

# Safety Management Systems in Healthcare

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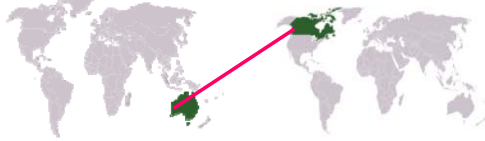
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**Australia & Canada share a common heritage, similar demographics, shared history and modern political & healthcare systems**

**Therefore, Australian patient safety experience should translate into the Canadian environment....**



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## The WA Department of Health Patient Safety Management System: five years on....

1. Approach
2. Results
3. Improvement?
4. Lessons learned

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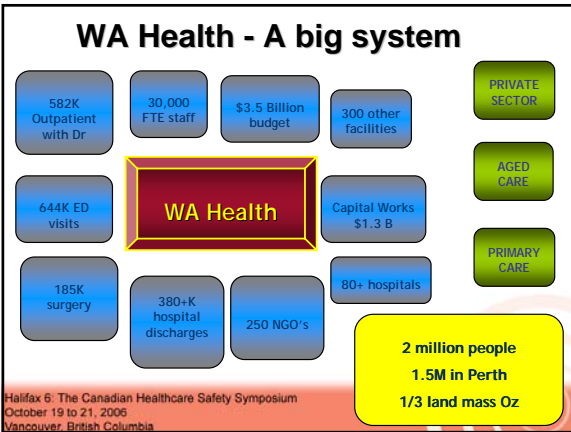
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- ### Approach: Overview 1
- Formal recognition by state government – late 90's
  - Establishment of departmental Office of S&Q - 2001
  - Establishment of Council of S&Q - 2002
  - Conjoint state strategic plans (98-03/03-08)
  - Strong & visible leadership (DG/CMO/CE's)
  - Clear identity - Office of S&Q
  - Brought in prophets from other lands
  - Taught ourselves; taught others (all teach/all learn)
  - Always used clinical leaders (clinical = doctor) (sorry..)
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## Approach: Overview 2

- Gathered the local evidence (harm/adverse events; cost)
- Established a local sense of urgency
- Built a guiding coalition (DG down and patients up)
- Focused on patient safety
- Developed a Clinical Governance Framework – safety management system - by our clinical staff
- Used CG to organise all safety management activities
- 2004 Premier's health reform Taskforce endorsed implementation of CG in 2 years
- Patient Safety is now aligned & highly visible in WA Health Strategic (10 yrs) & operational plans (1-4 years)

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## Approach: Overview 3

- Strong emphasis on Patient Safety especially Incident reporting & management (DATA)
- Used RCA & Human Factors – it works..
- Defined CG & the safety journey; developed policies & standards; now monitor with performance reporting (DATA)
- Performance reporting for DG & Chief Executives
- Public reporting to WA community (last 2 years)
- Legislative reform/support (v slow)
- Get to the \$\$\$ (NEED DATA)

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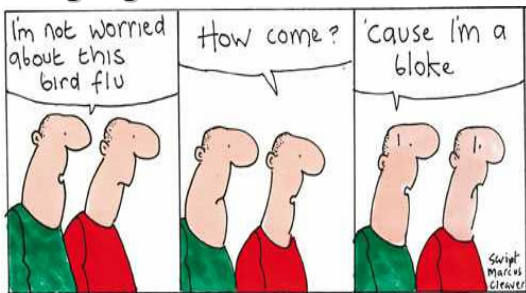
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## Language & Definitions.....



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## WA Health definition of CG

A systematic and integrated approach to assurance & review of clinical responsibility & accountability that improves quality & safety resulting in optimal patient outcomes

*Clinical Governance, Framework of Assurance, WA Department of Health (2001)*

Building a system to assure optimal health outcomes

*WA Clinical Governance Framework, WA Department of Health (2005)*

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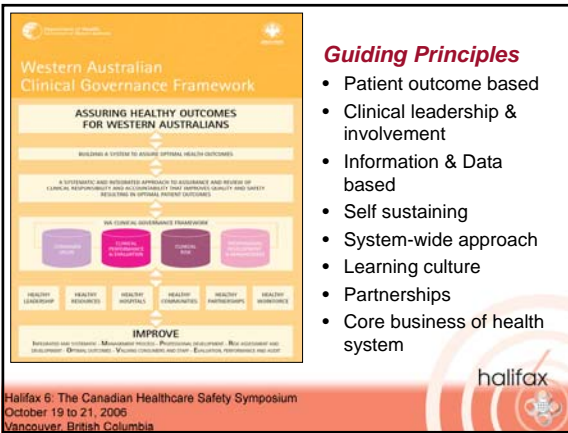
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### Guiding Principles

