



Foreword



Safe, high-quality health care for all Western Australians continues to be a major priority for WA Health.

I am pleased to be able to release this milestone report which describes the journey that WA Health has taken over the past decade to implement the necessary systems and clinical governance processes that are needed to improve patient safety and quality in the Western Australian health care system.

The patient safety journey in Western Australia gathered pace at the beginning of the 21st century. Over the last five years WA Health has systematically developed policies, frameworks and arrangements to improve the care for every patient within the system. In conjunction with this governance work, a shift towards a hospital and health service culture that puts patients at the centre of planning and service delivery is emerging.

This journey is not complete. Nor will it ever be complete. Together with the systematic implementation of the Patient First Program and the Safety and Quality Investment for Reform (SQiRe) Program in our health system, we all need to continue to work together to improve the safety and quality of health care delivery to the Western Australian community.

Dr Neale Fong
DIRECTOR GENERAL
November 2007



Preface

Every journey has a beginning. This report presents the patient safety journey in the Western Australian public health sector. It describes how the WA health care system, in partnership with many stakeholders, systematically developed clinical governance and patient safety frameworks to improve the care for every patient. It brings together, for the first time, an account of the progress and achievements in safety and quality, by all who work in the WA health care system.

At times, especially in the early stages of major system reform, progress can seem frustratingly slow. And whenever systemwide change is underway it can be difficult to appreciate, let alone quantify, what real improvements have been achieved. This report is designed to provide context and perspective about safety, quality and clinical governance to the reader. We also hope it will support improved planning for patient safety into the future.

Everyone who works in the Office of Safety and Quality in Healthcare has contributed to this status report. It should be read in conjunction with other key reports and policies published by WA Health, including the annual Sentinel Event Reports, the Safety and Quality Investment for Reform (SQuIRe) Handbook and the Patient First booklet. All of the Office of Safety and Quality in Healthcare publications can be viewed on our website: www.safetyandquality.health.wa.gov.au

The WA health care system is now at a crossroads in its safety and quality journey. Having paved the way by establishing strong foundations, supportive networks and a strong patient-oriented safety culture, we must now look ahead, build on those achievements, and thoughtfully define the next steps.

This report is one step in that next journey, and we are confident that through describing and reviewing our past work, continuing to report publicly and asking for feedback we can move forward with enhanced knowledge and renewed energy. Over the next five years, the WA health care system will continue to advance the cause of safe, high quality health care and demonstrate measurable and sustained improvements in patient safety for Western Australians.

Dr Dorothy Jones
PRINCIPAL MEDICAL OFFICER AND INAUGURAL DIRECTOR
OFFICE OF SAFETY AND QUALITY IN HEALTHCARE
November 2007



Executive summary

Patient safety is an important, daily health policy issue that demands significant attention. The last decade has seen all Australian governments recognise and respond to evidence that modern health care frequently causes unintended harm and injury to patients. It is now universally agreed that patient harm from adverse events and poor quality health care is unacceptable. In order to make a measurable difference to patient outcomes, significant reform and change is required; change in the knowledge, practices, behaviours and attitudes of all who work in health care. Reform is also required in the way that health workers interact with patients. This task is enormous and we are only now realising how extensive the necessary system reform and transformation will have to be, if the WA health care system is to get the care right for every patient, every time.

This document describes the WA Health patient safety and quality journey over the last decade. It is designed to inform the reader about the evidence, context and rationale for how WA Health, in 2007, has reached a significant milestone in the safety and quality reform journey. In fact, the WA health system is at a crossroads as it determines how best to consolidate and extend its early achievements and gains in patient safety and reform. Specifically, we are on the threshold of developing the next five-year strategic plan to support the 2007/08 - 2012/13 Australian Health Care Agreement. By reviewing progress to date, a clear way forward will emerge.

The WA health system responded early to the call for action to improve safety and quality. Initially, safety and quality activities were project based and ad hoc until the late 1990's when organised and systematic policies and programs were developed, within a single, unified State strategic plan. This progress was further accelerated by the advent of the Health Reform Committee in 2003 and the subsequent Health Reform Implementation Taskforce and WA Health's health reform agenda.

In recent years WA Health has established and delivered major reforms to improve health care quality and patient safety, such as:

- Defining and implementing the WA Clinical Governance Framework
- Implementing and monitoring the WA clinical incident reporting and management system
- Supporting and training the health workforce in patient safety, clinical incident investigation and root cause analysis techniques
- Establishing and extending the Statewide Sentinel Event Reporting Program
- Establishing and maintaining the Coronial Liaison Service and education
- Establishing the pilot and extension of the WA Open Disclosure Program
- Pioneering and establishing the first mandatory mortality review program in Australia
- Conceiving and implementing key safety and quality reform programs for health professionals and consumers, namely SQulRe and Patient First
- Establishing, supporting and leading patient safety networks including the WA Council for Safety and Quality in Health Care, the WA Clinical Governance Network and the Health Complaints Coordinators' Network.



The task ahead is to strengthen and extend the knowledge and use of quality improvement and change management tools; maintain a relentless approach to ensuring all care is patient centred; constantly monitor clinical practice improvement opportunities and deeply embed modern clinical governance and patient safety processes into daily practice. In this way, WA Health will build systematic clinical governance infrastructure and patient safety social capital, that matches the new technology, buildings and capital infrastructure - thus ensuring the delivery of the right care to the right patient every time.



Road to patient safety in Western Australia

Year	Milestone
1992	<ul style="list-style-type: none"> Completion of the Quality in Australian Health Care Study
1995	<ul style="list-style-type: none"> Publication of the Quality in Australian Health Care Study results Establishment of the Taskforce on Quality in Australian Health Care by Australian Health Ministers
1997	<ul style="list-style-type: none"> Establishment of the National Expert Advisory Group on Safety and Quality in Australian Health Care
1998	<ul style="list-style-type: none"> Negotiation of the Australian Health Care Agreement for 98/99 - 02/03 - specific funding allocated for safety and quality initiatives
1999	<ul style="list-style-type: none"> Development of the WA Strategic Plan 98/99 - 02/03 by WA Health to provide a vision for quality improvement in the WA public hospital system Establishment of an Interim Quality and Safety Committee within the Office of the Chief Medical Officer to oversee the implementation of the WA Strategic Plan 98/99 - 02/03
2000	<ul style="list-style-type: none"> Establishment of the Australian Council for Safety and Quality in Health Care (ACSQHC)
2001	<ul style="list-style-type: none"> Establishment of the Office of Safety and Quality in Healthcare (OSQH) in response to recommendations made by the Health Administrative Review Committee Consultation process by the Chief Medical Officer to identify elements of clinical governance for the WA public health system Development and implementation of the WA Clinical Governance Framework Release of the following Safety and Quality publications: <ul style="list-style-type: none"> Clinical Governance Issues paper Clinical Governance References by Topics Implementation of the Australian Incident Monitoring System (now the Advanced Incident Management System) Introduction of the Western Australian Audit of Surgical Mortality
2002	<ul style="list-style-type: none"> Establishment of a permanent Western Australian Council for Safety and Quality in Health Care (WA Council) to replace the Interim Quality and Safety Committee and to provide strategic advice to the Director General of Health and the Minister for Health Establishment of the Clinical Incident Management Support Business User Group
2003	<ul style="list-style-type: none"> Renegotiation of Australian Health Care Agreement for 03/04 - 07/08, with a continued emphasis on safety and quality Development of a second Strategic Plan for Safety and Quality in Health Care in Western Australia for 03/04 - 07/08 by the WA Council Commencement of mandatory Sentinel Event Reporting in WA (public and private hospitals)



Year	Milestone
2003 (cont)	<ul style="list-style-type: none"> ■ Co-hosted the First Australasian Conference on Safety and Quality in Health Care with the Australasian Association for Quality in Health Care and the Australian Council for Safety and Quality in Health Care ■ Release of the following Safety and Quality publications: <ul style="list-style-type: none"> ■ SNIPtS (Sharing News in Patient Safety) Newsletter ■ Introduction to Clinical Governance - A Background Paper ■ Western Australian Clinical Governance Guidelines ■ Qualified Privilege Guidelines ■ Credentialling: An Introduction ■ Incident Reporting and Management Policy ■ Western Australian Complaint Management Policy
2004	<ul style="list-style-type: none"> ■ The Health Reform Committee recommended (HRC Recommendation 74) that “<i>a Statewide Clinical Governance Framework which involves the following four pillars should be implemented within two years:</i> <ul style="list-style-type: none"> ■ <i>Clinical audit</i> ■ <i>Clinical risk</i> ■ <i>Consumer values</i> ■ <i>Professional development and management</i>” ■ Australian Health Ministers endorsed eight priority action areas that were proposed by the Health Reform Agenda Working Group to accelerate national efforts to reduce patient harm ■ Introduction of the annual WA Patient Safety Awards, to provide public recognition of individual, team and organisational achievements in improving and promoting patient safety ■ Establishment of the Western Australian Sentinel Event Review Group ■ Clinical Governance Implementation Project (HRC Recommendation 74) commenced ■ Review of national governance arrangements for safety and quality in health care (Paterson Review)
2005	<ul style="list-style-type: none"> ■ Launch of the Clinical Governance Implementation Project, and release of the following clinical governance publications: <ul style="list-style-type: none"> ■ Clinical Risk Management Guidelines for the WA health system ■ Correct Patient, Correct Site, Correct Procedure Guidelines for WA Health Services ■ Setting Standards for Making Health Care Better: Guidelines for implementing Clinical Governance in WA health services ■ Clinical Governance Standards ■ Clinical Governance Guidelines ■ Clinical Governance Framework poster ■ Implementation of Clinical Governance Standards as a measurement tool for evaluating the implementation of the WA Clinical Governance Framework



Year	Milestone
2005 (cont)	<ul style="list-style-type: none"> ▪ Establishment of the Coronial Liaison Team within the OSQH ▪ Establishment of the Western Australian Medication Safety Group ▪ Establishment of the Healthcare Infection Surveillance WA (HISWA) voluntary monitoring program with the Communicable Disease Control Directorate
2006	<ul style="list-style-type: none"> ▪ Establishment of a new Australian Commission on Safety and Quality in Health Care to replace the Australian Council for Safety and Quality in Health Care ▪ Completion of the Clinical Governance Implementation Project ▪ Release of the following safety and quality publications: <ul style="list-style-type: none"> ▪ Sentinel Event Reporting Policy, 2nd edition ▪ Western Australian Complaint Management Policy, 2nd edition ▪ Correct Patient, Correct Site, Correct Procedure Guidelines for WA health Services, 2nd edition ▪ WA Sentinel Event Report October 2003 - June 2005 ▪ WA Sentinel Event Report 2005 - 2006 ▪ Clinical Incident Management and Reporting Policy, 2nd edition ▪ From Death We Learn: Lessons from the Coroner ▪ Implementation of the WA Clinical Governance Framework as a mandatory requirement for Area Health Services ▪ Implementation of the National Inpatient Medication Chart in WA public hospitals ▪ Establishment of the Safety and Quality Investment for Reform (SQulRe) Program ▪ Establishment of the Patient First Program ▪ Establishment of Executive Director, Safety, Quality and Performance positions in each Area Health Service
2007	<ul style="list-style-type: none"> ▪ Release of the following safety and quality publications: <ul style="list-style-type: none"> ▪ The Western Australian Review of Mortality Policy ▪ Consent to Treatment Policy for the Western Australia Health System ▪ The Policy for Credentialling and Defining the Scope of Clinical Practice for Medical Practitioners ▪ WA Pharmaceutical Review Policy ▪ Patient First booklet and resource materials ▪ WA Sentinel Event Report 2006 - 2007 ▪ From Death We Learn, 2nd edition ▪ Safety and Quality Investment for Reform: A handbook for building a safer health care system ▪ Extension of the SQulRe Program and Clinical Practice Improvement Collaboratives ▪ Establishment of Patient Ambassador pilot ▪ Launch of Statewide Hand Hygiene program ▪ Extension and customisation of the Patient First Program to priority populations





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1. The call to action

MEDICAL MANSLAUGHTER: Hospital errors blamed for dozens of deaths and serious injuries

The West Australian, January 13 2006

QUEENSLAND'S DR DEATH LINKED TO 80 DEATHS

The Age, May 25 2005

HOSPITAL TOLL PUT AT 18,000: 1 in 10 patients put at risk, conference told

The West Australian, July 15 2003

The headlines seem to say it all: mistakes and errors in hospitals cause serious injury and death to patients.

What the headlines do not mention is that people who work in health care do not set out to deliberately cause harm to their patients. All health care workers appreciate the significant impact that unintentional mistakes and errors can have. Considerable effort is being invested into identifying, analysing and responding to such incidents. These unintentional incidents can be attributed to the human factor. That is, the capacity for error is part of everyday experience when one human works with another. The challenge is to build a safety management system that protects patients from incidents and harm that result from individual, organisational and system error.

