Patient Safety in Victorian Public Hospitals

Tabled 23 March 2016

The Auditor-General provides assurance to Parliament on the accountability and performance of the Victorian Public Sector. The Auditor-General conducts financial audits and performance audits, and reports on the results of these audits to Parliament.

On 23 March 2016, the Auditor-General tabled his performance audit report, *Patient Safety in Victorian Public Hospitals.*

Overview

The audit examined whether patient safety outcomes have improved in Victorian public hospitals.

The audit found that:

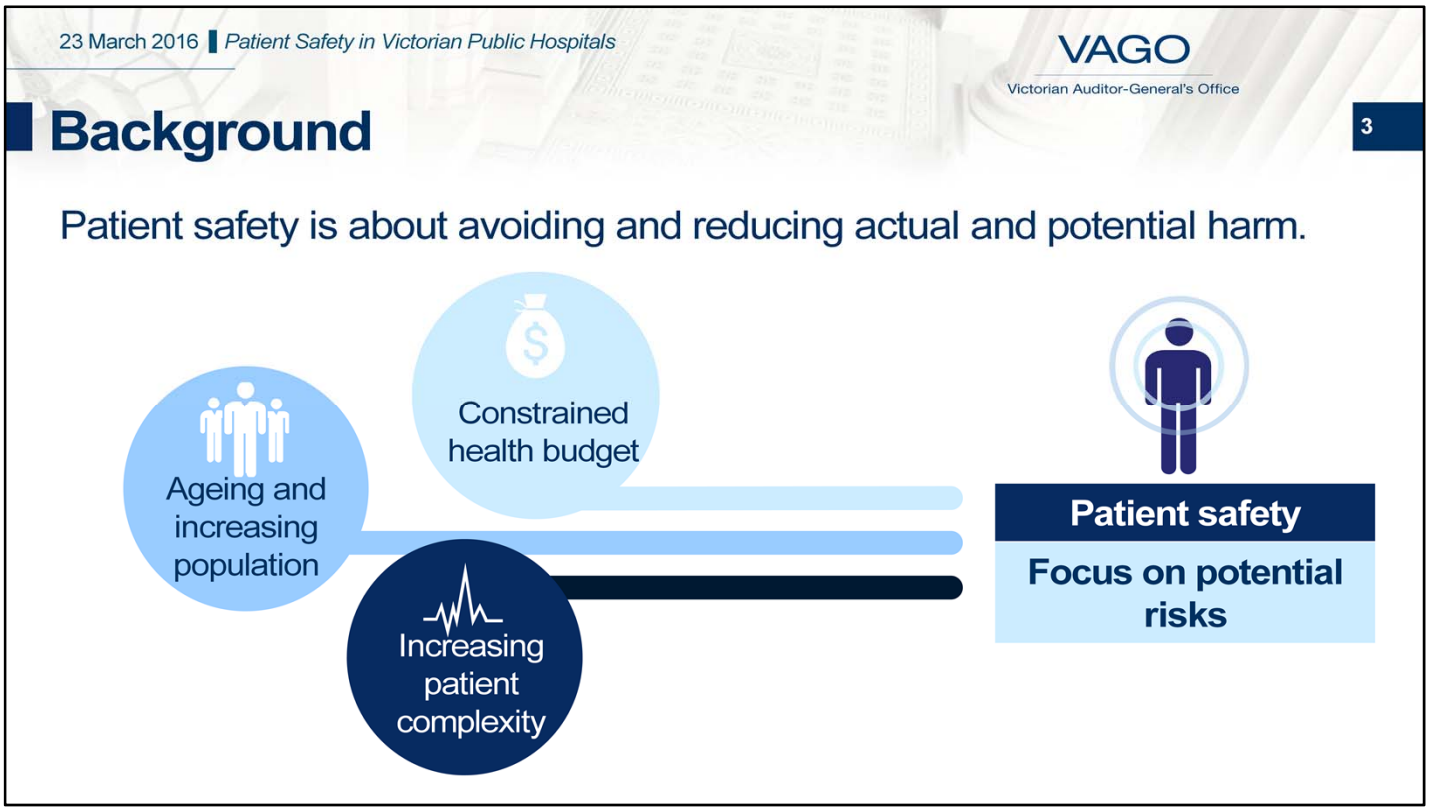
- neither the Department of Health & Human Services (DHHS) nor hospitals can comprehensively demonstrate improvement in overall patient safety outcomes
- systemic failures by DHHS means it is not effectively performing its statewide leadership role and is failing to adequately protect the safety of hospital patients
- while hospitals have improved their management of patient safety, further action is needed.

