Alan Wolff • Sally Taylor

ENHANCING PATIENT CARE

Foreword

As the title indicates, this is a "practical guide" to enhancing patient care through the improvement of quality and safety in hospitals.

A clear understanding of the key concepts of patient safety, risk management and quality improvement is critical to providing the care that we, as individuals and as a community, expect from our health system. Despite well trained, enthusiastic health care professionals trying to deliver the very best care possible, the system often fails them by a lack of support, encouragement and resources to collect the data, implement the processes and teach the methods that will help to deliver the very best care possible. This practical guide to implementation will help managers, and health professionals at all levels, achieve their goals in safety and quality.

Implementation of processes and methods that are known to work is likely to be the most cost-effective way of improving care. This guide takes the best information about implementation available from the literature and adds the authors' practical knowledge, which has been gained from almost 20 years of hands-on experience at their local hospital in rural Victoria. Their successes have been well publicised and are a credit to them.

Improving quality, addressing risk and providing the safest possible care is not an easy task, with many barriers and some resistance from busy doctors and nurses. Through their own experiences, the authors clearly understand the clinician's point of view, which should help reduce resistance to change. The long-term demonstration and evaluation of successful improvement in an Australian hospital using established methods from health care and other industries gives the guide considerable authority. It is easily accessible, well organised, clearly and simply written and is well referenced.

The authors have set out to produce "an integrated set of quality improvement and risk management modules that can be used individually or in various combinations" and "a practical, step-by-step approach to implementing and maintaining an effective clinical quality and safety program". In my view, they have achieved their goal and have, in so doing, provided great help and a marvellous resource document for everyone who is actively trying to improve care delivery.

Bruce Barraclough, AO
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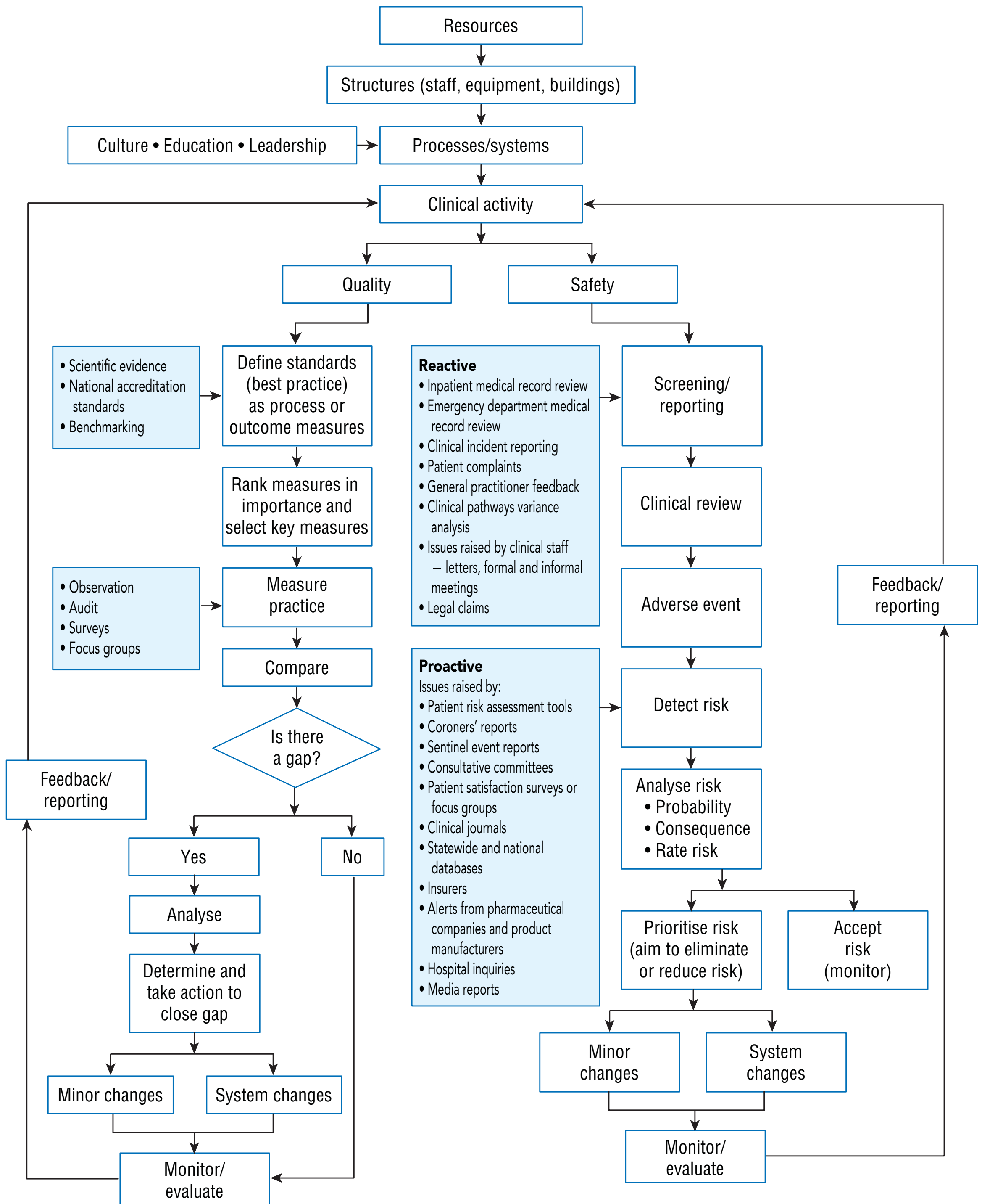
The Wimmera quality improvement and risk management model



