



# SNIPT'S Sharing News in Patient Safety



## Closing the Loop: Applying lessons learned from incident reporting in WA



Professor Bill Runciman provided the Keynote speech, 25 Years on: one doctors view on how incident reporting has influenced patient safety.

On 30 September 2004, the Office of Safety and Quality at the Department of Health held an AIMS Seminar "AIMS: The cornerstone of high reliability organisations." Organisations were invited to submit any initiatives arising from local analysis of AIMS data such as medication, falls, hospital acquired infection or closing the loop. Over 100 people attended and presentations on the day were from a wide variety of health care providers from around the state including both rural and metropolitan regions and services such as acute care, mental health, obstetrics and oncology. Presentations included topics such as:

- Development and implementation of a telephone based incident reporting system.
- Barriers to clinical incident reporting; an audit/observational system to capture clinical incidents.
- How much value has the AIMS Obstetric Healthcare Incident Type (HIT) added to the identification, analysis and minimisation of obstetric related incidents.
- Using data obtained through the AIMS process to make decisions about clinical management as well as to improve the quality and safety

to patients in the area of mental health.

- The impact of Communication Problems on Hospitals and Health Services.
- Safety initiatives arising from area wide analysis of AIMS data.
- Development of an insulin infusion order chart and guideline for use in a regional hospital.
- Failure mode and effect analysis and its use in reviewing medication incidents.
- In-patient falls prevention program.
- Development of a Falls Risk Management tool for use in the acute care setting.
- Development of a metropolitan-wide febrile neutropaenia card to flag at risk oncology patients presenting in ED.

Patient Safety awards were also presented to individuals who excelled in their development of sustainable patient safety initiatives that had a direct impact on patient safety.



Dr Dorothy Jones, Director Office of Safety and Quality, Health Care closed the AIMS Seminar

Dr Jones summarised the meeting as a very positive way of sharing lessons learnt and acknowledging local achievements. "I was very impressed by the quality of work presented and encouraged by the significant number of improvements underway in WA as a result of regular incident reporting and analysis", she stated, "this is something that will definitely become a regular event on the WA health

## 25 years on: One Drs view on how Incident Reporting has influenced patient safety



Professor Bill Runciman, President, Australian Patient Safety Foundation, presented the keynote address.

Since the Harvard Medical Study in the US, and the Quality in Australian Health Care Study (QAHC) identified the prevalence of error in health care in the early 1990's, the concept of reporting medical incidents has been adopted by health care institutions internationally and utilised at local levels.

Professor Runciman provided an erudite and entertaining reflection on the evolution of incident reporting. Beginning with Hippocrates, "Primum no nocere" (First do no harm), he described the progress of incident identification and reporting in the hospital setting over time.

The relative risk of suffering iatrogenic harm in Australia was described as 8,000 deaths per year and he highlighted the crucial role of reporting error in reducing this.

Subsequent to his role in the QAHC study, Professor Runciman was instrumental in the early development of the Australian Incident Monitoring System (AIMS), a sophisticated tool for capturing and analysing incident data. AIMS has been implemented across

health services in Australia, in an effort to assist staff in improving patient safety within hospital systems, and provides a single entry point for sentinel event, adverse event and near miss incident reporting. The most current version he reported, includes provision for complaints, medico-legal cases, occupational health and safety issues as well as audits.

Professor Runciman provided reassurance that WA was making headway in efforts to reduce error, and suggested that an increasing body of literature indicates Australian trends in reporting of incidents reflect what is being reported internationally and suggested further actions such as credentialing and accreditation, will only assist this process.

The presentation closed with the following quote:

*"The aim of science is not to open the door to everlasting wisdom, but to set a limit on everlasting error"*.

Attributed to Galileo (1564-1642) by Brecht (1898-1956).

## 2004 Patient Safety Awards

The Office of Safety and Quality received twelve nominations for the 2004 Patient Safety Awards. All nominations reflected the great work that staff across the state are doing in response to analysis of local AIMS data. Winners of 2004 Patient Safety Awards were:

### **Mr Keith Symes and the Clinical Governance Team, Great Southern Health Region**

For leadership and commitment to organisational development and support in a large rural area to Clinical Governance and Patient Safety.

### **Ms Wendy-Lee Pittick, Diabetes Nurse Educator, South West Area Health Service**

For the development and introduction of insulin infusion guidelines that improved clarity for nursing/medical practice and improved safe outcomes for the patient receiving insulin infusion.

