

# SAFER SYSTEMS BETTER CARE

## QUALITY SYSTEMS ASSESSMENT NSW STATEWIDE REPORT 2012

June 2013



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Front cover photograph: Daily multidisciplinary ward round Orange Base Hospital, Western NSW LHD.

From Left to right: Ged Hawthorne (Pharmacist), Lisa Simpson (Social Worker), Suja Joseph (SIBR Coordinator), Dr Binu Thampan (Registrar), Erin Fisher (Registered Nurse) and Dr Robert Zielinski (Consultant).

# Message from the Minister for Health and Medical Research



As part of the NSW Government's objective to return quality services, we committed to two key goals in *NSW 2021: A plan to make NSW number one*:

- To keep people healthy and out of hospital; and
- To provide world class clinical services with timely access and effective infrastructure.

Our commitment is to give communities and health care providers a strong and direct voice in improving patient care. New South Wales will work with the Australian Commission for Safety and Quality in Health Care to make sure facilities in NSW meet agreed national patient safety and quality standards. We will put patients at the centre of decision-making in the NSW Health system and, through mechanisms like the NSW Health Patient survey, we will seek and respond to health consumer feedback, as well as feedback from families and carers of those patients in our health system in NSW.

The Quality Systems Assessment is central to our strategy for improving healthcare in NSW, by identifying areas for improvement and enabling us to design and implement practical improvement strategies to make health care in NSW even better.

I note the *Safer Systems Better Care 2012* report demonstrates a highly positive quality and safety culture among those who work in the NSW public health system. Ninety-seven per cent of respondents in the 2012 self-assessment reported a positive quality and safety culture in their own work teams. This encourages me to feel that patients are in safe hands.

The Hon Jillian Skinner MP  
*Minister for Health and  
Minister for Medical Research*

# Foreword



Assessing the quality and safety of any health system is an important but typically difficult task. Improving the system can also be especially challenging. The task is particularly challenging for a system as complex as NSW Health, which encompasses over 200 public hospitals with approximately 1,200 clinical units, and one of the largest Ambulance systems in the world.

The Quality Systems Assessment has been administered within the NSW health system by the Clinical Excellence Commission annually since 2007/08, and gives local health care teams information that enables them to focus their quality improvement activities. In addition, it has enabled us over this time to provide a 'whole of system' view of the status of quality and safety processes in NSW.

This year's report, *Safer Systems Better Care, 2012*, presents the second system-wide census of key quality and safety activities undertaken in NSW. It shows substantial adherence to best practice guidelines in many areas, and some important areas for quality and safety improvement. I am also pleased to report on the development of the Quality Systems Assessment over the first five-year program cycle.

I would like to thank all of those who continue to participate in the Quality Systems Assessment for their contribution to this very important part of our efforts to ensure continuous improvement in the safety, quality, efficiency and effectiveness of the care provided to NSW patients.

A handwritten signature in black ink that reads "cliff Hughes".

Professor Clifford Hughes, AO  
*Chief Executive Officer*  
*Clinical Excellence Commission*

# Table of contents

Message from the Minister for Health and Medical Research .....	3
Foreword .....	4
Executive Summary .....	6
NSW recommendations for improvement and action strategies.....	7
The Quality Systems Assessment Program.....	11
The 2012 Quality Systems Self-Assessment.....	12
Repeat assessment topics .....	12
Participation .....	12
Reporting .....	12
The 2012 Self-Assessment findings.....	13
A note about the data .....	13
Safety and Quality culture .....	13
Patient based care .....	15
Clinical governance and clinical risk management .....	16
Clinical audit.....	18
Clinical review meetings .....	19
Mortality review .....	21
Credentialing and supervision of clinicians.....	23
Patient blood management .....	25
End of life care and management.....	26
State Improvement programs.....	28
Between the Flags .....	28
Clinical handover.....	30
Outcomes and reflections from the 5-year Quality Systems Assessment.....	31
Verification of 2011 QSA Self-assessment .....	33
Glossary .....	34
Acknowledgements .....	35
References .....	36



# Executive Summary

The 2012 Quality Systems Assessment (QSA) was undertaken by over 1,500 respondents at various levels of the health system, across 15 Local Health Districts (LHDs), the three Specialty Networks and the Ambulance Service of NSW (Ambulance Service), with an overall response rate of 96%. Respondents reported their experiences of clinical quality and safety issues, the tools and systems they use to manage risks, and their perceptions of the effectiveness of those tools and systems.

There are three self-assessment levels referred to in this Report.

- 1. Local Health District (LHD)** level includes self-assessments completed by LHDs, Justice Health State and Ambulance Service State.
- 2. Facility level** includes self-assessments completed by LHD facilities and Ambulance Service Divisions.
- 3. Unit level** includes self-assessments completed by departments/clinical units from LHDs, Justice Health clinical streams/units and Ambulance Service station/zones and paramedic.

The perception among respondents of a positive quality and safety culture has been sustained over time, and in 2012 reached 97%. The strength of the commitment of the workforce to deliver quality and safety is an important foundation from which to design and deliver further improvements and to respond to persistent and emerging risks to patients.

The 2012 self-assessment also showed a strong awareness and adherence to quality and safety requirements - particularly in the areas of clinical governance, clinical review processes, clinical supervision and patient blood management.

However, the 2012 self-assessment also directs attention to areas in which improvements can be made to achieve best practice. The implementation of the National Safety and Quality Health Service Standards is taking place statewide, and attention and care needs to be paid to monitoring implementation during this time.

Three strategic themes emerge across public health organisations (PHOs) in the 2012 self-assessment, and from reflection on the results from the five-year cycle:

- The need to improve communication and feedback at all levels of public health organisations;
- The need to continue to invest in developing organisational capacity and excellence in quality and safety; and
- The need to improve patient outcomes through building effective clinical teams.

In this Report, these three themes provide the basis for recommendations and action strategies for enhanced quality and safety in NSW, and are also being addressed through existing state interventions such as the NSW Patient Safety and Clinical Quality Program, which includes the QSA, and through the implementation of the National Safety and Quality in Health Service Standards.

One key issue for health systems across the world is the increasing demand from health care consumers for patient-centred care. This issue was raised prominently in the 2012 self-assessment. Strategies to address this issue must be based on a perspective which sees patients, their family and carers as being integral members of the health care team.

Finally, the QSA program has increased its own effectiveness in assessing, monitoring and reporting on clinical care and patient safety. Participation in the QSA has significantly improved since its first year (2007/08) and at the same time the program has also increased the number of facilities and clinical units which participate in the annual self-assessment.

This NSW Report, *Safer Systems Better Care 2012*, complements detailed data provided to individual public health organisations, makes recommendations for systemic improvements and proposes action strategies for all responsible parts of the Health system including the Ministry of Health, CEC, LHDs and Specialty Networks.

# NSW recommendations for improvement and action strategies

The recommendations for NSW have been made by taking into account the findings of the QSA over the past five years, relevant literature, the Garling Inquiry, and the experience gained in recent years from NSW programs which address National Safety and Quality Health Service Standards. The recommendations of the Independent Inquiry into Care provided by Mid Staffordshire NHS Trust ('the Francis Inquiry')<sup>1</sup> have also been considered, where relevant to QSA self-assessment findings.

From the analysis of the data three key themes emerged:

1. clinical governance at all levels of the organisation;
2. improvement program implementation; and
3. strengthening of teams.

Under each of these themes recommendations for implementation have been developed to achieve the desired improvement, as well as assigning who should lead.

All PHOs must implement an Improvement Plan based on these recommendations and findings from local self-assessment results.

**All public health organisations should continue to develop their clinical governance systems and processes through a sustained focus on communication, feedback and information-sharing across disciplines, between levels and between facilities.**

A recurring dissonance between levels of PHOs (unit, facility and LHD) exists throughout NSW and across several of the topic areas assessed since 2007/08. This is demonstrated by variations in responses between levels of PHOs relating to awareness of, and consistent implementation of, standardised systems and processes for clinical quality and safety. Some level of variation in specific knowledge and practice between levels of an organisation is expected – as those with governance roles in clinical units, facilities and at organisational levels have different responsibilities.



*Rhys Tamatea (Station Officer) and Paramedic Phillip Krucler, Bega Ambulance Service.*

However, the differences reported, over time, in the self-assessments of key patient safety and quality systems by different levels of the PHOs can represent a challenge to patient safety and the quality of clinical care where such differences in perception reflect differences in implementation of safety and quality systems or differences in clinical practice.

Ensuring quality systems are implemented to an appropriate level within and across PHOs is a shared

responsibility of all levels of PHOs, the Ministry of Health and the CEC. The Ministry and CEC develop, deliver, monitor and evaluate statewide policy and programs for NSW PHOs. Where no standardised system has been developed to support best practice in a clinical risk area and there is evidence of inconsistent practice, this Report recommends consistent systems be developed.

QSA TOPIC	RECOMMENDATIONS FOR IMPLEMENTATION	WHO SHOULD LEAD
Safety and quality culture	LHDs should foster and maintain a positive quality and safety culture by ensuring clinical governance structures and processes exist for regular and active communication about quality and safety within and across disciplines at facility and unit levels, such as through unit, department and facility multi-disciplinary committees.	LHDs and other PHOs
Patient based care	At all levels of PHOs patient-based approaches should be emphasised in training for clinical supervisors and in clinical leadership initiatives. It should also be integrated in planning, delivery and evaluation of all clinical services.	PHOs, The Health Education and Training Institute (HETI), CEC
Patient based care	All PHOs should engage their consumers and communities on matters of planning, improvement and monitoring based on guidance from the Ministry of Health about consumer engagement.	Ministry LHDs and other PHOs
Clinical governance and clinical risk management	LHDs should actively promote the availability of existing information, resources and training available to support clinical governance through formal and informal communication channels within and across all levels of the organisation and by all grades of employees	PHOs CEC HETI (provision of resources)
Clinical review meetings	LHDs should ensure all clinical review meetings report to the facility or district Clinical Governance Committee or equivalent to ensure LHDs can identify and respond to service-wide issues.	LHDs
Mortality review	Policy and guidance should be developed around death review for PHOs to implement, and PHOs should have in place a consistent and timely death review process which includes an independent review of the medical record, where appropriate. A centralised approach to collate outcomes of these review meetings would improve learning across the organisation and inform risk stratification and control measures at facility and organisation level.	Ministry of Health
End of life care and management	A statewide, standardised, evidence-based and consensus-focused best practice system around management of all aspects of end of life care should be developed, implemented and evaluated.	Ministry of Health ACI CEC



**Existing quality and safety initiatives and policies should continue to be implemented consistently through sustained support and monitoring by LHDs and other PHOs.**

Over the period of the QSA program, there has been substantial investment at local, state and national levels in programs and systems development for clinical quality and patient safety.

