2003–2008

Western Australian Strategic Plan for Safety and Quality in Health Care

Department of Health
Government of Western Australia

Message from the Minister for Health

Health care is increasingly complex in its delivery, personnel, technology and demand pressures. Inevitably problems, or adverse events, arise which affect both recipients and providers of health care. Recent well-publicised adverse events in Australia, Canada, the United Kingdom and the United States have made the community more aware of the frequency, human cost and economic burden of this problem.

Current trends have also clearly reinforced the need for sustained commitment to continued improvement in the safety and quality of health care from all those involved in the health system and from the Western Australian community.

The Western Australian Government through the Western Australian Council for Safety and Quality in Health Care is committed to the provision of safe and high quality health care services. The Government has allocated significant funding to enable the State to support and progress this vital work.

The Western Australian community wants and expects a safe health care environment that delivers quality services. With this in mind, I am pleased to present the Western Australian Strategic Plan for Safety and Quality in Health Care 2003-2008. This plan, which builds on the previous five-year plan, provides a strategic framework to promote the delivery of consumer focused, safe, quality health care in Western Australia.

Given the importance of implementing the quality improvement strategies within the health care sector, I have charged the Western Australian Council for Safety and Quality in Health Care with the responsibility for leading the implementation of the Western Australian Strategic Plan for Safety and Quality in Health Care 2003-2008. I have also asked the Council to work in partnership with health service managers, clinicians, academics, consumers and other safety and quality professionals to ensure that these important changes are implemented across the Western Australian health system.

I look forward to continuous and ongoing improvement in all Western Australian health services over the next five years.

Hon. Robert Kucera APM MLA
MINISTER FOR HEALTH

May 2003

Foreword

The Western Australian Council of Safety and Quality of Health Care ('the Council') was established by the Western Australian Department of Health in August 2002 to provide strategic advice to the Director General of Health and the Minister for Health on system-wide safety and quality issues and to provide direction and leadership for quality improvement in Western Australia.

The Council believes that everyone working in and with the Western Australian health system, including health service managers, clinicians, academics, consumers and other safety and quality professionals, has a critical role in improving the safety and quality of patient care. The Council has developed a Strategic Plan that provides a strategic framework to further promote the delivery of consumer focused, safe, quality health care in Western Australia for 2003 to 2008.

This Plan will foster a health care system for Western Australia that concentrates on consumer needs, and strives for continuous quality improvement in all areas of health care delivery. It will strengthen consumer involvement in the planning, delivery, monitoring and evaluation of health services and encourage the establishment of a non-blame culture. Individual and system accountability for the safety and quality of health care will be enhanced through the development and dissemination of improved evidence-based clinical practice and risk management systems and processes.

The Council recognises that a large number of excellent safety and quality initiatives have already been introduced and progressed under the auspices of the Western Australian Strategic Quality Plan 1998 – 2003. The Council believes these initiatives will provide a strong foundation and impetus for future safety and quality work to be undertaken across the state's health system during the next five years.

The Council will continue to scan the international, national and state safety and quality environment to continually improve its strategies and to identify emerging areas of importance. It will also evaluate safety and quality initiatives as they are implemented in the Western Australian health system to ensure that they deliver consumer focused, safe, quality health care. Furthermore, the Council will strive to recognise excellence in safety and quality by celebrating, publicising and sharing achievements for the benefit of the health system as a whole.

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1. OVERVIEW OF THE WESTERN AUSTRALIAN STRATEGIC QUALITY PLAN 2003–2008

The Western Australian Government is firmly committed to ensuring safe, high quality health care services are provided to the Western Australian community. The Government also recognises it shares this aim with everyone in the health system; including patients, residents, carers, consumers, clinicians, health care professionals, health care administrators, health care proprietors and the community.

This Strategic Quality Plan was developed by members of the Western Australian Council for Safety and Quality in Health Care ('the Council') and outlines a shared vision for improving the safety and quality of the Western Australian health system for financial years 2003/2004 to 2007/2008. This Plan provides a strategic framework for promoting the delivery of consumer focused, safe, quality health care in Western Australia.

The primary focus of the plan is to address safety and quality in the acute care sector. However, given that hospitals operate as an integral part of a wider health care system, those services at the interface between the hospital and the wider health system (eg the primary, community, aged care and mental health areas) are also included within the scope of the plan.

The plan recognises a large number of safety and quality initiatives have already been introduced and progressed across the Western Australian health system. It is intended that these initiatives will provide a strong foundation and impetus for future work during the next five years.

The long-term goal is to improve the safety and quality of the State's health care services and to build individual and organisational accountability systems across the State's health system, which will ensure the maintenance and continued improvement of health care.

2. FRAMEWORK FOR THE STRATEGIC QUALITY PLAN AND STRATEGIC INITIATIVES

This Strategic Quality Plan is built around four important interlinked strategic areas:

2.1 **Consumer Focused Health Care:** engaging consumers as partners at all levels of health care.

The views of patients and consumers of health care services are considered essential in health service planning, delivery, monitoring and evaluation. As a result, consumer involvement in the health system should be strengthened to address the identified paucity of current consumer input.[1] This input needs to be wide ranging, with special consideration given to minority and special needs groups.[2] Consumer participation in health care services must also be meaningful, with their concerns being addressed and their feedback used to enhance service delivery practices.[3, 4]

2.2 **Clinical Practice Improvement:** ensuring effective tools and methodologies are available to support clinicians in their work. This includes ensuring that evidence-based best practice information is developed, accessible and used to reduce variation in clinical practice.

