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A2 #qfa2

Building a safer tomorrow – using measurement and predictive analytics to prevent harm

Presented by:

Carrie Marr

Chief Executive Officer

Clinical Excellence Commission

Dr Bernadette Eather

National Manager, Clinical Quality & Patient Safety

Ramsay Health Care



@carriemarr



@Dr_Eather



People caring for people

Ramsay Health Care's Global Network



Ramsay
Health Care

77,000
Employees

480
Locations

8,500,000
Patient visits/admissions

11
Countries

Hospitals & Facilities

Ramsay Health Care's global network extends across 11 countries, with 8.5 million admissions/patient visits to its facilities in circa 480 locations. The combined entity employs 77,000 staff.



Ramsay
Health Care

Australia

In Australia, Ramsay Health Care:

- Is the largest operator of private hospitals in the country
- Leads the way in developing the role of private health care in Australia's balanced health care system
- Is recognised as a leader in teaching and research with an emphasis on both undergraduate and postgraduate training of the future medical and nursing workforce
- Operates four public facilities within the network
- Has developed a community pharmacy franchise network to better support patients following a hospital admission

32,000
Employees

1 million
Patient admissions

Australia
72
Hospitals

57
Franchised
community
pharmacies





Darwin to Perth	4396km
Perth to Adelaide	2706km
Adelaide to Melbourne	726km
Melbourne to Sydney	887km
Sydney to Brisbane	972km
Brisbane to Cairns	1748km



4,000
kms

5
Jurisdictions

National
Reporting
= Harm

Multiple
Reporting
Requirements



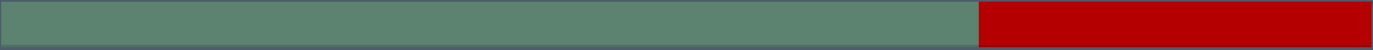
United States of America

Total Unprovoked 1657 Non-fatal and unprovoked 1513 Fatal and unprovoked 144



Australia

Total Unprovoked 904 Non-fatal and unprovoked 645 Fatal and unprovoked 259



South Africa

Total Unprovoked 395 Non-fatal and unprovoked 299 Fatal and unprovoked 96



Papua New Guinea

Total Unprovoked 118 Non-fatal and unprovoked 63 Fatal and unprovoked 55



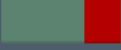
Brazil

Total Unprovoked 86 Non-fatal and unprovoked 56 Fatal and unprovoked 30



New Zealand

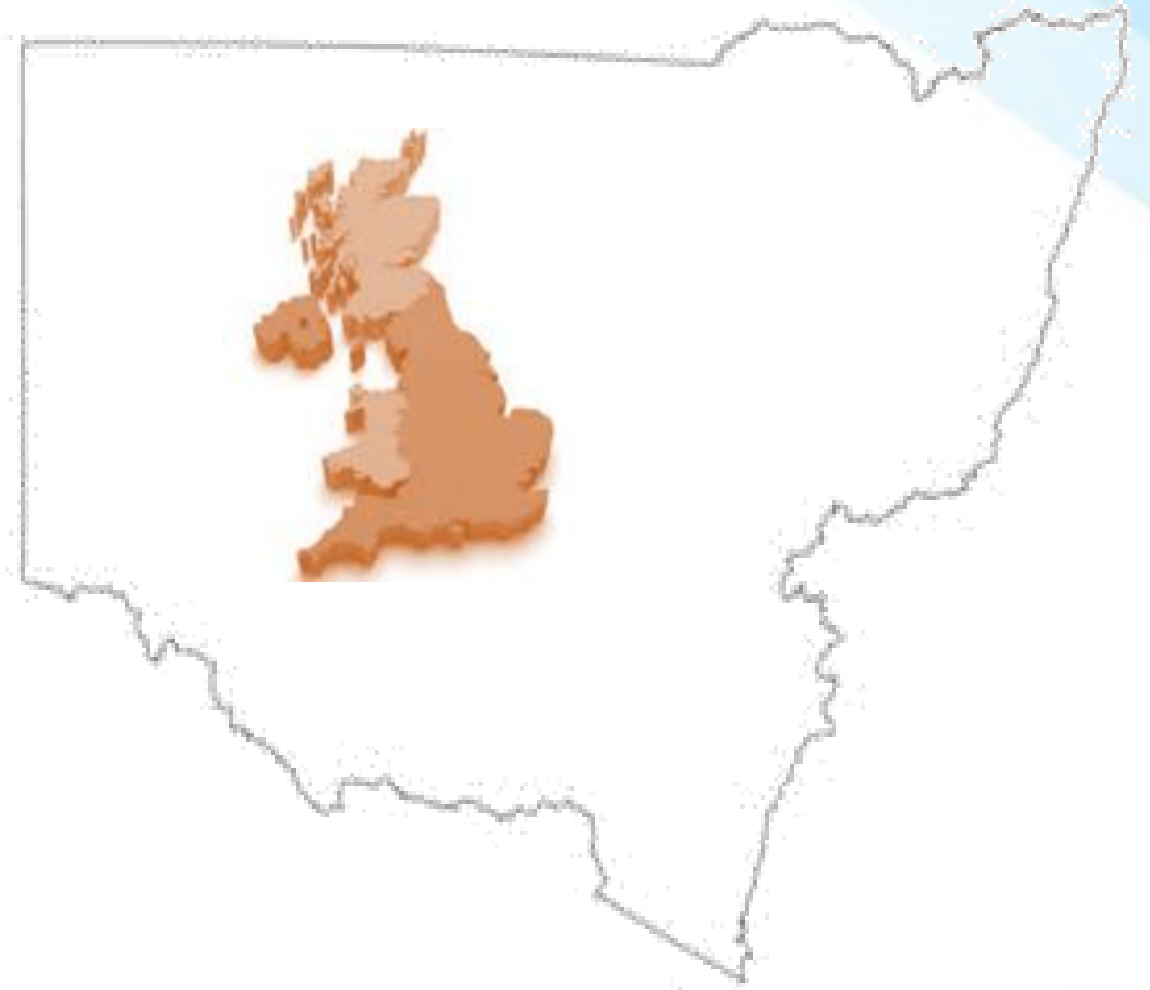
Total Unprovoked 79 Non-fatal and unprovoked 55 Fatal and unprovoked 24



New South Wales

NSW is 3.3 times the size of
the United Kingdom

Far West LHD is 80% of
the size of the UK



The NSW Health System

**THE NSW PUBLIC HEALTH SYSTEM IS WORLD CLASS.
IT IS THE LARGEST PUBLIC HEALTH SYSTEM IN AUSTRALIA.**

7.8  **MILLION**
NSW RESIDENTS ON **809,444** SQ. KM

228  **HOSPITALS***

319,000
SURGERIES PERFORMED

\$4605 
NSW STATE PRICE

Per national weighted activity unit for 2016-17.

\$21.7  **BILLION**
2017-18 BUDGET

17  **LOCAL HEALTH
DISTRICTS & SPECIALTY
HEALTH NETWORKS**

1.9  **MILLION**
INPATIENT EPISODES

114,000 
FULL-TIME EQUIVALENT STAFF

2.8  **MILLION**
EMERGENCY DEPARTMENT ATTENDANCES

985,799 
AMBULANCE EMERGENCY
RESPONSES

A typical day:

- **17,000** people spend the night in a public hospital
- **6,500** people are seen in public hospital emergency departments
- **5,600** people are admitted to a public hospital
- **270** babies are born
- **1,000** patients have their surgery (emergency or planned) performed

Over the past 14 years, some of our important achievements include:



1500

Since Between the Flags started in 2010, there has been a 53% reduction in the cardiopulmonary arrest rate across NSW hospitals to June 2017. Independent research estimated the program has **saved more than 1500 lives a year in NSW**



85%

Hand hygiene compliance has improved from 61% in 2009 to 85% in November 2017



35%

Staphylococcus aureus bacteremia infections fell 35% from 2011 to 2017



80%

Patients with sepsis now get IV antibiotics within 2 hours of diagnosis, up from 57% in 2011



30k

We developed the Quality Audit Reporting System

(QARS) in response to requests from local health districts and specialty health networks to assist with clinical audits, including the National Safety and Quality Health Service Standards. On average about 30,000 clinical audits are completed monthly



2500

Graduating over 2500 students from our clinical leadership programs

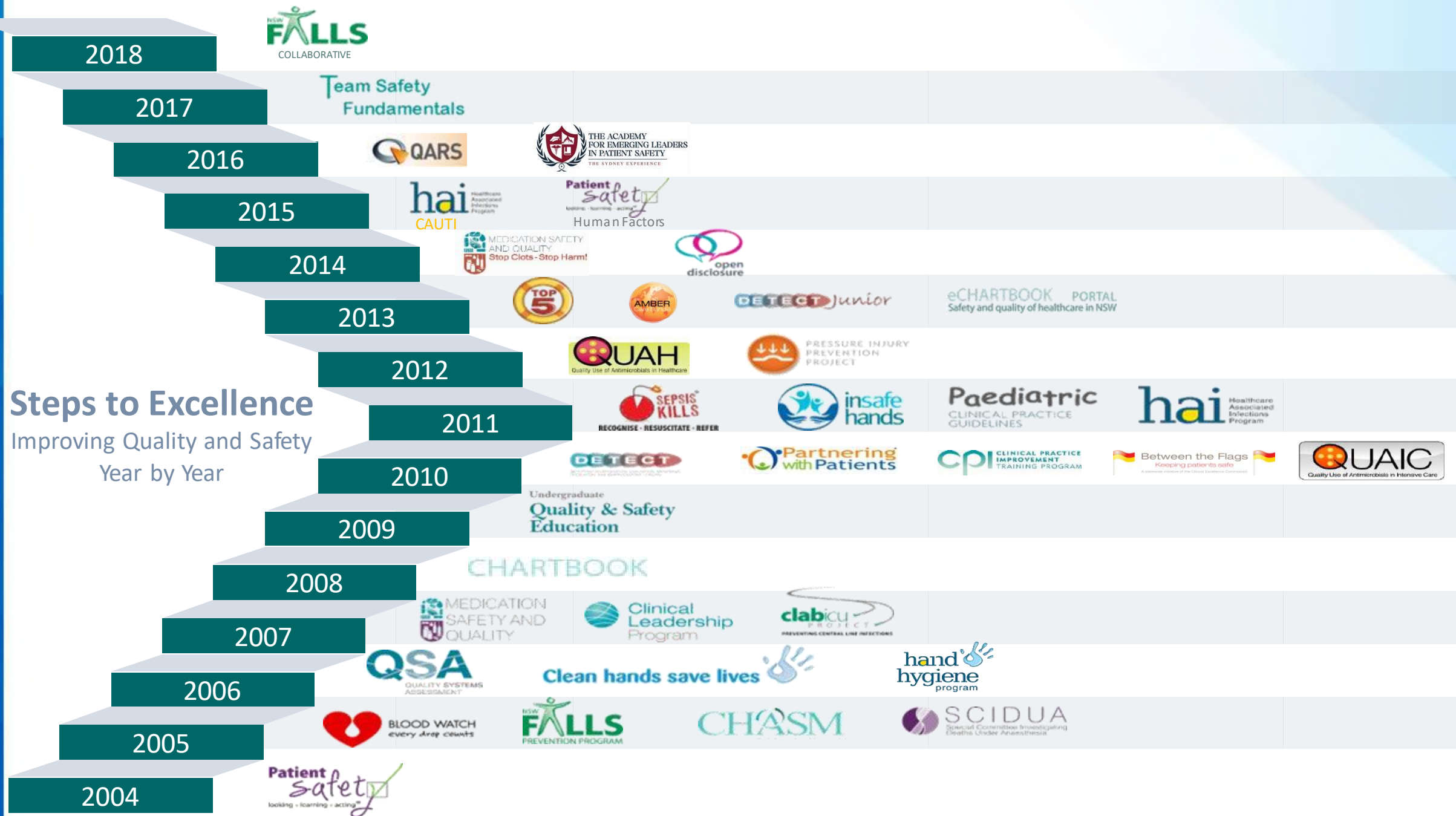


\$2.6m

Savings of \$2.6 million have been realised from better utilisation of blood products

Steps to Excellence

Improving Quality and Safety
Year by Year



“Every System is perfectly designed to deliver the results that it gets.”

*Theory of
Knowledge*

*Appreciation for
a System*

*Psychology
of change*

*Unwarranted
Variation*



“Every System is perfectly designed to deliver the results that it gets.”

The Four Leadership Questions

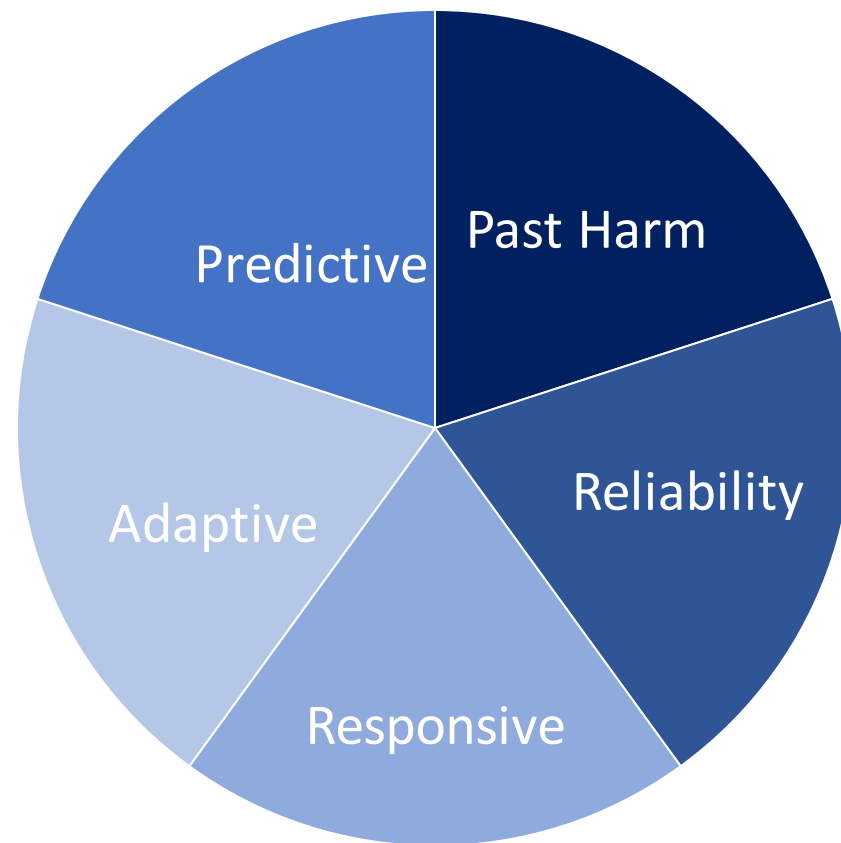
1. Do you know how good you are?

2. Do you know where you stand relative to the best?

3. Do you know where your harm, unwarranted variation and waste exists?

4. Do you know your rate of improvement over time?

What constitutes Safety?



Safety and reliability is a process of enquiry

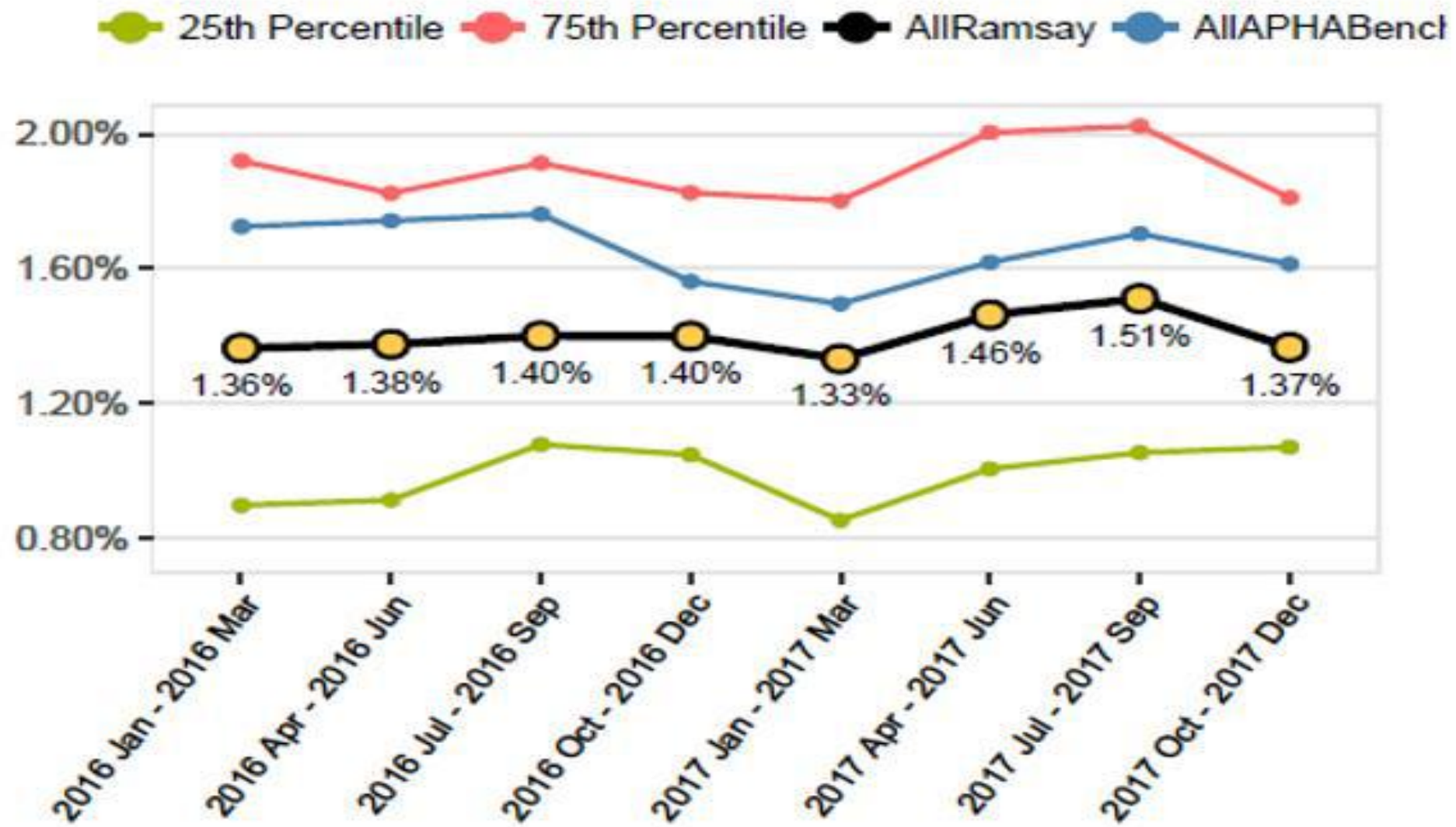


Measuring Quality & Safety

- ✓ What we often measure is not how safe healthcare systems are but how unsafe they have been in the past
- ✓ Process and not outcome
- ✓ Unwarranted variation
- ✓ Should we focus on error, harm or reliability?



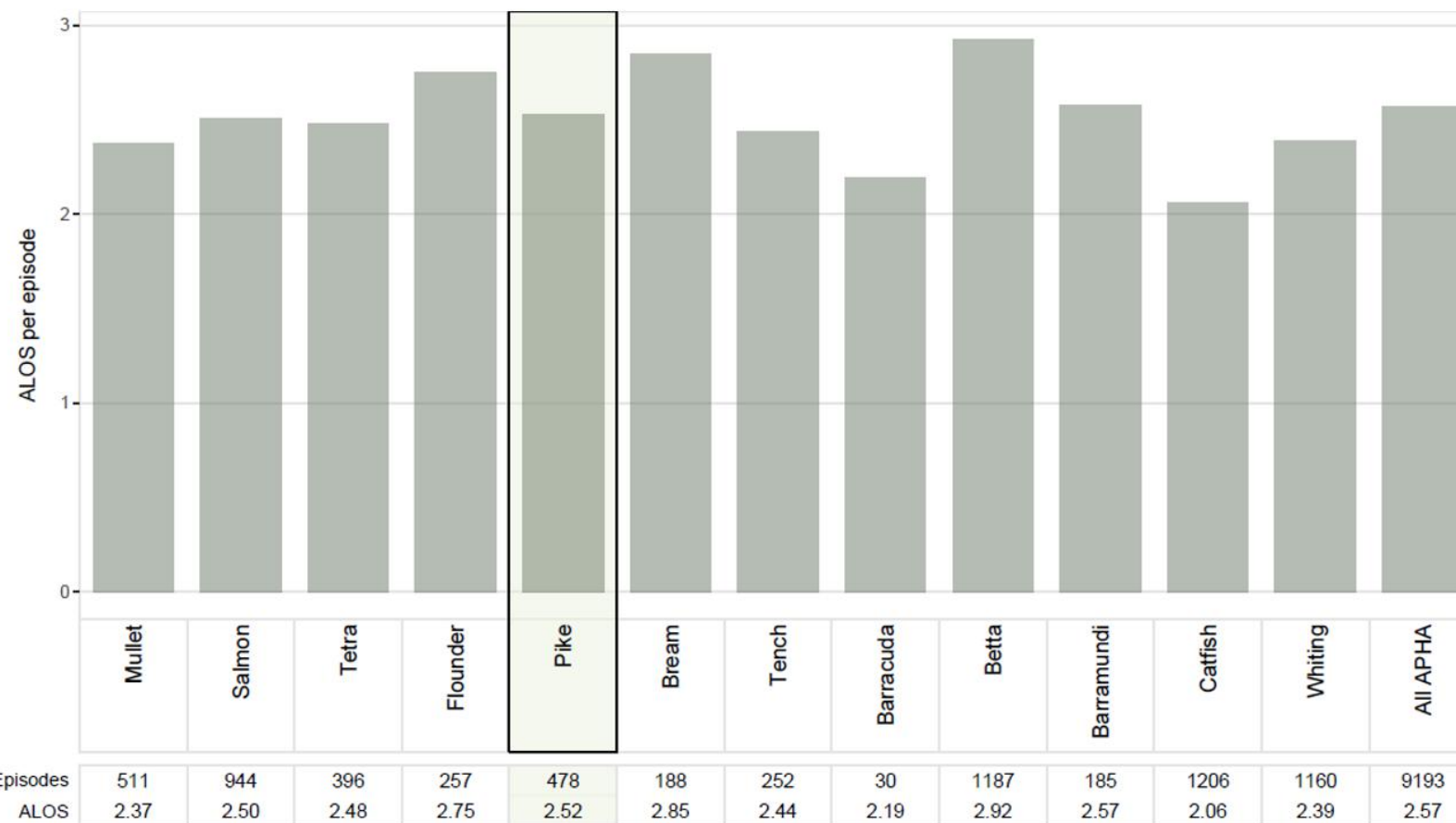
RHC Indicator	1H 2016		2H 2016		1H 2017		2H 2017	
	RHC	ACHS GAR	RHC	ACHS GAR	RHC	ACHS GAR	RHC	ACHS GAR
RHC 1: Medication errors (ACHS MS 6.3)	0.002%	0.015%	0.002%	0.014%	0.002%	0.019%	0.001%	0.015%
RHC 2: Unexpected readmissions within 28 days (ACHS HW 1.1)	0.505%	1.222%	0.478%	0.993%	0.442%	1.068%	0.401%	0.993%
RHC 3: Unplanned ret to OR during same admission (ACHS HW 2.1)	0.235%	0.214%	0.262%	0.276%	0.248%	0.253%	0.229%	0.214%
RHC 4: 1 or more pressure ulcers (ACHS HW 3.1)	0.026%	0.068%	0.038%	0.075%	0.037%	0.071%	0.033%	0.068%
RHC 5: All inpatient falls (ACHS HW 4.1)	0.274%	0.328%	0.276%	0.327%	0.267%	0.325%	0.260%	0.328%
RHC 6: Serious Inpatient falls (ACHS HW 4.2)	0.007%	0.008%	0.008%	0.009%	0.007%	0.008%	0.008%	0.008%
RHC 7: Cardiopulmonary arrests (ACHS HW 8.3)	0.064%	0.080%	0.071%	0.073%	0.063%	0.069%	0.048%	0.080%
RHC 8: Adverse transfusion events (ACHS HW 6.1)	0.032%	0.113%	0.021%	0.076%	0.021%	0.116%	0.041%	0.113%
RHC 9: Deaths addressed with clinical audit (ACHS HW 5.1)	100.000%	95.005%	100.000%	94.876%	100.000%	96.132%	100.000%	94.876%
RHC 10: Unplanned admission to ICU (ACHS ANAE 4.1)	0.197%	0.152%	0.213%	0.135%	0.108%	0.152%	0.125%	0.152%
RHC 11: Superficial hip SSI infections (ACHS INF 1.1)	0.273%	0.456%	0.273%	0.456%	0.310%	0.353%	0.391%	0.353%
RHC 12: Deep hip SSI infections (ACHS INF 1.2)	0.491%	0.641%	0.372%	0.560%	0.491%	0.486%	0.513%	0.486%
RHC 13: Superficial knee SSI infections (ACHS INF 1.3)	0.299%	0.394%	0.285%	0.412%	0.301%	0.349%	0.106%	0.394%
RHC 14: Deep knee SSI infections (ACHS INF 1.4)	0.316%	0.339%	0.301%	0.357%	0.127%	0.220%	0.395%	0.339%
RHC 15: Actual suicides (ACHS MH 6.1)	0.000%	0.013%	0.013%	0.021%	0.013%	0.030%	0.038%	0.013%
RHC 16: Significant self harm (ACHS MH 6.5)	0.557%	0.577%	0.409%	0.277%	0.538%	0.177%	0.552%	0.277%
RHC 17: 4th degree tears (ACHS MAT 3.6)	0.365%	0.287%	0.042%	0.371%	0.144%	0.300%	0.199%	0.287%
RHC 18: Apgar scores <7 (ACHS MAT 9.1)	1.107%	1.316%	1.168%	1.356%	0.979%	1.269%	1.329%	1.316%
RHC 19: Rehabilitation functional gain (ACHS Rehab 5.1)	97.239%	93.778%	98.002%	95.838%	98.191%	96.437%	98.673%	97.239%
	RHC	National	RHC	National	RHC	National	RHC	National
RHC 20: Hospital acquired Staph Aureus Bacteraemia (acsqhc)	0.287	2.00	0.336	2.00	0.342	2.00	0.418	2.00
RHC 21: Hospital identified C.Difficile infection (acsqhc)	1.59	2.0 - 3.0	1.64	2.0 - 3.0	1.85	2.0 - 3.0	1.74	2.0 - 3.0
RHC 22: Surgical proc/block involving wrong patient, site, proc.	0.0014%		0.002%		0.003%		0.002%	
RHC 23: Hand Hygiene (Hand Hygiene Australia)	87.1%	70%	88.8%	70%	89.1%	80%	88.8%	80%
RHC 24: Accreditation	43							
RHC 25: National Sentinel Events	6		8		3		10	
RHC 26: RHC Never Events	14		24		45		73	
	2016				2017			
RHC 27: Patient Satisfaction	Not surveyed							
RHC 28: Patient Experience	Not surveyed							



