

# QUALITY AROUND THE WORLD

5<sup>TH</sup> INTERNATIONAL  
CONFERENCE  
IN HEALTH CARE

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MELBOURNE AUSTRALIA

*Konnichiwa*



## Lessons in quality from around the world

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**Australian Institute of Health Innovation**  
**University of New South Wales**

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# Australian Institute of Health Innovation's mission

*Our mission is to enhance local, institutional and international health system decision-making through evidence; and use systems sciences and translational approaches to provide innovative, evidence-based solutions to specified health care delivery problems.*

<http://www.med.unsw.edu.au/medweb.nsf/page/ihi>



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# Leadership team

- **Professor Jeffrey Braithwaite**

Foundation Professor and Director, Australian Institute of Health Innovation, University of New South Wales

- **Professor Enrico Coiera**

Professor and Director, Centre for Health Informatics, Australian Institute of Health Innovation, University of New South Wales

- **Professor Ken Hillman**

Professor, Simpson Centre for Health Services Research, Australian Institute of Health Innovation, University of New South Wales



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# Background - the Centre

*The Centre for Clinical Governance Research undertakes **strategic research, evaluations and research-based projects** of national and international standing with a core interest to **investigate health sector issues of policy, culture, systems, governance and leadership.***

<http://www.med.unsw.edu.au/medweb.nsf/page/ClinGov> About



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# *Key lessons*



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# Research personnel: NHMRC Program Grant in Patient Safety

## Chief Investigators

Professor Jeffrey Braithwaite

Professor Johanna Westbrook

Professor Enrico Coiera

Professor Bill Runciman

Professor Ric Day



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# But first, an audience poll

- **Poll question #1:**

- Who is **pessimistic** about patient safety?
- [that we realistically **cannot** get levels of iatrogenic harm down, ie we cannot reduce rates of adverse events and near misses, and they might even be going up, based on existing strategies]

- **Poll question #2:**

- Who is **optimistic** about patient safety?
- [that we **can** get levels of iatrogenic harm down perhaps by a considerable amount, ie we will or can reduce rates of adverse events and near misses, based on existing strategies]



# Part 1: We have thrown a lot at patient safety ...



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# What are we doing?

- Safety improvement programs [training]
- Root cause analyses
- Incident monitoring
- IT
- Accreditation
- Credentialling
- Standards
- Policy
- Guidelines
- Procedures, checklists
- Restructuring
- Inquiries when things go wrong
- Try harder
- Hope
- [Insert your favoured strategy here]



# Part 2: What we are throwing these strategies at ...



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# The quality and safety problem: acute settings

- One in ten [it's probably more] hospital admissions experiences an adverse event of some kind [CCGR data averaged across studies in Australia, Canada, Denmark, New Zealand, UK and USA]
- One in twenty patients experience a complication from a medication or drug [Andrews et al, 1997]
- One in thirty develops a hospital acquired infection [Pittet et al, 2005]



# The quality and safety problem: community perspectives

- Proportion of recommended care delivered to adults in the United States of America: 54.9% [95% CI 54.3-55.5%] [McGlynn et al NEJM 2003]
- Proportion of indicated care delivered to children in ambulatory settings in the United States of America: 46.5% [95% CI 44.5-48.4%] [Mangione-Smith et al NEJM 2003]



# Part 3: Are we making headway?



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# Not at the systems level

- No known study to show a health system has improved across the board
- But isolated or notable changes
  - Pronovost's central line study [Pronovost et al 2006]
  - Surgical checklists study [Haynes et al 2009]
  - Hand hygiene [in some places]
  - Handover [in some places]
  - RCAs [in some places]



# Not at the systems level

- IT [especially in general practice]
- Improvements in clinicians' recognition of the importance of quality and safety
- Guidelines use [esp in general practice]
- The handling of dangerous materials and drugs eg anticoagulants, antibiotics and anticancer drugs [Degos et al BMJ 2009]

# Not at the systems level

- Having a process for identifying adverse events and following up [esp in general practice]
- But not systemic, widespread or ubiquitous change
- In short: progress has been painfully slow

# Part 4: Where are we now?



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# Now

- We are doing research on many of these problems
  - Specifying the amount of care that gets delivered to Australian patients
  - Looking at Root Cause Analyses
  - Examining staff views on patient safety and how to make care safer

# Now

- Looking at the way IT is used and how it addresses some problems but is not a panacea
- Investigating the real way care is delivered – through small scale clinical networks, communities of practice, and inter-professional groups



# Part 5: What more do we need? Delving deeper



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# What more do we need?

