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

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SAFETY THROUGH ACTION
Improving Patient Safety in Australia

Third Report to the
Australian Health Ministers’ Conference

19 July 2002
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3 National Guidelines for Credentials and Clinical Privileges
Statement from the Chair

Complex, adaptive systems such as health care are not amenable to simple fixes. This is the context in which our efforts to improve the safety of patient care resides.

Safety is the dimension of quality most valued by patients and their families. Patients want to feel secure and confident with trust in those caring for them. They want to be well informed about their illness and their care. They want to know that staff are not overworked or tired and are taking due care. They want qualified personnel and continuity of staff during treatment and they want their health systems to be funded to deliver best available care. There is no doubt that all involved in setting and delivering the national safety improvement agenda must strive to meet these requirements.

Health care providers have told us of their perceived barriers to improvement which include time, lack of feedback, little support for team building, few incentives and lack of recognition, a culture of blame, poor equipment and environment design and variable management support.

We know that unsafe care is causing harm to patients and is costly. We know that adverse events occur because of the complexities of the system resulting from error prone situations than error prone people. A fundamental change is needed to achieve a just culture where individuals feel more secure and are encouraged to seek, identify and report errors and system failures and opportunities for system improvement are acted upon. Safe patient care is a result of safe systems of care, not just the responsibility of individuals within the system.

The Safety and Quality Council has listened to these important messages and is taking forward a body of work to build a ‘safety net’ for health care.

The work of the Council is primarily designed to make patient care safer with a strong focus on improved risk management. Safer systems of care require improved data collection as well as better analysis and feedback and a commitment to systems re-design where problems are identified. Standards are needed to make the system as safe as possible in areas such as credentialling. Continuing professional development and performance review are an important part of this work. Key problems such as medication safety and health care associated infection are being targeted. The open disclosure initiative to be completed by the end of this year will help to increase trust as well as improve safety.

The national agenda for change to improve patient safety has been set and is well accepted. As I have travelled across the country to talk to health professionals, managers and consumers, I have listened to many stories about active practical changes being made. Health professionals are prepared to change and consumers are positive about this agenda, albeit not without some concerns. We need to be able to demonstrate that the work of the Council leads to better systems of care and measurable improvements in patient safety. Ministers have already shown leadership in their support for the agenda. Continued commitment is critical.

Together we can make a difference.

Bruce Barraclough
Chair
Australian Council for Safety and Quality in Health Care
Executive Summary and Recommendations

The Council

The Australian Council for Safety and Quality in Health Care was set up in January 2000 with the support of all Health Ministers. The Council’s mandate is to lead national efforts to promote the safety and quality of health care, in particular to improve patient safety.

Safety Through Action: Improving Patient Safety in Australia is the Council’s third report to Health Ministers. It summarises the Council’s work over the past 12 months and outlines future directions.

The Past 12 Months

The Council is leading a multi-faceted program of work. The following table highlights some significant achievements over the past 12 months within each of the Council’s priority areas.

<table>
<thead>
<tr>
<th>Supporting those who work in the health system to deliver safer patient care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Produced a summary analysis of the key findings of the King Edward Memorial Hospital Inquiry to better understand and widely disseminate lessons arising from the Inquiry</td>
</tr>
<tr>
<td>• Developed and nationally consulted on guidelines for credentials and clinical privileges and commissioned work on a national standard</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improving data and information for safer health care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Commissioned work to improve the use and value of coronial information for safety improvement</td>
</tr>
<tr>
<td>• Conducted a national workshop to identify national priorities for reducing health care associated infection</td>
</tr>
<tr>
<td>• Commenced work on a national medical device tracking system</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Involving consumers in improving health care safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Commissioned a national standard and guidelines to support open disclosure of adverse events</td>
</tr>
<tr>
<td>• Redeveloped the Council website as an accessible gateway for patient safety information</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Redesigning systems of health care to facilitate a culture of safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Initiated an exciting program recognising and supporting practical safety improvements in over 60 hospitals throughout Australia</td>
</tr>
<tr>
<td>• Commissioned work on educational strategies for patient safety improvement</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Building awareness and understanding of health care safety</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organised a world class 1st Asia Pacific Forum on Quality Improvement in Health Care</td>
</tr>
<tr>
<td>• Produced the Second National Report on Patient Safety focusing on medication safety</td>
</tr>
<tr>
<td>• Delivered hundreds of patient safety presentations to thousands of people throughout Australia including through a program of visiting speakers</td>
</tr>
</tbody>
</table>

This work is supported and informed by a senior Quality Officials’ Forum from Commonwealth, state and territory health departments. This ensures close links with the work being undertaken through the Quality Improvement and Enhancement Plans under the Australian Health Care Agreements.
Executive summary

The next 12 months

A national agenda for change has been set and is well accepted by consumers, health care professionals, managers and governments. The Council is providing national leadership to achieve improvements in patient safety with a particular focus on:

- reducing patient harm associated with medication use;
- reducing patient harm resulting from health care associated infection;
- coordinating national action to learn from serious adverse events; and
- developing national standards to support more open disclosure to patients and their carers.

The Council believes that real and lasting improvements to the safety of patient care which can be measured is the ultimate test of the effectiveness of its work.

The table below highlights some of the Council’s work program over the coming 12 months.

<table>
<thead>
<tr>
<th>Supporting those who work in the health system to deliver safer patient care</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Producing a national standard for credentialling and organisational support for implementation</td>
</tr>
<tr>
<td>• Developing and implementing national initiatives on safe staffing</td>
</tr>
<tr>
<td>Improving data and information for safer health care</td>
</tr>
<tr>
<td>• Implementation of phase one of an agreed national approach to serious adverse events</td>
</tr>
<tr>
<td>• Continued progress on a national medical device tracking scheme</td>
</tr>
<tr>
<td>• Finalisation and wide dissemination of national specifications for incident reporting and management systems</td>
</tr>
<tr>
<td>• Taking forward agreed national actions on health care associated infection</td>
</tr>
<tr>
<td>Involving consumers in improving health care safety</td>
</tr>
<tr>
<td>• Supporting widespread uptake of open disclosure standard</td>
</tr>
<tr>
<td>• Dissemination of patient safety information pamphlet for consumers</td>
</tr>
<tr>
<td>Redesigning systems of health care to facilitate a culture of safety</td>
</tr>
<tr>
<td>• Undertaking national collaborative change initiatives on medication safety</td>
</tr>
<tr>
<td>• Continuing to support local level innovations in patient safety</td>
</tr>
<tr>
<td>• Implementation of agreed national action on education for patient safety improvement</td>
</tr>
<tr>
<td>Building awareness and understanding of health care safety</td>
</tr>
<tr>
<td>• Continued development of the Council website and communications</td>
</tr>
<tr>
<td>• Active program of international and Australian speakers, conferences and workshops</td>
</tr>
</tbody>
</table>
Recommendations to Health Ministers

That Health Ministers:

1. Reaffirm their strong commitment to improving the safety and quality of health care;
2. Note the progress of Council’s work and play a leading role in implementing agreed national actions;
3. Commit further funds of $15 million for the Council’s third year program of work, and;
4. Agree to make the full Council Report publicly available.
Introduction

Purpose
In January 2000, Australian Health Ministers set up the Australian Council for Safety and Quality in Health Care to lead national efforts to improve the safety and quality of health care. The Council has placed particular emphasis on improving patient safety. An overview of the Council, including its Executive, State Quality Officials’ Forum and Working Groups, can be found at Appendix 1 and the formal Terms of Reference for the Council at Appendix 2. The Council reports annually to all Health Ministers. This third report of Council to Health Ministers Safety Through Action: Improving Patient Safety in Australia, summarises the Council’s work over the past 12 months, highlighting significant achievements and future directions.

The role of the Australian Council for Safety and Quality in Health Care is to lead national efforts to promote systemic improvements in the safety and quality of health care in Australia with a particular focus on minimising the likelihood and effects of error.

National Action Plan

Links with states and territories
The Council has active involvement and support from all jurisdictions and all Health Ministers with in-principle financial support of $55 million over five years to progress its program of work. The Council has set up a senior Quality Officials’ Forum from Commonwealth, state and territory health departments to support and inform the work of the Council. This ensures close links with the work being undertaken by states and territories through their Quality Improvement and Enhancement Plans under the Australian Health Care Agreements.

Mid-term review of quality improvement plans
The Council participated with all jurisdictions in the mid term review workshop for the Quality Improvement and Enhancement Plans (within the Australian Health Care Agreements) held in February 2002 in Hobart. The workshop highlighted the range and volume of activity being undertaken across jurisdictions (particularly at a local level) to improve the quality and safety of patient care. This has created a solid foundation on which to build into the future.

Key challenges for the future include:
- better ways of measuring how outcomes for patients are being improved as a result of the activities being undertaken and greater accountability for demonstrating this; and
- the need to build on the cooperative relationship between the Council and states and territories to get even better collaboration and sharing of proven approaches to avoid fragmentation and duplication of effort.

Linkages
The Council has established Working Groups in priority areas with wide involvement of experts from across the health care spectrum. Appendix 3 outlines these groups.
The Council has also developed partnerships with other national agencies and bodies to take forward priority work including the National Institute for Clinical Studies, Therapeutic Goods Administration, Private Health Industry Quality and Safety Committee, National Health Information Management Advisory Council and the National Health and Medical Research Council.

This year the Council is planning to formalise links with New Zealand to ensure greater sharing of information and ideas across the region.
1 Improving patient care

Health care will always carry a degree of risk. Some adverse events will occur even when health care is being provided by the best people in the best facilities. However, we know there are a significant number of adverse events which can be prevented or managed better when they do occur.

1.1 Greater openness when things go wrong

Effective and compassionate communication by health care providers to patients and their carers is essential for the provision of safe health care. Extensive consultation is being undertaken across Australia to develop national standards and guidelines to support open disclosure by health care providers to patients and their carers when things go wrong. Education and organisational support packages are also being developed which will assist in the implementation of the standards. Further information is at page 21.

1.2 Reducing preventable adverse events

The Council is committed to achieving a measurable reduction in preventable adverse events. A major focus for the coming year is on four key areas for patient safety improvement encompassing:

- reducing preventable patient harm associated with medication use;
- reducing patient harm as a result of health care associated infection; and
- coordinating national action to learn from serious adverse events.

Medication safety

The Council is leading national efforts to measurably reduce patient harm from medication use in Australia. The Council’s Medication Safety Taskforce, supported by key national stakeholders and organisations, is developing a national framework for improving medication safety in Australia by taking action at national, state and local levels. A key strategy to build capacity for change at a local level is the use of the Institute for Health Improvement (USA) Breakthrough Collaborative Methodology to improve medication safety. This methodology achieves demonstrable improvement in a short period by using existing knowledge about the nature and causes of adverse drug events and the mechanisms for addressing them. Further information is at page 24.

Reducing health care associated infections

The Council has identified reducing health care associated infections as a high priority, recognising the serious patient harm and the burden on the health care system that can result. Many health care associated infections are preventable and there are already many initiatives underway to reduce health care associated infections. However, there is scope for better coordinated national effort to improve patient safety.

