NEWSLETTER
JUNE 2003
aims
Advanced Incident Monitoring System

Patient Safety International formally takes over the reins

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Patient Safety International Pty Ltd (PSI) was formed in October 2001 as a fully owned subsidiary of the Australian Patient Safety Foundation (APSF). The role of PSI is to manage the commercial activities of the APSF ie developing, marketing and supporting the software system – Advanced Incident Monitoring System (AIMS). Recent private investment in PSI has meant that APSF now owns 79% of PSI.

PSI formally took over this role on 5 May 2003 with the transfer of certain APSF staff to PSI eg Client Services, Administration, Operations and IT Development.

The Board of Management of PSI has been expanded and now comprises members who come with a wide range of business knowledge as well as experience at board level across a wide range of industries:

- Mr Neil Anderson, Treasurer, APSF - Council representative. Neil is a director of BDO Consulting, SA. Neil's qualifications are in Accounting and Finance. Neil works as a strategic advisor to many SA businesses.
- Professor Bill Runciman, President APSF - APSF Council representative. Bill is the Head of Anaesthesia and Intensive Care at the Royal Adelaide Hospital and is one of the founders of the APSF, established in 1988, and has worked throughout the years to establish the AIMS classification system and the incident monitoring software.
- Dr Mark Herbertt – independent director. Mark runs a niche strategic planning consultancy and has extensive experience as a senior executive in large Australian-based IT corporations as well as in the Australian and UK health systems.
- Mr Marc Makrid – independent director. Mark's qualifications are in Business Marketing and his consulting experience brings together a significant level of involvement, both strategic marketing and human resources activities, in a wide range of industries/companies with strong IT involvement.
- Mr John Henshall – investment director. John has over 40 years senior management and director experience in a broad range of industries ranging from manufacturing and horticulture to service industries.
- Ms Margaret Gehrig, CEO, PSI – executive director. Margaret has held the position of CEO, APSF for the past two years and her qualifications are in Health Management with an extensive background in hospital management.

We believe that, in many ways, the patient safety movement is in an early, formative stage at the present time.

PSI looks forward to working with its staff and clients to ensure that the systems delivered to the end user fully meet their current needs as well as incorporate future requirements.

The PSI Board are cognisant of the effort that will be needed to take the organisation into the future by providing a 'state of the art' software solution that is fully supported through implementation, training and ongoing support requirements.

"A Must Attend Conference"

National Australian Conference on Safety and Quality In Health Care

Perth, WA 14th - 16th July 2003

For the first time, the Australasian Association for Quality in Health Care (AAQHC) has joined with the Australian Council for Safety and Quality in Health Care (ACSQHC) and the Western Australian Department of Health to host "Safety and Quality in Action".

The Conference is open to all delegates including consumers, those living with chronic conditions, clinicians & health managers from all sectors of the health system, including the primary, secondary, tertiary, community health aged care and mental health areas.

The GOAL of the Conference is to provide clear information and advice to consumers, clinicians, health care managers and policy makers about putting ideas and strategies into action.

Summary of topics:

- Setting the Scene for Action - Safety and Quality in 2003: Status and Challenges.
- Safety and Quality in Australia: The Role of the Australian Council for Safety and Quality in Health Care.
- Update on the current Australian context for Safety and Quality issues and challenge to start addressing the Safety and Quality in Action agenda.
- How to harness action and build a culture of Patient Safety and Quality.
- Where is the Safety and Quality Action in the UK?
- Patient Safety in Action: Putting Patients and Consumers First.
- Investigations, Inquiries & Royal Commissions: Do they effect change?
- Moving forward and translating shared lessons into action.
- Qualified Privilege and Medical Indemnity - How to provide protection for Safety and Quality activities without grinding to a halt!
- Quo vadis? Future actions and challenges for consumers, health care organisations and government to put Safety and Quality in action.

Speakers include:

Professor Bruce Barraclough, Chair, Australian Council for Safety and Quality in Health Care.

Mr Morton Hansen, Metropolitan Nyoongar Council of Elders.