This presents an opportunity to continue to deliver improvements in NSW, and highlights the need for ongoing implementation monitoring at all levels of PHOs from clinical unit to governance level.

QSA TOPIC	RECOMMENDATIONS FOR IMPLEMENTATION	WHO SHOULD LEAD
Patient based care	LHDs should encourage participation in the CEC's Partnering with Patients program and adopt the Patient Based Care Challenge.	LHDs
Clinical governance and clinical risk management	The CEC will assess the themes of falls, medication safety and transition of care through the 2013 QSA	CEC
Mortality Review	Death review policy and guidance for PHOs to implement should include consideration of implementation factors such as communications targeted to units which care for dying people more often, monitoring strategies and access to independent reviewers.	Ministry of Health
Credentialing and supervision of clinicians	PHOs require an updated statewide standardised process for credentialing linked to recruitment systems, and a model scope of clinical practice. PHOs should adopt and monitor credentialing processes once a statewide process and model is established.	Ministry PHOs
Clinical Audit	Statewide agencies and networks should assist PHOs in developing best practice models for clinical audit, medical record review, peer review or other quality review activities	Ministry PHOs
Clinical Audit	All PHOs should implement a calendar for audit activities and a person should be identified to monitor progress against the calendar, in each clinical unit.	Ministry PHOs
Patient Blood Management	LHDs should continue to implement the mandatory NSW Health blood management policy (PD2012_016) and in particular, ensure decisions about the indication and likely benefit of a transfusion are documented in the medical record. Compliance should be audited.	LHDs and other PHOs
Patient Blood Management	LHDs should move towards best practice by establishing procedures for the prescription of blood transfusions.	LHDs and other PHOs
Deteriorating Patient	Local health districts, supported by the CEC, should progressively implement strategies to address the barriers to escalation identified by staff at the unit level	LHDs CEC

## The role of clinical teams is strengthened to support patient quality and safety outcomes

Since the first QSA self-assessment in 2007/08, a number of initiatives at the level of the health system have been implemented which are intended to support safety and quality in clinical care, such as the establishment of the four 'pillar' agencies in NSW (CEC, Agency for Clinical Innovation, Health Education Training Institute and Bureau of Health Information) and the National Safety and Quality in Health Service Standards. In the context of these system-level changes, the 2012 self-assessment highlights opportunities for change to support patient quality and safety outcomes at the level of the patient care team. The benefits of focussing on patient care teams as a means of improving clinical quality and patient safety outcomes has been demonstrated<sup>2</sup>.

A number of NSW programs exist to address specific clinical risk areas. Ultimately, these programs depend on the patient care team to implement them and make them work for patients.

The foundations for 'healthy' teams which communicate well, focus on the patient and systematically reflect on practice, already exist in the staff of the NSW PHOs, as demonstrated by the optimistic culture and individual and collective commitment to delivering excellent compassionate healthcare, reported in the self-assessments over five years.

**'...building highly functioning health care unit teams which are resilient and adaptable, then replicating the essential attributes of these teams across health care organisations is a means of building high reliability healthcare systems'.<sup>3</sup>**

QSA TOPIC	RECOMMENDATIONS FOR IMPLEMENTATION	WHO SHOULD LEAD
Safety and quality culture	Education should highlight the evidence base for patient-centred care and demonstrate the links between patient-centred care at clinical unit level and initiatives at governance level. Education should be resourced and practicable for clinicians.	HETI LHDs
Safety and quality culture	Facilities and units should monitor, and provide reports to the quality committee, the implementation of improvement initiatives and programs where the risks targeted can reasonably be managed at unit level.	Facilities Clinical units
Clinical review meetings	Multi-disciplinary clinical review structures are needed to ensure risks are reviewed and necessary change is adopted. Facilities and units should ensure clinical review meeting participation from a diverse and relevant range of health professionals and support these structures in acting on identified clinical risks.	Facilities Clinical units
Credentialing and supervision of clinicians	PHOs should implement existing arrangements for performance reviews of all clinical staff including Visiting Medical Officers and staff specialists, nursing staff and allied health staff. A policy for the credentialing and performance review of Career Medical Officers should be established (if not already) and formalised compliance and monitoring processes implemented to ensure they are provided with appropriate professional development opportunities	Ministry PHOs
Credentialing and supervision of clinicians	An additional education and implementation resource is required to support PHOs to manage the investigation of possible sub-standard clinician performance, assess the seriousness of the complaint or concern, and effectively and promptly manage issues raised regarding clinical performance.	Ministry

# The Quality Systems Assessment Program

The QSA has been developed to provide clinicians and managers at all levels of all PHOs with information to assess progress towards achieving best practice in clinical quality and patient safety in their own area, and benchmark practice with colleagues across NSW.

The QSA features a multi-level assessment, based on evidence that an organisational approach to quality systems provides the most effective opportunity to assess quality systems. This method means that responses at different levels of the organisation can be correlated to assess the effectiveness of governing and reporting structures across the PHO, as well as the quality systems utilised in clinical departments and units.

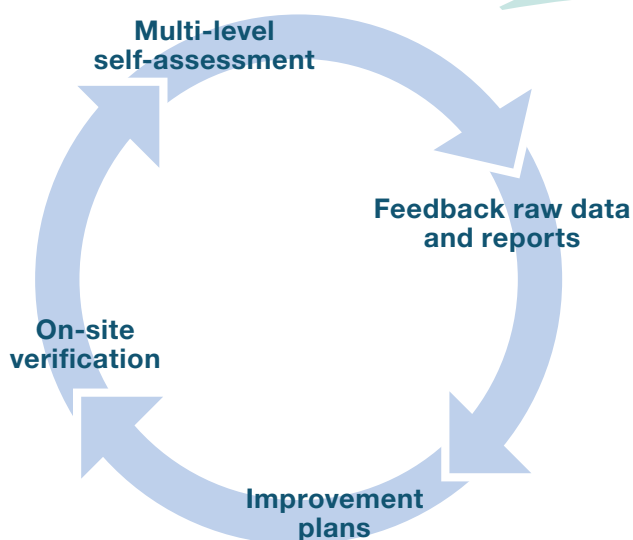
The program has four main elements (Figure 1):

- Multi-level self-assessment;
- Feedback data and reporting;
- Development of improvement plans ; and
- On-site verification.

The QSA operates in a dynamic state and national policy context and across PHOs with very different communities and health care needs.

LHDs and other participating PHOs receive detailed local data and support with analysis, which facilitates ownership of patient safety and clinical quality issues by those closest to practice.

*Figure 1 The QSA model*



*Julie Hall (RN), Meg Ross (CNS), Judy Lockhart (A/HSM) and Pam Nichols (RN). Warialda Multi-Purpose Service, HNELHD.*

# The 2012 Quality Systems Self-Assessment

## Repeat assessment topics

In 2007/08 the Patient Safety and Clinical Quality Program standards guided the development of the initial QSA self-assessment topics and established a baseline for the safety and quality systems and activities in NSW PHOs. The 2012 self-assessment provided the first opportunity to assess change in relation to high risk issues on a system wide perspective over the five years of the QSA. The topics assessed in Year 1 and Year 5 included:

- Governance and clinical risk management;
- Clinical audit;
- Credentialing and supervision of clinicians;
- Clinical review meetings and audits; and
- Patient blood management.

In 2012 the topic of End of Life (EOL) care and management was included in the self-assessment and it is reported briefly here as well as in a separate QSA publication *"Care for the Dying in NSW"* available at [www.cec.health.nsw.gov.au](http://www.cec.health.nsw.gov.au)

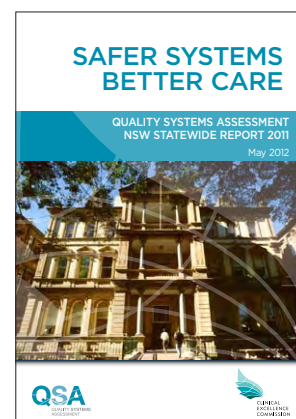
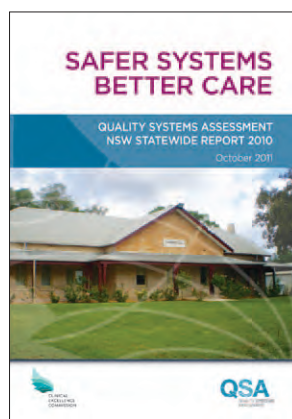
## Participation

In 2012 the self-assessment was undertaken by over 1,500 respondents across PHOs, and at various levels of the health system, with an overall response rate of 96%.

## Reporting

The *Safer Systems Better Care 2012* report is intended to provide an overview of current systemic themes in patient safety and clinical quality across PHOs, and highlights areas for improvement in managing these complex issues in a co-ordinated way. This year's report also incorporates alignments with the relevant National Safety and Quality Health Service Standards. Previous QSA reports are available at <http://www.cec.health.nsw.gov.au/programs/ksa>

Previous reports from Quality Systems Assessment program, available at <http://www.cec.health.nsw.gov.au/programs/ksa>



# The 2012 Self-Assessment findings

## A note about the data

Data was collected via a web-based self-assessment tool and managed by the QSA program team. The three self-assessment levels referred to in this *Safer Systems Better Care 2012* report are noted in the 'Executive Summary' section.

The report focuses on those responses given by participants in the self-assessment which align most closely to best practice. Thus, the data relating to "strongly agreed" and "always" answers on the Likert scale is included in this Report. "Agreed" and "often" are also presented where the inclusion of those data provide a more comprehensive picture of clinical practice and patient safety in NSW.

