Question on Notice
No. 315
Asked on 8 March 2006

MR HORAN asked the Minister for Health (MR ROBERTSON)-

QUESTION:

With reference to the failures in Queensland Health's Quality and Safety Program which were highlighted in the Davies Report—

Will he outline the action taken to date to improve patient safety and quality including (a) the budget allocated to the Patient Safety and Clinical Improvement Services as outlined in Queensland Health's most recent organisation structure and (b) the clinical and administrative personnel (include classification levels and reported separately), who have been appointed or seconded to draft workable policy, and drive its implementation, within the department's Patient Safety and Clinical Improvement Service?

ANSWER:

Two distinct organisational units have been established in Queensland Health's Reform and Development Division:

- Patient Safety Centre; and
- Clinical Practice Improvement Centre.

A Medication Safety Unit is currently located within the Patient Safety Centre but will transfer to the Chief Operations Office in the near future. This answer does not include information about that unit even though it contributes to improving patient safety and quality.

PATIENT SAFETY CENTRE

The Queensland Health Patient Safety Centre (PSC) was formed in early 2005 to take a lead role in planning, implementing, managing and evaluating patient safety initiatives and programs as part of the broader system to prevent and address patient harm.

The broader patient safety system involves health service providers at a local, area and statewide level. The PSC works in partnership with health services to coordinate and support statewide and local patient safety programs.

The PSC is committed to reducing preventable patient harm by:

- raising risk awareness and promoting a culture of safety at all levels within Queensland Health;
- building local district capacity for identification of vulnerabilities and implementation of solutions using a human factors approach.;
- building a central resource centre that adds value by providing training, support, data and trend analysis, and works with local areas to develop solutions for statewide implementation;
- developing and implementing comprehensive and integrated clinical incident management systems focused on learning and improvement rather than individual blame;

- developing patient safety tools for consistent use across the State;
- creating and supporting networks for discussion and shared learning; and
- involving healthcare consumers in system re-design and safety improvement.

A summary of progress in major patient safety initiatives follows:

Open Disclosure Pilot

Queensland Health is taking a lead role in piloting this program. The first of four clinician "train the trainer" workshops is currently underway with 80 clinicians participating in the training up to early April 2006. Other States have elected to follow Queensland Health's model. Seven Queensland Health sites and one private site are participating in this pilot

Ensuring Intended Surgery

This program has been rolled out statewide in partnership with the Royal Australasian College of Surgeons and the Queensland Perioperative Nurses Association. Three major workshops, seven video-teleconferences and 13 district presentations have been conducted. The number of staff trained to date exceeds 400. Compliance audits are currently being undertaken.

Incident Management Systems

In line with national requirements, Queensland Health has implemented a statewide reporting system, PRIME. This is being rolled out across the State with regular upgrades to minimum data sets to suit clinician need. 84% of health service districts have commenced implementation and of this number 62% have completed implementation. By June 2006, it is estimated that 87% of health service districts will have completed implementation. Five health service districts have yet to commence PRIME implementation. There has been a gradual increase in incident reporting across health service districts since the commencement of PRIME implementation. Queensland Health is now able to analyse clinical incident trends across the State with 29,000 clinical incidents entered since September 2004. Further development of PRIME as raised in the *Forster Report* 2005 is being addressed.

The Queensland Health Incident Management Policy and Clinical Incident Impact Statement have recently been reviewed and are currently in the consultation phase. The policy is due for release shortly.

Root Cause Analyse (RCA) Training has been provided to 21 health service districts statewide with a total of 693 staff participating in the health service district training to date and 306 staff participating in area health service training. It is expected that all health service districts will have undergone RCA training by August 2006. Legislative changes are being sought to provide privilege to RCA reports and teams.

Patient Safety Officers (37) have been trained and deployed into health service districts to support the implementation of key patient safety initiatives at the district level.

