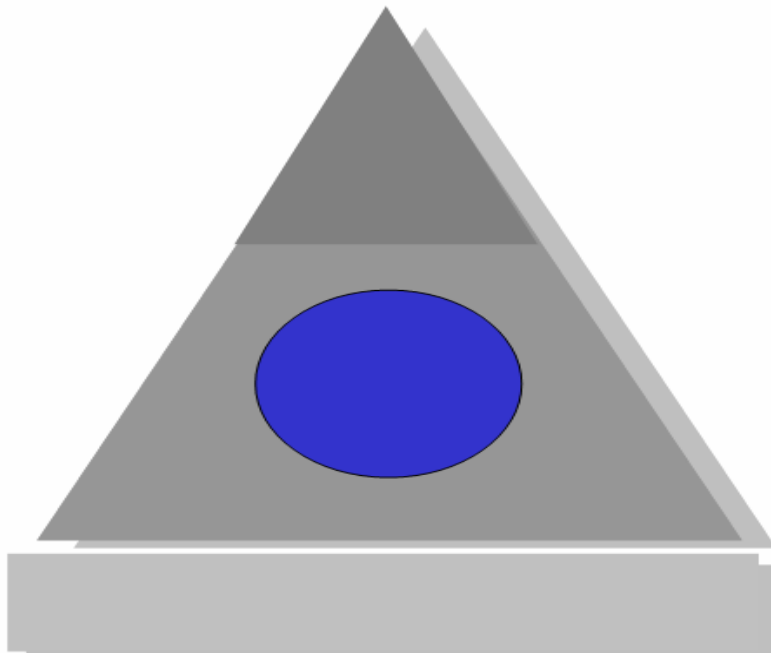




Government of South Australia

Department of Health

Safer health care: now and into the future



Summary of the South Australian Safety and Quality Program 2007 - 2011

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This document, written by Ragg Ahmed, is a distillation of the *South Australian Safety and Quality Framework and Strategy Project Report and Resource Documents* prepared by Dr Cathy Balding and Ms Anne Maddock on behalf of the SA Development of S&Q Programs Steering Committee for the SA Department of Health in February 2006.

Dr Balding and Ms Maddock wish to thank the Steering Committee, consumers and staff who gave generously of their time and expert advice over six months to contribute to the program development.

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Introduction

Safety and quality have become *the* major issues in health care. The era of “trust your doctor” has gone, and has been replaced by an era in which principles of accountability, transparency and consumers’ rights are ascending.

This is of great benefit to the health care system. For too long, problems were hidden and consumers suffered. Consumers rights – to honesty, to openness, to safe and effective care, to make decisions about their own health – have always existed, but they were not always recognised. While it is too early to say that this is the era of the consumer, it is an era in which consumers’ rights can no longer be ignored.

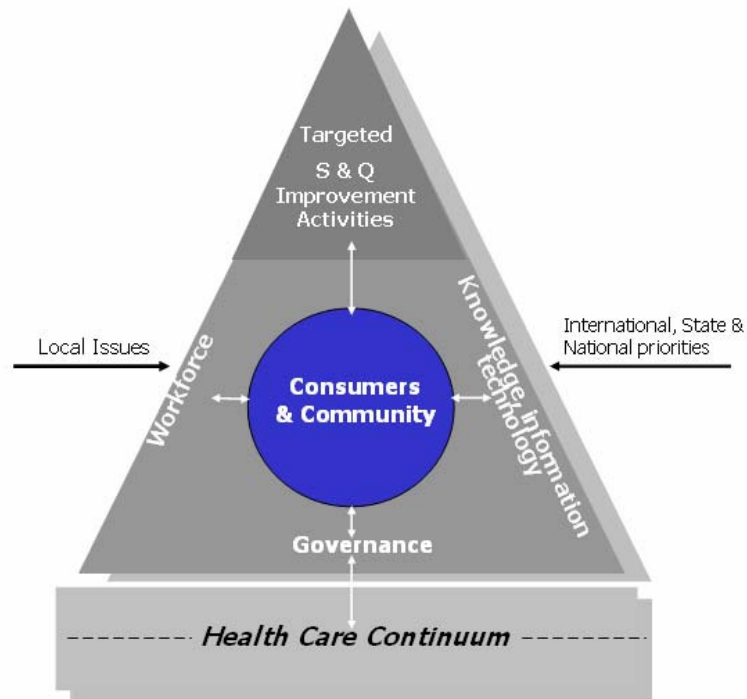
At the same time health care professionals have seen the need for better and safer ways to deliver care and have been steadily empowered to pursue these goals.