Modern health care is complex and clinical practices must be safe and of high quality. As a result, care should be based on scientific evidence and expert judgement.[5] The application of effective tools and methodologies to support clinicians in their work will ensure that health care service delivery is safe, promotes continuous improvement and ensures clinical best practice, engenders an environment which supports innovation and fosters a workforce culture that embraces all of the above.[6]

1 *Commonwealth Department of Health and Aged Care (1998). Commitment to Quality Enhancement: The Interim Report of the National Expert Advisory Group on Safety and Quality in Australian Health Care. Australian Government Publishing Service, Canberra, April 1998, op cit p.31.*

2 *Commonwealth Department of Health and Aged Care (1998). Commitment to Quality Enhancement: The Interim Report of the National Expert Advisory Group on Safety and Quality in Australian Health Care. Australian Government Publishing Service, Canberra, April 1998, p. 7.*

3 *Consumer Health Forum of Australia Inc. Report identified a number of key performance issues for consumers. These included issues on access, treatment effectiveness, communication and participation, care, continuity of care, human needs and service efficiency.*

4 *Consumer Focus Collaboration Strategic Plan 1997/8 – 2000/01, August, 1998 outlines strategies for strengthening consumer focus in health service delivery.*

5 *Brook, R.H. McGlynn, E.A. and Cleary, P.D. (1996). Quality of health care: Part 2: measuring quality of care, NEJM, 335 (13): 996-970.*

6 *Moss, F. and Garside, P. Organisational change: the key to quality improvement, Quality in Health Care, vol 7. This article identified organisational change as being instrumental in the achievement of quality improvement.*

2.3 **Risk Management:**
ensuring effective tools and methodologies are available to identify, manage and reduce risk at all levels of the health care system.

This initiative will involve the development and implementation of an integrated risk management system. Risk management is considered an essential component of quality improvement requiring dedicated support and development. The recent interim report by NEAG[7] noted that modern health care delivery is complex and risk-laden. Consequently, a strategic risk management initiative needs to address the requirement for health care systems to be proactive in managing risk.

A way forward will be to pursue objectives such as the development of seamless approaches to corporate and clinical governance for risk management.

This approach to risk management will also encourage learning from near misses and failures. In addition, risk management standards for the government health industry will be developed and implemented and management and employees will be made accountable for risk management. Finally, risk management will be promoted as an integral part of the organisational culture.

2.4 **System Improvement & Accountability:**
facilitating system improvement through redesign, improved accountability and greater use of information.

Accountability in health services is a vital component of quality and safety of health care. As a result, accountability should encompass a broad range of measures focusing not only on individuals or groups but on systems as a whole.

3. FRAMEWORK DEFINITION

The conceptual framework for safety and quality embraces an expansive definition of quality improvement provided by the Health Services (Quality Improvement) Act 1994,[8] which defines quality improvement as activities and programs intended to assure or improve the quality of care in a health service.

Two themes flow across these four strategic areas: leadership and communication. Both are vital to high quality, safe care. Leadership at all levels of the health system is deemed essential to building a successful quality system and culture, and has been placed as a theme running through all components of the Strategic Quality Plan.

The Council's key responsibility over the next five years will be to provide strong and consistent leadership to achieve the Strategic Quality Plan's goals and objectives, which call for significant cultural and systemic changes.

In turn, the Council will be seeking to form strong alliances and partnerships through engagement and communication with health service managers, clinicians, academics, consumers and other safety and quality professionals to drive the safety and quality agenda further and to ensure that these important changes are implemented across the Western Australian health system.

7 *Commonwealth Department of Health and Aged Care (1998). Commitment to Quality Enhancement: The Interim Report of the National Expert Advisory Group on Safety and Quality in Australian Health Care. Australian Government Publishing Service, Canberra, April 1998, p.i.*

8 *Health Services (Quality Improvement) Act 1994 and Health Services (Quality Improvement) Regulations 1995 Guidelines, Health Department of Western Australia op cit section 2.*

Figure 1: Conceptual Framework for the Strategic Quality Plan and Strategic Initiatives

8 *Health Services (Quality Improvement) Act 1994 and Health Services (Quality Improvement) Regulations 1995 Guidelines, Health Department of Western Australia op cit section 2.*

4. GUIDING PRINCIPLES

Supporting the four major areas of strategic focus is a set of principles that demonstrate a commitment to best practice and guide the application of the strategic initiatives at the local service level. These are:

4.1 **Access** – People have the right to access health services that are committed to the application of best practice approaches to the provision of patient care. This is provided on a needs basis, regardless of age, gender, ethnicity, religion, health insurance status and socio-economic status. Health services are also committed to the provision of readily accessible consumer health information.

4.2 **Efficiency and Effectiveness** - Health services are committed to the rational use of resource inputs to produce a service or output, as well as the attainment of stated outcomes.

4.3 **Reproducibility** – To ensure that clinical care is evidence-based, meets minimum standards and has the potential of being reproduced when required in other comparable settings.

4.3 **Safety** - Patient and staff safety is a major objective of health services, as is an approach based on prevention of adverse events. There is a commitment to risk management which facilitates a proactive approach to maintain safety and prevent adverse incidents.

4.5 **Appropriateness** – To ensure that clinical care is tailored to meet individual needs. Health services are committed to the provision of clinical care identified as beneficial and relevant for the individual.

4.6 **Participation of Consumers/Providers/Employees** - To ensure that health services are aware of the needs of consumers and modify and develop services accordingly. Health services are committed to strengthening pathways for consumers and people with special needs to influence areas of health services planning, delivery, monitoring and evaluation.

