Policy Directive

Patient Safety and Clinical Quality Program

Summary The Patient Safety and Clinical Quality Program provides a framework for significant improvements to clinical quality in our public health system.

Document type Policy Directive

Document number PD2005_608

Publication date 26 July 2005

Author branch Clinical Excellence Commission

Branch contact 02 9269 5500

Review date 30 September 2023

Policy manual Not applicable

File number

Previous reference N/A

Status Review

Functional group Clinical/Patient Services - Governance and Service Delivery, Incident Management

Applies to Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Community Health Centres, Dental Schools and Clinics, NSW Ambulance Service, Ministry of Health, Public Health Units, Public Hospitals

Distributed to Public Health System, Community Health Centres, Dental Schools and Clinics, Divisions of General Practice, Health Associations Unions, Health Professional Associations and Related Organisations, NSW Ambulance Service, Ministry of Health, Public Health Units, Public Hospitals, Tertiary Education Institutes

Audience Administrative;clerical;allied health;nursing.

Secretary, NSW Health

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

Policy Directive

Ministry of Health, NSW
73 Miller Street North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Telephone (02) 9391 9000 Fax (02) 9391 9101
http://www.health.nsw.gov.au/policies/

Patient Safety and Clinical Quality Program

Document Number	PD2005_608
Publication date	26-Jul-2005
Functional Sub group	Clinical/ Patient Services - Governance and Service Delivery Clinical/ Patient Services - Incident management
Summary	The Patient Safety and Clinical Quality Program provides a framework for significant improvements to clinical quality in our public health system.
Author Branch	Clinical Excellence Commission
Branch contact	Clinical Excellence Commission 02 9269 5500
Applies to	Area Health Services/Chief Executive Governed Statutory Health Corporation, Board Governed Statutory Health Corporations, Affiliated Health Organisations, Public Health System Support Division, Community Health Centres, Dental Schools and Clinics, NSW Ambulance Service, Ministry of Health, Public Health Units, Public Hospitals
Audience	Administrative, clerical, allied health, nursing.
Distributed to	Public Health System, Community Health Centres, Dental Schools and Clinics, Divisions of General Practice, Health Associations Unions, Health Professional Associations and Related Organisations, NSW Ambulance Service, Ministry of Health, Public Health Units, Public Hospitals, Tertiary Education Institutes
Review date	26-Jul-2010
Policy Manual	Not applicable
File No.	
Previous reference	N/A
Status	Active

Director-General

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

MOH.9999.0802.0003

NSW HEALTH

NSW Patient Safety and Clinical Quality Program

MOH.9999.0802.0004

NSW Department of Health
73 Miller Street
North Sydney
NSW 2060
Tel (02) 9391 9000
Fax (02) 9391 9101
www.health.nsw.gov.au

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to the inclusion of an acknowledgement of the source and no commercial usage or sale. Reproduction for purposes other than those indicated above require written permission from the NSW Department of Health.

© NSW Department of Health 2005

SHPN: (QSB) 050 104
ISBN: 0 7347 3839 0

PD2005_608

For more information and further copies, please contact:
Quality and Safety Branch
Tel. (02) 9816 0452
Fax. (02) 9816 0492

May 2005

Contents

Foreword		**iii**
1.	**Introduction**	**1**
2.	**Key components**	**2**
3.	**Guiding principles**	**3**
4.	**Patient expectations**	**4**
5.	**Roles and responsibilities**	**5**
6.	**Policy and standards**	**6–13**
7.	**Clinical Governance Units**	**14**
8.	**Incident management**	**15**
9.	**Clinical Excellence Commission**	**16**
10.	**Quality System Assessments (QSA)**	**17**
11.	**Key policy directives and related documents supporting the program**	**19**
12.	**Definition of terms**	**20**

Diagram 1: NSW Patient Safety and Clinical Quality Program flowchart **18**

Foreword

New South Wales is recognised nationally and internationally, as a leader in improving the quality and safety of clinical services provided to patients.

The NSW Patient Safety and Clinical Quality Program provides the framework for significant improvements to clinical quality in our public health system. Success depends on a culture of openness in which errors are acknowledged and reported so as to reduce the chance that others will make the same mistakes.

In a system as large and complex as the NSW public health system, it is unrealistic to expect that no mistakes will occur, and our aim is to develop a system that continually strives for ongoing improvement – where lessons are learnt from mistakes and are communicated to other health services.

