

NEWSLETTER

SEPTEMBER 2004

aims

AIMS: The Cornerstone of High Reliability Organisations

On 30 September 2004, the Office of Safety and Quality at the Department of Health in Western Australia held an AIMS Seminar – “AIMS: The cornerstone of high reliability organisations” – inviting organisations to submit initiatives arising from local analysis of AIMS data. Patient Safety awards were presented to individuals who had excelled in the area of patient safety and those who had developed sustainable patient safety initiatives that had a direct impact on patient safety.

Presentations on the day were from a wide variety of healthcare providers from around the state including rural and metropolitan regions. Presentations included topics such as:

- Development and implementation of a telephone based incident reporting system for pressure ulcers
- Barriers to clinical incident reporting; an audit/observational system to capture clinical incidents
- Pregnant pause: How much value has the AIMS Obstetric Healthcare Incident Type (HIT) added to the identification, analysis and minimisation of obstetric related incidents?
- Using data obtained through the AIMS process to make decisions about clinical management as well as to improve the quality and safety to patients in the area of mental health
- Look who's not talking: The impact of Communication Problems on Hospitals and Health Services
- Safety initiatives arising from area wide analysis of AIMS data
- Development of an insulin infusion order chart and guideline for use in a regional hospital
- Failure mode and effect analysis and its use in reviewing medication incidents
- In-patient falls prevention program
- Development of a Falls Risk Management tool for use in the acute care setting
- Development of a metropolitan-wide febrile neutropaenia card to 'flag' at risk oncology patients presenting in ED

Professor Bill Runciman, President, Australian Patient Safety Foundation, who gave the keynote address “25 years on: One doctor's view on how incident reporting has influenced patient safety” stated, “it was very exciting to see the impressive work being performed as a result of reports from staff on incidents – ‘closing the loop’ in this way is fundamental to exploiting the power of incident reporting in producing sustainable change”.

Dr Dorothy Jones, Director of the Office of Safety and Quality, summarised the meeting as a very positive way of sharing lessons learnt and acknowledging local achievements. “I was very impressed by the quality of work presented and encouraged by the significant number of improvements underway in WA as a result of regular incident reporting and analysis” she stated. “This is something that will definitely become a regular event on the WA health schedule”.

Full presentations can be found on the website:

<http://www.health.wa.gov.au/safetyandquality/presentations/index.cfm>

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Department of Health
Government of Western Australia

eliminating preventable harm in health care

AIMS Showcased in Product Café

In September, AIMS was privileged to be invited to participate in a Product Café at the Agency for Healthcare Research and Quality (AHRQ) **3rd Annual Patient Safety Conference; Making the Health Care System Safer** held in Washington D.C. AIMS was the only non-US participant with all others being recipients of AHRQ funding grants over the past years.

“AIMS demonstrates that research can be translated into a practical tool for all of healthcare”.

Dr Carolyn Clancy, AHRQ Director, opened the conference and spoke about the future theme for AHRQ funding ‘to translate research into practice’. Dr Clancy emphasised that while research is important, the findings do not often change healthcare – we need to ensure that research results in practical tools that can be used by healthcare workers. Dr Clancy encouraged all delegates to visit the Product Café to see the front-line leaders in patient safety. AIMS attracted considerable interest from all over the US, particularly as AIMS demonstrates that research can be translated into a practical tool for all of healthcare.

Keynote address by Sr Mary Jean Ryan, FSM – President and CEO of SSM Health Care

Sr Ryan gave an inspirational address and received a standing ovation from delegates. She emphasised that we have a moral obligation to keep our patients safe and that if organisations create opportunities for leadership to thrive, then the answers will come. We must do this as a matter of integrity.

Following are key points from her address:

- Good organisations are made by perseverance – perseverance isn’t trendy today when we live in an age of instant gratification (ask Nelson Mandela!)
- It will take perseverance to make our patients safe – requires a systemic overhaul of the entire healthcare system. We can’t use the excuse of the need for systemic change to not do what we need to now!
- SSM Health Care set up a near miss program – with monthly prize draws for employees that report near misses. In the first year they collected 100, 40 of those led to process improvements. They identified 16 best practices for which near misses should be reported if an error nearly occurs.
- Abbreviations are susceptible to misinterpretation, particularly when handwriting is poor.
 - u – unit
 - qd (everyday) easily confused with qid (4 times/day)
 - leading and lagging zeros eg 5.0 can easily be read as 50 (need to write it as 5 instead of 5.0.)

