'JGW-1'

CURRICULUM VITAE

John Gregory WAKEFIELD

MB ChB, FRACGP, FACRRM, Grad Cert Management

1. PERSONAL DETAILS

Name: John Gregory *WAKEFIELD*

Address:

Telephone:

Place of Birth: Chorley, England

Date of Birth:

Nationality: Dual: Australian/British

2. EDUCATION

Post Graduate:

Fellowship of Australian College of Rural and Remote Medicine **(FACRRM).** Awarded **1999.**

Graduate Certificate of Management (Health) Queensland University of Technology. GPA 6.5. Awarded **1999.**

Fellowship of the Royal Australian College of General Practitioners **(FRACGP).** Awarded **1997.**

Certificate from Educational Commission for Foreign Medical Graduates (USA) after successfully completing examination in Medical Sciences. **(FMGEMS).** Awarded **1990.**

Tertiary:

October **1983** to June **1988**

Liverpool University Medical School, Merseyside, England.

October **1983** to April **1985**	Pre-clinical Studies, Liverpool Medical School.
April **1985** to June **1988**	Clinical Studies, Royal Liverpool Teaching Hospital and Regional Teaching Centres.
Graduation July **1988**	**MB (Bachelor of Medicine) ChB (Bachelor of Surgery)**

Secondary: September **1976** to June **1983**

Preston Catholic College Boys Grammar School, Lancashire, England.

Other: **Fellowship with the Veterans Health Administration National Center for Patient Safety (NCPS).** January to April 2004, Ann Arbor, Michigan, USA. Supervisor Dr James Bagian, Director NCPS.

Advanced Provider Certification, National Association of Emergency Medical Technicians. (NAEMT) Awarded **1998.**

Instructor status, Pre-Hospital Trauma Life Support (PHTLS) Course of American College of Surgeons Committee on Trauma. Awarded **1998.**

Category 1 (b) Xray Operator License, Queensland Department of Health Awarded **1998.**

3. REGISTRATION

Medical Board of Queensland No. 895855
December 1989 to date. General Registrant.

UK General Medical Council No. 3281305 July 1988 to July 1991. Non-current.

4. PROFESSIONAL EXPERIENCE

Dec 2004 – PRESENT
Acting Executive Director of Queensland Health Patient Safety Centre (MS12)

The position is responsible for leading improvement in the quality of care provided to Queenslanders, by working with Health Service Districts to reduce medical adverse events and minimise untoward outcomes of clinical care.

Key successes to date:

- Fully endorsed submission and detailed operational plans for the Patient Safety Centre incorporating Incident Management Unit, Safe Medication Practice Unit and Centre for Healthcare Related Infection and Surveillance Program.
- Successfully managed re-organisation of pre-existing team members from previous QIEP Projects into new team.

- Successfully commenced implementation of state-wide incident management information system (PRIME) on time and on-budget.

June 2004 – November 2004
Director of Safety, Quality and Risk Management (MS10)
Princess Alexandra Hospital & Health Service District (PAH)

This newly created medical position is the first in the state and is responsible for leading the improvement of the safety and quality of clinical care provided at the PAH with a particular focus on systematisation of care and the minimisation of patient harm caused by adverse events.

Key successes:

- Reviewed the safety and quality resources, structures and processes at the PAH and developed a business case for a coordinated clinical governance unit with representation at Executive level and with medical leadership (endorsed by DEC).
- Restructure and amalgamation of the existing disparate resources in safety and quality under common leadership with clear purpose and strategies.
- Organisation wide planning session undertaken to identify priorities for action and develop operational plan with key performance indicators.
- Developed and implemented *Correct Surgery* policy and procedure which became the basis for the state-wide policy.

July 2001 – May 2004
Deputy Director Medical Services (Surgical Division) (MS10)
Princess Alexandra Hospital & Health Service District (PAH)

The position provides executive management of the Division of Surgery and supports the Chairman. The Division of Surgery of the PAH provides tertiary surgical services to Southern Queensland and Northern New South Wales. It also provides quaternary state services in spinal, head and neck, liver and kidney transplant surgical services. PAH is a leading surgical training hospital. The position encompasses operational and strategic roles necessary to ensure that clinical, activity and financial performance targets are achieved.

Key successes:

- Reduction of elective surgery waiting time benchmarks to target. Long Wait Category 1 (reduced from 30% to 4%). Long Wait Category 2 (reduced from 27% to 6%). Achieved through a comprehensive clinician engagement and accountability process and development of predictive long-wait reporting.
- Implementation of comprehensive healthcare governance process in Division to ensure defined accountabilities and devolution across clinical and corporate management.
- Re-design of the elective surgery bookings process around clinical safety and quality.
- Development of Intensive Care Unit Bed Management System to ensure transparent and quality use of ICU resources.

- Development and implementation of comprehensive Patient Safety System at PAH with integrated incident management systems and pro-active safety risk identification, corrective actions and governance.
- Development and piloting of pathology results reconciliation system (*Auscare*) to reduce risk of missed results and resulting patient harm.

April 2000 – June 2001
Executive Director Medical Services (MS9)
April 1999 – March 2000
Acting Executive Director Medical Services (MS9)
Bundaberg Health Service District

Key successes:

- Structural Change – Clinician Management and devolution
- Redevelopment – Medical leadership during $28M hospital redevelopment
- Information Management - As sponsor for T2 implementation in Bundaberg
- Clinical Risk Management – Developed risk management systems
- Integration – Initiated Forum with Division of GP and developed MOU
- ACHS Accreditation – Medical leadership in initial successful accreditation
- Elective Surgery – Successfully managed Bundaberg from worst performer in State to one of the best.

Jan 1999 – March 2000
Director of Clinical Training and Preceptor Southern Clinical School
Bundaberg Health Service District – 1 session per week

Key successes:

- Raised Hospital profile of education/training.
- Facilitated upgrade of existing education facilities.
- Secured Accreditation of Bundaberg Base Hospital for Intern training.
- Secured funding from QMEC for Medical Education Officer.
- Developed and implemented an Intern Training Program.

Jan 1999 – March 2000
Part-time Government Medical Officer
After-Hours

Key successes:

- After resignation of local GP's, negotiated a roster of hospital clinicians to ensure medical services to watch-house patients.

Jan 1999 – Feb 2000
Director, Department of Emergency Medicine
Bundaberg Health Service District

Key successes:

- Developing and Implementing a teaching program for interns, residents and nursing staff, and supervision of junior medical staff.

- Development of evidence-based clinical pathways and protocols to improve outcomes.
- Development of Quality Improvement Programs aimed at monitoring and improving performance against accepted performance indicators.
- Liaison with other organisations eg Queensland Ambulance Service to provide advice, teaching, clinical audit and coordination of emergency services to the District.

Jan 1993 – Dec 1998
Medical Superintendent with Rights to Private Practice Gin Gin Hospital and Mt Perry Health Centre
Bundaberg Health Service District

Jan 1991 – Jan 1993
Senior Medical Officer, Department of Emergency Medicine
Bundaberg Health Service District

April 1990 – Dec 1990
Principal House Officer
Bundaberg Health Service District

Jan 1990 – April 1990
Senior House Officer
Bundaberg Health Service District

July 1989 – Jan 1990
Senior House Officer
Countess of Chester Hospital, Chester, England

Aug 1988 – July 1989
House Officer
Whiston Hospital, Prescot, Merseyside, UK

5) MEMBERSHIP AND AFFILIATIONS

MEMBERSHIP OF PROFESSIONAL SOCIETIES

- Fellow, Royal Australian College of General Practitioners(1997 – present)
- Fellow, Australian College of Rural and Remote Medicine (1999 - present)
- Member Australasian Association for Quality in Healthcare (AAHQC). (2004)
- Member Australian Patient Safety Foundation
- Member, National Association of Emergency Medical Technicians (1998 – present)
- Member, Medical Superintendents Association of Queensland (1992 – present)

PROFESSIONAL COMMITTEES

Commonwealth Government:

- Member – Medical Indemnity Working Group (2005 – present)
- Member - National Breakthrough Collaborative in Medication Safety – Australian Council for Safety and Quality

Queensland Health:

- Chair – Ensuring Intended Surgery Advisory Committee (2005 – present)
- Member – QH Safety and Quality Board (2005 – present)
- Member – QH Medication Management Services Board (2004 – present)
- Member – QH Medication Safety Implementation Group (2003 – present)
- Member – Clinical Informatics Architecture Project (2005 – present)
- Member – Innovation Committee (2005 – present)
- Member - Specialist Aeromedical Advisory Committee to Queensland Emergency Medical Systems Advisory Committee (QEMSAC) (Jan 1999 to June 2001)
- Member - Corporate Project Board – Transition II, clinical benchmarking (Jan 1999 to June 2000)
- Chair – Bundaberg District Safety and Quality Committee (1999/2001)
- Chair – Bundaberg District Research and Ethics Committee (1999/2001)
- Chair – Bundaberg District Senior Medical Advisory Committee (1999/2001)
- Chair – Bundaberg General Clinical Training Committee (1999/2001)

University of Queensland:

- Member - Joint Liaison Committee Queensland Health/Post Graduate Medical Education Committee (Jan 1999 to June 2001)

6. HONOURS, AWARD AND GRANTS

Honours and Awards:

Australia Day Achievement Medallion – January 2000.
Awarded by Queensland Commemorative Events and Celebrations Committee, in recognition of service to the people of Bundaberg.

Robert Gee Prize – July 1988
Awarded July 1988 for best overall performance in the final clinical paediatrics.

Grants:

Commonwealth grant to attend National Case-mix Conference, Melbourne 2002

Commonwealth grant following joint submission from Bundaberg Health Service District and Division of General Practice for "Clinical Assistantships Project at Bundaberg Base Hospital. $200,000. January 2001

7. PUBLISHED ABSTRACTS

Wakefield J, Scotter H, Williams P. What have we learned from Root Cause Analysis at the Princess Alexandra Hospital. PAH Week, August 2004.

Graves J, Williams P, **Wakefield J.** Patient Safety Matters – The Princess Alexandra Hospitals Experience. Second Australasian Conference on Safety and Quality in Health Care. August 2004.

Wakefield J. Patient Safety and Uncle Sam. What Can We Learn from the U.S. Approach? PAH Week, August 2004.

8. PRESENTATIONS AND CONFERENCES

Numerous presentations and workshops with the most recent below:

March 2005
Inaugural Queensland Patient Safety Seminar Series *"Patient Safety: The View from the Top of the Cliff..... "* Brisbane

December 2004
Safety and Quality Planning Workshop for PAH. Coordination and facilitation of sessions. Brisbane.

November 2004
Rand Rounds PAH joint presentation on *Wrong site surgery* with Nowitzke A and Scotter H. Brisbane.

August 2004
State-wide Patient Safety Workshop coordinated and facilitated in conjunction with Dr James Bagian of US Veterans Health Administration. Brisbane.

April 2004
Patient Safety: A Comparison between the approaches in the United States and Australia. Presentation at National Center for Patient Safety, Ann Arbor, Michigan USA.

March 2004
Communication and Graded Assertiveness, High Risk Team Training Workshop, Veterans Health Administration, Atlanta, Georgia USA.

