Patient Safety Starts with ME
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Hospital Code Name: NSW Health Mid North Coast Local Health District
Elevator Pitch- What is the outcome/significance of your presentation?  
(This will be used in the program to describe your innovation)

- Quality Systems Assessment:
  - 25% more units believing there is a positive safety culture within their unit by April 2014
  - 15% more units believing Senior Management show patient safety is a top priority by April 2014
  - Clinical staff to understand the link between quality, evidence based care and patient outcomes
Quality Systems Assessment results for the Hastings Macleay Clinical Network of the Mid North Coast Local Health District reported less than state average results in Patient Safety & Quality questions.

Through staff interviews it was identified that a large number of clinical staff are unable to make the link between quality, evidence based care and patient outcomes.

Patient Stories demonstrated a clear gap in patient assessment and subsequent patient outcomes.

We introduced Patient Safety Boards and Innovation Boards to pilot sites across the clinical network.

Within 6 months of the beginning of the project we noticed a marked improvement.
Poor Quality Systems Assessment Results

- Quality Systems Assessment results for the Hastings Macleay Clinical Network of the Mid North Coast Local Health District reported less than state average results in Patient Safety & Quality questions.

- Through staff interviews it was identified that a large number of clinical staff are unable to make the link between quality, evidence based care and patient outcomes.

- Patient Stories demonstrated a clear gap in patient assessment and subsequent patient outcomes.
Aim:

- 25% more units in the Hastings Macleay Clinical Network believing there is a positive safety culture within their unit by April 2014
- 15% more units in the Hastings Macleay Clinical Network believing Senior Management show patient safety is a top priority by April 2014
- Clinical staff to understand the link between quality, evidence based care and patient outcomes – make patient safety & quality the centre of the care we provide to our patients
BASELINE DATA

Quality & Safety Culture
Positive Quality and Safety Culture
Responses “Strongly agree” or “Agree” that
“There is a positive patient safety culture in our department / clinical unit”
MNCLHD - 2007 to 2012

Staff Survey
Question 1: There is a positive patient safety and culture in our department?
Question 2: The actions of the facility senior management show that patient safety is a top priority?
KEY CHANGES IMPLEMENTED

![Diagram showing key changes implemented based on ability to influence and impact. The categories are divided into High Priority, Communication Tools, Patient Safety Boards, Innovation Boards, Flexible Visiting Hours, Patient Stories, IIMs Sharepoint, Vision Statements, Managers visibility, Feedback & Acknowledgement Training.](The Health Roundtable)
KEY CHANGES IMPLEMENTED

Innovation Boards

Patient Safety Boards

Patient Safety Boards and Innovation Boards were introduced to pilot sites across the Hastings McLeay Clinical Network.
OUTCOMES SO FAR

CCN Results compared to NSW Results
There is a positive patient safety and quality culture within your department/unit

HMCN Results compared to NSW Results
There is a positive patient safety and quality culture within your department/unit

22% Increase in strongly agree
LESSONS LEARNT – One Slide

- Utilisation of a comprehensive project plan with clearly defined in- and out of scope areas.
- Strong sponsorship was key for success. (Commitment to the change on all levels of the organisation).
- Choose project team members wisely. It’s hard to successfully implement without a strong project team.
- Don’t forget to involve our patients. Patient stories can be a very powerful tool to support the Case for Change!
Contact:

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