

National Health Service Approach to Adverse Events

Past	Future
Fear of reprisals common	Generally blame-free reporting policy
Individuals scapegoated	Individuals held to account where justified
Disparate adverse event databases	All databases co-ordinated
Staff do not always hear the outcome of an investigation	Regular feedback to front-line staff
Individual training dominant	Team-based training common
Attention focuses on individual error	Systems approach to identifying hazards and prevention
Lack of awareness of risk management	General risk management awareness training provided
Short-term fixing of problems	Emphasis on sustaining risk reduction
Manipulative use of data	Conscientious use of data
Many adverse events regarded as "one-off's"	Potential for replication of similar adverse events recognised
Lessons from adverse events seen as primarily for the service or team concerned	Recognition that lessons learned may be relevant to others
Passive learning	Active learning

An Organisation with a Memory, Report of an expert group on learning from adverse events in the NHS, chaired by the Chief Medical Officer, 2000 United Kingdom

What's new in the next release of AIMS

AIMS+ was released in December 2000 with a number of enhancements. Since then a team of software engineers has been working on restructuring the current AIMS+ technology. The new version, called AIMS 2, is a completely new product that improves the reliability and speed of incident monitoring.

Information already captured in AIMS+ will be converted to AIMS 2 through a conversion program. The new software may be run on a single machine, or it may be used in a client-server environment.

AIMS 2 comprises 4 applications. These are:

- The AIMS 2 data entry and coding application
- Administration and configuration application
- Analysis tool
- Data conversion application

AIMS 2 has been developed as separate applications to allow the programs to be updated and shipped independently. Importantly, the separate applications may have different users; the new application suite allows users to receive only relevant functions they will use.

There will be two releases of AIMS 2 – release 1 and release 2.

What is different about AIMS 2?

While we have made dramatic changes to the software 'engine' in AIMS 2, we have tried to make it easy to use for existing AIMS+ users. While the most significant changes to AIMS 2 release 1 are in reliability and speed rather than in appearance, AIMS 2 will allow the APSF to add functionality to the software rapidly, and reliably.

From the user's perspective the most significant changes in AIMS 2 are:

- The return of requested fields missing from AIMS+, for example, sex and race.

- The ability to differentiate between incidents relating to patients, staff, visitors, and equipment.
- Improved consistency in the CeDOC
- New coding screens for areas not well covered by CeDOC
- Unlimited workplace location tree size (previously limited to 3 levels)
- Significantly improved speed on standard reporting (up to 10 x improvement)
- Improved reporting format and consistency
- Integration with Crystal Reports
- Greatly improved database reliability
- Improved security
- Client-server operation
- Encrypted export of files from the database to the APSF
- Database audit trail

What will be included in AIMS 2 release 2?

AIMS 2 release 2 is due for release in August and will include the following features:

- A semantic query system (in the Analysis tool). This query system will replace the more limited Incident Summary Reporting facility of AIMS+. It will allow users to explore their data and save reports without having to understand the underlying database structure.
- Improved coding (in the AIMS 2 data entry). We will be expanding the ability to code a wider variety of incidents, such as pressure ulcers. We are improving the consistency and ease of use of the coding screens.
- Fine level security. While AIMS 2 release 1 improves security over AIMS+, AIMS 2 release 2 will allow much more sophisticated control of information access.

The semantic query system in AIMS 2 release 2 will enable users to drill down into the data without having to understand the underlying database structure. We will also include some basic data mining facilities that allow users to contrast and compare rates across locations, incidents, etc.

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Over the past 100 years Australians and New Zealanders have made their mark on the world stage through what has become to be known as the ANZAC spirit. It is this same "straight talking - can do" approach that has made ANZACs world famous that has resulted in the establishment of Patient Safety New Zealand (PSNZ).

The establishment of PSNZ isn't about nostalgic ties with our antipodean cousins, it's about taking AIMS and putting it on the world stage, creating a platform for innovation, and demonstrating how adaptable AIMS is to varying health markets.

In this article we outline the experiences of Patient Safety New Zealand in a rapidly changing and fragmented marketplace, but better still how a quality focus, an excellent product, and a learning philosophy can win the day.

PSNZs Objectives

PSNZ holds the AIMS licence for New Zealand and its primary objective is to promote and support AIMS in New Zealand. However, to do this we believe that it is important to create a focal point for patient safety issues in our country, and a forum by which good ideas can be exchanged between health providers, professional groups, universities and government agencies.

To achieve this we have worked hard and we are developing relationships with groups such as the New Zealand Society of Anaesthetists, the Ministry of Health, and the Accident Compensation Commission (ACC).