To create awareness of these problems they developed posters and put them in the toilets – errors were greatly reduced.

- Work done so far is only the tip of the iceberg – the easy and obvious problems. The challenge is in addressing the underlying problems. SSM Health Care knows that the lack of co-ordinated care and communication among and between caregivers is their greatest problem – this is the underlying problem to be addressed but how to address it!
- Communicated to patients ‘if something doesn’t feel right about your stay in hospital please let us know’
- Finance problems for healthcare - 45 million people in the US don’t have insurance – we treat them in the emergency room – most expensive place in the hospital!!
- Medical and nursing schools not training on ‘error’. School of nursing stated that it would take five years to get something back into the curriculum on error.

Agency for Healthcare Research and Quality (AHRQ)

Mission:

To improve the quality, safety, efficiency, and effectiveness of health care for all Americans.

Focus:

- Improves health care quality for all Americans
- Transforms research into practice
- Improves health care outcomes through research
- Uses evidence to improve health care

New AHRQ Patient Safety E-Newsletter.

To subscribe:

1. Send an email message to: listserv@list.ahrq.gov
2. In the subject line type: Subscribe
3. In the body of the text message type: **sub patientsafetynewsletter** and your full name

To receive the newsletter in text-only format:

1. Follow the steps 1 and 2 above.

In the body of the message type:

Sub patientsafetynewslettertext and your full name

You will receive an email confirmation.

If you have any questions contact Nancy Comfort in AHRQ’s public affairs office at nccomfort@ahrq.gov.

National Patient Safety Education Framework Project

<http://www.patientsafety.org.au/project/index.html>

The National Patient Safety Education Framework Project is funded by the Australian Council for Safety and Quality in Health Care and is managed through the Centre for Innovation in Professional Health Education (<http://www.ciphe.med.usyd.edu.au/>) at the University of New South Wales. Scheduled for completion in late 2004, the work is being undertaken by a national consortium in consultation with health care workers, consumers and other stakeholders around Australia.

Project objectives:

- Identify the key skills, knowledge, behaviours and attitudes related to patient safety for all health care workers
- Develop a simple, flexible framework that will act as a benchmark for training, educating and assessing health care workers in patient safety
- Help make patient safety concepts easy for everyone to understand and apply
- Help ensure all workers in the health system are equally competent and supported in adopting a patient-centred approach to their work

The consortium comprises:

Core Management

Project Director, Merrilyn Walton
Project Manager, Tim Shaw
Project Coordinator, Jackie Ross
Project Assistant, Shannon Byrne
Focus group analysis, Patricia Lyon & Vera Terry

Reference Group -

Clinical

Darryl Mackender, University of Newcastle, NSW
Judy Lumby, College of Nursing
Leonie Waterson, Royal North Shore Hospital, NSW
Ian Scott, Princess Alexandra Hospital, QLD

Consumer

Merryll Green, NSW

Health Systems

Bruce Armstrong, University of Sydney, NSW
Duncan Neuhauser, Case Western Reserve University, Cleveland, USA
George Rubin, University of Sydney, NSW
Bill Runciman, Australian Patient Safety Foundation, SA
Andrew Wilson, University of Queensland, QLD
Bob Gibberd, University of Newcastle, NSW

Education

Stewart Barnet, University of Sydney, NSW
Greg Ryan, University of Sydney, NSW
Simon Willcock, University of Sydney, NSW
Natalie Collison, Community Services & Health Industry Skills Council Ltd

Validation group

Experts chosen from outside the reference group will be used to validate competencies.

Stakeholders and wider community

Wide consultation will be undertaken through targeted focus groups and web-based review and feedback. Please email your details to Shannon Byrne at shannon@ciphe.med.usyd.edu.au to participate in this project.

The Framework

Once complete, the framework will describe the key competencies relating to patient safety for every worker in the health care system. The information will be divided into several layers and further, into learning topics. Learning topics are comprised of the learning domains: knowledge, skills, behaviours and attitudes, and then divided into stages to match the differing levels of responsibility each role has for patient safety. The important role and necessary competencies of the organisation as a whole will also be included in the framework.

