Dr Peter Kennedy
CREPS – 26 July 2007

"It is all in the narrative"

The NSW Patient Safety and Clinical Quality Program

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The key components of the Program are:

1. Systemic management of incidents and risks
2. A new incident management system
3. Clinical Governance Units (CGU's) in each Area Health Service (AHS)
4. A quality assessment program for all Public Health Organisations (PHOs)
5. Establishment of the Clinical Excellence Commission

2004

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"Too many people thought that incident reporting was the core and primary component of what was needed. These people thought that simply from the act of collecting incidents, solutions and fixes would be generated sui generis and that this would enhance safety."

Charles Billings 1998

"Billings cautions that the real meaning of the incidents is apparent only in the narrative. To make real sense of an incident the story must be interpreted by someone who knows the work and knows the context. Thus, if healthcare incidents reports are to be of real value they should be reviewed by clinicians and, ideally, by people who can tease out the human factors and organisation issues. Analysing a small number of incidents thoroughly is probably more valuable than a cursory overview of a large number of incidents."

Charles Vincent 2004

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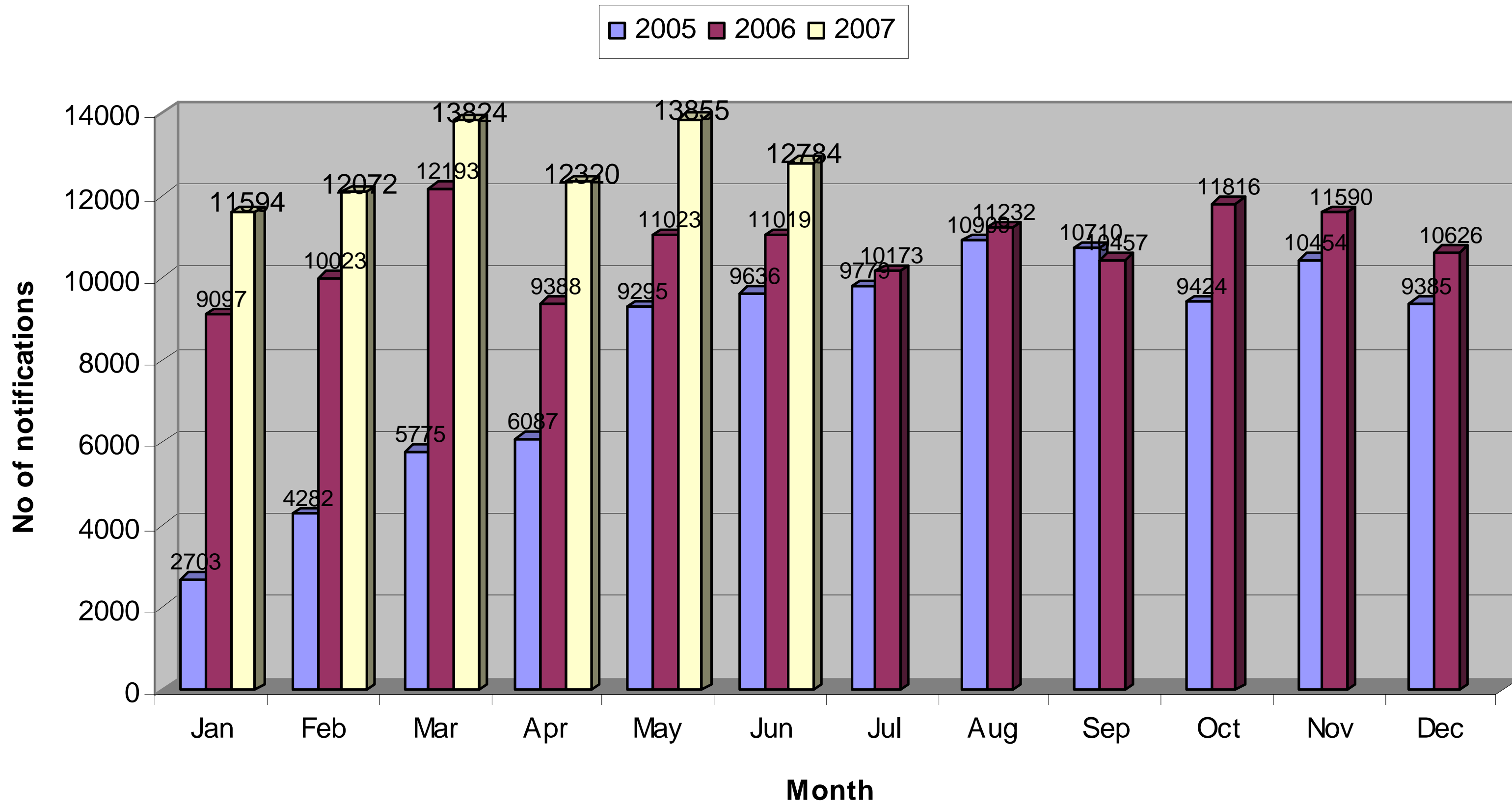
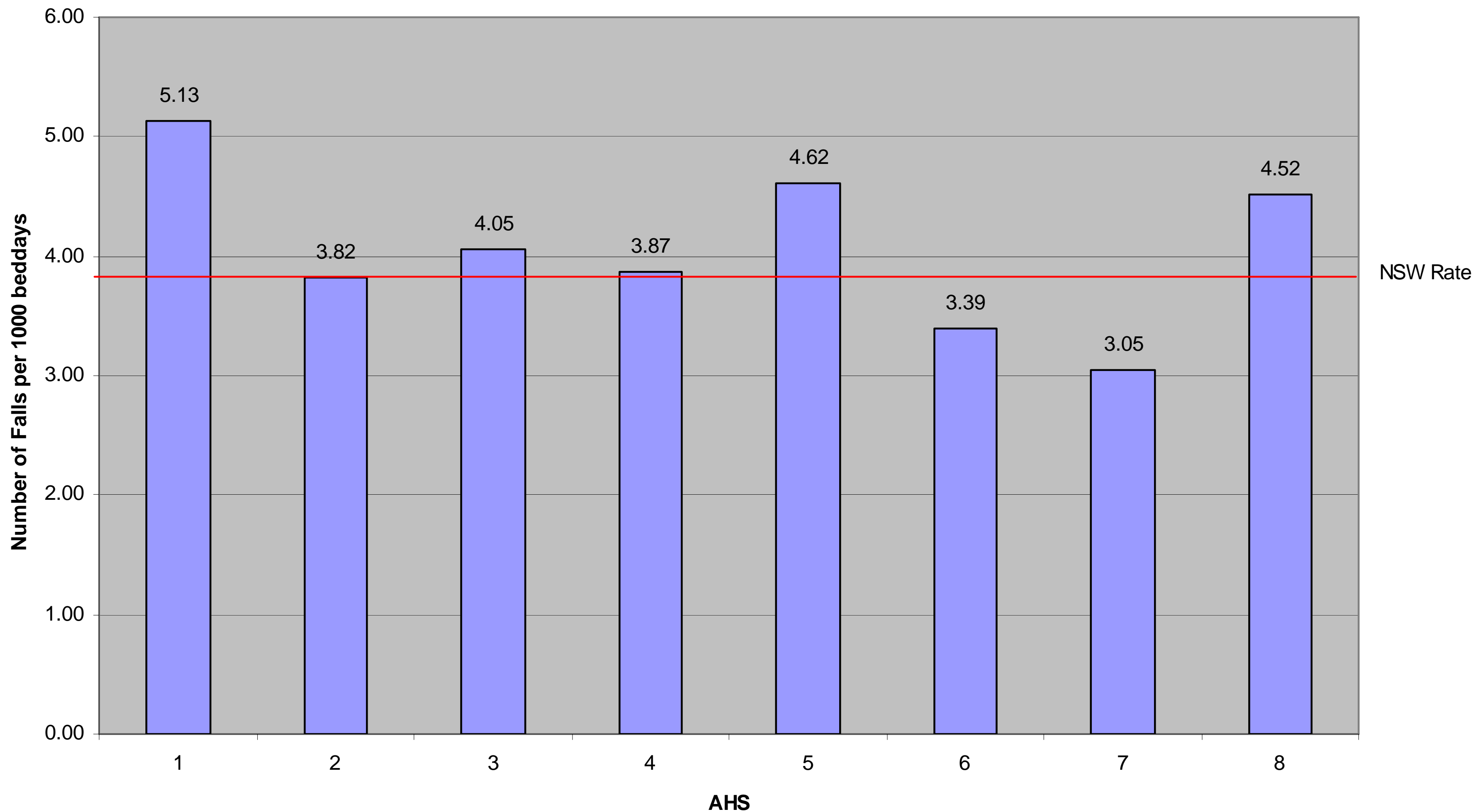
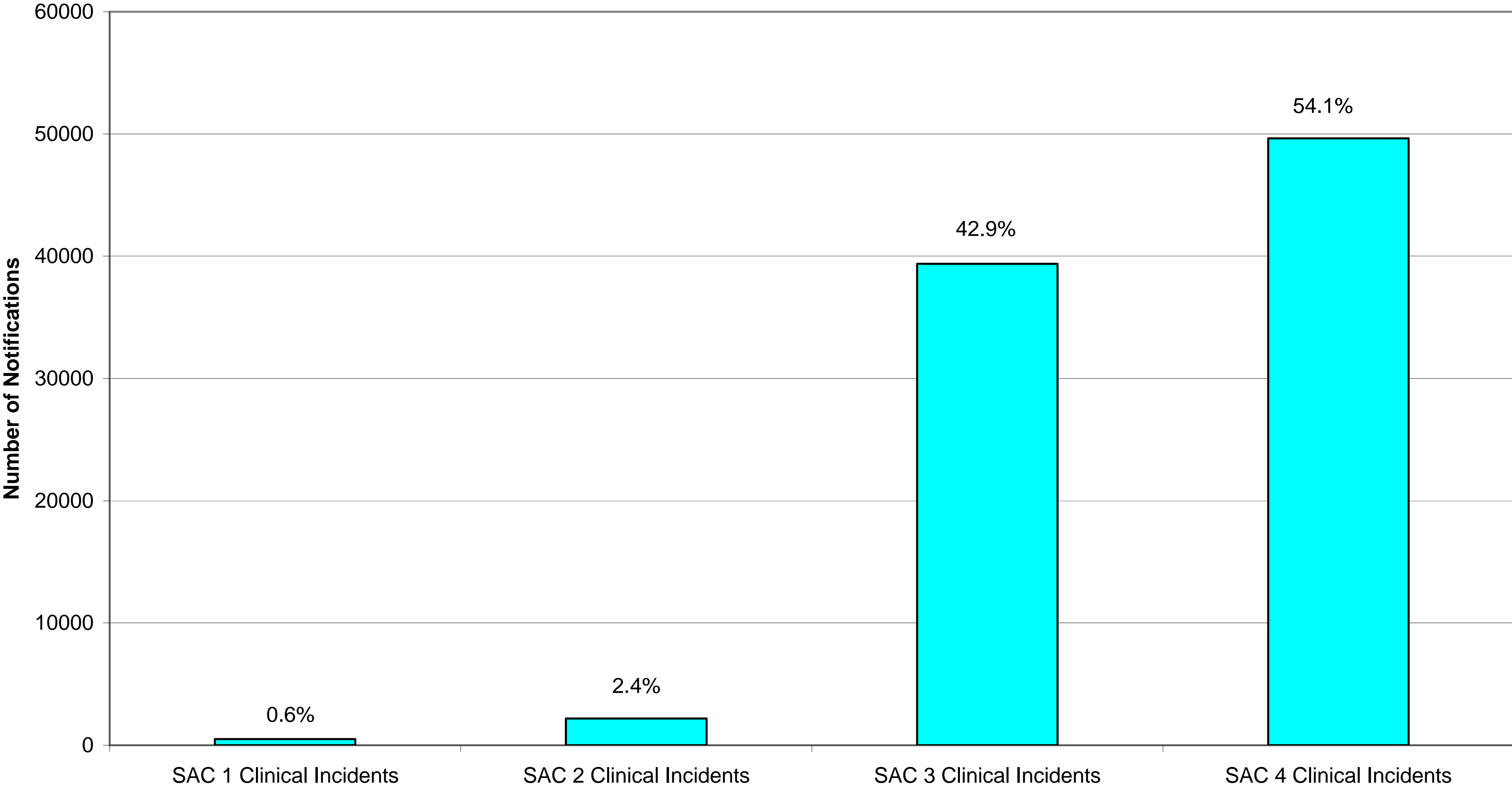
NSW Trend IIMS Notifications 2005/2006/2007



