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Consumer Update (February/March 2005)

Welcome to the 6th edition of Consumer Update – the newsletter on issues of interest to consumers arising from the work of the Australian Council for Safety and Quality in Health Care for Safety and Quality in Health Care (the Council).

This issue features information about Susan Sheridan, the keynote consumer speaker at the 3rd Australasian Conference on Safety and Quality in Health Care. It will be an exciting conference and we are looking forward to substantial participation by consumers in the conference debates.

Kate Moore
Council's Consumer Consultant

Consumers recognised with Australia Day Honours

In the Australian Honours List for Australia Day, two consumers involved in Council work were awarded a Medal in the General Division of the Order of Australia (OAM). They are **Myrtle Green**, a member of the Council's Consumer Advisory Committee, for service to the community through health, education, law and women's organisations and **Henry (Harry) James Collins** for service to the community, particularly the ageing, through membership of a range of advisory, health and social support boards and committees.

Congratulations and thanks to both Myrtle and Harry for their work.



Open Disclosure Pilot

The Open Disclosure Standard was formulated by the Council to provide a framework for an open, consistent approach to communication with patients when things go wrong in health care. This includes expressing regret for what has happened, keeping the patient informed, providing feedback on investigations and the steps taken to prevent a recurrence of adverse events.

The Standard was endorsed by Health Ministers in July 2003. In January this year, Federal and State Health Ministers considered how best to coordinate national implementation of the Standard and endorsed a pilot implementation process for open disclosure and the formation of a national steering committee to guide the process and report back to them. The steering committee will include representatives from Council, the States and Territories, consumers, clinicians,

hospitals and insurers and it will play a role in assisting Health Ministers to implement the new National Pilot. While details of the pilot are yet to be determined, it is expected to take 18 months, will be undertaken at hospital sites yet to be identified and will include an external evaluation which will inform Health Ministers' subsequent planning for the implementation of the Standard.



Improving Communication for Safe Continuity of Patient Care

The Council is hosting a national workshop on 19 April 2005 to consult with key stakeholders on possible options for national improvement in clinical communication to ensure safe continuity of patient care. In hosting the workshop the Council intends to:

- work with stakeholders to learn from their experiences and gain advice on their views on areas for improvement and commitment to national work in this area;
- agree on a common meaning for continuity of care in health care and how the Council could positively play a role in making improvement;
- recommend achievable action to be taken forward by the Council including identification of priority areas for targeting the work; and
- create a momentum for national improvement and launch stakeholder collaboration to drive improvements for safe continuity of patient care.

A variety of stakeholders including consumers will be involved in the workshop. The outcomes of the workshop will inform the Council in planning national action to be taken forward within its current term which ends on 30 June 2006. Work arising from the workshop will primarily aim to improve continuity of care

for patients and enhance patient safety in Australia.



Adverse Medicine Events Line Evaluation

Have you ever had a problem with your medications? Did you know you can get advice or make a report by calling the Consumer Adverse Medicine Events (AME) Line on? 1300 134 237

The Consumer Adverse Medicine Events (AME) line trial which began operation on 20 October 2003 is to undergo an evaluation.

The AME Line is a key Council medication safety project which allows consumers to report adverse medicine events. The AME Line provides information to members of the general public who suspect they have experienced an adverse medicine event. The AME Line is staffed by pharmacists who specialise in drug information.

A tender process is underway for the evaluation of the AME Line. Applications have been received by the Office of the Safety and Quality Council and will be assessed by a tender assessment panel. The evaluation is due to start towards the end of April 2005.



NSW Sentinel Events Report

NSW Health Minister Morris Iemma released the first *New South Wales Patient Safety and Clinical Quality Program Report* (the Report) on incident management in public hospitals on 31 January 2005 as part of a plan to improve patient safety.

A sentinel event is one in which death or serious harm to a patient has occurred and the Report identified 31 sentinel events in NSW public hospitals. This

number is comparable with the 30 sentinel events reported by Victoria in 2003/2004. The also measures ring all Category 1 incidents, which cover events such as clinical management problems, falls and wrong patient/site/procedure incidents.

Mr lemma outlined the NSW Government's commitment to addressing such problems in hospitals by establishing and funding the Clinical Excellence Commission (CEC) "to oversee the reporting of incidents and to ensure that systems are improved where faults are identified."

"I want doctors and nurses to feel confident that they can report incidents and that they will be reviewed and that lessons are learned and implemented as part of the Carr Government's determination to drive further improvement," Mr lemma said.

