Patient Safety in Public Hospitals

1 EXECUTIVE SUMMARY

1.1 Introduction

The risk that patients are harmed while receiving healthcare can never be mitigated entirely. Nevertheless, estimates suggest approximately 50 per cent of care-related injuries are avoidable, and the challenge for health services is to ensure their patient safety systems minimise the risk of harm.

Health services take a ‘systems’ approach to preventing incidents, acknowledging that while human error is unavoidable, the conditions that people work under can be controlled. Rather than blaming individuals, the ‘systems’ approach attempts to identify the underlying causes of incidents, and establish mechanisms to prevent them from recurring.

Clinical incidents are incidents that occur in a health setting that could have resulted, or did result, in the harm of a patient. In Victoria, the Department of Human Services (DHS) categorises clinical incidents according to the degree of harm, or potential harm, they cause. They range from near misses (incidents avoided through hospital strategies) to serious incidents.

Clinical incidents can have serious health and quality of life consequences for patients. At worst, they can result in death, and they can also have significant financial implications for health services, with costs estimated at around $511 million annually in Victoria.

The precise number of clinical incidents that occur in Victorian hospitals is difficult to estimate. Not all clinical incidents are recorded, and there are no data collection systems to aggregate their number and type. Several studies estimate that clinical incidents are associated with around 10 per cent of hospital admissions. In 2006-07, Victoria’s public health services admitted 1.35 million patients. This means that around 135 000 patients may have experienced a clinical incident—a proportion of which may have been serious. A concerted and systemic effort is warranted to reduce this number.

1.2 Findings

1.2.1 Patient safety governance

The audit looked at five health services. All had developed organisation-wide risk management frameworks, which included clinical risk. These frameworks outlined a consistent approach to treating and reporting of clinical risk. However, at the statewide level, there has until very recently been no overall quality and safety framework to guide and prioritise patient safety activity.

The relevant agencies had clearly documented descriptions of their own responsibilities, but there were instances where these responsibilities overlapped. This created uncertainty within the system. Overlap and duplication was most evident in the roles

and responsibilities of the Victorian Quality Council (VQC) and the Statewide Quality Branch (SQB). These agencies provide the majority of expert guidance and advice on quality and safety issues, and the overlap and duplication between these agencies has obscured leadership in the patient safety system. With unclear leadership, driving change and improvement will be harder.

Coordination arrangements for patient safety are not clear. DHS advised that it was taking steps to improve coordination through the development of SQB's new statewide role and responsibilities.

An effective patient safety regime requires collaboration and the sharing of knowledge among agencies. Numerous collaborative relationships exist in the patient safety arena. These provide a useful foundation for agencies to increase the sharing of ideas and contribute to sector-wide patient safety planning.

1.2.2 Patient safety performance

In Victoria there is no incident monitoring system that collates patient safety data across the state. Victoria is the only jurisdiction in Australia that does not have a statewide system to monitor the patient safety system's performance.

While some statewide data are collected, such as sentinel events, infection rates and pressure ulcers—these represent only a proportion of the available patient safety data. Consequently, DHS is unable to measure the safety performance of the system as a whole. The Minister for Finance's response to VAGO's 2005 audit recommendations informed Parliament that DHS would address many of the issues raised through its clinical governance policy.

DHS had engaged a contractor to consult with stakeholders on the clinical governance policy, at the time of the audit fieldwork. A draft clinical governance policy has since been developed that should address many of the issues identified in 2005.

The reviews of SQB and VQC, along with the action taken to date to develop a new clinical governance framework and a statewide incident reporting system, are important initial steps to improve patient safety. More significant change and innovation is required to bring about the improvements necessary to reduce Victoria's high number of patients who experience harm while in the hospital setting.

In the meantime, accountability for patient safety in Victoria will continue to be weak, effectively masking an unacceptably high level of incidents behind data gaps and inadequate reporting. The way forward in patient safety requires a step-change in how agencies work together to design and implement safety systems and manage the health system as a whole.

