

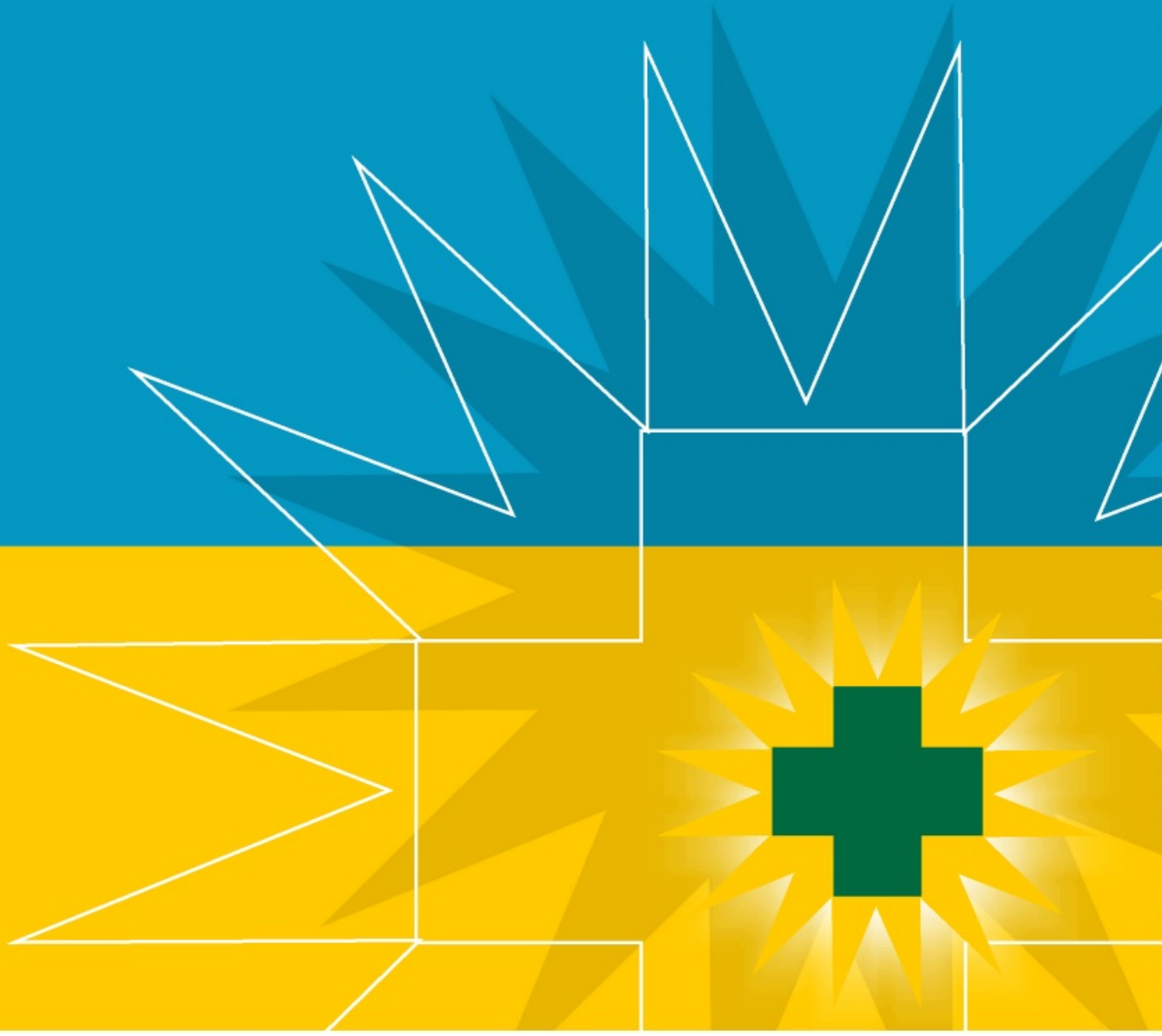
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**Safety+Quality**  
COUNCIL

JULY 2002

**NATIONAL REPORT ON  
QUALIFIED PRIVILEGE**

AUSTRALIAN COUNCIL FOR SAFETY AND QUALITY IN HEALTH CARE



# **National Report on Qualified Privilege**

**July 2002**



The Australian Council for Safety and Quality in Health Care was established in January 2000 by all Australian Health Ministers to lead national efforts to improve the safety and quality of health care, with a particular focus on minimising the likelihood and effects of error. Council reports annually to Health Ministers.

This document is referred to in Council's third report to Health Ministers - *Safety Through Action — Improving Patient Safety in Australia, Third Report to the Australian Health Ministers' Conference 19 July 2002*.

Further information on the work of the Council can be found at [www.safetyandquality.org](http://www.safetyandquality.org) or from the Council Management Group tel 02 6289 4244, fax 02 6289 8470 or email [safetyandquality@health.gov.au](mailto:safetyandquality@health.gov.au)

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# 1. Introduction

All health care professionals want to provide the best possible care for their patients. And patients, their carers and the community expect that the health care system will provide safe, high quality care.

Health care professionals and organisations need to review the outcomes of care they provide, to ensure that the safety and quality of the health care system continues to improve. These review activities are called quality assurance or quality improvement activities.

Some health care professionals are reluctant to participate in these activities, however, because they fear that:

- information they contribute about the safety and quality of care they provide may be incorrectly interpreted by the public or the media;
- such information may be used in litigation against them; or
- legal action may be taken against them for participating in the assessment and evaluation of the safety and quality of services provided by other colleagues.

**For this reason, laws are in place in all Australian States, the Australian Capital Territory and the Commonwealth that protect the confidentiality of some information generated by certain quality assurance and improvement activities.**

**The laws differ in all states and territories, but all are designed to encourage health care professionals to participate in quality assurance and improvement activities by providing for:**

- **the confidentiality of some documents and proceedings of health care quality committees or activities;**
- **the protection of those documents and proceedings from being used in legal actions; and**
- **the protection from legal liability for present and former members of health care quality committees, who were acting in good faith in carrying out their responsibilities.**

**These laws create rights and benefits, which have been described variously as “qualified privilege” or “statutory immunity”. In this Report, we will use the expression “qualified privilege”.<sup>1</sup>**

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<sup>1</sup> Although this should not be confused with the use of that expression as a defence to a defamation complaint.

While the laws support the public interest in encouraging health care professionals to take part in activities that will improve the safety and quality of health care, they necessarily reduce access to some categories of information – information that may also be of great interest to the public.

The laws therefore seek to achieve a balance between competing public interests – the public interest in encouraging health care professionals to take part in quality assurance and improvement activities; and the public interest in access to information about those activities.

## 2. About this Report

**This Report addresses:**

- **the context in which quality assurance and improvement activities are undertaken in the Australian health care system, and barriers to the participation of health care professionals in those activities;**
- **the need to adopt a ‘systems’ approach to safety and quality in health care, and an example of a systems error;**
- **the various public interest considerations that influence qualified privilege laws;**
- **the multiple ‘checks and balances’ contained in the laws, which seek to reflect the range of public interest considerations;**
- **other ways to access information about health care, and other health care safety and quality initiatives;**
- **the structure, scope and purpose of the various qualified privilege laws in the Commonwealth and all states and territories; and**
- **selected projects that have been undertaken utilising qualified privilege.**

**The report also provides a list of the committees/activities that have been declared under qualified privilege laws in each state and territory, together with details of relevant contact people in each state and territory.**

The Report represents the first stage of a two stage project which is being sponsored by the Australian Council for Safety and Quality in Health Care.

The aim of the project is to inform the public and health care professionals about the purpose and scope of qualified privilege laws and the types of activities that have been conducted under qualified privilege protection. It also aims to provide guidance to states, territories and health care organisations on future reporting about activities conducted under qualified privilege, and to review the administration of the various laws and, if possible, achieve greater national consistency.

An important outcome of the second stage of this project will be the development of a ‘template’ to assist states, territories and health care organisations with their future reporting to the public on qualified privilege laws and activities. This template will be completed by late 2002.

### **3. Quality Assurance and Improvement Activities – What are they and why are they needed?**

Governments, communities and health care professionals all place a high value on the accessibility, safety and quality of health care.

The Australian health care system is widely recognised as providing a very high standard of care. Like all modern health care systems, however, many opportunities exist to continuously improve the safety and quality of care. Health care professionals and the organisations within which they work need to review and learn from their experiences, and be prepared to change the ways in which things are done so that the care they provide is always of the highest standard.

By investigating health care processes and outcomes through quality assurance and improvement activities, opportunities can be identified to improve the design and operation of the systems within which care is delivered.

#### **Common quality assurance and improvement activities include:**

- **monitoring the rates of occurrence of selected events, such as infections acquired in hospitals, and comparing them against expected rates;**
- **screening medical records to identify the occurrence of particular events (such as unplanned readmission to the emergency department or unplanned readmission to hospital) and reviewing the care of patients who experience these events to determine whether they could have been prevented;**
- **identifying and investigating specific incidents that have been recognised as having caused, or having the potential to cause, harm to patients;**
- **regularly reviewing patient deaths (mortality reviews);**
- **systematically reviewing the outcomes of selected health care procedures, and comparing them against expected outcomes;**
- **committees of professional peers, who are available to counsel or assist other practitioners who are having difficulties which may lead to poor performance; and**
- **evaluating the training and performance of individual health care professionals for the purposes of determining the range of procedures that they are trained and competent to provide.**

The objective of all these activities is to develop better systems of health care in the future.

#### **4. Barriers to Participation by Health Care Professionals in Quality Assurance and Improvement Activities**

The need to use information about health care quality assurance and improvement activities to improve patient care is now well recognised. Many health care professionals, however, fear that the information they contribute to those activities might unfairly be used for other purposes, particularly if such information relates to an individual patient. These fears are contributed to by:

- a professional culture that personalises error and seeks and expects perfection. Health care professionals are trained to expect very high standards of performance from themselves at all times, and some find it difficult to acknowledge and learn from things that have not gone as well as expected;
- public and media attitudes to accountability of health care professionals, with a tendency to seek someone to blame if things go wrong;
- health care professionals' concerns that safety and quality information may be incorrectly interpreted by the public or the media, without full account being taken of such factors as the severity of the patient's illness or the complexity of the care provided; and
- the potential for legal action to result from the discussion, review, analysis and exposure of information generated through safety and quality improvement activities. Medico-legal liability as a result of something that has gone wrong for an individual patient, and defamation proceedings as a result of practitioners commenting on the quality of care provided by their colleagues, are both sources of concern to health care professionals.

So long as these fears persist, some health care professionals have been reluctant to contribute sensitive information to people and committees involved in health care safety and quality improvement activities. Qualified privilege laws seek to address these fears, while at the same time recognising the public interest in accessibility of information about the health care system.

## 5. Qualified Privilege as part of a Systems Approach to Safety and Quality

It is now well recognised that approaches that seek to blame individuals for forgetfulness or carelessness when things go wrong are not helpful in improving the safety and quality of health care. The preferred approach is to concentrate on the conditions under which individuals work and try to build defences to prevent errors or lessen their effects, because:

*“Even apparently single events or errors are due most often to the convergence of multiple contributing factors. Blaming individuals does not change these factors and the same error is likely to recur. Preventing errors and improving safety for patients requires a systems approach in order to modify the conditions that contribute to errors. People working in health care are among the most educated and dedicated workforce in any industry. The problem is not bad people; the problem is that the system needs to be made safer.”*

US Academy of Medicine, *“To Err is Human”*

It is important that the community has confidence that mechanisms for quality assurance and improvement are in place throughout the health care system, and that they are effective.

A common theme amongst patients who have experienced harm as a result of something going wrong during their health care is that they want to make sure it does not happen to someone else in the future.