Two learning topics are now in draft form and available for comment:

1. **Recognising, Reporting and Managing Adverse Events and Near Misses** - http://www.patientsafety.org.au/pdfdocs/Recognising_reporting_and_managing_adverse_events.pdf
2. **Appropriate Complaint Management** - <http://www.patientsafety.org.au/pdfdocs/appropriatecomplaintmgm.pdf>

APSF Founding Member Recognised for Contributions to Australian & New Zealand College of Anaesthetists



On the 21st of July, John Williamson FANZCA, was presented with an Australian and New Zealand College of Anaesthetists Council Citation "for his outstanding contributions to diving and hyperbaric medicine and incident monitoring, and for his long standing involvement with the Australian Patient Safety Foundation."

John's association with incident reporting began in the early 1980's, when he became one of a group of five anaesthetists from around Australia, who collaborated to commence Australian anaesthesia incident reporting on a vestigial scale. This group consisted of Dr Lyn Currie in Sydney, Dr Craig Morgan in Melbourne, Professor (then Dr) John Russell in Adelaide and Dr Robert Webb and John in Townsville. Subsequently, in 1985, Robert, John and another Townsville anaesthetist, Dr Geoffrey

Pryor, published the first Australian study of anaesthesia clinical incidents. The paper (Williamson JA, Webb RK, Pryor GL. Anaesthesia safety and the "critical incident" technique. *Aust Clin Rev* 1985;5:57-61), found a striking similarity between anaesthesia incidents occurring in Australia and in Massachusetts, USA. (The American data had been previously documented in 1978 in *Anesthesiology* by Dr Jeffrey Cooper and colleagues.)

A few years later in 1988 the APSF was founded by Professor Bill Runciman and the "Anaesthesia Incident Monitoring Study" (the original "AIMS") was born. Work continued on a larger scale, with a seminal issue of *Anaesthesia & Intensive Care* in 1993 by a now greatly enlarged team of anaesthetists and psychologists – spearheaded by Bill and which included the original five above. APSF's incident reporting developments now address the whole of Australian healthcare, with an increasing international influence.

Between 1990 and 1998, in collaboration with Christy Pirone RN, and Mr Steve Goble, John was involved in the establishment of the "Hyperbaric Incident Monitoring Study" (HIMS). This study is continuing at international level, under the leadership of Christy and Steve.

John retired from clinical practice in 1998, but he continues to contribute to incident monitoring and patient safety as a part-time specialist consultant at the APSF, collaborating on the development of the APSF HITS, their classification taxonomy and on special projects.

Congratulations John on this much deserved recognition!

Merck's Manual 1899 – Nothing is New!

PSI recently purchased the latest addition of the Merck's Manual for assistance with development of the AIMS classification. To our delight we also received a copy of the first Merck's Manual, published in 1899.

This small, pocket-sized book has a few comments of interest, which show that we are still, 100 years on, struggling with the same issues!

"Memory is treacherous. It is particularly so with those who have much to do and more to think of. When the best remedy is wanted, to meet indications in cases that are a little out of the usual run, it is difficult, and sometimes impossible, to recall the whole array of available remedies so as to pick out the best. Strange to say, too, it is the most thoroughly informed man that is likely to suffer to the greatest extent in this way; because of the very fact that his mind is overburdened. But a mere reminder is all he needs, to make him at once master of the situation and enable him to prescribe exactly what his judgement tells him is needed for the occasion"

Every addition to true knowledge is an addition to human power

Zero Tolerance Policies on Violence in Health Care – Useful or Counter-productive?

Dr. Klee Benveniste, APSF Researcher

In 1996, the Occupational Safety and Health Administration of the United States Department of Labor released guidelines for prevention of workplace violence to health care workers (OSHA, 1996), which mentioned the concept of zero tolerance, an approach derived from the criminal justice field.

In the United Kingdom in November 1996, a report on 'Health and Safety in NHS Acute Hospital Trusts in England' (National Audit Office 1996) identified physical assault as a significant problem for the National Health Service (NHS). Two initiatives were launched in October 1999; the first was a 'zero tolerance' campaign influenced by the US guidelines and the second initiative required such incidents to be reported and set targets for reductions.