- Understanding three aspects to patient safety:
- The magnitude of the predicament ✓✓✓
- The categories of harm ✓✓
- How to tackle and resolve some of these deep problems ✗



# What more do we need?

- Partnerships
- More involvement, ownership, improvement, trust
- Better leadership, management, cultures, teamwork
- Harness IT more effectively
- Social movements [eg, IHI initiatives]



# *What's the Commonwealth Fund data say?*



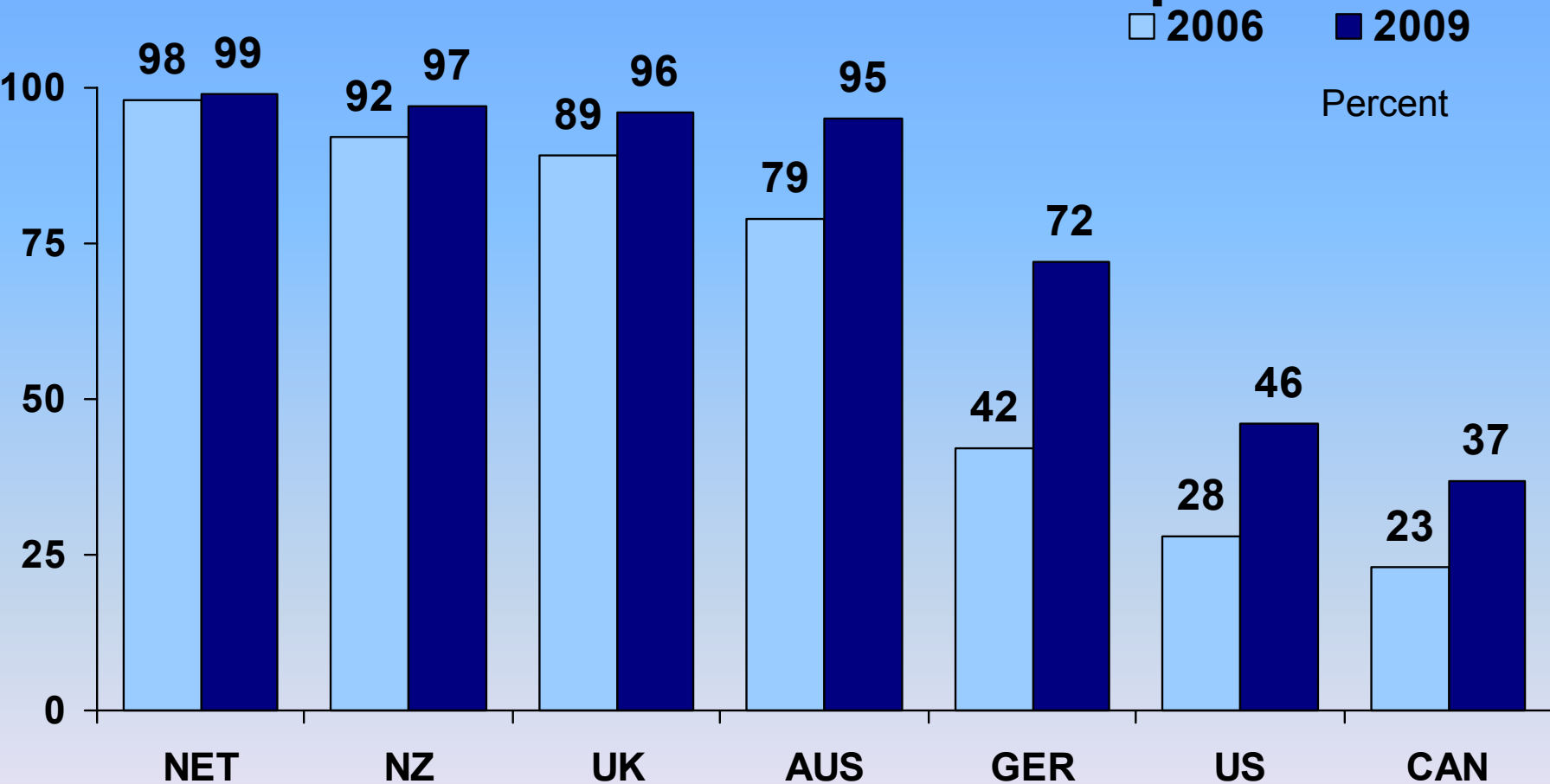
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# Doctors use of electronic patient medical records in their practice



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# Practice use of IT routinely

