
Getting the process right at institutional level

*Information; Accountability;
Action; Feedback.*

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Some key components of an
organisational approach to
clinical incident management
based on reflections from
Queensland

The only question that matters

What am I going to do differently tomorrow and how motivated am I to do this?

Presentation Outline

- What is the goal?
- Defining what we want folk to do
- Helping them to do it
- Knowing whether it worked
- Making "our" way "their" way...

What is the goal of IM?

Goal of IM

- To prevent patient harm
 - Identify and treat hazards before they lead to patient harm (n=many)
 - Identify and treat harm promptly to minimise impact (n=1)
 - Learn lessons from incidents and take action to reduce risk of recurrence (n=many)

Is there a burning deck?

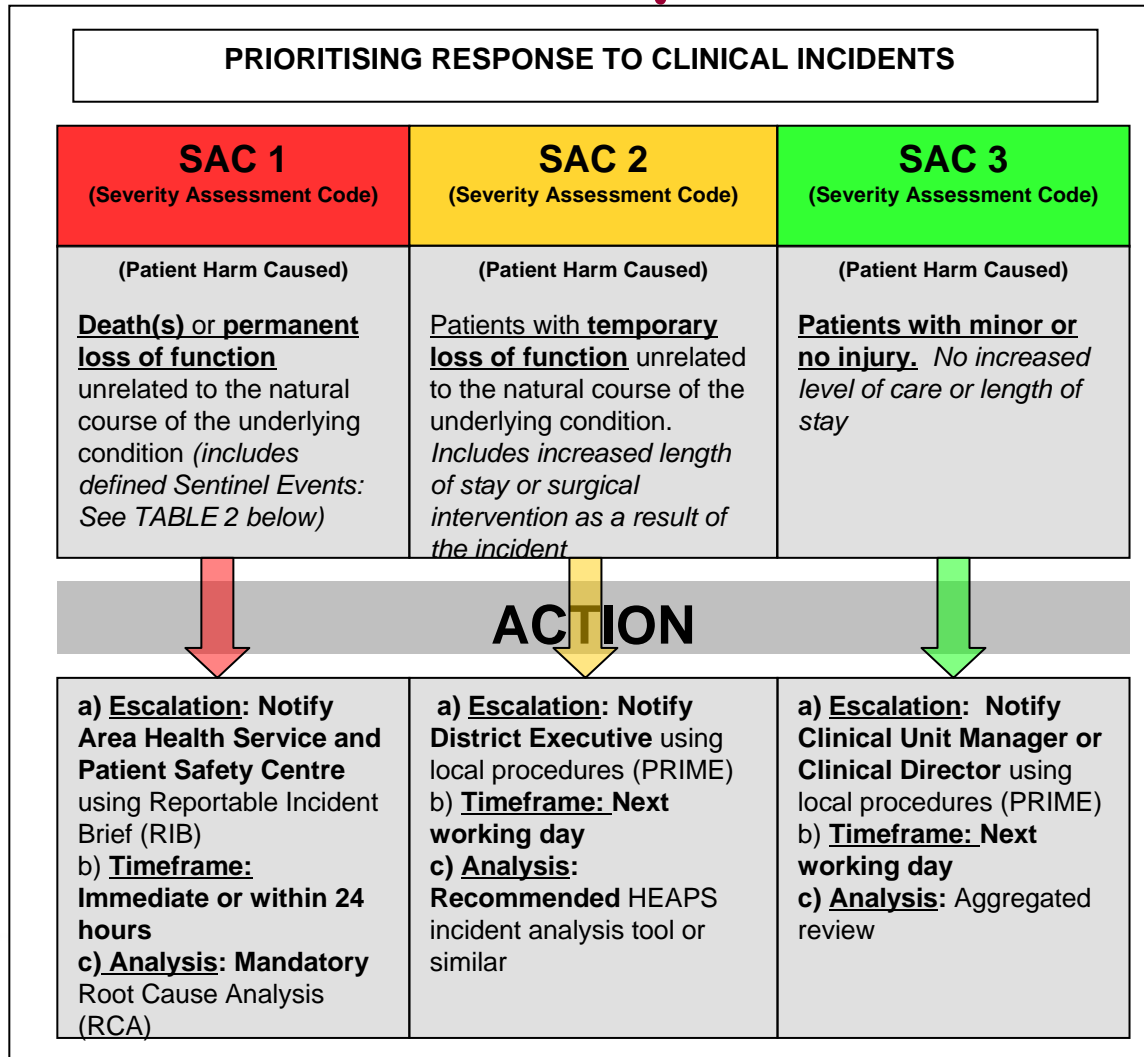
- Our job is to create a sense of urgency
- Present the evidence
- Audit and present findings (very powerful)
- Can't be a prophet in your own land but doesn't just happen!
- A local disaster focuses the minds of many!

