Government of Western Australia
Department of Health

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Safety and Quality

Newsletter

A Message from the Executive Director

Welcome to the second edition of the Safety and Quality Newsletter for 2021.

In recent months, we have been buffeted by the pressures of more patients, sicker patients, media reporting of high-profile clinical incidents, and a litany of stories of a system in crisis.

In this environment, I'm concerned about two major issues. The first is staff pride, morale and work satisfaction – and I want to offer a different reflection of who we are, to remind us of the legacy of good care and service that WA Health staff continue to provide each day. Every WA health service participates in national benchmarking; and many clinical areas contribute to national clinical quality registries. Data from these activities show that WA Health compares favourably with our national peers. In the past 12 months, WA Hospitals completed over 630,000 admissions. We have much to be proud of, because behind each of these numbers are individual patients and their families to whom we have tended with care.

The second issue is our patient safety culture. Over many years, WA has worked hard to establish robust systems to ensure safe care is delivered. This is shown through participation in national audit programs (one of which was born in WA!); in our high rates of clinical incident reporting – including of 'near miss' events ; in the development of safety and quality dashboards; and in emerging cross-sector collaboratives to improve care.

Clinical staff and the Department of Health work together to support quality improvement and patient safety, even where this involves uncomfortable discussions about complications of care and unwarranted variation. This shows a health system which is open to learning, where staff have embraced the opportunities for improvement, and are supported by processes that allow sharing of lessons learnt.

Despite the unpleasant focus of recent public and media scrutiny, we will learn from these patient stories and will identify where we could have done better. We will continue to scrutinise our own practice for further opportunities to improve the care we provide as a high-reliability organisation. There is no shame in this, and you all deserve to take pride in the work you do. It is who we are, who we want to be, and what we need to do to provide safe and quality care for West Australians.

Dr Audrey Koay

Executive Director

Patient Safety and Clinical Quality

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Email: PSCQ.CED@health.wa.gov.au

Who are the Patient Safety and Clinical Quality Directorate?

Although we've been around a while, we thought you'd like a refresh to learn a little more about the Patient Safety and Clinical Quality Directorate based in the Department of Health.

The Patient Safety and Clinical Quality Directorate (PSCQ) is dedicated to improving patient experience and outcomes in WA health care organisations. PSCQ sits within the Clinical Excellence Directorate; and is led by Dr Audrey Koay and supported by the Executive Office, Policies and Projects team, to deliver two main functions –

- Regulation, assurance, and reporting for patient safety
- Ongoing engagement to support quality improvement and promote high-value healthcare

What our specialist teams do:

HealthCare Quality Intelligence Unit

"Driving improvement through data"

- Sources and analyses quality-of-care data to monitor patient outcomes using national and WA based data systems
- Manages the Safety and Quality Indicator Sets – standardised indicators used by Department of Health and Health Service Providers

Licensing and Accreditation Regulatory Unit

"Monitoring WA healthcare organisations"

- Regulates public and private health service accreditation as part of the Australian Health Service Safety and Quality Accreditation Scheme
- Provides expert advice, investigations, reviews and responsive recommendations to areas of high risk or perceived non-compliance

Patient Safety Surveillance Unit

"Keeping the health system safe"

- Responsible for state-wide patient safety policy and reporting on complaints, clinical incidents, clinical risk management and review of death
- Produces annual 'Your Safety in Our Hands', and 'From Death We Learn' reports
- Manages the DatixCIMS Clinical Incident Management System

Medicines and Technology Unit

"Using medicines and technology well"

- Provides governance and support for safe, high quality and sustainable use of medicines & health technology
- Co-ordinates the State-wide Medicines Formulary and state-wide policies relating to safety and quality for medicines and health technology
- Leads the High Value Healthcare Collaborative

Reproductive Technology Unit

"Supporting families with infertility"

- Provides resources for the community on fertility technology and surrogacy
- Maintains a Voluntary Register for donor-conceived persons, their parents, and donors
- Provides executive support for the Reproductive Technology Council – which oversees the regulation of Assisted Reproductive Technology in WA

Mental Health Unit (MHU)

"Building capacity in mental health"

- Supports an evidence-based, patient-centred, caring, safe, respectful, and supportive mental health system
- Coordinates, monitors, and develops system-wide policies for public mental health services
- Liaises with the Office of the Chief Psychiatrist; the Mental Health Commission; the Minister for Health and Minister for Mental Health

Karen’s quality insight

“Quality is a mind-set and is a combination of both individual and collective effort.”

Introducing Karen Pedersen
Acting Manager, Reproductive Technology Unit

Patient Safety and Clinical Quality are pleased to welcome Karen Pedersen as the new Acting Manager of the Reproductive Technology Unit (RTU).