Percent reporting routinely:	AUS	CAN	FR	GER	ITA	NET	NZ	NOR	SWE	UK	US
Electronic ordering of laboratory tests	86	18	40	62	91	6	64	45	81	35	38
Electronic access to patients' test results	93	41	36	80	50	76	92	94	91	89	59
Electronic prescribing of medication	93	27	57	60	90	98	94	41	93	89	40
Electronic alerts/prompts about a potential problem with drug dose/interaction	92	20	43	24	74	95	90	10	58	93	37
Electronic entry of clinical notes	92	30	60	59	82	96	96	81	89	97	42



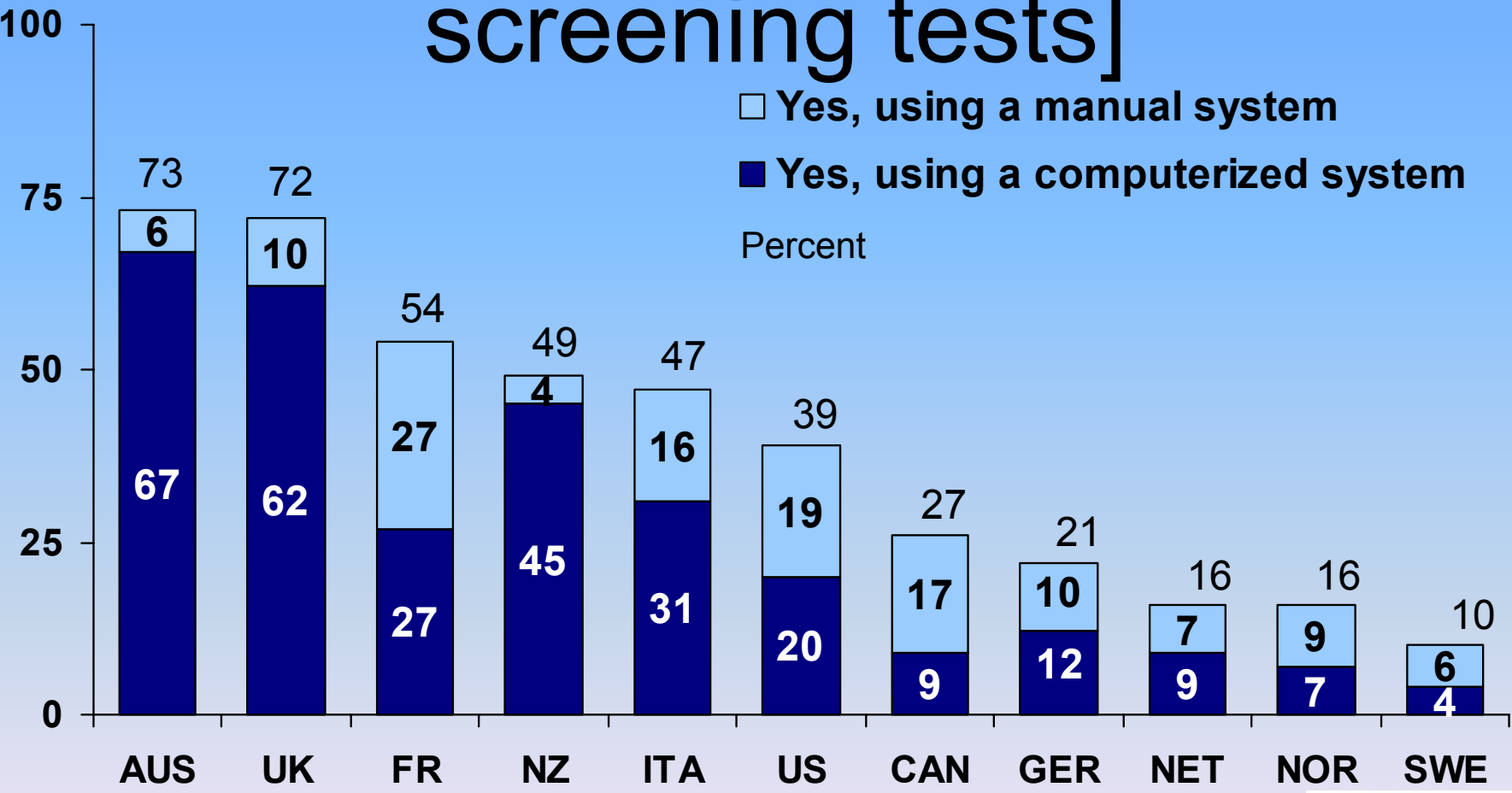
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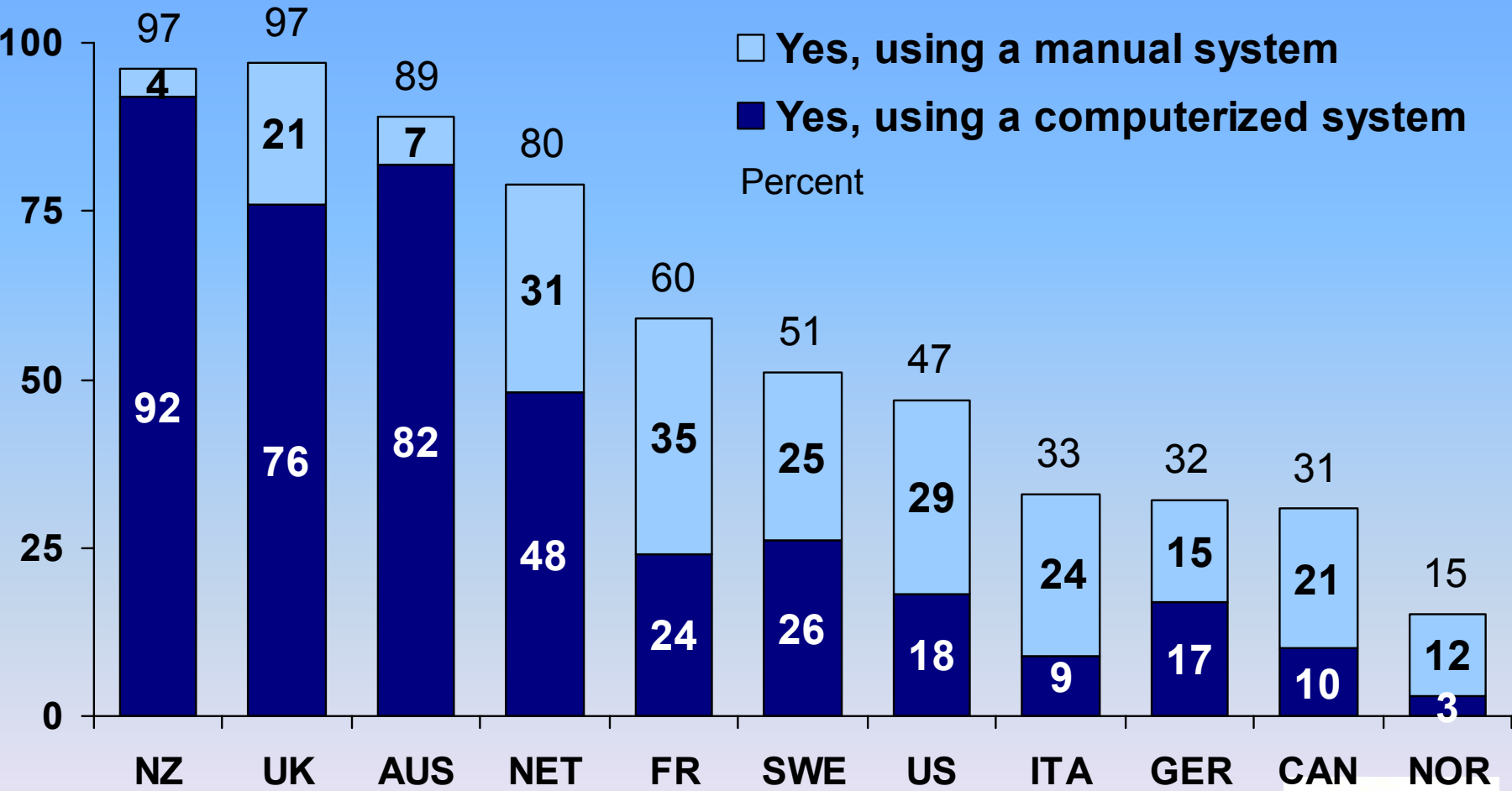
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# Doctor routinely receives reminders [guideline-based interventions or screening tests]