Mr Bob Kucera APM MLA Minister for Health (WA).

Professor Bryant Stokes, Chair, WA Council for Safety and Quality in Health Care.

Ms Sandy Thomson, National President, Australasian Association for Quality in Health Care.

Mr Terry Laidler, Psychologist and Communications Consultant.

Ms Elizabeth Garrigan, Vice President, AAQHC.

Professor Bob Helmreich, University of Texas, Austin.

Dr Heather Buchan, Chief Executive, National Institute of Clinical Studies.

Ms Susan Burnett, Director, Inter-Agency Working, UK National Patient Safety Agency.

Mr Martin Fletcher, Assistant Director of Patient Safety, UK National Patient Safety Agency.

Dr Michael Walsh, Deputy Chair, Australian Council for Safety and Quality in Health Care.

Mr Neil Douglas (WA) Professor Jan Davies (Canada) Mr Hugh Ross (UK) Dr Ross Wilson (NSW).

Ms Michele Kosky, Health Consumers Council of WA Inc, Ms Marilyn Beech, Consumer Advocate.

DAY TWO

Day two offers the opportunity of a 'Meet the Experts' Breakfast co-chaired by: Ms Irene Mooney & Ms Joan Sheppard, AAQHC. Experts attending the breakfast include: Professor Bob Helmreich (USA), Professor Jan Davies (Canada), and Dr Marjorie Pawsey (ACHS).

To attend this most significant and stimulating conference, please contact:

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Research Resources - Did you know?

JUST PUBLISHED:

Runciman WB, Merry AF, Tito F.

Error, blame and the law in health care - an Antipodean perspective.

Annals of Internal Medicine 2003;138:974-9.

EDUCATION FOR PATIENT SAFETY

Dr. Klee Benveniste, Research Officer

At a UK conference in 2001, Paul Barach commented that a safety curriculum was mostly absent from medical education whereas it is a cornerstone of all non-medical high risk industries. Further, it needs to be part of healthcare professional training from the first day and to cover, but not be limited to: human factors, communication, safety culture, team training, and simulation (Barach P. Lessons from the USA. In: Emslie S, Knox K, Pickstone M eds. Improving Patient Safety: Insights from American, Australian and British healthcare. Welwyn Garden City, Herts: ECRI. 2002. p. 31). Since then, there have been significant efforts to develop curriculum. It is interesting to look at recent examples in the United States and Australia.

The (US) National Patient Safety Foundation was awarded a three-year $782,588 grant from the Agency for Healthcare Research and Quality (AHRQ) to research and develop a standard method of patient safety education that will reach large audiences, ideally a web-based educational curriculum on basic patient safety principles for physicians, nurses, and the general public. The report on the needs assessment is: VanGeest JB, Cummins DS. An educational needs assessment for improving patient safety: results of a national study of physicians and nurses. Chicago: National Patient Safety Foundation. 2003. At: http://www.npsf.org/download/EdNeedsAssess.pdf

In March 2003, the Massachusetts Medical Society published a Patient Safety Curriculum for Health Care Professionals on the internet as part of the national educational campaign coordinated by the NPSF. It has three modules designed for teaching by practicing clinicians and experts in patient safety. It may be downloaded at: http://www.massmed.org/pages/ptsafetycurriculum.asp

The (US) Society of Academic Emergency Medicine Patient Safety Task Force has developed an excellent structured curriculum containing extensive reading lists equally suitable for group tutorials or individual self-education. It is available at: http://www.saem.org/download/patsfty.pdf

The American College of Physicians has Continuing Medical Education modules on patient safety for physicians. The curriculum covers many basics such as medication safety, office practice, teamwork, handwriting, electronic records, population management, communication and the role of the patient, cognitive limits and fatigue, and offers tools on how to achieve patient safety in ambulatory care. A summary is at http://www.acponline.org/ptsafety/pat_cme.htm

In Australia, ongoing patient safety education by the Council for Safety and Quality in Health Care has been described on their website under Education Initiatives at http://www.safetyandquality.org/index.cfm?page=Action In July 2002 their work on medication safety led to a media release containing tips for consumers: see http://www.safetyandquality.org/articles/Media/medication.pdf Recently, through the Commonwealth Department of Health and Ageing, the Council sought tenders to develop a National Framework for Education on Patient Safety to define the skills, knowledge and behaviours required for patient safety for those working in the health care sector in Australia.