There is nothing more important in overseeing a hospital than to ensure that it is as safe as possible for patients and healthcare workers. Hospitals aim to reduce and prevent inadvertent harm to patients as a result of their care. Clinical incidents—which can be caused by equipment failures, errors, infections acquired during the course of receiving treatment for other conditions or delays in treatment—can result in serious health related complications for patients and compromised quality of life. Clinical incident can also have considerable financial consequences. Health costs increase because patients stay in hospital longer, and more resourcing, such as additional diagnostic testing, is required. There can also be additional financial costs if compensation claims and legal action is taken against the hospitals involved.

The audit examined whether patient safety outcomes have improved in Victorian public hospitals. This included assessing how effectively public hospitals manage patient safety and whether they are adequately supported by the Department of Health & Human Services (DHHS), as the health system manager.

The audit found that:

- neither DHHS nor hospitals can comprehensively demonstrate improvement in patient safety outcomes
- systemic failures by DHHS means it is not effectively performing its statewide leadership role and supporting hospitals to improve patient safety outcomes
- while hospitals have improved their management of patient safety, further action is needed.



Patient safety is about avoiding and reducing actual and potential harm. An ageing and increasing population, a constrained health budget, and increasing patient complexity—where patients present with multiple diseases or disorders—are all creating increasing challenges for hospitals to effectively manage patient safety. While patient safety is related to quality of patient care, it differs in that it focuses on potential risks, rather than on whether the care has resulted in the best outcome.

Background – *continued*

- VAGO has conducted two previous performance audits on patient safety in 2005 and a follow-up audit in 2008
- This audit continues our focus on patient safety and the occupational health and safety (OHS) of healthcare workers.

Photographs courtesy of DHHS.

VAGO has conducted two previous performance audits on patient safety in 2005 and a follow-up audit in 2008, which examined the patient safety system at the health service and state levels and found a number of weaknesses. This included a lack of system-wide clinical incident monitoring and poor governance arrangements.

This audit continues our focus on patient safety and the occupational health and safety (OHS) of healthcare workers.

Focus of this audit

Key areas examined

- Whether DHHS and hospitals can demonstrate if overall patient safety outcomes have improved
- DHHS' statewide leadership and oversight role in patient safety
- Hospitals' management of patient safety.

