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apsf Help Desk

Local & International:
+61 8 8222 5495

National Toll Free:
1800 110 0215

Email:
aims@apsf.net.au

Visit our Website at:
www.apsf.net.au

Declaration of AIMS as a Quality Assurance Activity

The Australian Commonwealth quality assurance confidentiality legislation (Part VC of the Health Insurance Act 1973), which was introduced in December 1992, was developed to assist health care professionals to participate effectively in activities which examine the quality of care provided and which aim to improve the quality of that care.

AIMS is an Activity that has been declared by the Minister for Health and Aged Care since 1996. The purpose of the Activity is to reduce preventable iatrogenic injury in the Australian health care system through a national system for monitoring incidents and/or adverse events that occur in health services. The Activity provides an instrument for the capture of incident/adverse event data and the paper and electronic transmission of this data to the Australian Patient Safety Foundation. The data is used to develop local and national solutions to problems identified, to implement corrective strategies and to monitor their impact on incidents and adverse events.

The Commonwealth Qualified Privilege Scheme provides two main areas of protection for specific quality assurance activities. These areas are:

1. Confidentiality of information that identifies individuals

Declaration of a quality assurance activity protects the confidentiality of information that identifies individuals that becomes known solely as a result of declared quality assurance activities by:

- making it an offence to make a record of that information or to disclose that information to another person or to a court; and
- specifying that a person cannot be required to disclose, or produce documents containing such information to a court except in certain limited circumstances.

2. Assessment of other health care providers

A declaration offers protection from civil proceedings (apart from those relating to the breach of rules of procedural fairness) to people who participate in activities that involve the assessment or evaluation of the quality of health services provided by others. The protection applies if:

- the relevant person engaged in the review process in good faith;
- the review process adversely affects the rights or interests of a person who provides health services;
- the relevant person participates in the review process as a member of a committee for the purpose of making an evaluation or assessment of the services provided by a health care practitioner; and
- all or a majority of the members of the committee are health care professionals belonging to the same health care profession as the person who provides health services.

Responsibility of participants of declared activities

As a participant of a declared activity, you must not divulge information that identifies individuals that became known solely as a result of your activity. If you do not comply with this requirement the maximum penalty under the legislation is imprisonment of two years.

Continued on page 2...

Presidential Note



Professor W. Runciman
President APSF

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

AIMS, AIMS+, AIMS2 and AIMS3 – the evolutionary path

AIMS started in 1988 with a voluntary, anonymous, national incident reporting system for anaesthesia-related events. Completed forms were sent to the APSF, "key words" were generated, and the data stored in a FoxPro database, all essentially done by Dr Bob Webb.

With the Professional Indemnity Review, under the Directorship of Fiona Tito, funds were provided for both the Quality in Australian Healthcare Study, in which the APSF was involved, and pilot studies into using AIMS for six other medical specialties and across six large teaching hospital systems. These showed that AIMS was valuable in all these domains; the findings were presented at a national meeting in 1994.

In 1996 AIMS was introduced across the public healthcare system in South Australia, and was chosen for use in four networks in Victoria. It was at this stage that it became evident that the Generic Occurrence Classification (GOC) was too complex to use at individual healthcare levels. There were simply too many categories to generate useful trends or meaningful histograms. A simpler CeDOC classification was therefore developed for use at individual health facility level with the Part A form (with identifiers), and the GOC was reserved for the more detailed anonymous "Part B" forms.

Early in 2000, after intensive consultation with users in several States and Territories, the AIMS+ form was introduced. This was suitable for reporting incidents across the entire spectrum of healthcare, reducing duplication and complexity, and allowing options for anonymity or confidentiality if identifiers were provided. Also, it was realised that classification was better done at a local healthcare facility level than at a national level. To this end, systems for training coders and checking their quality of coding was developed.

AIMS2 has recently been introduced into Western Australia, the Australian Capital Territory, and Waitemata District Health Board in New Zealand. It represents a rewrite of the underlying database structure and a move away from the MS ACCESS database. The new software supports a system which can be run as a stand-alone application or on a state-wide level using SQL server. AIMS2 is designed to be used with the CeDOC® classification but allows for the progressive addition of the much more versatile and the powerful Healthcare Incident Type (HIT) screens. The initial HIT screen added to the AIMS2 software was one for pressure ulcers. HITs have been developed for Medication, Fall, Equipment and Obstetrics. A further 20 HITs due for completion by the end of 2002. AIMS2 has full security and audit functions.

