

# **Achieving sustainable change from a national level – successes and challenges**

*Humans and complex systems Think Tank*

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6 March 2009**

# ► Complex System



## Policy Responsibilities

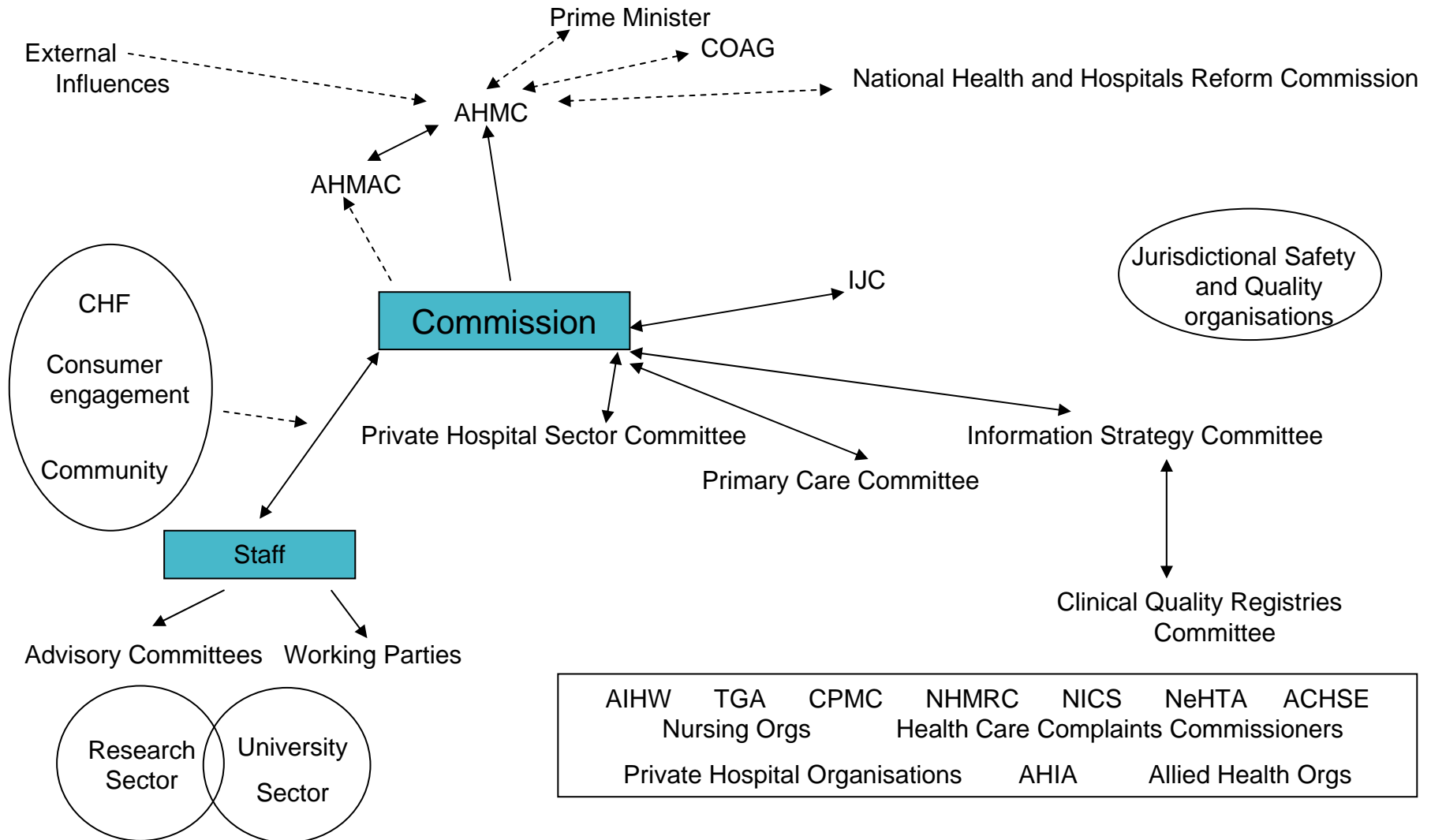
Commonwealth	State and Territory Govt.	Other – Non Govt. orgs
<ul style="list-style-type: none"> <li>- GPs, medical specialists &amp; others on MBS</li> <li>- PBS</li> <li>- Health promotion and prevention</li> <li>- Mental Health initiative</li> <li>- Indigenous initiatives</li> <li>- Drug and Alcohol initiative</li> <li>- Defence and Veterans Health</li> <li>- Aged Care</li> </ul>	<ul style="list-style-type: none"> <li>- Public hospitals, community services, ambulance &amp; patient transport</li> <li>- Health promotion and prevention</li> <li>- Workforce initiatives</li> <li>- Mental Health initiatives &amp;</li> <li>- Service Provision</li> <li>- Indigenous health services</li> <li>- Drug and Alcohol initiatives</li> <li>- Supervised training</li> <li>- Support CPD</li> </ul>	<p><b><i>Colleges and associations</i></b></p> <ul style="list-style-type: none"> <li>- Training programs</li> <li>- CPD</li> <li>- Credentialing role ?</li> </ul> <p><b><i>Training Bodies</i></b></p> <ul style="list-style-type: none"> <li>- Tertiary training of health professionals</li> </ul> <p><b><i>Private providers</i></b></p> <ul style="list-style-type: none"> <li>- Aged care</li> <li>- Psychiatric hospitals</li> <li>- Day procedure centres</li> </ul>
Regulatory Powers		
<ul style="list-style-type: none"> <li>- Private Health Insurance</li> <li>- MBS</li> <li>- PBS</li> <li>- TGA</li> <li>- Food agency</li> <li>- Aged Care &amp; Accreditation</li> <li>- Communicable Disease</li> </ul>	<ul style="list-style-type: none"> <li>- Registration</li> <li>- OHS</li> <li>- Private Hospital Licensing</li> <li>- Poisons</li> <li>- Environmental health</li> </ul>	<ul style="list-style-type: none"> <li>- Health Insurance</li> <li>- Medical colleges</li> <li>- Accreditation boards</li> </ul>

