Journey to a Just Culture
Mental Health partnering with Clinical Governance

Gold Coast Hospital and Health Service

Presenter: Director of Safe Healthcare

HRT1615 Patient Safety Improvement Group

19-20 October 2016

Melbourne

Email to: kate.tynan@healthroundtable.org

Innovations Information Slide only – delete after reading

Please read this note about the Innovations Session Oct 19   1pm -3.30

1. Please bring a printed colour copy of your "poster" to the workshop. (The 'Poster' are these A4 PowerPoint sheets you have prepared using this template).
2. Please attach your "Posters" to the wall in the lunch break before each session. The Roundtable team will be on hand to assist
3. We are expecting 30-40 poster presentations
    a. The sessions are' rapid fire' ; presenters speak about their innovation for 90 seconds ONLY - outlining the key outcome messages.
    b. With your permission we would like to video your 90 second presentation
4. When all rapid fire presentations are done, the delegates move around the posters to learn more detail about innovations relevant to their service
5. Towards the end of the session delegates will be asked to vote (with a red dot) on the most useful innovation
6. If time – presenters of the top two or three innovations will be asked to expand on the details and talk for about 5 minutes to the whole group
7. All poster presentations will be available on the member website
8. This interactive forum maximises the knowledge in the room and we encourage all delegates to steal shamelessly!

Key Problem

- Gold Coast Hospital and Health Service Mental Health Division Program – Zero Suicides
- Clinical Incident Management integral to understanding how to reduce suicides
- Review the incident analysis process for clinical incident management of suicides
- We need to consider this in the context of the first and second victim.

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Aim of this innovation

- What were we aiming to achieve?
  - An improved understanding of the current incident analysis process – based on the Queensland Health Best Practice Guide to Clinical Incident Management
  - Mapping the process against our Legislative and Departmental of Health compliance frames
  - Identify gaps in the current process
  - Identify the roles and responsibilities within the Clinical Incident Management process

- What was the improvement you were seeking?
  - Identify process improvements
  - Improve the culture of support within clinical incident management

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Baseline Data

- Clinical Incident Management Framework Review
  - Legislation, Policy and procedure, roles and responsibilities, system tools
- Literature Review
  - CINAHL, Trip, PSYCinfo, Clinical key, ProQUEST, Pubmed
  - Search words: sentinel events, critical incidents, adverse event, second victim, staff, care
- Voice of the staff – 10 focus groups asking frontline staff about their experience of the review process

Baseline Data

The Health Roundtable

Clinical Incident Management Framework Review findings:

Immediate Response

- De-briefing for individuals
- Engagement with families

Prepare for Analysis

- Assumption of error to be removed
- Want to be involved in the analysis process

Analysis process

- Enhance the positive aspects of care are identified
- Transparency and involvement in the development of recommendations

Baseline Data

Clinical Incident Management Framework Review findings:

Follow Through

- Staff don’t want to feel ‘blamed’
- Direct feedback to staff
- Ongoing support for consumers and staff

Close the Loop

- Dissemination of outcomes
- Changes need to be communicated

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Baseline Data

Literature Review findings:

- Limited research on second victims
- No clear consensus on how to design a support program for second victims
- Lack of organisational support post clinical incidents
- Supports are poorly accessed or not well utilised by staff
- Vicious cycle – clinician develops shame – leads to burnout or decrease in subsequent care – leads to more errors
- Second victims can experience effects that can impact on their lives months and even years later
- Extreme cases have reported suicidal ideation

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Baseline Data

Focus Group findings:

- Focus on building resilience prior to an incident
- Don’t want a blame culture
- Quarantined time to reflect on practice on a regular basis
- Critically reviewing practice and sharing learning's amongst the team
- Training in the review process of clinical incident management to dispel myths and to know what to expect

Key Changes Implemented

- Immediate Response
  - Developing a post incident de-brief tool
  - Implementing a Severity Assessment Code (SAC) 1 Executive Triage Model
- Prepare for Analysis
  - All staff involved have the option of attending the analysis
  - Consider changing the HEAPs name to remove the word error
- Analysis process
  - New approach to HEAPs that involves the whole team
  - Highlight the positive aspects of care
  - Premise in on learning

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Key Changes Implemented

- Follow through
  - Recommended changes are communicated
  - Thematic analysis of recommendations

- Close the Loop
  - Consistent method of dissemination of learning's
  - SAC 1 Case Summary reports

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Outcomes so far

It's Early Days

- SAC 1 Executive Triage model commencing on 25 October 2016
  - Clinical Governance Service collaboratively working with Clinical Directorates to improve the management of SAC 1 clinical incidents
- 100% of SAC 1 clinical incidents have a case summary for dissemination
- SAC 1 clinical incidents are tabled at the Critical Incident Review Committee

This is a journey…………

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Lessons Learnt

- There is limited research around the impact that SAC 1 clinical incidents have on second victims
- Clinical Incident Management needs to be a collaborative process between Clinical Directorates and Clinical Governance Services
- Organisations need to be actively managing all aspects of the Clinical Incident management process
- We have more work to do…………….

- For more information Contact: Director of Safe Healthcare
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