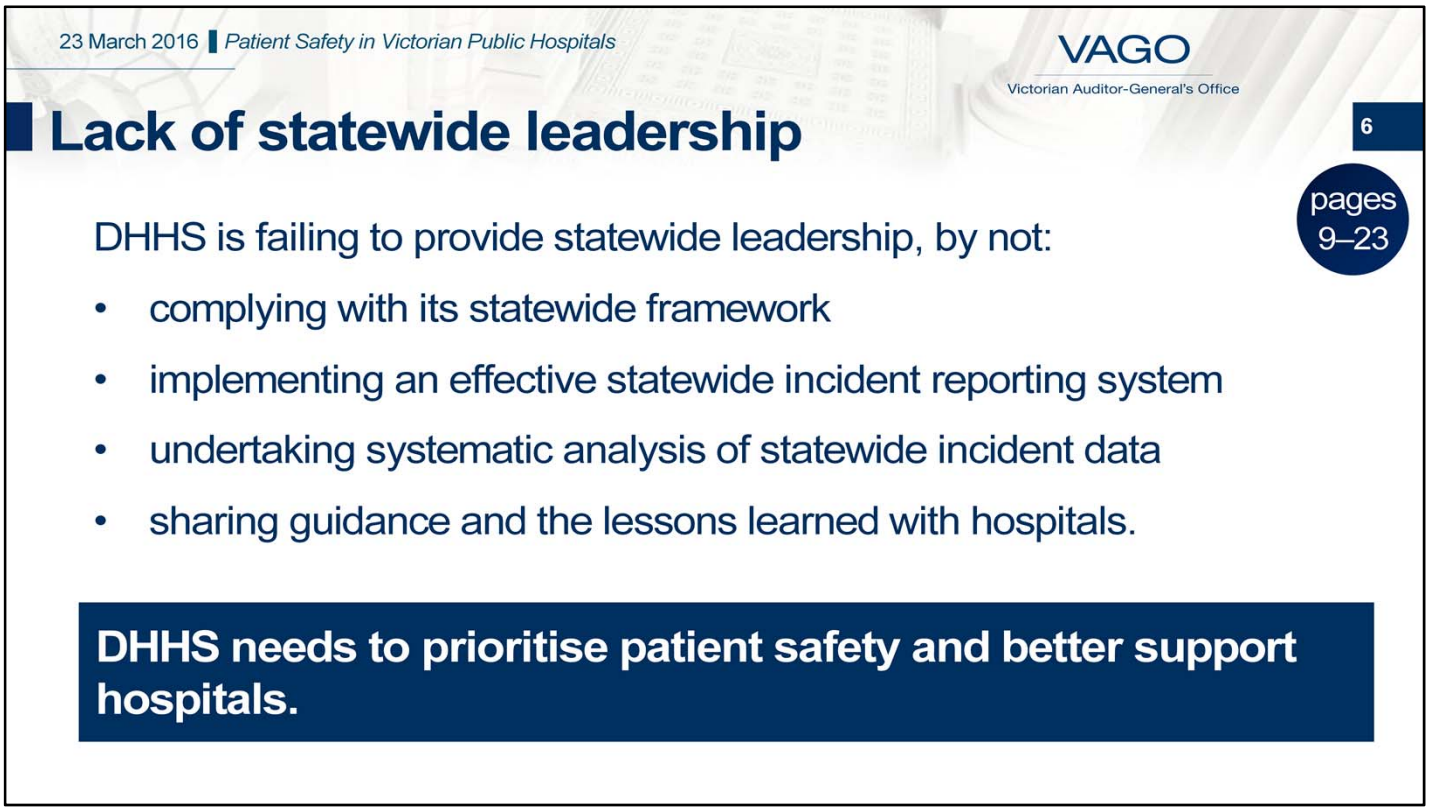
Audit scope

- DHHS, Victorian Managed Insurance Authority (VMIA) and four public hospitals

The objective of this audit was to determine whether patient safety outcomes have improved in Victorian public hospitals by assessing whether:

- DHHS and hospitals can demonstrate if overall patient safety outcomes have improved
- DHHS has provided statewide leadership and supported hospitals to improve patient safety outcomes
- hospitals have effectively managed patient safety

It also looked at how well the Victorian Managed Insurance Authority (VMIA) supports hospitals to improve patient safety.
The audit included site visits to four hospitals—three metropolitan and one regional.



The key findings in relation to DHHS indicate that it is failing to provide statewide leadership or oversight on patient safety. Systemic failures by DHHS—some of which were identified over a decade ago in our 2005 patient safety audit—collectively indicate that it is not giving sufficient priority to patient safety. DHHS needs to provide better support to hospitals to protect the safety of hospital patients.

While DHHS developed a key statewide patient safety framework in 2011—the Adverse Events Framework (AEF)—it has not complied with it.

DHHS has also not implemented an effective statewide incident reporting system. This limits its ability to have a system-wide understanding of patient safety and means it cannot effectively perform its role in providing leadership and oversight of the whole safety system. Despite indications that certain risks to patient safety have reduced over time, DHHS cannot demonstrate whether patient safety outcomes have improved.

Although DHHS receives patient safety information from a number of sources, it does not aggregate, integrate or systematically analyse this data to identify overall patient safety trends.
DHHS does not share guidance and lessons learned with hospitals to support them in improving patient safety outcomes.