## ▶ ACSQHC

### Health Ministers Established ACSQHC to:

- 1. Lead and coordinate safety and quality in health care**
- 2. Advocate for safety and quality and report publicly**
- 3. Recommend national data sets**
- 4. Provide strategic advice to Health Ministers**
- 5. Recommend nationally agreed standards**

# ▶ Effecting Change



## Commission Programs

1. **Australian Charter of Healthcare Rights**
2. **Open Disclosure**
3. **Basic Care Issues**
  - **Healthcare Associated Infection**
  - **Patient Identification**
  - **Medication Safety**
  - **Clinical Handover**
  - **Patient at risk**
  - **Falls Guidelines**
4. **Tools**
  - **Accreditation and credentialing**
  - **Information Strategy**

## ▶ ACSQHC and Health Ministers' Decisions: 2008

### **Initiative: Open Disclosure (April 2008)**

#### **Decisions**

- Work towards the implementation of the National Open Disclosure Standard in all health care facilities
- ACSQHC to support implementation

#### **Moving Forward**

- Ongoing Commission work:
- 100 patient stories
- Legal clear path
- Report to AHMC required
- Open Disclosure Standard is available on ACSQHC website

## ▶ ACSQHC and Health Ministers' Decisions: 2008

### Initiative: Accreditation of Healthcare Facilities (April 2008)

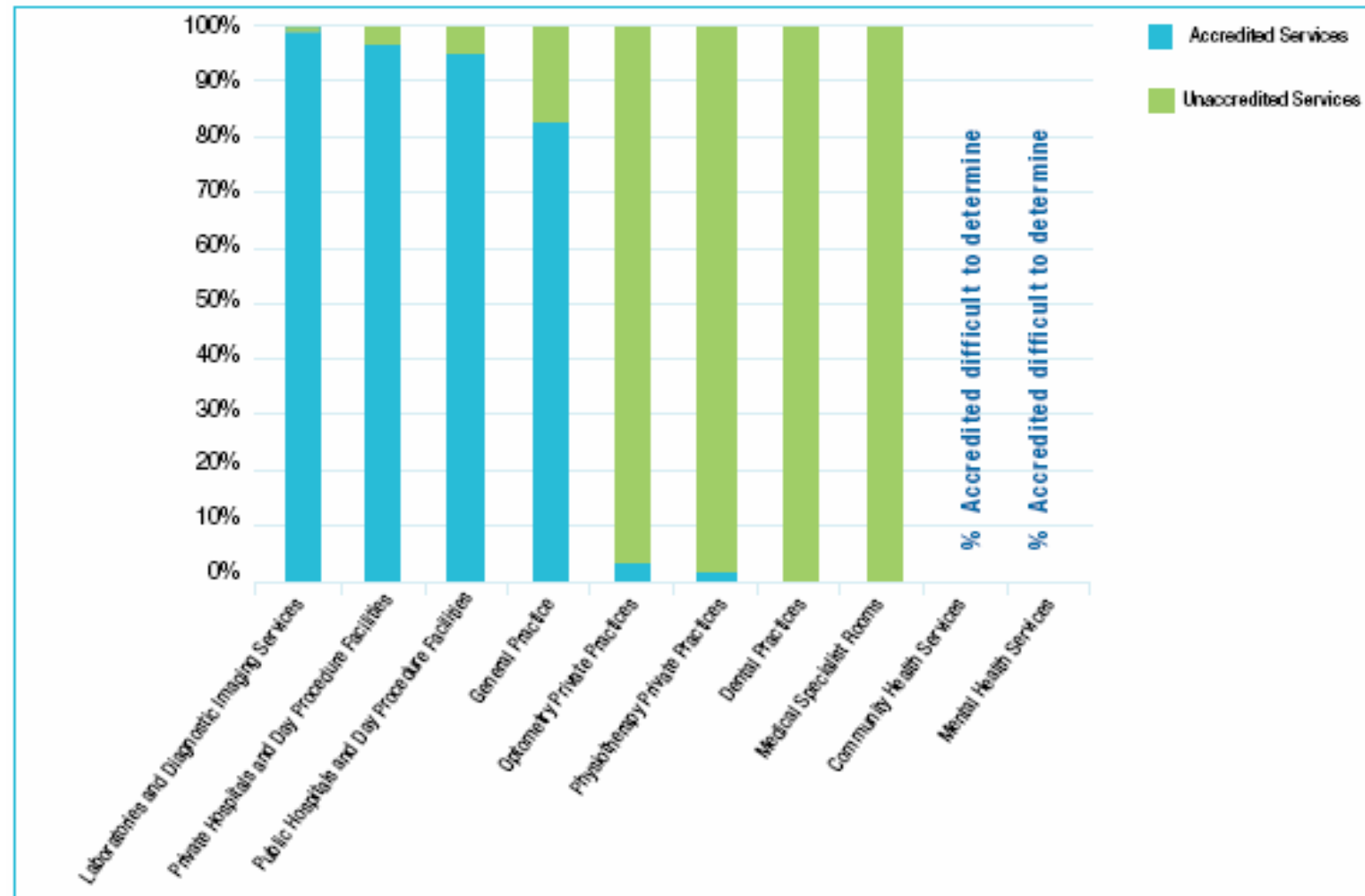
#### Decisions

- Endorsed the recommendations for implementation of reforms to safety and quality accreditation
- ACSQHC to develop Phase 1 model

#### Moving Forward

- Final Report on the Review of National Safety and Quality Accreditation Standards Feb 2008 is available on ACSQHC website
- Research underway on:
  - Short notice surveys
  - Surveyor participation
  - Patient journey
- Development of preliminary Australian Healthcare Standards initially in:
  - Healthcare Associated Infection
  - Medication Safety
  - Patient Identification
  - Clinical Handover
- National coordination of accreditation
- Mapping of regulation to mandate Australian Health Standards and the expansion of accreditation to high risk areas

**Figure 8.4:** Proportion of health services accredited, by health service type, as at January 2008



## ▶ ACSQHC and Health Ministers' Decisions: 2008

### **Initiative: National Patient Wristband Standard (July 2008)**

#### **Decisions**

- **Implementation of the National Patient Wristband Standard across Australia**

#### **Moving Forward**

- **The Standard is available on ACSQHC website**



# ▶ ACSQHC and Health Ministers' Decisions: 2008

## Initiative: Australian Charter of Healthcare Rights (July 2008)

### Decisions

- The Australian Charter of Healthcare Rights and its use to be the pre-eminent healthcare charter for Australia
- Implementation in all healthcare settings

### Moving Forward

- The Charter is available on ACSQHC website
- ACSQHC to facilitate working party to coordinate implementation

### AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the Australian health system. These rights are essential to make sure that, wherever and whenever care is provided, it is of high quality and is safe.

