Building foundations to support patient safety

Annual report of the 2008–09 Sentinel event program

A Victorian Government initiative

Victoria The Place To Be

Building foundations to support patient safety

Annual report of the 2008–09 Sentinel event program

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Foreword

The Victorian Government is committed to ensuring the delivery of high-quality, safe health care within the Victorian health system.

Review of errors is an important part to this, particularly those events deemed to be 'sentinel'.

In depth investigation of these events identifies breakdowns in the often complex health systems in place, and allows health services to identify risk and develop ways to reduce or eliminate the risk of reoccurrence.

Working collaboratively between the Department of Health, health services, clinicians and consumers has resulted in a strong culture of reporting when things go wrong.

A good safety culture encourages reporting; only when we are aware of something not working can we act to change this.

This is the seventh annual public report of the sentinel event program and it presents information on the 68 sentinel events reported within Victorian health services during 2008–09.

The focus of the program remains on lessons learnt in order to prevent similar sentinel events in the future, and will continue in 2009–10.

Hon. Daniel Andrews MP
Minister for Health

Acknowledgements

The Department of Health (the department) thanks Victoria's public health services, hospitals and participating private facilities for their ongoing contribution to the sentinel event program. The department acknowledges the Clinical risk management reference group, the consultative councils and expert advisory groups that work closely with the department to provide recommendations to health services on system issues. The department also acknowledges the patients and their carers who have experienced adverse patient outcomes.

Summary

The Victorian sentinel event program supports a learning environment within Victoria's health care system.

By examining sentinel events and the settings in which they occur and identifying system changes required, our aim is to reduce, or remove where possible, the likelihood of similar occurrence in the future.

The information on sentinel events received by the department is de-identified to preserve the privacy of patients, practitioners and organisations involved. The department shares the learnings from these events throughout the health care sector through:

- the *Risk Watch* newsletter[1] (available online at http://www.health.vic.gov.au/clinrisk/publications/riskwatch.htm)
- alerts for significant events
- sentinel event annual report (this document)
- recommendations to individual health services and the sector.

In 2008–09 the department was notified of 80 sentinel events. Twelve events were withdrawn either because they resulted from known complications of the patient's condition or required procedure, or because no system or process issues could be identified. Thus 68 sentinel events were notified with 67 reports analysed, one report was unavailable for full analysis at the time of writing this report.

How to use this information

A self-assessment tool is included in this report as a one-page patient safety checklist. Health services can assess their position against strategies for improvement identified by other health services.

This strengthens the learning concept and way forward for the program. Within the checklist are links to websites that have valuable references, resources and information to further assist with improvements.

Snapshot of the Victorian health system

The Victorian health system is a complex and busy environment.

In the 2008–09 reporting period, the Victorian Government dedicated an estimated $11,314 million[2] to health care, employed around 72,193[3] EFT (equivalent full time) staff, managed approximately 1.4 million[4] admissions to public health facilities, and performed more than 267,0004 surgical procedures.

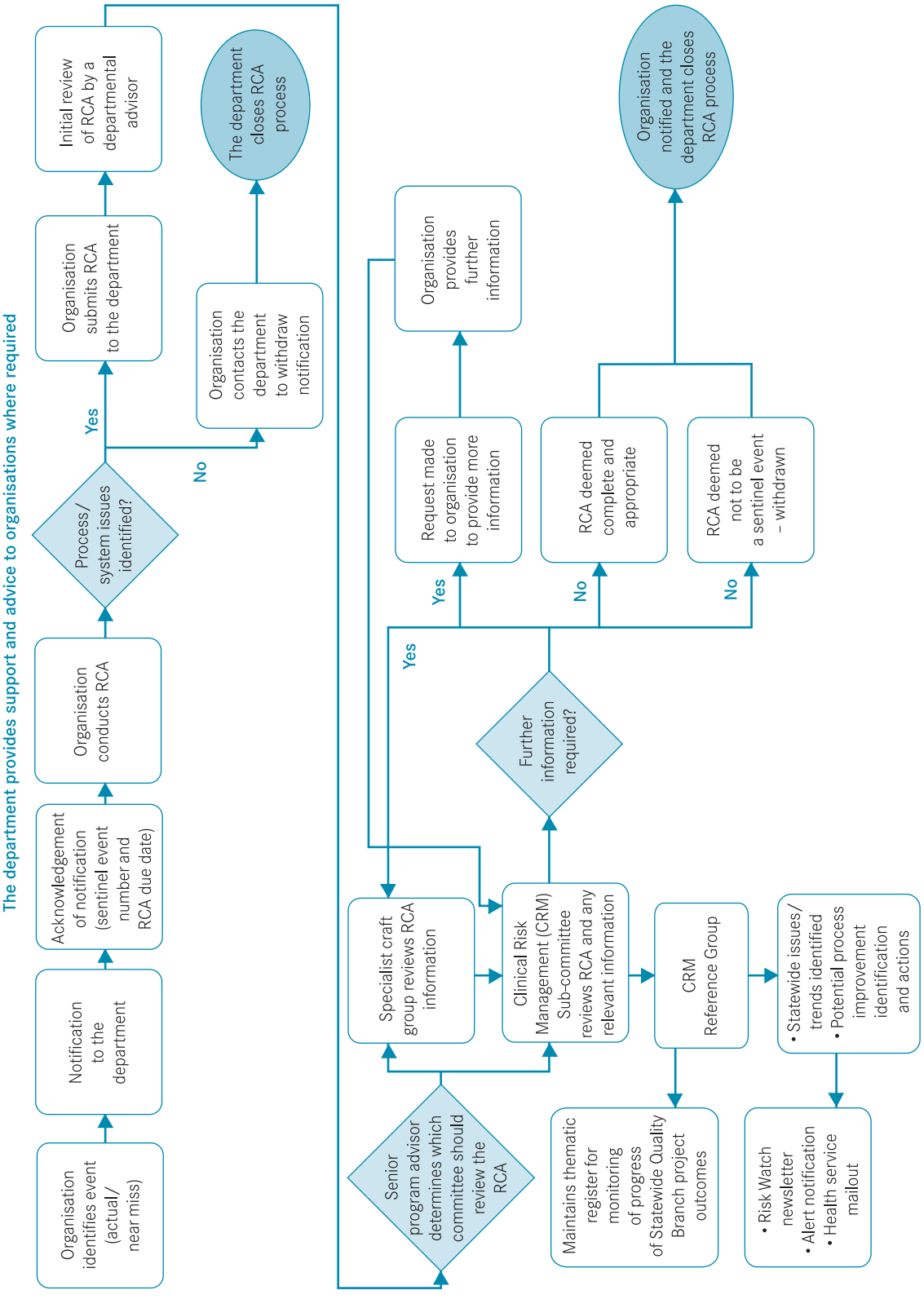
1 Department of Health, Risk Watch, State Government of Victoria, Melbourne. Available at www.health.vic.gov.au/clinrisk.
2 Department of Health Your Hospitals: July2008 to June 2009
3 Workforce Survey data, Service and Workforce Planning, Department Health
4 Department of Health Your Hospitals: July2008 to June 2009

Health service patient safety checklist

This checklist can be used by health services to ensure strategies are in place for minimising the risk of sentinel events occurring.

Issue	Strategies to address risk/issues identified	Yes	No	WIP	N/A
Procedures involving the wrong patient or body part	Organisational correct patient/correct site policy in place				
	Orientation in the "Time out" procedure for all operating suite medical and nursing staff				
	Team roles in the "Time out" procedure clarified and supported in written policy and procedures				
	Compliance with "Time out" is monitored regularly				
Patient identification	Patient identification is aligned to the new national standard available at: http://www.safetyandquality.gov.au/				
	Unique patient identifier (medical record number) keystone of patient identification process				
	Compliance with the patient identification process is monitored and reported to the Quality and Safety Program				
Medication safety	Adhere to the VMAC Quality Use of Medicines alerts available at: http://www.health.vic.gov.au/qum/initiatives/hrm.htm				
	• Wrong route administration of oral liquid medicines (alert and audit tool)				
	• Unfractioned Heparin (alert and audit tool)				
	• Subcutaneous Insulin (alert and audit tool)				
	• Fentanyl patch notice and Oxycodone alert (NSW health)				
Management of mental health patients with significant self-harm risks	Adherence to the Chief Psychiatrist Guideline regarding *Inpatient leave of absence* published September 2009 and accessible from: http://www.health.vic.gov.au/mentalhealth/cpg/index.htm				
	Mental health clients and carers are provided with a documented safety plan whilst on leave				
Falls minimisation	Health service endorsed *Falls minimisation strategy* are in place across all clinical services				
	Compliance with the falls minimisation strategy is monitored and reported to the Quality and Safety Program				
Blood safety	Blood safety policies and procedures include the storage, handling and correct administration are in line with EQuIP 4 requirements				
	Satellite blood refrigerators are monitored, alarmed and have a documented escalation process				
	Blood safety is incorporated into the organisational Quality and Safety Program				
Communication	Clinical handover occurs in a structured format at the change of each shift/ interhospital transfer. Resources and information at: http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-05#Tools				
Credentialing and scope of practice	• Policy and procedures include the introduction of new clinical services, procedures and interventions				
	• Credentialing and scope of practice policy for senior medical staff is implemented across the health service				

Figure 1: Department of Health sentinel event review process



Victorian health care sector sentinel event data

In 2008–09 there were fewer sentinel events reported, as well as an overall lower level of impact reported by Victorian hospitals. There were 23 deaths associated with reported sentinel events, compared with 28 reported deaths in 2007–08 and 38 reported deaths in 2006-07.

