Patient Safety Future Focus

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Chief Executive
Clinical Excellence Commission
6 October 2017

NSW Health Strategic Priorities

- Patient Safety First
- Better Value Care
- Systems Integration
- Governance and Accountability
- Data and Analytics

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Key Issues

- Improving quality remains a stated priority but implementation is weak
- Gaps in national leadership
- Compliance and improvement are out of balance
- Priority thickets….
- Unfocused approach to building capability
- Local accountabilities
- Asymmetries in measurement and reporting

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What is our approach to change?

Compliance	Improvement
States a minimum performance standard that everyone must achieve	States a collective goal that everyone can aspire to
Uses hierarchy, systems and standard procedures for co-ordination and control	Based on shared goals, values and sense of purpose for improved outcomes
Threat of penalties/ sanctions/ shame creates momentum for delivery	Commitment to a common purpose creates energy, will and ownership for delivery

Source: Helen Bevan

Socio -Technical Framework for Healthcare

GENERATIVE
Organization wired for safety and improvement

PROACTIVE
Playing offense - thinking ahead, anticipating, solving problems

SYSTEMATIC
Systems in place to manage hazards

REACTIVE
Playing defense – reacting to events

UNMINDFUL
No awareness of safety culture

- Senior leadership
- Clinical Leadership
- Reliable processes of care
- Process improvement
- Psychological Safety
- Effective teamwork
- Just and accountable culture
- Person and Family Centred Care

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Components of Proactive/Generative Learning Systems

People

- Leadership –senior & clinical, teamwork, psychological safety, human factors, organisational fairness, negotiation, engagement, resilience, communication

External

- Regulation, reporting requirements, competition

Organization Values

- Goals, rules, accountabilities, focus

Workflow

- Normative actions: procedures, protocols, idea generation, learning, reliable processes, measurement, process improvement, transparency

Technology

- Hardware, software, prediction, measurement

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Highly Reliable Organisations Guiding Principles

- Focus on being predictive and proactive
- Openness about failures
- They are not harm free, but harm does not disable them
- Emphasis on learning
- Obligation to act
- Accountability
- Just culture
- Believe daily work practices produce safer care
- Teamwork and leadership

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Adapting our approach…

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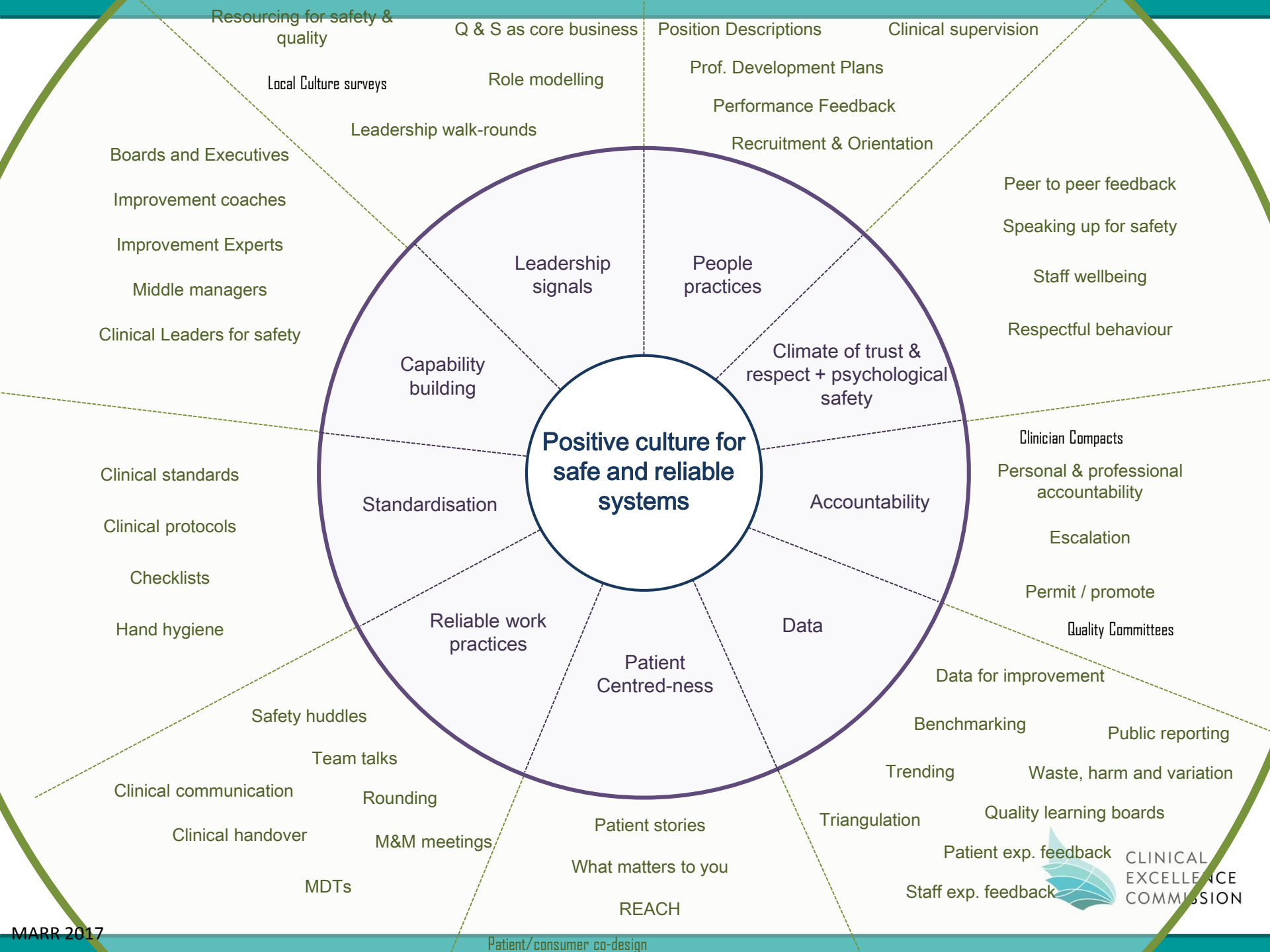