March 2004
Patient Safety Curriculum in Australia, Patient Safety Curriculum Leaders Workshop, Veterans Health Administration, Atlanta, Georgia USA.

February 2004
Patient Safety Manager Root Cause Analysis Training. Presenter and facilitator. Veterans Health Administration, Reno, Nevada USA.

January 2004
"The View from the Bottom of the Cliff" Two Years Experience with Root Cause Analysis. Presentation at the National Center for Patient Safety, Ann Arbor, Michigan, USA.

9. TEACHING EXPERIENCE

UNDER GRADUATE TEACHING:

Preceptor for Southern Rural Clinical School of University of Queensland Medical School January 1999 to June 2001.

UQ 4th Year Medicine Medical Students at PAH: Medication Safety Lecture Series addressing all aspects of Patient Safety with a focus on medicines and safe prescribing. In conjunction with Dr Charles Mitchell, Ian Coombes and Dr Danielle Stowasser.

POST GRADUATE TEACHING:

Pre-Hospital Trauma Life Support (PHTLS)
Instructor and Course Medical Director since 2000 delivering multidisciplinary courses throughout regional and metropolitan Queensland.

Root Cause Analysis (RCA), Healthcare Failure Mode Effects Analysis (HFMEA), Workshops. Delivering workshops to multidisciplinary audiences.

Intern Training Program: As Director of Clinical Training, and Director of Emergency Medicine, I have designed and delivered emergency curriculum to junior medical staff and pre-registration interns.

Examiner for Royal Australian College of General Practitioners

Orientation Programs for junior medical staff at Princess Alexandra Hospital. Provision of training in Patient Safety for new-starts.

Human Error and Patient Safety (HEAPS) Trainer. Delivering the HEAPS and mini-HEAPS courses.

COMMUNITY TEACHING:

A variety of community education sessions and lectures whilst living and working in rural and provincial communities.

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Queensland Government
Queensland Health

Job Description

1.	Position Number(s):	111139
	Position Title:	Executive Director Patient Safety Centre
	Unit/Branch/Division:	Patient Safety Centre Innovation and Workforce Reform Directorate
	Location:	Brisbane
	Classification Level:	MS 12
	Salary Level:	$5526.80 per fortnight
2.	Reports to:	Senior Executive Director Innovation and Workforce Reform Directorate
3.	Date of Review:	December 2004
4.	Delegates Authorisation:	DR MARK WATERS Senior Executive Director Innovation & Workforce Reform Directorate

1. PURPOSE OF POSITION

To lead improvement in the quality of care provided to Queenslanders by working with Health Service Districts (HSD's) to reduce medical adverse events and minimise untoward outcomes of clinical care.

6. ORGANISATIONAL ENVIRONMENT AND KEY RELATIONSHIPS

Role of the Organisational Unit:

Queensland Health is governed by a Board of Management established to focus on service delivery and position the Department to meet its strategic intents:

- Healthier staff
- Healthier partnerships
- Healthier people and communities
- Healthier hospitals
- Healthier resources

The Board of Management comprises the Director-General and five Senior Executive Directors each responsible for one of the following Directorates:

- Strategic Policy and Government Liaison
- Health Services
- Innovation and Workforce Reform
- Information
- Resource Management

THE INNOVATION AND WORKFORCE REFORM DIRECTORATE: aims to position Queensland Health as a "leader in health and a partner for life" by ensuring that:

- the design of service plans and models is undertaken with a long term strategic focus, informed by high quality information
- a workforce to deliver on future service requirements is designed, recruited, developed and retained and;
- innovation and improvement in service design and delivery is undertaken to maximise the quality, safety and value of our services.

The Innovation and Workforce Reform Directorate consists of six Branches/ Centres;

- Innovation Branch
- Workforce Reform Branch
- Statewide Health Services Planning Branch
- Skills Development Centre
- Patient Safety Centre
- Clinical Practice Improvement Centre

The Queensland Health Patient Safety Centre (PSC) has a lead role in planning, implementing, managing and evaluating patient safety initiatives and programs as part of the broader system to prevent and address patient harm, and ultimately improve health care services for Queenslanders to ensure healthier Queenslanders.

The broader patient safety system involves health service providers at a local and statewide level. The PSC works in partnership with Health Service Districts to coordinate and support statewide and local patient safety programs.

The PSC brings together three units with a common goal of improving patient safety: Centre for Healthcare Related Infections Surveillance & Prevention (CHRISP), Safe Medication Practice Unit (SMPU) and Safety Improvement Unit (SIU).

The PSC builds on successful statewide strategies in the specialised high risk areas of medications and infections by:

1. addressing high risk medications and systems, implementing medication review of prescribing, dispensing and administration systems, ensuring transfer of accurate and complete transfer of medication-related information and appropriately using information technology in medication management.

2. statewide coordination of infection management services through surveillance of healthcare related infections, assessment of the economic impact of infections, undertaking research to determine and influence behaviours associated with infections.

The PSC is committed to reducing preventable patient harm by:

- Raising risk awareness and promoting a culture of safety.
- Integrating and building on programs currently in place.
- Building local district capacity for identification of vulnerabilities and implementation of solutions using a human factors approach.
- Providing patient safety tools for consistent use across the State.
- Building a central resource centre that adds value by providing training support, data and trend analysis, and works with local areas to develop solutions for state wide implementation.
- Creating networks for discussion and shared learning.

Supervises

The position directly supervises the Director of the Safe Medication Practice Unit, Director of the Safety Improvement Unit and the Director of the Centre for Healthcare Related Infection Surveillance & Prevention.

Indirect Relationships

Major stakeholders that this position deals with on a regular basis include:
Executive Directors within Innovation & Workforce Reform Directorate.
Zonal Managers
District Managers
Executive Directors of Medical Services
Chief Health Officer
Director of Legal and Law Unit
Senior Executive Director Health Services
Principle Nurse Advisor
Principle Medical Advisor
Australian Council Safety & Quality Healthcare & subcommittees
Professional Colleges
Manager Public Health Services – Medicines and Pharmacy

Organisational Chart

Refer to attached organisational chart.

7. POSITION REQUIREMENTS (Duties, Responsibilities and Work Behaviours)

Queensland Health is committed to achieving our mission of promoting a healthier Queensland and our vision to be leaders in health – partners for life. We recognize that Queenslanders trust us to act in their interest at all times. To fulfil our mission, and sustain this trust we share four core values of: quality and recognition, professionalism, teamwork and performance accountability.

In addition we will be successful in promoting a healthier Queensland through the following five strategic intents; healthier staff; healthier partnerships; healthier people and communities; healthier hospitals and healthier resources. The primary duties and assessment criteria outlined in this job description reflect the commitment to our mission, vision, values and strategic intents which are required by this position.

Primary Duties and Responsibilities

1. Lead the establishment of an improved patient safety culture within Queensland Health, with particular emphasis on the development and implementation of a comprehensive clinical incident management system, statewide safe medication practice initiatives and infection surveillance and prevention program.

2. Manage and lead the development and implementation of patient safety related plans and strategies required to achieve the Strategic Intents of Queensland Health underpinned by the Innovation and Workforce Reform Strategy and the Strategy Map of the Queensland Health Quality & Safety Board.

3. Provide high level strategic advice, including the preparation of complex briefs and submissions to the Senior Executive Director, Innovation and Workforce Reform and the Queensland Health Board of Management.

4. Foster the development of state, national and international networks, effective partnerships and collaborative arrangements with internal and external stakeholders to support the achievement of improved patient safety outcomes within Queensland Health.

5. Represent Queensland Health on various state and national bodies in relation to Patient Safety matters including, clinical incident management, statewide safe medication practice, and infection surveillance and prevention.

6. Oversee the collection and interpretation of patient safety related data across Queensland Health to support the development and implementation of patient safety improvement initiatives.

7. Manage the budget of the Patient Safety Centre in accordance with government financial management and procurement practices and procedures

8. Lead development of systems, methods, tools and plans for improving and assessing Queensland Health's patient safety initiatives and programs.Work with other branches in the Innovation Workforce & Reform Directorate to develop formal strategies for education and training of Queensland Health employees on patient safety matters.

9. Oversee Queensland Health's (QH) initiatives to educate the general public, non QH professionals, media and other stakeholders concerning QH's patient safety activities and initiatives.

10. Develop and disseminate professional and technical information to HSD's regarding Patient Safety Strategies, issues and concerns.

11. Develop core competencies for Patient Safety Officers and assist in providing training and support to ensure that these competencies are maintained.

12. Manage the performance appraisal and development of subordinate staff.

13. Provide ethical decision making in the achievement of organisational goals.

14. Ensure there is a strategic approach to the development of contemporary human resource practices and policies including workplace health and safety, equal employment opportunity and anti discrimination, performance management and commitment to their implementation consistent with the mission, vision, values and strategic intent of Queensland Health.

15. Comply with and utilise procedures, policies, regulations and standards which impact upon the position, including contemporary human resource management requirements and practices, such as workplace health and safety, equal employment opportunity and anti-discrimination policies.

8. PRIMARY DELEGATIONS AND ACCOUNTABILITY

In addition to the responsibilities and accountabilities delegated to this position by the Director-General, this position is accountable for:

- the promotion of the Queensland Health mission, vision, values and strategic intents to staff.
- the planning and strategy development necessary to assist in achieving the outcomes required by the Queensland Government and the Queensland Health Corporate Plan, particularly in the areas of workforce reform.
- the quality and effectiveness of high level policy advice to the Director-General and the Minister and other Senior Executives on corporate priorities and strategic directions, complex and sensitive issues, and other matters of corporate policy.
- The establishment of effective mechanisms and processes to engender positive intergovernmental relations and linkages with national, interstate and other industry related groups.
- The organisational performance and strategic leadership of the Workforce Reform Branch.
- Managing expenditure in the Workforce Reform Branch ensuring it does not exceed the budget allocated for any financial year.
- The design, quality, procedures and effectiveness of performance arrangements and reporting for all matters associated with workforce reform in Queensland Health.

9. MANDATORY CRITERIA (Must be met to be considered for selection)

Mandatory: Eligibility for general medical registration with Queensland Medical Board.

"Appointment to this requires proof of qualification and/or registration with the appropriate registration authority, including any necessary endorsements, to be provided to the employing service prior to the commencement of duty."

10. ASSESSMENT CRITERIA

Your application for this position must specifically address each of the assessment criteria listed below, a general resume will not be sufficient. It should also contain the names and contact numbers of at least two referees, one preferably your current/previous supervisor, who may be contacted with respect to your application. Shortlisting and selection will be based on these assessment criteria. Verification of relevant data may also be sought with your permission.