In 2009 the Australian Commission on Quality and Safety in Health Care (the commission) amended the national definition for the sentinel event criterion "Procedure involving the wrong patient or body part" to "Procedure involving the wrong patient or body part resulting in death or major permanent loss of function" which resulted in a dramatic decrease in this category.

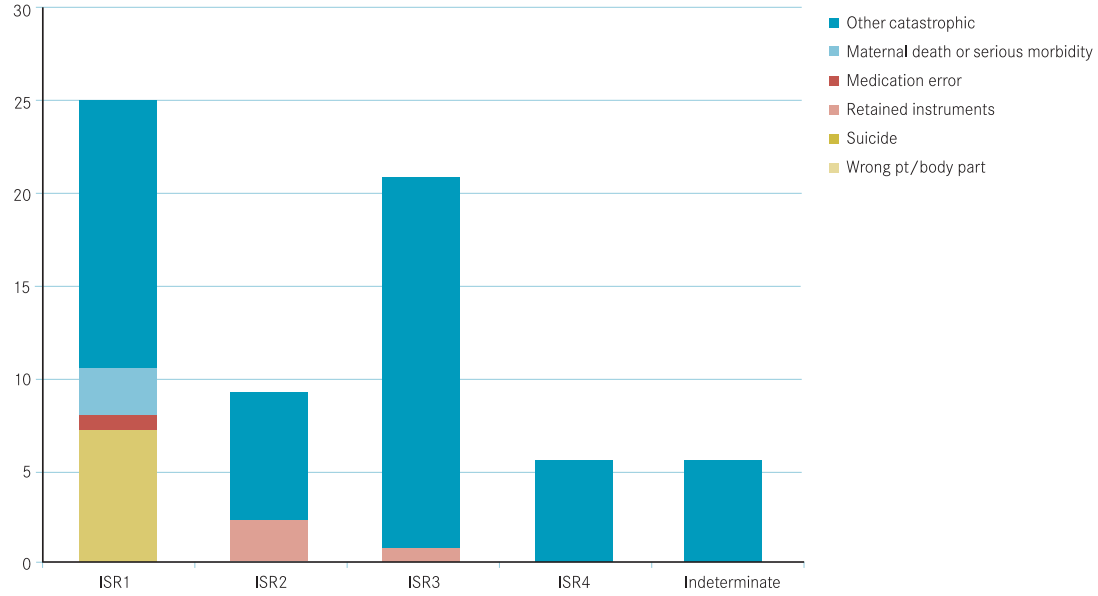
Victoria still encourages reporting of near miss low level events for this category which is captured under 'Other catastrophic' to separate them, and this has resulted in an increase in our reporting in this category for this period.

Table 1: Comparisons between reported events, 2002–03 to 2008–09

Classification of event	Frequency						
	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Procedure involving the wrong patient or body part resulting in death or or major permanent loss of function	16	14	25	25	20	37	0
Suicide in an inpatient unit	5	1	4	7	11	7	7
Retained instruments or other material after surgery requiring re-operation or further surgical procedure	9	8	5	6	8	11	3
Haemolytic blood transfusion reaction resulting from ABO incompatibility	0	1	1	0	1	2	1
Medication error leading to the death of patient reasonably believed to be due to the incorrect administration of drugs	3	4	1	2	3	2	1
Maternal death or serious morbidity associated with labour or delivery	4	2	9	2	2	6	3
Infant discharged to wrong family	0	0	0	0	0	0	0
Intravascular gas embolism resulting in death or neurological damage	0	0	0	0	0	0	0
Other catastrophic event (includes near miss events)	42	55	77	49	37	37	53
Total	**79**	**85**	**122**	**91**	**82**	**102**	**68**

Figure 2: Sentinel event severity rating 2008–09

ISR refers to incident severity rating. This is a process of classifying incidents to provide a standardised approach to response. The severity is divided into four categories that correspond to an appropriate level of management response.



ISR 1: severe (including death); ISR 2: moderate; ISR 3: mild; ISR 4: No harm (includes near miss); Indeterminate: Unable to be determined at this time

Figure 3: Breakdown of reported sentinel events 2008–09

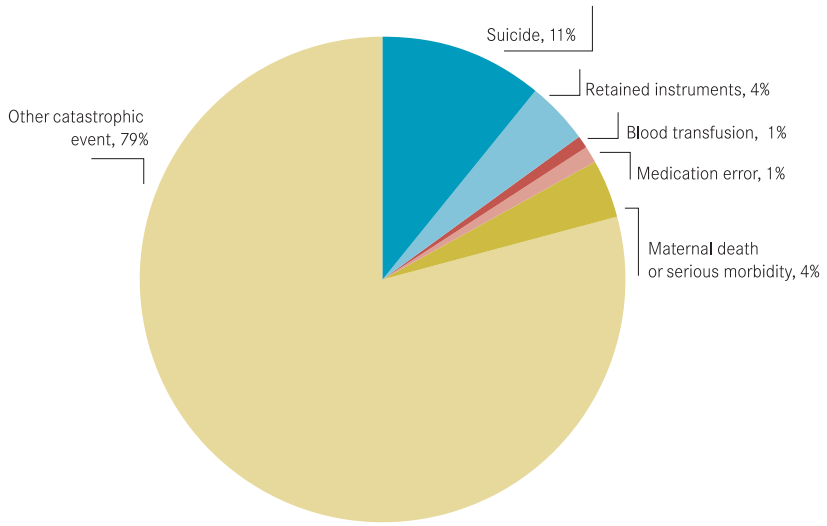


Figure 4: Breakdown of reported 'other catastrophic events – including near miss', 2008–09

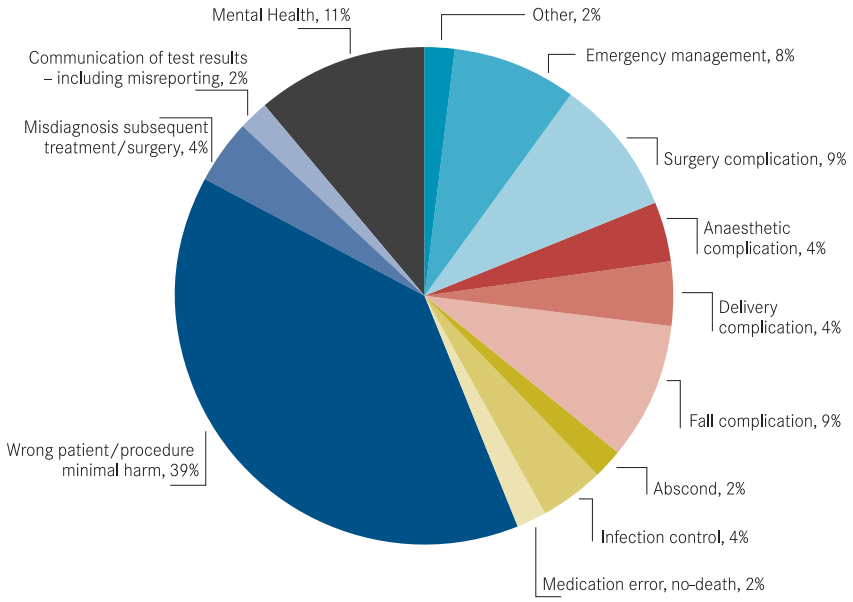


Table 2 illustrates the range of events reported under the 'other catastrophic event' category and compares the frequency of these sub-categories across the past six reports.

