



THE UNIVERSITY OF
NEW SOUTH WALES



CENTRE FOR CLINICAL GOVERNANCE RESEARCH

EVALUATION OF THE SAFETY IMPROVEMENT PROGRAM IN NEW SOUTH WALES: STUDIES NOs 10-12



REPORT ON THE MANAGEMENT OF RIB
PROCESSES, REPORTING PROCESSES AND
QUALITY AND SAFETY BRANCH
FUNCTIONS AND ACTIONS

***The Centre for Clinical Governance Research in Health
undertakes strategic research, evaluations and research-
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culture, systems, governance and leadership.***

First published in 2005 by The Centre for Clinical Governance Research in Health, Faculty of Medicine, University of New South Wales, Sydney, NSW 2052.

Printed and bound by University of New South Wales.

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National Library of Australia

Cataloguing-in-Publication data:

Series Title: Evaluation of the Safety Improvement Program in New South Wales

Report Title: Evaluation of the Safety Improvement Program in New South Wales: Study No 10 - 12 - Report on the Management of RIB Processes, Reporting Processes and Quality and Safety Branch Functions and Actions

A report submitted to the Clinical Excellence Commission and NSW Department of Health evaluating the Safety Improvement Program

Bibliography.

ISBN: 0 7334 2261 6

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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 Management 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 studies 10 – 12 in the evaluation of the Safety Improvement Program (SIP) in NSW. These studies centre on the way in which reportable incident briefs (RIBS) are managed, how reporting processes are conducted and how the Quality and Safety Branch functions in overseeing the SIP.

Generally, these activities and their management work well, although there are resource and systems constraints. The introduction of the Incident Information Management System (IIMS) is predicted to improve these processes.

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 studies 10-12. It focuses on the way in which Reportable Incident Briefs (RIBs) are managed, the reporting processes in NSW Health and the Quality and Safety Branch functions and actions in managing reportable incident briefs. This component of the evaluation was conducted by A/Professor Jeffrey Braithwaite, Ms Jo Travaglia, Ms Nadine A. Mallock and Dr Marjorie Pawsey.

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 	Jeffrey Braithwaite, Jo Travaglia, 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 summarises our findings in studies 10 – 12 made from observation when we visited the Department of Health to oversee the peak-level reporting processes and activities of the Quality and Safety Branch in managing SIP. We observed these processes and activities and conducted interview with Departmental stakeholders, during visits in January 2005.

4 METHODS

We list below in Table 2 the key tasks and methods drawn from the *Evaluation Protocol*. This shows the evaluation methods we used for studies 10-12 and the core questions we sought to answer.

TABLE 2: Key study tasks, evaluation methods, and core questions

KEY TASKS	EVALUATION METHODS	CORE QUESTIONS
Study 10: review the Reportable Incident Briefs management processes	We: <ul style="list-style-type: none"> Conducted an observational analysis of the RIB processes Interviewed a selection of Patient Safety Managers about the RIB management processes Interviewed DOH staff about the RIB management process 	How is RIBS information handled within the DOH?
Study 11: Examine reporting processes	We: <ul style="list-style-type: none"> Reviewed documentation about the management of RIBS, including the computerised data sets on-screen Followed through, and mapped the RIB reporting process against DOH circular 2003-88 [Appendix: RIB Management Process Flow] Interviewed a selection of Patient Safety and Clinical Governance Unit staff about the reporting process Interviewed and observed Quality and Safety Branch staff 	What is the flow of reporting processes within the DOH?
Study 12: Assess Branch functions and actions	We: <ul style="list-style-type: none"> Mapped the functions and actions of the Quality and Safety Branch, utilising an ethnographic approach Interviewed and observed Quality and Safety Branch staff about the functions of the Branch 	How well do Branch functions perform and what opportunities are there for improvement?

In summary, by conducting observational work within the DOH and interviews with key stakeholder groups we aimed to build an understanding of the way data centred on RIBs were managed. We turn to the results of our assessment under these studies.

5 FINDINGS

In this section we present our overall findings. We later suggest several improvements to the system, some of which are in train, and which essentially translate into exploiting, and capturing the benefits of, the IIMS system when it is implemented more fully.

Within Area Health Services (AHSs) RIBs are completed for Severity Assessment Code (SAC) 1 incidents, and SAC 2, 3 and 4 incidents if the Area Chief Executive judges this to be appropriate. There are well-enunciated definitions for SACs and guidelines for the assignment of incidents. In due course the RIB information will be processed electronically by the IIMS system, but not at this stage – perhaps in the second half of 2005.

From the DOH's standpoint the process of RIB management is as follows. Information (the RIB form or correspondence about RIBs) comes in to the Department's Executive Support Unit (ESU) which handles correspondence. The RIB information is manually entered into the TRIM database and is assigned an individual number to facilitate tracking. The initiating AHS is advised of the TRIM number for future correspondence.

