AAQHC Presentation Clinical Governance in Healthcare

KATHLEEN RYAN

AAQHC Life Member AAQHC Fellow ISQua Fellow
Director Clinical Governance & Information Services
Mid North Coast Local Health District, NSW

11 AUGUST 2021

History

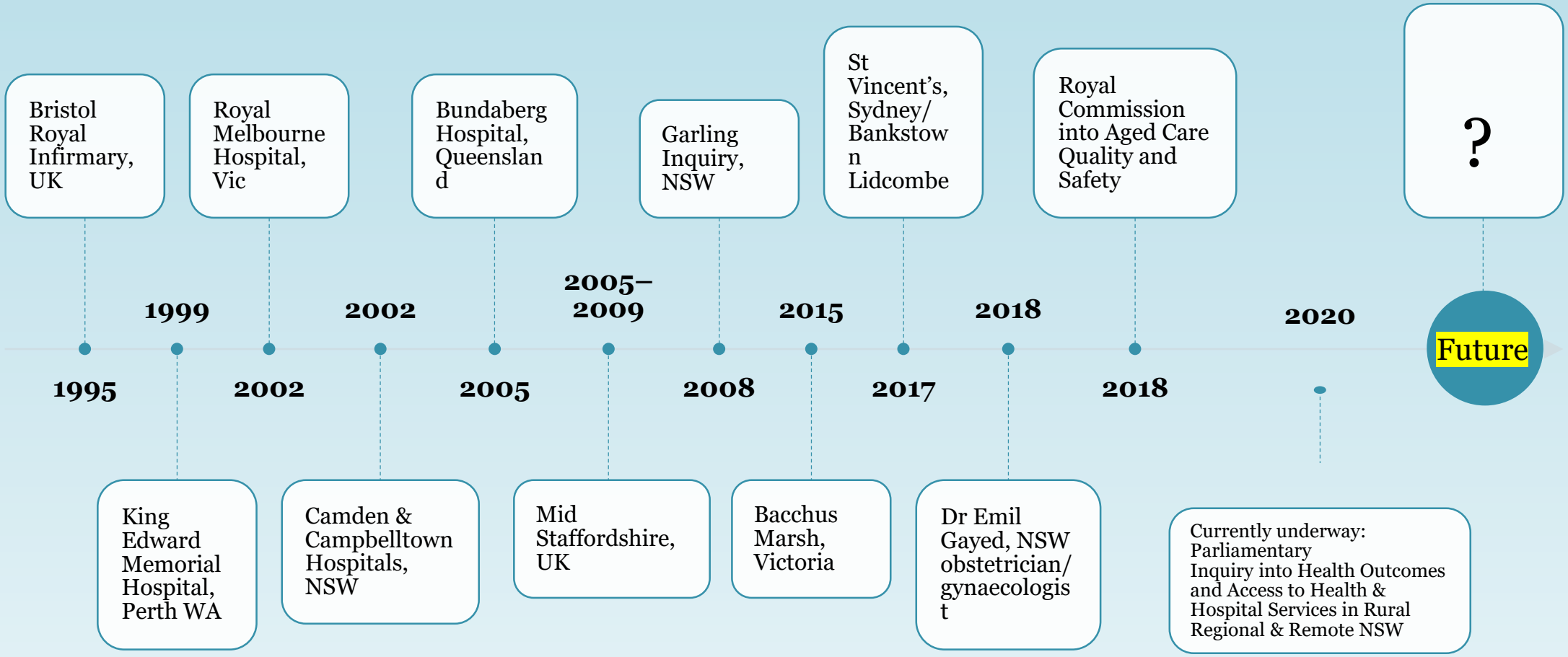
- **Clinical governance** emerged in health care following the Bristol cardiac surgery scandal in 1995, when an anaesthetist, Dr Stephen Bolsin exposed the high mortality rate among babies having complex heart surgery at the Bristol Royal Infirmary.
- He was unable to get action from hospital managers over his concerns citing the reason for this was staff wanted to maintain funding and the hospital unit's designation as a specialist heart facility .
- A subsequent enquiry investigated 53 operations carried out by two surgeons left 29 babies dead and four brain injured.
- Due to backlash from the medical fraternity, Dr Bolsin was forced out of the UK and accepted a post in Australia.

1995 Quality in Australian Healthcare Study (QAHCS)

Wilson RM[1], Runciman WB, Gibberd RW, Harrison BT, Newby L, Hamilton JD.

- A review of the medical records of over 14,000 admissions to 28 hospitals in NSW and SA revealed **16.6%** of admissions were associated with an "adverse event" resulting in disability or a longer hospital stay for the patient, and was caused by health care management.
- **51%** of the adverse events were considered preventable.
- In **77.1%** the disability had resolved within 12 months, but in **13.7%** the disability was permanent and in **4.9%** the patient died.