Self-assessment data from both the Ambulance Service and Justice Health has been included in this Report, where appropriate. The CEC recommends these organisations assess the applicability of each recommendation in relation to their clinical and governance environment.

It should be noted that while the self-assessment was undertaken based on Area Health Service boundaries

in 2007/08, the analysis and report development is based on the 2012 LHD boundaries.

## Safety and Quality culture

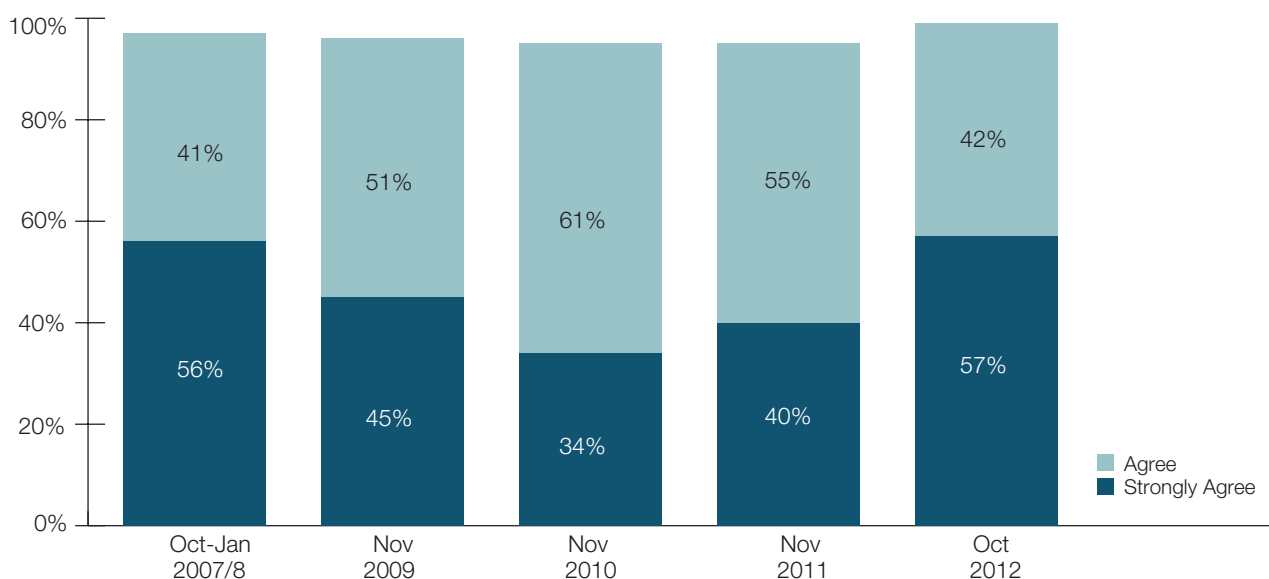
### National Safety and Quality Health Service Standard (NSQHS) 1

#### Governance for Safety and Quality in Health Service Organisations

Patient safety and clinical quality are essential values of the NSW public health system. Significant effort has been invested in establishing policies, systems, cultural supports and workforce development to identify gaps in practice, develop best practice responses and implement improvement strategies across the system.

Figure 2 demonstrates the positive and resilient culture in PHOs. The first QSA program cycle has witnessed substantial changes in the NSW Health system and at national level. PHOs can be seen responding to change and adopting change through this period.

*Figure 2: LHD unit level respondents reporting "Strongly Agree" and "Agree" that "There is a positive patient safety culture in our department/clinical unit" (Unit level 2007 – 2012)*





In 2012, 32% of LHD level respondents, 47% of facility level respondents, and 54% of unit level respondents “strongly agreed” that there is a positive safety and quality culture, with overall 57% of respondents strongly agreeing.

Improving clinical quality and patient safety is multi-factorial – high quality, safe clinical care is characterised by the interrelationship of formal governance structures and the actions of individuals and teams within a clinical unit or facility. In the literature a strong quality culture is cited as a main contributing factor in the effectiveness of a safety management system<sup>4</sup>.

The continued importance placed on safety and quality (Figure 2) reinforces the capacity of the NSW public health system to respond and adapt to structural changes whilst maintaining a consistent emphasis on patient safety and clinical quality culture. The strong response regarding positive safety and quality culture among units is a valuable foundation for initiatives supporting risk identification and mitigation across NSW.

***“The quest for excellence is never ending and we have a culture of cooperation amongst clinicians and management. We use data to initiate change practices”.***

**(Self-assessment respondent 2012)**

### **Action strategies:**

- LHDs should foster and maintain a positive quality and safety culture by ensuring clinical governance structures and processes exist for regular and active communication about quality and safety within and across disciplines at facility and unit levels, such as through unit, department and facility multi-disciplinary committees.
- Education should highlight the evidence base for patient-centred care and demonstrate the links between patient-centred care at clinical unit level and initiatives at governance level. Education should be resourced and practicable for clinicians.
- Facilities and units should monitor, and provide reports to the quality committee, the implementation of improvement initiatives and programs where the risks targeted can reasonably be managed at unit level.

## Patient based care

### NSQHS Standard 2

#### Partnering with Consumers

Patient based care is recognised as a dimension of quality and safety in health care, and involves transforming care to include patients, families and carers as 'care team' members. Different definitions and terminology have been used to describe the concept in this area. Patient based care is the engagement of patients not only in their own care but also in service governance to contribute to health service improvement.

Patient based care highlights the important role health systems can play at all levels to respect patients' preferences and values, providing emotional support, continuity and access to care. This includes providing patients, families and carers with coordinated care along with supportive communication, education and the inclusion of family and friends<sup>5</sup>.

The evidence about patient based care demonstrates an association with; decreased mortality<sup>6</sup>, decreased rates of hospital-acquired infection<sup>7</sup>, decreased surgical complications<sup>8</sup>, higher quality clinical care/best practice<sup>9</sup> and improved patient functional status.<sup>13</sup>

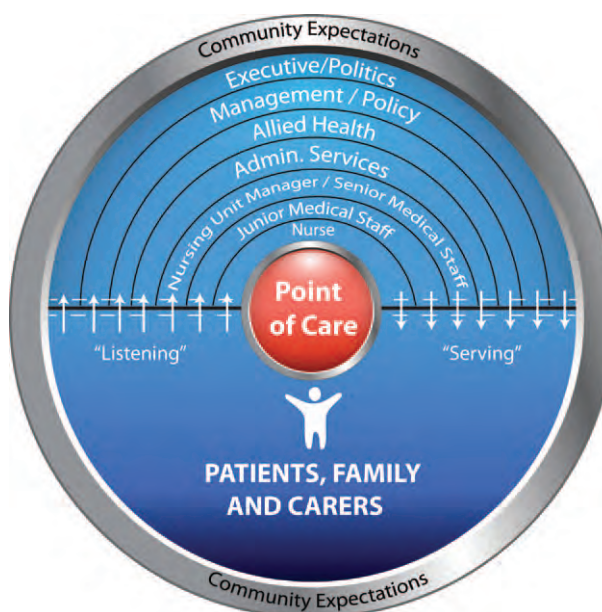
An emphasis on patient based care was included in the 2007/08 QSA with questions relating to patient complaints as a subset of the overall patient experience of care. The NSQHS Standards have moved services to focus on this area requiring, "consumers and/or carers (to be) supported by the health service organisation to actively participate in the improvement of the patient experience and patient health outcomes".<sup>10</sup> Whilst featured in Standard 2, this emphasis runs throughout the National Standards.

In 2012, 35% of respondents 'Agreed' that patients, families and carers were viewed as integral members of the healthcare team, an increase from 28% in 2011. In 2012, 78% of LHD level respondents and 75% of facility level respondents reported that

consumer participation in organisational processes such as planning, improvement and monitoring were included in the facility clinical governance framework. The results are encouraging and demonstrate there is scope for further improvement in this area.

The CEC operates under a model of care (Figure 3) that demonstrates an equal emphasis on partnering with patients, families and carers through governance to frontline services. This model seeks to improve safety and quality through partnership. The CEC Patient Based Care Challenge highlights practical strategies and goals to integrate patients, families and carers into health services to support safety and quality as mutually beneficial partners.

*Figure 3: Clinical Excellence Commission model of patient based care*



The Citizens Engagement Advisory Council, a committee of the CEC Board, provides advice to the CEC on optimal models and processes for engaging the community in promoting quality and safety in health care. Similar mechanisms for community engagement are in place in many PHOs.

### Action strategies:

- At all levels of PHOs patient-based approaches should be emphasised in training for clinical supervisors and in clinical leadership initiatives. It should also be integrated in planning, delivery and evaluation of all clinical services.
- All PHOs should engage their consumers and communities on matters of planning, improvement and monitoring based on guidance from the Ministry of Health and CEC about consumer engagement
- LHDs should encourage participation in the CEC's Partnering with Patients program and adopt the Patient Based Care Challenge (see [www.cec.health.nsw.gov.au/programs/partnering-with-patients](http://www.cec.health.nsw.gov.au/programs/partnering-with-patients)).

