

Data as Information – A Power Tool in Cultural Change

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Aim

To implement a standardised coordinated approach to incident management across a state wide health system

Safety Improvement Program

Implemented over three years; Root Cause Analysis training; Establishment of RIBs to provide timely escalation; Implementation of IIMS; Feeding data back to the system as information

Patient Safety and Clinical Quality Program

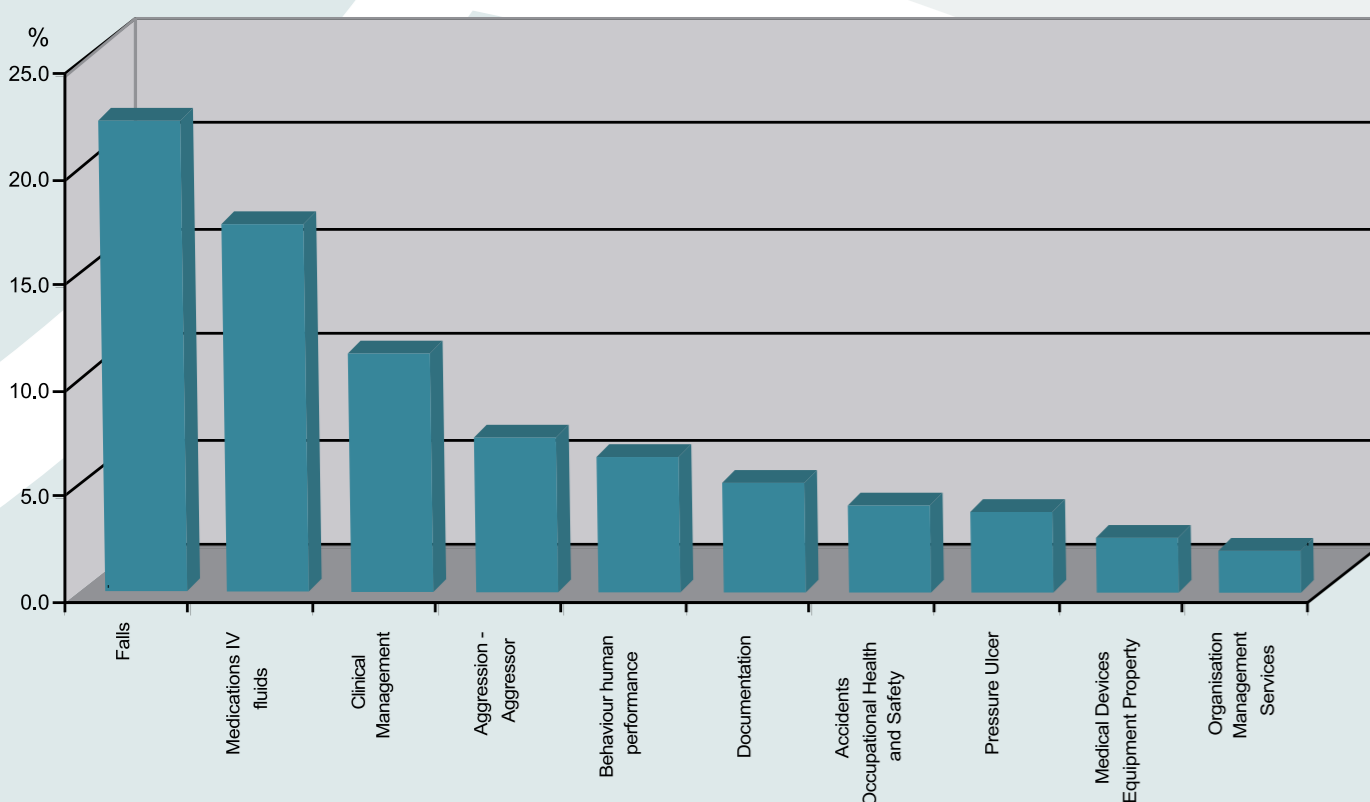
Establishment of the Clinical Excellence Commission; Ongoing support of IIMS; Introduction of Clinical Governance Units in each AHS

Incident Information Management System

- Over 100,000 NSW Public Health staff can notify incidents
- 30,000 Managers are registered on-line users
- Up to 250 concurrent users at any one time
- Between 9 and 12,000 notifications per month
- 125,000 notifications in the first 12 months
- Notification to the system is voluntary and does not represent all incidents that occur in the NSW health system
- Incidents are notified to four forms
- 70% of notifications are on the clinical form

Clinical Incidents are Classified to a Principal Incident Type

Most Common Clinical Incidents by PIT Jul 05 - Jun 06



- Falls represent 26% of all notifications
- Medications represent 18% of all notifications
- Clinical Management represents 13%
- Aggression represents 10%
- 15% of incidents resulted in some level of injury or harm
- Less than one percent of incident notifications resulted in death

