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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

Inside this issue

From the Director

Correct site surgery

In profile – Joanne Amos

De-Identifying IIMS Notifications

2008 Patient Safety Survey

RCA update

Safety alerts and notices

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From the Director...

It is almost time for the Annual HNE Health Quality Exposition and Scientific Program, which will be held in Taree this year, from midday on Thursday 11 September and Friday 12 September 2008.

As with previous years, the event will be associated with the Annual HNE Health Quality Awards presentations.

The feedback from previous year's events has been very positive, and we plan to focus this year on current topics of interest locally and nationally



around communication and teamwork in health care. The program will be available shortly, and in the meantime, please

remember these dates, and put them into your diary now.

This *Quality Matters* edition focuses on Correct Site Surgery and Procedures. The most recent HNE Health audit of correct site surgery showed good improvement overall, and this is a credit to all those involved. There are current audit activities underway in medication safety, and preparation for HNE Health Corporate EQUIP in early 2009 has commenced. Further information about audit outcomes will be provided in future editions of *Quality Matters*.

Correct site surgery

by Dr John Fisher, Associate Director

Correct site surgery is a protocol designed to ensure that the correct patient has the correct procedure at the correct time. A number of protocols or checks have been developed to ensure that this occurs, and two of these are known by the terms *Time Out* and *Site Marking*.

Time Out is a final verification or series of checks where all patient identification procedures undergo a final check, or *Time Out*, prior to surgery. *Site Marking* is a protocol that ensures that the site of the medical procedure is marked and so there is clarity about the site where it is meant to occur. This article examines HNE Health's response to these procedures under the rubric of 'Correct Site Surgery'.

Correct site surgery has become an important aspect of quality, safety and Clinical Governance. The Royal Australasian College of Surgeons is strongly committed to the implementation of correct patient, side and site surgery, as is NSW Health and HNE Health. Our surgeons are increasingly involved in the implementation of measures to prevent potential catastrophes that might result in the event of incorrect site surgery.

Audit data from Australia shows that there are recent occasions where incorrect site surgery occurs, both in operating theatres and in the fields of Radiology and Nuclear Imaging. An example has been reported by the Royal Australasian College of Surgeons, where there were a number of patients on a particular operating theatre list for the day. One patient did not attend that day, and the next patient on the list incorrectly received the operation intended for the first patient.

Time Out, or final verification, is now mandatory in all procedural areas. Monthly auditing is undertaken in relation to agreed performance indicators, which include compliance with the steps of the *Time Out* protocol, and compliance with clinical requirements for surgical antibiotic prophylaxis and venous thromboembolism prophylaxis. The *Time Out* check itself is the fifth and final check prior to commencing the operation or procedure.

Audit data relating to correct site surgery and *Time Out* from all hospitals within HNE Health is being collected, and is part of a NSW Health statewide system of auditing compliance with correct site protocols. It is anticipated this system will increase the attention paid to ensuring correct site surgery occurs, and reduce the potential for future incorrect site patient procedures. In HNE Health, there is an Area Reference Group established to monitor the audit results, and to work with clinical staff and managers to investigate any trends or incidents with local implications. (*continued over*)



In Profile... Joanne Amos

Joanne Amos, Patient Safety Officer, Lower Hunter Cluster

Joanne is one of the newer Patient Safety Officers having only worked with Clinical Governance for the last eight months. Jo's full-time position encompasses the Lower Hunter Cluster – Cessnock, Kurri Kurri, Singleton and Dungog District Hospitals as well as East Maitland, Cessnock, Singleton and Kurri Kurri Community Health Centres.

Jo's initial nursing background began as an Enrolled Nurse. She then embarked on a journey to Sydney and completed her Bachelor of Nursing at the University of Western Sydney. Her rural background soon lured her back to the country where she worked as a Registered Nurse and while completing postgraduate qualifications in Intensive Care.

In 2004, Jo and her family moved to the Hunter to improve access to services for her autistic son. Jo continued to work in intensive care at John Hunter Hospital for another 3½ years before joining the Clinical Governance team.