## Clinical governance and clinical risk management

### NSQHS Standard 1

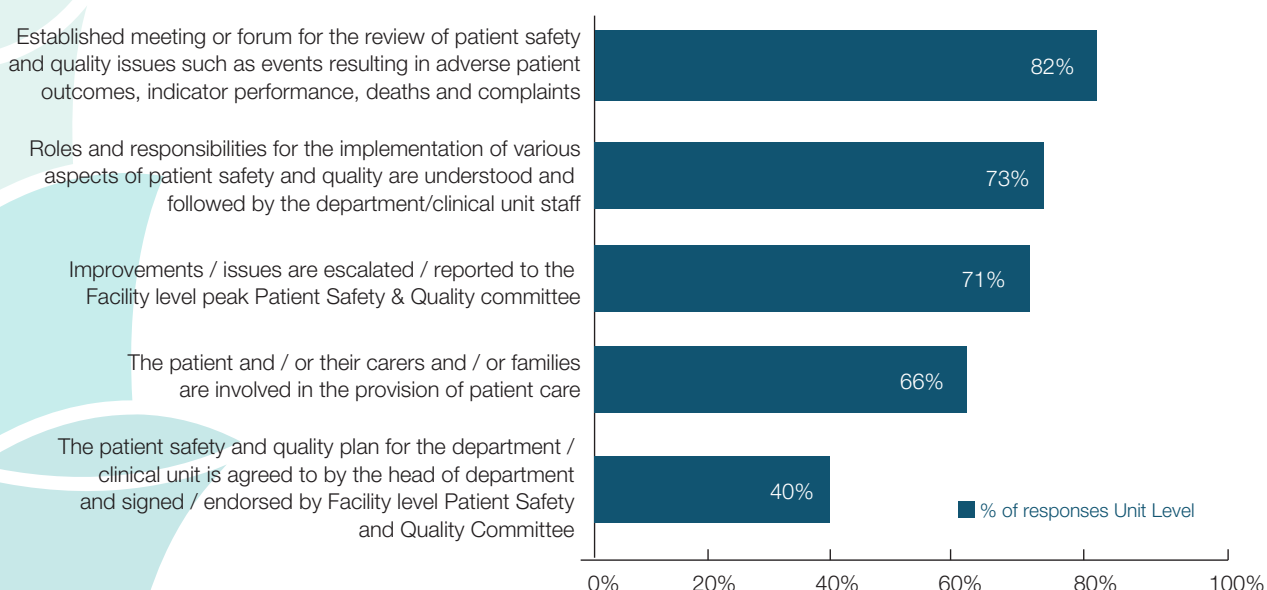
#### Governance for Safety and Quality in Health Service Organisations

The 2012 self-assessment revealed that 34% of respondents at unit level "strongly agreed" there was a clear, integrated and effective governance framework for safety and quality in place, including risk management and clinical incident management systems.

Clinician engagement and leadership plays an essential role in the effective implementation of good clinical governance. Units reported initiatives which are facilitated by their PHO to enable clinician development of leadership capability:

- Supports and fosters clinical innovation;
- Facilitates early participation in planning and decision making in change processes; and
- Provides specific training or mentoring programs.

*Figure 4: Proportion (%) Unit level (selected) responses to the question "Which of the following are included in the department/clinical unit governance strategy?" (Unit level 2012)*





An aspect where there was less agreement was on the provision of incentives to take on a safety, quality and leadership role. 30% of respondents at unit level strongly agreed that leadership was incentivised.

There was strong agreement across all organisational levels that actions arising from internal and external monitoring and review processes are implemented and evaluated (“always” or “often” 85% at unit level, 94% at facility level and 95% at LHD level).

***“We need to not let high activity in the unit impact on ways we address patient safety. We need to ensure that quality and patient safety are always the priority even when we are busy”.***

**(Self-assessment respondent 2012)**

In 2012 the self-assessment asked all levels of each PHO to identify the three highest risks to patient safety and describe the strategies implemented in response. In comparison to 2007/08 and 2009, falls and medication errors were again identified as the highest risks to patient safety by all levels of respondents. Staffing and skill mix were also identified again as key risks. However, unlike 2007/08 where there was little or no concordance between levels around risks identified, this year the risks are more closely aligned between organisational levels.

The main issues reported in the 2012 self-assessment included:

- Nearly half the respondents at unit level and facility level identified falls as a risk to patient safety and management;
- All aspects of medication management and safety were identified as a risk in 2007/08, 2009 and 2012; and
- The care and management of patients with mental health conditions, especially in the acute care setting/emergency department, were highlighted.

As issues in relation to communication/handover, falls and medication management have been highlighted at each level of each organisation, the CEC will assess the themes of falls, medication safety and transition of care through the QSA program in 2013.

### **Action strategies:**

- LHDs should actively promote the availability of existing information, resources and training available to support clinical governance through formal and informal communication channels within and across all levels of the organisation and by all grades of employees.
- The CEC will assess the themes of falls, medication safety and transition of care through the 2013 QSA.

## Clinical audit

### NSQHS Standard 1

#### Governance for Safety and Quality in Health Service Organisations

Clinical audit is a quality improvement process that seeks to improve patient outcomes through systematic review of care against explicit criteria, the identification from the review of action to improve clinical practice and the implementation of such actions<sup>11</sup>.

Based on the findings of the 2007/08 self-assessment, the CEC noted there was no prescribed statewide policy or guideline for undertaking clinical audit, and recommended the establishment of “best practice models for clinical staff to undertake clinical audit, medical record review, peer review or other quality review activities”<sup>12</sup>.

The 2007/08 recommendation has not been implemented on a statewide level. However, the 2012 self-assessment found consistent acknowledgement across the state by the units that there is a standardised approach (in the form of programs or systems) to clinical audit which is either based on a local facility approach or an approach

applied across the LHD (39% local approach and 45% LHD approach). 79% of units indicated they had undertaken a clinical audit in relation to a clinical outcome in the preceding 12 to 18 months.

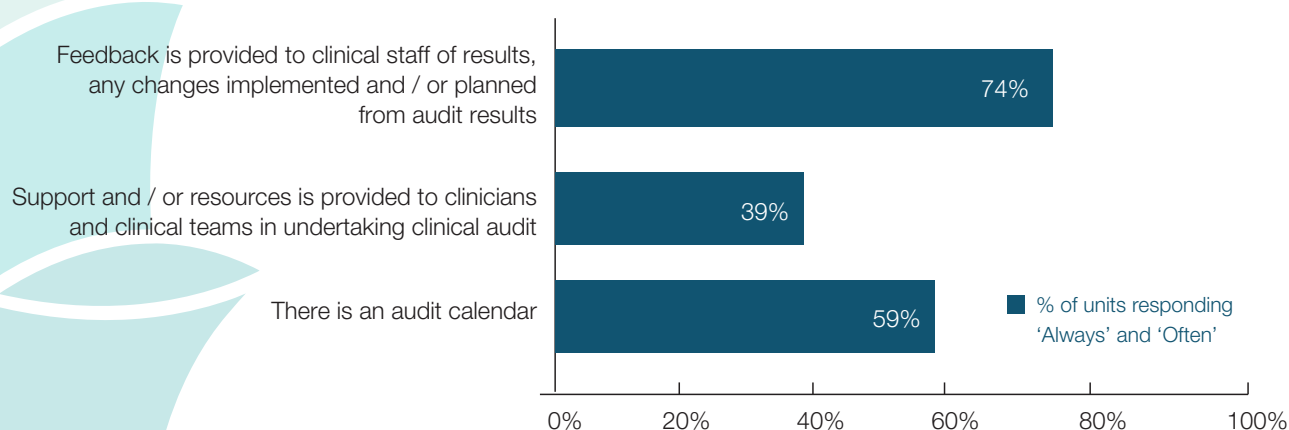
Over half of both unit and facility level respondents detailed that the following aspects were included in clinical audits:

- The results of audit are presented at clinical meetings;
- Action plans are developed and identify those responsible for improvements;
- Re-audit is applied to determine the effectiveness of improvements;
- Standards are developed from evidence-based literature and guidelines; and
- Each audit has a designated local lead.

Whilst the trends are similar, there was however some dissonance between the unit and facility level responses – facilities tended to give a stronger response to elements of the clinical audit program.

39% of unit level responses said that support and/or resources are “always” or “often” provided to clinicians and clinical teams in undertaking clinical audit.

*Figure 5: Proportion (%) unit level responses to various activities associated with clinical audit (Unit level, 2012).*





***“Our department supports clinical audits as it allows us as a team to reflect on practice and aim to improve same. It also provides the team with clinical data which is used as evidence when suggesting improvements as staff respond well when evidence is provided”.***

**(Self-assessment respondent 2012)**

Given the 2012 self-assessment findings about clinical audit practice, it is appropriate to re-state the recommendation made in 2007.

### **Action strategies:**

- Statewide agencies and networks should assist PHOs in developing best practice models for clinical audit, medical record review, peer review or other quality review activities.
- All PHOs should implement a calendar for audit activities and a person should be identified to monitor progress against the calendar, in each clinical unit



*Dr Nick Collins (SWSLHD) meeting with Jacqui Chapman, Registered Nurse and Jenny Griffiths, Health Service Manager, Nyngan Health Service during onsite verification visit.*

## **Clinical review meetings**

### **NSQHS Standard 1**

#### **Governance for Safety and Quality in Health Service Organisations**

The main purpose of clinical review meetings is to provide a forum for discussion about clinical adverse events (including deaths). To be most effective the meetings must be multi-disciplinary and even involve the input of partner agencies; include clear reporting lines; and establish a process for making recommendations and developing and allocating subsequent actions.

