



THE UNIVERSITY OF  
NEW SOUTH WALES



CENTRE FOR CLINICAL GOVERNANCE RESEARCH

# EVALUATION OF THE SAFETY IMPROVEMENT PROGRAM IN NEW SOUTH WALES: STUDY NO 8



REPORT ON RETURN ON INVESTMENT

***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 ABBREVIATIONS AND DEFINITIONS

### 1.1 Abbreviations

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

### 1.2 Definitions

|                                      |  |
|--------------------------------------|--|
| <b>Clinical Practice Improvement</b> | A combination of tools, techniques, skills and attributes designed to enhance care inputs, structures, cultures, processes, outputs or outcomes.   |
| <b>Culture</b>                       | 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. |
| <b>Ethnography</b>                   | 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.   |
| <b>Evaluation</b>                    | The systematic examination of a policy, program or project aimed at assessing its merit, value, worth, relevance or contribution.  |
| <b>Formative Evaluation</b>          | Evaluation conducted during a course of a policy's, program's or project's life.   |
| <b>Innovation</b>                    | The rate, propensity, capacity and effectiveness in adopting new ideas, practices or behaviours.   |
| <b>Organisational Culture</b>        | 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.   |
| <b>Summative Evaluation</b>          | Evaluation conducted at the end of a policy's, program's or project's life.  |
| <b>Triangulation</b>                 | 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 the first part of study 6 in the evaluation of the Safety Improvement Program (SIP) in New South Wales. This study provides an analysis of the value of the Safety Improvement Program in NSW to those who have participated in it. Evaluating the return on investment (ROI) of any venture is a complicated matter, requiring an accurate accounting of all aspects of expenditure, including financial, human and material resources, time, and intangibles such as a perception of value or gain on the part of the client. In this study participants in the SIP training courses were asked whether they felt that the RCA process, and the SIP as a whole, was worth the investment placed in it. Almost three quarters of all respondents to a questionnaire felt that despite the fact that RCAs are a time-consuming process, they were a good use of staff time and resources, and a similar number of participants felt they saw benefits of SIP that made it worth the investment.

A quarter of all positive responses (27%) mentioned cultural change had occurred, or other forms of change had, leading to improvements in safety. Some respondents mentioned increased accountability and awareness in the staff, while others indicated that SIP and RCAs were effective tools in improving patient safety. Two participants mentioned that the RCA process improved teamwork, and four people mentioned the need to extend the training in a number of ways. Some respondents, while praising SIP, indicated that while SIP was a good start, there was a need to examine its implementation and outcomes in the longer term.

A number of respondents provided open-ended responses. These participants felt that several factors were affecting the implementation of SIP. These included the differential implementation of SIP at AHS level; the implementation of the IIMS; the continued involvement of DOH in monitoring, recording and reporting of lessons learnt; the need to support staff and management training and release, and in particular the training and involvement of medical practitioners; the short, medium and long term implications for the implementation of recommendations and changes including management support, resource allocation, feedback to RCA participants; and finally acknowledgement that RCAs are one type of risk management tool, and one which can be used to divert attention from systemic issues, as much they are used to highlight them.

### 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 8. It focuses on the return on investment (ROI) of the SIP, so far. This component of the evaluation was conducted by A/Professor Jeffrey Braithwaite, Ms Jo Travaglia, Conjoint A/Professor Mary T Westbrook and Ms Nadine A. Mallock.

**TABLE 1: Evaluation Studies**

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

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

### 3.2 About this report

Evaluating the return on investment (ROI) of any venture is a complicated matter, requiring an accounting of aspects of expenditure, including financial, human and material resources, time, and intangibles such as perception of value or gain. Evaluating a program of the size and magnitude of SIP results in a number of difficulties.

One of the most difficult issues is the lack of data on the level of investments. The amount actually spent on SIP can be calculated in terms of the time, as well as resources spent. This is particularly important when one considers of all the parties involved: staff of the DOH, managers at all levels of AHS, and participants in the SIP training programs. Moreover, the investment is ongoing – while the implementation phase of SIP can be said to be completed, processing, monitoring and analysing data from SIP initiatives continues.