As a first step, the Council convened a national workshop in April 2002 to identify national priorities and strategies. These included focusing on high impact targets (ie reducing the incidence of surgical site and bloodstream infections); improving clinical practice (ie appropriate education, training and change management strategies); raising awareness of the need to act; conducting surveillance to improve patient safety; and providing national leadership. Further information is at page 17.
National action on serious adverse events

The Council consulted with the states and territories about developing a more nationally consistent approach to sentinel adverse events. Such an approach would improve the safety of patient care through better reporting and analysis of serious adverse events (sentinel events) to understand their underlying causes. The intention is to focus on improvement that is based on a systemic understanding of the adverse event, not on punishment of the parties involved, and the implementation of effective change in response to any preventable system failures identified. Further information is at page 15.
2 Action areas — achievements, work in progress and future directions

The following section outlines achievements, work in progress and future directions in the priority areas:

- supporting those who work in the health system to deliver safer patient care;
- improving data and information for safer health care;
- involving consumers in improving health care safety;
- redesigning systems of health care to facilitate a culture of safety; and
- building awareness and understanding of health care safety.
2.1 Supporting those who work in the health system to deliver safer patient care

Table 1  Summary of action in the priority area supporting those who work in the health system to deliver safer patient care

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Future directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Produced a summary analysis of the key findings of the King Edward Memorial Hospital Inquiry to identify lessons arising</td>
<td>• Wide dissemination of summary report and consideration of findings for national efforts</td>
</tr>
<tr>
<td>• Developed and nationally consulted on guidelines for credentials and clinical privileges</td>
<td>• Commissioning work on development of a national standard for credentialling and organisational support for implementation (for completion by July 2003)</td>
</tr>
<tr>
<td>• National workshop in July 2002 to consider actions required to improve standard setting and external review processes for health care services</td>
<td>• Leading agreed national actions to improve standard setting and external review processes (update in 2003 report to Health Ministers)</td>
</tr>
<tr>
<td>• Commenced work on a national report and reporting template on qualified privilege</td>
<td>• Recommendations to achieve greater national consistency for qualified privilege (for completion by October 2002)</td>
</tr>
<tr>
<td>• Formed specific Taskforce to consider options to support improvements in safe staffing</td>
<td>• Develop and implement national initiatives on safe staffing (update in 2003 report to Health Ministers)</td>
</tr>
</tbody>
</table>
Achievements, work in progress and future directions

It is essential that health care professionals are appropriately supported to deliver the safest possible patient care. The Council is working towards promoting a safe environment of care in areas such as standards development and review and developing practical tools to support the safe management of health care services.

Lessons from the Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital 1990–2000

The Council summarised the key findings and lessons arising from the Inquiry into the King Edward Memorial Hospital Obstetric and Gynaecological services (Attachment 2). The Council produced the report to support health care leaders, managers and staff in their efforts to improve the safety and quality of Australian health care.

Key findings of the Inquiry point to a lack of safety and quality systems at state, board and hospital level evidenced by ineffective accreditation and credentialling systems, inadequate incident reporting systems, poorly performing statutory mortality reporting and investigation systems and non-existent inter-hospital comparative data analysis. At hospital level, the Inquiry found many examples of exemplary care and significant effort on the part of individuals to overcome long-standing clinical and management problems. However, the Inquiry also found significant leadership, management and clinical performance problems.

Health care leaders, managers and staff have the opportunity to consider the Inquiry’s findings and the lessons arising, as the basis for identifying and responding to improvement opportunities in their own workplaces.

Credentials and clinical privileges project

Over the past year the Council has consulted nationally on the working draft paper entitled Credentials and Clinical Privileges Guidelines. This was included in Council’s report to Health Ministers’ in August 2001. There has been widespread support for a national set of guidelines for credentialling that incorporate procedures for ongoing performance assessment. In light of feedback received in the consultation, the Council has finalised the National Guidelines for Credentials and Clinical Privileges (Attachment 3).

To support implementation and uptake of these guidelines the Council has commissioned work to develop a national standard based on the guidelines, an organisational support package to accompany the standard and a communications plan to promote national uptake of these products.

The Council is initially focusing on the medical profession with a view to considering how the standard and support package can be adapted in the future to include all health care professional groups that exercise independent clinical decision-making.

National approach to medical registration

The Council is continuing to support work on the development of a more nationally consistent approach to medical registration. The Council is actively involved in the Working Party established by the Australian Health Ministers’ Advisory Council to further consider, refine and consult on the Draft Model for Medical Registration which was provided to Health Ministers in the Safety and Quality Council report in August 2001. The Working Party recently released a Discussion Paper to consult key stakeholders and the broader community on the proposed national approach to medical registration.
**Core safety standards**

The Council’s report to Health Minister’s in August 2001 noted the rationale and need for the development of core safety standards for use in the external assessment of health care provider organisations.

Over the past year the Council has focussed work on developing health care safety standards in areas of recognised need where these do not already exist. For example, the development of national standards to support open disclosure following adverse events (see page 21) and processes for credentialling and clinical privileging of health care professionals (see page11). This work includes investment in tools to support uptake at a local level such as educational programs.

The Council, in conjunction with key stakeholders, will continue to explore and identify gaps for development of core safety standards and compliance mechanisms, including possible mandatory requirements.

**Accreditation and external review**

Accreditation of health care facilities has contributed a great deal to quality practices and system-wide awareness of quality issues in health care. However, the Council is aware of a range of issues challenging accreditation and standards setting in the future including:

- lack of integration between systems;
- industry participation is often on a voluntary basis;
- lack of sanctions;
- the continuing acceptability of accreditation;
- innovative approaches taken in some sectors; and
- the high level of resources invested in this area.

There have been calls for the Council to undertake a range of activities to improve accreditation processes. The Council recognises that any national effort must lead to sustainable and demonstrable improvements in patient safety.

The Council is hosting a consultative workshop in July 2002 to consider current accreditation systems and potential areas for nationally led improvement. The workshop will bring together key stakeholders in the industry which will include senior managers, Boards, clinicians, consumers and standards setting and accrediting bodies. The workshop will consider priority actions required to ensure that standard setting and external review processes efficiently assist health services so that they can be assured they are delivering safe patient services.

**Qualified privilege**

The Council is working closely with all jurisdictions to strengthen the integrity of the existing qualified privilege schemes. The Council has recently commissioned work to:

- *produce a national report on qualified privilege* — qualified privilege schemes and the role they can play in improving the safety of health care are not well understood. The report is designed to de-mystify qualified privilege and describe some quality improvement activities that have benefited from the privilege. It will also provide a template for future reporting of privileged committees and activities at all levels of the health care system and help to spread the lessons that have been learned from the conduct of these committees and activities. The report will be completed in mid 2002; and
• **investigate, and where feasible, develop consistent approaches to assessing applications for qualified privilege under the different schemes** — promoting greater national consistency in approaches to qualified privilege is another important part of supporting the integrity and understanding of the protection afforded and the resulting obligations. This project will look at opportunities to support more consistent approaches to assessment of applications and also to administration of the schemes across Australia. Consultation with state and territory health departments is occurring and it is expected that draft guidelines will be ready by October 2002.

**Safe staffing**

The Council is interested in how staffing variables (eg fatigue, skill mix, supervision, staffing numbers and team functioning) affect patient safety and how improvements in or modifications to these variables will have direct positive effects on patient outcomes. The Council is reviewing strategies from other industries, including the airline industry, and the international literature in considering an integrated risk management approach to safe staffing. To assist in this work, the Council has recently formed a Taskforce to look at an approach to safe staffing and consider options for adding value at a national level.

The Council will consult widely, particularly with those directly affected, in developing tools to support management and implementation at a local level. Any strategies developed will aim to integrate the practicalities of day-to-day clinical life and minimise unintended consequences.

Council initiatives to support improvement in safe staffing might include:

- developing an indicator matrix to detect what effect (if any) staffing variables have on patient outcomes;
- promoting the use of local process improvement methodologies to address problem areas;
- providing training material on human factors in performance to encourage the recognition and risk management of performance issues such as fatigue; and
- developing and promoting best-practice guidelines and educational support material to support safe staffing (for example, rostering practices and handover communications).

The Australian Medical Association has already done significant work regarding hours of work by junior doctors. The Council's work on safe staffing will focus on all health care professions and will involve working with key stakeholders to explore collaborative and cooperative efforts to address this nationally significant issue in a risk management framework.
### 2.2 Improving data and information for safer health care

**Table 2** Summary of action in the priority area improving data and information for safer health care

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Future directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Consulted with states and territories on a national core set of sentinel adverse events</td>
<td>• Developing mechanisms to support implementation of agreed national system</td>
</tr>
<tr>
<td>• Developed a draft national specification for local incident reporting and management systems</td>
<td>• Finalising specification (by August 2002) and promoting widespread uptake of the specification</td>
</tr>
<tr>
<td>• Commissioned work to improve the value and use of coronial information for safety improvement</td>
<td>• Making recommendations to improve the use of coronial information and commencing improvement strategies (by December 2002)</td>
</tr>
<tr>
<td>• Conducted a national workshop to identify priorities for reducing health care associated infection</td>
<td>• Taking forward a national framework for implementing priorities and strategies (by mid-2003)</td>
</tr>
<tr>
<td>• Commenced work on a National Medical Device Tracking System</td>
<td>• Developing options for the key elements of the National Medical Device Tracking System (by September 2002) followed by consultation and development of the System</td>
</tr>
<tr>
<td>• Funded the first phase of a National Cardiac Procedures Register</td>
<td>• Continuing to support the development of the Register and its implementation in 2003</td>
</tr>
<tr>
<td>• Consulted on draft definitions for key safety and quality terms</td>
<td>• Undertaking final review of key safety and quality terms and definitions (by October 2002) and widely disseminating the final product</td>
</tr>
<tr>
<td>• Commenced work on a methodology to measure the nature and frequency of adverse events</td>
<td>• Commissioning work to develop a snapshot methodology (with work to commence in early 2003)</td>
</tr>
<tr>
<td></td>
<td>• Commissioning work to improve the use of morbidity and mortality data (work to commence by August 2002)</td>
</tr>
</tbody>
</table>
Achievements, work in progress and future directions

The Council is taking forward national work on making better use of data and information to support safer care. This will help health care professionals improve systems at a clinical level, so that when adverse events and ‘close calls’ do occur the information can be reported, analysed and learned from to address the problems.

Over the past year the Council has consulted widely on a paper entitled Safety in Numbers — A Technical Options Paper for a National Approach to the Use of Data for Safer Health Care which was included in the Council’s report to Health Ministers in August 2001. The purpose of this paper was to summarise existing national sources of data and to consider the gaps and limitations of those data.

Responses were overwhelmingly positive for the directions and targets outlined. Comments emphasised the complexities involved in better using data while providing some useful tips on how to do this to improve safety, as well as on other possible data sources.

The following diagram explains the relationship between incidents, adverse events and sentinel events — all of which are addressed by the Council’s work.

**Figure 1  Relationship between incidents, adverse events and sentinel events**

**National approach to sentinel adverse events**

Sentinel events are defined as those adverse events that cause serious harm to patients and that have the potential to seriously undermine public confidence in the health care system. The Council is working closely with all jurisdictions to develop and agree on a national core set of sentinel events in order to:

- encourage greater consistency in methodologies used to investigate and analyse sentinel events;
facilitate learning across Australia and disseminate successful preventive actions;

- analyse patterns and trends at a national level to identify further opportunities for improving patient safety;

- learn and disseminate lessons from analysis as well as from research, international collaboration and other sources of information; and

- facilitate effective change to prevent recurrence where possible and reduce risks to patients in the future.

A national approach to sentinel events is not intended to capture all events that would be useful to report but rather establish a manageable list of events that are of concern to consumers and providers, clearly identifiable, likely to indicate system breakdowns and which all states and territories agree warrant robust investigation and analysis.

The second phase of this work will include consideration of a model for implementation, appropriate governance arrangements, reporting lines, public reporting for accountability, medicolegal issues, indemnity for reporters and tools to support investigation. Work on the second phase will commence shortly.

The table below outlines a proposed national core set of sentinel events which have been broadly agreed by jurisdictions as potentially suitable for national aggregation and action.