Introduction

Health care is primarily about improving the quality of patients' lives, but its delivery can be a complicated process that requires the use of many complex systems. The treatments available for providing patient care are becoming increasingly more effective and complex, with an increased risk of errors occurring. Demand for health services is usually high, and advances in knowledge and technology are rapidly and continuously being made, while the resources available to provide services remain limited. As well as "a complex environment with multiple stakeholders, [there are] conflicting objectives and considerable restraints".[1]

Much of the care provided to patients is not supported by scientific evidence. There is wide variation in the treatment being given to patients with the same clinical conditions, and a significant proportion of the care recommended for the leading causes of death and disability are not being provided.[2] Further, some care that is provided causes preventable harm to patients,[3] and most errors are thought to be undetected and unreported.[4] Considerable cost is being incurred and valuable resources expended in providing suboptimal care.

There is an expectation by the community that health care will be of high quality, that people receiving health care will be safe while it is being delivered, and that errors in providing care are "neither acceptable nor inevitable".[4] Consequently, if the anticipated outcome of care is not achieved, retribution is often sought; hence, litigation by patients against clinicians and health services is increasing.[4] At the same time, health professionals and management are being held increasingly accountable for the quality and safety of the care they provide, not only by patients and their relatives, but also by governments and regulatory and funding bodies. Despite these conditions, the management of many health services still predominantly emphasises the service's financial situation and patient throughput targets, rather than the quality of care and the level of patient safety within the health service.

In our experience, most health care professionals want to provide the best possible care for their patients. However, even with the very best of intentions and the greatest vigilance, suboptimal care and errors in patient management occur frequently. Given the conditions under which health care is currently provided, how can health services and the professionals working within them ensure that they consistently provide a high-quality, safe service to their patients? The structures, processes and systems of health care delivery are created under the influence of leadership. Culture and performance need to be effectively monitored, and systems appropriately changed in response to the quality and safety of the care that is being provided.

