

Professional Standards Forum

7th April 2022

Quality Improvement *An Essential Component of Professional Practice*

Adj Assoc Professor Bernie Harrison MPH (Hons), Grad Cert Med Ed,
RN, RM, FCHSM,CE
Director ACHS Improvement Academy
School of Public Health, Faculty of Medicine and Health, University of
Sydney



Acknowledgement of country

I would like to acknowledge the traditional custodians of this land and pay my respects to Elders past, present and future for they hold the memories, the traditions, the culture and hopes of Aboriginal and Torres Strait Islander Australians



Objectives

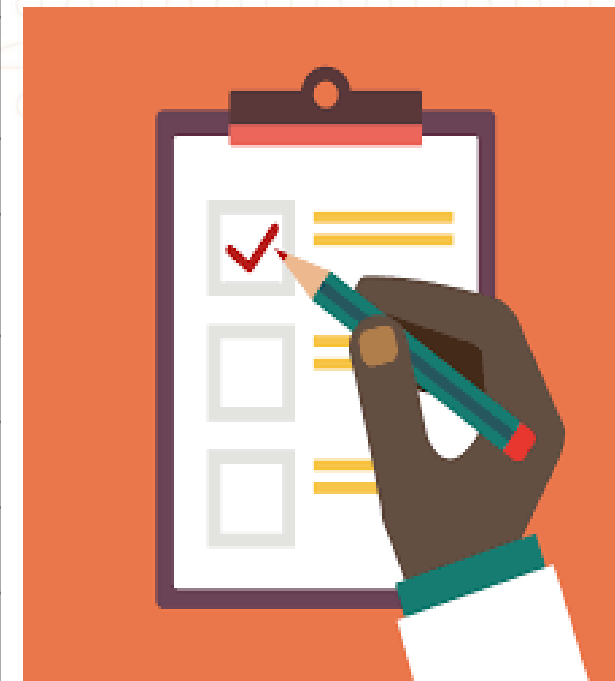
1. Understand – models that build regulatory and professional accountability
2. Gain insight into safety and risk to clients
3. Know how to develop ethical and accountable practice
4. Gain insights into quality improvement and the features of high reliability organisations
5. Understand how Professional Associations can support members



90 mins

11.45	5	Professional Indemnity review	Chat
11.50	5	Quality in Australian Health care study – findings Blame culture	Chat
11.55	5	Governance of health systems High profile failures- why things go wrong	Chat
12.00	10	Royal Commission into Banking Risk controls	Polls
12.10	5	Leadership for improvement	Invited Chat
12.15	10	QI theory - Deming Here's Lucy Chocolate Factory	Video (link)
12.25	5	High reliability – building into organisations DNA	Chat box
12.40	15	Titanic Case study	Break out Groups
12.55	5	Debrief	Report from individuals
13.00	5	Summary, Resources, Work with ACHS IA	
13.05	10	Questions (Roxanne)	Chat box

Program



1988 Report of the Royal Commission into Deep Sleep Therapy / The Honourable Mr Acting Justice J.P. Slattery, Royal Commissioner



- Deep Sleep Therapy (DST) made its first appearance in the media in November 1967 in the Sydney Morning Herald. The newspaper reported concerns about the excessive amount of drugs given to Ronald Carter, who was then 23 years old. He died in May 1967 while under deep sleep therapy. The drugs used in deep sleep therapy include Tuinal, Neulactil, Sodium Amytal, Placidyl and Serenace. All of these substances were restricted under Schedule 4 of the Poisons Advisory Committee.
- Dr. Harry Bailey [Director Chelmsford Private Hospital [1963-1979], a private psychiatric institution in [Pennant Hills](#) a suburb of Sydney] used DST for a variety of conditions, both psychiatric and non-psychiatric. 25 patients died from Deep Sleep Therapy and hundreds suffered side effects. The Citizens Commission on Human Rights (CCHR) investigated Deep Sleep Therapy*
- *Walton, Merrillyn (June 2013). "[Deep sleep therapy and Chelmsford Private Hospital: have we learnt anything?](#)". *Australasian Psychiatry*. **21** (3): 206–212. [doi:10.1177/1039856213486703](#). [ISSN 1039-8562](#).

Professional Indemnity Review and Federal Government Response

1991

- Professional indemnity review

1992

- AIHW pilot study HMPS

1994

- Quality in Australian Health care study

1995

- QAHCS released
- Taskforce on QAHC

1995

- Final report on compensation and professional indemnity

1996

- Final report on taskforce for QAHC
- Health ministers meeting

1996

- National expert advisory groups on safety and quality in health care

1998

- Interim report NEAG

2000

- Australian Council Safety and Quality in Health care

2006

- Australian Commission Safety and Quality in Health Care

2011

- Independent statutory Authority – Health reform

2013

- National Standards released
- Second edition released 2017

Patient Safety

458

THE MEDICAL JOURNAL OF AUSTRALIA Vol 163 6 November 1995

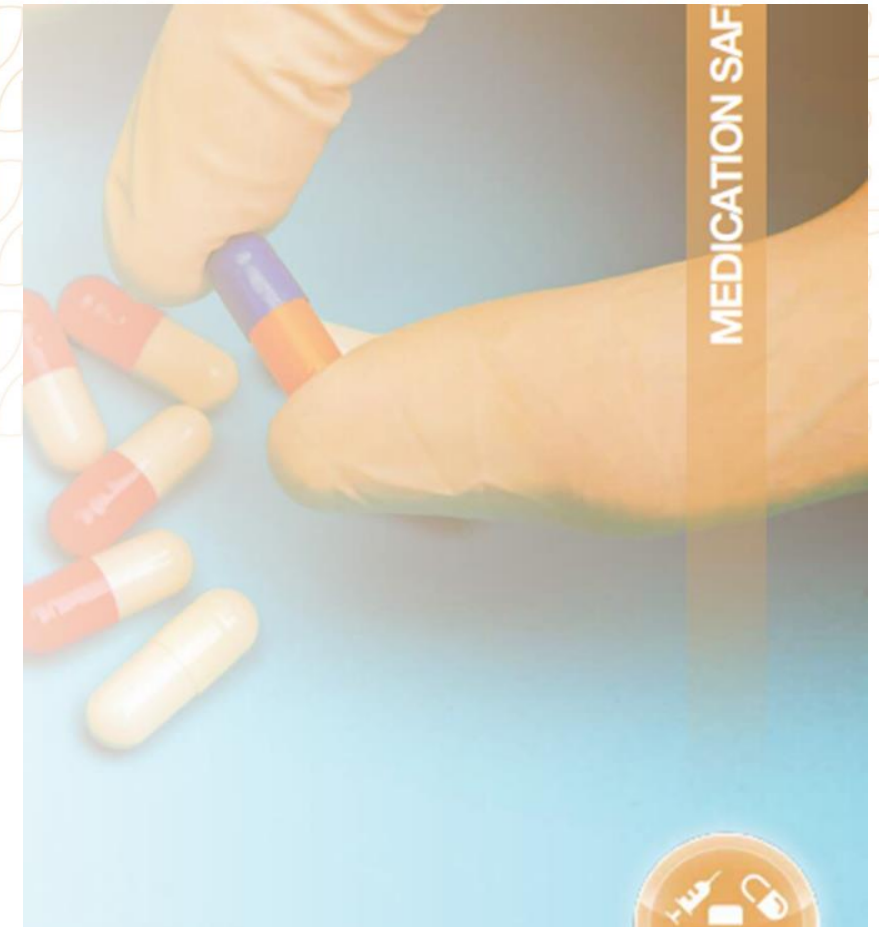
Health Care

The Quality in Australian Health Care Study

Ross McL Wilson, William B Runciman, Robert W Gibberd, Bernadette T Harrison,
Liza Newby and John D Hamilton

A review of the medical records of over 14 000 admissions to 28 hospitals in New South Wales and South Australia revealed that 16.6% of these admissions were associated with an "adverse event", which resulted in disability or a longer hospital stay for the patient and was caused by health care management; 51% of the adverse events were considered preventable. In 77.1% the disability had resolved within 12 months, but in 13.7% the disability was permanent and in 4.9% the patient died. (Med J Aust 1995; 163: 458-471)

In 2015 MJA recognised this paper as the most cited paper in its 100 year history