Evaluation of ROI for training often proves more difficult than for programs or services. The distance between participation and outcome can be weeks, or even years, and training providers, unlike adult educators, have, in the past, rarely assessed anything more than participants' satisfaction with the training experience with "happy" or "smile" sheets (Kirkpatrick, 1998). One estimate is that ROI is only ever calculated for approximately 10 – 20% of all training programs largely because of the difficulties involved in isolating the effects of training, converting these effects into monetary values and then comparing these to the actual costs of training and the incurred costs (Lilly, 2001).

Critics of the concept of ROI argue that as a financial measure of results, the ROI methodology is problematic. Firstly, ROI is a retrospective analysis – it tells you what has happened, but not necessarily why, or what can be done to improve it. In other words, it is not an effective diagnostic tool. Secondly, an ROI process cannot capture all of an organisation's strategic objectives, many of which, as indicated above, can be difficult to measure (Kirkpatrick, 1998). Thirdly, public health care in Australia cannot be measured by the types of ROI measures used in countries such as the USA, such as increases in market share. Finally, it is important to note the difference between what has been called the *economic case* for quality or safety, and the *business case*. While the economic case involves a direct cost-benefit analysis (such as the amount of money saved in preventing over-prescribing of medications), the business case recognised that while significant benefits may arise from an intervention, they may only occur over a number of years, and in some cases the beneficiaries may not even be those who originally invested in the process (such as health promotion interventions) (Butler, 2004).

Butler (2004) also argues that there is a *social case* for quality and safety. The social case can be viewed in two ways: firstly, it can be seen as "whatever it costs" – that is, that the value of human life and health is such that no cost is too great to prevent injury or death. Secondly, it can be measured in terms of the value of the intervention to the individual. Mancini-Newell and Christensen argue that ROI measures for patient safety must "evolve" a focus beyond financial benefit. Their measures of ROI include overall patient safety, patient satisfaction, and employee and physician satisfaction (Mancini Newell and Christensen, 2003).

In relation to SIP, measurement of patient safety outcomes or patient satisfaction were outside the scope of this evaluation. This is because one measure of SIP's success is an actual increase in the number of cases *reported* (as opposed to occurred) and secondly because as a structural and systemic response to safety, patients may never be aware of the operation of SIP per se. Longer term evaluations of SIP will be able to calculate the business case for SIP, in particular in relation to reduction in terms of incidents, once the baseline has been established.

## 4 METHOD

Table 2 below identifies the key task and methods drawn from the *Evaluation Protocol*. This shows the evaluation methods we used for study 8 and the core questions we sought to answer.

**TABLE 2: Key study task, evaluation methods, and core questions**

| KEY TASK                                 | EVALUATION METHOD  | CORE QUESTION   |
|--|--|---|
| Study 8: Assess the return on investment | We: <ul style="list-style-type: none"> <li>Analysed responses to three closed, and one open-ended, questions sent to all contactable participants in 24 SIP training programs</li> </ul> | Do key stakeholders perceive that SIP has provided an adequate return on investment by meeting its stated objectives? |

Three measures were taken of ROI. These focused primarily on the satisfaction of health professionals who have been involved in SIP through the training and RCA processes. From these measures we were able to assess the perceptions of key stakeholders as to the value and ROI of SIP. In other words, we took a much broader view of ROI than the economic one, for reasons discussed earlier. We were intent on trying to provide a perspective on the overall worth of SIP according to respondents to our questionnaire undertaken in study 3 rather than perform an economic evaluation, the data for which inevitably would be estimates.

## 5 FINDINGS

Table 3 provides health professionals' perspectives on a core tool of the SIP program, the RCA. It provides an indicator of the ROI of the expenditure of staff time and resources.