AIMS3 structure allows for scalability and as well as having the ability to classify root cause analysis information. This will be available to be run on a stand-alone basis, in a client server mode, or as a web-based system. Current AIMS users will be able to convert to the next generation of software in a "seamless" manner.

Declaration of AIMS as a Quality Assurance Activity *continued*

Areas not covered by a Declaration

In the past there has been some misunderstanding about the purposes and scope of protection provided by a declaration. Two examples of areas not covered by a Declaration are:

(a) Patient Consent

One misunderstanding is that a declaration overrides the general law relating to confidentiality and patient consent and thereby obviates any requirement that may exist to seek patient consent for a patient's medical records to be viewed by other than a treating doctor.

A declaration is irrelevant to the issue of whether or not patient consent is required.

(b) Disclosure of Information

Another misunderstanding is that 'all' information generated as a result of a declared activity can be kept confidential. This is not the case. The only information protected by a declaration is that which identifies individuals. In fact, the legislation requires participants of declared activities to report on the progress and outcomes of the activity (without identifying individuals).

This information is not designed to replace the information set out in the Health Insurance Act 1973 and the Health Insurance Regulations 1975. It is designed to provide a brief summary to help you understand the main purposes of the Scheme. You should refer to the Act and Regulations for precise requirements.

Source: Declaration of a Quality Assurance Activity – The Commonwealth Qualified Privilege Scheme Brochure, Commonwealth Department of Health and Aged Care.

Fiona Tito, *Enduring Solutions*

The Australian Patient Safety Foundation
is pleased to invite you to a National SUMMIT:

"HOT TOPICS in Patient Safety"

at the Adelaide Convention Centre
on Friday May 17 2002

AIM OF THE SUMMIT:

To address critical issues surrounding incidents, adverse events and sentinel events.

Speakers will address:

Root Cause Analysis,

Voluntary or mandatory reporting?

Legal Privilege or Public Accountability?

Anonymity or confidentiality?

Feedback and "closing the loop" in:
medication incidents, pre-operative assessment and
staff fatigue and performance.

KEYNOTE SPEAKER:

Dr Jim Bagian, MD, PE, Root Cause Analysis expert from the USA.

Dr. James P. Bagian has extensive experience in the fields of human factors and both aviation and patient safety. He was chosen as the first Director of the Department of Veterans Affairs' National Center for Patient Safety in 1998.

A former NASA astronaut for 15 years, he flew on two Space Shuttle missions and following the 1986 Challenger space-shuttle explosion, supervised the capsule's recovery from the ocean floor and led the development of the Space Shuttle Escape System that is now in use. Dr. Bagian holds a B.S. degree in mechanical engineering from Drexel University and a doctorate in medicine from Thomas Jefferson University. He is a member of the National Academy of Engineering and is on the faculty of the Uniformed Services University of Health Sciences and University of Texas Medical Branch.

Dr. Bagian received the American Medical Association's 2001 Dr. Nathan S. Davis Award for outstanding public service in the advancement of public health.

Dr Bagian specializes in human factors engineering (HFE), a body of knowledge about human abilities, limitations and characteristics relevant to design. HFE principles underlie most patient safety activities and view that "Systems must be fault-tolerant, realizing that humans make mistakes". This is the logic behind dual-control systems in cars and planes. On an organizational level, HFE helps increase feedback and teamwork, drives out fear, increases leadership commitment and improves direct communications. Such principles underpin the Root Cause Analysis model which will be presented by Dr Bagian at this Summit, "Hot Topics" on May 17 at the Adelaide Convention Centre.

Other speakers include:

Prof Alan Merry, Associate Professor and Anaesthetist from the University of Auckland, New Zealand, who will address reporting cultures and blame barriers as one of many human complexities related to health care systems.

Prof Drew Dawson from the Sleep Investigations Research Department at the Queen Elizabeth Hospital will speak on the effects of shiftwork and fatigue on staff performance, with its implications for rostering and manpower.

All health care professionals with an interest in patient safety and the improvement of quality in health care will find this a timely and essential meeting.

**For complete Program and Registration details
please visit our website: www.apsf.net.au**

Sharing Initiatives

Western Australian
experience,
Fremantle Hospital

Pressure Ulcers

MONITORING THE PROBLEM OF PRESSURE ULCERS

The frequency with which patients develop hospital acquired pressure ulcers is often seen as a good indicator of the overall quality of care provided by hospitals.

