

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 Therefore contact details for the former Council listed within the attached document are no longer valid.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>

SAFETY FIRST APPENDIX – Table 1: Priority areas at a glance

Priority Area and Expected Outcome	Preliminary strategies	Related Jurisdictional Activity	Achievements by July 2001
<p>Better using data to identify, learn from and prevent error and system failure.</p> <p>Expected Outcomes</p> <p>Regular and consistent national monitoring of key aspects of the safety and quality of health care will lead to a:</p> <ul style="list-style-type: none"> • reduced rate of adverse events; • useful and timely information and feedback for health care providers, consumers and other interested parties to improve the quality and safety of care¹; • greater public confidence that the health system is putting effective processes in place at all levels to address error and system failure. 	<ul style="list-style-type: none"> • Undertake national consultation and review to identify and agree strategic needs for national reporting and data sets, for example, sentinel events reports². • Develop a national approach to incident and adverse event reporting particularly for injury and death including: <ul style="list-style-type: none"> • identification of existing data sets capable of being better used nationally for safety improvement, for example, National Health Complaints Information Project (NHCIP), National Coronial Information System, casemix data³; • addressing gaps and inconsistencies in current data collections, for example, nosocomial infection, haemovigilance. • Promote implementation of feedback from national data sets and access to and analysis of national data sets by practising clinicians, health administrators, consumers and other key stakeholders. 	<p>A number of jurisdictions are investing in approaches to incident and adverse event reporting, for example, Western Australia, South Australia and Queensland.</p> <p>The proposed national approach to be adopted by the Council will complement these approaches by:</p> <ul style="list-style-type: none"> • gaining national agreement on consistent data definitions; • supporting a strong focus on investigative processes and systems improvement at a local level and effective use of feedback; • ensuring that national reporting provides early warning of emerging trends; • establishing effective and timely feedback processes from national data sets. 	<p>Foundation elements of the agreed reporting approach in place, including:</p> <ul style="list-style-type: none"> • agreement on the scope and components of a national approach to incident and adverse event monitoring and reporting; • progress on agreeing consistent data definitions; • established governance and communication strategy; • strategies to promote sustainability and best use of existing core national data sets. <ul style="list-style-type: none"> • Development of a national ‘code of practice’ for promoting effective feedback from national data sets and registers, for example, device tracking.

SAFETY FIRST APPENDIX – Table 1: Priority areas at a glance

Priority Area and Expected Outcome	Preliminary strategies	Related Jurisdictional Activity	Achievements by July 2001
<p>Promoting effective approaches to clinical governance and accountability which address both the competence of organisations and individuals.</p> <p>Expected Outcomes</p> <p>More effective mechanisms for supporting those who work in the health system to practice safely within a system which actively works to ensure safe, high quality care.</p>	<ul style="list-style-type: none"> • Develop best practice standards for clinical governance. • Develop best practice standards for national audits. • National consultation and agreement on areas to strengthen nationally significant legislative, regulatory and standards frameworks to support competence of organisations, for example through accreditation⁴, and competence of individual health care providers, for example through registration, credentialling, certification and re-certification processes⁵. 	<p>A number of jurisdictions are investing in the development of approaches to clinical and corporate governance (for example, work being undertaken by NSW on the implementation of the Framework for Quality) clinical review processes (for example, work being undertaken by WA on clinical peer review and quality improvement committees) and credentialling (for example, the statewide credentialling framework being developed by Queensland).</p> <p>The national work program of the Council will complement these approaches by:</p> <ul style="list-style-type: none"> • promoting information exchange on existing approaches and lessons to be learned; • development of national standards which support the efforts of jurisdictions to promote uptake of good practice; • achievement of greater national consistency in areas which are critical to ongoing jurisdictional activity to improve safety. 	<p>Foundation elements of an agreed approach in place including:</p> <ul style="list-style-type: none"> • development of national standards in relation to clinical governance and national audits; • establishment of a communication and uptake strategy, including identification of lead implementation sites; • priority areas for reform for legislative, regulatory and standards frameworks agreed.