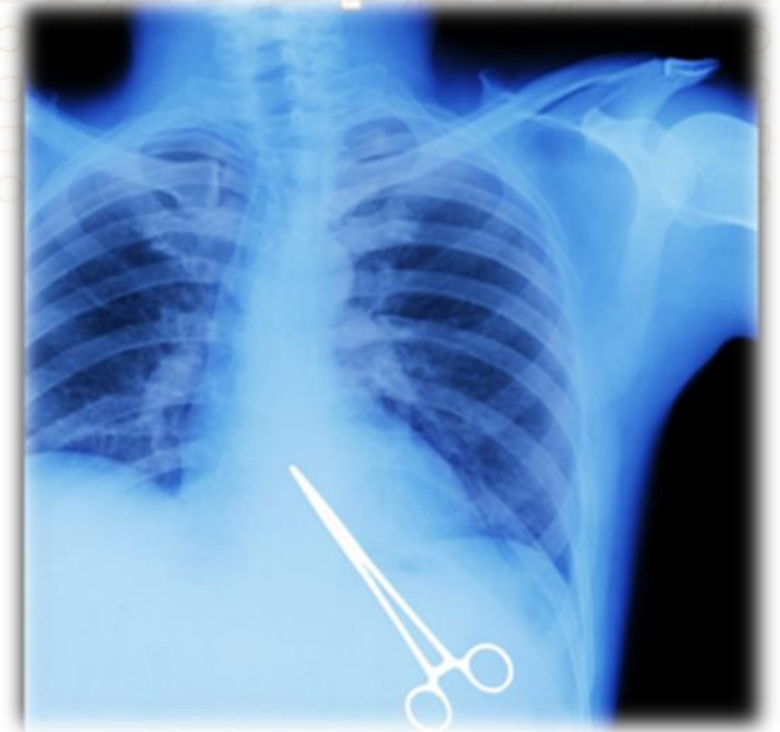
Epidemiology of adverse events (last 20yrs)

Medico legal studies measuring negligence

Harvard Medical Practice Study	3.5%
Utah Colorado Study	2.7%

Adverse event studies measuring preventable harm

*QAHCS Australia (16.6%)	10%
British adverse event pilot study	11%
Canada	7.5%
Singapore	12%
Japan	11%
Denmark	9%
NZ	12%
Spain	10%

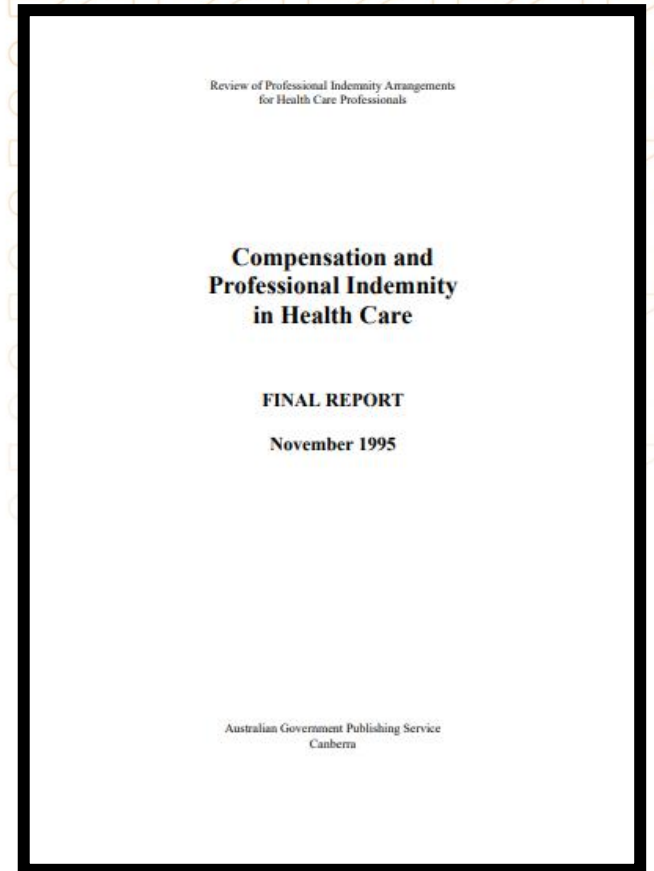


Chapter 5

47. The PIR recommends that for the extension of effective data collection and analysis for quality improvement, priority must be given to the development and promulgation of inexpensive, effective ways of providing feedback from quality data collection to practitioners and others involved in the health care system, such as administrators and consumers.

48. The PIR recommends that medical, nursing and health sciences faculties, as well as professional colleges, examine ways of training students and health professionals **in error identification and analysis**, as well as training them to seek appropriate supports when errors do occur, at undergraduate, postgraduate and continuing education levels.

49. The PIR recommends that health care institutions examine what support mechanisms exist in their facility **to assist health professionals to deal with errors in a positive manner** (for example an incident monitoring feedback group, peer support mechanisms, team care support groups and confidential counselling).



FIONA TITO Chair Review of Professional Indemnity Arrangements for Health Care Professionals

Dr Harold Shipman GP England

Who Was Harold Shipman?

British serial killer Harold Shipman, who worked in England as a medical doctor, killed over 200 of his patients before his arrest in 1998.

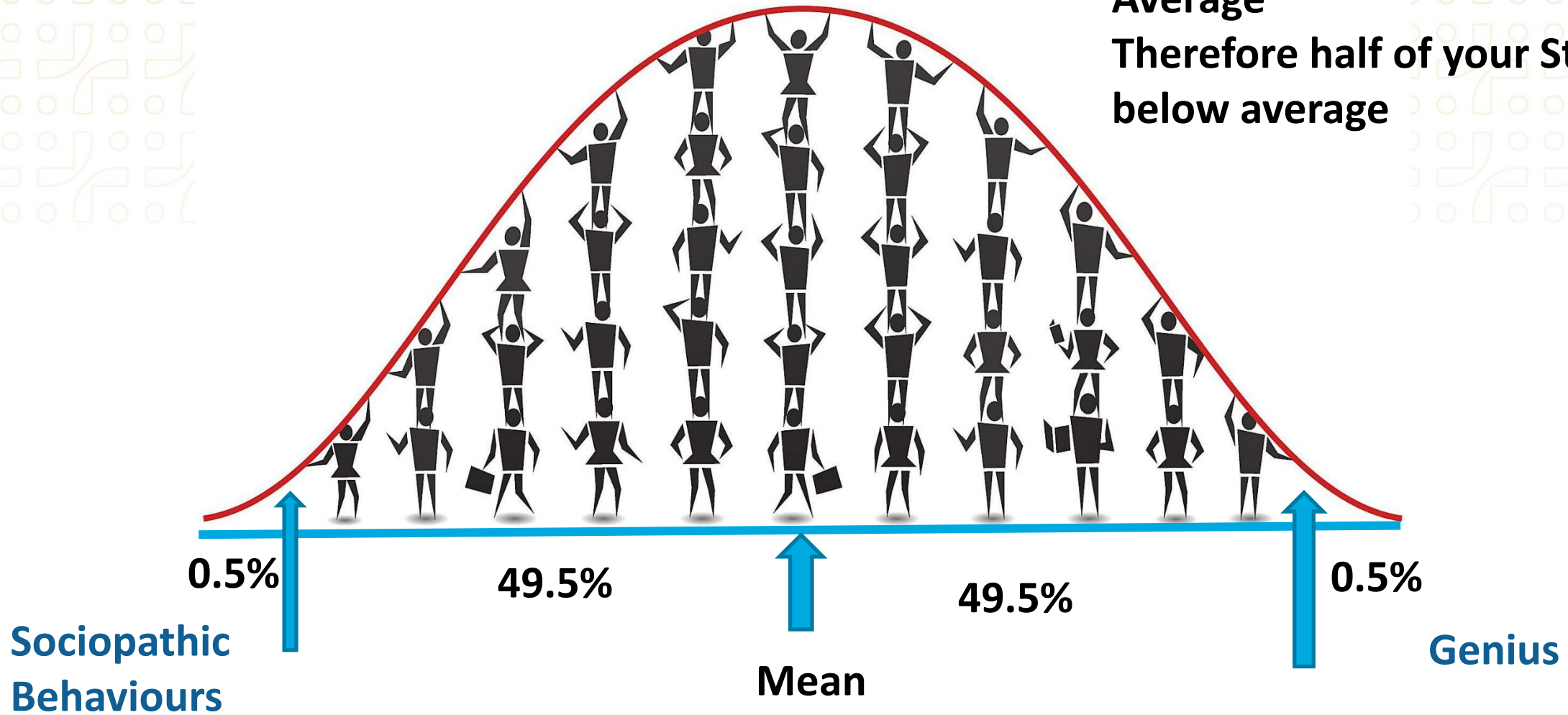
He attended Leeds School of Medicine and began working as a physician in 1970. Between then and his arrest in 1998, he killed at least 215 and possibly as many as 260 of his patients, injecting them with lethal doses of painkillers.



