

EWSLETTER

DECEMBER 2001



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National Patient Safety Agency United Kingdom

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The APSF has been successful in securing a contract with the National Patient Safety Agency (NPSA) in the UK to develop and support a pilot implementation of a national reporting system for learning from adverse events and near misses in the National Health Service (NHS).

The NPSA is a Special Health Authority established under the NHS and commenced operations as a legal entity as from 1 November 2001. The NPSA is led by Sue Osborn and Susan Williams in a joint Chief Executive role.

The purpose of the Agency is to take a national approach to improving patient safety by reducing the risk of harm caused through error.

The need for a national response on adverse events was established in a Department of Health report entitled "An Organisation With A Memory" and the implementation of a special agency and reporting systems was described in a further report entitled "Building A Safer NHS for Patients".

Against the impressive framework provided by these reports, the NPSA is now poised to demonstrate outstanding leadership in taking the learnings from adverse events and near misses and converting them into useful and workable solutions for improving patient safety across the whole of the NHS.

The NPSA aims to achieve its purpose through the following activities:

- Collect and analyse information from NHS organisations, NHS staff, patients and carers.
- Assimilate other safety information.
- Learn lessons and ensure they are fed back into practice.
- Produce solutions to prevent harm, specify national goals and track progress.

The system is intended to be designed to ensure that lessons learnt from one locality are easily applied across the NHS as a whole.

The intention is to:

- Capture and record information on adverse events and analyse them in the right way.
- Encourage local reporting of adverse events to reduce risk within the organisation concerned.
- Take selected reports to the national level for service wide action – where patterns, clusters and trends show scope to reduce risk in other parts of the country.

Approximately 28 NHS Trusts are involved in the pilot project which is due for completion by the end of March 2002. As part of the preparatory work, Clinical Risk Pty Ltd, a collaborating partner in the APSF's bid for the pilot system, has already provided training support in root cause analysis to the pilot NHS Trusts.

The NPSA web site can be found at www.npsa.org.uk and Clinical Risk's web site is at www.clinicalrisk.com.

**The APSF Council, Management & Staff
thank you for your continuing support
and wish you a very Happy Christmas
and prosperous New Year**



eliminating preventable harm in health care

Presidential Note



The year 2001 has been very busy and eventful for the APSF. An enormous amount of time and effort has gone into developing the new web-based incident monitoring system and a completely new way of classifying things that go wrong in healthcare. This new system is designed to capture information from all available sources – incidents, adverse events, sentinel events, complaints, medico-legal cases, coronial cases, the literature and morbidity and mortality studies. It can also capture information about work-related incidents and accidents.

It is based around a “generic reference model” which has been set up as the conceptual foundation of deconstructing and classifying things that go wrong. The actual classification is via a set of simple questions from which classifiers choose one or more answers from a set of terms. These are specific to each type of incident (eg fall, medication error) and are arranged according to how frequently they occur in that particular domain. The terms and frequencies may change depending on the specialty and nature of practice. The system is designed to be applied across the whole spectrum of healthcare, and to allow comparisons over time between health organisations, States and even nations.

The current APSF system (AIMS 2) is being trialed across 30 trusts in the NHS in the UK, to set the stage

for a possible “roll out” of the new system. Ray Blight is based in London and is now CEO of Patient Safety International, the subsidiary running this project owned by APSF. Marg Gehrig is now CEO of the APSF and Petri Collins is Manager of Client Services.

The first specialty-specific adaptation of this is for Intensive Care. This is being developed in conjunction with the John Hopkins School of Public Health which is setting up and trialing a web-based anonymous incident reporting system in 28 Intensive Care Units in the United States. This is based on our reference model and lessons learnt from the 10,000 incidents collected by the AIMS-ICU system developed by Ursula Beckman, who is co-ordinator of this new development. The program has the support of the Critical Care Society in the USA.

It is proposed to have the new system up, running and tested by late 2002.