The Charter recognises that people receiving care and people providing care all have important parts to play in achieving healthcare rights. The Charter allows patients, consumers, families, carers and services providing health care to share an understanding of the rights of people receiving health care. This helps everyone to work together towards a safe and high quality health system. A genuine partnership between patients, consumers and providers is important so that everyone achieves the best possible outcomes.

#### Guiding Principles

These three principles describe how this Charter applies in the Australian health system.

- 1 Everyone has the right to be able to access health care and this right is essential for the Charter to be meaningful.
- 2 The Australian Government commits to international agreements about human rights which recognise everyone's right to have the highest possible standard of physical and mental health.
- 3 Australia is a society made up of people with different cultures and ways of life, and the Charter acknowledges and respects these differences.



For further information please visit [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au)  
**AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE**

#### What can I expect from the Australian health system?

MY RIGHTS	WHAT THIS MEANS
<b>Access</b> I have a right to health care.	I can access services to address my healthcare needs.
<b>Safety</b> I have a right to receive safe and high quality care.	I receive safe and high quality health services, provided with professional care, skill and competence.
<b>Respect</b> I have a right to be shown respect, dignity and consideration.	The care provided shows respect to me and my culture, beliefs, values and personal characteristics.
<b>Communication</b> I have a right to be informed about services, treatment, options and costs in a clear and open way.	I receive open, timely and appropriate communication about my health care in a way I can understand.
<b>Participation</b> I have a right to be included in decisions and choices about my care.	I may join in making decisions and choices about my care and about health service planning.
<b>Privacy</b> I have a right to privacy and confidentiality of my personal information.	My personal privacy is maintained and proper handling of my personal health and other information is assured.
<b>Comment</b> I have a right to comment on my care and to have my concerns addressed.	I can comment on or complain about my care and have my concerns dealt with properly and promptly.

## ▶ AUSTRALIAN CHARTER OF HEALTHCARE RIGHTS

### *What can I expect from the health system?*

MY RIGHTS	WHAT THIS MEANS
1. ACCESS: I have a right to health care	I can access services to address my health care needs
2. SAFETY: I have a right to safe and high quality care	Safe and high quality health services are provided to me with professional care, skill and competence
3. RESPECT: I have a right to respect, dignity and consideration	The care provided respects me and my culture, beliefs, values and personal characteristics
4. COMMUNICATION: I have a right to be informed about services, treatment, options and costs in a clear and open way	I receive open, timely and appropriate communication about my health care in a way I can understand
5. PARTICIPATION: I have a right to be included in decisions and choices about my care	I may participate in making decisions and choices about my care and about health service planning
6. PRIVACY: I have a right to privacy and confidentiality of my personal information	My personal privacy is maintained and proper handling of my personal health and other information is assured
7. COMMENT: I have a right to comment on my care and to have my concerns addressed	I can comment on or complain about my care and have my concerns dealt with properly and promptly



# ▶ ACSQHC and Health Ministers' Decisions: 2008

## Initiative: Standardised terminology, abbreviations and symbols for use in hospital prescribing (Dec 2008)

### Decisions

- To be adopted Australia-wide

### Moving Forward

- *'National terminology, abbreviations and symbols to be used in the prescribing and administering of medicines in Australian hospitals'* document is available on the ACSQHC website

AUSTRALIAN COMMISSION ON  
SAFETY AND QUALITY IN HEALTHCARE

National terminology, abbreviations and symbols to be used in the prescribing and administering of medicines in Australian hospitals

#### Introduction

One of the major causes of medication errors is the ongoing use of potentially dangerous abbreviations and dose expressions.<sup>1</sup> This is a critical patient safety issue. A study to identify and quantify prescribing errors in a large US urban teaching hospital found that 39% of prescriptions contained a dangerous abbreviation. An abbreviation used by a prescriber may mean something quite different to the person interpreting the prescription. Abbreviations may not only be misunderstood but can also be combined with other words or symbols to appear as something altogether unintended.

In addition, there have been changes to training of health care professionals, to health care delivery and to societal expectations, which also necessitate a rethinking of the language used to communicate medication prescribing and administration. Latin was once the language of health care and its use made medical literature universally readable among educated persons.<sup>2</sup> Today, English is the predominant language of medical literature.<sup>3</sup> Despite this, Latin abbreviations continue to be used amongst health professionals. Although this may be increasing convenience, their routine use does not promote patient safety.<sup>4</sup> Changes to policy enabling staff with differing levels of training to administer medicines, also necessitates the use of English. This training does not include Latin nor does it include comprehensive

training in terms used for the administration of medicines. In addition, patients and their carers have the right to understand what is being prescribed and administered to them. Prescribing using codes or an uncodified language is no longer acceptable.

#### Objectives

In order to promote patient safety and clear and unambiguous prescribing of medicines, this document establishes the following:

- Principles for consistent prescribing terminology (Table 1)
- A list of recommended terms and acceptable abbreviations (Table 2)
- A list of error-prone abbreviations, symbols and dose designations that have a history of causing error and must be avoided (Table 3)

#### Scope

The principles and recommendations apply to:

- All medication orders or prescriptions that are handwritten or pre-printed
- All communications and records concerning medicines, including telephone verbal orders/prescriptions, medication administration records and labels for drug storage.<sup>5</sup>

Prescriptions should not contain ANY abbreviations other than those that are in universal and common use, such as the term 'per' meaning 'when required'. All drug names, products and procedures should be in English and written in full.

