



THE UNIVERSITY OF
NEW SOUTH WALES



CENTRE FOR CLINICAL GOVERNANCE RESEARCH

EVALUATION OF THE SAFETY IMPROVEMENT PROGRAM IN NEW SOUTH WALES: STUDY NO 5



REPORT ON SATISFACTION OF FACULTY
MEMBERS

The Centre for Clinical Governance Research in Health undertakes strategic research, evaluations and research-based projects of national and international standing with a core interest to investigate health sector issues of policy, culture, systems, governance and leadership.

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1. Safety Improvement Program (N.S.W.) - Evaluation.

2. I. Long, D. II. University of New South Wales.

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1 ABBREVIATIONS AND DEFINITIONS

1.1 Abbreviations

AHS	Area Health Service
CCGR	Centre for Clinical Governance Research at University of NSW
CEC	Clinical Excellence Commission
DOH	NSW Department of Health
IIMS	Incident Information Monitoring System
RCA	Root Cause Analysis
RIB	Reportable Incident Brief
SIP	Safety Improvement Program
SAC	Severity Assessment Code

1.2 Definitions

Clinical Practice Improvement	A combination of tools, techniques, skills and attributes designed to enhance care inputs, structures, cultures, processes, outputs or outcomes.
Culture	The configuration of attitudes, values, beliefs, meanings, behaviours and practices which together can be seen to be definitive of 'what people are' or 'where people come from'. Culture can be seen as a 'state' or something people possess, while it appears more fruitful to regard it as performance and also a process.
Ethnography	A research technique used for describing what human beings do in selected settings, usually comprising 'participant observation', field notes, narrative accounts, interviews, and other qualitative research methods.
Evaluation	The systematic examination of a policy, program or project aimed at assessing its merit, value, worth, relevance or contribution.
Formative Evaluation	Evaluation conducted during a course of a policy's, program's or project's life.
Innovation	The rate, propensity, capacity and effectiveness in adopting new ideas, practices or behaviours.
Organisational Culture	The collective set of relationships in organisations that differentiate one group from another in terms of dress, attitudes, values, behaviours, beliefs, language and shared meaning.
Summative Evaluation	Evaluation conducted at the end of a policy's, program's or project's life.
Triangulation	A multi-method research or evaluation design which adduces converging or diverging evidence drawn from pluralist sources to illuminate an object of inquiry.

2 EXECUTIVE SUMMARY

This report presents the results of study 5 in the evaluation of the Safety Improvement Program (SIP) in New South Wales. This study provides an analysis of interviews with faculty members who taught on the SIP training courses in September and December 2004.

Faculty reported being satisfied with the aims, content and delivery of the Safety Improvement Program, a position supported by the extremely positive participant evaluations (see studies 2(b) and 3). Although core curriculum content remained stable, constant adjustments were made in response to changing base knowledge of participants, and to external factors.

Concern was expressed over targeting of participants, with doctors and senior clinicians regarded as underrepresented among course participants. Concern was also expressed over the quality of causal statements being produced by current RCAs, and the perceived lack of implementation of RCA recommendations. The problem of conflating RCAs with safety improvement is highlighted: RCAs are designed to be a component part of an overall safety improvement program, and need to be seen as such, with appropriate emphasis and commitment to all areas of safety improvement.

3 INTRODUCTION

3.1 Overview

The NSW Department of Health (DOH) and the Clinical Excellence Commission (CEC) have commissioned the Centre for Clinical Governance Research (CCGR) at University of New South Wales to conduct a formal evaluation of the Safety Improvement Program (SIP). This is a program to enhance safety in New South Wales. The DOH has commissioned this evaluation as part of its knowledge management program in safety and quality under CCGR’s contract to Develop and Evaluate a Knowledge Management Program for Quality Branch. The CEC is interested in the extent to which the SIP will make health care in NSW safer and better under CCGR’s contract to conduct a Research and Evaluation Program into Safety and Quality.