### 5.1 Is undertaking an RCA a worthwhile process?

**TABLE 3: Undertaking an RCA is a time-consuming process. Is it a good use of staff time and resources?**

|                   | NUMBER (n = 461) | PERCENTAGE (%) |
|-------------------|------------------|----------------|
| Strongly agree    | 113              | 24.5           |
| Agree             | 230              | 49.9           |
| Unsure            | 91               | 19.7           |
| Disagree          | 20               | 4.3            |
| Strongly disagree | 7                | 1.5            |

### 5.2 Are RCAs recommendations being implemented?

Table 4 provides another way of looking at ROI. For the outcomes of RCA processes, and therefore, indirectly, SIP, were the recommendations implemented?

**TABLE 4: Following the RCA(s) you were involved in, were your recommendations implemented?**

|        | NUMBER (N = 255) | PERCENTAGE (%) |
|--------|------------------|----------------|
| Fully  | 48               | 18.8           |
| Partly | 128              | 50.2           |
| Unsure | 62               | 24.3           |
| No     | 17               | 6.7            |

### 5.3 Is SIP worth the investment?

Table 5 asks about the overall ROI for the SIP program. This is a key indicator of value: has SIP been worth the investment?

**TABLE 5: Considering the health system’s investment in the SIP, are the benefits you see worth that investment?**

|                   | NUMBER (N = 453) | PERCENTAGE (%) |
|-------------------|------------------|----------------|
| Strongly agree    | 136              | 30.0           |
| Agree             | 197              | 43.5           |
| Unsure            | 87               | 19.2           |
| Disagree          | 26               | 5.7            |
| Strongly disagree | 7                | 1.5            |

#### 5.4 Open responses to value of SIP

Table 6 provides a summary of the classification of open-ended responses about the value of SIP. A total of 208 (45%) of the 463 respondents to the CCGR questionnaire provided their comments in this section. Appendix 1 provides a table of the actual responses.

**TABLE 6: Comments on whether the benefits of SIP are worth that investment.**

|  | NUMBER (N = 119) | PERCENTAGE (%) |
|--|------------------|----------------|
| Yes  | 36               | 30.3           |
| Too early to tell  | 10               | 8.4            |
| More/various conditions/changes are needed for it to be worthwhile | 57               | 47.9           |
| No   | 12               | 10.1           |
| Don’t know, neutral/irrelevant answer                              | 4                | 3.4            |

## 6 DISCUSSION

Two sets of questions were considered as indicators of the ROI of SIP. The first two related to the core tool of SIP – the RCA process. Almost three quarters of all respondents (74.4%) either agreed or strongly agreed that despite the fact that RCAs are a time-consuming process, they are a good use of staff time and resources.

Only 18.8% of respondents felt that the recommendations that had made in an RCA had been implemented fully, while a further 50.2% felt they had been implemented partly. While 24.3% explicitly stated that were unsure, the large percentage of non-respondents must qualify our findings

The two additional questions address the question of the value of SIP. More than seventy percent (73.5%) of respondents strongly agreed or agreed that they believed there were benefits of SIP that made it worth the investment. Almost one in five (19.2%) were unsure, but a further 7.2% disagreed or disagreed strongly that the ROI on SIP was worthwhile. Overall, there is a strong level of agreement about the value of RCAs and the value of SIP as a whole.

A final question asked respondents for direct comments about the ROI of SIP. These were classified into general categories in order to provide an overview of the tenor of comments. 30.3 % of respondents to this question (n = 119) felt that the ROI on SIP was worth the investment, 8.4% felt it was too early to tell, almost half of respondents (47.9%) felt additional changes were necessary, and 10.1% felt that the investment was not worthwhile.

A quarter of all positive responses mentioned cultural change had occurred, or other forms of change had, leading to improvements in safety. Some respondents mentioned increased accountability and awareness in the staff, while others indicated that SIP and RCAs were effective tools in improving patient safety. Two participants reported that the RCA process improved teamwork, and four people noted the need to extend the training in a number of ways. Some respondents, while praising SIP, indicated that while SIP was a good start, there was a need to examine its implementation and outcomes in the longer term.