5. GOVERNANCE

Whilst the Office of Safety and Quality in Health Care will provide overall governance for the Strategic Quality Plan 2003 – 2008, the Western Australian Council for Safety and Quality in Health Care will provide a leadership role in monitoring and evaluating initiatives implemented by hospitals and health services across the Western Australian health system to ensure that they deliver consumer focused, safe, quality health care in Western Australia.

The Council will also continue to scan the international, national and State safety and quality environment to continually improve its strategies and to identify emerging priority areas.

A process of consultation with stakeholders including consumer groups and Area Health Services will be undertaken from 2003-2008 to ensure that the plan is relevant to the needs of health services at the local level and to ensure the involvement of consumers, clinicians and health service administrators in its implementation.

6. MONITORING AND REPORTING

The Strategic Quality Plan 2003 – 2008 is consistent with the recommended strategic areas for the Australian Health Care Agreements for Safety and Quality for 2003/04 to 2007/08, the action plans of the Australian Council for Safety and Quality in Health Care and the business plan of the Office of Safety and Quality in Health Care of the Western Australian Department of Health. The Council will establish minimum standards and other reporting requirements to enable it to monitor and evaluate achievements against the Strategic Quality Plan on a regular basis and provide reports to the Director General of Health Care.

In an attempt to monitor Western Australia's progress towards achieving the aims of this Plan, internal State reporting of achievements to date will be undertaken bi-annually. In addition, the State will report to the Commonwealth as required by the Australian Health Care Agreements 2003-2008.

7. THE WESTERN AUSTRALIAN STRATEGIC QUALITY PLAN 2003-2008

VISION

To promote the delivery of health care which is safe for consumers and of high quality through appropriate partnerships, with clients, carers, consumers, clinicians, health care professionals, health care administrators, health care proprietors and the community.

VALUES

Leadership... We will identify and support leaders who value safety and quality in health care and support a culture which focuses on system improvement not on blame.

Partnerships... We will work collaboratively with our partners to build capacity for delivering consumer focused, safe, quality health care in Western Australia.

Communication... We will achieve safe, quality health care through engagement and communication with patients, clients, carers, consumers, clinicians, health care professionals, health care administrators, health care proprietors and the community.

Accountability... We will promote individual and system accountability for delivering safe, quality health care in Western Australia.

Transparency... We will work within a team environment to support systematic improvements in health care, basing decisions on evidence in an open and transparent manner.

Equity... We will promote equity and fairness in all safety and quality programs, policies and standards.

STRATEGIC THEME AREAS

LEADERSHIP

Improved health care system that identifies and supports leaders who value safety and quality in health care and support a culture which focuses on system improvement not on blame.

COMMUNICATION

Improved communication systems and processes to facilitate the delivery of consumer focused, safe, quality health care.

STRATEGIC FOCUS AREAS

Our goals will focus on achieving the following outcomes:

CONSUMER FOCUSED HEALTH CARE

- Engagement of consumers as partners at all levels of health care.
- Enhanced patient and consumer knowledge through education and communication.
- Increased consumer participation in health service planning, delivery, and evaluation.

CLINICAL PRACTICE IMPROVEMENT

- Fostering of a continuous learning environment that supports the development and use of evidence-based best practice information to promote continuous system improvement and reduced variation in clinical practice.
- Improved use of health care data and information to achieve optimal health outcomes.

RISK MANAGEMENT

- Improved use of tools and methodologies to identify, manage and reduce risk at all levels of the health care system.

SYSTEM IMPROVEMENT AND ACCOUNTABILITY

- Improved accountability for the use of clinical resources and the safety and quality of health care outcomes through the development and oversight of health policy and regulation, corporate and clinical governance frameworks and health care standards.
- Clinician led system improvements through increased health workforce capacity.
- Continued oversight of licensed facilities to ensure the provision of a safe and appropriate environment of care consistent with the required legislation and minimum standards.

OUR GOALS AND OBJECTIVES

1. CONSUMER FOCUSED HEALTH CARE

Goal – To engage consumers as partners at all levels of health care.

Objectives

- To build capacity for increased consumer partnerships at all levels of the health care system.
- To promote consumers as partners in health care.
- To increase consumer participation in health service planning, delivery, and evaluation.
- To enhance patient and consumer knowledge through education and communication.
- To ensure consumer expectations and experience are valued.

2. CLINICAL PRACTICE IMPROVEMENT

Goal – To ensure effective tools and methodologies are available to support clinicians in their work. This includes ensuring that evidence-based best practice information is developed, accessible and used to reduce variation in clinical practice.

Objectives

- To foster a continuous learning environment that supports the development and implementation of evidence-based clinical best practice in health care.
- To support the health workforce in the development, use and adherence to evidence-based clinical guidelines and standards.
- To support the health workforce in the use of clinical audits to monitor and review clinical practice and performance.
- To improve health care data and information systems to support the monitoring, review and analysis of clinical performance and system failures.

3. RISK MANAGEMENT

Goal – To ensure effective tools and methodologies are available to identify, manage and reduce risk at all levels of the health care system.

Objectives

- To improve systems and processes to identify, manage and reduce risk at all levels of health care.
- To monitor and report incidents and adverse events using appropriate systems, including the Australian Incident Monitoring System (AIMS).
- To investigate individual and system incidents and achieve appropriate remedial action.
- To support appropriate qualified privilege processes for safety and quality activities.