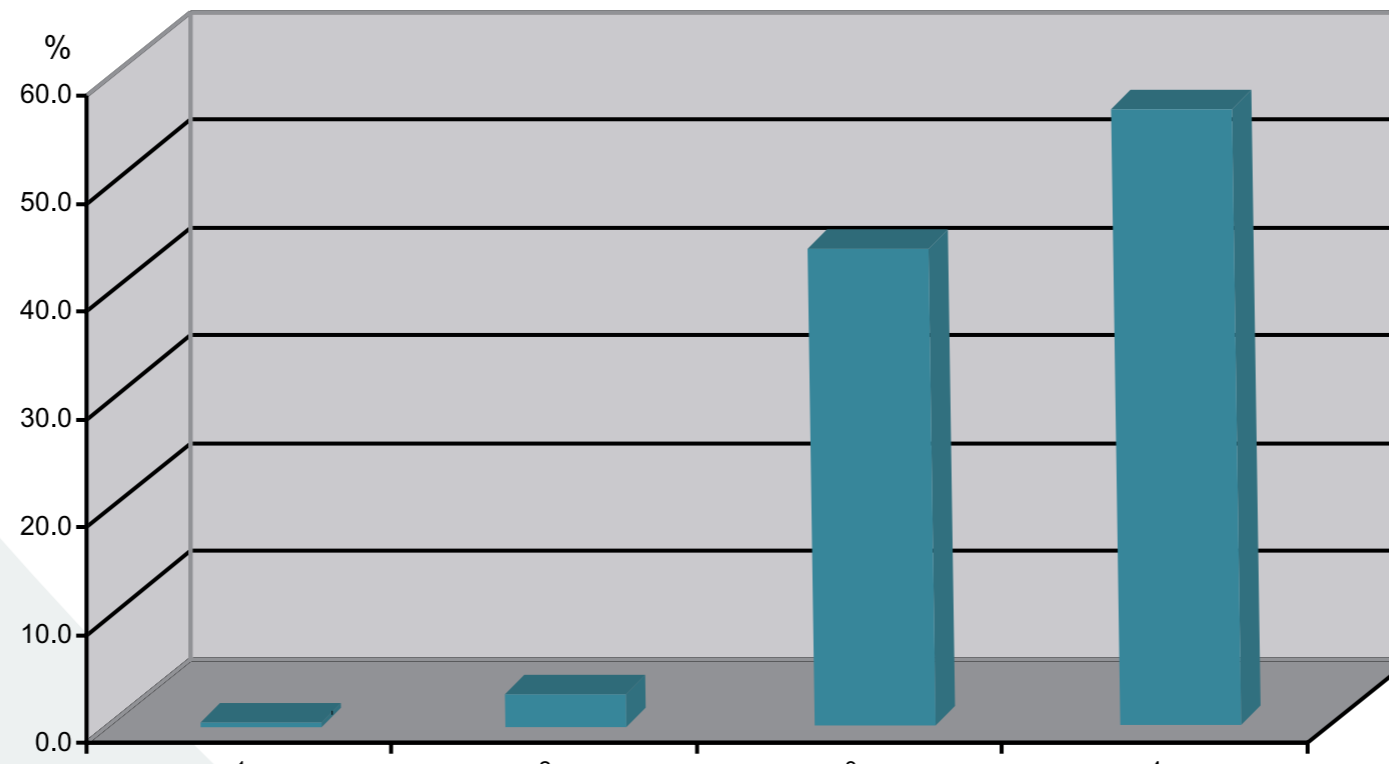
Falls

- Less than 0.1% of falls resulted in serious harm or death
- 20% of falls occurred in a geriatric unit
- 18% were in a general medicine unit
- 14% were in a rehabilitation or stroke unit
- 65% of patients were aged between 70 and 95 years
- 70% either tripped, slipped or lost their balance

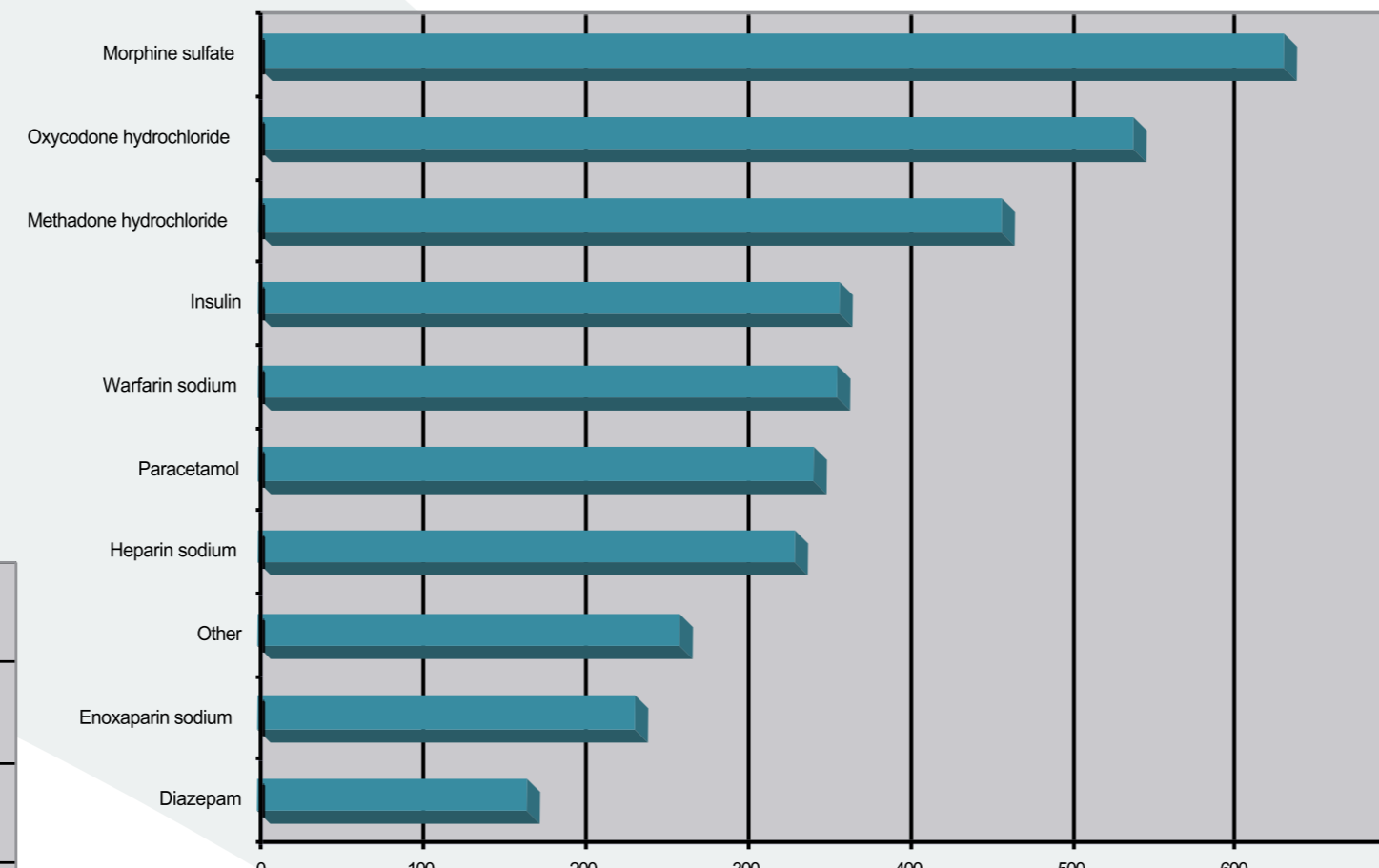
Medications

- Less than 0.1% of medication errors resulted in serious harm or death
- 12% occurred in a general medicine unit
- 6% occurred in a geriatric unit
- 5% occurred in a general surgery unit
- 4.5% occurred in an emergency unit

