

# NEWSLETTER

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apsf

## Incident reporting cultures, can they change?

### Inside:

- 1 Incident Reporting Cultures
- 2 Summary of APSF Summit
- 3 APSF Research News
  - Recent Publications
- 4 National
  - Open Disclosure Project
- 5 NSW
  - Reporting Culture News
- 6 Sharing Initiatives
  - ACT
    - Feedback for Reporters
- 7 Sharing Initiatives
  - WA
    - Phone Reporting
- 8 Diary Dates

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Patient safety is becoming an increasingly important item on health care agendas.

Governments, individual health care units, clinicians, and consumers reflect this welcome and timely reality in a growing number of quality and risk management initiatives.

Tort law reform, a growing number of risk management models and health care quality tools drive the impetus to analyse and remedy "what can go wrong" in health care and how to best deal with things if they do go wrong. Risk Management standard (AS/NZ4360) provides an explicit framework for addressing patient incidents.

NSW Health has produced a Clinician's Toolkit for improving Patient Care, and the National Open Disclosure Project was initiated by the Australian Council for Safety and Quality in Health Care in late 2001.

As part of this project, the Council plans to publish future data about the performance of the Australian health care system as a desirable way forward to greater openness.

Technological and clinical advances that have been made in health care are enormous but at the same time, as are their human implementers, they are never completely exempt from deficiencies. Human factors of health care are crucial and complex components affecting the reliability of the system.

The risk of error continues to be a genuine and potentially frightening reality to all carers and consumers. However, growing numbers of references and literature are now available on

the pitfalls of expecting humans to be perfect and on the dangers of a "blame and shame" approach to quality improvement.

People giving and receiving healthcare share a natural predisposition to rely on the principles of "clinical governance". This concept has been defined as: "the framework through which organizations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish".

A patient incident or adverse event is the complete antithesis of this concept and not surprisingly causes considerable stresses to all involved.

In addition, health care is traditionally based upon the Hippocratic philosophy, which states that, in health care we must ensure that above all, no harm is done.

Not surprisingly, the culture surrounding error in health care is potentially fraught with feelings of inadequacy, failure and defensiveness. However, we now recognise from increasing work done on performance data release, that public disclosure appears to be an effective way of improving quality. (Marshall et al JAMA 2000: 283; 1866-1874)

The topics included here are all designed to foster a learning approach to the management of preventable harm to patients and clinicians.

Each strategy is designed to ultimately realize a shift from punishment to prevention and from angst associated with incidents in health care to a desire to learn and act openly, supportively and constructively.

This newsletter is only a small reflection of the growing number of methods available to enhance patient safety. There are now many comprehensive programmes designed to prevent clinical errors based on a system's approach to error management, and development and implementation of techniques designed to reduce preventable harm to patients.

References are provided for further investigation of each of the topics included here.

# Summary of APSF Summit May 17

Further information about the Summit is available from:

[www.apsf.net.au](http://www.apsf.net.au).

"Hot topics in Patient Safety", was held at the Adelaide Convention Centre on May 17, and was attended by approximately 120 delegates. The summit was very well received and allowed plenty of discussion time for the more complex issues surrounding adverse events. The day was arranged to take advantage of the availability of prominent guest speakers Prof Jim Bagian from the US, Prof. Alan Merry from New Zealand and Fiona Tito from the ACT.

All speakers are well renowned for their specialist knowledge and experience in the complex and sensitive human and legal aspects of patient safety. Their presentations were complimented by a variety of addresses about equally important incident and risk management contexts, ranging from fatigue vs performance research, medication errors and pre-operative assessment systems improvement.

**Two presentations for the day are summarized, including the opening address by the SA Minister of Health and the key note speaker address by Professor Jim Bagian. The remaining talks delivered at the summit and brief speaker C.V.s are now available from our website, [www.apsf.net.au](http://www.apsf.net.au).**

The opening address. The SA Minister of Health, the Honourable Lea Stevens reflected a strong government commitment both nationally and at state level, to improving quality and safety in health care. She stated that the first out of five key strategic pillars for the ongoing development and reform of the South Australian health system is "improving the safety and quality of health care services". The Hon. Ms Stevens said that this issue has been placed on top of the health care portfolio list due to its importance to the Minister herself, to care providers and to consumers of health care. The Minister then listed the necessary initiatives to achieve this strategy as:

- 1 Developing a culture of openness.
- 2 Excellence in data sources, maintenance and analysis.
- 3 Empowerment of standard setting bodies and encouraging best practice.
- 4 Ensuring evidence-based practice
- 5 Including consumers in all aspects of their care, especially if things go wrong.