In Pike the most frequent major hospital-acquired complications were "Post-operative haemorrhage/haematoma requiring transfusion " with 2 cases

		Mullet	Salmon	Tetra	Flounder	Pike	Bream	Tench	Barracuda	Betta	Barramundi	Catfish	Whiting	All AHA
Surgical complications	Post-operative haemorrhage/haematoma requiring transfusion	1	2	4	7	2		2		2		2		33
Delirium	Delirium		1		1	1						1		5
Malnutrition	Malnutrition					1								1
Cardiac complications	Acute coronary syndrome including unstable angina, STEMI and NSTEMI	1												1
Cardiac complications	Arrhythmias	1	6		2			3		5		2	3	34
Cardiac complications	Cardiac arrest								1					1
Cardiac complications	Heart failure and pulmonary oedema									1				2
Falls	Fractured neck of femur													
Falls	Intercranial injury													
Falls	Intracranial injury													
	Average length of stay with major complications	3.48	5.83	6.27	7.72	4.69	3.20	7.16	1.95	6.38		12.74	5.82	7.17

The average length of stay for patients with the most common principal procedure* at Pike is 2.5 days, similar to the 2 exemplars weighted average at 2.5 days



* Most common principal procedure: 3051109 - Laparoscopic sleeve gastrectomy [LSG]

Barbara's journey

76 year old female
presented with #NOF post
fall at home



Discharged 55 days → Respite

Pneumonitis due to food and vomit

Gastroenteritis & colitis

Delirium (post-operative prolonged)

Pneumonia & post operative respiratory disorder

Constipation

Disruption of operating wound

Respiratory failure type 1

Wound infection following procedure

AV block

Surgically managed

Barbara's journey

76 year old female
presented with #NOF post
fall at home



Nil IIMS recorded

Discharged 55 days → Respite

Constipation

Disruption of operating wound

Respiratory failure type 1

Gastroenteritis & colitis

Delirium (post-operative prolonged)

Pneumonia & post operative respiratory disorder

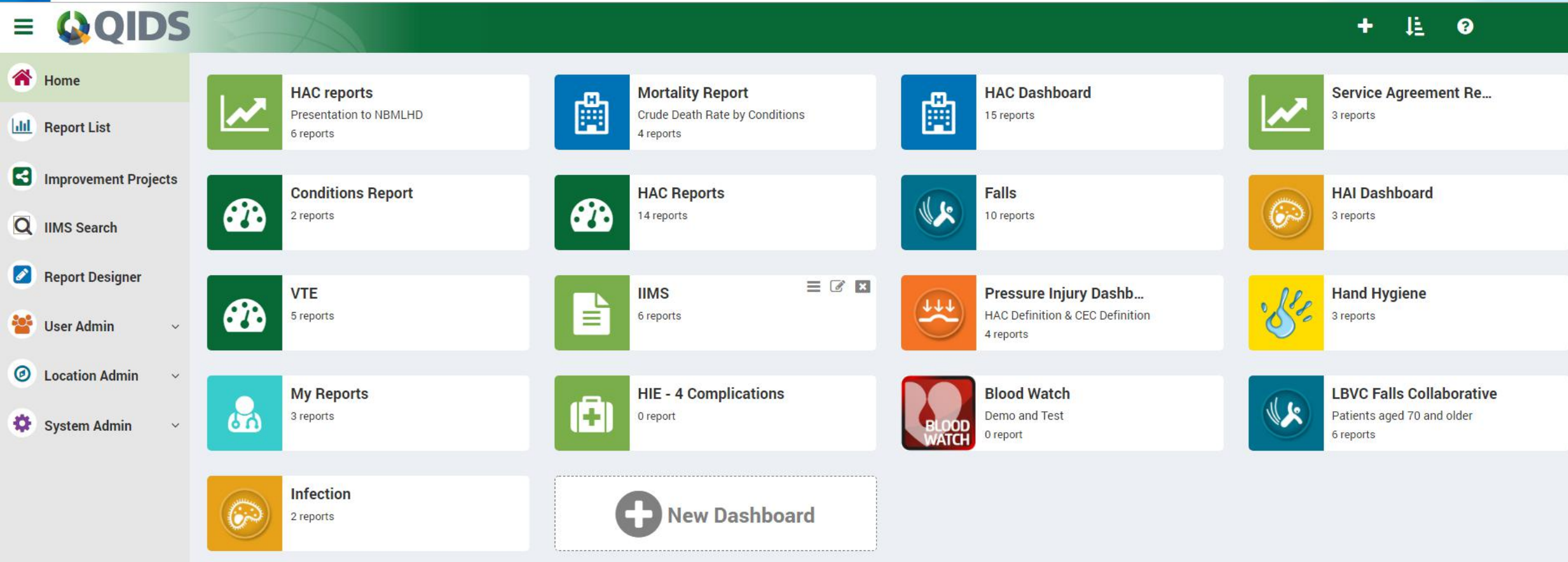
infection following procedure

AV block

When did it occur?
Where did it happen?
WHY did it happen?

Surgically managed

Functionality



The screenshot displays the QIDS dashboard interface. On the left is a sidebar menu with the following items: Home, Report List, Improvement Projects, IIMS Search, Report Designer, User Admin, Location Admin, and System Admin. The main dashboard area contains a grid of report tiles, each with an icon, title, description, and report count. The tiles are arranged in four rows. The first row includes HAC reports (6 reports), Mortality Report (4 reports), HAC Dashboard (15 reports), and Service Agreement Re... (3 reports). The second row includes Conditions Report (2 reports), HAC Reports (14 reports), Falls (10 reports), and HAI Dashboard (3 reports). The third row includes VTE (5 reports), IIMS (6 reports), Pressure Injury Dashb... (4 reports), and Hand Hygiene (3 reports). The fourth row includes My Reports (3 reports), HIE - 4 Complications (0 report), Blood Watch (0 report), and LBVC Falls Collaborative (6 reports). At the bottom of the grid is an Infection tile (2 reports) and a New Dashboard button. The top of the dashboard has a green header with the QIDS logo and navigation icons (+, list, ?).

Report Category	Description	Number of Reports
HAC reports	Presentation to NBMLHD	6 reports
Mortality Report	Crude Death Rate by Conditions	4 reports
HAC Dashboard		15 reports
Service Agreement Re...		3 reports
Conditions Report		2 reports
HAC Reports		14 reports
Falls		10 reports
HAI Dashboard		3 reports
VTE		5 reports
IIMS		6 reports
Pressure Injury Dashb...	HAC Definition & CEC Definition	4 reports
Hand Hygiene		3 reports
My Reports		3 reports
HIE - 4 Complications		0 report
Blood Watch	Demo and Test	0 report
LBVC Falls Collaborative	Patients aged 70 and older	6 reports
Infection		2 reports

54 - HIE Falls With Serious Injuries Trend Report (HAC)

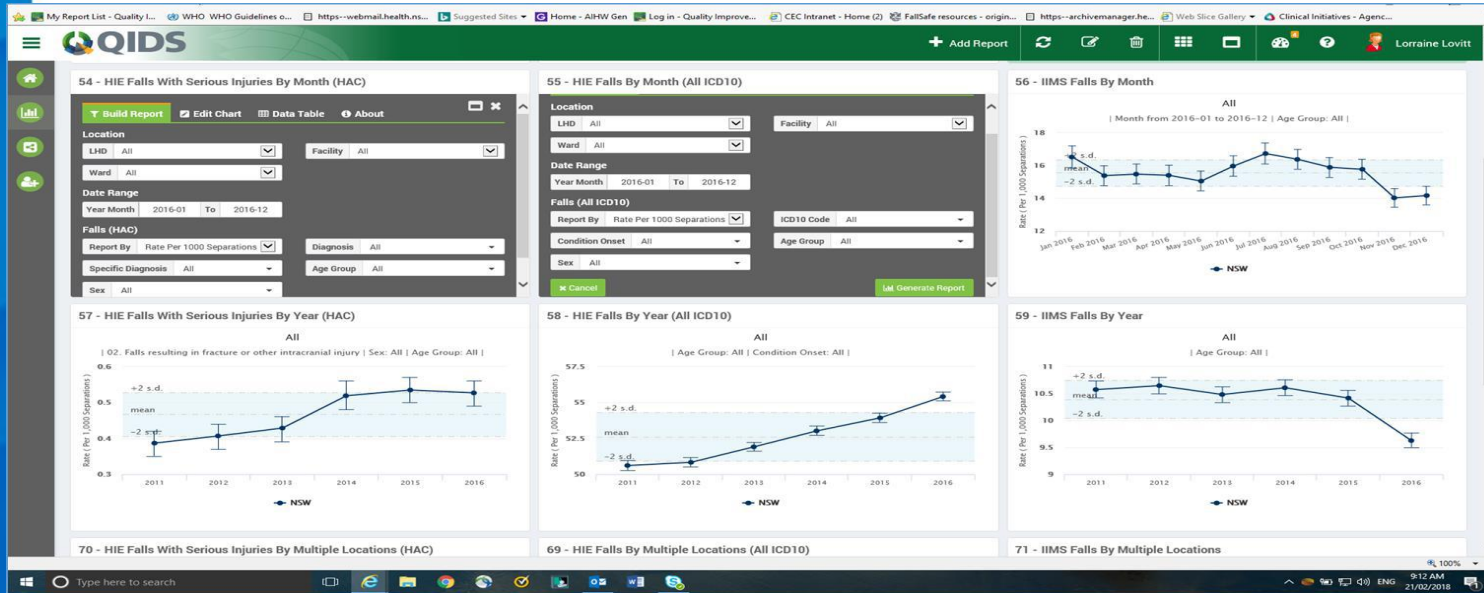


56 - IIMS Falls Trend Report

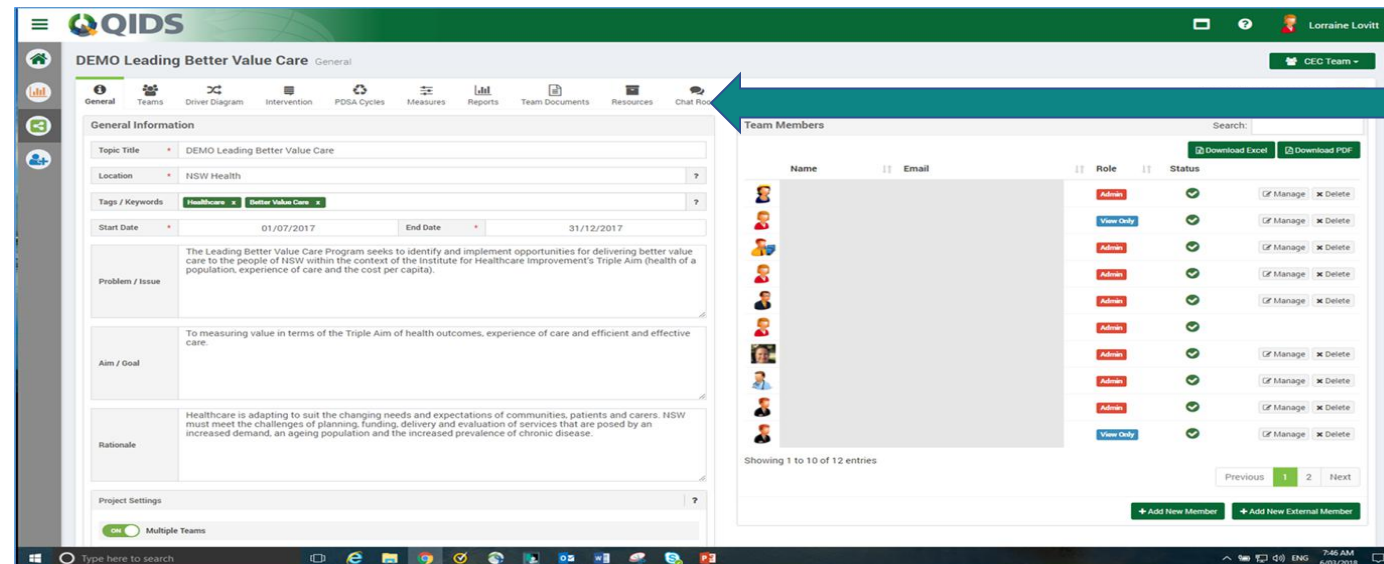


QIDS Improvement Collaboratives

Monitor falls data

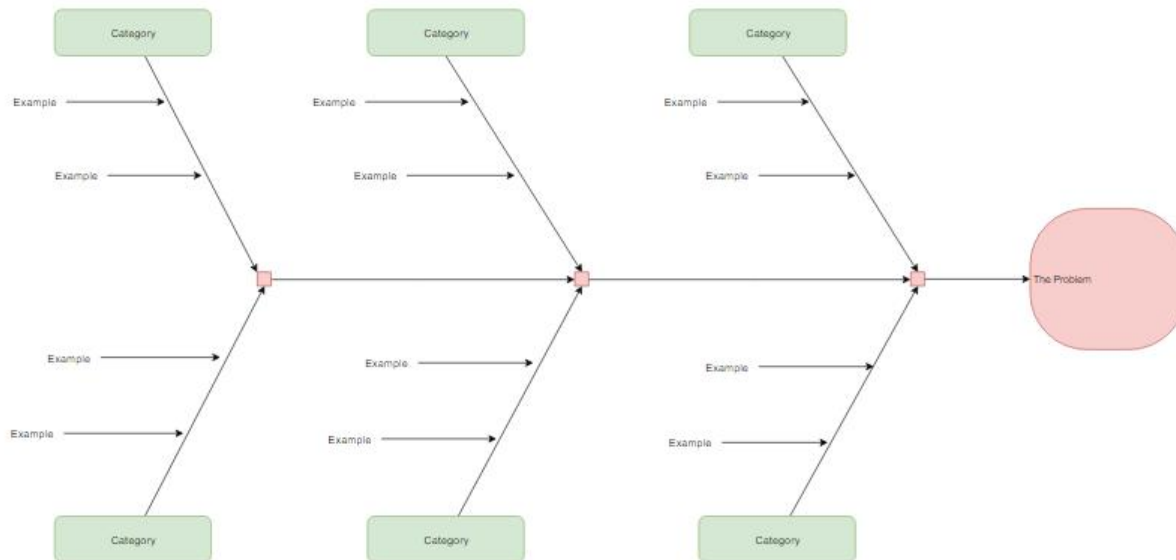


LHD team activity

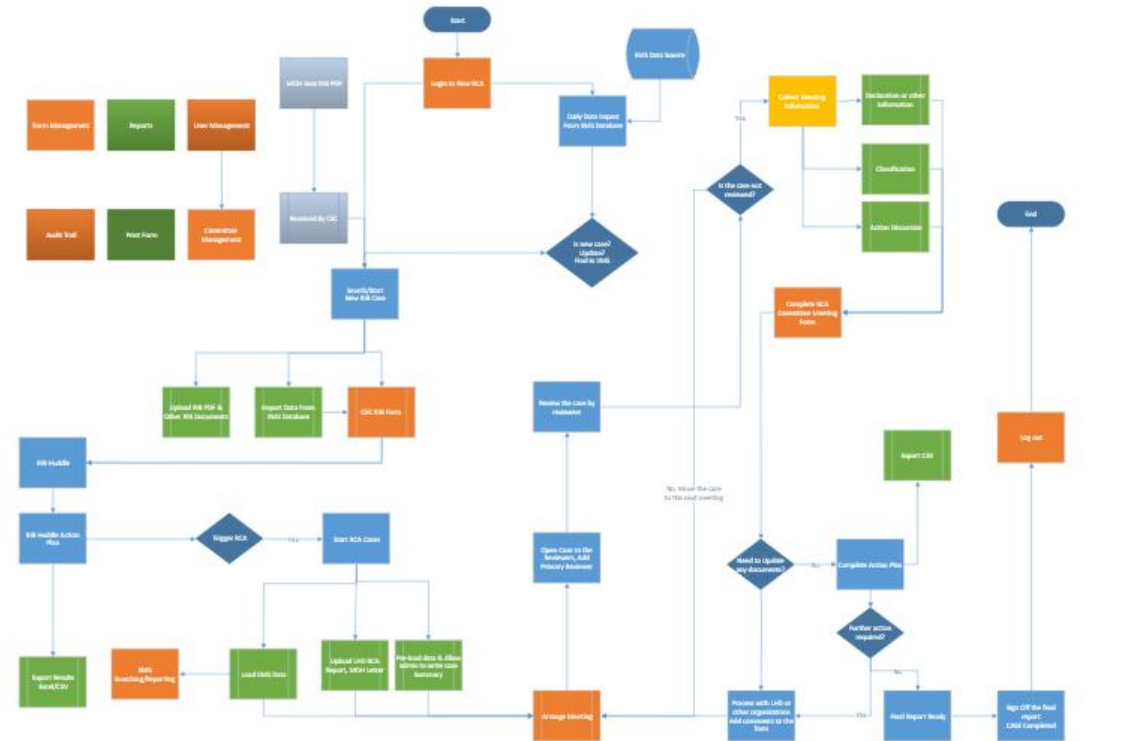


Resources

1765 - Fishbone



1766 - System workflow





General

Teams

Driver Diagram

Other Diagrams

PDSA Cycles

Measures

Charts

Team Documents

Resources

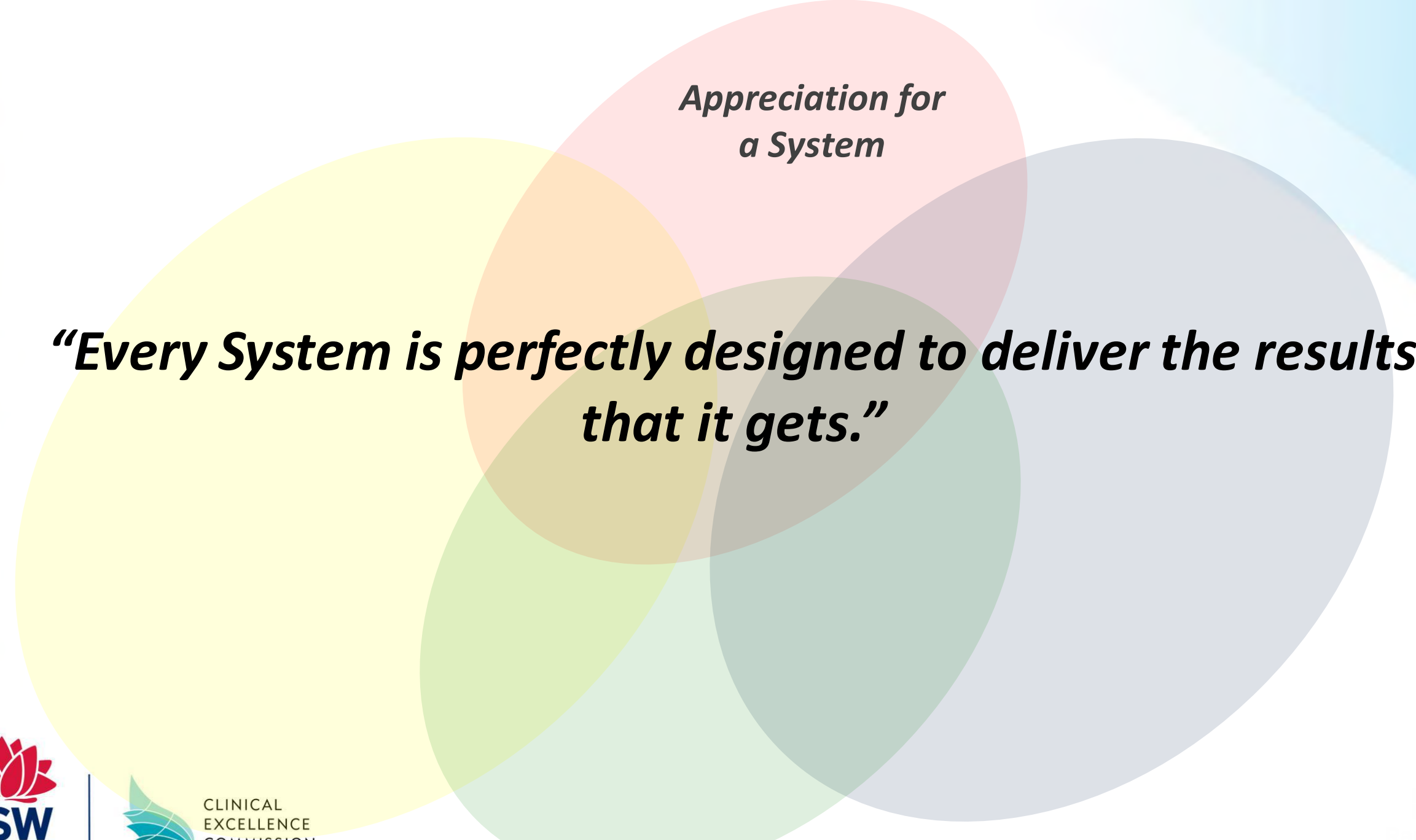
Chat Room

Post new topic

Search for topics

On-going and future development

- ◆ Still and always based on clinical team requests and needs; agile and transparent life-cycle developing process
- ◆ More data than HIE and IIMS will be on QIDS, e.g. pathology, perinatal...
- ◆ More functionalities, e.g. dashboard sharing, good report templates shared across NSW Health
- ◆ Combining administrative, clinical and non-traditional data sets (eg workforce, patient and staff experience) allows exploration of trends and patterns that may contribute to patient harm
- ◆ Use of SPC allows monitoring of improvement initiatives and unexpected variation



*Appreciation for
a System*

***“Every System is perfectly designed to deliver the results
that it gets.”***

High Reliability Organisation



ORGANISATIONAL DESIGN

Standardise Practice
Reduce Complexity
Learn from Mistakes



ORGANISATIONAL WORK

Commitment to Safety
Just Culture
Resources
Encourage Collaboration



ORGANISATIONAL FOCUS

Preoccupation with failure
Focus on near miss
Teams
Deference to frontline
expertise