	Assessment Criteria	Weighting Out of 10
AC1	Demonstrated ability to provide strategic leadership in relation to patient safety issues, and to develop and drive patient safety reform strategies that lead to an improved patient safety culture	10
AC2	Demonstrated capacity to contribute to the executive management of a large, complex, decentralised organisation and align performance to the organisation's strategic intents.	10
AC3	Demonstrated ability to lead and manage staff in accordance with contemporary human resource management principles, promote efficient resource usage and cultivate productive working relationships, partnerships and teamwork.	10
AC4	Demonstrated ability in facilitating effective change management processes and creating an environment that embraces change to enhance strategic performance and service to clients.	10
AC5	High level communication, consultation, negotiation and interpersonal skills and a demonstrated capacity to work with internal and external stakeholders to achieve organisational outcomes	10

11. ADDITIONAL FACTORS

Travel. Frequent travel is an expectation and requirement of the position

Qualifications. Possession of formal tertiary qualifications is not included as a requirement within the selection criteria for this position. An appropriate tertiary qualification in a relevant discipline (eg. Health science) is highly desirable.

The Innovation and Workforce Reform Directorate values the enhanced work performance deriving from formal tertiary study, and also acknowledges that enhanced work performance can result from other learning experiences which includes on-the-job training, structured professional development or life experiences.

Probation Requirements

The suggested wording for probation statements in Job Descriptions:

"All new permanent employees to Queensland Health will be required to undertake a period of probation upon commencement of duty. This period will be 3 months in length with a possible 3 month extension if performance objectives are not met."

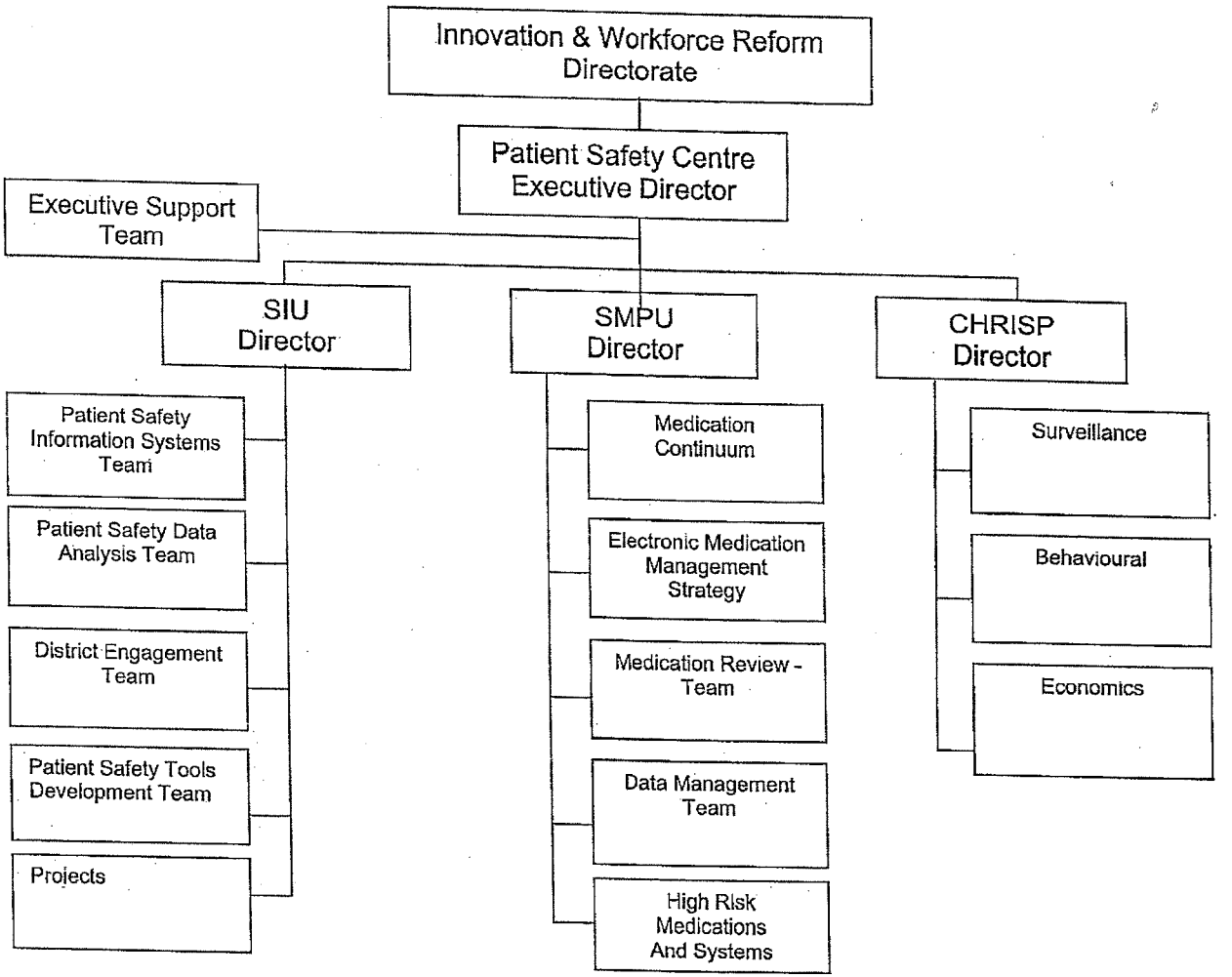
Equal Employment Opportunity: Queensland Health is an equal employment opportunity employer.

Smoking within Government Buildings: Smoking within Queensland Health Buildings ("buildings" to include corridors, passageways, walkways, balconies) other than in defined areas is prohibited.

Pre-Employment Checks

"This position may be subject to pre-employment history checks including a working with children suitability check (Blue Card), criminal history, identity or previous discipline history checks for the preferred applicant."

Patient Safety Centre Organisational Structure.



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Queensland Government
Queensland Health

Proposal for a Queensland Patient Safety Program

PREPARED BY: DR JOHN WAKEFIELD
DATE: 7 SEPTEMBER 2004

A Plan for a Queensland Health Patient Safety Program

EXECUTIVE SUMMARY:

Patient Safety has been identified as the most important health reform issue in Australia[6]. The Australian health ministers have issued a Joint Communiqué endorsing the recommendations from the Fourth Annual Report of the Australian Council for Safety and Quality in Healthcare[6]. This paves the way for a coordinated approach within Queensland Health which places Patient Safety at the core of how health services are delivered to Queenslanders.

Over the last decade, a wealth of evidence[1,2,4,14] has emerged from Australia and overseas regarding the unacceptable frequency of patient harm resulting from adverse events in healthcare systems. A number of high profile health system failures have placed this issue firmly in the public domain[3,18]. The Queenslanders that we serve want to know what is being done to address the issue.

Traditional approaches to the management of adverse events in health care frequently focussed on blaming individuals [2,4,12,16]. Errors were thought to be caused by 'bad' doctors, nurses or hospitals and punishment at great professional and personal cost often ensued. Not only has this punitive approach failed to improve patient safety, it has contributed to a culture of fear amongst clinical staff and a reluctance to report when things go wrong [12,16].

It is now been universally accepted that the 'shame and blame' approach to improving safety doesn't work [12,17].

Humans will always make errors[15]. Occasionally the best people make the worst mistakes. Evidence from other safety critical industries[5,15,16] suggests that our efforts should be directed towards establishing a *culture of safety*. In order to achieve this, staff need to be supported to report when things go wrong, or a near-miss occurs. Leaders, at all level must understand the vulnerabilities in the system. This should be followed by system re-design based on sound *human factors* principles, to reduce the opportunities for errors and to trap errors that would otherwise lead to patient harm[5].

The focus is on learning, and not blame. This does not mean that individuals are not accountable for their actions. However, it is important for staff to know what is blameworthy and what is not. Put simply, we need to develop a *'just culture'*[12] built on trust.

This Proposal provides a blueprint for Queensland Health to develop and implement a comprehensive Patient Safety System. The model is based upon national and international best available evidence [2,6,12,13,17] and seeks to sustainably embed safety into the way healthcare is delivered. This will be achieved through **leadership, staff development and system change.** It will build on the significant achievements of the Quality Improvement and Enhancement Program 1999-2003.

The Proposal will support Queensland Health's strategic aims[9] for healthier patients and healthier staff, by ***reducing preventable patient harm***.

This will be achieved by developing a consistent approach at a District and Corporate level to the ***identification, prioritisation and treatment of system vulnerabilities***. Underpinning this, will be the structural and process changes necessary to support the development of a culture of safety and ensure that the benefits are transferred to all Queensland Health patients.

In order to achieve this, there will be a substantial, district *implementation* phase, aimed at engaging local leadership, raising awareness and training in basic tools of Patient Safety. This will be followed in parallel by a *consolidation and capacity building* phase where local districts are provided with ongoing support from a central unit. This model has successfully been used in other key Queensland Health Program areas. It provides a combination of 'bottom up' and 'top down' approaches.

At District Level:

Districts will be supported by a safety officer, trained in Patient Safety and capable of providing local expertise, training and support to the District. The safety officer will be supported by key clinical champions to promote clinician engagement. They will coordinate local incident management systems [10,11] to enable the district to identify and respond to local vulnerabilities. They will be supported in this role by the central unit and will report locally identified issues as well as being a key local resource to assist in the implementation of 'top down' safety strategies.

At Central Level:

The Central Unit will be directed by a senior medical practitioner and supported by a team with content knowledge and skills in safety, project and change management and service improvement. It is anticipated that the director will report directly to the SED I&WR. The unit will coordinate the Patient Safety System. Functions will include training and support of the safety officers and districts, analysis of district incident and sentinel event data, prioritisation and reporting of organisation-wide vulnerabilities, and development and implementation of state-wide system improvement initiatives. The latter function will require linkages and partnerships with relevant groups, both at a corporate and district level.

Implementation of a Patient Safety System as outlined in this Proposal would provide the foundation for a fundamental shift in the culture of healthcare delivery in Queensland Health. It will acknowledge publicly that patient safety is an important issue in our healthcare system, and these proposals are an essential first step in addressing the problem. Most importantly, it will demonstrate to Queenslanders that Queensland Health is committed to improving safety for all that use our services. This in turn will send a strong message to our staff that we are prepared to invest in, and support them in achieving improved safety wherever care is delivered.

"Safety is the foundation upon which quality is built..."

Acknowledgment
Special thanks to Dorothy Vicenzino and Dr Andrew Johnson for their assistance in the preparation of this document.

Introduction:

Safety is the foundation of any healthcare system. *"First Do No Harm"* is the mantra of health practitioners from when clinical training first commences. While health providers aspire to prevent harm when patients are in their care, the evidence suggests that our systems of care create vulnerabilities which lead to patient harm.

This paper outlines a strategy to assist Queensland Health to achieve a health care system that is safer for patients.

Background:

Why Patient Safety?

Over the last decade, a wealth of evidence [1,2,4,14] has emerged from Australia and overseas regarding the unacceptable frequency of patient harm resulting from adverse events in healthcare systems. A number of high profile health system failures have placed this issue firmly in the public domain [3,18]. The Queenslanders that we serve want to know what is being done to address the issue.

The scale of the problem is significant. Large studies conducted in Australia and overseas highlight that this is a problem facing all modern healthcare systems. The Quality in Australian Healthcare Study found that 16.6% of patients suffered an adverse event during a hospital care episode. Half of these were considered preventable with 5% of these adverse events leading to death of the patient. Translated to Queensland Health, this would equate to 8 preventable deaths per day. These alarming statistics are comparable amongst other first world countries [2,14].