The South Australian health system has taken note of these changes. Partly, it has taken note because of mounting information and public pressure – various studies and inquiries have shown that the health system is not perfect, and that health professionals are fallible, and the public is now well aware of these imperfections and fallibilities.

But the South Australian health system, and indeed the health sector throughout Australia, has taken note of the change mainly because the change is for the better. It is the right thing to do. We acknowledge that systems are imperfect and health professionals are fallible, and we welcome being able to share that knowledge with the public. But we also acknowledge that the health care system should be safer than it is, that the quality of care, while of a very high standard, could be higher than it is and that, while there have been considerable improvements over the past decade, there is still room for more improvement.

Safer health care: now and into the future is a brief summary of a remarkably detailed, and still evolving program – the South Australian Safety and Quality Program 2007 – 2011. This program, which arises out of previous initiatives such as the Patient Safety Framework 2002 – 2006, is centred on the consumer, as figure 1 shows.

Figure 1: Key components of a balanced approach to safety and quality



The safety and quality program's main features are that it:

- depends upon knowledge, information management, information technology, good governance and a strong workforce
- is being implemented across the care continuum – hospital and community, public and private, rural and urban, primary to tertiary
- takes account of local, state, national and international issues
- is targeted to ensure the best value for time, effort and money
- reflects, and fits in with, national priorities and programs
- will be successful only if it is embedded in, not additional to, the normal routines of work.

The safety and quality program is based on the following principles.

- The health consumer is the focus of efforts to improve health care safety and quality.
- The effectiveness of improvement programs is evaluated according to their benefit to the consumer.
- A coordinated, systematic and system-wide approach is taken.
- Processes of care need to be simple.

- Those practising within the system are accountable for their own standards of care, and share responsibility for the system's standards of care.
- Consumers participate in their own care and treatment.
- Consumers participate in the planning, delivery and evaluation of health services.
- A partnership exists within and between health care organisations, consumers and the community.
- A safe and just culture is important.
- A robust communication and reporting structure improves health services through regular sharing of information and learning.
- The best available evidence is used.
- A team based approach is used.
- All health care providers have access to information about the outcomes of the care they provide, and the outcomes of the care provided by the systems within which they work.
- The health sector will report its progress to the public.

As described, the consumer is central to all. The program outlines principles and initial strategies for five main areas:

- safety and quality priorities
- consumer and community participation
- the workforce
- knowledge, information management and information technology
- clinical governance

It is in these five areas that most can be achieved.

What is the safety and quality program?

The South Australian Safety and Quality Program 2007 – 2011 is a work in progress. It has drawn on the Patient Safety Framework 2002 – 2006, as well as a thorough review of the literature and hundreds of meetings with consumers and people working in the health sector. It has taken that framework and broadened it beyond public hospitals to all sectors of the health system, and it has added depth.

The program is a vision of the future. It is a direction. It is a framework. It is these elements which are most strongly developed, and which form the core of this document.

But the program is also a series of strategies which have been and will be developed over the coming years. These strategies sometimes have simple aims – get people to wash their hands more often – or complex ones – link all aspects of the health system with real-time information – but they have at their core a concern for the safety and quality of care.

The program relies on the establishment of two key bodies – the South Australian Safety and Quality Council and the Consumer and Community Advisory Group. The relationships among these bodies, health care organisations and the Department of Health will be vital.

