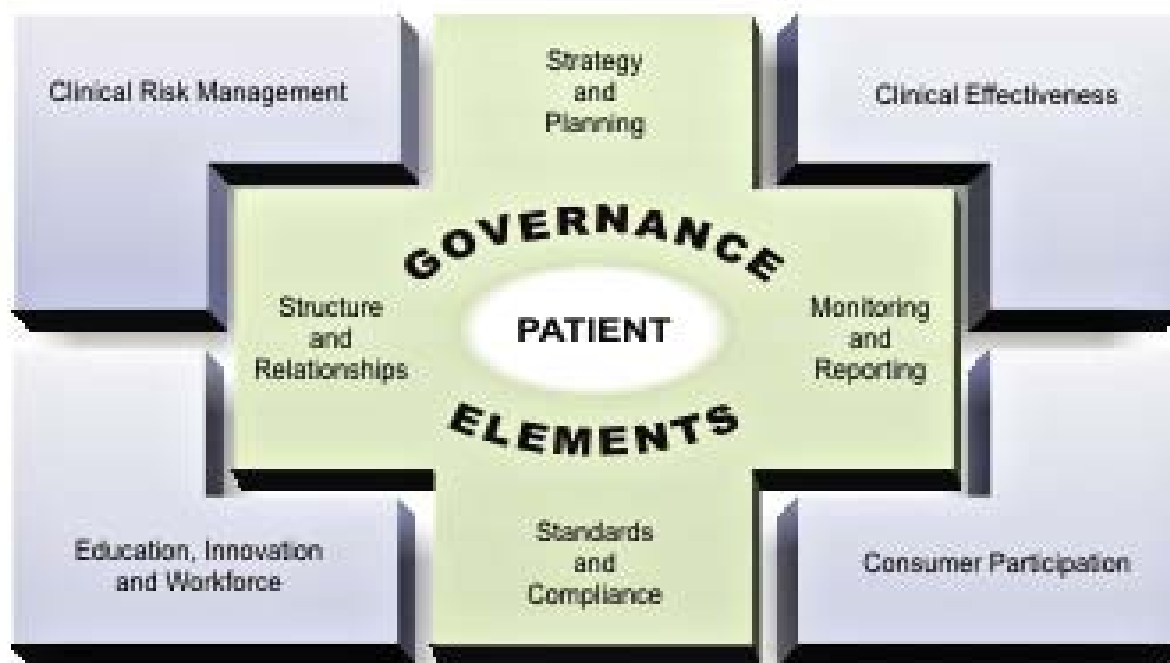


Redesigning hospital units to optimise outcomes using a clinical governance approach

Margaret Way
Director, Clinical Governance

Clinical Governance Framework



Clinical Governance Unit Purpose

The role of the Clinical Governance Unit is to support the delivery of safe and effective care across Alfred Health.



Clinical Governance
building safer systems

The Drivers for TeamStepps and SIBR

Clinical Governance – Arenas of Action

GOVERNANCE ELEMENTS		Structure & Relationships	Strategy & Planning	Standards & Compliance	Monitoring & Reporting
ACTION AREAS	RISK MANAGEMENT	Integrated Risk Management	Risk Register	Incident Reporting and Response	Incident Analysis / RCA
	CLINICAL RISK MANAGEMENT	Responding to Known Clinical Risks	Adverse Event Screening	Responding to Emerging Clinical Risks	Open Disclosure
	CLINICAL EFFECTIVENESS	Clinical Audit	Clinical Practice Improvement	Clinical policies	Research and Development
	EDUCATION, WORKFORCE & INNOVATION	Safety and Quality Culture	Workforce and Practice Innovation	Staff Education and Training	Competency of Staff
	CONSUMER & COMMUNITY PARTICIPATION	Consumer Participation	Patient Feedback	Patient Information	Consumer and Community Reporting