It has also been demonstrated in various studies that the prevention of harm reduces length of stay, additional associated treatments and interventions thereby reducing costs and essentially saving money and resources. The Australian Patient Safety Foundation estimated savings of over $4Billion dollars for Australian Health Care per year [19].

Traditional approaches to the management of adverse events in health care frequently focussed on blaming individuals [2,4,12,16]. Errors were thought to be caused by 'bad' doctors, nurses or hospitals with resultant punishment at great professional and personal cost. Not only has this punitive approach failed to improve patient safety, it has contributed to a culture of fear amongst clinical staff and a reluctance to report when things go wrong[12,16].

It has now been universally accepted that the 'shame and blame' approach to improving safety does not work [12,17].

Humans will always make errors[15]. Often the best people make the worst mistakes. Evidence from other safety critical industries [5,15,16] suggests that our efforts should be directed towards identifying vulnerabilities in our systems and learning how to address them. There is a need to move beyond blame and seek to establish a *culture of safety*. In order to achieve this, staff need to be supported to report when things go

wrong, or a near-miss occurs. Leadership focus at all levels must concentrate on understanding the vulnerabilities in the system. This should be followed by action to re-design systems based on sound *human factors* principles, to trap errors that would otherwise lead to patient harm[5]

The focus is on learning, and not on blame. This does not mean that individuals are not accountable for their actions. However, it is important for staff to know what is blameworthy and what is not. Put simply, developing a *'just culture'* built on trust[12].

The Australian Council for Safety and Quality in Health Care has initiated several projects on patient safety[6]. In April 2004, the Australian Health Ministers, endorsed several targets. These included:

- All public hospitals will use the '5 step - right patient, right site, right procedure protocol' by September 2004
- By January 2005, public hospitals will introduce new 'incident management' systems to monitor, investigate, analyse and guide their actions in dealing with patient safety incidents
- To further improve patient safety, by the end of 2005, all public hospitals will have in place a patient safety risk management plan
- To improve patient safety, by the end of 2005, require all public hospitals to report all sentinel events, and to contribute to a National Report on Sentinel Events
- To reduce the harm to patient from medication errors, by June 2006, all public hospital will be using a common medication chart
- By the end of 2006, every hospital will have in place a process of pharmaceutical review of medication prescribing, dispensing, administration and documenting
- All public hospital patients will now receive a copy of the booklet "10 tips for safer health care: what everyone needs to know".

What is Patient Safety?

Patient Safety is defined by the Institute of Medicine[17] as "***prevention of harm to patients***".

A Comprehensive Patient Safety Program for Queensland Health will provide an integrated approach to systems improvement. The following key elements at both district and corporate level are essential:

- Identification and understanding of vulnerabilities through incident reporting and analysis;
- System redesign utilising sound human factors principles;
- Implementation and spread of changes – ACTION;
- Measuring effect of change;
- Integrating this approach into the planning and delivery of health services

Enabling such a change requires structure and processes. An improved safety culture will result from consistent leadership behaviour in support of a 'just' approach to staff involved in incidents[12].

Structure:

The structure refers to accountability structures that range from the overarching governance to local management structures. The structure enables leaders to implement improvements across the whole organisation. It also describes management accountabilities and how networking across areas can facilitate system changes within and between areas.

At District Level:

Districts will be supported by a Safety Officer, trained in Patient Safety and capable of providing local expertise, training and support to the District Executive. The Safety Officer would be supported by key clinical champions to promote clinician engagement. They would coordinate local incident management systems to enable the district to identify and respond to local vulnerabilities. They would be supported in this role by the central unit and would report locally identified issues as well as being a key local resource to assist in the implementation of 'top down' safety strategies.

At Central Level:

The Central Unit will be directed by a senior medical practitioner and supported by a team with a range of content knowledge and skills in; Safety, project and change management and service improvement. It is anticipated that the director will report directly to the SED I&WR. It will coordinate the Patient Safety System. Functions will include training and support of the safety officers, analysis of district incident and sentinel event data, prioritisation and reporting of organisation-wide vulnerabilities, and development and implementation of state-wide system improvements. The latter function will require linkages and partnerships with relevant groups both at a corporate and district level. It is recommended that this central entity be located in a major hospital to facilitate clinical engagement, test key strategies, and promptly respond to emerging safety issues. It is also anticipated that the central entity would appropriately have a small satellite unit based in the major Northern Zonal hub.

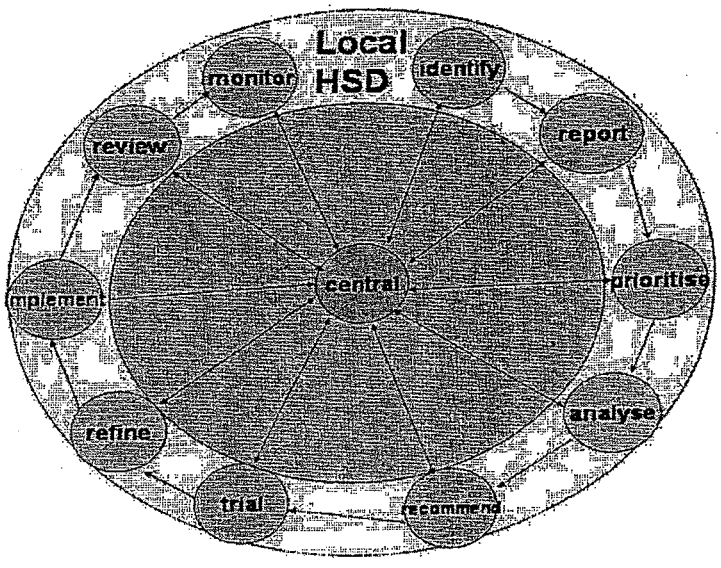
Processes:

These are the tools that are necessary to build capability and capacity within staff and within the organisation. In patient safety this infrastructure is necessary in order for the benefits to be realised. The tools include:

- An incident reporting information system
- Training and awareness packages in a variety of tools such as human factors, incident identification, incident analysis, trend analysis, system re-design, change management and project management.
- Open disclosure and other communication strategies
- Support and mentoring

- Specific strategies developed to reduce certain risks. Eg. correct site surgery, hand hygiene and common medication chart.

The local Health Service District and the Central Area will work closely together, in partnership. Manage locally – coordinate centrally.



Culture:

Culture is difficult to define. It is best conceptualised in the statement: *"The way we do things around here"*. A safety culture manifests as a set of values and behaviours that embed safety in the way business is conducted. For this to occur there must be leadership from the highest level in the organisation. The focus should be on learning, and not on blame. This does not mean that individuals are not held accountable for their actions. However, it is important for staff to know what is blameworthy and what is not. Put simply, developing a *'just culture'* built on trust. It is only in this setting that staff will be comfortable to report and the organisation will learn about vulnerabilities[12].

Evidence suggests that in order to achieve this, leadership must be made explicitly accountable for safety through service and performance agreements structured to deliver desired behavioural change.

Culture can be measured, and it is anticipated that a baseline cultural survey of staff and patients be undertaken as a means to compare the impact of the proposed changes.

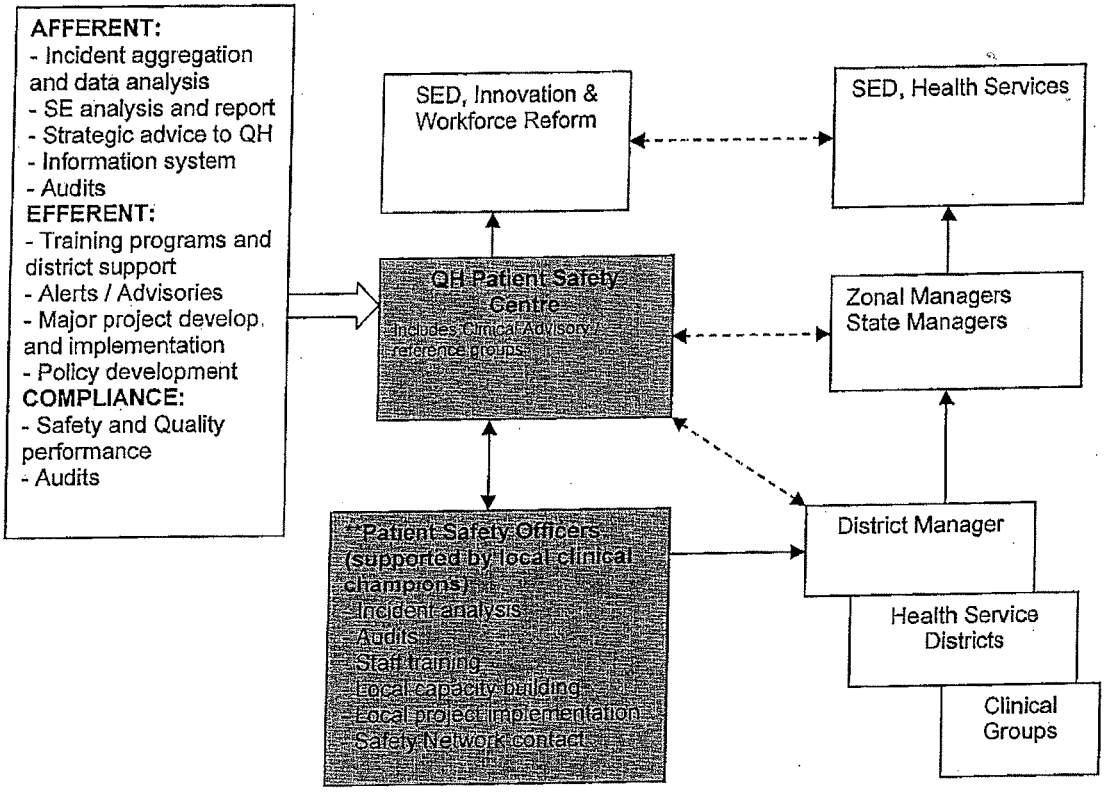
Aims of a patient safety program:

A comprehensive Patient Safety Program for QH is designed to achieve the following aims to:

- Provide opportunity for reform and systems improvement
- Embed patient safety as part of the fabric of the organisation
- Build local district capacity for identification of vulnerabilities, problem solving and implementation of solutions
- Provide patient safety tools for consistent use across the State

- Build a central resource that adds value by providing training support, data and trend analysis, and works with local areas to develop solutions for state and local issues
- Create networks for discussion and shared learning
- Integrate and build on programs currently in place

The model of patient safety:



** funded positions

The basis of the model is linking a central entity (Queensland Health Patient Safety Centre) with Health Service Districts. Therefore a specific staff member is employed to facilitate patient safety within the district. The central entity coordinates and supports the district by providing a consistent approach to core patient safety tools and skill building. Strong links are formed with clinical areas and lead clinicians. District Managers are supported to be accountable for patient safety which eventually is refected in service agreements and contracts.

Linkages - Quality

The collection of incident information, in combination with other measures such as clinical audit, clinical indicators, morbidity data, complaints, waiting list information and other access data forms, promotes improvements that are based on achieving patient outcomes while preventing harm.

