

2 Background

2.1 Patient safety

The provision of healthcare is complex, and the risk that patients may be harmed while in the care of health services can never be mitigated entirely. The challenge is to ensure that the patient safety system minimises the risk of harm.

An important contribution to patient safety is a strong commitment to clinical governance and clinical risk management by government and health services. Together, they must ensure that they have established clinical governance systems to monitor, support, evaluate and continuously improve patient safety. In health services, patient safety should receive, at the very least, the same level of attention as financial and corporate issues.

2.1.1 Clinical risk management

Clinical risk management (CRM) refers to how health services manage the risks associated with patients and patient care. It focuses on how health services implement their commitment to patient safety and incorporates the collection, analysis and reporting of patient safety information to identify and respond to risks. It outlines the roles and responsibilities of those involved and provides guidance on appropriate responses.

A central feature of CRM is incident reporting, which includes documenting actual and potential incidents, and the actions taken by health service staff to redress them. Incident reporting systems facilitate the collation of data to identify patient safety risks and monitoring performance over time.

2.1.2 Clinical incidents

Clinical incidents are incidents occurring in a health setting that could have, or did, result in harm to a patient. In Victoria, the DHS categorises clinical incidents according to the degree of harm, or potential harm, they cause.

Near misses

A near miss is an incident that has been avoided through patient safety strategies, but can also draw attention to risks of future events. Near misses are the most common type of clinical incident.

Adverse event

An adverse event is an incident that resulted in harm to a person receiving healthcare. Adverse events are less common than near misses and include incidents, such as medication errors, patient falls and equipment failures.

Sentinel event

A sentinel event is the most serious type of clinical incident. It is a relatively infrequent, clear-cut event, and occurs independently of a patient's condition. Importantly, the occurrence of a sentinel event commonly reflects hospital system and process deficiencies. Examples of sentinel events include procedures involving the wrong patient or body part, retained instruments after surgery and death from a medication error.

Causes and impacts of clinical incidents

Clinical incidents can occur when gaps in systems and processes allow errors. Health services take a 'systems' approach to preventing incidents, acknowledging that while human error is unavoidable, the conditions under which people work can be controlled. Rather than blaming individuals, the 'systems' approach attempts to identify underlying causes of incidents and put in place barriers to prevent them from recurring. This approach requires a culture of openness and transparency. It encourages clinicians to admit errors, an investigation into the events leading to the error, and the development and documentation of responses.

Clinical incidents can have serious health and quality of life consequences for patients. The consequences can be temporary, but in some instances they can result in death. Clinical incidents also have financial consequences. A recent Victorian study found that where patients experienced a clinical incident, their length of stay in hospital increased from 2.5 days to 12.6 days, while the cost of their stay increased from around \$2 000 to \$14 000. The study estimated the total cost to Victoria's health system annually was \$511 million¹.

¹ Ehsani J, Jackson T, Duckett S *The incidence and cost of adverse events in Victorian hospitals* 2003–04 *MJA* 2006; 184: 551–555.

Frequency of clinical incidents

The number of clinical incidents that occur in Victorian hospitals is difficult to estimate. Not all clinical incidents are recorded and data collection systems to aggregate the number and type of clinical incidents are not in place. While counting clinical incidents is important, this alone is not indicative of the level of safety of a health service, or the health system. Increases in reported incidents may indicate that safety is deteriorating; it may also indicate that reporting cultures and processes are improving.

Despite these difficulties, several studies have estimated that clinical incidents may be associated with around 10 per cent of hospital admissions. In 2006–07, Victoria's public health services admitted 1.35 million patients. This means that around 135 000 public patients may have experienced a clinical incident. During this period, 97 sentinel events, which include deaths, were recorded. It is not possible to accurately compare Victoria's performance with that of other State health systems due to differences in clinical incident definitions.

2.1.3 The patient safety system

In Victoria, patient safety management occurs within a complex health system, with many interdependent and interacting agencies. No agency is solely responsible for patient safety, and there are at least three levels in the system: the health service, State and national. Figure 2A highlights the patient safety system and the key bodies within it.

