JK9

Adverse Events Monitoring

The why, what and how of the new system

The Bristol story of a paediatric cardiac surgical service is not about bad people, people who did not care, nor of people who wilfully harmed patients.

The Ideal Health Care System

Everyone should have
access to
the right care delivered in
the right way,
safely, at
the right time, with the
best use of the available resources

Quality in Australian Health Care Study - cases per year

- Potentially preventable AEs 300,000
- Preventable permanent disability 50,000
- Preventable serious disability 15,000
- Potentially preventable death 12,000
- All injury and suicide deaths 6,000

- Wilson et al, MJA, 1995

The Likely Situation - Aus and US (NZ and UK)

- Potentially preventable AEs - 10% admission
- Potentially preventable cost - 5% of budget
- Deaths 50,000 pa - one every 10 minutes = US
- Two fully laden 747s every 1-2 days = US
- Two fully laden 747s every 2-3 weeks = Aus
- Six million dollars per day in Aus

Wilson et al, MJA, 1995

DEFINITIONS

- **Incident** - An event including adverse incident or circumstances which could have, or did lead to unintended and/or unnecessary harm to a person, and/or a complaint, loss or damage

DEFINITIONS

- **Adverse Event** – An incident in which harm resulted to a person receiving health care

- **Near Miss** – An adverse event or close call that did not lead to harm but could have

DEFINITIONS

- **Sentinel Event** – An undesired event that signals that something serious or sentinel has occurred and warrants in-depth investigation
- **Root cause analysis** – A systematic process whereby the underlying factors which contributed to a sentinel event are identified

OBJECTIVES

- Patient safety
- Systems focus – near misses
- No blame culture – negligence, wilful neglect
- Learning culture – prevent recurrence
- Would you be happy for your grandmother to be admitted to BBH ?

Aims of the new system

- To improve patient safety
- To identify system processes for improvement
- To improve the monitoring and evaluation of adverse events
- To increase the reliability of our reporting system and provide prompt feedback
- To ensure action is taken to address required improvements

Adverse Event Form & Minimum Dataset Forms

- Adverse Event Report form
- Sentinel Event Report form
- Falls Minimum Dataset form
- Pressure Ulcer Minimum Dataset form
- Occupational Exposure Questionnaire
- Security Report form

- (G:\QM\Risk Management\Adverse Event Monitoring)

What happens to the forms

- Complete all sections of the Adverse Event form
- Attach Minimum Dataset forms as appropriate
- Forward forms to your shift supervisor

Shift Supervisor's Responsibilities

- Check that all relevant details have been completed
- Outline any additional information about the adverse event or about the action taken
- Copy the report and retain a copy in the ward
- Forward original forms to the DQDSU

What DQDSU does next

- Date stamps and registers all reports
- Assesses the risk associated with the event
  - Low & Medium risks are monitored in trend reports
  - High, Very High & Extreme risks are sent to the relevant Director for investigation
- Forwards Minimum Data Set forms to appropriate areas
- Trends and reports the data

Feedback

- Monthly reports will be sent to each area
- Additional trend reports will be distributed to relevant committees such as CSFs, HOD etc

Performance Indicators

- Adverse Event Report form received by DQDSU within 2 working days
- High, Very High & Extreme Adverse Events investigation completed within 10 working days
- All Adverse Events closed within 28 days

Remember to:

- Complete all sections & appropriate forms
- Be factual
  - establish sequence of events that led to the incident
  - describe what actually happened
  - identify what you did as a result of the incident
- Forward completed forms in a timely manner

Remember to:

- Report near-misses
- Feel you can make a difference

Patient/Visitor Adverse Events

- Complete the left hand column
- IMHS Clients refers to Mental Health clients
- Reporter Details - the person filling out the form
- Names of witnesses (if any) and how we can contact them if needed
- Current patient diagnosis/problems - is the reason the person is being treated by the Health Service (provisional diagnosis or otherwise)

Patient/Visitor Adverse Events continued

- Adverse Event Type – key words to describe incident eg fall, pressure ulcer, medication error
- Next of kin/Medical Officer notified – include names of persons notified
- Open Disclosure section currently not completed

Staff Adverse Events

- Complete the right hand column
- Details relate to the staff member the event happened to not the reporter (although can be same person)
- Shift Type – fixed, standard, rotating
- Shift time - the intended start and finish time on the day the incident occurred (even if you did not complete the shift)

Staff Adverse Events

- Include names of witnesses (if any) and how we may contact them if needed
- Medical Officer notified – did you seek treatment through DEM, GP etc

Description of the Adverse Event

- The Description of the Adverse Event is the most important section
- State clearly what type of adverse event is being reported
- Be sure to include sufficient detail so that an appropriate risk assessment can be made
- Describe the event exactly – don't assume that certain details don't need to be recorded

Contributing Factors

- Indicate what may have contributed to this adverse event
- Think about the environment in which the event occurred
- Consider issues such as staffing, skill mix, other patients etc

Treatments/investigations

- Provide as much detail as possible, for example
  - What type of observations were ordered and for how long?
  - What blood tests/x-rays were ordered and why?
- Indicate whether the interventions ordered were as a direct result of the adverse event

Outcome of the Adverse Event

- All adverse events will have some impact on the people involved
- The impact may be physical, emotional, financial, psychological
- It may not necessarily impact on the subject of the adverse event
- The outcome may not always be obvious at the time of the event – any potential outcome may be listed for follow up during analysis if required

Prevention or Minimization of Outcomes

- This section helps us to identify where we might be able to make improvements to the systems we use
- Include details of how we can achieve these improvements, for example
  - If better communication could have prevented the event, what specifically needs to be done?
  - If practice or policy needs to be changed, what exactly are the changes required?