Patient Safety and Patients;

Involving consumers in improving health care safety

From the PSI desk:

There are reciprocal benefits to be gained by close collaboration between all involved in health care services. As patients are to be held at the centre of care processes, their active inclusion in service planning and evaluation is a logical service pre requisite.

As health care professionals we all have been or will be potential consumers of health care services and therefore we all have a secondary interest in optimising our health care services.

The levels of openness and collaboration which determine the link between trust and disclosure between people, also apply to the link between trust and disclosure of services, in particular where adverse events are concerned but also on a pro-active basis.

As in the case in Australia through the NSW Health Department 'Open Disclosure' Project, in America also, the linking of disclosure and trust is promoted as an important factor in health care.

Recently, two physician members of the American Academy of Orthopaedic Surgeons (AAOS) wrote a commentary on disclosure of adverse events that describes the pitfalls to avoid, and strategies for improving collaboration.

This article appeared in the AAOS online bulletin in April 2003.

The article can be found at:
http://www.aaos.org/wordhtml/bulletin/apr03/comm.htm

These authors state that while breaking the bad news of an untoward event to a patient or family member is always difficult and stressful, a systematic approach can improve the communication process and reduce the overall negative impact.

The article offers:

- A process plan.
- Suggested dialogue and its potential pitfalls.
- Suggested support and directions and their inherent pitfalls.

It is said that honest, timely disclosure of errors strengthens the provider-patient relationship and can reduce the risk of litigation.

This premise is also contained in Dr M O'Brien's presentations delivered at the 2002 ARCHI Toolkit sessions, "Improving Patient Safety – Can We Do More?" His presentation covers "The link between communication and risk management" in the context of litigation in adverse events being ameliorated by positive communication skills. His slides are available from the ARCHI website, or from the ARCHI National Office, Ph 02 4985 3165 or email admin@archi.net.au.

In a more proactive patient safety context, consumer inclusion ensures empowerment of those at the receiving end of services and ensures patient advocacy from those providing the services. A small snapshot of how various Australian Health Care organisations are currently proactively increasing consumer involvement in patient safety is covered here in this newsletter.

The Australian Council for Safety and Quality in Health Care's key priority areas for action clearly reflect and drive consumer focussed obligations identified in its stated role to:

- **Lead the way,** by developing a national strategy for improving safety and quality, defining national standards and influencing others to act to improve safety and quality in health care.
- **Define a framework for action**, by identifying national priorities and recommending specific actions that address the priorities.
- **Form partnerships**, by working with health care professionals, the Commonwealth, States and Territories, professional associations, private, non-government, and consumer organisations.
- **Coordinate existing activity** to better achieve action in priority areas.
- **Put consumers first**, by making sure that safety and quality measures are practical and will make a real difference.
- **Encourage public understanding** and increase the community's confidence in the steps being taken to improve the safety of health care.

All readers who wish to share current consumer focussed patient safety awareness initiatives for future inclusion in our newsletter are welcome to contact us on 08 8222 4336

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- **Promote monitoring and research** to address the many things we still don't know about challenges with safety and quality and how to fix them.

For further information, see the Council's website at **http://www.safetyandquality.org**

National Centre for enhancing consumer participation:

There are also a growing number of noteworthy health care quality focussed consumer groups. For example: established in 2000, the National Resource Centre for Consumer Participation in Health (NRCCPH) is a clearinghouse for information on consumer feedback and participation methodologies for health care providers and consumers. It is a centre of excellence in consumer participation where clients can seek advice and assistance to develop, implement, and evaluate feedback and participation methods and models. The NRCCPH is currently funded by the Commonwealth Government and was endorsed by the Australian Health Ministers' Advisory Council.