### Table 3 Proposed national core set of sentinel events

<table>
<thead>
<tr>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Procedures involving the wrong patient or body part</td>
</tr>
<tr>
<td>2. Suicide of a patient in an acute inpatient unit</td>
</tr>
<tr>
<td>3. Retained instruments or other material after surgery requiring re-operation or further surgical procedure</td>
</tr>
<tr>
<td>4. Intravascular gas embolism resulting in death or neurological damage</td>
</tr>
<tr>
<td>5. Haemolytic blood transfusion reaction resulting from ABO incompatibility</td>
</tr>
<tr>
<td>6. Medication error leading to the death of patient reasonably believed to be due to incorrect administration of drugs</td>
</tr>
<tr>
<td>7. Maternal death or serious disability associated with labour or delivery</td>
</tr>
<tr>
<td>8. Infant discharged to wrong family</td>
</tr>
</tbody>
</table>

### National specification for incident reporting and management systems

The Council is developing an Incident Reporting and Management Specification to support the identification and reporting, analysis and dissemination of information about factors contributing to incidents at a local level and to identify better ways to manage hazards and risks and improve systems of care.

The specification, which is being developed in conjunction with the State Quality Officials Forum, will include the attributes of a successful incident reporting and management model for health care and the process necessary at an organisational level to support the implementation and evaluation of the system.

The Council will continue to work with the State Quality Officials Forum and other key stakeholders to finalise the specification in August 2002 and promote uptake.
**Improved use of coronial data**

Coroners have a legal responsibility to investigate certain deaths to find out what happened and why. Currently coronial findings and recommendations are not routinely used to inform system improvement.

Ensuring that all deaths from adverse events are referred to the Coroner and that coronial findings are acted upon has potential to improve the safety of health care. It may also help to allay consumer concerns about whether ‘lessons’ are being learned from patient deaths that were potentially preventable.

The Council has engaged the Victorian Institute of Forensic Medicine to undertake a project *Coronial Death Investigation process in Australia: its role in reviewing the safety and quality of health care provision*. The project will make recommendations to the Council regarding:

- options for future directions regarding the use of coronial data (e.g., National Coroners Information System adverse events module, legislative and administrative system redesign, standards for investigative processes, short-term and long-term investment);
- improvements in administrative and legislative systems for ensuring that the coronial findings and recommendations can be effectively used for system improvement including feedback systems between coroners and health care service providers and processes for implementing change; and
- future directions for the development of standards and support tools for coronial processes.

**Reducing health care associated infections**

The Council identified reducing health care associated infections as a high priority area, recognising that infections can result in serious consequences for individual patients and place a significant burden on the health system.

While there are a number of initiatives underway to reduce health care associated infections there is significant scope for better stakeholder collaboration and national effort to improve patient safety in this area. As a first step the Council convened a National Workshop in April 2002 to consult key stakeholders on how a national response to reducing health care associated infections could build on current initiatives and accelerate improvements in patient safety.

The Workshop was successful in identifying national strategies to reduce health care associated infections and determining the key elements of a national approach for the Council to take forward. Specifically the Workshop agreed that the Council could coordinate national efforts in this area by:

- focussing on high impact targets;
- improving clinical practice;
- raising awareness of the need to act;
- conducting surveillance to improve patient safety; and
- providing national leadership.

In light of the Workshop and in consultation with key stakeholders, the Council is developing a national program of work to establish an appropriate national governance and leadership framework for implementing the priorities and strategies agreed at the Workshop.
**Medical device tracking system**

In the event of the risk of a device failure or problem, contacting patients with medical devices is sometimes difficult. This may mean delays in being able to provide appropriate advice or action to resolve the device problem and increased risk to patients.

The Council, in conjunction with the Therapeutic Goods Administration has engaged the Health Insurance Commission to develop a national system to enable patients with agreed priority implanted medical devices to be quickly and efficiently contacted when a recall or review notification is advised.

As a first step, work is being progressed to develop the conceptual elements of a national device tracking system. The Council will engage a range of expertise in the public and private sectors and work closely with consumers, professionals, governments and industry.

**National cardiac procedures register**

The Council is providing seed funding towards a National Cardiac Procedures Register. The aim of the Register is to continuously improve the safety and quality of care for patients undergoing cardiac procedures performed by cardiac surgeons and interventionist cardiologists, by providing a tool for measuring outcomes. A secondary aim will be to monitor trends in cardiac procedures, to inform strategic policy-making.

This project is important because coronary heart disease is first on the list of causes of death in Australia. Procedures aimed at restoring coronary blood flow to avoid these deaths are a high cost, high volume and relatively high-risk component of Australia's response.

A working group representing the National Heart Foundation, the Cardiac Society of Australia and New Zealand, the Australasian Society of Cardiac and Thoracic Surgeons, and the Australian Institute of Health and Welfare developed the proposal for the National Cardiac Procedures Register. Heart Support Australia and other consumer advocates also have an important role to ensure that consumers' interests remain at the forefront of the initiative. These groups will all have an ongoing role in the implementation of the Register.

**Vocabulary of key safety and quality terms**

The Council’s Shared Meanings project involves the development of agreed definitions for the terms used to describe safety and quality issues in the health care system to achieve a degree of consistency in how the terms are used.

The Council has obtained advice from various Australian and international safety and quality experts in the development of these terms and definitions and has consulted widely on a draft set of terms. In particular, the Council has sought feedback from a broad range of stakeholders through the Council website which includes draft definitions for key safety and quality terms, supporting material and opportunity to comment.

Review of the terms and definitions is currently underway. Once finalised they will be disseminated nationally and internationally. They will be made available on the Council website to encourage broad adoption of the terms across the health care system.

**Snapshot methodology**

There is no single source of statistics that provides a measure of the frequency or nature of adverse events in Australian health care. A major difficulty is that it is not always clear whether an adverse event resulted from the care provided or was part of the natural history of the patients’ pre-existing or current conditions.
The Quality in Australian Health Care Study is the most comprehensive study of adverse event rates undertaken in Australia. The Study looked at over 14,000 medical records across 28 public and private hospitals to determine rates of adverse events associated with patient injury and death and whether these events were potentially preventable. The findings were extrapolated across Australia, providing a 'snapshot' estimate of the rates of adverse events in public and private hospitals in 1992.

While there is a clear need to be able to measure the rates of adverse events over time at the national level, jurisdictional level and also within health care facilities, extensive retrospective reviews of medical records are expensive and labour intensive. The methodology is often not suitable for local application.

The Council intends to develop specifications for a methodology that will:

- provide information on the prevalence of adverse events in health care facilities;
- provide a benchmark against which performance can be measured over time; and
- may be applied at the national level or for individual facilities to measure performance.

It may be impossible to accurately measure the exact rates of all adverse events but it is likely that a system can be developed to estimate the prevalence of a defined set of adverse events and contributing factors using existing data sources supplemented by limited medical record review.

**Improving the use of morbidity and mortality data for safety improvement**

In Australia there are a number of sources of data on morbidity and mortality. These data sources all have significant limitations in design or extent of collection and do not provide a consistent or comprehensive national overview of the frequency and reasons for patient deaths associated with adverse events.

The Council will commission work on enhancing the quality and accessibility of existing national morbidity and mortality databases to improve the reliability, timeliness and predicability of these data sources. Work will involve liaison with the Australian Institute of Health and Welfare and the Clinical Casemix Committee Australia.
### 2.3 Involving consumers in improving health care safety

#### Table 4 Summary of action in the priority area involving consumers in improving health care safety

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Future directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Worked with consumers in all of the Council’s initiatives to improve health care safety</td>
<td>• Continuing to work with consumers and reviewing how to strengthen communication channels</td>
</tr>
<tr>
<td>• Commenced work to develop a national standard and guidelines to support open disclosure of adverse events, including education and organisational support packages to assist implementation</td>
<td>• Field testing of the draft standard and support packages and finalising standard in late 2002 with trial implementation throughout 2003</td>
</tr>
<tr>
<td>• Undertook market research on the <em>First National Report on Patient Safety</em> and identified the value of developing consumer resources based on the themes of the Report</td>
<td>• Developing a summary booklet for consumers based on the key messages of the report (late 2002)</td>
</tr>
<tr>
<td>• Commenced work to develop options for a national system for consumer reporting of adverse events</td>
<td>• Trialing a system for consumer reporting of adverse events throughout 2003</td>
</tr>
<tr>
<td></td>
<td>• Developing strategies for improved use of health care complaints for health care safety and considering options to promote uptake (by 2003)</td>
</tr>
</tbody>
</table>
Achievements, work in progress and future directions

The Council is striving to ensure that the experience of patients and their carers is effectively harnessed to drive improvements in the safety and quality of health care. Towards this end, the Council is continuing to promote a greater understanding of the challenges of health care safety, encourage greater openness so that we can all learn from mishaps and system failures, and facilitate consumer participation in system improvement processes.

Strengthening consumer involvement in improving health care safety

Strong consumer participation is vital to ensure that safety and quality improvements are practical and will make a real difference. The Council has shown strong commitment to working together with consumers and the community in its initiatives through:

- including consumers in the membership of the Council and all Working Groups;
- successful collaborations include consumer organisations as partners when tendering for elements of the Councils work;
- meaningful consumer consultation is undertaken and appropriately resourced;
- the Consumer Reference Network, which includes representation from a broad range of organisations with an strong interest in health care safety, provides advice to Council on its work and on dissemination of key safety messages to the broader consumer community; and
- feedback from consumers is used to improve the Council’s understanding of consumer needs.

While efforts in this area have been considerable, the Council will continue to review how it can improve and strengthen communication channels with consumers and the community and involve consumers even more effectively.

Supporting greater openness when things go wrong

Extensive consultation across Australia is underway to develop a national standard and guidelines to support more open disclosure of adverse events. Education and organisational support packages are also being developed to assist in the implementation of the standards. The standard will focus on communication around adverse events.

Support packages will provide practical guidance and tools for health care organisations on implementing the standards. They will give an indication of the resources and training that might be required to support the move towards more open disclosure. The draft standard and support packages will be field-tested in several locations around Australia with the final standard due late 2002.

Consultations to date have involved over 350 key stakeholder organisations and individuals who have identified that, while there are some very complex issues that need to be addressed, greater openness around adverse events is the right thing to do. In addition, a legal review was undertaken which provides an analysis of legislative and common law barriers to open disclosure.

It is expected that a second phase of this initiative will focus on a trial implementation of the standards and support packages in locations around Australia during 2003. The trial will assess their relevance, value and adaptability to the needs of a range of environments and priority populations.
Providing reliable information to consumers about health care safety

The Council is committed to communicating key safety messages to consumers and the community in ways that are useful and relevant, and that will have a positive effect on patient safety. As part of this initiative, focus group testing was undertaken based on the *First National Report on Patient Safety*. The research identified the potential value of a consumer resource communicating major themes from the Report. A summary booklet for consumers is being developed, which will include ‘10 tips’ to assist consumers to be more actively involved in their health care.

National approach to consumer reporting of adverse drug events

Consultations with consumers in Australia since the 1980s have consistently revealed that consumers want an adverse drug event reporting system which enables them to directly report their experiences with medicines, with these experiences taken seriously by the health system. The Council has been approached by the Australian Pharmaceutical Advisory Council which is seeking to develop a system for consumer reporting of adverse drug events.

In conjunction with the Australian Pharmaceutical Advisory Council, the Therapeutic Goods Administration and the National Prescribing Service, the Council is developing options for trialing a system for consumer reporting of adverse drug events over 18 months.