Sentinel Event Reporting and management has been standardised and monitored to ensure compliance with the Incident Management Policy statewide as per ministerial commitment.

The "10 tips for safer health care: what everyone needs to know" booklet has been distributed and is in popular demand throughout all settings within Health Service Districts.

Mental Health Sentinel Event

Achieving Balance: The Queensland Review of Fatal Mental Health Sentinel Events March 2005 outlines nine key recommendations which address systemic matters with a view to improving the care of persons with mental illness, and decreasing mortality and morbidity. The Mental Health Sentinel Events Implementation Secretariat was established to facilitate the implementation of the key recommendations.

Human Error and Patient Safety (HEAPS)

To date 6,000 staff have been trained statewide in HEAPS with the goal that all clinical middle managers statewide will be trained by within the next three years.

Falls Injury Prevention & Pressure Ulcer Prevention

Sustainable and practical approaches to these high risk areas are being implemented:

- cross-continuum, clinician-led collaboratives have been established to set achievable targets and to ensure the sustainability of this program (Consumer, Community, Public Health, Aged Care, Private Health Care and Public Hospital representation); and

- face-to-face support by the program coordinators provided to clinicians at facility or district level and to other key stakeholders to ensure that the guidelines have been implemented, ongoing staff education and resource provision and to encourage a cross continuum approach to falls injury prevention and pressure ulcer prevention.

Planning is underway to establish a major initiative in improving clinical handover. Ineffective clinical handover has been identified as a causative factor in 30% of major adverse events.

(a) Budget for 2005-2006 - $10,075,762.

(b) Personnel seconded or appointed

See attachment 1.

CLINICAL PRACTICE IMPROVEMENT CENTRE

The Clinical Practice Improvement Centre (CPIC) established in February 2005 was set up to:

- promote the use of known improvement techniques to reduce differences in clinical practice by supporting realistic, evidence-based solutions to gaps in care provision;

- engage clinicians from all disciplines in developing skills required for multidisciplinary improvement processes; and
- measure progress made towards specific targets in these activities and develop systems to ensure that such progress is sustainable.

(a) Budget for 2005-2006 - $7,716,000.

(b) Personnel seconded or appointed

See attachment 2.

A summary of progress made to date includes:

- ongoing work with clinicians in the Renal, Cardiac, Cardiac Rehabilitation, and Stroke Collaboratives to implement evidence based improvements and care;
- establishment of a Diabetes collaborative – focusing initially on paediatric care, pregnancy and management of type II diabetes;
- provision of consultancy and data analysis support to the Mental Health Branch for the establishment of a Mental Health Collaborative – initially focusing on inpatient management of schizophrenia;
- initial plans in place for the establishment of a Patient Flow statewide steering group to plan the use of process design to improve the responsiveness of services;
- training undertaken in quality methodologies to improve patient flow in acute services. This has led to teams being set up in three health service districts to map and streamline patient flow processes;
- establishment of a working group to standardise patient care protocols within the Emergency Department;
- hosted a statewide workshop to scope the establishment of a system of clinical networks;
- involvement in the development of a new policy and implementation guide for area and statewide clinical networks;
- continued assistance provided to promote the use of standardised Queensland Health clinical pathways in maternity, surgical and orthopaedic areas;
- continued assistance provided in the collection and measurement of pathway variance resulting in an increase in statewide median from 5.4% in 2004 to 7.14% in 2005;
- development of a system to monitor and track variation in patient quality of care. Trial of the system to be undertaken at the QEII Hospital in April;
- advanced negotiations with the Royal College of Surgeons for a Queensland Audit of Surgical Mortality;
- development of standardised documentation process for pre-admission and recovery pathways;
- work is in progress with an external agency on development of an on-line module for statistical process control to enable clinicians to better monitor performance;
- provision of data and data analysis support to varying clinical areas;
- exploration and development in progress for web based, real time, integrated clinical activity reporting; and
- support in terms of consultation, funding, and data collection provided at district level to enable clinical improvements to be undertaken on a project basis.