Fremantle Hospital & Health Service in Western Australia has been monitoring the occurrence of hospital acquired pressure ulcers since 1994. In July each year trained nursing surveyors undertake a point prevalence survey of all in-patients.

The aim is to establish the number of patients in the hospital on that day who have a pressure ulcer. The pressure areas of all patients are examined and documentation is reviewed to determine if a pressure ulcer was present on admission or occurred during hospitalisation.

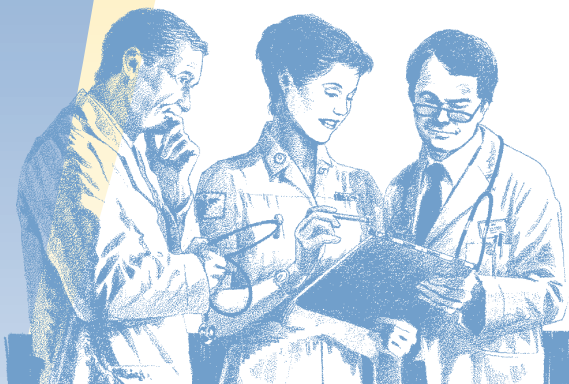
Prevalence surveys give information on the stage and site of pressure ulcers and can provide some indication of causative factors. Regular prevalence surveys over a period of time can also give some indication of the effectiveness of prevention strategies.

Since commencement of the surveys a number of different strategies have been implemented for primary prevention based on published evidence, a clinical trial, professional judgement and face validity of practices. These include:

- implementation of a risk assessment screening tool (the Braden Scale);
- introduction of pressure reducing high density foam overlay mattresses for patients assessed at risk;
- conducting a clinical trial of a new Australian Medical Sheepskin with low and moderate risk patients;
- an annual audit of the number, type and condition of pressure reducing/relieving equipment in the hospital;
- planned replacement of the standard hospital mattress with pressure reducing high density foam mattresses;
- purchase of pressure relieving alternating air mattresses for high risk patients;
- purchase of electric beds to assist in re-positioning patients;

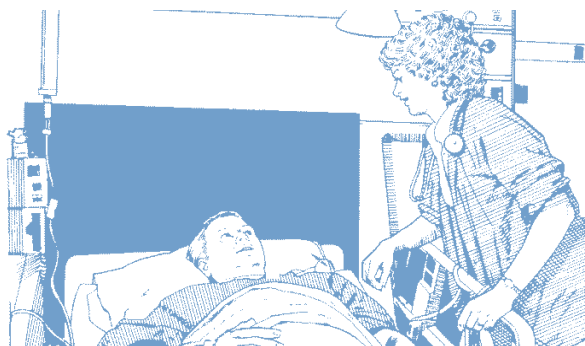
The recent introduction of the Australian Incident Monitoring System (AIMS 2) at the hospital will provide additional more comprehensive data and also allow determination of hospital acquired pressure ulcer incidence rates (the number of patients who develop pressure ulcers during their hospitalisation). Incidence rates provide a more active form of data and allow continuous monitoring of the situation. This will give staff a better indication of the success of preventative strategies.

It is also planned to undertake in-depth analysis of all AIMS data on pressure ulcer incidents to record severity and healing progress and to compare this with nursing workloads, staffing levels and availability of pressure reducing/relieving equipment.



The APSF wishes to thank Sunita for her contribution to this newsletter.

**For more information email:
sunita.mcgowan@health.wa.gov.au**



Pressure Ulcers

A COMMON PATIENT INCIDENT.

According to the Australian Wound Management Association research, pressure ulcers have been recognized for thousands of years, even documented in Egyptian Mummies. Since the late 1960, pressure ulcers have had a high profile in professional journals. Despite a plethora of research and acquired knowledge, pressure ulcers remain a problem in today's health care setting.

In 1997, Young estimated the cost of managing a Stage 4 (Stage 5 Torrance classification) pressure ulcer at \$A 61,230. Davenport estimated the cost of treating a stage 2 pressure ulcer at an additional \$586 per month. Pain, discomfort, decreased mobility, loss of independence and even social isolation are also to be considered very seriously.

Australian studies focus on acute care settings and report prevalence ranging from 5.4 to 15.6 percent. In the UK figures quoted range from 1.4% to 36.4%. In the US aggregate prevalence has been quoted at 11.7% over 265 acute care hospitals. An Australian study of 30 nursing homes reported an overall prevalence of less than 5%, with some figures reflecting that on admission, 17 to 35% of patients have pressure sores.

