

# EWSLETTER

SEPTEMBER 2003

aims

Advanced Incident Management System

## Legislation on Patient Safety in Denmark

### Inside:

- 1 Legislation on Patient Safety in Denmark
- 2 Update on the IRIS Report PSI Wins Award
- 3 New Version of AIMS tested in Hunter
- 4-5 Safety & Quality in Action Conference - July 2003
- 6-7 APSF Research Incident Types Research Staff Data Analysis Reports
- 8 Diary dates Customer Survey

In December 2001, Denmark established the Danish Society for Patient Safety. Its role is to gather, spread and develop knowledge and initiatives around patient safety.

In June 2003 the Danish Parliament passed the Act on Patient Safety in the Danish Health Care System<sup>1</sup>. It is believed to be the first legislation of this type in the world.

### Objective of the Act

The objective of the Act is to improve patient safety within the Danish health care system. The Act applies to the reporting of adverse events occurring in connection with the treatment of patients within the health care system. The National Board of Health in Denmark and the Minister for Interior and Health may lay down rules on which hospitals and other institutions of treatment are subject to the duty to report and the Board may also lay down special rules for the reporting system of private hospitals.

### Patient Safety Systems

Hospitals must receive, record and analyse reports on adverse events for use in the improvement of patient safety and treatment for the reporting of information to the National Board of Health.

Any health care professional, who becomes aware of an adverse event in connection with a patient's treatment or stay in a hospital, must report the event. The National Board of Health will receive reports on adverse events from the county hospitals and will establish a national register for such events. On the basis of the information received by the National Board of Health, they will advise the health care system on patient safety.

### Disclosure of Information

Reports on adverse events, which may be attributed to specific individuals, may without the consent of the patient or the involved health care personnel, be exchanged within the group of people who locally, within the hospital, handle tasks around receiving, recording and analysing reports. These reports may be passed on to clinical databases and other registers where information is recorded with a view to documentation and quality development within the patient safety area.

Hospitals may not disclose information about the reporting health care professional's identity to anybody except the people carrying out tasks around receiving, recording and analysing reports for use in the improvement of patient safety or the reporting to the National Board of Health.

Health care professionals reporting an adverse event will not, as a result of such reporting, be subjected to disciplinary investigations or measures by the employing authority, supervisory reactions by the National Board of Health or criminal sanctions by the courts.

The Act comes into force on 1 January, 2004 and will apply to all adverse events occurring after this date.

<sup>1</sup> ACT No. 429 of 10/06/2003 (Current)

 **Help Desk**

Local & International:  
**+61 8 8222 5495**

National Toll Free:  
**1800 110 021**

Email:  
**aims@apsf.net.au**

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

  
Patient Safety International

  
AUSTRALIAN PATIENT  
SAFETY FOUNDATION

# Update on the IRIS Project

**The Incident Reporting to Improve Systems (IRIS) project was introduced in the September 2002 issue of the PSI newsletter.**

IRIS is a collaborative project involving 20 units in 6 public hospitals in rural and metropolitan South Australia. Funded by the South Australian Hospitals Safety and Quality Council, the aim of the project is to increase the reporting rate and change the pattern of reporting by medical and nursing staff. The project was developed following a survey of medical and nursing staff and through analysis of focus groups, designed to identify barriers to reporting. It has been underway for three months and is being rolled out progressively throughout the hospitals.

A call centre has been established for incident reporting and operates 24 hours a day, 7 days a week via a freecall number- 1800NOTIFY. Reports are taken by registered nurses who enter incident details directly into AIMS. People who have been given authorisation, access the database to view incidents in their respective areas. In addition to the call centre, staff may report using a one-page report form and staff in one Intensive Care Unit also have the option of reporting directly into the AIMS.