Table 2: Comparisons between reported 'other catastrophic events – including near miss' 2002–03 to 2008–09

Event	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Complication of emergency management	9	11	6	4	2	1	4
Complication of anaesthetic management	*	6	1	0	0	0	2
Complication of surgical management	9	10	6	5	3	6	5
Foetal complication of delivery	3	0	1	2	2	0	2
Complication of inpatient fall (death or serious morbidity)	2	10	11	4	5	7	5
Complication of fall (not resulting in death or serious morbidity)	*	*	18	1	0	0	0
Patient absconding from inpatient unit with adverse outcome	2	1	1	2	0	1	1
Infection control breach	6	7	8	3	2	2	2
Hospital process issue	9	7	0	6	0	3	0
Medication error (not resulting in death)	*	*	9	7	3	5	1
Misdiagnosis and subsequent management	*	*	4	3	3	1	2
Communication of test results	*	*	3	1	0	0	1
Other – mental health management	*	*	4	3	6	7	6
Other – unspecified	2	3	5	8	8	4	1
A good catch/near miss					3	0	0
Procedure involving the wrong patient or body part not resulting in permanent loss or death	#	#	#	#	#	#	21
Total	**42**	**55**	**77**	**49**	**37**	**37**	**53**

**New catastrophic event classifications used in the 2004–05 data analysis*

#Procedure involving the wrong patient included in 2008–09

Themes emerging from the program in 2008–09

In conducting a root cause analysis (RCA), the health service considers what factors have contributed to the sentinel event occurring and these aid with the development of the risk reduction action plan to help prevent a reoccurrence. Many events involve more than one contributing factor, so the number of contributing factors can be greater than the number of events.

During 2008–09, a total of 332 contributing factors were identified. Analysis of the data shows that **'procedures and guidelines'**, **'communication'** and **'human resources/staff issues'** were the most commonly occurring contributory factors for 2008–09.

Contributing factors

Table 3: Factors contributing to sentinel events expressed as a percentage, 2002–03 to 2008–09

Contributing factor	Percentage of contributing factor						
	2002–03 Number of contributing factors = 210	2003–04 Number of contributing factors = 283	2004–05 Number of contributing factors = 291	2005–06 Number of contributing factors = 337	2006–07 Number of contributing factors = 305	2007–08 Number of contributing factors = 302	2008–09 Number of contributing factors = 332
Procedures/ guidelines	32	41	31	43	32	43	36
Human resources	17	17	24	14	15	18	15
Communication	16	17	27	20	18	16	20
Health information	7	9	4	2	12	9	8
Equipment	7	7	4	5	4	7	8
Physical environment	9	6	6	4	6	2	3
Facilities management	6	3	1	3	2	2	3
Patient behaviour*	–	–	–	5	6	3	7
Course of disease*	–	–	–	3	1	0	0
Other	6	0	3	1	4	0	0
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

** New contributing factor for 2005–06*

Table 4: Subcategories of contributing factors

Contributing factors	
Procedures/guidelines	**Facilities management**
Behavioural assessment	Transportation issues
Physical assessment	Intra-hospital issues
Patient observation process	
Clinical guidelines	**Human resources**
Patient/site identification	Staff allocation
Coordination of care	Staff training
	Staff supervision
Communication	Appraisals
Between staff	Recruitment
Between staff and patient/family	
Translation/NESB issues#	**Patient behaviour***
	Course of disease*
Physical environment	**Health information**
Environment (such as distraction)	**Equipment**
Security/design	**Other**

** New contributing factor for 2005–06*

 # Non-English speaking background

Patient identification

Patient identification is one of the nine priority program areas of the commission and Victoria is participating in the inter-jurisdictional working party on patient identification.

One of the first areas to be addressed is standardising patient identification bands. In 2008 the Australian Health Ministers' Conference (AHMC) endorsed the specifications for a national patient ID band. Design work is currently being undertaken and then implementation of the specifications will be rolled out.

The department supports this patient safety initiative and ask that health services utilise the standard in developing patient identification bands within their health service.

Although there is no timeline attached to this initiative it is anticipated the standard will be used consistently throughout all health services by 2010.

Links to the standard and specifications can be found at: http://www.safetyandquality.gov.au, under the programs tab on the web page. Further work in patient identification is being developed by the commission and the department will keep you informed of progress and outcomes.

Case study

A patient presented to a day procedure unit for an elective knee arthroscopy. The written consent stated 'left knee' and was signed by the surgeon and the patient.

The orthopaedic registrar checked the patient consent and marked the correct leg, as identified on the consent form. On transfer into the theatre room, the orthopaedic registrar was informed that he was not required for the surgery and took no further part in the procedure.

The patient was transferred into the theatre where the anaesthetist checked the wristband of the patient and asked the patient to state their name and what leg was being operated on. The patient stated their name and that it was their 'right knee', this answer was not checked against the consent form. The anaesthetist inserted the IV cannula in the non dominant hand and set up for a right knee arthroscopy.

The theatre staff indicated that they sighted a consent form, but could not recall checking what was written on the consent form with the patient.

As is normal practice, a 'time out' occurred, but the surgeon was not present as they were running late. The patient was anaesthetised prior to the surgeon's arrival into the theatre, who then donned surgical apparel and commenced the procedure on the right leg.

The patient was transferred to the recovery room where the nurse checked the patient's legs and noted that the marked leg was not the leg that had been operated on. The nurse then checked the consent form that identified the procedure had occurred to the wrong leg. The recovery nurse informed theatre staff of the error.

Prior to being booked for the elective surgery the patient visited the surgeon's rooms and discussed that both knees required the same operation. It was decided that the 'sorest knee' would be done first (left knee consented).

How did the health service address the issues identified?

- the existing procedure for 'verifying the correct patient, site, side' (*Time out*) for surgical/invasive procedures to be reviewed
- conduct random audits of the compliance with *Time out* procedure
- conduct education sessions for staff in the *Time out* procedure to develop a culture of adherence
- a staff member is designated to sign the *Time out* document rather than just be ticked
- a letter to all surgeons and anaesthetists advising that a designated person is now responsible for the coordination of *Time out*.

What are some actions other health services have undertaken when a similar event was identified in their health service?

- Introduce pre theatre group meetings prior to the commencement of the theatre list.
- Documenting the names of the individuals participating in the time out procedure for each procedure.

What is happening at the national level?

The commission is to expand the *Ensuring correct patient, correct site, correct procedure protocol* to other therapeutic areas. The commission has finalised the protocols and they have been endorsed by the commissioners. These protocols are available from the commission's website at: http://www.safetyandquality.gov.au.

What is happening at an International level?

In 2008 the World Health Organization released a surgical safety checklist as part of the Safe Surgery Saves Lives Global Patient Safety Challenge. The Surgical Safety Checklist includes a core set of safety checks for use in any operating theatre environment. It is designed to improve safety by focussing on anaesthetic safety practice, ensuring correct site surgery, avoiding surgical site infection and improving communication within the operating team.

The Surgical Safety Checklist combines a range of clinical and administrative processes that are necessary for safe surgery and has been the subject of rigorous international study; the results of which have been published in a premier peer-reviewed journal, the *New England Journal of Medicine*[5].

The Royal Australasian College of Surgeons and the commission support this initiative, to find out more about the World Health Organisation surgical safety checklist visit: http://www.who.int/patientsafety/safesurgery/ss_checklist/en/index.html.

Assessment and management of mental health clients

In 2008–09 about 60,000[6] people received care from specialist mental health services and there were approximately 22,000[6] admissions to public hospitals for mental illness.

Mental health patients are a potentially vulnerable group, often as a direct result of their mental illness which may lead to behaviours such as self-harm, aggression and violence. In this report there are seven sentinel events reported as suicides in an inpatient unit, with another six events relating to mental health issues reported under the 'other catastrophic' category.

What activities are being undertaken at a state level to address mental health safety issues?

- The Chief Psychiatrist has developed guidelines for inpatient leave of absence, available at: http://www.health.vic.gov.au/mentalhealth/cpg/index.htm.
- The Mental health division, Department of Health is developing a clinical practice guideline for the *Assessment and Management of People at Risk of Suicide*. This guideline is being developed specifically for use by clinical staff in emergency departments and acute mental health assessment services.

