

Please note that the following document was created by the former Australian Council for Safety and Quality in Health Care. The former Council ceased its activities on 31 December 2005 and the Australian Commission for Safety and Quality in Health Care assumed responsibility for many of the former Council's documents and initiatives. Therefore contact details for the former Council listed within the attached document are no longer valid.

The Australian Commission on Safety and Quality in Health Care can be contacted through its website at <http://www.safetyandquality.gov.au/> or by email mail@safetyandquality.gov.au

Note that the following document is copyright, details of which are provided on the next page.

The Australian Commission for Safety and Quality in Health Care was established in January 2006. It does not print, nor make available printed copies of, former Council publications. It does, however, encourage not for profit reproduction of former Council documents available on its website.

Apart from not for profit reproduction, and any other use as permitted under the *Copyright Act 1968*, no part of former Council documents may be reproduced by any process without prior written permission from the Commonwealth available from the Department of Communications, Information Technology and the Arts. Requests and enquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Intellectual Copyright Branch, Department of Communications, Information Technology and the Arts, GPO Box 2154, Canberra ACT 2601 or posted at <http://www.dcita.gov.au/cca>

A CHECKLIST

Patient Safety Management Systems

Australian Council for Safety and Quality in Health Care



Preface

Australian Council for Safety & Quality in Health Care

The Australian Council for Safety and Quality in Health Care (the "Council") has taken a keen interest in systems approaches to patient safety following the lessons learned from inquiries such as that conducted into adverse events at King Edward Memorial Hospital in Perth in July 2002. The Council recognises that a systems approach to patient safety is central to improvement in this field where responsibilities for patient care are shared, and many people and policies in an organisation are central to delivering good care to patients.

The Council is especially interested in building national capacity and sustainability for patient safety and quality. One of the key action areas in the Council's Strategic Plan is the design and articulation of key elements of a governance framework to support workforce managers in the health sector. It seeks to build on the resources already in place to improve and develop patient safety and quality. It also seeks to share its national expertise and resources by providing products that are useful to those with responsibilities and accountabilities for patient safety and quality. Consistent with Health Ministers' agreement at their Conference in April 2004 that all public hospitals have in place a patient safety risk management plan by the end of 2005, these materials will assist facilities to ensure that they can achieve this requirement.

The Council hopes that this Patient Safety Management Systems Checklist and the supporting Explanatory Notes provide a further positive contribution to the national patient safety agenda.

Bruce Barraclough

Chair

Australian Council for Safety and Quality in Health Care

Acknowledgments

ACT Health
Population Health Division
Office of the Chief Health Officer
PO Box 825
Canberra ACT 2600 Australia

Dr Wayne P Ramsey AM, FRACMA
Senior Fellow Clinical Governance

Dr Paul M Dugdale FAFPHM
Chief Health Officer

Ms Angela L Magarry FCHSE
Director, Office of the Chief Health Officer

Ms Olivia M Jakobs
Senior Policy Officer, Office of the Chief Health Officer

Ms Megan L Roach
Policy Officer, Office of the Chief Health Officer

ACT Health further acknowledges the contributions of the many individuals and organisations that participated in the development of the Patient Safety Management Systems Checklist and Explanatory Notes through the consultation process, including:

Hirondelle Private Hospital
North Shore Private Hospital
St Vincent's Hospital
Sydney Adventist Hospital
Healthscope Hospitals
Victorian Quality Council
Victorian Auditor-General's Office
Southern Health
The Kilmore and District Hospital
Echuca Regional Health
Office of Chief Clinical Advisor - Victoria
Modbury Public Hospital
Bayside Health
Werribee Mercy Hospital
Maroondah Hospital
Wodonga Regional Health Service
Southern Gippsland Division of General Practice
Australian Nursing Federation (Victorian Branch)
Manton Investment Group Ltd
Austin Health
St Vincent's & Mercy Private Hospital
The Canberra hospital
Royal North Shore Hospital
National Nursing Education Taskforce

Australian Private Hospitals Association
Australian Healthcare Association
Australian Health Insurance Association
Catholic Health Australia
Health Care Consumers Association - ACT
NSW College of Nursing
Australian College of Health Service Executives
Committee of Presidents of Medical Colleges
ACT Chief Nurse
Australian Medical Association
Consumers' Health Forum
Australian Nursing Federation (ACT Branch)
Sisters of Saint Joseph of Sacred Heart of Jesus.