But the program also relies on the endeavours of individuals and teams. Central organisations can manage only what they are given to manage – it will be the skills and energies of the people of South Australia – both consumers and health professionals – that make the program effective.

The program relies on goodwill. It is not a directive of the Health Department. It is a whole-of-system approach in which all players work towards a common goal through agreements and memoranda of understanding, through staff meetings and audit, and through corridor consultations and lunchtime chats. It will succeed only if it operates at all levels.

Safety and quality priorities

There are many aspects of health care that could be improved. There are many good ideas that could be used. There are many projects and programs that could be implemented. There is an enormous number of people with goodwill, talent and energy.

But it is impossible to do it all. To make improvements effectively, they need to be made selectively.

The Safety and Quality Program will support projects and initiatives which can demonstrate that they:

- are based on evidence of the greatest benefit for consumers
- focus on safety in the first instance – saving lives and reducing harm.

Agencies and funding bodies will also consider the main aspects of quality – safety, effectiveness, appropriateness, acceptability, patient centredness, access and efficiency.

While projects can and will run across all clinical areas, five priority areas have been chosen on the basis that they will achieve the greatest gain for the greatest number of consumers. They are described, with selected initial strategies, in table 1.

Table 1: Clinical safety priority areas with selected strategies

Priority area	Selected strategies
Safe use of medications	Implement standard medication chart nationally Continue pharmaceutical reform Continue the Quality Use of Medicines program
Falls prevention	Develop a falls prevention kit Develop vitamin D and calcium program for aged care
Infection prevention	Statewide infection surveillance program Surveillance of antibiotic use and resistance Hand hygiene strategies Surgical site infection
Safe use of blood products	Implement SA BloodSafe Program across the state
Pressure ulcer prevention	Statewide surveys Implement prevention strategies

A range of other strategies will be implemented in the initial years of this program. They include strategies as diverse as improving the effectiveness of handover within and between health care providers and organisations, and taking a planned approach to preventing suicide after discharge among people with mental illness.

Over time, further priorities and strategies will be developed by individuals, by health care organisations, the Health Department and the Safety and Quality Council. At all times, evidence of the greatest benefit for consumers and a focus on saving lives and reducing harm will be required.

A case in point: Washing hands

Health care-associated infection is of tremendous importance around the world. Australia is not alone in acknowledging that, despite knowing for 150 years that washing hands reduced deaths, our record still needs improvement.

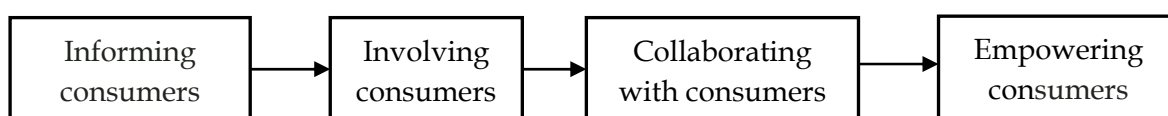
South Australia is working within a WHO framework to reduce the incidence of infection arising from health professionals not washing hands between patients. We will formally assess the scale of the problem, adopt an internationally recognised approach to surveillance, conduct an analysis of the root causes of the problem, develop solutions and monitor their progress after implementation.

Consumer and community participation

Consumer and community participation is essential for any safety and quality program to succeed. It is both the right, and the responsibility, of consumers to take part in such a program.

The degree of consumer participation in health care can vary from informing consumers, to involving consumers, to collaborating with consumers, to empowering consumers (see figure 2). There is evidence that the further along the spectrum consumer participation goes, the better the results for the health system.

Figure 2: The spectrum of consumer participation



To this end, the Health Department seeks to empower consumers. It will nominate an independent person to chair the South Australian Safety and Quality Council. The prime position in the prime body overseeing the safety and quality program will be somebody who is not a health professional, not a representative of any group, and who doesn't even work in healthcare. This is quite a departure from the norm. The Department will also establish a Consumer and Community Advisory Group, which will be one of the few permanent advisory bodies for the council.

