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A RESEARCH PROGRAM WITH THE CLINICAL EXCELLENCE COMMISSION, NSW TO PROSPECTIVELY STUDY THE COMMISSION'S PROGRAMS TO IMPROVE THE SAFETY AND QUALITY OF HEALTH CARE IN NEW SOUTH WALES: 2004 - 2005

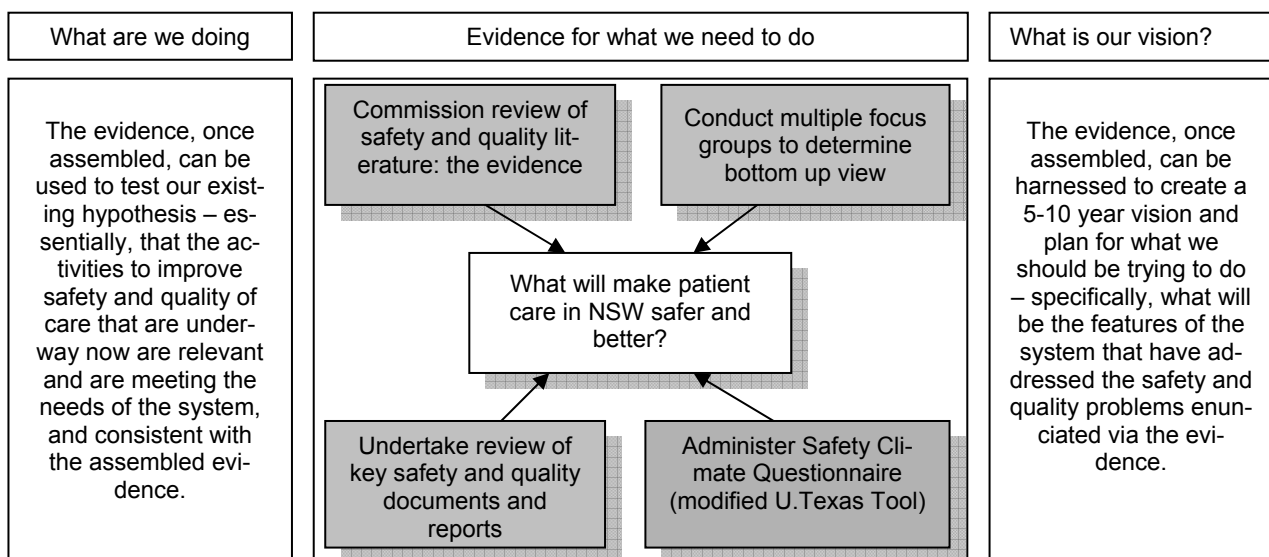
Funding Source: Clinical Excellence Commission, NSW

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Duration: 2004 – 2005

Description: We conducted two kinds of research with CEC. First we assembled evidence for what the CEC needed to do prospectively. This was to be conducted via four inter-related studies, including: a literature review; an analysis of major patient safety inquiries; a series of focus groups with health professionals and a safety climate survey. The CEC research framework is presented in Figure 1, with completed studies highlighted in gray:

Figure 1: a framework for research for 2004-2005



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We then tested CEC's existing hypothesis that its current program of work is resulted in (or supported and enabled) improvements in the safety and quality of health care in NSW, through evaluations of two CEC initiatives. The first evaluation was of the patient flow collaborative and the second of the Safety Improvement Program, (described in more detail later in this section). What follows are the key findings from the studies:

A technical review of the safety and quality literature

In this study we sought to assess the patient safety literature and suggest a new approach to safety for clinical teams. The review of the literature had two major aims. The first was to determine the level of avoidable harm currently occurring in health services around the world (as reported in the literature), and to explore the ways in which this harm is manifested. The second was to understand the causes of such harm. These causes appear in the literature under three headings: errors of individual clinicians; errors as a consequence of poor team-work; and errors as a consequence of environmental factors. The study concluded by examining the corrective measures suggested by the literature and by outlining a team-centred process which could be applied by health care services wishing to strengthen their existing safety activities. A monograph of this study, *Patient safety research: a review of the literature* will be launched by the CEC early in 2006.

Review of key safety and quality documents and reports

This study is based on a comparative analysis of eight patient safety Enquiries into alleged poor health care, in five countries. Three of the Enquiries are from Australia: Perth (King Edward Memorial Hospital), Melbourne (Royal Melbourne Hospital) and Sydney (Campbelltown-Camden). The remainder are from Scotland (Glasgow), England (Bristol Royal Infirmary), Slovenia (Celje Hospital), New Zealand (Southland) and Canada (Winnipeg Health Sciences Centre).

Two versions of the final report of this study, a full monograph entitled *Patient safety: a comparative analysis of eight enquiries in five countries* and a summary document, *Patient safety: a summary of findings from major international public enquiries*, have been produced, and will be released early in 2006.

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The study provides an analysis of the context, process, key findings and recommendations of the Enquiries. In doing so, it identifies common features of the events which led up to Enquiries, including: sub-standard healthcare; deficiencies in quality monitoring processes; individual care providers and patients raising concerns up to a decade before action was taken; the ignoring and at times abuse of critics of the services; deficiencies in team work; and the lack of involvement of patients and families as integral and informed members of the health care team.

Multiple focus groups

The aim of this study was to catalogue a wide range of views and capture the ideas of people across the health system. We gathered qualitative information from a range of stakeholder groups about the state of safety and quality in NSW, and how these might be improved. Twenty-five focus groups were conducted over a number of geographical and service settings. Participants included: nurses, doctors, allied health and non-clinical staff, GMITT groups, Department of Health policymakers, area health service staff, and academics.

Group discussions were tape recorded and analysed using Nvivo6 and Leximancer. The data gathered constitutes a vital bank of information and provides well-grounded insights into what CEC needs to do in the future to respond to safety concerns. A major report entitled *Giving Voice to Patient Safety* and a 'key points' document will be released early in 2006.

Safety Climate Questionnaire

The Safety Climate Questionnaire (marked with an asterisk in the Figure 1) based on the University of Texas tool, has been developed. It was subjected to rigorous testing through multiple design phases, and piloted and Australianised. An implementation kit has also been developed. These have been submitted to NSW Health and the CEC for comments. At this point there are questions of timing and utility of the administration of the questionnaire tool which are yet to be resolved.

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Selected Publications and Monographs

Braithwaite J, Westbrook JI (2004). The safety climate survey: implementation issue. *NSW Health Department, Quality Executives.* Sydney, 12 May.

Braithwaite J, Westbrook JI (2004). The safety climate survey: implementation issues. *NSW Health Department Quality Executives.* Sydney, 12 May.

Hindle D, Braithwaite J, Iedema R (2005). *Patient safety: a review of technical literature.* Centre for Clinical Governance Research, UNSW: Sydney, pp.101, ISBN 0 7334 2176 8.

Hindle D, Braithwaite J, Iedema R, Travaglia J (2005). *Patient safety: a comparative analysis of eight enquiries in five countries.* Centre for Clinical Governance Research, UNSW: Sydney, pp.177, ISBN TBA.

Hindle D, Braithwaite J, Travaglia J, Iedema R (2005). *Patient safety: a summary of findings from major international public enquiries.* Centre for Clinical Governance Research, UNSW: Sydney, pp.35, ISBN TBA.

Westbrook MT, Braithwaite J, Mallock NA (2004). *Report: NSW patient flow and safety collaborative: statistical research analysis for the Institute for Clinical Excellence.* Centre for Clinical Governance Research: Sydney, pp.18.