On January 13, 2004, Shipman was discovered hanging in his prison cell at Wakefield, having used bed sheets tied to the window bars of his cell.

Normal distribution of human performance

Half of your staff are above Average
Therefore half of your Staff are below average





It is well documented globally, across all sectors, healthcare has the following problems:

1. Variation in clinical practice
2. High rates of inappropriate care
3. Preventable injury and death
4. A striking inability to do “what we know works”
5. A large amount of waste and spiraling prices which limits access

Engineering a Learning Healthcare System: A Look at the Future: Workshop Summary (2011)

By National Academy of Engineering, Institute of Medicine Dr Brent James

Governance of Health Systems

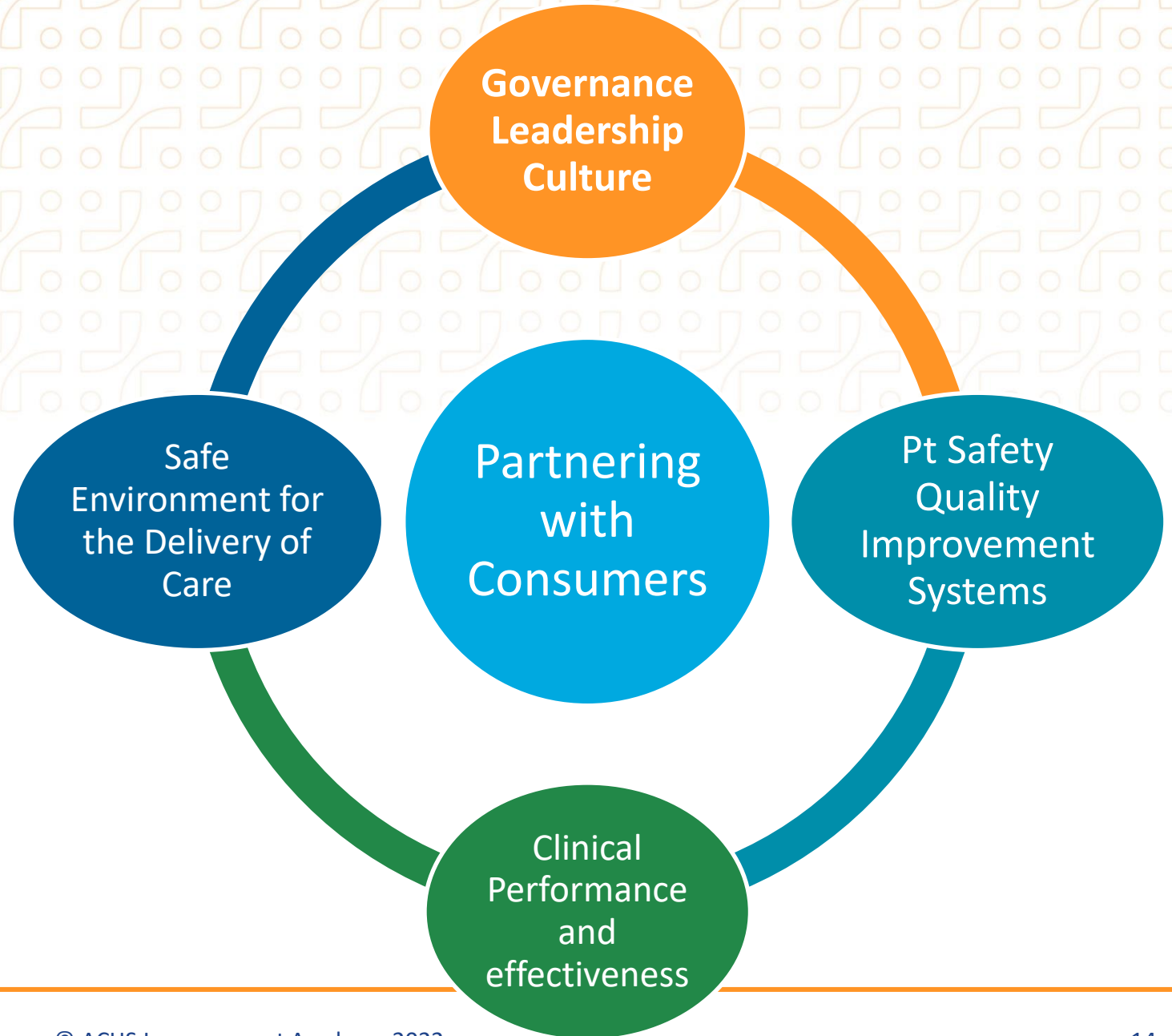
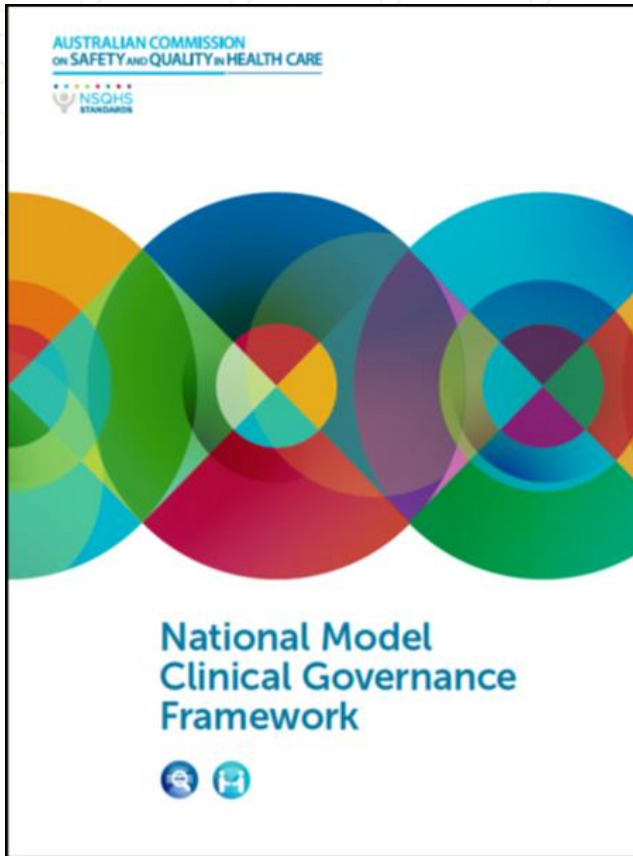
Compliance
Accreditation

Benchmark
Clinical
Indicators

Improvement
Training QI
Science

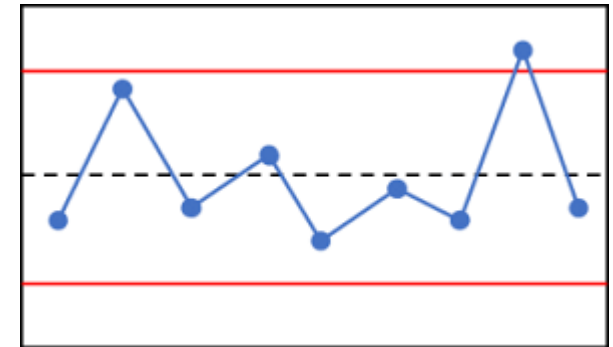


Clinical Governance Framework *five components (released 2017)*



Governing body responsibilities to ensure that the following Quality and Safety systems are in place

- Quality improvement and measurement
- Risk management
- Incident management
- Open disclosure
- Feedback and complaints management



Clinical governance and the National Model Clinical Governance Framework

This section describes how clinical governance is an integrated component of broader corporate governance and sets out the key elements of the Clinical Governance Framework, based on the NSQHS Standards.

Clinical governance as an integrated component of organisational governance

The responsibility of a governing body such as a board for clinical governance is an integrated element of its overall responsibility and accountability to govern the organisation (Figure 2). As a component of broader systems for corporate governance, clinical governance involves a complex set of leadership behaviours, policies, procedures and monitoring and improvement mechanisms that are directed towards ensuring good clinical outcomes.

The clinical governance system of a health service organisation therefore needs to be conceptualised as a system within a system – a clinical governance system within a corporate governance system.