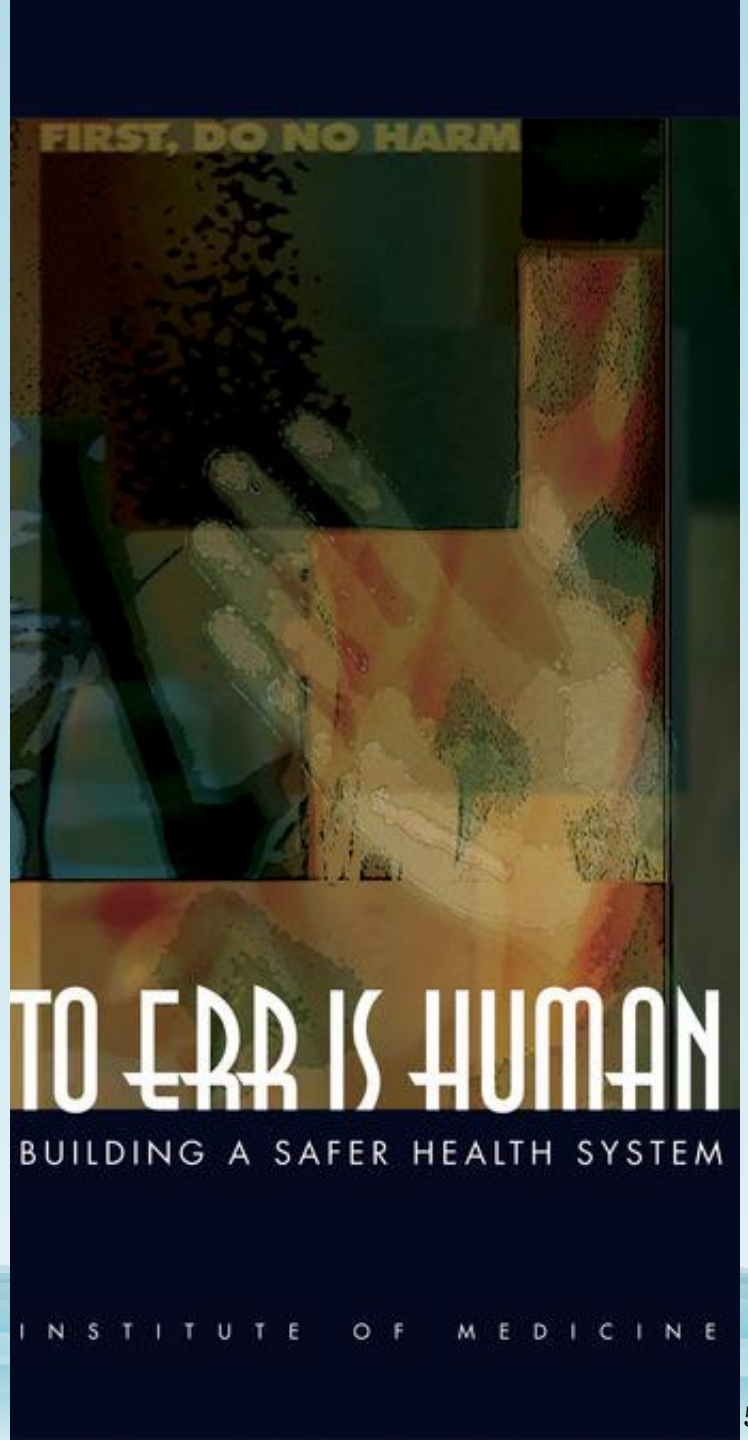
Do we have a problem?



Institute of Medicine (2000)

...as many as 98,000 people die in any given year from medical errors that occur in hospitals. That's more than die from motor vehicle accidents, breast cancer, or AIDS--three causes that receive far more public attention....

Ref: Raj Behal 2014



Australasian Association for Quality in Health Care

From the literature

Google – 582 "scholarly" articles

- Harvard Study USA: 4% of admissions
- Australian Study: 16.6% of admissions
- British study: 10% of admissions
- WHO: 1 in 10 patients

Cost

- NHS: average additional 8 days in hospital
- Australia: 8% of all hospital bed days

Outcomes of Inquiries

1

Inadequate clinical governance and systems to monitor and respond to performance issues or serious incidents.

2

Insufficient incident reporting, clinical profiling, mortality and morbidity review, credentialing, risk management and accreditation

3

Over 20 years of inquiries the recommendations remain almost the same.

4

We need systems to monitor and measure and respond to performance issues early with focus on continuous improvement.

Principles of Clinical Governance

- Shared accountability between Boards, Managers and Clinicians for clinical outcomes.
- Governance structures – defined points of accountability
- Robust monitoring and reporting systems
- patient-centred
- open and transparent culture
- all staff actively participate
- focus is on continuous quality improvement

What makes a good Clinical Governance system?

Structure - Organizational Structure (who is accountable for what), Committee Structure (HCQC/HCQC subcommittees), Governance Framework (Roles and Responsibilities of managers and staff),Clinical Governance Plan (2 year plan for Safety and Quality activities)

Processes - Clinical Incident Management System (IIMS, RCAs), Clinical audits, Clinical Indicators, Complaints Management, Death Reviews, M&Ms, Clinical Practice Improvement (PDSA cycles), P&P, Credentialing, Clinical Risk Management, Performance Management

Outcomes - Accreditation, Process Indicators/KPIs, Activity Data, Clinical Outcomes, Patient and staff satisfaction surveys

Australasian Association for Quality in Health Care

Patient safety and quality

Simply…

Quality

Everything that should happen for the patient, happens:

- Pre-operative antibiotic prophylaxis, VTE prophylaxis, colorectal cancer screening, immunizations, evidence-based treatments, survival after stroke, function after knee replacement….