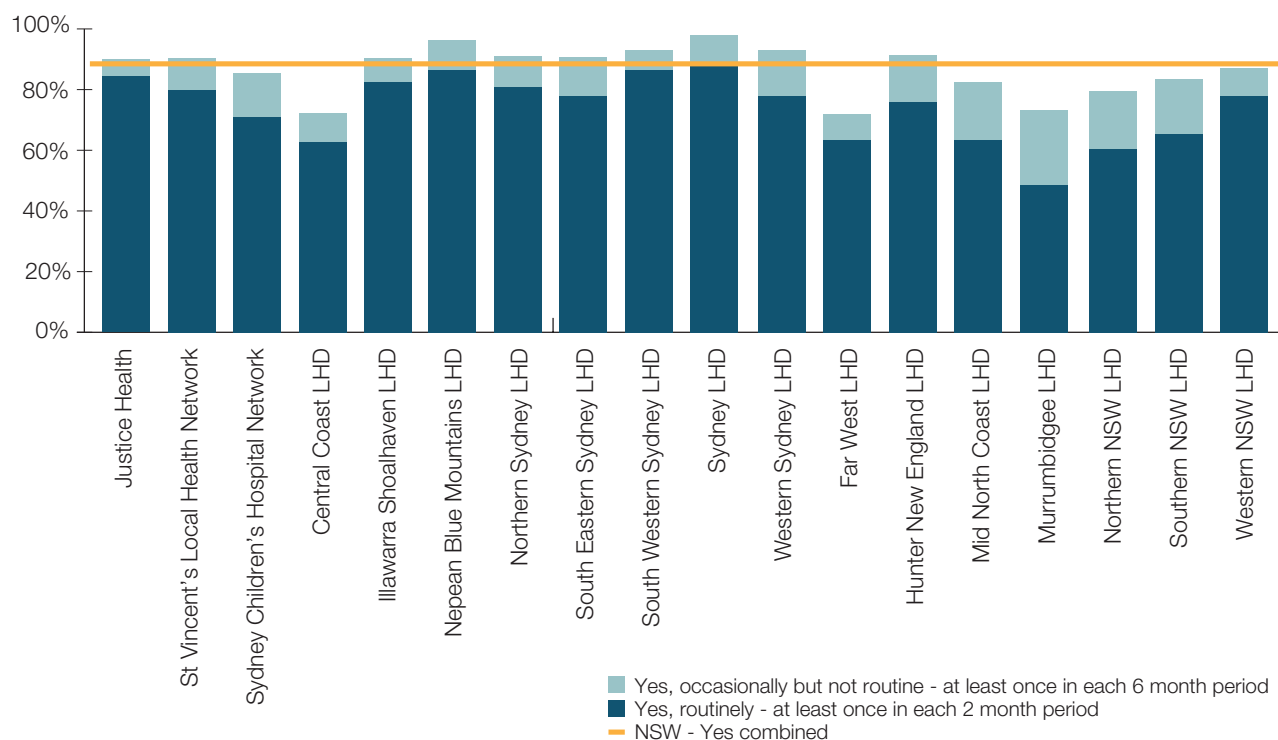
***“The purpose of a mortality and morbidity meeting is stated at the onset of each meeting. Included should be respect for the participants, criticise ideas not people, keep an open mind, listen constructively. The meeting should also include nursing and allied health staff”.***

**(self-assessment respondent 2012)**

89% of unit level respondents indicated they held a regular scheduled meeting or forum for the review of patient safety and quality issues. 76% of units held a meeting or forum routinely at least once in each two month period, and 13% of units did so occasionally but not routinely - at least once in each six month period (Figure 5).

Multi-disciplinary clinical review structures are needed to ensure information is shared and change adopted. 93% of units indicated a senior clinician “always” or “often” leads the clinical review meetings. 80% of unit level respondents indicated that clinical review meetings are “always” or “often” attended by staff from more than one discipline.

Figure 6: Proportion (%) unit level responses to the question “Do all departments/units in the facility have a regular scheduled meeting or similar forum for the review of patient safety and quality issues?”(Unit level, 2012).



**“Clinical reviews are received well within my unit with staff seeing the positive outcomes from the reviews and not seeing it as a “finger pointing” exercise. All staff are involved where possible and staff rotate presenting”**

**(Self-assessment respondent 2012)**

A key component of implementing and communicating decisions of clinical review meetings is to ensure meeting reports are forwarded to the hospital or district peak Clinical Governance Committee or equivalent to identify issues needing to be addressed across all services. Participants indicated this occurred at the facility level “always” or “often” 70% of the time and at the unit level “always” or “often” 62% of the time.

### Action strategies:

- LHDs should ensure all clinical review meetings report to the facility or district Clinical Governance Committee or equivalent to ensure LHDs can identify and respond to service-wide issues.
- Multi-disciplinary clinical review structures are needed to ensure risks are reviewed and necessary change is adopted. Facilities and units should ensure clinical review meeting participation from a diverse and relevant range of health professionals and support these structures in acting on identified clinical risks.

# Mortality review

## NSQHS Standard 1 Governance for Safety and Quality in Health Service Organisations

The NSW Health Patient Safety and Clinical Quality Program (PSCQP) requires each PHO to have in place a system for screening medical records of all patients who have died in their service. The intent of the process is to:

- Ensure appropriate mandatory reporting and review of patient deaths; and
- Determine whether changes in practice are needed to improve the safety and quality of patient care at the local and system level.

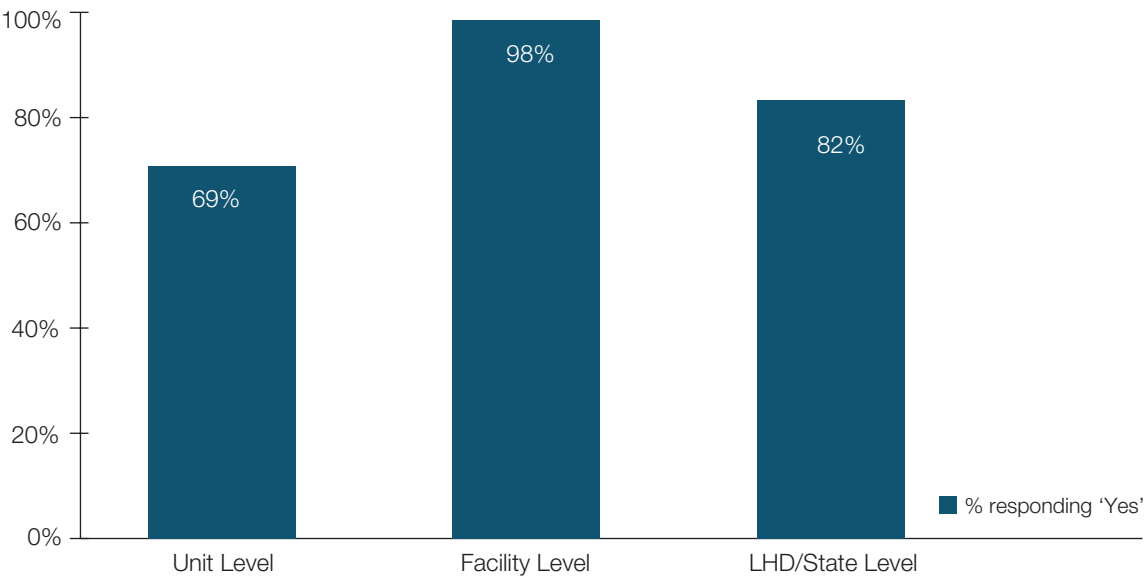
On the basis of the 2007/08 self-assessment the CEC recommended policy and guidance be developed around death review for PHOs, and PHOs put in place a consistent and timely death review process which includes an independent review of the medical record, where appropriate.

The 2012 self-assessment found that 97% of facility respondents indicated they have a process in place to ensure all inpatient deaths are identified for review and screening. At the unit level 91% of respondents reported “always” or “often” reviewing all relevant deaths in the unit when or if they occur.

The contemporary relevance of the 2007/08 recommendation is supported by the proportion of 2012 unit respondents (69%) who agreed that a standardised framework or guideline was followed for the review of all deaths. In contrast a higher proportion of facilities and LHDs respondents noted agreement that there was a standardised framework or guideline (Figure 6).

The variance between units and other organisational layers in LHDs could be improved by the development of a statewide, standardised framework or guideline regarding mortality review, and a program of communication, training and implementation support to embed the framework in a consistent manner across the health system. Policy development needs the support of the Ministry of Health to embed local implementation of appropriate mortality review systems.

Figure 7: Comparison of LHD, facility and department / unit level aggregated responses to the question about use of a standardised screening framework or guideline for the review of all deaths



***“The mortality and morbidity meetings held within our department now include all staff and are a great tool for reflecting on practice and seeing perspectives that are not able to be discussed in the clinical setting”.***

**(Self-assessment respondent 2012)**

The self-assessment also asked whether a review was undertaken of end of life management with regard to pain management, comfort and the level of patient and carer involvement in decision making. Across NSW units 80% of respondents detailed they routinely reviewed a patient's end of life management in regard to comfort and pain and patient and carer decision making involvement<sup>14</sup>.

However 10% of units which reported providing care weekly or more often for people who are dying or approaching the end of their life indicated they did not “always” or “often” review all relevant deaths. Statewide policy direction and implementation support is required to deliver the mortality review systems which support quality improvement.

Once statewide policy is endorsed LHDs should focus attention on implementation of the approach to mortality review such that all relevant deaths are always reviewed.

### **Action strategies:**

- Policy and guidance should be developed around death review for PHOs to implement, and PHOs should have in place a consistent and timely death review process which includes an independent review of the medical record, where appropriate. A centralised approach to collate outcomes of these review meetings would improve learning across the organisation and inform risk stratification and control measures at facility and organisation level.
- Death review policy and guidance for PHOs to implement should include consideration of implementation factors such as communications targeted to units which care for dying people more often, monitoring strategies and access to independent reviewers.

*Sharon Simpson Health Service Manger and Sue Stove, Nursing Unit Manager, Narrabri District Health Service.*



# Credentialing and supervision of clinicians

## NSQHS Standard 1 Governance for Safety and Quality in Health Service Organisations

Credentialing and the scope of clinician performance (including clinical supervision) are aspects of the broader work on clinical governance and quality in the health sector. Both clinical supervision and credentialing reduce errors and improve patient care.

In 2012, there was adequate agreement (42% at unit level, 65% at facility level) that there was a process established and working effectively for the identification and investigation of potential impaired clinical performance (Figure 7).