The Centre is a collaboration between three organisations: The Health Issues Centre, The Australian Institute for Primary Care La Trobe University, and The Women's and Children's Hospital Adelaide.

Functions of the NRCCPH include:

- critically analysing various methods and models.
- actively promoting the benefits of community and consumer feedback and participation.
- undertaking special projects.
- providing advice and information about methods and models of community and consumer feedback and participation.
- publishing resources from projects of the centre.

The NRCCPH can provide specific information on consumer involvement methods such as individual interviews, focus groups, surveys, forums, search conferences, working groups, consumer advisory committees and consumer or community members on committees.

The NRCCPH also provides a Hospital Audit Tool that can be used to determine the level of organisational commitment to community and consumer feedback and participation in hospitals.

The NRCCPH publications include the Human Services sponsored Kit: Putting People first: "Communicating with Consumers; Good Practice Guide to Providing Information". This was published in 2000, compiled by Kate Silburn.

For more information on the NRCCPH, see their website: **http://www.participateinhealth.org.au/.**

'Listening and Learning – the consumer voice in the ACT'

Some twelve months ago a small but dedicated team began the process of improving systems for consumers to provide feedback to ACT health services. The project was funded by the ACT Health Quality and Safety Forum and builds on the work already being undertaken in each of the organisations. It highlights the ACT Government's commitment to involve consumers at all levels of health care and goes some way to address a long held concern of consumers that nobody is listening to what they have to say.

When people hear the word 'feedback' they generally think of 'complaints'. The project set out to broaden the scope of feedback to include compliments and suggestions; to reinforce the notion that feedback is a core part of health care; and to encourage the use of feedback to improve health services.

The consumer voice adds a unique perspective on the way our health services operate. There are many forms of feedback such as patient satisfaction surveys, telephone surveys and focus groups. The project focussed on feedback initiated by consumers themselves – information consumers want to tell us 'in their own words and in their own time' about their experiences of health care. To enable that voice, the project worked in collaboration with a wide range of stakeholders including consumers, health professionals and managers to develop and implement ACT wide standards for managing consumer feedback.

The ACT Health Consumer Feedback Standards are entitled 'Listening and Learning' to reflect the ethos of effective feedback. They are accompanied by a 'Service Improvement Tool', which enables health services to assess and improve their practices for managing consumer feedback.

The Australian Council on Health Standards (ACHS) has reviewed the standards and believes that by using them the service areas would obtain a high level of achievement against the ACHS EQuIP Standards, which relate to consumer feedback rights and participation. The project team is currently implementing the standards and the 'Service Improvement Tool' across the ACT Health portfolio. It will take many years of cultural change before feedback is seen as integral to health care. Nonetheless, there is willingness and commitment at all levels of health care to improve relationships between consumers and providers. The work of the ACT Consumer Feedback Project has played a part in contributing to that process.

A key message to come out of the project is that - it is only by working in partnership with consumers, listening to and learning from their feedback, that we can build a high quality safe health care system.

Contact: Leonie Harrison 02 6207 9135

"Welcome on Board" program, South Australia.

The Modbury Hospital in Adelaide conducted a project under the Safety Innovations In Practice scheme in early 2002. It was called "Welcome on Board" and it involved selected General Medical inpatients in monitoring their own safety and thus reducing adverse events over a 3 month period. The project, information sheets and consent forms were all approved by the Hospital's Ethics Committee. The project team developed consumer exclusion criteria, staff information, patient information and a comprehensive kit for volunteers who interviewed patients. The unit Manager of the Medical Ward identified patients suitable for inclusion. Trained volunteers were responsible for undertaking the trial enrolment process with willing patients.

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Enrolled patients were given information about safety in hospital and a laminated list of possible questions to ask the nursing, medical and allied health staff.