The Evaluation Protocol for this project noted: “SIP is a comprehensive safety program introduced to the NSW health system in 2002. It aims to improve patient safety by focussing on health care incident management. The objectives of SIP are:

- To make health care safer through constantly correcting system vulnerabilities by understanding why errors occur.
- To develop a culture where health care incidents are identified, reported, investigated, analysed and acted upon in a supported environment.
- To implement an information system that assists health care workers to achieve the first component.”

The overall evaluation of SIP takes the form of 12 inter-related studies (Table 1). This report documents the outcomes of study 5. It presents the results of the analysis of interviews with faculty members who taught on the SIP training courses in September and December 2004. This component of the evaluation was conducted by Ms Debbi Long.

TABLE 1: Evaluation Studies

STUDY	TITLE	COMMENTS, ACTIONS AND TIMEFRAMES	LED BY/TEAM
Study #1	Literature Review	<ul style="list-style-type: none"> • National and international literature on patient safety and RCA processes • Appraisal of the evaluation process through the extant literature 	Peter Nugus, Jo Travaglia, Jeffrey Braithwaite
Study #2	Review of education and training program	<ul style="list-style-type: none"> • 2 a) Triangulated review of educational value of RCA program • 2b) Meta-analysis of SIP training program evaluation forms 	Jo Travaglia, Mary Westbrook, Peter Nugus, Rick Iedema, Debbi Long, Nadine Mallock

Study #3	Achievements of aims and objectives and stakeholder satisfaction	<ul style="list-style-type: none"> • Questionnaire to all course participants • Review of course evaluations 	Mary Westbrook, Nadine Mallock
Study #4	Ongoing applicability of training to participants	<ul style="list-style-type: none"> • Questionnaire to all course participants • Survey of international SIP programs to benchmark the current program in an international context 	Nadine Mallock, Mary Westbrook, Jeffrey Braithwaite
Study #5	Satisfaction of Faculty members	<ul style="list-style-type: none"> • Detailed interviews with faculty staff 	Debbi Long
Study #6	Program outcomes at local, area and state levels	<ul style="list-style-type: none"> • Review of RCA data submitted to the DOH • Questionnaire to all course participants • Interviews with key stakeholders 	Jo Travaglia, Jeffrey Braithwaite, Mary Westbrook, Nadine Mallock, Marjorie Pawsey
Study #7	Lessons learnt	<ul style="list-style-type: none"> • 7 a) In-depth observation and review of RCAs in situ • 7 b) Focus groups 	Rick Iedema, Rowena Forsyth, Christine Jorm, Peter Nugus
Study #8	Return on investment	<ul style="list-style-type: none"> • Questionnaire to all course participants • Interviews with key stakeholders 	Jeffrey Braithwaite, Jo Travaglia, Mary Westbrook, Nadine Mallock
Study #9	Effectiveness of SIP Committee	<ul style="list-style-type: none"> • Observation of Steering Committee • Review of outcomes 	Nadine Mallock, Jeffrey Braithwaite
Study #10	Management of RIB process	<ul style="list-style-type: none"> • Focus group • DOH data • Interviews with key stakeholders 	Jeffrey Braithwaite, Jo Travaglia, Nadine Mallock, Marjorie Pawsey
Study #11	Reporting processes	<ul style="list-style-type: none"> • Focus group • DOH data • Interviews with key stakeholders 	Jeffrey Braithwaite, Jo Travaglia, Nadine Mallock, Marjorie Pawsey
Study #12	Branch functions and actions	<ul style="list-style-type: none"> • Focus group • DOH data • Interviews with key stakeholders 	Jeffrey Braithwaite, Jo Travaglia, Nadine Mallock, Marjorie Pawsey

3.2 About this report

This report discusses the results of interviews undertaken with faculty members of the Safety Improvement Program, exploring their satisfaction with the Safety Improvement Program course. Data collection is outlined in the Methods section (part four), and the (semi-structured) interview schedule can be found in the appendix.