Positively, 90% of unit level respondents indicated

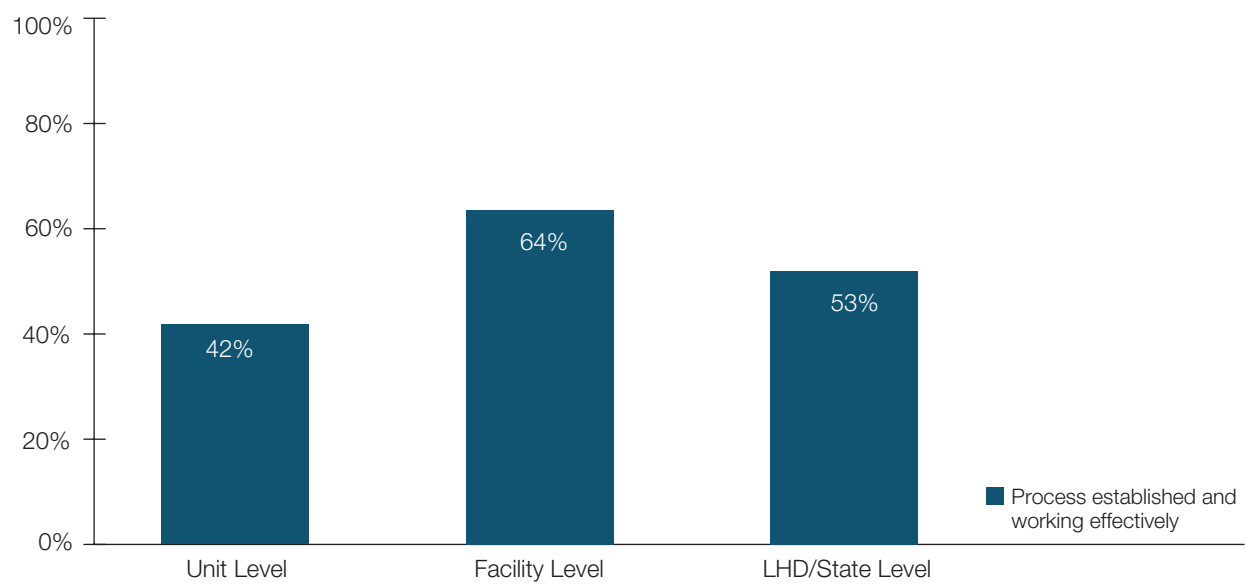
they “always” or “often” ensured procedures which entail a potential risk to patient safety are performed by staff with previous experience and who have been tested and credentialled.

In relation to clinical supervision, the results of the self-assessment suggest widespread knowledge across all levels of the health system in relation to guidelines and frameworks regarding the supervision of clinicians.

***“Supervision of medical staff is the responsibility of more senior medical staff... While nursing and allied health staff are responsible to the appropriate senior medical member in the department for clinical issues, their professional development reporting is also to a nominated Nursing or Allied Health staff member”.***

**(Self-assessment respondent 2012)**

Figure 8: Comparison of LHD, facility and department / unit level aggregated responses in relation to having a formalised process for the identification and investigation of potential impaired clinical performance established and working effectively.





There was widespread agreement that senior clinicians who have responsibility for the supervision of clinicians are supported in this role through education and training to develop their skills, with a unit average of over 80%. The self-assessment results also demonstrated considerable agreement that the unit monitors incidences where lack of point of care supervision has been identified.

The need for supervision of junior clinicians has been raised in inquiries into acute care in NSW and overseas, and a culture which supports help-seeking by clinicians in pursuit of clinical quality should be fostered among PHOs.

95% of unit level respondents indicated they “always” or “often” ensured junior staff have access to guidelines/protocols giving them permission to escalate critical patient care decisions to senior clinicians as required.

**“Junior doctors must never be put in the position where they do not feel able to ask a more senior doctor for help and advice. Some senior doctors don’t appreciate being disturbed at home or after hours and so discourage junior doctors from seeking their assistance...if the patient needs help, then it should be given”.<sup>15</sup>**

### Action strategies:

- PHOs require an updated statewide standardised process for credentialing linked to recruitment systems, and a model scope of clinical practice. PHOs should adopt and monitor credentialing processes once a statewide process and model is established.
- PHOs should implement existing arrangements for performance reviews of all clinical staff including Visiting Medical Officers and staff specialists, nursing staff and allied health staff. A policy for the credentialing and performance review of Career Medical Officers should be established (if not already) and formalised compliance and monitoring processes implemented to ensure they are provided with appropriate professional development opportunities.
- An additional education and implementation resource is required to support PHOs to manage the investigation of possible sub-standard clinician performance, assess the seriousness of the complaint or concern, and effectively and promptly manage issues raised regarding clinical performance.

## Patient blood management

### NSQHS Standard 7

#### Blood and blood products

Patient blood management aims to improve clinical outcomes by avoiding unnecessary exposure to blood components. It includes the three elements of:

- Optimisation of blood volume and red cell mass;
- Minimisation of blood loss;
- Optimisation of the patient's tolerance of anaemia.

In 2012, the self-assessment results regarding blood management showed that the vast majority of LHDs (94%), units (88%) and facilities (92%) were using the appropriate NSW Health policy<sup>16</sup>. Further, 73% of units had restrictions in relation to the prescription of blood transfusions and 72% of units "always" or "often" defined and documented the clinical indication and evidence for the likely benefit for each transfusion in the medical record.

The results also indicated that 76% of unit level respondents review the appropriateness of blood product use, which contributes to excellence in transfusion practice.

#### Action strategies:

- LHDs should continue to implement the mandatory NSW Health blood management policy (PD2012\_016) and in particular, ensure decisions about the indication and likely benefit of a transfusion are documented in the medical record.
- LHDs should move towards best practice by establishing procedures for the prescription of blood transfusions.



*Medical staff at  
Ryde Hospital*

## End of life care and management

### NSQHS Standard 9

#### Recognising and Responding to Clinical Deterioration in Acute Health Care

End of life care is provided to people who are living with, and who are impaired by, a life limiting illness. It is not defined by prognosis or diagnosis.

Quality end of life care is realised when strong networks exist between specialist palliative care providers, primary specialists and support care providers and the community – working together to meet the needs of people requiring care<sup>17</sup>.

In the 2012 self-assessment respondents were asked to indicate the frequency with which care is provided for people who are dying or approaching their end of life – across NSW 31% of respondents reported that they did so “often”, which meant weekly or more often than weekly. The frequency

of care reported by rural and regional respondents was greater (37%) than for metropolitan (28%) or metropolitan network-based respondents (24%).

- 63% of units that responded to the self-assessment indicated care is provided for people who are dying or approaching the end of their life, their families and carers.
- 92% of responses from the Ambulance Service indicated care is provided for people who are dying or approaching the end of their life, their families and carers.
- 61% of units reported they routinely identified patients who were likely to die in the next six to 12 months.
- Units indicated the most challenging issues when managing patients at the end of life were incomplete documentation in the medical records (59%); staff members not feeling comfortable initiating the conversation with the patient, their family or carer (53%); and poor communication between staff and family or carers (31%).



*Dr Stephen Della-Fiorentina (WSLHD) and Sue Mack, Health Service Manager, Bingara Multi Purpose Service*

- 87% of units responded that education and training is provided to relevant clinicians in relation to end of life management. Areas covered included symptom management (66% of units); advance care directives (58%); using the principles of a palliative approach (56%); and communication skills (50%).
- 32% of units responding to the self-assessment indicated they did not monitor any performance measures relating to end of life care.
- Of those that did monitor performance measures, 78% of units reported monitoring complaints and compliments; 40% indicated the involvement of palliative care teams in patient end of life management; and 33% reported the number of patients with a documented end of life care plan.

The CEC recommends the development of a standardised, evidence-based and consensus-focused best practice system around managing all aspects of end of life care.

The CEC has engaged an expert group of clinicians to review the self-assessment data regarding end of life care (full findings can be found on the CEC's website [www.cec.health.nsw.gov.au](http://www.cec.health.nsw.gov.au)). Their advice, in *Care for the Dying in NSW*, was that such a system would include:

- The development of a process to identify those at risk of dying in a timely manner in order to initiate advance care planning processes and consider referral to appropriate support services;
- A statewide system to flag those patients with advance care planning documents to ensure accessibility to all health professionals including paramedics;
- Tailored training programs in communication skills relating to end of life care;
- A statewide end of life care pathway to ensure all dying patients benefit from a standardised approach to individualised end of life care, incorporating excellent symptom control, a prompt

for communication to address social, spiritual and cultural needs as well as bereavement support for families and carers;

- All facilities ensuring the physical environment supports the need for communication with patients and their families by identifying suitable spaces for this to occur, and consider the need for privacy in bed allocation to dying patients; and
- Implement a statewide death review approach, exploring the circumstances of the death, including symptom management in the last 24 hours of life.

### Action strategies:

- A statewide, standardised, evidence-based and consensus-focused best practice system around management of all aspects of end of life care should be developed, implemented and evaluated.

# State Improvement programs

The QSA provides an opportunity to review major quality and safety improvement programs on an annual or biennial basis as part of the evaluation of program adoption and implementation.

## Between the Flags

### NSQHS Standard 9

#### Recognising and Responding to Clinical Deterioration in Acute Health Care

The early recognition of deteriorating patients is an issue in hospitals and in health care delivery across the world. The *Between the Flags* Program was designed by the CEC to establish a 'safety net' in all NSW public hospitals and healthcare facilities to systematically identify and respond to clinical deterioration in patients, and was introduced in January 2010 to NSW hospitals.

In 2012 unit level respondents were asked about the barriers and challenges to escalating the care of the deteriorating patient. The main issues highlighted included:

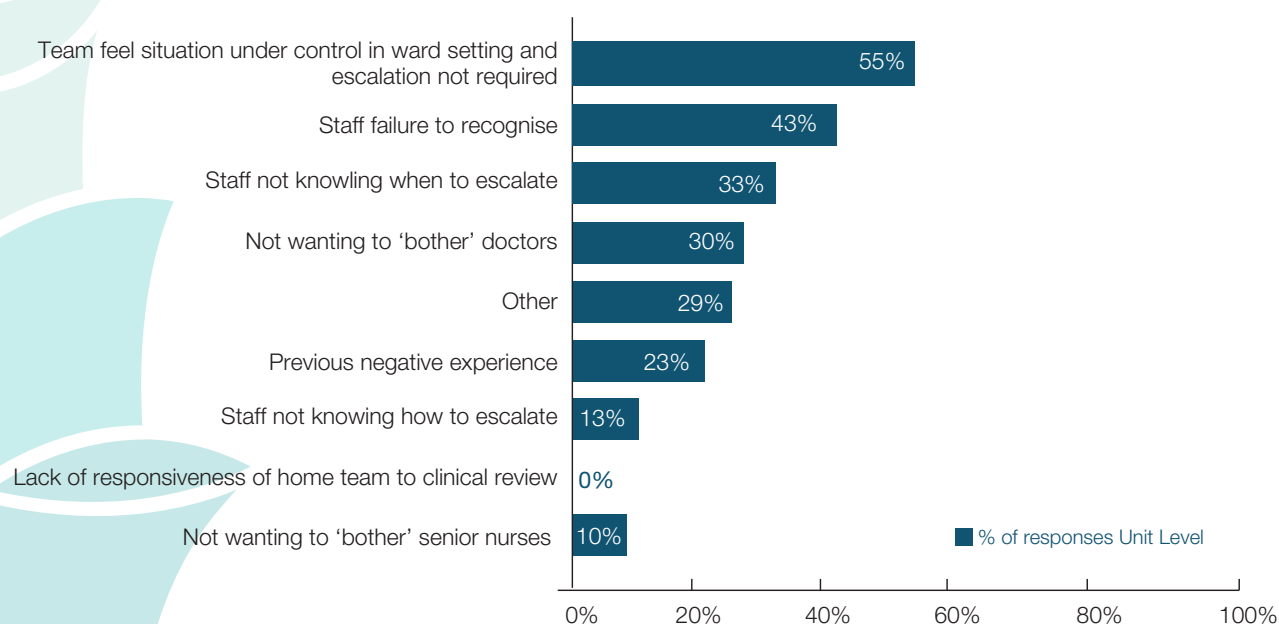
- Team feel situation under control in ward setting and escalation not required;
- Staff failure to recognise deterioration;
- Staff not knowing when or how to escalate;
- Staff not wanting to bother doctors or senior nurses.