Safety

Everything that *should not* happen to the patient, *does not* happen:

Missed diagnosis of cancer, CLABSI, pressure ulcer, morphine overdose, wrong site surgery, preventable death…
(Ref: Raj Behal 2014)

Why is patient safety important?

- The effects of harming a patient are widespread and can have long lasting physical and emotional consequences for the patient, family and staff
- There is a financial impact on the organisation, $$$, ALOS

What the experts say:

Brent James
Intermountain Healthcare,
European Forum Paris, 2008

- Massive variation in clinical practice
- High rates of inappropriate care
- Unacceptable rates of preventable injuries
- Under-use of effective treatments

“We need new ways of thinking…”

Professor Jeffrey Braithwaite, Founding Director, Australian Institute of Health Innovation, Director of the Centre for Healthcare Resilience and Implementation Science and Professor of Health Systems Research, Macquarie University

The key measures of health system performance have frozen for decades:

- **60%** of care is based on evidence or guidelines;
- the system wastes about **30%** of all health expenditure;
- and some **10%** of patients experience an adverse event

Ref: Braithwaite J. Changing how we think about healthcare improvement *BMJ* 2018; 361 :k2014 doi:10.1136/bmj.k2014

Why do things go wrong?

Issues well-known but not handled.

- **Bristol Royal Infirmary** - poor clinical practices and outcomes in **surgery for babies with heart problems were** well known within the hospital, GPs, Royal College of Surgeons and the Department of Health.
- Similar failures in **pediatric cardiac surgery** in **Winnipeg**, Manitoba, in 1994.
- Serious problems in **obstetric services** at the **King Edward Memorial Hospital in Perth** were investigated in 2001 where a long history of repeated complaints and a trail of litigation stretching back many years were revealed.

Lack of management systems.

Problems often centered on an **individual clinician or small team** rather than looking at *system failures*

Organisations **lacked fundamental management systems** for quality review, incident reporting, and performance management

There is **little collaboration** between **managers** and clinicians

There is a **lack of coherent clinical leadership**

Organisation is isolated and inward-looking and unwilling to learn from elsewhere.

Staff and patients are **disempowered, vulnerable, and poorly placed** to raise concerns

Leadership and management

Consistent with Francis' findings from Mid Staffordshire, good management is as important as good leadership

The wellbeing of staff is closely linked to the wellbeing of patients

Staff engagement is a key predictor of patient outcomes

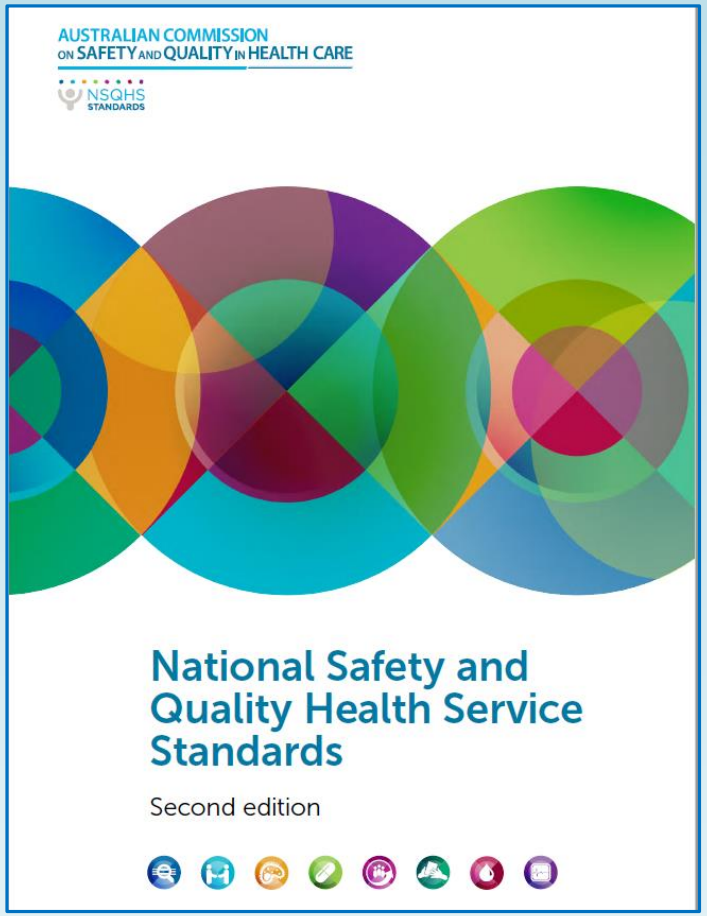
Achieving high levels of engagement is only possible in cultures that are generally positive, when staff feel valued, respected and supported, and when relationships are good between managers, staff, teams and departments.

https://www.kingsfund.org.uk/audio-video/robert-francis-lessons-stafford

Australasian Association for Quality in Health Care

Responding to systems failures

At a National Level



- Australian Commission for Safety and Quality in Health Care established
- National Accreditation Scheme
- Focus on high-risk clinical areas
- Mandated by the Minister

2018 Royal Commission into Aged Care Quality and Safety

February 2016, a male patient of the South Australian government-run Oakden Older Persons Mental Health Service was referred to the Royal Adelaide Hospital with significant bruising to his hip with no explanation. His family complained to government authorities

Oakden closed in 2017 after it was revealed that a patient with Parkinson's disease was beaten by another resident at least thirteen times between December 2016 and March 2017 and did not receive recorded medical care despite being reported to the Australian Aged Care Quality Agency.