The next major challenge is to develop the additional classification screens required for each of the medical specialties. Development of the adaptation of the screen for each of the other medical specialties will require support from these specialties as well as some funding.

The reference model and preferred definitions of key terms in healthcare have been put up on a web site under the auspices of the Australian Council for Safety and Quality in Healthcare, www.healthandsafety.org. This provides a means whereby any interested parties can make suggestions and comments about the definitions of key terms for use in the safety and quality literature.

For further details contact:
Heather.Smith@apsf.net.au

News from the APSF Team



A number of changes in the management structure have occurred in the APSF recently.

Mr Ray Blight, formerly CEO APSF, has taken up the position of Project Manager for the UK pilot project with the National Patient Safety Agency. This has meant Ray is based permanently in London until the end of the pilot in March 2002.

Ms Margaret Gehrig has taken up the position of Chief Executive, APSF and will be responsible for the Australian operations. Margaret has held the position of Manager, Client Services and Support with the APSF for the past two years and has a background of 20 years in health at senior hospital levels. The Foundation recently appointed Ms Petri Collins to take over the client services

management role. Petri has more than 25 years of experience in a wide variety of health care settings, including the pharmaceutical industry. Her experience includes recent clinical nursing work, nurse education and management roles, with many years of Quality Improvement involvement.

Petri has completed research theses in Neonatal Casemix issues and Nursing Staff Appraisals. Her consulting experience includes the development of an accredited GP training program in the area of HIV/AIDS, Regional Health Care training needs analyses and Service Excellence programs.

The Foundation welcomes Petri to the team and believes that the skills, experience and knowledge she brings will enhance the Foundation's operations. Petri will be contacting our clients in the very near future to introduce herself and continue to ensure a high level of support.

Sharing Initiatives

ACT Adverse Event Monitoring Project, Using AIMS

The ACT Department of Health, Housing and Community Care (DHHCC) education strategy was designed to accommodate four distinct work site groups; Mental Health, Acute Hospital, Community Care and Disability Service.

Education sessions also targeted professional groups: Medical, Nursing, Allied Health, Support Services, Clerical Staff, Hotel Services.

It was hoped that by using this approach, staff had more than one opportunity to attend an AIMS Education Session and were able to have their professional and team needs addressed in the appropriate forum.

Education Strategy:

Four stages were defined and implemented:

Stage 1: Awareness Raising, (called locally the drip stage).

Every opportunity was taken to filter information on incident monitoring and risk management. Strategies included: Library display, resources and news articles. E-mail message to whole of campus, Archie Conference feedback and Newsletter series on Risk, Safety, Incidents, APSF and AIMS. At every opportunity, the need for Incident Monitoring Data to aid decision was expressed. The APSF Newsletter, APSF leaflet and Posters were distributed in the Staff Cafeteria.

Stage 2: Formal Education, (called the chip stage locally).

Two job-share education officers were recruited to ensure timing flexibility and support. The CEO/Executive introduced the project to staff. Next, Management Forums were informed of the education plan and support was sought, followed by an intensive week of presentations by the APSF and local work groups discussion sessions (incorporated into existing meeting structures).

Stage 3: Implementation Support.

On the day of implementation, posters were displayed in key public areas, singly or in groups, with one-line messages:

“AIMS for Safety”, “Put Safety First”, “Protect Others”, “Protect Yourself”, “Support AIMS”

“AIMS for Safety” stickers were designed and placed on PCs, in community cars and worn by staff. The General Training Program provided by APSF was placed in each ward/clinic/unit resource folder.

All old incident forms were removed and replaced with the new AIMS form and staff informed of this action. This created an opportunity for informal discussion. One week after implementation a repeat walk around was conducted. At this time, we distributed Minties with an “AIMS for Safety” sticker on the packet. This created an opportunity to obtain spontaneous feedback on the form, and to capture those who had not attended training. An unexpected benefit of distributing the Minties was proof of contact. When staff complained that had not heard about AIMS, we would ask if they had recently received a bag of Minties, with an AIMS sticker on the packet. Most staff did remember the Minties and therefore they DID have contact with the AIMS educators.