The Government has invested $55 million in improving frontline clinical care through the NSW Patient Safety and Clinical Quality Program. The Program is ambitious and sets the agenda for one of Australia's most comprehensive clinical quality programs, ensuring patient safety and excellence in healthcare is the top priority for the NSW health system.

The key components of the program are:

- Systematic management of incidents and risks
- A new Incident Information Management System
- Clinical Governance Units in each Area Health Service
- A Quality Assessment Program for all public health organisations
- The establishment of the Clinical Excellence Commission.

These initiatives are designed to support clinicians and managers with improving quality and safety for patients and will focus on promoting and providing the delivery of the best care in health services. Key to the success of the program is the active involvement of doctors, nurses, allied health professionals, health managers and our community.

With this level of commitment, the result will be a more consistent approach to high quality patient care and people in NSW will continue to enjoy access to one of the best health systems in the world.

Morris Iemma
Minister for Health
May 2005

1 Introduction

There is a growing body of international and Australian knowledge that has contributed to the evolving concept of quality improvement in healthcare.

Borrowing from other high-risk industries where safety is paramount, the health industry is developing techniques to better identify risks, investigate and analyse incidents and to improve practice. These techniques allow health services to manage known risks actively and to develop systems to identify new or emerging risks.

In healthcare, as in any industry, sometimes things go wrong. Equipment can fail, systems can prove inadequate and errors of judgment are made. In relatively few cases, serious incidents occur that might have been prevented and some of these result in serious harm to patients. The majority of these incidents are not the result of a single action by an individual but, more commonly, are generated by a chain of events.

Preventing error depends on identifying the deficiencies in the sequence of events and fixing any identified problems. It is crucial to capture all the relevant information about an incident, investigate all known causes and to take decisive action to protect patients from a recurrence of that kind of event.

The aim of the *NSW Patient Safety and Clinical Quality Program* is that all significant adverse incidents are reported and reviewed so that education and remedial action can be applied across the whole health system. This shift in thinking about how we deal with error, combined with the rollout of a new system for electronic reporting of incidents, will lead to an increasing number of events being reported. Somewhat paradoxically, a rising number of events reported will be one measure of success for the program.

This first year of the program lays the groundwork for what is potentially one of the greatest ever systemic improvements to clinical quality in our public health system. Future success will depend on a culture of openness in which errors are acknowledged and reported so as to reduce the chance that others will make the same mistakes.

Everyone working in the health system is encouraged to contribute their knowledge of how and when mistakes are made in this constructive spirit, free of anxiety that the response will be unnecessarily punitive. The lessons from each localised incident can then be used to inform safety improvements in every health facility throughout NSW.

MOH.9999.0802.0010

2 Key components

The NSW Patient Safety and Clinical Quality Program has five key components:

1. The systematic management of incidents and risks both locally and statewide to identify remedial action and systemic reforms
2. The Incident Information Management System (IIMS) to facilitate the timely notification of incidents, track the investigation and analysis of health care incidents, enable the reporting about incidents, particularly the provision of trended information by incident type, and to understand the lessons learned
3. The establishment of Clinical Governance Units (CGU) in each Area Health Service (AHS) to implement the NSW Patient Safety and Clinical Quality Program
4. The development of a Quality Systems Assessment (QSA) Program for all public health organisations undertaken by an external agency, to determine whether the above components are in place and working well. The focus of the assessments is on AHS patient safety and clinical quality systems
5. A Clinical Excellence Commission (CEC) to promote and support better clinical quality and to advise the Minister for Health on where systemic improvements can be made.

Guiding principles

3

The NSW Patient Safety and Clinical Quality Program is underpinned by guiding principles:

1. **Openness about failures** – errors are reported and acknowledged without fear of inappropriate blame, and patients and their families are told what went wrong and why
2. **Emphasis on learning** – the system is oriented towards learning from its mistakes and extensively employs improvement methods for this
3. **Obligation to act** – the obligation to take action to remedy problems is clearly accepted and the allocation of this responsibility is unambiguous and explicit
4. **Accountability** – the limits of individual accountability are clear. Individuals understand when they may be held accountable for their actions
5. **Just culture** – individuals are treated fairly and are not blamed for the failures of the system
6. **Appropriate prioritisation of action** – action to address problems is prioritised according to the available resources and directed to those areas where the greatest improvements are possible
7. **Teamwork** – teamwork is recognised as the best defence against system failures and is explicitly encouraged and fostered within a culture of trust and mutual respect.