The popularity of these three reporting methods will be assessed over the trial period. In the initial stages we have found that the call centre has been utilised more by metropolitan hospital staff than rural staff- 60% of all reports generated compared with 10% in rural hospitals. Reports generated by medical staff at one hospital have increased from 1% of all reports received pre-intervention to a current level of 8%. It is apparent that patterns relating to types of incidents reported are also changing, particularly by nurses, who remain the primary reporters. In addition to the traditional and important reports relating to falls and medication errors, many nurses are reporting issues relating to organisational management (staffing/experience levels, change in activity levels), impairment of communication, security, building and fixtures and clinical practice.

Feedback has been an integral component of the intervention and consists of individual or aggregate feedback dependant on the severity of the incident, where the incident has occurred, whether the reporter has identified themselves and how the report has been generated. Serious adverse events are investigated using root cause analysis methodology. Staff reporting directly into AIMS can track the management of their report. Some areas have established regular meetings where incidents are assessed by medical and nursing staff, and strategies developed to prevent their recurrence. Other areas chose to incorporate feedback into existing departmental meetings. Monthly newsletters are distributed to staff to highlight system changes implemented across intervention units. The IRIS project will conclude in April 2004, after which time we will assess its impact on reporting rates and its sustainability.

## PSI wins award

Patient Safety International were delighted to receive the Australian British Chamber of Commerce (ABCC) 2003 Export Award for UK Export Growth.

The ABCC is a platform with over 80 years experience in Australian-British trade. It provides a platform to forge new partnerships into the 21st century. The Chamber provides unique access and plays a crucial part in assisting organisations to penetrate the British, European and Asian markets. It is a forum, a meeting place for like-minded people interested in furthering their own business ambitions.

The ABCC is the way forward into 2004. The Chamber encourages the development of new insights and the promotion of the Anglo-Australian link. It acts as a "springboard" to both new and established, small and large companies throughout Australia.

Source: <http://www.big.wa.gov.au/busenv/supplied/support/ABCC.htm>

# New version of AIMS tested in Hunter

The new AIMS software was beta tested across three sites in the NSW Hunter Area Health Service from April 2003 to July 2003. This beta test was undertaken jointly by Hunter Area Health Service, PSI and the NSW Department of Health (DoH).

The goal of the beta test was to test the functionality and technical robustness of the AIMS advanced software in a controlled environment. Hunter Area Health Service provided an ideal controlled environment in which the functionality, stability and load testing of the software could take place.

The beta test of the AIMS product was successful with:

- 2200 total incidents entered into the system
- 1700 incidents classified
- Very few errors (9) identified in the software

- Approximately 80 users interacted with the system, deploying three different service delivery models involving ward level staff, Patient Safety Officers and Nurse Unit Managers
- Significant lessons learnt regarding data capture, classification and service delivery model benefits/constraints; which will guide the planning and implementation of the AIMS Pilot Project

## What Next

The NSW DoH has now commenced a three month multi-site project to pilot the advanced AIMS software. The purpose of this project from a NSW perspective is to provide an opportunity to pilot the AIMS software and understand the service delivery models that are supported by the software functionality, resource implications, barriers and success factors for implementation.



NSW Pilot Training with Chrissy Ceely from Childrens Hospital Westmead & Chris Marshall from PSI

# aims

*Advanced Incident Management System*

## Dr. Klee Benveniste, Researcher, APSF

"Mind-blowing", I kept saying, when anyone at the conference asked me what I thought of it. Over 650 delegates attended the conference in Perth in July.

Keynote speakers were excellent, particularly Professor Bob Helmreich from the University of Texas, consumer advocates Michele Kosky, Karen Carey-Hazell and Marilyn Beech, and the panel of experts who presented a "hypothetical" ably led by Terry Laidler. In the concurrent sessions, up to six choices were available; one I attended was a two-day root cause analysis workshop condensed into 2 hours!

There was extensive information about action taking place in patient safety and healthcare quality, both in the presentations and the extensive poster display. Numerous information booths were there, including the Patient Safety International booth demonstrating the Advanced Incident Management System software, manned by PSI CEO Margaret Gehrig and Operations Manager Kim Bannon.