4. SYSTEM IMPROVEMENT AND ACCOUNTABILITY

Goal – To facilitate system improvement through redesign, improved accountability and greater use of information

Objectives

- To increase the number of Western Australian hospitals and health services that are accredited by an appropriate external accreditation agency.
- To promote improved accountability for the use of clinical resources and the safety and quality of health care outcomes through the development and oversight of health policies and regulations, corporate and clinical governance frameworks and health care standards.
- To facilitate the redesign of health systems to ensure the delivery of high standard, safe, quality health care.
- To ensure that licensed facilities are safe and provide an appropriate environment of care consistent with the required legislation and minimum standards.
- To monitor, identify and report compliance with licensing requirements.
- To identify and regulate areas of non-compliance associated with licensing.
- To ensure that tools and methodologies are available to support the licensing requirements.
- To enhance the development of the licensing process by engaging in consultation with relevant stakeholders.
- To develop and implement the licensing standards applicable to the proprietor, premises and arrangements for management, staffing and equipment.
- To review the licensing requirements of the Hospitals and Health Services Act 1927, with particular attention to nursing homes and private psychiatric hostels.
- To facilitate the application of licensing standards to both the private and public sector.

8. STRATEGIC GOALS, OBJECTIVES AND STRATEGIES

1. CONSUMER FOCUSED HEALTH CARE

GOAL

To engage consumers as partners at all levels of health care.

1. **Objective** - To increase consumer participation in health service planning, delivery, and evaluation.

   Strategies

   - Develop a consumer participation policy and guidelines for health services.
   - Develop strategies with consumers and health care providers to increase consumer participation in health service planning, delivery, and evaluation.
   - Provide support for the recruitment, training and maintenance of consumer representatives in health care.
   - Develop and implement education and training programs to enable consumers to participate in health service planning, delivery, and evaluation.

2. **Objective** - To enhance patient and consumer knowledge through education and communication.

   Strategies

   - Develop education and training programs to enhance consumer knowledge on quality and safety initiatives and issues.
   - Develop, implement and evaluate marketing strategies to promote safety and quality initiatives.

3. **Objective –** To promote consumers as partners in health care.

   Strategies

   - Develop and market a patient charter for the Western Australian health system.
   - Develop strategies to engage consumers as partners in health care.
   - Develop strategies to educate stakeholders on the benefits of involving consumers as partners in health care.

4. **Objective** - To ensure consumer expectations and experience are valued.

   Strategies

   - Create knowledge base on consumer expectations and feed back.
   - Work with stakeholders to develop appropriate indicators of consumer feedback.
   - Continue to evaluate and report on consumer expectations and experience, including consumer satisfaction and develop change management strategies as required.

2. CLINICAL PRACTICE IMPROVEMENT

GOAL

To ensure effective tools and methodologies are available to support clinicians in their work. This includes ensuring that evidence-based best practice information is developed, accessible and used to reduce variation in clinical practice.

1. **Objective** - To foster a continuous learning environment that supports the development and implementation of evidence-based clinical best practice in health care.

   Strategies

   - Provide structures that foster a continuous learning environment and the continuous review of professional development and performance.
   - Support the development of appropriate policies and processes to improve the credentialling of medical practitioners and health professionals across the health system.
   - Provide structures that support the development, implementation and utilisation of best practice models and clinical guideline information.
   - Support collaborative development and use of priority evidence-based clinical guidelines and standards.

2. **Objective** - To support the health workforce in the development, use and adherence to evidence based clinical guidelines and standards.

   Strategies

   - Develop strategies to ensure evidence-based practice information is developed, accessible and used.
   - Monitor the development and implementation of evidence-based clinical practice information.
   - Improve the dissemination and uptake of evidence-based clinical practice information.
   - Support clinicians to reduce inappropriate clinical practices and to develop processes to improve adherence to evidence based practice.
   - Review and report on system improvements to ensure improvements are accessible and used.

3. **Objective** - To support the health workforce in the use of clinical audits to monitor and review clinical practice and performance.

   Strategies

   - Develop strategies to support the health workforce in the use of clinical audits to monitor and review clinical practice and performance.
   - Support the use of clinical audits and data to increase compliance to best practice and to support clinicians to reduce inappropriate clinical practices and to develop processes to improve adherence to evidence based practice.

4. **Objective** - To improve health care data and information systems to support the monitoring, review and analysis of clinical performance and system failures.

   Strategies

   - Improve mortality and morbidity data sets to monitor, review and analyse system failures.
   - Improve the translation and use of health care data and information to achieve optimal health outcomes.
   - Promote systems and processes to improve the collection, analysis and dissemination of safety and quality data and health information to support health care improvement.
   - Improve access of data, targeting priority areas that require improvement.
   - Further develop morbidity and mortality audits to improve the review and analysis of system failures and opportunities for system improvements.

3. RISK MANAGEMENT

GOAL

To ensure effective tools and methodologies are available to identify, manage and reduce risk at all levels of the health care system.

1. **Objective** - To improve systems and processes to identify, manage and reduce risk at all levels of health care.

   Strategies

   - Develop processes for review of targeted complaints, medico-legal issues, falls and medication errors to enable timely response and review to high level or frequently occurring incidents for health system improvements.
   - Review targeted complaints, falls and medication errors to develop system wide safety and quality improvements.

2. **Objective** - To monitor and report incidents and adverse events using appropriate systems, including the Australian Incident Monitoring System (AIMS).

   Strategies

   - Finalise and disseminate Statewide guidelines for monitoring and reporting clinical incidents.
   - Develop improved systems for monitoring and reporting incidents and adverse events including the Australian Incident Monitoring System (AIMS).
   - Develop strategies to improve participation in timely clinical incident reporting, monitoring and review for improvement.

3. **Objective** - To investigate individual and system incidents and achieve appropriate remedial action.