In 2018, ICAC reported findings of maladministration against five individuals and Oakden painting a picture of life for some of the most vulnerable members of society were "**poorly cared for, forgotten and ignored**"

On the eve of the September 2018 broadcast of the *Who cares?* series by *Four Corners* investigation into the aged care sector and the abuse and neglect of the elderly in nursing homes, Scott Morrison announced there would be a recommendation to the Governor-General that a Royal Commission into aged care be established

The Royal Commission was established on 8 October 2018

Final report "Care, Dignity and Respect" was tabled 1 March 2021

148 recommendations

Royal Commission

"Changes committed to are often slow to eventuate or fall away prior to implementation."

and

"While governments have responded with ad hoc reforms to elements of the system, they have not been able to resolve the underlying problems with a system that has failed to provide the Australian community with the assurance of quality and safety in aged care that it expects."

Royal Commission Final Report – critical areas for attention

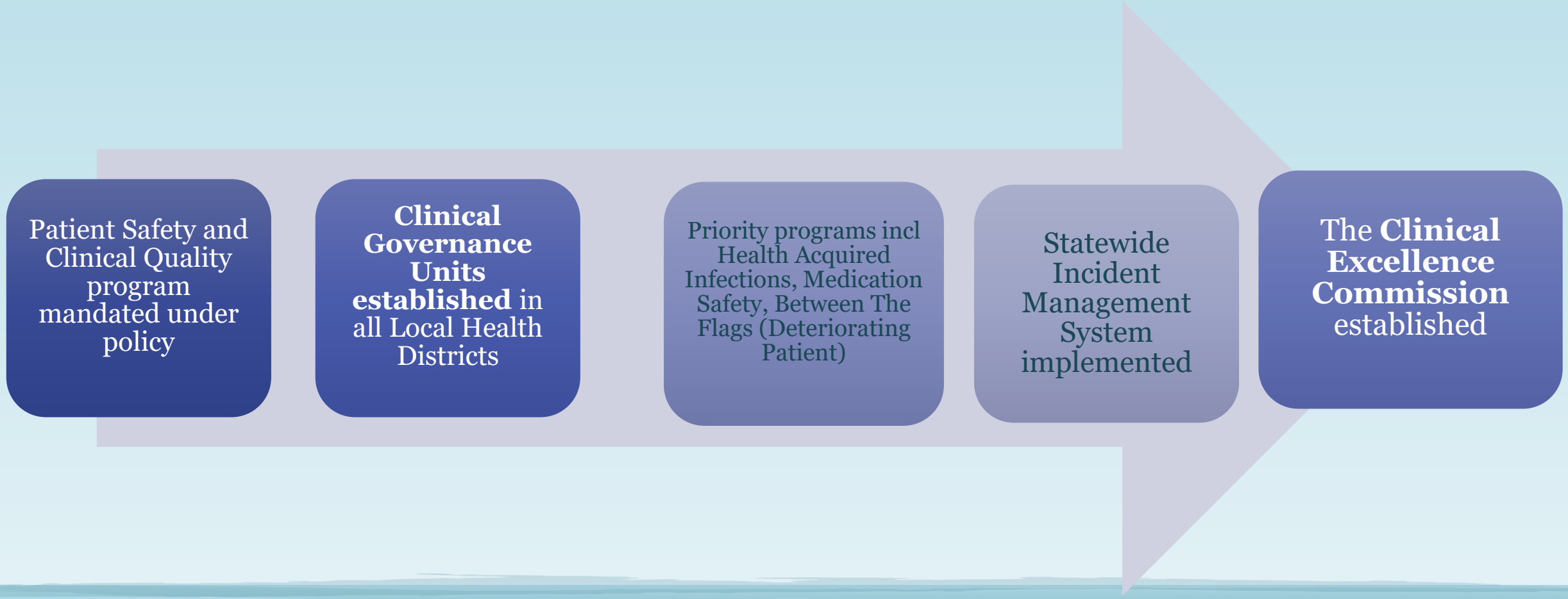
- Assessment and care planning
- Infection control
- Restrictive practices
- Complex care
- Dementia care
- End of life care
- Mental illness
- Diet, nutrition, hydration and weight loss
- Oral health
- Would care, pressure ulcers
- Assaults

Ref: https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-executive-summary.pdf