Emergency

Ambulance
Entry Only

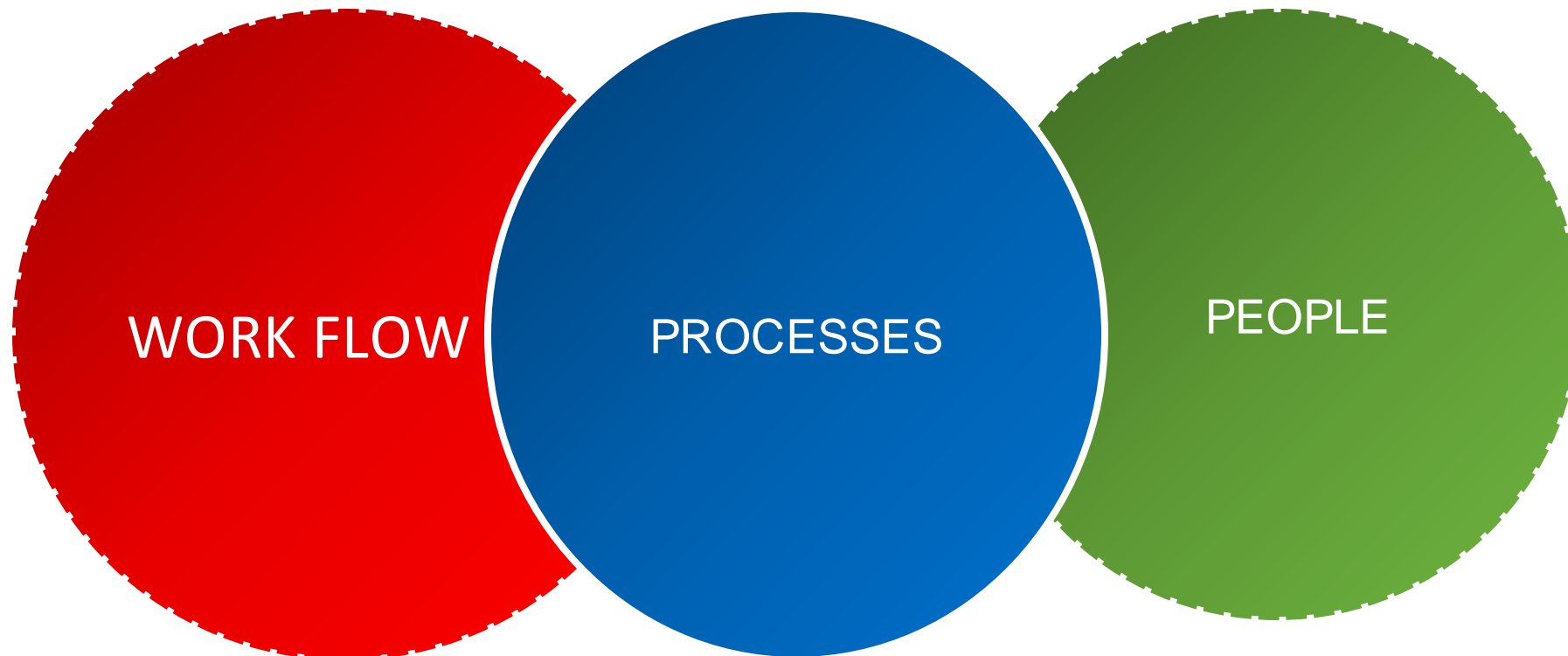


Visitor Car Park
Entry via Pring St

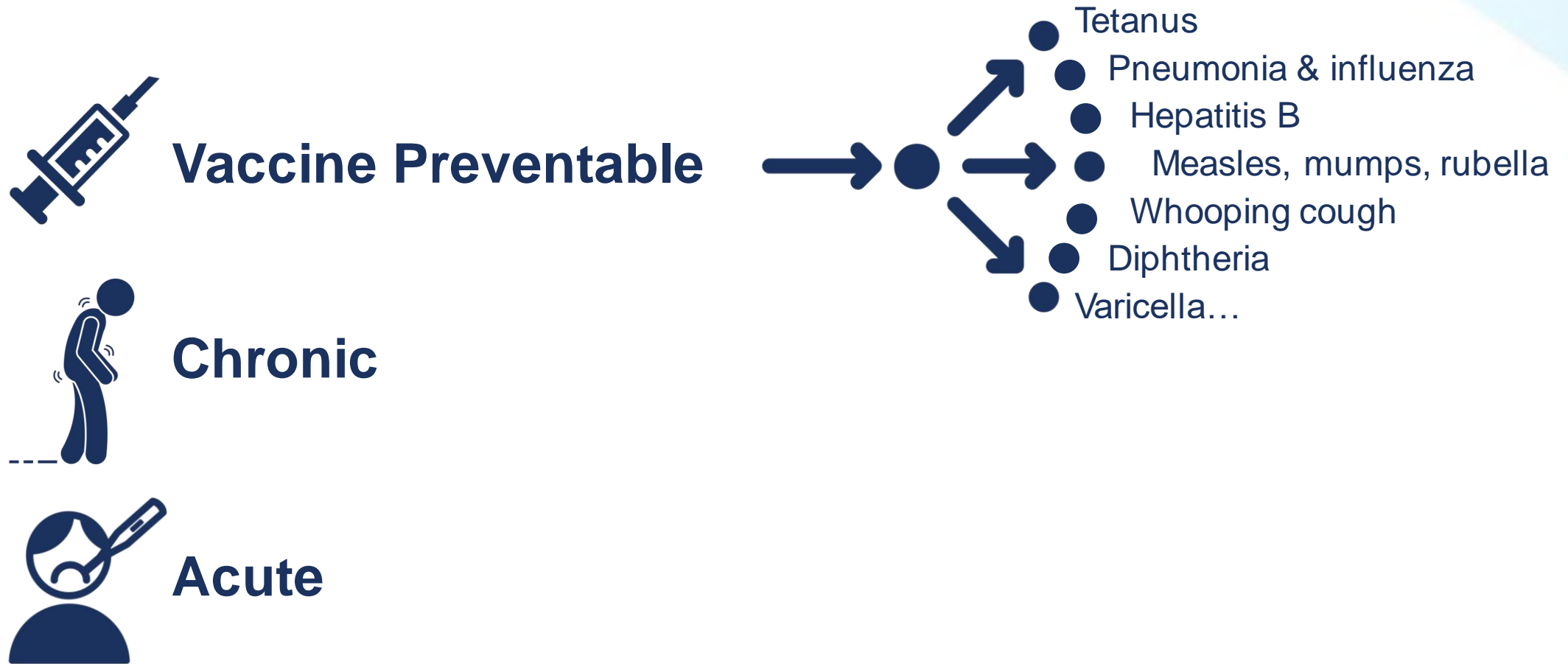


Ramsay
Health Care

Systems Approach



Potentially Avoidable Hospitalisations: Overview



Potentially Avoidable Hospitalisations: Overview



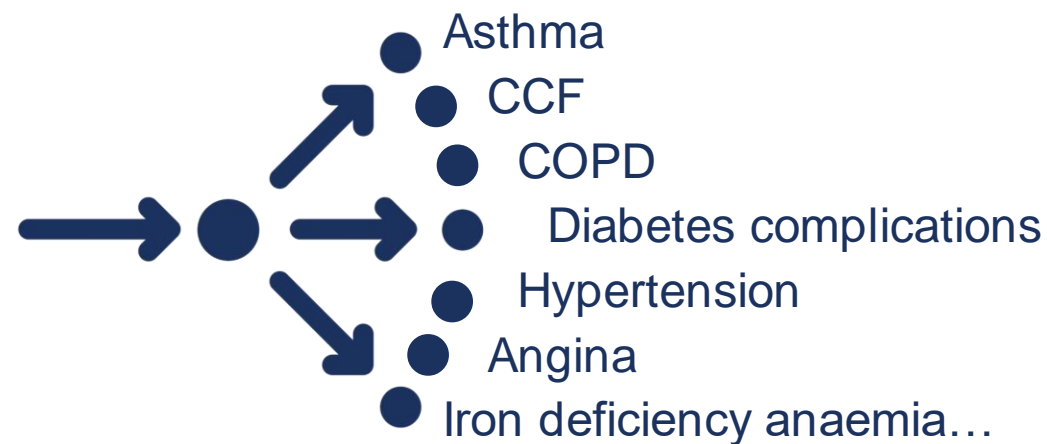
Vaccine Preventable



Chronic



Acute



Potentially Avoidable Hospitalisations: Overview



Vaccine Preventable



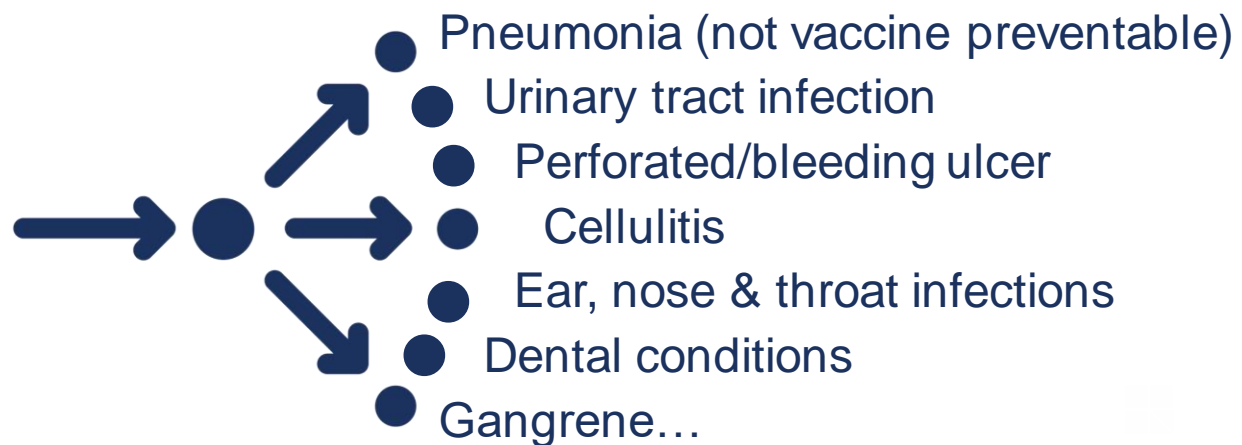
Chronic






Acute



CLINICAL
EXCELLENCE
COMMISSION

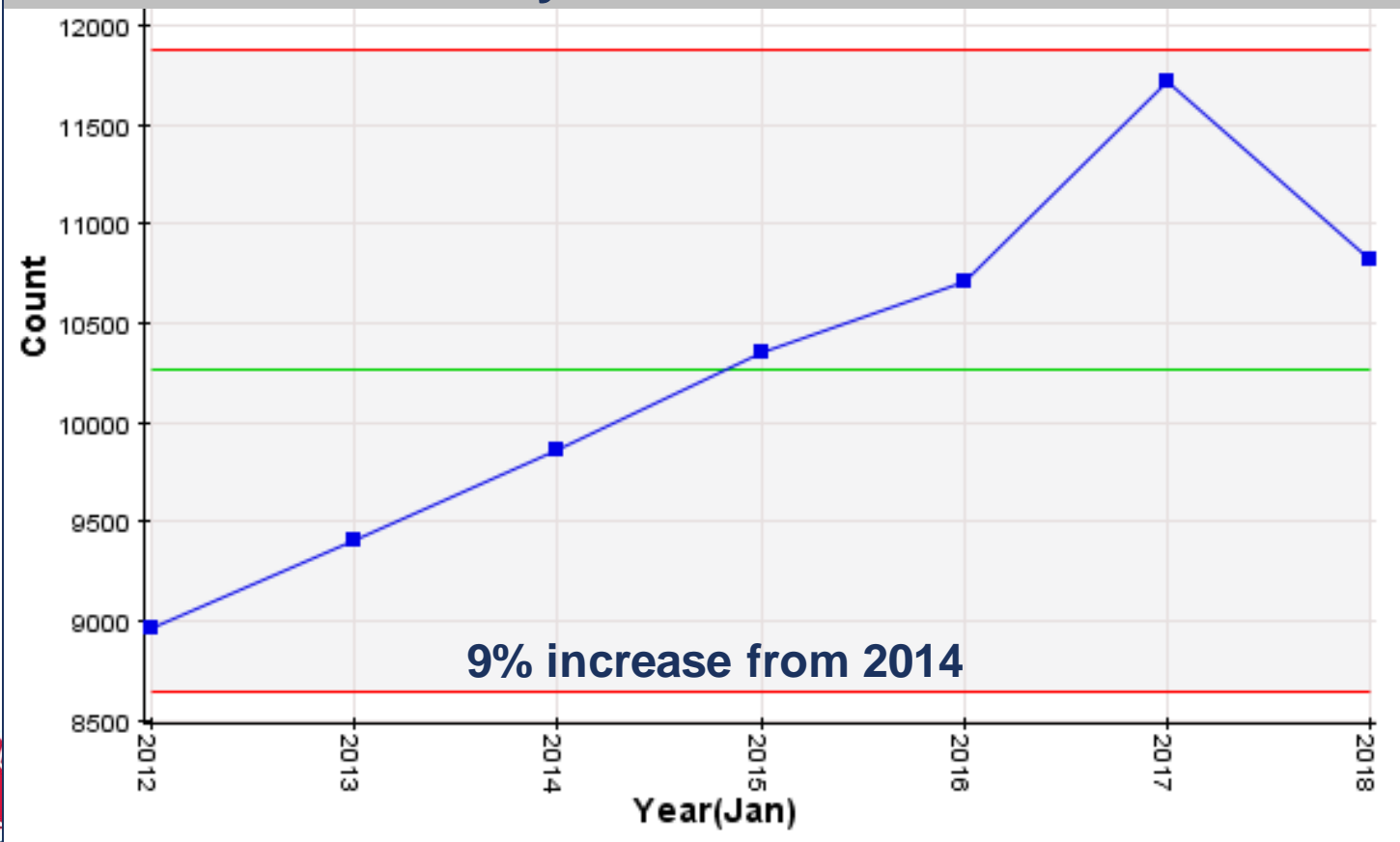


Potentially Avoidable Hospitalisations: Overview

		2018 Numbers		
		% of total PAHs	Admissions	Total bed days
	Vaccine Preventable	13%	1,428	12,747
	Chronic	50%	5,405	29,431
	Acute	37%	4,098	18,407
			10,931	60,585

Number of admissions

Potentially Avoidable Hospitalisations Yearly Volume 2012-2018



9% increase from 2014



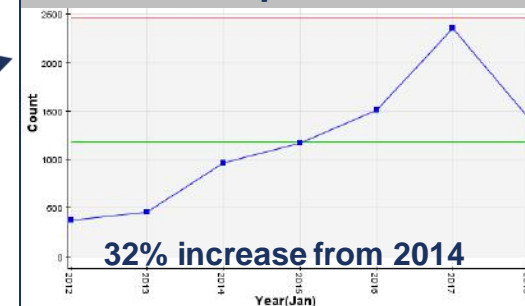
NSW
GOVERNMENT



EXCELLENCE
COMMISSION

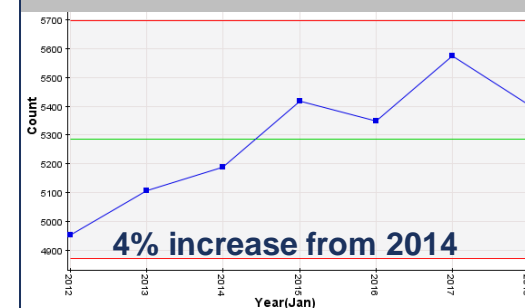


Vaccine-preventable



32% increase from 2014

Chronic



4% increase from 2014

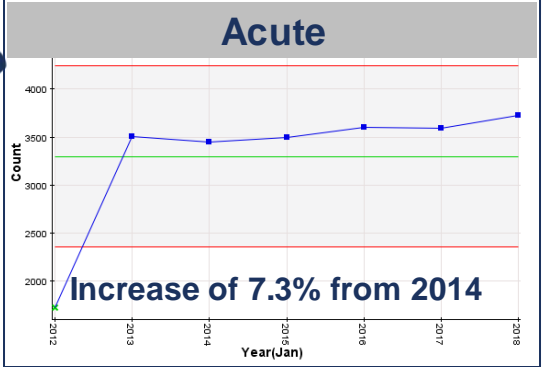
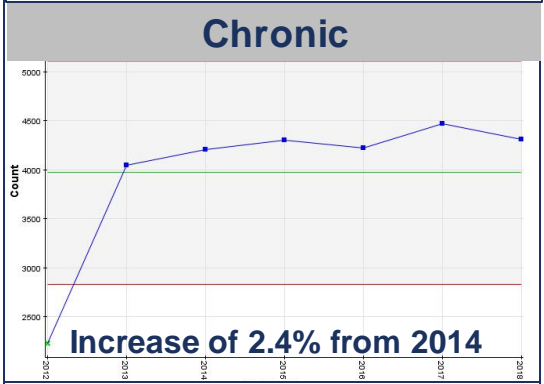
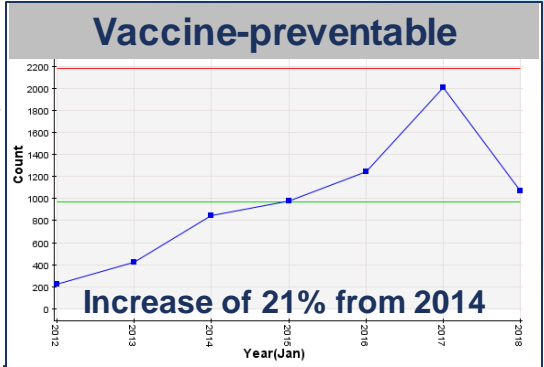
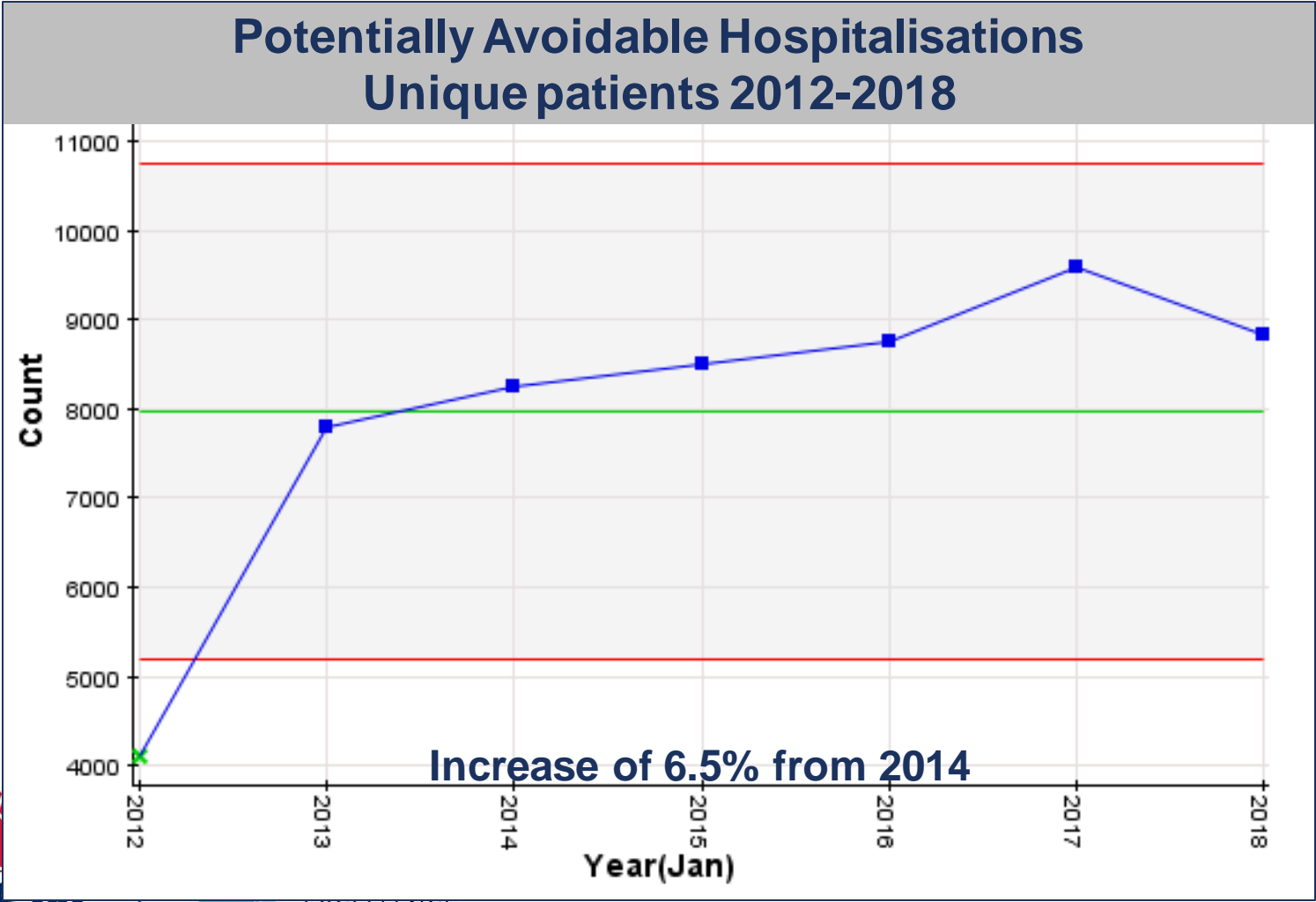
Acute



7% increase from 2014

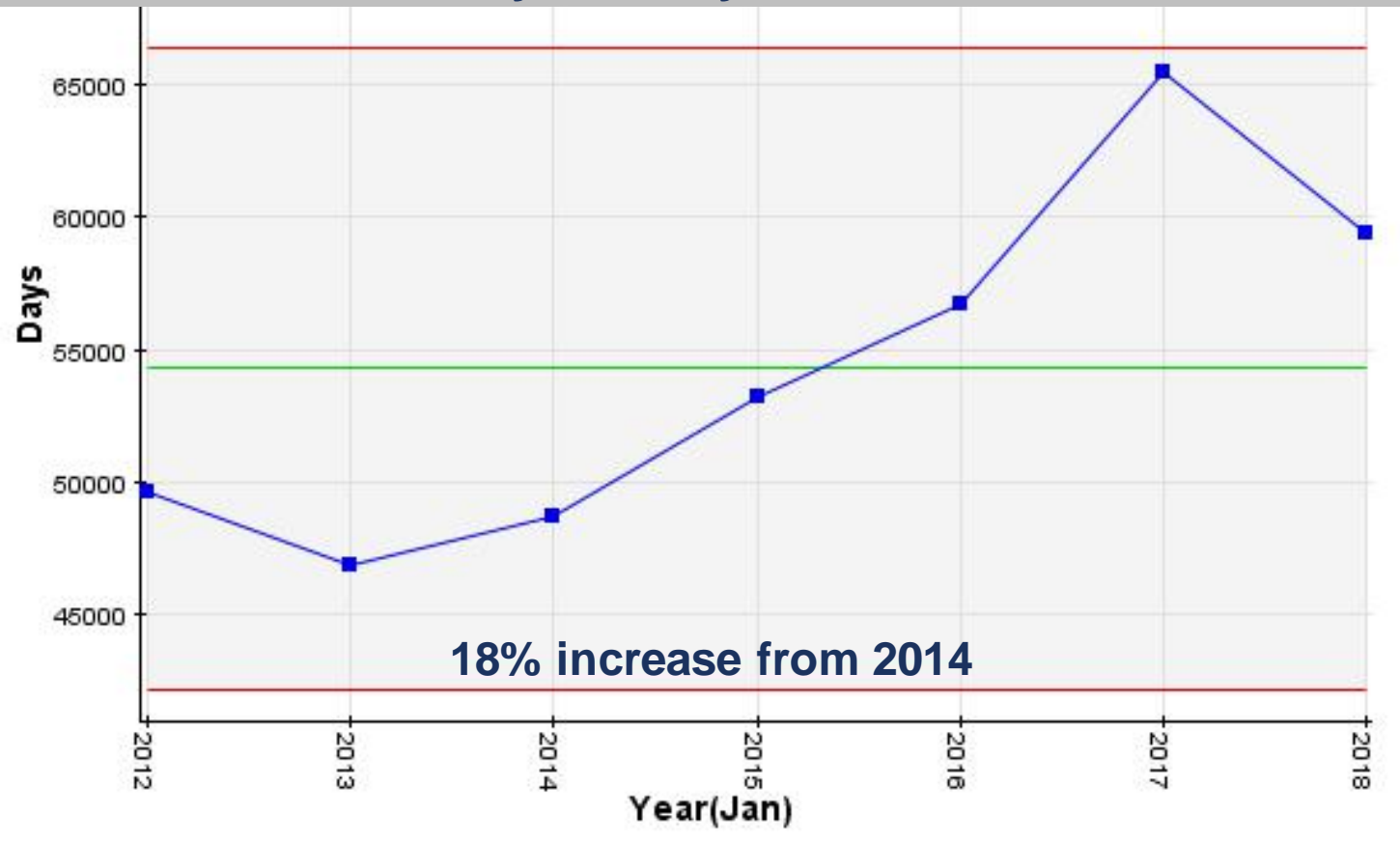


Number of unique patients

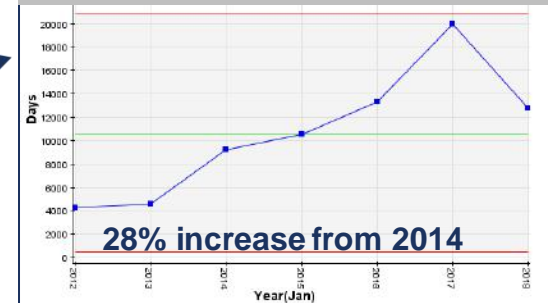


Number of bed days used

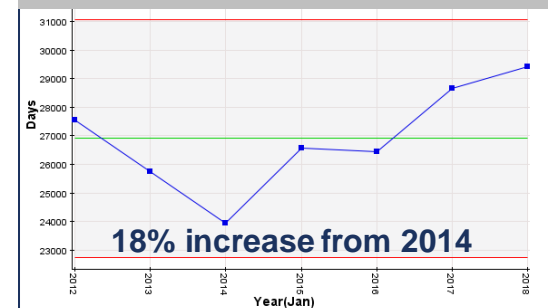
Potentially Avoidable Hospitalisations
Yearly bed days 2012-2018