4 Patient expectations

As a patient admitted to a hospital or requiring treatment from a health service what might you reasonably expect?

1. Appropriate treatment for my condition when I need it
2. The best possible care at all times, based on the latest evidence
3. To be treated with respect and have easy and honest communication with the doctors, nurses and other health care professionals who are providing care to me
4. To be looked after by clinicians who have the necessary clinical skills for the work that they do
5. Those who provide care to me are well-supported and part of effective teams, and have access to the resources (including equipment and information) they need to do their work
6. Systems are designed to prevent inadvertent or accidental harm to me while in hospital
7. If I have concerns, I will be able to talk to someone immediately and have my concerns addressed to my satisfaction
8. If something goes wrong with my care, that there is a system in place to openly report, investigate and fix the underlying problems so that others are not harmed. In addition, I will be told openly and honestly what went wrong and receive an apology
9. Reassurance that there is an external body evaluating the safety of care in hospitals and working to improve quality and safety in the NSW health system.

Patient expectations have been incorporated into standards and performance measures developed to monitor the effectiveness of the implementation of the NSW Patient Safety and Clinical Quality Program.

Roles and responsibilities

5

NSW Department of Health

The NSW Department of Health is established under section 6 of the *Health Administration Act 1982* and supports the Minister in performing his statutory functions including responsibility for patient safety and clinical quality in the NSW health system. The Quality and Safety Branch is responsible for the development of the essential components of the NSW Patient Safety and Clinical Quality Program with lead responsibility for:

- Setting standards for Area Health Service Quality Systems
- Developing policies on quality and safety that need statewide implementation
- Developing and reporting on system wide quality indicators
- Monitoring and analysing serious clinical incidents, and taking appropriate action such as advice and warnings to the health system
- Overseeing statewide clinical governance issues
- Overseeing consistent implementation of the NSW Patient Safety and Clinical Quality Program.

Area Health Services

Area Health Services (AHS) and all Public Health Organisations (PHO) are responsible for the quality and safety of the services provided by their facilities, staff and contractors. With the recent implementation of the health reforms, clinical governance has been embedded in the new AHS through the mandatory requirement for all AHS to establish a consistent organisational structure, including a Clinical Governance Unit (CGU) directly reporting to the Chief Executive (CE). These Units are responsible for the rollout of the NSW Patient Safety and Clinical Quality Program within their AHS.

Clinical Governance Units

The Clinical Governance Units (CGU) have the roles of support, performance and conformance to develop and monitor policies and procedures for improving systems of care. The CGU will contribute to the program by ensuring it is uniformly implemented across the state and for overseeing the risk management of patient safety and clinical quality by building upon existing incident management and investigation systems.

The Clinical Excellence Commission

The Clinical Excellence Commission (CEC) is a statutory health corporation established under the Health Services Act by the NSW Minister for Health as part of the NSW Patient Safety and Clinical Quality Program, and builds on the foundation work carried out by the Institute of Clinical Excellence established in 2001. The core mission of the CEC is to identify issues of a systemic nature that affect patient safety and clinical quality in the NSW health system and to develop and advise on implementation strategies to address these issues. Part of the role of the CEC is to acquire and share information about how well the NSW health system is performing and to use this information to improve the performance of the system.

The CEC has a statewide research oversight, monitoring, education and advisory role. It is not directly responsible for the implementation of the NSW Patient Safety and Clinical Quality Program.

6 Policy and standards

The NSW Patient Safety and Clinical Quality Program lists standards that Area Health Services are required to comply with. This builds upon existing frameworks, programs and initiatives currently well established in all Area Health Services. The Program is based on standards against which a health service's quality system will be assessed.

These standards are derived from existing Departmental policies and guidelines that are familiar to health service staff, administrators and clinicians.

Governance responsibility for identifying patient safety risks and undertaking remedial action is vested in Area Health Services and public health organisations and it is their responsibility to undertake activity to address the standards mandated by the Department.

Standards

Standard 1
Health services have systems in place to monitor and review patient safety.

Standard 2
Health Services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

Standard 3
An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

Standard 4
Complaints management systems are in place and complaint information is used to improve patient care.

Standard 5
Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates.

Standard 6
Performance review processes have been established to assist clinicians maintain best practice and improve patient care.