The great variation in reported incident or prevalence of pressure ulcers reflects inconsistencies in data acquisition and how pressure ulcers are defined and classified... Reliable data on the incidence and prevalence of pressure ulcers by stage, diagnosis

and risk factors will permit better planning for allocation of resources to at risk populations.

(SOURCE: Clinical Guidelines for the prediction and prevention of pressure ulcers 2001 Pp4-5)

Pressure Ulcer Guidelines Development

The Australian Wound Management Association (AWMA) Pressure Ulcer Interest Subcommittee (PUISC) has recently developed Clinical Practice Guidelines for the Prediction and Prevention of Pressure Ulcers. These guidelines include a discussion on aetiology of pressure ulcer development and a selection of ulcer risk assessment tools.

Further objectives of the subcommittee were to collate national data on the incidence and prevalence of pressure ulcers in Australia; produce an inventory of pressure reducing and pressure relieving equipment; disseminate and update the guidelines.

The Pressure Ulcer Guidelines offer recommendations to help health care professionals provide quality care across a large range of health care settings and is available from:

To find the Guidelines visit:
www.awma.com.au

Contact person:
nancy.magazinovic@health.qld.gov.au
Fax: 07 3350 8825

THE AIMS RESPONSE TO PRESSURE ULCER DATA NEEDS.

Within AIMS, the pressure ulcer component has been designed to enable the recording of the richest possible information on pressure ulcers from any health care setting. Prior to the initial AIMS pressure ulcer classification screen development, the APSF undertook a thorough review of pertinent literature to identify all current trends and priorities relevant to pressure ulcers. This research process identified crucial issues, which became the basis of the variables included in the data classification screen. Clinical practitioners with expertise in pressure ulcer management were then consulted to critique and validate the final AIMS pressure ulcer associated variables.

Some examples of the AIMS "pressure ulcer" variables or questions collected:

- **The body site and stage** of the pressure area or ulcer. All possible body sites can be recorded. The scale used by the Pressure Ulcer Interest Sub-Committee of the Australian Wound Management Association forms the basis of the AIMS staging prompts.
- Any **complications** that developed.
- Whether the ulcer was **present on admission** or **developed** during admission.
- Status as a **new ulcer or worsening** of an existing pressure ulcer.
- **Risk assessment status** as "conducted" or "not conducted", what risk assessment tool was used and the actual result of the assessment. The AIMS pressure ulcer feature offers a choice between the Norton, Braden and Waterlow tools risk criteria or "other" if applicable.
- The **risk factors** associated with the patient which may have contributed to the development of the ulcer. This list includes the known risk factors frequently identified in the literature
- The **patient's care** after identification of the ulcer.

The latest AIMS pressure ulcer feature is a well researched tool for quality improvement in any health care setting which accepts the care of patients requiring pressure ulcer prevention or management.

APSF Research and Education News

Klee & Kay can be contacted via aims@apsf.net.au

The APSF is pleased to have as part of the team research and library support staff:

Introducing our research staff

DR. KLEE BENVENISTE is our part-time Research Officer. Klee has a Ph.D. in injury epidemiology from Flinders University School of Medicine where she had 20 years of experience in research, administration and teaching in the Department of Primary Health Care. Klee was also an honorary psychologist to Flinders Medical Centre for over 15 years and held research grants in the field of head injury. She has also worked at QEH, RAH and Southern Child and Adolescent Mental Health Services.

Klee is consolidating our research resources into a library collection, preparing a bibliography of our published material, and provides literature research support for our publications and software development, especially new software being trialled in the UK.

KAY WALKER, our part-time Research Assistant, replacing Sara Szep who left for Canberra. Kay has 25 years experience in tertiary teaching and research, mainly in health-related social sciences. Over the years she has been the joint recipient of a number of significant research grants, particularly in the area of eating disorders and psychiatry.

Kay is also a Microsoft Certified Professional and has administrative and research experience in the telecommunications industry, town planning research and disability services.

At the APSF, Kay is responsible for aggregating and analysing data contributed by users of the AIMS system across Australia. This enables the collected information to be used to write articles and reports, from which significant practical gains in patient safety can emerge.

APSF related PUBLICATIONS OF INTEREST:

Beckmann U, Gillies DM. Factors associated with reintubation in intensive care: an analysis of causes and outcomes. *Chest* 120(2): 538-42; 2001.