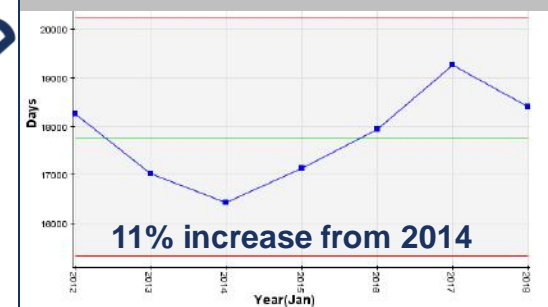
Vaccine-preventable



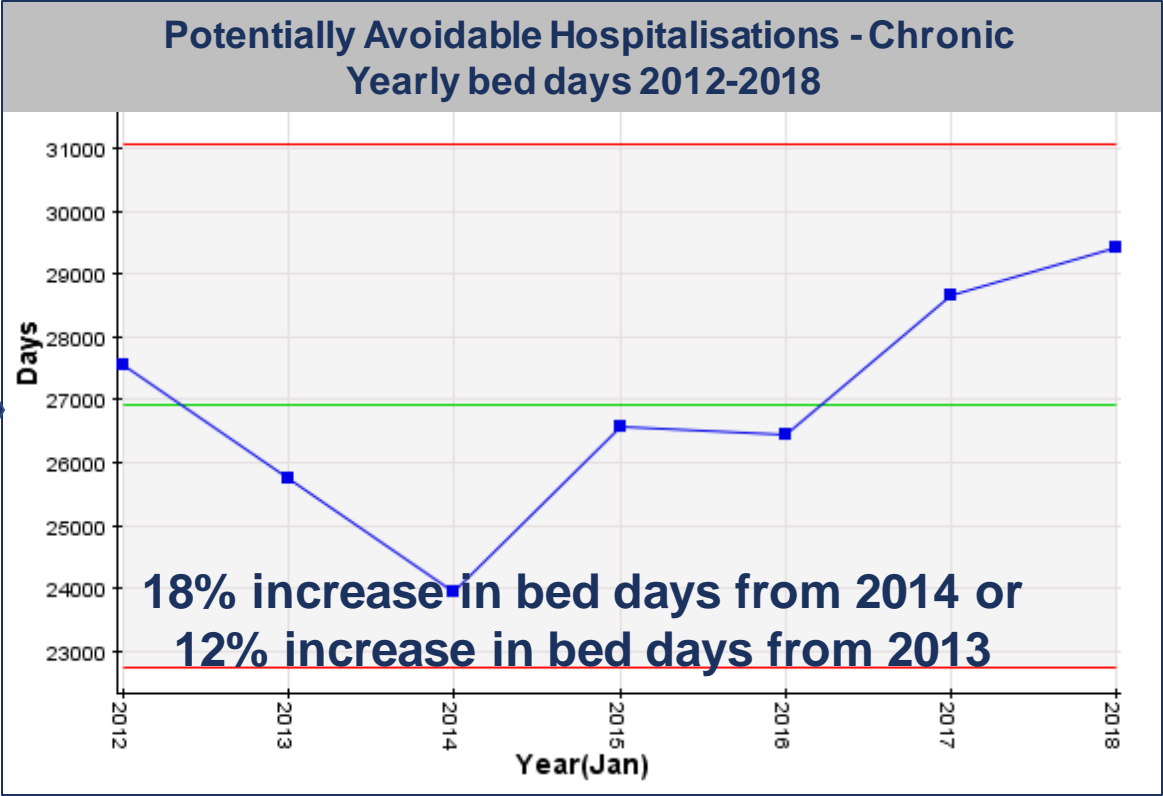
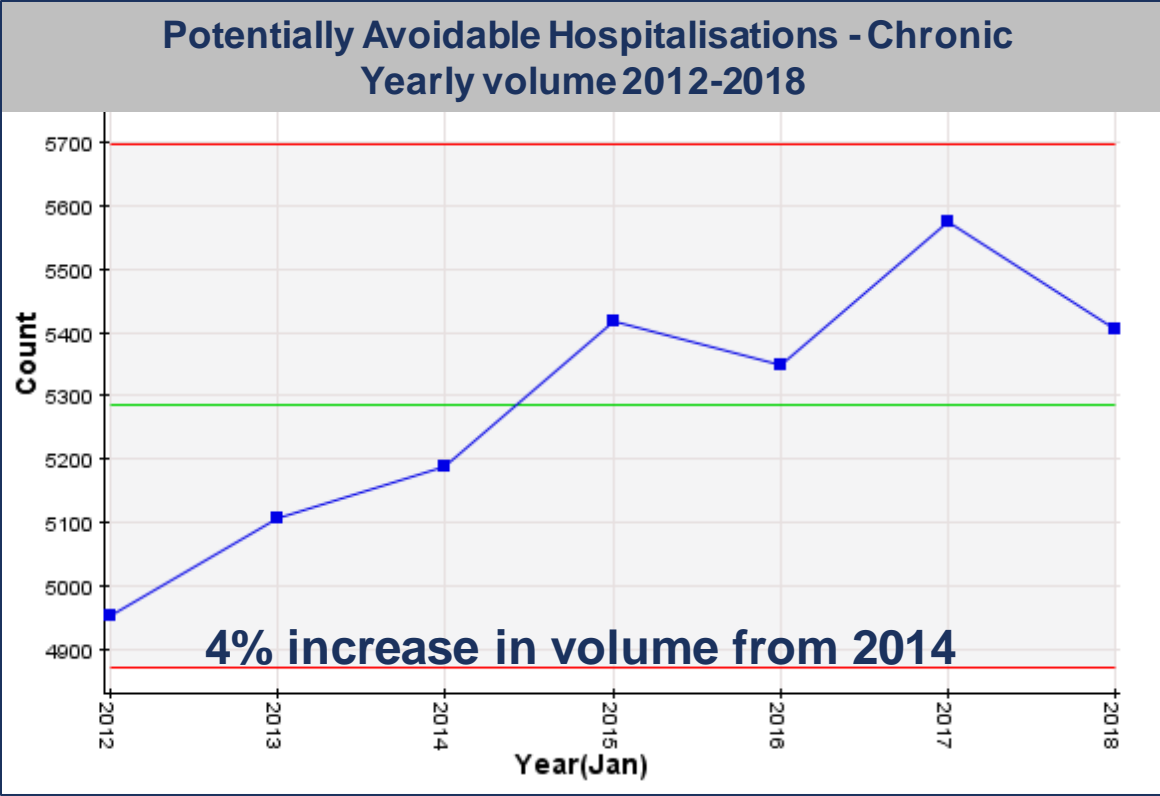
Chronic



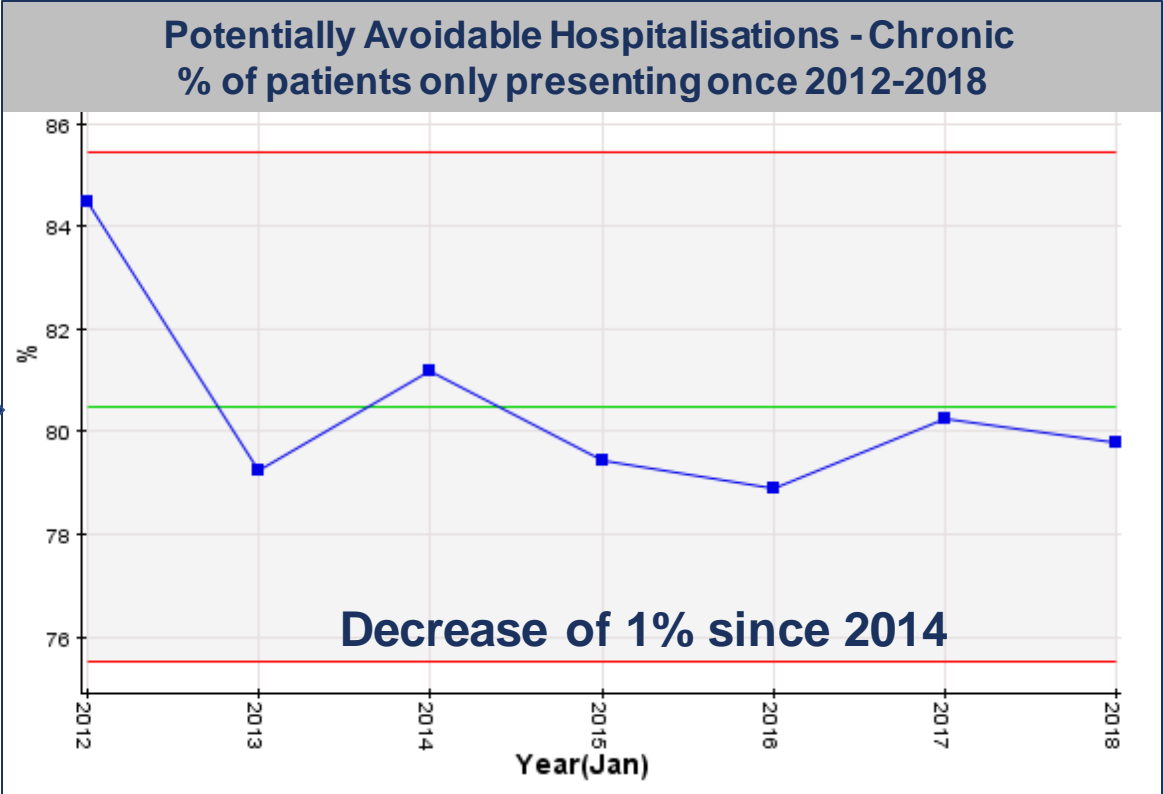
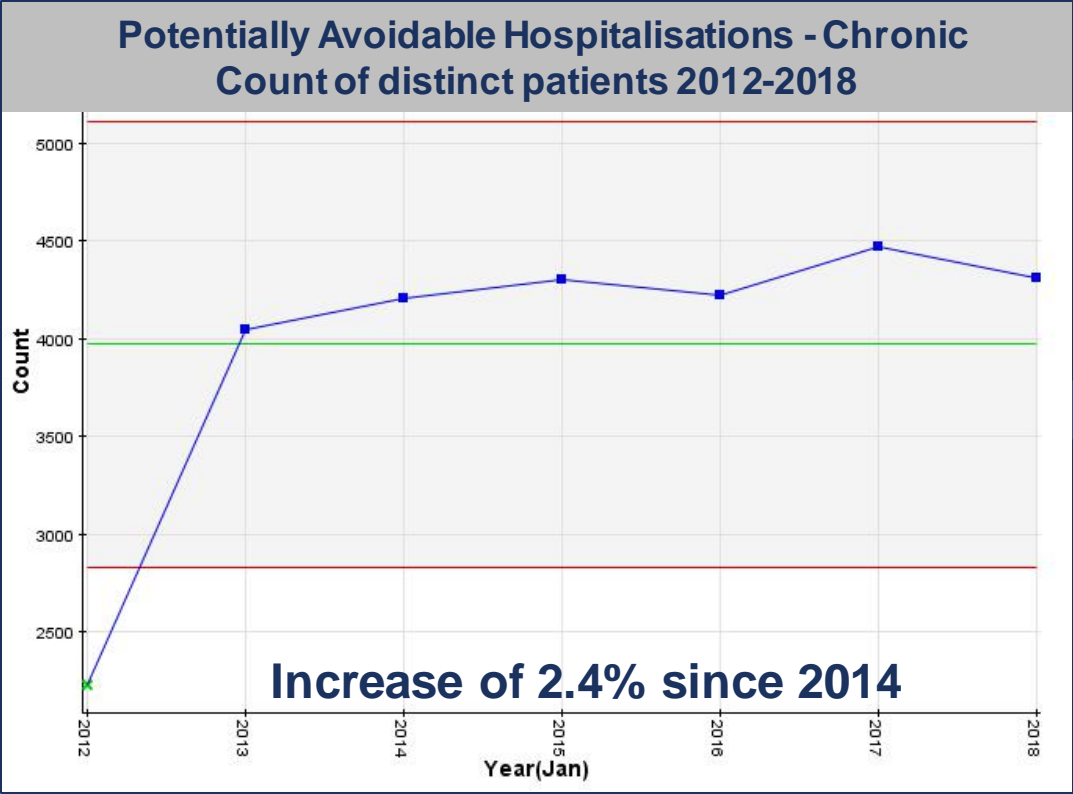
Acute



Drilldown on the chronic group cohort

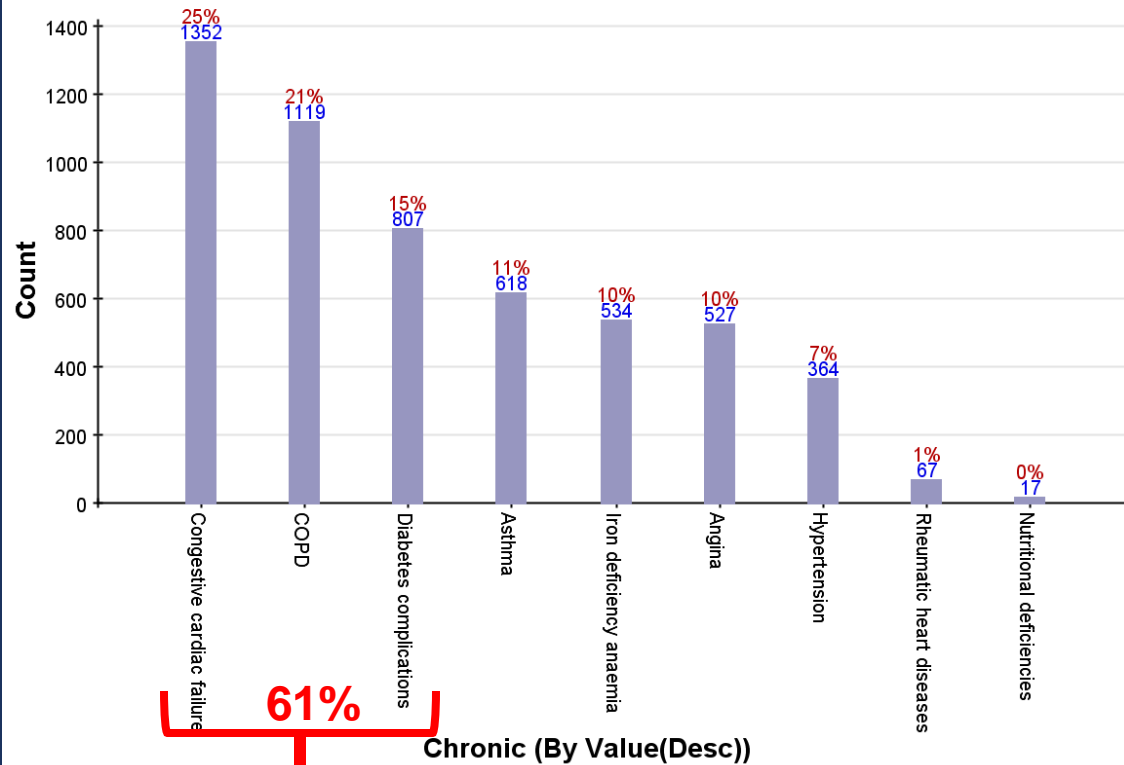


Drilldown on the chronic group cohort

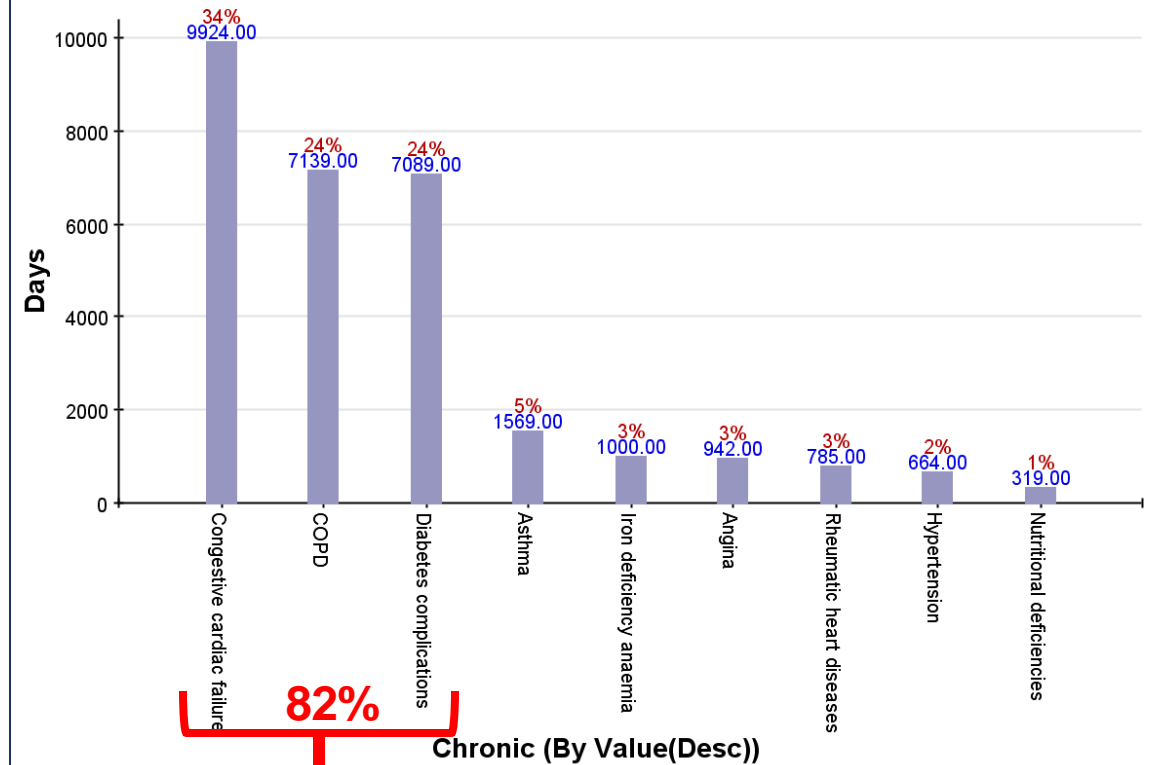


Chronic disease types. Volume and bed days

Potentially Avoidable Hospitalisations - Chronic
Volume by condition 2018



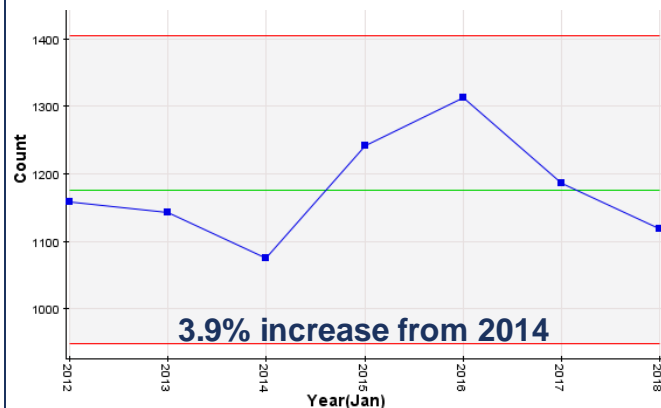
Potentially Avoidable Hospitalisations - Chronic
Bed days by condition 2018



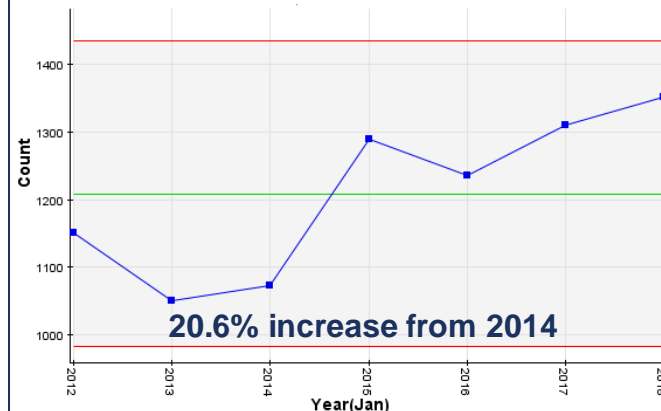
Drilldown on the chronic top 3: Volume and bed days

Volume

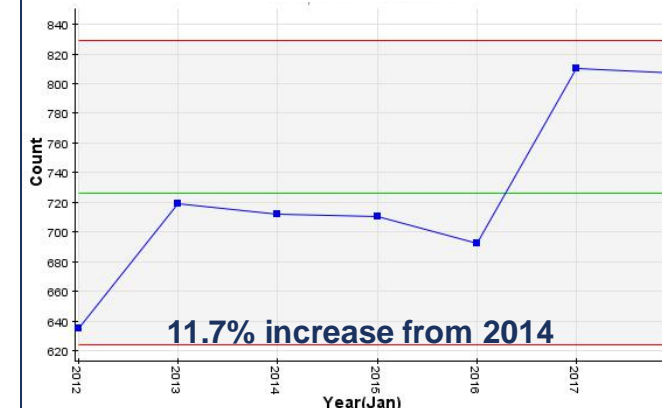
COPD



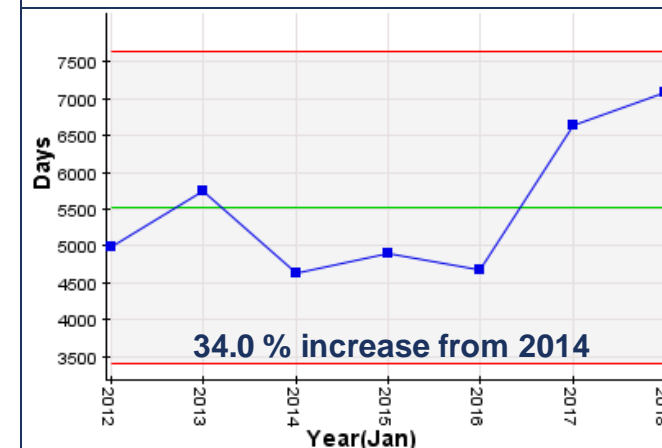
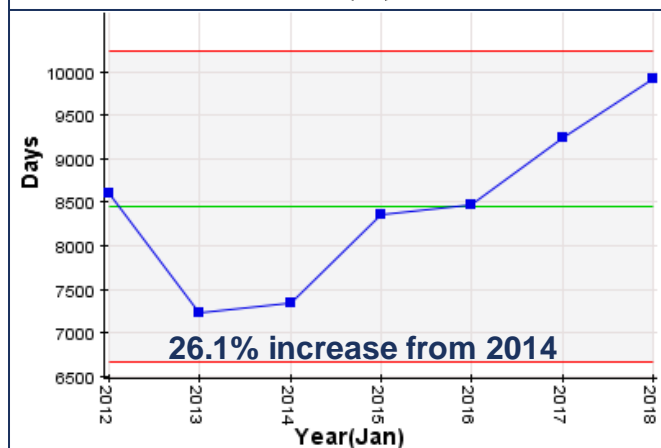
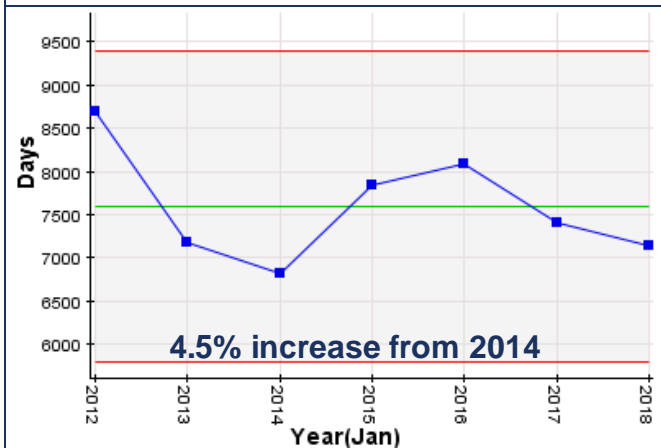
CCF



