

Incident Management-systems support

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What we are trying to achieve with Incident Management ?

- Patient safety is the cornerstone of high quality care
- Ensuring patient safety requires more than good intentions, diligence, and vigilance on the part of all healthcare professionals
- True commitment to patient safety requires action, not just statements about its importance
- Building the skills and capacity of staff in identifying and acting on patient safety issues
- Increased awareness of preventable patient harm
- Culture of safety non-punitive environment
- System analysis

Doing Incident Management well requires

1. Skilled & knowledgeable staff
2. A supportive environment
 - Culture
 - Policy, procedures and rules
 - Building Systems
3. Implementation
4. Ongoing improvement
 - Measures of effectiveness

IM involves linking four systems

1. Patient care system
2. Staff support system
3. Improvement system
4. Risk management system

The systems can be in conflict

The challenge is to work together in
the patient's interest

= keep patients safe

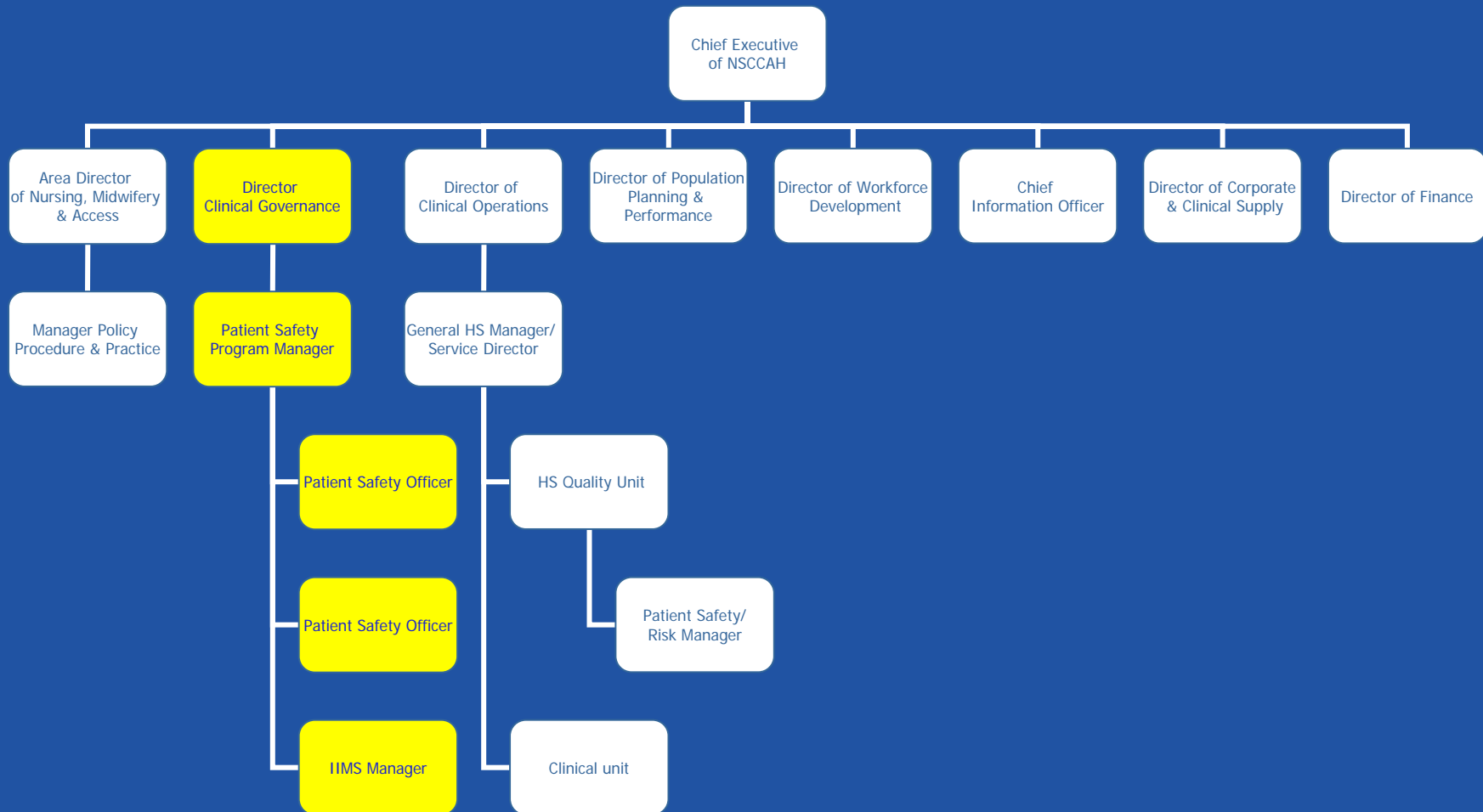
Specific skills

- Clinical - use of expertise in clinical speciality
- Investigative - structured methods applied (RCA, LP, aggregated analysis)
- Staff management - staff support by dept manager/HR