Better use of health care complaints information for safety improvement

The Council believes that the experience of consumers is a valuable and under-utilised source of information about the safety of the health care system. The Council has a keen interest in ensuring that consumer complaints are managed well and that they are used to inform system improvements. The Council has met with the Health Care Complaints Commission to discuss how these objectives might be achieved and is awaiting a proposal from them to take this work forward.
### 2.4 Redesigning systems of health care to facilitate a culture of safety

**Table 5** Summary of action in the priority area redesigning systems of health care to facilitate a culture of safety

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Future directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Commenced work to use a Breakthrough Collaborative Methodology to improve medication safety</td>
<td>• Commence collaborative initiative by end 2002 along with medication safety innovations program</td>
</tr>
<tr>
<td>• Initiated the Safety Innovations in Practice Program (SIIP) to recognise and support practical safety improvements at the local level</td>
<td>• Producing a compendium of projects for national dissemination and undertaking a second phase of the SIIP program</td>
</tr>
<tr>
<td>• Commenced work on educational strategies for patient safety improvement at the undergraduate, postgraduate and continuing education levels</td>
<td>• Continuing to develop and promote uptake of educational strategies (update in 2003 report to Health Ministers)</td>
</tr>
<tr>
<td>• Consulted with states and territories to nationally disseminate Queensland Health guidelines for prevention of patient falls</td>
<td>• Considering the value of developing education and support packages to assist in the uptake of the guidelines</td>
</tr>
<tr>
<td>• Provided support for a national trial to evaluate the effectiveness of the Medical Emergency Team system</td>
<td>• Continuing to support the national trial and evaluation of the Medical Emergency Team system</td>
</tr>
<tr>
<td>• Consulted with key stakeholders to improve safety and quality in mental health</td>
<td>• Continuing to ensure inclusion and relevance of mental health issues in Council initiatives</td>
</tr>
</tbody>
</table>
Achievements, work in progress and future directions

The Council recognises that, when it comes to making health care safer, doctors, nurses and other health care professionals are often let down by outmoded and poorly designed health care systems which cannot cope with the complex demands of modern health care. Systems redesign goes hand in hand with cultural change, and in 2002 the Council will continue its support of national work in these areas through projects aimed at improving health systems and processes.

Medication safety initiatives

The Council is leading national work to improve medication safety in Australia. Some specific initiatives being undertaken are:

- **the Medication Safety Breakthrough Initiative** — the Council is planning to use the Breakthrough Collaborative Methodology developed by the Institute of Healthcare Improvement (USA) to reduce patient harm from medication use by 50 per cent within 12 months. The Council will support organisations through education and networking mechanisms throughout the initiative.

- **Medication Safety Innovative Initiatives Program** — A complementary stream of funded activity will be offered to enable health care organisations to implement innovative, evidence-based approaches to reduce patient harm from medication use. This program recognises the diversity of academic thought and clinical approaches to improve medication safety.

Safety Innovations in Practice Program

The Council’s Safety Innovations in Practice Program provided funding to health care providers at a local level to undertake targeted initiatives to improve health care safety. The Council funded over 60 projects nationally within a range of hospitals and health care organisations.

Some of the key theme areas and projects funded in this program included:

- medication safety
  - improving admission-related medication safety;
  - redesigning medication charting; and
  - establishing standards for medication storage.

- improving patient care and safety
  - reducing over-sedation of endoscopy patients;
  - safe manual handling of the large dependent patient; and
  - improving patient care through better use of interpreter services.

- systems redesign
  - evaluating and redesigning nursing assessment and care planning documentation;
  - developing educational and motivational resources for prevention of infection in acute care settings; and
  - developing automated computerised discharge advice sheets for the emergency department.

The results of projects funded under this program are currently being compiled for national dissemination and promotion of practical safety improvements. The Council considers national
dissemination of reports of these projects to be an important opportunity to promote innovative tools and approaches.

Following a review of the Program, the Council intends to develop Safety Innovations in Practice Program Phase 2.

**Educational strategies**

The Council considers education as a key lever for making improvements to patient safety and one of the foundation elements for redesigning systems and facilitating a culture of safety in health care. In particular, the Council recognises the importance and need for health care professionals to learn about risk management, human factors and a systems approach to safety and communication and teamwork within complex systems.

The Council is leading a program of work around education in health care safety at various coordinated levels as follows:

- **undergraduate medical and nursing education** — the Council has commissioned a joint working party of the Australian Council of Deans of Nursing and the Committee of Deans Australian Medical Schools to initiate work on safety and quality education in medical and nursing undergraduate education. This project involves defining the essential knowledge, skills and attitudes regarding safety and quality in health care and assessing the degree to which these may already be covered in current nursing and medical curricula. The outcomes of this project will determine future directions for the Council’s work on undergraduate education.

- **postgraduate education through professional colleges** — the Council is working with the Committee of Presidents of Medical Colleges to scope work on a postgraduate education program focussing on safety and quality. It is anticipated that this exercise will consider the development of a single safety and quality education module to supplement and integrate with the core activities of the Medical Colleges. Initially the module would be developed for the Medical Colleges represented by the Committee of Presidents of Medical Colleges with the intention to adapt the module to include other health care professional groups.

- **continuing education and training** — the Council is progressing work to develop and encourage innovative approaches to continuing education and training, which equip working health care practitioners with relevant knowledge and skills to support safer health care practice. A steering group has been formed to undertake a broad consultation process to obtain advice on current educational activities throughout Australia, in order to identify areas of duplication or areas where there are gaps. The consultation process is designed to inform the Council on where it should focus national effort in this area to provide most value to health care professionals and managers working in health care settings.

**Reducing patient falls**

Prevention of patient falls in health care facilities has been identified by the Council as a key area for action. Queensland Health recently produced *Falls Prevention Best-practice Guidelines for Public Hospitals and State Government Residential Aged Care Facilities*. The Guidelines take a practical approach to falls prevention and are based on best-practice principles.

In keeping with the Council’s undertaking to disseminate valuable work already completed by a state and territory department of health, the Guidelines will be distributed nationally. They will be accompanied by a feedback form to assist with revision, if appropriate, and possible development into national guidelines. In light of feedback received, the Council may consider the value of developing an education and support package to assist in uptake of the guidelines.
**National Trial of Medical Emergency Team Model**

The Council is supporting a national trial to evaluate the effectiveness of the Medical Emergency Team system. The Trial has been funded through the National Health and Medical Research Council. Additional financial support for the Trial from states and territories have been recognised as ‘in-kind’ contributions for the purposes of the Council’s budget.

The MET system has been implemented in a number of Australian hospitals. The system has three components; identifying high risk patients at an early stage; providing a rapid response to those patients; and providing feedback on the effectiveness of the MET system. Preliminary data indicate that the system has been well utilised and effective. There is however insufficient evidence of the effect of the MET system to support the implementation of such a system nationally.

The primary aim of this study is to test the hypothesis that the implementation of the hospital wide MET system will reduce the aggregate incidents of the following three adverse events; unplanned admissions to intensive care units, cardio pulmonary arrests and in-hospital deaths.

**Improving safety and quality in mental health**

The decision by the Australian Health Ministers’ Advisory Council for their National Mental Health Working Group to work with the Council to strengthen the agenda related to safety and quality in mental health services is important. The Council is working with the National Mental Health Working Group on how it can add value to existing efforts at the national level to improve the safety of mental health care and promote awareness and relevance of Council’s work program.
### Table 6  Summary of action in the priority area building awareness and understanding of health care safety

<table>
<thead>
<tr>
<th>Achievements</th>
<th>Future directions</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Produced the <em>Second National Report on Patient Safety</em> focusing on patient harm associated with medication use</td>
<td>• Widely disseminating the Report and developing the <em>Third National Report on Patient Safety</em></td>
</tr>
<tr>
<td>• Redeveloped the Council website as an accessible gateway for information on patient safety</td>
<td>• Further development of the Council website and its functions</td>
</tr>
<tr>
<td>• Organised a world class 1st Asia Pacific Forum on Quality Improvement in Health Care</td>
<td>• Providing scholarships for the 2nd Asia Pacific Forum on Quality Improvement in Health Care (to be announced by end of July 2002)</td>
</tr>
<tr>
<td>• Introduced an international speaker program bringing international experts in patient safety to Australia</td>
<td>• Continuing to create opportunities for international speakers to share their expertise and experience within Australia</td>
</tr>
<tr>
<td>• Delivered hundreds of patient safety presentations to thousands of people throughout Australia</td>
<td>• Continuing to undertake and promote presentations and conferences on patient safety</td>
</tr>
</tbody>
</table>
Achievements, work in progress and future directions

The Council has developed a communications strategy to generate awareness of the work of the Council and gain the commitment, support and involvement of all stakeholders.

Second National Report on Patient Safety

The Council’s Second National Report on Patient Safety — Improving Medication Safety (Attachment 4) provides evidence on effective interventions for reducing the risk of patient harm resulting from medication error. It also provides detailed discussion about key issues surrounding medication safety more generally. The Report is presented in the context of the Council’s broader safety system improvement message and targets consumers of health services, health care providers and health care managers.

The Council website

The Council has redeveloped its website (www.safetyandquality.org). The redevelopment aimed to ensure that the website would improve community awareness of the Council and its activities and provide an authoritative and accessible gateway for information on patient safety. The website has also been used as a tool for actively consulting with stakeholders on health care safety terms and credentials and clinical privileges guidelines. The website receives an average of 68,414 hits a month.

Future work on the website will include raising the website’s presence through search engines, publications and promotional material. Future options may include allowing people to subscribe to an alert system that lets them know when something new has been added to the site and production of an electronic newsletter.

1st Asia Pacific Forum on Quality Improvement in Health Care

The 1st Asia Pacific Forum on Quality Improvement in Health Care, organised by the Council in collaboration with the British Medical Journal Group (UK) and the Institute for Healthcare Improvement (USA) was held in Sydney on 19–21 September 2001. The Forum was the first conference on safety and quality improvement of this importance to be held in the region and attracted over 650 participants from 24 countries.

The Forum was a unique gathering of some of the world’s influential thinkers on quality improvement and provided an opportunity for health care professionals, managers, policy makers, academics and consumers to participate and exchange practical ideas to improve health care not just in Australia, but on the global stage.

The Council produced videos of the plenary sessions and a CD-Rom of all forum presentations which have been provided free of charge to hundreds of organisations across Australia.

It is envisaged that the Council will be involved in future Forums in the region.

Scholarship Program for 2nd Asia Pacific Forum on Quality Improvement in Health Care

Planning is well underway for the 2nd Asia Pacific Forum on Quality Improvement in Health Care in Singapore, 11–13 September 2002. The Council is providing up to 10 scholarships nationally, to recognise and reward individuals working at the “grass roots” level of improving safety and quality in health care. This will include two positions for consumers. The scholarships will provide invaluable international experience for committed people who without the Council’s support would not normally be able to attend the conference.
**International speaker program**

To create opportunities for bringing to Australia high-level international thought on patient safety the Council introduced a new visiting speaker program for 2002. As part of this program, three international experts in the patient safety arena were brought to Australia:

**Dr John Oldham** (Head, National Primary Care Development Team, Derbyshire, UK) spoke at a Workshop on the Council’s collaborative initiative to improve medication safety. At the workshop Dr Oldham introduced the theory and practice of the Breakthrough Collaborative Methodology developed by the Institute of Healthcare Improvement (USA) and shared his experiences and successes in using the methodology.

**Dr James Bagian** (Director of the Department of Veterans Affairs’ National Center for Patient Safety, US) was co-sponsored by the Council, NSW Health and the South Australian Department of Human Services, and the Australian Patient Safety Foundation to visit Australia in May 2001. Dr Bagian spoke at a number of workshops and provided an insight into the Department of Veterans Affairs’ safety improvement model which was introduced to gather and analyse data.

**Professor Charles Vincent** (Department of Psychology, University College of London) is an international leader in adverse event analysis and clinical risk management and a Commissioner with the UK Commission for Health Improvement, visited Australia in June 2002. The Council sponsored Professor Vincent's keynote address at the Australian Association for Quality in Health Care's Annual Conference and organised visits to New South Wales, South Australia, Northern Territory and Victoria.

In the future the Council will continue work to create opportunities for international speakers to share their expertise and experience within Australia and to promote these opportunities to a broad range of stakeholders.

**Conference and seminar sponsorship**

Sponsorship of conferences and seminars, both nationally and internationally, has been successfully used in the past as a vehicle for raising awareness of the Council and its work and making linkages with key groups. Some of the conferences that have been supported by the Council in the past year have included:

- 1st Asia Pacific Forum on Quality Improvement in Health Care (September 2001);
- 4th International Conference on the Scientific Basis of Health (September 2001);
- Australia Forum, International Society for Quality in Health Care International Conference (October 2001);
- Workshop series on Breakthrough collaborative change processes with the Institute for Healthcare Improvement (February 2002);
- Australian General Practice Accreditation Limited Inaugural Quality in Practice Conference (February–March 2002);
- Patient Safety Seminar Australian Resource Centre for Hospital Innovation (May 2002); and
- 13th National Australasian Association for Quality in Health Care Conference (June 2002).