Under this model, it is important to recognise the following:

- Clinical governance is of equivalent importance to financial, risk and other business governance
- Decisions about other aspects of corporate governance can have a direct affect on the safety and quality of care, and decisions about clinical care can have a direct affect on other aspects of corporate governance, such as financial performance and risk management
- Governing bodies are ultimately responsible for good corporate (including clinical) governance
- Governing bodies cannot govern clinical services well without the deep engagement of skilled clinicians working at all levels of the organisation

- Clinicians, managers and members of governing bodies have individual and collective responsibilities for ensuring the safety and quality of clinical care; as well as being reflected in the NSQHS Standards, many of these responsibilities are specified in relevant professional codes of conduct.

Figure 2: Corporate governance responsibilities



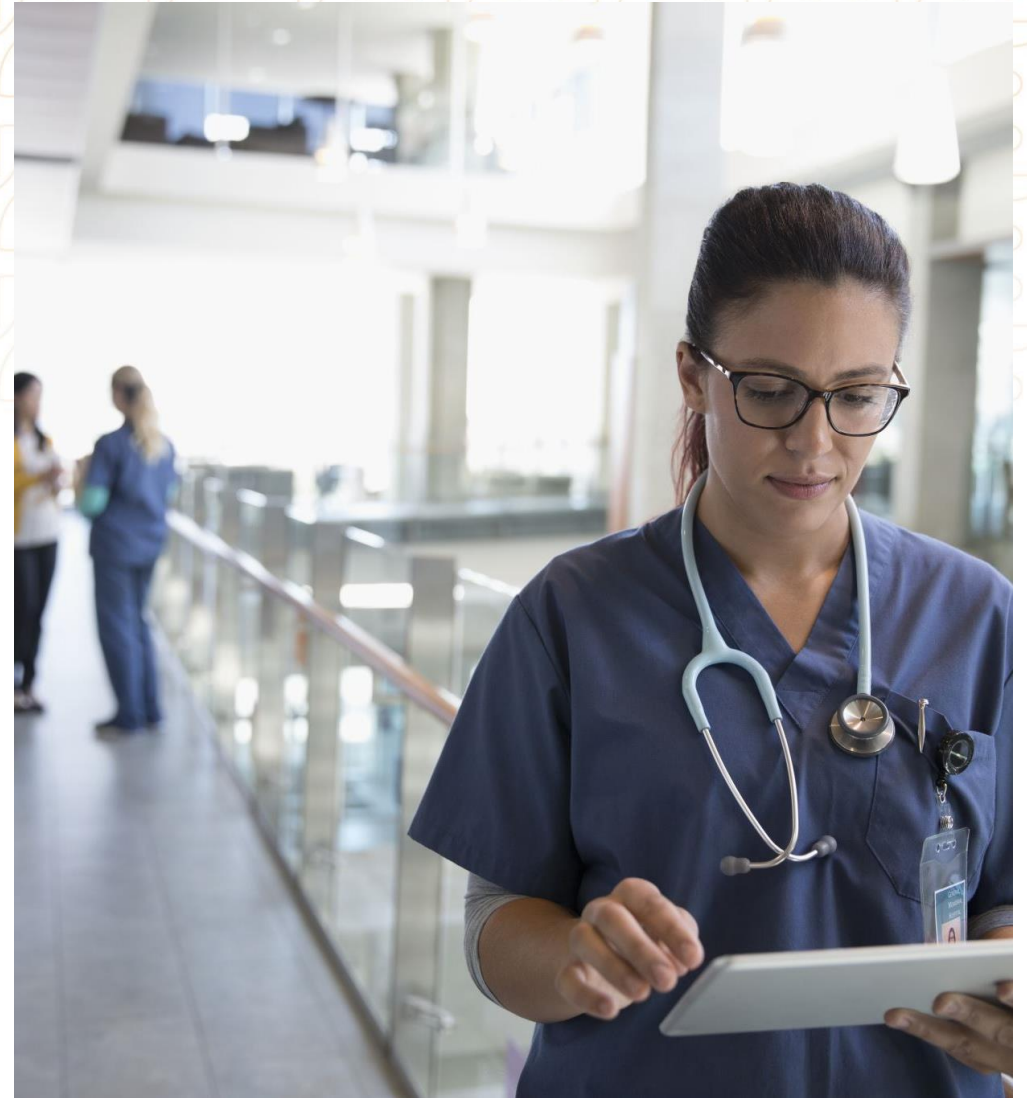
Although it is ultimately the responsibility of a governing body to set up a sound clinical governance system, and be accountable for outcomes and performance within this system, implementation involves contributions by individuals and teams at all levels of the organisation. There is also reliance on well-designed systems that deliver, monitor and account for the safety and quality of patient care.

The responsibility of the governing body such as a board for clinical governance is an integrated element of its overall responsibility and accountability to govern the organisation.

Everyone is accountable

Although it is ultimately the responsibility of a governing body to set up a sound clinical governance system, and be accountable for outcomes and performance within this system, **implementation involves the contribution by individuals and teams at all levels of the organisation.** There is also reliance on well designed systems that deliver, monitor and account for the quality of patient care.

Ref: National Model Clinical Governance



Clinical Governance Standard



Criterion 1: *Governance, leadership and culture*

The governing body:

- Provides leadership to develop a culture of safety and quality
- Provides leadership to ensure partnering with consumers
- Sets priorities & strategic direction for safe high quality clinical care
- Approves the clinical governance framework
- Ensures safety and quality roles & responsibilities are defined at all levels

ATTESTATION STATEMENT IS NOW A REQUIREMENT OF BOARDS

High Profile Clinical Governance Failures in Australia

- Chelmsford Royal Commission Deep Sleep Therapy – NSW 1988
- King Edward Memorial- WA 2002
- Campbelltown and Camden Hospitals - 2003
- Bundaberg Qld 2005
- CALHN Chemotherapy under dosing 2015
- **Djerriwarrah – Vic 2016** →
- St Vincents Chemo underdosing 2016
- Oakden – SA 2018



Professor Alan Spigelman's list of features of Clinical Governance Failures by Boards and Executives

1. Poor organisational structure
2. Poor lines of responsibility
3. Absent monitoring of patient safety/quality
 - No adverse event reporting or response system
4. Poor supervision of junior staff
5. Poor communication skills
 - between health professionals, departments, facilities, with patients & families
6. Absent Board / Management input to safety
 - Over emphasis on fiscal matters
7. Poor clinical audit systems
8. Non-compliance of staff re safety
9. No information to families when things went wrong
10. Professional silos, nurses disempowered
11. Poor documentation in medical records
12. Blame culture
13. Poor credentialing
14. Fragmented quality structure
15. Poor recognition of concept of accountability
16. Lack of will to tackle difficult issues

Spigelman, A. D. and Rendalls, S. (2015) 'Clinical governance in Australia', *Clinical Governance: An International Journal*, 20(2), p 56-73

Other industries not immune to scandal

Royal Commission into Misconduct in the Banking, Superannuation and Financial Services Industry 2019

- 1.1 pg 2
- “First, in almost every case, the conduct in issue was driven not only by the relevant entity’s pursuit of profit but also by individuals’ pursuit of gain, whether in the form of remuneration for the individual or profit for the individual’s business. Providing a service to customers was relegated to second place. Sales became all important. Those who dealt with customers became sellers. And the confusion of roles extended well beyond front line service staff. Advisers became sellers and sellers became advisers. The conduct identified and condemned in this Final Report and in the Interim Report can and should be examined by reference to how the person doing the relevant acts, or failing to do what should have been done, was rewarded for the conduct”.