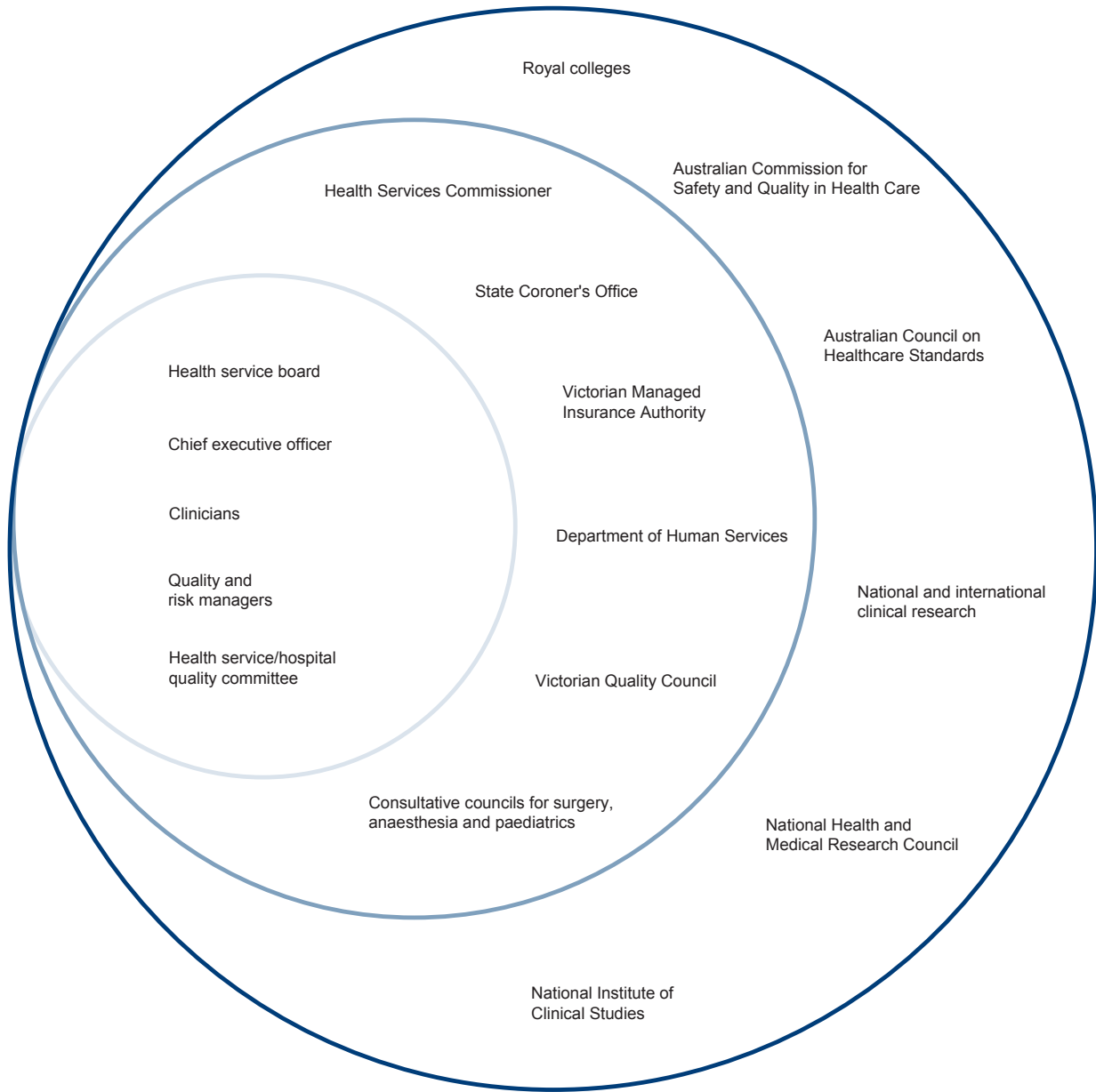
In health services, responsibility for patient safety ultimately lies with the board and the chief executive officer. Quality committees and quality and risk managers also perform a key role, acting as a conduit between clinical staff and senior management, and the monitoring and reporting of clinical incidents. Clinicians (medical and nursing staff) perform a crucial role in the patient safety system—while treating patients, they are also responsible for preventing and reporting clinical incidents.

At the State level, a range of agencies contribute to the patient safety system, including:




- DHS is responsible for statewide policy and planning, funding, and performance monitoring
- VQC is responsible for project work, including clinical governance guidance
- the Victorian Managed Insurance Authority (VMIA) is responsible for risk management advice
- Consultative councils, the State Coroner's Office (SCO) and the Health Services Commissioner are each responsible for investigating incidents and complaints.