The Council will continue to support and promote conferences as important opportunities for sharing information and ideas about health care safety.
3 Council finances

The Council Management Group (within the Commonwealth Department of Health and Ageing) manages the Council finances on behalf of the Council and provides financial reports on a regular basis to both the Executive and the full Council. All funds are held in a special account established under the *Financial Management and Accountability Act 1997* with receipts and payments reported formally in the annual report of the Commonwealth Department of Health and Ageing.

The Council has developed principles, processes and protocols (based on Commonwealth guidelines) to guide the procurement of work as part of implementing its national action plan, including the role of states and territories in leading bodies of work on behalf of the Council.

Generally, the tasks of the Council are performed under consultancy contracts and funding agreements, with the Council identifying needs and specifying the nature of work to be performed primarily through both open and select tender processes. There is no intention to solicit proposals for projects on an ongoing basis in the manner that is typically used for a grants program, nor does the Council fund unsolicited proposals.

### 3.1 Establishment and administration funds

The budget for establishment and administration ($5 million over five years) is provided in accordance with the Health Ministers’ agreement of August 1999 to establish the Council. These funds have been expended as shown in Table 3.1. Major categories of expenditure include secretariat costs, Council meetings (sitting fees and travel costs for eligible Council members) and the Chair’s salary and administrative support.

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999–2000</td>
<td>$0.2m</td>
</tr>
<tr>
<td>2000–2001</td>
<td>$1.2m</td>
</tr>
<tr>
<td>2001–2002 (est)</td>
<td>$1.0m</td>
</tr>
</tbody>
</table>

Consistent with the Health Ministers’ agreement of August 1999, jurisdictions will be asked to provide their agreed share of $1 million for the 2002–2003 financial year.

### 3.2 Project funds

At their meeting in July 2000, Health Ministers agreed in-principle to a budget for projects of $50 million over five years with $5 million in direct funds being provided for the first year of the program of national action. All jurisdictions have contributed the agreed amount for the first year. The indicative budget for use of these funds over the life of the Council is set out in Table 3.2 and Figure 3.1.

<table>
<thead>
<tr>
<th>Financial year</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000–2001</td>
<td>$5 million</td>
</tr>
<tr>
<td>2001–2002</td>
<td>$10 million</td>
</tr>
<tr>
<td>2002–2003</td>
<td>$15 million</td>
</tr>
<tr>
<td>2003–2004</td>
<td>$20 million</td>
</tr>
<tr>
<td>2004–2005</td>
<td>$25 million</td>
</tr>
</tbody>
</table>

Around half of the budget for Year 2 is available for “in kind” projects, however few significant proposals for “in kind” funding have been received from participating jurisdictions to date. The State Quality Officials Forum intends to review the process for ‘in kind’ funding and make recommendations to the Council about how it might be improved.
### Table 8  Indicative budget of project funds over the life of the Council

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocated</td>
<td>2,435</td>
<td>9,375</td>
<td>2,270</td>
<td>1,500</td>
<td>1,400</td>
<td>16,980</td>
</tr>
<tr>
<td>Available</td>
<td>0</td>
<td>9,209</td>
<td>12,640</td>
<td>9,709</td>
<td>7,463</td>
<td>39,020</td>
</tr>
<tr>
<td>Total</td>
<td>2,435</td>
<td>18,584</td>
<td>14,910</td>
<td>11,209</td>
<td>8,863</td>
<td>56,000</td>
</tr>
</tbody>
</table>

**Figure 2  Indicative budget allocation**
### 3.3 Commissioned projects

Details of project commissioned in 2001–2002 are outlined in Table 3.3 below.

**Table 9  Projects commissioned in 2001–2002**

<table>
<thead>
<tr>
<th>Key Area of Work</th>
<th>Project</th>
<th>Consultant/Contractor</th>
<th>Amount ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Supporting those who work in the health system to deliver safer patient care</strong></td>
<td>Printing and despatch of <em>Towards Clinical Excellence</em></td>
<td>New Zealand Ministry of Health</td>
<td>6,588</td>
</tr>
<tr>
<td></td>
<td>Distribution Services — Consultation Credentials and Clinical Privileging</td>
<td>National Mailing and Marketing</td>
<td>3,643</td>
</tr>
<tr>
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<td>Qualified Privilege – report and national directions</td>
<td>Corrs Chambers Westgarth Lawyers</td>
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<td>Sponsorship of Quality in Practice Conference</td>
<td>Australian General Practice Accreditation Ltd</td>
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<tr>
<td><strong>Improving data and information for safer health care</strong></td>
<td>Health Care Acquired Infection workshop facilitation and report</td>
<td>PALM — Lynnette Glendining and Jeff Fitzgibbon</td>
<td>9,335</td>
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<tr>
<td></td>
<td>Development of Privacy Matrix Tool</td>
<td>Corrs Chambers Westgarth Lawyers</td>
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<td></td>
<td>Scoping paper on Clinical Audit</td>
<td>National Breast Cancer Centre</td>
<td>16,000</td>
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<td>Support for Phase 1 of National Cardiac Procedures Register</td>
<td>Various (coordinated by Department of Health and Ageing)</td>
<td>430,000</td>
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<td>Project to improve use of coronial data</td>
<td>Victorian Institute of Forensic Medicine</td>
<td>169,000</td>
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<td><strong>Involving consumers in improving health care safety</strong></td>
<td>Consumer Focus Collaboration Forum 16 May 2001</td>
<td>Department of Health and Ageing</td>
<td>50,000</td>
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<td>Focus group testing of the <em>First National Report on Patient Safety</em></td>
<td>NFO Donovan Research</td>
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<td>Open Disclosure Project</td>
<td>Northern Sydney Health Service (consortium lead)</td>
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### Council finances

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<th>Key Area of Work</th>
<th>Project</th>
<th>Consultant/Contractor</th>
<th>Amount ($)</th>
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<td>Redesigning systems of health care to facilitate a</td>
<td>Safety Innovations in Practice Program</td>
<td>Various hospitals/health services</td>
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<td>culture of safety</td>
<td>Facilitation of discussion at 1st Asia Pacific Forum, production of</td>
<td>Julie McCrossin, Top Dog Production, TVD Broadcast, Centerlink Business TV Facilities</td>
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<td>videos and CDs</td>
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<td>Redevelopment of website</td>
<td>ADCORP</td>
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<td>Report of improving medication safety workshop Options Paper Medication</td>
<td>Kerry Deans</td>
<td>7,412</td>
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<td>Safety</td>
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<td>Collaborative Initiative to Improve Medication Safety — analysis and</td>
<td>Kerry Deans, Drs Oldham and Partners</td>
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<td></td>
<td>write up of expression of interest, presentation and facilitation</td>
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<td></td>
<td>Institute of Healthcare Improvement Educational Workshops</td>
<td>Jointly funded with National Institute of Clinical Studies and Dept of Human Services</td>
<td>100,000</td>
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<td></td>
<td>Preparing Medication Safety Report</td>
<td>University of South Australia</td>
<td>32,852</td>
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<td></td>
<td>Undergraduate Education Project (Stage 1)</td>
<td>Monash University</td>
<td>38,000</td>
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<td>Contribution to Medical Emergency Response Intervention and Therapy</td>
<td>University of New South Wales</td>
<td>600,000</td>
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<td></td>
<td>(MERIT) trial (recognised as ‘in kind’ from states and territories)</td>
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<td>Building awareness and understanding of health care safety</td>
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<td>International speaker program</td>
<td>Prof Charles Vincent</td>
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<td></td>
<td></td>
<td>Dr James Bagian (Australian Patient Safety Foundation)</td>
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<td>Sponsorship — tool kit seminar on patient safety</td>
<td>Royal Newcastle Hospital, Australian Resource Centre for Hospital Innovations</td>
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<td></td>
<td>Cost of advertising projects across all priority areas in national</td>
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<td>36,467</td>
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<td>papers</td>
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Appendices

1. The Council at a glance

The Council
Australian Health Ministers established the Australian Council for Safety and Quality in Health Care in January 2000 to lead and coordinate national efforts to improve the safety and quality of health care in Australia. The Council has 24 members with a wide range of skills and experience who are all committed to making a difference to the safety and quality of health care. All Council members are appointed for the full term of the Council.

The full Council meets up to five times a year and reports annually to Health Ministers at the Australian Health Ministers’ Conference. It also reports regularly to the Health Ministers’ Advisory Council.

Council Executive
At the Council’s annual strategic planning workshop on 7–8 August 2000, it was agreed that a Council Executive would be formed to facilitate decision-making (particularly ‘out of session’ decision-making). It was agreed that the Executive would consist of five members and include the Chair and Deputy Chair. At the Council’s second strategic planning workshop (15–16 November 2001), membership of the Executive was re-evaluated and expanded to include the Chair of the State Quality Officials Forum.

The broad role of the Executive is to ensure timely and transparent decision-making on behalf of the Council. The Executive meets approximately every six weeks and regularly reports to the Council.

State Quality Officials’ Forum
In June 2000, the Council formed the State Quality Officials’ Forum. The Forum, in which all jurisdictions are represented, has been instrumental in facilitating ongoing dialogue and sharing of information on safety and quality issues. It has played an important role in information exchange and identifying areas of work that are being addressed by Commonwealth and state and territory health departments.

The State Quality Officials’ Forum meets up to five times a year and regularly reports to the Council.

The Working Groups
At the Council’s strategic planning workshop on 7–8 August 2000, it was agreed that a number of Working Groups be formed to coordinate and develop work plans and projects in priority areas. The Working Groups have continued to build on their strong start by developing frameworks for the Council’s ongoing program of work.

At the second strategic planning workshop on 15–16 November 2001, the Council agreed to clarify and strengthen its lines of responsibility and communication and to take a more flexible approach to Working Groups in order to better support its role as a body with governance of a national initiative. The Council agreed that “fit-for-purpose”, time-limited working parties should be formed and disbanded as the need arises.
Council Management Group (formerly known as the Secretariat)

The Council Management Group is located within the Commonwealth Department of Health and Ageing. In September 2001, it was agreed to designate a more comprehensive role for the Council Management Group including the appointment of a Director and staff to provide operational and policy support for the Council, the Council Executive and the Working Groups. At the second strategic planning meeting on 15–16 November 2001, it was agreed that the Secretariat be redefined as the Council Management Group to formalise the scope of its role.
2. Terms of Reference of the Council

Role
The role of the Australian Council for Safety and Quality in Health Care is to lead national efforts to promote systemic improvements in the safety and quality of health care in Australia with a particular focus on minimising the likelihood and effects of error.

Tasks
1. Provide advice to Health Ministers on a national strategy and priority areas for safety and quality improvement.
2. Develop, support, facilitate and evaluate national actions in agreed priority areas.
3. Negotiate with the Commonwealth, states and territories, the private and non government sectors for funding to support action in agreed priority areas.
4. Widely disseminate information on the activities of the Council including reporting to Health Ministers and publicly at agreed intervals.