Kluger MT, Tham EJ, Coleman NA, Runciman WB, Bullock MF. Inadequate pre-operative evaluation and preparation: a review of 197 reports from the Australian incident monitoring study. *Anaesthesia* 55(12): 1173-8; 2000.

Thomas EJ, Studdert DM, Runciman WB, Webb RK, Sexton EJ, Wilson RM, Gibberd RW, Harrison BT, Brennan TA. A comparison of iatrogenic injury studies in Australia and the USA. I: Context, methods, casemix, population, patient and hospital characteristics. *Int J Qual Health Care* 12(5): 371-8; 2000.

Runciman WB, Webb RK, Helps SC, Thomas EJ, Sexton EJ, Studdert DM, Brennan TA. A comparison of iatrogenic injury studies in Australia and the USA. II: Reviewer behaviour and quality of care. *Int J Qual Care* 12(5): 379-88; 2000.

continued on page 8

St Andrew's Private Hospital SA and AIMS

Recently St Andrew's Hospital in Adelaide decided to participate in the Australian Patient Safety Foundation AIMS2 program. This is the first private hospital in South Australia to use AIMS.

St Andrew's Hospital is an independent non-profit private hospital. It has 217 beds and is situated at 350 South Terrace, Adelaide. St Andrew's is a fully accredited acute surgical/medical hospital with 7 Theatres, 2 Procedure Rooms, a 14 bay Recovery Room, Critical Care Unit, Emergency Department, Day Patient Suite, Short Stay Suite, and Chemotherapy Suite.

The Hospital has a focus on Risk Management as one of its main strategic activities and the patient accident and incident monitoring program is an important part of this strategic focus. The AIMS2 program will enable the Hospital to benchmark and learn from other organisations as well as provide a system that will allow comprehensive report writing. Like many organisations the Hospital has struggled to use our previously collected accident and incident information in a manner that facilitates real change. We are looking forward to the new system being used as a tool to facilitate change.

For more details, please contact Marianne, Marketing Director at St Andrew's Hospital via: mzanelli@stand.com.au

Poole's Algorithm

Nursing Management of Disturbed Behaviour in Older People

I often think that care of older people involves a lot of 'crossed fingers' and hope.

Hope that they won't suddenly get up out of the chair and fall just when we nip across the corridor to get the medication trolley. 'Fingers crossed' that that they won't wake up and get out of bed without ringing the buzzer first to ask for help, when we have reduced staffing at night.

The dilemma.

As we age we become prey to physiological degenerative changes plus wear and tear that reduces the effectiveness of our organs. Whilst multiplying life experiences produces individuals who become increasingly different from each other the older they get, this also results in surprisingly few common syndromes for illness presentation, namely confusion, incontinence, immobility and falls. Confusion is particularly complex to assess and manage and requires enlightened, committed carers who not only understand the physiology but also are not prey to ageist attitudes.

The most effective care involves timely treatment and support however, staffing ratios mostly do not meet these requirements. Despite the complexity of care needs, and propensity for recovery, aged care is still seen as the premise of Assistants in Nursing rather than the specialist nurse. All these syndromes increase the threat to safety of the older person quite apart from the illness that first caused the symptoms.

The major threat is injury from falls.

Increased risk of falls.

The heightened risk for falls is obvious if a person becomes immobile because the resultant loss of muscle strength and balance is well appreciated. The risk for increased falls in an incontinent person is also obvious due to the possibility of spills, slips and trips that occur with haste. However, the increased risk due to confusion may not be so obvious to inexperienced carers of older people.

When people are confused they do not appreciate risks and take care or ask for help. Very often the desire to make sense of their confused world is the very thing that creates the risk of added injury as they seek reassurance. Therefore carers need to understand the causes and management of confusion so that they can set up appropriate strategies to protect their older clients.

Confusion – the greatest risk factor.

Confusion has many causes and numerous comprehensive manuals, books, journal articles and education courses have been created to address the management challenges. Mostly they focus on challenging behaviour and care of people with dementia. However, there are other causes of confusion and other behaviours which do not appear particularly challenging, that are important, need appropriate assessment and management strategies and certainly threaten the safety of the older person, particularly the falls risk.

A flow chart for management of disturbed behaviour.