Standard 7
Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.

MOH.9999.0802.0015

Standard 1

Health services have systems in place to monitor and review patient safety.

Components

Committee structure

The Area Heath Service has clearly articulated its commitment to quality improvement and patient safety and has an effective committee structure that oversees quality improvement and patient safety.
PD2005_585 A Framework for Managing the Quality of Health Services in NSW, issued 1999.

Clinical Governance Unit

The Area Health Service has established a Clinical Governance Unit responsible for managing patient safety and clinical quality and has developed an operational plan consistent with Departmental directives.
NSW Clinical Governance Directions Statement, issued 2005.

Establishing clinical indicators and performance information

The Area Heath Service monitors and analyses performance information on quality and patient safety using performance measures and clinical indicators included in strategic planning and business documents.
PD2005_585 A Framework for Managing the Quality of Health Services in NSW, issued 1999.

Monitoring and reporting performance information

The Area Heath Service monitors, analyses and compares performance information on quality and patient safety reported to Area executive and Advisory Council and strives to compete with the best performing facilities.
PD2005_585 A Framework for Managing the Quality of Health Services in NSW Issued 1999.
PD2005_604 Incident Management Policy, 2005.

Using performance information to improve patient care

Performance information is used by Area executive to evaluate and improve safety and patient care and to develop strategies to reduce clinical and patient safety risks.
PD2005_585 A Framework for Managing the Quality of Health Services in NSW, issued 1999.
PD2005_604 Incident Management Policy, 2005.

Public awareness of quality and safety

The Area Health Service publicly reports information on patient safety activities and outcomes.

Patient safety performance

Health services perform to desired levels against targets for patient safety and performance is improving.

MOH.9999.0802.0016

Standard 2

Health services have developed and implemented policies and procedures to ensure patient safety and effective clinical governance.

Components

Minimum requirements

The Area Health Services develop, implement and review patient safety policies and protocols for incident management, complaint management, complaints or concerns about clinicians, new interventions and correct patient/site/procedure.

Implementation

Systems are in place to effectively disseminate, implement, review and update new policies and procedures on patient safety to health facilities in the Area, including Departmental directives and safety alerts.
NSW Clinical Governance Directions Statement, 2005.

Detailed policy review – new interventions

The Area policy on new interventions is consistent with Departmental guidelines and risk assessments are undertaken before new procedures are introduced. An implementation plan is prepared for each new procedure introduced by the Area.
PD 2005_333 (Circ 2003/84) Model Policy for the Safe Introduction of New Interventions, 2003.

Detailed policy review – correct patient/site/ procedure (Note: does not apply to the Ambulance Service)

Health Services have developed an implementation plan to ensure all procedural teams comply with the Model Policy on Correct Patient/Site/Procedure.
PD 2005_380 (Circ 2004/56) Correct Patient/Site/Procedure Model Policy, 2004.

Policy Directives and Related Documents

GL2005_061 NSW Health Better Practice Guidelines for Frontline Complaints Handling, 1998.
PD2005_585 A Framework for Managing the Quality of Health Services in NSW, NSW Health, 1999.
PD2005_586 Guideline on the management of complaints or concerns about a clinician, 2001.
GL2005_062 The Clinician's Toolkit for Improving Patient Care, NSW Health 2002.
PD2005_337 (Circ 2003/88) Reportable Incident Briefs to the NSW Department of Health, 2003.
PD2005_380 (Circ 2004/56) Correct Patient, Correct Site, Correct Procedure Model Policy, 2004.
PD2005_404 (Circ 2004/82) NSW Health Incident Information Management System Policy, 2004.

MOH.9999.0802.0017

Standard 3

An incident management system is in place to effectively manage incidents that occur within health facilities and risk mitigation strategies are implemented to prevent their reoccurrence.

Components

Notifying and assessing incidents

The Area Health Service supports a culture that facilitates incident reporting, the use of systems to notify and record incidents using the Severity Assessment Code (SAC) matrix to identify matters requiring investigation, and ensures incident reports are forwarded to relevant authorities within the required timeframe.

Investigating incidents

High-risk incidents are investigated in accordance with Departmental guidelines by a multidisciplinary team nominated by the Area executive in a timely manner to analyse the incident, and to recommend key actions to minimise the risk of recurrence.