It is recommended that hospitals develop policies for prescribing terminology together with strategies for implementation within their institutions. In developing strategies, hospitals may wish to refer to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) 'Implementation Tips' for eliminating dangerous abbreviations (<http://www.jointcommission.org/PatientSafety/DoNotUseList>).

Although this document provides recommendations it is not all-inclusive. There may also be specific circumstances where other terminology may be considered safe. However, before hospital Drug and Therapeutic Committees (DTCs) decide to include such terminology in local policies the principles outlined in Table 1 should be applied. DTCs should continue to monitor incidents associated with prescribing terminology.

Please note this document is valid as at November 2008 and will be modified on the basis of regional advice which associated with terminology, abbreviations and/or symbols used in the prescribing or administration of medicines. In addition when moving to electronic prescribing a reassessment of what is safe terminology should be made.

## ▶ ACSQHC and Health Ministers' Decisions: 2008

### Initiative: Healthcare Associated Infection (Dec 2008)

#### Decisions

- Healthcare Associated Infection surveillance in all hospitals
- Monitoring and reporting of *Staphylococcus aureus* bacteraemia to jurisdictions and nationally
- Monitoring and reporting of *Clostridium difficile* to jurisdictions and nationally

#### Moving Forward

- Surveillance document '*Reducing harm to patients from healthcare associated infection: the role of surveillance*' is available on ACSQHC website
- Report to AHMC required

## ▶ ACSQHC and Health Ministers' Decisions: 2008

### **Initiative: Healthcare Associated Infection – National Hand Hygiene (Dec 2008)**

#### **Decisions**

- National approach to the monitoring of hand hygiene standards

#### **Moving Forward**

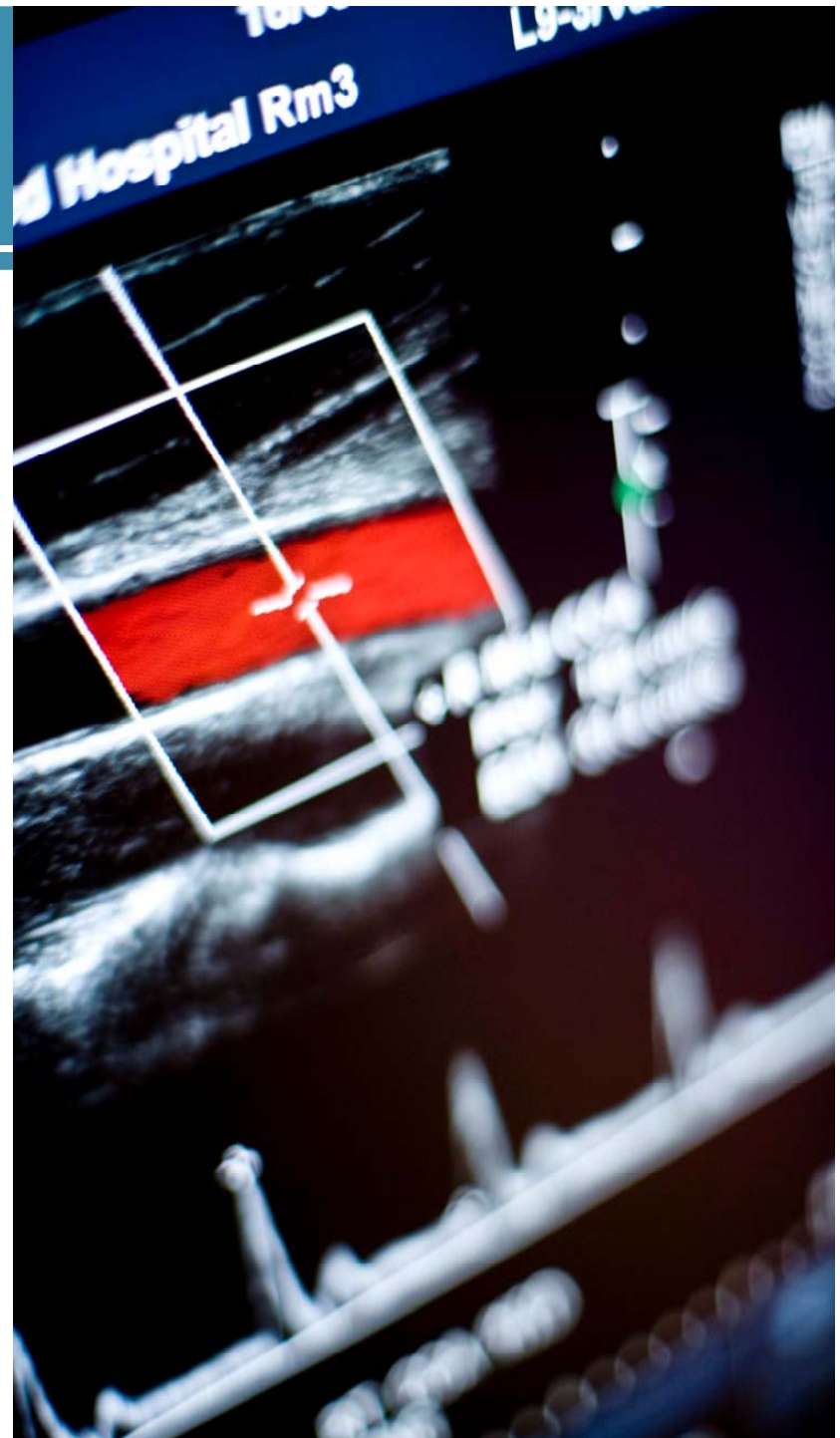
- Details on Hand Hygiene Australia are available on the Hand Hygiene Australia website: <http://www.hha.org.au/>



► Harvard study – 17yrs on

“Although much good work has been carried out there is a sense at the coalface of hospital medicine not a lot has changed. Why not? What can be done about it?”