Therefore, using 'mind mapping' theories [1] to enhance assimilation and retrieval of learning, and using the adjective 'disturbed' to encompass all behaviours that might be of concern, an algorithm (or flow chart with questions and answers) has been created to address the management of disturbed behaviour in older people.

Using lines, shapes and colours to denote prioritisation, this details the management of the major components - aggression, delirium, depression/or other mental disorders and dementia, plus an outline of 'Supportive Communication and Care techniques.

Three educational packages, each modified to address particular issues in Acute Care, Aged Care Facilities or Community Care are available, comprising of a booklet of Lecture Notes and Resources plus a matching coloured A1 sized poster which summarises the information [2,3,4].

Evaluation.

A project to evaluate the effectiveness of the package in Aged Care Facilities has been implemented [5] but data is not yet finally collated. However, early results show that staff in 37 facilities were more confident, more aware of the causes of disturbed behaviour, able to retain the knowledge and exhibited enhanced practice. This must be presumed at this stage to mean that in understanding the causes, assessment and treatment options plus management strategies for disturbed behaviour in older people, patient safety was enhanced. Plans are presently being made to expand this evaluation to a rural area and the acute sector.

References

1. Buzan, T and Buzan, B. (1995) *The Mind Map Book*. London: BBC Books.
2. Poole, J. (1) (2000) 'Nursing Management of Disturbed Behaviour in Older People in Acute Care - an education package', Sydney: Government Printing Service.
3. Poole, J. (2) (2000) 'Nursing Management of Disturbed Behaviour in Aged Care Facilities - an education package', Sydney: Government Printing Service.
4. Poole, J. (2001) 'Nursing Management of Disturbed Behaviour in Older People in the Community - an education package', Sydney: Government Printing service.
5. Poole, J. and Mc Mahon, C. (2001) *An Evaluation of the Effectiveness of the Educational Programme – Poole's Algorithm: Nursing Management of Disturbed Behaviour in Aged Care Facilities*, (unpublished). Sydney: Royal North Shore Hospital.

The APSF wishes to thank Julia Poole for her contribution to this newsletter.

For further details contact:

**Julia Poole CNC Aged Care
Royal North Shore Hospital,
St Leonards, 2100**

Ph No (02) 9926 6632

Fax (02) 9906 4301

jpoole@doh.health.nsw.gov.au

The Report: "Iatrogenic Injury in Australia" by Professor Bill Runciman and Jerry Moller can now be found on the internet address: www.apsf.net.au

Hard copies of this report are available for \$10 to cover postage & handling from the "Australian Patient Safety Foundation", GPO Box 400, Adelaide SA 5001

The APSF Newsletters can be found on the internet address: www.apsf.net.au

Diary Dates for March 2002



Newsletter Contributions

If you would like to contribute an article or details on events that are of interest to readers, please let us know.

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

7th European Forum on Quality Improvement in Health Care

March 21-23 in 2002. Edinburgh.

This is late notice but the contact details may be useful should you wish to look into the program and abstract details. Patient safety topics are broad.

Email: quality@bma.org.uk, Website: www.quality.bmjpg.com

5th WONCA world conference on RURAL HEALTH

April 28 - May5 2002. Melbourne

Working together, Communities, Professionals and Services. Over 400 Abstracts received from 26 Countries. Broad Theme!

Email: ruralhealth@meetingplanners.com.au

2nd annual E-PHARMA event.

May 29-31 2002. Sydney

Full update on e-initiatives eg BMMS (Better Medication Management System), HIC initiative issues, privacy and security, and e-marketing.

13th Annual AAQHC Conference

June 6 and 7, 2002. Surfers Paradise

"Riding the Waves of Quality"

From "Getting the Nod" to "Making Air". Or in other (Healthspeak) words: topics from:

Winning CQI tools and processes, monitoring systems, no blame, taking risks, to:

Future IT initiatives, listening to patients partnerships in care etc.

Organiser: Beverley Evorall

Phone 07 5510 8829, email: becm@ozmail.com.au

Website: www.sci.usq.edu.au/aaqhc

Clinical Risk conference

17th & 18th June 2002. Coolangatta

Public Hospital Coolangatta.

"Clinical Risk Management", Module III Australasian Society for Healthcare Risk Management. Covers risk management skills that are unique to healthcare, including the Quality Improvement process, credentialing and clinical risk, registration cost remains at \$880 including GST as with other modules (members discount will apply to that figure). Please put it in your diaries.

AuSHRM Incorporated
PO Box 253
Rundle Mall Adelaide SA 5000