We spoke to Karen to understand more about to find out what makes her tick, and what’s in store for Reproductive Technology in WA.

Tell us a little bit about your background

I have a PhD in Pharmacology, postgraduate studies in health economics, policy and health technology assessment, and have worked in a variety of biomedical research and healthcare organisations both within Australia and internationally.

Prior to the move to the RTU I was working in the Medicines and Technology Unit in PSCQ.

What got you interested in Reproductive Technology?

It is a highly complex and sensitive area and one which is being challenged by changes to the social landscape, medical and technological advances, and shifts in public perceptions.

What’s on the agenda for the rest of 2021?

The RTU has recently successfully completed three-year relicensing of the WA Fertility Clinics. This activity is a requirement under the Human Reproductive Technology Act 1991 (HRT Act) and the RTU worked with members of the Reproductive Technology Council (Council) to undertake this activity.

In addition to continuing to support the work of Council, the RTU will be preparing Council’s annual report and undertaking preparatory work towards possible legislative changes we are hoping might occur.

What are you hoping to achieve in your new role as Manager of the RTU?

It would be great to see contemporary legislation in WA to help regulation of the sector and for the RTU to assist in this. The sector has been very keen for this to occur for sometime and managing expectations while regulating under the current legislative framework is an ongoing challenge.

Bright Ideas and New Networks: NMHS Inspire Conference

“INSPIRE stands for Ideas and Networks for the Safety of Patients & Improvement of Real Experiences”

The inaugural North Metropolitan Health Service INSPIRE Conference was held at Harry Perkins Institute on Friday 26 March 2021.

The conference brought together clinicians and safety and quality professionals from across WA Health to explore key challenges and recent innovations for safety and quality.

Participants were treated to a range of interesting knowledge-sharing opportunities, including presentations, as well as breakout session workshops and poster presentations on display in the Harry Perkins foyer; all designed to generate discussion and new collaborations.

Poster presentations in the Harry Perkins foyer

Informative presentation on pressure injuries

Highlights from the INSPIRE program include an invited presentation from Erika Lori, Senior Physiotherapist at the State Head Injury Unit, who used her recent experience in completing a 25-hour endurance ultra-marathon at Lake Tahoe, Nevada, to reflect on goal setting, perseverance and motivation in the rehabilitation and safety and quality context.

Dr Tina Bertilone at the Institute for Healthcare Improvement, Boston, in 2019

The Patient Safety and Clinical Quality Directorate’s very own Dr Tina Bertilone shared her knowledge as a leader in system-wide quality improvement and recounted her time at the Institute for Healthcare Improvement immersion week in Boston in July 2019.

Finally, Dr Melanie Murray, RN and post-graduate lecturer in safety and quality at Murdoch University, explored key insights into human factors and situational awareness for patient safety, highlighting the importance of recognising the impact of healthcare environments and context on preventable human error.

Access the program to find out more about the INSPIRE conference here.

Spotlight on Quality Improvement: What's Stupid Around Here?

Consumers typically spend in the order of 30 mins or more, waiting. Time spent thinking, observing, and formulating opinions about the environment and by extension – the organisation"

'What's stupid around here?' a relatable and simple phrase, was the tagline for a novel pilot program at Sir Charles Gairdener Hospital to seek consumer feedback while waiting for outpatient clinic appointments.

During their wait, participants of the program were given a clipboard with information about the project, a pen, post-it notes, and a question: "Please tell us what's stupid around here".

Project leads, Stacey Fuller and Jeremy Goh said "when we go to the shops and see a long line with only one checkout open, we don't think "this is an area for improvement", we think, "that's stupid"– it encourages candid responses that are unfiltered."

230 responses were posted by consumers on dedicated boards over four days, which led to the project team making eight rapid changes in the area. For those "hard to fix issues" (i.e. parking), the team investigated ways to update patients with information prior to their appointment. The team also "closed the feedback loop" with communication around the changes made following the pilot.

The team feel the greatest lesson from the project was that sometimes simple ideas are the best — here at PSCQ we feel this perfectly captures the spirit of continuous quality improvement!

Did you know that the **Safety and Quality Information System**, run by the Healthcare Quality Intelligence Unit, shows data on patient experience from WA Health services?

Two measures, captured from the Department of Health Epidemiology Unit's Patient Experience of Health Survey, show key results in:

- Respect during treatment (percentage of patients who said they were shown respect while being examined or interviewed)
- Politeness (percentage of patients who were always treated with politeness and consideration).

The Healthcare Quality Intelligence Unit are currently exploring more ways to provide valuable information on patient experience of healthcare.