Implementing recommendations

Recommendations arising from investigations are implemented in health facilities to improve patient safety. Incident data is monitored and analysed to detect trends and determine whether system-wide improvements are needed. Feedback on the outcome of investigations is provided to the Root Cause Analysis (RCA) team and the person who reported the incident (where identified) and feedback is provided to staff on policy and procedural changes.

Incidents involving the death of a patient

Systems are in place to monitor deaths and determine whether changes in practice are needed to improve patient care.
PD2005_337 (Circ 2003/88) Reportable Incident Briefs to the NSW Department of Health, 2003.
PD2005_604 Incident Management Policy, 2005.

MOH.9999.0802.0018

Standard 4

Complaints management systems are in place and complaint information is used to improve patient care.

Components

Complaint monitoring and review

Responsibility for the timely management of complaints and feedback on the outcome of investigations to complainants is assigned appropriately and systems are in place to record, monitor and review complaints.

Systems improvement

Complaint data are monitored, analysed to identify trends and to determine whether system-wide improvement is needed to prevent recurrence. Processes are in place to address the systems issues identified by complaints, to implement recommendations by health facilities and to ensure complaints information is reported to Departmental and other relevant authorities.

Management of complaints or concerns about individuals

Complaints or concerns against individuals are dealt with according to Departmental policy and within relevant timeframes.

GL2005_061 NSW Health Better Practice Guidelines for Frontline Complaints Handling, 1998.

PD2005_586 Guideline on the management of complaints or concerns about a clinician, 2001.

MOH.9999.0802.0019

Standard 5

Systems are in place to periodically audit a quantum of medical records to assess core adverse events rates.

Components

Health services have developed an appropriate system of chart review.

Systems improvement

The results and recommendations of chart reviews and investigations are reported to management/Area executive and staff, and the recommendations are implemented to effect system improvement.

GL2005_062 The Clinician's Toolkit for Improving Patient Care, NSW Health 2002.

MOH.9999.0802.0020

Standard 6

Performance review processes have been established to assist clinicians maintain best practice and improve patient care.

Components

Performance review process

Health services have developed an appropriate system of performance review and meetings where clinical management issues are adequately discussed and improvement action identified and documented.
GL2005_062 The Clinician's Toolkit for Improving Patient Care, NSW Health 2002.
PD2005_500 Appointment of staff specialists, 2005.
PD2005_496 Appointment of visiting practitioners, 2005.
PD2005_497Delineation of clinical privileges for visiting practitioners and staff specialists, 2005.
PD2005_498 Performance review of visiting practitioners, 2005.

Systems/performance improvement

Performance review reports are forwarded to an appropriate delegate within the Area for action, matters requiring further review are investigated, and feedback is provided to staff on any policy and procedural changes to effect system improvement.

MOH.9999.0802.0021

Standard 7

Audits of clinical practice are carried out and, where necessary, strategies for improving practice are implemented.

Components

Topic selection

Health services have developed a program of clinical practice audits that targets major care processes or practices considered to be high risk.

Review process

People with relevant skills and knowledge conduct the audits. Audits are conducted in an efficient and effective manner against pre-determined components or performance standards.

Systems improvement

The audits identify clinical management issues that need to be addressed to improve patient safety and quality care. Audit results are reported to management/Area executive and feedback is provided to staff on policy and procedural changes and ongoing monitoring of the effectiveness of systems changes is in place.

MOH.9999.0802.0022

7 Clinical Governance Units[1]

The developing focus on the integrity and accountability of health systems through clinical governance is integral to improving the performance of health systems and the enhancement of clinical care through analysis and feedback. The concept of clinical governance integrates clinical decision-making within an organisational framework and requires clinicians and administrators to take joint responsibility for the quality of clinical care delivered by the organisation.

With the recent implementation of the health reforms, clinical governance has been embedded in the new Area Health Services (AHS) through the mandatory requirement for all AHS to establish a consistent organisational structure, including a Clinical Governance Unit (CGU) as a direct report to the Chief Executive (CE).

Core functions

The primary focus of the CGU can be summarised as the risk management of patient safety and clinical quality through implementation of the NSW Patient Safety and Clinical Quality Program. The Program will be implemented in collaboration with the Clinical Excellence Commission (CEC), the Department and the CGU.