Information from quality assurance and improvement activities should be used for this purpose, rather than to attribute blame or to punish individual health care professionals if things have not gone as well as expected.

Accountability is vital, but experience in other industries confirms that it is best achieved through a ‘systems approach’ that ensures that health care professionals are practising within their areas of skill and competence, in well designed systems that support safe practice and that create opportunities for health care professionals to learn from their experiences.

This ‘beyond blame’ approach is now well-established in many other highly complex industries such as the airline industry, where it has been shown to be far more effective in improving safety and reducing risk than an approach which personalises error and seeks to blame individuals if things go wrong.

*“When medical errors do surface, often with heart rending accounts of the suffering of the primary victims – the patients harmed – the reaction in medical settings is most commonly an attempt to fix blame and to punish someone.*

*This will not work. If we can take any lessons from the stunning progress in safety in aviation and other high risk industries it is that fear, reprisal, and punishment produce not safety, but rather defensiveness, secrecy and enormous human anguish. Scientific studies in human factors engineering, organisational psychology, operations research, and many other disciplines make it clear that, in complex systems, safety depends not on exhortation, but rather on the proper design of equipment, jobs, support systems and organisations. If we truly want safer care we will have to design safer care systems.”*

**Berwick, D, Leape, L. “Reducing errors in medicine. It’s time to take this more seriously”  
BMJ 1999; 319:136-147**

Maintaining the confidentiality of some health care quality assurance and improvement information reassures health care professionals that it will not inappropriately be used to attribute blame to them or their colleagues if things have not gone as well as expected. This helps them to contribute to these activities with confidence and is consistent with the preferred ‘systems approach’ to health care safety and quality.

## **6. An Example of a Systems Error in Health Care**

At one hospital over a four month period 28 patients had at least one ERCP (endoscopic retrograde cholangiopancreatography). This is an investigation in which an instrument is passed through the gullet, stomach and duodenum and into the bile duct system near the liver and pancreas. A dye can be injected and X-rays can be taken of the bile duct system.

Conray 280 is a contrast medium used to assist in outlining body structures on x-ray.

Phenol (10%) in 60% Conray 280 is a corrosive substance used to stimulate scarring in some tissues.

Of the 28 patients, 17 patients were mistakenly injected with Phenol (10%) in 60% Conray 280, instead of Conray 280 alone.

Many of the 17 patients suffered major complications including inflammation of the pancreas, bile duct damage, ongoing pain and liver damage.

The error was not immediately apparent as it is not uncommon for patients having this procedure to have similar symptoms to those associated with the complications.

The error was detected by the health care professionals involved. Their willingness to report it ensured that a thorough investigation could be conducted into its causes.

While the standard of care provided by the medical practitioner and the nursing staff in the operating theatre was investigated it was also found that there were five system errors that had resulted from failures in the workplace and organisational processes.

The investigation identified the following system errors:

- the computerised system for ordering drugs and injections was inadequate;
- the staff in the hospital pharmacy had inadequate training in the use of the computerised ordering system;
- there was no feedback loop in the ordering system to detect a significant change in a pattern of ordering over time;
- a contrast medium in a 20mL vial costing \$7.50 was replaced with a solution containing phenol in a 5mL vial at a cost of \$21. There was no system to detect an order that caused a significant cost increase repeated over a five month period; and
- a contrast medium was replaced with a caustic solution and no health care professional in the operating theatre adequately checked the solution before it was injected into the patient. This indicated a lack of appropriate education about staff responsibilities in the operating theatre.

All of these errors were addressed by the hospital and it is very unlikely that the problem will recur in the future.

## **7. Competing Public Interests**

There is clearly a strong public interest in ensuring that the health care system provides care of the highest possible safety and quality.

If health care quality assurance and improvement activities are impeded because health care professionals fear that by taking part in them they will be exposed to unfair consequences, there is an important public interest in addressing those potential consequences so that health care professionals feel confident to take part in the activities.

This is the basis upon which it is argued that there is a public interest in maintaining the confidentiality of information generated through health care quality assurance and improvement activities, if that confidentiality is a prerequisite to successful participation by health care professionals in those activities.

**However, the public interest in encouraging participation by health care professionals in safety and quality activities needs to be balanced against other public interests, including:**

- **access to information;**
- **openness and transparency;**
- **accountability;**
- **consumer autonomy; and**
- **empowerment.**

**These public interests are recognised in qualified privilege, freedom of information and privacy laws and are also being addressed by a range of initiatives in the health care sector.**

## 8. Checks and Balances in Qualified Privilege Laws

Qualified privilege laws are designed to provide only the protection necessary to encourage health care professionals to take part in quality assurance and improvement activities. They do not protect all information or documents created or reviewed by quality assurance or improvement committees or activities, and they are not designed to deprive the community of important information to which it has a legitimate right of access.

In fact, each law contains a variety of checks and balances.

**These “checks and balances” include:**

- **reference to public interest considerations before the protection is conferred;**
- **limitations on the nature and extent of the protection conferred by the legislation; and**
- **imposition of corresponding obligations upon the beneficiaries of the statutory protection.**

These checks and balances limit the protection available and require health care professionals and organisations to conduct their quality assurance and improvement activities in particular ways if protection is to be claimed and maintained.

The complexity of the various checks and balances has resulted in some confusion amongst health care professionals in some states about the application of the laws in specific circumstances. Several states and territories are reviewing their laws to explore ways to clarify and streamline them and the accompanying administrative processes.

While the details of relevant checks and balances vary between jurisdictions, the following features are common to all states, territories and the Commonwealth:

- only those organisations recognised by the relevant law, and only those activities categorised by the law, are eligible for qualified privilege. It should not be assumed that such protection will be granted readily or at all; ultimately, the relevant legal requirements (including a public interest requirement) need to be satisfied;
- the immunity generally applies only to bodies or activities that have been approved by the Minister and that have been notified to the public through Government Gazettes. It is not conferred lightly.

The Department of Human Services for the State of Victoria, for example, has indicated that applicants must provide a comprehensive suite of materials demonstrating both eligibility under the Act and the existence of an appropriate public interest argument. The Department requires that applicants provide such materials as a copy of the applicant's by-laws or constitution, its quality plan and terms of reference for each committee for which qualified privilege is sought, together with a submission outlining the "public interest case" that would justify the conferring of the protection.

The public interest issues which the Minister considers have been described as follows:

*"Making a public interest case involves considering the weighing up competing public interests and attempting to demonstrate that the public interest overall is best served by granting statutory immunity (qualified privilege) to the committee concerned. This involves consideration of whether the potential detriment to members of the public (through possibly denying them access to health care quality information) is outweighed by the potential public benefit inherent in encouraging participation by health care professionals in effective quality improvement activities conducted by approved committees which lead to demonstrable improvements in health care outcomes."*

**Victorian Department of Human Services**

Other features of these laws include:

- information or documentation that does not identify, expressly or by implication, a particular individual or individuals (for example, summary statistics) may not attract any or all of the qualified privilege protection;
- information or documentation generated for several purposes, only one of which is the protected quality assurance or improvement activity, may not be protected;
- where the protection is conferred upon a specific body or committee, it does not follow that the committee can extend the protection to its subcommittees;
- the statutory protection might, in appropriate circumstances, be overridden by those provisions of Freedom of Information laws which encourage release of information in the public interest. Consequently, a tribunal may consider, in the appropriate circumstance, that the public interest considerations expressed in the Freedom of Information laws might override the public interest considerations relating to qualified privilege; and
- with few exceptions, the protections and privileges conferred by the laws cannot be waived. Consequently, protected committees or persons are strictly bound by relevant legal obligations and therefore cannot, for example, elect to

disclose or share information in circumstances where it is felt that it would be convenient, appropriate or necessary to do so.

Administrative tribunals in a number of states have considered the validity and application of qualified privilege laws. The general approach in such instances has been to attempt to balance competing public interests including the public interests in:

- hospitals being open to scrutiny of their management;
- enhanced accountability of hospitals;
- the promotion of consumer rights amongst users of health care services;
- informing the public as to the occurrence of adverse events and quality improvement programs in the institutions; and
- non-disclosure where disclosure would be likely to impair the collection of similar information in the future.

Generally, these tribunals have upheld the principle that the balance of public interests is best served by maintaining the confidentiality of information resulting from health care quality assurance and improvement activities, if that information could not be obtained without the co-operation and involvement of the relevant health care professionals.

Tribunals have, however, been rigorous in their assessment of the application of the laws and the balance of public interests and, in some cases, have ordered the release of health care quality assurance and improvement information. In these circumstances, the tribunals have strongly emphasised the need for openness and transparency within the health care system.

## 9. Other ways to obtain Information about Health Care

There is an increasing recognition in all modern health care systems of the rights of individual patients, their carers and the broader community to obtain information about the safety and quality of health care.

**It is vital that the public interest in the accessibility of health care information is met as fully as possible, while at the same time recognising the need to remove barriers that inhibit participation by health care professionals in safety and quality improvement activities.**

While qualified privilege laws protect the confidentiality of some health care quality assurance and improvement information, it is important to note that:

- the protection, once granted, does not cover ‘primary’ materials such as clinical notes or other materials prepared as part of the ongoing care of a patient. Similarly, letters of complaint, minutes from other committees which may be referred to the protected committee and incident forms are not protected by these laws. All of these documents remain accessible to patients through normal ‘access requests’ under Freedom of Information and privacy laws (see below);
- some qualified privilege laws only protect the confidentiality of health care quality assurance and improvement information that identifies individual patients or health care professionals. Information that does not identify individuals is not protected by these laws; and
- some qualified privilege laws require provision of a report on the protected activity to the Minister or to the public.

In addition, a range of other initiatives aim to promote access by patients and the broader community to health care information.

**For example:**

- **newly enacted privacy laws confer rights of access to personal information and health care records in both public and private organisations;**
- **some state governments require publicly funded health care organisations to make available to the community reports on the safety and quality of care they provide; and**
- **other health care organisations and professional groups are also developing reports on the safety and quality of health care in recognition of the community’s wish to access such information.**

## 10. Other National Safety and Quality Initiatives

Qualified privilege law does not function in isolation, but is one of several aids to quality assurance and improvement which are widely used in the health care system.

The Australian Council for Safety and Quality in Health Care (“**Council**”) is developing a range of national projects designed to improve the safety of the health care system. These projects complement a large number of similar activities being conducted by state and territory health departments, health care organisations, professional groups and individual health care professionals. All of these activities seek, in various ways, to measure, maintain and improve the safety and quality of health care.

Two major national initiatives are the ‘Open Disclosure’ project, and a project to develop guidelines to ensure that health care professionals are practising safely within their areas of training and expertise (the ‘Credentialling and Clinical Privileging’ project). In addition, Council is pursuing a number of initiatives designed to improve the reliability and accessibility of information provided to consumers about health care safety and quality.

### **Open Disclosure**

**Of particular relevance to the accessibility of health care information, Council is pursuing a major project designed to improve openness and communication in health care. It involves the development of a national standard and guidelines to support open disclosure to patients and their carers when things go wrong in health care. The standard will address the need to provide an expression of regret when something has gone wrong, and an explanation of what happened, the potential consequences, and the steps being taken to manage the event and prevent its recurrence. Health care organisations will be provided with educational and support packages to assist them to implement the standard. The project will be completed in 2002.**

### **Credentialling and Clinical Privileging**

**Council has produced guidelines to assist health care organisations to develop best practice approaches to reviewing the training and expertise of health care professionals and determining the areas in which they are approved to practice. This process is called ‘credentialling and clinical privileging’. A national standard for this process will now be developed, together with an organisational support package to assist with its implementation. This project will be completed in 2003.**

## **Improving Consumer Access to Health Care Information**

Following on from its first publication *First National Report on Patient Safety*, Council is developing a summary booklet for consumers based on the key messages contained in that report and incorporating ‘ten tips’ to assist consumers to become more actively involved in their health care.