A Checklist

Patient Safety Management Systems

The provision of health care is a complex business. It is not surprising then, that there are inherent risks of harm associated with being a patient. In the Quality in Australian Health Care Study (QAHCS, Wilson et al., 1995), it was found that 16.6% of admissions were associated with an adverse event. Approximately half (51%) of these adverse events were assessed as having a high preventability. Extrapolating the data to all hospitals, Wilson et al estimated that about 470,000 admissions in 1992 were associated with an adverse event, and that 3% of all admissions resulted in permanent disability or death.

According to the QAHCS study, as many as 50,000 patients may have suffered permanent disability, and 18,000 may have died as a result of their health care in 1992. These figures are those most often quoted by the media, and represent the highest estimates of the rate of adverse events. When this data was re-analysed to take into account differences in methodology compared with the Utah/Colorado Medical Practice Study (UTCOS), it was estimated that 10.6% of admissions in Australia would have been associated with an adverse event (Thomas et al., 2000).

According to Thomas et al. (2000), the overall number of adverse events is less important than doing something to prevent them. Patient safety management systems can assist in achieving this end, and these materials have been designed to support this process. Patient safety management systems have evolved from the lessons learned from other high-risk industries, such as commercial aviation, and the oil and gas industry. These industries have achieved exemplary safety records by assuming positive and proactive attitudes to safety and the operation of effective safety management systems (Hudson, 2003).

! What is a Patient Safety Management System (PSMS)?

A Safety Management System is a series of cross-organisational processes designed to protect against risks. These processes are used to identify, classify, and manage risks to the safety of an organisation's operation. A Safety Management System is an integral part of an organisation's risk management framework. It is generally used to:

- minimise the direct and indirect costs of incidents and accidents;
- meet legal responsibilities to manage safety;
- improve productivity; and
- market the standards of an organisation (Civil Aviation Safety Authority, 2002).

The basic premise of a Safety Management System is that errors can occur at all levels of an organisation, and that seemingly minor errors in one area can combine with errors that occur in other areas and result in the occurrence of an adverse event. This has been described as the "Swiss cheese effect", where breaches of safety defences have occurred and cause a hazard that results in losses (Reason, 1995).

A Patient Safety Management System (PSMS) is based on the same principles that apply to a Safety Management System. However, it differs in that where the main concern of most

industries is about staff and production, the risks in health are mainly to patients as they journey through the health care system. A PSMS reflects a recognition of the potential for errors to occur and actively seeks to minimise harm to patients through integrated policies, procedures, and work practices. A PSMS is a system based on a set of shared values and beliefs. The ultimate goal of a PSMS is to establish robust defences to monitor and improve patient safety, and to ensure that errors in health care do not result in adverse events.

! What are the key attributes of a successful PSMS?

A successful PSMS is one that is interlinked with other activities for managing risk and is embedded in the organisation's culture. This cultural orientation will be reflected in a commitment to patient safety that permeates the organisation, from top-level managers down. A PSMS is a systematic, explicit, and comprehensive process for managing the risks that patients face in a health care setting. A successful PSMS has the following attributes:

- the discovery and assessment of the hazards of particular operations;
- the specification of how these hazards are to be managed; and
- what is to be done if things, despite best endeavours, go wrong.

! Is patient safety management the same as quality management?