Polls - you can choose more than one

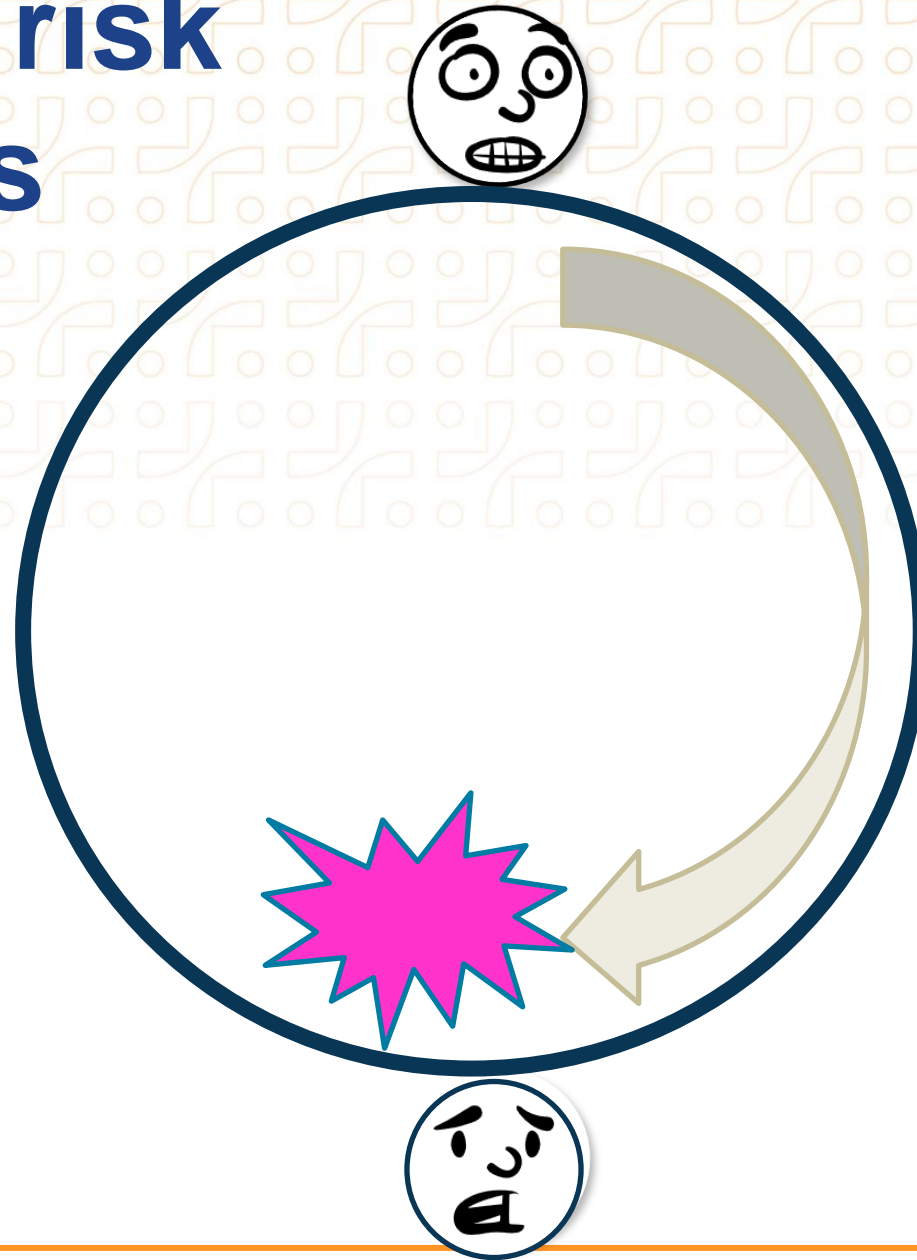
Poll 1. Whose prime role is it to protect the customer?

1. The Federal Government increasing regulation
2. The Professional Associations setting standards
3. The organisations board
4. The organisations executive
5. The organisations front line financial service teams
6. Australian Competition and Consumer Commission

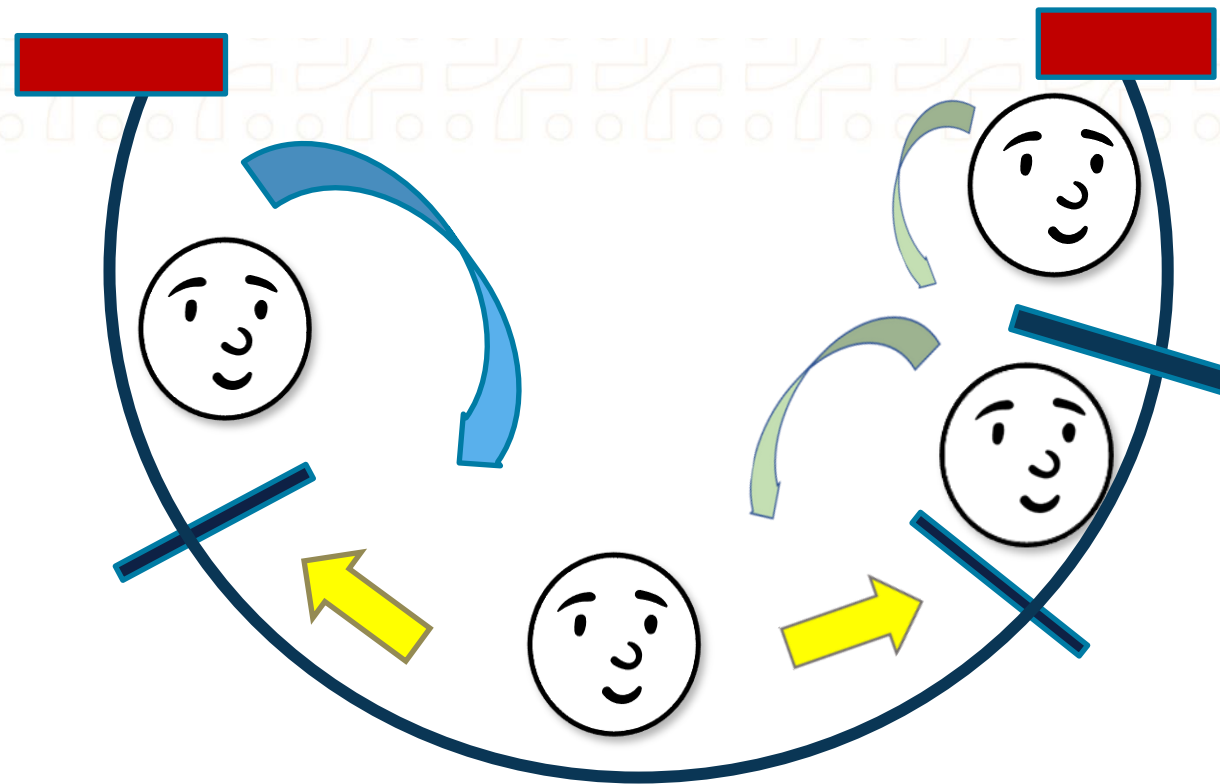
Poll 2. What strategies would prevent this recurring?

1. Change the culture
2. Increase compliance and regulation
3. Change the structures of Boards
4. Focus on the customer
5. Empower the front line to improve services
6. Increase risk controls
7. Mandate training in ethics for all staff
8. Change the bonus and reward systems for staff