The need to do good and not harm when treating patients has long been acknowledged; indeed, it is set down in the Hippocratic Oath: *"I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone"*¹ and the World Medical Association's Declaration of Geneva: *"I solemnly pledge myself to consecrate my life to the service of humanity; and I will practice my profession with conscience and dignity; the health of my patient will be my first consideration...."*²

However, it is only recently that we have begun to fully appreciate the extent to which preventable clinical incidents contribute to adverse events that cause injury to patients. Quantifying the relationship between these complex issues is still being refined.³

Since the early 1990s, a number of high profile international studies have highlighted the fact that adverse events caused by system failures, human error and problems with surgery, medical devices and medications, pose a significant threat to the safety of patients and a significant cost to health funders and governments.³



In 1992 the first Quality in Australian Healthcare (QAHC) Study estimated that adverse events were associated with up to 16.6% of hospital admissions, and suggested that nearly half of those events may have been preventable.⁴ By 1995 that figure had been revised down to 10.6%.⁵ The UK Department of Health, in its 2000 report, *An Organisation with a Memory*,⁶ estimated that adverse events occur in approximately 10% of hospital admissions or about 850,000 adverse events a year. The Hospitals for Europe's Working Party on Quality Care in Hospitals estimated, in 2000, that every tenth patient in hospitals in Europe suffers preventable harm and adverse effects related to his or her care.⁷ New Zealand and Canadian studies have also reported relatively high rates of adverse events, approximately 10%.^{8,9,10,11}

While it is now universally agreed that up to 10% of hospital patients may suffer an adverse event, this accepted norm is based on the retrospective, subjective medical record review methodology used in the original Harvard Medical Practice Studies (1984)^{12, 13} and repeated in Australia (1992),⁴ New Zealand (1998),^{10,11} United Kingdom (1999-2000)⁶ and Canada (2001).^{8,9}

It is tempting to use 1:10 as a 'benchmark' of likely prevalence of adverse events in modern hospitals, however, prospective incident reporting systems show a lower frequency of adverse events. The epidemiology of adverse events needs further work, and governments and researchers are now doing analysis on this topic. The reader should accordingly keep in mind that the concept of 'adverse events' is broadly defined and encompasses a wide range of clinical circumstances, from medication omission with no consequence to the patient, through to acquired infection from hand hygiene failure, pressure ulcer acquisition, or a retained swab or intra-abdominal pack causing significant consequences for the patient.

The cost of treating iatrogenic harm and adverse events is considerable and represents a substantial loss of opportunity in terms of providing the Australian community with optimal health care. This cost, however, does not quantify the suffering and anguish experienced by those who have suffered an adverse event, or the collateral effect on families and carers. The suffering that comes with serious adverse events such as the loss of a limb or bodily function, or the loss of a loved one, is immense and immeasurable. This is often compounded because of the obligation to continue using the hospital or health care system that inflicted the suffering. Furthermore, patients are not the only ones who suffer. It has been demonstrated that health care workers involved in adverse events are at an increased risk of career change, depression and suicide.¹⁴ The impact on doctors and nurses can be so severe that they have been described as the second victim in a serious adverse event.¹⁴

The WA health care system recognises that health care is increasingly complex in its delivery, personnel, technology and demand pressures. Inevitably, the WA health care system is exposed to many clinical and corporate risks on a daily basis. Serious adverse events or sentinel events are important to describe and understand. However, in addition to rare, serious events there are many more opportunities for error to occur during the numerous transactions and encounters that occur in the relentless, daily pattern of modern hospital care. It is therefore just as important to focus on the frequent clinical incidents, near misses and improvement opportunities in daily clinical practice. Simple behaviours such as ensuring hands are cleaned properly are as vital to patient safety outcomes as crisis simulation management and communication training and expertise.

Accordingly, the identification, management and treatment of corporate and clinical risks across the WA health care system is not only a core requirement of Treasurer's Instruction (TI) 825: Risk Management and Security^{15,16} but also a key element of the WA Clinical Governance Framework^{17,18} and the Western Australian Strategic Plan for Safety and Quality in Health Care 2003 - 2008.¹⁹



The WA health care system now has comprehensive clinical risk management policies and processes established which are binding on all personnel who are accountable through their relevant Chief Executive to the Director General. The constant challenge is to ensure that the loop is closed and all identified clinical risks are treated, mitigated or accepted.

The beginning of the 21st century was characterised by media reports describing patients being injured as a result of medical treatment and demand by government, health consumers and the community for more accountable and safer health care delivery. In response, the Western Australian Government, via WA Health, formally established the Office of Safety and Quality in Healthcare (OSQH). This approach highlighted the government's early and proactive approach to dealing with safety and quality in the WA health care system. Building on the work that had gone before, it was now time to accelerate the response to develop systemwide capacity.

The case for action had been established - and the WA health care system responded.



2. Laying the foundation

The Australian policy response to the 1992⁴ and 1995⁵ QAHC studies was careful and measured. Australia was seen as an early responder in the global patient safety movement and was the envy of many other countries. Even now, in 2007, many developed countries still have no organised patient safety activities or formal clinical incident reporting and monitoring programs in place.

Western Australia also responded early to the emerging evidence about patient safety. In the 1990's, health care quality issues were tackled via casemix and purchasing reforms and significant clinical leadership emerged in the late 1990's from the then Office of the Chief Medical Officer. This work laid the foundation for the definitive response and establishment of the WA Office of Safety and Quality in Healthcare (OSQH) in the next decade.

In the early years of patient safety reform there was significant debate and disagreement about how and in which order the patient safety and quality problems should be tackled. Many clinicians, especially doctors, felt unfairly criticised and beleaguered, and patients felt completely left out and ignored if they complained about their care. Furthermore, those patients who did try to find out more about their own health care problems often reported that they felt stymied, rebuffed and ignored by hospitals and organisations. Legal redress, although financially successful for some, was also not providing the best results for many people who had experienced unintended harm as a result of the care they had received.

Coupled with this emerging recognition that the existing system had to change was the development of the electronic technology era and broader access to information. The age of rapid information exchange and its concurrent expectation of rapid response and action was upon us all.

2.1. National response

In 1995 Australian Health Ministers established the Taskforce on Quality in Australian Health Care to address issues raised by the QAHC studies and to provide recommendations on national strategic action. That was followed in 1998 by the establishment of the National Expert Advisory Group on Safety and Quality in Australian Health Care, and in 1999 by the provision of approximately \$600 million in funding for states and territories to undertake safety and quality initiatives through the *Australian Health Care Agreement 1998/99-2003/04*. Access to the funds was conditional on states and territories developing local strategic plans.

In January 2000, Australian Health Ministers established the Australian Council for Safety and Quality in Health Care (ACSQHC)²⁰ to lead national efforts particularly in patient safety. The ACSQHC's program of work over its five-year life was grouped into the following headings:

- 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
- Building awareness and understanding of health care safety.²¹

In 2004, Health Ministers commissioned the 'Review of Future Governance Arrangements for Safety and Quality in Health Care' (the Paterson Report).²² The Paterson Report made a number of strategic recommendations to improve the leadership and national coordination of safety and quality in health care in Australia.



The Paterson Report Team considered that the ACSQHC had made a valuable contribution to raising awareness of safety and quality issues, particularly among clinicians and administrators involved in quality improvement activities. However, with the benefit of hindsight, the Paterson Report found that aspects of the current ACSQHC's governance arrangement had hampered its effectiveness, particularly the lack of formal links and partnerships between the states and territories, other jurisdictions and key bodies.²²

Australian Health Ministers therefore agreed to establish the Australian Commission on Safety and Quality in Health Care (the Commission), which commenced operations on 1 January 2006. Under its terms of reference, the Commission is required to:

- Lead and coordinate improvements in safety and quality in health care in Australia by identifying issues and policy directions, recommending priorities for action, disseminating knowledge, and advocating for safety and quality
- Report publicly on the state of safety and quality including performance against standards
- Recommend national data sets for safety and quality, working within current multilateral governmental arrangements for data development, standards, collection and reporting
- Provide strategic advice to Health Ministers on 'best practice' thinking to drive quality improvement, including implementation strategies
- Recommend nationally agreed standards for safety and quality improvement.²³

2.2. WA Response

1. First steps

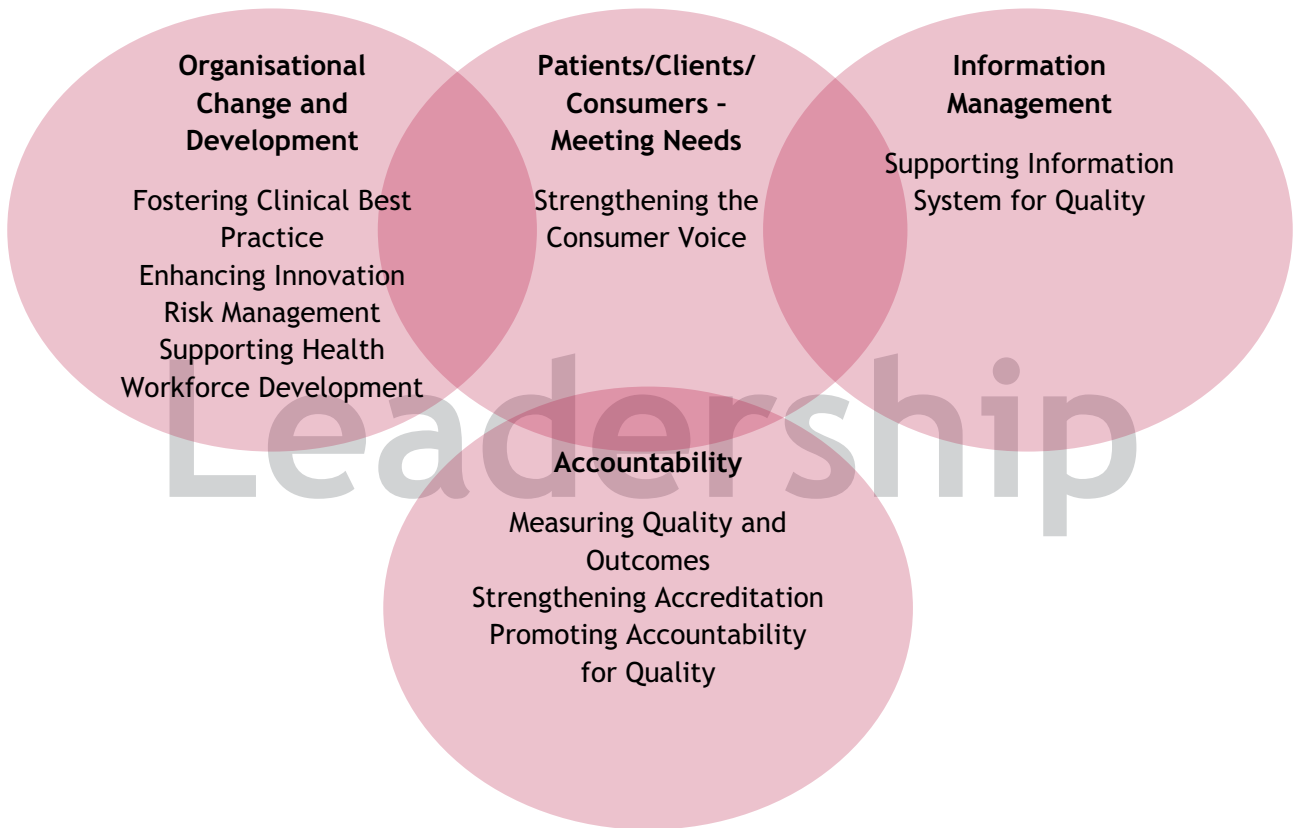
The WA Chief Medical Officer established an Interim Quality and Safety Committee to oversee the development and implementation of the first WA Strategic Quality Plan 1998/99 - 2002/03, for the five year *Australian Health Care Agreement (AHCA) 1998/99 - 2002/03*.²⁴

This plan was built on four strategic areas:

1. *Patients, Clients, Consumers* - strengthening the consumer voice
2. *Organisational Change and Development* - with four strategic initiatives:
 - i. fostering best practice
 - ii. enhancing innovation
 - iii. risk management
 - iv. supporting health workforce development
3. *Information Management* - supporting information systems for quality
4. *Accountability* - measuring quality and outcomes, strengthening accreditation, promoting accountability for quality.



Figure 1. Conceptual Framework for Quality 1998/99 - 2003/03²⁴



II. The Founding of the Office of Safety and Quality in Healthcare (OSQH)

In June 2001, the WA Government released the Health Administrative Review Committee's (HARC) report²⁵, which recommended that a specific quality of care unit be established within the newly established Health Care Division.

Since its establishment, the OSQH has been an integral part of the WA health care system, and has remained closely aligned with the work of the clinical divisions, Chief Medical Officer and health reform and policy groups. More recently, the OSQH has been structurally aligned with the Health Policy and Clinical Reform Division. This has ensured strong partnerships with the clinical and policy development of the Health Networks.

Another recommendation of the HARC report was to establish Area Health Services. Under these arrangements operational responsibility for the implementation of key clinical governance and safety and quality initiatives was vested in the Area Health Service Chief Executives, Regional Directors and Health Service Managers. Consequently, the responsibility of the OSQH became strategic policy, program and standards development, and performance monitoring, thus ensuring accountability for the provision of safe, high quality health care and leading change management at a system level.

The advent of Area Health Services resulted in strong partnerships being developed between the OSQH, Chief Executives and their leadership teams. New linkages have also been forged with the emerging Area Clinical Governance and Safety, Quality and Performance Units. Strong leadership and support for patient safety development has also been forthcoming from the Director General and members of the State Health Executive Forum (SHEF).



Over time, a strong health service infrastructure around clinical governance, safety, quality and performance has been developed. This was formally recognised in January 2007 with the establishment of the Clinical Governance Network. This network, which meets monthly, is chaired and supported by the OSQH and comprises members from all Area Health Services and hospital sites (see Appendix B).

2.3. Establishment of the WA Council for Safety and Quality in Health Care

By 2002 the importance and value of ongoing oversight and a strategic approach to patient safety, quality and clinical governance issues had been recognised, and later that year the Minister for Health established the WA Council for Safety and Quality in Health Care (WA Council) as a permanent committee. The WA Council is tasked with providing strategic advice to the Director General and Minister for Health on system-wide safety and quality issues, and providing 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 care system
- Providing strategic direction for quality improvement in health in WA
- Providing an expert forum for safety and quality development in WA.