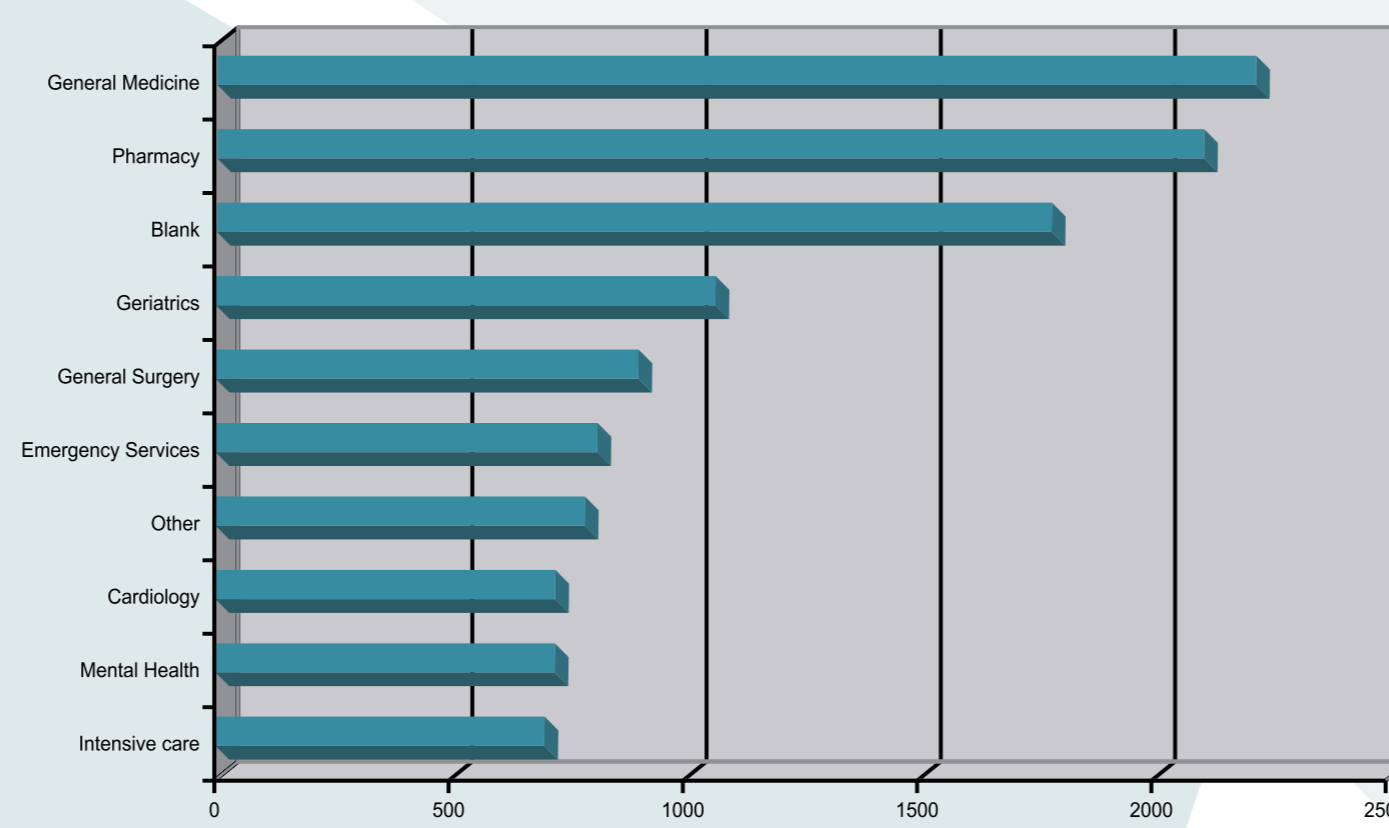
All Incidents by SAC Jul 05 - Jun 06 (excluding blanks)