### **Ms Wendy McIntosh, Nurse Unit Manager, Bunbury Regional Hospital**

Wendy's falls prevention project has resulted

in a number of initiatives such as development of a risk identification tool, a standardised referral process and many prevention strategies, all of which have resulted in demonstrated improvement in practice and a reduction in the number of falls.

### **Ms Peggy Briggs, Clinical Nurse Consultant, Cancer Services, Fremantle Hospital**

Peggy developed a medical alert system for rapidly identifying febrile neutropenic patients who presented to ED. This system now identifies the patient to the ED triage nurse to enable prompt medical review. This system is now being rolled out to the other major teaching hospitals in the state.

### **Mr Ian Cooper, Deputy Chief Physiotherapist, Sir Charles Gairdner Hospital**

Ian is the project manager of a recently adopted audit and maintenance system for ward use patient walking frames within SCGH.



Dr Brian Lloyd presents a Patient Safety Award to Peggy Briggs, one of the six recipients of the 2004 Patient Safety Awards.

The impetus for this project was an incident involving a frame collapsing with a patient and the resulting investigation uncovered the lack of a system wide process for checking these frames. Both staff and patients are very reassured by the existence of this maintenance audit which hopefully will prevent recurrence of accidents due to suboptimal or non-existent maintenance programs.

**North Metropolitan Health Service Falls Focus Group.** Heather Gluyas, Rochelle Kelly, Vivienne Why, Mary Gibson, Andrew Hill, Helen Myers, Dr Sue Nikoletti (SCGH and OPH)

This team received an award for their work on the Fall Risk Management Tool Project, an innovative approach to fall risk identification and management. The team comprised a mix of clinicians, management and researchers who worked effecti-

vely together to develop, implement and evaluate an evidence based Falls Risk Management Tool on eight wards across SCGH and OPH.

The team utilised innovative methods for implementing and evaluating the project and procedures are now being developed to ensure the sustainability of the project. The developed tool has been well received and will be implemented in other areas across the two hospital sites.



The inaugural AIMS seminar was attended by over 100 attendees from across WA as well as executive staff from the Department of Health. Pictured from left, Dr Brian Lloyd, Mr Mike Daube, Professor Bill Runciman, Dr Dorothy Jones, Professor Bryant Stokes and Dr John Mulligan.

## Patient safety publications available

The Australian Council for Safety and Quality in Health Care released its 2004 Annual Report 'Maximising National Effectiveness to Reduce Harm and Improve Care' on 29 July 2004.

The Council's Annual Report and accompanying stand-alone reports are now available from the Council's website at: <http://www.safetyandquality.org>

- ▶ ACSQHC Annual Report 2004 'Maximising National Effectiveness to Reduce Harm and Improve Care'
- ▶ Standards for Credentialling and Defining the Scope of Clinical Practice
- ▶ Charting the Safety and Quality of Health Care in Australia
- ▶ Better Practice Guidelines on Complaints Management for Health Care Services
- ▶ Safety Innovations In Practice (SIIP) Program Mark II
- ▶ Setting the Human Factor Standards for Health Care: Do Lessons from Aviation Apply?
- ▶ State and Territory Action to Improve Patient Safety.

# Lessons Learned

## Lesson one: Infection control documentation



Review of AIMS Principal Incident Type(PIT) reports and comparison with Australian Council on Health Care Standards (ACHS) clinical indicator data determined that infections were occurring but that they were not being reported and recorded in the

AIMS System. This made analysis and review of the complete picture of clinical incidents occurring difficult. In response to this, staff education at ward level was undertaken during which the scope of the AIMS report and the system that includes hospital acquired infections was discussed.

A process was established to flag possible incidents for review by Infection Control Clinical Nurse Specialist (CNS) with ward follow up, investigation and documentation in AIMS as appropriate and the Infection Control CNS was provided with access to the AIMS system to ensure ongoing review of AIMS data, in particular PIT reports and Other reports.

Following this intervention, clinical indicator data demonstrated a greater number of incidents within the AIMS system were being captured.

It was suggested that this process could be facilitated in other institutions by close liaison between personnel responsible for the AIMS system and Infection Control Personnel and comparison of clinical indicator data with AIMS held data.

The improved reporting and report generation offered by AIMS allows better identification of trends and cohorts of incidents and a more thorough review.