The WA Council reports directly to the Director General and Minister for Health. Membership of the WA Council is multi-disciplinary, with members being appointed by the Director General for three-year terms (see Appendix C for current membership). The OSQH provides secretariat and policy and program support for the WA Council and works with the WA Council in providing strategic advice on safety and quality issues to the Director General and the Minister. One of the successful features of the WA response to patient safety strategy and direction setting has been the strong partnership between the OSQH and the WA Council and a shared Statewide plan. The work of the OSQH is presented to the WA Council at its quarterly meetings and is reviewed, scrutinised and strengthened.

Another key feature of the WA Council's program of work has been the establishment of strong partnerships with the private and primary care sectors. This approach has ensured an integrated Statewide approach to patient safety and quality policy and planning across the WA health system.

2.4. Getting the emphasis right in the early years: establishing international and national partnerships

Early on, as the strategic agenda for safety and quality in WA was being defined, the OSQH and the WA Council sought international and national expert advice. Few health systems in the world had established government patient safety structures or programs. Key decisions about WA priority setting were needing to be made, and in these early years the 'how to' textbooks had yet to be written.

It was recognised early that patient safety, although only one domain of quality, was underdeveloped and could be quantified. Freedom from adverse events and patient safety was the global focus and WA sought to respond effectively. (See Appendix D for a complete list of the domains of quality and safety).

The Veterans Health Administration System in the US was an early pioneer of root cause analysis and standardised investigation protocols when clinical adverse events had occurred. This approach was investigated and used very early in WA, and soon became the standard adopted in Australia.



A key success factor for patient safety in WA was the early establishment of a close working relationship with international human factors experts. Specific relationships with national leaders in the US, UK and Canada were also established. Professors Jim Reason, Bob Helmreich and Jan Davies who had pioneered Human Factors and Crew Resource Management programs in aviation and subsequently health care, were invited to work closely with the OSQH from 2002. These Professors visited WA several times and contributed to conferences, policy development, awareness raising and expert training in human factors for WA clinicians.

In 2005, the OSQH shifted its focus towards supporting skill acquisition in clinical leadership and change management in patient safety. Professor Miles Shore from the Kennedy School of Government (Harvard University) presented to clinical and management personnel across WA Health to raise awareness about clinical leadership and change management.

The patient safety focus is now shifting towards ensuring that the established patient safety initiatives have a visible and tangible impact in measurably improving outcomes for patients using WA hospitals and health services.



3. Setting the WA Strategic Frameworks

3.1. The WA Clinical Governance Framework

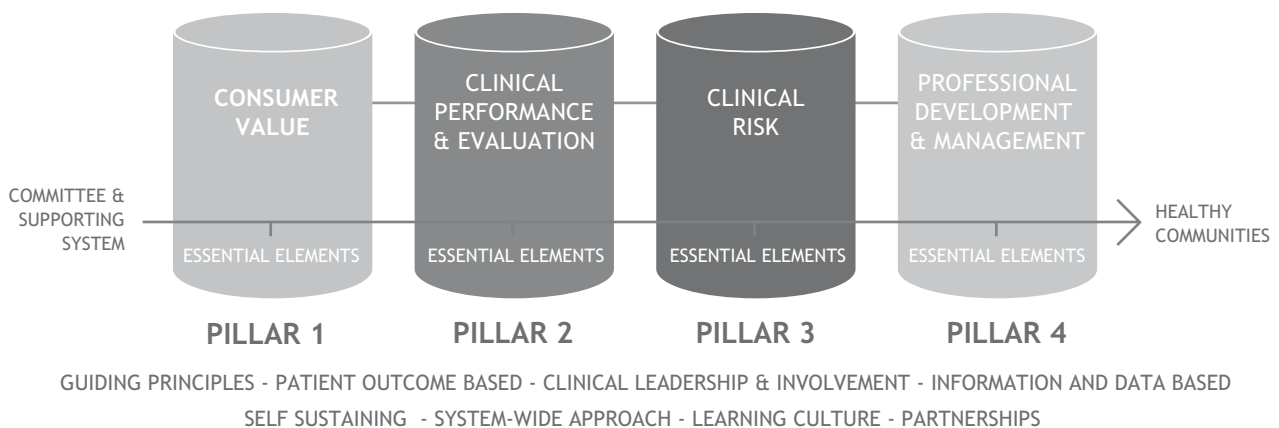
The WA Clinical Governance Framework,^{17,18} developed in 2001 has guided the strategic directions and development of policies, standards and tools since 2002.

The WA Clinical Governance Framework defines a series of interdependent patient safety concepts that have been developed to foster a shared and unified approach to promoting and assuring the delivery of safe, high quality health care in WA.

Developed by WA clinicians in a series of workshops in 2001, the WA Clinical Governance Framework is a conceptual model used to group together critical areas that need to be addressed in a long-term, consistent manner if safety and quality are to improve. Under the WA Clinical Governance Framework these critical areas are referred to as the four pillars:

1. *Consumer Value* - engaging and involving consumers in the planning, delivery and evaluation of health services, and as active participants in their individual health care
2. *Clinical Performance and Evaluation* - promoting and supporting the introduction, use, monitoring and evaluation of evidence-based clinical standards
3. *Clinical Risk* - identifying and reducing potential clinical risks, and examining adverse incidents for causative and contributing factors
4. *Professional Development and Management* - ensuring the appointment and ongoing employment of appropriately skilled and experienced staff, and the safe introduction of new procedures.

Figure 2. Clinical Governance Framework for the WA Public Health System^{17,18}





3.2. State strategic plans for safety and quality

After the Strategic Quality Plan Western Australia 1998/99 - 2002/03²⁴ expired, the second strategic plan for quality was released in 2003: the Western Australian Strategic Plan for Safety and Quality in Health Care 2003-2008.¹⁹ Building on the first strategic plan and the WA Clinical Governance Framework, this plan describes the goals, objectives and strategies to be achieved over a five-year period. They are grouped under four strategic focus areas:

1. *Consumer Focused Health Care* - engaging consumers as partners at all levels of health care
2. *Clinical Practice Improvement* - promoting and supporting the development of evidence-based practice information, and ensuring the information is accessible and used to reduce variation in clinical practice
3. *Risk Management* - ensuring effective tools and methodologies are available to identify, manage and reduce risk at all levels of the health care system
4. *System Improvement and Accountability* - facilitating system improvement through re-design, improved accountability and greater use of information.

Embedded within the four focus areas are two key strategic themes considered to be vital to the achievement of the overall plan:

- Leadership - identifying and supporting leaders who value safety and quality in health care; supporting a culture that focuses on system improvement, not blame
- Communication - improving communication systems and processes to facilitate the delivery of consumer-focused, safe, quality health care.

These strategic concepts are detailed in Figure 3 below.

Figure 3. Conceptual Framework for the Strategic Quality Plan 2003/04-2007/08¹⁹





WA is about to embark on its third five-year plan (2008-2013) for future Statewide safety and quality directions. Together with the WA Clinical Governance Framework, the third Strategic Quality Plan will lead and drive systematic development and implementation of safety and quality initiatives across the WA health care system. There will be a renewed emphasis on clinical risk management, consumer focus and patient empowerment.



4. Building the WA Patient Safety Management System - managing clinical risk

Most high-risk industries use safety management systems to capture important information about work environment problems and hazards. This information is used to identify and manage risk and improve future performance. Examples that the health care system has looked to for inspiration are the aviation, nuclear power, and oil and gas industries.^{26,27,28} In the last decade, Australian health care systems have started building health-specific patient safety management systems.

Strongly embedded within health care reforms in WA and throughout the world, is a systems approach to error, human factors and learning.^{29,30} This is in sharp contrast to previous management practices, which sometimes saw poor patient outcomes lead to interrogation of individuals, and the use of a 'shaming and blaming' tactic to deliver apparent but unproductive organisational change.³¹ It has subsequently been appreciated that if learning is to be effective and contribute to the prevention of errors, it requires information about clinical incidents to be reported and managed in a systematic way.

Increasingly, external auditing bodies and health consumers also want to know about the rate and extent of clinical practice improvement to reduce adverse events and address human error. Transparent hospital governance processes, access to information, prompt disclosure and timely feedback when things go wrong are increasingly becoming features of patient safety management systems. Governments, accreditation bodies and regulators also expect incident reporting, risk management and improvement strategies to be demonstrably embedded in hospital practice.

4.1. How we manage patient safety in WA

The WA Clinical Governance Framework described in chapter 3.1 provides the foundation for the WA Patient Safety Management System.

The WA Patient Safety Management System has four elements:

1. *Identification* of problems through local reporting of clinical incidents, issuing of national alerts, medical literature, etc
2. *Analysis* of problems to identify associated hazards and risks
3. *Development and implementation* of policies and clinical practice improvement programs to address specific and general problems, such as policies and evidence-based programs
4. *Monitoring and analysis* of results produced, and dissemination of lessons learned.³²

The objectives of the WA Patient Safety Management System are two-fold, to ensure that:

- At a local level, action is taken whenever an incident occurs
- At a system level, health care providers across the State learn from each other's mistakes and errors.

The over-arching goals are to:

- Minimise the likelihood of specific incidents re-occurring
- Act on any events that do occur so as to improve the overall safety and quality of health care.^{30,33,34}



Work undertaken by the OSQH and other stakeholders between 2002 and 2007 has provided the WA health care system with the essential databases, information systems, reporting and risk management tools to provide a solid base for the WA Patient Safety Management System over the next five years.

Specifically, Pillar 3, Clinical Risk Management, is the most important clinical governance function that underpins the management of patient safety. It is here that clinical incident reporting, investigation, management, prevention and feedback and learnings occur. This was the first work undertaken by the OSQH. In addition to the development of the Advanced Incident Management System (AIMS) and Sentinel Event reporting, there has been a significant investment in human factors knowledge, understanding and training. The WA health care system was an early adopter of the Veterans Health Administration model of Human Factors Training and Root Cause Analysis (RCA) training.³⁵

The future focus of the OSQH will now move towards monitoring and auditing safety and quality processes and outcomes. The implementation of a coherent monitoring and auditing program will ensure that safety and quality initiatives are consistently implemented across the WA health care system, and that they achieve improved health service delivery and patient care outcomes for the WA community.

4.2. Clinical incident reporting sources in WA

WA Health has established a number of complementary clinical incident reporting systems, some voluntary and others mandatory. These systems are fit for purpose and vary according to the clinical issue, severity of outcome and medico-legal arrangements. They are generic in so far as they may relate to all hospital patients; specialty-specific, such as for anaesthesia and surgery; include all incidents; or focus on a subset such as sentinel events. Some hospitals also include patient complaints, coronial cases and medico-legal issues within their patient safety management systems.

The goal of these wide-ranging incident monitoring systems (see Table 1), is to create a systematic approach so that all clinical incident reports are managed by the most appropriate part of the hospital or health service.



Table 1. Clinical incident information sources for patient safety in WA

1	Clinical incident reporting and monitoring using AIMS
2	Sentinel event management program
3	RCA and clinical investigations (internal & external)
4	Hospital morbidity and mortality reviews & audit
5	Medical record reviews (retrospective, standard method)
6	Quality improvement committees in hospitals
7	Statutory death reporting committees - eg maternal, neonatal, anaesthesia
8	Coronial investigations
9	Complaint registers, Freedom of Information (FOI) requests, ministerial letters of complaint
10	Medico-legal cases
11	Registers and reporting systems - eg trauma, adverse drug reactions, equipment failure
12	Public health surveillance data - eg notifiable infections
13	Literature, textbooks, Cochrane reviews
14	Routine data collections, surveys, observational studies
15	Accreditation and licensing reporting requirements
16	Royal Commissions and judicial inquiries
17	Auditor-general and parliamentary inquiries

These various incident monitoring systems have provided valuable data on problem areas, and have enabled the WA health care system to prioritise its program of prevention work over the past five years. Examples of WA public health services using clinical incident information to improve accountability and patient safety systems and processes are PathWest and BreastScreen WA. Integrating accountability arrangements and voluntary incident monitoring systems into their quality improvement programs has enabled PathWest and BreastScreen WA to improve the quality and safety of pathology and breast cancer screening programs across WA.

4.3. Prioritising action - developing the policies, programs and pillars: OSQH work plans 2002-2007

Given the finite resources available to the OSQH and Area Health Services, a considered decision was made in 2001 to prioritise the implementation of the four pillars of the WA Clinical Governance Framework in the following order:

1. Development and implementation of clinical incident reporting tools
2. Collection of patient safety data to identify problem areas
3. Provision of education to health professionals and health administrators
4. Development and implementation of policies and clinical practice improvement programs to address specific and general problems.



The early developmental work of the OSQH focused on populating the Clinical Governance Pillars. The following tables summarise the key policies and programs populating each pillar.

Table 2. Pillar 1: Consumer Value

- Procedure-specific information sheets for patients to assist practitioners with gaining consent to treatment and the disclosure of risks to patients
- Procedure specific consent forms
- Statewide complaints data collection, analysis and reporting
- Patient First Program
- New Consent to Treatment Policy to assist health practitioners with gaining consent to treatment and the disclosure of risks to patients.

Table 3. Pillar 2: Clinical Performance and Evaluation

- WA Audit of Surgical Mortality (WAASM)
- Statewide laboratory identification and monitoring of key healthcare associated infections across the WA health care system
- Healthcare-associated Infection Council of WA (HICWA) to oversee a Statewide response to healthcare associated infections, including surveillance, monitoring and policy/procedure development
- WA Review of Mortality (WARM) Policy
- National Inpatient Medication Chart
- WA Process of Pharmaceutical Review Policy
- From Death We Learn - Sharing Lessons from Coronial Inquests.

Table 4. Pillar 3: Clinical Risk Management

- Standardised voluntary clinical incident reporting arrangements for WA
- Advanced Incident Management System (AIMS) in all WA public hospitals
- Human factors theory and training
- US Veterans Health Administration RCA investigation model as the WA standard for clinical incident investigation
- Statewide Clinical Risk Management Guidelines
- Statewide Clinical Incident Management Guidelines and Sentinel Event Policy
- Root Cause Analysis Training to Area Health Service staff
- Qualified Privilege - *Health Services (Quality Improvement) Act 1994*.



