 2007 reporting period.

Figure 7. Percentage of complaints resolved in 35 days July to December 2007



How complaints were resolved

Forty-six per cent of complaints were resolved with an explanation. This shows the need to provide better information for patients. 35 per cent of complaints were resolved with an apology. Many people simply need to know that the impact of any event on their lives has been understood and the outcome regretted.

Information gathered in IIMS about complaints complements information gathered on incident notifications. Issues identified are addressed as an important part of Statewide initiatives described throughout this report.

Patient survey

In 2007 the NSW Department of Health conducted its first Statewide patient survey. The survey is one of several strategies being used to gain a complete picture of patient and carer experiences of the health system and to link this feedback to service improvements.

Almost 75,000 people completed the questionnaires. Eighty-eight point one per cent of respondents rated their care good/very good and very good/excellent. Community health patients were the most likely to give this response (95.7 per cent) followed by day-only patients (93.9 per cent) paediatric inpatients (92.8 per cent) and outpatients (90.7 per cent). Non-admitted emergency patients were less satisfied (81.7 per cent) and mental health patients were the least satisfied (64.1 per cent).

There was little difference in overall care ratings in terms of location, although female patients, young adults and patients from a non-English speaking background on average provided lower ratings.

Results

The results show that the key drivers of a good patient experience are:

- the availability of doctors and nurses
- confidence and trust in nurses
- having enough say about treatment
- being able to discuss anxieties and fears with nurses.

Patient ratings regarding the availability of doctors and nurses were generally positive, with 72.4 per cent rating the availability of doctors as good/very good/excellent while nurses achieved an 81.2 per cent rating.

Confidence and trust in nurses was rated in the 'always' category in 73 per cent of the questionnaires. Sixty-four point seven per cent of respondents felt that they 'always' had enough say in their treatment. A lower 49.4 per cent felt they could 'always' discuss anxieties and fears with nurses. Mental health and emergency patients were more inclined to feel that they were unable to discuss anxieties and fears with nurses. Adult rehabilitation mental health and overnight patients were more inclined to feel they did not have enough say in their treatment.

The areas identified by patients requiring improvement include:

- involvement of family and friends
- emotional support
- provision of information and education
- better continuity of care and transition to other facilities or to return home.

The NSW health system performed best in the areas of:

- respect for patient preferences
- access to care
- co-ordination of care
- physical comfort.

This information will help identify priority areas for action, provide focus for improvements and will assist in the redesign of service delivery to better meet patient needs. The survey will be repeated in the next two years to monitor trends.

Overall, patients in all categories rated the following highly:

- courtesy of doctors, nurses, admissions staff and other health professionals
- how well doctors and nurses worked together as a team.

Non-admitted patients (emergency department, outpatients, community health) all rated highly:

- the completeness of care
- the explanation of what was done to them.

The top nine opportunities for improvement identified by NSW patients in 2007 were:

1. health care professionals (doctors, nurses, counsellors, therapists) discussing anxieties and fears with the patient
2. patients having confidence and trust in health care professionals (doctors, nurses, counsellors, psychologists)
3. the ease of finding someone to talk to about concerns
4. doctors and nurses answering patients' questions understandably
5. patients receiving enough information about their condition/treatment
6. test results being explained understandably
7. patients having enough say about and being involved in care/treatment decisions
8. being given information about patients' rights and responsibilities
9. staff doing everything possible to control pain.

Responding to the patient survey

Each Area Health Service Chief Executive has received detailed, actionable reports for all services/facilities and each is developing action plans to address high priority areas for patients. Area Health Services are also celebrating achievements with staff.

Improving patient experience is a long-term endeavour. Future surveys will monitor progress. Responding to the issues raised by the survey is now built into NSW Health's performance management system. Information provided by the patient survey provides a focus for improvement and assists in the redesign of service delivery to better meet patient needs.

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/

Further information

Further information on the work of the NSW Patient Safety and Clinical Quality Program can be found at:

The Quality and Safety Branch website www.health.nsw.gov.au/quality/index.html
and the Clinical Excellence Commission website www.cec.health.nsw.gov.au/

Feedback

We welcome your feedback. Any enquiries about this publication, or comments, should be directed to:

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Appendix

Why do small numbers require special consideration?

The Clinical Excellence Commission and the NSW Department of Health are concerned with each and every incident that occurs in our health care system. Any increase in the number of incidents that create patient harm must first be measured in terms of the impact on the individual lives of those concerned.

Small changes in numbers between one reporting period and another are not a reliable indication of the success or failure of the NSW Patient Safety and Clinical Quality Program. A small increase or decrease in numbers is often the result of random (chance) factors. The effect of these factors is diminished as the numbers become large, because chance is less likely to be the reason for many similar events.