Current 'Quality' resources in Health Service Districts have a variety of roles. Some focus on accreditation requirements; others coordinate quality initiatives, data collections or incident management. Some have centralised groups while others have

a devolved model. Extensive consultation will need to be undertaken to identify governance and management arrangements for patient safety and quality are consistent and ensure the outcomes of the patient safety program.

Centrally, quality initiatives have been managed by different project teams. It may be considered that, key projects that have been focused on improving patient safety become a part or be closely linked with the central patient safety entity. These projects may include:

- Falls prevention
- Medication Safety
- Pressure ulcer prevention
- Infection management
- Correct site surgery project
- Open Disclosure
- Human Error and Patient Safety Program
- Incident Analysis Training
- Root Cause Analysis Training
- Integrated Risk Management Information Systems which includes clinical incident reporting and complaints management
- Sentinel Event Reporting
- Coronial Data Management
- Complaints Policy
- Incident Management Policy

Consistent feedback from Health Service Districts has been that projects have been implemented in an ad hoc fashion, placing a added burden on scarce or non existent resources. It is planned that initiatives are consolidated and undertaken in a coordinated and prioritised way.

Linkages – Strategic Direction

Currently, patient safety is reflected, under Strategic Objective C7, *ensure safe and quality health outcomes*[9]. It would be recommended that a Patient Safety and Quality Strategy Map be developed with appropriate targets and measures. As a result Health Service Districts, clinical groups and services could align with the key strategic initiatives. As the program develops, input may also be provided to inform future strategic directions based on emerging issues.

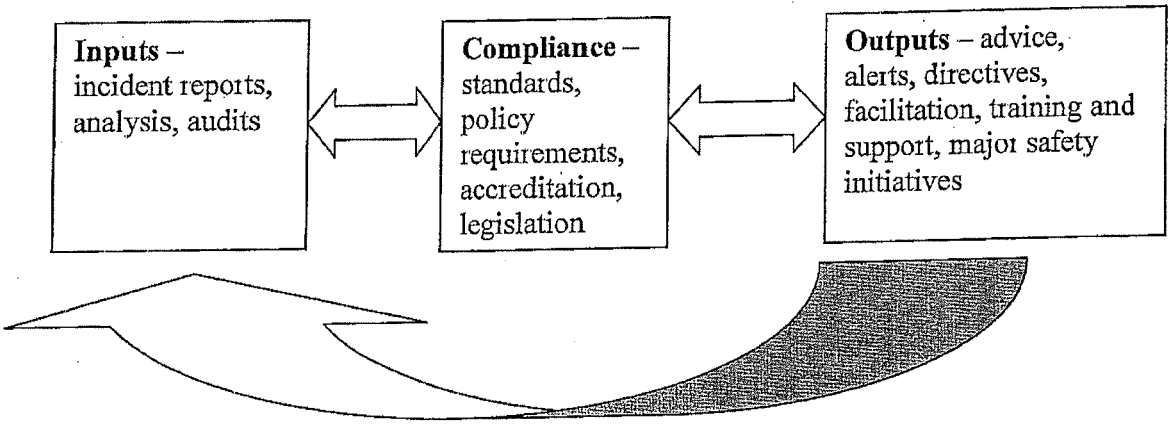
The Innovation Strategy Unit would be charged with the development of this strategy map and work.

Communication strategy

An extensive communication strategy will be required to support this program. The table below outlines some of the key communications that will need to be undertaken. These involve networking with existing groups, the establishment of new groups and the establishment of written information sheets. The basis of the communication strategy is to create opportunity for staff to obtain and discuss information with their peers.

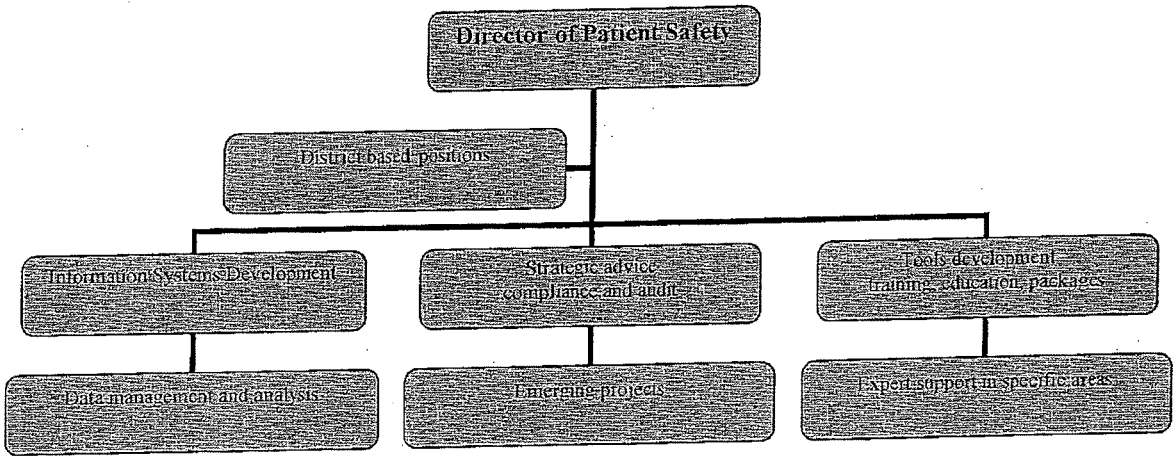
Expert advisory groups for key services and key areas	Safety Newsletter
Working reference parties	Safety website
Clinical Champion network	Annual forum or Symposium
Coronial advisory groups	Quarterly Zonal or state-wide patient safety officer meetings
CHO quality councils	Maintain electronic networks
Colleges and Associations	National and other states
Key Corporate office areas	Clinical Safety Research

Summary of activities of both a central and district based patient safety centre



Structure of the QH Patient Safety Program:

This proposed structure shows the functional entities that will come together. The structure is based on the coordination of 6 bodies of work. These are functionally aligned and each compliments the other.



Implementation and associated resources for a QH Patient Safety Program

Please note:
An assessment will be required to assess what current positions will be transferred.
All estimates are based on:

- *District based positions that is public sector*
- *Position establishment in Forestry House ($10,500) – this describes accommodation set up cost excluding computers.*

Total funding required is detailed in attachment 1.

It is recommended that implementation of the QH Patient Safety Program occurs in 3 phases and be coordinated by a core management group.

Phases of Implementation:

Phase 1 Urgent and immediate requirements

Component 1	Training and awareness of the Incident Management Policy, root cause analysis, recommendations and actions.
Component 2	Health Service District resource
Component 3	Information systems development and implementation

Phase 2 Establishment of data management and analysis

Phase 3 Consolidation and capacity building
Component 1 Patient safety advice, directives and monitoring
Component 2 Tools development, training, education and packages
Component 3 Emerging Projects.

Management of the QH Patient Safety Program

It is recommended that the Director of Patient Safety and the Manager of Patient Safety be appointed as soon as possible. These staff will:

- establish the positions (that is review current positions and identify possible positions for transfer to the program)
- undertake consultation over this proposal
- coordinate phase 1 as described
- progress phase 2 and phase 3

Phase 1: Immediate and urgent requirements

Significant work in the area of incident management has been undertaken centrally by the Integrated Risk Management Program and locally, by a number of Health Service Districts. As a result of this work, the QH Incident Management Policy[10] was endorsed by the Director-General, on 10 June 2004. This policy endorses the reporting of sentinel events and the reporting of the underlying causes and recommendations for the management of these events. Reporting of sentinel events

commenced on 1 July 2004. Currently reporting is low with only a few districts having reported events.

Work has also been undertaken to develop a supporting information system for clinical incidents, complaints management and risk. The first phase of this system will be ready for deployment October 2004.

Urgent and immediate requirements include:

- Training and awareness in the requirements of the policy
- Training and support in root cause analysis, recommendations and actions
- Implementation of the information systems for clinical incidents, complaints and risk.

Component 1: *Training and Awareness in the requirements of the incident management policy, root cause analysis, recommendations and actions*

It is recommended that a multi-pronged approach be undertaken and that these 2 activities be the first part of a roll-out of patient safety in QH.

Based on experience from NSW and from PAH and Townsville, it is recommended that a minimum of 3 Staff (including 1 medical officer) travel to Health Service Districts and provide an introduction to patient safety. (This may also be used for training and induction of staff members within the program.)

The program to be presented to HSD would include:

- Introductory meeting with District Executive
- Introduction to concept of patient safety (evening session of 2 – 3 hours targeting district staff, GP's, specialists and private providers.
- Training to participant level competency in root cause analysis, development of recommendations and implementation of actions based on human factors design (2 days - targeting key district staff)

To emphasise leadership commitment, it is recommended that a key part of the evening strategy, would be to include a senior member of executive management to present on the expectations and accountabilities of the program. This could potentially be the relevant Zonal Manager or the Senior Executive Director, Health Services or Innovation and Workforce Reform.

Development of the training materials (power-points, handouts, reading) will need to be completed for provision of this phase. Along with an extensive marketing and communication strategy developed at a state and local level. Staff providing these sessions will need to have experience in root cause analysis, human factor systems and have extensive knowledge of patient safety.

Sessions should be provided on a district by district basis, with a separate session for zonal staff and relevant corporate office areas. This would mean a total of 42 sessions would be undertaken. Based on the NSW experience of providing one session every 2 weeks, this would be a roll-out of 18 months. Given the urgency, it may be possible to run two teams in parallel leading to full implementation in 12 months.

Resources required.

It is recommended that a medical officer, 2 principal project officers and a senior project officer would be required to develop and deliver the introductory program.

Component 2: *Health Service District Resource*

To build capacity in districts to address patient safety, it is recommended that funds be provided to fund patient safety officers across the state. It has been demonstrated the National Center for Patient Safety in the US, that district based positions that are dedicated to patient safety are required to ensure that enough capacity is provide for patient safety to be a local priority. Most other jurisdictions in Australia have also employed local patient safety officers or clinical risk managers.

A total of 25 patient safety officers is recommended. The role of the patient safety officer is to provided a link between HSDs and the central program, facilitate local implementation of patient safety, provide a resource for root cause analysis expertise, human factors and change management. It is anticipated that it will not be possible to recruit safety officers with all the required skills and knowledge. It will therefore be essential to provide an ongoing program of training and support/mentorship from the central program content experts.

The patient safety officer should directly report to a HSD executive. The HSD should also identify key lead clinicians – medical, nursing and allied health who will champion patient safety in their district.

Training and support will need to be provided to the patient safety officers with 4 state wide meetings conducted per annum. There will also be regular teleconference meetings to provide operational support. This could also be supported by an annual symposium to showcase key local strategies with potential for spread.

District Based Positions resources required:

Officers would be placed in:

Northern Zone:	
Townsville - includes Bowen and Charters Towers	2 position
Cairns - includes Cape York, Torres, Tablelands and Innisfail	2 positions
Mackay- includes Moranbah	1 positions
Mt Isa,	1 position
Total	**6 positions**

Central Zone	
RBWH	1 position
TPCH	1 position
RCH	1 position
Sunshine - includes Gympie	1 position
Rockhampton – includes Gladstone and Banana	1 position
Fraser Coast	1 position
Bundaberg	1 position
Redcliffe/Caboolture	1 position

Central Highlands and Central West	1 position
North Burnett and South Burnett	1 position
Total	**10 positions**

Southern Zone	
PAH	1 position
Logan	1 position
QEII	1 position
Bayside	1 position
West Moreton	1 position
Toowoomba includes Northern Downs and Southern Downs	2 position
Gold Coast	1 position
Charleville and Roma	1 position
Total	**9 positions**

Resources:
A total of 25 senior project officer positions are recommended for HSD's as outline above.