Quality and patient safety management systems are based on the same principles: they are both planned and managed, and depend on measurement, monitoring, and improvement. However, there are also differences of emphasis; in particular, patient safety management focuses on potential risks rather than whether the outcomes of care have been optimised. A PSMS should reflect the recognition that human and organisational errors will never be eliminated completely, and works to ensure that actions are taken to minimise the safety risks associated with patient care.

! Who is accountable for the PSMS?

While everybody in the health sector is responsible for ensuring patient safety, there are various levels of accountability for a PSMS. At the highest level, the Commonwealth, State and Territory governments are ultimately accountable for patient safety, and this is achieved through the legislative and regulatory framework within which our health services operate. In an operational sense, the levels of accountability can be summarised as follows:

CEOs and Executive

CEOs and their Executives are responsible for an area or network that usually encompasses more than one facility and/or service. CEOs and their Executive are accountable for patient safety in this area of responsibility.

Managers/Clinician Managers

Managers and clinician managers are responsible for a work area. They are accountable for actions in their work area, including the operations of their teams.

Health care Professionals

Health care professionals are responsible for day-to-day practice within their sphere of work, and are accountable for their own individual actions.

Patients

Insofar as their condition allows, patients and their carers assume a degree of responsibility for themselves to reduce their exposure to safety risks. This includes seeking information and assistance from their health care professionals as required.

! How do you know if your PSMS is successful?

A successful PSMS will have the following seven characteristics:

1. Demonstrated senior managerial commitment to patient safety.
2. Agreed policies and procedures concerning patient safety.
3. Clearly defined accountability arrangements for patient safety.
4. Systematic approach to the identification and investigation of patient safety risks.
5. Systematic approach to the management of all sources of patient safety risk.
6. Process of review and evaluation.
7. Systematic approach to training and education for staff.

! How might the PSMS checklists be used?

Four separate PSMS Checklists have been prepared for CEOs and their executive members, managers and clinician managers, health care professionals, and patients. Every checklist considers each of the seven characteristics of a successful PSMS from these different perspectives. The PSMS Checklists do not assess patient safety, and have not been designed for external benchmarking. The checklists:

- are intended as an internal management tool only;
- allow managers and staff at all levels of an organisation to undertake an assessment of the PSMS; and
- may be used to gauge the attitudes of health professionals and patients about the effectiveness of the organisation's PSMS.

Final Comments

Patient Safety Management Systems Checklists

In the international literature, there is a large body of research being undertaken in patient safety. The attached PSMS Checklists seek to make a significant contribution to this work. It should be noted, however, that in the development of the PSMS Checklists, much consideration was given to the Australian context, including the national agenda developed by the Safety and Quality Council. There are linkages between the PSMS Checklists and other supporting tools; for example, 10 tips for safer health care (Quality and Safety Council, 2004), and A National Standard for Open Communication in Public and Private Hospitals following an Adverse Event in Health Care (Quality and Safety Council, 2003).

References

- Civil Aviation Safety Authority (2002, July). *Safety Management Systems: What's in it for you?* Retrieved from <http://www.casa.gov.au>
- Hudson, P. (2003). Applying the lessons of high risk industries to health care. *Quality and Safety in Health Care*, 12(Suppl. 1), 7-12.
- Reason, J. (1995). A systems approach to organisational error. *Ergonomics*, 38, 1708-1721.
- Thomas, E. J., Studdert, D. M., Runciman, W. B., Webb, R. K., Sexton, E. J., Wilson, R. M., et al. (2000). A comparison of iatrogenic injury studies in Australia and the USA 1: Context, methods, casemix, population, patient and hospital characteristics. *International Journal for Quality in Health Care*, 12, 371-8.
- Wilson, R. M., Runciman, W. B., Gibberd, R. W., Harrison, B. T., Newby, L., & Hamilton, J. D. (1995). Quality in Australian Health Care Study. *Medical Journal of Australia*, 163(9), 458-471.