Absent risk controls



Building in risk controls

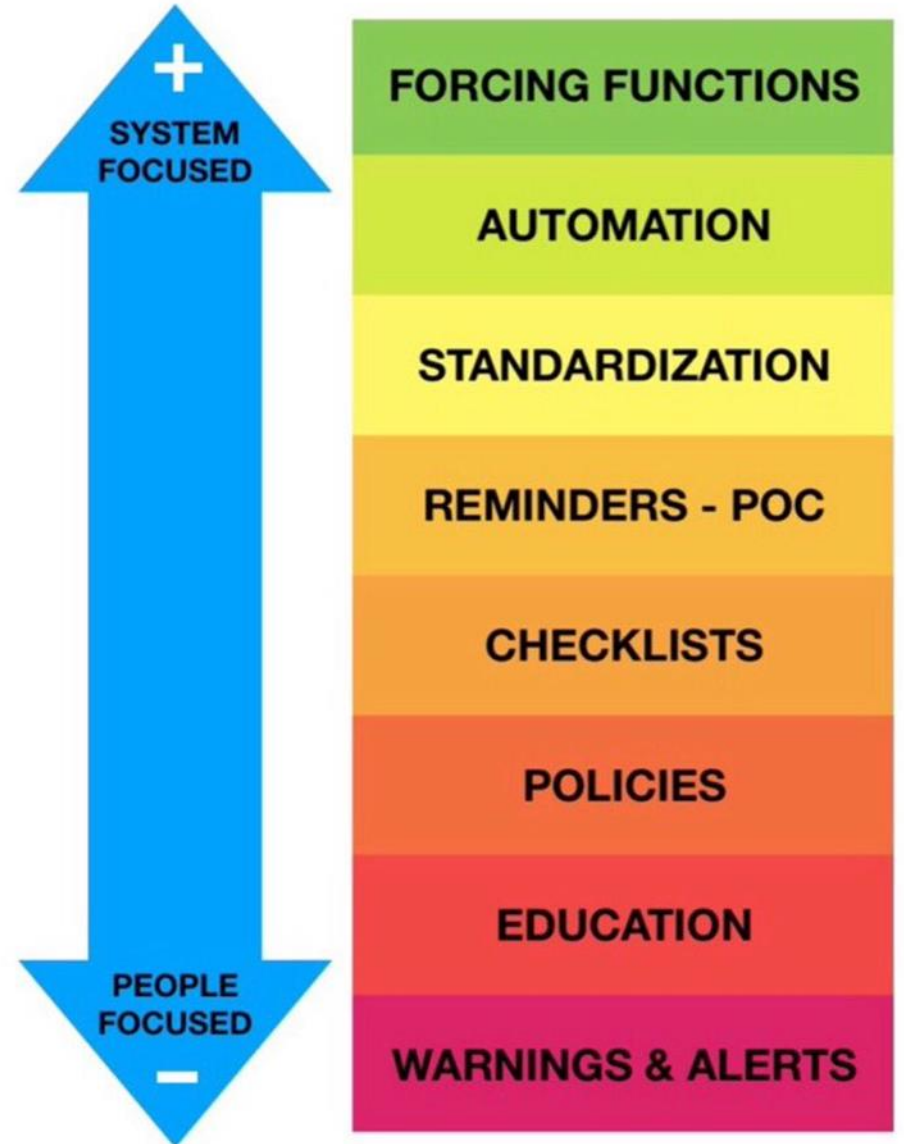


Improving systems

It takes engagement of front line and innovative practice

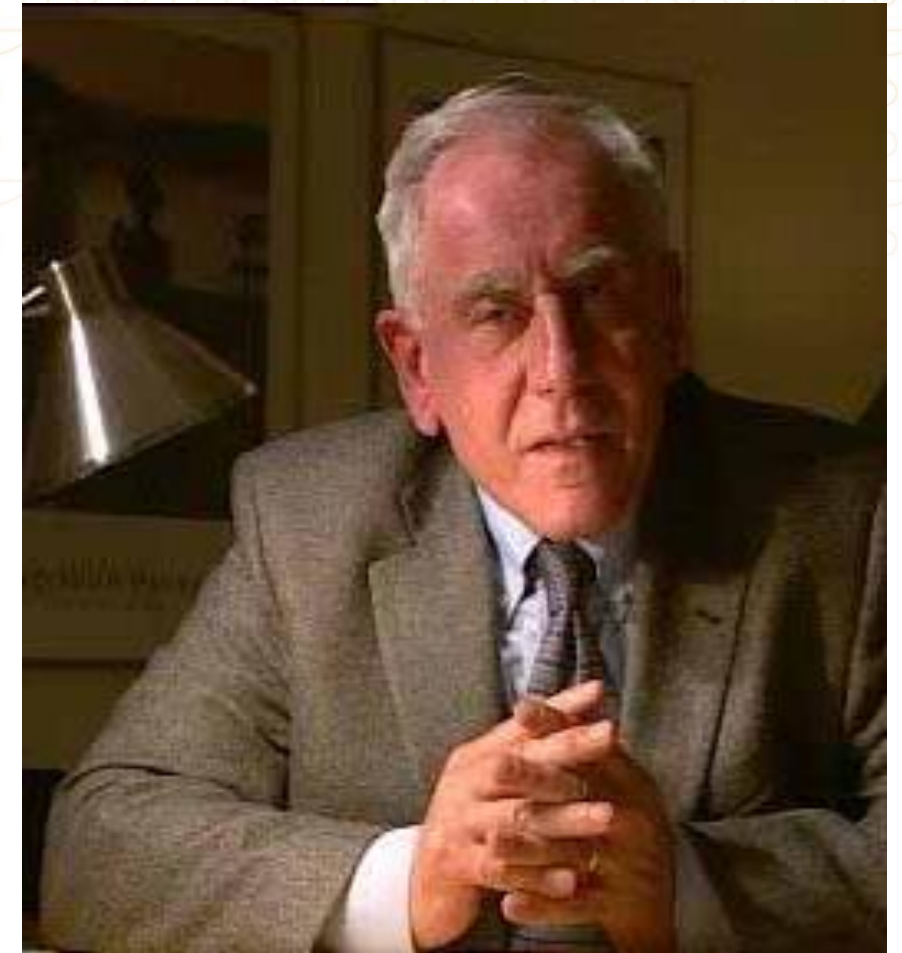


Hierarchy of Intervention Effectiveness



Professor James Reason is recognised as a **world leading expert on human error**

“It is simply not possible to order in a package of Error Management measures, implement them and then expect them to work without further attention. You cannot put them in place and then tick them off as another job completed. In an important sense, the process – the continuous striving toward system reform – is the product”.



Problem is concepts of leadership in quality and safety:

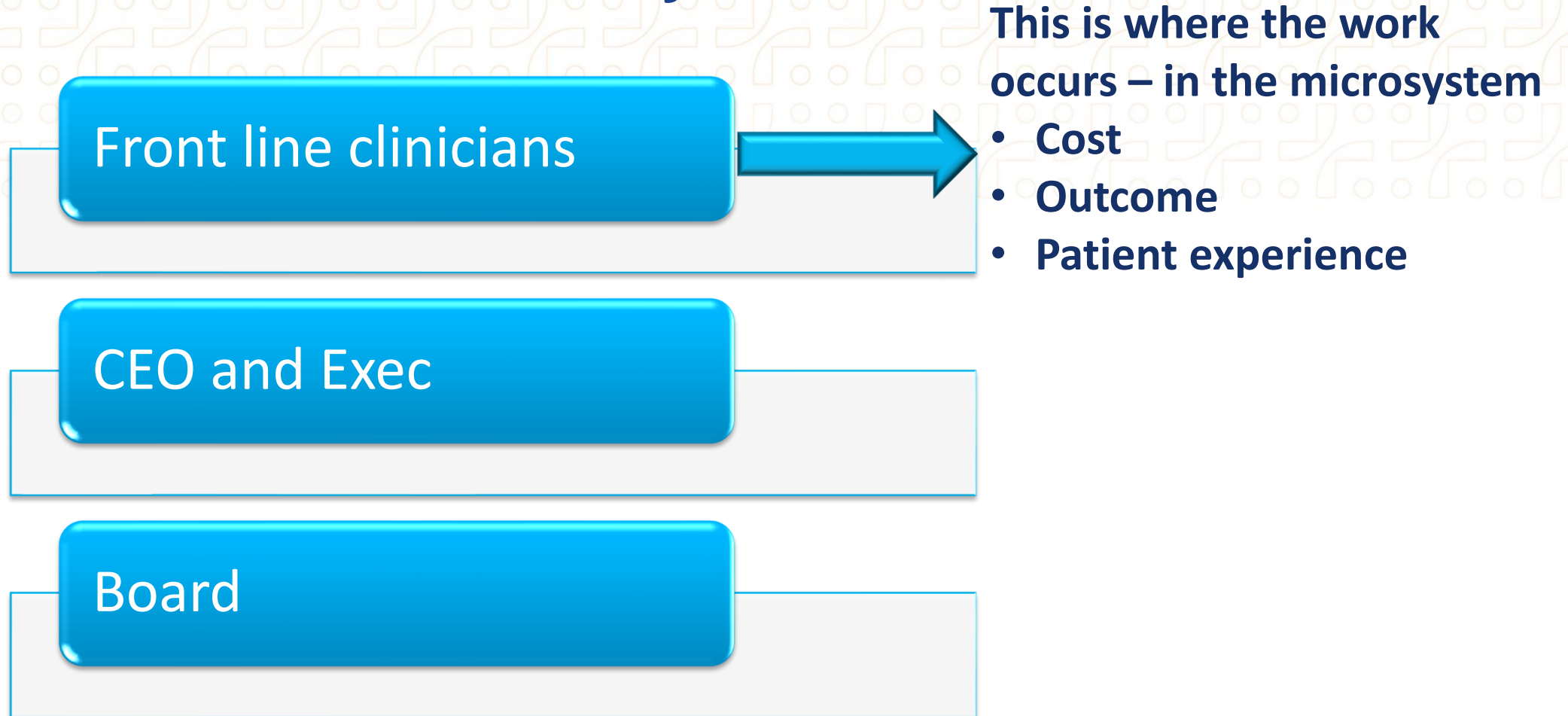
Traditional Corporate Governance

Board

CEO and Exec

Clinical Units

Contemporary leadership for quality and safety





“If you can’t describe what you are doing as a process, you don’t know what you are doing”
– W. Edwards Deming

And the reason why you don’t know what you are doing is:

Because everyone is doing it differently!



We need to think like process engineers

‘Variation is a root cause to waste in a production system because it creates interruptions in the production system. Variation is dissipating through the production flow and reduces productivity; therefore, to minimize the effect, variations need to be handled with great care’.