We have also invested in analytical capability so that users of AIMS and groups interested in reducing avoidable injury can analyse and assess problems within a short timeframe.

The Number One Health Issue

Patient safety is emerging as a number one health issue in New Zealand. High profile scandals such as the Gisborne Cervical Screening, the misdiagnosis of women in Northland, and the Peter Davis (the Prime Minister's husband) article in the New Zealand Medical Journal titled "Adverse Events Regional Feasibility Study: Indicative Findings" have all shot patient safety to the forefront of District Health Boards (DHBs) minds.

The other interesting feature of the New Zealand health market is the linkages between primary and secondary care, and disability support. DHBs are responsible not just for hospitals but GPs, Rest Homes (Nursing Homes), home health care etc. Incidents such as dementia patients being scalded in hot baths, or privacy breaches in a GPs surgery have also taken centre stage, and has led the Ministry of Health to launch a Sentinel Events Pilot Project.

Such a range of high profile incidents has led almost every DHB to institute some form of risk management strategy. The challenge for PSNZ has been to differentiate AIMS as a learning tool in an environment where DHBs have looked to short term investigation tools for their incident reporting.

Nothing like Healthy Competition

The first thing we found about the New Zealand market was that the high profile of patient safety issues and the relative vacuum of monitoring tools led to a rapid influx of products and competitors to PSNZ. These ranged from International Insurance Companies who would provide incident monitoring software free of charge for DHBs who insured with them, to home grown (albeit sophisticated) tools to track and investigate incidents. However, despite this we found that positioning AIMS in the market was not too difficult, as AIMS is such an outstanding product. Furthermore there are no other systems that have the strength of coding algorithms, the quality of technical support (which is provided by the APSF office in Adelaide), and the extensive data base of incidents which will enable DHBs to benchmark themselves against their peers.

The National Aging Research Institute has completed a national stocktake of falls and falls injury prevention activities. This project provided an overview of the falls prevention activity occurring in Australia in mid-2000. Whilst not exhaustive, it does provide a representative snapshot of the programs in operation at that time, and highlights some of the key issues to ensure effectiveness and sustainability.

The stocktake had three primary components:

- informant interviews with key stakeholders;
- a paper based survey of 122 programs which met the criteria for inclusion; and
- detailed evaluation of a small number of selected programs.

The results of the project have highlighted that there is a strong, varied and growing

level of falls prevention activity occurring across Australia. Five areas were identified where action is necessary to ensure that the health and community system is well placed to address the important public health issue of falls in older people:

- communication;
- resource sharing;
- program evaluation and research;
- workforce training; and
- coordinated effort.

These findings echo the views of the participants of the national forum held in June 2000.

The full report "Falls prevention activities for older people; a national stocktake" is now available. The report can be downloaded from the website or hard copies can be requested.

The "Directory of falls and falls injury prevention programs - May 2000" provides a summary of programs included in the national stocktake. This information is included in the stocktake report, as well as in this stand-alone document.

To order publications

Orders for hard copies of publications can be made by emailing phd.publications@health.gov.au or phone 1800 020 103 and ask for extension 8654.

When ordering hard copies you will need to provide the following details:

- your name and address for postage, including postcode;
- telephone and facsimile numbers in case we need to contact you to clarify your request;
- title of the document; and
- number of copies required.

Visit the updated website: www.health.gov.au/pubhlth/strateg/injury/falls/index.htm.



Diary Dates for 2001

Australian Society for Psychiatry, Obstetrics and Gynaecology (ASPOG) Annual Conference

10th – 12th August 2001

Werribee Mansions, Melbourne

For further information please contact the Conference Organiser on Tel +61 3 9380 1429, Fax +61 3 9380 2722 or email: conorg@ozemail.com.au

Reduce Adverse Events & Improve Patient Outcomes

27th – 29th August 2001

Eden on the Park, Melbourne

For further information please contact Tracy Hart on Tel +61 2 9923 5081 or email: thart@iir.com.au

Health Care in Perspective 2001

Incorporating the 13th National Casemix Conference

16th – 19th September 2001

Hotel Grand Chancellor, Hobart

For further information, please contact Casemix Conference Secretariat on Fax +61 2 6285 1336 or email: conference@conlog.com.au

1st Asia Pacific Forum on Quality Improvement in Health Care

19th – 21st September 2001

Hilton Hotel, Sydney

For further information please contact Julie Goodrick on Tel +61 2 6289 4236, Fax +61 2 6289 8470 or email: julie.goodrick@health.gov.au

The 4th International Conference on the Scientific Basis of Health Services

Turning Your Thinking Upside Down

22nd – 25th September 2001

Sydney Convention and Exhibition Centre

For further information please contact the Conference Secretariat on Tel +61 2 9252 3388, Fax +61 2 9241 5282 or email: iscbhs@capcon.com.au

Australasian Trauma Society One Day Clinical Meeting

28th September 2001

Hotel Grand Chancellor, Hobart, Tasmania

For further information please contact Conference Design Pty Ltd on Tel +61 3 6224 3773 or email: mail@cdesign.com.au

For further details contact:

For further information please contact Richard Catto on telephone +64 3 474 5000, email catto@benchmarking.co.nz

Sharing Initiatives is a regular column in our newsletter. We encourage all AIMS participants to send in any contributions that they would like to share with other AIMS participants.