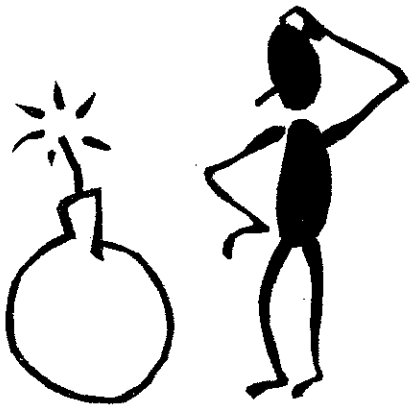
QH Defined Sentinel Events

- Procedures involving the wrong patient or the wrong body part
- Retained instruments or other material after surgery requiring re-operation or further surgical procedure
- Haemolytic blood transfusion reaction resulting in ABO incompatibility
- Medication error leading to the death of a patient reasonably believed to be due to incorrect administration of drugs

QH Defined Sentinel Events

- Infant discharged to wrong family
- Maternal death or serious morbidity associated with labour or delivery
- Intravascular gas embolism resulting in death or neurological damage
- Suicide of a patient in an inpatient unit
- Any serious and rare event

Any questions?



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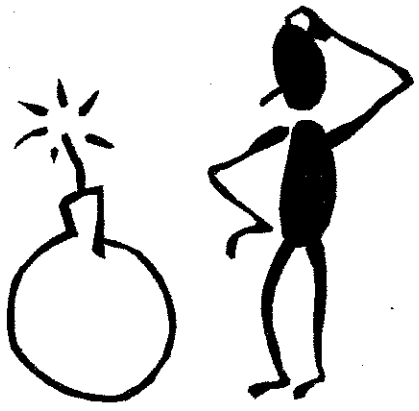

Your time is valuable! Don't waste it searching for data or information we may easily be able to access for you!

District Quality and Decision Support Unit

Jenny Kirby (Decision Support)	2208
Leonie Raven (Quality)	2026
Terry Fleming (Finance)	2056

Bundaberg Health Service District
January 2003

If you can't measure it you can't manage it

DQDSU can assist you to identify areas where improvements can be made, and provide information to support change in practice.

Quality improvement is common sense... the challenge is to make it common practice!

Queensland Government
Queensland Health

Bundaberg Health Service District

District Quality & Decision Support Unit

"Requesting a Meaningful Report" - A Clinicians Guide

VK10

Getting Started

To determine if the District Quality & Decision Support Unit can be of assistance to you, the following may help:

- Do you know if you are performing the key activities of your role effectively?
- How can you demonstrate this?
- Do you want to determine whether a 'gut feeling' belief is true or false?
- Do you want to make a change in practice?
- Do you want to support a point?
- Do you have an ACHS (or other) Clinical Indicator to address?
- Do you know how many patients you (or your department) treated last month compared to previous months?
- Would you like to profile a specific set of patients?

Help Us to Help

We recognise that your time is valuable, and our aim is therefore to create a meaningful report that will assist you to effectively meet your objective.

You can assist us to do this by being as specific as possible about what you want to know, and having a clear idea about the use of the report. The following steps may help you in this:

STEP 1: What are the issues you feel could be addressed or circumstances you wish to change in order to improve the service that your department provides?

STEP 2: Contact DQDSU, and we will assist you in determining what data is available to support your decision in meeting the objective. (See contact numbers on reverse).

Working Together

STEP 3: We will then determine if the information you require is captured in our current data set (If not, we will advise of the next best available data source).

STEP 4: Before your report can be generated, we will need to ascertain details from you such as:

- The time period you wish the data extracted from
- The frequency you require the report (eg once only, monthly etc).

We will endeavour to determine exactly what you wish to demonstrate, so that we can produce the most meaningful report possible for you.

We may have the answers to your questions

District Quality and Decision Support Unit

Jenny Kirby (Decision Support) 2208

Leonie Raven (Quality) 2026

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District Quality & Decision Support Unit

"Supporting Your Decisions in Care"

Who are the District Quality and Decision Support Unit?

A key role of the District Quality and Decision Support Unit (DQDSU) is to assist Doctors, Nurses and Allied Health professionals to routinely monitor the quality of care provided to patients.

For example, the DQDSU can provide regular reports on clinical indicators relevant to your area which will assist you in 'flagging' opportunities for improvement in patient care.

We can provide information on the type and number of patients you have treated, their length of stay and a profile of clinical information related to their care.

When you identify an opportunity for improvement, the Quality Coordinator can assist you to complete the quality improvement activity.

Does this mean more work for me?

NO! Most of the information required to generate meaningful, helpful and reliable reports, can be extracted from various information systems you (or your colleagues) <u>are already entering data into!</u> These include HBCIS (which consists of radiology, theatre, emergency and appointment scheduling modules) AUSLAB, Pharmacy, and Patient-Nurse Dependency (Trendcare).

DQDSU utilises a database called "Transition II" which is able to draw data from all of these information systems into one central database.

WE ARE A ONE-STOP SHOP! Save yourself (and others) the time and frustration of accessing multiple databases, come to us first.

Why would I be interested in using DQDSU information?

Reports generated for you by DQDSU can:

- Allow you to compare your activity with other hospitals
- Demonstrate your throughput/activity levels
- Support evidence-based practice – provide evidence for anecdotal beliefs
- Assist in the collection of clinical indicators relevant to your area
- Assist in the monitoring of adverse events, sentinel events, and complaints
- Assist you in demonstrating outcomes of current practice - this can then be used to support changes in practice, clinical pathways, and support your business cases.