Another group of respondents (n = 10) felt it was “too early to tell” if SIP was successful. These comments spoke to the idea that longer term cultural change was required.

Yet another group of respondents (n = 57) represented almost half of all respondents (47.9%). This group indicated that some changes were required to SIP if it is to improve. The changes suggested included:

- Increased acceptance; culture change
- Differential “uptake” of RCA process across areas
- Awaiting incident reporting system
- Continued involvement of DOH in monitoring, recording and reporting
- Staff and management training and release

- Resource issues
- Involvement of medical practitioners
- Implementation of recommendations/changes
- RCA is only part of the risk management process, and can take the focus away from broader issues by concentrating on individual incidents
- Feedback.

A small group (n =12) was negative, and remained unconvinced of the benefits of the RCA processes. Some comments included that the process cost too much, that they had not been involved in an RCA since training, or that there had been no impact, or evidence for the value of the RCA process so far. A final group, the “unsure” respondents, identified the issue that there was no clear indication of how much had been spent on SIP so far.

## 7 CONCLUSION

Overall SIP was believed to have provided a worthwhile ROI for the time and resources spent on it. There are significant levels of satisfaction with SIP, and the RCA process.

Concerns, however, were raised about the longer term monitoring and impact of SIP, the resources needs at an AHS for the training of staff, the process of RCAs, and the implementation of their associated recommendations. Moreover, while cultural changes were seen to have occurred by the group most positive towards SIP, those who were more ambivalent felt that more significant and sustained change would be required before SIP was deemed successful. This may be a factor of the differential implementation of SIP across AHSs.

This differential implementation of SIP at AHS level, along with the establishment of baseline measures of incidents of different types of adverse events, the role of Quality and Safety branch in monitoring, recording and feeding back information on both incidents and strategies, and the evaluation of the implementation of RCA recommendations at a local level, will provide the next generation of ROI indicators for SIP.

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## 9 APPENDICES

### 9.1 Appendix 1: Participants' responses to open-ended question

*N.B. All spelling and grammatical errors are accurate representations of participants' responses.*

**TABLE 5: Responses to the health system's investment in the SIP: the benefits are worth the investment**

| Positive responses  |
|---|
| <ul style="list-style-type: none"> <li>▪ It appears that many AHS's are embracing the programme and not only developing ways to improve but having the courage and the conviction to impliment them</li> <li>▪ Especially for Ambulance Service, Front line staff need more info, participation /training and newsletter.</li> <li>▪ There have been some short term benefits in the last couple of years but the benefits will be long term in the provision of safe places for all patients, staff and visitors.</li> <li>▪ The program reinforced the need to improve the quality of care and that is a good thing. The benefits lay in the resolution of issues identified in RCAs. If the organisation follows up on recommendations and is able to resolve issues found in RCAs it will have been worth the investment.</li> <li>▪ Staff are more aware of investigation process.</li> <li>▪ This process brings attention to the indicators of care that the analysis of incidents brings.</li> <li>▪ Improving teamwork, accountability and the means to make change</li> <li>▪ Yes - some strategy needs to be undertaken and this seems a good enough one.</li> <li>▪ It is an important step in the longer term cultural change required in health care safety.</li> <li>▪ I feel the culture in our facility is changing and staff wish to see system improvements actions occur</li> <li>▪ Yes It is a planned approach. Constant monitoring of improvements. Good management tool</li> <li>▪ We need to remove the current shame/blame culture and build one of trust and working together to improve health outcomes.</li> <li>▪ Health system needs to constntly look at what is happening within the system. It needs be accountable</li> <li>▪ awareness and reporting of incidents and more thorough investigation of issues</li> <li>▪ I feel as more individuals are exposed to the culture of investigation and improvement more challenges in the health system will be unearthed but eventually this will lead to an overall improvement for all health services</li> <li>▪ in most cases we wont see the benefits because the improved system will hopefully stop serious incidents occurring there will be no tangible benefits obvious.....except the fact that less serious incidents occur. A benefit of multidisaplinary cooperation is hoped</li> <li>▪ It is about culture change and informing people within Health that the change is being led and endorsed from the top.</li> <li>▪ The development of a no blame culture and looking at systems and processes rather than individuals is very beneficial especially when you are dealing with different professional groups. It is alsos beneficial to the staff involved as it done in a supportive manner and they are given good feedback.</li> <li>▪ Cultural change is occurring</li> <li>▪ I think the training should be rolled out to everyone! Perhaps not all of it, but certainly getting everyone to see the video, it was an eye opener and very well explained.</li> </ul> |