# Practice routinely sends reminders [preventive care, follow-up]



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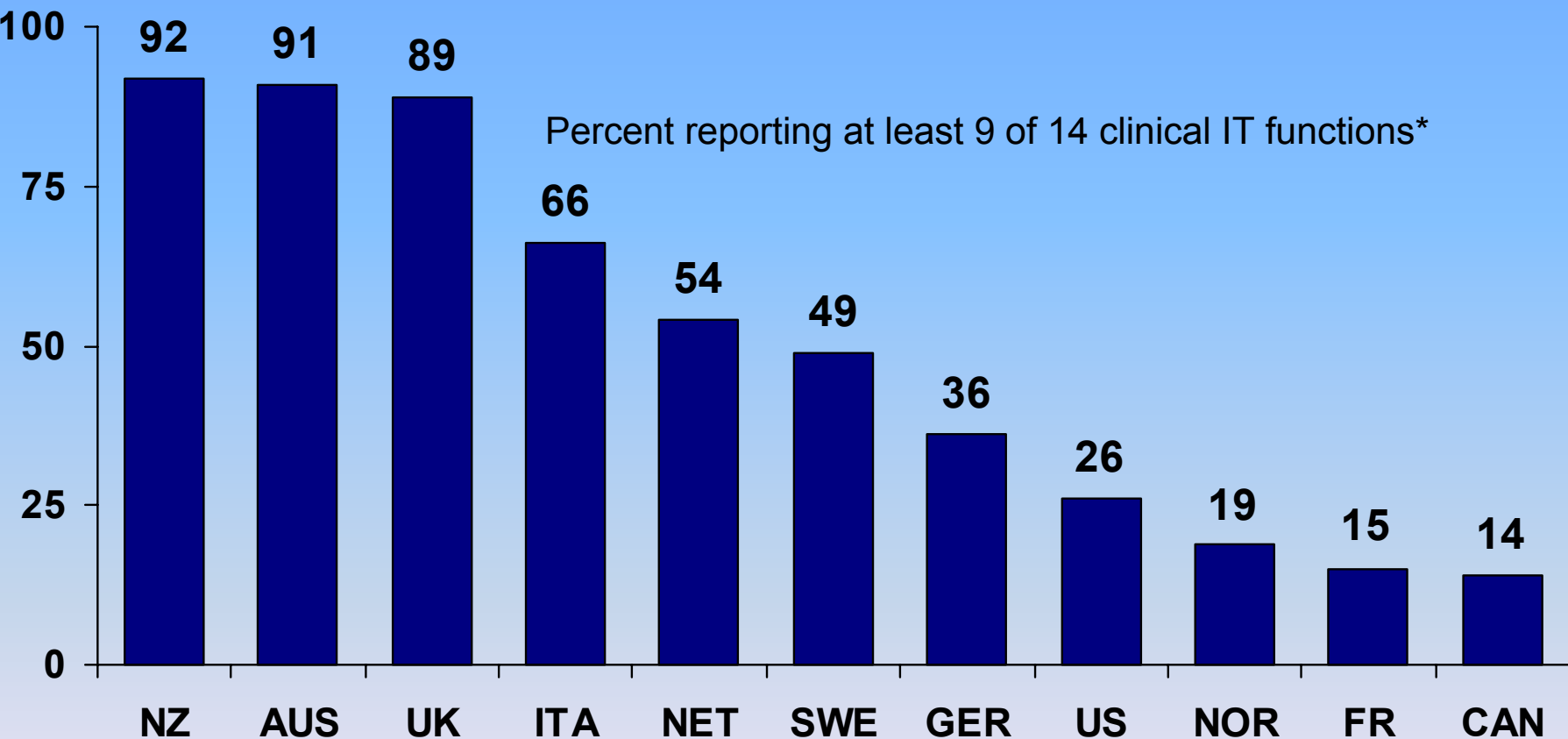


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percentages may not sum to totals because of rounding