Similarly, Council will be releasing a consumer summary and tips from the *Second National Report on Patient Safety*, which will focus on medication safety.

## **Improving Reporting to Consumers on Qualified Privilege**

Council is leading a project that will provide states, territories and health care organisations with a ‘template’ for improving reporting to the public on activities that are occurring under the protection of qualified privilege laws. This project will be completed in late 2002.

**Council’s web site also enables consumers to access reliable health care safety and quality information and provides a link to other key sites around the world:**

[www.safetyandquality.org](http://www.safetyandquality.org)

## **10. Analysis of Qualified Privilege Laws in each State, Territory and the Commonwealth**

The underlying aim of qualified privilege laws is to ensure that health care professionals can review the safety and quality of care they provide and learn from the information gained to improve care for patients in the future, without fear that the information will be used for other purposes. The laws create a raft of rights, privileges, entitlements, obligations, immunities and embargoes, the common thrust of which is to promote the public interest in the improvement of health care safety and quality. The ‘privilege’ conferred by these laws both entitles and requires people affected by them to refuse to provide information or documentation that would otherwise be obtainable through a variety of legal processes.

The Commonwealth law is intended to add to, rather than to replace, the laws of the states and territories. The Commonwealth law generally only applies to activities in which health care professionals from several states or territories are taking part, whereas the laws of the states and territories are intended to be used for safety and quality activities that are occurring within their boundaries.

**The following tables address the questions:**

- **where do qualified privilege laws come from?**
- **who is eligible to seek qualified privilege protection?**
- **what kind of activities can be protected?**
- **what are the other criteria for eligibility?**
- **what benefits do the qualified privilege laws confer?**
- **what are the checks and balances in qualified privilege laws?**

## Who is Eligible to Seek Qualified Privilege Protection?

Only the organisations identified in the relevant laws are entitled to apply for qualified privilege. Those organisations are described in the following table, which adopts the language contained in various laws. Consequently, there is substantial overlap between categories (for example, the Queensland law deals with “public sector health services” which will include public hospitals. The table does not, however, specifically contain a ‘tick’ in the public hospital section for Queensland).

Jurisdiction	Public hospital	Denominational hospital	Community health centre	State funded residential care service	Day procedure centre	Private hospital	Multi purpose service	Supported residential service	Psychiatric service	Professional association	Public health organisation	Public sector health service	Chief executive	Licensee of private health facility	Body controlling health service	Other
ACT					✓ <sup>2</sup>	✓										✓ <sup>3</sup>
CTH	N/A – Relevant law covers “activities” rather than committees.															
NSW	✓									✓ <sup>4</sup>	✓					✓ <sup>5</sup>
QLD										✓		✓	✓	✓		
SA	Governor may authorise persons or members of specified groups to have access to confidential information.															
TAS										✓ <sup>6</sup>					✓	✓ <sup>7</sup>
VIC	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓						✓ <sup>8</sup>
WA										✓ <sup>9</sup>					✓ <sup>10</sup>	

<sup>2</sup> Private day hospital facility (private sector quality assurance committee).

<sup>3</sup> Public sector quality assurance committees are appointed by the Minister.

<sup>4</sup> As prescribed by the *Health Administration Regulation 2000* (NSW).

<sup>5</sup> Establishment or other body as prescribed by the *Health Administration Regulation 2000* (NSW).

<sup>6</sup> Governing body of professional association.

<sup>7</sup> Specified committees established by Secretary of Department.

<sup>8</sup> Agency registered or deemed to be registered under Division 2 of Part 3 of *Health Services Act 1988* (Vic).

<sup>9</sup> Governing body of professional association.

<sup>10</sup> Health service means any medical, hospital, ambulance, paramedical, dental, pharmaceutical, mental health, nursing home, palliative care, community health or environmental health service, any service relating to or associated with the provision of such services or any other service related to or associated with the maintenance or improvement of the health, or the restoration to health, of persons or the prevention of disease in or injury to persons.

## What Kind of Activities Can be Protected?

Consistent with the public interest in facilitating quality assurance and improvement activities, most of the laws accommodate activities or bodies which seek to assess or evaluate the quality of a health service. Some laws cast the net slightly wider, as outlined in the accompanying table.

Jurisdiction	Mortality / morbidity investigations and research	Assessment / evaluation of quality of health services	Reporting and making of recommendations re: health services	Monitoring implement'n of recomm'tions	Review of clinical privileges of health service providers	Review of clinical practices of health service providers	Review of clinical competence of health service providers
ACT	✓	✓	✓	✓	✓ (public sector only)		
CTH		✓	✓	✓		✓	✓
NSW		✓	✓	✓			✗ <sup>11</sup>
QLD		✓	✓	✓			
SA	✓	✓					
TAS		✓				✓	✓
VIC		✓				✓	✓
WA		✓	✓	✓		✓	

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<sup>11</sup> Expressly included.

## Are There Any Other Criteria for Eligibility?

Even if an organisation that is covered by the law is engaged in an activity or has established a body which is itself eligible to seek qualified privilege, the law establishes additional requirements which need to be met before the protection is conferred upon the activity or the body. Again, the details vary between states and territories but common to most is a requirement that before approval is given by the Minister, the applicant must demonstrate that qualified privilege would facilitate the functions of the committee or activity and that the protection granted by the law is in the public interest. The relevant criteria are outlined in the accompanying table.

Jurisdiction	Committee members must have appropriate training/ experience	Committee members must be appropriately authorised to engage in the quality assurance activity	Committee must be established under relevant by-laws / constitution of its governing organisation	Functions of committee facilitated by provision of immunity	Prohibition on disclosure of information is in the public interest	Committee must adhere to rules of natural justice	Application of immunity must be in public interest
ACT			✓			✓	
CTH		✓					✓
NSW	✓		✓	✓	✓	✓	
QLD	✓		✓	✓	✓	✓	
SA							
TAS				✓	✓		
VIC			✓	✓	✓		
WA	✓		✓	✓	✓	✓	

## What are the Benefits Conferred by Qualified Privilege?

Once again, the details vary between states and territories. The variables are described in the accompanying table.

Jurisdiction	Committee members prohibited from recording or divulging information	Committee reports / members not to identify individual health service providers	Committee reports / members not to identify individual health service recipients	Committee members and documents cannot be subpoenaed / compelled to produce documents	Committee members protected from suit / liability for good faith actions	Committee members have qualified privilege in proceedings for defamation	Evidence of information or documents re: findings / proceedings of committee not admissible in court proceedings	Committee members indemnified in respect of defending proceedings in respect of good faith acts and omissions
ACT			✓	✓	✓ <sup>12</sup>	✓ <sup>13</sup>	✓	✓ <sup>14</sup>
CTH	✓			✓	✓			
NSW	✓	✓	✓	✓	✓ <sup>15</sup>	✓	✓	✓
QLD	✓	✓	✓	✓	✓	✓ <sup>16</sup>	✓	✓
SA	✓	Note also no breach of law or principle of professional ethics where confidential information supplied to relevant persons. <sup>17</sup>					✓ <sup>18</sup>	
TAS	✓			✓ <sup>19</sup>			✓	
VIC	✓ <sup>20</sup>			✓			✓	
WA	✓	✓	✓	✓ <sup>21</sup>	✓	✓ <sup>22</sup>	✓	✓

<sup>12</sup> Protection also provided to persons assisting committees who receive no fee or reward for so acting.

<sup>13</sup> Protection also provided to persons assisting committees who receive no fee or reward for so acting.

<sup>14</sup> Indemnity also provided to persons assisting committees who receive no fee or reward for so acting.

<sup>15</sup> Protection also provided to persons acting under the direction of a committee.

<sup>16</sup> In respect of committees, committee members and persons acting under direction of committees, it is accepted that such persons have an interest in knowing the truth concerning the reputation and character of the person who is the subject of the investigation or inquiry.

<sup>17</sup> 'Relevant Persons' are defined as those persons authorised by the Governor.

<sup>18</sup> Section 64D, Health Commission Act 1976 (SA) defines 'confidential information' and therefore what is not admissible.

<sup>19</sup> Applies also to persons preparing information or documents for the proceedings or purposes of a committee as if they were members of the committee.

<sup>20</sup> Committee members, officers, employees all prohibited from recording or divulging information.

<sup>21</sup> Civil proceedings only.

## What are the Checks and Balances in Qualified Privilege Laws?

Jurisdiction	Committee must be established under the by-laws/ official procedures of organisation	Relevant minister must be satisfied that functions of committee are facilitated by provision of immunities	Persons engaging in relevant activity must be authorised to do so	Members of committee must have appropriate training and expertise	Relevant minister must be satisfied that application of immunities is in public interest	Relevant minister must be satisfied that prohibition on disclosure of information is in public interest	Non-identifying information is not protected	Members can be compelled to give evidence in respect of acts and omissions of committee / members	Certain information is to be made publicly available by committee	Committee required to provide annual report to relevant Minister	Committee required to provide annual report to the public	Consent override on certain embargoes	Other
ACT	✓											✓ <sup>23</sup>	✓ <sup>24</sup>
CTH			✓		✓		✓					✓ <sup>25</sup>	✓ <sup>26</sup>
NSW	✓	✓		✓		✓		✓		✓	✓	✓ <sup>27</sup>	✓ <sup>28</sup>
QLD	✓	✓		✓		✓		✓	✓			✓ <sup>29</sup>	
SA													
TAS		✓				✓							
VIC	✓						✓						
WA	✓	✓	✓	✓		✓	✓ <sup>30</sup>	✓		✓	✓	✓ <sup>31</sup>	✓ <sup>32</sup>

<sup>22</sup> Any statement or report made in good faith is taken to be published for the information of the public and for the discharge of public functions.

<sup>23</sup> Written consent (from health service recipient).

<sup>24</sup> Members of committees and people acting under the direction of committees must disclose personal and pecuniary interests in matters being considered.

<sup>25</sup> Disclosure of information permitted if person(s) directly/indirectly identified consents to the disclosure.

<sup>26</sup> Minister may authorise disclosure where information about a serious offence.

<sup>27</sup> Written consent (health service provider and recipient).

<sup>28</sup> Information may be disclosed in certain circumstances (disclosure approved by Chief Health Officer); identifying information may be disclosed where urgently required in interests of public health or required for purposes of medical research (provided certain other conditions are met).

<sup>29</sup> Written consent (health service provider and recipient).

<sup>30</sup> Non-identifying information and documents may be given in evidence.

<sup>31</sup> Written consent (health service provider and recipient).

<sup>32</sup> Minister may establish standards for making non-identifying information available to the public.

### **13. Case Studies – Qualified Privilege Laws in Action**

The following section contains case studies of activities and projects conducted under qualified privilege laws in a number of health care settings around Australia.

These case studies demonstrate the different types of quality assurance and improvement activities that are being conducted under qualified privilege protection, and the improvements in health care safety and quality that have been achieved through some of those activities.

Case studies are presented from:

- Wimmera Base Hospital, Victoria
- The Children’s Hospital at Westmead, New South Wales
- BreastScreen, Western Australia
- Barwon Health, Victoria
- The Western Australian Audit of Surgical Mortality
- The Australian Incident Monitoring Study, South Australia

## **Case Study 1 - Risk Management including Limited Adverse Occurrence Screening at Wimmera Base Hospital**

### **Wimmera Base Hospital's approach to Risk Management**

Wimmera Base Hospital is located in Horsham, 300 km north west of Melbourne, Victoria. The Hospital provides services to 43,000 people in the Wimmera region, including 13,500 people in the town of Horsham.