   Strategies

   - Finalise and disseminate Statewide guidelines for the investigation and analysis of clinical incidents.
   - Develop and implement a nationally consistent root cause analysis methodology to investigate individual and system incidents and achieve appropriate remedial action.
   - Provide training and education to health professionals in the root cause analysis methodology to support improved investigation of individual and system incidents.

4. **Objective** - To support appropriate qualified privilege processes.

   Strategies

   - Develop improved qualified privilege processes to encourage health professionals to participate in safety and quality improvement activities.

4. SYSTEM IMPROVEMENT AND ACCOUNTABILITY

1ST GOAL

To facilitate system improvement through redesign, improved accountability and greater use of information.

1. **Objective** - To increase the number of Western Australian hospitals and health services that are accredited by an appropriate external accreditation agency.

   Strategies

   - Develop processes to ensure health service accreditation is used for health care system improvement.
   - Develop policies and processes to support Western Australian hospitals and health services to attain accreditation by an appropriate external accreditation agency.
   - Work with stakeholders to develop reporting framework for health system accreditation data.
   - Monitor progress of hospitals and health services against the framework.

2. **Objective** - To promote improved accountability for the use of clinical resources and the safety and quality of health care outcomes through the development and oversight of health policies and regulations, corporate and clinical governance frameworks and health care standards.

   Strategies

   - Promote accountability for health care outcomes at all levels of the health care system.
   - Develop a culture of accountability and transparency for safety and quality through the engagement of all stakeholders.
   - Promote the systematic deployment, oversight and reporting of appropriate health policy and regulations, clinical and corporate governance frameworks and health care standards.
   - Monitor the progress of health services in developing and implementing safety and quality policies, regulations and health care standards.
   - Monitor the progress of health services in developing and implementing frameworks and processes for clinical and corporate governance.
   - Develop processes to market, educate and train consumers, clinicians, health care professionals, health care administrators, and health care proprietors in the intent and appropriate use of health policies and regulations, corporate and clinical governance frameworks and health care standards.

3. **Objective** - To facilitate improvements for safety and quality through the redesign of health systems.

   Strategies

   - Facilitate the redesign of health systems to ensure the delivery of high standard, safe, quality health care.
   - Support the development of mechanisms to enhance the continuum of care between the hospital system and the wider health care system (eg the Primary, Secondary, Tertiary, Community, Aged Care and Mental Health areas).

2ND GOAL

To ensure that licensed facilities are safe and provide an appropriate environment of care consistent with the required legislation and minimum standards.

1. **Objective** - To monitor, identify and report compliance with licensing requirements.

   Strategies

   - Monitor, identify and report compliance with licensing requirements.
   - Develop processes to work with stakeholders to undertake remedial action where non-compliance with licensing requirements is identified.

2. **Objective** - To identify and regulate areas of non-compliance associated with licensing.

   Strategies

   - Identify and regulate areas of non-compliance associated with licensing.
   - Develop processes to work with stakeholders to undertake remedial action where non-compliance with licensing requirements is identified.

3. **Objective** - To ensure that tools and methodologies are available to support the licensing requirements.

   Strategies

   - Develop and implement appropriate tools and methodologies to support the licensing requirements.
   - Ensure that tools and methodologies are made available to stakeholders to support the licensing requirements.

4. **Objective** - To enhance the development of the licensing process by engaging in consultation with relevant stakeholders.

   Strategies

   - Develop programs and strategies to engage and consult with relevant stakeholders in the development of licensing processes.

5. **Objective** - To develop and implement the licensing standards applicable to the proprietor, premises and arrangements for management, staffing and equipment.

   Strategies

   - Engage and consult with relevant stakeholders to develop and implement the licensing standards applicable to the proprietor, premises and arrangements for management, staffing and equipment.

6. **Objective** - To review the licensing requirements of the Hospitals and Health Services Act 1927, with particular attention to nursing homes and private psychiatric hostels.

   Strategies

   - Review the licensing requirements of the Hospitals and Health Services Act 1927, with particular attention to nursing homes and private psychiatric hostels.
   - Develop recommendations for the amendment of the licensing requirements of the Hospitals and Health Services Act 1927, to meet the needs of nursing homes and private psychiatric hostels.

7. **Objective** - To facilitate the application of licensing standards to both the private and public sector.

   Strategies

   - Develop recommendations for the State Health Management Team for the creation and application of licensing standards to both the private and public sector.
   - Work with stakeholders to develop appropriate licensing standards for both the private and public sector.
   - Facilitate the application of licensing standards to both the private and public sector.

5. LEADERSHIP & COMMUNICATION

GOAL

To identify and support leaders who value safety and quality in health care and support a culture which focuses on system improvement not on blame.

1. **Objective** - Develop a team based approach to continuous improvement and learning.

   Strategies

   - Develop strategies to support continuous professional development and cross discipline team work.

2. **Objective** - Foster clinician commitment to accountability and responsibility.

   Strategies

   - Support the development and implementation of standards for credentialling and clinical privileges of the health workforce.
   - Work collaboratively with educators to improve undergraduate and continuing professional development and clinical skills training focusing on patient safety and quality.
   - Support continuous professional development and 're-education'.
   - Support the development of improved performance management processes in line with credentialling.
   - Develop processes for acknowledging and rewarding improvements in clinical practice.
   - Support the development of standardised orientation programs for health professionals and health service staff on safety and quality.

3. **Objective** - Support the development of clinical champions and a health system culture of valued clinicians.

   Strategies

   - Develop process for identifying and rewarding outstanding practice and innovation.
   - Develop a process for identifying outstanding clinical practice and implementing it across the health care system.
   - Support the development of clinician led improvements through increased health workplace capacity.