The Minister also voiced the intention to encourage and support all positive action which heeds evidence that health care consumers are sure to be turned into litigants by excluding them from their care process, denying them their rights and losing their trust and confidence by avoiding openness and public accountability.



# Summary of APSF Summit May 17. cont

**Key note address.** Professor Jim Bagian is the current Director of the National Centre for Patient Safety (NCPS), Department of Veteran Affairs (VA), in the USA. He explained why and how a culture of safety was developed within the VA, drawing on the principles of risk management he has used in aviation and in his 15 years with NASA. As an astronaut, he flew on two Challenger missions and was responsible for the investigation into the fatal Challenger disaster.

Major reasons for needing a change in VA culture were: lack of systems insight, superficial solutions (addressing the person without fixing the actual system or problem), inadequate follow up, and lost opportunities to improve patient safety. Trust and buy-in were initially lacking due to feelings of failure, a blame culture, blind adherence to rules and traditional focus on individuals when things went wrong. Professor Bagian made a strong point about the requirement for:

- 1 A determined focus on learning rather than accountability
- 2 Maintaining a supportive, non-punitive approach, unless an intentional unsafe act is involved.
- 3 A committed focus on close calls (near misses)
- 4 Emphasizing narrative reports.
- 5 Multidisciplinary reviews
- 6 Identifying vulnerabilities NOT statistics.
- 7 Prompt feedback and openness.

Professor Bagian also stressed the importance of the role of Patient Safety Managers or their equivalent and for clear structured processes for these people to follow, thus linking the causes and actions of each incident. For example, he introduced flowcharts and a system of incident triage cards for use in root cause analysis where appropriate.

**Further information about the Summit is available from:**

[www.apsf.net.au](http://www.apsf.net.au).

The APSF intends to make the "Hot topics in Patient Safety" Summit an annual event.

**For further information about the NCPS visit their website:**

<http://www.patientsafety.gov/tools.html> for Root Cause Analysis information and

<http://www.patientsafety.gov/causation.html> for "Using the Five Rules of Causation"

## RESEARCH NEWS

### Recent Publications:

**Available on DHS website:**

Prof. Bill Runciman's presentation at the forum on Safety and Quality in Mental Health.

This was held by the Department of Human Services on 14 November 2001 and is available on the DHS website at [www.dhs.sa.gov.au/publications.asp](http://www.dhs.sa.gov.au/publications.asp) as a 33-slide.pdf file.

It is entitled:

**'Incident Monitoring - the national and state picture and application to mental health services. Safety and Quality in Mental Health. Time for Action'.**

**In Print:**

Durie M, Beckmann U, Gillies DM. Incidents relating to arterial cannulation as identified in 7,525 reports submitted to the Australian Incident Monitoring study (AIMS-ICU).

**Anaesthesia and Intensive Care 30(1): 60-5; 2002.**

Morrison AL, Beckmann U, Durie M, Carless R, Gillies DM. The effects of nursing staff inexperience (NSI) on the occurrence of adverse patient experiences in ICUs.

**Australian Critical Care 14(3): 116-21; 2001.**

Runciman B, Merry A, Smith AM. Improving patients' safety by gathering information. Anonymous reporting has an important role.

**British Medical Journal 323(7308):298; 2001.**

### Also of Research Interest

A systematic review from the USA is available on the internet at [www.achpr.gov/clinic/ptsafety/](http://www.achpr.gov/clinic/ptsafety/)

Entitled: **'Making Health Care Safer: a Critical Analysis of Patient Safety Practices'**, It was prepared for the Agency of Healthcare Research and Quality, by the University of California at San Francisco - Stanford University Evidence-based Practice Center. (UCSF)

Major sections include: incident reporting and root cause analysis, adverse drug events, infection control, surgery and peri-operative medicine, institutionalized elders, clinical topics (e.g. prevention of venous thrombo-embolism), organisational issues, systems and human factors, the role of the patient, as well as safety program promotion and analysis.

This 662 page full report is downloadable (1.7 MB) or individual chapters are downloadable as .pdf files.

The **World Health Organization has published 'Injury Surveillance Guidelines'** in conjunction with the Centers for Disease Control and Prevention. It can be downloaded from the WHO web-page at [http://www5.who.int/violence\\_injury\\_prevention/main.cfm?s=0006](http://www5.who.int/violence_injury_prevention/main.cfm?s=0006) and contains useful guidance to assess the validity and quality of the surveillance process.