The CGU will build upon existing incident reporting and investigation systems enhanced through the implementation of the Incident Information Management System (IIMS). Functions that will guide the role of the CGU in 2004/05 are:

1 Structural establishment

2 Incident management

3 IIMS implementation

4 Complaints management

5 Death review

6 Continuous Quality Improvement (CQI) support

7 Communication training

8 Policy development

9 Clinician performance review

10 Reporting

11 External reports.

Other functions

- Management of individual performance issues. The establishment of clinician performance review is a key part of the NSW Patient Safety and Clinical Quality Program. The role of the CGU will be to determine an appropriate performance management framework for the health service, in collaboration with the CEC, and be a source of advice and expertise regarding due process for those line managers.
- Complaints management. The CGU will ensure a single point of access for staff and the public to register complaints and to take responsibility for the management of serious complaints. The CGU will lead the process of complaints management but should not take over this function on behalf of the health service.
- Integrated risk management. Clinical risk management is an integrated responsibility for clinical operations and for the CGU. The CGU will advise and support clinical operations in the recognition and management of clinical risk. It is not intended that the CGU assume global risk management responsibility for the health service.

1 *Draft NSW Clinical Governance Units Implementation Framework, 2004.*

Incident management 8

A quality improvement framework requires routine examination of all incidents that cause patient harm. Most adverse events are not caused by a single, individual action. They usually result from a chain of events where inadequate safeguards and other systemic vulnerabilities erode patient safety. Preventing incidents depends on identifying the deficiencies that allowed the event to occur and fixing those problems.

In the past, information about adverse events was generally derived from single studies and often specific only to a hospital or clinician. Through the NSW Patient Safety and Clinical Quality Program, Area Health Services are now well placed to systematically collect incident information to effect system-wide improvement.

In NSW, all incidents that result in detriment to a patient are 'reportable' – they must be reported to management and, depending on their severity, the AHS and the NSW Department of Health for analysis and remedial action.

The NSW Patient Safety and Clinical Quality Program aims to develop a culture where health care incidents are identified, reported, investigated, analysed and acted upon. The lessons learned locally will be disseminated statewide through a knowledge management strategy.

The Program is supported by an information system, the Incident Information Management System (IIMS), that assists heath care workers to achieve this.

The Incident Information Management System (IIMS)

The Incident Information Management System is an electronic system activated in all AHS in December 2004 to:

- Record all healthcare incidents, both adverse events and incidents that did not result in adverse events, but might have, in four categories:
    1. Clinical
    2. Complaints
    3. Property security and hazards
    4. Staff, visitors and contractors
- Assist managers to deal with incidents in their areas
- Record the results of reviews and investigations of incidents
- Provide reports on all incidents recorded in the system.

There are 100,000 potential users of the IIMS system that includes all NSW health system employees and contractors. A comprehensive training and education program has been developed using 'e-learning modules', a CD-ROM, DVD and video to ensure all potential users have consistent training in the use of the IIMS.

Full deployment was completed in May 2005 across the whole of NSW.

9 Clinical Excellence Commission[1]

The Clinical Excellence Commission (CEC) is a statutory health corporation established under the Health Services Act and launched by the NSW Minister for Health as part of the NSW Patient Safety and Clinical Quality Program and builds on the foundation work of the Institute of Clinical Excellence established in 2001. The NSW Department of Health, public health organisations, the Health Care Complaints Commission (HCCC) and professional registration boards are the other principal organisations with major roles in this program.

The CEC will work effectively in partnership with these organisations to:

- Promote and support improvement in clinical quality and safety in public and private health services
- Monitor clinical quality and safety processes and performance of public health organisations and to report on these to the Minister
- Identify, develop and disseminate information about safe practices in health care on a state wide basis, including (but not limited to) developing, providing and promoting training and education programs, and identifying priorities for and promoting the conduct of research about better practices in health care
- Consult broadly with health professionals and members of the community in performing its functions
- Provide advice to the Minister for Health and Director-General of Health on issues arising out of its functions.

Patient safety risk identification

A major role of the CEC will be to analyse information from a range of relevant sources regarding adverse events, to identify trends, causes and preventative strategies and to work with Public Health Organisations (PHO) to facilitate ongoing improvements in the health care system. The CEC will analyse information provided by the Department and PHO. This may include information from the following sources to identify systemic issues that need to be addressed:

- Root Cause Analyses (RCAs)
- Incident Information Management System (IIMS)
- Coroners' findings and recommendations
- Special Committees' and expert committees' reports
- Treasury Managed Fund and medical defence organisations
- Quality System Assessments (QSA)
- Information from the Health Care Complaints Commission
- Literature reviews, research and other sources as appropriate
- Special reviews.