4. **Objective** - Develop a 'no blame' culture across the heath care system.

   Strategies

   - Work with stakeholders to develop realistic expectations of clinicians' infallibility so that error is not seen as failure.
   - Develop processes to support open disclosure of error across the health system.
   - Develop processes to support clinicians and health professionals when something goes wrong.

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I. HISTORY OF THE NEW SAFETY AND QUALITY AGENDA

The Western Australian Department of Health is firmly committed to ensuring safe, high quality health care services are provided to the Western Australian community. However, the Government recognises it shares this aim with everyone in the health system; including patients, residents, carers, consumers, clinicians, health care professionals, health care administrators, health care proprietors and the community.

The Government's commitment has been demonstrated by the significant investment in quality initiatives by the State's public hospitals and health services under the Western Australian Strategic Quality Plan 1998/99 – 2002/03, which was ratified by the Commonwealth Government and the Western Australian Government in November 1999.

It is important to recognise that people have worked tirelessly develop improved safety and quality processes and systems to improve individual patient outcomes.

There is however, a 'new' or re-energised quality and patient safety movement emerging in Australia, resulting from a number of social, cultural and scientific changes. These include more informed and empowered consumers, the increased availability of research evidence to clinicians, an increasing public awareness of the risks associated with health care, and the increasing pace of development and dissemination of new and complex technologies and drug treatments.

Recent data suggests the risks of being admitted to a hospital as a patient may be significant. If the national results reported in the Australian Health Care Study[9] are extrapolated to the Western Australian population, for every 10 patients admitted to an acute care bed in Western Australia one person may suffer an adverse event, although not all of these will result in actual injury. At least half, and maybe more, of these adverse events and injuries are considered preventable through improved design of clinical, administrative, management and diagnostic activities.[10]

The challenge now is to reduce the preventable risks and to promote a culture of quality and responsibility across the system. An important way to achieve this is through the development of a 'no blame' culture that encourages staff to ask why adverse events happened and how they can be avoided or reduced in future.

The Western Australian Council for Safety and Quality in Health Care has developed this Strategic Plan for Safety and Quality in Health Care in Western Australia for financial years 2003/04 to 2007/08. This Plan provides a strategic framework for promoting the delivery of consumer focused, safe, quality health care in Western Australia. The long-term goal is to improve the safety and quality of the State's health care services and to build individual and organisational accountability systems across the state's health system, which will ensure the maintenance and continued improvement of health care.

9 *Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L & Hamilton JD. The Quality in Australian Health Care Study. MJA, 1995; 163:458-471.*

10 *Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L & Hamilton JD. The Quality in Australian Health Care Study. MJA, 1995; 163:458-471.*

II. EVIDENCE-BASE FOR SAFETY AND QUALITY IN HEALTH CARE

System failures, human error and problems with medical devices and medications can all lead to potentially preventable adverse events. An adverse event is defined as 'an injury or complication which resulted in 'death, disability or prolongation of hospital stay and was caused by the health care received rather than by the disease from which the patient suffered'.[11]

Not all adverse events are due to error and are therefore preventable. For example, a patient may react badly to a drug even though all evidence suggests that the drug was appropriately administered.[12] Similarly, not all adverse outcomes are due to adverse events incurred during clinical care. Sometimes, poor clinical outcomes are due to the natural history of the disease suffered by the patient.

The Harvard Medical Practice (HMP) Study[13,14] and the Quality in Australian Health Care (QAHC) Study[15] into medical error remain the benchmarks in providing population level data on the rates of injuries or adverse events to patients in hospitals. Both studies identified a substantial amount of unnecessary human suffering as a result of medical error. For example, the HMP Study estimated that medical error in the United States resulted in 44,000-98,000 unnecessary deaths and 1,000,000 excess injuries each year. The consequences for patients also included prolonged admission or residual disability at the time of discharge in 3.7% of acute care admissions.[15]

11 Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L & Hamilton JD. The Quality in Australian Health Care Study. MJA, 1995; 163:458-471.

12 Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L & Hamilton JD. The Quality in Australian Health Care Study. MJA, 1995; 163:458-471.

13 Brennan TA, Leape LL, Laird NM, Herbert L, Localio AR, Lawthers AG, Newhouse JP, Weiler PC and Hiatt HH. Incidence of adverse events and negligence in hospitalised patients. Results of the Harvard Medical Practice Study I. NEJM, 1991; 324:6:370-376.

14 Leape LL, Brennan TA, Laird NM, et al. The nature of adverse events in hospitalised patients: results of the Harvard Medical Practice Study II. NEJM, 1991; 324:6:377-384.

15 Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L & Hamilton JD. The Quality in Australian Health Care Study. MJA, 1995; 163:458-471.