Component 3: ***Information System development and implementation***

Background:
In December 2003, approval was received to develop and deploy an interim system for clinical incidents, complaints management and risk management. The clinical incident system is known as PRIME will be ready for deployment at the end of September 2004. The first phase of the system is based on minimum requirements and it is anticipated that as the system is used, enhancements will be made to increase functionality. It is anticipated that this will be an iterative process. The complaints component (phase 2) will be ready for deployment in January 2005. There are processes that occur simultaneously, such as deployment of one phase, while the other phase is being developed.

This project has been through IM/IT gatekeeping, and the initial capital component and the recurrent system component is fully funded. However additional funds for enhancements may be advisable given the current feedback on possible reporting requirements.

Health Service Districts will be asked to support the system by providing staff who will be District Super Users (DSUs) and Facility Super Users (FSUs). Several districts who currently have systems (manual, spreadsheets or local based systems) have staff that will be able to undertake these roles. These DSUs and FSUs will be provided training by I-Net services and ongoing support from zonally based system change managers.

Change managers are recommended as districts implement this system and migrate from existing business processes to using PRIME. They support DSUs and FSUs through training, support and hands on help. It is also anticipated that changes will be introduced to the clinical system after Phase 2 deployment, as staff and districts increase their usage and identify further requirements.

Resources required:

The principal project officer position that manages this project currently exists. An additional 3 Systems Change Management Positions (1 for each zone) and a senior project officer is recommended for this component.

Time frame for Phase 1 implementation: Summary

Activity	Planned start date	Anticipated completion
Approval		September
Identify and train DSU, FSU for information system	September 04	October 04
Establishment of all positions (PD's, JEMS)	October 04	November 04
Recruit to positions	November 04	December 04
Completion of plan	November 04	November 04
Development and training in packages	December 04	January 05
Provision of sessions	January 05	July – Dec 05

Phase 2: Establishment of Data Management and Analysis

With the implementation of the information system, there will be the creation of essentially, new data bases. There are potentially 5 new data sets – data collection commencing in July 2004 for Sentinel Events, October / November 2004 for Clinical Incidents, January 2005 for Complaints Management, June 2005 Risk registers. As well the outcomes of coronial events will commence to be collected for distribution. It would be recommended that the analysis component would be co-located with the systems development and systems change management, and the business change component.

As awareness is raised and training is rolled out, the volumes of reported information will increase. Therefore a group to manage this data, provide initial trend analysis, data quality reviews, provide reports and undertake qualitative analysis of information will be required.
Resources required:

Based on anticipated data collections, minimum resources would be a principal project officer, senior project officer and project officer. The lead position of principal project officer would be established in January 2005 with the other positions created on when needed.

Phase 3: Consolidation and Capacity Building

Component 1: *Patient Safety Advice, Directives and Monitoring*

With PRIME deployed, HSDs engaged and patient safety officers in place, data commencing to be collected at a local and central level, the next phase of the establishment of a patient safety program will commence.

Information will not only be generated from the information system but will also be generated as an output of incident and root cause analysis. This information will need to be reviewed for quality and analysed to identify issues and recommendations for state-wide action. This includes **alerts, directives and major patient safety initiatives**. This is a cyclic activity, support and feedback is provided to areas undertaking incident analysis and root cause analysis as well as analysis and trending of data. As well, follow-up audit, compliance testing and other monitoring methods will need to be conducted to assess the robustness of the recommendations.

(Alerts – identify risks or situations that staff should be aware of that could lead to harm.
Directives – mandated patient safety solutions that require specific action eg removal of certain concentrations of potassium chloride from wards
Initiatives – projects undertaken in response to systemic vulnerabilities that have led to significant patient harm eg development and implementation of ensuring correct surgery protocol)

The volume of work in the area may increase as networks are established.

It would also be anticipated that this area would also include a media officer. Given the nature of patient safety, a media officer would be advised to assist in media releases regarding reports, information received, ministerial enquiries.

Resources required:

It is recommended that the 2 principal project officers and the lead medical officer who have undertaken the face to face roll out, will form the basis of this group when the introductory rollout is completed. A position that provides coronial coordination currently exists.

An additional position for a media officer will be required.

Component 2: *Tools Development, training education and packages.*

In addition to the packages developed for Phase 1, patient safety requires several other tools to be developed to support the initiative. These tools include:

Incident analysis
Root Cause Analysis
Aggregated Root Cause Analysis
Human Error and Patient Safety
Health Failure Mode Effect Analysis
Open Disclosure
Complaints management
Video support

Some of these packages are developed and need to be revised, some are partially developed and some need more rigorous educational and assessment components.

The packages need to be developed that is the power-points, the written support, the facilitators notes, location of guidance on the web and possible on line packages. Not all of these packages are provided simultaneously. However, there is a graduation of complexity in analysis which is complemented by other material.

Resources required:

It is recommended that a principal project officer lead the development of these packages and that the senior project officer that developed the support packages in phase 1 support this activity.

Component 3: *Emerging Projects:*

It would be anticipated that a number of specific projects would be undertaken every year in relation to patient safety. These projects relate the national agenda and emerging requirements for QH. Currently, projects include Open Disclosure Project and the Correct Site Surgery Project. An initial assessment of current will need to be undertaken.

A maximum of 3 project of this nature would be undertaken per annum.

Resources required:

2 project officers would be required for this activity – a principal project officer, and a senior project officer.

Expert Support in specific areas

These areas include:

- Falls prevention
- Medication Safety
- Pressure Ulcer Prevention
- Infection control

These areas (except for Falls Prevention) currently exist within the Quality and Safety Program. Consultation and negotiation will need to be undertaken regarding the:

- Ongoing function of these areas
- Relationship with the QH Patient Safety Centre

Critical Success Issues:

There are several issues that will need to be resolved as this program is developed and implemented. These form the basis of critical success issues and are as follows:

- The leadership and relationship between SED, I &WFR and the SED HS is critical to the success of this program.
- The coordination and integration of safety, quality and risk needs to be undertaken and what does this mean at the coal face.
- The patient safety program will incorporate targeted safety project interventions eg 'correct site surgery' and ongoing functional safety program areas eg 'medication safety'. How this is undertaken is critical.
- How to promote the importance of patient safety in line with other strategic priorities and building on previous work undertaken is also critical for success.

- The over-arching governance arrangements and decision making will need to be clarified.

Conclusion:

The above outlines a proposal of what would be required to provide an effective Patient Safety System for Queensland Health. This has been presented in two phases. The first phase addresses immediate critical issues of:

1. Provision of awareness and training of the Incident Management Policy, organisational requirements and introduction to root cause analysis.
2. Provision of capacity for Health Service Districts to undertake this activity by providing patient safety officers
3. Support for the implementation of the information system to support the reporting and analysis of clinical incidents.

The second and third phase then continues to build capacity and capability for the organisation. This is through:

1. Data base development and support
2. Provision of advice, compliance testing and audit
3. Development of support tools such as advanced training in root cause analysis, human factors, systems re-design
4. Development of initiatives in response to emerging issues.

This outline for the second and third phase is only indicative of work to be undertaken. These phases will build on the feedback received during phase one development and implementation.

Implementation summary:

1. Endorsement of the general approach by the SED, I & WFR
2. Create team and district positions, develop core skill set
3. Undertake extensive consultation to identify champions and to raise awareness in the organisation (base on NSW model for roll out)
4. Undertake baseline assessment of patient safety culture
5. Progress critical work
6. Review other programs for co-location

