CENTRE FOR CLINICAL GOVERNANCE RESEARCH

EVALUATION OF THE SAFETY IMPROVEMENT PROGRAM IN NEW SOUTH WALES: STUDY NO 9

REPORT ON THE EFFECTIVENESS OF THE REPORTABLE INCIDENT REVIEW COMMITTEE

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

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 study 9 in the evaluation of the Safety Improvement Program (SIP) in New South Wales. This study provides an analysis of the role and effectiveness of this Committee. This Committee supports and monitors the performance of the Safety Improvement Program by giving advice on its strategic direction, overseeing the processes of policy development and feeding information back to the AHSs and the community. The Committee also plays an important role in reviewing reportable incident reports.

The Committee has set policy, assessed progress with incidents, and reviewed much data since it first met in December 2003. One of the major recent outcomes includes the first report on incident management in the NSW public health system 2003-2004, recently released. The Committee is well organised and structured. The Committee's main challenge is with the low attendance rates of its members due to competing work pressures and its ability to handle the RIB process effectively mainly due to the nature of the current reporting system.

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 heath 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 9. It provides an overview of the role and effectiveness of the Reportable Incident Review Committee This component of the evaluation was conducted by A/Professor Jeffrey Braithwaite and Ms Nadine Mallock.

TABLE 1: Evaluation Studies

STUDY	TITLE	COMMENTS, ACTIONS AND TIMEFRAMES	LED BY/TEAM
Study #1	Literature Review	• 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	• 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	• Questionnaire to all course participants • Review of course evaluations	Nadine Mallock, Mary Westbrook
Study #4	Ongoing applicability of training to participants	• 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	• Detailed interviews with faculty staff	Debbi Long
Study #6	Program outcomes at local, area and state levels	• 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	• 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	• Questionnaire to all course participants • Interviews with key stakeholders	Jeffrey Braithwaite, Jo Travaglia, Mary Westbrook, Nadine Mallock
Study #9	Effectiveness of SIP Committee	• Observation of Steering Committee • Review of outcomes	Nadine Mallock, Jeffrey Braithwaite,
Study #10	Management of RIB process	• Focus group • DOH data • Interviews with key stakeholders	Jeffrey Braithwaite, Jo Travaglia, Nadine Mallock, Marjorie Pawsey
Study #11	Reporting processes	• Focus group • DOH data • Interviews with key stakeholders	Jeffrey Braithwaite, Jo Travaglia, Nadine Mallock, Marjorie Pawsey
Study #12	Branch functions and actions	• Focus group • DOH data • Interviews with key stakeholders	Jeffrey Braithwaite, Jo Travaglia, Nadine Mallock, Marjorie Pawsey

3.2 About this report

The committee under the name of the Safety Improvement Steering Committee first met in December 2003. It has recently changed its name to Reportable Incident Review Committee and its Terms of Reference. The Committee was set up to "*to oversee the management of health care incidents reported to the Department of Health and to provide strategic direction and advice on policy development that focuses on health care system improvement*".

In particular, the Committee's role is to provide support to and monitor the performance of the Safety Improvement Program by focusing on system improvement, policy development, issues management and health system and community feedback. The Committee also plays an important role in reviewing reportable incident reports (see the Appendix for the complete Terms of Reference).

4 METHODS

A member of the SIP evaluation team attended two consecutive meetings of the Reportable Incident Review Committee and observed how the Committee functions in practice. In addition, agendas, minutes and the Terms of Reference of the Reportable Incident Review Committee were content analysed. In particular, the assessment focused on:

- How are meetings organised?
- How does the Committee communicate in meetings?
- What kinds of topics are discussed in the meetings?

5 FINDINGS

5.1 How are meetings organised?

Meetings are held monthly at the NSW Health Department. Dates and times are set up in advance, however, difficulties in finding a meeting room often require a re-arrangement of times. Membership of the Reportable Incident Review Committee has been formalised in the Terms of Reference and includes high level representatives of 14 Department of Health branches (see list of branches in the Terms of Reference in the Appendix). The Committee is multidisciplinary in its approach.

The attendance usually ranges from 7 to 13 representatives; attendance is sporadic, with members from some branches infrequently attending. In other cases, the representative or delegate does not oversee his or her branch and is therefore only to a limited extent able to report on incidents and associated issues affecting the whole branch. The level of turnover is high. In total, 37 different people attended eleven meetings in 2004. Only five people attended more than 50% of the meetings.

Comprehensive minutes are taken by one of the staff members of Quality and Safety branch. These notes are usually circulated together with the forthcoming agenda and supplementary materials.

5.2 How does the Committee communicate in meetings?

As with NSW Health Committees generally, one person chairs the meeting. This person guides the others through the agenda items and leads discussions. Specific people are assigned to topic items on the agenda. Each branch usually presents reports on their RIBs, SAC 1s and other important business. Others are welcomed to make comments or suggestions. Members of the Committee come from different areas and some clarification of perspectives is often needed. Participants generally have the opportunity to have their say. Issues arising will be discussed by the group and if applicable an action plan will be formulated and followed-up at the next meeting or after the meeting. This approach facilitates ownership by the group and also ensures that issues are followed up. There is open discussion and sharing of experiences and problems amongst the Committee members. There does not seem to be a dominant person. The acting chairperson balanced time pressures and the need for discussion appropriately.