DIABETES COMPLICATIONS



Bed days

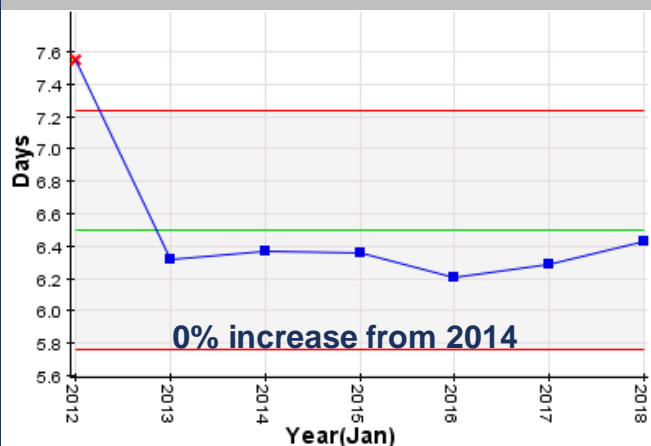


Drilldown on the chronic top 3: LOS and bed days

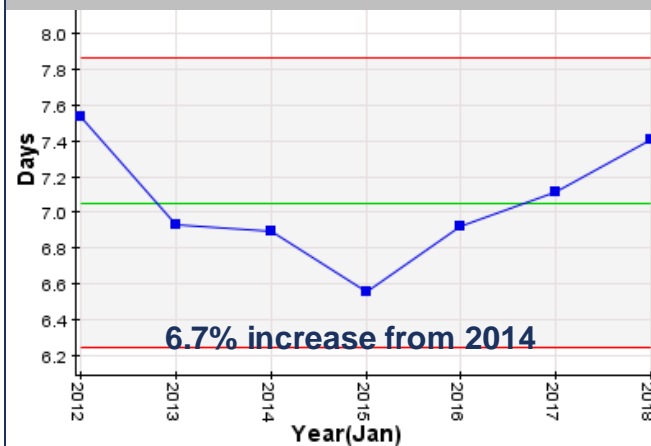
Avg LOS

Bed days

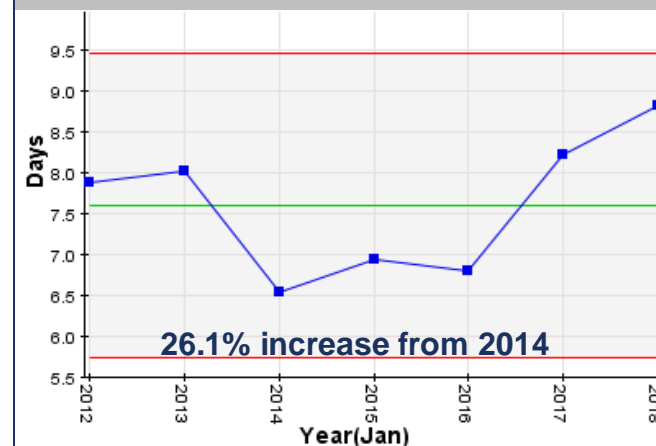
COPD



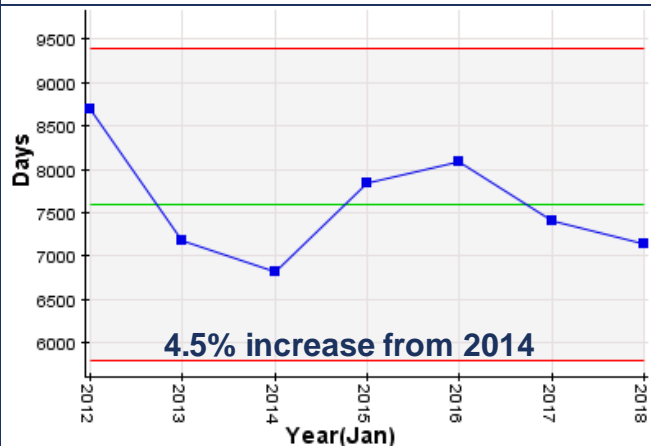
CCF



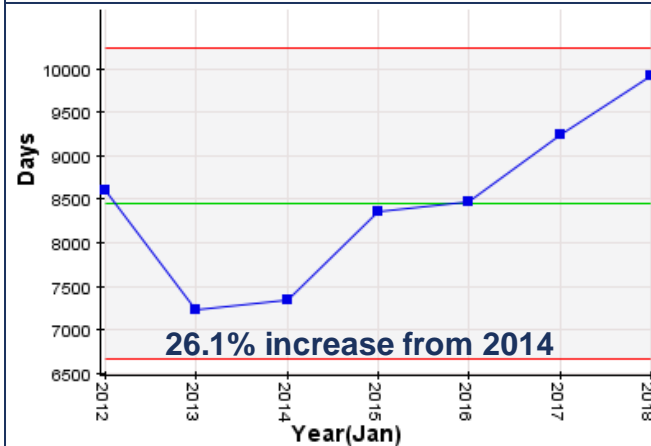
DIABETES COMPLICATIONS



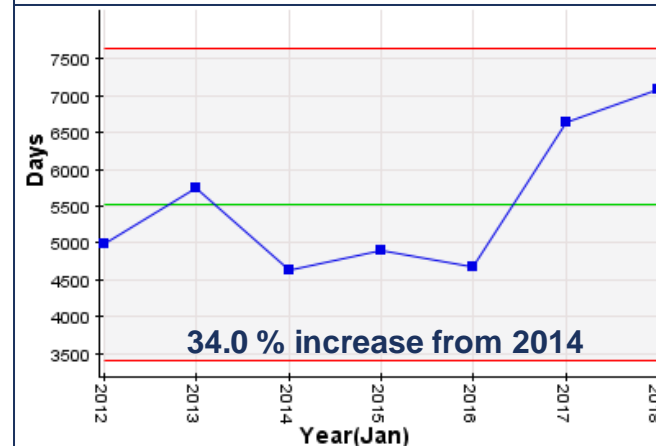
COPD



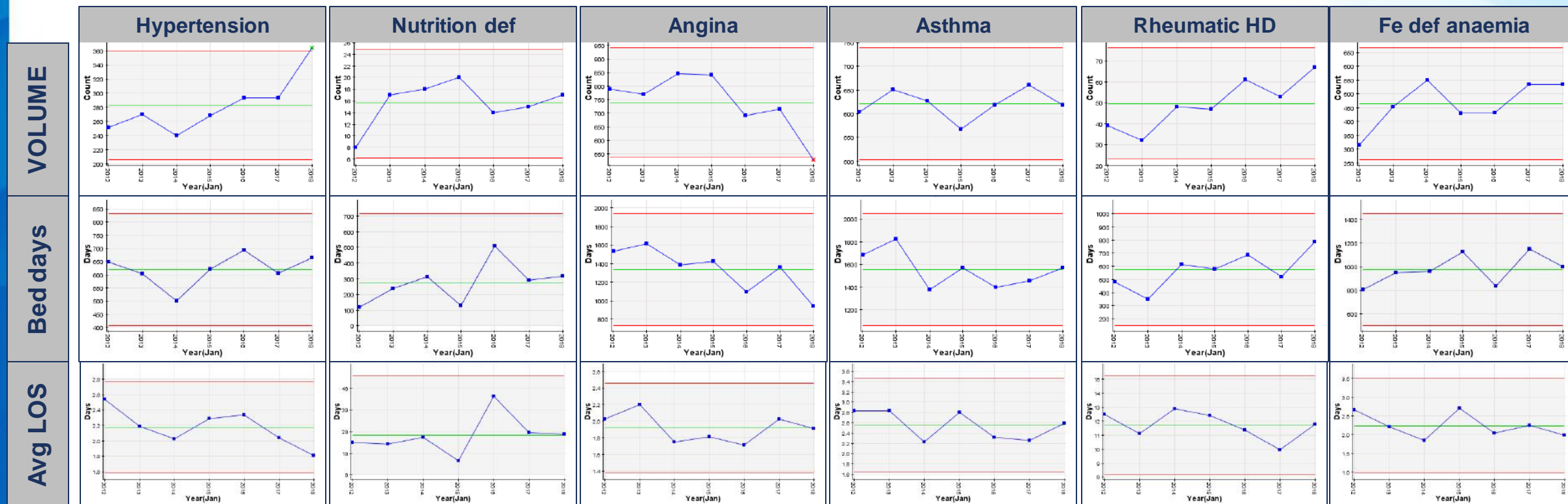
CCF



DIABETES COMPLICATIONS



Overview of all the other chronic conditions



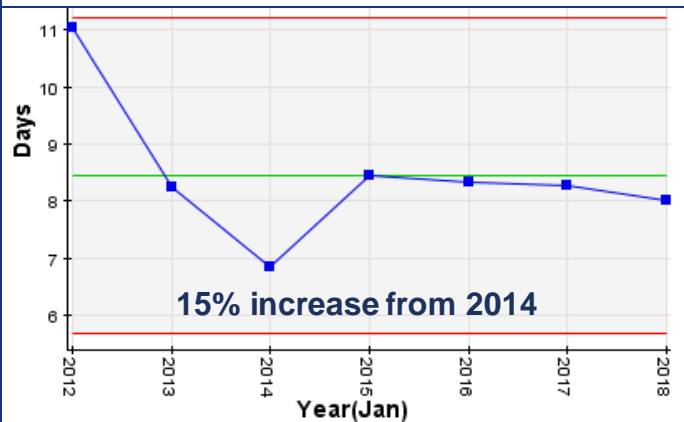
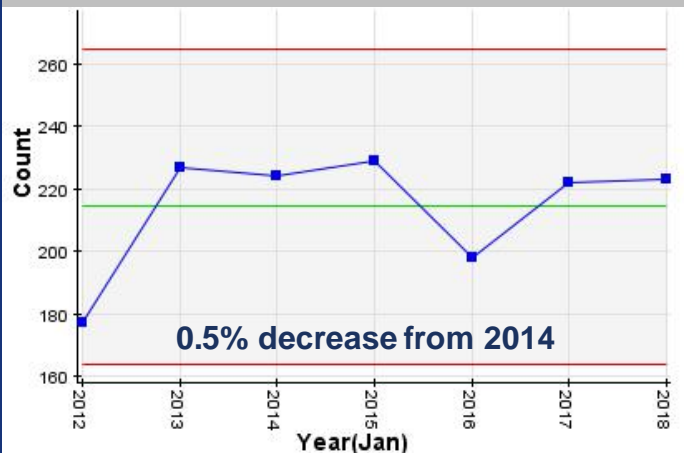
Of note: General trend in most conditions is more or less flat

So, where do we focus our diabetes inpatient efforts?

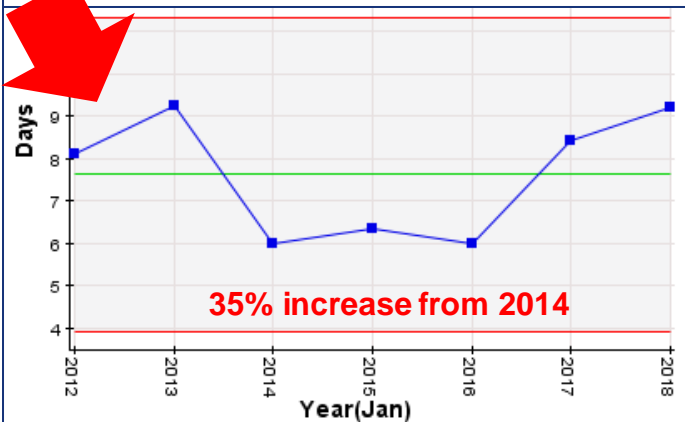
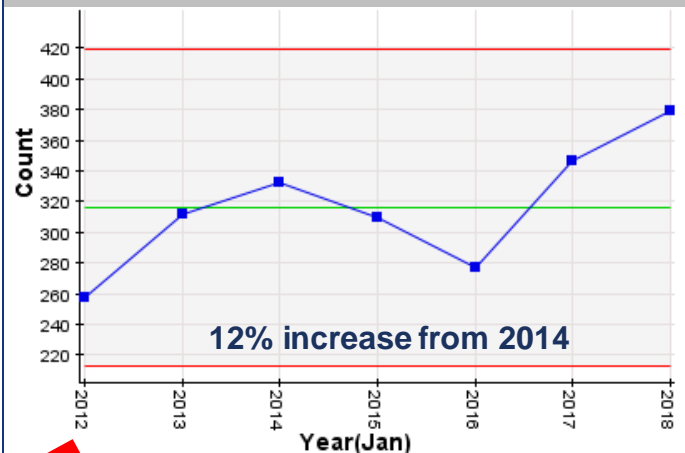
Volume diabetes complications

Avg LOS diabetes complications

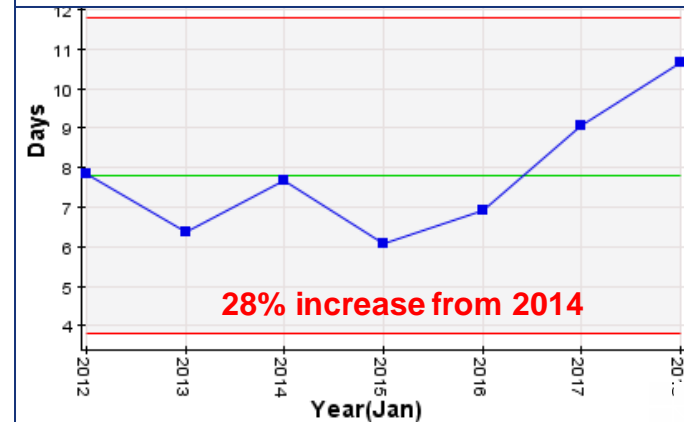
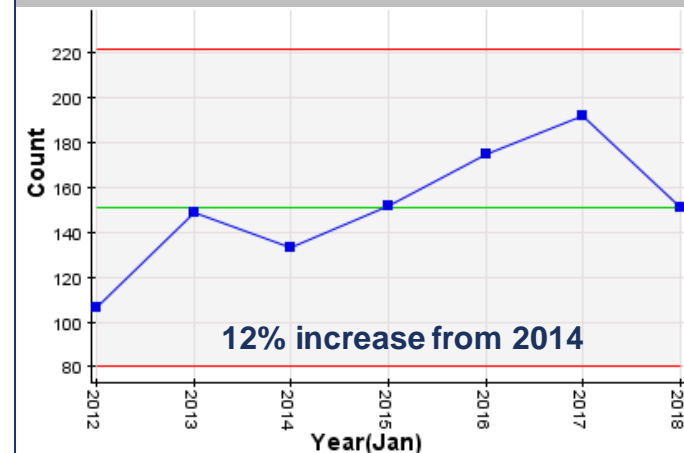
Hospital A



Hospital B



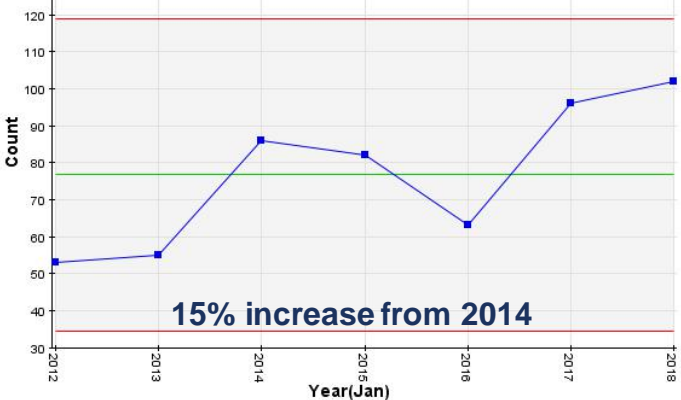
Hospital C



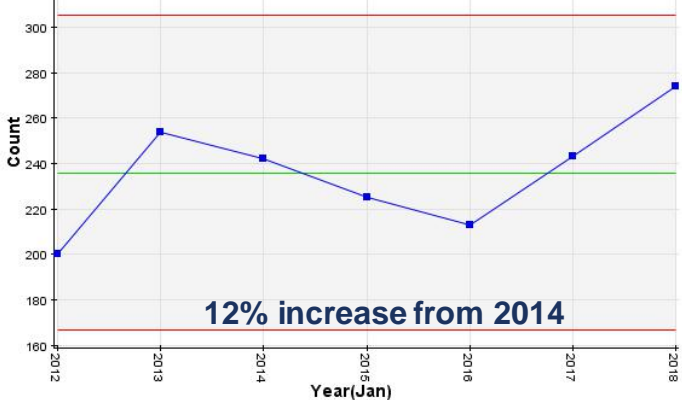
Drilldown hospital B by diabetes complication type

Volume

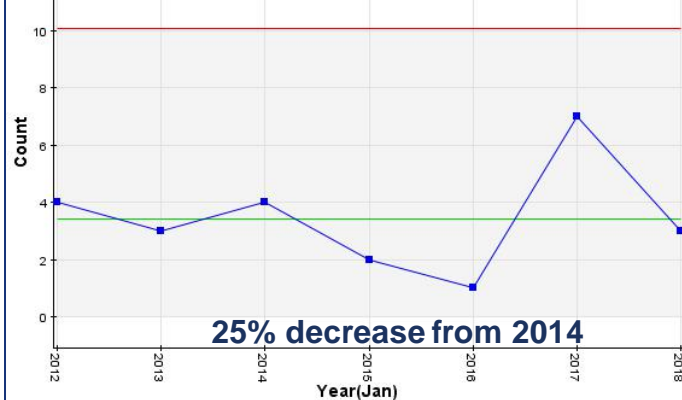
Type 1 Diabetes Complications



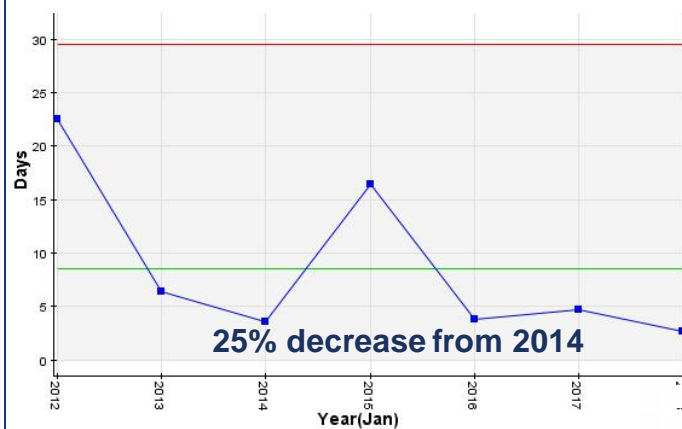
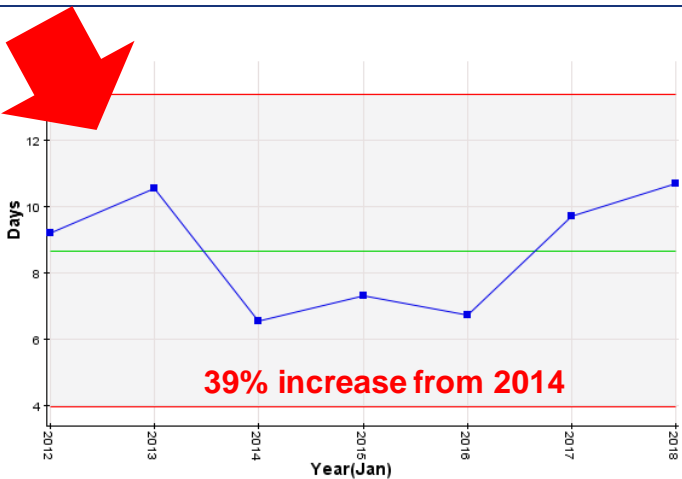
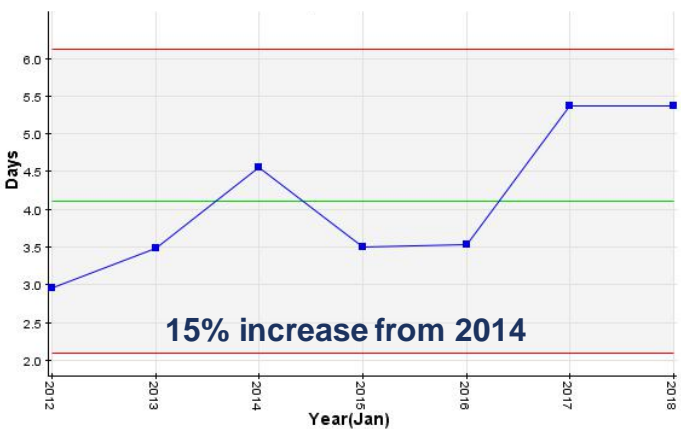
Type 2 Diabetes Complications



Other/unspecified Diabetes Compl



Avg LOS

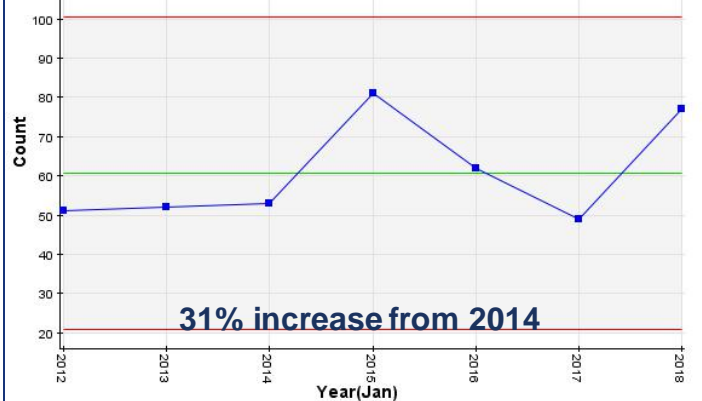


Drilldown hospital B by diabetes complication type

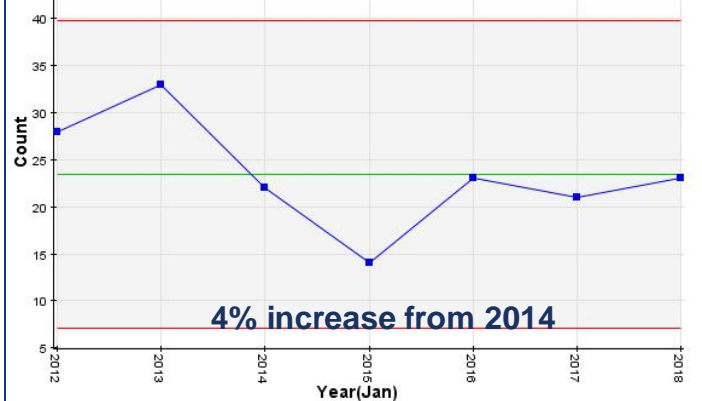
Volume

Avg LOS

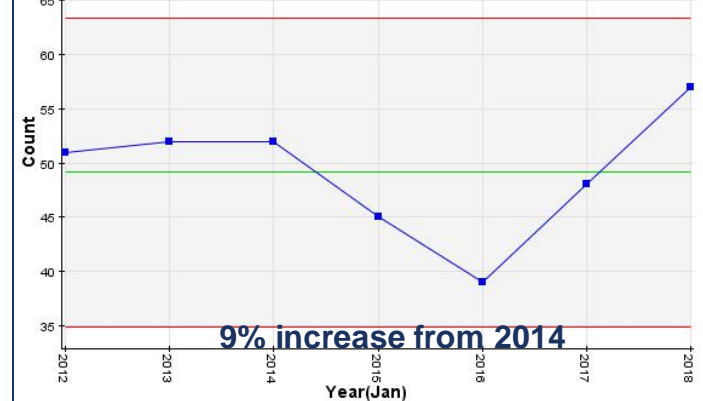
Type 2 Diabetes Foot Ulcer



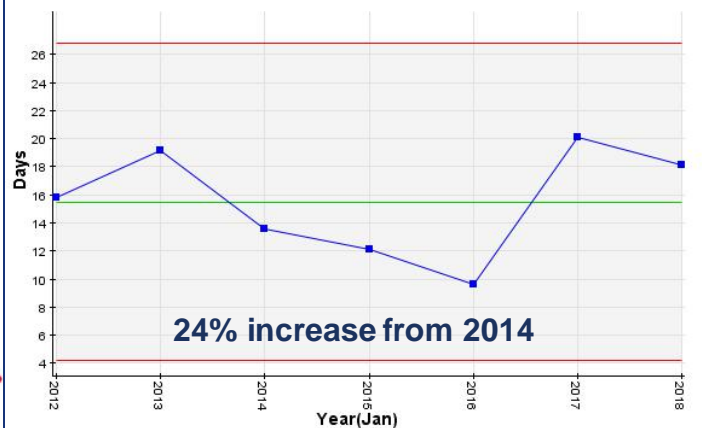
Type 2 Diabetes with poor control



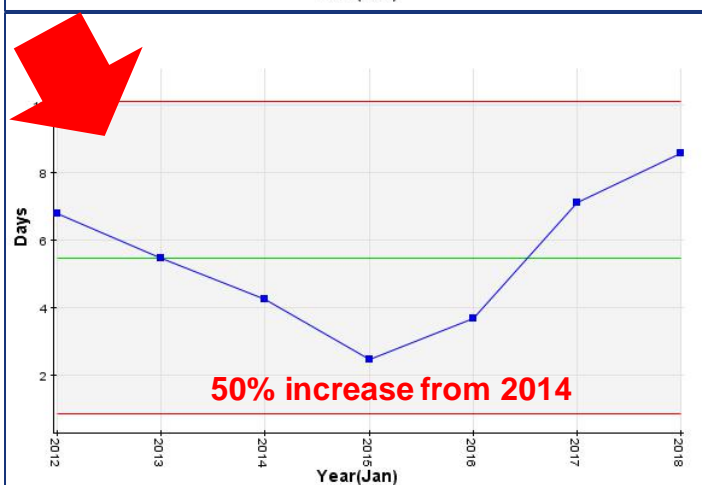
Type 2 Diabetes Hypoglycaemia



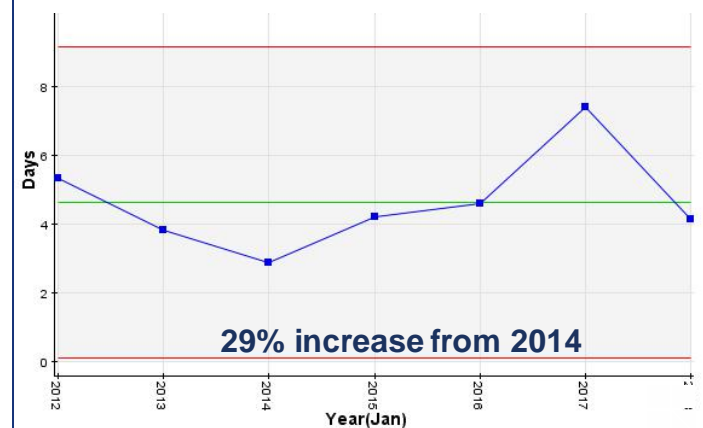
24% increase from 2014



50% increase from 2014



29% increase from 2014



Summary

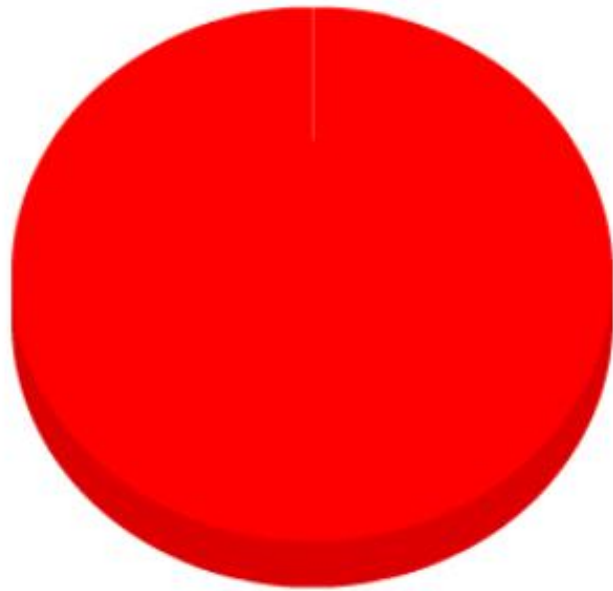
- ◆ Changes in overall LOS and volumes are not experienced homogenously at all facilities –
- ◆ Therefore, high level monitoring and reporting is not sufficient to drive or inform locally actionable improvement strategies across the system
- ◆ By drilling down progressively, a defined, actionable improvement strategy can be developed (describing the territory rather than the map)
 - Potentially avoidable admissions
 - Chronic
 - Diabetes
 - Hospital B
 - Type 2 Diabetes
 - Poorly controlled



“Every System is perfectly designed to deliver the results that it gets.”

*Theory of
Knowledge*

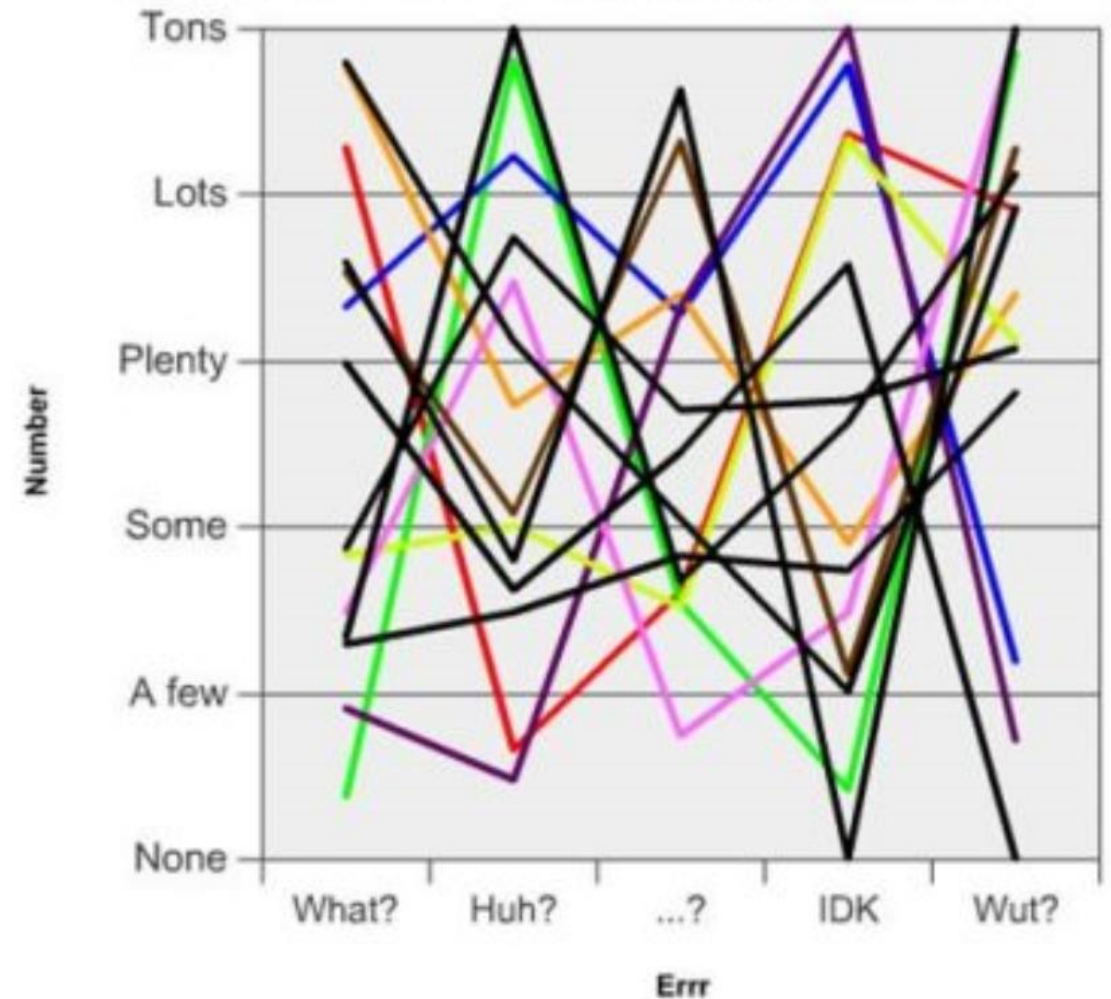
Why I hate pie charts.



