Journey to Target Zero – a Major Metropolitan Hospital Perspective

Dr Lee Hamley
Chief Medical Officer Alfred Health
• a lack of basic care
• an acceptance of poor standards
• failure of local governance
• the role played by external organisations which had oversight.
• several reviews…..

2013 NHS Francis Report – Mid Staffordshire Foundation Trust
Targeting Zero 2016 – Back to the Future

- expert review - a number of the deaths were avoidable or potentially avoidable, with many of them involving *common and recurring deficiencies in care*

- The review identified that the health service had inadequate clinical governance and was not monitoring and responding to adverse clinical outcomes in a timely manner.
VASM Data

- Preventability question – preventability of mortality
  - General management issues
  - Preoperative issues
  - Intraoperative issues
  - Postoperative issues

- **Benefits and Challenges of a Positive Outlier – A major metropolitan health service perspective**
Alfred Health Audited Deaths

Compared to like State & National Hospitals

- Median age: slightly lower
- Male:Female ratio: slightly higher
- Emergency admission %: slightly higher
- At least one operation: higher
- ASA Status: higher
- Preop risk of death: higher
Audited deaths

• **Positives**
  - Use of ICU
  - Postop complications
  - Unplanned return to OR
  - Unplanned return to ICU
  - Deaths with fluid balance issues
  - Clinically significant infection

• **Negatives**
  - DVT prophylaxis

• **Similar**
  - Delay in surgical diagnosis; delay in transfer in; elective Sx as planned; consultant in theatre; unplanned readmission
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# Clinical Governance Framework - Action areas

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**Alfred Health**

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Strategy

- Alfred Health casemix – large number of Statewide Services; Major Trauma Centre ->
- More 24/7 support
- Internal role delineation between campuses
- Core clinical services -> W@S
- Clear delineation of what can/ can’t be managed at each Alfred Health site
  - e.g. stopped transfers of patients with acute abdomen
  - restricted thyroid surgery by location
The Alfred Trauma Activity

3,116 Trauma Call Outs

1,468 Major Trauma

9,102 Trauma Admissions

17,831 Injury Attendances

1,321 ISS>12

Part of Alfred Health
Trauma Audit 2016-2017
Culture and Leadership

- Strong clinical leadership
- Culture of improvement
- Unit Heads & NM Programs
- 360 review process for SMS
- Complaint/ concern re clinical practice
People Matters Survey – Highest scoring results

• My organisation provides high quality services to the Victorian community - 96%
• In my organisation, earning and sustaining a high level of public trust is seen as important
• My workgroup strives to achieve client satisfaction
• My manager is committed to ensuring clients receive a high standard of service
• In my workgroup, work is undertaken using best practice approaches
Monitoring scope of practice

- **Senior Medical Staff**
  - cGov system generally by craft group
  - Some cross craft groups eg complex spine; procedural dermatology
  - allows reporting to Board etc
  - Annual check to ensure nothing has changed

- **Procedural JMS**
  - Now also electronic ->who can open theatres without on site consultant
  - Visible
Improvement & Audit

• **Organisational redesign**
  - Timely Quality Care Project – consistently in Top Quartile for 4-hour targets
  - Hospital at Night & Clinical Lead

• **Other Improvement Projects**
  - Mandatory MET & MET sustainability
  - Fasting clock, EBET, ERAS

• **Audit & transparency**
  - All units undertake M&M – surveys re M&M
  - Transparency – annual presentation by each Unit
    - Clinical audit policy
  - Regular presentations to Board
MET/Code Blue by Day of week

- Monday
- Tuesday
- Wednesday
- Thursday
- Friday
- Saturday
- Sunday
Clinical Risk & Incident Management

• Deaths
  – Bottom up – Unit M&Ms
  – Top down - all deaths screened daily in mortuary against flags ->
    • Escalation to DMS for decision
    • Refer to Unit M&M; CORC; other

• Incidents - > Clinical Outcome Review Committee (CORC)
  - Senior clinical panel
  - Hears case reviews & RCAs
  - Recommendations have senior clinical sponsor – 3month time frame for implementation
  - Report to Board Quality Committee
  - Identification of emerging risks
Feedback to the clinical community

**Grand Round**

*Cases from Clinical Review*

- Regular presentations
- ID; transfers; VTE; appendicitis; NGTs
Monitoring outcomes

We need to improve –
  VTE prophylaxis
  Pressure injuries
  NGTs
  HAC

• Governance Element – Monitoring and Reporting
VTE

- High outlier in HRT data
- Issue identified in VASM audited deaths
- VTE Pharmacist role in 2017
- Internal snapshot 2017 (surgical excl ICU)
  - Appropriate overall 74%; high risk group 77%; low risk group 46% (small nos)
  - Action plan – improve mechanical prophylaxis for high risk patients; appropriate VTE Prx when no C/I; less Prx in low risk/ document reason
Nasogastric tubes

- 3 cases in late 2016 / early 2017 involving complications following unsuccessful NGT insertion
- Involved both fine and wide-bore NGTs
- All had attempts ++ at blind insertion (>AH guidelines)
- Estimated ~ 1800 NGT insertions per year (since 2014)
- 13 reported serious incidents since 2010 (=0.01%) but probably under reported
- Most involve incorrect position or pneumothorax
  - Guideline revised; restrict attempts to two per staff member; restrict after hours insertion of fine-bore NGT; insertion under guidance if > 3 attempts; mandatory CXR; insertion and monitoring Charts; etc
2018 changes

- Fine bore NGTs to be inserted in high use (approved) wards/areas by credentialed staff
- Fine bore NGTs removed from other clinical areas.
- Fine bore NGTs in ‘non-approved’ areas to be inserted by an ‘Expert NGT Insertion Team’
- Separate Guideline for fine bore and wide bore NGTs
- Fine bore NGT insertions approved by a consultant
- Fine bores can only inserted within defined hours
- High risk pts to be referred to ENT, Radiology etc.
- The Nutrition Committee to oversee NGT risk management, QI activities & KPIs
...in all modern health systems, patients frequently suffer avoidable harm while receiving care.

No one should accept avoidable harm as an inevitable and ineradicable feature of healthcare, and few do. Around the world, and in many Australian states, system managers are partnering with clinicians in a concerted effort to lift the safety and quality of care, and protect patients better.

In Victoria many health services are working tirelessly to do the same.

Duckett et al 2016