Table 5. Pillar 4: Professional Development and Management

▪ Clinical Training and Education Centre (CTEC) and simulation services
▪ Central review of accreditation status of area health services and hospitals
▪ WA Policy for Credentialling and Defining the Scope of Clinical Practice for Medical Practitioners.

4.4. Aligning and implementing nationally agreed patient safety initiatives

In addition to implementing the WA Clinical Governance Framework, the OSQH, working in conjunction with the WA Council, coordinated the implementation of eight major safety and quality initiatives that were endorsed by Australian Health Ministers in April 2004 under the auspices of the National Health Reform Agenda.³⁶ These included:

1. National Open Disclosure Standard to aid the open disclosure of adverse events
2. A standardised sentinel event list, with public hospital reporting of all sentinel events, together with national reporting on sentinel events
3. An incident management process in all public hospitals, incorporating incident management, monitoring, investigation, analysis, and action arising
4. A common medication chart to be used by all public hospitals
5. A process of pharmaceutical review of medication prescribing, dispensing, administration, and documenting processes for the use of medicines, in all public hospitals
6. A “Right Patient, Right Site, Right Procedure” protocol to be used by all public hospitals, to reduce the risk of wrong procedures (subsequently renamed the Correct Site, Correct Patient, Correct Procedure protocol)
7. Consumer booklet “10 tips for Safer Health Care: what everyone needs to know” to be provided to all public hospital patients, to help consumers become more actively involved in their health care
8. Requirement that a patient safety risk management plan was in place and used in all public hospitals.

WA Health has successfully implemented all of these eight key recommendations. A summary of WA Health’s report to Australian Health Ministers on action taken to implement each of the eight areas is provided at Appendix E.



5. Review of accountability arrangements 2004

The Health Reform Committee (HRC) reviewed accountability arrangements within the WA health care system, including the implementation of the WA Clinical Governance Framework, in 2004. The HRC's review found that although significant progress had been made in terms of strategy and policy frameworks, clinical governance structures and processes were deficient. Consequently the HRC recommended that WA Health should take urgent action. In particular, the HRC recommended that a *"Statewide Clinical Governance Framework should be implemented within two years and involve the following four pillars:*

1. *consumer values,*
2. *clinical performance and evaluation,*
3. *clinical risk, and*
4. *professional development and management".*³⁷(Recommendation 74)

The OSQH was charged with establishing a Clinical Governance Implementation Project to oversee the development and implementation of an improved Statewide clinical governance framework for the WA health care system. The purpose of the Clinical Governance Implementation Project was to achieve the following outcomes:

- Improved communication of clinical governance policies and guidelines
- Improved awareness of individual and organisational clinical governance responsibilities and accountabilities
- Improved clinical audit controls and processes
- Identification and implementation of minimum acceptable standards of practice
- Increased adherence to agreed best practice guidelines and processes
- Improved clinical performance indicators that enable measurement and reporting on clinical governance activities and outcomes.

In 2006, the OSQH successfully completed the work associated with Recommendation 74 of the HRC Report. In particular, a suite of clinical governance documents and standards were developed, endorsed and inserted into departmental accountability and risk management requirements.

The Auditor General subsequently audited the work done in relation to Recommendation 74 and noted the timely and accurate completion of this systemwide reform issue.³⁸

In 2006, the implementation of clinical governance in WA was again audited, this time by WA Health's Internal Audit Branch as part of a regular internal audit cycle. The survey results indicated that further work is required to ensure that the clinical governance systems and processes, developed as part of this project, are fully implemented at all levels of the health service and are being used appropriately in the delivery of safe, high quality, evidence-based health care services to patients.

In 2006/07, the Office of the Auditor General audited the reporting of adverse events in the WA health care system. This report was published in October 2007 (www.audit.wa.gov.au).



6. Acting on the evidence: establishment of the Patient First and Safety and Quality Investment for Reform Programs

In 2006, the OSQH initiated the Patient First Program³⁹ and the Safety and Quality Investment for Reform (SQiRe) Program,⁴⁰ to ensure the delivery of safe, high quality, evidence-based health care to the WA community. Both of these programs focus on the key vulnerabilities and adverse event priorities described by WA data sources.

There is a deliberate synergy through the combination of the SQiRe and Patient First programs. Concentrating on the same patient safety risks, the SQiRe Program is focused on the health care team and seeks to ensure that health care workers practice evidenced-based care, while the Patient First Program is focused on the patient, to ensure that patients are empowered and have the information and skills to promote good outcomes from their care. The two programs overlap in four key areas, namely: falls, medication safety, pressure ulcers and preventing infections.

6.1. Safety and Quality Investment for Reform (SQiRe)

The SQiRe Program was established by the OSQH in July 2006 to underpin:

- Increased uptake of clinical governance capacity and processes within Area Health Services, and
- Systemwide clinical practice improvement in eight clinical priority areas where WA patients can have better outcomes.

The SQiRe Program consists of three interdependent tiers, as outlined below:

Tier 1: Clinical Governance	Implementation of accountability arrangements and policies and procedures under the four pillars of the WA Clinical Governance Framework
Tier 2: Clinical Practice Improvement (CPI) Program	Implementation of eight mandated evidence-based programs (where appropriate) and support clinical practice improvement at the local level
Tier 3: Incentive Scheme	A clinical practice improvement incentive scheme

Tier 2 of the SQiRe Program contains eight, evidence-based Clinical Practice Improvement (CPI) initiatives:

1. Acute Myocardial Infarction
2. Venous Thromboembolism
3. Pressure Ulcers
4. Falls Prevention
5. Medication Reconciliation
6. Central Line Associated Blood Stream Infections
7. Surgical Site Infections
8. Hand Hygiene.



Measurement and evaluation is a major part of the SQuIRe Program. Measurement is occurring in several ways including peer assessment against existing clinical governance standards; departmental Internal Audit assessment; external audit of adverse events by the Office of the Auditor General; process measures within the eight CPIs; and use of the Institute for Healthcare Improvement Collaborative Teams Assessment Tool. At a system level, measurement involves reporting against the WA Health Operational Plan, Chief Executive and Director General performance indicators.

The immediate return on investment includes alignment of executive leadership, a designated central coordinating team, relentless communication using meetings, website and email methods and increased use of the IHI Model for Improvement. Area Health Service self-assessment surveys and independent audits in 2006 and 2007 also show improved compliance against the eight Clinical Governance Standards.

Currently, 34 metropolitan and rural hospitals across WA are participating in the eight mandated CPI initiatives. 104 separate improvement projects involving 144 team leaders and 600 clinicians were established in the first 6 months of 2007. Over 300 participants have attended Clinical Practice Improvement workshops facilitated by WA Health. Many hundreds more have attended hospital-based team meetings. There has been a gradual improvement in performance by all sites.

WA Health has identified a number of barriers in implementing the SQuIRe Project, including:

- Internal governance and reporting structures always changing
- Competing priorities and heavy workloads for clinical staff
- Poor access to IT and data for performance measurement purposes.

These challenges are typical of the early barriers often identified by participants in large cultural organisational change programs.

The priority focus of the SQuIRe Program will now move from capacity building to ensuring that the return on investment in clinical governance capacity and CPI initiatives results in measurable and tangible improvements in patient safety.

6.2. Patient First

In August 2006 the OSQH in collaboration with the WA Council launched the Patient First Program.³⁹ The Patient First Program, based on a national US initiative called the Speak Up Program,⁴¹ encourages patients to take a role in preventing health care incidents and errors by becoming active participants in their own health care. The Patient First Program has been specifically designed to empower patients to enable them to speak up about their own health care.

The Patient First Program educates patients and consumers about the risks inherent in receiving care, and generally aims to increase public understanding of health-related issues. Various community organisations have been involved in the implementation of the Patient First Program, including the Health Consumers' Council, Community Advisory Councils in the metropolitan area and District Health Advisory Councils in rural regions.

The initial rollout of the Patient First Program has been extremely successful with a large proportion of WA health consumers coming into contact with resources from the Program. An evaluation study is now underway. Future iterations of Patient First resources will include materials specifically developed for priority groups of patients who use hospital services. This material is also being adapted for culturally and linguistically diverse populations in WA.



6.3. Encouraging patient involvement

Optimum patient care requires the patient to work in partnership with the health care system, and actively participate in the decision making process. The Australian High Court case of *Rogers v Whittaker (1992)* was a landmark medico-legal case that clarified the legal obligations and requirements relating to health practitioners obtaining consent from patients. In its decision, the High Court made it clear that a patient can only make an informed decision about whether or not to undergo a specific treatment if they are aware of the benefits and risks of the treatment. Ensuring patients understand the information given to them by health practitioners is thus a key requirement.

To facilitate better standards of health care, patients and health care consumers need to become more involved in the operation of the broader health system. In part, this can be achieved through encouraging patients to ask questions, gain a better understanding of their treatments and recovery process, and provide feedback through comments and complaints. Taking such an approach, the Patient First Program empowers patients from the start of their treatment and bolsters confidence that they will be given a satisfactory explanation should unintentional harm occur.

In 2007, WA Health also updated its Consent to Treatment policy⁴³. This policy aims to improve guidance for health practitioners in relation to obtaining a patient's consent to treatment. Tools were developed for health practitioners to use to provide more relevant information to patients and to assist the patient in making informed decisions. As part of the rollout of the Consent to Treatment policy, a suite of patient information resources (e.g. procedure-specific information sheets) have been acquired to assist a patient understand their procedure, the risks and benefits and potential outcomes of the procedure they might be considering. Patients can now be provided with easy to understand information that facilitates an ongoing dialogue between doctor and patient.



7. Using the WA Patient Safety Management System to close the loop

The following section outlines some examples of how the OSQH has used the WA Patient Safety Management System to drive clinical practice improvement and patient safety across the WA health care system.

Each section provides an overview of the rationale for the intervention (i.e. the *Situation* that gave rise to the need for action), the *Action* taken to address the issue, the *Results* of that action, and the *Improvements* (including the dissemination of relevant information) that were produced or were required as a result of implementing the relevant action.

7.1. Coronial under-reporting

The final report on the Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital (KEMH), ‘the Douglas Inquiry’⁴⁴ concluded that staff had repeatedly failed to report deaths that occurred at the hospital and that there was a lack of appropriate clinical governance systems and processes.

Recommendation R11.5 of the Douglas Inquiry Report therefore stated “KEMH should formulate and adopt procedures to ensure that deaths required by law to be reported, are in fact reported.”

Following the release of the Douglas Inquiry the State Coroner commented that he was concerned that under reporting may not be restricted to KEMH but could be more widespread within the health system.

WA Health in association with the Office of the State Coroner proceeded to develop the Death In Hospital Form to increase health professionals’ awareness of ‘reportable deaths’ under the *Coroners Act 1996* and other reporting mandatory and statutory obligations following the death of a patient. The Death in Hospital Form was released in early 2007 and implementation was strongly encouraged to promote awareness of reporting obligations and facilitate timely and accurate reporting of reportable deaths under the *Coroners Act 1996*.

It is envisaged that the implementation of the Death in Hospital Form will improve governance activities around reporting and auditing of deaths. This initiative integrates well with mortality review processes across the system.

7.2. Mortality review

There are over 2000 deaths each year in WA, most of which are anticipated, however, a small percentage of these deaths may be unexpected and preventable, resulting from a medical intervention or absence of appropriate treatment.

Both national and international literature and well-publicised events have illustrated the potential human cost of adverse events and the need for a collaborative approach to reducing adverse events, system failures and human error.

The Bristol Royal Infirmary Inquiry,⁴⁵ Quality in Australian Health Care Study,^{4,5} King Edward Memorial Hospital Inquiry⁴⁶ and the Inquiry into Campbelltown and Camden Hospitals⁴⁷ have all emphasised the importance of clinical audit by peer review as an integral part of clinical practice. Clinical audit is now recognised as part of the evidence base that is required to evaluate and initiate change in the practices of individual clinicians and hospital systems.



WA was the first State to recognise the value of surgical audit. In late 2001, WA Health, in collaboration with the Royal Australasian College of Surgeons, established the WA Audit of Surgical Mortality (WAASM) project based on a successful world best practice audit methodology from the Scottish Audit of Surgical Mortality.

There have been many positive outcomes since the introduction of the WAASM project. In addition to improvement in the use of VTE prophylaxis there have been other achievements such as more appropriate use of High Dependency Units/Intensive Care Units, a reduction in the use of futile surgery, and a decreasing trend in the proportion of cases associated with a deficiency of care.⁴⁸

There is ample evidence that implementation of the WAASM project has had measurable improvements across the system. An evaluation study undertaken in 2005 by UWA showed peer review audit can facilitate change to both clinical and hospital practice. The study showed surgeons, hospitals, policy-makers and consumers were highly supportive of the project and its capacity to provide clinical accountability as demanded by the community, health care providers and the surgical profession.

The benefits of information obtained from the WAASM project have highlighted the value of audit and review in clinical settings. The successful outcomes of the WAASM project led the Royal Australasian College of Surgeons to extend the project to other Australian states. These benefits and further demands by the community to ensure that health care was safe resulted in WA being the first State in Australia to make a review of all deaths (both surgical and medical deaths) mandatory via the WA Review of Mortality Policy (WARM).⁴⁷ The implementation of the WARM Policy commenced on 1 January 2007. Hospitals and Area Health Services are required to report on a quarterly basis and provide the information and lessons learned from the investigation of preventable deaths.

Lessons learned from the WARM process will be integrated with results of health-related coronial findings and information appropriately shared across the system to maximise benefits and improve patient care. Key messages are regularly disseminated via the publication, *From Death We Learn*.^{49,50}

Taking its lead from the WA health care system, Queensland Health now uses the WARM process as one of their standards for death review.