- Risk management - identify what risks need to be managed and acted upon accordingly
- Issues management - target approach specific clinical issues i.e. CPI

Supportive environment

- Leadership
- Interface value systems
 - Clinical
 - Organisation
- “Support”- access to , staff feel comfortable to seek advice
- Policy

AHS operational structure is vital to Patient Safety



Role of the PSP in NSCCAHS

- The Patient Safety Program/ Manager (PSPM)
 - ✓ Oversees the Patient Safety & Clinical Quality Program (IM one element)
 - ✓ Accountable for the system - report on progress to AQIC
 - ✓ Undertakes systems analysis of Incidents- feeds into RM system –Q & S plan
 - ✓ Support for CPI

- PSPM works with
 - ✓ Meets regularly with DCG/CE- Review SAC1/2 RIB's
 - ✓ Regular meetings with Clinical Operations Committee (General Managers/ Service Directors & Area Director of Nursing)
 - ✓ Support Health Services Quality Units (HS) (IIMS, RCA)
 - ✓ Clinical Networks

Implementation

- Keeping things positive
- Local ownership of incidents & RCA's – support by CGU
- Improvement focus
 - analysis of incidents, by incident type & system error
- Recurrent incident types- specific program development- standardisation
- May vary according to facility size and complexity

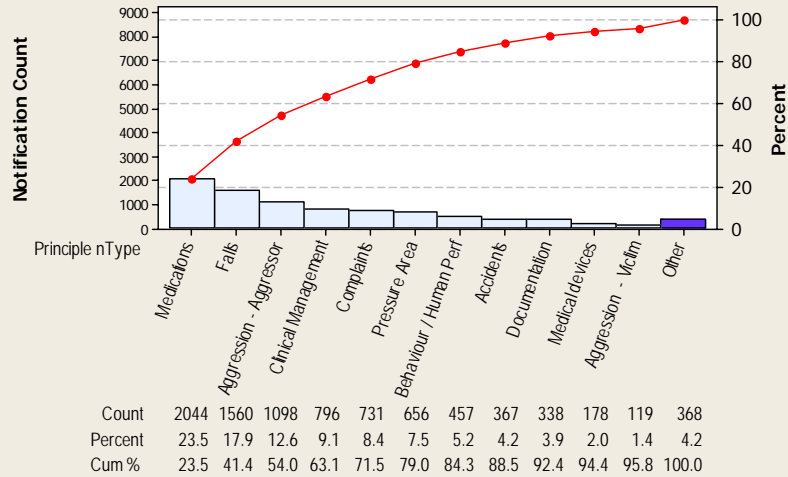
Our approach for serious (SAC 1) incidents