National Patient Safety Education Framework



Bookmarks

- FRONT COVER
- The Australian Council for Safety and Quality in Health Care
- Foreword
- Project Team and Project Contributors
- CONTENTS
- A Guide to the Framework
- Patient Narratives
- Principles underpinning the Framework
- 1. COMMUNICATING EFFECTIVELY
- 2. IDENTIFYING, PREVENTING & MANAGING ADVERSE EVENTS & NEAR MISSES
- 3. USING EVIDENCE & INFORMATION
- 4 WORKING SAFELY
- 5 BEING ETHICAL
- 6 CONTINUING LEARNING
- 7 SPECIFIC ISSUES
- GLOSSARY
- BACK COVER

Components of the safety and quality education framework

1. Communicating effectively

- 1.1 Involving patients and carers as partners in health care
- 1.2 Communicating risk
- 1.3 Communicating honestly with patients after an adverse event (open disclosure)
- 1.4 Obtaining consent
- 1.5 Being culturally respectful and knowledgeable

2. Identifying, preventing and managing adverse events and near misses.

- 2.1 Recognising, reporting and managing adverse events and near misses
- 2.2 Managing risk
- 2.3 Understanding health care adverse events and near misses
- 2.4 Managing complaints

3. Using evidence and information

- 3.1 Employing best available evidence-based practice
- 3.2 Using information technology to enhance safety

4. Working safely

- 4.1 Being a team player and showing leadership
- 4.2 Understanding human factors
- 4.3 Understanding complex organisations
- 4.4 Providing continuity of care
- 4.5 Managing fatigue and stress

5. Being ethical

- 5.1 Maintaining fitness to work or practice
- 5.2 Professional and ethical behaviour

6. Continuing learning

- 6.1 Being a workplace learner
- 6.2 Being a workplace teacher

7. Specific issues

- 7.1 Preventing wrong site, wrong procedure and wrong patient treatment
- 7.2 Medicating safely

In October 2008 Alfred Health undertook an organisation wide Patient Safety Culture Survey



INSTRUCTIONS

This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10 to 15 minutes to complete.

- An "event" is defined as any type of error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.
- "Patient safety" is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery.

SECTION A: Your Work Area/Unit

In this survey, think of your "unit" as the work area, department, or clinical area of the hospital where you spend most of your work time or provide most of your clinical services.

What is your primary work area or unit in this hospital? Mark ONE answer by filling in the circle.

- a. Many different hospital units/No specific unit
- b. Medicine (non-surgical) g. Intensive care unit (any type) i. Radiology
- c. Surgery h. Psychiatry/mental health m. Anesthesiology
- d. Obstetrics j. Rehabilitation n. Other, please specify:
- e. Pediatrics k. Pharmacy
- f. Emergency department l. Laboratory

Please indicate your agreement or disagreement with the following statements about your work area/unit. Mark your answer by filling in the circle.

Think about your hospital work area/unit...	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. People support one another in this unit	1	2	3	4	5
2. We have enough staff to handle the workload.....	1	2	3	4	5
3. When a lot of work needs to be done quickly, we work together as a team to get the work done.....	1	2	3	4	5
4. In this unit, people treat each other with respect	1	2	3	4	5
5. Staff in this unit work longer hours than is best for patient care ...	1	2	3	4	5
6. We are actively doing things to improve patient safety.....	1	2	3	4	5
7. We use more agency/temporary staff than is best for patient care.....	1	2	3	4	5
8. Staff feel like their mistakes are held against them	1	2	3	4	5
9. Mistakes have led to positive changes here	1	2	3	4	5
10. It is just by chance that more serious mistakes don't happen around here.....	1	2	3	4	5
11. When one area in this unit gets really busy, others help out.....	1	2	3	4	5
12. When an event is reported, it feels like the person is being written up, not the problem.....	1	2	3	4	5

Patient Safety Culture dimensions

Unit- level aspects of safety culture

- Supervisor or manager expectations and actions promoting safety
- Organisational learning-continuous improvement
- Teamwork within units
- Communication openness
- Feedback and communication about error
- Non punitive response to error

Staffing

- Hospital-level aspects of safety culture:
- Hospital management support for patient safety
- Teamwork across hospital units

Hospital handovers and transition

- Outcome indicators
- Overall perceptions of safety

Frequency of event reporting

Patient safety grade

- > Number of events reported

Highest scoring composites were 'teamwork within units/departments' (74.4% positive response) and 'manager expectations and actions promoting patient safety' (70.4% positive response).