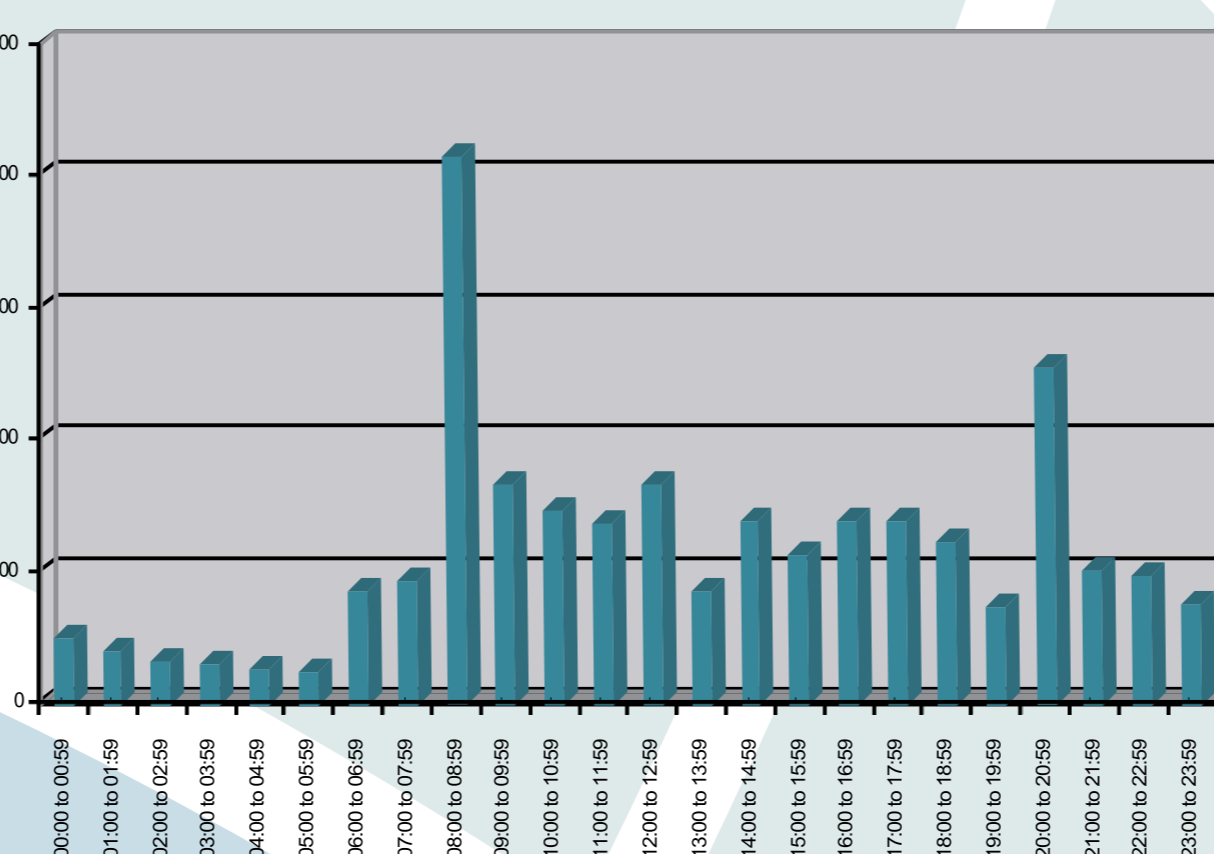
Most Commonly Identified Medications



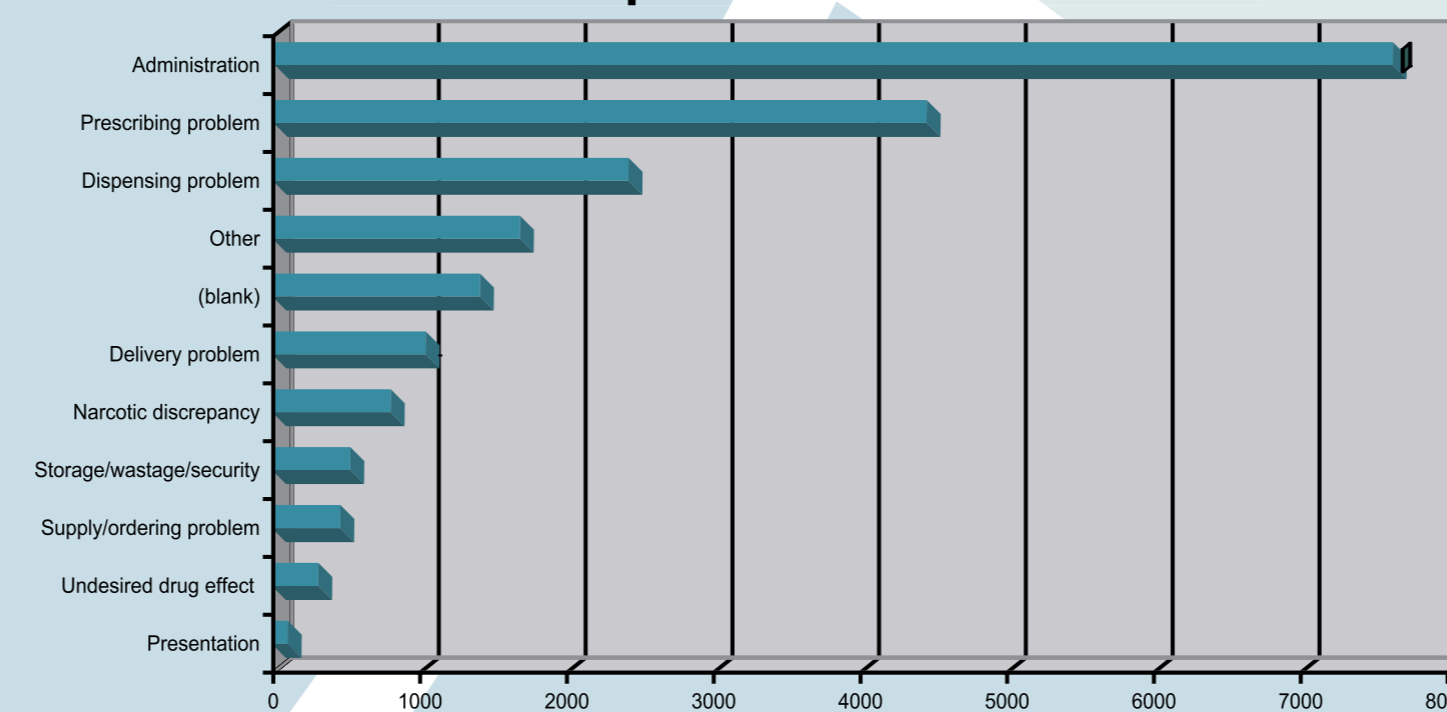
Most Commonly Identified Services



Time of medication error



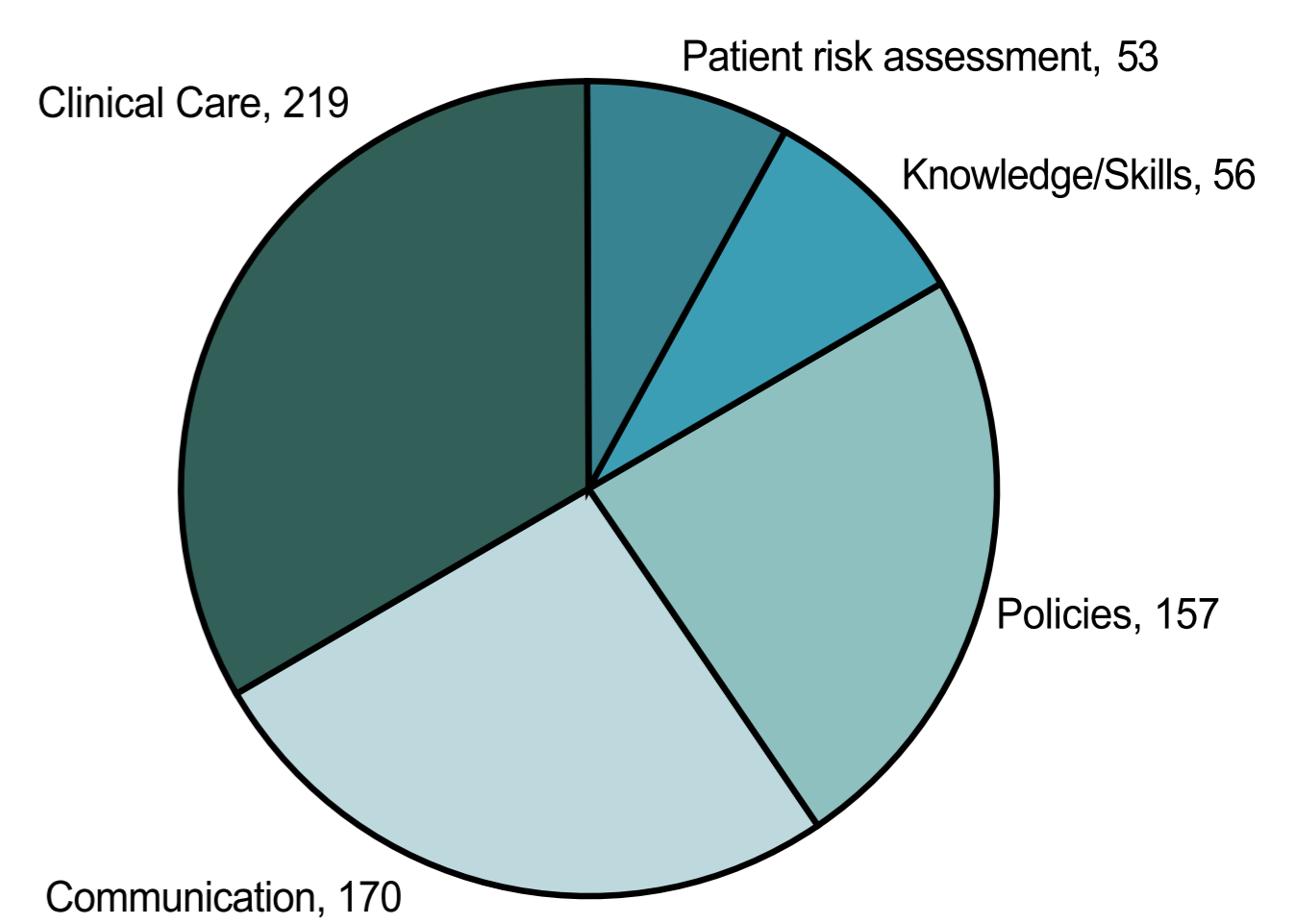
Medication problem associated with:



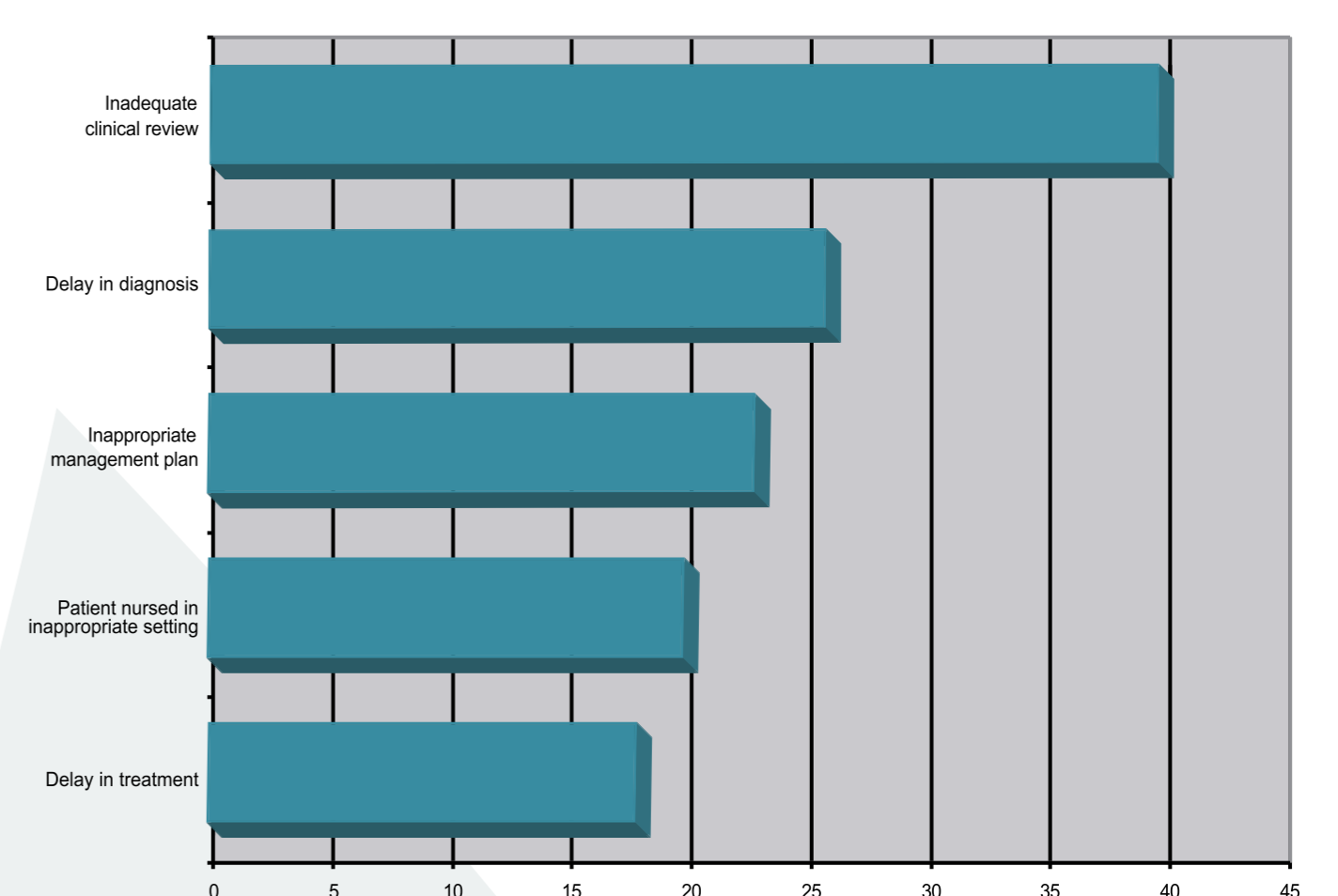
Serious Adverse Events

- Represent less than 1% of all clinical notifications
- Each RCA is analysed for risks identified from the root causes and contributing factors

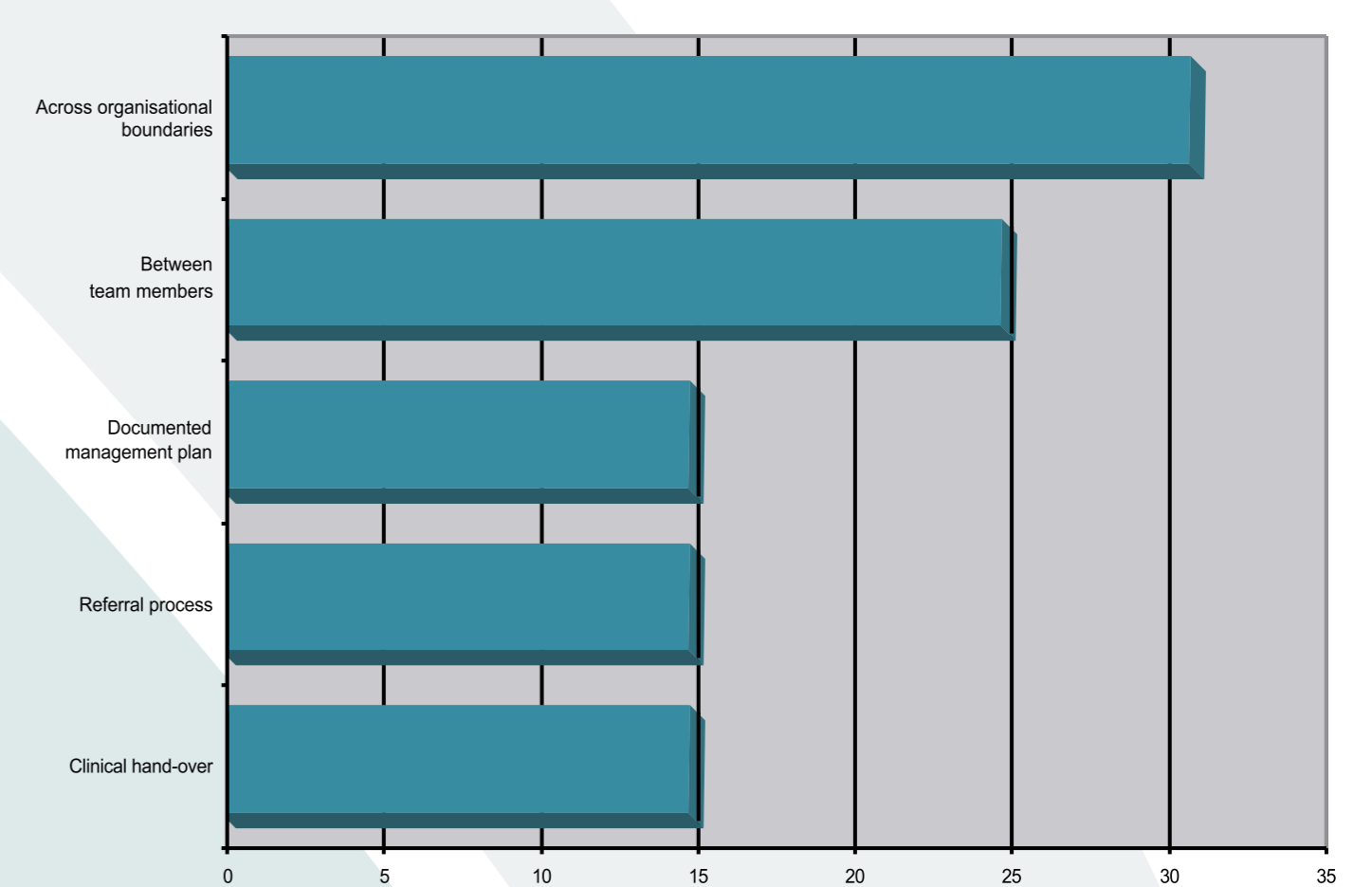
Most Commonly Identified from RCA Analysis