Urgent (<6 hours) conference: senior mgt + clinicians

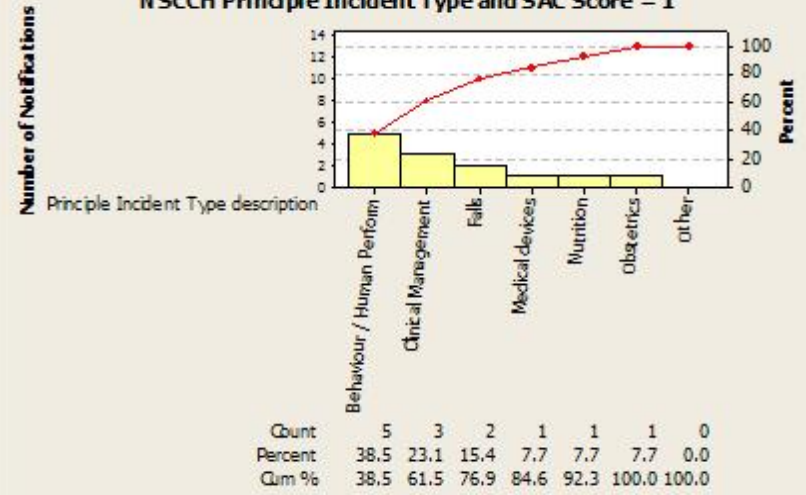
- What do we know? The facts so far
- What don't we know? Who will find out?
- The patient
 - Immediate needs
 - Care responsibility
 - Contact
- Staff support
- Immediate corrective action
- RCA team selection
- Commence investigation

Incident Reporting

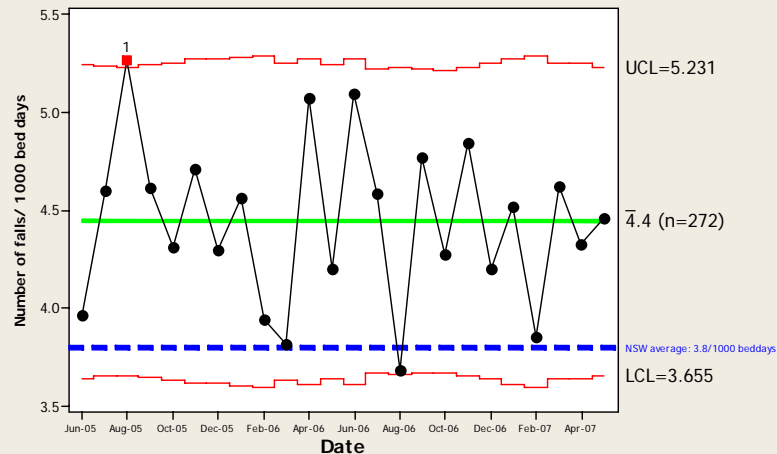
NSCCH Principle Incident Type Jan-May 2007



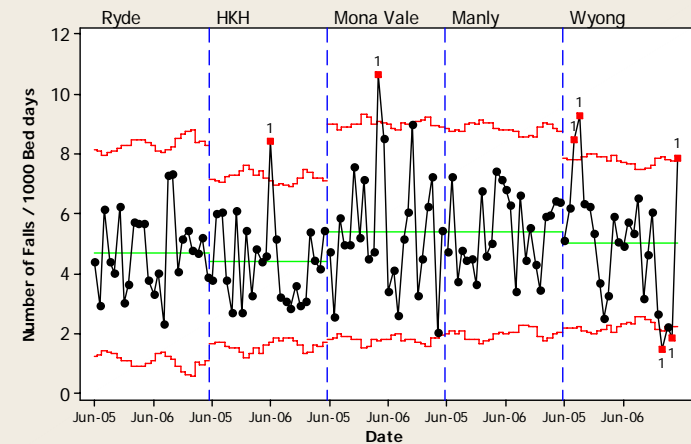
N SCCH Principle Incident Type and SAC Score = 1



NSCCHS: All reported falls (A1, B1, D2, Mental Health) per 1000 Bed days
June 2005 - May 2007



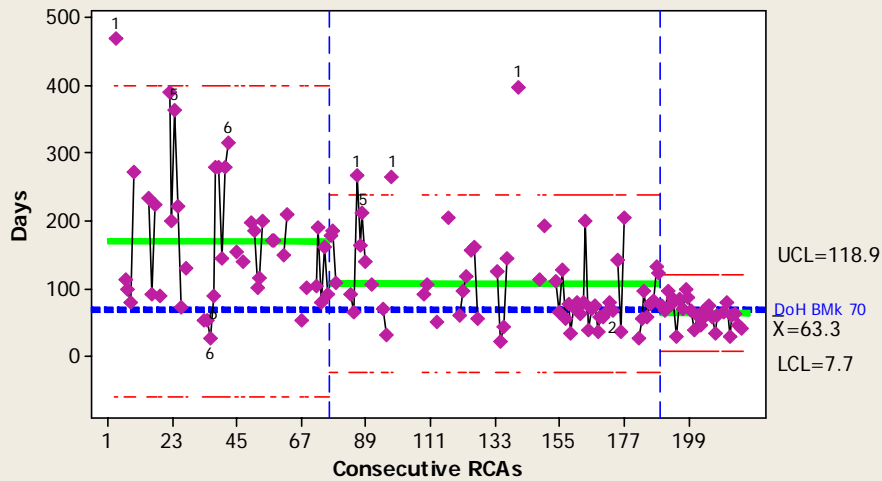
Falls per Thousand Beddays - B1 facilities
June 2005 - May 2007



