

THEME

Applying Best Practices in Healthcare Delivery

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APHM / ASQua / ISQua International Healthcare Conference 2009



Clinical Governance *The ISQua Perspective*

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Clinical Governance UK

“A system through which (NHS) organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish”

Scally & Donaldson, 1998

Clinical governance

- Clinical governance is defined as “systems by which the governing body, managers and clinicians share responsibility and are held accountable for patient care, minimising risk to consumers and for continuously monitoring and improving the quality of clinical care”

What is this about?

- Right care
- Right patient
- Right time
- Right clinician (with right skills)
- Right way

With a good experience for the patient

World Health Organisation

aspects of clinical governance:

Professional performance review

Resource use

Risk management

Patient satisfaction

Corporate governance in healthcare

Financial aspects – solvency / profit

Targets – output

Audits

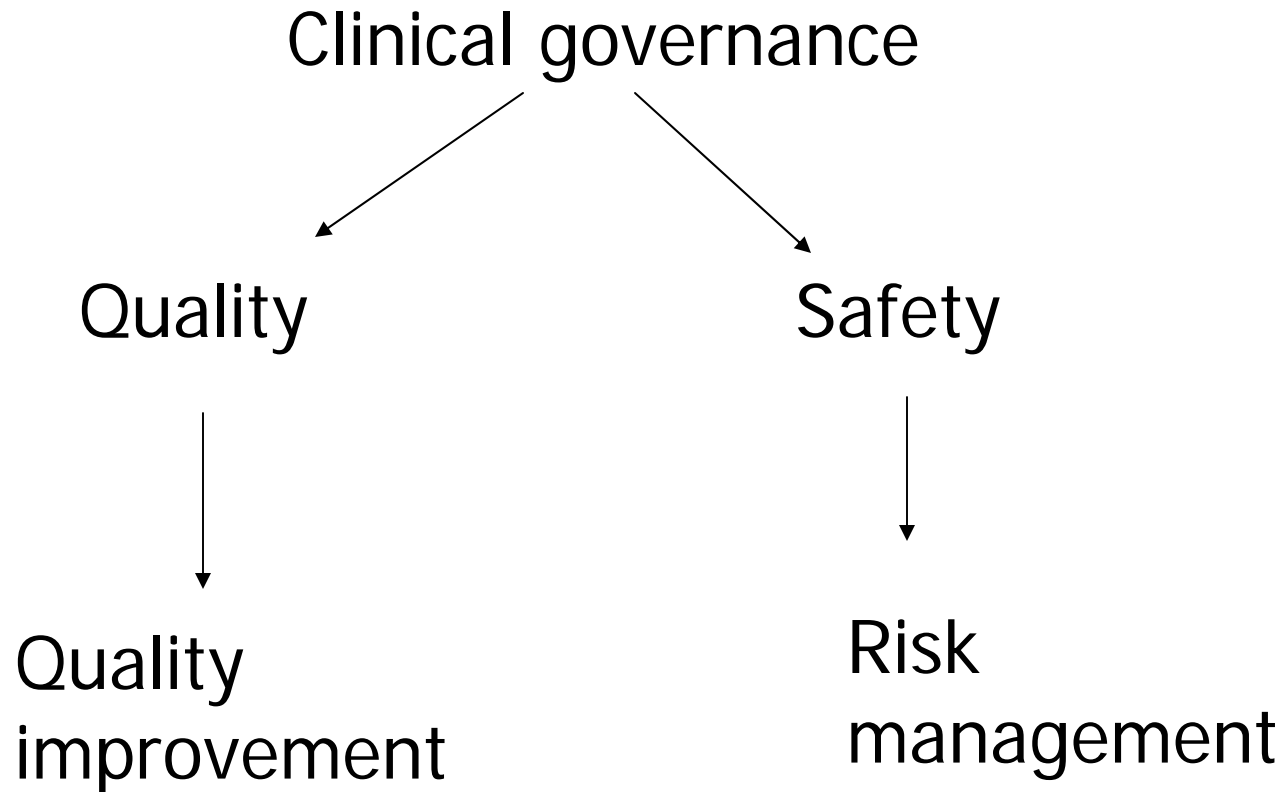
Fairness

Transparency

Ethical business activity

+ Regulation of clinical output / outcomes

Clinical governance – two major components



Components of a Clinical Governance Programme

Evidence based medicine – providing best practice

Credentiailling and defining scope of practice
(qualifications, experience, high standard of care over time)

