Summary

Background: Health policy makers in many countries have proposed protocols to reduce so-called 'never events', meaning adverse incidents in hospitals that are preventable, such as incidents involving the wrong patient, wrong site, or wrong procedure. Reporting systems now indicate that these types of adverse incidents are more frequent than initially assumed; for example, 53 such incidents were reported across Australia for 2004-05. The Australian Health Ministers in April 2004 called for all public hospitals in Australia to implement the 'Ensuring Correct Patient, Correct Site, Correct Procedure' protocol, as part of a broad strategy to introduce and standardize patient safety check procedures in hospitals.

Aims: This study sought lessons for health sector governance from experiences with the protocol. Did policy implementation differ between States and between hospitals? Did different groups of professionals support or object to the protocol? What strategies were used to promote compliance with the protocol by hospitals and health professionals?

Methods: Information was obtained from the eight States and Territories on implementation strategies and audits. A literature review and website search was undertaken. Over 72 interviews were conducted with national and State policy makers, hospital managers, and health professionals.

Results: Promulgation of the protocol differed between the States, reflecting different public sector cultures and administrative structures, with the States variously issuing guidelines, policies and directives. Most States left it to hospitals to work out the details of the protocol and many hospitals left it to units and/or clinicians. Most hospitals began by introducing the protocol in operating theatres. The take-up of a protocol within a hospital depends upon its acceptability to health professionals, and introducing a standard procedure into operating theatres proved more difficult than expected, especially since patient identification practices vary between surgical specialties. The protocol also revealed different safety cultures, since nurses generally tend to prefer rules-based practice while surgeons prefer discretionary practice. In some hospitals, rather than an opportunity for team-building, the protocol aggravated tensions between professional groups. Hospital managers tried multiple regulatory mechanisms, both supports and sanctions, to promote compliance. Most began with softer mechanisms, such as information and training, and later escalated to stronger mechanisms, but stopped short of severe sanctions. Some hospital audits suggest that protocol compliance in operating theatres in general rose over four years from below 30 percent to over 70 percent and in some units rose to over 90 percent.

Conclusions: Policy makers saw the protocol as a self-evidently sensible solution. Compliance by health professionals, however, proved to be low and slow, especially since the authority attached to the protocol was often ambiguous. Hospital managers proved to be responsive regulators in that they tried multiple regulatory mechanisms. Achieving compliance required supplementing the soft mechanisms traditionally used by the health sector by stronger mechanisms, however, such as directives issued by clinical leaders, and by regular compliance monitoring. Once embedded in operating theatres as 'the way we do things', the protocol appears to be low-cost and not intrusive in terms of staff time and effort. Although the principle of a patient safety check generally is accepted, there was little agreement on the principle of a standard protocol, either within many hospitals or within a State, let alone across Australia.