A review of hospital safety and quality assurance in Victoria

Alfred Health response

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Theme 1: Fostering continuous improvement and clinical excellence

Principles and approaches for Victoria include:

Building on existing knowledge and skills – There are already highly skilled staff (both clinical and administrative) involved in safety and quality improvement in Victoria. Options for harnessing these skills include: rebuilding capacity and capability in the DHHS Safety and Quality Unit; improving participation through existing structures e.g. reference/ advisory groups, Colleges and professional networks and developing collaborative relationships with other agencies.

Better supported clinical leadership. Developing workforce capability and leadership offers an important platform for better health care quality and safety outcomes, and a more systematic and predictable quality and safety response across the health and disability sector (Rimmer 2012)[i]. A competency framework could be used to identify the core competencies, similar to those identified by the US Institute of Medicine. [ii] Currently there are limited local avenues for clinical leadership training; and limited leadership development offered by DHHS. As a result, training has been sourced by health services from other jurisdictions or countries such as the new ACHS Quality Academy based in Sydney, Ko Awatea in New Zealand and Intermountain Healthcare in the US..Options for Victoria include sponsored access to international programs and 'train the trainer' models to increase capability. There is little opportunity to showcase best practice and innovations in Victoria or across a national setting. Jönköping County Council in Sweden hosts an annual 'Microsystem' Festival which helps to an build international community and culture for improvement.

Sharing and networking – to foster collaboration with peers so that data, improvements and initiatives are spread across the sector. The existing Clinical Networks have provided a basis for this, particularly in some of the specialised areas, but greater coherency and integration in approach is required for example between existing clinical networks and the Dr Foster collaborative. Other models include supporting participation in benchmarking groups such as the Health Roundtable which has facilitated learning sessions and collaboratives between hospitals in Australia and New Zealand since 1995. The Health Roundtable is also a member of the University Health System Consortium (UHC), which is an alliance of 120 academic medical centres, and 300 affiliated hospitals in the US. Conferences also provide opportunity and the annual APAC forum sponsored by Ko Awatea, with initial collaboration with the DHHS also has held intensives in various hospitals to increase access to experts.

Improving coherency and collaboration in engagement with health services. Actions arising from this review should align with the newly established Better Care Victoria initiative which has a focus on best practice innovations that could be tailored for implementation in Victoria. Close links could also be established with other statutory authorities for innovation and improvement such as New South Wales (Clinical Excellence Commission) and Scotland (Healthcare Improvement Scotland (HIS)). The Clinical Excellence Commission, established in 2004 to promote and support improved clinical care, safety and quality across NSW provides resources and programs in a range of areas including infection control, clinical leadership, clinical practice improvement, medication safety, deteriorating patients, patient based care, sepsis, teamwork, pressure injuries, accreditation, data sharing and quality and safety education. This work has been guided by issues identified through incident investigation and international best practice, but access is limited to NSW Health.

Theme 2: Improving hospital governance

Principles and approaches for Victoria include supporting earned autonomy, which recognises the achievements of high performing health services. Recognising their strategies and investments provides a useful counterbalance to focussing only on the negative aspects of failure (Baker, Kings Fund 2011[iii]) and (Hollnagel 2014)[iv]. (See *Standardised Reporting* for an example of earned autonomy in action.)

Improving monitoring against the National Standards (NSQHS). The accreditation process can be used effectively and strategically to ensure system and processes keep patient safety at front and centre of the organisation. At Alfred Health, positive patient identification and graphic observation charts to detect clinical deterioration had better traction with staff when introduced in the lead up to accreditation. However, the current system allows considerable variation in the approaches health services take. A good example of sharing the learnings was sponsorship by the DHHS for a 'Top Ten Tips' Seminar conducted by Alfred Health in 2013. Two hundred staff from approximately 66 health services across Victoria attended. A CD of resources was offered to health services.

Including Patient Safety as a Strategic Priority – Making patient safety a strategic priority is not about resources or organisational size. The following measures at Alfred Health help to maintaining a safety culture:

- Patent safety and quality as first agenda item for Executive and Board meetings
- Integrate safety and quality into operational meetings, position descriptions and organisational structures
- Include a CEO overview / presentation on safety and quality as part of orientation
- Host an annual Chairman of the Board award for Patient Safety and Quality

Improving Incident management and systems for learning from error – The current VHIMS system has not provided feedback to health services on numbers, classifications or key clinical risks. The Riskwatch newsletters have been adhoc and focussed on individual incidents instead of systemic issues and actions. Using the concept 'Patient Safety Intelligence' (used by UHC) emphasises the importance of aggregating themes and understanding risks. Previous education organised by DHHS on Root Cause Analysis incorporated an understanding of human factors and engineering controls to develop effective solutions that eliminate the risk where possible, but these programs have been minimized. An example of good practice in learning from error is presenting learnings from adverse events at clinical meetings such as Grand Rounds. This sends powerful messages to clinicians, especially those in training, that things do go wrong, but there is an organisational expectation that actions will be taken to avoid recurrence. It is powerful to hear senior clinicians acknowledging and expressing regret for what has happened - this alone can be very effective in bringing about cultural change.

Robust approach to risk management and the provision of clinical services – a consistent theme from the instances of clinical governance failure was the issue of small specialised or high risk services. A strategic approach to assessing both the viability and safety of these services, and the development of partnerships with major service providers provides an alternative approach to managing these services without closing them down. An example of this at Alfred Health was the development of the Women's at Sandringham agreement for the provision of Obstetric Services at a smaller campus of a large health service. This partnership approach allows the provision of high quality services that are accessible to the local community, but is overseen by a major provider of maternity services, in this case the Royal Women's.