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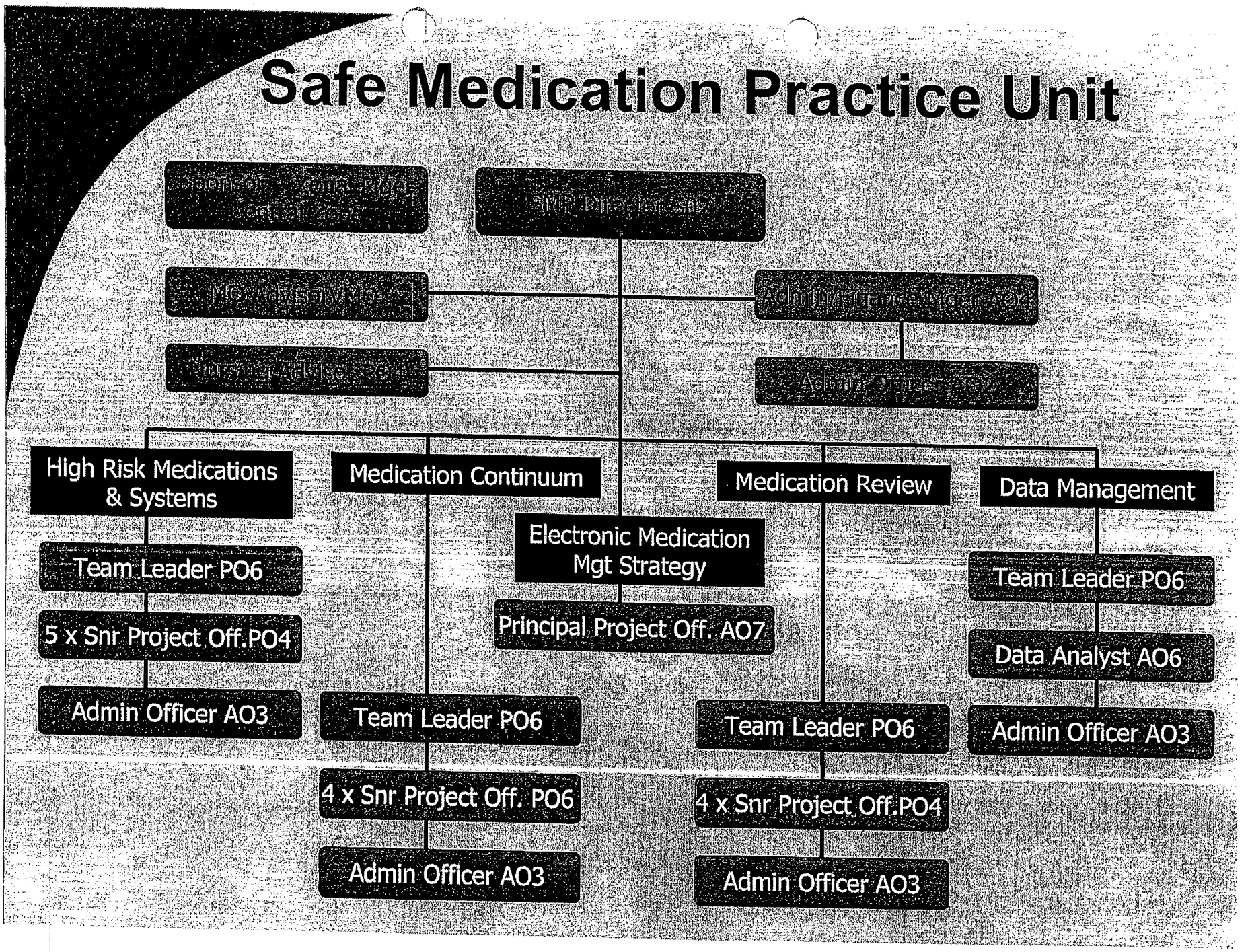
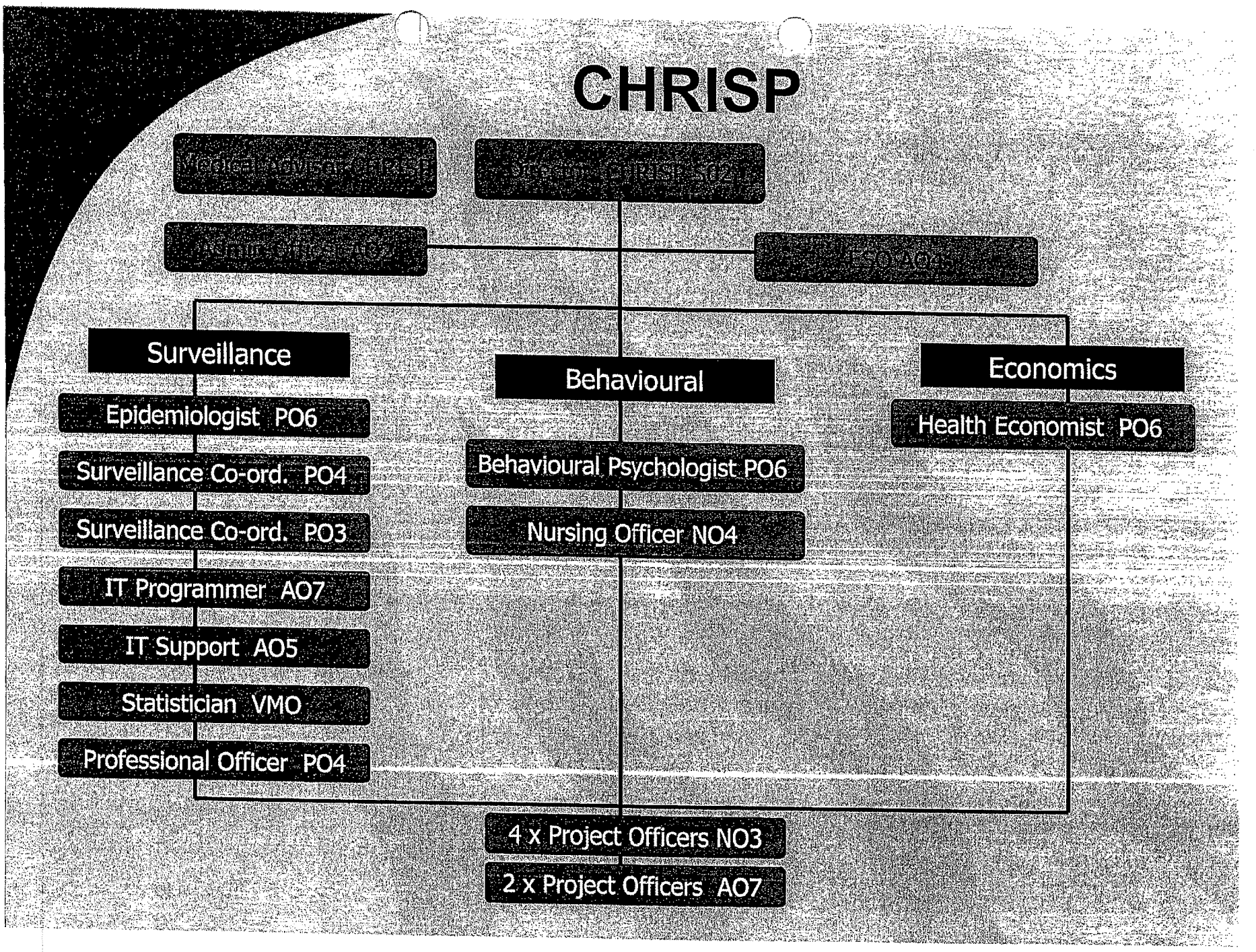
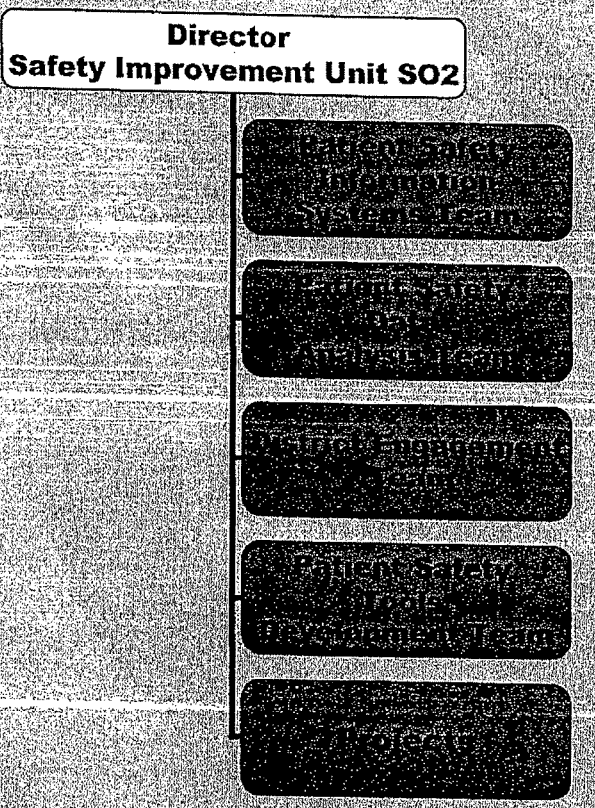
Patient Safety Centre
Organisational Chart

Safe Medication Practice Unit




CHRISP
Surveillance
Epidemiologist PO6
Surveillance Co-ord. PO4
Surveillance Co-ord. PO3
IT Programmer AO7
IT Support AO5
Statistician VMO
Professional Officer PO4
Behavioural
Behavioural Psychologist PO6
Nursing Officer NO4
Economics
Health Economist PO6
4 x Project Officers NO3
2 x Project Officers AO7

SAFETY IMPROVEMENT
Unit Structure



Safety Improvement Unit

Patient Safety Centre

Operational Plan 2005-2006

Overview

Our mission	*'Promoting a healthier Queensland'*
Our values	Professionalism, teamwork, performance accountability, quality and recognition
Guiding Principles	We exist to support those delivering healthcare We will evaluate our work to determine value for money We will treat others with honesty, respect and fairness We accept responsibility for our actions

Who we are

The Patient Safety Centre is one of six divisions in the Innovation and Workforce Reform Directorate.

The Safety Improvement Unit is one of three units in the Patient Safety Centre.

The Unit consists of five teams
- District Engagement Team
- Patient Safety Tools Development Team
- Patient Safety Information Systems Development
- Patient Safety Data Analysis Team
- Patient Safety Projects

The Unit consists of a central unit within the Patient Safety Centre as well as providing staff (25 Patient Safety Officers) in Health Service Districts.

What we do

The Safety Improvement Unit is committed to reducing preventable patient harm by:

- Raising risk awareness and promoting a culture of safety
- Integrating and building on programs currently in place
- Building local district capacity for identification of vulnerabilities and implementation of solutions using a human factors approach
- Providing patient safety tools for consistent use across the State
- Building a central resource centre that adds value by providing training support, data and trend analysis, and works with local areas to develop solutions for state wide implementation
- Creating networks for discussion and shared learning.

The Safety Improvement Unit aims to:

1 develop, implement and maintain organisation-wide clinical incident management systems that form a part of an effective clinical governance framework
2 develop, implement and maintain patient safety information systems that include clinical incident, consumer feedback and risk management
3 identify emerging patient safety priorities that become apparent from the analysis of incidents and from coronial reports.

The Patient Safety District Engagement Team is to provide training, education, support and coordination of district based Patient Safety Officers and other district based staff. The Team will provide 'just in time' support and training in the application of patient safety tools, patient safety system, ensure integration and consistency of approach across the state.

The Patient Safety Tools Development Team will manage the development of tools to build capacity for clinical incident management and complaints management. They will update the tools as required and also assist in the development of tools and supports for high risk areas and other patient safety projects.

The Patient Safety Information Systems Development Team develops and implements information systems to support the management and reporting of clinical incidents, complaints management and risk management. This Team also coordinates user groups and enhancements, facilitate and lead the training in the system and assists in the re-designing of business systems processes associated with clinical incident and complaints management.

The Patient Safety Data Analysis Team manages the data sets and databases for the PRIME: Clinical Incident and Consumer Feedback Information System. They coordinate the analysis of the information, production of reports and assist in the identification of system vulnerabilities. They also coordinate the provision of information for national groups.

The Patient Safety Projects Team are targeted projects that address issues arising form the state and national agendas as well as approved projects from the Safety and Quality Board.

This plan

This plan provides an overview of the Safety Improvement Unit Operational Plan for the financial year 2005-06. This is a working document which will be modified in response to emerging priorities and needs.

Key priorities

The Safety Improvement Unit contributes to 4 of the 5 key priorities of the Innovation and Workforce Reform Directorate:

1. Standardisation of systems and clinical practice
2. Developing a culture of safety
3. Exploit the full potential of the skills development centre consistent with QH Strategic Intents
4. Systematically applying innovation through the organisation

The work of the Safety Improvement Unit is focused on the following strategic areas contained in the Queensland Health Safety and Quality Strategy Map:

1. standardize processes for high risk areas (C1)
2. improve key business processes and systems (C2)
3. demonstrating culture of safety and quality (C4)
4. influence and operationalise national and state agendas (IP1)
5. improve communication processes (IP3)
6. Partner with educational institutions and professional bodies (IP5)
7. Develop and maintain mechanisms for reporting (IP6)
8. Managers and leaders are actively involved in safety and quality activities (IP7)
9. Skill workforce in continuous quality improvement (LG1)
10. Support mechanisms to share learnings (LG2)
11. Engage clinical and business leaders to drive safety and quality agenda (LG3)
12. Improve knowledge management to support quality and safety (LG4)

These are underpinned by the following:

- Promoting the delivery of safe, quality health services requires a demonstrated culture of patient safety throughout the organisation
- Patient safety will be a leadership and management priority within Queensland Health
- Patient harm from adverse events will be reduced through a coordinated statewide evidence-based approach
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The Safety Improvement Unit is also committed to meeting the following commitments made at the April and July 2004 Australian Health Ministers' Conferences (AHMC):

- That all public hospitals have an incident management system in place by January 2005 incorporating incident management, monitoring, investigation, analysis and action arising.
- To require all public hospitals to report all sentinel events, either to the state department or to an agreed third party, no later than the end of 2005.
- That all states and territories will contribute to a national report on sentinel events to be produced by the end of 2005.
- That all public hospitals will adopt the 5 step right patient, right site, right procedure protocol for verifying the site of surgery and other procedures to reduce the risk of wrong site procedures by the end of September 2004.
- That all public hospitals will have in place a patient safety risk management plan by the end of 2005.
- The National Open Disclosure Standard: A National Standard for open communication in public and private hospitals, following an adverse event in health care will be implemented by June 2006.
- The development of a Minimum Data Set for safety and quality.