# Practices with advanced electronic health information capacity



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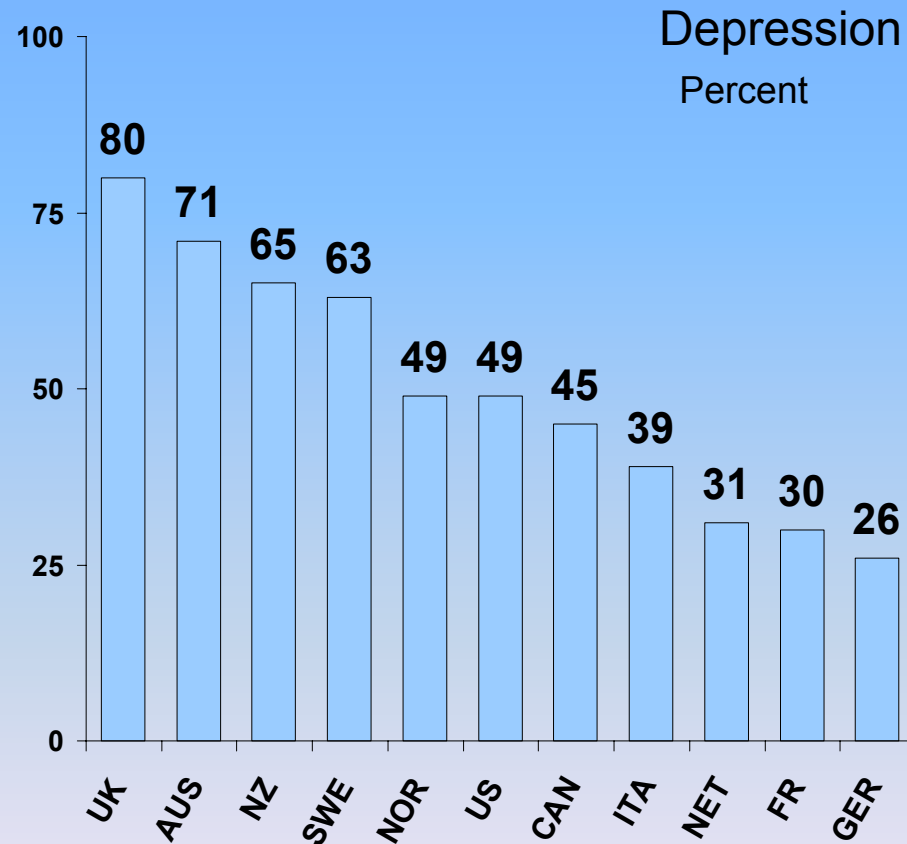
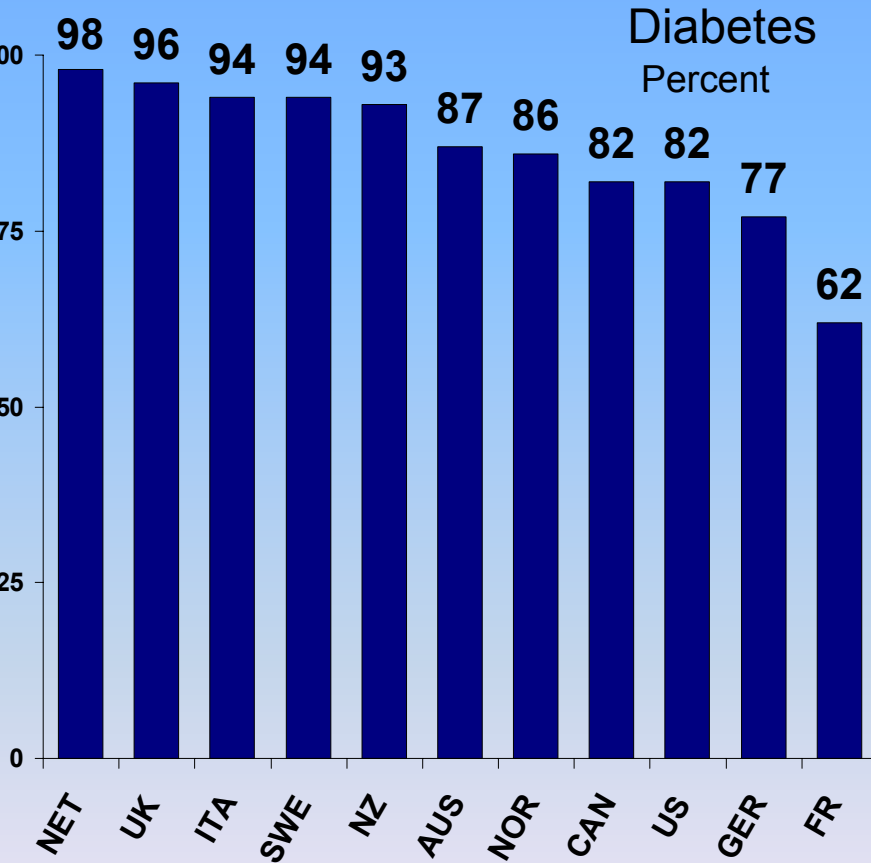


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# Practice routinely uses written treatment guidelines



