

NB: This is a work-in-progress. Any numbers in here must be taken with a grain of salt

Safety of Australian hospital care

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Agenda

- What is the size of the safety problem?
- What is the potential scope for improvement?
- What should we do about it?

Different world views - 1

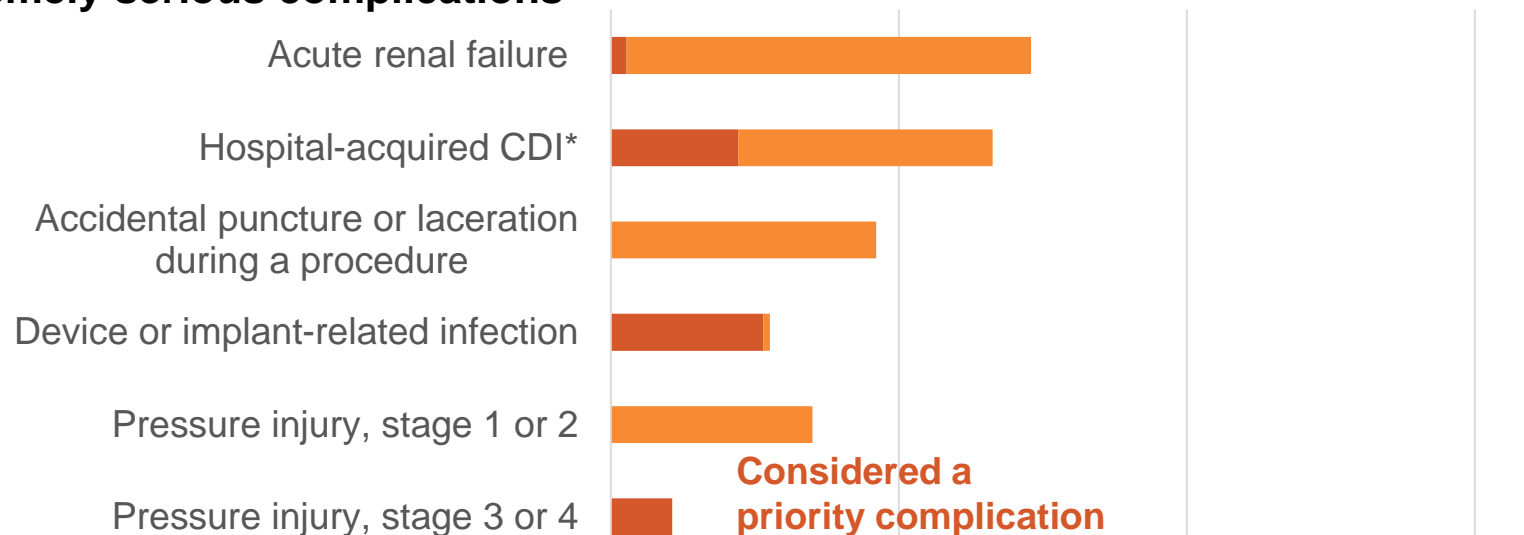
- 8 sentinel events
- ‘Hospital Acquired Complications’’: developed by the Australian Commission on Safety and Quality. To be included, a clinical panel had to agree that the complication was serious and that clinical risk mitigation strategies may reduce (but not necessarily eliminate) the risk of that complication occurring.
- All complications: Any diagnosis that occurred during course of admission.

Different world views - 2

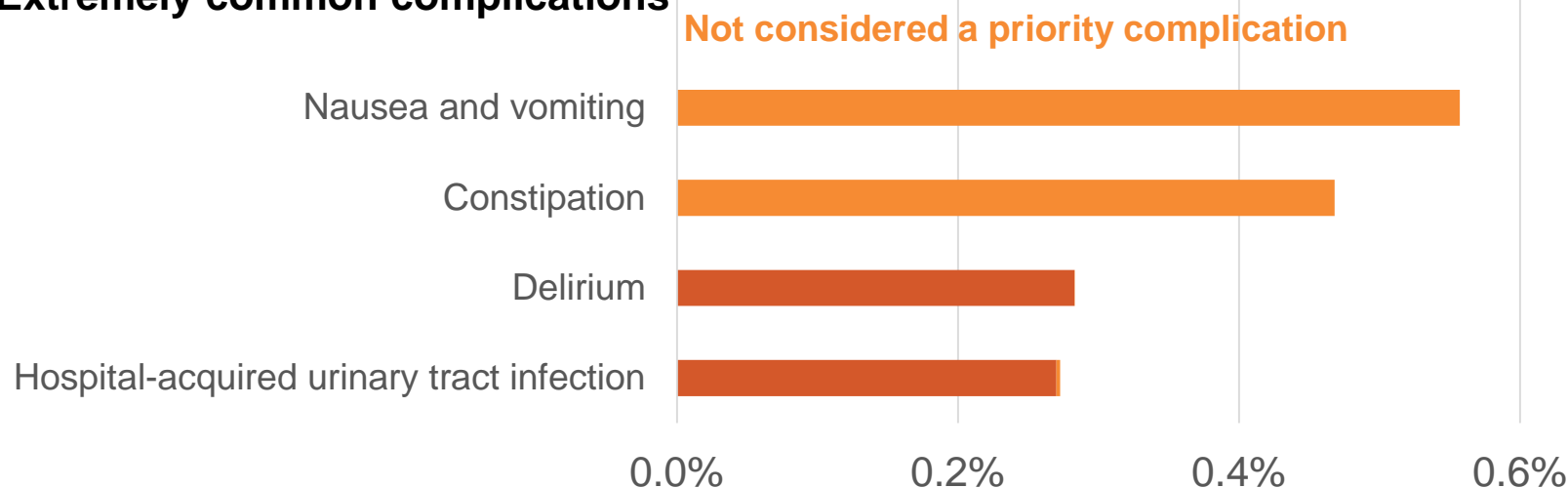
	All admissions	Multiday admissions
Sentinel events	0.0012%	Not published
Designated 'Hospital Acquired Complications'	2%	5%
All complications	11%	27%