1 *NSW Clinical Excellence Commission Directions Statement, 2004.*

Quality System Assessments

10

The effectiveness of the implementation of the NSW Patient Safety and Clinical Quality Program will be routinely monitored through an external review process, the Quality System Assessments (QSA) conducted by the Clinical Excellence Commission (CEC).

The QSA is an annual review of Area Health Services (AHS) to identify, analyse and advise on issues of a systemic nature that affect patient safety and clinical quality in the NSW health system. The CEC will assess AHS and PHO to identify if there has been effective implementation of the Program.

Specifically, the QSA will review patient safety arrangements in AHS focusing on compliance with the standards and policy requirements developed by the Department. The key areas for review are:

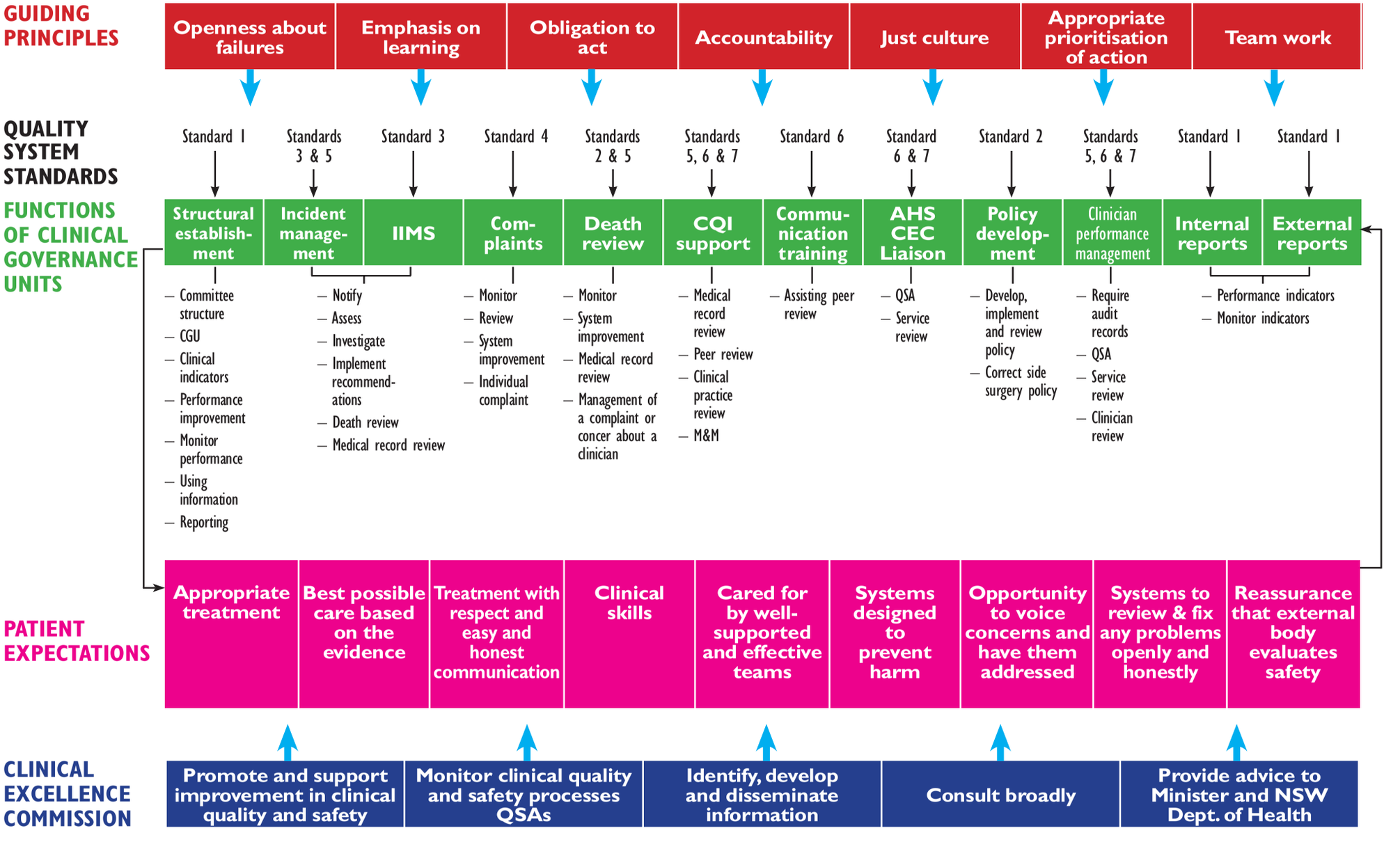
- Quality and safety reporting structures
- Safety polices and procedures
- Incident management
- Complaint management
- Medical record reviews
- Audits of clinical practices.