5.3 What kinds of topics are discussed in the meetings?

A range of topics is presented and discussed in the Committee's meetings. Permanent items on the agenda include business arising, a report by Quality and Safety Branch on RIB and RCA issues, individual branch reports on RIBs and actions arising from the Safety Improvement Program. Within these broad themes, specific topics are discussed. These include the definitions of SACs, classification of RIBs, VMO reporting, underreporting problems, RCAs reports, correct patient, correct procedure and correct site model policy, translation of patient brochures and the Safety Improvement education training program. These topics are relevant to the Safety Improvement Program.

6 DISCUSSION

The Reportable Incident Review Committee appears to work effectively and according to the Terms of Reference. It provides high level support and advice on policy development, education and training and RIB management and dissemination processes.

It handles and discusses appropriate issues central to the Safety Improvement Program, well, for instance, by overseeing the correct side surgery policy, the translation of the patient brochures and the definitions of SACs. However, the RIB process which can be regarded as the bread and butter of the Committee according to its Terms of Reference, suffers because data are not assessed in detail. The Committee has put systems in place to encourage reporting but does not make extensive use of the rich data collected. The Committee seems challenged with decision-making regarding what kind of data should be collected and categorised, by whom, in which format, in which detail and overall what kind of analysis is required. Mitigating this, the current reporting system does not allow for detailed analyses to a large extent. The IIMS (Incident Information Management System) which will be implemented in NSW hospitals this year will hopefully remedy or at least ease some of these issues.

Some branches have low participation rates at the Committee's meetings, which may be an indication of a failure to engage participants. Another issue is the high turnover of members. That only five members have attended more than 50% of the meetings may be a cause for concern. Chairing responsibilities seems to change quite frequently. The role of the chairperson has recently been assigned to the Deputy Director-General, Health System Performance but was then re-assigned in February 2005. It is arguable whether a Committee can function effectively with such a high turnover rate of members and instability in the assignment of the Chair.

7 CONCLUSION

This is in principle a well structured Committee within the context of various challenges it faces. The Committee seems to be able to make important decisions on a range of issues related to the Safety Improvement Program within tight time frames. It has achieved much within the first years of its existence. The name change reinforces that the main role of the Committee is to oversee, provide support and advice on the reportable incidents process.

However, there is scope for the Committee to handle this process more effectively. The Committee has identified the need to report on and analyse RIB data and has put systems in place to ease and encourage reporting. It is timely to make use of the collected data and oversee and support analyses that will allow and possibly show system improvements. The Committee might focus on getting appropriate high level membership by strongly reinforcing the importance of its role to the directors of NSW Health Department branches involved. It needs a strong, skilled and consistent working group to achieve its aims.

8 REFERENCES

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9 APPENDIX

9.1 Reportable Incident Review Committee Terms of Reference December 2004

Vision

To improve the safety and quality of health care provided in NSW.

Purpose

The Reportable Incident Review Committee is to oversee the management of health care incidents reported to the Department of Health and to provide strategic direction and advice on policy development that focuses on health care system improvement

The Reportable Incident Review Committee will provide support to and monitor performance of the Safety Improvement Program (SIP) including the Reportable Incident Briefing (RIB) system. The committee will oversee:

- System improvement – ensure that lessons learned are shared and that improvement occurs across the system.
- Policy development – ensure that policy is developed and/or reviewed by the appropriate branch as required.
- Issues management – identify where system improvement or policy development is required and that feedback is provide to the system.
- Health system and community feedback – determine scope of reports to be provided back to the system and to the community.

Key Responsibilities

The Reportable Incident Review Committee will:

- Advise on the strategic direction for incident and issues management within NSW;
- Receive and review reports provided through the RIB system;
- Oversee the implementation of processes for the effective management of incidents reported to the Department of Health;
- Assess and endorse system wide policy development that arises from incidents reported to the Department;
- Provide advice on the development of regular reports to the Area Health Services and the community.

Membership

Membership of the Reportable Incident Review Committee will comprise of representatives from the following areas – the member will be either the Director of the unit or the delegated person responsible for oversight of RIBs:

- Deputy Director-General Health System Performance (Chairperson)
- Communications
- Director-General's Office
- Employee Relations
- Executive Support Unit
- Finance and Business Management
- Legal and Legislative Services
- Mental Health Branch
- Nursing and Midwifery
- Population Health
- Primary Health and Community Partnerships
- Private Health Care Branch
- Quality Branch
- State Wide Services.

Secretariat

Quality and Safety Branch

Accountability

The Committee will report to the Director-General through NSW Health Management Board.

Frequency of Meetings

Meetings will be conducted monthly. Additional meetings may be called as required.