*Scott I, Poole P, Jayathissa S. Int Med J. 2008*



## ▶ Literature

# On the Trail of Safety and Quality in Healthcare

*Richard Grol, Donald Berwick, Michael Wensing BMJ 336 (2008) 74-76*

**Major problems persist to improve the quality and safety of healthcare**

### **Factors include:**

- Resistance to change among health professionals
- Organisational structures that block improvements
- Dysfunctional financial incentives

**Research agenda topics suggested**

## On the Trail of Safety and Quality in Healthcare

*Richard Grol, Donald Berwick, Michael Wensing BMJ 336 (2008) 74-76*

### Research agenda topics suggested include:

- How to achieve sustained change in normal care
- How to guide clinicians towards scientifically correct and safe practice
- How to provide new evidence at the point of care
- How to create a culture of change and continuous improvement in the ward or practice

## ▶ Doom Loop

- Ever changing executives
- Destabilized middle management
- Shifting array of overlaid strategies
- Dissatisfied staff members
- Questionable results

*Collins 2001 – Good to Great: Why Some Companies Make the Leap ... and Others Don't.*

## ▶ “Systemic failure”

**“No commitment to care: staff bemoan lack of concern” SMH Sep 29-30 2008**

- Management “obsession with filling out useless forms and mindless application of protocol”
- “Fire all the middle management in hospitals who have created this environment and contribute nothing and you will have plenty of hospital funding”.
- Low morale is attributed to constant change of management and clinicians losing their decision making power to bureaucrats.


▶ **Q: It has been said by others: “I give good care, but the system often lets patients down”**

S4 - I think most doctors feel that way. They try to do their best in their little niche but they struggle to make contributions, the system doesn't allow them to make contribution.


S26 - I've ... figured ways of getting round the system now ... I am not prepared to say that I couldn't work out the system enough to protect my patients from it, I'm not prepared to say that. I won't do that, I've worked a way round a lot of the things that have holes in the floor that people sort of slip through and I just plug them up.

▶ I. It sounds like you'd like to be more involved in some of the systems stuff?

**S3. Yes theoretically.** If, if I felt there was a system that was truly trying to analyse what was going on ... there should be all players involved and then when you decide to make changes you monitor it and see how it goes. Also you shouldn't have to reinvent the wheel each time... the other day I was in the operating theatre and thinking how silly it was that the phone was above where the sterile gowns and the scrub sister were. I just laughed at it. It's so stupid. If I go near the phone I might de-sterilise the gowns. And I thought we've been building modern hospitals for 40-50 years [yet] ... every time we build an operating theatre we make it up and parts of it don't work. We shouldn't have different systems everywhere in all hospitals ... So there should be some effort to try and do that, so a system that had all those things in it and then I would plug into it in the appropriate spots



S3. ... we're probably deluding ourselves if we don't think that part of giving good care is trying to improve the system. **I think we insulate ourselves from the difficulties in the system by saying "well all I can is what I am doing right now because I can't control those other things"**. I think you're still not giving good care if you don't try and address the system problems that result in the total care not being good....



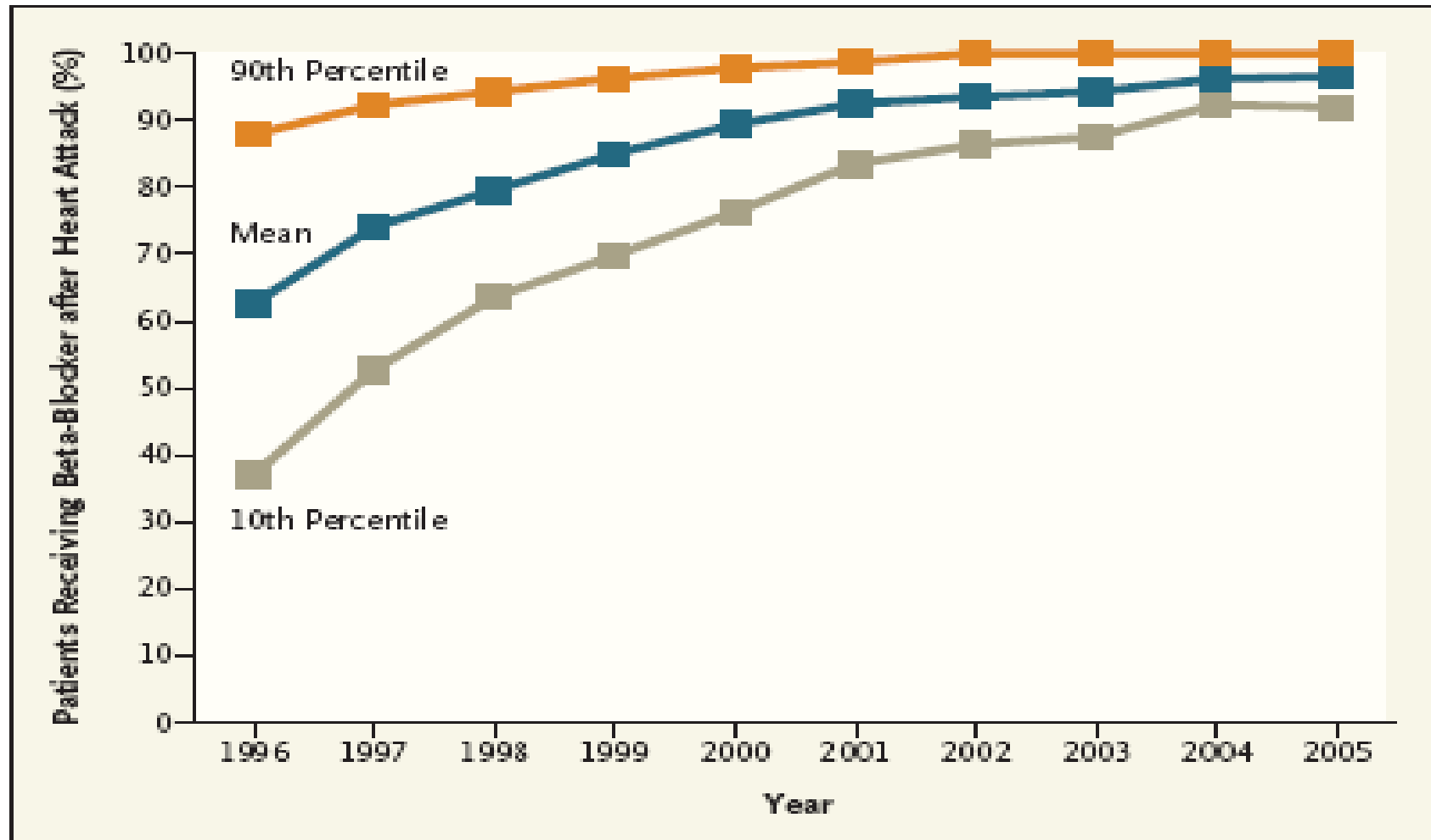
**S38** You know, you can run a hospital from any kind of building or tent ... it's not so much the facilities as the staff morale and people working together and feeling valued ... My own view is that is probably where we should try because the other decisions are really at a political level and high, and unless you want to actually become a hospital administrator (which some people do very well), I think it is hard to do that and remain in a clinical practice. I don't think I could continue as a surgeon and try to get involved in the management side and do an MBA and try to learn how to do that. But, if people [were] a little bit more prepared to meet and forget about past differences and history, I think perhaps where I might have a role here ...”

