

AUSTRALIAN COMMISSION ON
SAFETY AND QUALITY IN HEALTH CARE

Sharing information about
incidents nationally -
the questions to answer first

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Information Strategy

- Supporting quality improvement
- Supporting regulatory functions & organisations
- National & international benchmarking
 - National indicators
- Improving national information infrastructure
 - National data standards

The landscape

- Academic studies including QAHC study
 - Various estimates of adverse events
- National sentinel events report
 - Recommendations for the future
- State/Territory incident reporting systems
- Root cause analyses
- Registries
- Surveys of general practice (BEACH)
- And much more – here and overseas

Routine data - long term feature in landscape

- 5% of 7.3 m hospital separations in 2005-06 related to an 'adverse event'
- Victorian data on hospital separations with 'complications' flagged
 - Useful for detecting patterns
 - Able to identify sentinel events
 - Variation from voluntary event reporting
- Many other sources of health data
 - An inventory being developed
 - The promise of statistical data linkage

Other landscapes: roads?

■ Deaths on roads

- Autopsies – hypotheses re alcohol
 - Blood alcohol testing for drivers in crashes
 - Random breath testing
 - Social research on attitudes to drink-driving and resulting campaigns
- Deaths wearing seat belts investigated – improvements in belt design

■ Crashes with injury

- Less reliable for monitoring, but useful for detecting patterns, factors, trouble spots – improved road design

■ Harm minimisation

Some definitions

■ Incident

- An event or circumstance which could have resulted, or did result, in unnecessary harm to a patient (WHO 2007).

■ Adverse event

- An incident which results in harm to the patient (WHO 2007).

■ Sentinel event

- Event that led to serious patient harm (AIHW 2007)

Some implications to guide us

- Know what we need to know, and how information will be used
 - Data must be fit for purpose
- Data reflect the purposes, practices and system of their source
 - Different data sources provide different information
- Use what we have and learn from the past
- An array of data, from multiple sources and study methods, over time produces results

Sharpening our questions (1)

- Know our purpose
- Data fit for purpose
- Use what we have and learn from the past
- **Implications for sentinel events**
 - Is the purpose to monitor trends or to alert us to events?
 - Are definitions related to purposes?
 - Can we use 'routine' data?

Sharpening our questions (2)

- Know our purpose
- Data fit for purpose
- Be aware of the data creation process
- Incident information from voluntary reports
 - Is the purpose to detect broad patterns rather than monitor with precision?
 - Value in national harmonisation?
 - Value in national collation?

Sharpening our questions (3)

- Know our purpose
- Use what we have

The broader picture on incidents

- What important questions about safety and quality can we answer
 - across the spectrum of health care settings?
 - using existing data collections?