Thank you to Dr Alan Wolff and Sharon Burmeister, for their contributions to this edition.

Further information is available from the following references or by contacting the author



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Wimmera Health Care Group Clinical Risk Management Program

Clinical risk management is about reducing the probability of negative patient events. This involves firstly detecting adverse events then analysing their risk severity and taking appropriate action to prevent their recurrence. The Wimmera Clinical Risk Management Project began this process by developing several methods for detecting adverse events. The initial detection method was medical record review using a two step process of screening all inpatient medical records using general medical outcome criteria (eg return to the operating theatre, readmission within 21 days of discharge) and then medically reviewing those records that screened positive. This method detects many adverse events in an effective and efficient manner. Analysis of these adverse events and the taking of appropriate action has resulted in a reduction in the rate of inpatient adverse events that has been sustained over six years.

Two Step Process

The two step process has been modified in this project for use in reviewing emergency department medical records. Using modified screening criteria adverse events in the emergency department have been efficiently detected. With the taking of appropriate action the rate of adverse events has been reduced from 3.5% to 0.6% of all patient attendances over eighteen months.

To improve the detection of adverse events a coordinated method of clinical incidents being reported by staff members has been introduced. Clinical incidents and near misses

are reported by staff both to the hospitals involved in this program and to a national database of the Australian Incident Monitoring (AIMS) program. The most common incident reported has been patient falls (47.7% of all incidents reported). Using a patient falls risk assessment tool and appropriate action to prevent falls a significant reduction in the number of falls resulting in fractures has been achieved over the last year. A significant finding was the low overlap of adverse events detected by both the medical record review process and clinical incident reporting. Each detection method appears to find a different sample of adverse events.

Adverse Events

Despite using these comprehensive methods to detect adverse events, some events are still not found. An adverse event may occur after a patient is discharged from hospital but the event may be due to their treatment while they were in hospital. For example, a wound infection after surgery may develop several days after discharge. To capture this important information, each hospital inpatient discharge summary that is sent to the patient's local doctor also contains an adverse patient event reporting form. If the patient's doctor detects an adverse event after discharge it can easily be reported to the Clinical Risk Management program.

Some adverse events occur infrequently and may only be detected once every few years in individual hospital clinical risk management programs. To maximise the benefit of this pool of valuable information about serious but infrequent events, this project has used information about adverse events that have occurred at other hospitals as if the event has actually occurred at Wimmera Base Hospital. Information about such adverse events is available from coronial reports, consultative committee annual reports (eg The Consultative Council on Obstetric and Paediatric Mortality and Morbidity, The Victorian Consultative Council on Anaesthetic Mortality and Morbidity and the Consultative Committee on Road Traffic Fatalities), insurers, medical indemnity organisations and medical and nursing journals. In this project after an adverse event is reported by one of these sources, the question is asked could this adverse event

continued

occur here? If the answer is yes, analysis and action are taken to reduce the probability of such an event occurring. Our experience has been that it is not necessary for a hospital to wait to actually experience a particular low frequency adverse event to benefit from it having occurred elsewhere.

Risk Assessment

In a similar preventative vein, undertaking a risk assessment on each patient admitted to the hospital has prevented common adverse events. For example each patient over 65 years of age who is admitted to the Hospital undergoes a falls risk assessment. Those patients assessed as high risk for having a fall while in hospital are managed on adjustable height beds and in rooms close to the nurses' stations so that if assistance is required it is quickly at hand. Following the implementation of this strategy the number of falls resulting in fractures has decreased from 11 to 2 in one year.

Using Clinical Pathways

There is sometimes a delay in adverse events being detected by reviewing medical records or by staff members reporting clinical incidents. To capture the details of more adverse events shortly after they occur, the use of evidence-based clinical pathways for particular clinical situations have been expanded for both inpatients and emergency department patients. Variances from pathways are recorded in the medical record and analysis of the variance is undertaken promptly. The expansion of the use of clinical pathways as outlined above together with variance analysis, will improve the detection of adverse events and reduce the time between an adverse occurring and the event being reported and action being taken.