23% of unit level respondents reported a previous negative experience of escalation was a barrier.

***"BTF has given nurses the confidence to call clinical reviews - no longer intimidated by fear. This simple change of documentation has been one of the best changes in 20 years to ensure patient safety".***

**(Self-assessment respondent 2012)**

*Figure 9: Proportion (%) Unit level (selected) responses to the question what are "the top three barriers or challenges to escalating the care of the deteriorating patient" (Unit level 2012)*





Evidence about the factors behind the failure of bedside clinical staff to activate rapid response systems in the care of a deteriorating patient suggests that even where there is long-standing organisational commitment to such systems, clinical staff act on local sociocultural factors and intra-professional hierarchies within the clinical environment<sup>18</sup>.

The study by Shearer et al (2012) found that failure to activate the rapid response system was more often due to sociological barriers than cognitive ones. The barriers identified in this Victorian study are comparable to those identified in NSW PHOs: staff feeling they should be able to manage patients by themselves on the ward (41% nursing staff and 40% medical staff); a cognitive failure to recognise the meeting of identified escalation criteria (31%); and concern about a negative response from a colleague (13% for nursing colleagues and 26% for medical colleagues).

Such findings suggest that implementation of systems for the management of deteriorating patients is challenging to traditional hierarchical models of referral in clinical care, and therefore implementation focus needs to be sustained for a significant period<sup>19</sup>.

### Action strategies:

- Local health districts, supported by the CEC, should progressively implement strategies to address the barriers to escalation of care of the deteriorating patient, identified by staff at the unit level.

*The Between the Flags program has increased nurse confidence to escalate care for deteriorating patients*



# Clinical handover

## NSQHS Standard 6

### Clinical Handover

When a patient's health information is communicated from one health professional to another, such as from the staff of one shift to another, the process of clinical handover occurs.

The use of standardised tools and methods in handover minimises content omissions, incomplete or unclear information, conflicting advice and time wasting<sup>20</sup>.

The 2009 self-assessment reported that at network/cluster level (as it was in 2009), the main issues identified as impacting the clinical handover related to the lack of, or breakdown of, the communication process, lack of a standardised process for handover, and poor documentation. At facility level the barriers were the same<sup>21</sup>. Accordingly a recommendation was made in the 2009 self-assessment report.

#### 2009 recommendation

The standard key principles of the strategy for safe clinical handover should be implemented in all [public health services]. This strategy is...mandated as policy directive: (PD2009\_060).

Since 2009, the public health system has demonstrated significant progress in:

- use of a standard clinical handover tool at the unit level (50% in 2009 to 96% in 2012);
- monitoring of the quality of the handover process at facility level (70% in 2009 to 94% in 2012);
- undertaking clinical audits to monitor handover outcomes at facility level (34% to 58%); and

- providing staff feedback on audit findings (31% in 2009 to 40% in 2012 at facility level and from zero per cent of Area Health Services in 2009 to 59% of LHDs in 2012).

Between 2010 and 2012 the number of respondents reporting that nurses in the unit "always" or "often" conduct shift to shift clinical handover at patient's bedside at least every 24 hours rose from 28% to 41% (this remains an important shift towards best practice though the combined response for "always" and "often" remained stable). The self-assessment findings represent an improved system response to the issue of clinical handover. The statewide implementation of the national standard for clinical handover will also focus attention and practice in NSW PHOs on this key issue.

However there remain some persistent and system-wide challenges to best practice clinical handover. In 2012, self-assessment respondents were asked to identify the top three challenges to clinical handover in units. The responses in order of prevalence were:

- Lack of protected time to provide or receive a detailed handover;
- Lack of time to prepare for a handover;
- Lack of training in effective clinical handover, communication and teamwork skills;
- Changing workplace practices leading to reduced continuity of care and increasing numbers of handovers; and
- Lack of standardisation of clinical handover processes within the unit.

# Outcomes and reflections from the 5-year Quality Systems Assessment

The QSA, designed by the CEC, has demonstrated its value since its inception in 2007/08. The program has shown increased engagement with clinicians and managers at all levels in all PHOs in NSW in a relatively short period of time. In a period of substantial change in health structural reform and quality and safety policy development, this is significant. Obtaining support and developing ownership for quality and safety among these key change-agents has been shown in evidence to be a crucial factor in successful clinical care initiatives.

***“I value the QSA feedback and consider it a very good tool to assess the capacity of the organisation’s ability to provide safe and effective health care”.***

**(Self-assessment respondent 2012)**

A number of the key outcomes of the QSA are detailed below.

- All PHOs in NSW participating in the QSA have been represented in each of the five annual self-assessments from 2007/08 to 2012.
- The number of respondents participating in the self-assessment has significantly increased over time, reinforcing that engagement with the program is strong, sustained and growing.
- Importantly, the number of facilities and clinical units which participate in the self-assessment has also increased. As these units are the frontline of the public health system, they are key actors in the early identification of emerging risks and vulnerabilities in practice, and are also uniquely positioned to be implementers of better practice.
- The QSA has delivered an increase in the number of respondent units and facilities involving more than one person completing the self-assessment. This group-based response provides a balanced risk assessment about the effectiveness of mitigation strategies in use at unit level.

- The response rate has increased by 14% since 2007/08, adding reliability and statistical power to the QSA data.

The focus on improvement within the clinical risk management framework of the QSA has facilitated the adoption of statewide improvement strategies and the development of local structures and tools to support clinical best practice.

- The timely and comprehensive provision of local data to LHDs, Specialty Networks, Justice Health and the Ambulance Service has been important in building local ownership of quality and safety.
- The responsiveness of the QSA program to the needs of LHDs and other PHOs has also been important in the development of a program identity and brand – these are among the CEC’s tools for the promotion of quality and safety in NSW.

The development of the improvement plan, which addresses risks identified through the self-assessment and the means by which improvement will be achieved, provides an integrated approach between the self-assessment, statewide recommendations and policy development, and local implementation and monitoring.

***“The QSA program identifies strengths and weaknesses in relation to processes in place around high risk quality and safety issues. It also highlights areas of improvement in education, policy development and knowledge transfer”.***

**(self-assessment respondent 2012)**

The value of the on-site QSA Verification Program also increases each year and its relevance continues to grow. Over the past four years the program has demonstrated:

- A verification program that relies on peer review is feasible and can be successful;

- The accuracy of self-assessments in the QSA is high and therefore clinical staff are able to accurately self-rate their performance in this context; and
- All PHOs have areas for improvement however each organisation has developed innovative ways to improve patient safety.

In moving forward with the QSA, the CEC will continue to be central to policy and practice development in quality and safety and will also continue to adapt the self-assessment process to current and emerging issues.

- In the context of the National Safety and Quality Health Services Standards, the QSA pro-actively (and pre-emptively) allows PHOs to seek out risks and gaps in practice, and provides the data needed to demonstrate achievement of accreditation actions, criteria and standards.

The QSA will support PHOs in accreditation by providing such evidence and facilitating data comparison across NSW including benchmarking against comparable facilities and the State average.

- The design of the QSA provides scope on an annual basis to assess contemporary issues in health care delivery, with the selection of topics for detailed assessment. This is a future-focused approach which supports ongoing and forward investment in the assessment of issues which are dynamic and contentious. Development of topics for future self-assessments will continue to take place in light of the development of effective systems responses to topics considered in previous self-assessments.



*QSA Assessors - Nicholas Marlow, Director of Nursing Community Health, Sydney Local Health District and Linda Davidson, Director Nursing and Midwifery/Site Co-ordinator, Gosford Hospital.*

# Verification of 2011 QSA Self-assessment

On-site verification of self assessment responses occurs annually. 2012 was the fourth year of verification so by the conclusion of the 2013, all facilities in NSW will have participated over the first program cycle. The Verification process uses almost 100 clinicians trained as Assessors, including doctors, nurses, allied health professionals and Ambulance paramedics.

On-site verification aims to substantiate self-assessment responses from the previous year by discussing responses with respondents, and assessor-review of evidence such as policies and guidelines cited in self-assessment response. While the accuracy rate demonstrated in the verification has been consistently high (97.7%-98.6%), the process also aims to support PHOs to:

- Determine areas for improvement;
- Review use of self-assessment results from the previous year;
- Review improvement plan progress; and
- Work cooperatively across each complex and unique health care organisation with renewed insight into local quality and safety improvement projects.

***“The collaborative discussions with all members of the verification team provided the opportunity for review of our processes, highlight the strengths of the service and gain knowledge regarding future projects”.***

**(Self-assessment respondent 2012)**

A sample of questions was verified from each of the following themes from the 2011 self-assessment:

- Management of sepsis;
- Delirium;
- Suicide management; and
- Paediatrics.

## Summary of results

On-site verification for the 2011 QSA made the following findings.