**Further Australian Patient Safety Foundation library assistance is available from [Klee.Benveniste@apsf.net.au](mailto:Klee.Benveniste@apsf.net.au)**

# The "Open Disclosure" Project

**The Open Disclosure Project is a 2001 initiative by the Australian Council for Safety and Quality in Health care (ACSQHC) designed to assist more open communication between patients and health care providers.**

According to Dr Hammett who directs the Project, improved communication will drive the systems change required to achieve safer care for all Australians. His statement supports the view of the ACSQHC, which recognises the vital nature of timely and appropriate information flows to more positive outcomes of adverse events.

Acknowledgement and apologies when things go wrong reassures patients that they can trust health care providers to respect their needs and that lessons will be learnt from any incidents when they occur.

A comprehensive literature and legal review were undertaken at the start of the project to ensure thorough consideration of all relevant contexts.

The reviews were combined with expert advice to produce the project's "issues paper".

All three of the above documents are available on the web as is general information about the Open Disclosure Project.

As a vital part of the project, national consultations are now continuing with key stakeholder groups, including lawyers, clinicians, insurers, health managers and consumers.

This consultation is designed to alleviate some of the possible anxiety and confusion about being "open" when things go wrong, for example what to say, what not to say and what the personal, organisational, or even legal implications can be.

To address these concerns, the project's intent is to produce:

- 1 A set of **National standards** to support open disclosure during and following an adverse event
- 2 A training and **organisational support package** to assist in the implementation of the standards.

Ultimately the Open Disclosure Project aims to bring clarity to a sensitive and possibly confusing incident reporting culture and identify what needs to be done to support greater openness.

A positive shift in reporting cultures to more open disclosure is the antidote to destructive "naming and blaming" processes often associated with iatrogenic injury.

Such a shift will in turn have a positive effect on health care providers' willingness to report and their ability to remedy any practices which can lead to adverse events.

The consequent increase in levels of patient trust and patient safety will be the desired outcomes for all parties involved in health care.

**More information on this project can be obtained from:  
[www.nsh.nsw.gov.au/teachresearch/cpiu/OD.htm](http://www.nsh.nsw.gov.au/teachresearch/cpiu/OD.htm)**

# NSW Reporting Culture News

## **NSW Health is committed to developing a system-wide approach to improving the safety and quality of health care provided in NSW.**

A comprehensive strategy to address this issue is currently underway in NSW. The strategy aimed at improving safety for patients and other consumers of NSW health services requires concurrent action at the clinical, facility, Area Health Service and State levels. It focuses on two key components: – management of serious or adverse events and general incident management. Both require reporting, monitoring, investigation and action to be undertaken and both are integral to improving the safety and quality of care.

A change in culture across the health system is imperative to successful implementation of this strategy. The program being implemented in NSW is adapted from the Veterans Affairs in the USA and focuses on prevention not punishment. The goals of the system are to influence the health care culture towards a safety mindset; to maintain a systems approach to safety; to identify process vulnerabilities through incident management; and to address safety issues in order to improve health care quality.

The model uses various methods for collecting and analysing data from the workplace to form the most accurate picture possible. Root cause analysis is the tool used to identify prevention strategies. The aim is to understand how and why an event occurred and to identify strategies to prevent the same or similar event from occurring again.

This occurs through continually asking:- "what happened, why did it happen, and how can we prevent it happening again". This process, focusing on the system and not the individual, has been a major factor in building a culture of safety within the Veterans Affairs and moving beyond a culture of blame to a "just culture".

NSW Health currently has a number of sites piloting this program and anticipates being in a position to roll out the project across the State by early 2003.

The NSW Quality and Clinical Policy Branch have also developed a "Clinicians Toolkit" for improving patient care.