The CEC will provide the QSA Report to the Chief Executive of the AHS and Public Health Organisation, and a copy to the Department of Health. The AHS and PHO will notify the Department of the actions taken to address safety and quality issues contained within the report, and work with the Department to ensure appropriate implementation. It is acknowledged that from time to time significant issues may be identified from a Quality Systems Assessment.

The Department will support AHS and PHO to address risks identified by the CEC, or through its own sources of information and advice. The Areas can also approach the CEC for advice and assistance in improving quality systems.

MOH.9999.0802.0026

Patient Safety and Clinical Quality Program



Documents supporting the program 11

GL2005_061 NSW Health Better Practice Guidelines for Frontline Complaints Handling, 1998.

PD2005_585 A Framework for Managing the Quality of Health Services in NSW, NSW Health, 1999.

PD2005_586 Guideline on the management of complaints or concerns about a clinician, 2001.

GL2005_062 The Clinician's Toolkit for Improving Patient Care, NSW Health 2002.

PD2005_337 (Circular 2003/88) Reportable Incident Briefs to the NSW Department of Health, 2003.

PD 2005_333 (Circular 2003/84) Model Policy for the Safe Introduction of New Interventions, 2003.

PD2005_404 (Circular 2004/82) NSW Health Incident Information Management System Policy, 2004.

PD 2005_380 (Circular 2004/56) Correct Patient, Correct Site, Correct Procedure Model Policy, 2004.

PD2005_500 Appointment of staff specialists, 2005.

PD2005_496 Appointment of visiting practitioners, 2005.

PD2005_497 Delineation of clinical privileges for visiting practitioners and staff specialists, 2005.

PD2005_498 Performance review of visiting practitioners, 2005.

NSW Clinical Governance Directions Statement, 2005.

PD2005_604 Incident Management Policy, 2005.

NSW Patient Safety and Clinical Quality Program Implementation Plan, 2005.

12 Definition of terms

Adverse event

Any event or circumstance leading to avoidable patient harm which results in admission to hospital, prolonged hospital stay, significant disability at discharge or death.

Area Health Advisory Councils (AHAC)

A clinical and community advisory body established in Area Health Services following the health reforms to give clinicians including doctors, nurses and allied health professionals, health consumers and local communities a stronger voice in health decision-making.

Area Health Services (AHS)

Area Health Services provide the operational framework for the provision of Public Health Services in NSW. They are constituted under the Health Services Act 1997 and are principally concerned with the provision of health services to residents within the geographic area covered by the Area Health Service.

Clinical Excellence Commission (CEC)

A statutory health corporation established under the Health Services Act to promote and support improvement in clinical quality and safety in NSW health services.

Incident Information Management System (IIMS)

A state-wide electronic reporting and incident management system designed to underpin the NSW Safety Improvement Program.

Incident[1]

An unplanned event resulting in, or having the potential for, injury, damage or other loss.

Public Health Organisation (PHO)

Means an area health service, a statutory health corporation or an affiliated health organisation in respect of its recognised establishments and recognised services, as defined in section 7 of the Health Services Act, and in addition, for the purposes of this document, includes the Ambulance Service of NSW.

Quality System Assessment (QSA)

Criteria for the collection and analysis of information on the quality and safety of health services designed to test the effectiveness of the systems in place to monitor and improve quality and patient safety.

Severity Assessment Code (SAC)

A risk matrix used to stratify the consequence and likelihood of an incident to generate a numerical rating from 1 to 4. SAC 1 events always require investigation and notification to the Area Health Service Executive and the NSW Department of Health. SAC 2 events require notification to the Area Executive and local assessment as to the level of investigation required. Incidents rated 3 or 4 will be managed locally by the Area Health Service.

1 *NSW Health First Report on incident management in the NSW public health system 2003-2004.*