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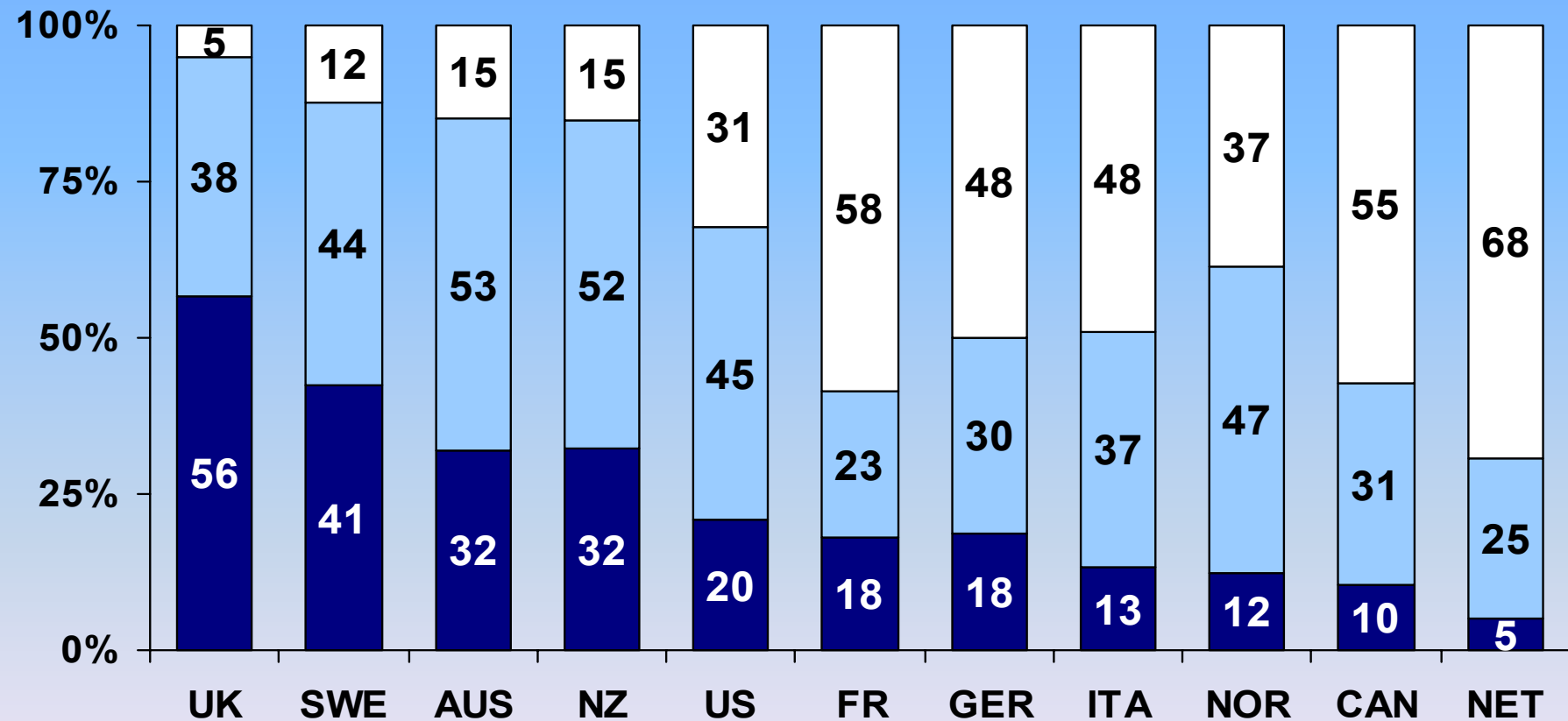
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# Practice has process for identifying adverse events and follow-up?