In 1989, the Director of Medical Services, Dr Alan Wolff, initiated an adverse occurrence screening program at the Hospital. The Hospital has since implemented a number of additional strategies to identify adverse outcomes of patient care, and to use the knowledge obtained to ensure that all patients receive the safest possible care. This integrated 'risk management program' involves all members of the health care team – doctors, nurses, pharmacists, allied health professionals and support staff.

The adverse occurrence screening technique developed at Wimmera Base Hospital has been implemented in a number of hospitals around Australia. This year, the Victorian Department of Human Services provided funding for adverse occurrence screening to be implemented in all Victorian acute care hospitals.

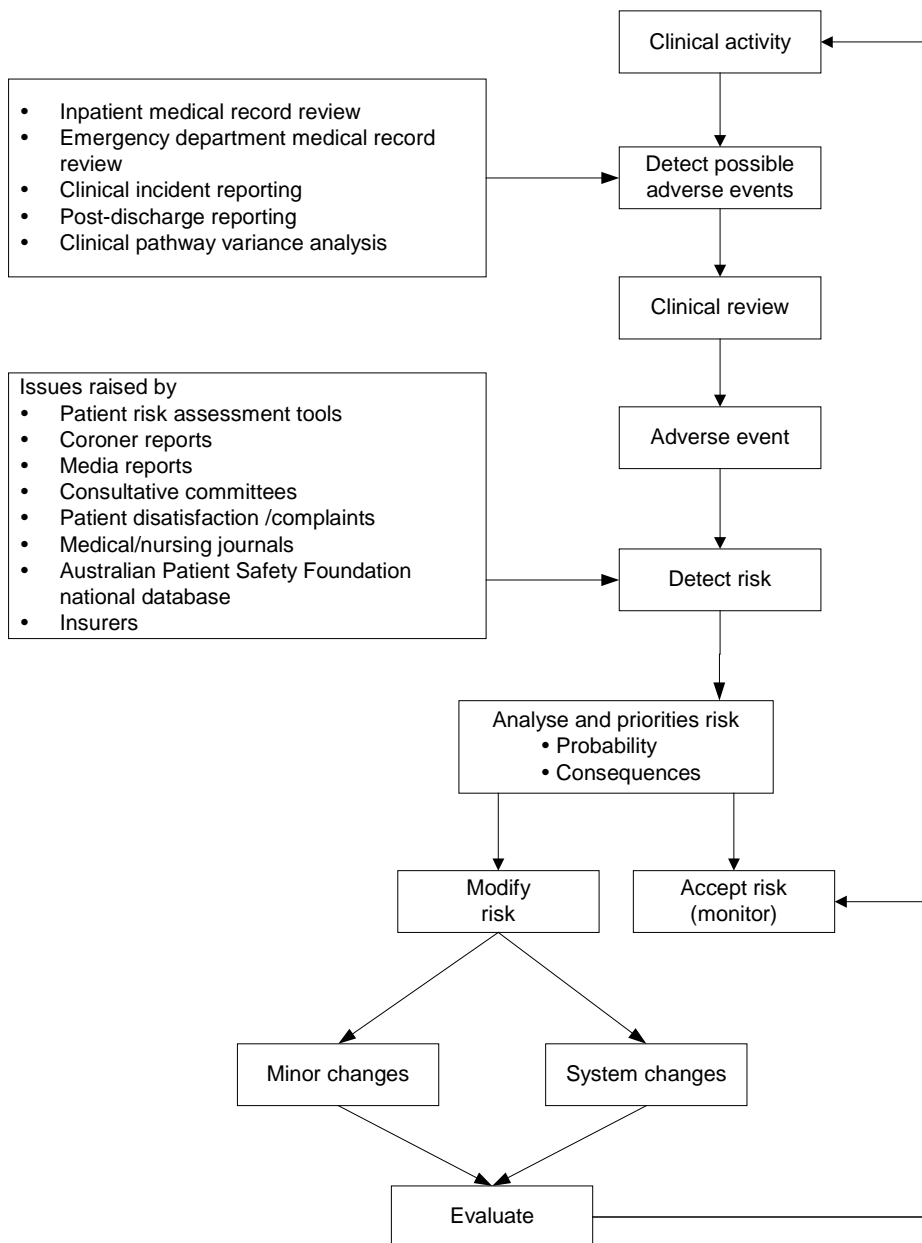
The Hospital's risk management program is overseen by the quality committee, which has been declared for a number of years as a committee that is eligible to conduct quality assurance and improvement activities under qualified privilege.

Dr Wolff believes that the availability of qualified privilege has been essential to the success of the clinical risk management program:

*“All of our staff are very proud of their achievements in improving patient safety. Qualified privilege has allowed them to freely and frankly review individual patient outcomes. The whole health care team has learned from those reviews, enabling us to deliver safer care in the future.”*

**Dr Alan Wolff, Director of Medical Services, Wimmera Base Hospital**

## Wimmera Base Hospital's Clinical Risk Management Model



## Limited Adverse Occurrence Screening at Wimmera Base Hospital

One of the strategies used at the Wimmera Base Hospital to identify adverse events (“things that go wrong”) is Limited Adverse Occurrence Screening, which involves the following:

1. Screening of all medical records by medical records staff, to determine whether any of the following have occurred:

- death
- return to operating theatre within 7 days
- transfer from a general ward to intensive care
- unplanned readmission within 21 days of discharge
- cardiac arrest
- transfer to another acute care facility
- length of stay greater than 21 days
- booked for theatre and cancelled

2. Detailed review by medical staff of all records that screen positive, to determine whether an adverse event has occurred.
3. Analysis of the probability of the adverse event occurring again, and the severity of its consequences.

**For example, failure to give the right drug at the right time to a patient who has suffered a heart attack may be assessed as having a moderate probability and a high level of consequence. The risk severity rating is determined to be high and the event requires analysis and action.**

4. Development of a strategy to reduce the likelihood of the adverse event happening again.

**For example:**

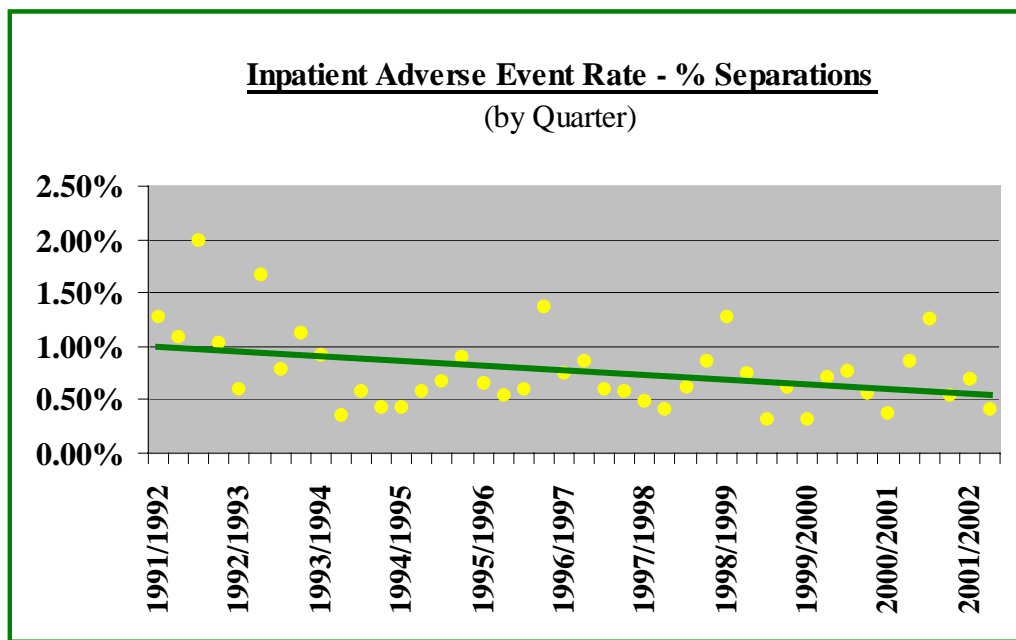
**Surgeons often vary in their approach to prescribing drugs to prevent clots developing in leg veins during surgery. A standard form with guidelines for different levels of risk has been developed. The anaesthetist completes the form before each operation and, if indicated, starts drug treatment in consultation with the surgeon;**

**Several patients developed fluid on the lungs after rapid blood transfusion. A blood administration protocol was developed and incorporated into the form that is used to order blood from the blood bank.**

**Some patients with significant medical problems were inappropriately discharged from the emergency department without review by a senior doctor. A list of conditions requiring review by a senior doctor was devised. Junior doctors and nursing staff were consulted during the preparation of the list, which was prominently displayed in the Emergency Department.**

The Hospital also uses other sources of information to ensure it detects and learns from adverse events. Medical records from the Emergency Department are reviewed using the same model as that used for inpatient record review. A clinical incident reporting system ensures that adverse events and ‘near misses’ are reported and acted on. General practitioners who identify, after their patients have been discharged from the Hospital, that something may have gone wrong with their care are encouraged to report those events to the Hospital. The Hospital is also vigilant in identifying reports about serious adverse events from other sources (for example, the Coroner, medical indemnity organisations, professional journals and the media) and ensures it asks the question “Could this happen at Wimmera Base Hospital?” and acts on the answer.

The Wimmera Base Hospital’s efforts to improve patient safety have been highly successful. The rate of adverse events at the Hospital, both for inpatients and patients attending the Emergency Department, has fallen steadily over several years. The Hospital is widely considered to be leading the way in patient safety.



**Clinical Pathways – An Outcome of the Clinical Risk Management Program at Wimmera Base Hospital**

In 1997, several members of the clinical risk management team noticed that a number of adverse events were clustered around the management of several medical conditions. It was agreed that these adverse events could best be prevented by developing clinical pathways to guide the management of patients who presented with these conditions.

Clinical conditions were chosen for the development of pathways using the following criteria:

- adverse events had been detected by the clinical risk management program;
- the clinical conditions were treated frequently in the Hospital; and
- the consequences of treating the conditions poorly were significant.

**The conditions chosen were:**

- **stroke**
- **heart attack**
- **hip and knee replacement**
- **hysterectomy**
- **fractured hip**
- **pneumonia acquired in the community**
- **asthma**
- **large bowel resection**
- **gall bladder removal by laparoscopy (key hole surgery)**
- **appendicitis**

The entire treatment team participated in the development and implementation of the pathways. The literature was reviewed to ensure that the pathways reflected best practice in the management of patients with each of the conditions. Checklists and reminders were incorporated into the pathways to assist in their implementation. Methods to measure the success of implementation of each pathway were agreed in advance. The pathway itself became the medical record, with all members of the treatment team entering in the pathway document details of the care they provided to the patient.

After the pathways were introduced, the medical records of each patient who was admitted with the condition were reviewed after the patient's discharge to see if the pathway had been followed. The patient care teams were provided with regular information about their achievements. Where improvement had not occurred, reminders were put in place, messages were left in staff communication books and ward meetings and further education sessions were held for relevant staff. In some cases, pathways were altered to make them clearer and easier to use.

The introduction of pathways at the Hospital resulted in measurable improvements in patient care:

### **The Right Medication at the Right Time**

Patients with heart problems were more likely to receive the right medication at the right time, and to have necessary pathology tests at the right time. Each of these changes represents best practice in caring for patients with heart problems.