In order to prevent mistakes in hospitals, NSW has chosen to undertake Root Cause Analysis (RCA) on all Category 1 incidents, a process that assists in determining what happened, why it happened and the underlying causes.

The RCA process has already identified a number of clinical improvements to reduce the number of falls suffered by patients in hospitals. These improvements are in the process of being implemented across NSW, with some hospitals having already introduced them. They include:

- The use of arm bands on high risk patients;
- Establishing on site 'Fall Reduction Teams'; and
- Eliminating hazards such as high beds and bed rails with high risk patients.

A number of protocols are also to be introduced to deal with 'wrong patient/wrong site/wrong procedures'.

The data that was released in the report will form part of the Council's National

Sentinel Events Report on adverse incidents in public hospitals due for release at the end of the year.

Patients for Patient Safety

In the October 2004 edition of this newsletter we told you about the World Health Organisation's (WHO) World Alliance for Patient Safety. One of the six action areas of the Alliance is *Patients for Patient Safety*. The focus of this area is to ensure that the perspective of patients and families, consumers and citizens in both developed and developing countries is a central reference point in shaping the work of the Alliance.

The following objectives have been set for 2005:

- Develop the WHO Patient Safety website as a means of informing and inviting interested consumers from around the world to become involved in *Patients for Patient Safety* and to help establish networks with existing initiatives and groups;
- Promote the active involvement of consumers in each of the six action areas of the World Alliance for patient safety; and
- Identify, recruit and train a small number of *Patients for Patient Safety* ambassadors to advocate for and support the work of the World Alliance worldwide and contribute to greater opportunities for patient involvement in patient safety throughout the world.

The six action areas of the World Alliance are:

1. **Global Patient Safety Challenge**, focusing over an initial two-year cycle on the challenge of health-care associated infection;
2. **Patients for Patient Safety** involving patient organisations and individuals in Alliance work;
3. **Taxonomy for Patient Safety** ensuring consistency in the concepts, principles, norms and terminology used in patient safety work;

4. **Research for Patient Safety** promoting existing interventions in patient safety and coordinating international efforts to develop solutions;
5. **Solutions for Patient Safety** promoting existing interventions in patient safety and coordinating international efforts to develop solutions; and
6. **Reporting and Learning** generating best practice guidelines for existing and new reporting systems.

At a recent teleconference between Ms Betty Johnson from Council, representatives from the Office for Safety and Quality and the WHO *World Alliance for Patient Safety*, the Council expressed its interest in being involved with WHO on this initiative. If you are interested in registering your interest, or just seeking further information, you can do so through: <http://www.who.int/patientsafety> or <mailto:p4ps@who.int>.



More Languages for 10 Tips

Queensland Health has produced a summarised version of Council's *10 tips for safer healthcare: what everyone needs to know* booklet as well as a 10 tips pamphlet. The summarised booklet is available in English as well as Arabic, Cantonese, Croatian, Filipino, German, Greek, Hindi, Italian, Macedonian, Mandarin, Polish, Serbian, Spanish, Turkish and Vietnamese.

The pamphlet has also been translated into Bosnian, Dutch, Hmong, Laotian, Samoan and Torres Strait Creole, and a version has been developed targeting Aboriginal people.

Electronic versions of both the summarised booklet and pamphlet are available in all these languages from the Queensland Health website at

http://www.health.qld.gov.au/quality/10_Tips/default.asp.



Clinical Leadership Program

The Council has recognised the significant contribution that nurses and midwives can make in improving the safety and quality of health care by providing \$1.5 million over 2 years for the national implementation of a Clinical Leadership Program.

Council's support for the Program followed the 'Healthy Hospitals: Transforming the Work Environment for Patient Safety' workshop in March 2004. The outcomes of the workshop highlighted among other things, the need to provide capacity/support to develop nurses' and midwives' leadership qualities and build on their professionalism and commitment, with particular focus on middle managers in the profession.

The Clinical Leadership Program was developed by the Royal College of Nursing of the United Kingdom and has had outstanding success in producing positive outcomes for nurses and midwives involved. The Royal Adelaide Hospital brought the Program to South Australia, where it ran as a two year introductory project with positive outcomes.

Some of the outcomes realised in South Australia include increased confidence and enthusiasm among experienced nurses, which is leading to improved retention rates, better care outcomes and patient safety. The Program will enable these outcomes and benefits to be spread across Australia, directly influencing improvements in patient safety and developing leaders who can sustain a culture of safety in the health workforce.