Part five, Findings, outlines the results of the interviews. Firstly, faculty's understanding of the aims of course, and the effectiveness of these aims, are discussed. Faculty's comments on course content are reported, including opinions regarding the importance of communication skills in the course curriculum. Faculty's description as to how adaptations were made to the course over the two years of its implementation, and the changes in context and participant knowledge are reported. Differences of opinion were found regarding the targeting of participants. Part four concludes with faculty's opinion regarding the effectiveness of SIP training in producing people who are adequately equipped to undertake RCAs, and their comments on the potential effectiveness of RCAs for improving patient safety.

In part six, the Discussion section, three points are made. The first addresses the concern expressed by faculty that RCAs will only contribute to patient safety if adequate implementation of recommendations is undertaken. The second point offers a comment on the communication among the teaching team, which was found to be very effective. Finally, there is a comment on the potential danger of conflating the specific tool, Root Cause Analysis, with the broader concept and overall aims of patient safety improvement.

4 METHODS

The faculty of the SIP training program consists of four teaching staff: one employed by the NSW Health Department, one seconded from a senior Area Health Service position, and two contract lecturing staff. The researcher attended a SIP training session in December 2004, and then conducted individual interviews with each faculty member. Two of the interviews were conducted in December 2004, and two in early February 2005. The interviews were semi-structured and aimed to elicit faculty opinion on the aims, design, content, participant selection, participant feedback and evaluation, and outcomes and effectiveness of the course. Faculty were also asked to reflect on the role and effectiveness of RCAs in improving patient safety.

The interview schedule is presented in Appendix 1.

5 FINDINGS

All four faculty members agreed in their reflections on many aspects of the course delivery. There were a small number of differences of opinion: what is highly significant is that each of these areas was flagged by each faculty member as a difference. That is, they were aware of each other's opinions, and anticipated each other's responses in great depth and with at times quite remarkable accuracy. All mentioned the level of debriefing and consultation that went on amongst them at various stages of course delivery: this is certainly reflected in their knowledge of each others' opinions. Faculty's opinions are reported below in the following sections: Aims, Content, On-going improvement of course, Targeting of participants, Effectiveness of SIP training, and Effectiveness of RCAs in improving patient safety.

5.1 Aims

There was general agreement regarding the aims of the course: "To improve patient safety by empowering people to accurately identify system vulnerability revealed by the evaluation of an adverse event". The course was understood to be designed to provide clinicians and managers with an awareness of adverse events, and give them the skills to respond.

One member went further to differentiate between the aims in the first year of the course (2003), which was seen as more focussed on awareness raising, and targeted at gaining the engagement with senior managers and clinicians, while introducing the RCA process to the people who would be undertaking them. All agreed that the engagement of senior managers was fundamental to the success of the RCA process. The second year (2004) was identified as being focussed more directly on teaching people how to undertake RCAs.

All faculty members saw these aims as realistic. There was not total agreement as to how well these aims had been achieved. Although it was generally felt the aims had been met, one faculty member stated that "the glaring deficiency is in the target audience", feeling that the course had not reached the number of doctors it needed to in order to be effective. This point will be discussed in more depth below.

A further comment from one faculty member was that they had a broader aim, and that was to introduce people to the concept of human factors, in the hope of disseminating what they saw as potentially life-changing ideas into the health care system.

5.2 Content

When asked how satisfied they were with the contents of the course, three faculty members expressed satisfaction. One was not as satisfied, commenting that communication issues should be more fully addressed. It was not clear the extent to which faculty agreed on this point, and one view was that this was "outside their brief".

Apart from this, the general agreement was that the course content was excellent, and that the course left people able to undertake RCAs. They all commented on the positive evaluations, citing that course participants wrote things like “This is the best course I’ve ever attended”. All mentioned the amount of inter-relating between faculty members as a contributing factor to the course’s success.

5.3 On-going improvement of course

Although the core units and broad curriculum remained unchanged, faculty stated that the course was constantly “tweaked”. Factors which were said to contribute to the evolution of the course included participant feedback, observation of faculty as to difficulties which participants may have with particular aspects of the course, and faculty discussion/debrief of teaching sessions. External factors which were cited, by a member of the faculty, as influencing course design and direction included:

“Camden and Campbelltown, of course. And the Walker Inquiry was one of the biggest, it was seismic. From Walker we took the point that you have to separate out accountability and systems failure.”