Number of Falls notified in IIMS per 1000 bed days by AHS for the period of Jul 05 – Jun 06




Number of Incidents by SAC- NSW
For the period of Jul 06- Jun 07
Number of Notifications
60000
50000
40000
30000
20000
10000
0
0.6%
2.4%
42.9%
54.1%
SAC 1 Clinical Incidents
SAC 2 Clinical Incidents
SAC 3 Clinical Incidents
SAC 4 Clinical Incidents

	Who Signs off on notification?	Who Investigates?	Who is responsible for implementing recommendations?
SAC4 45.7%	**Local** **Department Manager** Confirms SAC score and start investigation– 5 Days	**Local** **Department Manager** – 28 days	**Local** **Department Manager** If Facility/Service implications
SAC3 50.7%	Completes RIB if likely to evoke external interest		
SAC2 3.7%	**Facility/Service Manager** AREA CE decides whether to send to DOH	**Facility/Service Manager** Coordinates detailed investigation	**Facility/Service Manager** CGU - If Area wide implications
SAC1 0.7%	**Area CE signs off RIB** Submitted to NSW Health	**RCA Team –** nominated by Facility/Service Manager. **If Clinical SAC 1 Privileged RCA – team signed off by Area CE**	**Facility/Service Manager** CGU - If Area wide implications

Incident Management – 7 Steps

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Identification

Feedback

Notification

Analysis and action

Patient Safety

Prioritisation

Classification

Investigation

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(adapted from NHS http://www.npsa.nhs.uk/site/media/documents/500_Final%20Seven%20steps%20intro.pdf)

Step 6 Analysis and Action: Analysis

- "The true purpose of incident analysis is to use the incident as a window onto the system – in essence, looking at current weaknesses and future problems."

  Vincent, C. 2004, Analysis of Clinical incidents: a window on the system not a search for root causes, Quality and Safety in Health Care 13, 242-243

- Analysis of the incident can allow the care team to reflect on safety in their clinical area.

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Step 7 Feedback

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- Feedback has been identified as an essential component of a successful incident management system.
- There needs to be feedback to the patient and / or their family / carer.

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Feedback to Staff and the Clinical Team

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Feedback to staff

- Enhances reflective practice
- Promotes error wisdom
- Assists in sustaining improvement
- Promotes a safety culture

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On-going Education - SSWAHS

- Clinical Incident Management Skills – (4 hrs, 610 staff attended)
- Quality Tools – (4 hrs, 807 staff attended)
- Clinical Indicators – (3 hrs, 229 attended)
- Clinical Practice improvement – 102 attended
- Writing Quality Award Applications – (2 hrs, 199 attended)
- Your role in taking a patient complaint - (2.5 hrs, 136 attended)
- IIMS Clinics (1.5 hrs, 171 staff attended)
- RCA training - (2 day training, 330+ attended)
- Staff Orientation
- Performance Review

Attendance as at June 2007

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How do you Correctly Identify a Patient

In the past there have been errors where the wrong patient has received either the wrong blood, medication, consultation, test or procedure. These errors have occurred because the patient has not been correctly identified.

