



Victorian Quality Council

Minutes of the meeting held on Monday 15 April 2002 in the Spencer Room, Savoy Park Plaza Hotel.

Present:

- Dr Michael Walsh (Chair)
- A/Prof Christine Kilpatrick (Deputy Chair)
- Dr Jenny Bartlett
- Ms Stella Axarlis
- Mrs Kerry Bradley
- A/Prof George Braitberg
- Dr Tom Callaly
- Ms Geradine Cowin
- Prof Peter Choong
- Ms Maree Cuddihy
- Prof Paddy A Dewan
- Dr Brendan Flanagan
- Dr Peter Greenberg
- Dr Jane Hendtlass
- Dr David Hillis
- Ms Wendy Hubbard
- Ms Ann Maree Keenan
- Dr Marcus Kennedy
- Prof John McNeil
- Mr Greg Pullen
- A/Prof Leslie Reti
- Dr Michael Sedgley
- Dr Jill Sewell
- Dr Christine Walker
- Dr Tony Weaver
- Dr Alan Wolff

1. WELCOME AND APOLOGIES

No apologies.

2. MINUTES OF LAST MEETING

2.1 Minutes from meeting of 26 November 2001

A/Prof Les Reti was an apology for meeting of 26/11/01.
With that amendment, the Minutes were accepted.

2.2 Report on VQC workshop 31 January and 1 February 2002

The Chair requested comments on the document.

Appropriateness of care was not to include credentialing of clinicians.

Following today's discussions, further review and refinement of the document will be required.

Action:

- **The Chair will review the document and re-agenda for 17 June meeting**

2.3 Executive Minutes of 7 March meeting

The Chair reported that the position of Manager, Consultative Councils Secretariat has been advertised. The interview panel will consist of Dr Walsh, Dr Christine Kilpatrick and Dr Jenny Bartlett.

Dr Walsh reported on a meeting with Dr Patricia Mackay, Chair, Consultative Council on Anaesthetic Mortality and Morbidity (CCAMM). An agreed issue for CCAMM and VQC to work together was pain management.

Action:

- **The Chair, and a couple of other members, will meet with CCAMM to discuss and report to the next meeting.**

It was noted that Prof Ross Wilson was invited to attend the June meeting but is unavailable. He will be invited to subsequent meetings.

The Chairs of all Consultative Councils (Consultative Council on Obstetric and Paediatric Mortality and Morbidity, Consultative Council on Anaesthetic Mortality and Morbidity, Surgical Consultative Council) are to meet with Dr Walsh and Dr Bartlett on 24 April 2002 to discuss their relationship.

Action:

- **Dr Walsh will report on this at the 17 June meeting.**

VQC logo mock-ups were presented for consideration of the meeting. Feedback to the Chair during the meeting was requested.

3. MATTERS ARISING

3.1 Strategic Plan and Report to the Minister

Suggested changes and alterations to the wording in the Strategic Plan and Report are noted below –

- “Clinician support” is preferred to the term “buy-in” throughout both documents.

- Strategic Plan, page 7, Actions – replace “establish minimum data set” with “establish uniform data set”.
- Strategic Plan, page 9, Actions - replace “change the culture of the medical profession” with “assisting clinicians to acknowledge, and practice, safety and quality ...”.
- Report to the Minister, last line, page 7, appropriateness of care. Remove “(suitability to practice) – improve credentialing processes”.
- Mandatory reporting versus contractual reporting, on a range of issues, was raised. Proposed that, in the next calendar year, the VQC prepare and circulate a draft discussion paper on the merits of the various forms of reporting.
- Valid, risk adjusted and appropriately managed information involves disclosure. See item on Open Disclosure.

Action:

- **The Strategic Plan and Report to the Minister will be discussed at the next meeting.**
- **A draft paper on voluntary, contractual and mandatory reporting needs to be developed.**

3.2 Appropriateness of Care working group

Dr Jane Hendtlass (Chair) reported on the discussions the group had in this area. There was considerable discussion about the role of an “appropriateness” working group as part of the Council’s work or whether appropriateness should form part of every aspect of Council’s work.

It was agreed that there were areas of over-utilisation and under-utilisation of procedures and investigations, where there was compelling evidence of best practice.