In the opinion of one faculty member, changes were apparently also made in response to:

“... legislation, and the Health Department’s wishes. And things that are likely to cause media attention, which is valid from the minister’s viewpoint”.

Over the time in which the course had been delivered, the base knowledge of the participants had shifted dramatically. When the training first started, most of the course participants were unaware of what RCAs were, whereas now at least half of the participants in a course will have had some level of involvement in an RCA. This changing knowledge base of participants has had to be accommodated, although faculty commented that basics still had to be covered to make sure every course participant had a thorough knowledge of the RCA process. According to one faculty member:

“They say they know how to do it, but then you get to the breakout groups and there’s some gap in their knowledge. You have to go through it from the beginning, step by step, with everyone.”

It was agreed that as RCAs become entrenched in the system, this level of starting knowledge of course participants will continue to change.

5.4 Targeting of participants

Faculty responses varied when asked whether targeting of participants was appropriate. It was pointed out that the Area Health Services had the final choice as to which of their employees attended the course.

It was felt that the attendance of senior managers, patient safety managers, and senior clinical staff such as Nurse Unit Managers (NUMs), quality managers and department heads was appropriate. Two faculty members were adamant that doctors were sadly lacking from the course participants. One commented:

“We’re only getting 15-20% doctor attendance. Clinicians are at the pointiest end of most medical mistakes, for us only to be getting 15-20% is missing the target”.

Another faculty member felt that a higher level of clinician attendance and engagement in the process will happen as more doctors become involved in RCAs. There was also a comment that the private sector had been absent from the SIP training.

When asked if there were people attending the course who shouldn’t be, there were suggestions that maybe it was less relevant for some of the lower level managers, Occupational Health and Safety (OH&S) people, dental, pathology, and for some allied health people who had attended.

“In terms of an adverse event, in acute, it’s rarely something the OT [occupational therapist] or the physio or the speech therapist’s done”.

One faculty member was passionate in rejecting the idea that community members on RCAs could enhance their effectiveness. It was felt that community representatives who did not have a hospital background would not necessarily have adequate understanding of the complexities of a hospital environment. It was expressed that having people in an RCA such as community representatives who were “unfettered by accountability” might “harm the flow of free and frank discussion” necessary for RCAs to be effective.

5.5 Effectiveness of SIP training

When questioned as to whether the SIP training was effective in terms of producing people who could successfully undertake RCAs, the general opinion was that it was, however there remained considerable variation in the quality of causal statements that were being produced from RCAs currently being undertaken. Of those who had seen causal statements being produced, the comment was that quality varied greatly between Area Health Services, with some Area Health Services producing high quality RCAs, while others were “mediocre or poor”. Differences were ascribed to commitment to the RCA process, allocation of resources (mainly staff time) and senior management engagement. “We need to put barriers in place to make sure they are only being signed off once they’re up to standard. We need to lift the bar ... We can’t just say ‘improve them’, we need to give them a tool.” It was agreed that having the new positions of Clinical Governance director for each health service as being the person responsible for ‘signing off’ on each RCA should contribute significantly to improved quality of RCA reports.

5.6 Effectiveness of RCAs in improving patient safety

When asked whether RCAs are improving patient safety, faculty's response was that it is too early to evaluate. When asked if they thought RCAs had the potential to improve patient safety, the unanimous response was yes, but only if the implementation of recommendations was carried through. One faculty member said: "If recommendations are made and nothing is done, RCAs alone are not going to be effective in improving patient safety." That was seen to be the crucial next step which required attention.

It was also emphasised by one faculty member that RCAs are only part of a Safety Improvement Program:

"RCAs are crucial, but they are not enough on their own. They are a very good way of stopping the nasty stuff, but they are reactive, rather than proactive. RCAs are shutting the door after the horse has bolted ... ideally they need to be tied into a program that's looking at proactive assessment ... this alone will not make the system safer ... this is a very small component of the package".

6 DISCUSSION

In general, faculty expressed themselves as being extremely satisfied with the structure, content and delivery of the SIP course. There was some difference of opinion as to how effectively participants were being targeted. Faculty members committed to RCAs as an effective safety improvement tool. However, this optimism was tinged by concern about the implementation of recommendations generated from RCAs.