Rating the Risks

In this clinical risk management program it has become apparent that it is not possible to manage the risk associated with all the adverse events detected. Therefore as each adverse event is detected the risk associated with the event is determined. The probability and consequences of the risk are assessed and a risk severity rating is given to the adverse event in accordance with the Standards Australia Risk Management Standard. The adverse events are then ranked according to their risk severity rating. Those with the most severe rating are given priority for analysis and action aimed at eliminating or reducing their risk. In the case of adverse events with low risk severity, a decision is made as to whether to take action or to accept the risk and continue monitoring the particular adverse event.

Taking Action

The actions taken to manage clinical risk have been a large component of this program to date. A model has been developed based on the work of Thomas Nolan in system improvement. In essence after an adverse event has been detected, the risk is analysed and if the risk severity is high a multidisciplinary team is assembled. An aim for quality improvement is established by the team together with a balanced set of outcome measures. Options to improve systems involved in the adverse event are derived empirically or from research (where possible evidence-based) or observation and are examined in detail. Small-scale tests are undertaken to implement chosen improvement strategies after baseline measurements are taken. Measured results of the tests are analysed and improvement strategies are adopted, modified or

abandoned. Further small tests are then undertaken if required, following the same sequence. This strategy has underpinned the significant improvements that have been achieved in the adverse event rates in this Clinical Risk Management program. A major component of the system improvements program has been the implementation of the results of research into error prevention. Adverse events are analysed to identify latent factors (eg workload, level of supervision, communication and equipment) and active factors (eg memory lapses and slips) that contributed to the error occurring. Actions taken have concentrated on improving the work environment and removing total reliance on the weakest components of human cognitive function especially short-term memory and the ability to be distracted from the task at hand. Strategies utilised to address these issues include simplification of systems, standardisation of procedures, use of reminders and checklists, and the timely delivery of information.

Wolff AM, Bourke J. Reducing medical errors: a practical guide. *Med J Aust* 2000; 173: 247-251.

Wolff AM, Bourke J, Campbell IA, Leembruggen DW. Detecting and reducing adverse events: outcomes of the Wimmera clinical risk management program. *Med J Aust* 2001; 174: 621-625.

apsf Website

The APSF has redeveloped and updated its website. Browse the site www.apsf.net.au when you have time.

Any suggestions or comments to Diane Turner please Tel +61 8 8222 5544 or email Diane.Turner@apsf.net.au

Occurrence Reporting is Part of a Bigger Picture

Incident reporting is an integral component of the Waitemata District Health Board's (WDHB) Quality and Risk Framework. The strategies of this programme involve doing the right thing, achieving the right outcomes, monitoring using the right information and achieving performance excellence.

providing support for the staff directly involved. Their responsibilities include: staff liaison, immediate internal notification of key relevant people, family support, dealing with outside agencies and ensuring clinical record security. They will also assist with Significant Incident Review Panel briefing.

Significant Incident Review Panel (SIRP)

A SIRP is formed for each individual serious incident occurring within a service. The panel ascertains the facts surrounding the incident and identifies factors contributing to the incident. The General Manager will call a meeting of the SIRP within 24 hours of the event. Key people and relevant others are invited to attend. A Chairperson is elected and an individual is identified to project manage the investigation.

Time lines for reporting are also established. On completion of the investigation the SIRP panel prepares a written report of its findings, including recommendations to achieve improvement and prevent recurrence. The General Manager then consults with the Chief Executive, a final decision and recommendations for action are agreed.

Review Committee

This committee meets monthly and its members include the Quality Facilitator, Divisional Quality Managers, Legal Advisor, Chief Medical Officer, Customer Services Officer and the Occurrence Reporting Co-ordinator. Its purpose is to monitor complaints and consumer feedback, analyse occurrence trends and monitor investigations by external bodies. Continuous Quality Improvement processes within services are also audited to ensure closure of the quality loop.

Investigation Processes Workshop

WDHB introduced the APSF Incident Report in December 2000. It appears that the structure of the form alone has resulted in an improvement in the information documented by the reporter. However, it became evident that the managers and quality representatives involved in the investigation of incidents required further development of the skills required to investigate. In response to this need the Quality Facilitator and the Occurrence Reporting Co-ordinator now facilitate a workshop titled "Investigation Processes".