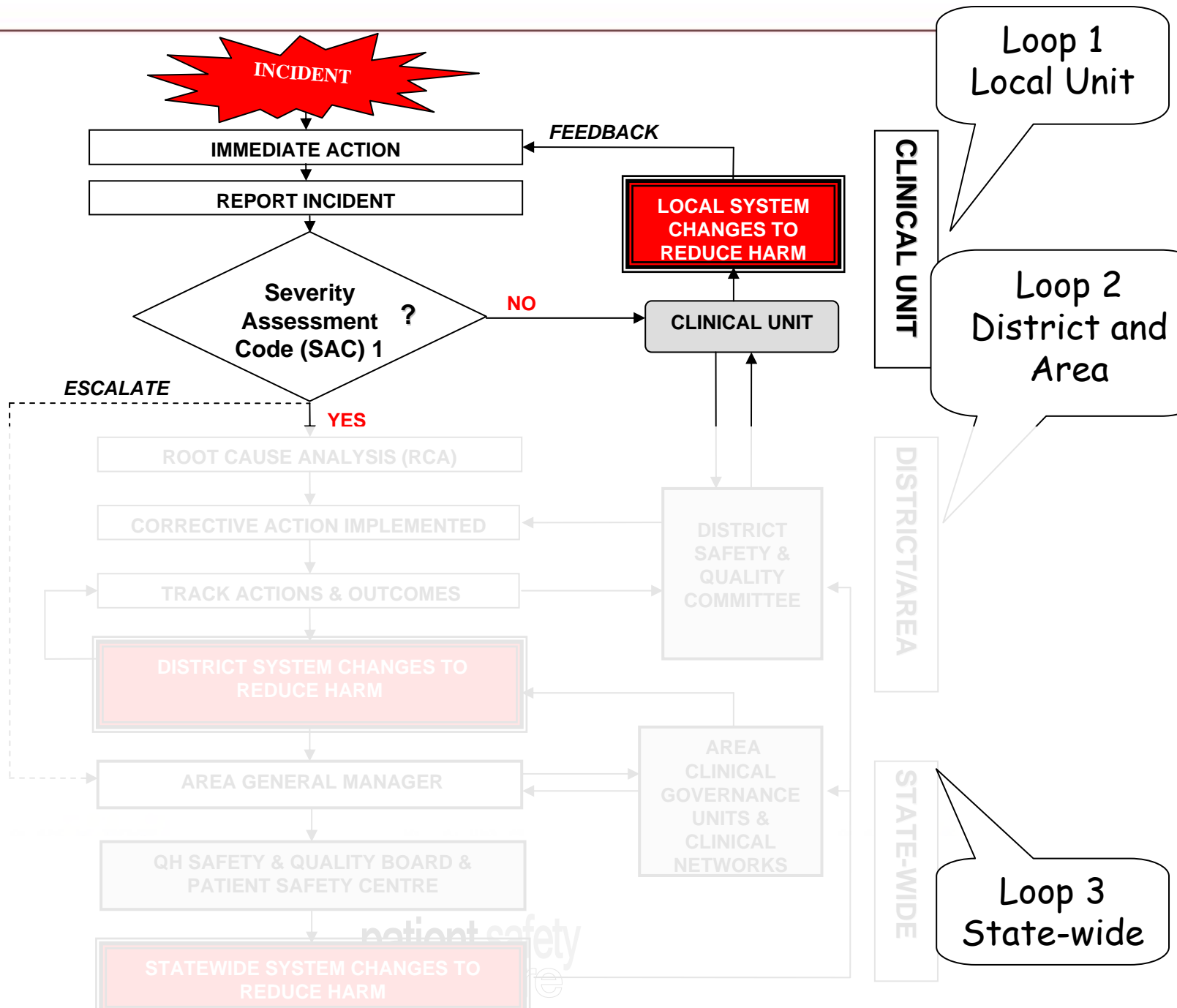
Defining what we want folk to
do?