Stage 4: Feedback Stage.

It was planned to run feedback sessions using the AIMS Reports. Due to difficulties with the AIMS2 database we were unable to introduce reporting within the 2-month time frame. Therefore we commenced a newsletter to keep staff informed. This first newsletter was sent out six weeks after implementation. The CEOs and Executive members provided comment and appreciation through the staff newsletters.

Education Strategy by Site:

Community Care, Disability Program, Calvary Health Care and the Canberra Hospital:

The education strategy for each separate site included a variety and numerous presentations and workshops, both formal and informal. These included initial contact at Senior Quality Forums, presentations at each team's management forum and presentations at local work groups. Project Information was mailed out in pay slips, Risk Management Articles placed on the Intranet and Australian Patient Safety Foundation presentations and workshops were conducted. The Minties strategy was also used.

Education Strategy by Professional Grouping:

Junior Medical Officer Staff Group:

This education is currently still in progress.

Visiting Medical Officer and Staff Specialist Group:

Presentations have been given to the Medical Staff Committee / Medical Council and to Clinical Divisions by Dr Shirley Bowen and Prof. Bill Runciman

(President of the APSF). Individual follow-up will be undertaken by education officers and via an AIMS Information Package.

Resident & Registrar Medical Officer Group:

Clinical division heads were contacted and asked to include an AIMS Education session in their Peer Review and/or Division meetings.

Information Packages were distributed at each presentation, containing a relevant BMJ Article, APSF Information Sheet, and APSF Newsletter

Two sessions were conducted by Dr Bill Runciman, and Information Packs and Forms were placed in the RMO Lounge.

Nursing and Allied Health Grouping:

These Divisions will be targeted at a group level, through unit, ward and area meetings, with intensive input from the education officers and this is currently progressing.

SUMMARY.

The above strategies were designed specifically so that staff had more than one opportunity to attend an AIMS Education Session and were able to have their professional and team needs addressed in the appropriate forum. To date the Department is delighted with the cultural change that has occurred around incident reporting and we would like to thank all staff who have supported this important initiative.

Further information is available from:

Ellen O'Keeffe

Tel 02 6205 1966

E-mail Ellen.O'Keeffe@act.gov.au

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 Ellen O'Keeffe, AIMS Project Officer, Clinical Quality Unit, Office of the Chief Health Officer, ACT for her contribution to this edition.

Contributions or enquiries should be forwarded to Petri Collins, email: petri.collins@apsf.net.au

Emergency Medical Information Book

For further information please contact:

Arthur Jeffries,
Project Chairman,
Emergency Medical
Information Book,

PO Box 304,
St Agnes, SA 5097

Tel +618 8261 4055

Promotional Videos are also available.

There is no doubt whatsoever, these books have saved lives.

THE NEXT ONE MAY BE YOURS

The concept of the Emergency Medical Information Book arose from a 'need' identified by Ambulance Paramedics through difficulties they experience when called to an emergency. If the person is on their own, are unconscious or gravely ill, they cannot assist Paramedics. If their partner is present, he or she is often so distraught and confused, they are unable to give necessary details of the patient's condition, or the medication they are on.

When this happens, the only action the Paramedics can take is to physically collect all medications in the house and take them to the hospital with the patient. **This is time consuming and causes delays in making a diagnosis and the commencement of treatment, thus putting the patient's life in jeopardy.**

The Emergency Medical Information Book overcomes this problem. It consists of four pages, which have prepared space to record patient information (name, address and relative contact numbers), a short medical history (particularly important for people with diabetes and allergies), current medical condition and medications, and a contact number for their doctor.

Prior to the introduction of the book, all details were checked thoroughly by members of the AMA, directors of Emergency and Accident departments at three major hospitals, Ambulance personnel, together with other health professionals, for the accuracy and suitability for inclusion.