Nationally, agencies such as the Australian Commission on Safety and Quality in Health Care (ACSQHC) perform a strategic policy role, while the Australian Council on Healthcare Standards (ACHS) accredits health services, and in Victoria is the primary accreditor. The focus of the accreditation process is quality and patient safety.

Figure 2A
The patient safety system



Legend

-  Health service
-  State
-  National

Source: Victorian Auditor-General's Office.

2.1.4 Patient safety policy context

At the highest level, Victoria's commitment to improve the safety and quality of its health services is directed by *Growing Victoria Together*—the government's social, economic and environmental policy. It notes the government's priority is to provide high-quality health services. The government's policy is implemented through DHS's departmental plan and clinical risk management strategy, and the VQC's safety and quality improvement framework.

Departmental plan

The departmental plan articulates the government's priorities in its area of responsibility. In relation to patient safety, objective 3 outlines the actions DHS will take during 2007-08 to improve human service safety and quality. Particular actions include:

- developing a clinical performance management plan that identifies both outstanding and concerning clinical practice and targets responses to achieve the greatest benefit
- improved public information on the quality and outcomes of healthcare
- setting and maintaining appropriate standards for health professionals.

Clinical risk management strategy

DHS's clinical risk management strategy was developed in 2001. It aims to reduce the rate and severity of clinical incidents and promote the use of a systems approach to manage clinical risk. All health services are required to:

- implement incident reporting systems
- participate in sentinel event reporting
- develop processes for analysis and response to clinical incidents
- educate staff
- conduct medical record audit for adverse events.

Safety and quality improvement framework

VQC's safety and quality improvement framework is a guide that provides health services with a strategic overview of the principles and practices they need to establish robust quality and safety practices, including:

- leadership and accountability for the safety and quality of healthcare
- principles for managing the safety and quality of health services
- organisational focus for quality activities and reporting
- cultural requirements of quality and safety improvement.

The *Health Services Act 1988* also demonstrates the government's commitment to improve the quality and safety of healthcare at the local (health service) level. The Act requires that:

- health service boards ensure there are systems in place to manage risk and monitor the quality of services provided
- health services address quality problems in a timely manner
- health services strive to continuously improve the quality of services.

2.1.5 Funding for patient safety

The Victorian government funds DHS and VQC to manage elements of patient safety, including planning and the development of resources. DHS in turn funds health services for each episode of care—a portion of which is used for the maintenance and improvement of service quality, including patient safety.

This funding is not tied to quality initiatives or services. While required to meet quality and safety reporting requirements and performance measures, health services have discretion over how they use these funds. Based on advice from DHS, estimated 2007-08 quality funding for:

- health services was \$44.6 million—representing 1.4 per cent of total funding for inpatient and outpatient services, and an increase of \$11.6 million, or 35.1 per cent since 2003-04
- the SQB of DHS was \$22 million—an increase of \$4 million, or 22.2 per cent since 2003-04
- VQC was \$3.2 million—an increase of around \$0.2 million, or 6.6 per cent since 2003-04.

Additional program and project funding is available from DHS and VQC for patient safety initiatives.

2.2 Audit objective and method

The objective of the audit was to examine the patient safety arrangements in Victoria's public hospitals. We examined how well DHS worked with a selection of agencies within the patient safety system (the VMIA; SCO; and selected health services) to manage patient safety. The focus of this audit was at the health service and State levels of the patient safety system.

The audit also examined whether DHS and health services had addressed recommendations made in VAGO's 2005 patient safety performance audit. Our office did not audit the VQC because this agency was being independently reviewed at the time of our audit.

Our office audited the same five health services that we audited in 2005. We did not identify these health services at that time, and have maintained anonymity in this audit. We also sent a short questionnaire to 86 health services, which focused on patient safety systems, training and incident reporting. The survey was structured to allow comparisons with VAGO's 2005 patient safety questionnaire.

The audit was performed in accordance with the Australian Auditing Standards applicable to performance audits, and included tests and procedures sufficient to allow audit conclusions to be reached. The total cost was \$202 000. This cost includes staff time, overheads and printing. Further information on the conduct of the audit is detailed in Appendix A of this report.