Reviewing the progress of the initiatives, the National Audit Office (NAO) published 'A Safer Place to Work: Protecting NHS Hospital and Ambulance Staff from Violence and Aggression' (National Audit Office, 2003). The NAO found that violence accounted for 40% of all occupational health and safety incidents reported by NHS Trusts in 2001/2 and cost an estimated £69 million per annum (National Audit Office 2003, p. 4). Only a fifth of the NHS trusts had achieved their target of reduction by 2001. The National Audit Office stated that the increase in reported incidents of violence in the NHS was mirrored by an increased tendency to resort to physical and verbal aggression in society generally.

In Australia in 2001, the New South Wales Minister of Health established a Taskforce on Prevention and Management of Violence in the Health Workplace. The Taskforce prepared a series of reports, including a literature review on occupational violence, which summarised primarily American research on factors associated with client-initiated violence in health-care (Mayhew and Chappell 2001), and recommended the policy of 'Zero Tolerance' now adopted in New South Wales (NSW Department of Health 2003).

A substantial part of the NSW policy document outlined the legislative environment based on occupational health and safety, workers compensation, mental health legislation, anti-discrimination, privacy and crimes legislation, as well as policy on police liaison and other action taken after the incident such as apprehended violence orders, criminal prosecution and witness assistance. It is important to note that:

"it is not the intent of this policy that inappropriate action be taken against patients whose violent behaviour is a direct result of a medical condition. In these circumstances, the emphasis is on prompt, effective clinical management and compassionate care of the patient, while at the same time protecting the safety of that patient, as well as the safety of staff and others who may be affected by the behaviour" (NSW Department of Health 2003, p.3).

The recent APSF summit included a panel discussion on 'zero tolerance' policy for aggression in health care and revealed very mixed opinions. On the one hand, staff needs to know that action will be taken against violent people and the employer has a responsibility to provide a safe environment for staff and patients. On the other hand, health professionals pointed out that there must be tolerance for some verbal aggression from patients or relatives when they feel care is substandard. Also, there are many cases of assault or abuse from patients who are not in control of their behaviour, and who can diagnose a patient during a crisis? Examples were given where zero tolerance led to an escalation of the problem by calling in security. Refusal of treatment was also criticised and described as impractical.

There was a consensus among health workers present at the summit that the slogan of "zero tolerance" was inappropriate and even offensive, and some suggested more courteous and informative slogans to use both in posters and for the policy itself.

It became apparent that zero tolerance approaches to violence adopted from overseas have caused very mixed reactions among health care professionals that need to be noted by State health departments.

References

Mayhew C, Chappell D. Occupational Violence: Types, Reporting Patterns, and Variations between Health Sectors. Taskforce on the Prevention and Management of Violence in the Health Workplace. Discussion Paper No. 1. School of Industrial Relations and Organisational Behaviour, and Industrial Relations Research Centre, Working Paper Series 139. Sydney: University of New South Wales. 2001. Available at: www.health.nsw.gov.au/health-public-affairs/violence/DiscussionPaper1.pdf

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National Audit Office. Health and Safety in NHS Acute Hospital Trusts in England. House of Commons, HC 82 1996-97. 1996. Information available at: www.nao.org.uk/pn/969782.htm

NSW Department of Health. Zero Tolerance—response to violence in the NSW Health workplace: policy and framework guidelines. North Sydney: NSW Department of Health. 2003. Available at: www.health.nsw.gov.au/pubs/z/pdf/zero_tol_guide.pdf

Occupational Safety and Health Administration, US Department of Labor. Guidelines for preventing workplace violence for social service workers. OSHA 3148-1996. 1996. Available at: www.geocities.com/europanth/harrosha.html

Analysis of AIMS3 Falls Data

At 30 percent of total incidents, falls are the most common incident type reported. To gain a deeper understanding of how and why falls occur, the South Australian Department of Health (SADoH) invited APSF researcher Peter Hibbert to analyse their AIMS3 database. Taking advantage of the powerful classification and analytical capabilities of the AIMS3 software (released June 2003), Peter was able to illuminate the key factors behind falls incidents in South Australia.