Clinical audit: measuring performance across six dimensions of quality - of individuals and organisations, and comparing with best practice examples

Components of a Clinical Governance Programme

Professional development

Consumer involvement – determining individual and group needs

Organisational factors – resources, leadership support, education, communication, culture, climate

Dimensions of quality health care

□ Safety

- System, process, teamwork, technical and non-technical skills, supervision

□ Appropriateness

- Problem solving using evidence based medicine

□ Access

- Timeliness

□ Consumer centeredness

- The experience the patient has while undergoing best evidence based care

Dimensions of quality health care

- Effectiveness
 - Right thing, right time, right person – evidence based care
- Efficiency
 - No waste of time / effort; no rework; appropriate support – human & IT

Health professionals with competencies to support this agenda

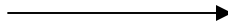
Reporting results of clinical governance programme

Through committees and management structure
to CEO and Board

Reporting

To public about
Improvements to
care and safety

To all clinical staff



Accountability for Clinical Governance

Needs to be clearly defined from boardroom to bedside

- ❑ Ultimately responsibility of CEO and governing board
- ❑ Ranks equally with reporting of organisation's finances
- ❑ Clinicians have professional “daily responsibility” for effective implementation of compliance with organisation clinical governance programme but with a high level of autonomy in areas of clinical expertise

Key factors in establishing and maintaining an effective clinical governance programme

Support of governing board and management by the provision of:

- ❑ Allocated protected time for clinical governance activities e.g audit, CME, skills updates
- ❑ Ensuring work conditions conducive to high quality safe care
- ❑ Support for audit (IT, analysis, staff)
- ❑ Dealing with poor performance in a timely and fair way
- ❑ Provide access to clinical database & email results and evidence based guidelines to support clinical decision making

The New South Wales Patient Safety and Clinical Quality Program

The key components of the Program are:

1. Systemic management of incidents and risks
2. A new incident management system
3. Clinical Governance Units (CGU's) in each Area Health Service (AHS)
4. A quality assessment program for all Public Health Organisations (PHOs)
5. Establishment of the Clinical Excellence Commission

Guiding Principles

1. Openness about failures
2. Emphasis on learning
3. Obligation to act
4. Accountability
5. Just culture
6. Appropriate prioritisation of action
7. Teamwork

Summary of 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. Audit of clinical practices are carried out and where necessary strategies for improving practice are implemented.

The role of the Clinical Governance Unit is to implement the NSW Patient Safety and Clinical Quality Program

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. Clinical performance review
10. Reporting
11. External reports

Incident Management and Root Cause Analysis Policy

Purpose:

The Health Service aims to ensure the provision of safe and appropriate care to the highest standard for all people in New South Wales. This will be achieved through the effective management of incidents where system vulnerabilities are identified and rectified to prevent similar occurrences. Root Cause Analysis (RCA) is one tool used in the effective management of incidents.

Analysis and Action: Analysis

- “The true purpose of incident analysis is to use the incident as a window onto the system – in essence, looking at current weaknesses and future problems.’

Vincent, C. 2004, Analysis of Clinical incidents: a window on the system not a search for root causes, *Quality and Safety in Health Care* 13, 242-243

- Analysis of the incident can allow the care team to reflect on safety in their clinical area.