### **Improving the Care of Patients Who Have Suffered a Stroke**

Good nutrition is important for all patients, but solid food can be harmful to some patients following a stroke because they experience difficulty swallowing. After the introduction of the clinical pathways, 94.2% of patients at the Hospital who had suffered a stroke had a specialist assessment of their swallowing ability within 24 hours of admission, compared to 50% of patients before the pathways were introduced. Patients with good swallowing reflexes can now resume a normal diet as soon as possible, while those who are experiencing difficulty swallowing are provided with alternative nutritional support.

### **Safe and Efficient Use of Resources**

Length of hospital stay for patients who were admitted for a hip or knee replacement operation reduced at the Hospital following introduction of the pathways, from 12.2 days to 8.4 days, without any increase in readmission rates.

## Case Study 2 - Clinical Review Committee, the Children's Hospital at Westmead

In June 1999, the NSW Minister for Health approved The Children's Hospital Clinical Review Committee as an approved Quality Assurance Committee under Division 6B of the Health Administration Act 1982.

The Committee's membership includes nurses, doctors and allied health staff. The Committee Chairman, Dr Stuart Dorney, believes that the opportunity for health care professionals from all disciplines to freely and openly discuss quality problems has resulted in important improvements to patient care:

*“Qualified privilege protection is only necessary where there is concern that if specific discussions or investigations relating to individuals were not kept confidential, important issues might not be referred to us in the future. But health care professionals are certainly more confident in referring issues to us because they know that the protection is available if necessary.*

*Health care professionals need the opportunity to learn from adverse events, and it is in our patients' interests that we look at all the circumstances surrounding their care.*

*This will only be possible, however, if we can openly review those events without fear that the results of our work might be used for purposes other than helping us all to improve the quality of care we provide to the children of NSW.*

*Our early successes have created an environment in which our health care professionals now feel able to openly raise issues that they believe would benefit from further discussion and investigation, in an environment of trust and support.”*

Dr Stuart Dorney, Chairman, The Children's Hospital Clinical Review Committee

In assessing each issue that is referred to it, the Committee considers the following questions:

- what are we trying to accomplish?
- how will we know that a change is an improvement?
- what changes can we make that will result in an improvement?

Last year, a doctor contacted the committee with concerns about the frequency of pressure areas in children who were admitted to the Hospital for surgical procedures. Pressure areas occur over bony areas such as the pelvis, the heels and the lower back in patients who are unable to feel local pain and pressure, or who have limited mobility. They often cause significant illness to patients and distress to their carers.

Discussion confirmed that other members of hospital staff had noticed that pressure areas were developing in children being cared for in several areas of the hospital.

On review, it was learned that in 1999 the hospital's rehabilitation service had reported that 18% of its patients experienced severe problems as a direct consequence of hospital acquired pressure areas. A similar snap shot study over a six week period in the Intensive Care Unit in 1998 had shown that 10% of children in intensive care develop pressure areas of varying degree and significance.

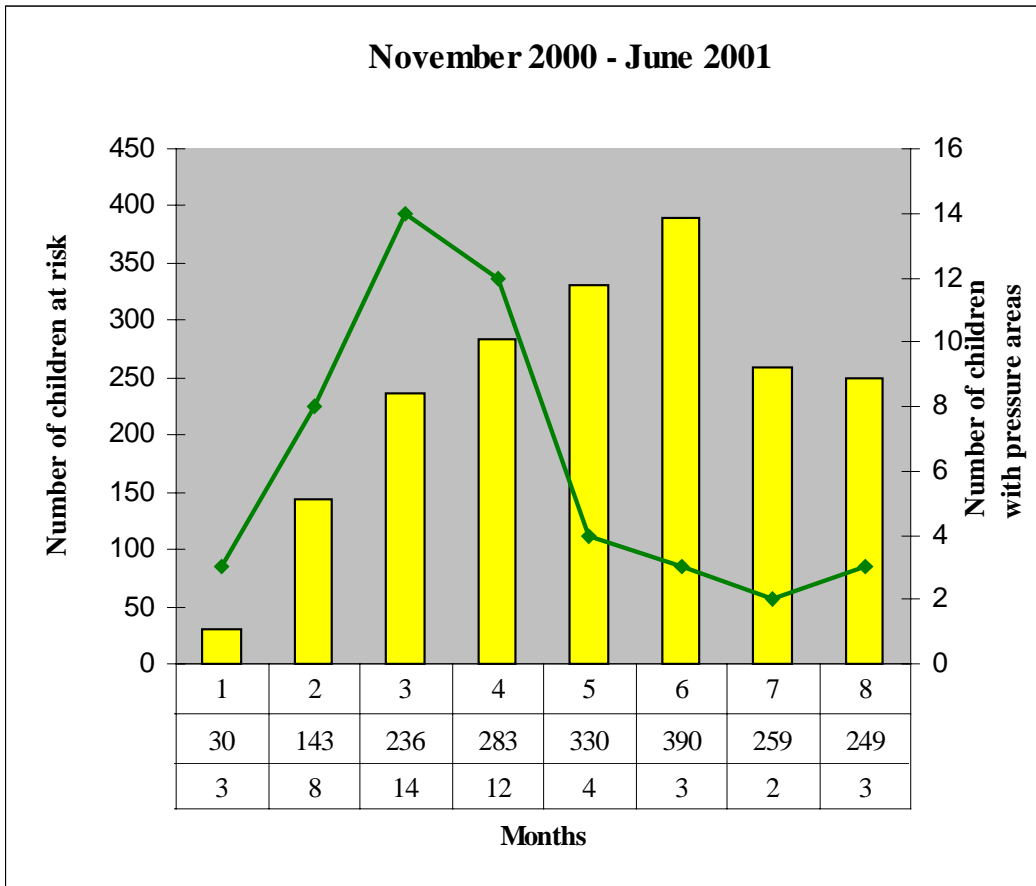
A Continuous Practice Improvement Team was formed, which aimed to reduce the incidence of pressure areas across the hospital to less than 5% in one year.

**Education was identified as one of the most important areas, to dispel two prevailing myths:**

- **myth one was that children do not get pressure areas. This myth was believed by members of staff at all levels, from bedside nurses to members of the Executive;**
- **myth two was that if specialist mattresses and other devices were available to assist with the care of children who were at risk of pressure areas, they would be prevented from developing. Devices were perceived as a panacea and a substitute for meticulous nursing care specifically aimed at preventing pressure areas.**

The Continuous Practice Improvement Team developed and implemented across the Hospital a standardised tool to assess children's risk of developing pressure areas. A web page was developed, and a protocol for managing children with suspected spinal injuries was implemented. Its focus was on ensuring that suspected spinal injuries were investigated as a priority, so that spinal collars could be removed from children who did not have an injury. The risk of pressure areas decreases significantly with the removal of spinal collars in these children.

The Hospital achieved its original goal, which was to reduce the incidence of pressure areas across the Hospital to less than 5%. The goal was re-evaluated and decreased further in April 2001 to 0%. All general ward areas of the Hospital have achieved that goal, with no patients at all suffering from pressure areas. High risk areas, such as Intensive Care, have now reduced their rate to between 0.2% and 0.5%.



*“We have learnt a lot from this project. We have learnt about teamwork, that by looking at just one aspect of patient care with multi-disciplinary involvement, facts, data and education, we can improve and ensure patient safety. We have learned to be creative. Finally, we have also learned to negotiate hurdles in collaboration with other children’s and adult hospitals.”*

**Linda Justin, Clinical Practice Improvement Coordinator,  
The Children’s Hospital**

## Case Study 3 - BreastScreen Western Australia

Breast cancer is the most common cause of death from cancer in Australian women. The BreastScreen Australia Program aims to reduce death and illness from breast cancer by maximising early detection. Quality assurance and improvement is integral to all of its processes.

BreastScreen is a national program. The program is separately administered in each State and Territory. A National Advisory Committee coordinates advice on national policy, integrating feedback from States and Territories, the Commonwealth, relevant professional bodies and indigenous and consumer representatives.

A number of indicators to monitor the Program have been developed by epidemiologists, health economists, health statisticians and specialist medical professionals. The indicators have been endorsed by the National Advisory Committee and are collected by all State and Territory programs and reviewed nationally. Five key indicators, listed below, are compiled from BreastScreen program data and state and territory Cancer Registries and are published annually by the Australian Institute of Health and Welfare.

### BreastScreen Quality Indicators

#### Indicator 1 – Participation Rate

- Percentage of eligible women attending for a mammogram.

#### Indicator 2 - Detection Rate for Small Cancers

- The rate of detection of small invasive cancers by age and state/territory.

#### Indicator 3 – Sensitivity

- *Indicator 3a – interval cancer rate.* The rate of breast cancers diagnosed between screening episodes.
- *Indicator 3b – program sensitivity.* The percentage of breast cancers detected by the Program amongst all breast cancers found in Program-screened women in a specified period.

#### Indicator 4 – Incidence

- The rate of all new cases of breast cancer in each state and territory and nationally by age.

#### Indicator 5 – Mortality

- The death rate from breast cancer for each state and territory and for the whole of Australia by age.

Review of interval cancers (those that appear between screening mammograms) is one important way of determining any areas of possible delay or inaccuracy in diagnosis.

BreastScreen WA conducted a review of interval cancers for women attending for screening and assessment between July 1996 and June 1998. The review was covered by qualified privilege. A clinical audit was conducted of all aspects of the assessment of each woman who subsequently developed breast cancer, according to the Cancer Registry, within 24 months of having a “normal” outcome of her screen. The objective of the audit was to identify any reasons for delay in diagnosis of breast cancer and to demonstrate any systems errors and areas for improvement.

Each patient’s mammograms and other investigations were reviewed to determine whether:

- the cancers were true interval cancers (that is, review of the initial mammograms and other investigations confirmed that they had been normal); or
- the diagnosis has been delayed (that is, review of the initial mammograms and other investigations suggested that the cancer had developed in the region of assessment).

*“The BreastScreen Program is committed to excellence. The availability of qualified privilege allowed BreastScreen WA to critically review its past performance in order to show any errors, without the risk of such information being used for other purposes. The review enabled the Service to modify systems and to improve performance and quality.”*

**Dr Liz Wylie, Medical Director, BreastScreen WA**

The audit showed that of the women who were assessed at their last screen, 0.4% developed interval cancers. Review of the medical records confirmed that in 39% of these cases the cancer had developed in a different area of the breast to the area assessed and the mammograms and other investigations were normal in retrospect. These cancers were confirmed as true interval cancers.

In the remaining cases, the cancer had developed in the area of assessment. Review suggested that there was some degree of abnormality but no definitive cancer diagnosis could be reached.

In 13% of these cases it was found that there were communication problems between radiology and pathology specialists, which led to a failure to correlate suspicious lesions and determine the most appropriate management for individual clients.

The review enabled BreastScreen WA to modify their systems and thus improve their quality of service.

Communication issues have been reduced noticeably since all clients have been offered further investigation at BreastScreen WA assessment centres. This same-day multidisciplinary breast assessment service has been available at two metropolitan teaching hospital sites since April 1999.

New reporting guidelines that comply with the National Breast Cancer Imaging Guidelines have been adopted. The summary 'synoptic report' at the conclusion of the narrative component of the imaging reports has improved the clarity and accuracy of x-ray and ultrasound reports at the assessment centres and the screening units and facilitated communication between specialists in the multidisciplinary team.

It is also hoped that increased use of ultrasound at BreastScreen assessment centres will assist in the detection of subtle cancers. In addition, different biopsy techniques, increased suspicion of calcification on mammography and early follow up films for lesions that are difficult to biopsy have been introduced at BreastScreen WA.

Reviews of performance such as this are an integral part of quality improvement practice to enable the highest standard of service, and demonstrate the commitment to continuous quality improvement that characterises the Program.