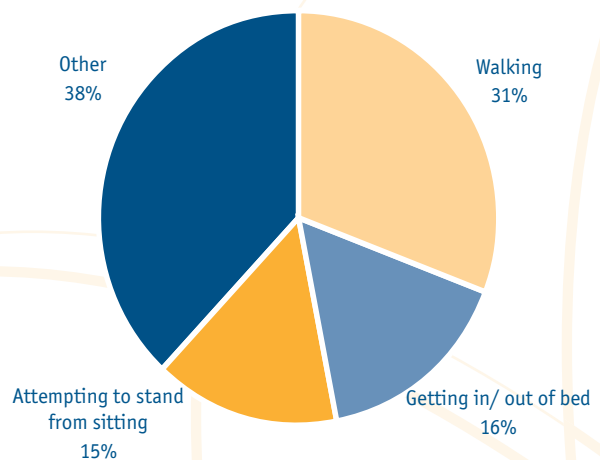
Peter presented the results of his analysis of the SADoH AIMS database at a one-day conference, Falls Prevention as a Patient Safety Priority: Showcasing Outcomes from Falls Prevention Initiatives held in Adelaide this past June. The conference was a joint effort between the Association for Quality in Healthcare (SA) and Clinical Systems, SADoH.

Since the state-wide AIMS3 roll out began in July 2003 over 4,400 incidents have been collected. The majority of incidents collected are falls (30%), followed by medication (20%). Analysis revealed that falls represented a greater percentage of total incidents for facilities in rural areas. This is likely due to the different mix of care types between metro and rural and specifically, that aged care facilities are often attached to rural health services.

Focusing on the 1300 falls incidents in the database, analysis revealed that the most important patient contributing factors were: age; confusion/dementia; poor balance or unsteady on feet; lifestyle diminished activity or mobility; fatigue/exhaustion; generalised weakness/frailty and unco-operative/non-compliant/obstructive behaviour.

Most falls happened while patients were walking (31%), while getting into and out of bed (16%) and attempting to stand from a sitting position (15%) were also common activities at the time of a fall. Staff ideas about how falls could be prevented, were consistent with these findings. Reporters felt that falls could be prevented with improved staff supervision and increased patient assistance.

Most Common Activities at Time of Fall

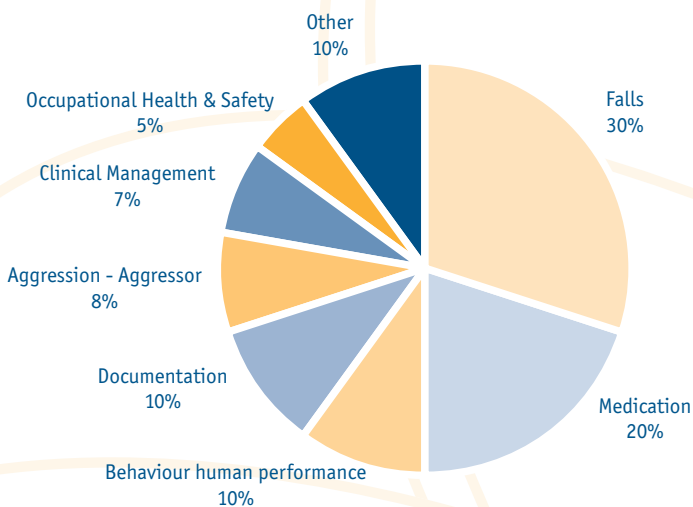


Staff contributing factors were reported less often than patient factors and related mainly to issues of supervision, teamwork and communication.

Differences in reporting rates and the importance of contributing factors across health services indicate a need for analysis to be undertaken at both local level such as a ward or department, and at an aggregated state level. Development of effective corrective strategies is reliant on detailed, accurate and relevant information about how and why things go wrong.

For information about APSF research services contact Peter Hibbert: peter.hibbert@apsf.net.au

Principal Incident type



Book Review

Clark RB. **Health Care and Notions of Risk.** Melbourne: Therapeutic Guidelines Limited. 2004. 66 pp. Available from: www.tg.com.au

In 1999, an Australian Patient Safety Survey was conducted, involving a telephone-based population survey of 1500 persons in five mainland states of Australia. In this slim volume, Richard Clark has adapted the survey report for general professional readership. The survey studied patients' experience of medical adverse events and perception of risk relating to the Australian health care system. The findings are compared to the results of a similar 1997 US population survey from which it was adapted, and the Quality in Australian Health Care Study, which involved medical record review.