Understanding the Effect of Variation in a Production System

•November 2014

•[Journal of Construction Engineering and Management](#) 140(11):04014051

DOI:[10.1061/\(ASCE\)CO.1943-7862.0000887](https://doi.org/10.1061/(ASCE)CO.1943-7862.0000887)

Authors:

[Søren Munch Lindhard](#)

•[Aalborg University](#)



Waste in Systems creates the following:

1. Spiralling costs
2. Rationing
3. Overuse and Underuse
4. Adverse events/harm
5. Delays in treatment/service
6. Patient/client dissatisfaction
7. Staff dissatisfaction
8. Undermines public trust



Craft Based Practice

Features

- Individual craftsman
- Apprenticeship model
- Slow to produce
- High quality
- Not mass customised
- Expensive
- No standard operating procedures
- Failure is individually focused

Craft based practice

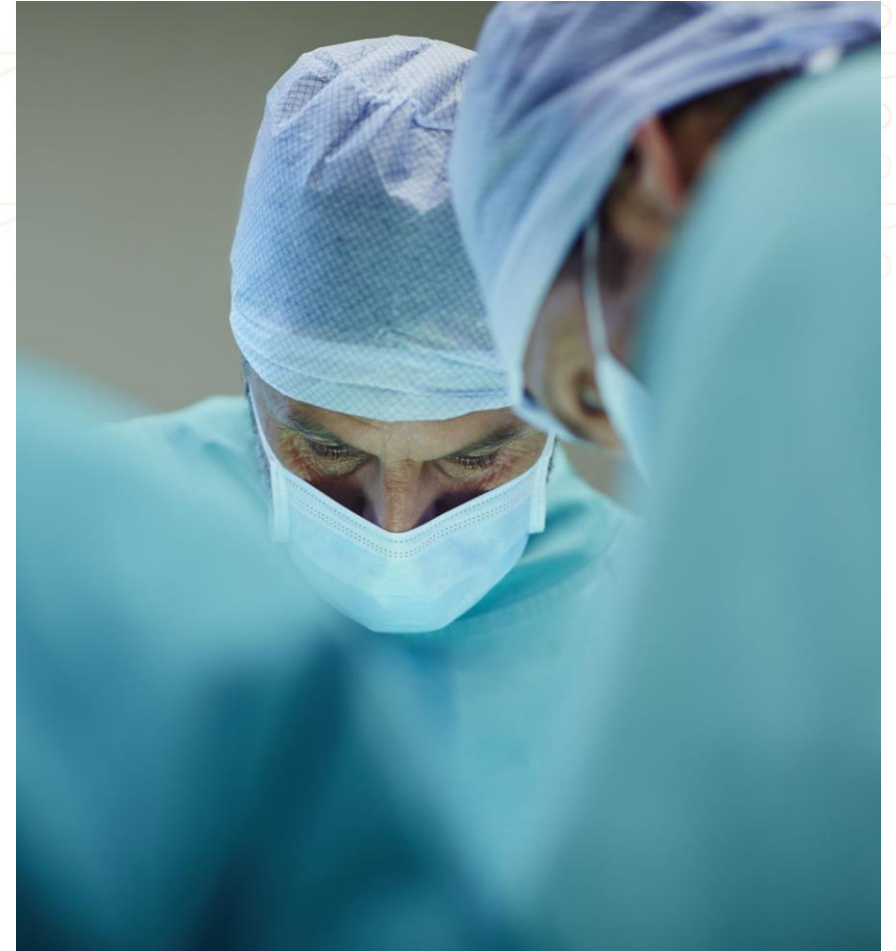


Problem with craft based practice-

Dr Brent James IHC 2010

1. Each clinician an independent expert
2. Crafts a unique solution for each patient
3. We protect this with vigour

Problem: We have outgrown craft-based practice and need to replace personal autonomy with accountability



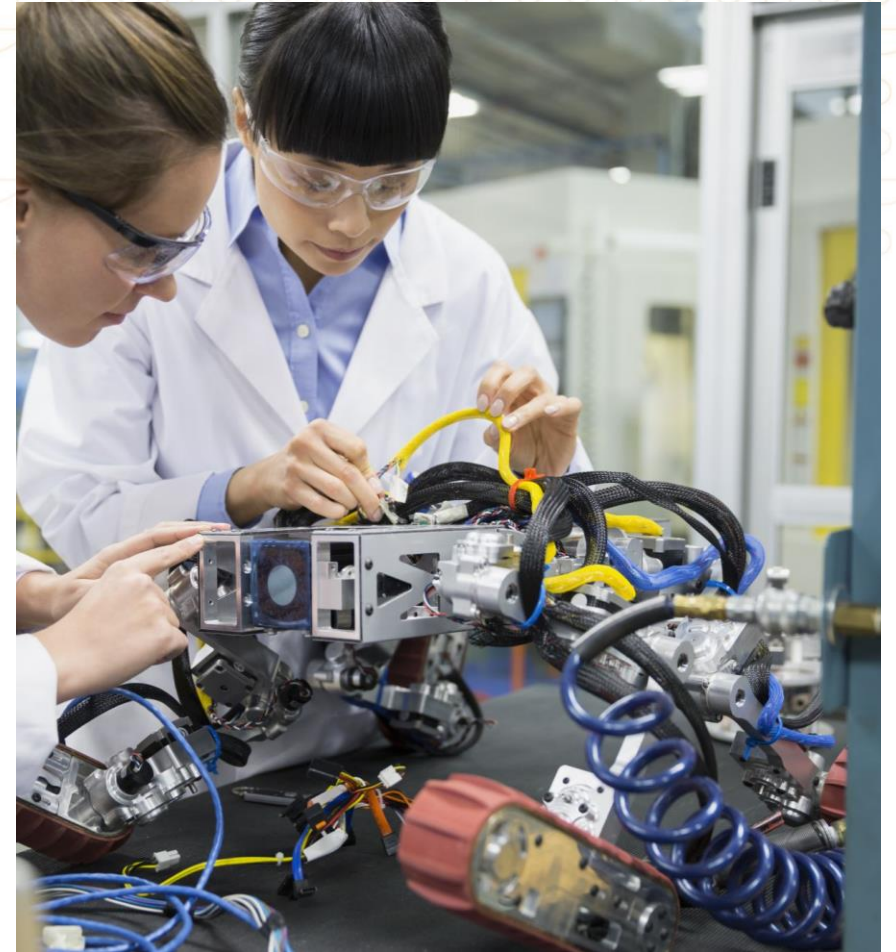
Taylorism: 1911 Scientific Management

1. Hierarchical leadership
 2. The managers apply scientific management (time and motion studies) and the workers perform the tasks
 3. Fixed, not fluid
 4. Split locations for manufacturing and office work
 5. Work specialised with division labour
 6. Office features a symbol of status
 7. Product /outcome focused not customer focused
 8. Demand exceeds supply
- <https://www.youtube.com/watch?v=K3axU2b0dDk>