This symbolises the program's approach – that consumers be embedded at the highest level.

In general, the program's approach is that all involved in health care will benefit if:

- consumer involvement in their care is increased
- consumers relate their experiences of health care to health professionals
- the rights and responsibilities of consumers are respected and promoted
- consumers are informed and empowered
- consumers work with health services in not just the delivery of health care, but at every step from policy and planning through to evaluation and improvement
- a conscious effort is made to build the capacity of consumers to be part of all of the above.

High priority initial strategies include:

- improving and auditing the complaints management process
- developing a state-wide consent form
- ensuring the use of the cultural respect framework
- developing an annual report for the public on health care organisation performance

- developing consumer information resources, especially for high risk areas
- holding public forums on selected topics
- improving regular patient surveys
- improving consumer and community education
- using consumer stories to highlight safety and quality issues.

A case in point: The complaints management process

All health care organisations have a person – sometimes called the patient adviser – who receives complaints and suggestions about the care and services provided. Complaints are investigated and responded to according to a protocol. This protocol defines response times and the manner in which information should be provided, and to whom.

At the same time, a second system collects information about adverse events, including deaths.

The new Health and Community Services Complaints Commissioner also collects information as a result of complaints directed to her.

The data are all kept separately. A lot could be learned, and more improvements made, if the data from these systems were brought together.

These data would be of even more value if the consumer's story (de-identified) could be included in staff training and other improvement activities which would be developed as a result.

The workforce

The workforce is the primary resource of any organisation. Its importance is even greater in a labour-intensive industry such as health.

Many factors concerned with the workforce have an impact on safety and quality, such as the mix of skills, the degree of clarity about responsibilities, workforce numbers, workforce distribution, the level and standard of supervision, the physical and mental health of employees, team dynamics, workforce competency, the value placed on employees, the level of support offered to employees, the workforce design and the workplace design.

While these all need to be addressed, the priority areas revolve around:

- workforce planning
- workforce competence and development
- workforce design
- staff health and safety.

There are national and international shortages of doctors, nurses and many other health professionals. These shortages, which are expected to continue for some time, have a particular impact on two issues – access to health services and the safety and quality of care. Workforce planning requires more than just addressing shortages. It requires improving the allocation of human resources and improving, and more clearly understanding, the impact of skills mix, staffing numbers and role delineation on patient safety.

Workforce competence and development relies on a range of factors, including learning and development, developing a culture of enquiry, credentialing, defining the scope of practice, and developing leadership roles and responsibilities.

Poor workforce design can increase the potential for systems to fail and for people to make mistakes. Efforts are being made to learn from other industries about the safe design of the workforce.

Staff health and safety is sometimes forgotten, but should not be, as issues of safety and quality extend to staff as well as consumers. There is a link between staff stress – brought on by bullying, low morale, sleep loss and so on – and the health and safety of staff and patients.

High priority initial strategies include:

- continuing to implement the state-wide workforce plan
- recruitment and support of international medical graduates
- developing the state-wide Workforce Development Strategy
- embedding the National Patient Safety Education framework throughout the system
- reviewing the curriculum for health professionals
- implementing the Safe Doctor SA initiative

- reviewing the whistle blowing policy
- implementing the Country Health Strategic Plan
- developing guidelines for bullying and violence.

A case in point: International medical graduates

International medical graduates have made up 20-25 per cent of Australia's medical workforce for some years. This situation, which is similar to that of most developed nations, is unlikely to change soon. International medical graduates perform a vital role by working in areas of need, quite often in places where there are insufficient Australian medical graduates to work.

Past practice has been to give great attention to the recruitment of international medical graduates, but to leave them to their own devices once they have started work. This has sometimes created problems – for doctors working in a foreign culture and facing different health problems than they are used to, for patients who may be facing language and cultural barriers, and for the communities they serve should tensions arise.