Feedback

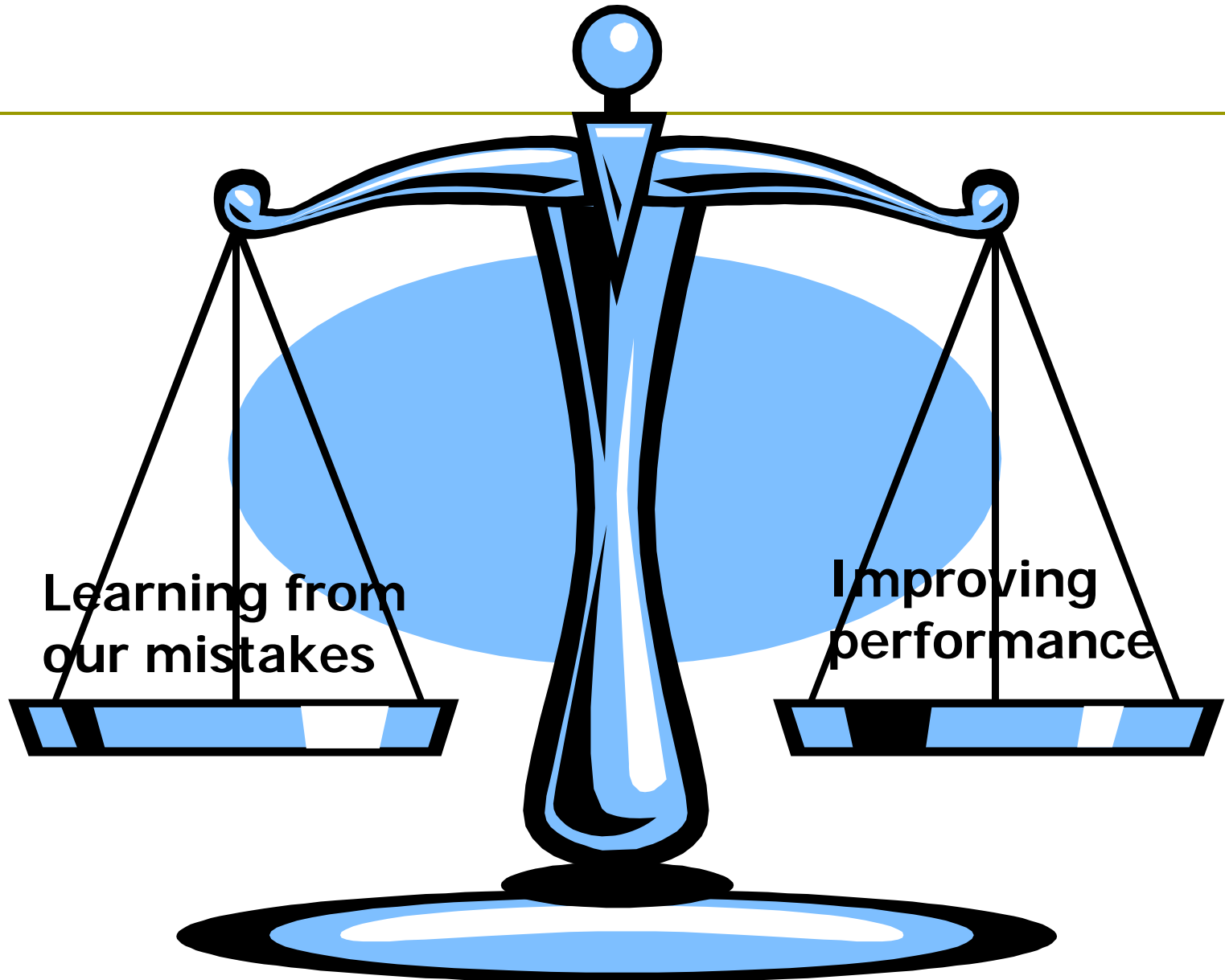
- ❑ Feedback has been identified as an essential component of a successful incident management system.
- ❑ There needs to be feedback to the patient and /or their family/carer.

Feedback to staff and the clinical team

Feedback to staff

- Enhances reflective practice
- Promotes error wisdom
- Assists in sustaining improvement
- Promotes a safety culture

PATIENT SAFETY & QUALITY



Reactive approach

Learning from our mistakes

Incident Management System

Root Cause Analysis

Facilitated Incident Monitoring

Death Reviews

Morbidity/Mortality Meetings

Medical Record Audits

Open Disclosure

Complaints

Pro-active change

Achieving Best Practice - Decreasing Variance

Clinical Practice Improvement

Clinical Quality Improvement

Outcome Databases

Clinical Indicators

Audits

Performance Data

Peer Review

Journal Clubs

Collaborative

Accreditation

Failure Mode Effect Analysis

Second Global Patient Safety Challenge

- <http://www.who.int/patientsafety/safesurgery/en/>



Checklists used for verification (supporting clinical governance)