The Program focuses heavily on the person in care, through observations and interviews with patients regarding their experiences in the health care system. In the South Australian Program, the

observations of care included issues relating to privacy, dignity, comfort, safety and communication.

While the Clinical Leadership Program has a nursing and midwifery focus, there is potential for the program to be further developed across disciplines into allied health and medicine, as has been achieved in the UK.

The Steering Group that has been set up to guide the Clinical Leadership Program has a consumer representative.



Victorian Auditor-General's Report

A report by the Victorian Auditor-General, Wayne Cameron, titled "Managing patient safety in public hospitals" was tabled in the Victorian Parliament on 23 March 2005.

The report focuses on clinical risk-management in acute care, and paints a picture of a high degree of variability in the quality of this across Victorian hospitals. A number of recommendations are made on the areas where improvement can be made, especially with regard to the development of risk-management systems, the managing and reporting of incidents and the training of staff.

In the report, the involvement of patients in clinical risk-management programs is seen as an important step towards improving patient safety. The report acknowledges that currently, while progress is being made in involving patients, some health services need to be more active in this respect.

A copy of the report can be viewed at www.audit.vic.gov.au/reports_par/agp102cv.html.

Chartbook Available

The Council's *Charting the Safety and Quality of Health Care in Australia* (Chartbook) is now available in both hard copy format and interactive CD ROM.

The Chartbook provides a comprehensive overview of the safety and quality of the Australian health care system from published data collected from many sources, and reports in a range of areas, including:

- consistently providing effective care;
- reducing the provision of inappropriate care;
- eliminating avoidable mistakes;
- lowering barriers to accessing service;
- improving responsiveness to patients; and
- reducing racial, ethnic, gender, socioeconomic, and other disparities and inequalities in access and treatment.

The interactive CD ROM version of the Chartbook allows users to access information in an easy to navigate presentation style. It allows individual sections to be opened and printed, and is suitable for both MAC and PC formats.

An electronic copy of the Chartbook is available in the Publications section of the Council website at www.safetyandquality.org.

If you would like a hard copy or interactive CD ROM version please contact:

The Office of the Safety and Quality Council
MDP 46

GPO Box 9848, Canberra ACT 2601
Phone 02 6289 4244 Fax 02 6289 8470
Email: safetyandquality@health.gov.au



3rd Australasian Conference on Safety and Quality in Health Care

The 3rd Australasian Conference on Safety and Quality in Health Care, to be held in Adelaide from 11 to 13 July 2005, will incorporate 3 major themes in the

exploration of the 'Evolution or Revolution' conference theme.

1. Leadership and Governance – will it take a revolution to make healthcare safe?
2. Quality – are we on the right track?
3. Reducing patient harm – have we been revolutionary enough?

Consumer issues are included throughout the conference program. However, the second theme, 'Quality – are we on the right track?' will have a strong consumer focus and target a range of specific interest areas, including:

- Indigenous health care;
- Aged care;
- Partnerships – acute, primary and "self-care";
- Mental Health;
- Empowering Consumers; and
- Personal and organisational experience and response when medical error occurs: including open disclosure, effective communication and support.

Further information regarding the conference can be found at the conference website <http://www.sapmea.asn.au/conventions/aaqhc2005/index.html>.

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Consumer scholarships to attend 3rd Australasian Conference on Safety and Quality in Health Care

Application forms and Information regarding the consumer scholarships for the 3rd Australasian Conference on Safety and Quality in Health Care is now available on the Council website at <http://www.safetyandquality.org/index.cfm?page=Events>

The scholarships are aimed at providing consumers who would otherwise not be able to attend the opportunity to take part

in this world class conference on safety and quality in health care.

The selection principles are:

Essential Criteria

1. Demonstrated interest in improving the safety and quality of health care.
2. Willingness and opportunities to share things learned from the conference with health consumer groups or networks and health services.
3. Capacity and opportunity to apply the things learned to health projects and programs at a local or national level.

Desirable Criteria

4. Commitment and/or linkages to health consumer and carers groups or networks in Australia.
5. Understanding and experience in safety and quality issues in health care.

See the end of this newsletter for information about the scholarships and how to receive an application form.

Applications close on 20 April 2005.