The objectives of this 2-3 hour workshop include:

1. Understand the need to investigate incidents and complaints in a consistent manner
2. Know what is reported, to whom and how
3. Understand how to investigate
4. Develop skills to document / report investigation reviews
5. Develop Continuous Quality Improvement processes

Clinical Safety & Risk Management

- Assessment & response systems
- Monitoring & Surveillance
- Processes compliance with legal requirements
- Clinical Practice & Review
- Back-up systems

Best Practice

- Staff Management
- Peer Review
- Best Practice Guidelines
- Patient Information
- Patient-focused models
- Research

Compliance with Industry Standards

- Contract expectations
- Accreditation & Licensing
- Legislative & Compliance Management
- Quality Systems

Consumer Focus

- Code of Rights
- Interpreter Services
- Complaints Processes
- Information Resources
- Case Management Models

- Models of care
- Health Outcomes



WAITEMATA DISTRICT HEALTH BOARD QUALITY AND RISK FRAMEWORK

Incident reporting is not the quality system but a tool used within the quality framework. It is used for gathering information to enable us to monitor the quality of systems and processes within our organisation. It allows us to learn from individual events as well as identify patterns and trends from groups of events. Reporting and analysis is essential to enable information obtained from the incident reporting process to be used effectively as a learning tool.

Some of the initiatives that the WDHB has established that support the incident reporting processes include:

Quick Response Team (QRT)

The QRT is a team of senior managers that are on call 24 hours to attend any significant incident, regardless of division or facility. Their role is to stabilise the situation by

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The hardest thing to date has been raising the profile of Patient Safety New Zealand and ensuring that CEOs, Risk Managers, Quality Managers and Clinical Leaders are aware of AIMS, PSNZ and our link to the APSF. Now we have achieved this the next hardest thing is to educate DHBs that the best way to reduce risk through avoiding adverse events is to create a reporting culture and learning environment. It is all too tempting for managers to institute a simple and inexpensive investigative tool which will in effect discourage staff from sharing their experiences.

Waitemata DHB an Excellent Site

As readers will be aware Waitemata DHB is already a user of AIMS. Waitemata covers the north shore and west of Auckland. It is potentially the largest DHB in New Zealand (when the 2001 census results are released)

and serves over 10% of New Zealand's population. Waitemata's experience with AIMS over the last 12 months is a credit to all concerned. With the support of the APSF they have installed AIMS over a very diverse organisation operating from multiple sites. The closeness of partnership with the APSF has meant that they have tackled teething problems in typical ANZAC fashion and both sides have shown dedication and commitment.

For PSNZ, Waitemata is emerging as an excellent reference site, with a number of New Zealand's largest DHBs having already sent staff to view AIMS in Waitemata and discuss applications to their own situation. While Waitemata's primary relationship is with the APSF we have enjoyed the opportunity to support them and learn from their experience.

Exciting Times

The future of Patient Safety in New Zealand is exciting. The small size of the market and speed of developments has created an environment where AIMS 2 should thrive. It also will throw up some interesting challenges such as the role of ACC who covers hospitals for medical misadventure, the role of the Ministry which is developing sentinel events reporting, and not to mention the proliferation and competition from what we like to call "shell based" reporting systems. (i.e. stand alone with no data pooling between hospitals).

The other exciting thing about PSNZ is its involvement in the non-hospital sector, and through this we hope to be able to feed back ideas and innovations to our parent the APSF. One of the best things about small markets is that ideas flow quickly and easily. The best thing about working with the APSF is that 'can do' ANZAC spirit.

ARCHI...Sharing the experience of achieving change

The Australian Resource Centre for Hospital Innovations (ARCHI) was established in 1998 as a national clearinghouse for information and resources on innovative health care delivery. ARCHI is funded by the Commonwealth Department of Health and Aged Care.

ARCHI makes available information and resources on innovative health care delivery from hospitals to the community for both acute and chronic illness. ARCHI's goals include the collection of information on projects, models of care, clinical pathways, guidelines and work in progress as well as contact information on the health professionals involved in this work and disseminate the information as widely as possible. It's all about sharing the experience of achieving change.

The most recent ARCHI Toolkit Seminar, on "Demystifying Clinical Governance and

Risk Management" was held at Old Parliament House, Canberra on 10th April 2001. It was a highly successful, information rich day, with approximately 200 attendees from all Australian states and from New Zealand. There was considerable sharing of ideas as well as presentations of both "big picture" and local level applications of clinical governance and risk management. The primary aims of the seminar were:

- To inform clinicians and managers about clinical governance and risk management, and
- To showcase practical examples of clinical governance and risk management which demonstrate that clinical outcomes need not be compromised for efficiency gains.

If you have information to share or want to know more about ARCHI, contact your

local Satellite Project Officer or the ARCHI National Office.

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Presentations from this seminar are available on the ARCHI web page www.archi.net.au/toolkit.html.