It was great to hear comments about usage of the Australian Incident Management System (AIMS) software from all over Australia. At the 'Meet the



Sarah Michael and Professor Bill Runciman

Experts' breakfast, Dr. Dorothy Jones of the Western Australian Department of Health stressed the importance of "investing in people" by properly training the classifiers in hospitals. She also introduced Rob Crooke, who managed the software and database on a central server for Western Australia. Three important groups (clinicians, classifiers and technical support) work well together. She said that incident information flows from the "top down" as well as from the "roots up" within the State.

Sarah Zilko and Jill Porteous, at a later presentation, said WA was the only State running AIMS on a central server. AIMS 2.4 had been rolled out to 70 sites across Western Australia from July 2001 and there were over 30,000 incidents recorded. The central collection allowed the system to be accessible, and to balance security versus access. Data from State-wide analysis was presented. They described how some limitations were overcome, detailing the data mining process and



A happy group enjoying the cocktail party

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 5544



Dr. Klee Benveniste talks with John Forster of Austin and Repatriation Medical Centre in Victoria about his poster (photo courtesy of Andrea Polonowita)

was presented. They described how some limitations were overcome, detailing the data mining process and the hospital actions which occurred to reduce incidents. They emphasised that it was important for clinicians to guide technical support staff in the data query process.

Dr. Paul Douglas, of Hunter Health in New South Wales, described the use of AIMS in the Hunter Valley region. This is the latest version of AIMS software being pilot tested. Paul said he wanted to pay tribute to APSF/PSI for creating a great product. The Hunter Health Governance Unit has also invested in training nine Patient Safety Officers to assist clinicians, 25% of the medical officers have been through a communication course, and every health professional has a copy of the 'Clinicians Toolkit'. Timely reports and root cause analysis were important and there has been a significant increase in reporting.

As well as hearing interesting presentations and feedback, it was a chance to network and research. We are currently looking at

the issue of violence and aggression in the health workplace and I found three posters describing useful initiatives dealing with aggression:

- Andrea Polonowita and John Forster, Psychiatric Liaison Nurses at Austin and Repatriation Medical Centre in Victoria have developed a risk assessment tool and framework to assist staff to identify potential for aggression of patients and/or visitors and to assist staff to be pro-active rather than reactive in managing incidents of aggression.
- Tracy Cassidy, Victorian Psychiatric Quality Coordinator and Dr Chris Breakwell, Project Manager, from The Melbourne Clinic, Healthscope, displayed a project on risk management strategies for aggressive behaviour.
- Prof. Anthony Snell, Director of Rehabilitation and Aged Care Services, Bendigo Health Care Group, described a regional dementia management strategy with an aggression management program as a key component.

The conference was excellent, intense and valuable. It showed the benefit of bringing together the combined knowledge of the Australasian Association for Quality in Health Care, and the Australian Council for Safety and Quality in Health Care and the Western Australia Department of Health.

Well done!



Adrienne Copley & Janice Wheldon at Conference Dinner

## Incident Types

A preliminary analysis was recently undertaken by the APSF using the aggregated Australian Incident Management System (AIMS) database to determine the proportion of incidents received by incident classification.

Incidents from a sample of eighteen hospitals and health services were extracted from the AIMS database from the years 2001 and 2002. Over 14,000 incidents were included in the analysis.

The incidents are classified according to the table (shown below) with their relative frequencies shown.

There were differences in frequencies of classification from

the overall averages when health services were analysed in terms of rural and metropolitan areas.

56.8% of rural health services' incidents were falls, compared to 45.0% for metropolitan health services.

Incidents categorised as Therapeutic Devices/Equipment occurred as 10.6% of total metropolitan incidents and 6.9% of total rural incidents. Documentation and Behaviour incidents in the metropolitan health services were 8.1% and 11.4% respectively of the total metropolitan incidents, whilst the comparative figure for rural health services was 4.0% and 8.6% respectively.