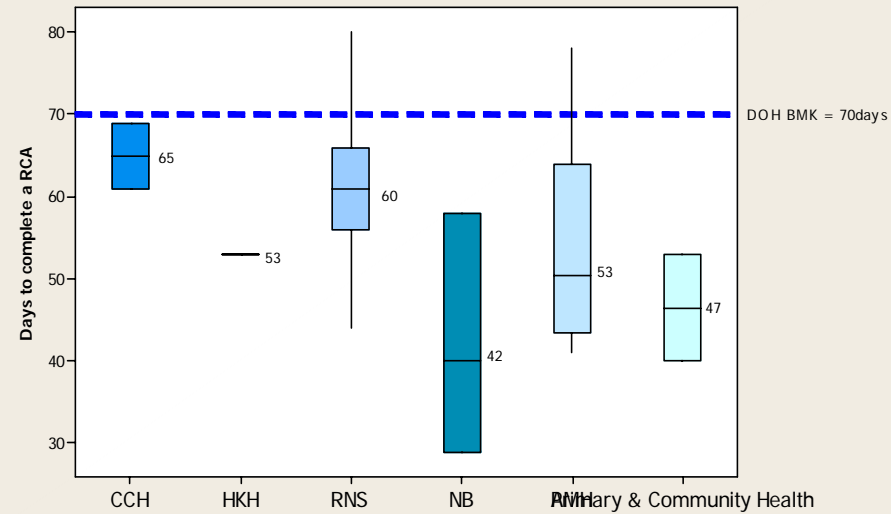
System performance

Turnaround Time for RCA completion in Days

Days from Notification of RIB to DOH and submission of RCA reports to DOH
July 2002- December 2006



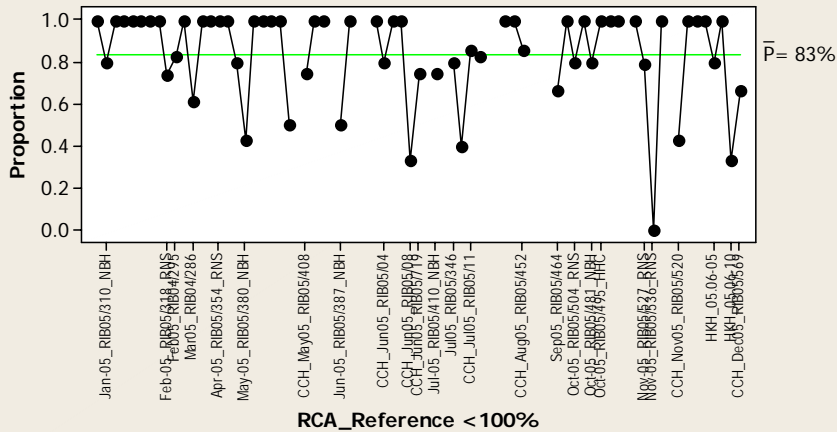
KPI 1: Time between RIB submission to NSWhealth to RCA report submission to NSWhealth Health Services October 2006 to May 2007



