Safety

An essential building block for quality care

Safety is central to healthcare quality. It means eliminating unnecessary risk to patients. In recent years, safety has come to the fore as a pressing concern for patients and healthcare professionals.

Well-defined, evidence-based sets of patient safety indicators have been published by many international and national organisations. In Australia, a number of safety indicators are used by healthcare professionals and included in National Healthcare Agreements. Despite good progress on the development of relevant safety measures, they are not used effectively and information is often unavailable or too unreliable to report.[1]

Internationally, differences in attitudes towards incident reporting mean that safety information should be interpreted carefully. For example, an increase in the rate of adverse events could, on face value, be interpreted as evidence for deteriorating quality. Instead, it might actually represent an improvement. Why? There may be greater willingness to report adverse events within a 'safety culture' where people see opportunities to learn and prevent future incidents. This, rather than a true increase in the incidence of adverse events, could be behind the higher numbers.

At the same time, comparisons across countries or hospitals must be drawn with care. Higher numbers could reflect more accurate reporting or data collection systems, rather than poorer relative performance.

Patient survey data may be insightful as patients themselves can identify adverse events and take appropriate action.

It should be noted though, that patients do not necessarily have all the information needed to decide whether there has been an error in their care. They might be unaware of some errors that occur or assume errors in situations with a poor outcome, when in fact no mistake was made.

It is possible that high levels of media coverage of patient safety incidents may make people more likely to report such incidents in their care when asked about them.

This chapter covers:

- Safety-related outcomes, such as falls
- Safety processes, such as provision of written and verbal patient information
- Patient reports of medication errors and rates of medication reviews carried out by their GPs and general practice staff.

What we learnt about NSW	How does NSW compare Internationally?		
	Higher ranking	Middle ranking	Lower ranking
One in 10 adults **(10%)** think a medical mistake has been made in their treatment or care in the past two years though the extent of any harm was not assessed	NSW rate is similar to most comparators but is significantly higher than in four other countries		
Seven in 10 hospitalised patients **(69%)** report being discharged with written instructions about what to do when they return home and which symptoms they should monitor		■	
More than nine in 10 adults patients **(94%)** who had a medical test in the previous two years report experiencing no delays in being notified about abnormal results		■	
One in 20 adults **(5%)** report being given the wrong medication or wrong dose by a doctor, nurse, hospital or pharmacist		■	
More than seven in 10 adults taking at least one prescription have had a GP or other staff member at their regular place of care review their medications **(78%)** and explain potential side effects **(76%)**.	■		

Managing for safety: outcomes

One in 10 adults think a medical mistake has been made in their care in the past two years but harm was not assessed

Safety can be measured in terms of medical mistakes or 'adverse events' — some of which are preventable and cause harm. International studies of hospital care show that up to 17% of admitted patients experience an adverse event.[2,3,4] In 2008-09, events were recorded in almost 5% of Australian hospitalisations.[5]

In NSW, patients safety reporting focuses on 'incidents' or events that pose a risk to patients, regardless of whether actual harm occurs. Between January and June 2009, healthcare staff made 62,369 clinical incident notifications. There were 327 serious incidents reported, a rate of 0.11 per 1,000 bed days - or 0.04% of all admissions. Over time, the rate of incidents per 1,000 bed days has increased from 14.6 in 2005-2006 to 19.6 in 2008-2009.[6]

In 2010, the Commonwealth Fund survey found that one in 10 NSW adults (10%) reported a medical mistake had occurred in their care or treatment in the previous two years (Figure 4.2). The extent of harm was not assessed.

The 2009 ABS Patient Experience Survey found 4.6% of NSW people aged 15 or over reported they had received medication, medical care, treatment or a test that caused harm in the previous year. Australia-wide, the rate was 5.2%.[7]

Patients are at risk of falling in hospitals particularly when they experience confusion or impaired balance. For every 1,000 NSW hospitalisations in 2007-08, 2.5 falls were recorded that resulted in harm. Across Australia, the rate was 2.2 falls resulting in harm per 1,000 hospitalisations (Figure 4.1).