■ Yes, works well    
 ■ Yes, needs improvement    
 ■ No process



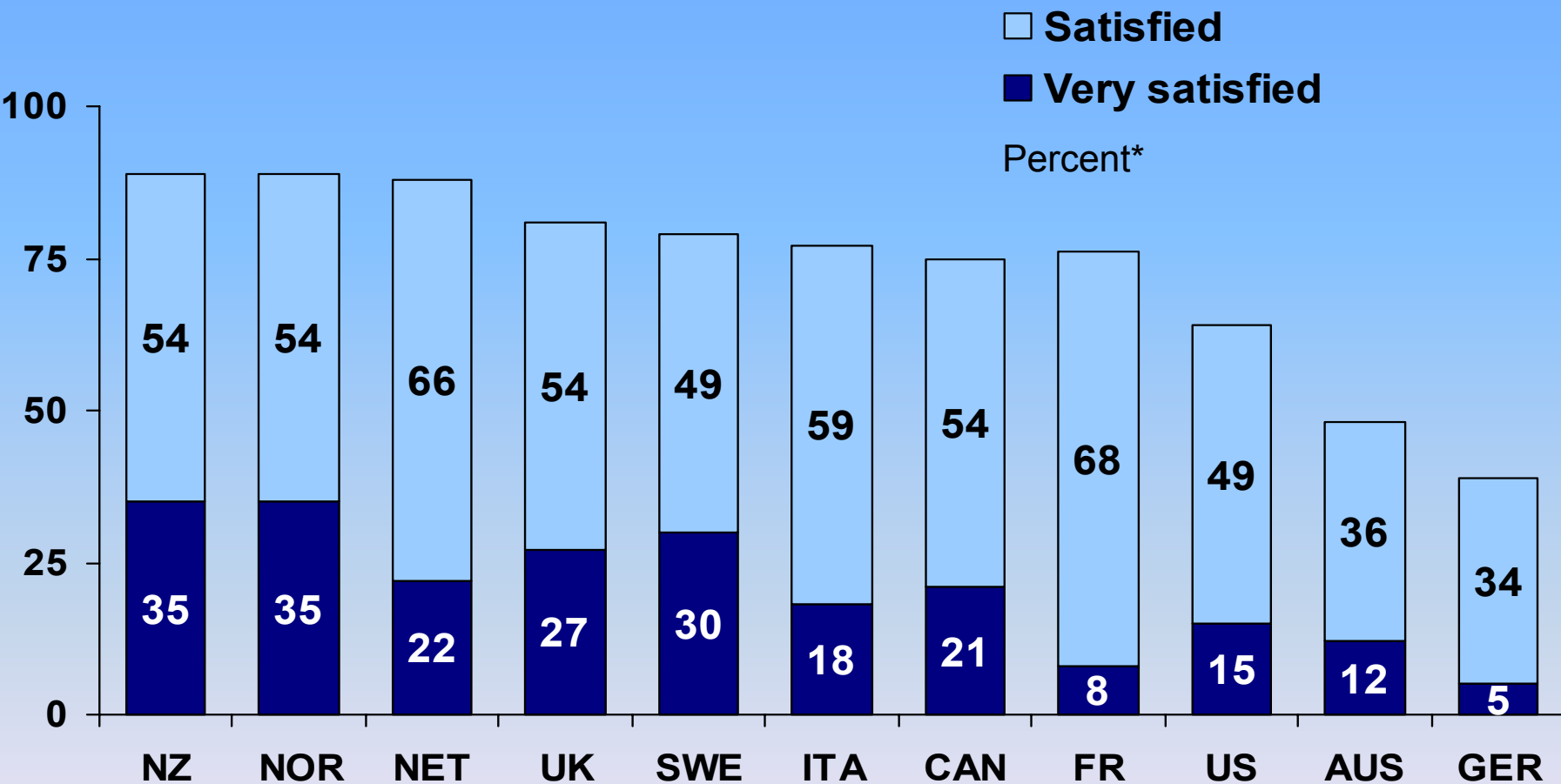
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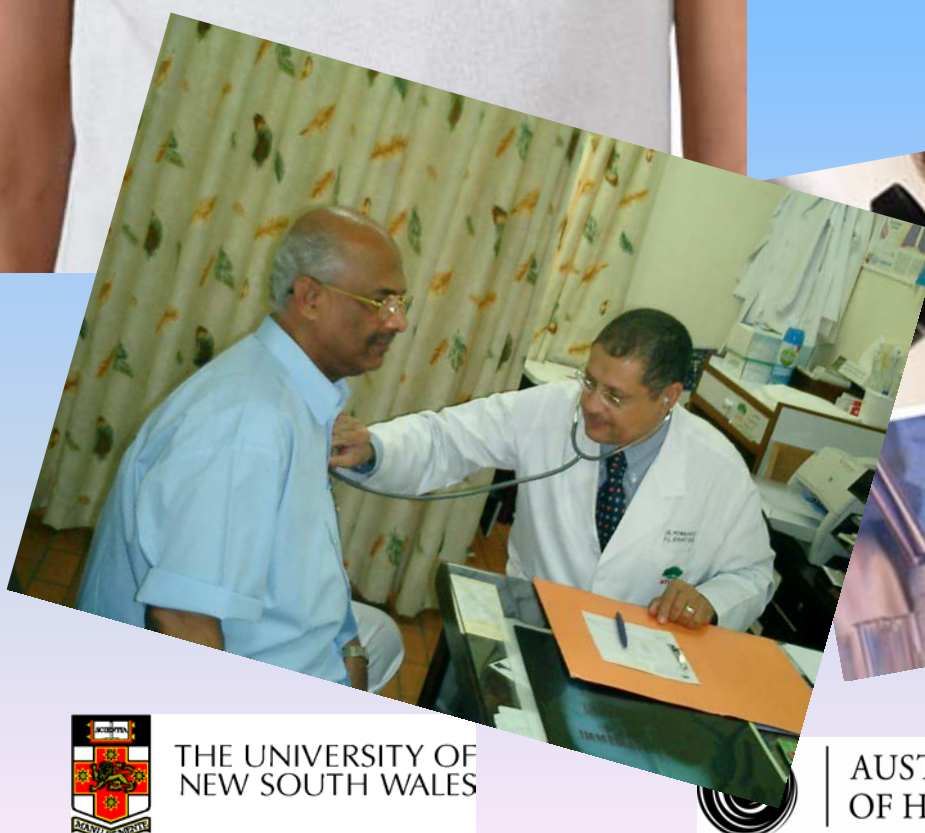


# Physician satisfaction with practicing medicine





# Thank you



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