Overall, 10% of respondents had experienced an adverse event. Of these, a third involved a medication error, one-fifth involved misdiagnosis or wrong treatment and one-tenth involved a mistake during a procedure.

Specifically, 11.4% reported having an adverse event during a hospital admission, and 9.7% experienced an adverse event from a doctor's clinic visit. Patients were more likely to have experienced an adverse event if they were young adults aged 18 to 34 years, Australian-born, had poor self-reported health status, visited a regular doctor for a only a short period, experienced multiple hospitalisations in the last 12 months, were not informed of a risk, or had refused treatment after being informed of risks. Only half of patients who had an adverse event were satisfied with the health provider's response. Improved communication and thoroughness were cited as the major means by which the adverse event could have been prevented.

The survey is a useful addition to the Australian literature on patient safety, providing an insight into consumer experience and attitudes towards risk in health care. While there has been much research done by health services, and particularly by record review, reports of the consumer experience have tended to rely on formal complaints, which reflect only part of the wider patient population experience. This slim text would be a useful resource to stimulate discussion among professionals and students regarding risk in healthcare and appropriate responses when adverse events occur.

Dr Klee Benveniste
Researcher
Australian Patient Safety Foundation

WHO – World Alliance for Patient Safety

Forward Programme 2005

The World Health Organisation (WHO) has announced a plan to reduce medical errors and foster a 'culture of safety' in health care around the world. The World Alliance of Patient Safety will pool the resources of governments, civil society organisations, scientists and researchers to develop and share methods to reduce medical errors. The United States, United Kingdom and Australia are key players in the initiative.

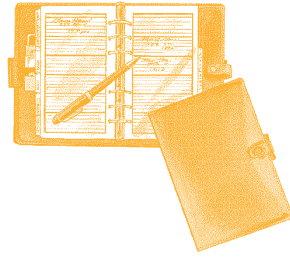
In the introduction to the Forward Programme 2005, WHO states that "answers to the following crucial questions should be sought internationally, so that best practice can be established to provide decision-makers with options when shaping their strategies:

- What can policies and regulations governing the health-care system do to improve health-care safety?
- How can we best create leadership, undertake research and develop tools to enhance the knowledge base about safety?
- How can we best identify and learn from adverse events through mandatory and voluntary reporting systems?
- What are the best mechanisms for raising standards and expectations for improvements in safety through the actions of oversight bodies, group purchasers and professional associations?
- How do we best deal with issues related to the cost of safety measures, and possible variations in acceptable levels of risk, especially in resource-poor settings?"

The Programme addresses six action areas:

1. Global Patient Safety Challenge 2005-2006
2. Patient and consumer involvement
3. Developing a patient safety taxonomy
4. Research in the field of patient safety
5. Solutions to reduce the risk of health care and improve its safety
6. Reporting and learning to improve patient safety

For full details on this report go to the link:
<http://www.who.int/patientsafety/en/>



Safety and Quality Conferences Dates

25-26 November 2004

**ACHIEVING EFFICIENCIES IN CLINICAL MANAGEMENT: MOBILE,
TELE AND WIRELESS TECHNOLOGIES**

Flemington Racecourse, Melbourne VIC

Details: www.archi.net.au

1-3 December 2004

NATIONAL CONFERENCE ON QUALITY AND SAFETY IN HEALTH CARE

Chicago, IL, USA.

<http://www.jcrinc.com/education.asp?durki=5961>

9-10 December 2004

IMPROVING SAFETY AND SECURITY IN THE HEALTH WORKPLACE

Carlton Crest, Auckland, New Zealand

Details: www.archi.net.au

22-24 February 2005

14TH ANNUAL NATIONAL MEDICO-LEGAL CONGRESS

Sofitel Wentworth, Sydney, NSW, Australia

Details: <http://www.iir.com.au/conferences>

13 -15 April 2005

10TH EUROPEAN FORUM ON QUALITY IMPROVEMENT IN HEALTH CARE

ExCel Conference Centre, Docklands, London, UK

Details: <http://www.bma.org.uk/forms.nsf/confweb/JBEY-5Z4KX5>