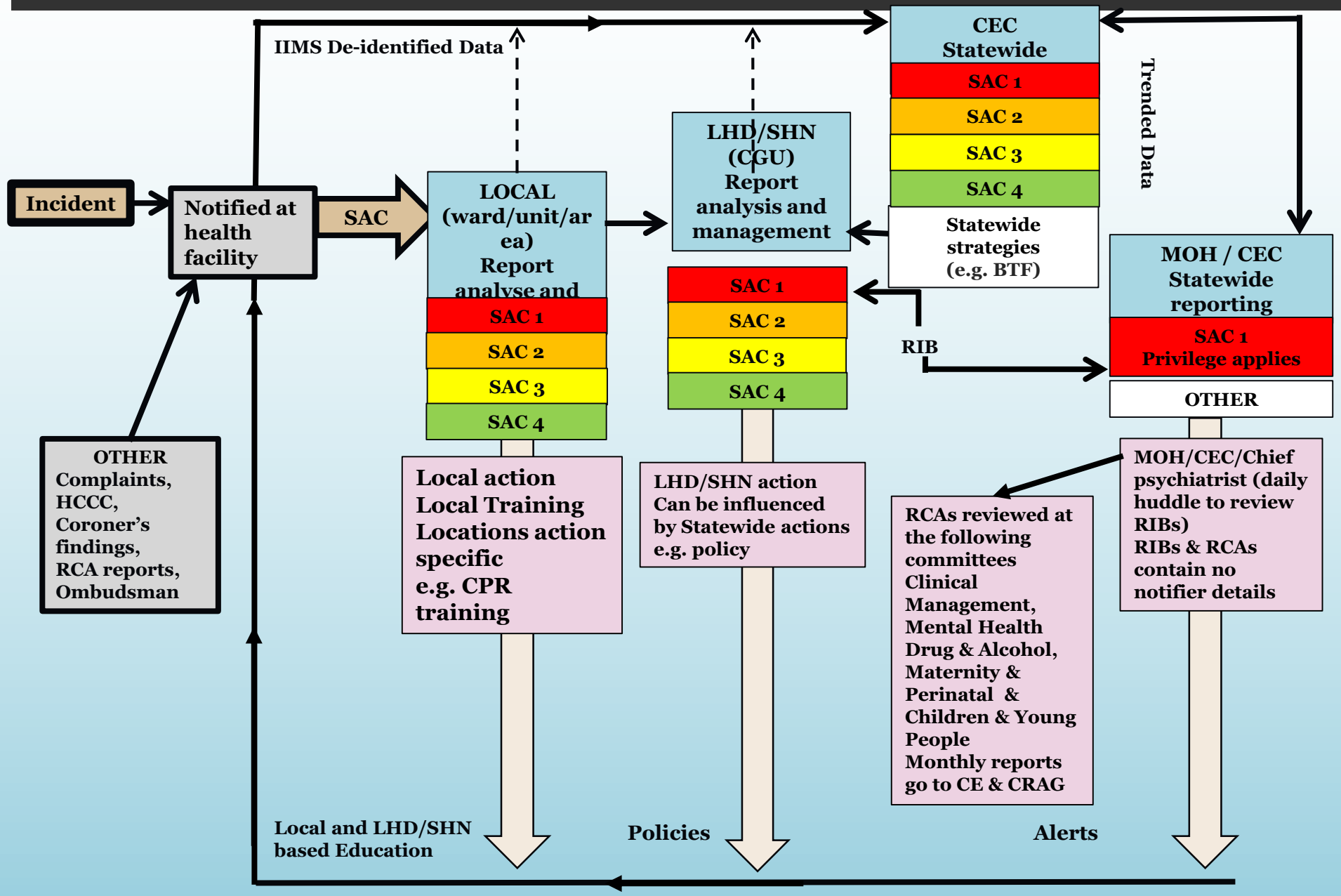
Strategies

- Use of clinical indicators and benchmarking
- Serious incident Response Scheme (SIRS)
- Focussing on person-centred care
- More Allied Health Engagement
- Better documentation
- Strengthening Community engagement
- Open disclosure/communication
- Improving complaints management systems

State Level - NSW Ministry of Health



NSW Incident Management: Investigation and Corrective Action



2020 – NSW Introduction of new serious incident management LEGISLATION and POLICY

Serious Incident Investigation and Management

New Legislation mandates:

- Preliminary risk assessment/immediate response
- Early and continuous open disclosure/support for family
- Patient and families contribute to investigation
- Care for the care giver / staff support
- Separation of findings report and recommendations
- Alternate methodologies to be identified and approved
- Sharing lessons

New Legislation

Provides for an enhanced systems approach to serious incident investigation

- Improved involvement of family and care teams.
- Early action and organisational commitment.
- Improved investigation methodologies.

Individual accountability

- We are all responsible for raising concerns if we observe “poor care”.
- If there is “notifiable conduct”, we are obligated to report to external bodies.

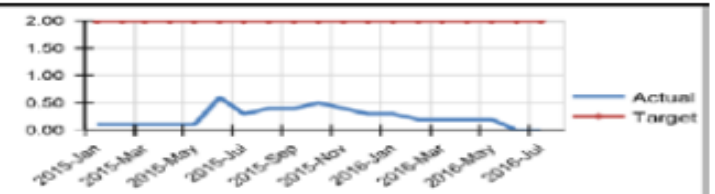
Australasian Association for Quality in Health Care

Reporting to the Board

The Board

Boards were established in NSW after the health reforms in 2011 to ensure effective **clinical** and corporate **governance** frameworks were established to support the maintenance and improvement of standards of patient care and services (*Health Services Act 1997*).