The originator of the book was a Paramedic from the South Australian Ambulance Service (SAAS), Modbury Station, in 1998. Because the SAAS could not afford to produce the book, the Rotary Clubs of Tea Tree Gully, Modbury and Golden Grove (from the Rotary District 9500) were

approached for financial support to produce the quantity of books for a "pilot project" to be conducted within the City of Tea Tree Gully Council area. The Clubs were impressed by the book and readily agreed to allocate \$5,000 to produce a total of 5000 books for the trial (\$1 per book).

These books were distributed by the officers of the Modbury Station of SAAS to the elderly and the chronically ill citizens within a group of Retirement Villages, Elderly Citizens Homes, and other needy people within a controlled area, so that an accurate record of the trial could be carried out.

The book is kept in a clear plastic sleeve with magnetic strips on the rear, which adhere to the refrigerator door for easy access.

During the trial which lasted for 3 months, the ambulance officers recorded more than 200 occasions when the books were put to use. This figure was far in excess of what had been expected, and made the Ambulance Service realise that there is a real need for such a book.

Following a complete assessment of the trial results, some changes to the books were recommended. The changes were checked by the authorities used previously, and incorporated into the current book.

Because of the success of the pilot project, Rotary recognised the benefits the book offered and agreed to promote this project throughout Australia.



Robert Brokenshire, MP, Minister for Emergency Services, officially launched the project in June 2000.

Since the books were first released, 75,000 have now been printed and distributed throughout the state, by Rotary in conjunction with the SAAS.

The project has expanded into Victoria and Queensland with the orders for 20,000 having been placed to date. In addition, Rotary is currently holding discussions with the Melbourne Metropolitan Ambulance Service, the Ambulance Service of New South Wales, and the Northern Territory Ambulance Service. In fact, on 13th June 2001, the Ambulance Service of NSW agreed to become involved.

Whilst the colour of the book is green and white in SA, it will be different colours in the other states, subject to the corporate colour of that state's Ambulance Service. The books have been altered slightly, so that no changes will be required when other states join.


A community service project from Rural Ambulance Victoria and your local Rotary club.



Emergency Medical Information Book.

Name

Book started/...../.....

AMBULANCE  000.

MAKE SURE YOU UPDATE YOUR INFORMATION REGULARLY.

Other than for a small grant from the State Government, the \$75,000 required to conduct the project has been raised by the Rotary Clubs.

There is no charge for the book but the Rotary Clubs are encouraging recipients to make a "gold coin" donation. Any monies received from these donations is being used to print more books.

Because of their acceptance by the residents of SA, and because they are becoming more widespread, when an ambulance is called in an emergency, one paramedic now goes straight to the refrigerator to pick up the book. **In a life-threatening situation, the information in this book allows for faster response by paramedics in identifying medical conditions, and can lead to treatment**

being commenced prior to the patient being transported to the hospital. If the patient does not have a book, the paramedics will leave one there and then, as they carry a small supply in the ambulance.

Ambulance officers report that the books are being used on a daily basis, and being recovered from throughout the state.

CHIC'S Health IT News - 22/11/01

CHIC Australian Health IT Study Tour

(2-7 Dec 2001 - Bris-Syd-Melb)

See the health IT systems being used in the workplace and discuss implementation issues with the users! Numbers are limited to 10 participants - register now to secure your place.

Full details at <http://www.chic.org.au/auststudytour.asp> or contact Vanessa McGee (vanessa.mcgee@chic.org.au) - Tel: 07 3238 0533).

Presentations from CHIC EHR Seminars - Now available to CHIC Subscribers via the secure subscriber site (<http://ehits.chic.org.au/news/presentation/EHR.doc>) EHR Seminar attendees will also receive access to the soft copies of the presentations via email notification.

EVENTS- NOVEMBER/DECEMBER

e-Business for Health

(27 Nov- Mel, 28 Nov- Bris, 29 Nov Syd) Hosted by IBM, this event includes a videoconference presentation from Dr Allen Ausford from Alberta Wellnet (Canada), on the design, build and implementation of Canada's first Pharmacy Information Network, supported by Electronic Health Records.