5 Haynes AB et al A Surgical Safety Checklist to reduce morbidity and mortality in a global population, N Engl J Med 2009, 360:491-499

6 Victorian Department of Human Services, Mental Health Branch

Medication errors and near misses

Medicines are the most common treatment used in health care but can also be a common cause of harm. Errors may occur during any stage of the medication process of prescribing, dispensing, storage, preparation and administration.

Two reported sentinel event cases of administration error that occurred in time pressured environments were reviewed by the Victorian Medicines Advisory Committee.

Case study

A patient with a number of underlying medical conditions was given an incorrect oral medication by a nurse whilst they were arranging the transfer of the patient to another hospital for further investigations.

When organising the medication due prior to transfer, the nurse had mistaken the medication prescribed for a *look alike sound alike* medication. The medication was checked with a newly medication endorsed division 2 nurse.

During transport the patient became lethargic, drowsy and developed a low blood pressure, after medical review at the receiving hospital, the patient was referred to a tertiary hospital.

The patient responded to reversal of the incorrect medication, though remained physically unwell, on x-ray a left lung consolidation was detected, the patients observations continued to deteriorate. After discussion with the family, and given the medical condition of the patient, they were deemed not for resuscitation and later died.

How did the health service address the issues identified?

- Review of adherence to medication administration procedures.
- Review of processes for clinical handover particularly in relation to interhospital transfers.

What medication safety measures may further minimise the risk of this error?

- Introduction of strategies to minimise risk for *look alike sound alike* medications. For example:
  - use of both generic and brand names on prescriptions
  - use of Tallman lettering
  - completion of the indication field on the national inpatient medication chart
  - use of alert stickers on packaging and storage labels.
- Create a culture of safety to produce an environment where practitioners and senior leaders can learn together about how to create safer systems of care.

What further information is available to address this patient safety issue?

Reducing risks associated with *look-alike, sound-alike* medication names is one of the nine patient safety solutions developed by the World Health Organisation Collaborating Center for Patient Safety. Strategies for reducing risks are included in an information leaflet which can be found at:

http://www.ccforpatientsafety.org/common/pdfs/fpdf/Presskit/PS-Solution1.pdf

Clinical handover is an area of potential high risk and may often occur in a time pressured environment. The Victorian Quality Council (VQC) and the commission have collated information and tools on clinical handover and Inter-hospital transfer which may provide useful information for hospitals reviewing this process; these can be accessed from: http://www.health.vic.gov.au/qualitycouncil/activities/handover.htm. http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/content/PriorityProgram-05#Tools).

The Quality Use Of Medicines Program provides leadership to improve the quality use of medicines (QUM) within Victoria. QUM means selecting management options wisely, choosing suitable medicines if a medicine is considered necessary and using medicines safely and effectively to get the best possible results.

High-risk medicines

High-risk medicines are those that have a heightened risk of causing significant or catastrophic harm, should an error in their use occur. The acronym PINCHS is used to raise awareness of:

- **p**otassium
- **i**nsulin
- **n**arcotics (such as morphine)
- **c**hemotherapy
- **h**eparin (and other medicines that effect blood clotting)
- **s**ystems (such as avoiding wrong route errors).

VMAC's High-risk Medicines Working Party has worked to reduce the hazards from these medicines.

A well-recognised method to raise awareness of medication safety issues is via the distribution of an alert. Following research to determine best practice, several alerts regarding high-risk medicines and systems have been developed. These include:

- insulin (subcutaneous administration)
- heparin
- wrong route administration of oral liquid medicines.

Audit tools were also developed to accompany the alert tools. These were designed to help health services improve processes to reduce risks. Further information about alerts and audit tools can be found at: http://www.health.vic.gov.au/qum/initiatives/hrm.htm.

In July 2009, an on-line survey was conducted amongst Victorian health professionals to find out whether the alerts had been helpful in changing practices and to identify barriers and future priorities. A full report of the survey will be available later this year on the QUM website under high risk medicines.

Key findings from the survey were that health services found the alerts facilitated changes to charts, stock management, policies and education and orientation programs.

Perceived barriers included resources and processes for changing policies and procedures. Health services indicated that they would value further safety information on insulin infusions, intravenous pumps, cytotoxic agents, allergy recording, omission of medicines and opioids.

National inpatient medication chart

A key project undertaken by VMAC was the implementation of the national inpatient medication chart across all Victorian hospitals. This meant that clinicians could be trained to use one system, whichever health service they were working at, thus reducing error due to lack of familiarity with the chart.

Recent developments include the availability of a standardised:

- paediatric chart
- long stay chart
- format for a printable A4 chart.

Information about these charts, together with supporting information and a national audit tool may be found at: http://www.health.vic.gov.au/qum/initiatives/nimc/index.htm.

Quality Use of Medicines indicator initiative

The use of indicators has been shown to effectively drive improvements in quality by demonstrating areas for improvement. The QUM indicator initiative encourages Victorian health services to measure and benchmark performance in medication safety systems. The tools promoted for uptake are the Medication safety self assessment (MSSA)[7] for Australian hospitals tools and the Indicators for quality use of medicines in Australian hospitals.

The MSSA and MSSA-AT (for antithrombotic therapy) tools focus on safe structures and processes for medications, while the indicators for QUM measure the outcomes of processes. Both the MSSA and MSSA-AT (for antithrombotic therapy) tools were developed with a web based tool that allows hospitals to enter their audit information and generate reports.

Following the launch of the QUM indicator initiative and training workshops in metropolitan and regional areas, 27 Victorian hospitals have recorded their participation in the MSSA audit which is a great achievement. Further information about the tools and information to support their implementation can be found at http://www.health.vic.gov.au/qum/initiatives/qum_indicators.htm.

7 Acknowledgements: The MSSA tools were originally developed by the Institute of Safe Medication Practice (ISMP) in the United States and have been adapted for use in Australia by the New South Wales Therapeutic Advisory Group (NSWTAG) (copyright is retained by NSWTAG)

Haemolytic blood transfusion reactions

The Blood matters: better, safer transfusion program commenced in 2004 as a joint initiative of the department and the Australian Red Cross Blood Services (ARCBS). The program aim is to improve outcomes in patients requiring blood and blood product transfusion in hospitals by enhancing the safety and appropriateness of blood and blood product use and focusing on patient blood management (individualised care with attention to detail and better treatment outcomes).

Case study

Patient Smith presented with symptomatic anaemia requiring the administration of two units of red blood cells (RBC). The first unit was commenced in the emergency department then patient Smith was transferred to the short stay observation unit, where two registered agency nurses were both rostered to work.

Upon completion of the first unit of blood the patient services assistant (PSA) was requested to collect the second unit of blood from blood bank. The transfusion request form for patient Jones was taken from the central desk and given to the PSA, who then collected the blood and gave it to the registered nurse.

The transfusion report form and RBC unit for patient Jones was checked at the central desk by two registered nurses. The RBC unit for patient Jones was then taken to the bedside of patient Smith and commenced without a bedside patient and blood component identification check being performed.

Patient Smith developed signs and symptoms of an acute haemolytic transfusion reaction which was initially not recognised but eventually managed and required admission to hospital.

Patient Smith did not sustain significant injury however the patient did subsequently form Rh(D) antibodies, this means the patient is limited to only having Rh(D) negative blood for any future transfusions.

How did the health service address the issues identified?

- Reinforce patient identification protocol within the unit.
- Placing current admission documents relating to the administration of blood components and products at the patient's bedside.
- Implementation of beds that have fold up tables/trays at the base to facilitate checking and documentation practices at the bedside.
- Implementation of ring bound folders to securely fasten patient admission documents, and the introduction of a labelling system for admission folders that identifies the patient.
- The cancelling of all pending/outstanding requests or medical orders by the medical officer to be incorporated into the admission criteria document/protocol.
- Prerequisite that one of the staff members allocated to a department is a permanent staff member.

What are some actions other health services have undertaken when a similar event was identified in their health service?

- Pre transfusion processes in place on the ward are brought into alignment with the organisations procedures and best practice.
- The ward and divisional management staff continue to work on strategies to increase skill mix and availability of staff within the ward. This includes initiatives to assist senior nursing staff to prioritise the myriad of clinical demands that may arise at periods of high activity.

What activities are being undertaken at a state level to address these patient safety issues?

The department's Blood matters: better safer transfusion program, has developed a statewide collection tool for monitoring serious transfusion incidents; part of the role of the group that oversees this program is to make recommendations for patient safety in such cases as above.