Incidents such as trauma during childbirth are often preventable. Severe perineal lacerations, involving injury to the anal sphincter muscles (3rd degree) and breach of the rectal mucosa (4th degree) can cause significant suffering and extended hospitalisation. Severe perineal lacerations occurred in 1.6% of NSW vaginal births in 2008, the same rate recorded for Australia as a whole (Figure 4.3).

Figure 4.1: Falls resulting in patient harm that occurred in a healthcare setting, NSW and Australia, 2007–08[μ]

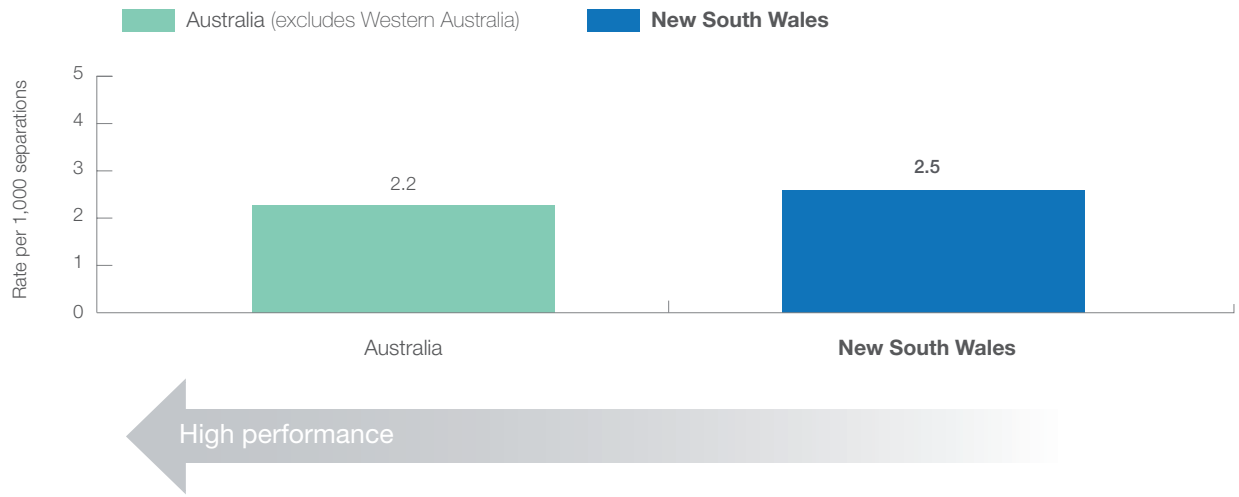


Figure 4.2: **Survey 2010:** In the past two years, was there a time you thought a medical mistake was made in your treatment or care?*