Most Common Risks in Clinical Care



Most Common Risks in Communication



Current and future initiatives

- Open disclosure – informing a patient when an error has occurred
- Medication safety – achieving quality use of medications
- Falls – implementing strategies to minimise injury as a result of a fall
- Communicating for clinical care -
- Communicating at clinical handover
- Hand hygiene – reducing Hospital acquired infections through good hand washing techniques and use of alcohol hand gels
- Blood haemovigilance – improving appropriateness of blood transfusions

Raising the Bar in Incident Management – a State Journey

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Vision for patient safety in NSW

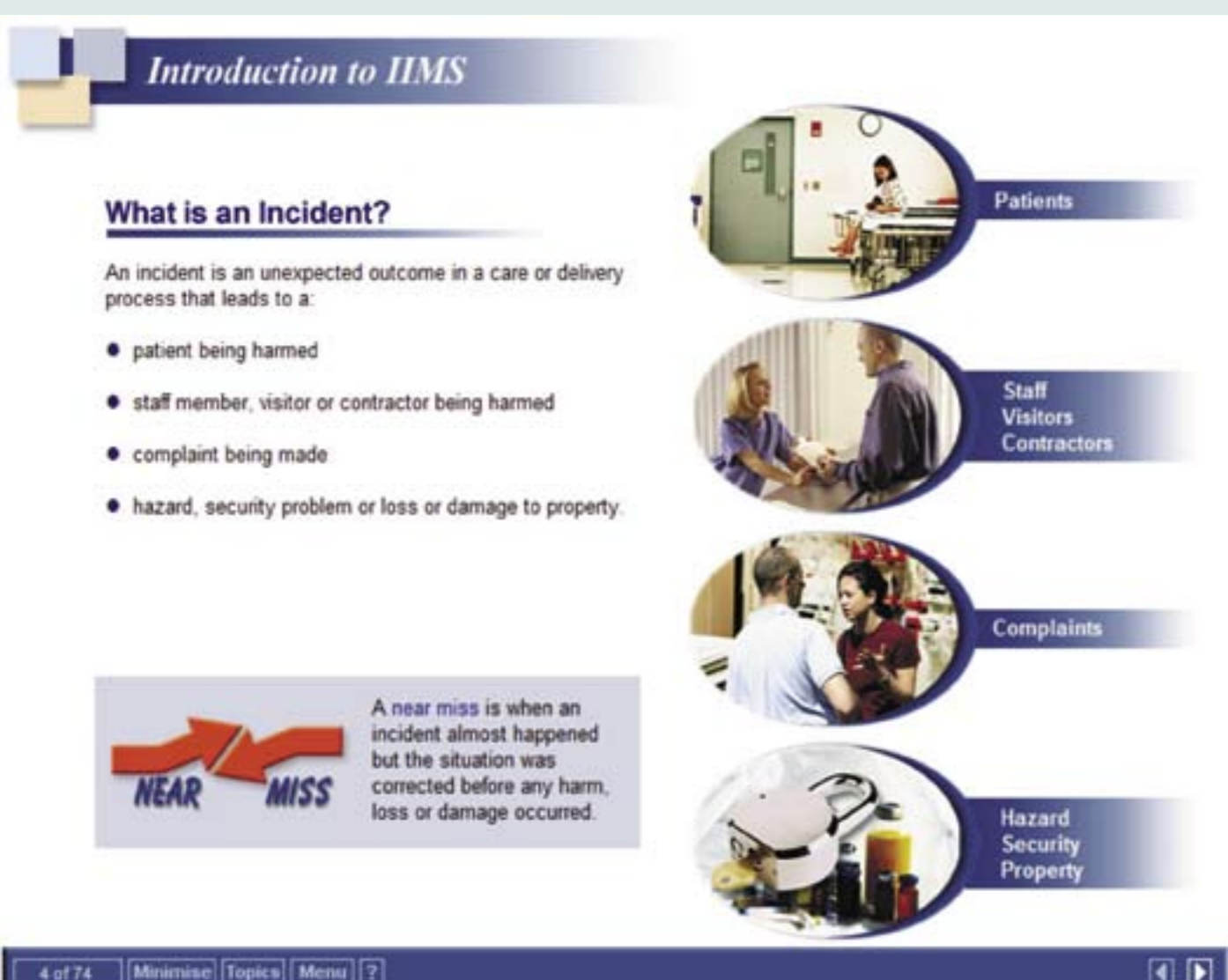
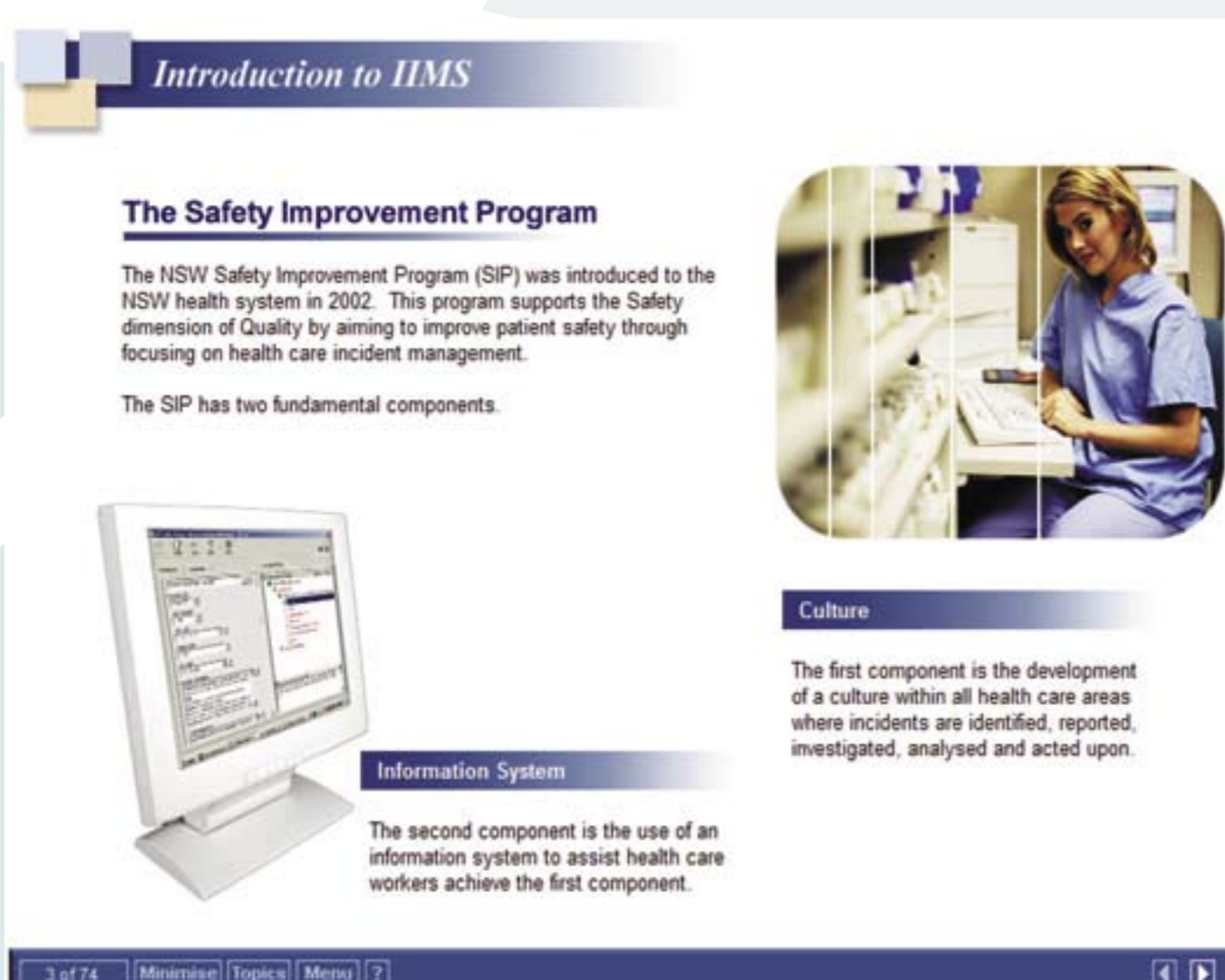
A culture of openness in which errors are acknowledged and reported. Staff in every unit know what incidents have happened and what has been done to ensure they don't happen again. Lessons learned from each incident are shared across the system.