Example: Board Performance Report
NSW Mid North Coast Local Health District

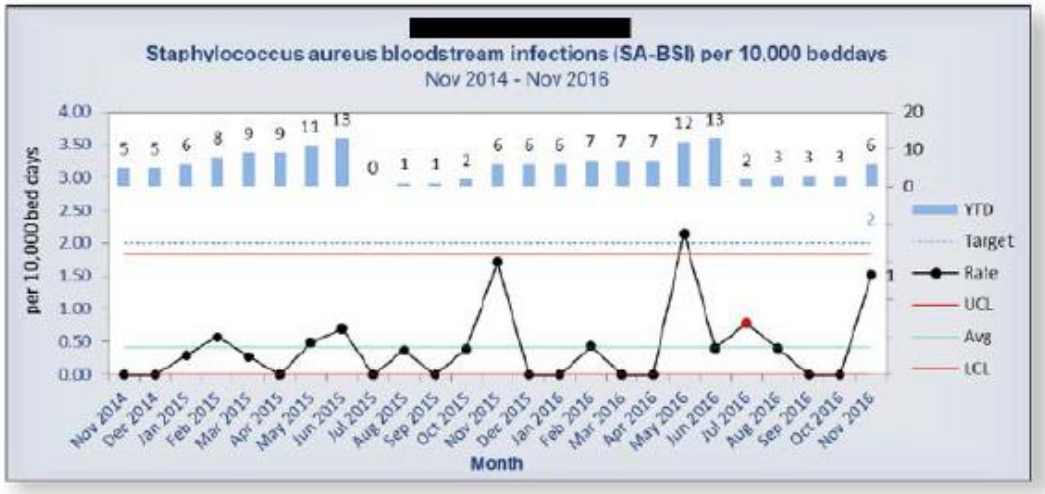
Tier 1	Patients with (D1a-F8) Staphylococcus aureus bloodstream infections (SABSI) per 10,000 bed days	0.00	2.00(T)	●	Last report from the Ministry of Health is July, awaiting August report. Page 13 of 104	

G: Green - Performing to Target | O: Orange - Under Performing (within 10% tolerance of Target value) | R: Red - Not Performing

↗ Improved on previous month ↘ Decreased performance since previous → Steady - same as previous month

Safety and Quality			Target	Current	As At	Eval
1	Tier 1	Staphylococcus aureus bloodstream infections (SA-BSI) - rate per 10K bed days	<2.00	1.52	Nov-16	G ↘
2	Tier 2	Patient Experience Survey following treatment - rated good and very good - %	80%	93%	Mar-14	G ↗
3	Tier 2	Hospital acquired pressure injuries - rate per 1K stays	0.50	0.00	Aug-16	G ↗
4		Hand Hygiene Program - Correct Moments - %	82%	91%	Dec-16	G ↗
5		Root Cause Analysis - completed within 70 days - %	100%	100%	Dec-16	G →
6		Complaints Resolved within 35 Days - %	80%	61%	Nov-16	R ↗
7		Clostridium difficile Infections (CDI) - rate per 1,000 acute separations	1.00	0.48	Nov-16	G →
8		ICU Central Line Associated Bloodstream (CLAB) Infections - number	0.00	0.00	Nov-16	G →
Emergency Department KPIs			**Target**	**Current**	**As At**	**Eval**
9	Tier 1	Transfer of Care from Ambulance to ED within 30 minutes - %	90%	92%	Dec-16	G →
10	Tier 1	Emergency Treatment Performance - Patients with total time in ED <= 4 hrs - %	61.0%	61.1%	Dec-16	G ↗
11	Tier 1	Presentations staying in ED > 24 hours - number	0	25	Nov-16	R ↗
Unplanned Readmissions			**Target**	**Current**	**As At**	**Eval**
12		Unplanned Hospital Re-admissions within 28 Days of Separation - %	6.20%	6.50%	Oct-16	O →
13		Unplanned and emergency re-presentations to same ED within 48 hrs - %	6.20%	5.90%	Nov-16	G ↘
14	Tier 2	Non-Urgent Patients waiting more than 365 days for an appointment - number of patients	0	3	Sep-16	R →
Incidents			**Target**	**Current**	**As At**	**Eval**
15		Total Clinical Incidents - rate per 1,000 beddays	30.00	20.56	Nov-16	G ↘
16		SAC 1 Incidents - number	0	0	Nov-16	G ↗
17		SAC 2 Incidents - number	0	9	Nov-16	R ↘
18		SAC Score 3/4 - number	22.16	22.61	Nov-16	R ↘
19		No SAC Score	0	56	Nov-16	O ↘
20		Clinical Management Incidents	3.54	4.92	Nov-16	O ↘
21		Falls per 1,000 bed days	4.00	4.71	Nov-16	R ↘
22		Falls - With Harm (SAC 1 and 2)	0	1	Nov-16	R ↗
23		Medication Incidents - per 1,000 bed days	3.59	5.88	Nov-16	R ↘

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

Governing the Quality of Healthcare

- 2017 Research '*Governing the quality of care in Australian public healthcare organisations*'* examined how managers and boards work together to govern the quality of care, and how performance is reported to Boards.