■ Im color blind.

memecenter.com

Increase in Confusing Graphs

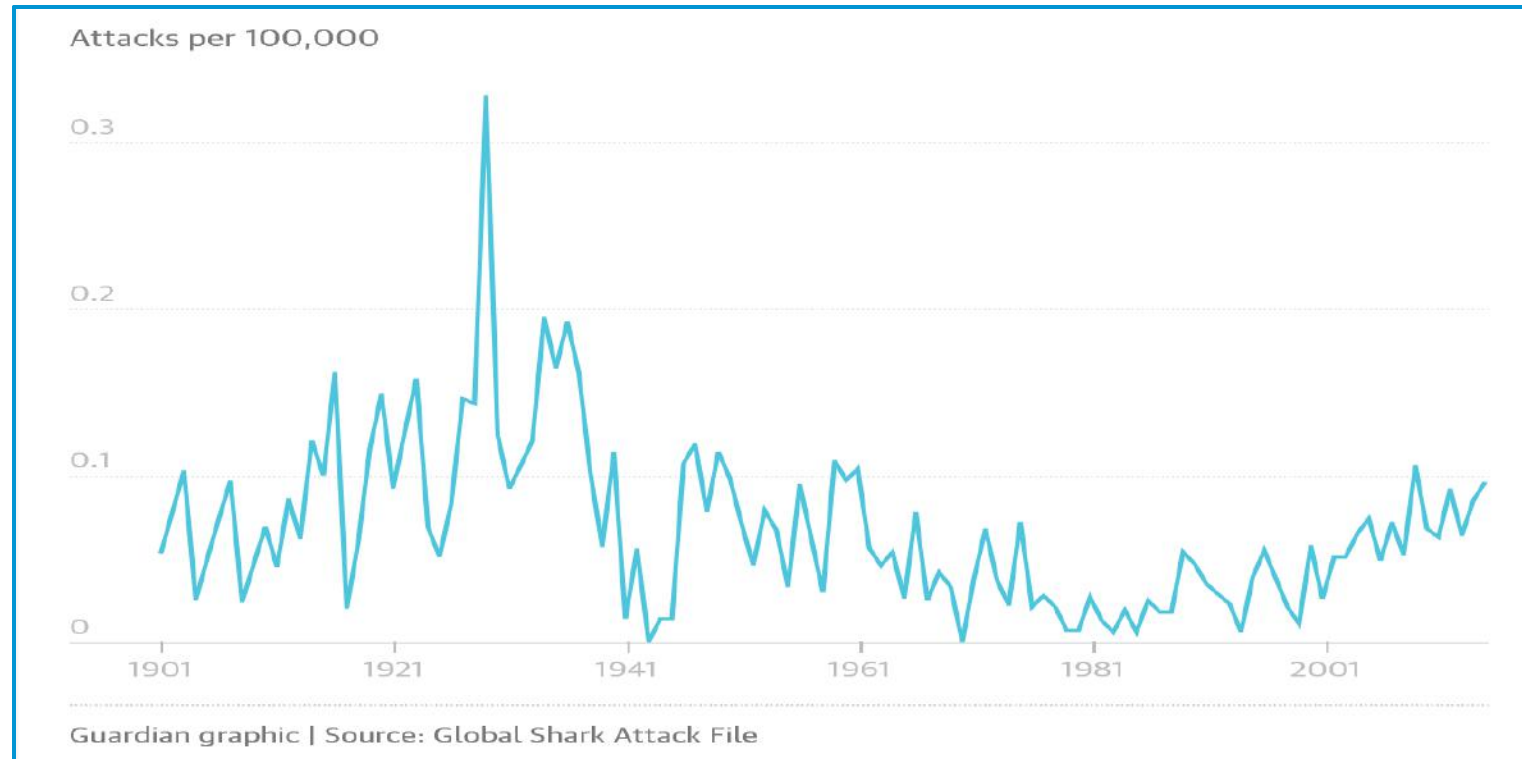


Things to consider when presenting data

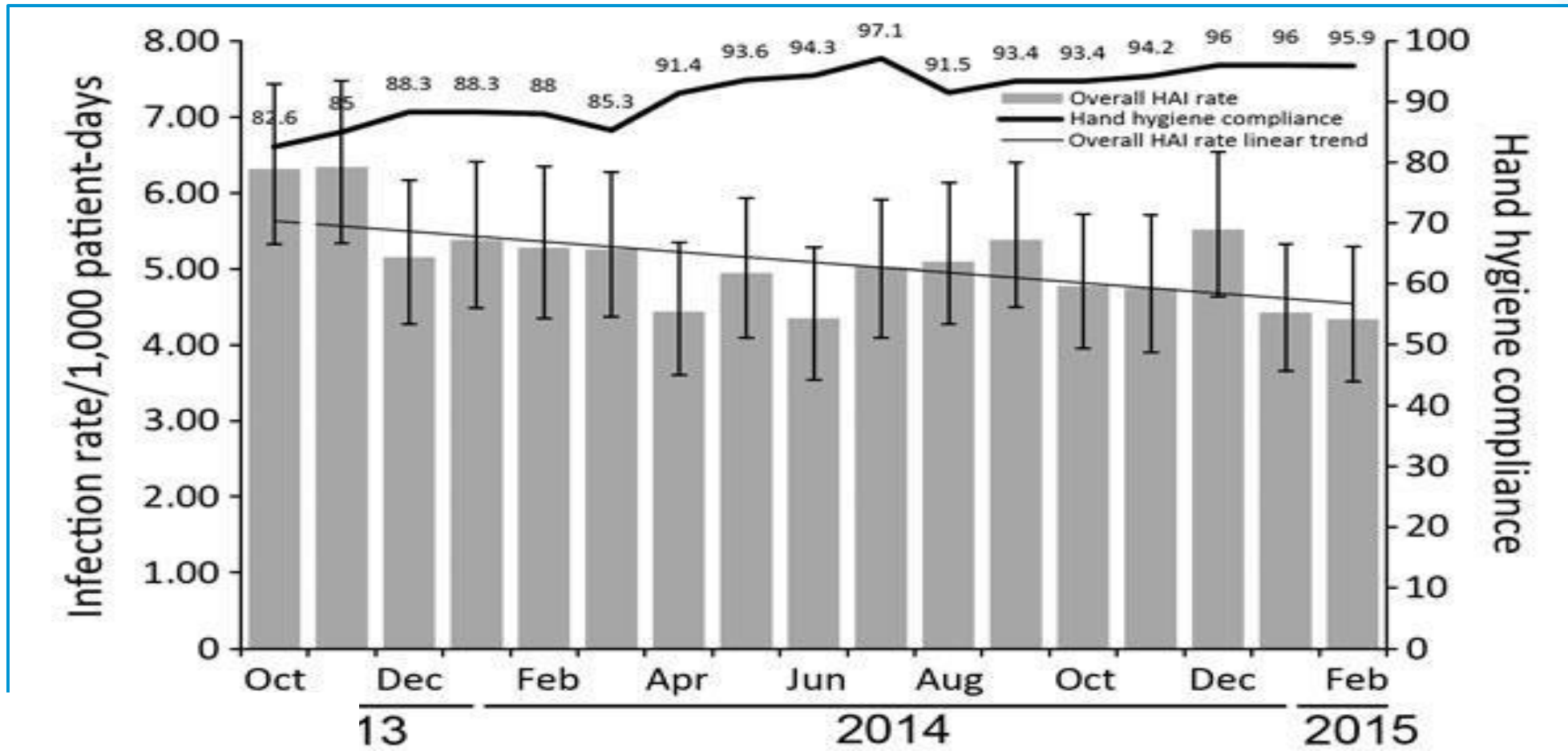
- ✓ Numbers versus rates
- ✓ Process and outcome
- ✓ Scale can lead to misinterpretation
- ✓ Aggregated vs local data
- ✓ Incidents vs Harm vs Reliability
- ✓ Common cause vs Special Cause
- ✓ Make it meaningful and targeted- tell a story
- ✓ How many patients is that?
- ✓ MEASURE WHAT MATTERS



Things to consider when presenting data: Numbers versus Rates



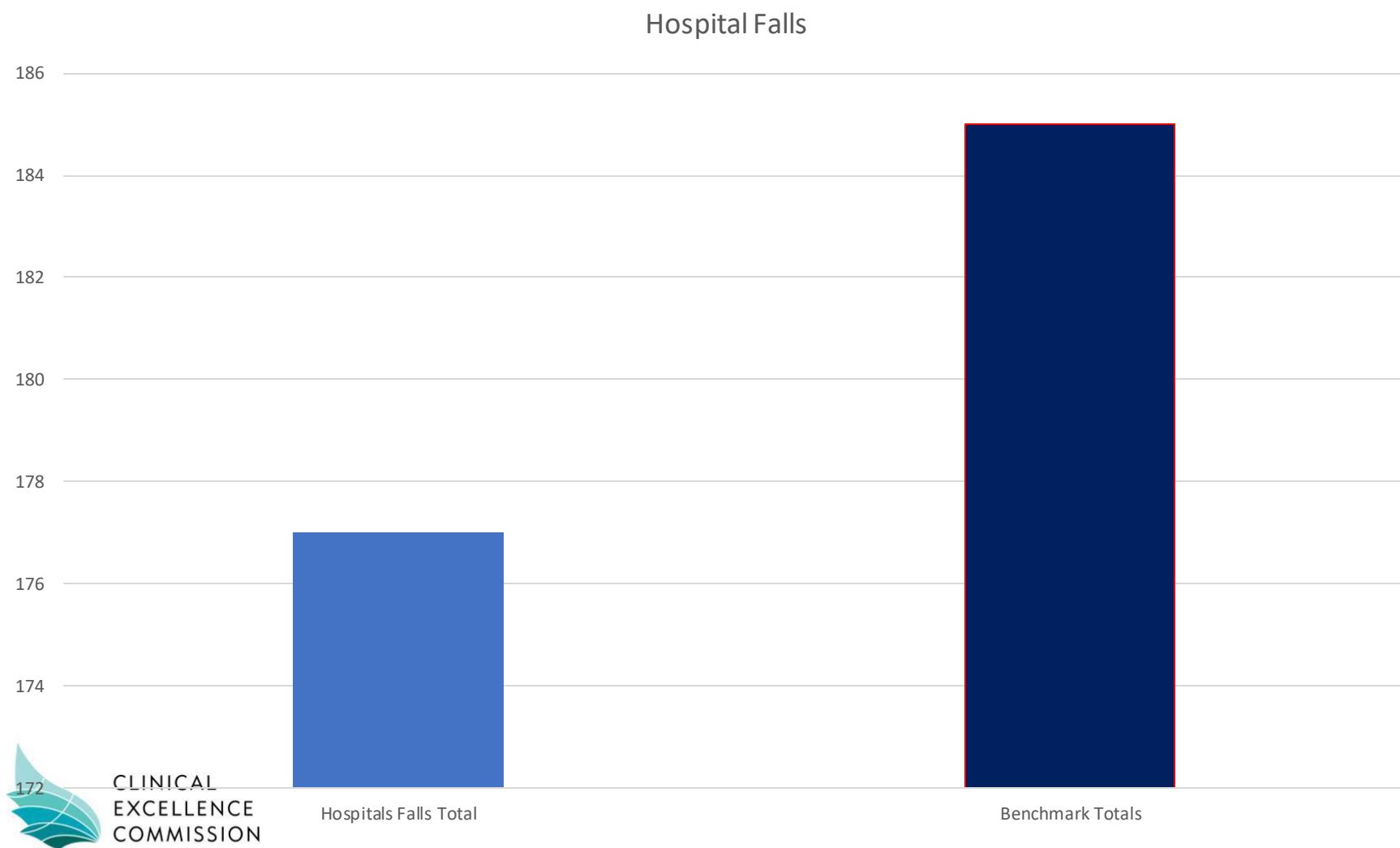
Things to consider when presenting data: Process and Outcome



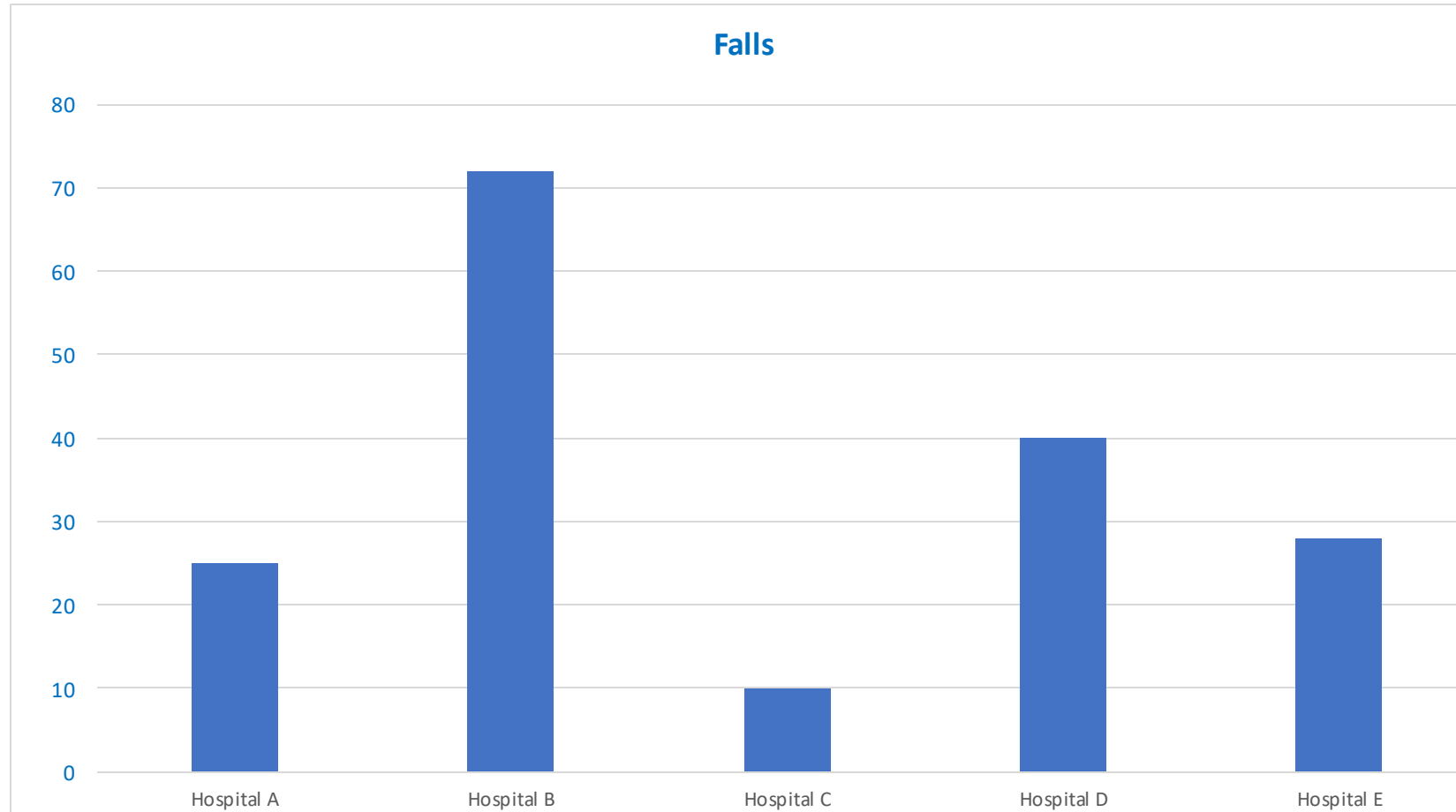
Things to consider when presenting data: Scale can lead to misinterpretation



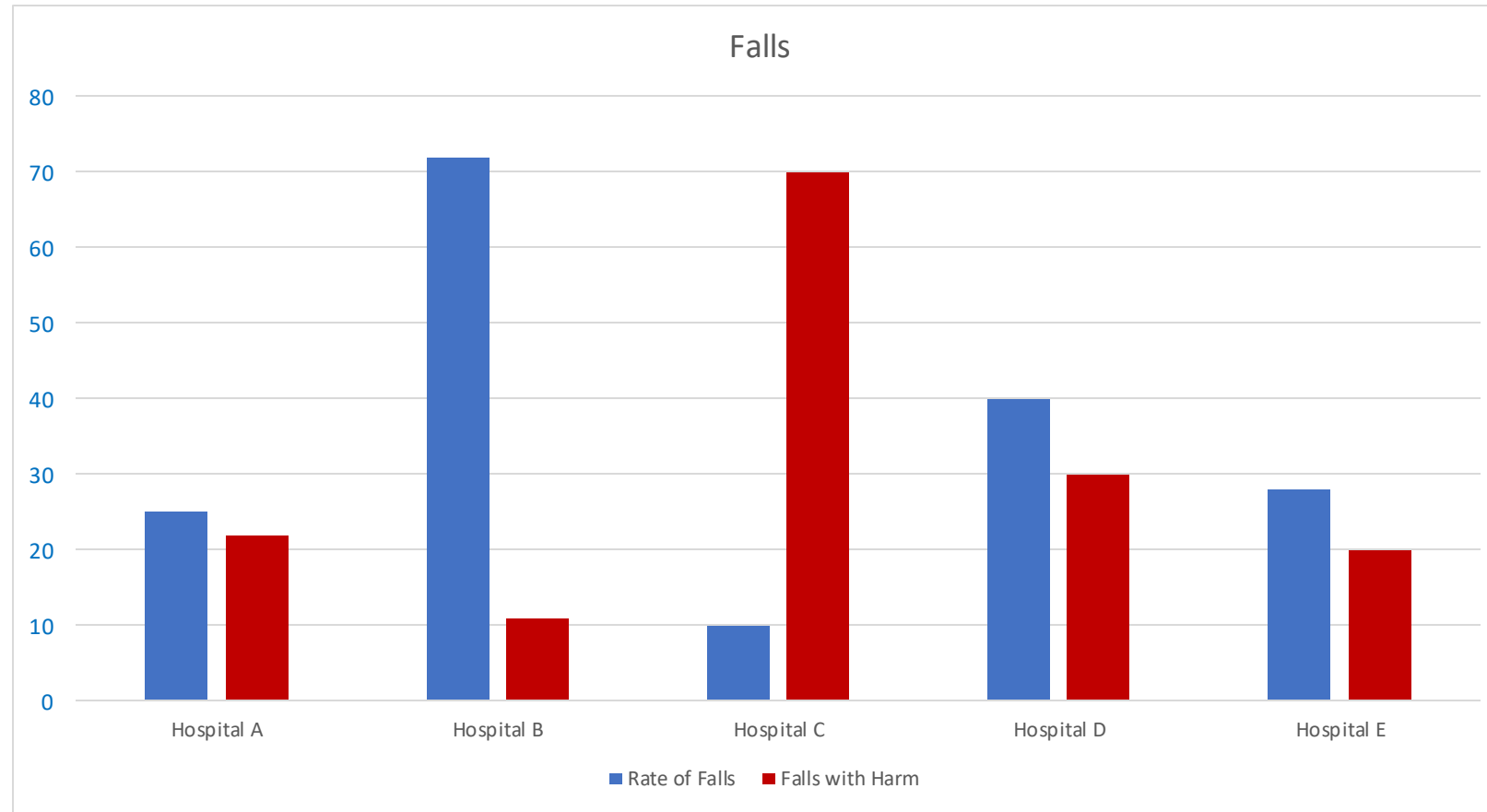
Things to consider when presenting data: Scale and Aggregated versus Local Data



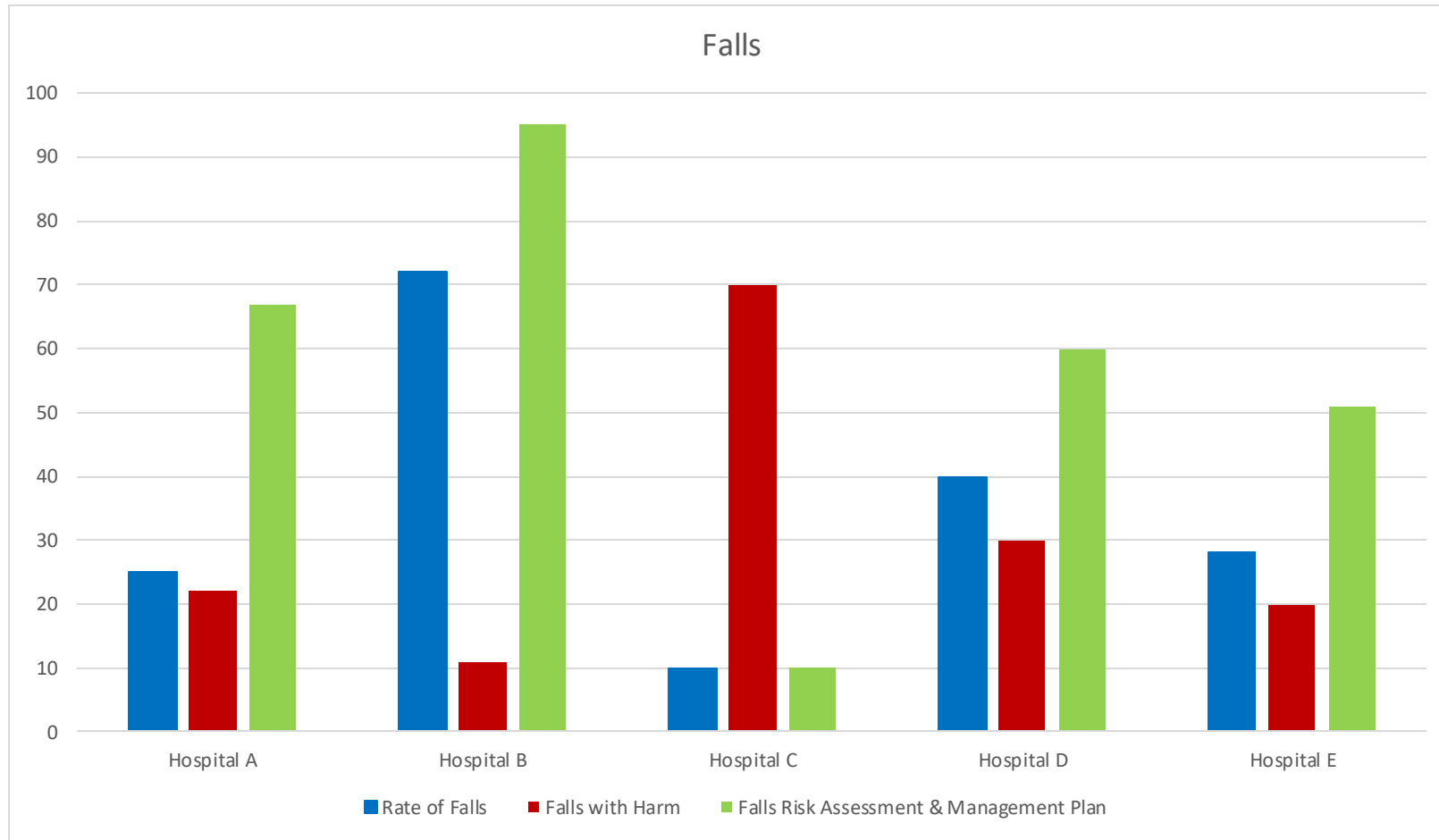
Things to consider when presenting data: Aggregated versus Local Data