Comparing dedicated mental health services to the overall average showed a large increase in the frequency of behaviour and safety incidents at these services with 31.6% and 13.8% of incidents respectively.

Classification	Percentage Frequency (%)
Falls .....	47.3
Medications.....	15.9
Behaviour .....	10.8
Therapeutic Device.....	9.8
Safety .....	7.9
Documentation.....	7.3
Nutrition .....	0.6
<b>Total</b>	<b>100</b>

## Publication:

Runciman WB. Lessons from Australia. In Emslie S, Knox K, Pickstone M. Improving Patient Safety: Insights From American, Australian and British Healthcare. Based on the proceedings of a joint ECRI and Department of Health Conference to introduce the National Patient Safety Agency. ECRI: Welwyn. 2002. pp. 47-54.

## Research Resources

The Australian Council for Safety and Quality in Health Care released a series of reports in July 2003. All are available through the Council's web-site at [www.safetyandquality.org](http://www.safetyandquality.org)

- 'Patient Safety: Towards Sustainable Improvement - Fourth Report to Australian Health Ministers' Conference'
- 'National Action Plan Update'
- 'Safety and Quality and the Health Reform Agenda'
- 'Standards Setting and Accreditation Systems in Health: Consultation Paper'
- 'Safe Staffing: Discussion Paper'
- 'Improving the Consistency of Approaches to Qualified Privilege Schemes'
- 'Open Disclosure Standard: a National Standard for Open Communication in Public and Private Hospitals, following an Adverse Event in Health Care'
- '10 Tips for Safer Health Care - What Everyone Needs to Know'
- 'National Strategy to Address Health Care Associated Infections'.

# APSF Research

The APSF Research Group currently includes four staff - Professor Runciman, Peter Hibbert, Dr Klee Benveniste and Dr John Williamson who are responsible for:

- a. Providing qualitative and quantitative analysis of databases;
- b. Effective organisation of research activity and research resources;
- c. Advice on appropriate statistical and analytical techniques;
- d. Structuring data mining tools and techniques and applying them to the various databases;
- e. The development and maintenance of appropriate research standards for cost effective client (and other stakeholder) support;
- f. Associated tasks necessary to provide quality research reports and services, on time, including design, execution and interpretation;
- g. Ongoing review of all research activities; and
- h. Collection and maintenance of patient safety reference material.



Dr Klee Benveniste



Peter Hibbert

## Research Staff

### Peter Hibbert Senior Analyst

Peter has recently joined the APSF as a Senior Analyst in the Research Department. Peter is responsible for ensuring that the national aggregated database stored at the APSF is secure, ensuring data quality is maintained to meet stakeholder's needs and that data is sent to the APSF on a regular basis.

Peter is also responsible for producing reports to stakeholders and responding to their specific incident monitoring data needs.

Peter originally trained as a physiotherapist and has 12 years experience of working in the public and private health systems, both in Australia and the United Kingdom.

More recently, Peter has been working as a consultant for a firm specialising in the health and community care sectors. Peter has gained post-graduate qualifications in information technology, and is currently pursuing further studies in econometrics.

### Dr Klee Benveniste Researcher

Klee has a Ph.D. in the field of injury epidemiology from Flinders University School of Medicine. She has been employed

in a variety of medical research support positions over 30 years beginning in the Department of Community Medicine at Royal Adelaide Hospital/University of Adelaide in 1974. She was employed for 15 years in the Department of Primary Care and Community Medicine at Flinders University, at Southern Child and Adolescent Mental Health Services, and on her own grants at Flinders Medical Centre.

She has had extensive experience in literature review, data analysis, report preparation and publication of research in the field of public health. Projects involved evaluation and planning of health services (including community health centres, general practice, emergency departments, palliative care, mental health); and epidemiological research, especially on injury.

Klee gained wide clinical experience as an honorary psychologist providing diagnostic neuropsychological assessments at Flinders Medical Centre for 15 years and she has been a registered psychologist for 25 years.