Kaizen

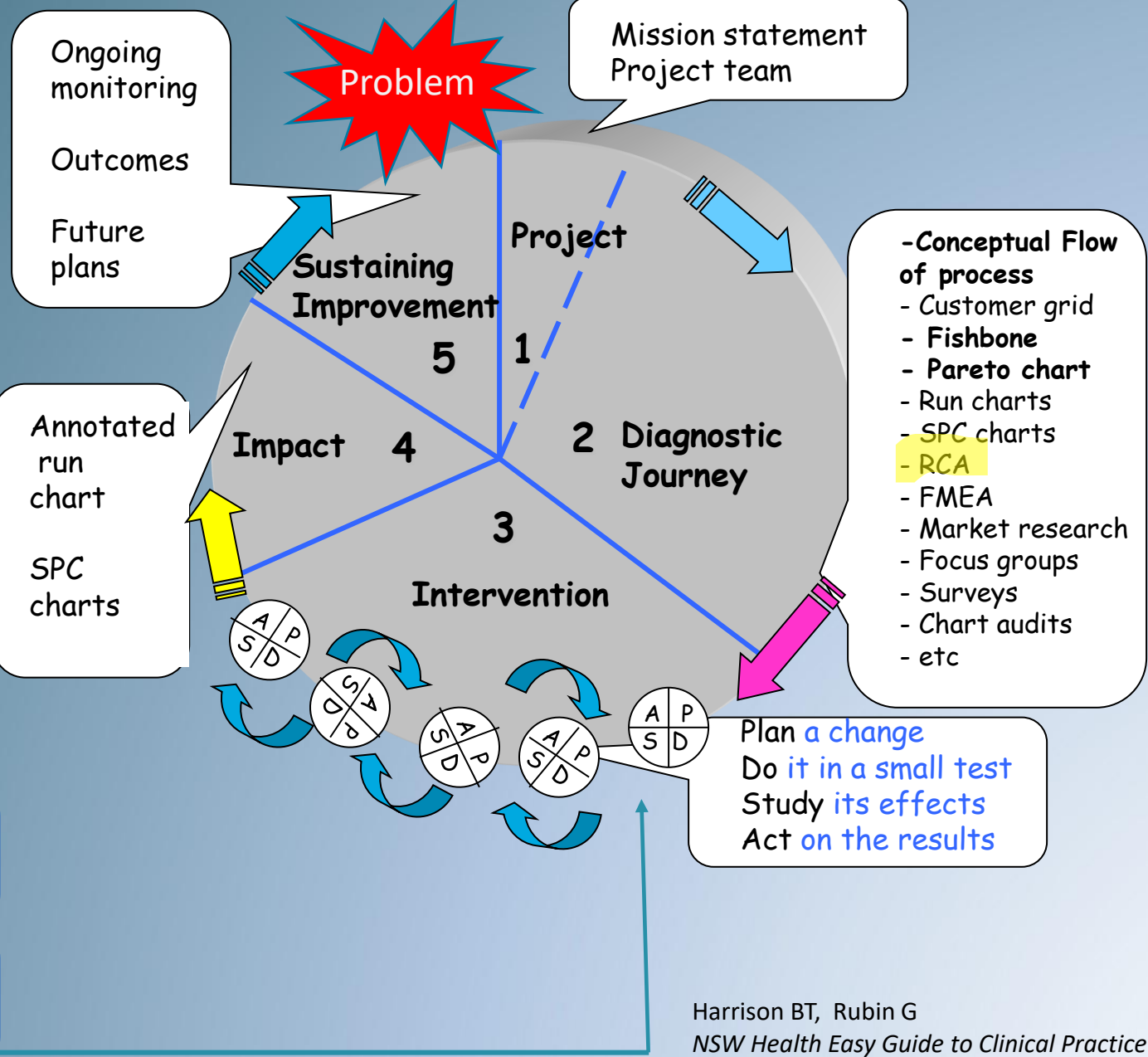
- Quality – *perspective customer*
- Effort – *discretionary effort (intrinsic motivation)*
- Involvement of all employees – *interdisciplinary*
- Willingness to change- *no excuses*
- Communication – *manage ‘black holes’ and handoffs*
- Measurement – *Statistical Process control*
- Reduction in variation – *common and special cause*
- Team based work – *invest in team training*



Clinical Practice Improvement

Model for Improvement

- What are we trying to accomplish?
- How will we know change is an improvement?
- What changes can we make that will result in improvement?



Harrison BT, Rubin G
NSW Health Easy Guide to Clinical Practice Improvement 2002

An aerial photograph of an aircraft carrier at sea, viewed from a high angle. The ship is oriented diagonally across the frame, moving towards the bottom left. The deck is filled with numerous fighter jets parked in neat rows. The superstructure, including the island and various masts, is visible towards the rear of the ship. The entire image is overlaid with a semi-transparent blue filter. Centered over the image is the text "How do high reliability industries do this and what can we learn?".

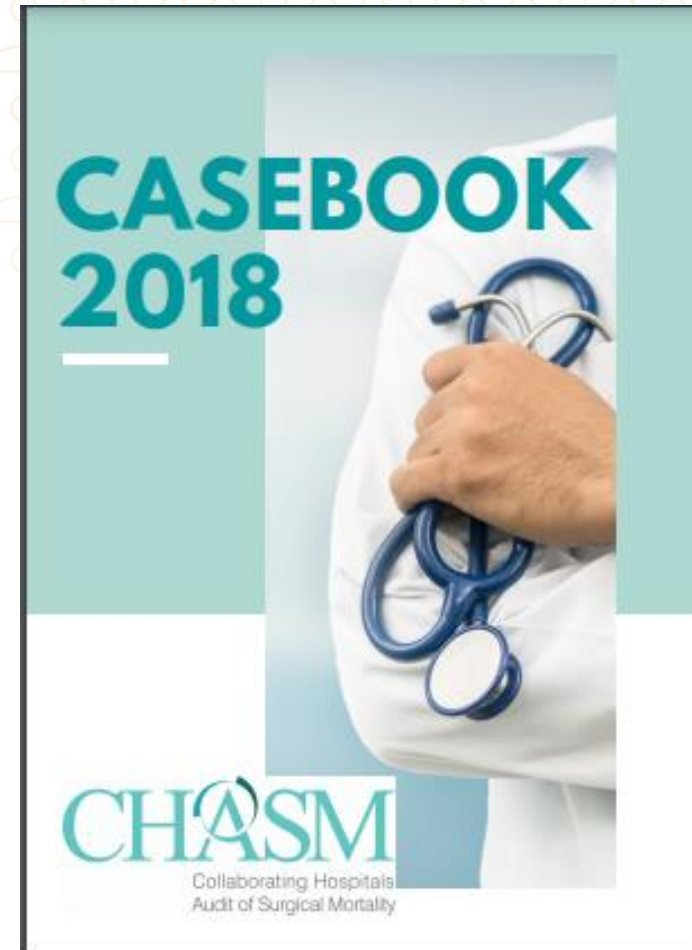
How do high reliability industries do this and what can we learn?

Five High Reliability Principles

1. Pre occupation with failure and remain alert.
2. Resist the temptation to simplify their observations and their experiences of their environment.
3. Sensitivity to operations and the reporting of deviations.
4. Recognise errors occur but ensure that errors don't disable it.
5. Deference to expertise ensure 'requisite variety of experience'.

Chassin M, Loeb J. High-Reliability Health Care: Getting There from Here. The Milbank Quarterly, Vol. 91, No. 3, 2013 (pp. 459–490)

How central associations can support members



Case Study



The Titanic- a catastrophic failure

More than 1,500 people died when the Titanic struck an iceberg in 1912. Over the years, many have researched and investigated the details of its sinking, and it has been determined that a number of design issues and poor decisions led to its sinking in just over two and-a-half hours.

As one of the biggest ocean liners of its day, the Titanic featured 16 watertight compartments. If four of those flooded, the ship would still be able to stay afloat. Six compartments flooded though because the bulkheads were not tall enough to hold the water. Some potential causes behind the ship's sinking include, designs that failed to take into account its size and mobility, the speed the ship was traveling, ignored warnings about the likelihood of icebergs and other factors.

One flaw that is undisputed though: There were not enough lifeboats for everyone on board. The 20 lifeboats would only have had space for roughly 1,200 people, while more than 2,200 passengers and crew were on board the ship. Additional lifeboats had been removed from the design because the ship owners were worried that it made the ship look unsafe and seemed packed on the deck.

<https://online-engineering.case.edu/blog/disastrous-engineering-failures-due-to-ethics>

What are the key issues and areas to improve?

Macro <i>Legislation</i> <i>Governance</i>	Meso <i>Board</i> <i>Executive</i>	Micro <i>Front line work force</i> <i>Consumers</i>

Breakout Group Activity 15 minutes

Populate the spread sheet – key issues and areas to improve

Someone be prepared to turn on video to report back



Report back



For more information

<https://www.achs.org.au/improvement-academy/ACHS>



Quality Improvement Lead Training Program Objectives



- Understand International and Australian best practice in quality and safety
- Develop skills in Quality improvement science
- Develop skills in Quality improvement tools
- Develop skills in Human Factor, Reliability science and Failure Modes and Effects Analysis (FMEA)
- Develop skills in Measurement for improvement, statistical process control charts
- Develop skills in Microsystem change and Plan do study Act (PDSA)
- Understand the principles of Patient/consumer engagement
- Understand the principles of Change management, spread, and sustainability
- Develop skills in Improvement teams/high performing teams
- Understand Leadership and high-level governance responsibilities for Quality and Safety

Other Resources

- Clinical Excellence Commission
<https://www.cec.health.nsw.gov.au/CEC-Academy/quality-improvement-tools>
- Clinical Excellence Queensland Health
<https://clinicalexcellence.qld.gov.au/priority-areas>
- Australian Commission for Safety and Quality in Healthcare
<https://www.safetyandquality.gov.au/>



THE AUSTRALIAN COUNCIL
ON HEALTHCARE STANDARDS

5 Macarthur St Ultimo
NSW, Sydney 2007

T (02) 9281 9955

F (02) 9211 9633

Email:

improvementacademy@achs.org.au