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2015
2014
2013
2012
2011
2010
2009
2008
2007
2006
2005
2004
Steps to Excellence
Improving Quality and Safety - Year by Year
hai Healthcare Associated Infections Program CAUTI
Patient safety looking learning acting
Human Factors
TAKE 2 THINK, DO
MEDICATION SAFETY AND QUALITY Stop Clots - Stop Harm!
open disclosure
TOP 5
AMBER Care Bundle
DETECT Junior
eCHARTBOOK PORTAL Safety and quality of healthcare in NSW
QUAH Quality Use of Antimicrobials in Healthcare
PRESSURE INJURY PREVENTION PROJECT
SEPSIS KILLS RECOGNISE · RESUSCITATE · REFER
insafe hands
Paediatric CLINICAL PRACTICE GUIDELINES
hai Healthcare Associated Infections Program
DETECT
Partnering with Patients
cpi CLINICAL PRACTICE IMPROVEMENT TRAINING PROGRAM
Between the Flags Keeping patients safe
QUAIC Quality Use of Antimicrobials in Intensive Care
Undergraduate Quality & Safety Education
CHARTBOOK
MEDICATION SAFETY AND QUALITY
Clinical Leadership Program
clabicu PROJECT PREVENTING CENTRAL LINE INFECTIONS
QSA QUALITY SYSTEMS ASSESSMENT
Clean hands save lives
hand hygiene program
BLOOD WATCH every drop counts
NSW FALLS PREVENTION PROGRAM
CHASM Collaborating Hospitals' Audit of Surgical Mortality
SCIDUA Special Committee Investigating Deaths Under Anaesthesia
Patient safety looking learning acting
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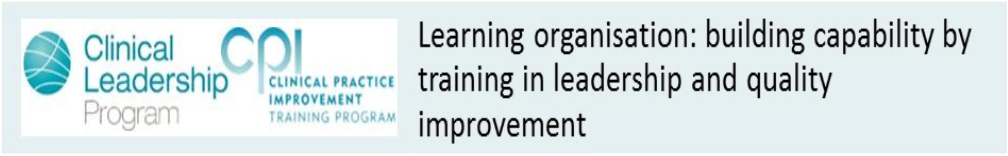
Supporting Learning Systems

Safety & Quality

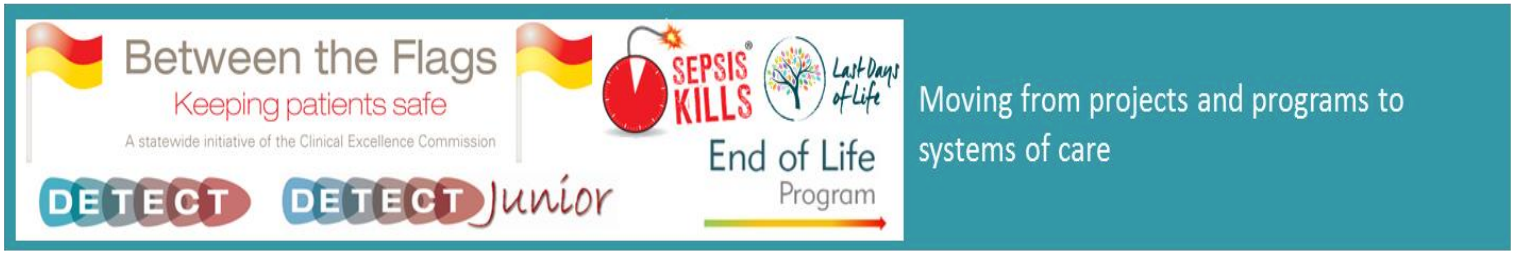


Learning organisation: building capability by training in leadership and quality improvement