Questions related to particularly 'risky' issues, namely, medications, falls, mobility and intravenous therapy. During the initial interview and at follow up visits undertaken by volunteers, the importance of asking all staff relevant questions was emphasised. After discharge a telephone interview was conducted to determine whether the patient had

- asked any of the possible questions
- had received any useful information as a result
- what the attitude of staff had been to **any** questioning.

Staff questionnaires were circulated during and after the three month period to detect whether any difference had been noticed in the volume of questions asked and, if so, the staff member's reaction.

Desired 'Welcome on Board' project outcomes included:

- increased questioning by patients
- general empowerment of patients
- a reduction in unsafe incidents, especially related to medications, falls and intravenous therapy
- positive reactions of staff to the increased involvement of patients in their care.

According to both patient and staff questionnaire responses, there was little change in the rate of questioning by patients. Staff professed themselves as ready willing and able to answer questions as necessary. Patients did not admit any change in level of questioning but did express appreciation of the personal support of the volunteers and the telephone interviewer. Incidents, medication, falls and intravenous therapy in the ward were reduced from 22 to 15 compared with the same 3 months in 2001.

Further information and copies of the project tools are available from Dr Richenda Webb, Director Medical Services, Modbury Hospital (08) 8161 2050 or email webbr@healthscope.com.au

All readers who wish to share current consumer focussed patient safety awareness initiatives for future inclusion in our newsletter are welcome to contact us on 08 8222 4336

"PATIENTS EDUCATING CLINICIANS –

A new paradigm for reducing adverse medical events",

Northern Sydney Health.

Description of Project:

The "Patients Educating Clinicians" project investigated junior medical officers' understanding of and attitudes toward adverse medical events.

The project utilised the unique knowledge and experience of patients who have been involved in an adverse medical event in order to provide junior doctors (in their first and second year of work) with first-hand knowledge of the effects that these events have on patients.

All junior medical officers (JMOs, level one interns and RMO1s) employed by Northern Sydney Health (NSH) were invited to participate in a three hour education session. They were all given time off from their routine clinical duties to attend.

The Chief Executive Officers / Directors of Medical Services of all hospitals agreed to the JMO involvement and were supportive of the programme. Ethics committee approval was obtained.

Prior to and after participating in the education sessions, the junior medical officers (JMOs) were asked to fill in a questionnaire which asked them about:

- attitudes towards adverse medical events
- understanding of the effect that such events have on the patients involved.
- knowledge of the availability of support for medical staff involved in adverse medical events.

Pre- and post education questionnaire responses were then compared to determine whether the experience resulted in any significant change in attitude or knowledge.

The patients involved in the project were also asked to complete a questionnaire which asked them about their experience of the education session.

The education sessions consisted of:

- an introduction to the programme and adverse events
- small group discussion involving one patient, five junior doctors and a facilitator
- group discussion without the patient present

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- an interactive session discussing the management of the adverse events and exploring ways in which the management could be improved
- a session on the personal and hospital resources that JMOs can draw upon should they be involved in an adverse event.

The three things that worked best in the Project:

1) The programme resulted in statistically significant positive changes in the attitudes and understanding of JMOs.

2) The patients, who were willing to speak about what for many was a very traumatic experience. They showed a great belief in the value and importance of such a project. Many of them stated that participation in the project had helped them to gain some kind of closure to their experience.

3) The interaction between the patients and the junior doctors and the obvious rapport that developed between them. Some junior doctors were obviously moved by the experience and many expressed surprise that an adverse medical event could affect an entire family for many years.

How this project could be implemented in other settings/organisations – the lessons to be learned for others.

This project has the potential to be incorporated into JMO education programmes around Australia. The experience of meeting with a patient who has suffered an adverse event face-to-face and talking with them about that experience appeared to be a very worthwhile experience for JMOs. In carrying out this pilot project, we have made many contacts with organisations such as the Health Care Complaints Commission and the Quality branch of NSW Health, who have expressed an interest in being involved in the project should it be carried out on a longer-term basis.

While probably not as confronting, this project could also be delivered in the form of a videotape, thus enabling widespread exposure of JMOs to this important topic.