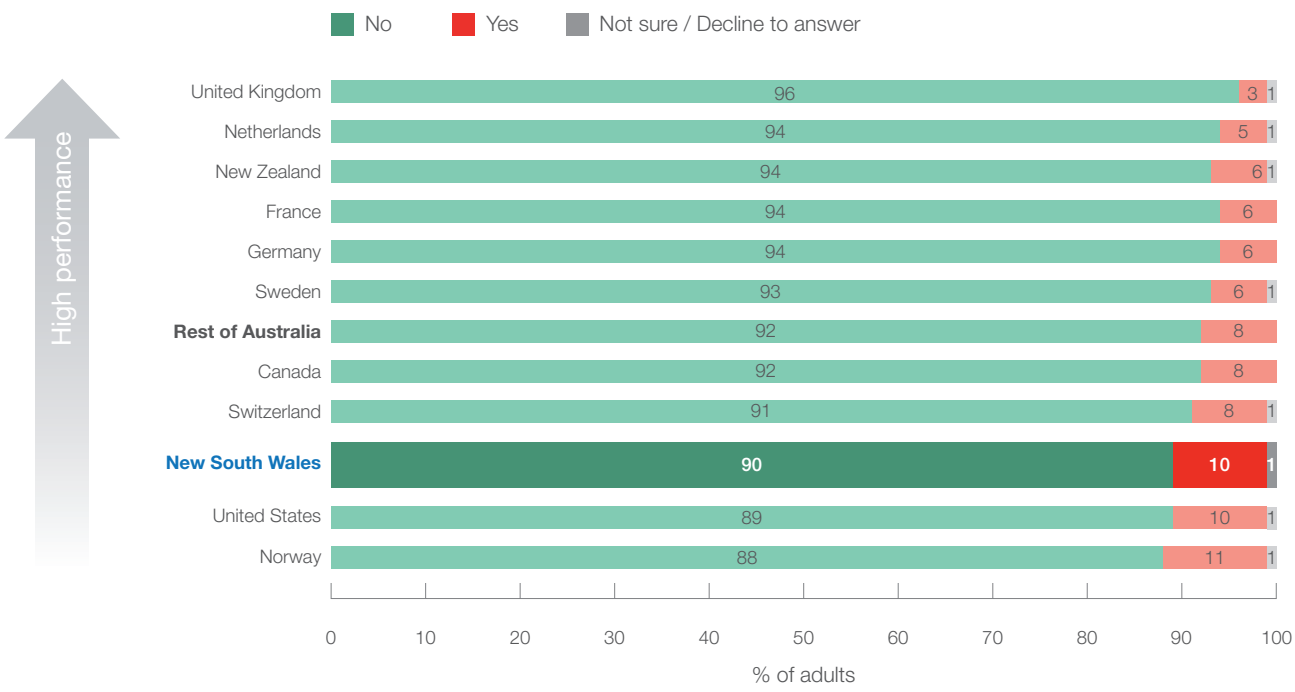
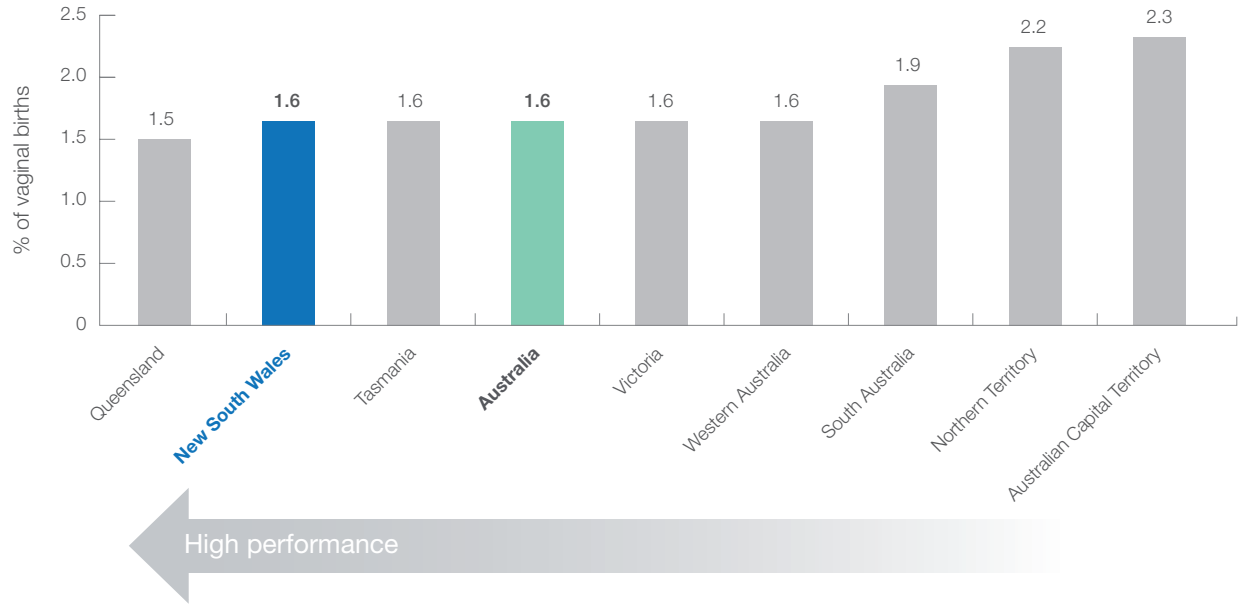


Figure 4.3: Third and fourth degree perineal lacerations following vaginal birth, 2008#



(μ) COAG Report NHA 43.1, citing Admitted Patient Care National Minimum Dataset (Notes: Rates are not age or casemix standardised which affects interpretability, as falls are more common among older people and people with certain health conditions, such as those affecting balance or strength; around 25% of records did not specify the place of occurrence).