To ensure you have the right patient and the correct documents relating to that patient, please follow the steps below whenever:

- allocating a wristband identification
- administering medications or blood products
- taking blood samples and other specimens
- providing any other treatments, procedures (including x-rays & scopes) or consultations (outpatients/private consulting rooms).
- collecting / delivering a patient
- handing over a patient to another department eg from ED to Operating Suite/Ward

Steps to correctly identify a patient and their relevant documents

STEP 1 ASK THE PATIENT:

1. What is your name?
2. When were you born? *and where applicable*
3. Why are you here?

STEP 2 MATCH UP THE ANSWERS GIVEN IN STEP 1 WITH ALL RELEVANT DOCUMENTS

Is the name, DOB and procedure (where relevant) stated by the patient in step 1 the same as what is printed on any relevant documents such as the:

- patients wristband identification (ALWAYS check)
- medical record
- clinic / procedure list
- referral/order letter / sheet
- medication sheet
- label on: medications / blood products / contrast / isotope
- previous x-rays / test results

- Before you ask the 3 questions in Step 1 you may wish to tell the patient that you will be asking a few questions to ensure they are correctly identified and that you have all the correct documents. This may reduce any concerns the patient has about having their identity verified so often.
- It is important that you let the patient answer the questions in step 1. Don't presume you know their name & DOB. This is called "Open Ended Questioning" (see below for more information). The first two questions, if answered in an open-ended way, give staff two pieces of information that when combined significantly reduce the risk of patient identification error. The third question is helpful to ensure that the right procedure or process is applied to the patient, and that the patient has an understanding of his/her condition and treatment.
- You need to be very thorough when identifying **NESB and elderly / confused patients.** Many of our miss-identification errors have occurred with NESB / elderly patients who have not understood the questions they have been asked. Interpreters are often needed for NESB patients and should be pre-arranged where possible. Interpreter service phone numbers 95159500 (Eastern Zone) 98286088 (Western Zone).

Open Ended Questioning Open ended questions can be defined as Questions which encourage the respondent to provide their own answers . Closed questions, on the other hand, are ones which encourage an answer such as "yes" or "no". An open ended example would be "Can you please tell me your name?", while an example of a closed question would be "Is your name Jane Smith?" In the busy hospital environment, it is understandable that staff may view closed questions as time saving, but this has the potential to increase the risk of a patient being incorrectly identified. For example, a patient named "Jean Smith" could mistakenly answer "Yes" to the question "Are you Jane Smith?"

Feedback We are always trying to improve what we do. Please send any comments / feedback about this document to: Wendy Jamieson, SSWAHS Area Manager Quality, Clinical Governance Unit, ph 02-9515 9339 wendy.jamieson@email.cs.nsw.gov.au
Version 1 October 2005

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Clinical Governance Unit

How Do You… Series

- How do you take a frontline complaint
- How do you communicate with a complainant
- How do you manage an angry complainant
- How do you Review Medical Records
- How do you Write a complaint investigation report
- How do you use the investigation process
- How do you Understand the concepts of a Safety Culture
- How do you become error wise
- How do you Correctly Identify a Patient
- How do you write a reportable incident brief
- How do you run effective team meetings
- How Do You Gather Information Regarding an Incident by Interviewing Staff
- How Do You: Understand Clinical Governance
- How Do You: Understand the Concepts of Reflective Practice

Incident Management

Benefits of Surveillance:

Identifies low frequency high risk incidents eg wrong size prothesis-now included in wrong site surgery policy

- Early alert of similar incidents across AHS which prompts analysis and remedial action eg Anticoagulation therapy – Guidelines being developed
- Provides high level awareness of incident types and enable serious incidents to be flagged & outcomes monitored
- Identifies issues (near miss incidents) which may have area wide implications eg equipment failure

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Surveillance

- Chief Executives
- General Managers
- Clinical Directors; and
- Clinical Quality Council
- Department Heads

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Team Meetings

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- Discuss Incidents
- Determine Actions
- Provide feedback and support

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Issues

- Recognising a sick patient
- Appropriate clinical response to a sick patient
- Clinical Handover
- Supervision / on call
- Transfers
- Patient Identification

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Review of Root Cause Analyses - Common Themes - SSWAHS

- 24 RCAs undertaken at SSWAHS from January 2005 to October 2005.
- Mental Health RCAs relating to suspected suicide were excluded
- RCA categories identified

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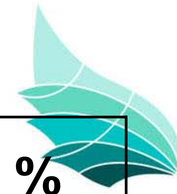

