AUDITOR GENERAL FOR WESTERN AUSTRALIA

"Serving The Public Interest"

M E D I A S T A T E M E N T

17 October 2007

AUDITOR GENERAL CALLS FOR BETTER REPORTING AND MORE EFFECTIVE LEARNING TO REDUCE INCIDENCE OF ADVERSE EVENTS IN PUBLIC HOSPITALS

Auditor General Colin Murphy has released his report into Adverse Events in Public Hospitals. The report released in Parliament today found that whilst the vast majority of patients in our public hospitals are treated safely and without incident adverse events are still a significant issue in Western Australia.

Clinical Incidents range from near misses and minor incidents which do not affect the patient's health or treatment to those which cause harm and death to the patient. Those incidents which cause harm are generally referred to as Adverse Events.

There are no indications to suggest that the incidence of adverse events in WA is unusually high and on the basis of reported incidents, adverse events with severe or catastrophic outcomes for patients are rare.

WA Health's finalised incident reports show that in 2006 there were 25 769 clinical incidents of which 15 614 were adverse events. Of these 820 were rated as critical causing serious harm or death. The Quality in Australian Health Care Study (1995) found that around 50% of adverse events may be preventable.

Adverse events also consume healthcare resources. WA Health estimate they may be costing up to $380 million a year. Reducing adverse events could release resources to treat additional patients.

WA Health has established state wide incident reporting, but there are deficiencies that limit the understanding of adverse events. The examination found that under-reporting of adverse events is a significant issue, estimating that around one third are reported, and that there is a lack of a coordinated approach to improving reporting.

Information from incident reports is not timely. The Auditor General found that, as of the end of June 2007, there were 7 000 reports waiting to be finalised, more than half of which related to incidents that happened more than 6 months earlier.

The examination found that WA Health has multiple systems which capture information on adverse events but is not systematically using all the available information sources to build a more complete understanding of adverse effects.

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The Auditor General's report states that WA Health has the foundations of a coordinated approach for improving patient safety, but system wide learning from adverse events is at an early stage. Monitoring of the implementation of initiatives to reduce adverse events, and evaluation of the benefits realised, has been limited.

The Auditor General has recognised that hospitals manage and respond to individual adverse events, and found localised examples of successful change. However WA Health needs to ensure that the examples of good practice and improvement are transferred across the whole system.

Whilst understanding that the demands on our public hospitals are increasing, the Auditor General believes that: "WA Health needs to balance its focus on delivering services in the face of increasing demand with a stronger focus on doing no harm." He has made a number of recommendations to achieve this including a call for:

- Increased reporting with improved timeliness of data
- Better utilisation of all available data sources
- The setting of system wide priorities to allow the health system to target efforts to where the greatest benefits can be realised
- Increased sharing of information between hospitals and across the system
- A coordinated program to monitor initiatives and evaluate progress.

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