- Recommendations:
  1. Triangulating traditional safety and quality KPIs with other sources, eg *patient experience data* to derive additional insights

  2. Further analysis of low/no harm incidents and near misses to strengthen system defence

  3. Moving beyond process and outcome KPIs to indicators for ***system culture, leadership and overall resilience***

Ref: Brown, A Governing the quality of healthcare in Australian public hospitals. Final Research Report for Case Study Organisations October 2018. PhD Student, University of Melbourne

Australasian Association for Quality in Health Care

SUMMARY

As Quality and Safety Experts

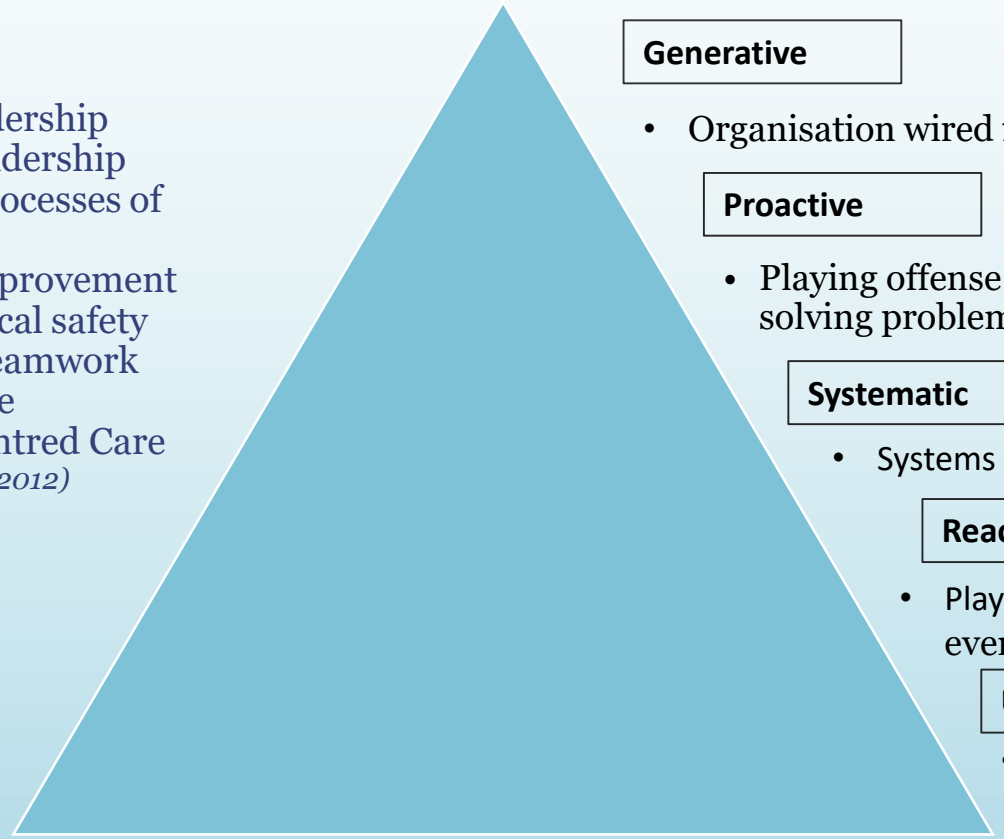
- Acknowledge we are imperfect humans in an imperfect world and an imperfect workplace
- Engage with clinicians and other managers to minimise harm
- Understand the systems needed to minimise harm
- Question how reliability can be improved and build the necessary systems

“High-performing health care organisations build in-house capacity for quality improvement and in so doing learn from others”

Ham, Berwick and Dixon (2015). *Improving quality in the English NHS - A strategy for action“. The King’s Fund: London.*

- Senior leadership
- Clinical leadership
- Reliable processes of care
- Process improvement
- Psychological safety
- Effective teamwork
- Just culture
- Person-Centred Care

(Frankall, A., 2012)



Generative

- Organisation wired for safety and improvement

Proactive

- Playing offense - thinking ahead, anticipating, solving problems

Systematic

- Systems in place to manage hazards

Reactive

- Playing defensive – reacting to events

Unmindful/Pathological

- No awareness of safety culture

Socio-technical framework for healthcare

Questions for you and your organisation

(Ref IHI)