This point that was emphasized repeatedly by each faculty member. All felt confident that high quality RCAs would eventually be carried out, and all felt that this was a very important safety improvement tool. However, the heavy investment in terms of time and resources that has gone into RCA training will only be reflected in quality improvements within the health care system if there is adequate commitment to implementation.

Apart from the viewpoints of faculty, two things emerge as significant. One is the level to which communication among the teaching team was effective in allowing a standardised course to be adapted to the constantly varying needs of the context in which the course was being delivered, and the changing base knowledge of participants. There was a strong investment in team communication: debriefing sessions were undertaken after each teaching session and after each course. This is an unusually high level of self-monitoring for a teaching team, and the results were obviously and uniformly effective.

The second comment has to do with a conflation of Root Cause Analysis with Safety Improvement. Although the course was entitled as a “Safety Improvement Program”, most participants, and at many times faculty, saw the course as being mainly a “Root Cause Analysis” course. This would suggest that RCAs and Safety Improvement are being conflated in a way that may result in a blindness to the fact that Root Cause Analysis is in reality only one small component of a much broader Safety Improvement Program. The risk is, as one of the faculty pointed out, that other important aspects of safety improvement may be overlooked.

7 CONCLUSION

In general, faculty reported being satisfied with the content and delivery of the training for SIP. Extremely positive participant feedback supported their view that the course delivered high quality training in undertaking RCAs. Some concern was expressed regarding targeting of participants, and the quality of causal statements being produced, and what was seen as a lack of implementation of RCA recommendations. Differences of opinion were expressed over the importance of communication skills as part of the curriculum. It was emphasised that RCAs are designed to be a component part of an overall safety improvement program, and need to be seen as such, with appropriate emphasis and commitment to all areas of safety improvement.

8 REFERENCES

Centre for Clinical Governance Research in Health (2004). *Protocol: evaluation of the Safety Improvement Program*. Kensington: Centre for Clinical Governance Research, University of NSW.

NSW Health (2004). *Department brief for SIP evaluation*. North Sydney: NSW Department of Health.

NSW Health Quality and Safety Branch (2003). *Reportable Incident Briefs to the NSW Department of Health*. North Sydney: NSW Department of Health. Circular No. 2003/ 88 (File No. 03/ 11299).

9 APPENDIX

9.1 Appendix 1: Interview schedule for SIP faculty members

TABLE 2: Interview schedule for SIP faculty members

INTERVIEW SCHEDULE
<ul style="list-style-type: none"> ▪ What do you see as the main aims and objectives of the course? ▪ Do you think they are appropriate? Realistic? ▪ How well do you think they have been achieved? ▪ Are you satisfied with the contents of the course? <i>(if so: in what way? if no: in what way?)</i> ▪ How do you feel about the design of the course? ▪ Are you satisfied with the outcomes of the course? <i>(if so: in what way? if no: in what way?)</i> ▪ <i>(We are privy to some of the course evaluations submitted by course participants.)</i> What feedback did you receive from the course evaluations? ▪ Have you made any changes based on suggestions made in the course evaluation? <i>(if so, what changes?)</i> ▪ Have you made changes to the course for other reasons? <i>(if so, what were the changes? what were the reasons? Have the changes been successful?)</i> ▪ Are there any (other) changes you'd like to see made to the course? ▪ Did you receive any queries about the course from participants (either during or after the course)? <i>(if so: what were they?)</i> ▪ In your opinion, who should be attending the course? ▪ Do you think that the selection process for participants is targeting all the appropriate potential participants? ▪ In your opinion, is the current process of training for RCAs resource-effective? Are there ways in which it could be made more resource-effective? ▪ Is there anything else you'd like to tell me about the course? ▪ In your opinion, how effectively do you think RCAs are currently being carried out? ▪ How effective do you feel RCAs are being/will be in improving patient safety? ▪ Is there anything else you'd like to comment on regarding RCAs? ▪ Is there anything else I should ask you about?