7.3. Communication

Failures in communication between health care personnel have been implicated in a number of studies as a major threat to patient safety. A 2005 report of the Joint Commission of Accredited Health Care Organisations ('the Joint Commission') reported that root cause analyses of sentinel events identified communication failures as being responsible for 60% of all sentinel events. Communication is open to error during time of transition or handover.⁵¹

Local sentinel event data shows that communication issues make up approximately one-quarter of all contributing factors for reported sentinel events during the 2005/06 and 2006/07 financial years.^{52,53}

An analysis of AIMS data (2001-2007) identified that communication issues were one of the three most common contributing factors in critical incidents involving staff, with 21% of all critical incidents listing communication problems as a staff contributing factor.



The above data reinforces the need for WA Health and individual Area Health Services to improve the communication process via the development of better patient handover processes and protocols.

The OSQH has responded to this need by funding a pilot Clinical Handover project in 2007 to address the recommendations arising from an audit of WA health services by the Internal Audit Branch of WA Health. The goal of the pilot study was to improve shift-to-shift handover processes using currently available electronic tools. As a result of the pilot program, there has been an increase in interest in the use of electronic tools to strengthen communication between health professionals during shift-to-shift handover. The adaptation of currently available information systems to support handover processes are now being given consideration Statewide.

A Statewide Clinical Handover Working Group was also established to develop a Statewide policy framework to guide hospitals and health services with improving local handover processes. Health professionals working across the WA health care system have developed a draft policy document which will guide nurses and doctors on ways to improve the patient handover process across a number of disciplines and establishments. The adoption of a standardised process across the State will reduce variation in practice and promote safer care.

The WA initiatives are consistent with work currently being led by the Australian Commission on Safety and Quality in Health Care. This work will form part of Australia's contribution to the World Health Organization Patient Safety Alliance, High Fives Initiative.⁵⁴

At a national level, in March 2007 the Commission identified clinical handover as one of its priority programs. WA Health has been successful in tendering for funding to support a project that will contribute to improving inter-hospital handover processes nationally and internationally. Participation in international and national initiatives will provide WA the opportunity to benefit from lessons learned nationally and internationally, which contribute to safer patient care.

7.4. Healthcare-associated infections

Healthcare-associated infections (HAIs) are one of the most common, most significant and most preventable adverse events and as such has been identified as a major priority for action by national and international organisations, including ACSQHC,^{55,56} Joint Commission of Accredited Healthcare Organisations,⁵⁷ World Health Organisation⁵⁸ and UK Department of Health.

The above organisations have highlighted that the management of HAIs requires the integration of monitoring and prevention strategies into other clinical governance structures and requires multidisciplinary teamwork, changes and re-engineering to complex organisational systems, ongoing investment, and committed leadership.

In WA, antibiotic-resistant organisms pose a threat to patient safety. Infections with these organisms are associated with poorer clinical outcomes, higher treatment costs, longer hospital stays, and greater outbreak potential than those with antibiotic-susceptible pathogens. While prevention of all HAIs is vital, the presence of these organisms in a health care setting poses an additional threat. A comprehensive Statewide system has been established, for the notification and investigation of two of the key types of these pathogens that have proved to be problematic in a WA setting: *Methicillin-Resistant Staphylococcus Aureus* (MRSA) and *Vancomycin-Resistant Enterococcus* (VRE).



The WA health sector has been recognised as leading Australia in its control of the most important antibiotic-resistant pathogen - MRSA. The Gram Positive Bacteria Reference and Typing Unit at Royal Perth Hospital, funded in part by the OSQH since 2003 in partnership with Curtin University, provides detailed typing and analysis of all MRSA isolates in WA. It is now recognised as the national reference laboratory for this work.

The Statewide comprehensive program of compulsory notification, laboratory identification, computerised alerting and a uniform approach to management of MRSA in a health care setting, sets WA as the standard from which other jurisdictions can learn.^{59,60} Using Healthcare-associated Infection Surveillance WA (HISWA) data, Ferguson⁵⁹ estimated that between 123 and 157 deaths could be prevented each year if other jurisdictions in Australia achieved WA's infection rates.

The effectiveness of the WA approach to Infection Control has been highlighted in a recent Medical Journal of Australia article by Collingdon et al,⁶¹ which reported that in “countries where ‘search and destroy’ campaigns have been implemented, MRSA has been kept at very low levels in hospitals” (Table 6). “In Western Australia, infections caused by multiresistant strains of MRSA in hospitals remain uncommon, partly due to screening and isolation of patients transferred from affected areas, such as the eastern states”. Furthermore, “it is no coincidence ‘that the state with the lowest prevalence of health care associated MRSA (Western Australia) is the only state in which MRSA infections are notifiable.’”⁶¹

Table 6. Comparison of Infection Rates between WA and other Australian States/Territories

State	Healthcare-associated MRSA bacteraemia events	Year(s) of data	Rate per 100,000 population
ACT*#	30	2006	9.2
Darwin	16	2006	13.3
NSW*	424-589	2003-5	5.5-8.0
Queensland*	133	2005	3.4
South Australia*	37	2006	2.4
Tasmania*	3	2006	0.6
Victoria*	270-330	2000-6	5.4-6.6
Western Australia*	22	2006	1.1
Total	935-1160		4.6-5.7

* Private Hospital estimates/data included in figures from these jurisdictions.

ACT Hospitals draw one third of their patient load from adjacent NSW regions.

In 2005, a Statewide HAI surveillance program was established with financial support from the OSQH. Private and public hospitals voluntarily contribute data regarding key HAI indicators using standardised methodology and definitions. Analysis of data collected by HISWA shows a high uptake among WA hospitals, with 44 private and public hospitals participating. Initial data from the surveillance program shows that infection rates for a number of key indicators have fallen during the first year of data collection including MRSA HAI, and surgical site infections after key elective orthopaedic procedures. The success of HISWA allowed the HISWA team to be expanded to form the Healthcare Associated Infection Unit (HAIU) in 2007.



In 2006, formation of the Healthcare-associated Infection Council of WA (HICWA) was endorsed by the State Health Executive Forum to develop a coordinated approach to the governance and delivery of optimal programs for HAI monitoring and prevention in WA.

HICWA is implementing a system that will require all public hospitals in WA to monitor key HAI indicators in 2007/08 using the HISWA system. This mandatory surveillance program will further embed the monitoring of key HAI outcomes into WA hospitals, which in turn underpins prevention programs.

Providing evidence-based education and awareness about infection control to all health care workers, and regularly updating such information is a challenging task, particularly with a mobile workforce. Hospitals within two Area Health Services in WA will be evaluating an Infection Control eLearning program in the latter half of 2007 in collaboration with Hunter New England Health Service in NSW. This pilot project in WA is funded and led by the OSQH, and is anticipated to lead to a similar program being available on a national scale.

In 2006/07, the OSQH provided support for implementation of three HAI prevention interventions across the State - improving hand hygiene, reducing surgical site infections, and reducing central line infections, under the SQuIRe CPI Program. These three targeted interventions align with outcome indicators monitored by HISWA, and the content and delivery of the programs build on proven models for sustained clinical practice improvement and collaborative learning. It also provides WA health care staff with appropriate skills and training in relation to improvement and implementing change within the WA health care system.

The results of the CPI Program in terms of improved patient outcomes will be expected to become evident during 2007/08 when the program is fully implemented. Early feedback indicates that the program has achieved a greater focus on HAI as a priority for hospitals, and successfully engaged hospital leadership and clinicians more broadly in the challenge of reducing HAI. Review of the CPI Program will allow it to be expanded to include other HAI prevention strategies, and refinement of outcome measures for the HAI targets.

7.5. Medication safety

Every year in Australia almost 200 million prescriptions are dispensed in hospitals and the community, equating to about 10 prescriptions per year per person.⁶² National and international literature suggests that medication errors account for approximately 20% of reported adverse events in hospitals.⁶²

There are a number of systems and processes in place within the WA health care system to monitor and report medication errors in WA hospitals. These systems include:

- Medication errors reported to AIMS
- Sentinel Event reports involving medication errors
- Medication errors coded and reported to the Hospital Morbidity Data System
- Monitoring and reporting of medication errors to the Therapeutic Goods Administration (TGA) and the national Adverse Medicine Events Line.

Analysis of sentinel event data shows that only 5% of reported sentinel events are medication related. An analysis of AIMS data (2001-2007) shows that although medication incidents are rarely critical (eg outcome level 7 or 8), they make up 41% of near miss or no injury incidents. This data suggests that addressing medication safety can significantly improve the quality of health care.



Following the release of the *Second National Report on Patient Safety: Improving Medication Safety*,⁶² Australia's Health Ministers agreed on two initiatives to improve medication safety in Australian hospitals:

- All public hospitals will use a common medication chart by June 2006
- Public hospitals will have in place a process of pharmaceutical review of medication prescribing, dispensing, administration and documenting processes for the use of medicines by the end of 2006.

These initiatives have been fully implemented in all public hospitals across WA. The roll out of the National Inpatient Medication Chart (NIMC) in WA was completed in June 2006. A post implementation audit was conducted in February 2007. The results of the audit were published in October 2007.⁶³

Implementation of the Pharmaceutical Review Policy⁶⁴ was completed in March 2007. A baseline audit and gap analysis has been conducted to determine the current level of compliance by WA Health Services against the five standards outlined in the Pharmaceutical Review Policy. A report will be submitted to the State Health Executive Forum, identifying resource requirements for health services to be fully compliant with the five standards.

The OSQH also supported medication safety initiatives through funding the Western Australian Therapeutics Advisory Group (WATAG).

The OSQH has also established the Medication Reconciliation initiative under the SQuIRE CPI Program. The Medication Reconciliation CPI initiative comprises four steps:

- Medication history
- Confirmation
- Reconciliation
- Medication liaison.⁶⁵

Participating sites are currently implementing the four-step medication reconciliation process. Results from Area Health Service data shows that participating sites have improved their compliance in each of the four-steps of the medication reconciliation process.

7.6. Falls

A fall is defined as: *"unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of syncope or overwhelming external force."*⁶⁶

There are a number of systems in place within the WA health care system to monitor and report inpatient falls in WA hospitals. These systems include:

- Falls reported to AIMS
- Sentinel Event reports involving falls
- Hospital Morbidity Data System.

Analysis of AIMS data from 2001 - 2007 show that falls represent 16% of all critical incidents and thus cause significant harm to patients. The 2006/07 Sentinel Event Report identified that approximately 10% of reported sentinel events could be attributed to falls.⁵³



WA recognised early on that falls caused significant harm to hospital inpatients and falls prevention activities, policies and awareness programs were commenced in 2003.

In 2004, WA Health developed a Statewide 'Falls Policy for Older Western Australians'.⁶⁷ The ACSQHC in association with Queensland Health released national falls prevention guidelines for hospitals and residential aged care facilities in July 2005.⁶⁸

Prior to July 2006, responsibility for the implementation of the Falls Policy for Older Western Australians lay with different areas of the Department of Health. In 2006, the Department of Health established the Falls Network, comprising health professionals, patients, carers, consumers and others, to improve the coordination, planning and policy development for falls prevention programs and services across the State. The OSQH is an observer member of the Falls Network and works with the Network to support the implementation of the Falls Prevention CPI initiative.

The OSQH has worked with the Falls Network and Area Health Services to establish the Falls Prevention initiative under the SQuIRe CPI Program. This CPI initiative aims to prevent falls in WA public hospitals by ensuring patients are assessed to determine their risk of falling, and where a patient is identified as being at risk of falling, ensuring that appropriate falls-prevention interventions are implemented. Participating CPI teams are implementing, monitoring and reporting against the prescribed process and outcome measures. A key outcome of the Falls Prevention CPI initiative is the development of a standardised risk assessment tool for the WA health care system. This work is being led by the Falls Network in conjunction with members of the SQuIRe Falls Prevention teams.

7.7. Pressure ulcers

A pressure ulcer is defined as *“any lesion caused by unrelieved pressure resulting in damage of the skin and underlying tissue”*.⁶⁹

Pressure ulcer prevention strategies have been underway in the WA health care system since 2002. For example, Fremantle Hospital has been systematically reporting pressure ulcers to AIMS since 2002. Fremantle Hospital and other hospitals have also been conducting point prevalence surveys since 1994. The prevalence and incidence of pressure ulcers in WA health care facilities has been confirmed in many Australian studies.⁷⁰⁻⁷⁵

The results of national literature and point prevalence pressure ulcer surveys conducted over the years in WA hospitals have highlighted that a coordinated approach was needed to rollout this project across the State. In 2006, the WA Council commissioned the WA Chief Nursing Officer to oversee the establishment of the WoundsWest project.

WoundsWest is a three-year, Statewide project being undertaken in partnership with Curtin University and the Silver Chain Nursing Association, and with the support of the Nurses Board of Western Australia.⁷⁶ WoundsWest aims to develop a Statewide system of audit, clinical guidelines, education, electronic wound imaging and remote expert referral which will improve patient outcomes and achieve significant cost savings through the implementation of evidence-based wound management across WA.

The OSQH has also established a Pressure Ulcer initiative under the SQuIRe CPI program. WA public hospitals are required to ensure that patients receive a pressure ulcer risk-assessment and use appropriate pressure ulcer prevention strategies to reduce the occurrence of pressure ulcers in health care facilities.



A Statewide point prevalence pressure ulcer study conducted in WA hospitals in May 2007 (n=2,777 patients) identified a pressure ulcer prevalence rate of 10.9%. The prevalence of hospital acquired pressure ulcers was 7.9%.⁷⁷ The WoundsWest survey team regularly performs a Statewide wound prevalence survey, including evaluation of pressure ulcer incidents. A pressure ulcer prevention and management educational resource is also currently under development.