- ❑ Enhances communication
- ❑ Facilitates teamwork
- ❑ Draws the team together
- ❑ Facilitates post-op communication- handover made safer
- ❑ Empowers all members of the team
- ❑ Reduces errors
- ❑ Increases best practice adherence
- ❑ Improves recall performance
- ❑ Are safety checks and reminders

WHO's 10 Objectives for Safe Surgery

1. The team will operate on the correct patient at the correct site.
2. The team will use methods known to prevent harm from administration of anaesthetics, while protecting the patient from pain.
3. The team will recognize and effectively prepare for life-threatening loss of airway or respiratory function.
4. The team will recognize and effectively prepare for risk of high blood loss.
5. The team will avoid inducing an allergic or adverse drug reaction for which the patient is known to be at significant risk.

WHO's 10 Objectives for Safe Surgery

6. The team will consistently use methods known to minimise the risk for surgical site infection.
7. The team will prevent inadvertent retention of instruments or sponges in surgical wounds.
8. The team will secure and accurately identify all surgical specimens.
9. The team will effectively communicate and exchange critical information for the safe conduct of the operation.
10. Hospitals and public health systems will establish routine surveillance of surgical capacity, volume and results.

...and was found to reduce the rate of postoperative complications and death by more than one-third!

Haynes et al. A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. *New England Journal of Medicine* 360:491-9. (2009)

Results - all sites

	Baseline	Checklist	P value
Cases	3733	3955	-
Death	1.5%	0.8%	0.003
Any Complication	11.0%	7.0%	<0.001
SSI	6.2%	3.4%	<0.001
Unplanned Reoperation	2.4%	1.8%	0.047

Haynes et al. A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. New England Journal of Medicine 360:491-9. (2009)

Change in Death and Complications by Income Classification

	Change in Complications	Change in Death
High Income	10.3% -> 7.1%*	0.9% -> 0.6%
Low and Middle Income	11.7% -> 6.8%*	2.1% -> 1.0%*

Haynes et al. A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population. New England Journal of Medicine 360:491-9. (2009)

* p<0.05

What problems does this checklist address?

□ Safe Anaesthesia and Resuscitation

- An analysis of 1256 incidents involving general anaesthesia in Australia showed that pulse oximetry on its own would have detected 82% of them.¹

¹ Webb, Anaesthesia and Intensive Care, 1993.

What problems does this checklist address?

□ Minimising risk of infection

- Giving antibiotics within one hour before incision can cut the risk of surgical site infection by 50%^{1, 2}
- In the eight evaluation sites, failure to give antibiotics on time occurred in almost one half of surgical patients who would otherwise benefit from timely administration

¹ Bratzler, The American Journal of Surgery, 2005.

² Classen, New England Journal of Medicine, 1992.

What problems does this checklist address?

□ Effective Teamwork

- Communication is a root cause of nearly 70% of the events reported to the Joint Commission from 1995-2005.¹
- A preoperative team briefing was associated with enhanced prophylactic antibiotic choice and timing, and appropriate maintenance of intra-operative temperature and glycemia.^{2, 3}

¹ Joint Commission, Sentinel Event Statistics, 2006.

² Makary, Joint Commission Journal on Quality and Patient Safety, 2006.

³ Altpeter, Journal of the American College of Surgeons, 2007.

Support for implementation

WHO Guidelines for Safe Surgery

Additional resources available online at

www.who.int/safesurgery

www.safesurg.org

Web-based community of hospitals, organizations, and clinicians participating in this program

Safe Surgery Saves Lives Program Team based in Geneva and Boston

Regulation of the healthcare system needs to ensure

- Quality improvement – doing the right thing for patients more often
- Risk management – doing the wrong thing for patients less often

“Quality improvement in health care is a journey,
not a destination...”

Wolff & Taylor 2009

“As with any strategy in life: keep it simple, do
your best, do not give up and success is likely
to follow”

Buchanon J.: Learning from Legends: Australian Cricket, Fairfax Media Publications. 2008

Alan Wolff • Sally Taylor

ENHANCING PATIENT CARE

A PRACTICAL GUIDE TO IMPROVING QUALITY AND SAFETY IN HOSPITALS