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Category	No.	%
Failure/delay to recognise sick patient	8	33
ID/wrong patient/procedure	6	25
Delay in Diagnosis	3	12.5
Clinical Care	3	12.5
Self discharge	1	4.17
Fall	1	4.17
Failure to comply with mandatory notification	1	4.17
Death in OT	1	4.17
Total	**24**	**100**

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Significant Issues

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All categories

- Clinical handover, documentation and communication

Failure/delay in recognising a sick patient

- Clinical handover significant in 50% of RCAs
- Calling MET calls or medical follow up post MET call
- Communication/supervision of Junior Medical Staff

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Guidelines

- Clinical hand-over
- On call
- Supervision
- Second Opinion

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Policies

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- Anticoagulation
- Organophosphate poisoning
- Naso gastric tubes
- Head injury in elderly
- Intravenous sedation outside theatres

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Patient Safety and Quality

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LEARNING FROM OUR MISTAKES

IMPROVING PERFORMANCE

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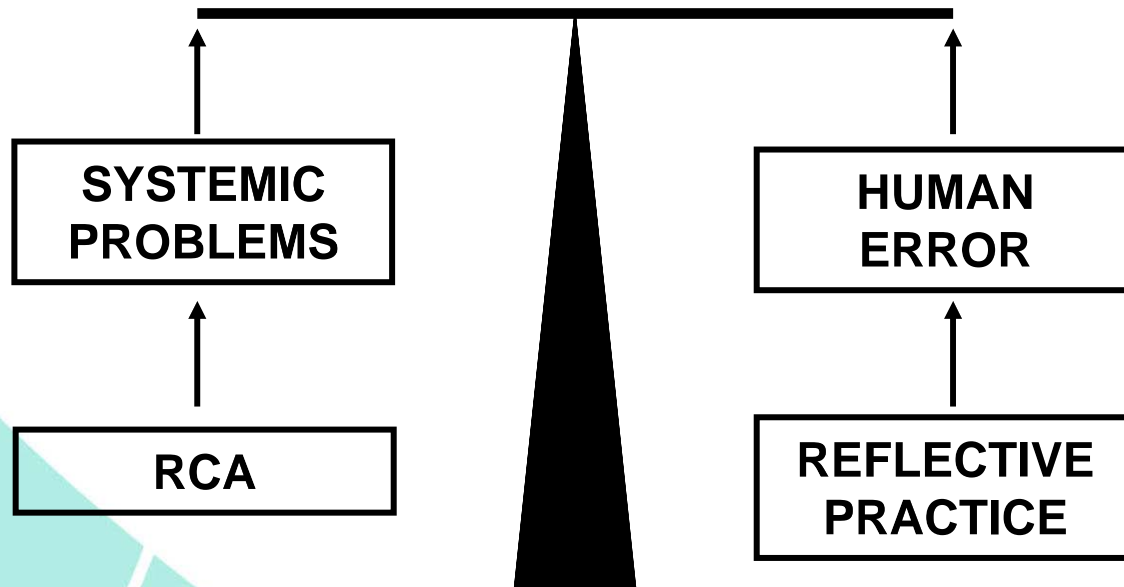
Investigation

Systemic Issues – Root cause analysis

Human Error – Reflective Practice



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The Challenge

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"So I am called eccentric for saying in public: that hospitals, if they wish to be sure of improvement,

- Must find out what their results are.
- Must analyse their results, to find their strong and weak points.
- Must compare their results with those of other hospitals...
- Must welcome publicity not only of their successes, but for their errors.

Such opinions will not be eccentric a few years hence"

Ernest Amory Codman, 1917

(Surgeon, USA, 1869-1940)

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"You must be the change you wish to see in the world"

Donald M. Berwick, MD, MPP
2005 American College of Physicians

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SSWAHS CGU

CLINICAL EXCELLENCE COMMISSION

CGU Team

- Wendy Jamieson
- Carol Walker
- Suzie Snook
- Jun Bai
- Margaret Scrimgeour
- Graeme Slade
- Mary-Ellen Go
- Kim Breckon
- Daniel Lalor

Others involved in CGU Education Programs

- Catherine Maloney
- Sheila Moloney
- Dr Nick Collins
- Dr Martin Gallagher
- Juliana Celcer
- Dr John Sammut

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