Developing the "How To"

- Standard vs Guideline
- Principles "just" not "no blame"
- Accountabilities
- Information
- Action required
- Performance - Process vs Outcome
- Who, What, When, How?

Accountability & Action





INCIDENT

IMMEDIATE ACTION

REPORT INCIDENT

Severity Assessment ?
Code (SAC) 1

NO

LOCAL SYSTEM CHANGES TO REDUCE HARM

CLINICAL UNIT

FEEDBACK

CLINICAL UNIT

Loop 1
Local Unit

Loop 2
District and Area

ESCALATE

YES

ROOT CAUSE ANALYSIS (RCA)

CORRECTIVE ACTION IMPLEMENTED

TRACK ACTIONS & OUTCOMES

DISTRICT SYSTEM CHANGES TO REDUCE HARM

DISTRICT SAFETY & QUALITY COMMITTEE

DISTRICT/AREA

Loop 3
State-wide

AREA GENERAL MANAGER

AREA CLINICAL GOVERNANCE UNITS & CLINICAL NETWORKS

STATE-WIDE

QH SAFETY & QUALITY BOARD & PATIENT SAFETY CENTRE

STATEWIDE SYSTEM CHANGES TO REDUCE HARM



"Problem-owners"

- Identified, created, partnered:
 - Falls; Pressure Ulcer; Blood; Medical Equipment; Mental Health; Procedural; Infection; Medication;
 - Flushed out significant governance issues

Helping them to do it....

Support & resource the change

- People - 41 PSOs
- Processes - "How To"
- Tools - Incident analysis, cognitive aids, information system, standard methodology
- Training - HEAPS, RCA, Leadership for PS, Info Sys, Data analysis
- Legislation - RCA
- Decision-support *blame/individ/sys*

The right measures and feedback

What do we measure?

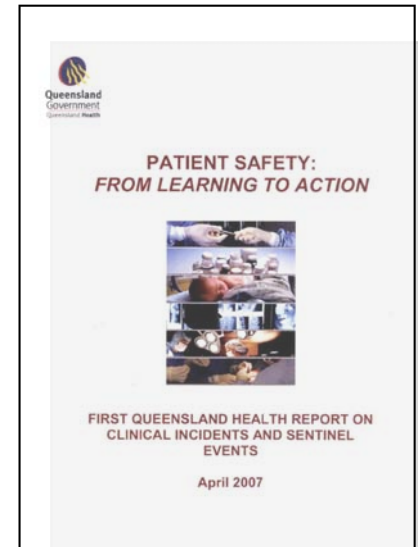
- Are we doing what we said we would do? (process compliance)
 - Timeframes; quality of rca; recommendations etc.
- Is it making a difference? (harm reduction - safety performance)
 - Audits; culture (proxy); casemix (developmental); SPC trigger tools (not yet) **NOT INCIDENT OR SE REPORTING**

Behavioural Change

Is safety a noun or a verb?

Culture change

- HEAPS - over 8000 trained (Minister!)
- Leadership development
- Seat at the table
- Rewarding Quality - P4P
- Feedback of learning - First report
- Measure culture - baseline and after 3 years of reform



Regulating change?