Klee joined APSF in 2001 as a postdoctoral Research Officer. Her role at the APSF is literature research and resource collection development and she works with Professor Bill Runciman on his research.

**Peter and Klee can be contacted on (08) 8222 5115.**

## Data Analysis Reports

The APSF is currently considering its future business model, the types of services that it delivers to its stakeholders, and its role in disseminating incident monitoring and reporting information. The APSF intends to produce regular reports to be distributed to clients with the data sources of these reports being incident reporting and monitoring literature and the national aggregated database stored at the APSF.

The APSF is aiming to produce a short, bi-monthly report on a topic of interest as well as a more comprehensive bi-annual report. The first of the short reports – Burns Received in Hospitals – was distributed in September. A full report on the analysis will be available for interested parties as well as a one-page summary for general distribution. These documents will be sent via email to the relevant personnel for distribution to others in their organisation at their discretion. Both types of reports will be orientated towards topics of interest amongst stakeholders as well as trends that are apparent from analysing the database. APSF is currently working with its clients to ensure that all de-identified data is sent in a timely manner to the APSF for aggregation and analysis.

We appreciate feedback from stakeholders on the format and dissemination strategy of reports and other APSF activities. To assist us in ensuring the APSF meets stakeholder's requirements, we have distributed a questionnaire to stakeholders with the first report. Feedback from this questionnaire will assist the APSF in responding to clients needs in a timely, efficient and satisfactory manner.

# Safety & Quality Conference Dates 2003-4



**17-19 October 2003.**

**Third Halifax Symposium on Healthcare Safety: 'From Theory to Reality',**

Pier 21 Conference Centre, Halifax, Nova Scotia, Canada.

Website: <http://www.halifaxhealthcaresafetysymposium.ca>

**2-5 November 2003.**

**ISQua's Twentieth International Conference. 'Rewarding Results – Two Decades of Continuous Improvement',** Wyndham Anatole Hotel, Dallas, Texas.

Website: <http://www.isqua.org>

**5-7 November 2003.**

**International Summit on Optimizing Patient Flow Throughout the Hospital,**

Hyatt Regency, San Francisco, California, USA.

Website: <http://www.ihl.org/conferences/summit/flowsymmit2003/index.asp>

**6 November 2003.**

**'Working Differently: Achieving Better, Safer Health Care',**

QEII Conference Centre, London, United Kingdom.

Website: <http://www.quality.bmjg.com>

**1-5 December 2003.**

**Sixth Australian Aviation Psychology International Symposium,**

Darling Harbour, Sydney, Australia. 3 Dec: Healthcare Safety, and Rail Safety

Workshops. Website: <http://home.vicnet.net.au/~aavpa/symposium.htm>

**2-5 December 2003.**

**15th Annual National Forum on Quality Improvement in Health Care,**

'The Courage to Change', New Orleans, Louisiana, USA.

Website: <http://www.ihl.org/conferences/natforum>

**23-24 February 2004.**

**ARCHI Toolkit Seminar: 'Mental Health, Hospitals, Communities',**

Stamford Grand, Adelaide, South Australia. Website: <http://www.archi.net.au>

**26-29 February 2004.**

**2nd International Congress, Australian General Practice Accreditation Ltd. and Quality in Practice Pty. Ltd.,**

Conrad Jupiters, Gold Coast, Queensland, Australia.

Website: <http://www.agpal.com.au>

**12-14 May 2004.**

**9th European Forum on Quality Improvement in Health Care,**

Copenhagen, Denmark. Website: <http://www.quality.bmjg.com>

**28-30 July 2004.**

**National Medicines Symposium 2004,**

**'Quality Use of Medicines – Time for Total Integration',**

Brisbane Convention and Exhibition Centre, Brisbane, Queensland, Australia.

Website: <http://www.nps.org.au> (click on 'Events')

## 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:

+61 8 8222 5544

## Postal Address

GPO Box 400  
Adelaide  
South Australia 5001

## AIMS Customer Service Survey



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

