Australasian College for Emergency Medicine

Attachment One

28 February 2020

ACEM Submission to the SA Health Review of the SA Safety Learning System

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to provide feedback to the South Australia Health (SA Health) review of the Safety Learning System (SLS).

ACEM is the peak body for emergency medicine and has a vital interest in ensuring the highest standards of emergency care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. As such, ACEM has a vital interest in quality assurance activities promoting excellence and safety in patient care.

In its current form, ACEM members report concerns about the ease of use, functionality and transparency of the SLS and its failure to improve patient safety inside SA Health. We have responded to the questions posed by the review below. This includes detail about our reasons for concern, a number of specific examples provided by emergency physicians, and some suggested measures for improving the system.

1. Does the SLS fulfil its purpose in relation to reporting (sometimes known as 'notifying'), managing and analysing incidents?

1.1 What are the factors that facilitate the SLS to fulfil its purpose of reporting, managing and analysing incidents?

- Open access to SLS by all with a HAD logon
- A culture, especially within Nursing staff, that encourages active use of the system.

1.2 What are the barriers to the SLS fulfilling its purpose of reporting, managing and analysing incidents?

<u>Culture</u>

Historically, the culture at SA Health has not consistently been open and transparent in regard to patient safety, and it has not consistently learned from patient safety events. This impacts on the use of the SLS. A senior clinician commented that:

> "At the heart of the problem, SLS is a reactionary incident reporting tool underpinned by a name, shame and blame approach rather than meaningful quality improvement."

In addition, this system is often used to lodge personal complaints (*see the comments on noise below*) and the ability to lodge anonymous "complaints" (as opposed to incidents) can lead to inflammatory behaviour:

> "It feeds into the destructive model of silos which has such a negative impact on our practice and patient safety."

<u>Interface design limitations</u>

The current SLS interface is clunky, unintuitive and not user friendly. Key limitations of the SLS data entry interface include:

- The inability to nominate more than one clinical area or clinical unit easily on a SLS report. As described by one user:

> "It is sometimes not one "system" broken – there may be a few holes in the cheese lining up (e.g. TIA clinic referrals where radiology refuses to scan but we have not educated well enough on pathways). You can only click on the dropdowns towards 1 "location" to direct the SLS at."

- The assignment of SLS reports to a clinical area, rather than a clinical team, also results in a system where issues relating to a specific unit's management or a process aren't initially directed to the correct area. This can be rectified, but only after review of the case by a manager or senior clinician in the wrong area. This promotes frustration and delays timely responses to learning events. As described by SA Health staff:

> "SLS reports are currently being pigeonholed by the clinical area in which the incident occurred, meaning issues pertaining to inpatient or consulting units/doctors, and issues with ward transfers relating to ward staff or processes are not being directed to the right people for review."

> "Those submitting SLS report are hampered by the complicated drop-down tree stem often resulting in wrong area or wrong person receiving the SLS report."

> "Adding additional reviewers from different units is complicated. There is no obvious master list to whom to forward for comment unless you understand the inner working of the numerous departments (medical or otherwise)."

- The current list of drop-down options provided when generating an SLS report largely dictates how a SLS report will be themed, which can then limit how it may best be directed and themed.

> "Systems issues are poorly catered for except in comments where all the meaningful narrative resides. Some things like medication incidents are better suited than others – omission in care, contributors to flawed decision making and so on. I do worry that lumping everything into one is set for problems – security incidents, OH&S, medication, clinical decision making, access to everything etc."

<u>Noise to signal ratio in reporting</u>

In attempting to provide a single platform for number of different reporting concerns SA Health has significantly diluted the ability of the SLS to identify key trends and clinical safety concerns. This concern is described below by senior Emergency Physicians:

> "Efforts to reduce the noise, while not reducing the true signal, will help in improving patient safety. The SLS system has become the tool used to record anything that someone wants to record e.g. pressure sores, even when they are present when the patient arrives at the hospital which is clearly not a patient safety problem. Every code black is being recorded on SLS. These things are probably worth recording for the organisation, but not via a system designed for patient safety."

> "The volume of 'incidents' that get logged impedes the usefulness of the system as a tool to identify meaningful quality and safety issues. As a manager there is so much signal noise in the system that the important SLS reports can be missed. There are also significant differences between professional groups in the likelihood that they will use the system. In my experience doctors should use the system more often, nurses should use it less often. Many SLS reports are lodged "just in case". How you discourage people from using a safety system safely, how you change work place cultures of various groups of public servants and whether you should are all good questions. However, there is no doubt that SLS reports are a growth industry and the productive output of the entire endeavour is negatively affected by the volume of "incidents" logged on the system."

> "There is a whole lot of work to sieve through to find the few cases where there is an issue that needs attention. Far too often it is used inappropriately e.g. ward nurses highlighting that the patient's sheets haven't been changed in the ED."

Lack of response

There may be a lack of response from relevant units when there is a genuine issue. This may be impacted by there being too much noise, but individual units are also able to 'hide' incidents by responding to them internally.

Difficulty in data extraction

There is difficulty in extracting data for analysis of trends and issues, especially at systems and process levels. Senior clinicians reviewing SLS reports find it difficult to extract higher level data to explore trends/issues in patient care. Clearly the identification of 'clusters' of event needs to be a key function of the SLS – allowing senior clinicians to identify patient safety risks requiring systems level intervention and allowing process review. However in its current iteration, through a combination of poor interface design, limitations in training and variable designation of reports, this ability is frustratingly difficult.

Individual SLS reports are not meaningfully coded or categorised after assessment to allow for identification of trends and patterns. The analysis of these patterns must be undertaken at a system-wide level to identify problems that may seem minor at a site or departmental level but are important when combined across the system.