SAFETY FIRST APPENDIX – Table 1: Priority areas at a glance

Priority Area and Expected Outcome	Preliminary strategies	Related Jurisdictional Activity	Achievements by July 2001
<p>Redesigning systems and facilitating a culture of safety in health care.</p> <p>Expected Outcomes</p> <p>A system that</p> <ul style="list-style-type: none"> • is patient centred; • supports multidisciplinary team approaches; • has a culture of learning for quality and a willingness to share information; and • recognises the inevitability of error and system failure and actively works to minimise the impact and prevention of errors. 	<ul style="list-style-type: none"> • Encourage national uptake of existing tools and activities developed by states and territories. For example, clinical decision support systems, automated approaches to reduce medication errors, effective patient discharge systems, models of multi-disciplinary peer review processes, approaches to care pathways, approaches to clinical practice improvement⁶. • Develop a change management strategy to facilitate cultural change across the health system. • Facilitate the development of appropriate safety and quality training for all health professionals.⁷ 	<p>A number of jurisdictions are investing in approaches to redesign systems and facilitate culture change through for example the development of clinical indicators/guidelines and pathways and evidence based practice (Western Australia, Tasmania and Queensland); developing a cooperative approach to the delivery of health services for specific diseases (Tasmania); and the establishment of a change facilitation structure (Queensland).</p> <p>The proposed national approach to be adopted by the Council will complement these approaches by:</p> <ul style="list-style-type: none"> • ensuring information on evidence based best practice approaches is available to all jurisdictions; • promoting uptake of tried and tested innovation; and • facilitating education on patient safety for health professionals. 	<p>Foundation elements of an agreed approach in place including:</p> <ul style="list-style-type: none"> • agreed national approach to promoting cultural change; • establishment of lead implementation sites for clinical decision support; • development of a national conference on safety and quality improvement; • development of undergraduate and joint college education modules on safety and quality.

SAFETY FIRST APPENDIX – Table 1: Priority areas at a glance

¹ Recommendations 18, 19 and 20: the importance of providing performance information to the general community (*Final Report of the Taskforce on quality in Australian health care 1996*)

² Recommendation 17: the importance of greater use of valid safety and quality of care indicators in health service provision and the need to agree to definitions and approaches to be adopted nationally (*Final Report of the Taskforce on quality in Australian health care 1996*); National Expert Advisory Group National Action 5 outlined in their *Final Report to Health Ministers* (1999): Facilitate agreement on common systems for the collection and analysis of incidents, adverse events and complaints.

³ Recommendation 25: the importance of information pertaining to settlements or judgements for injury against health providers being more available for analysis ; Rec 33: the importance of national analysis of complaints data and its role in improving the safety and quality of care (also highlighted by the National Expert Advisory Group in their *Interim Report to Health Ministers* (1998) (*Final Report of the Taskforce on quality in Australian health care 1996*).

⁴ Recommendations 7, 8, 9 and 10: the importance of participation in a mandatory accreditation process (*Final Report of the Taskforce on quality in Australian health care 1996*).

⁵ Recommendation 22: the need to review existing peer review processes and address how they are integrated into systemic improvement approaches; recommendations 23 and 24: the need to develop recertification and credentialling processes, the need to integrate credentialling with accreditation processes and their more widespread adoption by health care services (*Final Report of the Taskforce on quality in Australian health care 1996*); recommendation x: the need to develop evidence based approaches to self assessment and peer review; recommendations xii and xiii: the need to support the role of colleges and professional bodies in certification, credentialling and maintenance of professional standards (*Commitment to Quality Enhancement – Interim Report of NEAG 1998*); *NEAG National Action 7*: facilitate improvements in the quality of current accreditation mechanisms that address the safety and quality of the system in operation (NEAG *Final Report to Health Ministers* 1999).

⁶ Recommendations 36 and 37: the importance of IT to improve links between services and providers and the need to demonstrate computerised clinical decision support systems in hospitals (*Final Report of the Taskforce on quality in Australian health care 1996*); *NEAG National Action 8*: facilitate improvements to the design and management of the health system that promotes smoother transitions for consumers across existing health service boundaries; *NEAG National Action 9*: research and develop clinical and administrative systems that have a system wide focus and application (NEAG *Final Report to Health Ministers* 1999).

⁷ Recommendations 42, 45 and 46: the importance of training on safety and quality for health care providers including error identification and what to do when things go wrong (*Final Report of the Taskforce on quality in Australian health care 1996*; *NEAG National Action 10*: agree on national requirements for education and training of all health care providers to support their involvement in quality management and collaborative approaches to health care delivery (NEAG *Final Report to Health Ministers* 1999).