VAGO
Victorian Auditor-General's Office

Hospitals' progress

pages 25–36

- There have been significant improvements in clinical governance since our previous audits.
- Further work needs to be done by hospitals to improve incident management.
- Hospitals cannot demonstrate whether overall patient safety outcomes have improved.

Hospitals need to further improve their management of patient safety.

Since our 2005 and 2008 audits, positive progress has been made by the four audited hospitals in developing clinical governance frameworks. In connection with this, there are also indications that progress has been made towards a positive safety culture. This is based on feedback from our focus groups at the audited health services, which included patient safety often being talked about as a priority by leadership. A positive culture helps to encourage staff to report incidents.

However, further work needs to be done by hospitals to improve incident management. The audit found that hospitals did not investigate or review all clinical incidents. Investigations and reviews also varied in quality and there was limited evaluation of the impact of the actions recommended by these.

The audit also found that hospitals cannot demonstrate whether overall patient safety outcomes have improved. Hospitals monitor patient safety and are aware of the types of patient safety risks that can occur and the likely impact of these. However, their understanding of the prevalence of these risks and the effectiveness of their controls to mitigate the risks could be improved through better incident management. A lack of system-wide data from DHHS also limits hospitals' ability to understand statewide trends and prevalence to compare their performance with peer hospitals and learn lessons. Not having a full understanding of the prevalence and impact of patient safety risks means that the highest risks may not be identified and prevented or mitigated.

Recommendations

		Accept
That DHHS, as a matter of priority:		
1	reviews, updates and complies with its 2011 *Adverse Events Framework*	✓
2	implements an effective statewide clinical incident reporting system	✓
3	aggregates, integrates and systematically analyses clinical incident data	✓
4	implements a more effective process for hospitals to report sentinel events	✓
5	promptly disseminates lessons learnt from sentinel events to hospitals	✓
6	includes meaningful indicators in its performance assessment score	✓
7	shares patient safety data with other relevant government agencies	✓
12	in collaboration with hospitals, improves training in incident investigations	✓
13	reviews its 2011 *Victorian health incident management policy* and associated guide.	✓

In total, we made 13 recommendations.

Nine of these are for DHHS. These relate to improving its statewide leadership and oversight role of patient safety and supporting hospitals to improve patient safety outcomes.

Recommendations – *continued*

		Accept
That hospitals:		
8	ensure timely feedback is provided to those who report incidents on the recommendations from incident investigations and the outcomes of actions implemented	✓
9	evaluate all recommendations from incident investigations for effectiveness, as per DHHS' revised policy and guidance	✓
10	ensure review of patient safety incidents with a lower incident severity rating, to identify risk prevention opportunities	✓
11	ensure that incident investigations comply with DHHS's policy and guidance.	✓

Four recommendations are for hospitals and relate to improving their incident investigation management.

All agencies have accepted the recommendations.

The key messages from the audit are that:

- Neither DHHS nor hospitals can comprehensively demonstrate improvement in overall patient safety outcomes.
- DHHS is failing to adequately protect patients. It needs to prioritise patient safety and better support hospitals.
- And, while hospitals have made progress in managing patient safety since our previous audits, further improvement is needed.

Overall message

As a matter or priority, DHHS needs to fulfil its leadership role and support hospitals to improve patient safety outcomes.

The overall message from this audit is that as a matter of priority, DHHS needs to fulfil its leadership role and support hospitals to improve patient safety outcomes.

Relevant audits

- *Managing Patient Safety in Public Hospitals* (March 2005)
- *Patient Safety in Public Hospitals* (May 2008)
- *Consumer Participation in the Health System* (Oct 2012)
- *Infection Control and Management* (June 2013)

Relevant audits are listed on this slide.

Contact details

For further information on this presentation please contact:

Victorian Auditor-General's Office
[p] 8601 7000
[w] www.audit.vic.gov.au/contact_us.aspx

All our reports are available on our website.

If you have any questions about this or other reports, or if you have anything else you would like to discuss with us including ideas for future audit topics, please call us on 03 8601 7000 or contact us via our website.