In undertaking these tasks, the Council will:

1. Work collaboratively with stakeholders, in particular building on the existing efforts of health care professionals and consumers to improve the safety and quality of health care.
2. Establish partnerships with existing related national bodies and organisations, in particular the National Institute of Clinical Studies and the National Health Information Management Advisory Committee to facilitate action in agreed priority areas.
3. Consider and act to improve health care in the priority areas identified as a result of national consultations undertaken by the National Expert Advisory Group on Safety and Quality in Health Care including:
   - methods to enable increased consumer participation in health care;
   - implementation of evidence-based practice;
   - agree national framework for adverse event monitoring, management and prevention including incident monitoring and complaints;
   - effective reporting and measurement of performance, including research and development of clinical and administrative information systems;
   - strengthening the effectiveness of organisational accreditation mechanisms;
   - facilitate smoother transitions for consumers across health service boundaries
   - education and training to support safety and quality improvement
4. Co-opt members with specific expertise and establish sub-committees and reference groups as required.
3. Membership

The Council

Members:

Professor Bruce Barraclough (Chair)
Immediate past President, Royal Australasian College of Surgeons
Professor and Director of Cancer Services for the Northern Sydney Area Health Service

Dr Michael Walsh (Deputy Chair)
Chief Executive Officer, Bayside Health, Victoria

Professor Lesley Barclay
Director, Centre for Family Health and Midwifery, University of Technology, Sydney

Dr Shirley Bowen (resigned December 2001)

Dr Heather Buchan
Chief Executive Officer, National Institute of Clinical Studies

Associate Professor Kaye Challinger
Chief Executive Officer, Royal Adelaide Hospital

Ms Marie Colwell
Director, Asoka Systems Pty Ltd

Professor John Horvath AO
Area Director, State-wide Renal Services, Royal Prince Alfred Hospital

Professor Clifford Hughes AO
Head, Cardio-Thoracic Surgical Unit, Royal Prince Alfred Hospital

Ms Betty Johnson AO
National Secretary, Older Women’s Network Australia

Professor Brendan Kearney
Executive Director, Statewide Services, South Australian Department of Human Services

Dr Len Notaras
Director, Clinical and Medical Services, Royal Darwin Hospital

Ms Jane Phelan
Consumer, with an extensive background in journalism

Professor Paddy Phillips
Department of Medicine, Flinders Medical Centre

Professor Bill Runciman
Head, Department of Anaesthesia and Intensive Care, Royal Adelaide Hospital

Professor Nick Saunders (resigned May 2002)

Professor Richard Smallwood AO
Commonwealth Medical Officer, Commonwealth Department of Health and Ageing
Appendix 3

Professor Bryant Stokes AM
Department of Neurosurgery, Saint John of God Hospital

Dr Heather Wellington
Coordinator Health Practice, Corrs Chambers Westgarth, Lawyers

Dr Ross Wilson
Director, Quality Assurance, Royal North Shore Hospital

Dr John Youngman
General Manager, Health Services, Queensland Health

Co-opted Members:
Dr Jenny Bartlett
Director, Quality and Care Continuity Branch, Metropolitan Health and Aged Care Services, Victorian Department of Human Services

Dr David Brand
Consultant, Client Solutions

Dr Paul Dugdale
Chief Health Officer, Australian Capital Territory Department of Health and Community Services

Ms Pat J. Martin
Chief Executive Officer, Royal Hobart Hospital

Dr Vin McLoughlin
Assistant Secretary, Priorities and Quality Branch, Commonwealth Department of Health and Ageing

Professor Chris Silagy AO (1960–2001)
Chair
National Institute of Clinical Studies

The Council Executive

Members:
Professor Bruce Barraclough (Chair)
Dr Michael Walsh (Deputy Chair)
Associate Professor Kaye Challinger
Ms Betty Johnson
Dr Ross Wilson
Dr John Youngman

Invited Member:
Mr Martin Fletcher, Director Council Management Group

Supported by:
Ms Kirsty Cheyne-Macpherson, Council Management Group
The State Quality Officials’ Forum

Members:
Dr John Youngman (Chair) — Queensland
Dr Heather Buchan — National Institute of Clinical Studies
Dr Len Notaras — Northern Territory

Co-opted Members:
Dr Jenny Bartlett — Victoria
Dr Vin McLoughlin — Commonwealth

Invited Members:
Ms Jenny Berrill — Australian Capital Territory
Ms Mary Blackwood — Tasmania
Dr Dorothy Jones — Western Australia
Kae Martin — South Australia
Ms Lorraine Porter — Northern Territory
Ms Maureen Robinson — New South Wales

Supported by:
Ms Kirsty Cheyne-Macpherson, Council Management Group

Working Groups, Advisory Groups and Task Forces

Data and Information Working Group

The Data and Information Working Group was established to take forward national work on making better use of data and information to support safer health care.

Members:
Professor Lesley Barclay (Chair)
Ms Marie Colwell
Professor Clifford Hughes
Professor Paddy Phillips
Professor Bill Runciman
Dr John Youngman

Invited Members:
Ms Maxine Drake, Health Care Consumers of Western Australia
Ms Jenny Hargreaves, Australian Institute for Health and Welfare
Dr John McEwen, Therapeutic Goods Administration
Mr Onno van de Wel, South Australian Department of Human Services (resigned)

Supported by:
Ms Denise Callander, Council Management Group
Ms Sandra Gagalowicz, Council Management Group

Standards and Accreditation Working Group

The Standards and Accreditation Working Group was established to take forward national work on supporting those who work in the health system to deliver safer patient care. The Working Group was recently disbanded with the introduction of ‘fit-for-purpose’ groups.
Members:
Professor John Horvath (Chair)
Dr Heather Wellington (Co-chair)
Associate Professor Kaye Challinger
Ms Betty Johnson
Professor Richard Smallwood

Co-opted Member:
Dr David Brand
Ms Pat J. Martin

Invited Member:
Ms Kate Moore, Enduring Solutions

Supported by:
Ms Amanda Collins, Council Management Group

Consumer Working Group
The role of the Consumer Working Group is to oversee a range actions including actively promoting opportunities for consumer feedback and participation in improving health care safety and quality, facilitating partnerships with consumer organisations that have expressed an active interest in improving health care safety, ensuring that consumer identified priorities are fed into Council’s strategic planning and developing resources to communicate key safety messages to the broader consumer community.

Members:
Ms Betty Johnson (Chair)
Professor Lesley Barclay
Professor Clifford Hughes
Ms Jane Phelan
Professor Bryant Stokes

Co-opted Member:
Dr David Brand (Co-chair)

Invited Members:
Ms Amanda Adrian, Commissioner, NSW Health Care Complaints Commission
Mr Lou McCallum, Chair, Consumers Health Forum
Dr George van der Heide, Director, Consumer Strategies Section, Commonwealth Department of Health and Ageing

Supported by:
Ms Julie Bate, Council Management Group

Continuing Education Task Force
The Council established the Continuing Education Task Force to undertake a scoping exercise on continuing education in health care and to inform Council on directions to take to progress work in this area.

Members:
Dr Len Notaras
Professor Nick Saunders (resigned)
Invited Members:
Mr Richard Russell (Chair), risk-e
Mr Martin Fletcher, Council Management Group
Ms Elizabeth Foley, Royal College of Nursing, Australia
Mr Patrick Hertnon, Confederation of Postgraduate Medical Education Colleges
Dr Jim Hyde, Royal Australasian College of Physicians
Mr Tony Landers, Tenix Defence Limited
Ms Kate Moore, Consumer representative
Ms Lin Oke, OT Australia
Professor Alan Pearson, School of Nursing and Midwifery, La Trobe University
Professor Don Roberton, Committee of Presidents of Medical Colleges

Supported by:
Ms Amanda Collins, Council Management Group

Consumer Reference Network
The Consumer Reference Network comprises representatives from key consumer organisations from across Australia. Its role is to provide advice to Council on consumer initiatives and related elements of its work plan and information on consumer priorities and issues for safety.

Members:
Ms Betty Johnson (Chair)
Ms Jane Phelan

Co-opted Member:
Dr David Brand (Co-chair)

Invited Members:
Ms Amanda Adrian, Commissioner, NSW Health Care Complaints Commission
Ms Margaret Brown, President, Health Consumers of Rural and Remote Australia
Ms Meredith Carter, Executive Director, Health Issues Centre
Ms Amanda Cornwall, Senior Policy Officer, Public Interest Advocacy Centre
Ms Maxine Drake, Health Consumers’ Council of Western Australia
Ms Irene Gibbons, Chief Executive Officer, Carers Australia
Ms Janne Graham, Health Care Consumers’ Association of the Australian Capital Territory
Ms Merryl Green, Consumer, Maternity Alliance
Ms Sophie Hill, Co-ordinating Editor, Cochrane Consumers and Communication Group
Ms Helen Hopkins, Executive Director, Consumers’ Health Forum of Australia
Ms Lorraine Long, Medical Error Action Group
Mr Lou McCallum, Chair, Consumers’ Health Forum of Australia
Ms Kate Moore, Enduring Solutions
Dr Christopher Newell, Private Health Industry Quality and Safety Working Group
Ms Debra O’Connor, Chair, Consumer Advisory Committee, Health Insurance Commission
Mr Ken Patterson, Australian Capital Territory Community and Health Services Complaints Commissioner
Ms Fiona Tito, Enduring Solutions
Dr George van der Heide, Director, Consumer Strategies, Commonwealth Department of Health and Ageing

**Supported by:**
Ms Julie Bate, Council Management Group

**Implantable Medical Device Tracking Task Force**

The Task Force has been established to guide Council work on the development of a national tracking system that associates people with implanted medical devices. Such a system should have the capacity to establish improved processes for quickly and efficiently tracking patients with implanted medical devices in the event of a serious medical device failure.

**Members:**
Ms Marie Colwell  
Professor Brendon Kearney  
Professor Clifford Hughes (Chair)  
Dr Heather Wellington

**Co-opted Members:**
Dr Vin McLoughlin, Assistant Secretary, Priorities and Quality Branch, Commonwealth Department of Health and Ageing

**Invited Members:**
Ms Cheryl Burns, Executive Director, Nursing Services, Prince Charles Hospital  
Ms Denise Callander, Council Management Group  
Professor Stephen Graves, Project Director, Australian Orthopaedic Association National Joint Replacement Registry  
Ms Jenny Hargreaves, Head, Hospitals and Mental Health Services Unit, Australian Institute of Health and Welfare  
Mr Ben Horgan, Arthritis Federation  
Ms Rita Maclachlan, Assistant Secretary, Conformity Assessment Branch, Therapeutic Goods Administration  
Mr Warren Ryan, Senior Director, Industry and Government Affairs, Medtronic  
Ms Joanne Smith, Clinical Information Design, Health Insurance Commission  
Dr David Welsh, General Practitioner

**Supported by:**
Mr Michael Flood, Therapeutic Goods Administration  
Ms Sandra Gagalowicz, Council Management Group  
Ms Alicia White, Health Insurance Commission

**Medication Safety Taskforce**

The role of the Medication Safety Taskforce is to develop, implement and monitor national initiatives to achieve measurable improvement in medication safety on behalf of the Council. The Taskforce has a particular focus on driving ‘a platform for action’, monitoring the program, assessing and monitoring data and developing standards for governance.

**Members:**
Associate Professor Kaye Challinger  
Ms Betty Johnson  
Dr Len Notaras
Ms Jane Phelan
Professor Paddy Phillips
Professor Bill Runciman
Dr Ross Wilson

**Co-opted Member:**
Dr David Brand (Co-Chair)

**Invited Members:**
Professor Ric Day (Co-Chair), Professor of Clinical Pharmacology, University of New South Wales
Ms Di Aldous, Director of Pharmacists, Royal Hobart Hospital
Ms Jenny Bergin, Pharmacy Guild of Australia
Dr Ian Boyd, Secretariat Adverse Drug Reactions Advisory Committee, Therapeutic Goods Administration
Ms Mary Emanual, Australian Self-Medication Industry
Ms Janne Graham, Deputy Chair, Australian Pharmaceutical Advisory Council
Professor Maree Johnson, Royal College of Nursing Australia
Ms Roberta Lauchlan, Private Health Industry Quality Working Group
Dr Amanda Ling, Private Health Industry Quality Working Group
Dr John McEwen, Secretariat Adverse Drug Reactions Advisory Committee, Therapeutic Goods Administration
Ms Nancy Pierce, Consumers’ Health Forum
Dr Peter Roush, Australian Divisions on General Practice
Ms Juliet Seifert, Australian Self-Medication Industry
Dr Sepehr Shakib, Staff Specialist, Clinical Pharmacology and General Medicine, Flinders Medical Centre
Dr Danielle Stowasser, Program Area Manager, Quality Use of Medicines, Queensland
Ms Penny Thornton, Society of Hospital Pharmacists of Australia
Dr Lynne Weekes, Chief Executive Officer, National Prescribing Service
Mr Guy Wilmington, Australian Pharmaceutical Manufacturers Association
Ms Fiona Woodward, Australian Pharmaceutical Manufacturers Association

**Supported by:**
Ms Kirsty Cheyne-Macpherson, Council Management Group
Ms Ruth Rutherford, Council Management Group
Dr Adele Stevens, Council Management Group

**Open Disclosure Advisory Group**
The Open Disclosure Advisory Group was established to provide advice to the Council on elements of the conduct of the Open Disclosure Project. Its membership is drawn from a broad range of organisations and provides technical expertise, operational knowledge and support to the Project, as well as promoting stakeholder linkages.