The lowest scoring composites were 'staffing' (35.7% positive response) and 'handovers and transitions' (27% positive response).

Safety and Quality Education – Human Factors



Centre of
Research Excellence
in Patient Safety

HUMAN FACTORS TRAINING OPTIONS FOR ALFRED HEALTH

A joint project with Alfred Health Clinical Governance Unit and Centre of Research Excellence in Patient Safety.

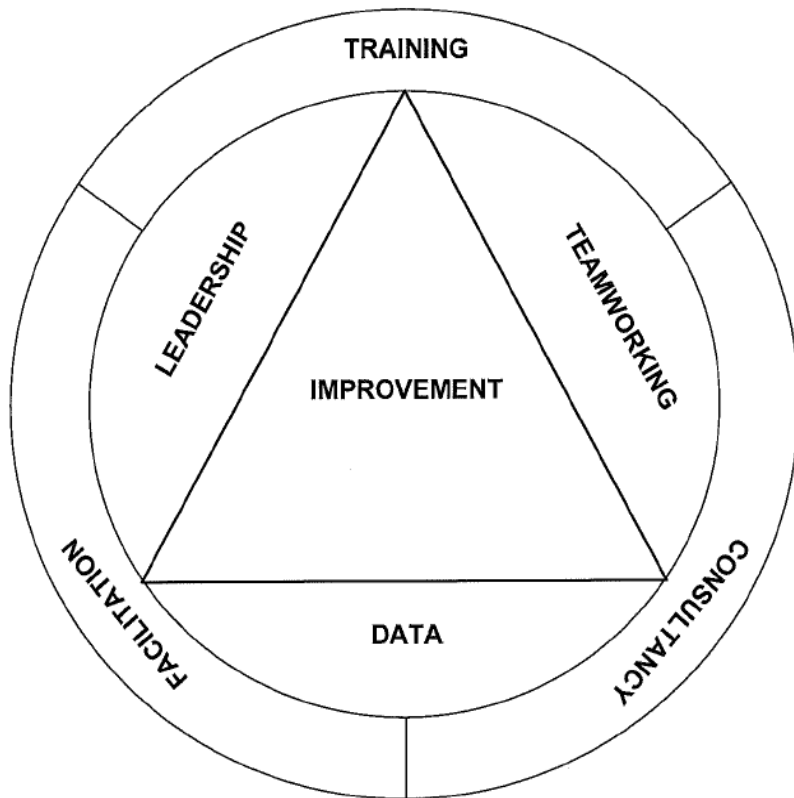
June 2009

Critiquing Criteria	TeamSTEPPS	
5.1 Core NTS Elements	TeamSTEPPS consists of only four of the core non-technical skills elements, however they were chosen as the four most relevant to healthcare professionals. These include: Leadership, Communication, Situation Monitoring and Mutual Support.	√
5.2 Scheduling and time constraints	This model has different course times. All staff that has direct clinical contact and for all other team members that do not have direct clinical contact but play a supporting role in patient care. This model also promotes yearly refreshers.	√
5.3 Adaptability to multiple layers of staff	This course is designed to be delivered to multiple layers of staff, including non clinical staff.	√
5.4 Evaluation of Training	This course has a number of published articles evaluating its effectiveness (refer to section 3.2.1.6).	√
5.5 Financial Feasibility	Would require a course facilitator/ coordinator to prepare and deliver the training. There are no financial costs involved in purchasing this model and all lectures, power point presentations and activities are provided in the package.	√
5.6 Adaptation to Australian Context	.This model was designed in the United States but has been used successfully within the Australian (SA)	√
5.7 Adaptation or use in healthcare	Was designed specifically for healthcare	√

Capacity Building – using a clinical governance approach

GOVERNANCE ELEMENTS		Structure & Relationships	Strategy & Planning	Standards & Compliance	Monitoring & Reporting
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My role – adding value to the redesign of hospital units