- Patient outcome based
- Clinical leadership & involvement
- Information & Data based
- Self sustaining
- System-wide approach
- Learning culture
- Partnerships
- Core business of health system

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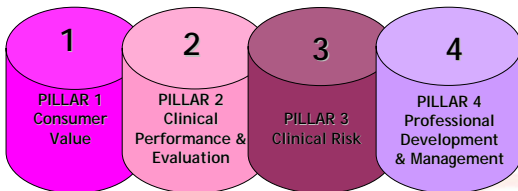
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## WA Clinical Governance Pillars



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## WA Safety Management Program using the CG Framework



What did we do first?  
Order of deployment...  
Pillar 3,2,4 and 1

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### Pillar 3: Clinical Risk Management



- Incident Reporting & Management (since 2000). Use AIMS.
- Sentinel Event Reporting & Management (2003) mandatory
- Clinical Incident Investigation & Human Factors (RCA) Training (2000)
- Qualified privilege & Registration of QI Committees under WA *Health Service QI Act 1994 (amended)*
- CE & AHS Risk Management protocols/OC; now required, not optional

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### Pillar 2: Clinical Performance & Eval'n



- Specialist clinical audit programs – all & ongoing
- Surgical Mortality Audit – WAASM
  - DVT prophylaxis
  - Fluid balance
- Coronial Liaison & Reportable deaths
- Mortality Review – mandated 06-07
- Medication Safety focus
  - Implementation of National Inpatient Medication Chart (NIMC)
  - Low hanging fruit – KCI, Vincristine
- Falls program
- Health Care Acq Infections (HISWA)

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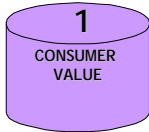
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## Pillar 1: Consumer Value



- Consumer participation framework
- Consumer training in advocacy
- Informed Consent
- Complaint Management
- Public Hospitals Patient Charter
- Open Disclosure (saying sorry)
- ACSQHC 'Ten Tips' resources
- 'Patient First' for health consumers

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## Pillar 4: Professional Development & Management



- Credentialing & clinical privileges all HCW
- Scope of clinical practice
- Accreditation services/hospitals
- Patient Safety Education
- Simulation & Skills based training
- Performance Management

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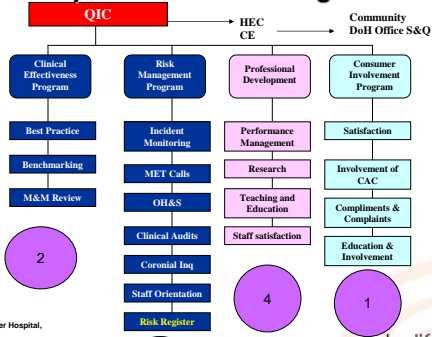
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## WA Hospital - SCGH CG Program



Sir Charles Gairdner Hospital,  
Western Australia

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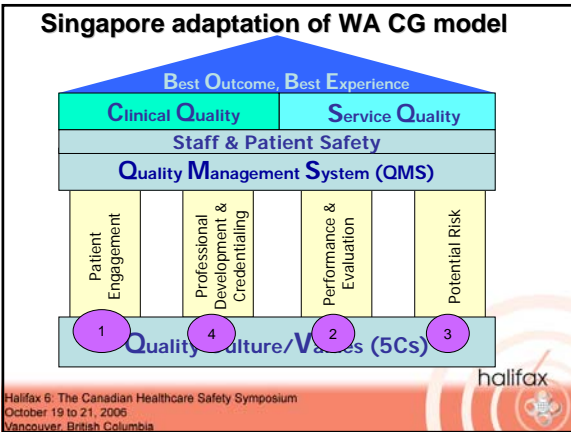
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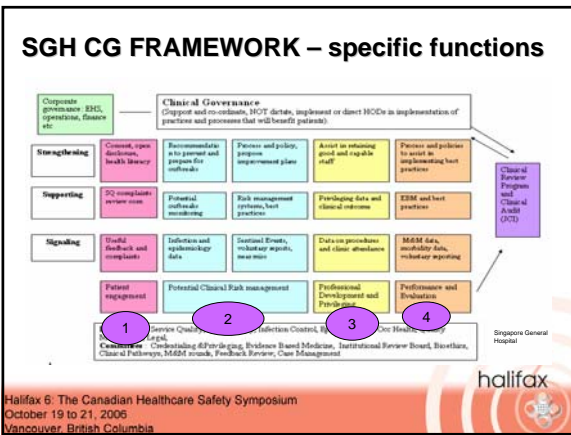
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- ### WA Health contracts for patient safety in 06-07:
1. Clinical Governance Program
    - 4 pillars
    - Not optional any more
  2. Clinical Governance Standards
    - 8 standards (voluntary in 2005)
  3. Clinical Practice Improvement program
    - 7 required clinical priorities
    - Evidence in literature
    - Local data supports CPI
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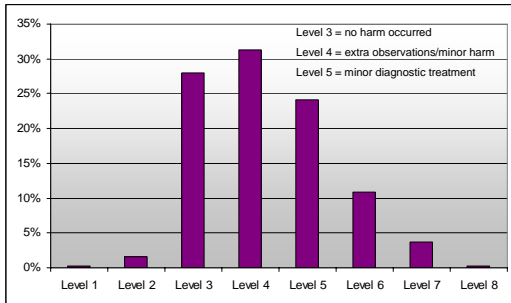
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### WA AIMS: Total Incidents by Outcome