1.3 Recommendations

Statewide governance

DHS should implement, as a priority, the recommendations from its 2007 review of the Quality and Safety Branch **(Recommendation 3.1)**.

RESPONSE provided by Secretary, Department of Human Services

The department is implementing the recommendations from its 2007 review.

Improvements in patient safety governance

DHS should implement, as a priority, the outstanding recommendations from the previous performance audit, as outlined in the Minister for Finance's report to Parliament. In particular, DHS should advise health services of appropriate clinical incident definitions **(Recommendation 3.2)**.

RESPONSE provided by Secretary, Department of Human Services

The recommendations made in 2005 resulted in two large scale projects being developed, these being the Review of

clinical governance in Victorian public health services, with the objective to develop a statewide framework to ensure clinical governance is supported, and the Incident information system project, to establish a statewide reporting capacity for all incident data.

The clinical governance framework project has delivered a draft framework and way forward for Victoria which is currently being reviewed by quality and safety groups and the department.

Both these projects will address the recommendations made in 2005 and are being progressed as a matter of priority.

Statewide performance monitoring

DHS should implement the incident information system or a similar system with statewide reporting and analysis capability as a priority **(Recommendation 4.1)**.

RESPONSE provided by Secretary, Department of Human Services

The Incident Information System (IIS) development commenced in early 2006 and is a significant project.

- *To date the following outcomes have been achieved through the IIS project.*
- *A clear set of definitions relating to clinical incident management.*
- *Establishment of a standardised incident severity rating (ISR) methodology.*
- *Development of a standardised incident classification model based on World Health Organisation's International Classification for Patient Safety (WHO IC4PS).*
- *Development of an incident data set that formally defines the clinical incident information to be collected and the associated data collection methodology.*

The development of a comprehensive taxonomy and data dictionary is reaching completion. It is now a matter of software development by others; implementation of data streams for hospitals to the department, VMIA, the Health Services Commissioner and Worksafe; implementing the necessary data storage; and developing the benchmarks and feedback reports to all stakeholders. The scope of the project has been altered over time in response to requests from hospitals to ensure the approach is reflective of a whole suite of incident management, not just clinical incidents. An appropriate business case will be finished in 2008. Training within hospitals will be a key to the success of the project.

Internal accountability

DHS should establish a performance measurement framework to enhance internal accountability for patient safety **(Recommendation 4.2)**.

RESPONSE by Secretary, Department of Human Services

The department is developing a program measures framework to underpin measures associated with the Statement of Priorities (SoP). This framework will monitor performance against the measures while identifying measures for inclusion in subsequent SoP iterations.

A new set of performance indicators associated with Australian Health Care Agreements include a number (to be finalised) of quality indicators that are currently in development. The department is contributing to the development of this list of indicators.

The department funds and participates in a number of external registry projects aimed at measuring quality of care. These focus on high risk/high cost clinical areas such as cardiac surgery and intensive care. The data from each registry is subject to review with feedback mechanisms in place. Many of these will be further developed through the clinical governance framework.

RESPONSE provided by Secretary, Department of Human Services

Extracts from the Secretary's response relevant to the recommendations have been included in the text above. The full text of the Secretary's response has been reproduced at Appendix D, page 43.

RESPONSE provided by the Chief Executive Officer of the Victorian Managed Insurance Authority (VMIA)

A response provided by the Chief Executive Office of the VMIA, which does not refer specifically to the recommendations is included at Appendix E, page 51.

RESPONSE provided by Acting Secretary, Department of Justice

The Department of Justice welcomes the report and, through the State Coroner's Office, will continue to collaborate with the Department of Human Services to improve patient safety.

Quicklinks

Contents (pdf of report)

Foreword

1. Executive summary
2. Background
3. Governance in the patient safety system
4. Monitoring performance in patient safety
5. Appendix A: Audit conduct
6. Appendix B: Key stakeholders in the patient safety system
7. Appendix C: Review of the Safety and Quality Branch
8. Appendix D: Department of Human Services' response
9. Appendix E: Victorian Managed Insurance Authority repsonse

Full Report (1.2MB)