## Case Study 4 - Improving Outcomes of Heart Surgery at the Geelong Hospital

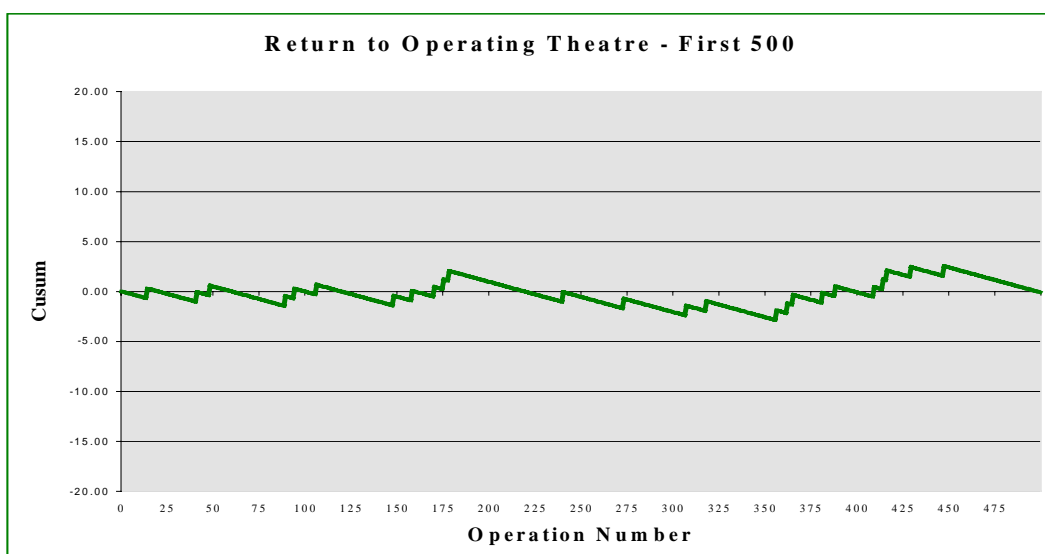
The Geelong Hospital is a major regional teaching hospital which provides general hospital services to a population of approximately 250,000 people, and complex referral services to a wider population of approximately 400,000 people.

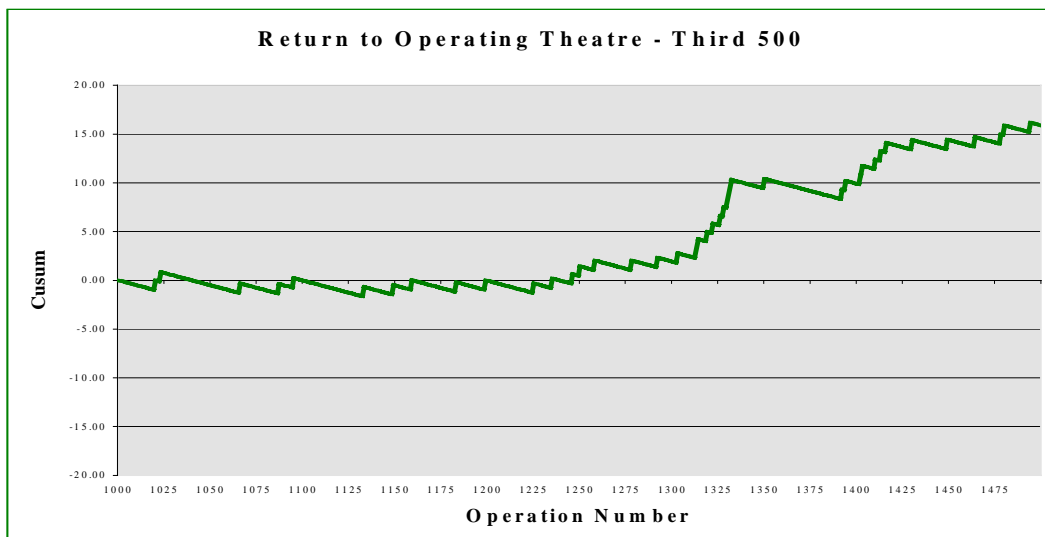
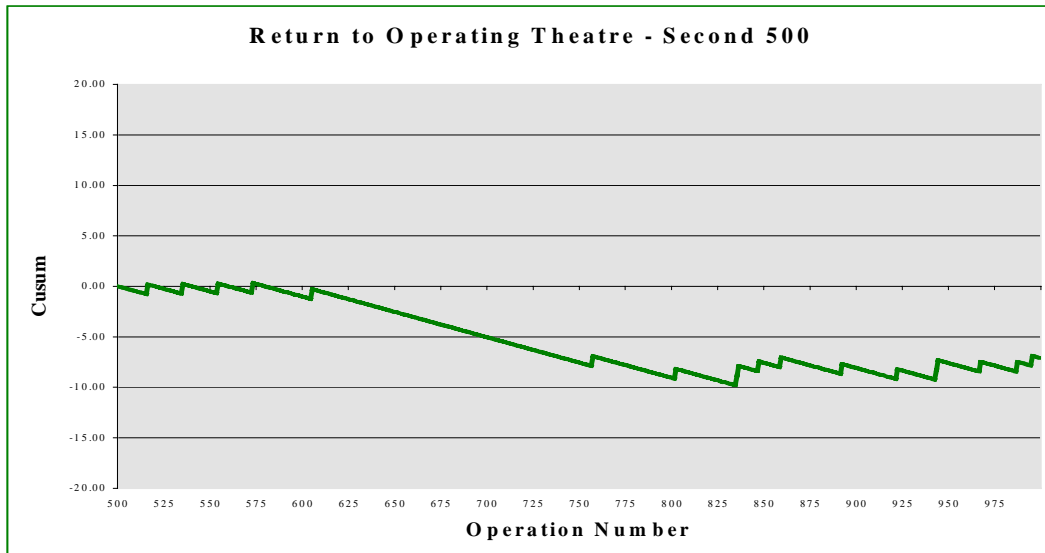
The Hospital commenced a new heart surgery service in 1997. Heart surgery is relatively high risk surgery, with known complication rates. The Geelong Hospital cardiologists, cardiac surgeons and anaesthetists have closely monitored the safety and quality of the care they have provided since the service commenced. Almost 1500 operations have now been performed at the Hospital and patient outcomes have been excellent.

The heart surgery service uses an innovative statistical technique, called 'cusum analysis' to identify statistically significant, as opposed to random, changes in complication rates. Data collection is ongoing and analysis of patient outcomes is ongoing. By graphing patient outcomes according to this technique, changes in outcomes can be detected at a glance as soon as they become statistically significant. If such a change occurs, care protocols can be reviewed in detail to determine why outcomes may have changed.

Qualified privilege has assisted in this process, by enabling the health care professionals who provide this service to openly and rigorously review their care protocols at various times when it has become apparent that outcomes have changed.

One important complication that has been carefully assessed is post operative bleeding, requiring patients to be returned to theatre for additional procedures. This is a relatively common post operative complication in heart surgery patients. The Hospital's overall rate of post operative bleeding is 5.5%, which is comparable with the better performing units in Australia and internationally.





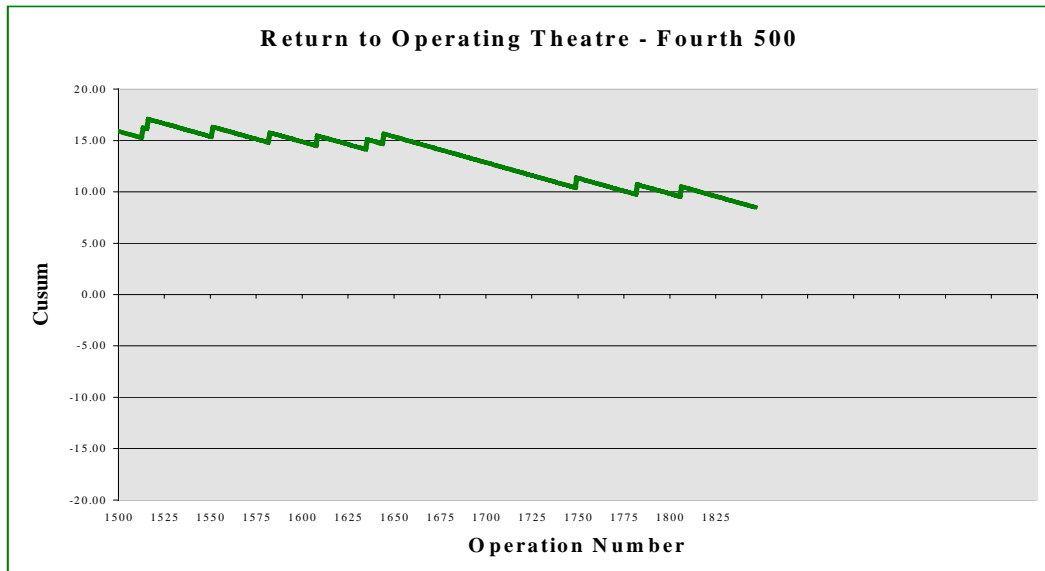
Since the service commenced, there have been some variations in the rate of post operative bleeding that have alerted the Hospital to the need to review its care protocols. For example, after approximately 600 patients had been treated, the post operative bleeding rate improved without any apparent explanation. After approximately 1200 patients had been treated, the rate of post operative bleeding increased above expected levels and a complete review of care protocols was initiated.

Detailed analysis provided explanations for the reduction in performance, but not for the earlier improvement in performance. Increased post operative bleeding rates were found to be associated with:

- an increased rate of emergency surgery;
- new staff;

- the length of time patients were on cardio-pulmonary bypass (“heart lung bypass”); and
- patients’ kidney function prior to operation.

Changes were made to care protocols, which resulted in a reduction in post operative bleeding rates and improved patient outcomes.



Associate Professor Steve Bolsin, Director of Anaesthesia at the Hospital, says that the service’s health care professionals have been delighted with the opportunities to improve patient care provided by this study:

*“Confidentiality of the information has enabled the health care professionals involved in this ongoing study to feel confident about reviewing their care of individual patients. It has enabled them to identify factors that were causing unexpected outcomes, and to address those factors. We’ve all learned from this study and it has provided a major quality benefit for the Hospital and its patients.”*

**Associate Professor Steve Bolsin, Director of Anaesthesia, Barwon Health**

## **Case Study 5 - Independent Review of Patient Deaths After Surgery in Western Australia**

The Western Australian Safety and Quality of Surgical Care Mortality Sub-Committee ('WAASM') was established on 1 June 2001 to independently review patient deaths that occur within 30 days of an operation, or occur on a surgical ward even if the patient has not had an operation.

The WAASM is fully supported by the Royal Australasian College of Surgeons, the main professional organisation of surgeons in Australia. It is the largest ongoing surgical review that has ever been carried out in Australia. If successful in Western Australia, it will provide a model for other states and territories.

The WAASM identifies, through mortuaries, records offices, wards and doctors' room, all deaths that occur within 30 days of an operation or in patients on a surgical ward, even if they have not had an operation.

Information from the surgeon is collected by the WAASM office via a questionnaire. Together with the hospital and doctor's case notes, this information is forwarded to a case note reviewer who is a surgeon who works in a different hospital from the one in which the patient died (in normal circumstances, the care of patients admitted for terminal care will not be reviewed). The case note review is a confidential process. The reviewer completes a report on the case, including a summary, and identifies any opportunities to improve patient care. A copy of the report is sent to the original specialist.

The WAASM retains statistical information about patterns of care in surgical patients, and is also able to undertake more detailed inquiries about specific areas of clinical practice that are identified through the case reviews as needing more investigation.

The process will provide important educational information for surgeons, surgical trainees, other health care professionals and consumers. A selection of case note reviews will be regularly circulated to specialists and trainees. An annual report, containing analyses of the data and commentaries covering all the surgical subspecialties, will be published.