## ▶ What has changed?

- Multidisciplinary team work is normal
- Multidisciplinary stroke units are in widespread use
- MET teams are present in >75% of hospitals
- We have specialist emergency physicians – in large numbers, working long hours
- Adverse events are monitored and investigated and appear to be stable despite the increase in acuity of the population
- ‘Miracles’ are the norm - cancer survival and intensive care rescue, survival of premature infants, joint replacements

## ▶ “Eulogy for a Quality Measure”

*Lee 2008*



Use of Beta-Blocker Treatment after Myocardial Infarction, 1996–2005.

Data are from the National Committee for Quality Assurance.

## ▶ High Performing Health Systems: Delivering Quality by Design

### *Baker et al 2008, Longwoods Toronto*

- Birmingham East and North Primary Care Trust and Heart of England Foundation Trust
- Veterans Health Administration – Network 1
- Jonkoping County Council, Smaland, Sweden
- Intermountain Healthcare, Salt Lake City, Utah
- Henry Ford Health System, Detroit, Michigan

## ▶ Quality Improvement includes:

- Concept of continuous improvement
- Organization wide commitment and worker participation
- Knowledge of customer needs
- Systems thinking and systematic analysis of processes
- Use of scientific data-driven analytic methods
- Use of interdisciplinary and cross-functional teams
- **Successful micro-systems** – consumers, clinicians & support staff “understand their clinical unit as an interdependent group with the capacity to make changes” and “develop a common purpose and collaboration to improve outcomes”.

## ▶ Quality Improvement includes:

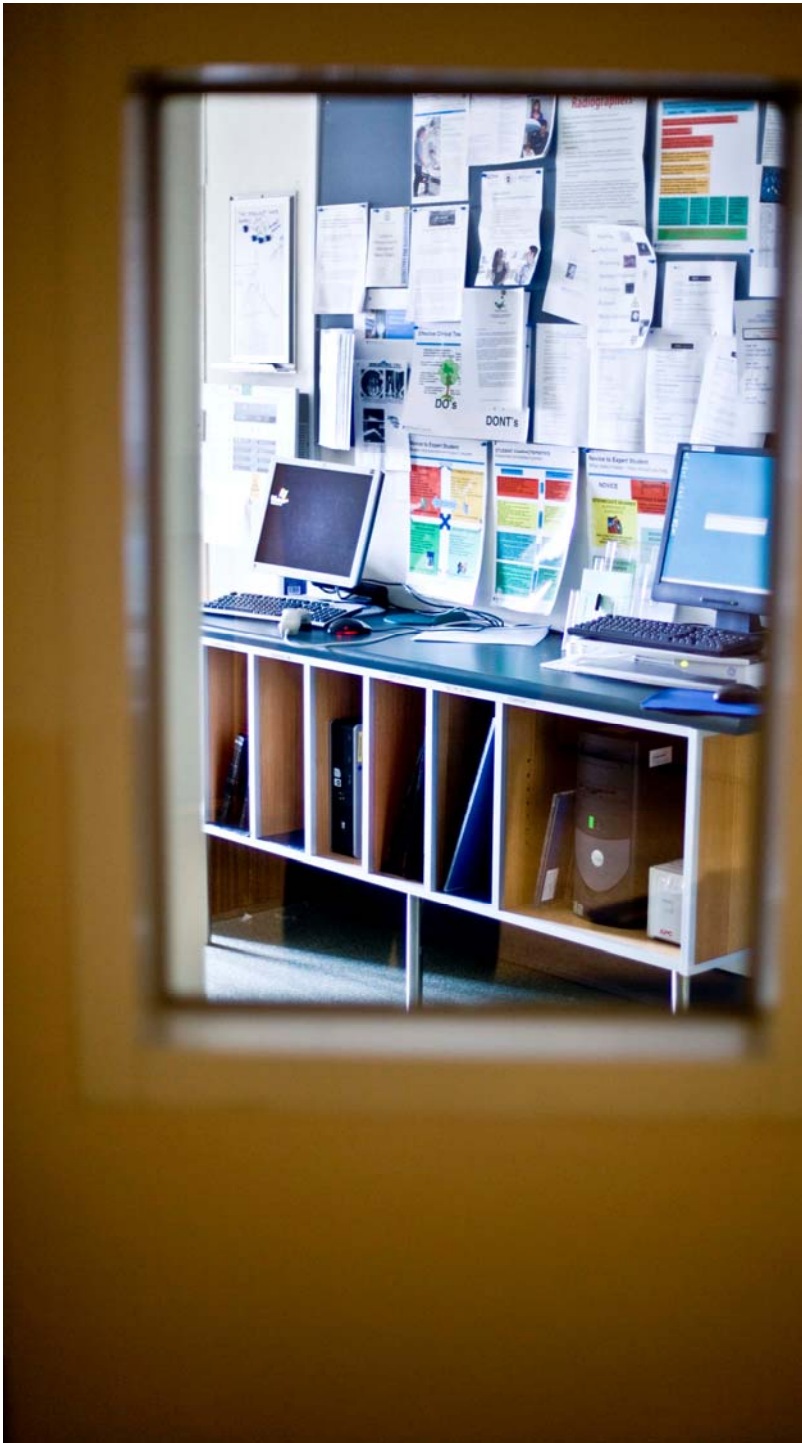
- Build the long term vision “project by project, phase by phase”
- Strategies of insuring “that healthcare administrators could be recognized as having successful careers by remaining in one institution and achieving success in that role.”
- Detailed data/indicator collection & use for improvement
- Build relationships with political environment and influence national policy
- Not using consultants but building internal capacity - widespread training in quality for frontline clinicians