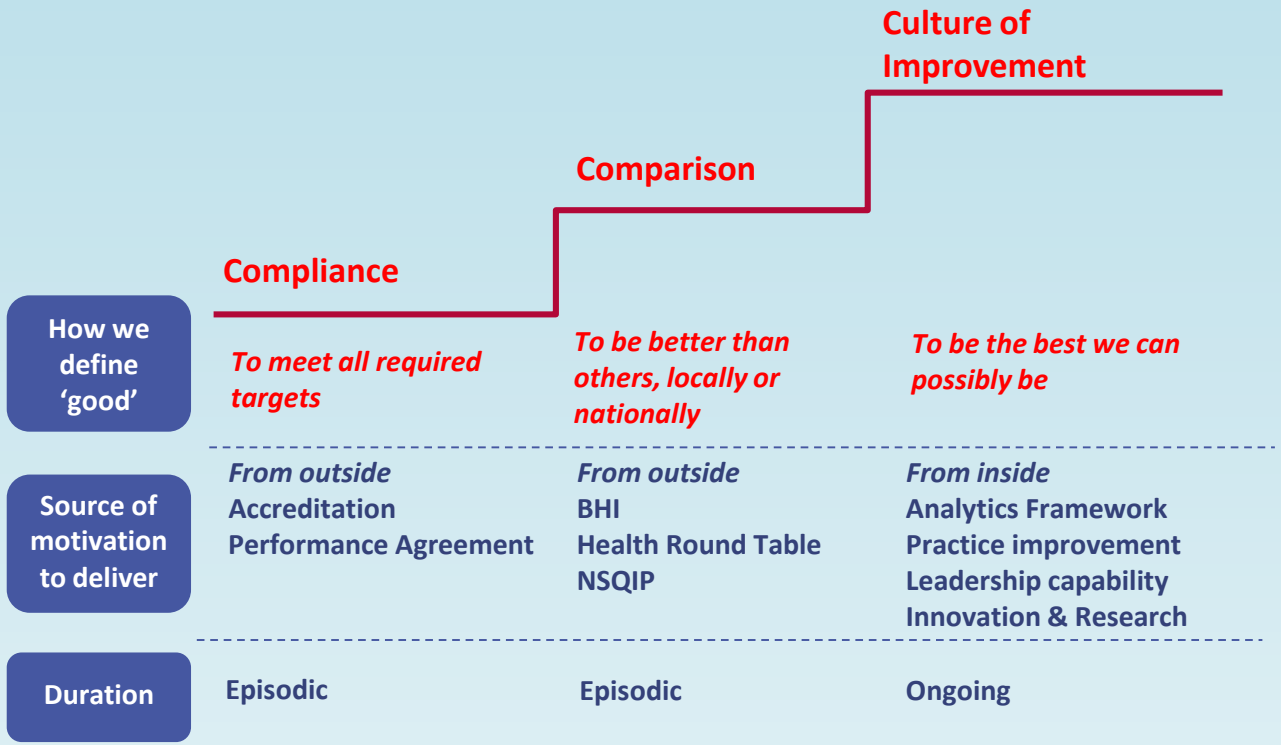
- Is clinical governance embedded in your organisation?
- Are quality and safety included in your strategic vision and clearly articulated to all staff?
- Is there evidence of a culture of trust and openness in your organisation?
- As a manager, do you champion the quality and safety culture?
- Does everyone take responsibility for quality and safety?
- Are there strong partnerships between patients, managers, clinicians and other staff?
- Is your organisation transparent about clinical outcomes?
- Are your clinical governance processes and systems open to public scrutiny?
- Do Board members receive the data they need to inform them of the quality and experience of patient care?

ACTION needed by you

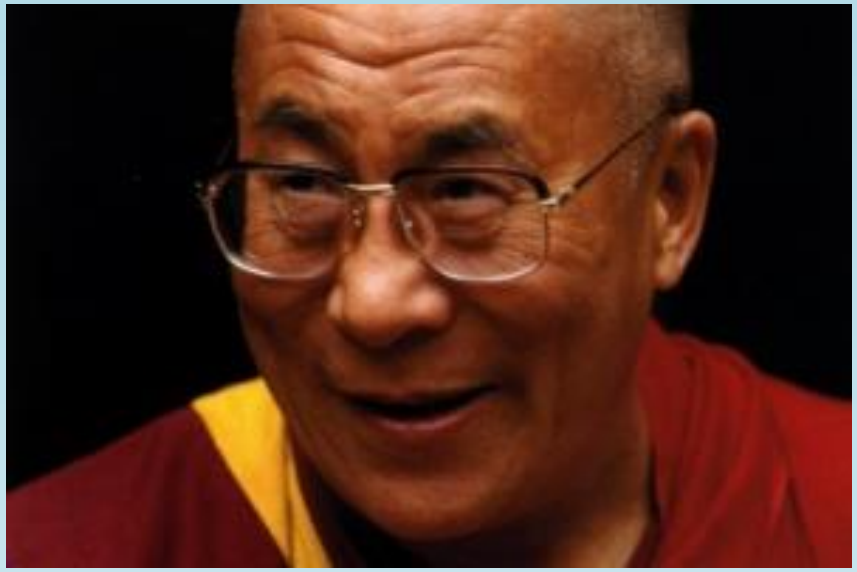
Ensure **it is easy for staff** to:

- Report on patient safety concerns during clinical rounds
- Flag errors and safety issues on handover and walkarounds
- Participate in regular, multidisciplinary team safety meetings; and
- Receive immediate feedback on errors and safety reports
- Have access to the incident management system
- Identify the lessons to be learned from adverse events
- Undertake Continuous Improvement to upskill clinical teams in improvement science.

Our Quality Journey



Our purpose



Our prime purpose in this life is to help others…

And if you can't help them, at least don't hurt them.

Dalai Lama

Questions?

Kathleen Ryan
Life Member AAQHC, Fellow AAQHC, Fellow ISQua

Director Clinical Governance & Information Services
Mid North Coast Local Health District, NSW
Mob: 0414372294 : kathleen.ryan1@health.nsw.gov.au