#### Positive responses

- It is a good process that I think is changing attitudes & should have significant long term benefits to the system
- Centralised system also allows lessons learned to be shared when applicable
- It is probably a very costly exercise but if it saves the life of only one patient it is worth it. when adopted by everyone it should decrease the stress on employees as well as the result of incidents
- I think it has given us a consistent framework to apply to investigate incidents. It has improved reporting in this area. It has brought together people across a range of areas to consider problems that have occurred - so built understanding and relationships that otherwise would not have occurred. I think it assists to share the responsibility for problems from just one team to more broadly in the service. It formalises the process from implementing actions and provides a monitoring process. It is labour intensive and demanding, so I think we need to monitor over a longer time the impact. I think one of the difficulties is spreading the learning across other centres. Also, a number of staff continue to find it confronting to be involved in - both as investigators and as interviewees.
- The increase in reporting since its introduction is one benefit. Anything to improve culture and move it towards a more transparent, no blame, learning culture that pursues excellence has merit. A cost benefit analysis, if possible might produce interesting results.
- It is a good start.
- There is more transparency now, and patient and staff safety is a priority.
- I think the resources are well spent but once you are trained you are asked to become involved in too many RCAs as others are not willing
- should be part of all new staff orientation.
- The best initiative undertaken by the DoH in respect of patient safety.
- Promoting reporting of incidents and then managing them effectively to minimise the opportunity for repetition will offer a safer work place and care environment for all and this will in turn save resources and money - that has to be good in the current health system.
- Valuable way of improving the safety of patient care.
- Definitely.
- The opportunity to correct errors and the opportunity to undertake this process in a formal way instead of adhoc.
- There is greater awareness of incidents and even though some recommendations are not great, on the whole more happens than with other types of investigations.
- If changes occur as a result of RCAs then staff will be willing to participate and embrace the concept

**TABLE 6: Responses to the health system’s investment in the SIP: it is too early to tell if the benefits are worth the investment**

| “Too early to tell”  |
|--|
| <ul style="list-style-type: none"> <li>▪ Too early yet to see whether the programme and the cultural changes within health see system improvements/changes in relation to SIP or if we continue to get the "identification" stages working and fail to deliver on the "taking action" and "evaluating effectiveness" phases of this work.</li> <li>▪ Better awareness of patient safety etc but still evolving to maybe see full benefits as yet</li> <li>▪ The system is a long-awaited and potentially highly effective program for changing the culture and practices in health care by making real contributions to the knowledge base to actually improve patient safety and reduce adverse events.,The time frame is necessarily long, 5 years for really discernable benefit, continuing over the next 20 years for maximal effect.</li> <li>▪ I feel it is too early to comment-the RCA process is new in terms of cultural change</li> <li>▪ I think that its too early to tell. One of the key challenges will be to ensure that effective processes are implemented to ensure that the lessons learn't are shared across the system and guide policy and practice. Information management has never been one of Health's strengths.</li> <li>▪ it takes a while for some processes to take effect</li> <li>▪ I need to see the system working and the improvements it makes to see if it is good value for money. I have a concern that the system does not allow for the enviromental factors that influence health care delivery and that it doesn't become a point and blame exercise and that the clinicians are not that involved.</li> <li>▪ Too early to tell, certainly RCA alone which is an investigative/ diagnostic tool will not improve the quality and safety of health care unless linked to improvement methods</li> <li>▪ too soon to tell</li> <li>▪ If there is improved openness about what is happening in the health system then the investment is worthwhile. the outcomes from all interventions needed to reviewed to ensure that they benefit the patient/client - any we get the best from our health dollar</li> </ul> |