Implementation of recommendations

NSCCH - Implementation of RCA Recommendations

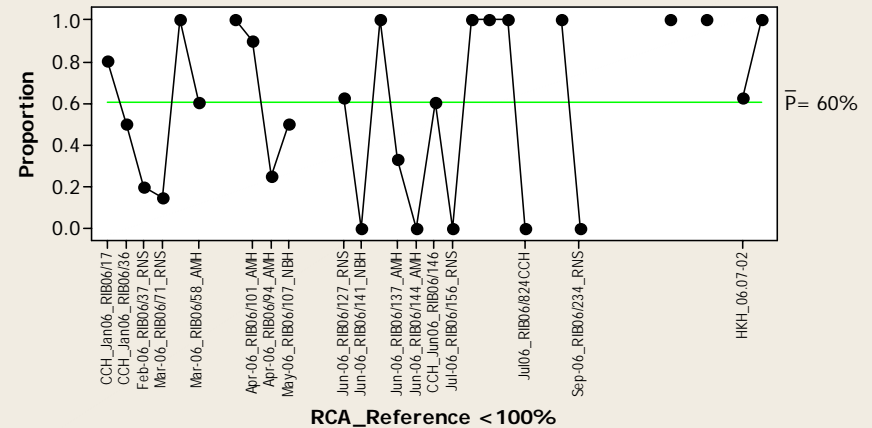
Proportion of RCA Recommendations Implemented by December 2006 for Critical Incidents Notified in 2005



27 critical incidents notified in 2005 still have recommendations outstanding.

NSCCH - Implementation of RCA Recommendations

Proportion of RCA Recommendations Implemented by December 2006 for Critical Incidents Notified in 2006



17 critical incidents notified in 2006 still have recommendations outstanding.

System analysis of RCA's findings

- Root Cause Analysis (RCA) causal statements are typically highly specific to the incident, - quality is important!
- By exploring the more general aspects of each incident, improvements with a much wider effect can be identified.
- Also, by mapping every causal statement to a system-level action, risk due to incomplete local action is much reduced.
- 100 RCA reports from between July 2005 and April 2007 were analysed, covering 365 separate causal statements, identifying 388 system issues looking at operational and strategic issues.

Meta-Analysis 100 RCA's by Principle Incident Type

No. of RCA's	IIMS PIT
53	Clinical Management
22	Behaviour
12	Falls
6	Medications/IV
2	Pressure Ulcers
5	Other

- Key Systems Analysis
- 70 issues
 - Communication (20)
 - Knowledge/Skills/Competency (13)
 - Policies/ Procedures, Guidelines (10)
 - Work environment & scheduling (11)
 - Equipment (8)
 - Patient Factors (8)

Top 10 The major operational issues

($\geq 5\%$ of causal statements) = 67%

1. Failure to recognise patient clinical care needs
2. No current clinical policies/procedures/guidelines
3. Information sharing across clinical teams
4. Failure to document assessment or management plan
5. Failure to involve patient or family in decision making
6. Information sharing within the clinical team members
7. Patient complexity with multiple co morbidities
8. Inadequate clinical assessment
9. Failure to escalate care
10. Insufficient staff to patient ratio

The major strategic system level issues

(in descending order of frequency)

1. **Communication**: between team, within teams, documentation)
2. **Knowledge, Skills, Competency**: failure to recognise patient clinical care needs, inadequate clinical assessment, inadequate monitoring of patient's condition
3. **Policy, Procedures, Guidelines**: no policies, unaware of policies, policies unclear
4. **Equipment**: unavailability
5. **Environment and work scheduling**: insufficient staff to patient ratio workload and skill mix miss match, Inefficient processes to support clinicians
6. **Patient Factors**: patient complexity

Deteriorating patients

- Failure to recognise patient clinical care needs
- Failure to escalate care
- Inadequate clinical assessment
- Failure to communicate patient clinical risks
- Inadequate monitoring of patient's condition
- Failure to diagnose
- Delay in diagnosis

Communicating/coordinating patient care

- Information sharing across clinical teams
- Failure to document assessment or management plan
- Failure to involve patient or family in decision making
- Information sharing within the clinical team members
- Inadequate information systems
- Clinical handover practices
- Failure to communicate patient clinical risks
- Failure to communicate transfer of care
- Failure to document care given
- Missing documents
- Illegible documentation

Summary of Key Messages

- Takes time to
 - establish the system links at AHS level
 - build skill in both line management & clinical expertise in IM and system analysis
- Needs commitment at all levels
- Needs some \$\$ to undertake improvements
- Its early days