(*) 2010 Commonwealth Fund International Health Policy Survey (Notes: Percentages may not add up to 100 due to rounding; NSW estimate is 10% with 95% confidence interval from 8 to 11%; confidence intervals for other countries are available in the *Technical supplement* at www.bhi.nsw.gov.au).

(#) AIHW Australia's Mothers and Babies 2008.

Managing for safety: processes

About seven in 10 patients are given written instructions about what to do when they leave hospital

Combining verbal and written health information for patients delivers consistent messages and has been shown to improve their knowledge and satisfaction. Providing written instructions for patients leaving hospital is particularly important.[8]

In 2010, most NSW adults hospitalised in the previous two years received written information on what to do when they returned home and symptoms to watch out for (69%). About a third (30%) weren't given this information. NSW adults ranked in the middle of the countries surveyed in terms of receiving written instructions on leaving hospital (Figure 4.4).

Information gaps can occur when test results are not properly communicated. Problems in systems of reporting test results contribute to diagnostic delays and can result in significant consequences for patients.

Most NSW adults (94%) who had a medical test in the previous two years did not experience a delay in being notified of abnormal results (Figure 4.5). Three per cent of adults in NSW who had a medical test in the previous two years said they had been given an incorrect result for a diagnostic or laboratory test – a percentage similar to that reported in other countries (Figure 4.6).

Figure 4.4: **Survey 2010:** When you left the hospital, did you receive written information on what to do when you returned home and what symptoms to watch for?*