Attachment 1

Role	Classification	Notes	To be appointed
Senior Director	MS12	Appointed	
Nursing Director	NO7	Acting	Advertised
District Support *	Patient Safety Officers (2) A07 Patient Safety Officers (27.5 FTE - 37 staff) AO6	Centrally located Appointed	
Audit & Analysis	AO7 AO6	Vacant Appointed	To be advertised shortly
Reporting System *	Incident Reporting & Management System Implementation Team (PRIME) A07 AO6 AO7 (3)	 1 appointed 4 temporary staff (June 2006)	
Program Implementation	Ensuring Intended Surgery* AO7	Temporary position (June 2006) Consultancy provided by Surgeons	
	Pressure Ulcer Prevention A07	Vacant	Advertised - To be interviewed shortly
	Falls Injury Prevention AO7	Vacant	Advertised - To be interviewed shortly
	Coronial Data Management A07	Appointed	
	Mental Health Sentinel Event Management & Quality Systems AO7 (2) AO6 AO3 AO6	 Acting Vacant Vacant Secondment 12 months (March 2007)	 To be interviewed shortly To be appointed
	Human Error and Patient Safety (HEAPS) MO Coordinator AO4	 Temporary contract Secondment 12 months – October 2006 (Temporary)	
	Informed Consent AO7	Awaiting transfer of files and application for ongoing funding. Vacant	

Role *continued*	**Classification**	**Notes**	**To be appointed**
External Partnerships & Curriculum	Medical Indemnity National Collection* AO7	Appointed	
	Open Disclosure* AO7	Acting- Temporary position for 2 years (December 2008)	To be advertised shortly
	National Open Disclosure* AO7	Awaiting National funding transfer. Temporary position (December 2006)	
Policy, Standards & Communication	AO7 AO6	Acting Vacant	To be advertised To be advertised
Support Unit	Business Manager & Projects AO6 ESO & Finance AO4 AO3 ESO AO3 Team Support	Appointed -Secondment for maternity leave cover Secondment while project in progress Acting Acting	 To be appointed To be interviewed To be interviewed
Temporary Projects	Quality Information System project AO6 AO5	Temporary secondments QHPS & PSC June 2006	
Medical Administration Experience	Registrar MO	Temporary Secondment Cost neutral – funded by SHNGA	

* denotes Ministerial Commitment

Please Note:
Of the staff currently working for the Patient Safety Centre, 84.7% have current professional clinical registration/licenses (61% District or Area Health Service based).

Attachment 2

Role	Classification	Notes	To be Appointed
Senior Director	MO2-2	Appointed	
Director	SO2	Appointed	
Collaborative	Manager AO8	Appointed	
	Principal Project Officer AO7 x 8 FTE	4.2 FTE appointed 1.3 FTE temporary appointment	2.5 FTE to be advertised
Pathways and Processes	Manager AO8	Appointed	
	AO7 x 6 FTE	3.2 FTE appointed	2.8 FTE to be advertised
Measurement and Analysis	Manager AO8	Appointed	
	Principal Project Officer AO7 x 6	2 FTE appointed 3 FTE Temporary appointment	4 FTE to be advertised
	Data Manager AO5 x 2	1 FTE appointed 1 FTE temporary appointment	1 FTE to be advertised
	Collections Officer AO3 x 1	1 FTE temporary appointment	Advertised yet to be selected
District Liaison	Manager AO8	Appointed	
	Principal Project Officer AO7 x 4	4 FTE appointed 1 FTE seconded - temporarily vacant	
Facilitation & Group Learning	Manager AO8	0.5 FTE temporarily appointed	
Audit of Surgical Mortality	Manager AO8	Appointed	
Centre Administration	HR/Finance Officer AO5 x 1	Appointed	
	Administration Officers AO3 x 2		Advertised yet to be selected
	Administrative Assistant AO2 x 1	Appointed	