It provides clinicians with: "a guide about the various strategies that are available to them for identifying problems with systems of care, with an individual clinician's practice, and to give

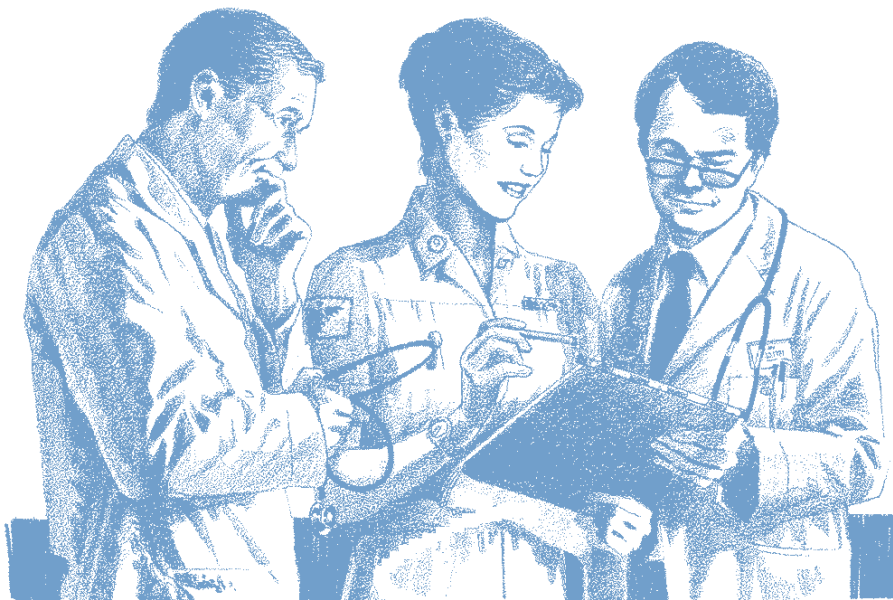
them an overview of the pragmatic scientific methodology that can be used to act upon the information that those methods provide, in order that care is continually improved."

## **Copies of the Toolkit are available from:**

Better Health Care Centre,  
Locked mail bag 5003,  
Gladesville, NSW 2111  
ph. +61 2 9816 0452.

## **For more information about the general patient safety strategy and initiatives in NSW contact:**

**Sarah Michael,**  
**Quality and Control Branch,**  
**+61 2 9391 9551**  
**smich@doh.health.nsw.gov.au**



# Sharing Initiatives

## Dispelling the myth of the great incident abyss

Whilst nursing staff are the greatest contributors to incident reporting how often do they get feedback on the reports that they generate? Common thoughts are that the "incident report falls into a black hole". Given the fact that we would like to increase reporting of incidents and near misses we need to develop more strategic means of involving and engaging staff at the grass roots level. By providing a high level of feedback it is proposed that staff will more likely complete incident forms in the future.

At Calvary Health Care ACT we have established a means of communication with staff at all levels to address feedback. Firstly in introducing AIMS, the AIMS Support Officer conducted individual education sessions on each ward area to

introduce the AIMS form, discuss reporting near misses and to establish a culture of no-blame around reporting incidents. This was well received and generated a 100% increase in levels of report writing in the following months.

In November the AIMS Support Officer implemented a feedback form, in its infancy the feedback form notified the reporter and reinforced the use of the data as a quality tool to establish projects that would improve patient safety. The feedback form has been redesigned on numerous occasions and its latest version (see opposite) gives a greater amount of information relating to the investigation of the incident and the outcomes generated from the results. Even if the incident does not warrant further investigation, it is important to acknowledge the efforts of the reporter and to inform them of their contribution to patient safety. The form has been distributed to all AIMS national users as a result of interest shown in this form at the recent AIMS Consumers meeting in Adelaide.

In addition to this Calvary will generate local ward reports that are not designed to sit on the desk of the Nurse Unit Manager, rather the AIMS Support Officer will talk to these results at the ward level at the relevant ward meetings. The goal of this strategy is to reinforce safety as an agenda item (for everybody), and to discuss incidents that may be occurring in the ward area that have not generated reports, look at the main issues in each ward area and to facilitate quality activities to address the main issues.

Future areas that Calvary will develop in this area are teams of interested ward staff to act as patient safety investigators. The goal of this team will be to meet regularly and to explore common "near-misses" and what might be done to eliminate the risks before they come to fruition and cause patient harm.

These measures are aimed at engaging the very people we depend upon in the reporting of issues pertaining to patient safety in their areas of work. To leave them out of the feedback loop is not sensible and needs further exploration.

For more information contact either

Jeff Brooks, Aims Support Officer, Calvary Health Care ACT ([jeff.brooks@calvary-act.com.au](mailto:jeff.brooks@calvary-act.com.au)) or  
Judith Manning, Quality Manager ([judith.manning@calvary-act.com.au](mailto:judith.manning@calvary-act.com.au)).