**TABLE 7: Responses to the health system’s investment in the SIP: changes required if the benefits are to be worth the investment**

| Changes required   |
|--|
| <ul style="list-style-type: none"> <li>▪ As yet I am not sure that there has been a widespread acceptance by the ambulance service. But if the outcomes are accepted then the benefit would be worth any investment.</li> <li>▪ I have moved to a hospital only 40minutes away and the changes made from the RCA have obviously not been promulgated to the other hospitals.The same conditions exist here that existed prior to the RCA at the other hospital and there is no one interested in making the changes requires.Given the amount of time expended on an RCA it would be worth ensuring the outcomes are disseminated to all AHS and that there be an expectation that changes occur in other hospitals</li> <li>▪ Must be combined with a easy to use, widely accepted reporting system (eg web or email based)that has resources to follow up the large numbers of minor and major incidents that are occurring. Incident reporting needs to be made a priority of the workplace rather than something people are too busy to do.</li> <li>▪ There needs to be an ongoing committment to ensure more staff are trained but this is sometimes difficult to release from rosters, to assist this please consider running again in rural health services</li> </ul> |

### Changes required

- Need to provide additional staff to backfill the time spent doing this. I believe in the process, just can see it already putting strain on already strained managers. With more budgetry, HR and admin responsibility being pushed down to Managers responsibility, as well as increased reporting requirements through EQuIP and Numerical Profile as well as other NSW Health Frameworks and Plans, taking those managers and clinicians out of their workplace to do this, or stressing them with more duties could just be that system error that can cause a problem.
- I think this program has great potential in improving patient safety - I think the barriers of culture and paranoia in some professional groups, particularly after the "Cam Affair" though have been underestimated and this is a "chipping away process". Also, I don't feel RCA teams and recommendations carry the weight with administrators/managers that they should
- Need more clinicians to attend training not just managers
- RCA, at best, forms part of the risk management process. Often, what a RCA Team focuses on is only part of a service. It doesn't help us to allocate resources wisely. What I observed so far is an incident occurred & we spent heaps on trying to fix it (which may or may not improve system issues due to experience and knowledge of individual RCA Teams). A better approach may be doing aggregated RCAs on similar incidents: identify issues --> feedback to management --> prioritise issues (amongst other known issues) --> build into business plan / operational plan --> implement --> periodic review
- It will be worth while once IIMS is in place, to hopefully give statistics and enable better utilisation of skills learnt in SIP training. In the long term with IIMS and SIP the reporting, investigation and improvement processes and statistical analysis of incidents should work improve both clinical outcomes and the work environment of all staff in the health industry.
- SIP is important, but investment in training and support should be better directed towards concrete outcomes
- being able to implement changes that have longer term benefit are challenging in a smaller rural facility with utilitarian approaches to health care delivery
- As I am not sure if the recommendations were implemented not sure however there is an increased awareness generally which should benefit patients.
- Definitely worth the investment, however it is a significant (and largely unresourced) investment. The cutting back of management and re-investment in front line clinical services as part of the amalgamations is only going to worsen this position.
- Long term yes but there are some hoops to get through in attitude and culture changing as well as acceptance by medicos
- I believe that all staff should strive for better outcomes for patients and staff. Sometimes staff just see more paperwork but little changes of practice.
- IF this translates into appropriate management ie in this rural area, casualised workforce, short funding cycles, high staff turnover etc all leads to an increased risk of adverse events, and more time needed to train and support staff. Treasury could stop this but chooses not to at the moment. Thus they do not support good practice, but expect somehow we will do it - along with more clinical work, more data entry etc.
- As long as it is used as a positive step to implement the required changes by addressing the identified problem/s
- As long as staff are given feedback and are not continually unable to implement recommended improvements because of resource issues.
- the sip deals with rare events that definitely are significant however they do not reflect the bulk of work performed. we need to invest the high resources to the 'bulk' of what we do
- Systems must be established to manage clinical safety and risk. However resources need to follow that training and evaluation continues.
- has to be the way forward and has to be driven by all levels within the state and AHS