7.8. Venous thromboembolism (VTE)

Venous thromboembolism (VTE) is the disease process that presents as deep vein thrombosis (DVT) and/or pulmonary embolism (PE). Deep vein thrombosis is the occurrence of a blood clot in the deep veins of the leg or thigh (femoral, popliteal or calf veins), or pelvis or abdomen (iliac veins or inferior vena cava). Pulmonary embolism occurs secondary to DVT when part of the clot dislodges and travels via the venous circulation to the lungs.⁷⁸

International and Australian literature suggests that the prevalence of VTE in all hospital admissions is 2 to 3 per 1000 beddays.⁷⁹ Without prophylaxis, the incidence of objectively confirmed hospital-acquired VTE is approximately 10%-40% among medical and surgical patients and higher following orthopaedic surgery, up to 40%-60%.^{78,80} Approximately 10% of hospital deaths are attributable to PE.^{81,82}

Following the commencement of the WAASM project in 2001, it was confirmed that DVT/VTE was common post surgery and that VTE was a common cause of death. The 2003 WAASM Report⁸³ identified that in 63% of cases audited DVT/VTE prophylaxis was inappropriate. There was anecdotal evidence that there was limited consistency with respect to the management of DVT/VTE increasing the risks of patient harm or even death.

As a result of the 2003 WAASM Report it was recommended that hospitals and clinicians review the efficiency of DVT prophylaxis regimes. In 2004 WA Health and WAASM also agreed that the system would benefit from the promotion of the Best Practice Guidelines for the Australia and New Zealand: Prevention of VTE,⁸⁴ and that the WAASM audit should include information on surgeon's decision-making related to VTE/DVT prophylaxis.

The 2004 WAASM Report⁸⁵ showed that there was evidence that surgeons were changing practice and that there was a demonstrated increase in the use of appropriate DVT prophylaxis. An evaluation study of the WAASM Project identified that the WA health care system was becoming more aware of the issues around VTE prophylaxis and there were increasing efforts to improve clinical practice. The evaluation also identified the WAASM project's ability to influence clinical and hospital practice.

The most recent WAASM Report (2006)⁴⁸ showed an increase from 61% to 69% of the appropriate use of VTE prophylaxis.

WA Health continues to recommend that patients should undergo a VTE risk assessment to assist decision-making regarding appropriate prophylaxis for patients, through its safety and quality publications such as SNIPTS and From Death We Learn.^{49,50}

A VTE initiative has also been established under the SQuIRe CPI Program. The goal of the VTE CPI initiative is to increase the use by WA clinicians of evidence-based strategies such as the use of VTE prophylaxis and risk assessment programs to prevent venous thromboembolism in hospitalised patients. Review of the VTE CPI initiative will demonstrate the extent of improvements and also provide other avenues to accelerate system improvements.



7.9. Ensuring correct procedure is performed on the correct patient and at the correct site

Surgical, medical, anaesthetic, radiology or oncology procedures performed on the wrong body part, wrong side of the body, wrong patient or at the wrong level of the correctly identified anatomical site are preventable adverse events.

International and Australian literature suggests that the incidence and cost of wrong-site surgery is significant, not only to the patient and clinician involved, but also to the health care system.

Australian States and Territories collect and report data on procedures carried out on the wrong patient or body part as part of the sentinel event reporting process, mandated by Australian Health Ministers in April 2004. In New South Wales 13 such sentinel events were reported in 2003/04 and 14 were reported in 2004/05.⁸⁶ Victoria has been collecting and reporting data on wrong site surgery as part of its Sentinel Events Program since 2001. In 2001/02 nine sentinel events reported to the Victorian Department of Human Services involved procedures carried out on the wrong patient or body part. Subsequently, 16 sentinel events involving procedures carried out on the wrong patient or body part were reported to the Victorian Department of Human Services in 2002/03, 14 in 2003/04,⁸⁷ and 25 in both 2004/05⁸⁸ and 2005/06.⁸⁹

In Western Australia, WA Health has collected and analysed sentinel event data since October 2003, when the WA Sentinel Event Policy was introduced into the WA health system. Between October 2003 and June 2007, 22 sentinel events involving procedures on the wrong patient or wrong body part were reported to the Chief Medical Officer.⁹⁰ Six sentinel events involving procedures on the wrong patient or wrong body part were reported to the Chief Medical Officer between 1 July 2006 and 30 June 2007.⁵³

In April 2004 Australian Health Ministers approved the Australian Council for Safety and Quality in Health Care's (ACSQHC's) Ensuring Correct Patient, Correct Site, Correct Procedure Protocol.⁹¹ It was also agreed at this meeting that *"all State and Territory jurisdictions would ensure that all public hospitals adopt the five step right patient, right site, right procedure protocol for verifying the site of surgery and other procedures to reduce the risk of wrong site procedures"*.⁹¹

The protocol is consistent with the Royal Australasian College of Surgeons' Correct Patient, Correct Site and Correct Side Guidelines⁹² and was adapted from material produced by the Veterans Affairs National Centre for Patient Safety in the United States.⁹³

In November 2005 the Correct Patient, Correct Procedure and Correct Site Policy and Guidelines for Western Australian Health Services was developed by the WA Council for Safety and Quality in Health Care.⁹⁴ This Policy, revised and reissued in November 2006,⁹⁵ provides a standardised approach for health professionals in WA hospitals and health services to prepare patients for surgical, anaesthetic, medical, radiology and oncology procedures.



The five key steps to the Correct Patient, Correct Site and Correct Procedure Policy and Guidelines for WA health services are outlined below.^{94,95}

Step 1: Ensure that valid informed consent has been obtained

Step 2: Confirm the patient's identity

Step 3: Mark the site of the surgery or invasive procedure

Step 4: Take a final 'team time-out' in the operating theatre, treatment or examination area

Step 5: Ensure the correct and appropriate documents and diagnostic images are available.

In the 2006/07 financial year there were six sentinel events reported involving the wrong body part.⁵³ Each of these sentinel events arose as the result of quite different issues with no discernible repeating pattern. Communication and policy, procedure and guidelines were identified most often as contributing factors, and were regularly identified together and often related to a lack of clear understanding or knowledge of the policy and process.

Analysis of these sentinel events since 2004 demonstrates an increased awareness of reporting throughout hospitals due, in part, to the implementation of the Correct Patient, Correct Procedure and Correct Site Policy and Guidelines. There is increased awareness of this Policy document throughout hospitals not only in operating theatres but also in non-surgical areas such as diagnostics. Increased reporting from these clinical areas in hospitals is now being seen.⁵³

WA Health is currently developing an audit tool and will undertake an evaluation during 2007/08 to assess the level of implementation and compliance against the Correct Patient, Correct Site and Correct Procedure Policy and Guidelines by WA health services.



8. Next steps

In order to ensure that WA Health provides consistently safe, effective and responsive care to patients, and is an attractive employer for the clinical workforce, there needs to be:

- Courageous and persistent leadership at all levels to manage the reform and change agenda manifested by introducing, implementing, maintaining, embedding and continuously improving the WA safety and quality programs
- Long-term and genuine executive commitment to clinical governance, patient safety and quality at all levels of the WA health care system
- Ongoing implementation of clinical governance processes and responsibilities at all levels of the health care system
- Significant reduction in variation in clinical practice and standardisation in priority clinical improvement areas (the CPI areas)
- Further investment in operational capacity, building on existing safety and quality infrastructure and ensuring that clinical governance process management is timely and effective
- Extending the current WA health care system safety culture that is open to learning from errors and adverse events and sharing these results with patients and the community
- Significant hospital based investment in clinical work and process redesign based on evidence-based safe practice and patient centred principles
- Genuine inclusion of patients and consumers in all aspects of health care design, planning and decision-making.

It is clear that patient safety and health care quality, which originally developed and emerged as a separate “discipline” is now a mainstream issue which affects every clinician, manager, patient and consumer. Safety and quality matters, it belongs to us all and we must all take responsibility and participate.

WA Health has drawn up comprehensive, patient-centred, strategic and operational plans, built strong foundations and established effective performance monitoring indicators. The challenge now is to ensure that all of health’s support functions are harmonised - i.e. data and information systems, the built environment, workforce practices, policies, improvement programs, clinical treatment and practice in order to continuously improve the quality and safety of health services patients in Western Australia.



References

1. Lasagna, L (1964). Hippocratic Oath - Modern Version. Tufts University (www.pbs.org/wgbh/nova/doctors/oath_modern.html)
2. World Medical Association (1948). Declaration of Geneva. Adopted by the 2nd General Assembly of the World Medical Association, Geneva, Switzerland, September 1948 and editorially revised at the 173rd Council Session, Divonne-les-Bains, France, May 2006 ([http://www.ama.com.au/web.nsf/doc/WEEN-6UA5D8/\\$file/WMA_Declaration_of_Geneva.pdf](http://www.ama.com.au/web.nsf/doc/WEEN-6UA5D8/$file/WMA_Declaration_of_Geneva.pdf))
3. World Health Organisation (2002). Quality of Care: Patient Safety. Agenda Item 13.9 of the Fifty-Fifth World Health Assembly (http://www.who.int/gb/ebwha/pdf_files/WHA55/ea5513.pdf)
4. Wilson, RM, Runciman, WB, Gibberd, RW, Harrison, BT, Newby, L & Hamilton, JD. The Quality in Australian Health Care Study. *MJA*, 1995; 163:458-471
5. 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
6. Department of Health (2000). An organisation with a memory: Report of an expert group on learning from adverse events in the NHS chaired by the Chief Medical Officer. Crownright. Department of Health. HMSO
7. Standing Committee of the Hospitals of the EU (2000). The quality of health care/hospital activities: Report of the working party on quality care in hospitals of the sub-committee on Coordination
8. Davis, P et al (2001). Adverse Events in New Zealand Public Hospital: Principal Findings from a National Survey. *NZ MedJ* 2002; 115 (1167): u271
9. Davis, P et al (2003). Adverse Events in New Zealand Public Hospital II: Occurrence and Impact. *NZ MedJ* 2003; 116 (11837): u624
10. Hunter, D, Bains, N. Rates of adverse events among hospital admissions and day surgeries in Ontario from 1992 to 1997. *CMAJ* 1999;160(1):1585-6 (<http://www.cmaj.ca/cgi/reprint/160/11/1585>)
11. Baker, Gr et al (2004). The Canadian Adverse Events Study: incidence of adverse events among hospital patients in Canada (www.cmaj.ca/content/full/170/11/1678)
12. Leape, LL. Error in Medicine. *JAMA* 1994; 272(23):1851-7
13. Brennan, TA, Leape LL, Laird NM, Hebert L, Localio AR, Lawthers AG, et al. Incidence of adverse events and negligence in hospitalized patients. Results of the Harvard Medical Practice Study I. *N Engl J Med* 1991;324(6):370-7
14. Wu, A. Medical error: the second victim. *BMJ* 2000;320:726-727
15. Department of Premier and Cabinet (1999). *Corporate Governance Guidelines for Western Australian Public Sector Chief Executive Officers*. Department of Premier and Cabinet, Government of Western Australia
16. Treasurer's Instruction (TI) 825 Risk Management and Security. Extracted from the Western Australian Financial Administration Bookcase, 825. (Department of Treasury and Finance (<http://www.treasury.wa.gov.au>))



17. Department of Health (2001). Clinical Governance, the Framework of Assurance (<http://www.clinicalgovernance.health.wa.gov.au/publications/index.cfm>)
18. Department of Health (2005). Western Australian Clinical Governance Framework (www.safetyandquality.health.wa.gov.au)
19. Department of Health (2003). *Western Australian Strategic Plan for Safety and Quality in Health Care 2003-2008* (2nd Edition) (http://www.health.wa.gov.au/safetyandquality/docs/WASQ-Plan2003_2008.pdf)
20. Australian Council for Safety and Quality in Health Care (<http://www.safetyandquality.gov.au>)
21. Australian Council for Safety and Quality in Health Care. Patient Safety: Towards Sustainable Improvement' - 4th Report to The Australian Health Ministers Conference, 31 July 2003. (http://www.safetyandquality.org/articles/Publications/safety_action.pdf)
22. Department of Health and Ageing (2005). *National Arrangements for Safety and Quality of Health Care in Australia: The Report of the Review of Future Governance Arrangements for Safety and Quality in Health Care*
23. Australian Commission on Safety and Quality in Health Care. (<http://www.safetyandquality.gov.au>)
24. Department of Health (1999). *Western Australian Strategic Plan for Safety and Quality in Health Care 1998/99-2002/2003* (http://www.health.wa.gov.au/safetyandquality/docs/WASQ-Plan2003_2008.pdf)
25. Department of Health (2001). Report of the Health Administrative Review Committee
26. Reason, J. Human error: models and management. *BMJ*. 2000;320:768-70
27. Reason, J. Beyond the organisational accident: the need for "error wisdom" on the frontline. *Qual Saf Health Care*. 2004;13:ii28-ii33
28. Helmreich, RL. On error management: lessons from aviation. *BMJ*. 2000;320:781-5
29. Department of Health Expert Group. An organisation with a memory. Report of an expert group on learning from adverse events in the NHS 2000
30. World Health Organisation (WHO). Reporting and learning for patient safety. 2005 [cited 2005 9th March]; Available from: http://www.who.int/patientsafety/reporting_and_learning/en/
31. Sharpe, VA, editor. Accountability: Patient Safety and Policy Reform. Washington DC: Georgetown University Press; 2004
32. Provonost, PJ and Holzmuller, CG et al. Using Incident Reporting to Improve Patient Safety: A conceptual Model. *Journal of Patient Safety*: 3(1); March 2007
33. Leape, LL. Reporting of Adverse Events. *N Engl J Med*. 2002;347(20):1633-8
34. Merry, A, Smith, AM. Errors, Medicine and the Law. Cambridge: Cambridge University Press; 2001
35. Department of Veterans Affairs National Center for Patient Safety. Root Cause Analysis Program (<http://www.va.gov/ncps/>)
36. Australian Health Ministers Conference, April 2004. Agenda Item 2.1.1.4 Health Care Reform Agenda - Health Reform Agenda Working Group (HRAWG) Report on Priority Actions