**The WAASM is unique because it:**

- **has included surgeons, health care managers, public health researchers and consumers in its design and management;**
- **has established standardised reporting protocols and methods of analysis to enable future comparisons of surgical mortality among the states and territories in Australia and against international standards;**
- **will ensure that information about its outcomes is widely disseminated to surgeons, health care managers, public health researchers and consumers; and**
- **will develop best practice standards and guidelines for surgical practice in hospitals, based on scientific and clinical knowledge.**

The WAASM will prove to be a powerful source of information about the quality of care of surgical patients in Western Australia, in both the private and public hospital systems.

Qualified privilege is important to encourage surgeons taking part in the WAASM to critically analyse the care of individual patients, without fear that such analysis will be used against them or their colleagues. The majority of surgeons were not prepared to take part in this important quality assurance and improvement activity until qualified privilege was available. There was a significant increase in the number of surgeons who agreed to take part once qualified privilege protection had been granted. There have been only five surgeons who have not participated following a post operative death, and 82% of all surgeons have agreed to take part.

## Case Study 6 - The Australian Incident Monitoring Study – a National Approach to learning from Adverse Events

The Australian Patient Safety Foundation (“APSF”) was formed in 1988 as a non-profit organisation dedicated to advancing and promoting patient safety. One of its original aims was to establish incident monitoring systems to provide a mechanism for finding out what was going wrong in healthcare.

The first system established was a voluntary anonymous national reporting system for the discipline of anaesthesia. During analysis of the information received, it became apparent that incident monitoring was a powerful source of information which did not appear to be readily available from any other source.

Trial incident monitoring studies in other disciplines were commenced. Also, a study was conducted into establishing incident monitoring across 6 major teaching hospitals; this led to the establishment of incident monitoring systems encompassing the entire spectrum of health care.

The Commonwealth qualified privilege law has provided much valued protection to the program over many years, reassuring health care professionals that the information they send to the program cannot be used for other purposes.

Professor Bill Runciman, who has led the APSF since its inception, says that three messages have come across loud and clear as a result of this national incident monitoring program.<sup>33</sup>

*“The first is that everyone wants there to be a single form to initiate reporting of anything that goes wrong. The second is that there is universal support for the right to anonymity for the small number of very sensitive reports, and for the right of confidentiality and qualified privilege for any other reports. The third is the need for feedback and evidence that steps have been taken to fix the problems that have been identified.*

*There is absolutely no doubt that a health care professional is unlikely to report if he or she knows that the information can be retained somewhere in a file or a databank, associated with his or her name. Assurances of confidentiality are simply not enough; the confidential nature of the information must be protected by qualified privilege.*

*It is most important that a system which allows anonymous or confidential incidental reporting does not replace existing legal or disciplinary process. These processes are a vital part of responding to the needs of those who have been injured, but they have only a minor role in improving patient safety.”*

**Professor Bill Runciman, Head, Australian Patient Safety Foundation**

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<sup>33</sup> Runciman T.B, “Quality and Safety in Health Care” *Quality and Safety in Health Care* (In Press, 2002).

The APSF has many examples of the way in which information about things going wrong in health care can be used to improve patient care for the future. One important lesson was learned about anaesthetic machines. Action as a result of the following incident has, without doubt, made the practice of anaesthesia much safer:

**In 1994, whilst a patient was undergoing a total hip replacement, the anaesthetist decided to replace the vaporiser (the component of the anaesthetic machine that delivers the gaseous anaesthetic drugs to the patient). When the new vaporiser was inserted into the system it failed to seal properly, allowing room air to enter the anaesthetic breathing circuit. As a result, the patient did not receive enough anaesthetic drugs and awoke, but was paralysed and could not alert the operating theatre staff that he was awake. Fortunately, the epidural anaesthetic that had previously been inserted into his spinal space was working effectively, and he felt no pain. However, he was fully aware of what was going on around him. Upon recovery, he not surprisingly complained and inquired about how this could have come about; the matter received some attention from the national media. The professional bodies representing anaesthetists called for all such vaporiser interfaces with anaesthetic machines to be recalled and modified. The manufacturers suggested that this was an operator problem. The APSF searched its database for vaporiser incidents. A quite extraordinary array of problems was located within a few hours, although almost no useful information was found in the literature and, up to that time, there had been very few reports of problems with anaesthetic vaporisers in Australia. Over half of the 136 reports represented pure “human-factor” problems (for example a vaporiser left on the wrong setting, or a vaporiser left off when it was supposed to be on). Several fatal and potentially fatal problems had occurred, and it was quite apparent that standard practices with respect to the filling, care and use of vaporisers were exposing patients to a wide variety of avoidable hazards. It became clear that the only practical solution was to monitor the concentration of volatile agent in the patient’s breathing circuit. As a result of the information yielded by the APSF database, the College of Anaesthetists set up a guideline (in effect, a national standard) requiring specific monitoring of the concentration of anaesthetic drugs in the breathing circuit during anaesthesia.**

Professor Runciman says that work done by the APSF has shown that 80% of the things that go wrong occur too infrequently to be amenable to routine surveillance or research techniques.

*“This means they have to be analysed after the event by people who were involved and had first-hand experience of what actually happened. It is therefore absolutely vital, in the interests of obtaining accurate and detailed information about the causes of things that go wrong, that the information is confidential and cannot be used to make comparisons or to compromise any individuals. Qualified privilege is fundamental to ensuring that this is the case for any process of finding out what has gone wrong.”*

**Professor Bill Runciman, Head, Australian Patient Safety Foundation**

## 14. Committees and Activities that receive Qualified Privilege Protection (by Jurisdiction)

Jurisdiction	Organisation	Committee or Activity
Australian Capital Territory	ACT Community Care, Department of Health and Community Care	Quality Improvement Council Quality Improvement Advisory Committee
	All Territory Public Hospitals	Division of General, Vascular, Paediatric and Cardiothoracic Surgery Morbidity/Mortality Audit and Quality Case Review Maintenance of Anaesthetics Professional Standards Committee
	Calvary Health Care	Medical Division Committees Medical Staff Council Executive Committee Medical Appointments Committee and Clinical Privileges Sub Committee Morbidity and Mortality Review Committee Peer Review Committee Quality Improvement Committee
	The Canberra Hospital	Anaesthetic and Pain Management Quality Improvement Committee Clinical Ethics Committee Clinical Privileges Committee Death Review Committee Immunology, Rheumatology, and Dermatology Death Review Committee Intensive Care Unit Morbidity and Mortality Review Committee Maternal and Neonatal Morbidity and Mortality Committee Maternal and Perinatal Morbidity and Mortality Committee Mental Health Services Clinical Incident Review Committee Neurosurgery Unit Morbidity and Mortality Committee Patient Care and Quality Improvement Committee
	John James Memorial Hospital	Department of Anaesthesia Morbidity and Mortality Review Committee Ethics Committee Patient Care Review Committee Perinatal Morbidity and Mortality Review Committee Quality Management Committee Urology Morbidity and Mortality Review Committee
	Private Sector Committees	Brindabella and Mugga Warra Endoscopy Centre Quality Assurance Committee

Jurisdiction	Organisation	Committee or Activity	
Commonwealth	Adelaide Women's & Children's Hospital	Australian & NZ Paediatric Intensive Care Registry	
	AIMS Dentistry Management Committee	Australian Incident Monitoring Study (AIMS) in Dentistry	
	AMADA Quality Management (C/- AMA)	AMADA Medical and Dental Accreditation	
	Australian and New Zealand College of Anaesthetists	Maintenance of Professional Standards Program of the Australian and New Zealand College of Anaesthetists	
	Australian and New Zealand College of Anaesthetists	Maintenance of Professional Standards Programme of the Faculty of Intensive Care of the Australian and New Zealand College of Anaesthetists	
	Australian and New Zealand College of Anaesthetists	Professional Practice Review	
	Australian and New Zealand Association of Physicians in Nuclear Medicine (Inc)	Joint Nuclear Medicine Specialist Credentialling Program	
	Australian and New Zealand Association of Physicians in Nuclear Medicine (Inc)	Nuclear medicine practice Accreditation Program	
	Australian General Practice Accreditation Ltd.	Australian GP Accreditation	
	Australian Orthopaedic Association	National Joint Replacement Registry	
	Australasian Society of Cardiac and Thoracic Surgeons	ASCTS Cardiac Surgery Database Project	
	Australian Patient Safety Foundation	Australian Incident Monitoring System (AIMS) of the Australian Patient Safety Foundation	
	Australian Red Cross Blood Service	Analysis of Adverse Events arising from Transfusion of Blood Products	
	Centre for Hospital Management and Information Systems Research	A project to assess the extent to which clinical work is organised and managed	
	Haemophilia Centre, Royal Perth Hospital	National Bleeding Disorder Registry of Australia	
	Infection Control Review and Certification Service (NSW) PTY LTD	Infection Control Review and Certification	
	National Joint Registry, Orthopaedic and Trauma Service	National Joint Replacement Registry	
	Northern Territory Department of Health & Community Services		Gove District Hospital, Australian Incident Monitoring Study (AIMS)
			Barkly Health Service, Australian Incident Monitoring Study (AIMS)
			Katherine Hospital, Australian Incident Monitoring Study (AIMS)
Alice Springs Hospital Morbidity and Mortality Review			
Australian Incident Monitoring System (AIMS) of the Royal Darwin Hospital			
Quality Assurance Services Pty Ltd	Accreditation of General Practices		
Royal Australian College of Obstetricians and Gynaecologists	Continuing Education and Certification Program of the Royal Australian College of Obstetricians and Gynaecologists		

<b>Jurisdiction</b>	<b>Organisation</b>	<b>Committee or Activity</b>
<b>Commonwealth (cont.)</b>	Royal Australasian College of Physicians	Maintenance of Professional Standards Program of the Australasian Faculty of Rehabilitation Medicine (Royal Australasian College of Physicians)
		Maintenance of Professional Standards Program of the Royal Australasian College of Physicians
	The Royal Australian and New Zealand College of Psychiatrists	Maintenance of Professional Standards Program of the Royal Australian and New Zealand College of Psychiatrists
	Royal Australian and New Zealand College of Radiologists	Quality and Accreditation Program of the Royal Australian and New Zealand College of Radiologists
	Royal Australian College of Obstetricians and Gynaecologists	Management of Labour Practice Improvement Project
		Obstetric And Gynaecological Ultrasound Project
	Royal Australasian College of Surgeons	Australian Safety and Efficacy Register of New Interventional Procedures
		Surgical Audit for Breast Disease
		Surgical Audit of the Royal Australasian College of Surgeons
	Royal Prince Alfred Hospital Medical Centre	Australia and New Zealand Heart Valve Registry
	Royal Prince Alfred Hospital	Patient Database and Intensive Care Unit Registry of the Australia and New Zealand Intensive Care Society
	The Royal College of Pathologists of Australasia	Pathology Incident Monitoring and Management
		RCPA Continuing Professional Development
University of Sydney	Risk Watch - computerised incident monitoring	
Western Australian Safety and Quality of Surgical Care Project, Centre for Health Services Research, Department of Public Health University of WA	Western Australian Audit of Surgical Mortality (WAASM)	
<b>New South Wales</b>	Bowral District Hospital	Medical Quality Assurance Committee
	Central Sydney Area Health Service	Cytology Quality Assurance Committee
	Gosford Hospital	Medical Quality Assurance Committee
	Grafton Base Hospital and Health Service	Medical Quality Assurance Committee
	Goulburn Base Hospital	Medical Quality Assurance Committee
	Hawkesbury District Health Service	Clinical Review Subcommittee
	Hornsby Ku-ring-gai Hospital and Community Health Services	Clinical Review Medical Review Sub-Group