Substantial harm is caused to patients from complications that are excluded from the priority complication list

Extremely serious complications

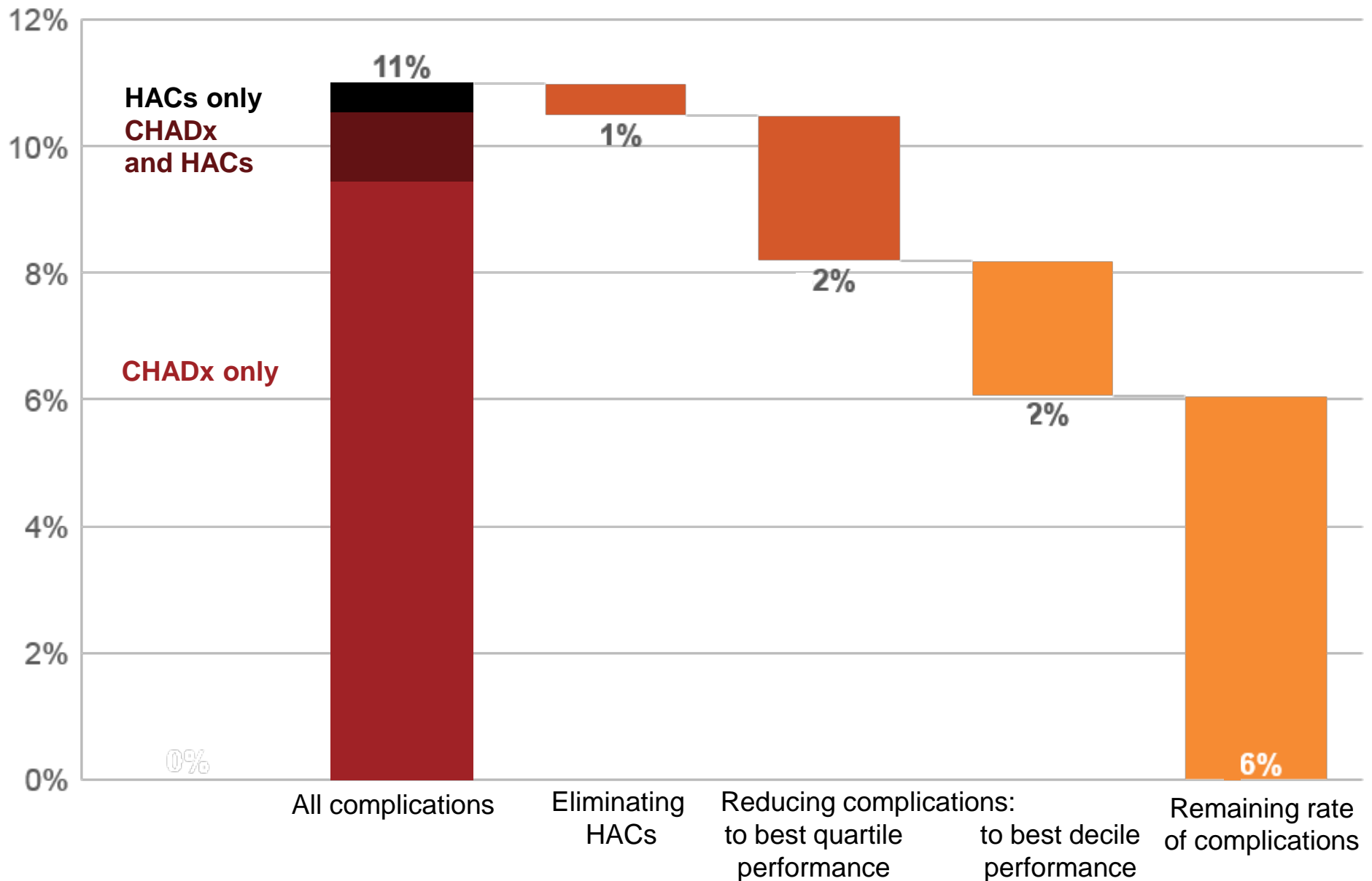


Extremely common complications



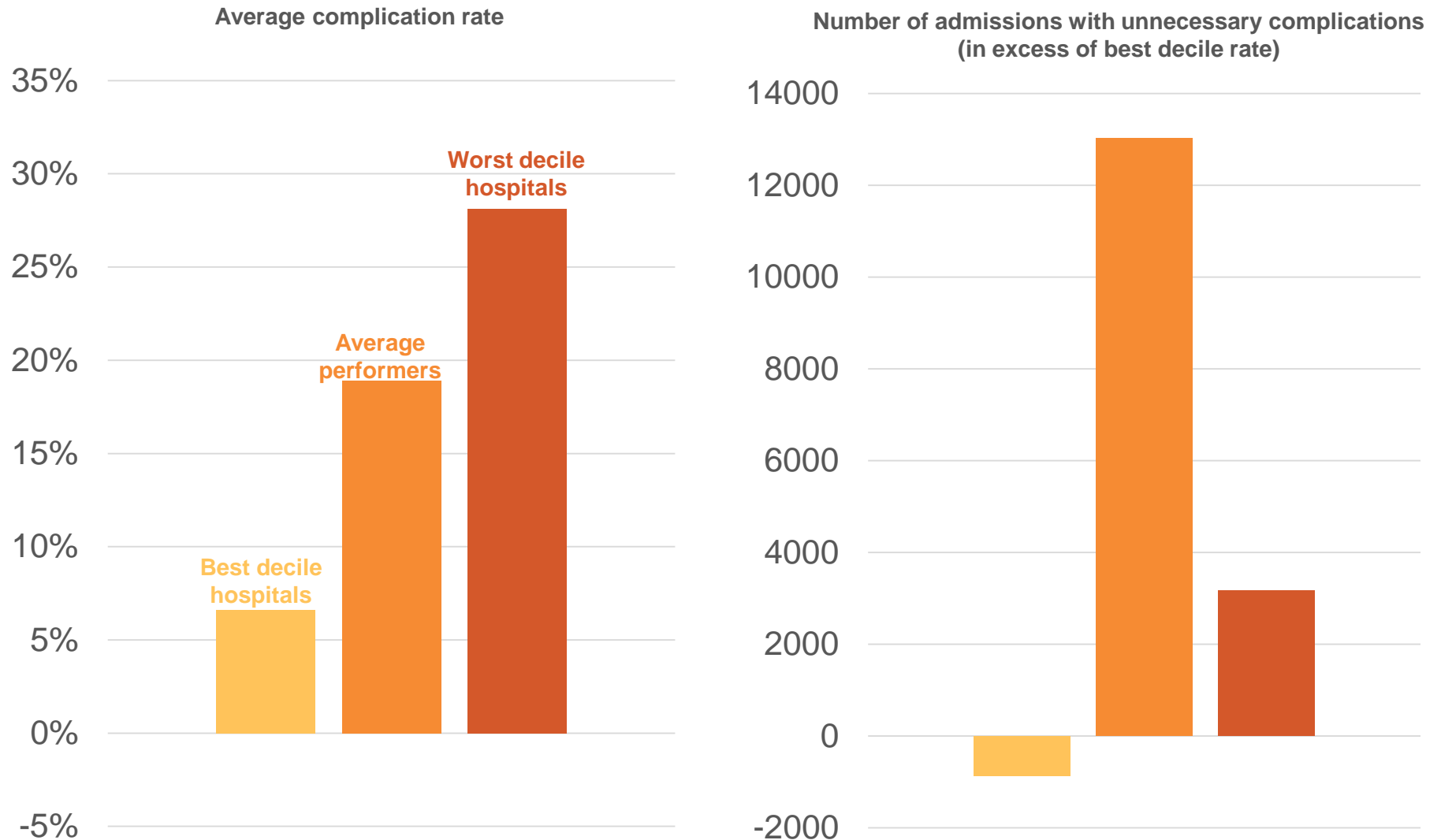


We should be aiming to halve the number of complications that occur in Australian hospitals



The greatest opportunity to make Australian hospitals safer is to move average hospitals closer towards excellence

Incidence of excess complications as a percentage and count of annual medical cardiology admissions, by performance category





How do we get there?



Recommendations

- ‘Actionability’ of existing data collections needs to be improved
- Publish comparative data for public and private hospitals
- Give clinical teams the tools to use the data to improve their performance
- Get hospital accreditation to pay some attention to complications
- Put financial incentives on hospital management to pay attention to complication rates