Suggested recommendations with this event were:

- Compliance with bedside identity check – all staff should be familiar with the requirement to review the wristband of a patient and/or verbal confirmation of the patient details prior to administering any blood product and this should match the product and the paperwork exactly prior to transfusion proceeding.
- Training of staff in transfusion administration. It is recommended that the health service address training and assessment for staff involved in transfusions in awareness of and adherence to guidelines for administration of blood products.
- That prohibiting transfusion from short stay observational unit may not be necessary if important elements relating to staff members training and adherence to protocol can be implemented, ensuring the health service has maximum use of this unit.

What is happening at the national level?

Blood safety

A review of The Australian and New Zealand Blood Transfusion Society and Royal College of Nursing Blood Administration guidelines that outline all steps in the administration of blood products developed in 2004, and for release in 2009.

The South Australian Department of Health, BloodSafe program, has developed a national blood safety training initiative. This e-learning program has been designed to provide clinical staff with an opportunity to develop their knowledge of blood and to encourage safe transfusion practice and the appropriate use of blood components. Further details are available at: https://www.bloodsafelearning.org.au.

The National Blood Authority is developing the reporting and governance frameworks for a voluntary haemovigilance program for Australia. It will report on serious transfusion related adverse events occurring in public and private hospitals. This initiative will contribute to our understanding of peri-transfusion errors, incrementally improve safety and quality, and ultimately deliver better transfusion outcomes. Further information is available at: http://www.nba.gov.au/haemovigilance/index.html.

Blood matters: better, safer transfusion program

Broadly the framework for the program is to:

- Raise awareness and increasing knowledge of transfusion practice.
- Monitor and evaluates current practice against guidelines for prescribing and administering of blood products.
- Record and analyse data about incidents, including adverse events and near misses, to inform policy and procedure development.

Incident monitoring

The Serious transfusion incident monitoring (STIR) system is now in its third year of operation. It is a voluntary system with 68 per cent of hospitals that transfuse in Victoria participating in the system. The first de-identified aggregate report was released in 2008 and this summarises findings and makes recommendations for practice improvement. The report is accessible at: http://www.health.vic.gov.au/best/downloads/stir_report_06-07.pdf.

Haemovigilance incident data for 2008 show that 63 per cent of events reported were acute transfusion reactions and 35 per cent were procedural errors. This is a reduction in procedural errors from 2007.

It is unknown if this is under reporting or improved transfusion practice. Ongoing monitoring of serious transfusion incidents will continue to highlight areas of transfusion practice that warrant review and improvement.

Education and training

Education and training are fundamental aspects of the Blood matters program. The program focuses on the transfusion nurse role for coordinating activities, supported by the entry-level qualification of a graduate certificate in transfusion practice. This course has been run since 2003, and from 2009 the students receive a University of Melbourne Award. The course is being redeveloped in 2009 for 2010 delivery and has received national endorsement from states and territories.

Transfusion nurse role

There are now 18.4 government-funded positions in Victoria and four funded through individual health services and the Australian Red Cross Blood Service, the most of any jurisdiction in Australia.

In 2009-10 a new transfusion trainer role is to be implemented in rural Victoria to extend the dedicated time available in hospitals for transfusion improvement activities.

Minimising the risk of falls and fall-related injuries

Falls are a common problem in our older population and in particular for those in high-risk-falls populations within our health and residential care settings. Given the impact on quality of life, independence, and function, this area continues to warrant review and ongoing vigilance.

Case study

An elderly patient with a history of falls and a stroke presented to an emergency department (ED) and admitted as an inpatient. They had presented to the ED the previous week following a fall at home resulting in pain, swelling and bruising.

In the late evening they were found on the floor near their bed and were noted to have a large facial haematoma. Neurovascular observations were commenced and the CT confirmed a large cerebral haemorrhage with right frontal lobe midline shift. They were intubated and immediately transferred to a metropolitan hospital.

How did the health service address the issues identified?

- Improve the identification of patient's at risk of falls at a ward level by disseminating information regarding this event to regular staff meetings and by other means of communication including staff education sessions.
- Improve patient identification for falls risk at the ward level by ensuring that an electronic alert is generated on the medical record and at nursing handover by including falls risk information.

What activities are being undertaken at a state level to address these patient safety issues?

- To support clinicians in identifying and implementing interventions, the Victorian Quality Council (VQC) has developed an online falls minimisation education package with modules for acute, sub-acute and residential care settings. The objectives of the package are:
  - to provide standardised education for falls minimisation for the Victorian health sector
  - to improve patient safety by improving understanding of the link between falls risk factors and the implementation of falls prevention strategies.
- During the development of this package, feedback from the sector identified the need for organisations to be able to track staff members who had completed the package. In response, the VQC is currently developing a mechanism for returning data from the package to health services. Participants will be required to log in and a summary of their details will be sent to their hosting health service on completion of the package.

This functionality is expected to be available in 2010. All Victorian Health Services will be invited to utilise the package in this way. Resources can be found at: http://www.health.vic.gov.au/qualitycouncil/fallsprevention.

What is happening at the national level?

The National Ageing Research Institute was commissioned to summarise the *Minimising the risk of falls and fall-related injuries guidelines* into an introductory module. An Expert working group was then convened to develop case based scenarios relevant for the various settings. These provide readers with the opportunity to apply learning to practical and relevant examples of patients they are likely to encounter. Information can be found at:
http://www.mednwh.unimelb.edu.au/tips_on_ageing/falls.htm.

Infection control breach

Infection associated with health care is a common adverse outcome in health care systems around the world. Whilst not all can be prevented systems are in place to reduce this risk within our health services.

Case study

Following the end of the day's work and clean up; nurse 1 commenced loading the autoclave with the newly cleaned and packaged instruments. Nurse 1 closed the steriliser's door but could not access the 'on' switch as it was blocked by nurse 2 who was filling the water chamber of the benchtop steriliser. Nurse 1 walked away assuming nurse 2 would turn the steriliser on when she had completed her task. However, nurse 2 also walked away without switching on the autoclave.

The next day, nurse 3 unloaded the equipment from the autoclave and placed it on the 'sorting' bench. Nurse 3 and nurse 4 took the equipment without checking sterilisation status and commenced setting up the sterile 'set ups' for the clinician's use. These set ups were then used by the clinician in their respective surgeries.

The health service identified some causative factors that led to this infection control breach.

- A shared responsibility for 'sterilisation' duties and lack of communication between the two nurses.
- Inexperience and pressure to meet workload demand resulted in a failure to follow established procedure, such as checking for sterilisation status.
- No formal method of assuring that sterility had been achieved.

Compliance with Australian standards:

As part of their infection control program health services must ensure that they comply with the Australian standards and other relevant guidelines. Standards particular to this incident are:

- *AS/NZS: 4815:2006 Office-based health care facilities – Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment*
- *AS/NZS: 4817:2003 Cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities.*

These two standards provide detail on the requirements for:

- Maintaining sterilisation cycle records that include date, load number, exposure time and temperature, name/identification of person authorising release of contents, specific contents of the load.
- Documentation required for the release of processed items – either parametric or non parametric.

What are we doing to make health care safer in Victoria?

Victorian clinical governance policy framework

Clinical governance is about being accountable for providing good, safe care to patients and is fundamental to continuous improvement in patient safety.

It is an expectation that all health services have a formal and effective clinical governance framework by the end of 2009 and the means to measure and monitor compliance with the framework, will be implemented from 2010.

The Victorian clinical governance policy framework has been developed to guide health services to implement a framework or review and further develop existing frameworks within their service.

The associated toolkit provides a practical guide through the use of checklists and key references to assist with reviewing the roles and responsibilities of key stakeholders within the health service. More information can be found at:
http://www.health.vic.gov.au/clinrisk/publications/clinical_gov_policy.htm.

Open disclosure

Open disclosure refers to the process of open communication with patients and their families following an adverse event. This process not only facilitates communications among health care professionals but also between health care professionals and patients. It is fundamental to continuing to develop trust and accountability within Victoria's health care system.

Building on from the work undertaken in previous years the department provided open disclosure education and training to a broad range of metropolitan and regional health service staff.

Over 700 people attended from a wide range of professional backgrounds and included the support from the Victorian Managed Insurance Authority (VMIA) to assist hospitals promote active engagement with patients.

The most significant challenges for the participants appeared to be the challenge of the term open 'disclosure' – it has been suggested they use the term 'open explanation', in the context of an information continuum.

Acknowledging the harm to a patient in a way that is honest and frank, but not at odds with their insurance policy requirements continues to remain a challenge for most organisations.

More information can be found at: http://www.health.vic.gov.au/clinrisk/opendisc.htm.