37. Department of Health (2004). *The Final Report of the Health Reform Committee (HRC): A Healthy Future for Western Australians* (http://www.health.wa.gov.au/HRIT/publications/docs/Final_Report.pdf)
38. Auditor General for Western Australia (2006). Auditor General's Performance Examination report - Early Diagnosis: Management of the Health Reform Program
39. Department of Health (2006). Patient First (<http://www.safetyandquality.health.wa.gov.au/programs/patientfirst.cfm>)
40. Department of Health (2006). Safety and Quality Investment for Reform (SQulRe) Program (<http://www.safetyandquality.health.wa.gov.au/squire/index.cfm>)
41. Joint Commission on Accreditation of Health Care Organizations. Speak Up Program (<http://www.jointcommission.org/PatientSafety/SpeakUp/>)
42. Department of Health (2005). Strategic Intent 2005-2010 (http://www.health.wa.gov.au/hrit/publications/docs/Strategic_Intent_2005-2010.pdf)
43. Department of Health (2006). Consent to Treatment Policy for the Western Australian Health System (http://www.safetyandquality.health.wa.gov.au/programs/pdfs/61030_Consent_Policy_final.pdf)
44. Douglas, N, Robinson, J, Fahy, K (2001). *Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital* (http://kemh.health.wa.gov.au/general/KEMH_Inquiry/index.htm)
45. Kennedy, I (2001). *Learning From Bristol: The Report Of The Public Inquiry Into Children's Heart Surgery At The Bristol Royal Infirmary 1984 - 1995* (<http://www.bristol-inquiry.org.uk/index.htm>)
46. New South Wales Health (2004). Special Commission Of Inquiry Into Campbelltown And Camden Hospitals
47. Department of Health (2007). Western Australian Review of Mortality (www.safetyandquality.health.wa.gov.au/programs/clinical_audit_warm.cfm)
48. Royal Australasian College of Surgeons (2006). Western Australian Audit of Surgical Mortality (WAASM) Annual Report 2006 ([http://www.surgeons.org/Content/NavigationMenu/WhoWeAre/Regions/WA/WAASM/WAASM_Annual_Report_2006_\(public\).pdf](http://www.surgeons.org/Content/NavigationMenu/WhoWeAre/Regions/WA/WAASM/WAASM_Annual_Report_2006_(public).pdf))
49. Department of Health (2006). *From Death We Learn: 'Lessons from the Coroner'*
50. Department of Health (2007). *From Death We Learn: 'Speak for the dead to protect the living'*.
51. World Health Organization (WHO) Patient Safety Alliance -Clinical Handover <http://www.jcipatientsafety.org/>
52. Department of Health (2006). The Second WA Sentinel Event Report 2005-2006
53. Department of Health (2007). Delivering Safety Health Care in Western Australia: WA Sentinel Event Report 2006-2007
54. World Health Organisation. The five elements of the Global Patient Safety Challenge (<http://www.who.int/gpsc/elements/en/>)
55. Australian Council for Safety and Quality in Health Care (2003). National Strategy to Address Health Care Associated Infections



56. Australian Infection Control Association Expert Working Group (2001). *National Surveillance of Healthcare Associated Infection in Australia*. A report to the Commonwealth Department of Health and Aged Care
57. Joint Commission on Accreditation of Healthcare Organisations (USA). Meeting the Joint Commissions 2007 National Patient Safety Goals
58. World Health Organisation. WHO Guidelines on Hand Hygiene in Health Care (http://www.who.int/patientsafety/events/05/HH_en.pdf)
59. Ferguson, J. A call to arms. *Australian Infection Control* 2007; 12(2): 39-40
60. Charles, P, Johnson, DR, Grayson, ML. Conundrums in community-acquired pneumonia. *MJA* 2006; 185 (3): 131-132
61. Collignon, PJ, Grayson, ML and Johnson, PDR. Methicillin-resistant *Staphylococcus aureus* in hospitals: time for a culture change. *MJA* 2007; 187 (1): 4-5
62. Australian Council for Safety and Quality in Health Care (2002). *Second National Report on Patient Safety: Improving Medication Safety*. Canberra: Commonwealth Department of Health
63. Department of Health (2007). *National Inpatient Medication Chart (NIMC). Post-implementation Audit Report - February 2007*
64. Department of Health (2007). *Pharmaceutical Review Policy* (www.safetyandquality.health.wa.gov.au)
65. Adapted from the Institute for Healthcare Improvement's (IHI) Preventing Adverse Drug Events How to Guide (<http://www.ihl.org/IHI/Programs/Campaign/Campaign.htm?TabId=2#PreventAdverseDrugEvents>)
66. Agostini, JV, Baker, DI and Bogardus, ST. Prevention of Falls in Hospitalised and Institutionalised Older People (www.ahrq.gov/clinic/ptsafety/chap26a.htm)
67. Department of Health (2004). *The Falls Policy for Older Western Australians* (http://www.safetyandquality.health.wa.gov.au/docs/Falls_Policy_document.pdf)
68. Australian Council for Safety and Quality in Health Care (2005). *Preventing falls and harm from falls in older people. Best practice guidelines for Australian hospitals and residential aged care facilities* ([http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/CC63330AF385C3F2CA25718F000CCC30/\\$File/falls.pdf](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/CC63330AF385C3F2CA25718F000CCC30/$File/falls.pdf))
69. Australian Wound Management Association (2001). *Clinical practice guidelines for the prediction and prevention of pressure ulcers*. Cambridge Press
70. Prentice, J. (2001) Personal communication Australian Bureau of Statistics, Canberra.
71. Porter, A & Cooter, R. Surgical management of pressure ulcers. *Primary Intention* 1999; 7(4): 142-147
72. Prentice, J and Stacey, M. Pressure Ulcers: the case for improving prevention and management in Australian health care settings. *Primary Intervention* 2001; 9(3): 111-120
73. Woolridge, M. Address at the launch of the Australian Medical Sheepskin, St Vincent's Hospital, Melbourne, 2 July 1997



74. Walker, M and Caldwell, J (unpublished). Impact of pressure ulcers on patient costs and length of stay and pressure relieving equipment recommendations: A report from the pressure ulcer prevention working party at Flinders Medical Society, July 2003. Cited in Victorian Quality Council (2003). Pressure Ulcer Point Prevalence Study (PUPPS) Report 2003
75. Victorian Quality Council (2003). Pressure Ulcer Point Prevalence Study (PUPPS) Report 2003 (http://www.health.vic.gov.au/qualitycouncil/downloads/pupps2/statepupps_report.pdf)
76. WoundsWest. (<http://www.health.wa.gov.au/WoundsWest/home/>)
77. WoundsWest (2007). Point Prevalence Survey of Pressure Ulcers in Western Australian public hospitals (in print)
78. National Institute of Clinical Studies (2003). Interventions to improve uptake of venous thromboembolism prophylaxis in hospitals
79. National Institute of Clinical Studies (2005). The incidence and risk factors for venous thromboembolism in hospitals in Western Australia, 1999-2001
80. Geerts, WA, Heit, JA, Clagett, GP et al. Prevention of venous thromboembolism. *Chest* 2001;119:1325-1755
81. Anderson, FA, Wheeler, HB, Goldberg, RJ et al. A population based perspective of the hospital incidence and case fatality rates of deep vein thrombosis and pulmonary embolism: the Worcester study. *Archives of Internal Medicine* 1991; 151:933-938
82. Lindblad, B, Erikksson, A and Bergqvist, D. Autopsy verified pulmonary embolism in a surgical department: analysis of the period 1951 to 1968. *British Journal of Surgery* 1991; 78:849-852
83. Royal Australasian College of Surgeons (2003). Western Australian Audit of Surgical Mortality (WAASM) Annual Report 2003 (www.surgerons.org)
84. The Australian and New Zealand Working Party on the Management and Prevention of Venous Thromboembolism. Prevention of VTE: Best Practice Guidelines for the Australia and New Zealand, 3rd edition. (<http://www.safetyandquality.health.wa.gov.au/squire/Attachments/14.%20ANZ%20Prevention%20of%20VTE%20Ed3%202005.pdf>)
85. Royal Australasian College of Surgeons (2004). Western Australian Audit of Surgical Mortality (WAASM) Annual Report 2004 (www.surgerons.org)
86. NSW Department of Health (2005). Patient Safety and Clinical Quality Program: Report 2004-2005 (http://www.health.nsw.gov.au/pubs/2005/pdf/patient_safety.pdf)
87. Victorian Department of Human Services (2004). *Sentinel Event Program Annual Report 2002-2003*. Victorian Department of Human Services (<http://www.health.vic.gov.au/clinrisk/downloads/sentinelevents0203.pdf>)
88. Victorian Department of Human Services (2005). *Sentinel Event Program Annual Report 2004-2005*. Victorian Department of Human Services (<http://www.health.vic.gov.au/clinrisk/downloads/sentineleventswebfinal.pdf>)
89. Victorian Department of Human Services (2006). *Sentinel Event Program Annual Report 2005-2006*. Victorian Department of Human Services (<http://www.health.vic.gov.au/clinrisk/downloads/sentineleventswebfinal.pdf>)
90. Department of Health (2006). *WA Sentinel Event Report: October 2003 to June 2005*. (<http://www.health.wa.gov.au/safetyandquality/>)



91. Australian Council for Safety and Quality in Health Care (2004). *Ensuring Correct Patient, Correct Site, Correct Procedure Protocol*. (<http://www.safetyandquality.org/>)
92. Royal Australasian College of Surgeons (2006). Implementation guidelines for ensuring correct patient, correct side and correct site surgery (www.surgeons.org)
93. Department of Veterans Affairs National Patient Safety Agency (2004). *VHA Directive 2004-028 Ensuring Correct Surgery and Invasive Procedures*. Department of Veterans Affairs, Veterans Health Administration, Washington DC. (<http://www.patientsafety.gov/CorrectSurgDir.DOC>)
94. Department of Health (2005). *The Correct Patient, Correct Site and Correct Procedure Policy and Guidelines* by WA Health Services
95. Department of Health (2005). *The Correct Patient, Correct Site and Correct Procedure Policy and Guidelines* by WA Health Services (2nd edition)
96. Australian Council for Safety and Quality in Health Care (2001). Dictionary of Shared Meanings
97. Sennett, C, and Starky, K. Measuring and Improving Efficiency in Health Care: Report From an ABIM Foundation/IOM Meeting. *ABIM Issue Brief*, June 2006
98. Ministry of Health (2003). *Improving Quality (IQ): A systems approach for the New Zealand Health and Disability Sector*. Wellington, New Zealand
99. Donabedian, A (2003). *An Introduction to Quality Assurance in Health Care* (edited by Rashid Bashshur. Oxford University Press



Appendix A: Glossary

Accepted Practice	With respect to a particular medical condition, the level of performance currently expected from the average medical practitioner or health care system
ACSQHC	Australian Council for Safety and Quality in Health Care (2000-2005)
Adverse Event	A clinical incident resulting in harm to a person ⁹⁶
Clinical Incident	An event or circumstance resulting from health care which could have, or did lead to, unintended harm to a person, loss or damage, and/or a complaint. Clinical incidents may include near misses and adverse events ⁹⁶
Clinical Governance	A systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes ^{17, 18}
Commission	Australian Commission on Safety and Quality in Health Care (established January 2006)
CPI	Clinical Practice Improvement program, the second tier of the SQulRe Program
Harm	Includes death, disease, injury, suffering and disability ⁹⁶
Iatrogenic harm	Harm inadvertently caused by a clinician or by medical treatment or diagnostic procedures
Near miss	A clinical incident that may have caused, but did not cause, harm ⁵³
OSQH	Office of Safety and Quality in Healthcare
Preventable	An event is considered preventable if it arises as a result of an error in management due to failure to follow accepted practice at an individual or system level
QAHC	Quality in Australian Health Care Study
Root Cause Analysis	A systematic and comprehensive methodology to identify the gaps in hospitals systems and processes of care that may not be immediately apparent and which may have contributed to the occurrence of a clinical incident or near miss
SQulRe	Safety and Quality Investment in Reform Program, consisting of three tiers: <ul style="list-style-type: none">▪ Clinical governance infrastructure▪ Clinical Practice Improvement▪ Investment
WA Council	WA Council for Safety and Quality in Health Care



Appendix B: WA Clinical Governance Network (as at November 2007)

Child and Adolescent Health Service

Dr Maxine Wardrop

North Metropolitan Health Service

Mr Beress Brooks

Ms Sandra Miller (SCGH)

Ms Tracy Robertson (WNHS)

Mr Hal Boronovskis (SKHS)

Mr Ian Matthews (NMAMHS)

Ms Jane Newcomb (OPH)

South Metropolitan Health Service

Ms Patricia O'Farrell

Ms Jodie McNamara (FHHS)

Ms Debbie Bridgeford (AKHS)

Mr Angus (Jack) Rennie (RPH)

Ms Del McGuinness (RPH)

Ms Marie Thomter (BHS)

Ms Terri-Lee Barrett (PRKHS)

Dr Paul Mark (SMAHS)

WA Country Health Service

Ms Jill Porteous

Dr Geoff Masters

Office of Safety and Quality in Healthcare

Dr Dorothy Jones (Chair)

Ms Tanya Gawthorne

Ms Lyn David

Ms Louise O'Brien (Secretariat)