Evidence suggests that patients affected by an adverse event spend longer in hospital and have higher hospital costs. In the HMP Study, the incremental cost associated with an adverse drug event was US $2,595 and the length of stay was increased by 2.2 days. Among adverse drug events deemed by the authors as being preventable, the excess cost was US $4,685 and the length of stay was increased by 4.6 days. The cost of adverse drug events for a 700 bed teaching hospital was estimated to be US$5.6 million per year.[16]

Preventability of an adverse drug event was assessed by the detection of 'an error in the management due to the failure to follow accepted practice at an individual or system level'; accepted practice was taken to be 'the current level of expected performance for the average practitioner or system that manages the condition in question'. [17]

In the QAHC Study, investigators reviewed the medical records of 14,179 admissions to 28 hospitals in New South Wales and South Australia during 1992.[18] An adverse event was found in 16.6% of admissions. Nearly half of the adverse events resulted in minor disabilities, but 13.7% were followed by permanent disability and almost one in twenty patients died. The authors considered over half of the these adverse events were preventable.[19]

In the QAHC Study an extrapolation to all acute hospitals within Australia (from the 1992 data) suggested that 50,000 patients in Australia would have suffered permanent disability and 18,000 would have died.[20] If it is assumed that Western Australia has approximately 10% of the national population, it may be extrapolated that in 1992, about 5,000 people would have suffered permanent disability and 1,800 people would have died from hospital acquired adverse events. Furthermore, there would have been an extra 47,000 admissions accounting for 330,000 extra bed days in hospital, as each person suffering an adverse event or hospital acquired injury stayed in hospital, on average an extra week. The direct cost to health services of adverse events is conservatively estimated to cost the WA health system an additional $97million per year.

The methodology used in this study was criticised for a number of reasons, and more recent work suggests that the more likely figure for adverse events in association with hospital admissions in Australia is 10.6%.[21] Again, the authors estimated half of these errors are preventable.

16 Weingart, SN, Wilson, RM, Gibberd, RW, Harrison BT. Epidemiology of Medical Error. BMJ, 2000; 320: 774-777.

17 Wilson, RM, Harrison, BT, Gibberd, RW, Hamilton, JD. An analysis of the causes of adverse events from the Quality in Australian Health Care Study. MJA, 1999; 170:411-415.

18 Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L & Hamilton JD. The Quality in Australian Health Care Study. MJA, 1995; 163:458-471.

19 Weingart SN, Wilson R McL, Gibberd RW & Harrison BT. Epidemiology of medical error. BMJ, March 2000; 320 (7237): 774-777.

20 Wilson RM, Runciman WB, Gibberd RW, Harrison BT, Newby L & Hamilton JD. The Quality in Australian Health Care Study. MJA, 1995; 163:458-471.

21 Wilson, RM, Harrison, BT, Gibberd, RW, Hamilton, JD. An analysis of the causes of adverse events from the Quality in Australian Health Care Study. MJA, 1999; 170:411-415.

22 Commonwealth Department of Health and Aged Care. The Final Report of the Taskforce on Quality in Australian Health Care, Australian Government Publishing Service, Canberra, June 1996.

23 Commonwealth Department of Health and Aged Care (1998). Commitment to Quality Enhancement: The Interim Report of the National Expert Advisory Group on Safety and Quality in Australian Health Care. Australian Government Publishing Service, Canberra, April 1998.

24 Commonwealth Department of Health and Aged Care (1998). Commitment to Quality Enhancement: The Interim Report of the National Expert Advisory Group on Safety and Quality in Australian Health Care. Australian Government Publishing Service, Canberra, April 1998., p.i.

III. THE AUSTRALIAN RESPONSE

Although quality programs have existed for many years, before 1999 there was no systematic and statewide approach. Following release of the QAHC Study, Australian Health Ministers established the Taskforce on Quality in Australian Health Care. Two years later, following publication of the Taskforce's final report, the National Expert Advisory Group (NEAG) on Safety and Quality in Australian Health Care was established to build on the work of the taskforce and provide expert advice to Health Ministers on safety and quality in Australian health care.[23]

The interim report by NEAG recommended five key actions areas to be targeted.[24]

These relate to:

- providing appropriate and accessible consumer health information;
- providing better frameworks for health care organisations to manage quality of care through their organisation;
- improving systems for self assessment and peer review by all clinical service providers;
- encouraging learned colleges, professional associations, and medical and nursing administrators to actively ensure quality performance through ongoing certification programs; and
- strengthening the quality focus of organisational accreditation processes through requiring organisations to demonstrate mechanisms for quality enhancement.

In July 1999, Health Ministers endorsed, in principle, the Interim Report of the National Expert Advisory Group,[25] which recommended actions to enhance the safety and quality of health care, including the establishment of a national Australian Council for Safety and Quality in Health Care, responsible for providing national leadership and coordination for health care safety and quality activities.[18]

In addition, for the first time, Australian Health Ministers agreed that dedicated funding would be provided for safety and quality under the Australian Health Care Agreements (AHCA) 1998/99–2003/04. In total, the Commonwealth Government agreed to provide about $600 million to Australian States and Territories over five years. The AHCA allocated $62.5 million for quality improvement activities over five years in Western Australia to enable the State to undertake specific quality improvement and enhancement projects in public hospitals.

The AHCA required every State and Territory to develop a strategic quality plan to provide a vision for quality improvement within the public hospital system.[26] After the Western Australian Strategic Quality Plan 1998/99-2002/03 was endorsed by the Western Australian and Commonwealth Governments in November 1999, a series of initiatives were developed to implement the plan and to enhance a quality improvement approach to the Western Australian health system.

In July 2003, the Commonwealth Government and Australian States and Territories ratified a new Australian Health Care Agreement for 2003/2004 – 2007/2008.[27] There is ongoing emphasis on safety and quality matters in this agreement. The WA Strategic Quality Plan 2003-2008 has been reviewed and updated to ensure that it remains relevant to the WA health system.

25 Commonwealth Department of Health and Aged Care (1999). Implementing Safety and Quality Enhancement in Health Care. Final Report to Health Ministers from the National Expert Advisory Group on Safety and Quality in Australian Health Care. Australian Government Publishing Service, Canberra, July 1999.

26 Health Department of Western Australia (2000). Western Australian Strategic Quality Plan 1998-2003 (http://www.health.wa.gov.au/Publications/stratplan/quality_plan.pdf).