**Members:**
Professor Bruce Barraclough (Chair)
Ms Betty Johnson
Ms Jane Phelan

**Co-opted Member:**
Dr David Brand

**Invited Members:**
Ms Jenny Berrill, Director, Quality Management Unit, Australian Capital Territory Department of Health and Community Care
Ms Mary Blackwood, Manager, Divisional Support Unit, Tasmanian Department of Health and Human Services
Ms Lucy Bylhouwer, Partner, Blake Dawson Waldron
Professor Michael Chesterman, Emeritus Professor, University of New South Wales Faculty of Law
Ms Merryl Green, Consumer, Maternity Alliance
Dr Roham Hammett, Open Disclosure Project Director
Mr Graham Jonstone, Victorian State Coroner
Dr Alice Killen, Executive Director, Mater Hospital, Sydney
Mr Bill Madden, Partner, Blessington Judd Solicitors
Dr Robert Paterson, Board Member, United Medical Protection
Dr Jonathan Phillips, President, The Royal Australian and New Zealand College of Psychiatrists
Mr Alan Rose, Phillips Fox
Ms Fiona Tito, Enduring Solutions
Ms Jennifer Williams, Chief Executive Officer, Austin and Repatriation Medical Centre
Ms Beth Wilson, Victorian Health Services Commissioner
Associate Professor Brenda Wilson, Executive Director of Nursing and Patient Services, Flinders Medical Centre

**Supported by:**
Ms Julie Bate, Council Management Group
Ms Jane Wood, Tasmanian Department of Health and Human Services (lead jurisdiction)

**Safety and Quality Definitions Task Force**
The Safety and Quality Definitions Task Force was established to manage the development and consultation of key terms and definitions used to describe safety and quality issues.

**Members:**
Professor Bill Runciman (Chair)
Professor Paddy Phillips

**Invited Members:**
Dr Maree Bellamy, Standards Australia
Ms Jenny Hargreaves, Australian Institute of Health and Welfare
Director and Associate Professor James Harrison, National Injury Surveillance Unit
Ms Julie Rust, National Centre for Classification in Health

**Supported by:**
Ms Denise Callander, Council Management Group
Ms Barbara Levings, Council Management Group
Editorial Team — Second National Report on Patient Safety

An editorial team was convened by Council to act as a reference group during the preparation of the Second National Report on Patient Safety — Improving Medication Safety.

Co-opted Member:
Dr David Brand

Invited Members:
Mr Martin Fletcher (Chair), Council Management Group
Ms Janne Graham (Deputy Chair), Australian Pharmaceutical Advisory Council
Ms Maxine Drake, Community Development Coordinator, Health Consumers’ Council of Western Australia
Ms Jenny Hargreaves, Head, Hospitals and Mental Health Services Unit, Australian Institute of Health and Welfare
Ms Penny Thornton, Society of Hospital Pharmacists of Australia

Supported by:
Ms Rita Raizis, Council Management Group

Safe Staffing Task Force

The Safe Staffing Task Force has been formed to look at an approach to support improvement in safe staffing and consider options for value adding at a national level.

Members:
Professor Clifford Hughes (Chair)
Associate Professor Kaye Challinger
Professor John Horvath

Co-opted Members:
Dr Jenny Bartlett
Ms Pat J. Martin

Invited Members:
Composition of the task force is currently being finalised. It is anticipated that the task force will comprise a wide range of expertise and skills including medical, nursing, health management, government and research.

Supported by:
Ms Cathie O’Neill, Council Management Group

Nursing Issues Working Party

The Council formed a small informal group to consider nursing engagement issues and safety and quality improvement issues that are specific to nursing professionals.

Members:
Professor Lesley Barclay
Associate Professor Kaye Challinger
Ms Marie Colwell

Co-opted Members:
Ms Pat J. Martin

Supported by:
Ms Amanda Collins, Council Management Group

**Council Meetings**
- 15–16 August 2001
- 16 October 2001
- 15–16 November 2002 (Annual Strategic Planning Workshop)
- 12 December 2001
- 13 February 2002
- 30 April–1 May 2002

**Council Executive Meetings**
- 29 June 2001 (Joint meeting with the National Institute of Clinical Studies)
- 8 August 2001
- 6 September 2001
- 10 October 2001
- 1 November 2001
- 15 November 2001
- 6 December 2001
- 1 February 2002
- 13 March 2002
- 11 April 2002 (Joint Executive meeting with the Australian Medical Association)
- 19 April 2002
- 5 June 2002
5. Activities of Chair and Council members

Schedule of Activities 2001–2002

June 2001

- Data and Information Working Group consultative workshop, Canberra
- Standards and Accreditation Working Group workshop, Canberra
- Data and Information Working Group meeting, Canberra
- Meeting with the Hon Michael Moore, Australian Capital Territory Minister for Health, Canberra (Chair)
- Attendance at the Australian Association for Quality in Health Care Conference, Melbourne
- State Quality Officials Forum meeting, Sydney
- Meeting with the Hon Dean Brown, South Australian Minister for Health (Chair)
- Attendance at Health Outcomes Conference 2001, “The Odyssey Advances”, Canberra

July 2001

- Medication Safety Taskforce national workshop
- Meeting with Ms Patricia Faulkner, Chief Executive Office, Victorian Department of Human Services (Chair and Council Management Group)
- Meeting with the Hon Wendy Edmond, Queensland Minister for Health (Chair)
- Meeting with Victorian State Coroners and Institute of Forensic Medicine, Melbourne (Chair)
- Presentation to the National Health Information Management Advisory Council (Chair)
- Meeting with Hon Michael Wooldridge, Federal Minister for Health and Aged Care, Canberra (Chair)
- Meeting of the Chairs of National Bodies, Canberra (Chair)
- Attendance at the Jurisdictional Indemnity Working Party meeting, Canberra (Chair, Council Management Group)
- Consumer Working Group meeting, Sydney
- Qualified Privilege Advisory Group meeting
- Attendance at the Health Informatics Conference 2001 “Realising Quality Health Care” (Member – Professor Lesley Barclay)
- Attendance at the Special General Meeting of the Australian Medical Council, Melbourne (Chair)
- Presentation at the Health Leaders Forum, Sydney (Chair)
- Presentation at New South Wales Department of Health’s Benchmarking Forum, Sydney (Chair)
**August 2001**

- Presentation to the Australian Health Ministers’ Conference (Chair)
- Presentation to the Western Australian Department of Health’s Risk Management Group, Perth (Chair)
- Presentation at the Northern Rivers Health Conference, Coolangatta (Chair)
- Presentation at the Northern Sydney Health Conference (Chair)
- Presentation to the Clinical Support Systems Project Princess Alexandria Hospital, Brisbane (Chair)
- Meeting with HCF Health Fund, Sydney (Chair)
- Attendance at the Royal Australian College of General Practitioners’ meeting, Canberra (Chair)
- State Quality Officials Forum meeting, Canberra

**September 2001**

- Meeting with the Chief Executive Officers and senior staff of Medibank Private and AXA health funds, Melbourne (Chair)
- Presentation to the Management of Clinicians Program, Terrigal (Chair)
- Presentation to the HCF health fund board, Sydney (Chair)
- Attendance at the Australian Medical Council and Committee of Presidents of Medical Colleges medical registration meeting, Sydney (Chair)
- Meeting with the Australian Medical Association’s Executive Board, Canberra (Chair)
- Attendance at Nuffield Trust Centenary of Federation Seminar on Sustainable Health Financing, Canberra (Chair and Council Management Group)
- Australian Council for Safety and Quality in Health Care CEO workshop with Professor Donald Berwick, Sydney.
- Presentations at the 1st Asia Pacific Forum on Quality Improvement in Health, Sydney (Chair and Council Members)
- Presentations at the International Conference on the Scientific Basis of Health Care, Sydney (Chair and Council Members)
- Meeting with the Australian Council for Healthcare Standards Safety Board, Sydney (Chair)
- Meeting with Australian General Practice Accreditation Ltd, Sydney (Chair)
- Presentation to the Dupont Corporation on safety processes, Sydney (Chair)
- Data and Information Working Group meeting

**October 2001**

- Presentation and chairing of the Australia Forum and contribution to Indicators Workshop at the International Society for Quality in Health Care Inc Conference, Argentina (Chair)
- Meeting with MBF health fund Executive Board, Sydney (Chair)
• Attendance at the National Casemix Forum
• Medication Safety Taskforce meeting, Sydney
• Keynote address to the Australian Society of Anaesthetist’s Kester Brown Lecture, Canberra (Chair)
• Meeting with the Pharmacy Guild of Australia, Canberra (Chair)
• State Quality Officials Forum meeting, Canberra
• Presentation to the Australian Private Hospitals Associations 21st National Congress “Opportunities and Challenges — A New Era for Private Hospitals”, Sydney (Member: Dr David Brand)
• Meeting with the Hon Craig Knowles, New South Wales Minister for Health, Sydney (Chair)
• Visit to the Clinical Support System Project Hunter Program (Chair)
• Presentation to the New South Wales Medical Board Strategic Planning Meeting, Sydney (Chair)
• Launch, with the Hon Craig Knowles, New South Wales’ Minister for Health, of the Clinical Support System Project Hunter Region, Newcastle (Chair)
• Attendance at the Chairs of National Bodies meeting, Canberra (Chair)
• Presentation to the Australian Health Ministers Advisory Council Review of the Australian Medical Workforce Advisory Committee, Sydney (Chair)

November 2001
• Presentation to the 6th National Forum on the Prevocational Medical Experience, Sydney (Member – Professor John Horvath and Council Management Group)
• Attendance at the Centre for Midwifery and Health’s overview of the Australian Midwifery Action Project preliminary findings, Melbourne (Chair)
• Attendance at the National Health Priority Action Council’s Mental Health Forum (Council Management Group)
• Presentation to the Illawarra Area Health Service’s Safety Issues and Quality Management in Health Care Seminar, Wollongong (Chair)
• Joint meeting of the Consumer Working Group and Consumer Reference Network, Sydney
• Presentation to the Society of Hospital Pharmacists 25th Federal Conference, Hobart (Chair)
• Visit to the Clinical Systems Support Project Austin, Melbourne (Chair)
• Keynote address and panel discussion at The Alfred Hospital Week, Melbourne (Chair)
• Attendance at Medical Services Advisory Committee meeting and dinner, Canberra (Chair)
• Attendance at the Australian Council on Healthcare Standards’ annual dinner (Council Member – Dr John Horvath and Council Management Group)
• Attendance at South Australian Mental Health Symposium, Adelaide (Council Management Group)
• Qualified Privilege Advisory Group meeting
• Presentation to the Australian and New Zealand Medical Boards and Councils Conference, New Zealand (Chair)
• Standards and Accreditation Working Group meeting, Sydney
• Presentation to the Peter MacCallum Cancer Institute, Victoria (Chair)
• Presentation to the Health Leadership Network’s “Building Clinical Leadership for Quality and Safety” (Chair and Council Member — Dr Ross Wilson)
• Presentation to the Committee of Presidents of Medical Colleges meeting, Sydney (Chair)