Victorian health incident management system

The primary aim of Victorian health incident management system (VHIMS) project is improving quality through incident management.

The key goal of the project is to implement a systematic approach for reporting clinical incident, consumer feedback and occupational health and safety data. It will enable statewide multi-level data analysis to support quality improvement initiatives for Victorian publicly funded health services.

VHIMS is a collaborative project involving a diverse range of health services and organisations across Victoria.

VHIMS in scope health services include:

- 88 public health services and all other services running under their auspices
- 39 funded (stand-alone) community health services
- Ambulance Victoria
- Royal District Nursing Service
- Ballarat District Nursing Service and Healthcare
- 14 bush nursing centres
- Forensicare
- 5 public sector incorporated residential aged care services.

The following incident types are within the scope of the VHIMS project:

- clinical incidents – Events or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person receiving care. This includes adverse events and near misses
- consumer feedback (including complaints, compliments and enquiries)
- occupational health and safety incidents (staff incidents)
- incidents of all severity levels, including near misses (incidents that don't cause harm).

Implementation

The department will commence a three month lead implementation in October 2009 with six health services. Following an evaluation in January 2010 a phased statewide implementation will commence.

Implementation has been planned in waves to extend over a 12 month period. Timing of the phases outlined below is subject to change by the VHIMS project board:

- wave one, February to April 2010
- wave two, May to July 2010
- wave three, August to October 2010
- wave four, November 2010 to February 2011.

Implementation will be supported by education and training of health service based project officers, these positions will be backfilled by the department for 12 weeks. The project officers will act as project leads for their health service in planning for transition, coordinating education and implementation.

Generic education materials are being developed by the department in a train the trainer framework. These materials will form the basis for the health services education programs.

There will be flexibility within the toolkits for services to include their local policies and governance processes.

International and national interest

The department has joined the World Health Organisation (WHO) patient safety alliance reporting and learning group and will continue to actively participate in the ongoing development of the International classification for patient safety (ICPS) program over the next five years. Much of the preliminary work in basing a granular representation of the ICPS concepts in a workable incident classification system has been incorporated into the VHIMS taxonomy. Victoria is well positioned to act as a leader in this ground breaking work.

The commission have expressed an interest in VHIMS as the concepts are well grounded in the WHO ICPS framework and support the ongoing development of patient learning systems with a common format and meaning.

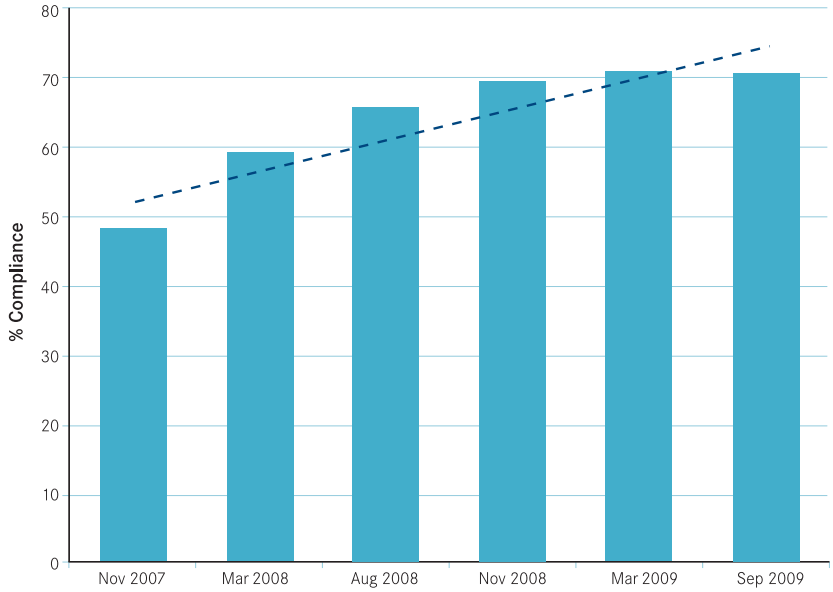
Infection control and cleaning

Hand hygiene in Victoria

All public hospitals have hand hygiene (HH) programs in place that are aimed at reducing healthcare associated infections. Regular audits using a standardised audit tool are undertaken in each health service to measure health care workers' compliance with hand hygiene. The first two audits used the validated Victorian compliance tool. The remaining audits used the WHO's 5 moments for hand hygiene tool, modified slightly for Australian conditions, and now the national standard.

In Victoria, there has been an overall increase in HH compliance from 48% in 2007 to 71% in 2009. There has also been a corresponding reduction in methicillin resistant Staphylococcus aureus (MRSA) bloodstream infections by 50%.

Figure 5: Statewide average hand hygiene compliance



Overall HH Compliance for the State has improved as follows:

November, 2007:	*48% (95% CI 47%-48%)*	*November, 2008:*	*69% (95% CI 69%-70%)*
March, 2008:	*59% (95% CI 58%-59%)*	*March, 2009:*	*71% (95% CI 70%-71%)*
August, 2008:	*66% (95% CI 65%-66%)*	*September, 2009:*	*71% (95% CI 70%-71%).*

The rate of MRSA bacteraemia has been reduced from 0.0157 per 100 separations to 0.0106 per 100. This is equivalent to 108 fewer patients developing MRSA bacteraemia in the state's hospitals over the past two years.

From 1 January 2010 all hospitals in Victoria will submit all Staphylococcus aureus bacteraemia (SAB) data not just the subset MRSA, as the aim is to reduce all SAB infections in health services to 2 per 10,000 bed days by 2011.

Surveillance – The Victorian hospital-acquired infection surveillance system (VICNISS) has been funded by the department since 2002 to collect, analyse and report data, and will commence benchmarking with other jurisdictions in the future.

Hospital cleaning

Following a comprehensive statewide review, the cleaning standards for Victorian health facilities were released in February 2009. New reporting requirements come into effect in 2010 when acute public hospitals and health services will be required to submit results of three external cleaning standards per annum.

To support the changes in reporting requirements a course in cleaning standards auditing has been approved by the Victorian registration and qualifications authority and will be offered by Registered training organisations in the metropolitan and rural regions across Victoria.

Clinical engagement program

Credentialling

In 2009 an update of the *Credentialling and defining the scope of clinical practice for medical practitioners in Victorian health services* ('the policy') was completed.

The department stipulated that the policy should be fully implemented across all Victorian publicly funded health services by October 2012, which allows for a full contract cycle for all senior doctors.

The policy has also been recently expanded to include the credentialling of general practitioners and other doctors who provide services to residents of publicly operated residential aged care facilities (RACF).

The guidelines outline the minimum standard for the introduction of the credentialling process into RACF. They provide an opportunity for organisations to enhance collaboration with medical practitioners and strengthen credentialling processes. These guidelines are not mandated.

The policy provides practical advice regarding the required organisational processes and is supported by a suite of tools which are available at:

http://www.health.vic.gov.au/clinicalengagement/credentialling/index.htm.

A regular review of practice – the future

The policy recognises that regular appraisal of a senior doctor's scope of clinical practice is critical to the ongoing relationship between the doctor and organisation, as clinician skill sets and organisational capability may evolve over time.

Next steps

The Statewide Quality Branch has a suite of projects currently underway to enhance clinical engagement, working closely with senior medical staff and health services to further policy implementation and facilitation of safe, high quality health care. These include:

- Commissioning DLA Phillips Fox, in association with SACS Consulting and the Royal Australasian College of Medical Administrators, to develop a performance appraisal and support process for senior medical staff in Victoria's public health services, due for completion at the end of 2009.
- The development of an understanding clinical practice toolkit which will deliver a practical guide for clinicians and managers to support the implementation of the clinical governance framework, the credentialling and scope of practice policy, and the performance appraisal and support process.
- A formative evaluation of the policy to determine the impact of the implementation of the policy on selected health services. The results will inform a summative evaluation of the policy scheduled for 2012.

The department sees this work as an opportunity to build on the outstanding work organisations are doing to strengthen their credentialling and defining scope of practice processes and the skilful clinical work being performed by Victorian senior medical staff.

Victorian public healthcare awards

Now in its sixth year, the Victorian public healthcare awards are Victoria's most comprehensive health care awards program which celebrate quality, innovation and excellence across our public healthcare system. The Awards recognise the diverse ways in which excellent public health and healthcare is achieved by honouring initiatives, projects, campaigns, services, individuals and teams delivering work that is improving Victoria's public healthcare.