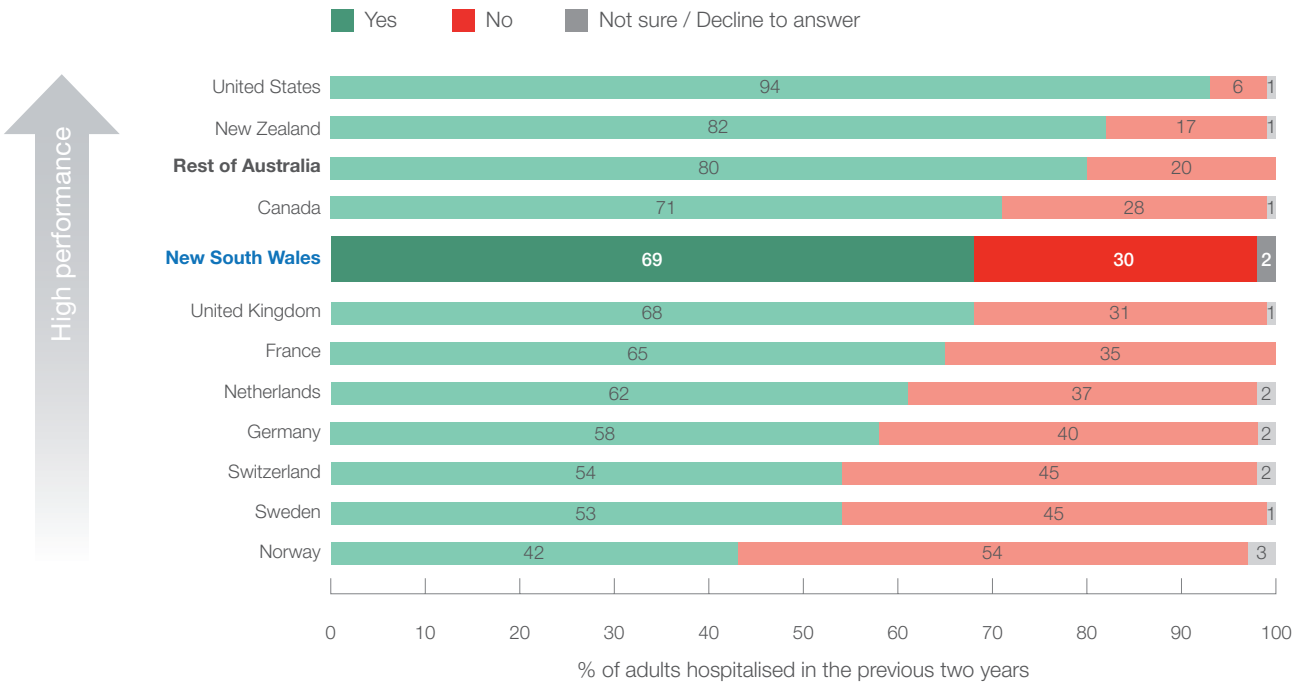


Figure 4.5: **Survey 2010:** In the past two years, have you experienced delays in