## ▶ Quality Improvement includes:

- Operational line responsibility for doctors – employed doctors
- Electronic medical records (plus clinical reminders, protocol support)
- Investment in information systems so that it can be confidently used for benchmarking and performance improvement – “reliable flow of useful information”
- Integration of health & social care
- Integration of primary and hospital care

The image shows the Google logo in its multi-colored, 3D style, with the word "Australia" written in a simple black font below it. The letters are: G (blue), O (red), O (yellow), g (blue), l (green), e (red).

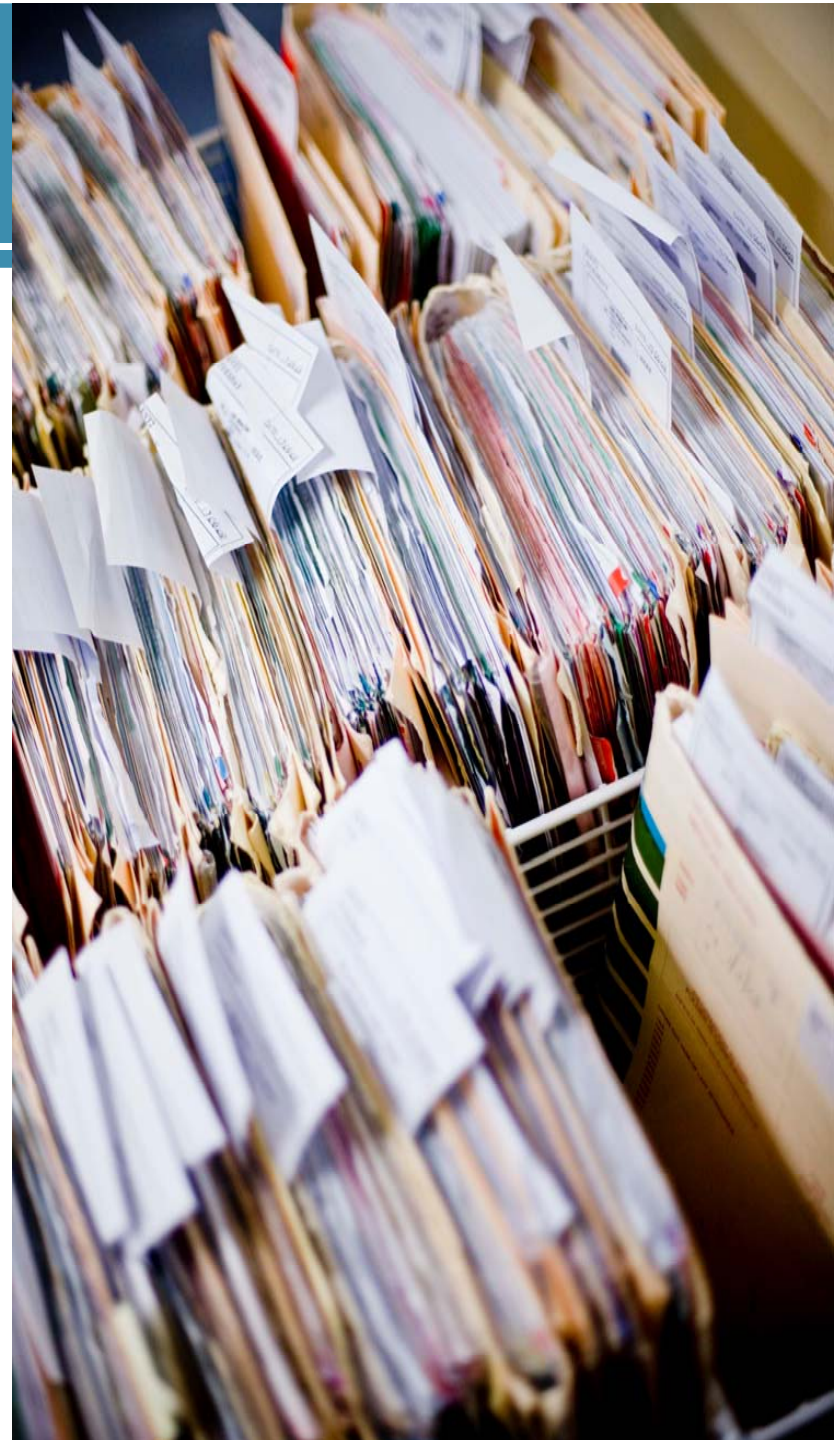
Google<sup>TM</sup>  
Australia



▶ Without technology...

“fragmented and inaccessible clinical information adversely affects both the cost and quality of health care as well as compromising patient safety”

*Anderson, Int J Med Inform 2006*



## ▶ What does unsuccessful national action look like?

**Lots of committee meetings and no change**

WHY?