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### Performance Monitoring examples

- Reporting of KPIs to DG monthly
  - Sentinel events
  - Serious clinical incidents (AIMS Level 7 & 8)
  - Nosocomial infections (MRSA)
  - Credentialing (doctors/nursing)
- Reporting of additional KPIs to the DG on a quarterly basis:
  - All monthly KPIs &
  - Clinical Governance Pillars x 4

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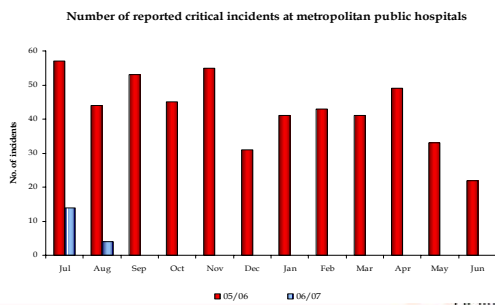
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### Clinical Incidents (AIMS 7 & 8) Monthly KPI's



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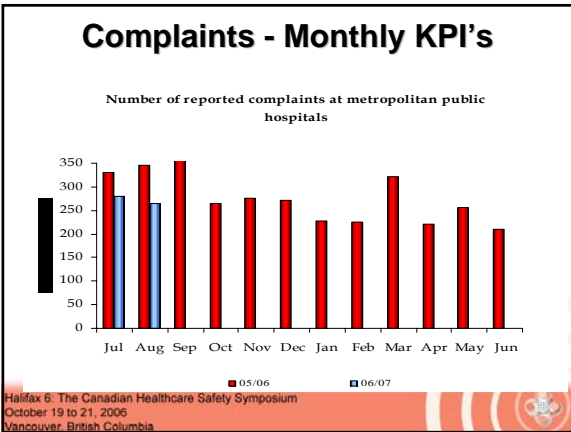
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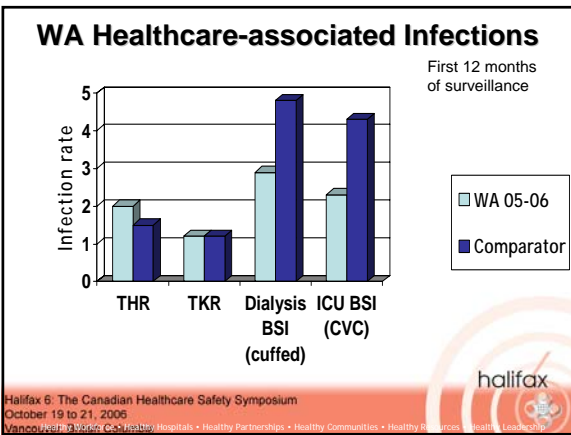
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# IMPROVEMENT

## Did we make a difference to Patient Safety?

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## WA Health - Improvements

- CG-Safety Management Program in place
- Used and trusted by clinicians & managers
- Alignment of safety objectives & plans
- Some system data shows improvement
- Documented improvement in surgical pt care
- Less media hysteria
- Coalitions continue, strengthen, renew

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## WA Health - Improvements

- Safety now in JMO PGY1 & 2 curriculum
- Reduced Sentinel Events – 2 categories
- Reduced DVT in WA surgical patients
- Reduced medico-legal claims (\$1M)
- Data that AIMS is trusted & used
- Evidence that safer culture is emerging (trust/learning/safety aware)
- Reduction in reported adverse events
  - Falls
  - Medication error
  - ?pressure ulcer