Appendix C: WA Council for Safety and Quality in Health Care

- Professor Bryant Stokes, Neurosurgeon (Independent Chairman)
- Dr Simon Towler, Chief Medical Officer & Executive Director, Health Policy and Clinical Reform, Department of Health (Deputy Chairman)
- Dr Rowan Davidson, Chief Psychiatrist, Department of Health
- Dr Phillip Della, Chief Nursing Officer, Department of Health
- Dr Dorothy Jones, Principal Medical Officer and Director, Office of Safety and Quality in Healthcare, Department of Health
- Ms Sunita McGowan, Director Nursing Research & Evaluation, Fremantle Hospital, South Metropolitan Health Service
- Dr Peter Kendall, Senior Staff Specialist, Fremantle Hospital, South Metropolitan Health Service (March 2005-present)
- A/Professor Moira Sim, General Practitioner
- A/Professor Rhonda Marriott, School of Nursing, Murdoch University
- Professor Richard Vaughan, Organisational Development Division, Department of Health
- Captain Mike Markham, QANTAS Airways
- Ms Susan Milos, Manager, Licensing Standards and Review Unit, Health Protection Group, Department of Health
- Ms Lyn David, Manager, Office of Safety and Quality in Healthcare, Department of Health
- Ms Tanya Gawthorne, Manager, Office of Safety and Quality in Healthcare, Department of Health
- Ms Karen Carey (Consumer Representative)
- Mr Rasa Subramaniam, (Consumer Representative)
- Dr Jon Mulligan, Director of Medical Services, WA Country Health Service (2003-2007)
- Ms Carol Conley, A/Director of Legal and Legislative Services, Department of Health (2005-Nov 2006)
- Mr Bob Mansfield, Consumer Representative (December 2005 to September 2006)
- Mrs Susan Terry, Director of Nursing, St John of God Hospital-Subiaco (2003-September 2006)
- Professor Jon Olynyk, Fremantle Hospital, South Metropolitan Health Service (2003-March 2005)
- Dr Brian Lloyd, Chief Medical Officer (2003-2006)
- Ms Sally Skevington (2003-2006)

Observer members

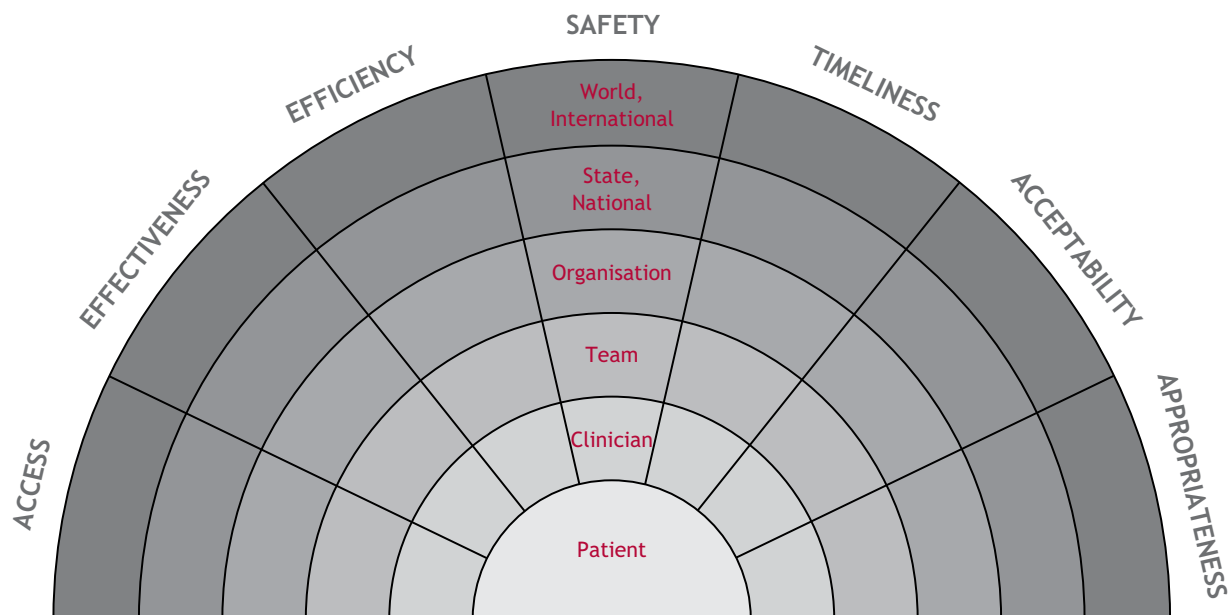
- Dr Shiong Tan, General Practitioner and Board Member, Australian Commission on Safety and Quality in Health Care
- Mrs Sandy Thomson, Assistant Auditor General, Strategy Policy and Innovation, Office of the Auditor General



Appendix D: Domains of patient safety and quality

The following principles demonstrate WA Health's commitment to best practice and guide the application of strategic initiatives for patient safety and quality at the State, Area Health Service and local hospital levels:^{19,97}

Figure 4. The domains of patient safety and quality across the health care system^{98,99}



Access

People have the right to access timely and appropriate health services that are delivered using best practice approaches to the provision of patient care. Health services also provide readily accessible consumer health information.

Efficacy and Effectiveness

Efficacy is the ability of a health services to bring about an improvement in the safety and quality of health care. Effectiveness relates to a health service delivering agreed services or outputs, as well as to attaining improvements in patient outcomes.

Efficiency

Technical efficiency relates to health services using all available resources rationally to produce a service or output, as well as to attain stated outcomes.

Safety

Patient and staff safety is a major objective of health services. There is a commitment at all levels of the health service to manage risk, which includes taking a proactive approach to maintain patient safety and prevent adverse incidents.



Timeliness

Timeliness relates to health services providing efficacious treatments and services to the right people for the right indications.

Acceptability

Patient care is provided on a need by need basis, regardless of age, gender, ethnicity, religion, health insurance status and socio-economic status.

Appropriateness

Health services are committed to the provision of clinical care that is tailored to meet an individual's identified needs, that is beneficial and relevant for the individual.

Participation of Consumers/Providers/Employees

Health services are committed to enabling consumers, providers, employees and other people with special needs to participate in the planning, delivery, monitoring and evaluation of health services.



Appendix E: WA action to implement the eight safety and quality initiatives mandated by Australian Health Ministers, April 2004

The following section outlines how Western Australia has progressed against each of the national health reform initiatives.

Incident Management System (achieved January 2005)

AHMC Decision: All public hospitals will have an 'incident management' system in place by January 2005, incorporating incident management, monitoring, investigation, analysis and action arising.

- The management of incidents or adverse events in the WA public health sector is an important component of the Western Australian clinical risk management strategy.
- The Advanced Incident Management System (AIMS) has been placed into all Western Australian public hospitals and health services to record clinical incidents consistently across the State.
- Western Australia has also developed and implemented a Statewide Incident Reporting and Management Policy to facilitate improved management and investigation of near misses and adverse events reported to the Advanced Incident Management System (AIMS).

Reporting of Sentinel Events (achieved 2005)

AHMC Decision: All public hospitals to report all sentinel events either to the State department or to an agreed third party.

- Western Australia implemented a Statewide Sentinel Event Reporting Policy in October 2003. This policy requires both public and licensed private hospitals to report sentinel events (rare events with catastrophic outcomes) to the Chief Medical Officer within 7 working days.
- The investigation findings, including recommendations, must be forwarded to the Sentinel Events Officer within 45 working days of initial notification.
- Incidents that are thought to have state-wide relevance are discussed at quarterly Sentinel Event Review Group (SERG) meetings. If there is an issue that is thought to require urgent attention a Statewide alert is issued.
- Hospitals and health services are notified of relevant findings and recommendations arising from Sentinel event investigations by way of 'The Sentinel', a quarterly publication which describes de-identified incidents and the recommendations which have been implemented to reduce the occurrence of similar errors in the future.
- WA released its inaugural Sentinel Event Report (October 2003 to June 2005) in January 2006. The WA Sentinel Event Report 2006-2007 was released in October 2007.



AHMC Decision: All States and Territories will contribute to a national report on sentinel events.

- WA contributed to the development of a national report on sentinel events.
- The 1st National Sentinel Event report was published by the Australian Institute for Health and Welfare in July 2007.

Adoption of the ‘5 step right patient, right site, right procedure’ protocol
(achieved May 2005)

AHMC Decision: All public hospitals adopt the ‘5 step right patient, right site, right procedure’ protocol for verifying the site of surgery and other procedures to reduce the risk of wrong site procedures by the end of September 2004.

- In May 2005, the WA Council for Safety and Quality in Health Care and Office of Safety and Quality in Health Care jointly published a ‘correct patient, correct site and correct procedure’ policy and guidelines to reduce the risk of wrong site surgical, medical, radiology and oncology procedures in WA health services. These guidelines were revised and re-issued in November 2006.
- This policy and guideline is consistent with the national ‘5 step right patient, right site, right procedure’ protocol and the Royal Australasian College of Surgeons’ ‘correct patient, correct site, correct procedure’ guidelines.
- Copies of the policy and guideline and resource materials developed by the Australian Council for Safety and Quality in Health Care were issued to Area Health Services for distribution to relevant clinical units.

Provide patients with ‘10 tips for safer health care: what everyone needs to know’ booklet
(achieved December 2004)

AHMC Decision: All public hospitals will provide each hospital patient with a copy of the consumer booklet “10 tips for safer health care: what everyone needs to know” at or before the time of admission.

- WA Health has distributed copies of the ‘10 tips for safer health care: what everyone needs to know’ booklet to Area Health Services.



Patient Safety Risk Management Plan in place (achieved 2005)

AHMC Decision: All public hospitals will have in place a patient safety risk management plan by the end of 2005.

- The identification, analysis and management of risk is a core requirement of the Department of Premier and Cabinet's *Guidelines for Managing Risk in the Western Australian Public Sector* (1999) and Treasurer's Instruction (TI) 825: *Risk Management and Security*.
- The WA Health has developed a the *Clinical Risk Management Guidelines for Western Australian Health Services* to assist Health Service Executives, Clinicians, Risk Management and Quality Co-ordinators meet their Clinical Risk Management responsibilities through the identification and management of clinical risk areas in a consistent and systematic way, and in accordance with State and local priorities.
- The *Clinical Risk Management Guidelines for Western Australian Health Services* is consistent with the WA Health's *Health Risk Management Framework* and *Health Risk Management General Procedures Manual*, which provides a structured approach for incorporating clinical risk management into the broader risk management process of Health Services.

Common medication chart be in use in all public hospitals Australia (achieved June 2006)

AHMC Decision: That a common medication chart be in use in all public hospitals Australia by June 2006.

- A pilot was conducted nationally of the common medication chart between January and May 2005. Three WA sites were involved in the pilot (Joondalup Health Campus, Broome Kimberly Health Service and Kalgoorlie Regional Hospital).
- In December 2005 Area Chief Executives agreed to implement the NIMC by 30 June 2006.
- The NIMC was implemented in all WA public hospitals in June 2006 (with the exception of the WA mental health and paediatric facilities who were awaiting the development and release of the standardised long stay chart and paediatric chart).
- In February 2007, WA health services undertook a post-implementation audit to evaluate the implementation and correct use of the NIMC in WA and to identify further areas for improvement in medication management and medication safety education.
- The NIMC audit assessed health service compliance against the following five areas of the NIMC: patient identification, allergies and adverse drug reactions, prescription details, warfarin dosing and administration and clinical pharmacist activity. Preliminary data from the audit indicates that there are a number of new features of the NIMC that are being complied with well by WA clinicians.
- The results of the audit were published in October 2007.



Public hospitals have in place a process of pharmaceutical review of medication prescribing, dispensing, administration and documenting processes for the use of medicines
(achieved December 2006)

AHMC Decision: That public hospitals have in place a process of pharmaceutical review of medication prescribing, dispensing, administration and documenting processes for the use of medicines by December 2006.

- The implementation of a process of pharmaceutical review was completed in March 2007, via the WA Pharmaceutical Review Policy.
- A baseline audit and gap analysis was conducted in August 2007 to determine the current performance of WA Health Services against the five standards outlined in the Pharmaceutical Review Policy.
- A report will be submitted to the State Health Executive Forum in late 2007, summarising the results of the analysis.



Appendix F: OSQH publications

The OSQH has developed and released a suite of patient safety information documents, which can be downloaded from: www.safetyandquality.health.wa.gov.au

Year	Publication
2001	Clinical Governance Issues paper
	Clinical Governance References by Topics
2003	SNIPtS (Sharing News in Patient Safety) newsletter
	Introduction to Clinical Governance - A Background Paper
	Western Australian Clinical Governance Guidelines
	Qualified Privilege Guidelines
	CredentiaLLing: An Introduction
	Incident Reporting and Management Policy
	Western Australian Complaint Management Policy
	WA Strategic Plan for Safety and Quality in Health Care 2003-2008
2005	Setting Standards for Making Health Care Better: Guidelines for implementing Clinical Governance in WA Hospitals
	Clinical Risk Management Guidelines for the WA Health System
	Correct Patient, Correct Site, Correct Procedure Guidelines for WA Health services
	Clinical Governance Standards
	Clinical Governance Guidelines
	Clinical Governance Framework Poster
2006	Western Australian Complaint Management Policy, 2nd edition
	Sentinel Event Reporting Policy
	Patient First Program
	WA Sentinel Event Report October 2003 - June 2005
	From Death We Learn: Lessons from the Coroner
	Correct Patient, Correct Site, Correct Procedure Guidelines for WA health Services, 2nd edition
	Clinical Incident Management and Reporting Policy, 2nd edition
	WA Sentinel Event Report 2005 - 2006
2007	From Death We Learn, 2nd edition
	WA Review of Mortality Policy
	The Policy for CredentiaLLing and Defining the Scope of Clinical Practice for Medical Practitioners
	Consent to Treatment Policy for the Western Australian Health System
	WA Pharmaceutical Review Policy
	WA Sentinel Event Report 2006 - 2007