**December 2001**

• Presentation at the Wentworth Area Health Service’s Annual General Meeting, Sydney (Chair)
• Open Disclosure Project Advisory Group meeting, Sydney
• Attendance at breakfast seminar with Hon Tom Schieffer, United States of America’s Ambassador to Australia, Sydney (Chair)
• Presentation to Flinders Medical Centre’s Annual Quality Meeting, Adelaide (Chair)
• Attendance at the Victorian Department of Humans Services’ Public Reporting Awards for Quality of Care Reports, Melbourne (Council Management Group)
• State Quality Officials Forum meeting, Melbourne
• Meeting with the Royal Australian College of Nursing, Canberra (Chair and Council Management Group)
• Attendance at the Health Leader Forum, Sydney (Chair)
• Meeting with Mr Malcolm Crompton, Federal Privacy Commissioner, Sydney (Chair)
• Open Disclosure Advisory Group meeting, Sydney

**January 2002**

• Meeting with Hon Kay Patterson, Federal Minister for Health and Ageing and Secretary Department of Health and Ageing Ms Jane Halton (Chair and Council Management Group)
• Meeting with Mr Peter Broadhead, Assistant Secretary, Commonwealth Department of Health and Ageing, Canberra (Chair)
• Attendance at the Australian Health Minsters’ Advisory Council’s Working Group on Medical Registration (Council Member — Dr Heather Wellington)
• Meeting with Interact Management Consultant regarding health care data collection and analysis, Sydney (Chair)
• Presentation to the Geelong Hospital, Melbourne (Chair)
• Meeting with Dr David Watters, Geelong Hospital, and Dr Steve Bolsin, regarding information systems
• Presentation to the Victorian Quality Council’s Strategic Planning Workshop, Cammeray Waters, Victoria (Chair)
**February 2002**

- Presentation at Queensland Health’s “Safety First Risk Management” workshop (Council Member — Dr John Youngman)
- Joint meeting of the Consumer Reference Network Consumer Working Group, Sydney
- Meeting with Ms Fiona Tito, Executive Director Enduring Solutions, Mr Rhys Ollerenshaw, Dr Penny Gregory, Chief Executive, Department of Health and Community Care and Ms Jenny Berrill, Director Quality Management Unit, Australian Capital Territory Department of Health and Community Care, to discuss risk management and medical indemnity reform, Canberra (Chair and Council Management Group)
- Meeting with the Ms Jane Halton, Secretary, Commonwealth Department of Health and Ageing, Canberra (Chair and Council Management Group)
- Presentation to Tasmanian consumer networks and General Practice Liaison Councils, Hobart (Council Member — Ms Betty Johnson)
- Presentation to senior nurses from the Royal Hobart Hospital and members of the University of Tasmania’s School of Nursing, Hobart (Council Member — Professor Lesley Barclay)
- Presentation to the clinical staff of the Royal Hobart Hospital on Clinical Governance and Credentialling, Hobart (Chair and Council Member — Dr Ross Wilson)
- Presentation to the Mid Term Review of Quality Improvement and Enhancement Plans workshop, Hobart (Chair, Deputy Chair and Council Member — Professor Richard Smallwood and Dr Ross Wilson)
- State Quality Officials Forum meeting, Hobart
- Presentation to the clinical staff of Launceston Hospital on Clinical Governance and Credentialling, Launceston (Chair and Council Member — Dr Ross Wilson)
- Meeting with Mr Jim Hyde and Mr Paul Long, Royal Australasian College of Physicians, regarding the complaints project, Sydney (Chair)
- Presentation to the MBF and Clinical Risk Management Forum, (Chair and Council Member — Dr David Brand)
- Participation at the Institute for Healthcare Improvement Training Program, Melbourne (Council Members — Dr Ross Wilson, Dr David Brand and Council Management Group)
- Presentation to the Financial Review’s 4th Annual Health Congress, Sydney (Chair)
- Presentation National Medico-Legal Conference, Sydney (Chair)
- Presentation at Queensland Health’s “Safety First — Quality and Risk Management” workshop (Council Member — Dr John Youngman)
- Presentation at the Australian General Practice Accreditation Ltd Quality in Practice Conference, Gold Coast (Chair and Council Member — Dr David Brand)
- Meeting with Mr Alistair Mant, regarding leadership principles, Canberra (Chair).

**March 2002**

- Presentation to and chairing of the Open Disclosure Workshop to the Royal Australian College of General Practitioners, Melbourne (Chair)
Appendix 5

- Meeting with the Hon Jon Thwaites, Victorian Minister for Health, and Dr Jenny Bartlett, Victorian Department of Human Services, Melbourne (Chair)
- Presentation to and chairing of the Open Disclosure Workshop to medical indemnity organisations, Melbourne (Chair)
- Standards and Accreditation Working Group meeting, Sydney
- Medication Collaborative Workshop, Sydney
- Meeting with Ms Rosemary Bryant, Royal College of Nursing Australia, Canberra (Council Management Group)
- Presentation to and facilitation of the Health Leaders Network (HLN)’s “Leadership for Clinicians” workshop, Sydney (Chair)
- Presentation to the Health Care Complaints Commissioners’ annual meeting, Leura (Chair)
- Presentation to the Board and staff of the Adelaide Community Health Alliance, Adelaide (Chair)
- Meeting with Dr Richard Russell, Managing Director, Risk-E, to discuss future Council initiatives in continuing education, Canberra (Council Management Group)
- Presentation to the Northern Territory Health Clinical Risk Management Symposium, Darwin (Chair)
- Meeting with the Hon Jane Aagaard MLA, Northern Territory Minister for Health and Community Services, Darwin (Chair)
- Medication Safety Taskforce meeting, Sydney
- Meeting with the Adverse Drug Reaction Advisory Committee (Council Management Group)
- Continuing Education Steering Group meeting, Melbourne
- Meeting with the Women’s and Children’s Hospital Network, Melbourne (Council Management Group)
- Presentation and attendance at the National Medicines Symposium, Canberra (Chair and Council Members — Dr Heather Wellington, Dr David Brand and Ms Betty Johnson)

April 2002

- Presentation to the Royal North Shore Hospital’s scientific staff, Sydney (Chair)
- Meeting with Professor Alan Pearson, Joanne Briggs Institute, Sydney (Chair)
- Presentation to the Mater Hospital Grand Rounds, Sydney (Chair)
- Meeting with the Hon Craig Knowles, New South Wales Minister for Health, Sydney (Chair)
- Presentation to the Women’s Hospitals of Australasia and Children’s Hospitals of Australasia’s National Conference, “Women and Children — they’re our future”, Perth (Deputy Chair)
- Meeting with Mr David Wright, Australian Government Practice Accreditation Ltd (AGPAL), Canberra (Council Management Group)
- Health Care Associated Infection workshop, Sydney
• State Quality Officials Forum meeting, Sydney
• Presentation to the Frankston Hospital, Melbourne (Chair)
• Presentation to the Australian Medical Association’s Seminar on Australian Health Care Agreements, Canberra (Chair)
• Australian Council for Safety and Quality in Health Care Executive Meeting, Sydney
• Presentation to the Australian College of Emergency Medicine’s “Quality Management” workshop, Melbourne (Council Member — Dr Heather Wellington)
• Presentation at the Australian Government’s Medical Indemnity Summit, Canberra (Chair)
• Presentation at the MBF Forum, Sydney (Council Member — Dr Heather Wellington)
• Continuing Education Steering Group workshop, Sydney
• Chairs of National Bodies meeting, Canberra (Chair)

May 2002
• Attendance at the Australian Resource Centre for Hospital Innovation Toolkit seminar, “Patient Safety — can we do more?”, Perth (Chair and Council Management Group)
• Meeting with the Hon Bob Kucera APM MLA, Western Australian Minister for Health, Mr Mike Daube, Director General Department of Health Western Australia, and Mr Brain Lloyd, Deputy Director General Health Department of Western Australia, Perth (Chair and Council Management Group)
• Meeting with Mr Stephen Smith MP, Shadow Minister for Health and Ageing, Sydney (Chair)
• Participation at the Victorian Department of Human Services’ “Proposed Health Services (Private Hospitals and Day Procedure Clinics) Regulations 2002” meeting, Melbourne (Chair and Council Management Group)
• Meeting with Dr Margaret Tobin, Victorian Department of Human Services, Melbourne (Council Management Group)
• “Making Patient Safety Practical” National Workshop with Dr James Bagian, Adelaide
• Attendance at the Australian Patient Safety Foundation’s Annual Summit, Adelaide (Council Members — Ms Betty Johnson, Ms Jane Phelan and Dr Ross Wilson)
• Presentation to the Victorian Adverse Drug Events “Beyond Blame Seminar”, Melbourne (Council Member — Dr David Brand and Council Management Group)
• Implantable Medical Device Tracking Taskforce meeting, Sydney
• Attendance at the New South Wales Quality Awards, Orange (Chair)

June 2002
• Medication Safety Taskforce meeting, Sydney
• State Quality Officials Forum meeting, Sydney
• Presentation to the Australasian Association for Quality in Health Care Conference, Gold Coast (Chair)
6. Communications

Media releases 2001–2002

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<td>“Time to Move: Reducing Medication Errors in Health Care”</td>
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All media releases are available on the Council website

Publications

Safety First
Report to the Australian Health Ministers’ Conference
27 July 2000

National Action Plan 2001
December 2000

Leading Improvements In Safety And Quality In Health Care
(Brochure)

Lessons For Health Care: Applied Human Factors Research
Report Of A Special Medical Seminar
22 November 2000

Ensuring Safety Is Core Business For Australian Health Care: Priorities For 2001 (Brochure)

A Consumer Vision for a Safer Health Care System
Improving Medication Safety
Report of a Medication Safety Workshop sponsored by the Australian Council for Safety and Quality in Health Care
July 2001

Safety in Practice — Making Health Care Safer
Second Report to the Australian Health Ministers’ Conference
1 August 2001

Process for ‘In-Kind’ Contributions from Jurisdictions
August 2001

The Public Interest in Health Care Qualified Privilege
Issues Paper
August 2001

First National Report on Patient Safety
August 2001

Safety in Numbers — A Technical Options Paper for a National Approach to the Use of Data for Safety Health Care
August 2001

Draft Model for Medical Registration
August 2001

Credentials and Clinical Privileges Guidelines
August 2001

Core Standards for Health Care Safety
August 2001

Report of the Review Workshop conducted by the Australian Council for Safety and Quality in Health Care
18 September 2001
7. Overview of attached reports

1. **National Action Plan 2002** builds on the achievements of the *National Action Plan 2001*, and outlines the Council’s second full year program of work. It identifies major areas where action will result in tangible benefits to the community, and provides a blueprint for achieving outcomes within the Council’s five newly defined priority areas.

2. **Lessons from the Inquiry into Obstetrics and Gynaecological Services at King Edward Memorial Hospital 1990–2000** summarises the key findings and lessons arising, from the Inquiry into the King Edward Memorial Hospital Obstetric and Gynaecological services. The Council has produced this report to support health care leaders, managers and staff in their efforts to improve the safety and quality of health care by considering the lessons arising, as the basis for identifying and responding to improvement opportunities in their own workplaces.

3. **National Guidelines for Credentials and Clinical Privileges** has been developed after national consultation and widespread support for a national set of guidelines for credentialling that incorporate procedures for ongoing performance assessment. These guidelines will be used as a basis for developing a national standard and organisational support package to support implementation.

4. **Second National Report on Patient Safety — Improving Medication Safety** provides evidence about effective interventions for reducing the risk of patient harm resulting from medication error in the delivery of health care. It also provides a detailed discussion about key issues surrounding medication safety more generally. The Report is presented in the context of the Council’s broader safety system improvement message and targets consumers of health services, health care providers and health care managers.