Objectives

The Safety Improvement Unit has 2 major objectives for 2005/06. These objectives are designed to ensure that IWR Directorate Priorities are achieved, that the strategic focus as outlined in the QH Safety and Quality Map is maintained and that Ministerial Commitments are attained.

IWR Directorate Priority	QH Safety and Quality Map link	Ministerial Commitment	Safety Improvement Unit Objective	Initiatives
Standardisation of systems and clinical practice Developing a culture of safety Exploit the full potential of the skills development centre consistent with QH Strategic Intents	Standardize processes for high risk areas (C1) Improve key business processes and systems (C2) Demonstrating culture of safety and quality (C4) Influence and operationalise national and state agendas (IP1) Improve communication processes (IP3) Partner with educational institutions and professional bodies (IP5) Develop and maintain mechanisms for reporting (IP6) Managers and leaders are actively involved in safety and quality activities (IP7) Skill workforce in continuous quality improvement (LG1)	That all public hospitals have an incident management system in place by January 2005 incorporating incident management, monitoring, investigation, analysis and action arising. That all public hospitals will have in place a patient safety risk management plan by the end of 2005. The development of a Minimum Data Set for safety and quality.	To standardise clinical incident management within a clinical governance framework across the state.	Review of Incident Management and Complaints Management Policy Implementation, maintenance, support and upgrade of state wide clinical incident /consumer feedback information system Develop and conduct Baseline Safety Cultural Survey Development of training packages in: • Incident management • Coronial System Management • Complaints Management • Patient safety • Communication and team training • Human factors • Root Cause Analysis • Health Failure Mode Effect Analysis Review and advise on qualified privilege for clinical incident management which support

				legislation Deployment and support of Patient Safety Officers Implementation of Patient Safety System and Health Service District Training Implementation of the Patient Safety Risk Management Plan by Dec 2005.
Systematically applying innovation through the organisation	Operationalise national and state agendas (IP1) Support mechanisms to share learnings (LG2) Improve knowledge management to support quality and safety (LG4) Engage clinical and business leaders to drive safety and quality agenda (LG3)	The National Open Disclosure Standard: A National Standard for open communication in public and private hospitals, following an adverse event in health care will be implemented by June 2006. To require all public hospitals to report all sentinel events, either to the state department or to an agreed third party, no later than the end of 2005. That all states and territories will contribute to a national report on sentinel events to be produced by the end of 2005. That all public hospitals will adopt the 5 step right patient, right site, right procedure protocol for	To prioritise system vulnerabilities risks and identify or develop treatments for these risk by the development and implementation of State wide safety initiatives	Development of Alerts, Advisories and Directives based on the analysis of information from sentinel events, clinical incidents, complaints, root cause analysis and coronial reports Analysis of patient safety related information – that included the incident reporting database, complaints management database as well as other sources of incident data Implementation of state wide initiatives of: Ensuring Correct Site Surgery Open Disclosure Implementation and monitoring of best practice approaches to high risk areas of falls and pressure ulcer prevention

		verifying the site of surgery and other procedures to reduce the risk of wrong site procedures by the end of September 2004.		

Further information

For further information contact:

Safety Improvement Unit
3636 6569

Work Plan

Objective	*Key performance indicator/s*	*Basis for comparison*
1. To standardise clinical incident management within a clinical governance framework across the state.	Success will be measured by: • Improvement in patient safety culture, measured by cultural survey conducted prior to implementation and 2 years post implementation. • All HSD have staff trained in Root Cause Analysis • Patient Safety Officer deployed and trained in 25 sites. • PRIME clinical incident and consumer feedback information system implemented in 80% HSD's by June 2006	2 yearly comparison aggregated and yearly % comparison Number of staff trained Number of Patient Safety Officer in place Number of areas using the system in HSD
2. To prioritise system vulnerabilities risks and identify or develop treatments for these risk by the development and implementation of State wide safety initiatives	Success will be measured by: Ensuring correct surgery • training provided to top 25 HSDs by Dec 2005 • Audit of areas indicates 100% compliance Open Disclosure Pilot • Pilot completed and evaluated by June 2006	

Initiative	**Who**	**When**	**KPI**	**Key partners**	**Resources**
Review of Incident Management and Complaints Management Policy	SIU – Director	March / April / May 2005	Policy reviewed	All QH	
Implementation, Maintenance, support and upgrade of State wide Incident /complaints information system	SIU – PS Information Systems Team	Dec 2004 – June 2006 implementation Support and	Information system implemented in 80% HSD by June 2006	Health Services Directorate (HSD)	5 FTE

		Maintenance - ongoing		Information Directorate	
Baseline Safety Cultural Survey	SIU – PS Tools Development Team in conjunction with PS Data Analysis Team	May 2005 for undertaking survey	Survey undertaken in all HSDs	HSD	1 FTE
Development of training packages in: • Clinical incident management – May 05 • Coronial System Management – July 05 • Complaints Management December 05 • Patient safety – May 05 • Communication and team training – Sept 06 • Human factors - Dec O5 • Root Cause Analysis – May 05 • Health Failure Mode Effect Analysis – July 06	SIU – PS Tools development Team Human Error and Patient Safety Program	March 2005 – ongoing	Packages Developed by date indicated	HSD	4 FTE 2 FTE (25 FTE HSD)
Review and advise on qualified privilege for clinical incident management with support legislation	SIU – Tools Development Team	March 2005 - July 2006	Advice by May 05	HSD	1 FTE
Deployment and support of Patient Safety Officers	PS District Engagement Team	May 2005 - ongoing	Number of Patient Safety Officers employed	HSD	4 FTE 25 FTE HSD
Implementation of Patient Safety System, Patient Safety Risk Management Plan and Health Service District Training	PS District Engagement Team	May 2005 - ongoing	All HSDs attend initial session by June 2006 Patient Safety Risk Management Plan in Place by December 2005	HSD	5 FTE 25 FTE HSD
Development of Alerts, Advisories and Directives based on the analysis of information from sentinel events, incidents, complaints, root cause analysis and coronial reports	SIU – Patient Safety Data Analysis Team	Ongoing	Minimum of 6 Alerts developed per annum	HSD	4 FTE
Analysis of the patient safety related information – including clinical incident reporting data base,	SIU – Patient Safety Data	Ongoing	Reports produced for Safety and Quality	HSD	4 FTE

complaints management database as well as other sources of incident data	Analysis Team		Board – 2 per year		
Implementation of state wide initiative - Ensuring Correct Surgery	SIU Project officer for Ensuring Correct Surgery	June 2006	25 top facilities attended training Audit of activity indicate 100% compliance December 2005	HSD and Colleges	1 FTE
Implementation of state wide initiative – Open Disclosure	Project officer for Ensuring Correct Surgery	July 2006	Pilot completed and evaluated by June 2006	HSD, Legal Unit, Insurers	1 FTE
Implementation and monitoring of best practice approaches to high risk areas of falls and pressure ulcer prevention	Project officer	Ongoing	Guidelines implemented and monitored in 80% HSD	HSD	2 FTE

'JGW-5'

Safety Improvement Unit

Patient Safety Centre

Operational Plan 2005-2006

Overview

Our mission	*'Promoting a healthier Queensland'*
Our values	Professionalism, teamwork, performance accountability, quality and recognition
Guiding Principles	We exist to support those delivering healthcare We will evaluate our work to determine value for money We will treat others with honesty, respect and fairness We accept responsibility for our actions

Who we are

The Patient Safety Centre is one of six divisions in the Innovation and Workforce Reform Directorate.

The Safety Improvement Unit is one of three units in the Patient Safety Centre.

The Unit consists of five teams
- District Engagement Team
- Patient Safety Tools Development Team
- Patient Safety Information Systems Development
- Patient Safety Data Analysis Team
- Patient Safety Projects

The Unit consists of a central unit within the Patient Safety Centre as well as providing staff (25 Patient Safety Officers) in Health Service Districts.

What we do

The Safety Improvement Unit is committed to reducing preventable patient harm by:

- Raising risk awareness and promoting a culture of safety
- Integrating and building on programs currently in place
- Building local district capacity for identification of vulnerabilities and implementation of solutions using a human factors approach
- Providing patient safety tools for consistent use across the State
- Building a central resource centre that adds value by providing training support, data and trend analysis, and works with local areas to develop solutions for state wide implementation
- Creating networks for discussion and shared learning.

The Safety Improvement Unit aims to:

1 develop, implement and maintain organisation-wide clinical incident management systems that form a part of an effective clinical governance framework
2 develop, implement and maintain patient safety information systems that include clinical incident, consumer feedback and risk management
3 identify emerging patient safety priorities that become apparent from the analysis of incidents and from coronial reports.

The Patient Safety District Engagement Team is to provide training, education, support and coordination of district based Patient Safety Officers and other district based staff. The Team will provide 'just in time' support and training in the application of patient safety tools, patient safety system, ensure integration and consistency of approach across the state.

The Patient Safety Tools Development Team will manage the development of tools to build capacity for clinical incident management and complaints management. They will update the tools as required and also assist in the development of tools and supports for high risk areas and other patient safety projects.

The Patient Safety Information Systems Development Team develops and implements information systems to support the management and reporting of clinical incidents, complaints management and risk management. This Team also coordinates user groups and enhancements, facilitate and lead the training in the system and assists in the re-designing of business systems processes associated with clinical incident and complaints management.

The Patient Safety Data Analysis Team manages the data sets and databases for the PRIME: Clinical Incident and Consumer Feedback Information System. They coordinate the analysis of the information, production of reports and assist in the identification of system vulnerabilities. They also coordinate the provision of information for national groups.

The Patient Safety Projects Team are targeted projects that address issues arising form the state and national agendas as well as approved projects from the Safety and Quality Board.

This plan

This plan provides an overview of the Safety Improvement Unit Operational Plan for the financial year 2005-06. This is a working document which will be modified in response to emerging priorities and needs.

Key priorities

The Safety Improvement Unit contributes to 4 of the 5 key priorities of the Innovation and Workforce Reform Directorate:

1. Standardisation of systems and clinical practice
2. Developing a culture of safety
3. Exploit the full potential of the skills development centre consistent with QH Strategic Intents
4. Systematically applying innovation through the organisation

The work of the Safety Improvement Unit is focused on the following strategic areas contained in the Queensland Health Safety and Quality Strategy Map:

1. standardize processes for high risk areas (C1)
2. improve key business processes and systems (C2)
3. demonstrating culture of safety and quality (C4)
4. influence and operationalise national and state agendas (IP1)
5. improve communication processes (IP3)
6. Partner with educational institutions and professional bodies (IP5)
7. Develop and maintain mechanisms for reporting (IP6)
8. Managers and leaders are actively involved in safety and quality activities (IP7)
9. Skill workforce in continuous quality improvement (LG1)
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Further information

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Safety Improvement Unit
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