Patient safety: how are we doing in Australia and England?

In both Australia and England, the harm we do to patients has become a very public issue, provoking somewhat different government responses in each country. It is too early to tell how effective those responses will be.

Patient safety became a very public issue in Australia in 1995 with the publication of the Quality in Australian Health Care study (Wilson et al, 1995). It showed that we were harming 16.6% of patients admitted to hospital, with half of that harm being preventable. These figures have been re-examined, and the best estimate is probably nearer 10%, which is very similar to what has been found in England (Vincent et al, 2001). The extent and nature of the problems in the two countries appear to be the same. What, then, are we in Australia trying to do about it?

THE AUSTRALIAN RESPONSE

After some years and a lot of debate, the Australian Council for Safety and Quality in Health Care was established in 2000. The Council is comprised of clinical leaders – the Chairman was President of the College of Surgeons at the time of his appointment; senior representatives of the Commonwealth, State and Territory Governments; and consumers. It has a substantial budget, and its first priority is to improve patient safety as the most critical element of the quality of care.

The Council's principal initiatives have been set out under the following headings:

1. Better use of data to identify, learn from and prevent error and system failure
2. Supporting those who work in the health system to practise safety
3. Actively promoting opportunities for consumer feedback and participation
4. Redesigning systems and facilitating a culture of safety.

The following statements in the National Action Plan embody the important principles which the Council intends to adhere to:

- We must stop blaming individuals and put much greater effort into making our systems of care safer and better
- We must acquire better data about adverse events and near misses
- We must ensure that the experience of patients is effectively harnessed to drive improvements
- We need to promote greater community understanding of the best approach to ensuring health-care safety
- We must learn what works and what does not in reducing errors or mitigating their effects, drawing from the experience of other industries and other countries
- We must establish a culture of safety.

In putting these principles into practice, the Council has produced substantial policy documents and action plans, and has begun a series of projects. It jointly auspiced with the *British Medical Journal* and the Institute for Healthcare Improvement (IHI), Boston, the First Asia-Pacific Forum on Quality Improvement in Health Care last year, and the Chairman and other Council members have delivered many presentations on patient safety around the country. These initiatives have helped overcome the scepticism among doctors about our safety statistics, and have greatly widened the understanding that something needs to be done about them.

PROJECTS ON PATIENT SAFETY

The work of the Council on patient safety has a broad scope; the following represent some of the more important projects underway.

The Safety Innovations in Practice project attracted proposals from 225 hospitals, 64 of which received funding from the Council. This support for operational research is designed to pinpoint what works at a local level which might have wider application.

The 'Open Disclosure' project is designed to foster greater openness when things go wrong. Extensive consultation is being undertaken across Australia to develop national standards and guidelines. Educational and support packages are also being developed to assist the implementation of these standards. This has the strong support of all Australian health ministers, who have also agreed to consider the question of tort law reform to remove some of the barriers to 'saying sorry'. This is seen as a complex but critically important initiative to improving patient safety.

A project to identify national priorities for reducing health-care-associated infections has been launched. There have been a number of other similar programmes in train, but the Council's aim is to develop a national response which builds on the previous work.

A Medication Safety Taskforce has been established, which will oversee two national programmes aimed at minimizing preventable harm from medications. The first is a 'Breakthrough Collaborative' involving a number of organizations to reduce adverse drug events by 50% within 12 months, using the methods developed by the IHI in Boston (Berwick, 1989). The second is to fund a 'Medication Safety Innovative Initiatives Grant Programme', whereby proposals from organizations will be sought for projects aimed at improving medication safety.

Work has been started on a national system for tracking medical devices. This will allow patients with implanted medical devices to be contacted quickly should a recall or review be advised.

Educational strategies concerning patient safety are being developed, for

doctors and nurses in particular. For undergraduate courses, a working group involving the Australian Council of Deans of Nursing and the Committee of Deans of Australian Medical Schools has been set up. For postgraduate training, the equivalent body working with the Safety and Quality Council is the Committee of Presidents of Medical Colleges. Education is seen by the Council as an important building block for improving the safety of care.

The Council is working with states and territories to agree on a national core set of 'sentinel' events. These are events that cause serious harm and should be entirely preventable, e.g. operating on the wrong patient or the wrong side. The approach is to agree on a manageable list of perhaps 10 or 12 events which are likely to indicate system breakdown.

These projects provide a flavour of the work of the Council without capturing the full scope of its activities. Some of the projects are new, while others build on work started in one or other jurisdiction, in order to provide a uniform, nationwide approach.

Under the banner of 'supporting those who work in the health system to deliver safer patient care' are initiatives in medical registration, credentialling and clinical privileges. These initiatives are directed toward ensuring that doctors are fully trained and prepared for the particular work they will be required to do, so that their competence can be relied on. This focus on individual competence is seen by the Council as a necessary part of any overall strategy toward improving patient safety, but it is acknowledged that the main emphasis should be on learning how to improve the systems in which, and with which, doctors must work.

Other work had been going on over recent years in patient safety which preceded the setting up of the Safety and Quality Council, e.g. the work of the Patient Safety Foundation on incident reporting using the Australian Incident Monitoring System methodology (Runciman et al, 1998). The principal goal of the Council is to bring these somewhat fragmented initiatives into a national framework which will provide momentum for change across the whole country. It is still too early to claim that the work of the Council is saving lives, but there is a considerable expectation that it will.

THE ENGLISH RESPONSE

There is excellent work going on in England on patient safety. There are first rate, high level policy documents: *An Organisation with a Memory* and *Building a Safer NHS for Patients* (Department of Health, 2000, 2001). You have world leaders in the understanding of human error and what this means for patient safety. The work of James Reason (2000) and Charles Vincent (Vincent et al, 2001) in understanding adverse events, their sometimes shattering effect on patients and staff, and what to do about them, is starting to exert great influence in both England and Australia. There is a newly established National Patient Safety Agency promoting a culture of reporting adverse events and near misses. There are various initiatives such as the Serious Hazards of Transfusion Scheme which are directed at improving the safety of patient care.

KEY POINTS

- Patient safety is a major issue in England and Australia.
- Making our systems of care safer requires greater effort.
- Better data are needed about adverse events and 'near misses'.
- We must learn what works and what does not in reducing errors or mitigating their effects.
- We must stop blaming individuals.

I do wonder, however, about a potential imbalance between, on the one hand, what might be called the 'regulatory' measures, and on the other, the supportive, innovative and developmental work that will be needed. New agencies have been created which are variously seen to be adding further impositions on the health workforce. The National Institute for Clinical Excellence, Commission for Health Improvement, National Clinical Assessment Authority, the Council for the Regulation of Health Care Professionals, a 'new look' General Medical Council, clinical governance, annual appraisal and revalidation may each have a sound rationale, but they have come with a bit of a rush on a somewhat dispirited workforce. Patient safety requires competent doctors, but even more urgently it requires reform of the 'complex adaptive system' in which we work.

CONCLUSION

In both Australia and the UK there is now an acceptance that we must improve the safety of our care. We have much to learn about how this can be best achieved, but I believe a good start has been made. We shall see if I am right. HM

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