✓	Pt safety culture survey
✓	Collaborative research on team training (CREPS) - TeamSteps
✓	Project proposals – grants and EOIs
✓	Improvement - Facilitation
✓	Research and development – Ethics, abstracts and presentations
✓	Collaboration – VQC, SA Dept of Health, Worthing Hospital, UK, Emory US
✓	Evaluation – data, audits, observations, videos
✓	Project Management
✓	Education and Training
✓	Documentation – manuals / records of actions
✓	Leadership and teamwork – mentoring, steering

The System of Improvement

Evaluation and Resource development

Videos

- Handover
- SIBR Rounds
- Patient Bed Boards



Evaluation and Research and Development

ALFRED HOSPITAL ETHICS COMMITTEE Application for Ethical Review of Low Risk Projects

A. GENERAL INFORMATION	
PROJECT TITLE	Implementation of a structured approach to multidisciplinary ward rounding on an acute medical ward
PRINCIPAL INVESTIGATOR	Name & Title/Position: Assoc Professor Harvey Newnham, Clinical Program Director, Emergency and Acute Medicine
	Ph no(s): 990 30198 Fax 990 30843
	Email: H.Newnham@alfred.org.au
	Department: General Medicine

THE ALFRED
INPATIENT PROGRESS NOTE

ALL ENTRIES MUST BE DATED, SIGNED AND DESIGNATED

Date, Time & Designation: _____

U.R. _____

Signature: _____

Clinic Name: _____

Structured Interdisciplinary Bedside Rounds (SIBR) within General Medicine

PGMA PGMB PGMC PGMR Date: ___/___/___ Time: ___:___ am/pm

Team Members Present:

Primary Nurse: _____ Rounds Manager: _____
 Primary Doctor: _____ Consultant: _____
 Pharmacist: _____ Registrar: _____
 Allied Health Rep: _____ RMO: _____
 Relative Present: No Yes - Relative Name: _____

Working Diagnoses:

Summary of Current Issues:

Daily Goal: _____ Long-term Goal: _____

SIBR Checklist	Reviewed	SIBR Checklist	Reviewed
1. Reassessment status: _____ General Reassessment Plan: Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/>	9. Care Plan present: _____	<input type="checkbox"/>
2. Responsive Observations <input type="checkbox"/>	<input type="checkbox"/>	10. Vital signs <input type="checkbox"/>	<input type="checkbox"/>
3. No Alerts <input type="checkbox"/>	<input type="checkbox"/>	11. Intake / Output <input type="checkbox"/>	<input type="checkbox"/>
4. VTE Prophylaxis <input type="checkbox"/>	<input type="checkbox"/>	12. Cognition <input type="checkbox"/>	<input type="checkbox"/>
5. Medications <input type="checkbox"/>	<input type="checkbox"/>	13. Functional status / ADLs <input type="checkbox"/>	<input type="checkbox"/>
6. Foley Catheter <input type="checkbox"/>	<input type="checkbox"/>	14. FRAX Score completed <input type="checkbox"/>	<input type="checkbox"/>
7. Pressure ulcers / wounds <input type="checkbox"/>	<input type="checkbox"/>	15. BRADEN Score completed <input type="checkbox"/>	<input type="checkbox"/>

Action Plan

Patient / Family Concerns Addressed:

Family meeting needed: Yes No

Referrals: ACAS Inpatient team
 Rehab Outpatients
 Allied Health

Investigations:

Medication changes:

Other follow-up required:

Estimated D/C Date: ___/___/___ Estimated D/C Destination: _____
 Sign (scribed by): _____ Designation: _____

INPATIENT PROGRESS NOTE

SIBR Round Audit

Structured Interdisciplinary Bedside Rounds (SIBR)

1. Was the date of the round noted?
 Yes No

2. Was the time of the round noted?
 Yes No

3. Which team members were identified?

Nurse Pharmacist Allied Health Rounds Consultant Registrar RMO Relative Doctor None
 Team Members

4. Were any relatives present on the round?
 Yes No Not known

5. Were any working diagnoses identified?
 Yes No

6. Were any current issues noted?
 Yes No Goal stated but no timeframe

7. Is there a goal for the day documented?
 Yes No Goal stated but no timeframe

8. Is there a long term goal documented?
 Yes No

It's in our hands!



Clinical Governance
building safer systems