Patient Experience Week and the 2021 Health Consumer Excellence Awards

Celebrating the patient experience

Patient Experience Week is held annually in the last week of April to provide a focused time for organisations to celebrate accomplishments, re-energise efforts and honour the people who impact patient experience every day – from nurses and physicians, to support staff and executive professionals, patients, families and communities.

Patient Experience Week recognises the fundamental importance of patient experience in developing, improving, and maintaining safety and quality in health care.

Several Patient Experience Week events were held in WA, including a virtual conference delivered by Care Opinion, the provider of WA Health's online patient feedback forum.

This event brought together world-renowned international quality experts and local presenters to discuss the purpose of patient feedback as a 'missing link' in healthcare design.

Recognising Health Consumer Excellence

The Health Consumers' Council held the **Health Consumer Excellence Awards 2021** online event during Patient Experience Week, with specific categories awarded for health consumers, Aboriginal and Torres Strait Islanders, the provision of compassionate care, and diversity and inclusion in WA healthcare organisations.

The 2021 Consumer Award was given to Rebecca Carbone, a stroke survivor who has worked tirelessly to support other stroke survivors through individual support, advocacy, professional facilitation, and public speaking. Another nominee for the Consumer Award, Amber Bates, was highly commended for her work running Tiny Sparks WA – supporting WA families with high-risk pregnancy, neonatal admission, and beyond.

Joy Campbell, a volunteer at the Bethesda Palliative Care Unit, was awarded the Compassionate Care Award for her important work providing comfort and emotional assistance for people at the end of life. Nola Naylor, Director of Aboriginal Health Strategy at South Metropolitan Health Service, won the Aboriginal and Torres Strait Islander Award for delivering the Aboriginal Health Champions Network Program.

Read more about the Health Consumer Excellence Awards, nominees and winners here.

New Data for Procedure Specific Information Sheets

Launch of the PSIS Dashboard

The Patient Safety and Clinical Quality Directorate has launched an **interactive dashboard** which presents data from the Procedure Specific Information Sheets (PSIS) Library. This resource is designed for WA Health professionals to understand use of the sheets by displaying data about frequency of downloads.

The dashboard can be used by Hospital and Health Service Provider staff to monitor their own hospital's usage, and target education and promotional strategies to improve local consent processes.

The dashboard allows WA Health employees to explore downloads from January 2019 to present, and can filter information by health service, organisation, clinical speciality, title and even the language of the Procedure Specific Information Sheet.

Main landing page on the PSIS Dashboard

PowerBI for WA Health

The PSIS dashboard is hosted on Power BI, an online web application for interactive data visualisations.

If you'd like to understand more about how to use and make the most of PowerBI, **get in touch** with the Data Library team at the Department of Health, who offer free training and support.

What are Procedure Specific Information Sheets?

As part of the consent process, medical practitioners must provide the patient with all the information that will assist them to reach an informed decision; that is, whether or not to consent to the proposed treatment. Providing written information to patients is considered best practice in Australia.

The Department of Health provides a suite of over 350 information sheets for patients covering common procedures in 30 surgical and medical specialties. The sheets explain procedures, help patients understand aspects of their care, and allow them to provide informed consent. The sheets are written in clear, accessible English; and are available translated in 25 languages to accommodate the cultural and linguistic diversity in patients accessing healthcare in WA.

Access the PSIS library here.

Hand Hygiene WA
May 2021 Update

WA compliance results for Audit Period 1 2021

Full results are now available on the public hand hygiene **website**

Next audit period closes on 30 June 2021 (Audit Period 2 2021). Mark your calendars!

Public reporting – changes are coming!

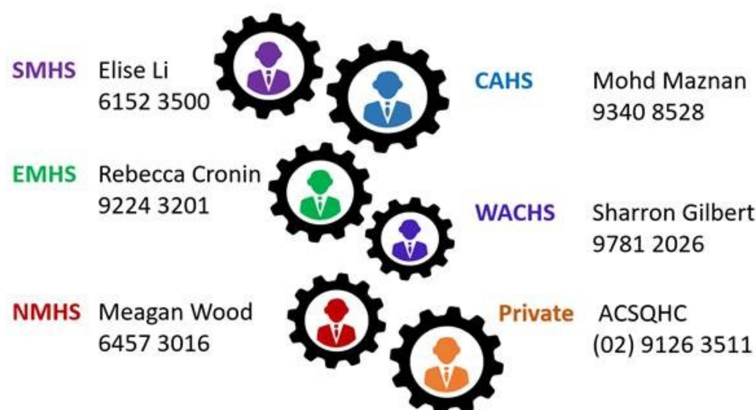
The hand hygiene compliance public **reporting pages** are being transitioned into an interactive online report (via PowerBI).