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Consumer to lead debate at safety and quality conference

A consumer from the USA is to be a keynote speaker at the 3rd Australasian Conference on Safety and Quality to be held in Adelaide in July this year.

Susan Sheridan is co-founder of Consumers Advancing Patient Safety (CAPS), a consumer organisation whose mission is to

- be a champion for patient safety in a new health care culture;
- be a voice for individuals, families and healers who wish to prevent harm in healthcare encounters through partnership and collaboration; and
- teach the healthcare community what consumers and providers need to

know whenever they interact within healthcare system.

Susan Sheridan's introduction to safety issues – and her motivation to make a difference – came through two grave medical errors experienced in her immediate family, which led to her son's permanent disability from untreated newborn jaundice, known as kernicterus (in 1995) and her husband's death in 2002 from a failure to communicate a diagnosis of cancer.

Susan is also co-founder of Parents of Infants and Children with Kernicterus (PICK), a non-profit organisation established in 2002 to prevent kernicterus and assist those people who have it to reach their full potential as human beings. In 2003 she co-founded Consumers Advancing Patient Safety.

In November last year Susan accepted an invitation to lead the consumer action area of the World Alliance for Patient Safety (see article on page 4 of this newsletter).

Council has also invited two other international experts in safety and quality to present at the conference.

Martin Fletcher works with the WHO World Alliance for Patient Safety. In this role, Martin is working on a number of global initiatives to promote action on patient safety throughout the world and greater international collaboration. For more information on this initiative, see previous article in this newsletter on Patients for Patient Safety.

Prior to commencing work with WHO, Martin worked for two years with the National Patient Safety Agency in England. In this role he helped establish a national patient safety reporting and learning system and led the work of the NPSA in the north of England.

Martin has a background in health care management and policy and from 2000 - 2002, Martin was the Director of the Office

of the Australian Council for Safety and Quality in Health Care within the Australian Department of Health and Ageing.

Ms Hilary Coates is a Programme Director at the Royal College of Surgeons in Ireland where she directs the Diploma in Quality in Healthcare programme and Leadership and Management, Patient Safety and Clinical Audit programmes.

She is a founding member and the immediate past President of the Irish Society for Quality and Safety in Healthcare (ISQSH) and the current Chair of the ISQSH Research Group, member of the World Health Organisation Patient Safety Alliance Research Group, and Vice - Chair of Leadership, Education and Learning committee of the International Society for Quality in Healthcare. She has worked on a number of national quality projects in Ireland including the National Patient Perception of the Quality of Healthcare Survey and the development of national guidelines for the Measurement of Patient Satisfaction.

We look forward to some exciting international perspectives on safety and quality at the conference this year.

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Report from the 2005 February and March Council and Executive Meetings

- Betty Johnson and Jane Phelan

Most of the items in this Newsletter have been discussed at meetings of the Council and the Executive on February 28/March 1 and March 9. Some other matters of interest include:

The Review of Future National Governance Arrangements for Safety and Quality in Health Care has been discussed widely and a submission on accreditation was made to the Review Committee in January 2005.

The Clinical Leadership Program: Formal agreement to run this program has been signed and a steering group has been established.

Other items that have been discussed are

- National Falls Guidelines;
- National Patient Education Framework;
- Health Care Associated Infections; and
- The Complaints Management Handbook (produced to complement the Best Practice Guidelines on

Complaint Management for Health Care Services).

Progress on these items will be reported in the next Newsletter.

Betty Johnson and Jane Phelan.

Consumer scholarships to attend the 3rd Australasian Conference on Safety and Quality in Health Care

The Australian Council for Safety and Quality in Health Care invites consumers to participate in the 3rd Australasian Conference on Safety and Quality in Health Care in Adelaide from 11-13 July 2005. The Council is offering a limited number of consumer scholarships to cover the costs of travel, registration and accommodation.

Consumers who have an interest in issues related to the safety and quality of health care and who are prepared to take the knowledge gained from the conference back to their local communities and health services are invited to apply for these scholarships.

Information about the scholarships and application forms can be found in the Events section of the Council's website:

<http://www.safetyandquality.org/index.cfm?page=Events#scholar>

by phoning

(02) 6289 4244

or from

The Office of the Safety and Quality Council
MDP 46
GPO Box 9848
Canberra ACT 2601.

Applications for the scholarships close on Wednesday 20 April 2005.

Details of the conference can be seen at the Conference website:
<http://www.sapmea.asn.au/conventions/aaqhc2005/index.html>

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