During her time at JHH ICU, Jo had the opportunity to relieve the Intensive Care Data Manager and gained experience in accreditation and quality activities. This fuelled a passion for pursuing quality in healthcare.

Jo describes herself as a dedicated mother who has mastered the ability to juggle six things at once. She can be contacted on 0434 367 654 or at joanne.amos@hnehealth.nsw.gov.au

De-Identifying Incident Information Management System (IIMS) Notifications

by Ms Di Dolan, Area Patient Safety Manager

Thank you to everyone for their continued strong reporting of incidents. Hunter New England Health has one of the strongest reporting cultures of all the Area Health Services. In April 2008 there were over 1400 clinical incident reports. IIMS reporting is integral to identifying system issues affecting patient safety.

Recently, Patient Safety Officers have noted an increasing number of IIMS notifications that are not de-identified. Reports should be de-identified with no staff names mentioned. When necessary the use of Dr A or Nurse C is the preferred method of reporting. Issues of staff differences are also best initially escalated to relevant managers with responsibility for managing emergent issues. To access IIMS go to: <https://iims.health.nsw.gov.au/switchboard.asp>

2008 NSW Health Patient Survey

by Ms Melissa Harvey, Accreditation Co-ordinator

The annual statewide patient survey is being conducted over an eight week period from May - July 2008. The survey seeks feedback from patients and carers on their experience of healthcare services provided with questions focusing on what patients and carers value. Over 30,000 surveys have been mailed to patients within the Hunter New England area who received their healthcare during February 2008. Please encourage patients to participate in this survey, which will provide local facilities and services with valuable information on how we meet the needs of patients and carers and how to improve care.

RCA update

A teenage boy was admitted for surgery and was commenced on heparin post-operatively. The surgeon gave a verbal order for 25, 000 units of heparin intravenously at 20 ml per hour. The recovery nurse thought this was a very high dose and sought clarification from the surgeon. The surgeon advised that as the boy weighed over 70 kg he required adult dosing. The medication order was not written in the patient's medication chart.

When the patient returned to the ward, the nurse noted the high infusion rate and sought clarification from the surgeon. The surgeon reviewed the order. The intention had been to prescribe IV heparin 25, 000 units in **500 ml** of normal saline at 20 ml per hour. However, the local adult heparin infusion protocol was to use **50 ml** of normal saline, and not 500mls. This meant that the dilution was not what was intended, and that the patient was receiving too high a dose.

Fortunately, the patient did not suffer from any lasting adverse effect. However, the incident highlighted the importance for all staff to provide and communicate standardised high-risk drugs protocols and to ensure that individual staff follow these protocols. The event could have been prevented had clinicians adhered to the read back procedure for giving or taking a verbal medication order as stated in the NSW Health Policy Directive PD2007_077

Medication Handling in NSW Public Hospitals.

http://www.health.nsw.gov.au/policies/pd/2007/PD2007_077.html

Colleagues looking after paediatric patients may also be interested in a recent Sentinel Event Alert, **Preventing Pediatric Medication Errors**, on the Joint Commission website at: http://www.jointcommission.org/SentinelEvents/SentinelEventAlert/sea_39.htm

Correct Site Surgery

(continued from page one)

The recent *Time Out* audit of 1332 patients showed that for all steps in the audit, there was 87% compliance or higher. This will be measured quarterly, and the results will be used by the Area Reference Group in developing its strategies.

A policy compliance procedure for *Site Marking* has been developed, and this describes a standard way in which all staff can identify the correct site of surgery as marked by the surgeon. The protocol for site marking applies in all clinical areas, including operating theatres, radiology, cardiac catheter units, vascular laboratories, emergency departments and nuclear medicine.

http://www.health.nsw.gov.au/policies/pd/2007/PD2007_079.html

For further information contact Dr John Fisher on 0429 100 422 or john.fisher@hnehealth.nsw.gov.au

Safety Alerts and Notices

Please click on the hyperlink under "issues covered" for more information

Number	Type	Issues covered	Date of issue
SN:008/08	N	Clexane	16 May 08
SN:004/08	N	Oxycodone (Revised)	8 May 08
SN:007/08	N	TGA Recalls	30 April 08