For more information, call Sally Green on 1 800 802 796 or to register visit: <http://www-7.ibm.com/au/e-business/event/>

AIMS and Consumers



We thank Kate Moore for her contribution to this issue.

Kate is from Weston in the ACT.

A large, untapped source of information lies waiting to be discovered by the Australian health care system in its quest to improve the safety of the services it offers. That information is held by the people who use the health care system – the patients, or the consumers, depending on which way you like to view them.

Many people who have been in a hospital can recount tales of how they, or other patients experienced an adverse event such as administration of the wrong drug or wrong dose, or other treatments which were inappropriate, poorly administered or just plain wrong. They, and their carers can tell stories about how they headed off an ‘event’ by pointing out a potential mistake before treatment was given. They can tell about poor discharge practices, and about poor communication – both between hospital staff and between health professionals and consumers. These are all well known causes of adverse events.

And yet, strangely, our information gathering systems have largely ignored the wealth of information held by this group of people. That, I hope, is about to change.

For years, organisations representing health care consumers have lobbied to have an accessible system through which consumers can report adverse drug reactions. The lobbying for a consumer adverse event reporting system was largely ignored because it was felt to be too difficult – and that consumer reporting would be unreliable.

However, an important study published in 1994¹ showed that while consumer perceptions about adverse reactions differed markedly from those of an expert panel, consumer reporting of clinical events was reliable and valid.

Last year, in Sweden, a consensus statement² issued by an international conference on Consumer Reports on Medicines recognised that existing systems of professional-based adverse drug reporting systems, while important, have ‘deficiencies and limitations and cannot stand

alone as representing an adequate feedback...’. That same statement also recognised that there is evidence that ‘direct consumer reporting can result in an earlier accumulation of signals.’

In Australia, the Australian Pharmaceutical Advisory Council is recognising that a system of direct reporting by consumers of adverse drug events would be of value. Last year it convened a working party on Consumer Reporting of Adverse Drug Events which is working through issues involved in setting up a system of consumer reporting.

So, we are now seeing some recognition of the value of consumer reporting of events relating to pharmaceuticals. This is all good news. What we also need is some recognition that consumer reporting of other adverse events will also add value to other systems of reporting. And that too is beginning to happen.

In the ACT, where I live, and where AIMS is being introduced into our public hospitals, I am told that consumers will be able to report adverse events through AIMS. There is in principle agreement to this, and options for how this will happen are being investigated. There are, of course, issues that need resolving, such as how and when to tell consumers that they can, and should report adverse happenings, and how to differentiate between an ‘event’ and a complaint.

But I don’t believe that the issues involved in consumer reporting of adverse events are impossible to resolve. I am pleased and proud to be living in the ACT where the importance of consumer feedback about health care services is about to be recognised. I am also reassured, because this means that the services I rely on will be safer and more effective. I look forward to our example being followed in other states and territories soon.

Kate Moore.

¹ Mitchell A.S., Henry, D.A., Hennrikus D., O’Connell D.L. Adverse Drug Reactions: Can Consumers Provide Early Warning? *Pharmacoepidemiology and Drug Safety*, Vol.3: 257-264(1994)

² *Consumer Reports on Medicines (CRM): Policy and Practice: Consensus Document adopted at the First International Conference on CRM September 29-October 1, Sigtuna, Sweden.*



Christmas Break



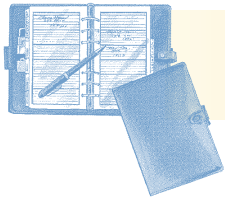
The APSF will be closed from 5pm Thursday, 27th December 2001 to 8am Wednesday, 2 January 2002.

The Help Desk will be available between these dates, with the exception of public holidays.

CONTACT

Local & International.....+61 8 8222 5495

National.....1800 100 021



Diary Dates for 2001

Inaugural AGPAL "Quality in Practice" Conference

Gold Coast Feb 28-March 3rd 2002

See www.agpl.com.au

The Australian General Practice Accreditation Limited's first conference which aims to showcase quality management strategies and programs in an interactive environment.