Jurisdiction	Organisation	Committee or Activity
New South Wales (cont.)	John Hunter Hospital	Department of Obstetrics and Gynaecology Sub-Committee for Perinatal Mortality and Morbidity Surgical Audit Committee Trauma Committee
	Lismore Base Hospital, Richmond District Health Service	General Surgical Audit Committee
	Manly Hospital and Community Health Service	Medical Quality Assurance Committee
	Mater Misericordiae Hospital	Standards Committee and 9 clinical review panels
	Mona Vale Hospital	Perinatal Death Review Committee
	Murwillumbah District Hospital and Tweed Heads District Hospital	Joint Surgical Services Subcommittee
	New Children's Hospital	Clinical Review Committee
	Northern Illawarra	QuaIL Committee and 16 Peer Review Groups
	NSW Red Cross Blood Transfusion Service	Quality Assurance Committee
	Royal North Shore Hospital	Quality Assurance Committee Quality Assurance at Royal North Shore (QARNS) Program
	Royal Rehabilitation Centre, Sydney	Clinical Care Review Committee
	Ryde Hospital & Community Health Services	Medical Review Committee
	Saint George Hospital and Community Health Service	Division of Surgery Quality Improvement & Clinical Information Committee Intensive Care Committee
	South West Sydney Area Health Service	Area Critical Care Committee
	St Vincent's Hospital Darlinghurst	Critical Medical Incidents Review Committee
	Sydney Adventist Hospital	Quality Care Review Committee
	Sydney Haematology and Oncology Clinic	Quality Assurance Committee
	The Maitland Hospital	Perinatal Review Committee
Wentworth Area Health Service	Clinical Advisory Committee	
Westmead Hospital	Confidential Review Committee	

Jurisdiction	Organisation	Committee or Activity
South Australia <sup>34</sup>	Abergeldie Specialist Hospital	Medical Advisory Committee Quality Improvement Committee
	Adelaide Community Healthcare Alliance Incorporated	Quality Improvement Committee Clinical Review Committee Practice Review Committee
	BreastScreen South Australia	Quality Improvement Committee – Interval Cancers Pathology Quality Improvement Committee
	Central Yorke Peninsula Hospital Incorporated	Managing Quality Outcomes Committee Clinical Review Committee
	Cowell Campus	Cowell Quality Improvement Committee
	Cummins and District Memorial Hospital Incorporated	Quality Improvement Committee
	Department of Human Services	Expert Panel on Infected Health Care Workers
	Eyre Regional Health Service Incorporated	Health Outcomes Review Committee
	Calvary Health Care Adelaide Incorporated	Hospital Executive Committee Nursing Executive Committee Surgical Services Committee (a sub-committee of the Medical Committee) Pharmacy Committee (a sub-committee of the Medical Committee) Infection Control Committee (a sub-committee of the Medical Committee) Occupational Health and Safety Committee Medical Committee Perinatal Sub-Committee Clinical Review Sub-Committee Anaesthetic Sub-Committee Critical Care Unit Sub-Committee Allied Health Committee Quality Committee

<sup>34</sup> Note – the relevant SA law relates to confidential information and defines when it may be used and in what circumstances it must not be disclosed. The law does not require committees or activities to be specifically declared by the Minister. This table, therefore, lists a large number of committees which may generate confidential information as defined in and protected by the Act.

Jurisdiction	Organisation	Committee or Activity
South Australia (cont.)	Flinders Medical Centre	Health Care Ethics Committee Quality Assurance Sub-Committee Cancer Registry Consumer Adviser Division of Medicine, Cardiac and Critical Care Services Quality Improvement Committee Emergency Department Audit Committee
	Gawler Health Service Incorporated	Quality Improvement Committee
	Julia Farr Services	Quality Activities Committee Quality Activities Co-ordinator Medication Advisory Committee
	Kingston Soldiers Memorial Hospital Incorporated	Morbidity and Mortality Review Committee
	Laura and Districts Hospital	Quality Management Committee
	Lower Eyre Health Services Incorporated	Quality Improvement Committee
	Loxton Hospital Complex Incorporated	Managing Quality Outcomes Committee Clinical Review Committee
	Mount Barker District Soldiers' Memorial Hospital Incorporated	Medical Services Committee Multi-Disciplinary Discharge Planning Committee Maternal and Neonatal Services Committee Improving Performance Committee Continuum of Care Committee
	Lyell McEwin Health Services	North Western Adelaide mental Health Service Northern Area Clinical Standards Committee North Western Adelaide Health Service Ethics of Human Research Committee Northern Domiciliary Care Quality Improvement Committee LMHS Nursing Quality Improvement Committee Tregenza Ave Aged Care Service Quality Improvement Committee Department of Anaesthesia QA Committee LMHS Trauma Committee LMHS Infection Control Committee LMHS Division of Obstetrics, Gynaecology and Paediatric Quality Council

Jurisdiction	Organisation	Committee or Activity
South Australia (cont.)	Murray Bridge Soldiers' Memorial Hospital Incorporated	Quality Improvement Committee
	Naracoorte Health Service Incorporated	Patient Safety and Clinical Performance Review Team
	Noarlunga Health Services Incorporated	Quality Review Forum Quality Assurance Sub-Committee of the Medical Staff Society Quality Co-ordinating Group, Mental Health Division Critical Incident Review Committee Psychiatric Casenote Audit Committee
	Northern Yorke Peninsula Regional Health Service Incorporated	Incident Review Sub-Committee
	Port Pirie Regional Health Service Incorporated	Patient Care Standing Committee Quality Assurance Committee Nursing Executive Committee Infection Control Committee Drug and Therapeutics Committee Levels 3, 4 and 5 Committees
	Repatriation General Hospital	Patient Services Sub-Committee Division of Surgery Quality Assurance Sub-Committee Division of Allied Health Quality Assurance Sub-Committee
	Royal Australasian College of Surgeons	Australian Safety and Efficacy Register of New Interventional Procedures – Surgical (ASERNIP-S)
	Royal District Nursing Service of SA Incorporated	Quality Committee Nursing Practice Committee
Royal Flying Doctor Service of Australia (Central Section)	Medical Retrieval Committee – QA Sub-Committee	

Jurisdiction	Organisation	Committee or Activity
South Australia (cont.)	Royal Adelaide Hospital	Operations Committee Management Committee, Emergency Department Trauma Service Morbidity and Mortality Committee Infection Control Committee Patient Adviser Clinical Practice Committee Treatment Ethics Committee Nursing Quality Council Eastern Regional Geriatric and Medical Rehabilitation Service Quality Activities Committee Department of Neurosurgery Audit Group Division of Surgery Audit Group Statewide Mental Health Service Glenside Campus, Clinical Indicators Committee Sentinel Event Panel North Western Area Health Service/Royal Adelaide Hospital Incident Monitoring Committee
	SA Ambulance Service	Medical Advisory Committee Medical Advisory Committee Paramedic Audit State Rescue Helicopter Service Medical Audit Sub-Committee
	SHine SA	Medical Advisory Committee Shine SA Doctors Meeting
	South Coast District Hospital Incorporated	Service Improvement Committee
	Southern Districts War Memorial Hospital	Medical Advisory Continuous Quality Improvement Committee – in conjunction with McLaren Vale Private Hospital
	Sportsmed SA	Clinical Audit Committee Clinical Outcome Review Committee Medical Advisory Committee Theatre Committee
	Stirling and Districts Hospital	Medical Advisory and Education Committee Theatre Suite Committee Medical Privileges Advisory Committee Patient Care Committee Obstetric Advisory Committee
	Strathalbyn and District Health Service	Hospital – Quality Assurance/Accreditation Committee Nursing Home – Quality Assurance Committee

<b>Jurisdiction</b>	<b>Organisation</b>	<b>Committee or Activity</b>
<b>South Australia</b> <i>(cont.)</i>	Tumby Bay Hospital and Health Services Incorporated	Quality Improvement Committee
	Waikerie Hospital and Health Service Incorporated	Quality Improvement Committee
	Whyalla Hospital and Health Service Incorporated	Improving Performance Committee Health Care Committee
<b>Northern Territory</b>	There is no qualified privilege legislation in the Northern Territory, although various activities being conducted in the Northern Territory receive qualified privilege protection via the Commonwealth legislation (refer to the Commonwealth section above).	
<b>Queensland</b>	Australian and New Zealand College of Anaesthetists	Professional Standards Committee
	Queensland Health	Committee to Enquire into Perioperative Deaths Medical Quality Processes Management Committee Mental Health Facilities Mortality Committee Queensland Maternal and Perinatal Quality Council Queensland Paediatric Quality Council
<b>Tasmania</b>	Australian and New Zealand College of Anaesthetists	Maintenance of Professional Standards (MOPS) Committee
	Department of Health and Human Services	Statewide Therapeutic Drug Committee
	North-West Regional Hospital	Morbidity and Mortality Committee
	Launceston General Hospital	Acute Care Program Quality Management Committee Regional Perinatal Mortality and Morbidity Committee- Department of Surgery Continuing Quality Management Committee – Department of Surgery Department of Medicine Quality Assurance Committee Clinical Privileges and Appointments Committee Obstetric and Gynaecological Mortality and Morbidity Committee Department of Medicine Mortality and Morbidity Committee Intensive Care Unit Mortality and Morbidity Committee Cardiology Mortality and Morbidity Committee

<b>Jurisdiction</b>	<b>Organisation</b>	<b>Committee or Activity</b>
<b>Tasmania</b> <i>(cont.)</i>	Royal Hobart Hospital	Division of Surgery Executive Committee Medical Services Committee Women's and Children's Clinical Services (WACS) Executive Committee Mortality Review Committee Serious Incident Panel Infection Control Committee Blood Transfusion Committee Safe Practice and Environment Committee Pathology Executive Committee Clinical Services Medicine Executive Committee
<b>Victoria</b> <sup>35</sup>	Bairnsdale Regional Health Service	Clinical Standards (Anaesthetic) Committee Clinical Standards (Risk Management) Committee
	Goulburn Valley Health	Patient Care Review Committee
	Kyabram & District Health Care Services	Quality Committee
	Mansfield District Hospital	Quality Assurance Committee
	Peninsula Health	Mortality Review Committee
	Peter MacCallum Cancer Institute	Clinical Risk Management Committee
	Robinvale District Health Service	Quality Assurance Committee
	Royal Victorian Eye and Ear Hospital	Patient Safety Committee
	The Royal Children's Hospital	Patient Safety Committee
	The Royal Women's Hospital	Adverse Clinical Event Screening
	Western District Health Service	Limited Adverse Occurrence Committee
	Wodonga Regional Health Service	Medical Peer Review Committee

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<sup>35</sup> Note – procedures for applying for qualified privilege protection have recently been amended in Victoria and many hospitals that have had qualified privilege protection in the past are in the process of reapplying.

<b>Jurisdiction</b>	<b>Organisation</b>	<b>Committee or Activity</b>
<b>Western Australia</b>	Australian and New Zealand College of Anaesthetists	Maintenance of Professional Standards Committee
	BreastScreen WA	BreastScreen WA Quality Improvement Committee
	King Edward Memorial and Princess Margaret Hospital	Obstetrics Clinical Outcomes Management Committee
	Sir Charles Gairdner Hospital	Sir Charles Gairdner Hospital Quality Improvement Committee
	Western Australian Safety and Quality of Surgical Care Association	Western Australian Audit of Surgical Mortality (WAASM) WA Safety and Quality of Surgical Care Research Sub-Committee WA Safety and Quality of Surgical Care Morbidity Audit Sub-Committee

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