2. To what extent does the SLS meet the objective of providing patient safety data for feedback to staff, patients and the healthcare system, thereby allowing improvements to patient safety?

The SLS in its current iteration fails to meet its objective of providing patient safety data for staff, patients and the health care system. As such, it is playing a very limited role in allowing improvement to patient safety. This is clearly very concerning as improving patient safety is arguably the SLS's core function.

Reasons behind this failure include:

- Platform design limitations that result in an inability of the SLS to be provide adequate information easily for analysis of underlying themes and problems.

  > "We regularly audit handover related SLS reports but struggle to gain meaningful analysis and capture the full repertoire of SLS reports which relate to handover. I have raised this frustration through Clinical Council and a minor set of SLS dashboard improvements did follow, but it's still not enough for a qualitative systematic analysis."

- Lack of an intuitive end user interface providing ease of searching and access for identification of issues by keyword or other search strategies.
- Lack of end user education. Whilst there are several modules on the completion of SLS reports and the management of reports, there is no information easily accessible to senior clinicians and managers about generating reports or using the SLS to identify themes and clusters.
- Lack of automatic feedback to the incident reporter on review of a SLS report. Following reporting on the SLS system, a reporter receives an automated email from the SLS with an incident number but nothing else follows. A clinician who makes a report has identified an issue they feel impacts on clinical safety, yet there is no function whereby they receive any communication from the SLS on any actions taken. The result of this is clear – a sense of disempowerment and disenfranchisement with a system that ends up being viewed as a "tick box" exercise related to superficially addressing core NSQHS standards without meaningful action. A clear outcome of any SLS report needs to be a response to the reporter with any actions resulting from the report, along with a regular summary of core themes and important SLS reports made to individual units, presented in a clinically meaningful manner. One senior clinician described the frustration in the following way:

> "In terms of the SLS process… one of the most frustrating things is that there is no feedback system - I do not know what the institution has learnt from the SLS I completed. For the most part the reviewer is keen to write something in the box and "close" the SLS - they might as well actually call it "brush under the carpet" and make a button labelled as such."

3. Can you provide examples of where the SLS was involved in improvements in practice resulting in safer patient care, or alternatively where opportunities were missed?

Unfortunately, there are far more examples of missed opportunities than of true successes related to the SLS. An example of the SLS resulting in potential improvement in practice was seen in one LHN where a senior clinician identified several cases related to protocol deviations in the work-up of patients presenting with Transient Ischaemic Attack. On identification of these, the senior clinician was able to provide some brief education to medical staff to help ensure the protocol was followed and patients received appropriate work-up prior to referral to this service.

It must be noted, however, that even in this case of a possible "success" of the system, the identification of the events was only possible because a single clinician was laboriously responding to many SLS reports and happened upon these cases. There was nothing to flag these cases and had they been processed by several different clinicians each instance of this problem would not have been identified as more than an isolated occurrence.

4. What (if anything) can be done at either LHN or SA Health level for the SLS to fulfil its purposes of:

4.1 Reporting, managing and analysing incidents to improve patient safety?

- Patient details are not presented in a way that makes lookup easy. Patient names should be derived from UR lookup if possible to link databases, rather than relying on accurate entry.
- The Matrix for classification of SLS should be visible above classification dropdown. Currently available as a link, but more of us than not have not committed the matrix to memory.
- SAC rating system is too subjective for those submitting the SLS – and most reporters have had no formal training in assigning these.
- Creating a cluster from historical SLS is neither straight forward nor easy.
- System-level analysis of events to identify common incidents that may not have been identified at a site or department level.

4.2 Providing patient safety data feedback to staff, patients and the health care system to allow improvements to patient safety?

- Embed a feedback loop to ensure each SLS report is associated with a response to the reporter/ appropriate units about actions taken or response to the concern raised.
- Publish regular (e.g. quarterly) reviews/reports on LHN and state-wide themes arising from SLS reports. These reviews/reports should be disseminated widely to the staff of relevant LHNs. The current annual reports lack sufficient detail to be particularly useful.

5. Do you have any comments relating to the functions of SLS to facilitate open disclosure and incorporate the end to end administration and process of complaints, coronial inquiries, medico-legal and insurance claims?

The inclusion of "adverse publicity" as a Level 3 SLS Criteria is fundamentally inconsistent with the integrity of the SLS as a patient safety mechanism. The intent of the SLS must be clearly focused on patient safety and learning for all clinicians to help develop the best level of care for the people of South Australia.

6. What needs to be done at either LHN or SA Health level for the SLS to facilitate these functions?

We suggest utilising a combination of data entry redesign – with a focus on providing a platform that is user-focussed and intuitive, with more flexibility in reporting (see previous answers for specific examples of improvements in the data entry platform required). In developing this new data entry platform, clinician input (medial, nursing and wider) must be sought from senior manager levels and front line clinicians.

We consider there is a strong need to develop greater ability of the system to identify meaningful clusters. For example, this could be achieved through the use of key word searches and theme analysis, with concomitant increases in educational material to allow senior staff and managers to be proactive in searching and reviewing SLS reports as part of their integrated quality assurance activities.

There is also a need to better define, with greater clarity, the intent of the SLS. Separate reporting functions clearly for security and OH&S reports from patient safety/clinical reporting is needed.

We also suggest removing "adverse publicity" from the SLS system – this is not a patient safety metric and has no place inside a system designed for this.

Thank you for considering our response. For any questions regarding this submission, please contact Ms Forest Taanetinorau-Morton at policy@acem.org.au.

Yours sincerely

Dr Mark Morphett
Acting Chair, SA Faculty

Ms Nicola Ballenden
Executive Director, Policy and Strategic Partnerships