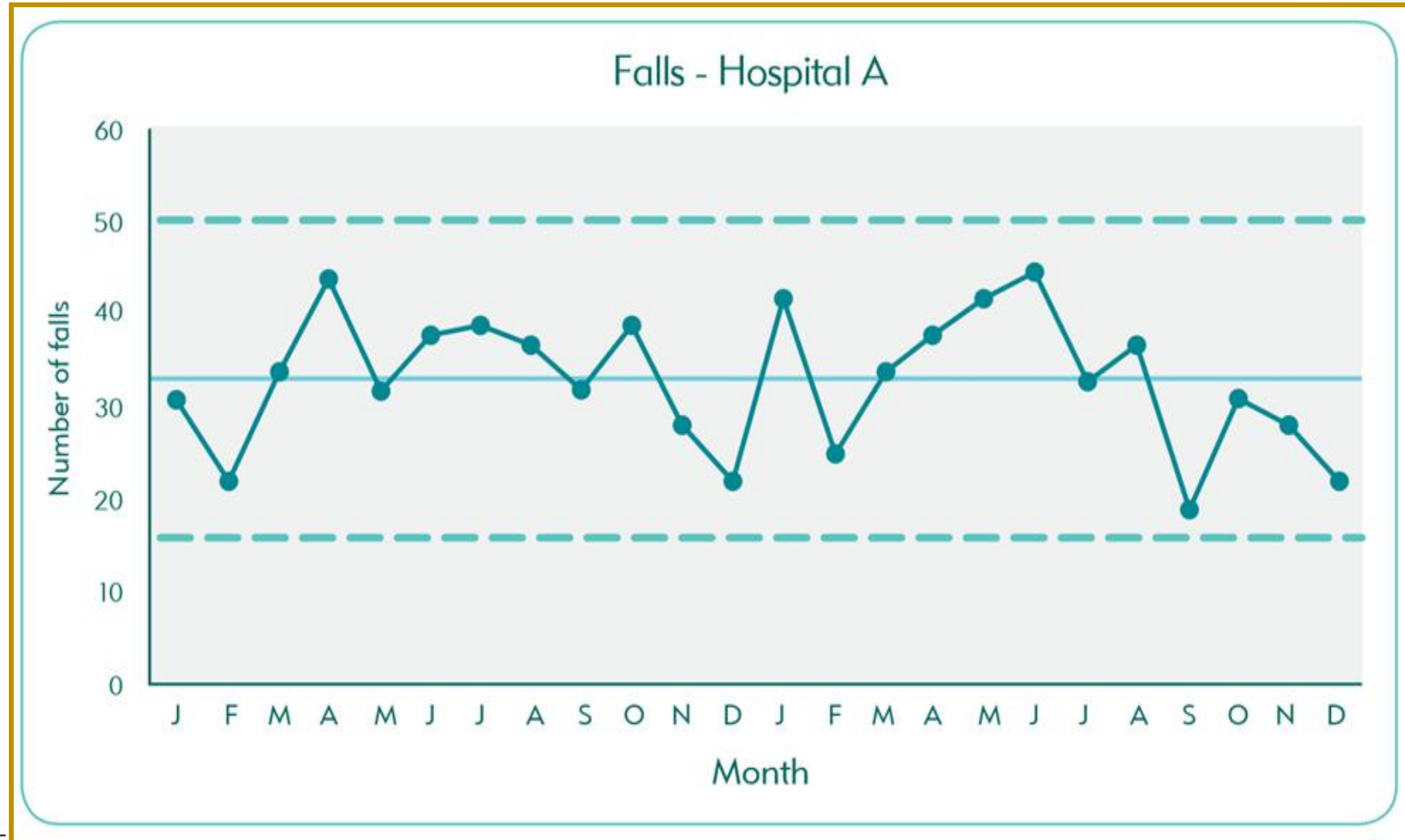
Things to consider when presenting data: Incidents vs Harm vs Reliability



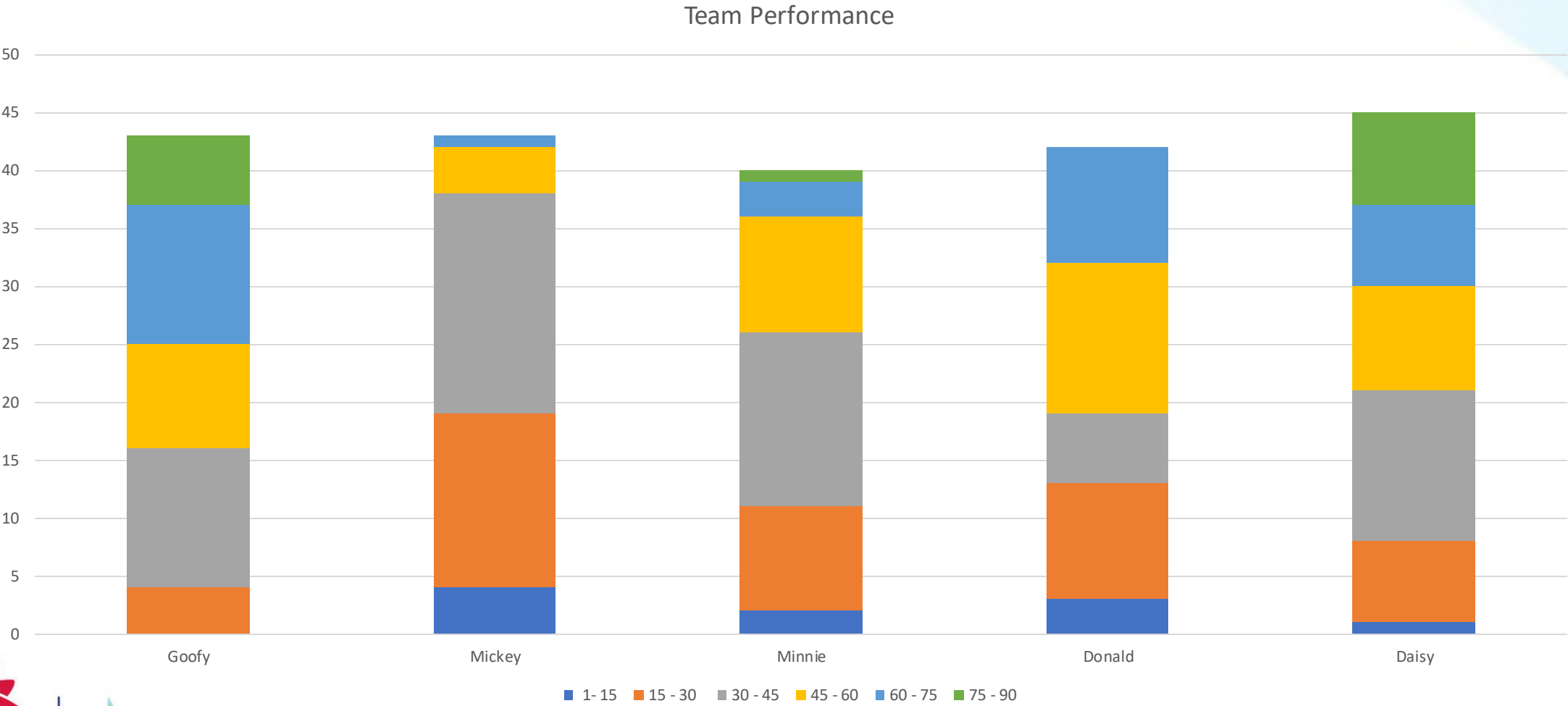
Things to consider when presenting data: Incidents vs Harm vs Reliability



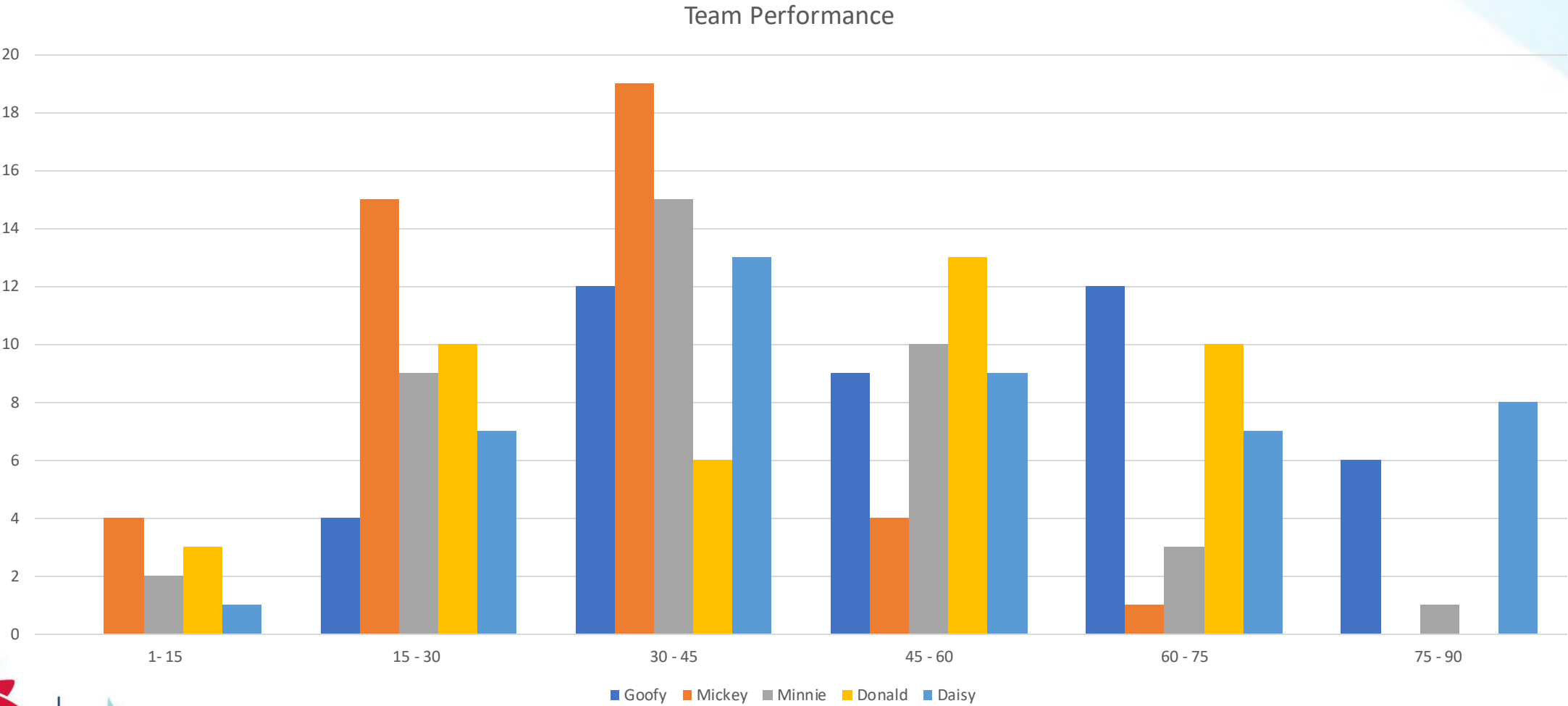
Things to consider when presenting data: Special Cause vs Common Cause



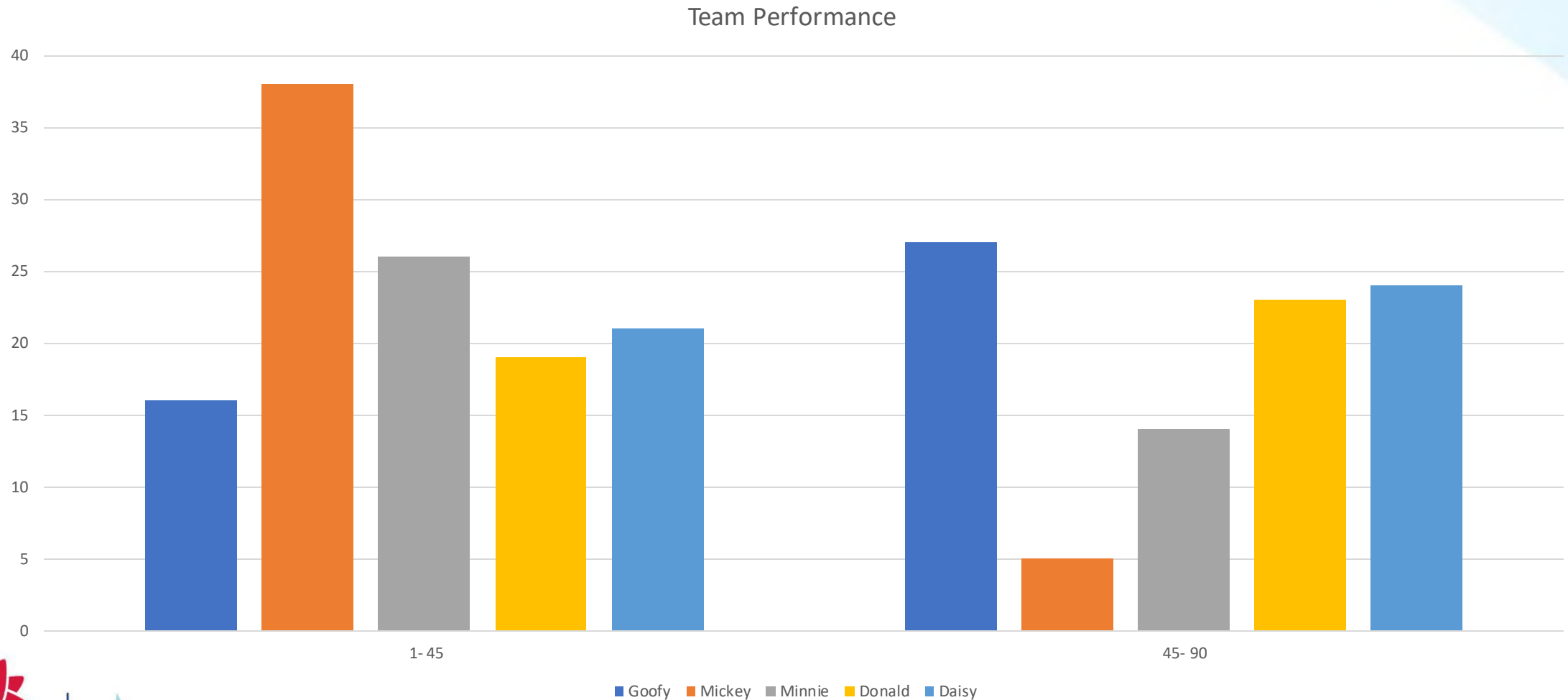
Things to consider when presenting data: Tell a Story



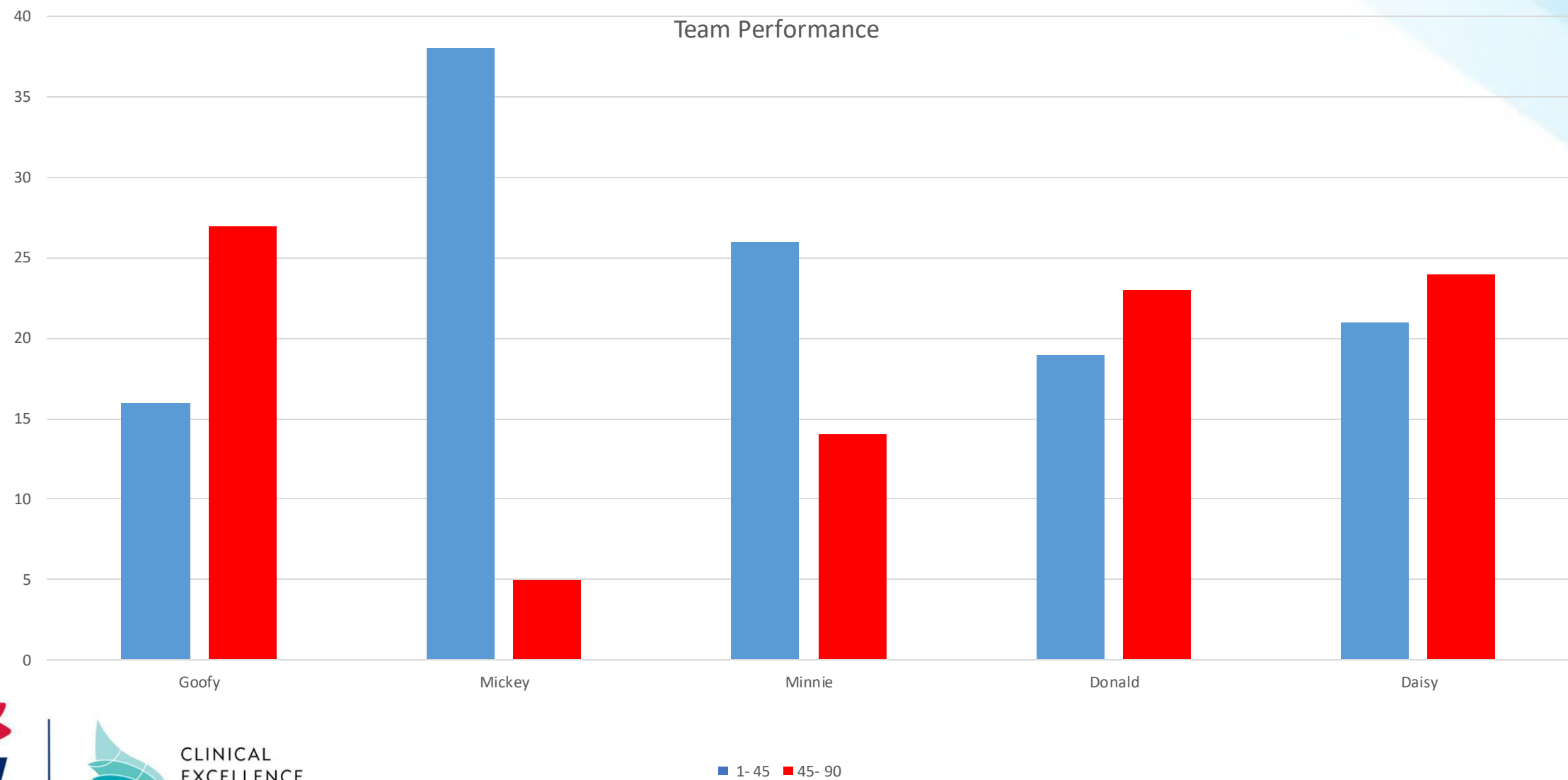
Things to consider when presenting data: Tell a Story



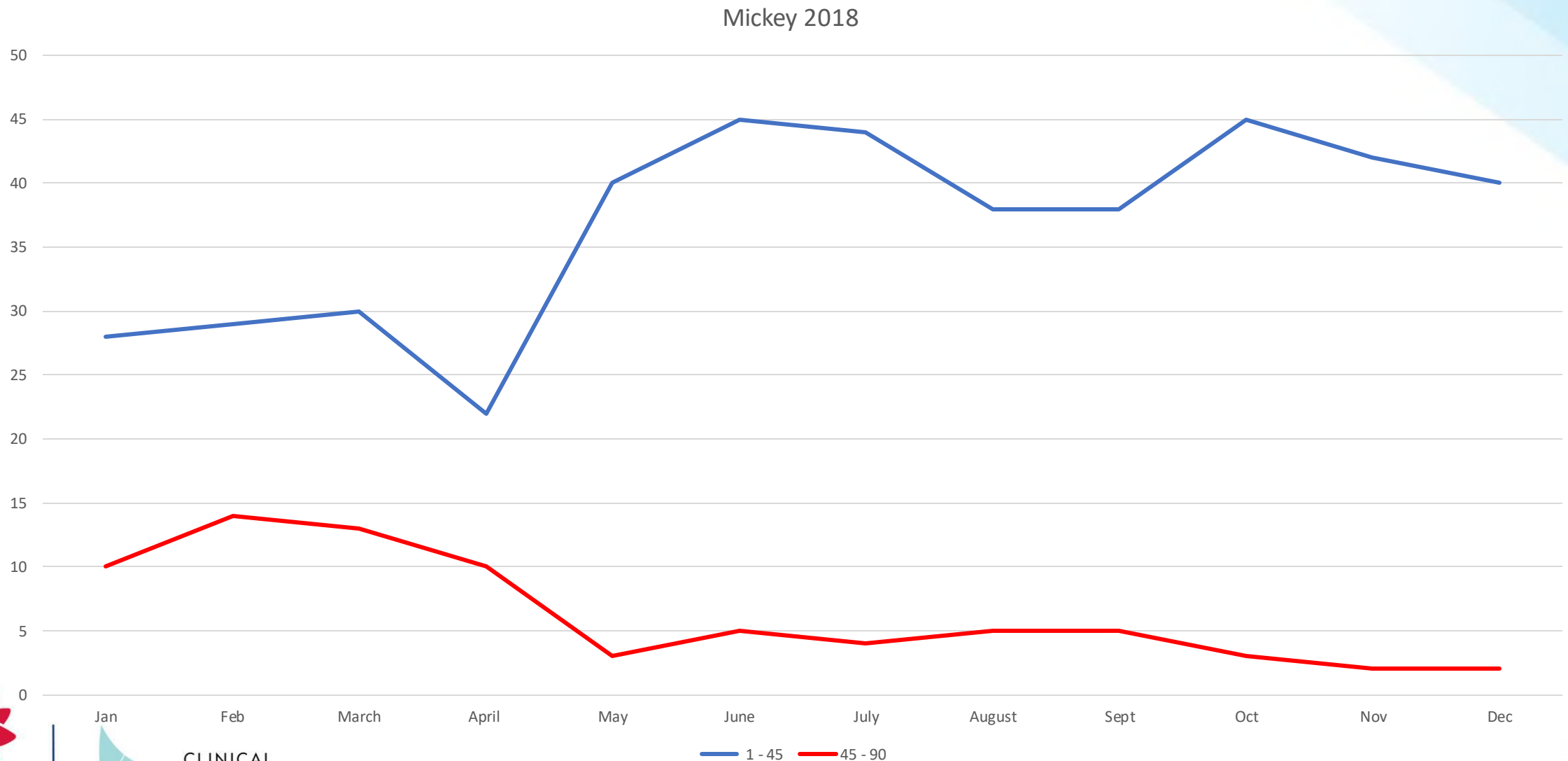
Things to consider when presenting data: Tell a Story



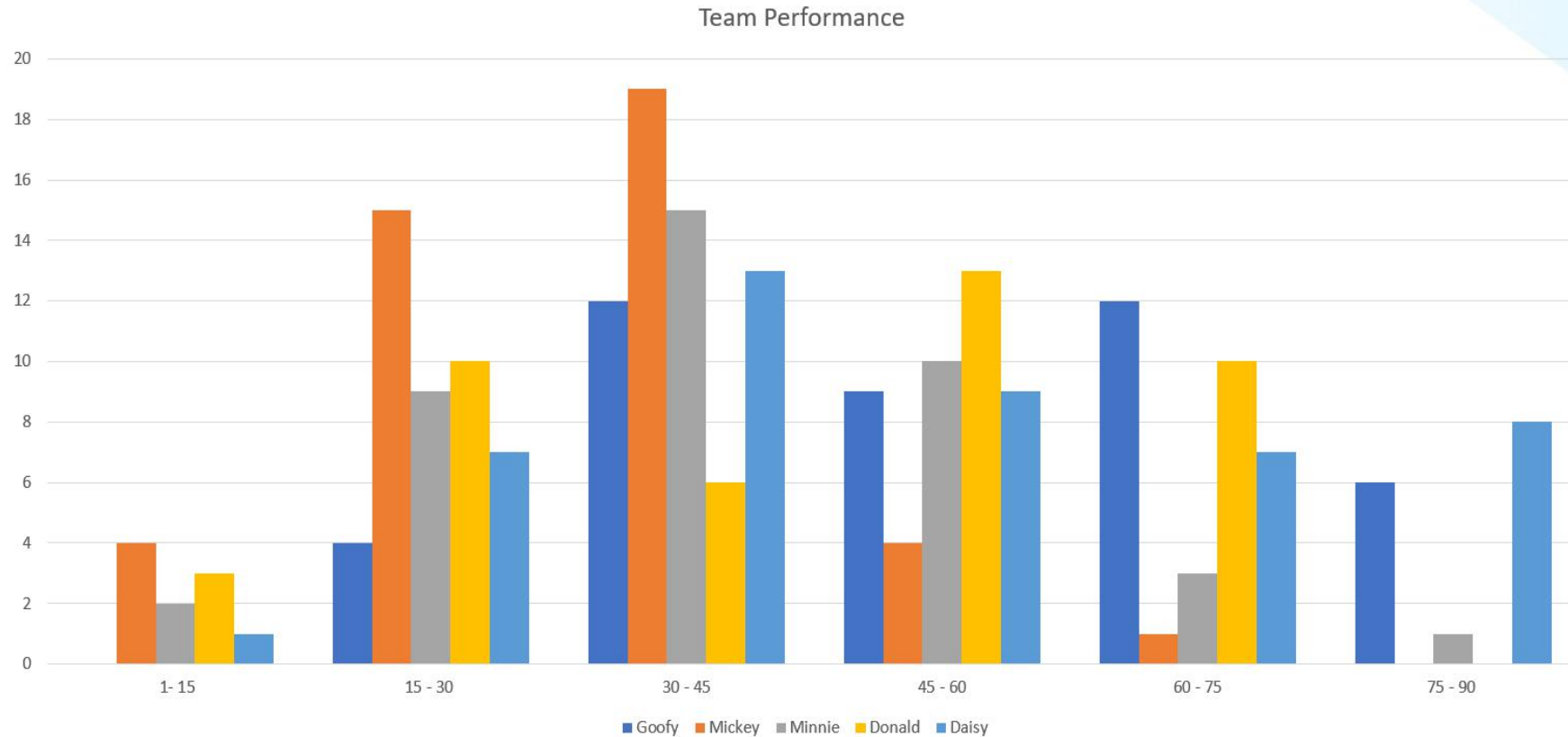
Things to consider when presenting data: Tell a Story



Things to consider when presenting data: Tell a Story

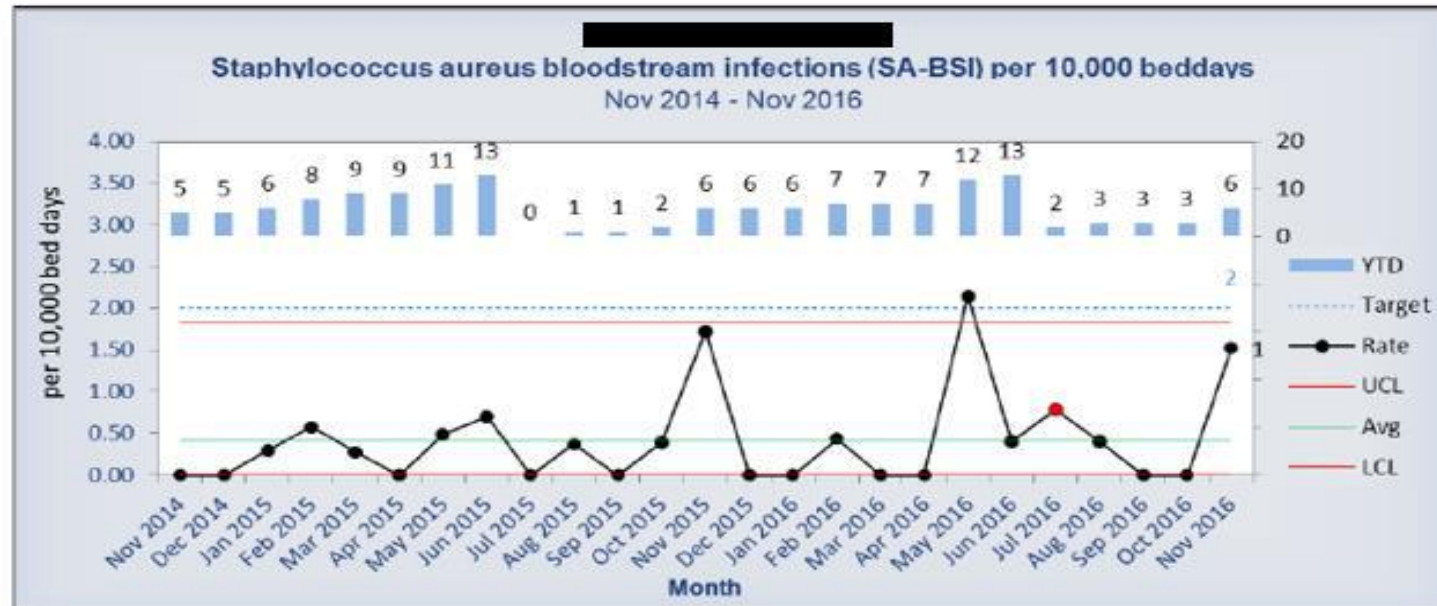


Things to consider when presenting data: Tell a Story



Things to consider when presenting data: How many patients is that?