Each year the Awards call for entries from all Victorian Government funded primary and acute healthcare providers and initiatives, and public health activities that are funded by government and other sources.

Awards are given for the Premier's Health service of the year and Excellence awards, Minister's awards for outstanding individual and team achievements, Category awards for leading healthcare and public health initiatives and the Department of Health's Secretary's award.

In 2009, a total of 17 awards were bestowed to health services from all corners of the state and from all types of services delivering healthcare including hospitals, ambulance services, primary health, and mental health and research institutes. Winners were assessed by a pool of 100 judges drawn from the health sector. Information on the 2009 winners and finalists can be found at:

http://www.health.vic.gov.au/healthcareawards/.

Patient safety initiatives

Pain management

In 2007, VQC published the *Acute pain management measurement toolkit* (the toolkit). The toolkit provides a range of validated measurement tools appropriate to the diverse needs of pain assessment. Following publication, the VQC implemented an intensive three-month project to support health services to implement the toolkit and evaluate its effectiveness. Feedback from the evaluation indicated that health services needed more guidance in relation to the reporting and governance of pain management.

In response to this request, the VQC has developed two audit tools along with supportive guidelines to enable the measurement of clinical performance at individual practitioner and organisational levels. They provide a simple mechanism to measure practice in these domains, and allow the consequent targeting of improvement strategies within this important clinical area.

The tools are available on the VQC website at:
http://www.health.vic.gov.au/qualitycouncil/activities/acute.htm.

The pressure ulcer clinical indicator data set

As an internationally acknowledged patient safety problem, pressure ulcers are a largely preventable adverse outcome of a healthcare admission, and recognised internationally as an indicator of the quality of care provided.

After consultation with health service representatives and recommendations of the pressure ulcer point prevalence survey (PUPPS3), the Statewide Quality Branch established the pressure ulcer clinical indicator data set (PUCI) to support ongoing surveillance of pressure ulcer occurrence in Victorian health services.

The PUCI focuses on outcome measures (number and severity of ulcers) and a process measure (risk assessment).

As an indication of performance the PUPPS3 showed that 66 per cent of patients surveyed had a completed risk assessment. Aggregated results for 2008–2009 PUCI data collection showed an increase from 82 per cent to 92 per cent in patient records surveyed containing a completed risk assessment.

Although measuring the number of completed risk assessments does not address the quality of the risk assessments performed or the linking to care plans, the completion of a risk assessment is the first step in ensuring the other steps do occur. Also it is a pure number that is not subjective or open to interpretation.

The PUCI statewide rate of pressure ulcers for 2008–2009 of 4.4 per 1000 bed days provides a basis for comparison at the end of 2009–2010. The PUCI provides a systematic approach to monitoring the incidence and the severity of pressure ulcers at the hospital level.

The Statewide Quality Branch will continue to use the PUCI to identify trends in the incidence of pressure ulcers and review and revise processes and procedures designed to prevent the development of pressure ulcers during hospital admissions.

Patient safety monitoring

There is a clear need to monitor and improve patient safety and performance of Victoria's hospitals. Initiatives are aimed at both monitoring as well as supporting decision making about best practice.

Victorian audit of surgical mortality

The Victorian audit of surgical mortality (VASM) is part of the Australian and New Zealand audit of surgical mortality (ANZASM), a bi-national network of regionally-based audits of surgical mortality that aim to ensure the highest standard of safe and comprehensive surgical care.

The objective of the audit is, peer review of deaths associated with surgical care. This includes:

- deaths that occur in hospital following a surgical procedure
- deaths that occur in hospital while under the care of a surgeon, even though no procedure was performed.

The audit process is designed to highlight system and process errors. It is intended as an educational rather than a punitive exercise. The first annual report for VASM (2008) is available at: http://www.surgeons.org/Content/NavigationMenu/Research/Audit/VictorianAuditofSurgicalMortality/VASM_Annual_Report_2008.pdf.

The surgical outcomes information initiative

The Victorian Surgical Consultative Council (VSCC) has developed an innovative method of providing surgical outcome information and improving surgical care in Victorian public health services. The Surgical outcomes information initiative (SOII) aims to review systematically surgical mortality and morbidity within Victorian health services and hospitals. The initiative uses the Victorian admitted episodes database (VAED) as the source of data.

The VAED data is a robust, high-quality, accessible data source that is used to support the casemix funding system. It has the capacity to identify specific case series that may involve specific diagnoses (including complications of care), procedures or service types.

As the VAED is an administrative database, only preliminary comparisons of surgical outcomes between health services can be made using the VAED data without the need to implement additional systems or processes. This comparison represents an initial screening mechanism to guide more in depth investigation and review of a surgical mortality series at the health service and hospital level.

Initially all Victorian public health services performing surgery were invited to participate in the SOII. Many Victorian private hospitals are participating in the initiative following an invitation late in 2008.

Although the health service reports are not public, there is a statewide aggregate data report available.

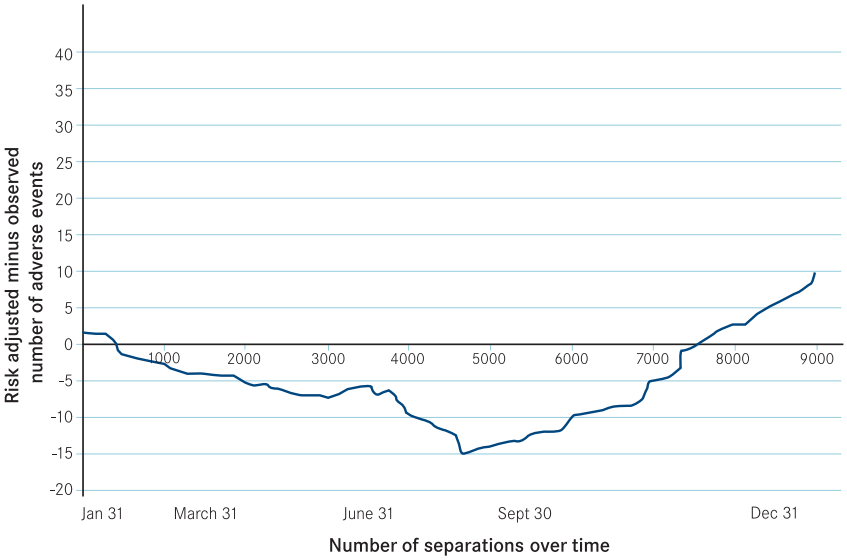
Patient safety indicators/variable life adjusted display

Tracking improvement and monitoring the rate of patient safety events at a hospital level can be enabled by analysis of routinely collected administrative data in conjunction with a set of well-developed indicators.

The department developed the AusPSIs primarily to support health services and the department in monitoring quality of care and patient safety. The Patient safety monitoring initiative (PSMI) is testing a suite of the AusPSIs across a number of Victorian health services. The PSMI provides reports to the health services in graphical format using a statistical process control chart known as variable life adjusted display (VLAD). This technique enables rapid identification of trends at hospital level potentially not captured when reporting periodic averages. That is, every patient outcome influences the chart. A flagging mechanism applied to the chart indicates areas of significant change as an 'apparent outlier'. An apparent outlier may represent an area of concern or exceptional practice.

The point at which the flag occurred and the trend leading up to it give hospitals a place to start when looking to see why the change occurred.

Figure 6: Patient safety indicator



The strength of the indicators is in their use as screening tools to identify apparent changes in performance rather than absolute event rates. These tools appropriately support the targeting of effort rather than providing an absolute measure of performance. The department is the first Australian body to undertake this work of translation and refinement for Australian use and places the department at the forefront in this area. The indicator set will ultimately be widely available for use with any administrative dataset.

The patient safety monitoring indicator set includes:

- death in low mortality diagnostic groups
- complications of anaesthesia
- in-hospital fracture
- postoperative haemorrhage or haematoma
- postoperative deep vein thrombosis/pulmonary embolus
- obstetric trauma – vaginal or caesarean delivery
- stroke in-hospital mortality
- heart failure in-hospital mortality
- AMI (heart attack) in-hospital mortality
- pneumonia in-hospital mortality
- hip fracture in-hospital mortality.

Engaging consumers in care

Doing it with us not for us the consumer, carer and community participation policy in the health service system has guided participation in Victoria since 2006. In 2008, the department's Participation advisory committee, reviewed the policy's implementation through an audit of reporting on the minimum set of participation indicators in health services' 2007-08 Quality of care report. Importantly, the findings of the audit reflect only what health services reported, which may or may not accurately represent the full range of participation strategies occurring at each health service.