Two documents on the area were cited:

- Agency for Healthcare Research and Quality (AHRQ) Report entitled “Making Health Care Safer: A Critical Analysis of Patient Safety Practices” July 2001.
<http://www.ahrq.gov/clinic/ptsafety/>
- “The RAND/UCLA Appropriateness Method User’s Manual”.
<http://www.rand.org/health/tools/appropriateness.html>

It was noted that Prof Jeremy Anderson (Centre for Clinical Effectiveness), A/Prof Don Campbell (Clinical Epidemiology and Health Services Evaluation Unit) and Prof Jeff Richardson (Centre for Health Program Evaluation) were key experts who may be useful to facilitate further work.

Action:

- **Secretariat to circulate papers.**
- **Further meeting to be scheduled.**

3.3 Blood Safety and Appropriateness working group

Dr Bartlett (acting Chair) advised –

- NH&MRC guidelines on use of blood and blood products have been widely circulated.
- The Commonwealth have a tender out to provide advice on best practice haemo-vigilance.
- The DHS sentinel events on ABO Incompatibility have been referred to the Victorian Blood Users

Group for advice on system wide improvement highlighted by these events. The DHS project funded on safety and appropriateness of Blood Utilisation has been asked to identify their goals and timelines associated with system-wide spread.

Action:

- **Further meeting to be scheduled.**
- **Roll out report from project to be circulated.**
- **National data on utilisation to be sourced.**

3.4 Falls Prevention working group

Ms Stella Axarlis (Chair) advised the group had met and conducted a workshop with invited experts/stakeholders from the field and DHS.

Discussion included –

- Lessons learned from research and falls projects does not appear to have been translated into
- systematic practice improvement.
- The group considered the “Falls Prevention Best Practice Guidelines” of the Quality Improvement and Enhancement Program, Queensland Health. The Guidelines were seen as an excellent resource, which could be modified for utilisation in Victoria.
- A communication strategy will be required which may include documents/guidelines (in several community languages) being placed on the VQC website.
- Falls in hospitals being recorded as a clinical indicator or a sentinel event was discussed. The working group identified that fractured neck of femur (NOF) in a clinical setting should be reported as a sentinel event either centrally or to health service quality committees.
- The group were asked to consider reporting and mapping of falls and how this was reported to the VQC.

Action:

- **Working Group to pursue how falls in hospitals should be mapped and reported.**
- **Working Group undertakes further meetings to look at modification and roll out of the Queensland program.**

3.5 Infection Control working group

Dr David Hillis (Chair) reported they had met and had referenced a considerable amount of information, including an article by A/Prof Denis Spelman, "Hospital-acquired Infections", MJA, Vol 176, 18 March 2002.

Discussion included –

- Wide variety of work currently being undertaken in the field including Victoria (papers circulated for Council planning days).
- National forum on 12 April where all States presented. There was no consistency of approach. The papers from this meeting are to be circulated when available.
- Number of committees oversighting this process – requires clarification.
- VICNISS (Victorian Nosocomial Infection Surveillance System) had commenced but no data will be available for 12 months. It will be reported to the VQC.
- It was noted that it was essential that data be risk adjusted and locally reported.

Action:

- **Further meeting to establish gaps in the current strategy and what interventions might link to the discussion on appropriateness.**
- **Diagram of DHS oversight committees to be provided.**

3.6 Medication Safety working group

A/Prof George Braitberg (Chair) reported the group had met and conducted a workshop with 20 invited experts/stakeholders. Recommendations from the workshop are in the VQC agenda papers.

Discussion included –

- A survey was circulated to all metropolitan, regional and district hospitals about medication safety issues with approximately 45 responses. All hospitals advised they had Pharmaceutical and therapeutic advisory committees.
- Standardisation of paper and electronic drug charts was seen as a key to decreasing the errors in prescribing and administration of drugs.
- Electronic prescribing was discussed. It was suggested that actions in the USA on this issue be considered.
- Group to co-opt relevant experts from the field and a consumer representative, and report to the next VQC meeting. Could develop a discussion paper for release.

Action:

- **Working Group to consider standardisation of paper and electronic hospital drug charts. Develop a discussion paper, including the views of consumers, for consideration at the next VQC meeting.**
- **Working Group to keep a watching brief on developments in electronic prescribing in the USA.**

3.7 Pressure Wounds working group

Mrs Kerry Bradley (Chair) reported the group had met and conducted a workshop with invited experts/stakeholders from the field. Recommendations from the workshop were circulated with the VQC agenda papers.