- Poor product – little evidence base, developed in isolation from users and NOT PILOTED and EVALUATED
- Attempt to mandate policy without an infrastructure for implementation and inadequate communication (must be 2 way)

## ▶ What does successful national action look like?

### **Extensive local change occurs**

#### WHY?

- Piloting has ensured product works and is affordable
- There is an appropriate implementation mechanism
- Levers are employed – funding, regulatory
- The product is compelling (evidence based and/or appealing in other ways)
- If it is seen as a valuable ‘innovation’ diffusion can occur

## ▶ Commission work

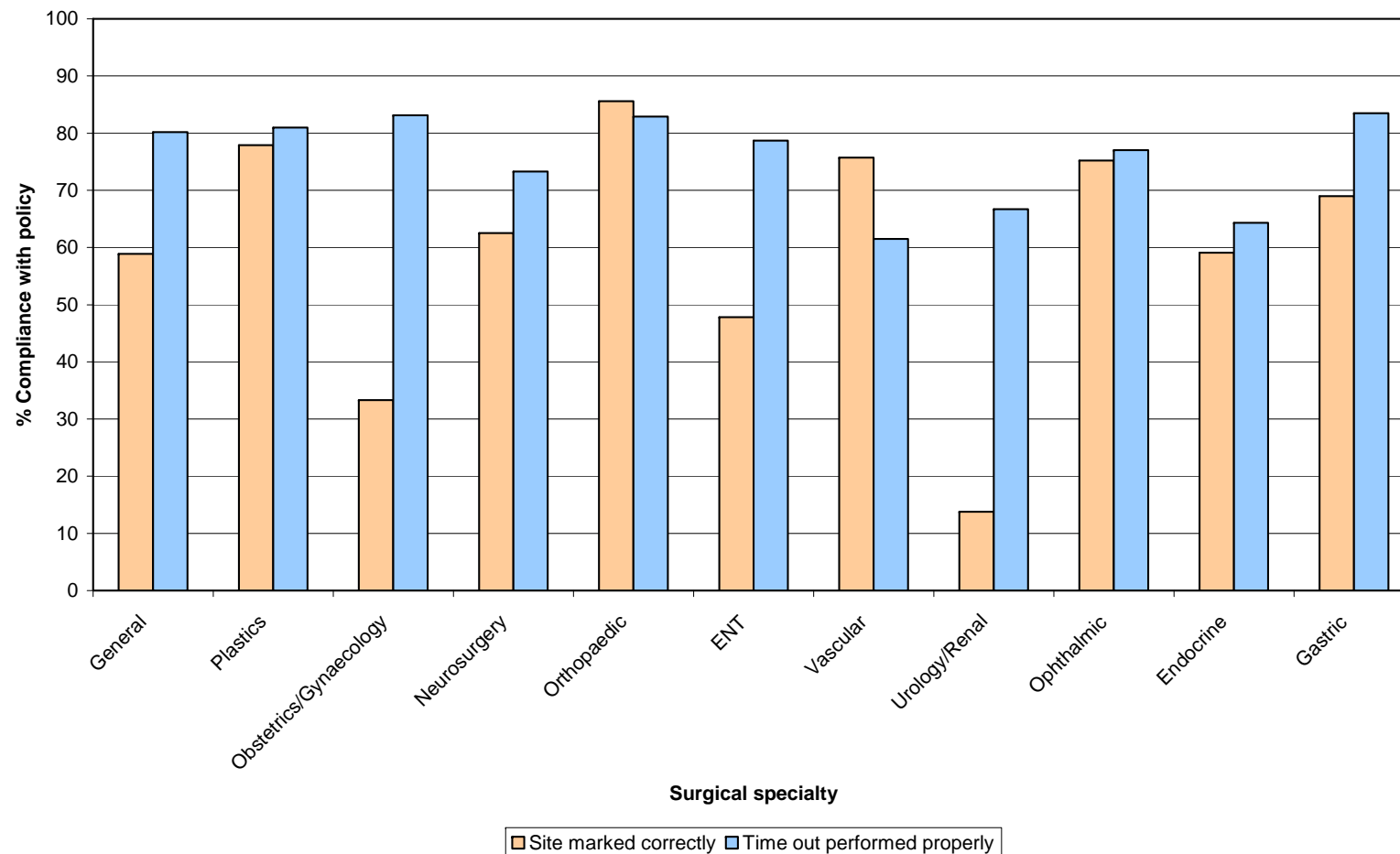
- Hygiene – evidence based, compelling case, reporting
- Patient Identification – piloted processes and tools
- Handover – research, attempt to develop a sticky product to encourage systematic practice
- OD – pilot, research, legal reform, implementation tools, reporting
- Patient at risk – research
- Credentialling- research into peer review, regulation
- Accreditation –into all high risk settings, reporting against AHS
- Information strategy - standards for Australian Clinical Quality Registries, national indicators,

## ► Successful or unsuccessful national action?



# ▶ Correct patient, correct site, correct procedure

Figure 3: Proportion of cases complying with site marking and time out steps, by surgical specialty



## ▶ Evaluation – 3Cs

### **I thought it would be easy...**

“I thought it would be pretty easy. I just sent the notice out in my hospital that we’re going to do it. And then looked at it six months later and nothing had really happened. I found I was the only one doing it.”

*Director of Surgery*

## ▶ Evaluation – 3Cs

### **Where's your evidence?**

“If you ever try to tackle clinicians on anything, they always ask, where's your evidence? I'm increasingly asking where's yours? That stops them in their tracks. It makes them think about why they keep doing things in a certain way. Often there actually is no evidence for what they are doing.”

*Hospital CEO*

## ► Evaluation – 3Cs

### **A waste of chocolate**

“After we put up the posters, and nothing much happened, we tried bribery. We purchased \$200 of Cadbury Timeout bars and said that we would reward each team when the correct site, correct patient, correct procedure was completed correctly and we had a wonderful response while the bars lasted. But as soon as the bars ran out, well people said we no longer have to do it. I said I’m not spending any more money on that. It’s not good for the staff, it’s not a long term solution, and it’s not appropriate so we stopped that.”

*Director of Surgery, Anaesthetist*

## ▶ Evaluation – 3Cs

### **Where's the common sense?**

“Each of the surgical groups had a different view. In the obs and gynae department, the concept of site marking was an issue. If I do a caesarean section do I have to put a big cross on a belly? Why should I have to do it?”

*Hospital S&Q Officer*

## ▶ Evaluation – 3Cs

### **QANTAS may have some tips for us**

“I tell them it is easier to get into an operating theatre as the wrong person, than it is to get on a plane. More checking occurs to make sure that you’re the right person on that airplane than the right person for that operation.”

*State S&Q Coordinator*

## ▶ Evaluation – 3Cs

**At QANTAS the pilots wear the same risk**

“Patients trust us so implicitly and completely that it’s scary. They don’t understand how vulnerable they are.”

*State S&Q Coordinator*



## ▶ National Safety and Quality Framework