Sharing lessons learned is extremely valuable to all those who work in clinical settings. If you have implemented anything in your workplace as a result of analysis of your own AIMS data, please let us know and we will publish your lessons learned.  
Please contact Marece Bentley 9222 0294

## Lesson Two: Safety measures for falls

Analysis of local data at one health service identified falls as a problem. Those most at risk of falling were identified through AIMS as those aged > 70 years (86%) and those dependent on mobility aids(84%). Staff focus groups were conducted where AIMS data was fed back to groups and input sought for the adaptation of an existing risk register. These resulted in the development of a falls prevention care plan, based on the AIMS contributing factors, staff feedback/ best practice and environmental audit. This was also linked to the Stay on your Feet Program.

Strategies included

**Continence** - regular toileting, bladder management protocol, screening for UTI, ensure call bell within reach.

**Mobility** - referral to physio, ensuring walking aid within reach, ensure call bell within reach, supervise mobility/in shower.

**Confusion** - reorientation, place patient in room visible from office, medication review, consider need for special.

**Age** - all patients > 70yrs have risk assessment on admission.

Reduction in falls - 8.7 per month (2002)

6.1 per month (2003)

Target < 5.0 per month

Many rural and non-teaching hospital staff will have spoken with the Clinical Incident Classifiers at infoHEALTH who are responsible for coding of AIMS incidents in the rural and non-teaching hospitals. Here are the faces to the names.



Clockwise from back row. Jo McCann, Rob Crooke (AIMS Application Coordinator), Carina Giura and Catherine Kelly.

## Lesson Three: Improving safety in mental health settings

These initiatives arose from a mental health setting. Several issues were highlighted through analysis of AIMS data as well as through the Incident Review Committee, including incidents reported that identified items for self harm as well as incidents involving patient to patient aggression or patient to staff aggression.

The following initiatives were implemented: Checklist for monitoring of medication changes, paper liners for rubbish bins, revision of escort procedure for at-risk absconders, perspex coverings for television controls, procedures for distribution of hot drinks on wards, revised cutlery monitoring procedures, bedroom audits after discharge and specially designed cigarette lighters for

wards.

Recommendations from the Incident Review Committee were passed to other appropriate committees.

These committees introduced the initiatives and these were generally disseminated through clinical review team meeting (if clinical), through meeting minutes, memos to staff, introduction of new policies with circulation lists, articles in the local newsletter or in some cases special meetings called of appropriate groups if non clinical .

Most of the initiatives have been evaluated and remain in place or have had some modifications included.

Through formal and informal networking groups (nursing mainly) new initiatives and ideas are often discussed and a number of these have already been applied or considered in other secure Mental Health Facilities. One example is the secure cigarette lighter, which is now also in use in several secure psychiatric wards and is being introduced to a peripheral Mental Health Service and is being considered at two other Mental Health Services. Some of the initiatives introduced have resulted from some ideas coming from other facilities or from joint discussion/ brainstorming at these networking groups.

These initiatives potentially have wide application and should be considered for facilities with Mental Health Units.

A recently published Australian study examined whether there was improvement of quality of inpatient care associated with the use of checklists and reminders when using clinical pathways.

By comparing key indicators before and after the introduction of clinical pathways, the authors were able to demonstrate significant improvements in the quality of care when checklists and reminders of best practice were integrated into patient medical records.

For each clinical condition chosen, a multi disciplinary team of 12-18 members was selected to develop the pathway, using information from a variety of evidence based sources. These pathways were circulated and

piloted prior to implementation and staff underwent training in the use of each pathway .

The study included 116 patients presenting with AMI admitted between 1 January and 31 December 1999 (pre-pathway) and between 1 October 2000 and 31 December 2002 (post-pathway), and 123 patients with stroke admitted between 31 July 1999 and 30 April 2000 (pre-pathway) and between 1 June 2000 and 31 December 2002 (post-pathway).

### Journal SNIPt'S

**The quality of hospital inpatient care can be improved by the use of checklists and reminders. Read on....**

Compliance with key process measures was measured before and after the introduction of the pathways and demonstrated increases in compliance resulting from use of checklists and reminders of between 21.4% and 48.1% for AMI pathways and 40.7% and 52.4% for patients with stroke.

These results compare favourably with other multi-hospital observational studies in which pathways were not used.

The authors state that although the results of this study may not be generalisable, that the methods used in the study provide a framework for developing and implementing clinical pathways that other hospitals could modify and use.

Wolff A, Taylor S, McCabe J. Using checklists and reminders in clinical pathways to improve hospital inpatient care *MJA* 2004;81:428-431

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