TRIM summary data are allocated by the ESU to the relevant lead Branch for action e.g. suicide cases go to Mental Health Branch, infection issues go to Communicable Diseases Branch. Quality and Safety Branch receives all notifications and the Branch's staff check assignments to ensure they are accurate. A summary of all TRIM database entries is sent twice daily via email to a large list of DOH staff including Quality and Safety Branch staff. Action is required from those who are assigned specifically to deal with that matter. When urgent action is required the relevant staff members get involved including the Media Unit and Minister's office. Whether or not there is urgent action, an RCA report for SAC 1 incidents is expected within 50 days from the relevant AHS. These are reviewed on a monthly basis by the Reportable Incident Review Committee.

The lead Branch is then required to deal with the issue. Examples of actions include: notify an equipment manufacturer, follow up with an AHS, or, if there are State wide implications arising from the incident, to consider and action these. A Safety Advocate [a bulletin about a safety issue of note] may be issued. Information is also presented at the SIP Steering Committee (now the Reportable Incident Review Committee). There are about thirty to forty SAC 1 notifications per month at present. This is expected to increase when the IIMS system is institutionalised.

We note in passing that the TRIM database is not ideal. It is a document tracking system rather than a database to analyse information. The fields are limited and there is a need to download data into a Microsoft Excel spreadsheet in order to analyse it. The remedy for this is when IIMS comes online there will be a lot more functionality, and the new system is designed to facilitate analysis of incidents.

A related issue is the categorisation of information. For example, categorisation of SAC 1 incidents is a problem. Sometimes these have to be manually categorised and analysed, eg in cases of death. The clinical management category is a particularly broad based one that requires analysis before meaningful sub categories can be derived.

We also note in passing some observations we made during our conduct of these studies about RCA reporting: This is a more ad hoc process than that which has been set up to review RIBs. The richness of the data set which has been assembled with the various RCA reports has not yet been tapped. Another related problem is that there is variation in the quality of documentation of RCA reports. This means that it is not so easy to assemble a standardised database. As a consequence, the DOH has not been able to take advantage of the RCA reports as much as it would like. A better system for this is needed, one which would enable DOH staff to analyse RCA data, understand what is happening with RCAs and examine the implications. In addition, such a system needs to provide feedback, in a timely manner, through AHS to clinical teams and services, to enhance performance.

The DOH is looking at the problem of capturing the benefits of RCA reports at the moment. Current DOH efforts are centred on writing a policy on RCAs to improve the quality and the standardisation of RCA documentation. It is also looking at improving its own quality control systems.

Within these constraints, the evaluation team judged that the DOH is managing these processes well. Systems are being improved, and these improvements are expected to streamline current processes and enhance the ability to manage data effectively.

6 DISCUSSION

From the foregoing we argue there is a strong need to progress from the TRIM data base and manual data analysis to manage SIP-generated data better, and produce more meaningful reports. IIMS will facilitate this because there will be a more streamlined system to classify by incident type. This classification will be dealt with at the AHS level – the people who complete the RIB form will do the assignment. This foreshadows the DOH will be able to manage data much better. It is expected when IIMS comes in the numbers of reportable incidents will rise considerably, but they will be more amenable to monitoring and management.

There is a resource issue. The DOH generally, and Quality and Safety Branch specifically, are limited in the resources available for this work. For example, patient falls may constitute the type of problem that needs to be investigated further, but the work of mapping trends, analysing the problem and dealing with larger issues to do with falls is reliant on staff availability.

Further, to do justice to SIP, there is a need to give timely feedback to the health system. To do this requires the resolution of two main issues: a) the design and execution of sophisticated analysis of the data sets and b) sufficient staff and skills within the DOH to do this. Both of these need to be looked at when the Incident Information Management System is implemented.

Relating information back to the health system is an issue that is continuously under review at the moment. Knowledge management takes place in various ways. For example there are internal reporting arrangements to the Reportable Incidents Review Committee. Staff of Quality and Safety Branch have made follow up visits to the AHS to feed back data. Liaison occurs with patient safety managers in various ways.

For the future, there is a recognition that the RIB processes under SIP can be improved and there are several opportunities to do so presenting themselves in due course. One is when IIMS comes on line. Another is once the Clinical Governance Units are fully established. Liaison between the DOH and the AHSs will be able to be strengthened via these units. Another planned approach to strengthening the management of knowledge produced by SIP will be for the DOH to look at improving its own quality control systems. Through these mechanisms it should prove possible for clear recommendations to be made back to the health system, and, if these are referred through the Clinical Governance Units, then we can think of there being in place a framework to improve the implementation of the recommendations.

7 CONCLUSION

In bringing this study to a conclusion, we can say that the SIP program comes together at the peak level in the DOH through its efforts in managing RIBs and reviewing data that arise from RIBs, managing RCA documentation and reviewing data emerging from these, too. Data are being used to improve the system and the processes of care but further work is needed to maximise the way feedback is provided to the system. Future initiatives such as the enhanced use of Safety Advocates, working closely with Clinical Governance Units, and using the IIMS system to its fullest will improve the way the DOH manages knowledge about safety in the future.

8 REFERENCES

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9 APPENDICES