Developments in NSW

- Safety Improvement Program launched 2002
- Patient Safety Clinical Quality Program launched by Minister 2004
- Incident Management Framework implemented
- First Incident Report released Jan 2005
- IIMS implementation commenced Nov 2004, completed May 2005
- Statutory Privilege for RCA teams Aug 2005
- Second Incident Report released Jan 2006

Education and training

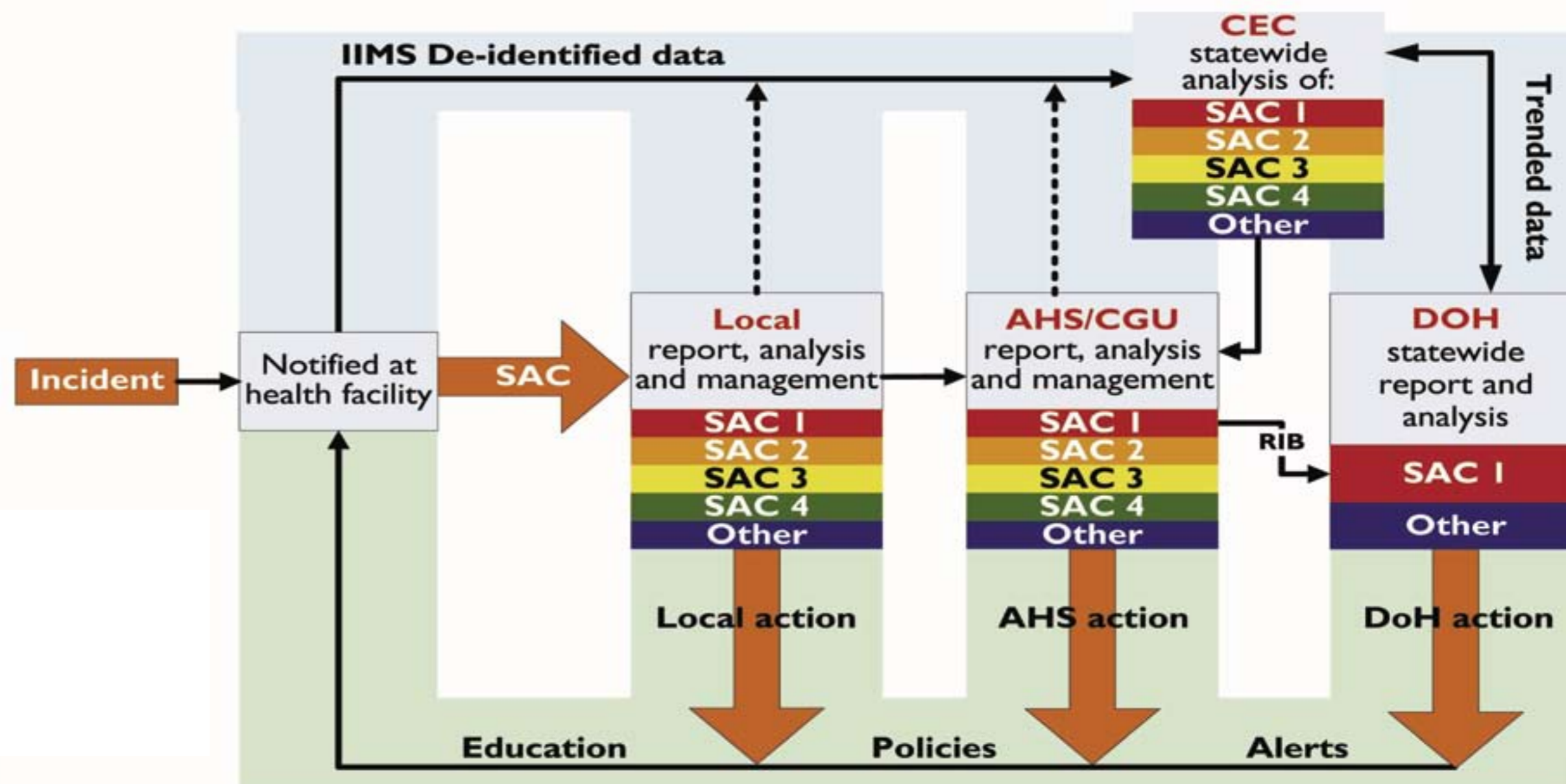
- Provided via an E-learning tool
- Divided into levels of training including:
 - An introduction to IIMS
 - Details on incident management
 - Incident data analysis
 - Workflow applications
 - Practice and assessment