- Overall, 13,140 self-assessment responses were verified. Assessors found inaccuracies in only 297 responses, giving an accuracy rate of 97.7%.
- This result is consistent with the findings of previous years' verification programs (Table 1).
- Feedback from staff interviewed remains positive in relation to the process.

On-site Verification for the 2012 self-assessment results commenced in February 2013 and will be completed in June 2013.

Table 1 Annual accuracy rate of self-assessment responses

YEAR	RESPONSES VERIFIED	INACCURATE RESPONSES	ACCURACY RATE
2007/08	2,795	36	98.6%
2009	20,438	277	98.6%
2010	16,095	392	97.8%
2011	13,140	297	97.7%



# Glossary

TERM	EXPLANATION
Adolescent/ Young Person	Person aged 16-18 years of age
Adult	Person over the age of 18 years
Child	Person aged up to their 16th birthday
CEC	Clinical Excellence Commission
Clinical governance	Clinical governance is the system through which organisations are accountable for continuously monitoring and improving the quality of their care and services and safeguarding high standards of care and services
Clinical risk management	Clinical risk management is an approach to improving the quality and safety of healthcare by identifying what places patients at risk of harm and taking action to prevent or control the risks.
Credentials	Credentials are defined under the Health Services Act 1997 as “documented evidence of a practitioner’s formal qualifications, training, experience and clinical competence” (cl 66).
Credentialing	The review, investigation and confirmation of a review of a practitioner’s credentials <sup>22</sup> to form a view about their competence, performance and professional suitability to provide safe, high quality health care services within specific organisational environments <sup>23</sup> .
IIMS	Incident Information Management System
ISBAR	Introduction, Situation, Background, Assessment, Recommendation
JMO	Junior Medical Officer
LHD	Local Health District
N/A	Not Applicable
NSQHS Standards	National Safety and Quality Health Services Standards see <a href="http://www.ncsi.com.au/National-Safety-Quality.html">http://www.ncsi.com.au/National-Safety-Quality.html</a>
NSW	New South Wales
PHO	Public Health Organisation
PSCQP	Patient Safety and Clinical Quality Program
Parent/ primary carer	Parent/s or person living with the child and assuming legal responsibility for, and providing direct care. This includes birth parent, step-parent, foster parent, legal guardian, custodial parent or safe and appropriate primary care giver
Patient and family-centred health care	Patient and family-centred care is an approach to the planning, delivery, and evaluation of health care that is grounded in mutually beneficial partnerships among health care providers, patients, and families. <a href="http://www.ipfcc.org/index.html">http://www.ipfcc.org/index.html</a>
QSA	Quality Systems Assessment

# Acknowledgements


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- The busy clinicians and managers who appreciate the value of the QSA and take the time to engage in the risk assessment process;
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- The staff who volunteer to be Assessors in the verification program; and
- The clinicians who assisted the QSA team in the self-assessment tool development and data analysis. Special thanks to:
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  - Dr Amanda Walker and the End of Life Care and Management Working Group (End of Life Care and Management);
  - Dr Tony Burrell and Ms Bronwyn Shumack (Credentialing/Supervision of Clinicians).

Organisation	QSA coordinator
Ambulance Service of NSW	Miriam McCartney
Central Coast LHD	Fiona Wilkinson
Far West LHD	Linda Sorum
Hunter New England LHD	Gary Martin
Illawarra Shoalhaven LHD	Vicki Biro
Justice Health	Rhonda Halpin
Mid North Coast LHD	Sarah Ashton
Murrumbidgee LHD	Nicole Smith
Nepean Blue Mountains LHD	Linda McCulloch
Northern NSW LHD	Pam Mitchell
Northern Sydney LHD	Helen Ganley
South Eastern Sydney LHD	Maria Jessing
Southern NSW LHD	Beverley McKay
St Vincent's Health Network	Chris Conn
The Sydney Children's Hospital Network	Kirsty Campbell
Sydney LHD	Toni Schouten
Sydney South West LHD	Ahmed Jamal
Western NSW LHD	Cathy Marshall
Western Sydney LHD	Alison Starr / Linda Rudd

# References

- 1 Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013; February 2013. Available at: <http://www.midstaffspublicinquiry.com/report>
- 2 Pain Charles H. et al, In Safe Hands: Releasing the potential of clinical teams, p. 3
- 3 Ibid, p.1
- 4 Organising for Safety: Third Report of the ACSNI (Advisory Committee on the Safety of Nuclear Installations) Study Group on Human Factors. Health and Safety Commission (of Great Britain). Sudbury, England: HSE Books, 1993.
- 5 Bauman AE, Fardy HJ & Harris PG. Getting it right: why bother with patient based care? Med J Aust 2003; 179 (5): 253-256.
- 6 Meterko M WS, Lin H, Lowy E, Cleary PD. Mortality among patients with acute myocardial infarction: The influences of patient-centered care and evidence-based medicine. Health Service Research 2010. 45(5):1188-1204
- 7 DiGioia AM. The AHRQ Innovation Exchange: Patient- and family-centered care initiative is associated with high patient satisfaction and positive outcomes for total joint replacement patients. Agency for Health Care Research and Quality, 2008.
- 8 Murff HJ, France DJ, Blackford J, Grogan EL. Relationship between patient complaints and surgical complications. Qual Saf Health Care. 2006;15:13-16.
- 9 Jha AK, Orav EJ, Zheng J, Epstein AM. Patients' perception of hospital care in the United States. The New England Journal of Medicine 2008;Volume 359 (18):1921-31.
- 10 Australian Commission on Safety and Quality in Health, National Safety and Quality Health Service Standards, Criteria to achieving the Partnering with Consumers Standard 2, Available at [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)
- 11 National Institute for Health and Clinical Excellence, United Kingdom, Principles for best practice in clinical audit. Oxford: Radcliffe Medical Press, 2002.
- 12 Clinical Excellence Commission. 2007/08 QSA Statewide Report, 2008, p.4
- 13 Clinical Excellence Commission. 2007/08 QSA Statewide Report, 2008, p.4
- 14 Clinical Excellence Commission. Caring for the Dying in NSW Public Health Organisations: A review of the data from the 2012 Quality Systems Assessment, 2013
- 15 Garling P. Final report of the special commission of inquiry acute care services in NSW public hospitals, 2008: overview. 2008: State of NSW, 27 November 2008 p 19. Available at [http://www.dpc.nsw.gov.au/\\_\\_\\_data/assets/pdf\\_file/0003/34194/Overview\\_-\\_Special\\_Commission\\_Of\\_Inquiry\\_Into\\_Acute\\_Care\\_Services\\_In\\_New\\_South\\_Wales\\_Public\\_Hospitals.pdf](http://www.dpc.nsw.gov.au/___data/assets/pdf_file/0003/34194/Overview_-_Special_Commission_Of_Inquiry_Into_Acute_Care_Services_In_New_South_Wales_Public_Hospitals.pdf)
- 16 NSW Health. Blood – Management of fresh blood components Policy Directive, PD2012\_016, 2012.
- 17 Palliative Care Australia. Palliative and end of life care glossary of terms, 2008. Available at <http://www.palliativecare.org.au/Portals/46/PCA%20glossary.pdf>

- 
- 18 Shearer B, Marshall S, Buist MD, Finnigan M, Kitto S, Hore T, Sturgess T, Wilson S &, Ramsay W. What stops hospitals clinical staff from following protocols? An analysis of the incidence and bedside clinical staff to activate the rapid response system in a multi-campus Australian metropolitan healthcare service. *BMJ Qual Saf* 2012; 21:569-575 doi:10.1136/bmjqs-2011-00692
  - 19 Ibid, p.574
  - 20 Payne CE, Stein JM, Leong T & Dressler DD. Avoiding handover fumbles: a controlled trial of a structured handover tool versus traditional handover methods. *BMJ Qual Saf* 2012: bmjqs-2011-000308Published Online First: 16 June 2012.
  - 21 Clinical Excellence Commission, 2009 QSA Statewide Report, 2010, p. 14-15
  - 22 NSW Ministry of Health. Statewide credentialing and scope of clinical practice project: background paper. NSW Ministry of Health, September 2011
  - 23 Australian Council for Safety and Quality in Health Care. Standard for Credentialing and Defining the Scope of Clinical Practice 2004 p 3

# CEC programs/projects



**Between the Flags** The Between the Flags Program aims to reduce the risk of hospital patients deteriorating unnoticed and ensure they receive appropriate care in response if they do



**BloodWatch** The CEC Blood Watch Program co-ordinates the implementation of improvements in transfusion practices across NSW.



**Chartbook** As part of its goal to provide assurance through credible public reporting, the CEC publishes an annual chartbook of health system indicators.



**Clinical Leadership** The CEC Clinical Leadership Program has a focus on improving patient safety and clinical quality by supporting and developing clinical leaders in the workplace.



**Collaborating Hospitals' Audit of Surgical Mortality (CHASM)** CHASM is systematic peer review audit of patients deaths who were under the care of a surgeon at some time during their hospital stay in NSW.



**Falls prevention** The NSW Falls Prevention Program extends Statewide across hospitals, community and residential aged care



**Hand Hygiene** The CEC leads the National Hand Hygiene Initiative based on the "5 Moments for Hand Hygiene" promoted by the World Health Organisation (WHO) – World Alliance for Patient Safety



**Medication Safety** The medication safety/quality use of medicines program focuses around the provision of tools and resources which enable hospitals to analyse and improve their medication management systems



**Partnering with Patients** The Partnering with Patients program fosters the inclusion of patients and family as care team members to promote safety and quality.



**Patient Safety and Incident Management** The patient safety program utilises Incident Information Management System (IIMS) and Root Cause Analysis (RCA) reports, to identify opportunities for improvements in the safety and quality of clinical care.



**QUAH** The Quality Use of Antimicrobials in healthcare.



**Special Committee Investigating Deaths under Anaesthesia (SCIDUA)** SCIDUA's primary function is to investigate deaths that occur while under, as a result of, or within 24 hours after the administration of an anaesthetic or sedation administered for a medical, surgical, dental or like procedure.



**Sepsis** This project aims to reduce preventable harm to patients with severe infection and sepsis through early recognition and prompt treatment.





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