27 Australian Health Care Agreement Reference Group Report for Safety and Quality 2002 (http://www.health.gov.au/haf/ahca.htm).

IV. THE AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE

In January 2000, Australian Health Ministers established the Australian Council for Safety and Quality in Health Care (ACSQHC)[28] to lead national efforts particularly in patient safety. Subsequently, Health Ministers agreed to provide $50 million over five years for the Council. The role of the Council is to:

- lead the way, by developing a national strategy for improving safety and quality, defining national standards and influencing others to act to improve safety and quality in health care;
- define a framework for action, by identifying national priorities and recommending specific actions that address the priorities;
- form partnerships, by working with health care professionals, the Commonwealth, States and Territories, professional associations, private, non-government, and consumer organisations;
- coordinate existing activity to better achieve action in priority areas;
- put consumers first, by making sure that safety and quality measures are practical and will make a real difference;
- encourage public understanding and increase the community's confidence in the steps being taken to improve the safety of health care; and
- promote monitoring and research to address the many things we still don't know about challenges with safety and quality and how to fix them.[29]

The ACSQHC's first National Action Plan 2001,[30] outlined four key action areas for implementation as part of a nationally coordinated and collaborative approach:

- better use of data and information throughout the system to support safer patient care;
- strengthening mechanisms to ensure safer clinical and organisational environments;
- actively promoting opportunities for consumer feedback and participation; and
- redesigning systems and processes of care to promote a strong culture of reliability and safety.

The Council's key priority work areas for its sixth year of work in 2005/2006 include:

- supporting those who work in the health system to practice safely;
- improving data and information for safer care;
- involving consumers in improving health care safety;
- redesigning systems of health care to facilitate a culture of safety; and
- building awareness and understanding of health care safety.[31]

28 Australian Council for Safety and Quality in Health Care. (http://www.safetyandquality.org/).

29 Australian Council for Safety and Quality in Health Care. (http://www.safetyandquality.org/).

30 Australian Council for Safety and Quality in Health Care. 'Safety First' - Report to The Australian Health Ministers Conference, 27 July 2000. (http://www.safetyandquality.org/publications.html).

31 Australian Council for Safety and Quality in Health Care. 'Safety Through Action: Improving Patient Safety in Health Care' – 3rd Report to The Australian Health Ministers Conference, 19 July 2002. (http://www.safetyandquality.org/articles/Publications/safety_action.pdf).

V. WESTERN AUSTRALIAN ACTION

1. THE WESTERN AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE

A permanent Western Australian Council for Safety and Quality in Health Care ('the Council') was established in August 2002 to provide strategic advice to the Director General of Health and the Minister for Health on system-wide safety and quality issues and provide strategic direction and leadership, particularly in matters related to:

- monitoring and evaluating the standard of safety and quality of the services within the WA health system;
- providing strategic direction for quality improvement in health in WA; and
- providing an expert forum for safety and quality development in WA.

2. THE OFFICE OF SAFETY AND QUALITY IN HEALTH CARE

In line with recommendations of the Health Administrative Review Committee (HARC) Report (2001), an Office of Safety and Quality in Health Care (OSQH) has been established within the Department of Health. The Office is centrally involved in the development, monitoring and evaluation of policies and standards for operational and health system quality and safety issues. The role of the OSQH is to:

- provide support to the WA Council for Safety and Quality in Health Care;
- develop Statewide, consistent policy and standards in safety and quality as required by stakeholders including: clinicians, area health service managers and staff and consumers;
- provide policy direction, support, and advice to stakeholders who are involved in improving the quality and safety of the State's health system;
- provide advice to the Minister for Health and the Director General of Health on safety and quality of health care issues; and
- provide a central monitoring function for the safety and quality of health care provided in the State.

The key priority of the OSQH is to develop, in partnership with clinicians and consumers, consistent policies and standards to enable the effective development and co-ordination of a system wide framework for clinical governance across the health sector.

Clinical governance is defined as a 'systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes'.[32]

In Western Australia, the framework for clinical governance includes: professional development through credentialing; clinical performance and evaluation of the correct use of treatment modalities; clinical risk management with adverse event and adverse outcome monitoring, performance and satisfaction; and assessment of consumer value with satisfaction and dissatisfaction.[24]

This framework also recognises that the elements required to create an environment for a safe and quality health service are the responsibility of both management and clinicians. This requires open and productive communication, a culture supportive of a quality service, adequate support from resources and information technology systems, and accountability and shared responsibility for performance.

3. AREA HEALTH SERVICES

While the planning, development and promotion of safety and quality standards and strategies is the responsibility of the Office of Safety and Quality in Health Care, the involvement of Area and Regional Health Services in the development of safety and quality standards and strategies is essential, given their overall responsibility for service provision and implementation of safety and quality policies and standards at the local level.

A systematic approach to clinical governance, which outlines responsibilities for safe and quality delivery of health care, has been implemented within each Area Health Service across the State. These governance systems will ensure that the quality of care is optimised and that risk to patients and staff is minimised.

ADDITIONAL INFORMATION

Health Care professionals are encouraged to contact their local or Area Health Service Safety and Quality Manager for local information. Alternatively, please contact:

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32 Department of Health (2002). AFramework for Clinical Governance in Western Australia.

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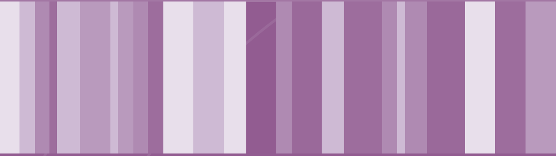

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