What would you like to see more/less of in the report?

Have your say now, email us your suggestions and feedback via **handhygienewa@health.wa.gov.au**

WA key contacts

For assistance with HHCApp (database) or the NHHI learning management system please contact the following people:



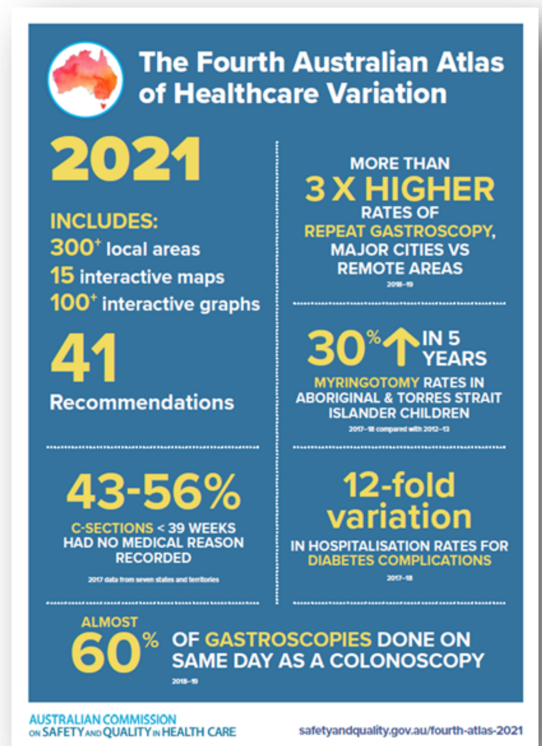
NHHI website links

- HHCApp:
https://nhhi.safetyandquality.gov.au
- eLearning modules:
https://nhhi.southrock.com

What’s New from the Commission

Introducing the Fourth Australian Atlas of Healthcare Variation

The **Fourth Australian Atlas of Healthcare Variation** is part of the Commission’s series of healthcare variation atlases examining variation in healthcare use according to where people live; providing valuable insights into the appropriateness and equity of healthcare delivery in Australia.



The Fourth Atlas covers six clinical areas: early planned births; chronic disease and infection; ear, nose and throat surgery in children and young people; lumbar spinal surgery; gastrointestinal investigations; and medicines use in older people.

More information about the **Atlas series** and the **development of the Fourth Atlas**, can be accessed on the Commission’s website.

Information on healthcare variation is also available on a state-by-state basis. **You can access information about WA’s performance in the state summary.**

Healthcare and patient safety professionals will be pleased with the latest offering from the Australian Commission on Safety and Quality in Healthcare – the Fourth Australian Atlas of Healthcare Variation.

The Atlas was launched during a **live launch webcast** on 28 April 2021 by a line-up of national healthcare leaders. Hear from speakers including: The Hon Greg Hunt MP, Minister for Health and Aged Care; Professor John Newnham, 2020 Senior Australian of the Year; and Professor Anne Duggan, Chief Medical Officer at the Commission).

What's New from the Commission

Publications in healthcare safety and quality

Recent publications in safety and quality in healthcare can be found on the Australian Commission on Safety and Quality in HealthCare's **On the Radar** update:

Highlights include:

- Third- and Fourth-Degree Perineal Tears Clinical Care Standard
- Measuring the economic impact of hospital-acquired complications on an acute health service
- Promise and perils of patient decision aids for reducing low-value care

My Health Record Advisory AS18/11: Demystifying digital identifiers

> ***"Better patient healthcare and health outcomes are possible when you have a health infrastructure that can be safely accessed, easily used and responsibly shared."***
>
> ***National Digital Health Strategy (2018–2022)***

A recent Advisory for Health Services from the Australian Commission for Safety and Quality in Health Care promotes the use of standardised identifying information in digital records.

Parts of this Advisory contain some tricky terminology, so we've broken things down for you with explanations in plain English to ensure this Advisory is easier to implement in your health service.

- Ensure that patient information is captured to align with National Healthcare Identifiers for patient identification, and that individual providers and your organisation are also identified correctly.
- Try to ensure that your organisation uses standard national clinical terminology. If you get stuck, the **National Clinical Terminology Service** has useful guidance.
- Make sure your organisation's policies and procedures which relate to the management of digital information and MyHealthRecord comply with Part 5 of the **My Health Records Rule 2016**. This is a lengthy list of requirements for participating health services, so it's best to check this information at the source.

We would love to hear from you. Send us your feedback or queries, and suggest a topic for the next newsletter

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This newsletter has been produced for informative purposes by:

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