Real time data for improvement

Development of high reliability patient care teams to improve culture

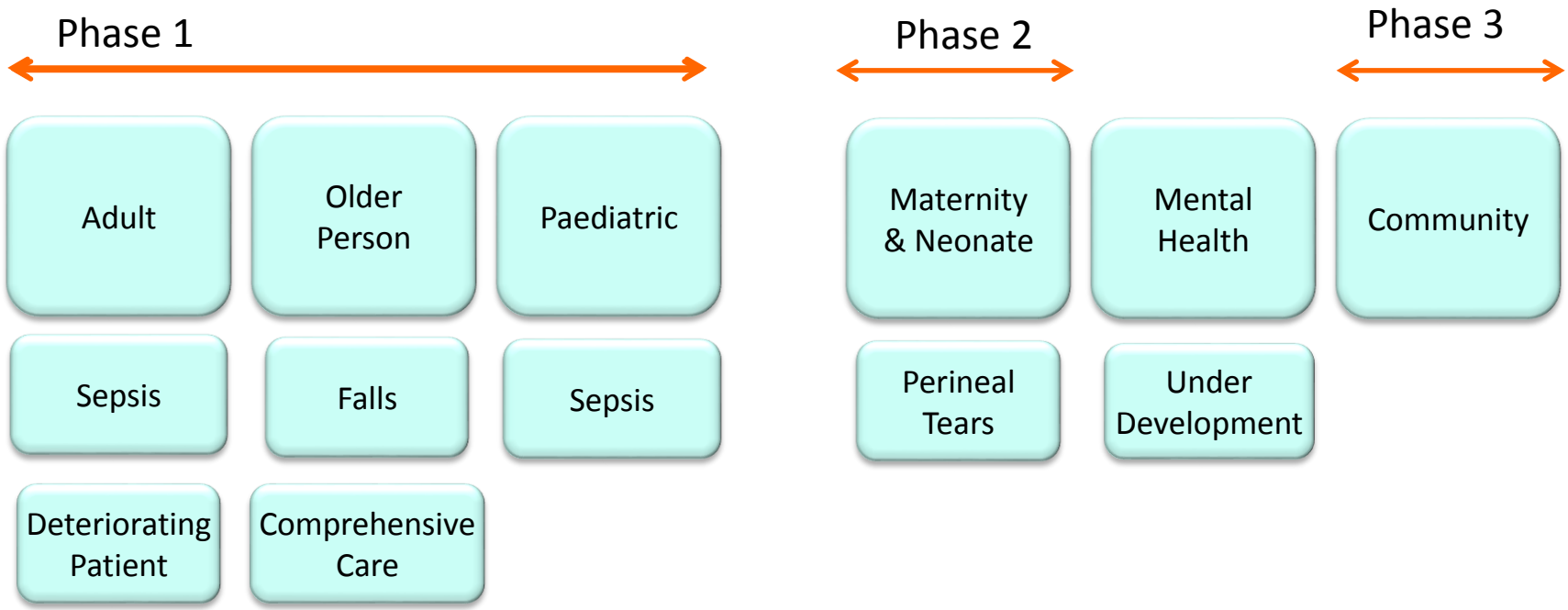
Ward based essentials of safety



Moving from projects and programs to systems of care

Statewide systems for incident monitoring and intelligence

NSW Patient Safety Program



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Capability Building

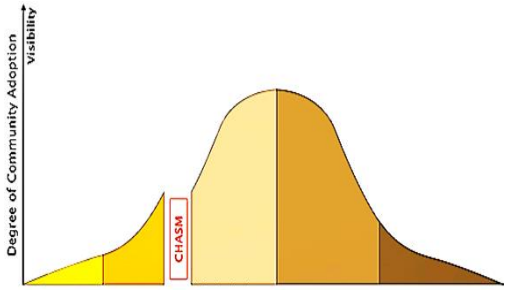
How will the change happen?

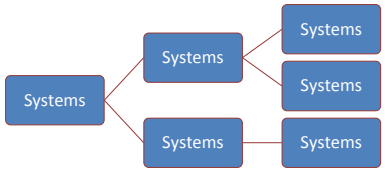
Values, Behaviour & Psychology

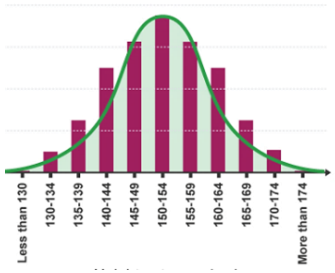
Systems Thinking & Leadership

Unwarranted Variation, Harm & Waste

Theory & Method



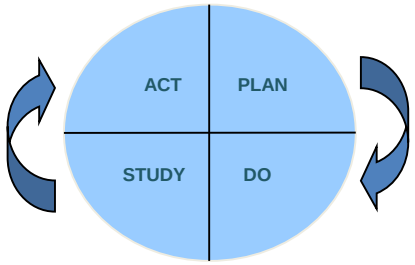




What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in an improvement?



Langley, Nolan et al 1992

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Supporting the Microsystem

http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0009/327564/CEC-Guide-to-Quality-and-Safety.pdf

Thank You

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