Theme 3: Strengthening oversight of safety and clinical governance

Principles and approaches for Victoria include and establishing reporting to DHHS by exception rather than instituting an onerous schedule of compliance-based reporting which could make it harder to detect early warning signs.

Strengthening DHHS mechanisms for oversight of data - A more effective structure and system for oversight of hospital safety and quality is required to detect and investigate early warning signs that suggest potential failures of clinical governance.

Review mechanisms for sharing information on investigations. Victorian Audit of Surgical Mortality (VASM) conducts reviews, however the results are only provided to individual clinicians, not the health services where they are employed. Health Services have no opportunity to detect patterns, themes or areas for improvement.

Strengthening quality and safety literacy- this applies at DHHS, Board, Executive, Clinician and management levels. Part of this process could involve improving selection criteria that include details of governance, safety and quality experience and skills. Core induction could include the fundamentals of improvement science, including Deming theory, data analysis and rapid cycle testing. It is beyond the majority of smaller hospitals to provide this in house.

Standardised Reporting – on safety and quality indicators and action plans. As the following suite of reports show, Alfred Health has a long standing commitment to open and transparent reporting and would advocate the following actions.

- A core set of measures of quality and safety to compare performance over time with like health services for example through VAED / Dr Foster / Health Roundtable, the ACHS Clinical Indicator Program and the NSQHS.
- Clinical validation of coded data. Through both the Dr Foster and HRT systems, it is possible to correlate findings between adverse screening systems and coded datasets to improve accuracy and relevancy for use by both clinical and administrative staff. For example, errors in classification of patients who are transferred to a tertiary hospital as an emergency, but are classified as elective / planned can lead to misrepresentation in a low risk of death cohort.
- A suite of key performance indicators should be accessible to staff on the intranet and the community via Internet thus supporting transparency and accountability for performance. Good examples from the US include Vidant Health and Emory.
- A robust clinical audit program should be in place for all Clinical Units with formal presentations on an annual basis, preferably chaired by an external expert and open to all staff. Smaller hospitals could potentially link into this.
- A Monthly Clinical Governance Report to the Executive should include data and commentary on clinical risks, incidents, complaints and accreditation progress against a gap analysis. An annual calendar of clinical governance related reports should be in place to ensure appropriate notification and management oversight.
- An annual clinical governance report to the DHHS could replace the current Annual Quality of Care Report.

There would be considerable benefit, in terms of benchmarking and improvement, to standardise reporting.

Better targeting of Patient Safety Goals. The current annual Statement of Priorities (SOP) and Performance Monitoring Framework (PMF) encompasses operational, external policy, safety, risk and consumer priorities, but the current list of safety and quality indicators are under developed. In contrast, US hospitals have more guidance from JHACO in setting and monitoring against National Patient Safety goals. Don Berwick (2013) identified a learning from Mid Staffordshire as: *Place the quality of patient care, especially patient safety, above all other aims*[v]*.*

Theme 4: Advancing transparency

Principles and approaches for Victoria include improving public reporting and accountability.

Engage, empower, and hear patients and carers at all times. Aim to improve transparency so the community can be confident that governance arrangements at both the system and hospital level can quickly identify and rectify quality of care issues and continuously improve processes and outcomes of care. For example, transparency about how incident investigations will be done, who will be involved, how the people involved will be treated and respected.

Improve the availability and access to information. Currently the Dr Foster data is available to 14 Victorian Hospitals, and access to The Health Roundtable data is by subscription. The Australian Safety and Quality Commission recently piloted access to a national database of VAED data, but the timeframes for making this available to health services are not clear. Hospitals that are pursuing full electronic health records should also be supported as this allows greater recording of data for patient safety and quality improvement that is currently collected manually and would allow greater use of that data (as per UHC system) to identify unexpected and unwanted variation

Improve the learnings from Sentinel Events – Currently the focus appears to be on individual cases and the feedback to health services is often delayed and focused on the report rather than any system wide learnings. A number of other jurisdictions and agencies provide health services with notice of a patient safety issue through a Patient Safety Alert system with a call to action, for example, NSW, VA (Veteran Affairs in the US) and JHACO (Joint Commission, Accreditation, Healthcare, Certification in the US) and provide options for signup for alerts. The Department of Health could consider notification of Sentinel Events in the context of both national and international knowledge instead of encouraging reinventing of the wheel. There is also extensive literature on failure to learn which is not unique to health (Walshe 2004).[vi]

Better transparency and sharing within between health services – Leading on from State-wide learnings from serious events, the opportunity to target key clinical risks that cross professional and specialist boundaries such as abnormal results follow-up would benefit from a Collaborative approach which has been championed by agencies such as IHI, UHC and HRT. This could align with Better Care Victoria, particularly in the provision of best practice services for chronic conditions such as heart failure and COPD, which not only contribute to a disproportionate percentage of hospitals admissions and readmissions, but are also subject to high variation in standards of care provided.

Explore options for greater linking between large and smaller health services - Some good clinical options exist for example through the use of Telehealth and for Statewide Services. There are also opportunities to improve standardization of practice through the sharing of clinical practice guidelines. The policy system, PROMPT that was developed by Barwon Health, was initially sponsored by the Department of Health for a number of pilot hospitals. Each of these hospitals has taken up the system at low cost, but the support for a statewide rollout by DHHS has not been sustained.

Better support for CEO stability and appointment – Distrust between clinicians and management has been cited in a number of reviews (eg NSW Inquiry into Campbelltown and Camden Hospitals). Greater focus on recruitment of CEOs with strong patient safety and quality literacy and support for stability of appointment are strongly supported by senior clinicians.

References

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