# Sharing Initiatives

## Telephone Reporting trial in Western Australia

**The Australian Incident Monitoring System currently relies upon a form as its data collection instrument. The form has provision for a patient identifier and other patient details, reporter and witness details, place of incident, doctor's examination, details of incident, contributing factors, treatment ordered, and factors tending to minimize or prevent the incident. There are also sections for details of management investigation.**

However, it is well recognized that clinicians do not reliably complete all the fields on forms - of all types.

Hospital laboratory requests frequently lack clinical or demographic data - including such vital information as the location of the patient and the name of the doctor to whom the results should be sent.

In the case of incident monitoring, one hospital estimated that approximately 30% of the AIMS forms received are deficient in one or more of the mandatory fields. This suggests that other avenues for reporting incidents should be explored.

Telephone reporting has been widely used in clinical and non-clinical areas to identify critical incidents. In Australia, "hotlines" are currently operating in conjunction with forms-based and web-based systems for incidents involving vaccinations, medical devices and aviation.

The proposal is to establish at one pilot site - Fremantle Hospital - a telephone "hotline" for reporting clinical incidents. The hotline would consist of a single telephone number which would connect to a computer-based voicemail system. Prompts would guide the user to enter data via the telephone keypad and to narrate the details of the incident and other items of information requested by the form. The data would then be entered directly into the AIMS database by a clerical officer in the same manner as data from the AIMS form. If successful, the system could be further rolled out. Some workflow issues will need to be addressed - in particular the requirement to notify management and conduct an investigation of some incidents. A process is being developed.

### Expected benefits

- § Increased reporting of clinical incidents by clinicians.
- § Less requirement for forms - leading to some decrease in costs.
- § Always available - unlike forms which may be unavailable at some sites.
- § Potential to extend to mobile workers and remote sites.
- § Increased security. Telephone calls are more secure than paper-based forms as they cannot easily be copied. The computer on which they are recorded can be password-protected.
- § Potential to remotely access incident reports by securely dialing into the computer - may be useful on weekends in order to ensure that no critical incidents are overlooked.

A contract for the hardware and software has been let and the trial is expected to begin in early June 2002. It will be evaluated after 3 months. The telephone reporting poster (see below) is available which reflects the reporting model.



### Contacts for further information:

Dr. Peter Barratt, Healthcare Division, WA Department of Health  
Kenneth Pendlebury, Performance Review Unit, Fremantle Hospital.

# APSF Research and Education News

**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](http://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](http://www.apsf.net.au)**

## Diary Dates for June 2002

**July 17-18, 2002 Canberra  
8th Annual National Health  
Outcomes Conference.**

Measuring outcomes, interpreting indicators, IT, evidence based data, economic modelling and other challenges.  
Email: [lorna.tilley@act.gov.au](mailto:lorna.tilley@act.gov.au)

**August 4-6, 2002 Melbourne  
Health Informatics  
Conference and Exhibition**

"Improving quality by lowering barriers"

Premier health IT event for all health practitioners, information experts, policy makers and educators.

Contact [www.hic.org.au](http://www.hic.org.au) for more details

**August 15-16, 2002 Hobart  
AHA National Congress 2002**

Building the Future. Addressing health care funding, assets and infrastructure planning, the ageing population, quality and safety, progress, priorities and responsibilities.

Baxter Health Care Innovation Awards and Sidney Sax Medal will be awarded.

Contact: +61 2 6285 1488  
or: [admin@aha.asn.au](mailto:admin@aha.asn.au)

**September 1-4, 2002 Melbourne  
Health Care in Focus, Best Practice,  
Best Management, Best Measurement.**

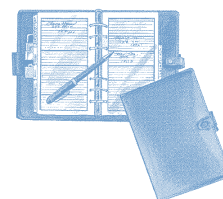
Incorporates the 14th Case-mix Conference. Topics being addressed:  
National and International Accreditation approaches.

Best use of information, Best Practice and workforce challenges, evidence based practice reviews. Funding issues, accountability, casemix, future management. What, how and why measure, and progress nationally?  
Email: [casemix.conf@health.gov.au](mailto:casemix.conf@health.gov.au)

**September 11-13, 2002 Singapore.  
2nd Asia Pacific Forum on Quality  
Improvement in Health Care.**

Themes: Improving patient safety, its culture, safe environments, anonymity, whistle blowing. Leadership for improvement, measuring quality and benchmarking for change, education and training for improvement, improving systems, patients with chronic disease, and evidence of quality improvement.

Website: [www.quality.bmj.pg.com](http://www.quality.bmj.pg.com)



### Newsletter Contributions

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

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