### Changes required

- I think all managers should be trained, and follow up annual refreshers if it is to work effectively, and consistently
- Suggest more investment in the follow-up of outcomes
- Only if recommendations are acted on and feedback to those involved in the RCA and the incident that started the RCA occurs
- The system is embryonic and needs more time and more people trained to truly provide any reasonable feedback on this. It is not the RCA process that truly makes the difference it is implementing and evaluating the recommendations that will make the difference.
- but.... requires close monitoring by DOH, so that local management dont assume an arbitrary approach, selecting certain recommendations, and rejecting others
- Only if ALL health workers change their ways
- Only if the rest of the hospital staff are brought up to speed and the culture becomes more open. Feed back sgould occur hospital wide to indicate the error and the RCA so that other staff become aware of the process.
- As long as recommendations made are appropriate & followed through.
- More needs to be done by NSW Health in pulling together common system problems from the whole organisation and briefing us about these.
- I believe if medical practitioners can be included regularly and even mandatorily, this would be a huge advantage in heightening awareness of a safety culture
- This is an area that must be actively pursued however resources are scarce.
- We need to be careful not to operate in isolation from OH&S and other health risk management operations - there needs to be more guidance on working together to integrate our processes
- The investment must be sustained for to be able to reap the benefits. We are only seeing the very early results.
- Need to foster the no blame system-based approach
- Would like to see results of other RCA's in other Areas - utilise that knowledge in the application across all organisations
- The investment should be in the front line
- We are not resourced to do the work. I want to make the improvements but just cant withg current staff levles and time
- Only if there are resources to implement changes
- Thing do change though slow do to underfunding to do cap works to improve work enviroment etc
- My position allows me to see more clearly the actual and potential benefits for the whole area. The investment is significant in terms of time and resources. all managers must be committed to support the process from start to end and beyond to implementation of recommendations otherwise a lot of time and resources will be very wasted.
- I think that RCA's are on track with dealing with difficult Incidents (if dealt with promptly). The RIB format should be rolled out for use with all Incidents with the SAC determining the amount of time to be be used in follow up.
- There are a couple of problems with the process. Firstly some of the recommendations are unrealistic or unable to be implemented. There needs to be more invovement outside the direct RCA team especially with advice on what is able to be implemented or should be implemented. An integral part of the process once an understanding of the incident has taken place is the role of other experts within the organisaton.
- There should be more sharing of information some recomendations may be applicable in other facilities. possibly incidents could be prevented in the future if we learnt from each others incidents
- I think that you have to have other favourable factors in place to achieve benefits. SIP will not overcome a lack of clinical leadership or a lack of interest or motivation towards clinical excellence.
- anything that helps pt outcomes has to be worth it. But dollars are limited
- So long as RCA is limited to serious events