A sample of the Alfred Hospital Initiative

The Alfred Hospital

**We take the issue of your safety seriously.
Here's how you can help …**

- Know who your care providers are (doctors, nurses and others). If we don't wear a name badge or introduce ourselves, ask for our name and position.
- Ask if we have washed our hands – we won't be offended!
- Make sure we confirm your identity when drawing blood, doing procedures or giving medication.
- Ask what each medication is for.
- Question us if a medication looks different, or if the routine changes.
- Write down any questions that you may have, as they arise. If you don't know where we are taking you – ask!
- Have a family member or friend present if needed when speaking with caregivers, having procedures done, or to speak up for you when you not able.
- Be sure you can read and/or understand any information given to you. If you cannot understand (or remember it!) ask your nurse or doctor for clarification. We don't mind helping you to understand your condition and treatment. That's what we're here for!
- Make sure you understand exactly which medications you are to take when you return home.

Copies of tools and resources developed as a result of the NSH project.

Statistical analysis of JMO responses to questionnaires.

Questionnaire for JMOs used to assess the effectiveness of the programme.

Questionnaire for patients used to collect information on their experience of the programme.

PowerPoint slides of presentations during the education session.

The Clinical Practice Improvement Unit-Northern Sydney Health would like to acknowledge the assistance of the Australian Council for Safety and Quality in Health Care through its SIIPS grants program in funding this project.

Contact Details:
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Empowering Patients program, The Alfred Hospital, Victoria.

One of the Bayside Health Strategic directions is to increase community participation in health. The Bayside Quality Unit considered the suggested consumer information from the ACQSHC, the Quality Interagency Coordination taskforce in the US and the various hospital initiatives available via the internet. As a result, they have recommended that the hospital trial a patient bedside card to encourage active participation of patients in their own health care.

The content of the card is shown. This information will be in a laminated tent card on the patient bedside table. It will be translated into several key languages on the card, and more cards will be available on request;

This Alfred Hospital initiative is still in its early days. The cards will be trialled at the Hospital and rolled out to the Bayside Health Group pending outcomes of the trial. The contact person at the Alfred Hospital is Ms Debbie Neilsen, Quality Manager. She can be contacted on 03 9276 2859

Diary Dates for 2003

July 14 - 16, 2003
National Australian Conference On Safety and Quality In Health Care.
Perth, WA
Title: "Safety and Quality in Action"
SEE PAGE this newsletter

July 29-31, 2003
IIR's 3rd Annual Adverse Event Conference.
Melbourne Vic

Topics include: Managing staff involved in Adverse Events (Aes), Using Emergency Teams to prevent and reduce AEs, Quality Improvement frameworks, Measuring clinical audit and peer review practices, Root Cause Analysis issues, reducing the impact of AEs, coroner report information as patient safety data, open disclosure, and personal and professional monitoring in Health Care.
See: www.iir.com.au/health or phone 02 9923 5090

July 28 - 30, 2003
Educating for Quality Healthcare International Symposium – Delivering Outcomes, Measuring Value
Mater Education Centre Brisbane, QLD

Over 30 case studies will cover key topics such as determining return on investment for education and human resources; evaluating and measuring outcomes; innovation in education delivery; leveraging technology through blended learning and e-learning and education initiatives for recruitment and retention.
See: edcentre@mater.org.au www.matereducation.com.au or
Telephone: 07 3840 8544

August 24 - 27, 2003, PSI are sponsors for:
The National Quality Colloquium at Harvard University

Patient Safety Officer training and practical healthcare quality initiatives for planners and providers
For further information, call 800-684-4549,
email: registrationhq@verison.net, or see www.QualityColloquium.com

November 2-5, 2003
20th International Conference of the International Society for Quality in Health Care.
Dallas, USA
Email: isqua@isqua.org or
see: www.isqua.org

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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AIMS Customer Service Survey

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Please note:
At PSI we are dedicated to high customer service standards and to ensure ongoing quality improvement strategies. If you have received a survey, or would like to provide us with feedback on how we are doing, please complete the form located on our website: www.apsf.net.au

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