While recruitment efforts will continue, extra efforts will be made to vet applicants, to orient them to South Australian conditions, to supervise and support their work and to monitor their progress.

With this support, international medical graduates should adapt more quickly to local conditions and have greater back-up. Potential problems should be detected earlier. South Australia will become more attractive to international medical graduates. A safer and higher quality health service should result.

Knowledge, information management and information technology

Healthcare workers say they are drowning in information and starving for knowledge. True. Health systems have become very good at counting and measuring, but have fallen behind in making use of that information properly.

It has also become clear that communication – within settings and between settings – is a huge problem. Most errors in the health system occur outside hospitals, and the time of discharge is a significant risk for many patients.

With these points in mind, the two key priorities for this aspect of the safety and quality program are:

- to improve communication within and between health care settings
- to implement and make more effective use of the available information systems.

Key planks for this are already in place, such as:

- the Department of Health Information Management and Technology Plan (2005 – 2010)
- the Advanced Incident Monitoring System (AIMS), which has recently been reviewed
- the roll-out of *HealthConnect*, which is a national health information network
- the implementation of the open architecture clinical information system (Oacis) in metropolitan hospitals.

High priority strategies that will build on these include:

- working with general practitioners to get better IT connections
- developing an infection control surveillance monitoring program
- expanding AIMS
- monitoring state-wide data trends in safety and quality
- improving knowledge exchange
- developing effective networking mechanisms

It is worth noting that work in these areas will take place throughout the state, but usually outside the province of safety and quality units.

A case in point: Infection control surveillance

Up to 10% of patients acquire an infection during their hospital stay. Increasing numbers of infections are resistant to the antibiotics which used to get rid of them. This is a costly problem for hospitals, and can be devastating for the patient involved.

Hospitals have infection control nurses who collect information about patients with infections, the antibiotics they are on and the response of their infection to treatment. Information is collected manually.

Paper-based systems mean that data management, analysis and reporting is time consuming and inefficient, and reports are out of date by the time they are available. Improvements to the systems of care are delayed, and sometimes not informed by all the necessary data.

A computer based system could integrate relevant information from different sources and generate reports in a timely way. As a consequence, prompt decisions could be made about interventions which will reduce the number of infections.

Clinical governance

Clinical governance is the system by which the governing body, managers, clinicians and staff share responsibility and are held accountable for:

- patient care
- minimising risks to consumers, and
- continuously monitoring and improving the quality of care and services.

The concept of clinical governance is similar to the concept of corporate governance. It involves:

- leading clinical safety and quality
- ensuring monitoring systems, based on measurable standards, are in place
- regularly monitoring and auditing safety and quality
- having systems in place to identify risks and opportunities early.

Good clinical governance requires that all this takes place in an environment of honesty, trust and commitment. This requires the leadership of an organisation to set clear goals and priorities, to establish clear roles and responsibilities, to take a systems approach, to develop a safe and just culture and to carry out rigorous internal and external evaluation, with reporting of results to the public.

High priority initial strategies include:

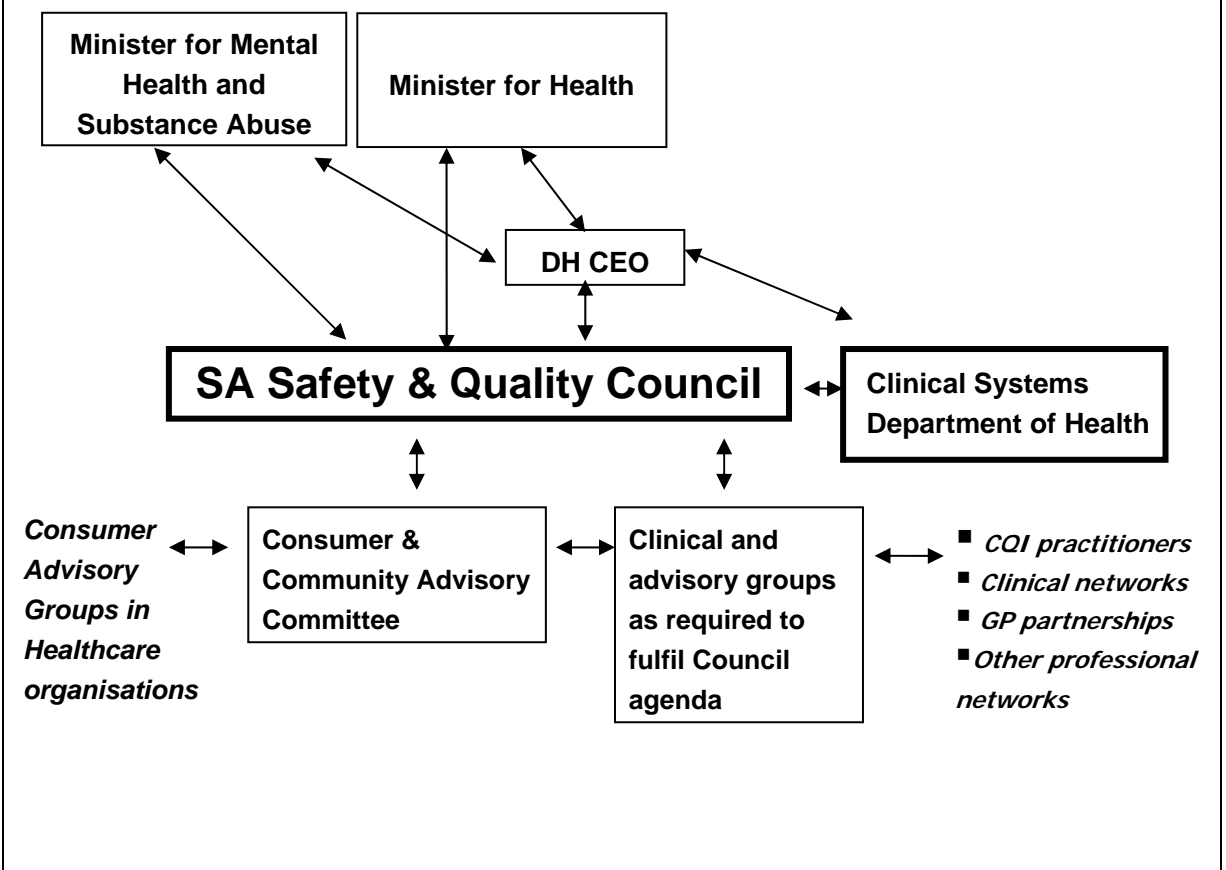
- convening the South Australian Safety and Quality Council (see page 14)
- supporting the initial framework and strategy development of the safety and quality program
- helping to implement the program
- evaluating its progress
- establishing a safety and quality grants scheme, with funds accountability
- developing a business case template for safety and quality activities.

A case in point: The South Australian Safety and Quality Council

The South Australian Safety and Quality Council will advise the Minister for Health, the Minister for Mental Health and Substance Abuse and the Chief Executive of the Department of Health on the implementation of this safety and quality program. It will monitor the work of the Australian Safety and Quality Commission, ensuring South Australia adopts national initiatives. It will also chart its own course.

The Council, in turn, will be advised by the Consumer and Community Advisory Group, which will draw representatives from consumer advisory groups throughout the health system and from peak consumer organisations. The Council will also be advised by a series of other clinical and advisory groups, and by sections of the Department of Health, as need be.

Figure 3: Proposed reporting and relationships of the South Australia Safety and Quality Council



For further information

This document, as already stated, is merely a distillation of a report prepared by Dr Cathy Balding and Ms Anne Maddock on behalf of the South Australian Department of Health in March 2006.

Anybody interested in more details of the program, particularly the many strategies to be undertaken, should read the full report, which is available on the safety and quality website of the Department of Health - www.safetyandquality.sa.gov.au. This document also includes resource documents for implementing several of the safety and quality activities discussed above.