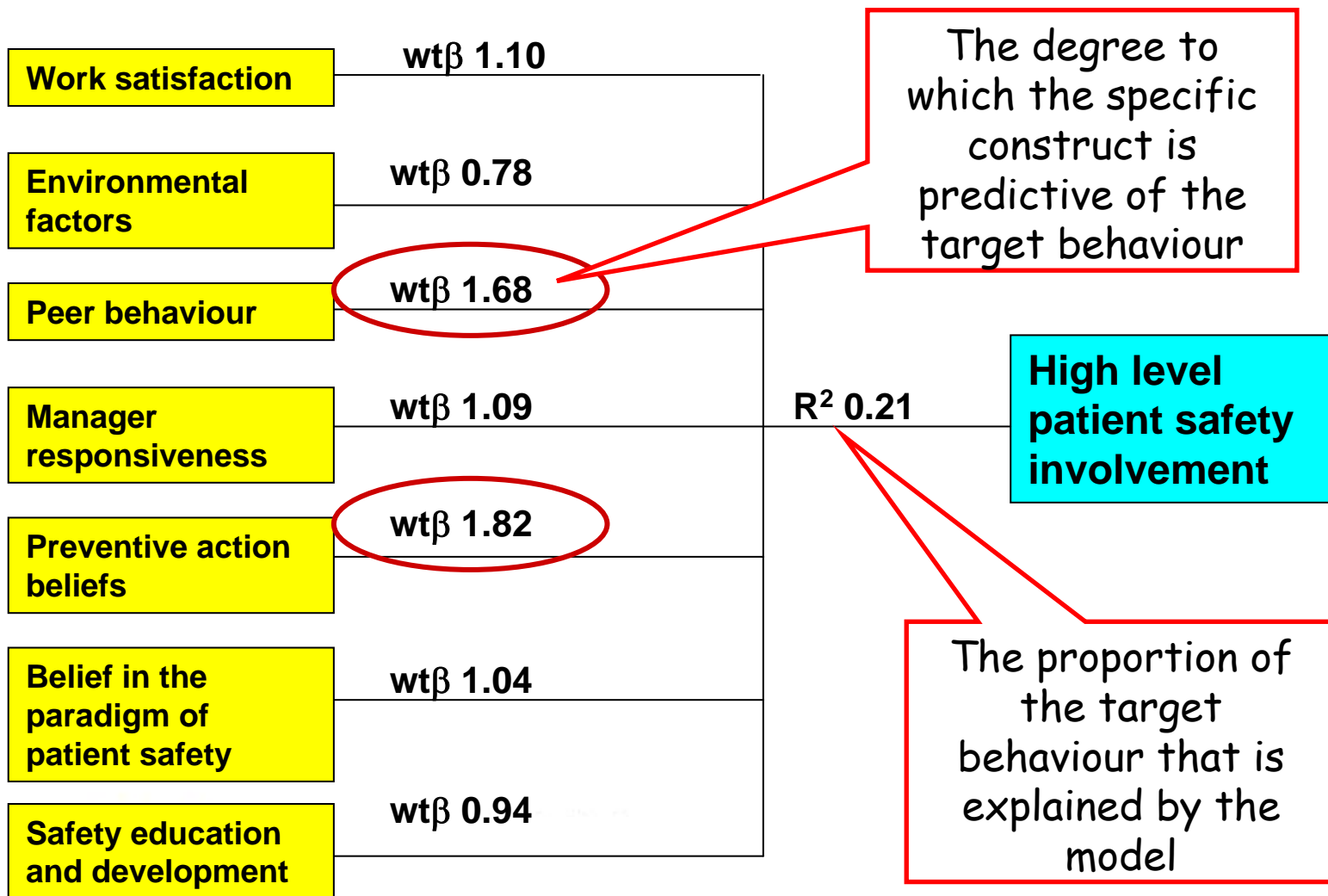
- Now we have the Healthcare Quality and Complaints Commission
- Power to create *mandatory* standards and police these
- Is the stick an essential component of safety improvement?

Biggest Challenges

Odds Ratios of IPSI

Intended Patient Safety Involvement (IPSI)	High Level	Low Level	OR (CI)
Junior Doctors	29.6	70.3	1.00
Senior Doctors	38.1	61.9	1.46 (1.01-2.13)
Allied Health	53.2	46.7	2.71 (1.91-3.73)
Junior Nurses	61.9	38.1	3.86 (2.83-5.26)
Senior Nurses	73.6	26.4	6.01 (4.78-9.16)

Model - all clinical healthcare workers



Key Messages

- Clear goal - Harm versus Error reduction
- Define the Information; Accountabilities and Actions.
- Invest in the people, processes, and tools
- Right Measures and feedback
- Behavioural change program