#### Changes required

- Change in culture amongst clinicians is occurring. Success of RCAs is in the implementation and follow up to ensure changes are sustained.
- It is a systematic way of examining incidents and getting to the root cause, communicating this to the team to improve practice and pt outcomes. In our organisation there needs to be more communication about the outcomes so that feedback is given to as many areas as possible so that everyone has the benefit of learning from one-another.
- I think it might help to formalise the investigation of adverse events. I think that we lack the time (resources) to do a good job in an RCA, given the pressures under which we are currently working, just to undertake our daily clinical/management duties.
- I suppose looking at the systems issues is good, however the events of last year (Campbelltown Hospital) - would make it seem that the health minister, the DOH, HCCC etc don't exactly seem to follow the same philosophy, that being looking at adverse events from a systems perspective. I think everyone needs to follow the same philosophy ie find someone to hang or look at deficiencies in the system.
- Well its a start. Wont be able to be fixed until we nationalise Medicine (and Law, for that matter)
- We are in the grip of "RCA" mania- churning them out and doing them by the dozen. I would rather we did ONE RCA PER YEAR PER AREA and focussed on ensuring that the recommendations were implemented and followed through. There are too many RCAs and too many recommendations and just too hard to keep track of them all. Doing RCAs does not improve patient safety. Implementing the recommendations does.
- With the introduction of Patient Safety Officer positions it may improve its a resource time issues to be involved even though in theory its supported.
- The difficulties are in the evaluation of the implemented recommendations. This is time consuming and not seen as a priority
- I think they are. However to conduct a full RCA is a labour intensive exercise and it is difficult to determine if the cost benefit is there. I am sure for SAC 1 incidents it is definitely worth it. However it is sometimes difficult to determine if some incidents warrant a full RCA when possibly an alternative investigative process could be more appropriate.
- The benefits only come from the implementations and that is the hardest part of RCA. RCA themselves should be a 'incident to undertake' rather a simple process. The real issue is the follow up and ownership of actions

**TABLE 8: Responses to the health system’s investment in the SIP: the benefits are not worth the investment**

| Negative  |
|---|
| <ul style="list-style-type: none"> <li>▪ as a vehicle of change has not touch the frontlines not understood or known course is poor and forgettable only one other person on our team had any exposure to rca before the rca</li> <li>▪ I have not been involved in an RCA since the training. I believe that with such a lapse in time between training and utilising the knowledge and skills learnt would mean I would find it difficult to conduct an RCA now. It is not something that is required to be used on a frequent or regular basis and therefore what is learnt is lost, through lack of use. Therefore a waste of time and money.</li> <li>▪ Feel that this was rolled as a roadshow rather than a learning program (despite the workshops) There is little to note whether follow up occurs</li> <li>▪ Huge investment with no result from my experience although I have greatly enjoyed the traing and feel it has been goog for my personal view of safety.</li> <li>▪ It has deflected undue resources from common events requiring correction to rare ones</li> <li>▪ As I said above I have seen very few recommendations coming down from the RCA's and from my presepective the same incidents which have been reported through RIB's are still occurring. I.e the near missess are not been stopped and continually reoccurr.</li> <li>▪ I remain concerned about the lack of information or quantification of the resources devoted to this activity. The evidential base for effectiveness appears weak. There has been no explicit undertaking to fund/resource implementaion of recommended actions resulting from the RCA processes. There is a touchingly naive assumption that 80% of recommendations generated by the process will be either cost neutral or save money. I would also like to see a strategic overvirew of how the SIPs will interact with existing adverse event monitoring systems.</li> <li>▪ Yet to see the benefits. There has been no report or feedback from DOH regarding serious incidents.</li> <li>▪ I haven't been asked to participate in a RCA, its over 6/12 since I trained so I feel that this time was wasted if the AHS is not going to make use of these skill which are probably in rapid decline due to lack of practise</li> <li>▪ RCAs are not the new religion. They are overhyped. They do not solve all problems, particularly complex interpersonal interreactions which is the main source of errors in my area of medicine.</li> <li>▪ It worried me that it was all costing so much including 2 nights accomodation for many people (not me). There were far too many people who were only loosely connected to patient care and some who never ever saw patients doing the training and not enough nurses. We need to train the GP's as well as they are the only medical staff we have.</li> <li>▪ the process is too cumbersome to allow many events to be analysed in this way, so even though there is great executive support and the recommended improvements are much more likely to happen, too much time and effort ends up getting spent on too few events to have a significant impact on overall patient safety</li> </ul> |

**TABLE 9: Responses to the health system’s investment in the SIP: unsure/unclear if the benefits are the investment**

| Mixed/neutral/don't know   |
|--|
| <ul style="list-style-type: none"> <li>▪ How much have they invested?</li> <li>▪ See below</li> <li>▪ Although unaware of the actual cost</li> <li>▪ Don't know the total cost of investment and the outcomes achieved directly attributable to the SIP</li> </ul> |