being notified about abnormal test results?*

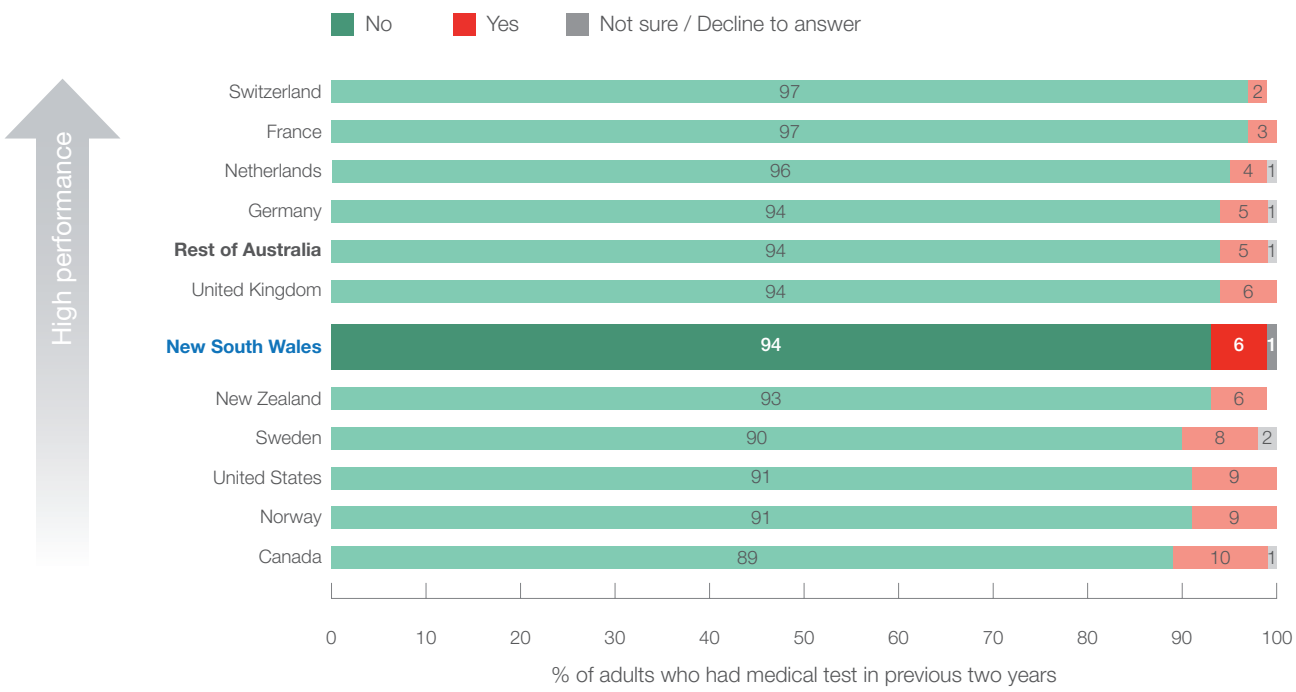
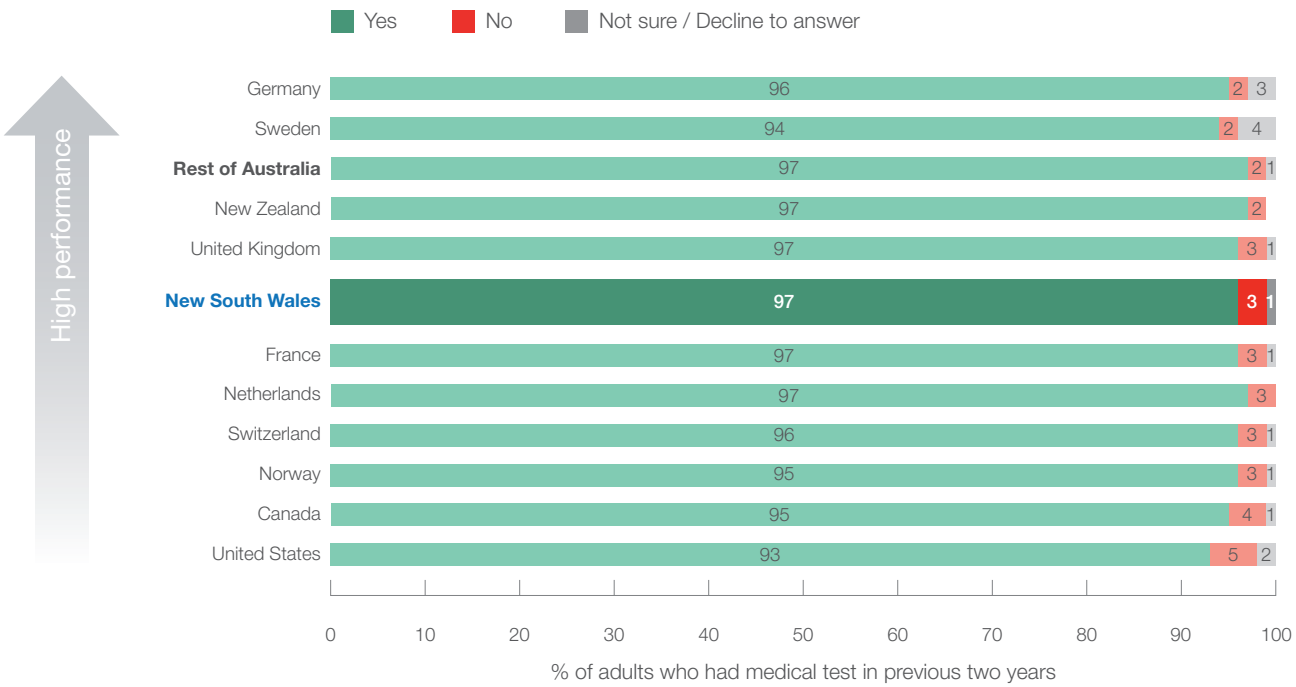