7th European Forum on Quality Improvement in Health Care.

March 21-13 2002 Edinburg. See www.quality.bmj.com

Major themes: Leadership, culture change and change management, Health policy, Patient Safety, measuring and improving quality. Invited audience will include health care leaders, practitioners and patients.

Risk 2002.

March 20-22 Sydney.

Monitoring, Measuring, Managing, and Mitigating Risk in a Changing Global environment.

Practical case studies and integration strategies from Pacific Dunlop, Toyota Australia Ltd, CSIRO, Aristocrat Technologies Australia, NRMA Insurance Ltd, Commonwealth Bank. Key note presentation "How

critical is Risk Management in today's Global Environment?" by Kevin Mutch from Rio Tinto.

Ph 02 9923 5090. Fax 02 9959 4684. Email: info@iir.com.au.

See www.iir.com.au

5th Annual Event "E-Health & IM&IT

Sydney March 26-28. See www.iir.com.au

Major themes: Policy update, moving from IT to IM (information management), current developments in e-health across the health spectrum, security and privacy, clinical information Intranet. Two major workshops: Legal update and Knowledge Management. Relevant to Hospitals, community and General Practice.

4th National patient Safety Foundation Conference:

"Patient Safety: Let's Get Practical"

April 22-24 2002 Indianapolis. Information on www.npsf.org and www.mederrors.org.

Focus will be on overall understanding of the culture of safety, related individual and shared accountabilities, practical tools and patient involvement strategies.

Helpdesk & Classifier Training Advice

The APSF has a 1800 toll-free number for callers requiring helpdesk or coder training advice. This number is for users within Australia and will be manned from 0900 to 1600 with the exception of South Australian and Australian public holidays.

The Toll Free Number 1800 110 021.

For Local & International callers, please use the helpdesk number **+61 8 8222 5495**.

Please direct all other enquiries to the main number **+61 8 8222 5544** or the direct line of the appropriate person.

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

Developing a Root Cause Analysis

For further information
please contact:

Roland Armarego
by email
roland@clinicalrisk.com or
Tel: 08 936 420 68.

Clinical Risk Pty Ltd is pleased to be able to offer assistance to APSF clients aspiring to establish an organisational root cause analysis (RCA) capacity. We provide assistance in policy and procedural development, executive management briefing, root cause analysis training, and programme and analysis review. For serious events, where there is a strong desire to have good independence and objectivity, we also provide service in leading investigations.

In relation to training, we offer several programs: -

- Three day basic RCA workshop
- Five day advanced RCA training (for application in more complex events)
- One day executive management orientation (for review of reports)
- Seven day investigation team leaders workshop
- Three day RCA conversion workshop (from basic to advanced level)

Our workshops are based on our extensive training experience in incident investigation techniques in a number of industries both nationally and internationally. Each workshop is focused on skill development. The techniques learned have life-cycle application and are equally applied within the organisation to planning and design, system or process review, and failure analysis. Our philosophy is that the effort for investigation should be focused on problem solving (rather than the allocation of blame) and that the investigation findings should be factually based.

The three-day basic RCA workshop is built around a full clinical case study to which the participants are required to apply the techniques learned and present findings. Although demanding our workshops are always fun. Topics covered include:

- Model Programme for Root Cause Analysis
- Events and Causal Factors Analysis
- Interviewing for Root Cause Analysis
- Change Analysis
- Hazard-Barrier-Target Analysis
- Human Errors
- Integration of Information
- Reporting findings

Advertising

If you would like to advertise events or services that you think may be of interest to readers, please let us know.

Contact:
Petri Collins, email:
petri.collins@apsf.net.au
or Facsimile,
+61 8 8232 6938

For more information –

Email: clinicalrisk@bigpond.com,
Website: www.clinicalrisk.com

Clinical Risk's mission is to improve patient safety by assisting health care providers to address systemic failure.