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## Improvement in care of WA surgical patients

- Pts where HDU/ICU care *not* used:
  - Reduced from 16% (02) to 4% (05)
- Increase in proportion of surgical patients receiving DVT prophylaxis:
  - From 61% (02) to 69% (05)
- Appropriate DVT prophylaxis (acc to peer reviewers) increased:
  - From 89% (02) to 94% (05)

Source: WAASM report 2006: data from 236 surgeons and audit of 2723 deaths under the care of a surgeon

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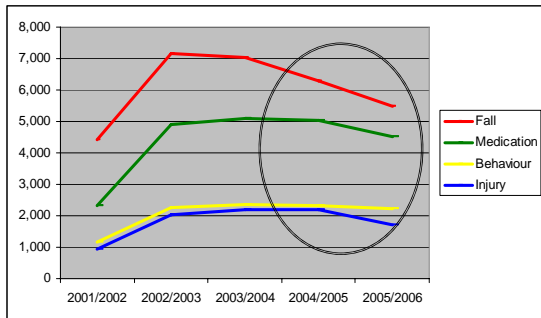
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### WA Clinical Incident data – 2001-2006



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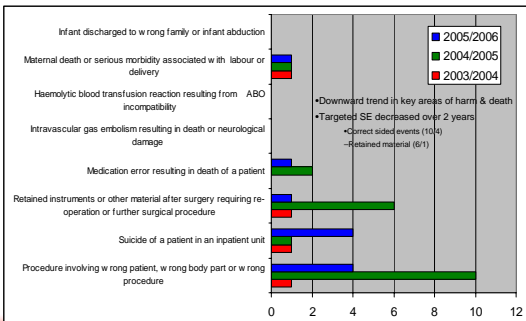
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### Improvement in SE's



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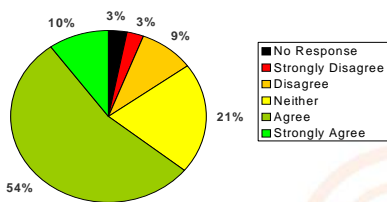
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### Learning from mistakes

Learning from mistakes in this unit has improved work practices (All)



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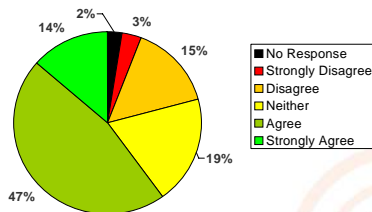
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## Improvement in culture

Open discussion of incidents is seen as important in my unit (All)



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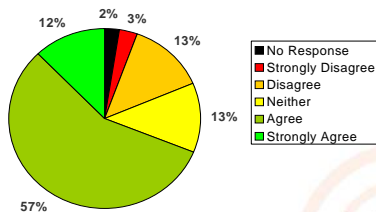
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## Improvement in culture

I am encouraged to speak up about incidents/ adverse events (All)



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## Some Lessons WA learned

- Focus on patient safety (worry about quality)
- Incident reporting & management program essential
- RCA worked for us (teams). Trojan horse for HF, systems thinking & culture change
- Define a CG/SMS program. Get it to the CEO/DG
- Manage change at all levels concurrently – align plans
- Use indemnity levers/contract requirements
- Be available & accessible to all clinicians (when they are ready). Recruit visible clinical leaders
- Give doctors & nurses & allied health back their own data
- It's all about communication and teams

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## Next steps for us....

- Improve connectivity with community & primary care
- Pay for performance/financial incentives; Casemix
- Improve Data Signals to identify areas of improvement
  - Specific safety data/admin data
- Improve data feedback to all clinicians
- Give all data back
- Audit, audit, audit, audit.....give results back (trust)
- We are awash with data – use it better (Bristol)
- Improve transparency to local community even more
- Recruit patients & consumers to manage own safety
- Pay consumers/patients
- Contract with consumers

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## Awash with data....

“Concerns were expressed and data were collected and discussed, though not all data were discussed by all those involved. Indeed, it could be said that <Bristol>\* was awash with data but was, at the same time, singularly uninformed.”

– Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995 Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984–1995, Page 176

\* < > : insert name of your health service/hospital

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## Where to now?

- Strengthening, deepening, widening of system reform to support CG/Safety Management Systems for WA patients
- Maintain the energy for change – renewal
- CPI, CG contract & performance monitoring
- Use and feed back data better
- Support the next generation of leaders (students)
- Evaluate last 5 years; prepare for next 5
- *Patient First Program* – patients as partners in safety. Launch November 2006

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