Figure 4.6: **Survey 2010:** In the past 2 years, have you been given incorrect results for a diagnostic or lab test?*



(*) 2010 Commonwealth Fund International Health Policy Survey (Notes: Percentages may not add up to 100 due to rounding; Figure 4.4, interpret German data with care due to small underlying base 73 responses; Figure 4.5, NSW estimate is 6% with 95% confidence interval from 4 to 7%; Figure 4.6, NSW estimate is 3% with 95% confidence interval from 2 to 4%; confidence intervals for other countries are available in the *Technical supplement* at www.bhi.nsw.gov.au).

Medication safety

More than seven in 10 adults receive information regarding appropriate use of medications

Medicines are the most common healthcare treatment and are associated with a higher incidence of errors and adverse events than other interventions. Many of these events are costly and potentially avoidable.

One in 20 NSW adults (5%) reported in 2010 that they had been given the wrong medication or wrong dose by a doctor, nurse, hospital or pharmacist in the previous two years (Figure 4.7).

People who take one or more prescription medicines should be provided with information about appropriate use and potential side effects. Medication reviews can reduce the occurence of inappropriate use.

In 2010, most NSW adults with a regular GP or general practice who take at least one prescription medication reported that in the previous year, their GP or staff at their general practice reviewed their medications (78%) and explained potential side effects (76%). Fewer than half (48%) were given a complete written list of their prescribed medications in the previous year. On the international stage, NSW performs well relative to other countries in terms of communication regarding appropriate use of medications (Figure 4.8).

Figure 4.7: **Survey 2010:** In the past two years, have you ever been given the wrong medication or wrong dose by a doctor, nurse, hospital or pharmacist?*

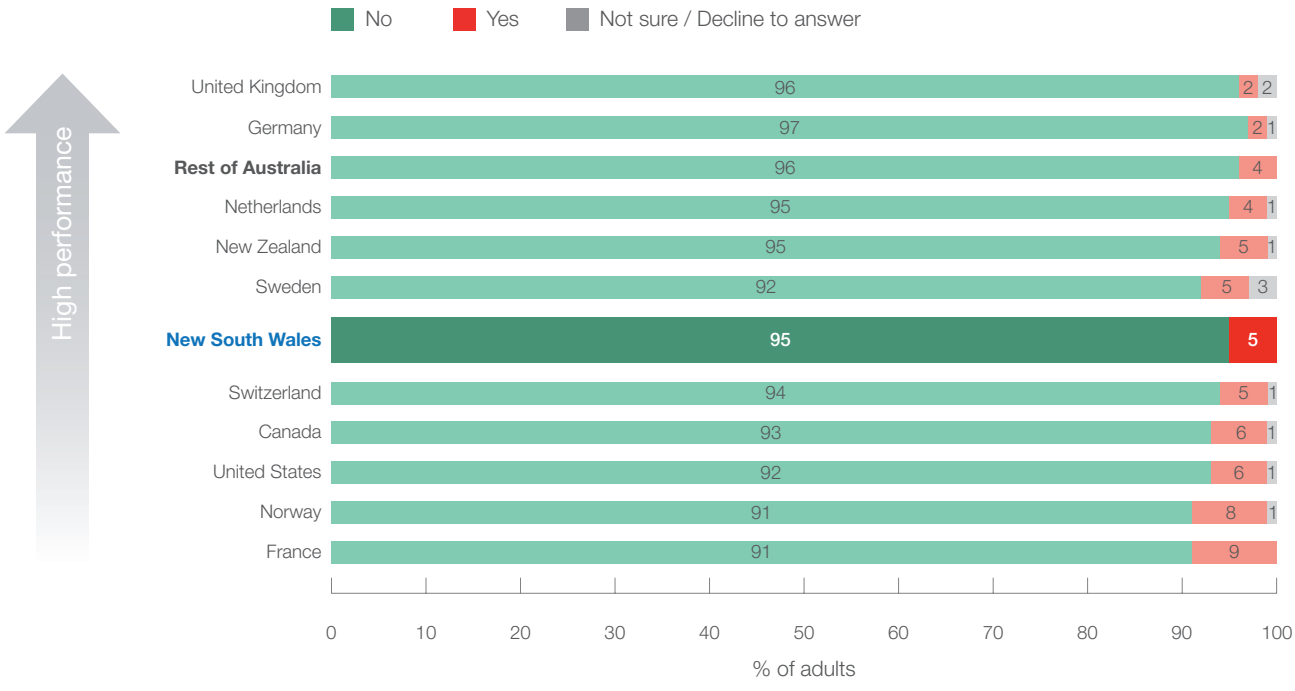
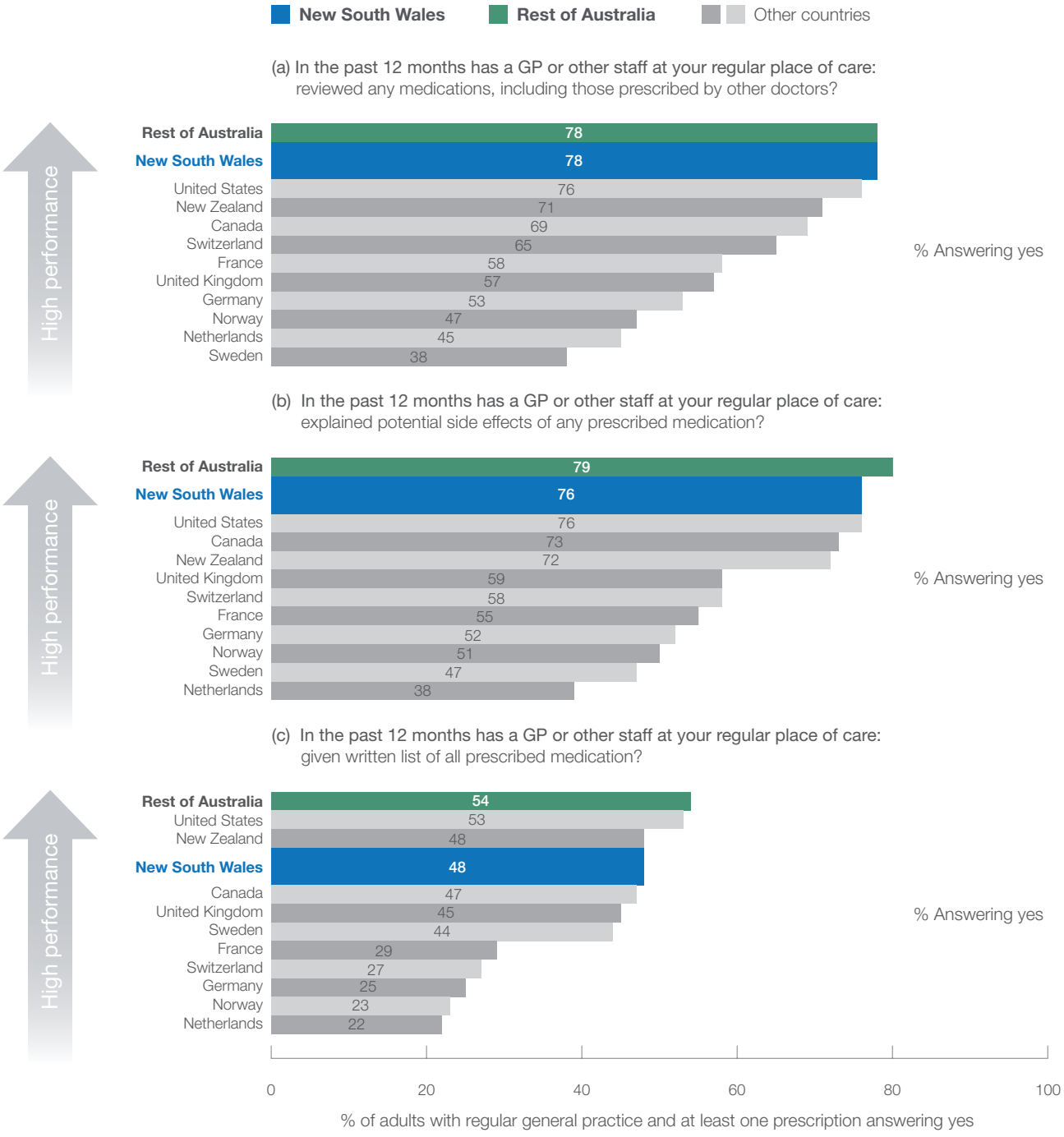


Figure 4.8: **Survey 2010:** In the past 12 months has a GP or other staff at your regular place of care:
(a) reviewed with you any medications you take, including those by other doctors;
(b) explained the potential side effects of any medication that was prescribed;
(c) given you a written list of all your prescribed medications?*



(*) 2010 Commonwealth Fund International Health Policy Survey (Notes: Percentages may not add up to 100 due to rounding; Figure 4.7 NSW estimate is 5% with 95% confidence interval from 4 to 6%; confidence intervals for other countries are available in the *Technical supplement* at www.bhi.nsw.gov.au).