Figure 1 - Staphylococcus aureus bloodstream infections (SA-BSI) - rate per 10K bed days



As At	Rate	Target	Variance	Eval
Nov-16	1.52	<2.00	0.48	G ➡

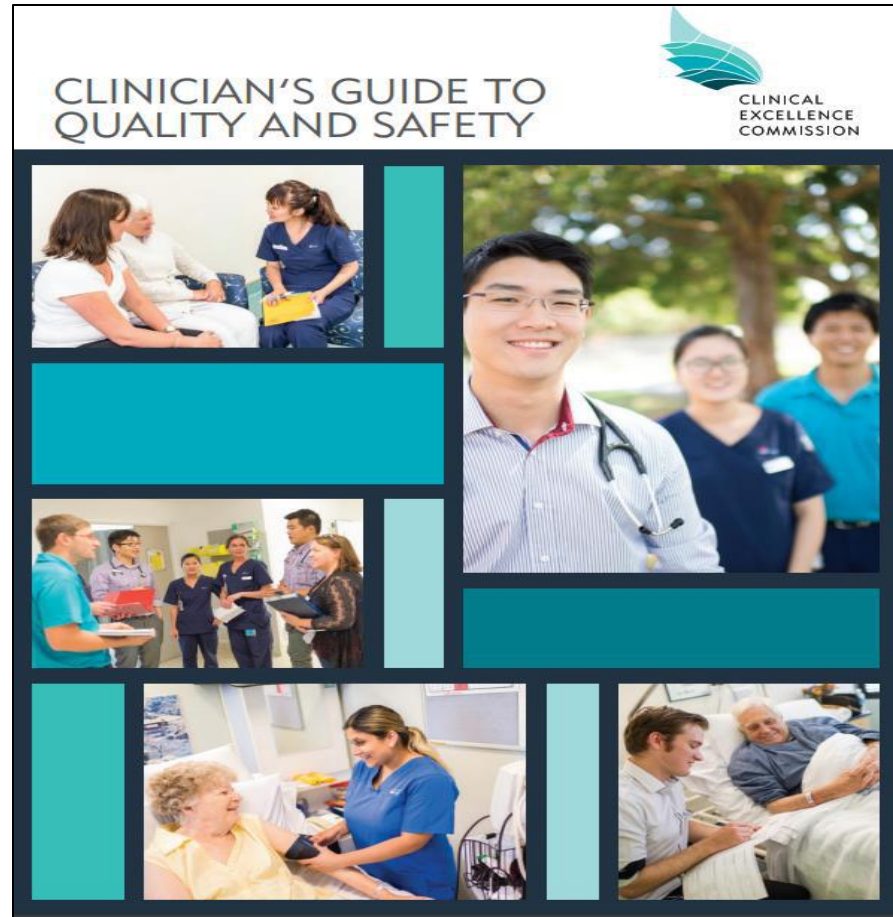
Current Actions and Strategies for Improvement



On Target, continued to be monitored to ensure KPI continues to meet Target.

Measure What Matters

- High reliability requires a deference to front line expertise:
 - this is where change happens
- Provide clinical teams with:
 - The right data
 - At the right time
 - In a format that 'tells a story'
 - That is important to them and their patients

QI ACADEMY





CLINICAL
EXCELLENCE
COMMISSION

About ▾ Patient Safety Programs ▾ Quality Improvement ▾ Incident Management ▾ Knowledge ▾

[Home](#) ▸ [Get Involved](#) ▸ [Events](#) ▸ [Calendar](#)

EVENTS CALENDAR

[View as calendar](#)

There are **15** upcoming events in the calendar.

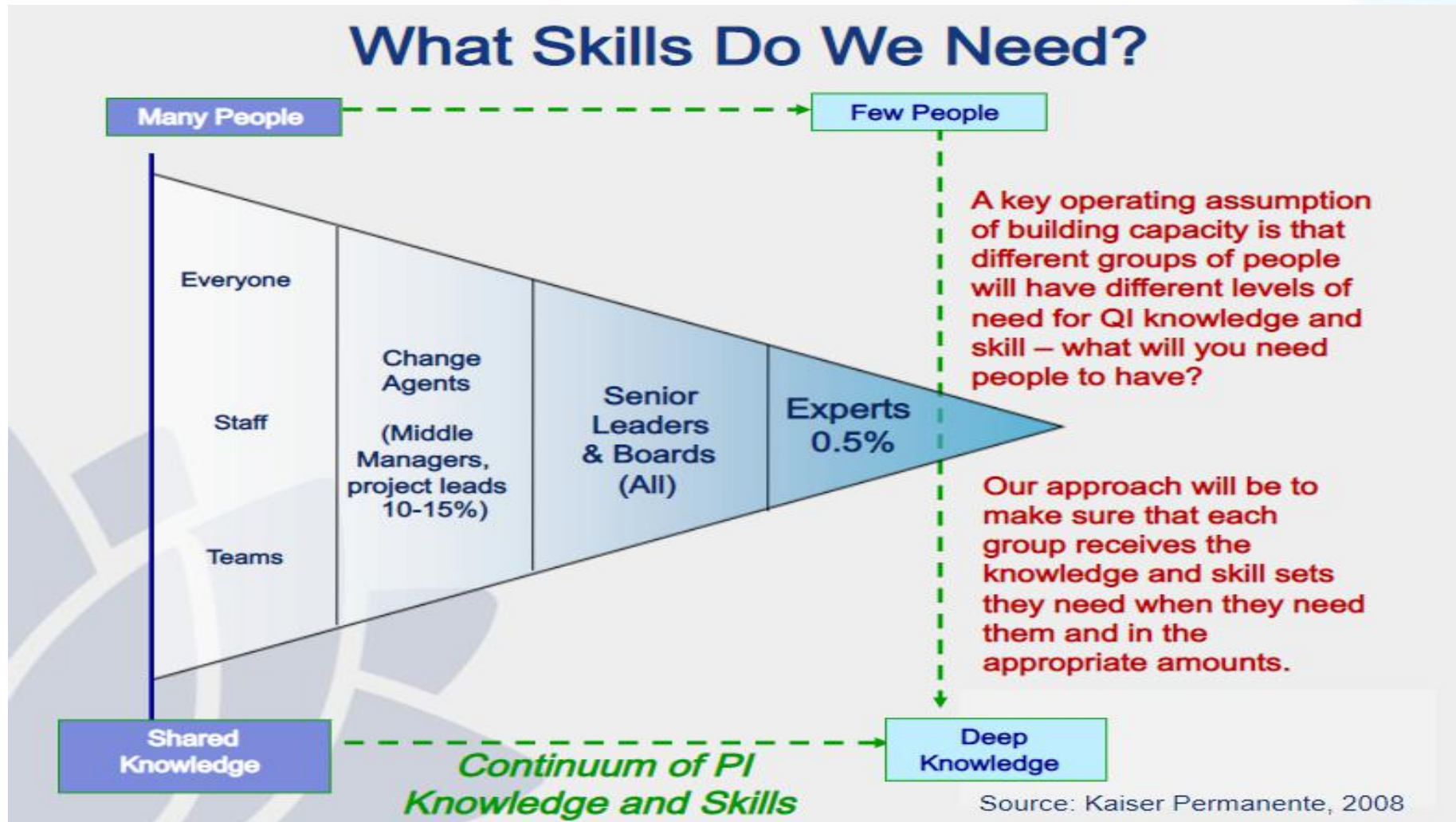
September
19

**IMPROVEMENT SCIENCE USING DRIVER DIAGRAM
WEBEX SEP 2018**
19th Sep 2018 1:00pm to 19th Sep 2018 2:00pm
Webex
[ADD TO CALENDAR](#)

September
19

**INTRODUCTORY WEBEX ON RUN CHARTS, PARETO
CHARTS AND BASIC MEASUREMENT SEP 2018**
19th Sep 2018 2:30pm to 19th Sep 2018 3:30pm
Webex

CAPACITY BUILDING



Three tiered development program in organisations

Bronze level

- Two online modules
- Raises awareness about improvement methods and patient safety language



Silver Level

- Five month program
- Application of bronze level theory to a small local improvement project



Gold Level (current pilot)

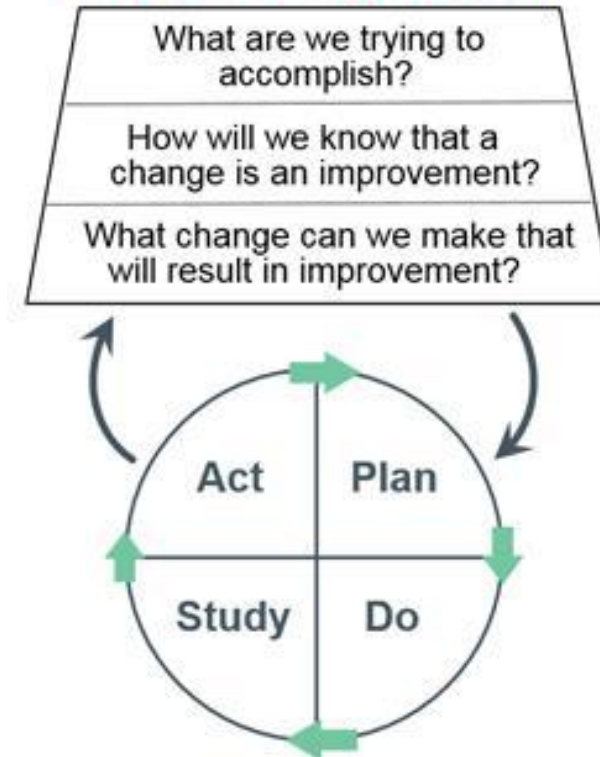
- Deeper application of Silver Level concepts to larger project
- Greater reflection on leadership and improvement personal competencies



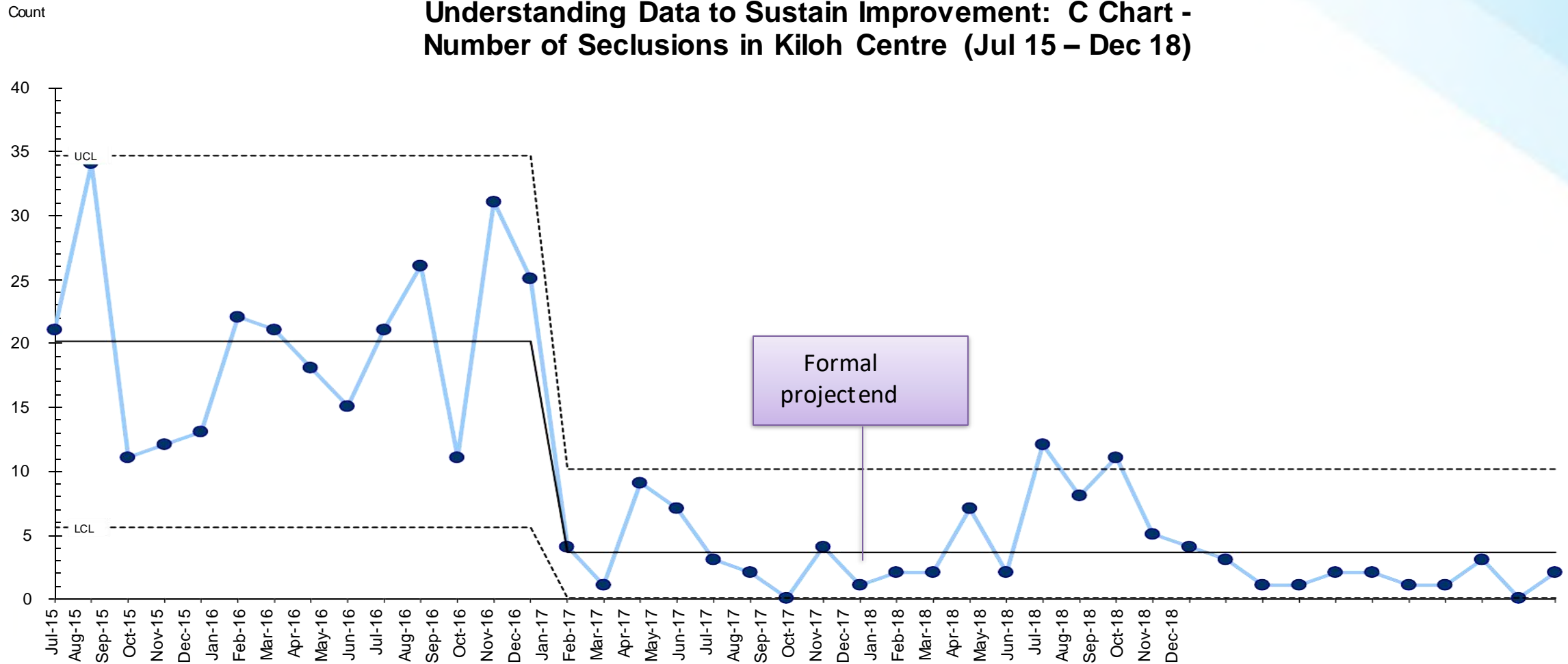
Building capacity and capability

- Building and enabling staff capacity in all aspects of continuous improvement
- Through coaching, guidance, training and facilitation.
- Facilitating staff independence & ownership of their QI improvement work
- Supporting ideas generation, momentum, sustainability and spread
- Engagement of front line staff in QI
- Recognising and celebrating QI
- Focusing improvement on consumer needs and person centred, compassionate care

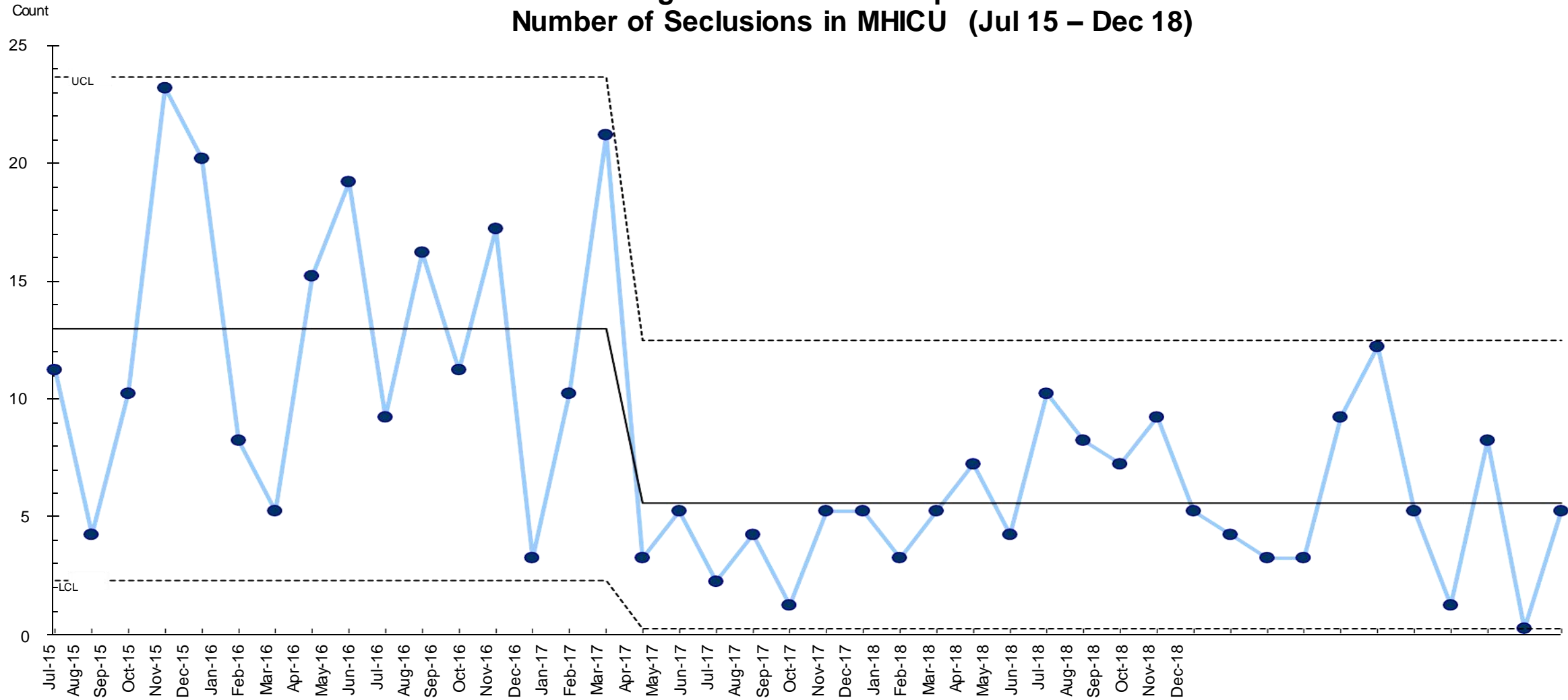
Model for Improvement



Understanding Data to Sustain Improvement: C Chart - Number of Seclusions in Kiloh Centre (Jul 15 – Dec 18)



Understanding Data to Sustain Improvement: C Chart - Number of Seclussions in MHICU (Jul 15 – Dec 18)



Silver Level Project: Keith's Closet

- The project identified that a high number of patients do not have adequate clothing.
- A seclusion room was converted into a wardrobe and filled with donations from staff and the community.
- The project has assisted to build therapeutic rapport between staff and patients.
- Community donations have provided the community with a greater understanding of what SESLHD Mental Health are working to achieve.
- Consumers in the community are also able to access the program.
- A former inpatient, with multiple admissions and seclusion events, now volunteers three hours each week to assist with the program.

“The closet provides patients with something uplifting as opposed to a medication routine”

- – Keith Donnelly RN/Case Manager ESMHS

Silver Level Project: Keith's Closet

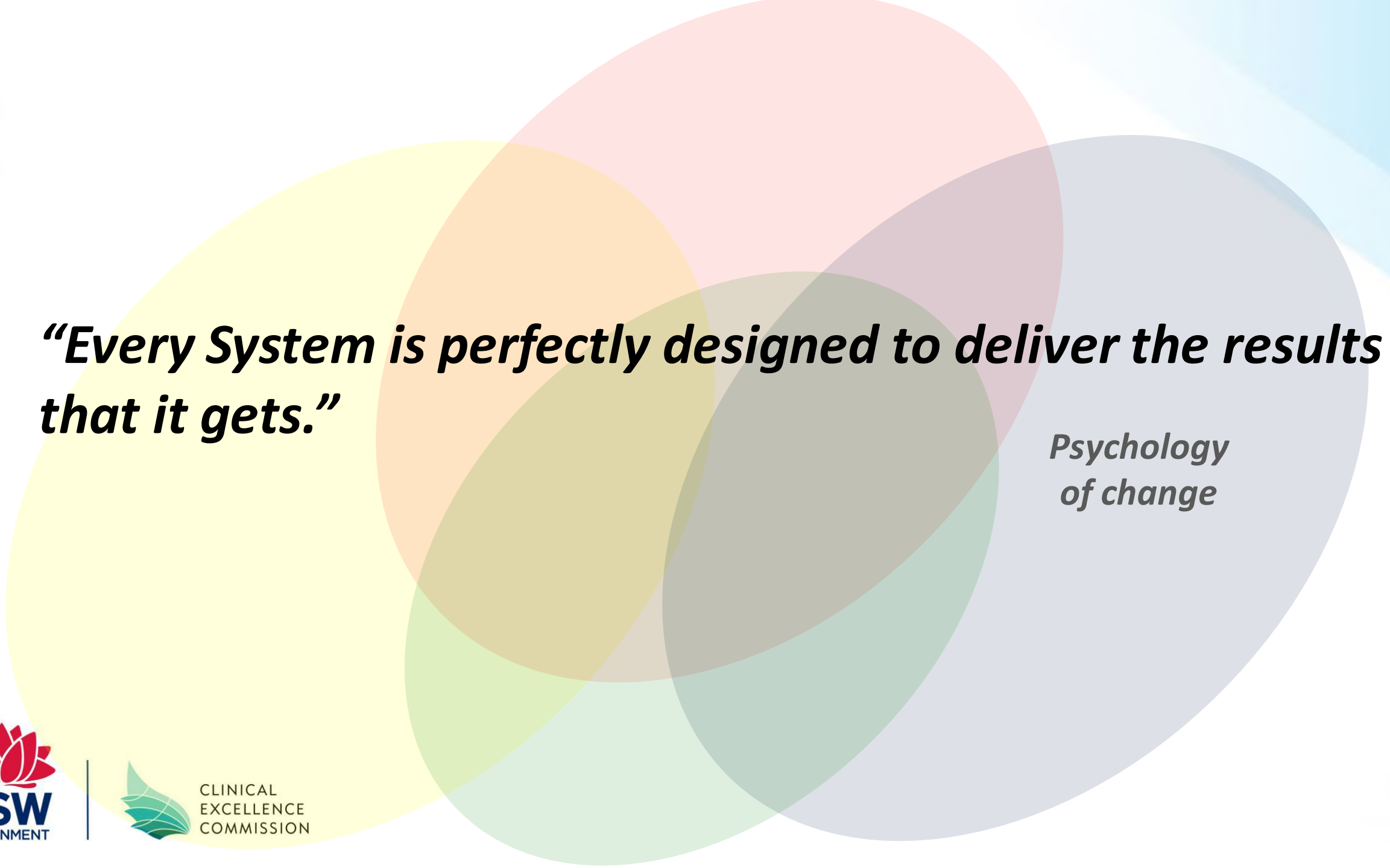


Silver Level Project: Keith's Closet



Silver Level Project: Keith's Closet





“Every System is perfectly designed to deliver the results that it gets.”

*Psychology
of change*

Clinician Engagement

Traditional Frameworks:

- Setting an agenda
- Informing
- Involving
- Empowering

How to measure clinician engagement?

Participation in system processes and reliability measures can demonstrate level of clinician engagement and further engage clinicians

Reliability Measures

- Time to definitive treatment
 - Operative intervention (e.g. #NOF)
 - Administration of Antibiotics- Sepsis pathway
- Risk assessment and management plans (falls, PIs, delirium)
- Care bundles- medication bundles, Central Line bundle
- Medication reconciliation
- Safety II = what do we do well

What else? Triangulation to culture

- Patient Experience
- Organisational culture- staff engagement
- Leadership
- Team work- training, supervision
- Outputs:
 - Exec walkrounds for patient safety
 - Safety huddles
 - Team based training
- Challenges
 - Timing
 - Data collection
 - Burden

Balanced Score Card

Cardiology



Hospital Onset Complications: AF, AMI, arrhythmias
Unplanned transfers to ICU
Readmissions



Timeliness and accuracy of reporting: ECGs, ECHOs
Discharge on medication bundle
Medication reconciliation



Preferred training hospital
Patient Experience measures

Balanced Score Card

Orthopaedics



Falls resulting in fracture
Hospital Acquired Infection: hip and knee prosthesis
Unplanned readmissions



VTE risk assessment and prophylactic management
Time to definitive treatment for #NOF
Antimicrobial management



Patient reported outcome measures
Post fall huddles
Patient Experience measures

Balanced Score Card

Safe Surgery



Incorrect procedures (near miss)
Incorrect prosthetic
Intraoperative burns



Team time out and safe surgery checklist
Antimicrobial management – recording and reporting on ABs and knife to skin



Staff trained in quality improvement and Quality projects
Staff retention
Number of multidisciplinary scenario training exercises (e.g. difficult intubation)

People create safety

Mindsets and attitudes shape health culture and behaviours

People create meaning

Interventions do not create change, people do

Mindsets & attitudes shape culture and behaviour

Social learning occurs through observation, imitation, sharing and reinforcement; making the implicit explicit

A continuous learning culture is one where **People change their behaviour** upon deepening & broadening of their skills, knowledge and worldviews – the learning process may be informal or formal

Creating Psychological Safety

...so that people can create meaning;

...and that meaning informs safety.

Creates curiosity and openness

Grounds the conversation

Decreases interpersonal risk

Psychological empowerment

Intrinsic motivation

Role clarity

Team cohesion

Transformational leadership behaviour

Changing the safety conversation

- Openness to share and learn from great results across teams
- Psychological safety to report, explore and learn when harm happens
- Data for dialogue, and dialogue for improvement...rather than judgement
- Seek to understand and create meaning as a Multidisciplinary Team approach to improvement



Figure 1. Model to guide and improve robust discussion about safety

Based on Leonard, Graham and Bonacum (2004).



- The map of reality is not reality
- Maps are reductions of what they represent
- They are a snapshot in time

Our role is to create the conditions, tools and resources to empower our teams to understand their territory

"A map is not the territory."
—Alfred Korzybski



THANK YOU AND QUESTIONS

Presented by:

Carrie Marr

Chief Executive Officer

Clinical Excellence Commission

Carrie.marr@health.nsw.gov.au

Dr Bernadette Eather

National Manager, Clinical Quality & Patient Safety

Ramsay Health Care

eatherb@ramsayhealth.com.au



[@carriemarr](https://twitter.com/@carriemarr)



[@Dr_Eather](https://twitter.com/@Dr_Eather)



People caring for people