Outcomes

- All incidents in NSW are notified to IIMS
- Each incident receives a risk rating using the Severity Assessment Code (SAC)
- The DOH is responsible for immediate action and policy review
- The CEC identifies issues of a systemic nature that affect patient safety and clinical quality in the NSW health system and to develop and advise upon implementation strategies to address these issues

Incident flow in NSW



Safety Improvement Program

- Standardised and coordinated approach to incident management
- Over 3,000 staff trained in Root Cause Analysis method

Aim

- To understand what happened, why it happened and how to prevent similar events recurring

Incident Management in NSW

- **Daily** monitoring and follow-up local unit level. Escalation of serious incidents to appropriate level
- **Weekly** review and feedback of incident data at local unit level
- **Monthly** review and action, local, Area and State levels
- **Long term** (6 monthly) analysis and recommendations for systems improvements, hospital, Area and State
- **Annual reports** system and community/Minister.

Return on Investment - Outcomes from Evaluations

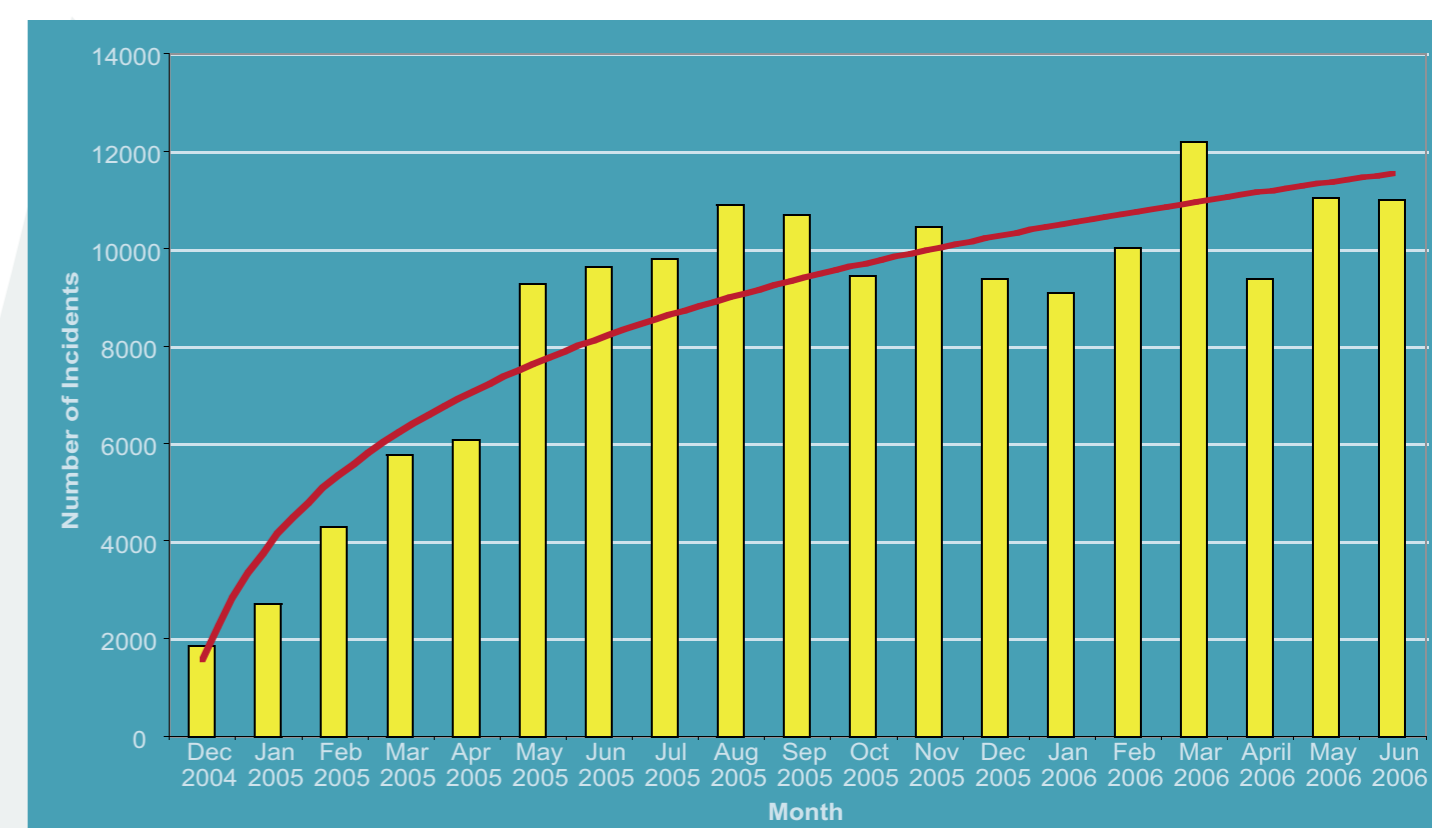
SIP

- Has made considerable gains in addressing safety
- Contributed to the safety efforts of policy makers, clinicians and managers
- Root Cause Analysis training program was highly rated and well regarded
- Sustainability needs to be ensured
- 89.4% of respondents felt that RCAs improve work practices
- 81.3% agreed there was improvement in communication about patient care
- 73% felt RCAs were a good use of time and resources

Incident Information Management System

- Over 100,000 NSW Public Health staff can notify incidents
- 30,000 Managers are registered on-line users
- Up to 250 concurrent users at any one time
- 125,000 total notifications to the system in the first 12 months
- 88,000 notifications related to clinical incidents

IIMS notifications since implementation in Dec 2004



IIMS

- Is beginning to be used in useful ways
- Facilities and wards are monitoring issues identified from the IIMS data
- Challenges include: improving medical notifications; Feedback to the system as a whole; Linking data to other programs improvement in software required
- The project implementation was described as a "textbook implementation"
- 98% of respondents felt the e-learning taught them how to use IIMS
- Awareness of IIMS is widespread but not evenly dispersed
- Managers satisfaction with IIMS is greater than non managers

RCA

Method enjoys widespread support; Represents an important step in linking incident management to quality; Has generated a stronger organisation and cultural focus on safety; Involvement of multidisciplinary teams has helped to create buy-in; Has helped to generate a stronger 'systems thinking' philosophy; Only 25% RCA's are completed within timeframes; Quality of recommendations are variable and often weak; Review suggested to make the model more flexible