Discussion included –

- A survey was circulated to all metropolitan and regional hospitals about pressure wounds.
- Consensus in the field about definition of a pressure wound and clinical guidelines was difficult to obtain and therefore measurement of prevalence is difficult.
- Several clinical practice guidelines have been developed.
- There is no mechanism for reporting pressure wound prevalence either locally or Statewide. A point prevalence study may be of use once definitions are established.
- Pressure wounds could become a clinical indicator of hospital performance.
- Agreed the working group would continue.
- Working group to develop definitions and consistent guidelines..

Action:

- **Working Group to develop paper, and recommendations, for a point prevalence study on pressure wounds in (public/private) hospitals and sub-acute facilities. Report to the next VQC meeting.**

4. REPORTS

4.1 Lessons from the Inquiry into the King Edward Memorial Hospital Obstetrics and Gynaecology services

Presentation by Dr Michael Walsh is attached for information.

Discussion included the following –

- Useful outcomes from the Inquiry, including the WA government has established a high level Steering Committee that reports quarterly to Parliament on the implementation of the Inquiry recommendations.
- Resources have been provided to implement the recommendations.
- Discussion about credentialing of doctors is occurring in WA.
- ACHS data is notoriously low value and a purpose built data collection system may have alerted authorities sooner.
- Whistleblower legislation, and training in this, was mentioned.
- Senior clinicians and other staff time have been provided to affected families/patients in WA in addressing their on-going concerns. Staff support and training is also occurring.
- There was poor supervision of junior doctors, and some patients were not seen by a senior clinician during their admission.
- Lessons for governance and management.

5. NEW BUSINESS

5.1 Public release of VQC Minutes/Papers

A Freedom of Information request for the ACSQHC Minutes has been submitted. As a result the ACSQHC have posted their Minutes and other papers on their website.

It was agreed to include Minutes and other completed VQC documents on the website.

Action:

- **Indicate on the agenda which papers/documents are to be placed on the VQC website.**
- **VQC Minutes, once approved, will be placed on the website.**
- **VQC Minutes from 26/11/01 will be placed on the website.**

5.2 Direction of Working Groups

It was proposed that the Working Groups continue, with the current membership and ability to co-opt relevant experts from the field.

Action:

- **Working Groups will continue with the same membership and the ability to co-opt experts from the field as required.**
- **Working Groups will report on further progress at the 17 June meeting.**
- **Working Groups need to provide comments on what they believe Health Services should be collecting in the way of information/data in their areas.**

5.3 VQC Communication Strategy.

ACSQHC have gone to tender on this issue.

The relevant documents will be circulated with the next VQC Agenda for discussion.

Action:

- **Secretariat to obtain relevant documents and circulate with the next Agenda.**

5.4 Medical Error Action Group

Information circulated with the agenda papers was noted.

5.5 AIMS reporting

No consensus about the value of AIMS reporting in Victorian hospitals, versus other forms of adverse event reporting.

Action:

- **Roll out of AIMS reporting nationally to be discussed at SQOF - Dr Bartlett to report to the next meeting.**
- **Invite Prof Bill Runciman to speak to VQC meeting on 17 June.**
- **Agenda time to discuss adverse event reporting.**

5.6 Standardisation of Incident Forms

Mr Greg Pullen reported that various incident forms were in use across the State. Standardisation of incident forms was seen as a quick win.

Action:

- **Further discussion at the next meeting.**

6. PRESENTATIONS

6.1 Open Disclosure project

Ms Maree Cuddihy reported on a focus group meeting relating to this project. She said it was emphasised that saying sorry does not necessarily lead to litigation, nor is it an admission of liability.

Dr Rohan Hammett, Northern Sydney Health, presented the ACSQHC project on Open Disclosure. The following information was noted –

- The open disclosure project was awarded in late 2001. The details around documentation of the project will be available in 2 weeks on the ACSQHC website (www.safetyandquality.org).
- The project team has commenced wide stakeholder consultations, including this meeting. As advised focus groups are being undertaken.
- A number of issues related to tort reform, medicolegal issues, medical indemnity etc, are being addressed.
- The consumer focus of the project is an essential element particularly in reference to what patients want from disclosure, both during the consent process and after an event.
- Engagement in a communication process around this project including engaging the media is an essential element.
- Standards Australia have been engaged to develop the detailed deliverables.
- The project deliverables are due at the end of 2002.

Dr Hammett was thanked for his presentation.

A copy of Dr Hammett's presentation is attached for information.

7. **ITEMS FOR INFORMATION**

Noted

8. **NEXT MEETING**

*17 June 2002
Level 12 Conference Room
Department of Human Services
589 Collins Street
Melbourne*