Evaluating effectiveness of participation projects

One of the gaps found when developing *Doing it with us not for us* was evidence on how effective participation was in improving the safety and quality of health care. To address this, a series of demonstration projects to evaluate the effectiveness of participation (EEP) were funded with all projects using a controlled before-and-after study design. The projects were completed and accepted for presentation at two national and one international conference, as well as submission to peer-reviewed journals. The successful projects can be viewed at: http://www.health.vic.gov.au/consumer/participate.htm.

Quality of care reports

The Quality of care reporting awards, now in their eighth year, distinguish the ability of health services and their community partners to report in an open and informative way to the public on the quality and safety of patient care. Reporting to the public is a key strategy in facilitating the continuous improvement of health care. Three interstate judging panels and our own Health Services Commissioner judge the reports.

The 2007–08 winners of the Excellence in quality of care reporting were announced at the 2009 Victorian public healthcare awards ceremony across the categories: metropolitan health services, regional and large rural health services, small rural health services and stand-alone community health services.

The reports aim to tell quality as it is including both the outstanding work and the areas for improvement, all of which need to be talked about with the community.

Community advisory committees

Community advisory committees (CACs) reporting to the boards of Victorian public health services were established under the *Health Services Act 1988* (Vic) s.65ZA and 65ZB to ensure community participation in our health services. To assist CAC members in working with their health service to improve the quality and safety of health care the department sponsored a member from each health service to attend the 6th Australasian safety and quality conference in 2008. The department also provides resources to the committee members and health services to develop their Community Participation Plans and monitors the implementation of these plans through an annual report produced by the health service.

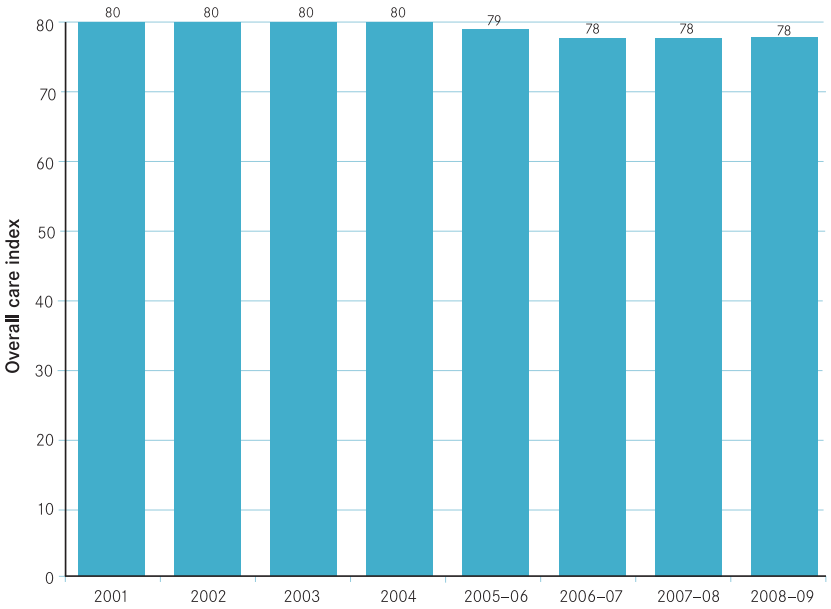
Victorian patient satisfaction monitor

The Victorian patient satisfaction monitor (VPSM) was established in July 2000 to provide systematic and regular feedback from adult inpatients about their hospital experience so that this information could be used by health services for quality improvement. Since then more than 120,000 Victorians have offered feedback, providing valuable insight into their experiences. In 2008 online reporting was introduced, allowing hospitals faster access to, and more detailed analysis of their results. Patients now have an opportunity to complete the survey on line.

Currently 107 health services participate in the survey. A maternity module was added in 2005 and an emergency department module will soon be trialled in 10 sites. Each health service receives an individualised six-monthly report that gives them their own results and then benchmarks them against similar health services. An annual report is publicly available on the website at: www.health.vic.gov.au/patsat/index.htm

This report gives each hospital an overall care index (OCI) score derived from responses to 25 of the survey's questions. The range of possible scores for the OCI is 20 -100. This score has remained fairly constant for the duration of the survey. The statewide OCI score for 2008-09 is 78.2.

Figure 7: Overall care index



Public hospital patient charter

The Australian charter of healthcare rights was developed by the commission and adopted for use in Australia by the Australian Health Ministers' Conference meeting in July 2008. Victoria supports the three key guiding principles and the seven rights articulated in the national charter and has developed the Australian charter of healthcare rights in Victoria brochure from these materials. This new brochure incorporates the content of the Victorian public hospital patient charter to enhance articulation of the rights of patients, consumers and carers in the Victorian setting. It is also congruent with the *Victorian Charter of Human Rights and Responsibilities Act 2006*. The Australian charter of healthcare rights in Victoria will be launched in September 2009 and will be translated into 17 community languages.

The Patient charter is available at http://www.health.vic.gov.au/patientcharter

Health service cultural diversity plans

The Statewide Quality Branch has undertaken a comprehensive review of current cultural and linguistic diversity (CALD) and cultural competence reporting requirements, minimum standards and benchmarks for Victorian health services.

From this review a new framework has been developed for health services to replace the health service cultural diversity plans (HSCDP). The *Cultural responsiveness framework* comprises standards and measures for cultural responsiveness, and consolidates multiple requirements for reporting on cultural diversity initiatives within health services. Implementation guidelines for the new framework were launched in September 2009 and are available at: http://www.health.vic.gov.au/cald.

Educating the health care sector

The department is not a training organisation, and seeks tenders for external providers to deliver appropriate educational packages as part of patient safety initiatives where applicable. The department does however continues to support education and training in clinical risk management (CRM) through its RCA education program and continues to build on work started in 2004–05 to provide a standardised statewide approach.

Further information on the sentinel event program and clinical risk management is available at: www.health.vic.gov.au/clinrisk/sentinel.

Glossary

The following terms are used frequently in this report. The department acknowledges that their usage varies and that a number of definitions are used in the literature.

adverse event	an unintended injury or complication that results in disability, death or prolongation of hospital stay and is caused by health care management rather than the patient's disease
ABO blood group	a system for classifying human blood based on the antigenic components of blood cells and their corresponding antibodies
behavioural assessment	processes involved in establishing a patient's cognitive state, particularly whether the patient is at risk of wandering, absconding or causing harm to staff
clinical guidelines	any policy, procedure or guidelines concerning the processes involved in the clinical management of patients
clinical risk management	an approach to improving quality in health care that places special emphasis on identifying circumstances that put patients at risk of harm and then acting to prevent or control those risks
clinical governance	a health service board's accountability for ensuring a framework and rigorous systems are established so health care safety and quality are monitored, evaluated and continuously improved
clinical pathway	a treatment regime agreed by consensus that includes all the elements of care, regardless of the effect on patient outcomes
cost	direct and indirect activities involving a negative impact, including injury, death, increased length of stay, time loss, money loss, service disruption, and reputation, political and intangible losses
harm	death, disease, injury, harm, suffering or disability experienced by a person
hazard	a source of potential harm or a situation with a potential to cause loss
incident	an event or circumstance resulting from health care that could have, or did, lead to unintended or unnecessary harm to a person and/or a complaint, loss or damage
incident severity rating (ISR)	a method to quantify the actual or potential consequences of an incident or near miss
monitor	to check, supervise, observe critically or record the progress of an activity or system on a regular basis to identify change
near miss	an incident that did not cause harm
risk	the chance of something happening that will have an impact on objectives; it is measured in terms of consequence and likelihood
risk assessment	the overall process of risk analysis and risk evaluation
risk evaluation	the process used to determine risk-management priorities by comparing the level of risk against predetermined standards, target risk levels or other criteria
risk management	the culture, processes and structures that are directed to the effective management of potential opportunities and adverse effects
root cause	a significant factor that contributed to an incident

root cause analysis (RCA)	a systematic process where the factors that contributed to an incident are identified
risk-reduction action plan	strategies required to reduce the risk of similar adverse patient outcomes occurring in the future
sentinel event	a relatively infrequent, clear-cut event that occurs independently of a patient's condition; it commonly reflects hospital system and process deficiencies, and results in unnecessary outcomes for the patient
underlying cause	the systems or process cause that allows for the proximate cause of an event to occur
VAED	Victorian Admitted Episodes Data Set

State Government Victoria
Department of Health