



New Zealand Safety Improvement Programme

A national approach to the management of healthcare incidents

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CONTACT US

For more information about any aspect of the programme or to access various documents associated with the project, please visit our website. Access to the website is available via:
<http://nzsip.communio.com>

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WELCOME

Kia ora and welcome to the first edition of the New Zealand Safety Improvement Programme newsletter. This bimonthly publication is designed to provide you with information about the programme on a regular basis.

INTRODUCTION

Healthcare is one of the most complex activities that humans engage in and as such, it can be expected that many hundreds of errors can and do occur at all levels within a health service on any one day. It is the result of the errors that is important. As well as other high risk industries, such as aviation, the health industry is implementing safety improvement systems and programmes.

PURPOSE

The purpose of the Safety Improvement Programme (SIP) is to achieve a nationally consistent approach to the management of healthcare incidents across the health and disability sector through the identification, investigation and analysis of incidents and acting upon them as (or before) they occur to minimise the chance of (re)occurrence of untoward outcomes in healthcare.

PRIMARY OBJECTIVES

The programme is intended to achieve:

- reduced harm to patients, their families/whanau and to clinicians
- a culture and environment within which patient safety is paramount and

- implementation (eventually) of an information system that will support the culture and assist providers in achieving the above.

KEY WORKSTREAMS

The three key areas in establishing this programme are the development of national policy; provision of education and training in all District Health Boards to implement the policy and train staff in incident management; and identification of the information system requirements to support the whole process. Although the project ends in August 2009, the programme established by the project will continue indefinitely.

CLINICAL GOVERNANCE

The implementation of an incident management system is but one of many components of clinical governance and quality improvement. The overall number of errors is far less important than the action taken to prevent their recurrence.

HOW DID IT START?

A report prepared for the Minister of Health in November 2006, entitled *Scoping the Priorities for Quality in the Health and Disability Sector*, helped determine six quality priority areas and outlined how they could be achieved. Four of the six programmes, including this one, now comprise a national quality improvement campaign sponsored by the Quality Improvement Committee (QIC) and overseen by District Health Board



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New Zealand (DHBNZ). Waikato District Health Board is leading this programme and has partnered with Communio Group Ltd. to achieve it.

PROGRAMME LAUNCH

To promote awareness and understanding of the programme, an exciting and educational launch of the New Zealand Safety Improvement Programme is to be conducted at the:

Nordmeyer Theatre
University of Otago, Wellington
23a Mein Street, Newtown

Monday 23rd June
1.00pm-4.30pm

Everyone is welcome!

WHO WILL BE THERE?

The Hon. David Cunliffe, Minister of Health will officially launch the programme and Mr Stephen McKernan, Director-General of Health will also address the audience. Representatives of key health and disability organisations and people with an interest in the programme, patient safety and incident management will also be in attendance.

KEYNOTE SPEAKER

The **keynote guest speaker** will be Dr James Bagian, Director of the National Centre for Patient Safety, Veteran's Administration USA. Dr Bagian is an engineer, a physician and an astronaut who has participated in two space shuttle missions and led the root cause analyses of the Columbia

and Challenger accidents. Dr Bagian has a great deal to teach us about the establishment of the VA patient safety programme, upon which most of the New Zealand programme will be based.

POLICY

A national policy on incident management must be broad enough to be relevant to the range of health and disability providers, and yet specific and descriptive enough to support a nationally consistent, methodological approach. The national policy must:

- be based on best practice and learning from international experience with similar systems
- satisfy legal and legislative requirements and
- be easy to use, effective and able to be implemented by service providers.

CONSULTATION

It is important to the development of the policy that a wide range of views is obtained and that consumers and appropriate family/whanau members have an opportunity to be involved. General consultation on the draft policy will be via an online survey available from May 26th to June 10th 2008. Visit the SIP website to access the online consultation survey. The final draft of the policy is due at the end of June.

INFORMATION SYSTEM

The information system for the Safety Improvement Programme must:

- support the processes that are being developed to manage incidents and
- satisfy the requirements of users, from clinicians to managers, to the DHBs and other organisations up to the Ministry.

This project will identify the specifications for the system. The development and implementation of the system will be a separate project.

EDUCATION AND TRAINING

Education and training will be provided from October 2008 to August 2009 in all District Health Boards to:

- assist DHBs and providers to implement the policy
- increase understanding of incident management across health and disability service providers
- provide high level skills and knowledge for the investigation of serious adverse events and
- establish a level of ongoing education and support.

CURRICULUM

The curriculum for the education and training programme will be developed and provided by a faculty selected for their expert knowledge, excellent reputations and passion for patient safety. Curriculum development will commence upon completion of the policy to ensure the training is relevant and accurately reflects the national processes.