There is now a great deal written about the quality of care provided to patients and the level of patient safety in health services. Twenty years ago, the occasional article about quality or safety would appear in major clinical journals. Now, whole journals are devoted to these topics, and the volume of literature is considerable. The terminology used in these publications has expanded, and can be confusing. There has been much activity being undertaken aimed at improving the quality and safety of clinical care, but there are still significant gaps in the quality of care provided to patients, and the number of adverse events experienced by patients while receiving care is still substantial. Health services need a simple, clear-cut and practical approach to delivering high-quality and safe health care to assist with their quality improvement and risk management programs.

This book has been written to assist the many health care professionals and health services who are strongly committed to providing high-quality, safe care to their patients, and who are searching for the best way to provide such care. It is written from the perspective of a health service that independently

wishes to improve the quality of care it provides for its patients and raise the level of patient safety in their facility, without these requirements being imposed on the service by external regulatory, accreditation and funding bodies. We have found that in most health services, there are individual clinicians and managers with a genuine passion and internal drive to provide the best care possible for their patients — without having this forced upon them as a requirement of their senior management or from external bodies.

Much of what is written about quality of care and patient safety is theoretical, and the evidence — especially about the effective implementation of quality and safety strategies — is limited. Relatively little is written of practical value to individual health services trying to satisfactorily address these important issues in their facilities. The task can be overwhelming for clinicians charged with the responsibility of developing, implementing and maintaining a quality and safety program for their individual health services Without clear overall direction from a comprehensive organisation-wide quality and safety program, individual health services may move in many directions simultaneously, with little overall integration and coordination. The next practical steps that individual health services should undertake in their quality and safety programs are often not clearly visible.

To fill this gap, we describe a simple and practical framework that can act as a signpost for health services wishing to establish a quality and safety program (or enhance an existing program) to effectively monitor and improve quality and safety in all the clinical areas of their health service.

The framework is:

- logical
- fully integrated
- easy to understand
- based on relevant theory, evidence, and 19 years of practical experience in designing and implementing a comprehensive clinical quality improvement and risk management program at the Wimmera Health Care Group in Horsham, Victoria.

We describe in detail an integrated set of quality improvement and risk management modules that can be used individually or in various combinations. A practical, step-by-step approach to implementing and maintaining an effective clinical quality and safety program will also be described, together with practical examples outlining how each component of the program can be used in practice.

References

1 Iles V, Sutherland K. Organisational change: a review for health care managers, professionals and researchers. London: National Co-ordinating Centre for NHS Service Delivery and Organisation R & D, 2001.

2 McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. *N Eng J Med* 2003; 348: 2635-2645.

3 Brennan TA, Leape LL, Laird NM, et al. Incidence of adverse events and negligence in hospitalised patients. *N Eng J Med* 1991; 324: 370-376.

4 Bion JF, Heffner JE. Challenges in the care of the acutely ill. *Lancet* 2004; 363; 970-977. □

ENHANCING PATIENT CARE

We all want the best possible standard of care for our patients.

But high-quality, safe health care can be difficult to achieve. Above all, it requires cultural change, which in turn can only occur through the dedicated, consistent efforts of clinical safety champions.

Alan Wolff and Sally Taylor are two such champions. Based on their well recognised work in the Wimmera Health Care Group in Victoria, Australia, they have created a commonsense guide to quality improvement and risk management. Their experience at a regional hospital has led to a pragmatic framework that guides other health services through the relevant evidence and theory, down to the finest details.

Enhancing Patient Care will be of use to anyone who wants to set up or improve a quality improvement and risk management program, regardless of size and budget.

About the authors

Alan Wolff is the Director of Medical Services at Wimmera Base Hospital. He has 27 years' experience in medical administration, and has a research interest in quality improvement and risk management methods and their use in hospitals. He was involved in the development of Wimmera Base Hospital's adverse event screening program, which began in June 1989 and was one of the first commenced in an Australian hospital.

Sally Taylor has worked in clinical risk management for 10 years and is currently the Clinical Risk Manager of the Wimmera Health Care Group. She has experience with quality and risk programs in both regional and small rural hospitals. She has a clinical background and qualifications in midwifery and intensive care nursing.

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