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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

Essentials of Care: putting patients at the centre

New Interventional Procedures to HNEH

Root Cause Analysis

In profile: Jay Nielson, Patient Safety Officer

CUEHL seminar

Clinical Governance Christmas Quiz results

Editorial team:
Dr Kim Hill, A/Prof Anne Duggan, Ms Barbara March and Ms Tracey Currie.

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From the Director...

Welcome to the first Quality Matters of 2009, and best wishes for a happy and prosperous 2009.

This month, the focus is on an important quality and safety matter. Patient care procedures on the incorrect patient, incorrect site or using the incorrect implant are rare events, but when they do occur, they have the potential to have significant clinical consequences.

The policies and protocols used



in Correct Site/Side/Procedure have arisen from collaboration between clinicians and managers, and through a number of groups, including the Royal Australasian College of Surgeons, National Commission on Safety and Quality and state authorities.

Below is some information about the latest in this area.

Dr Kim Hill
Director
Clinical Governance

Correct Site Surgery - Protocol to reduce Possibilities of Error in Patient Identification

The Final Report of the Special Commission of Inquiry into Acute Care Services in NSW Public Hospitals (handed down in November 2008) noted the importance of procedures for correct patient identification, including correct surgical site, correct procedure performed, and correct patient.

The Correct Patient, Correct Procedure and Correct Site Policy Directive PD2007-079 outlines key responsibilities and exceptions and applies to procedures that expose a patient to potential risk, including those performed in operating theatre, dentistry, endoscopy, radiology, nuclear medicine, chemotherapy and radiation therapy, as well as on the ward. The purpose of the policy is to prevent such incidents occurring by describing the steps that must be taken to ensure that the correct intended invasive or diagnostic procedure is performed on the correct patient, at the correct site and with the correct prosthesis or implant as indicated.

Implementation of the policy in HNEH has involved monitoring and review of reported incidents involving incorrect patient, procedure and site, and initiation of regular audits to monitor policy compliance and ensure practices are being maintained.

As part of this implementation policy compliance audits are conducted on a quarterly basis, and all surgical facilities in HNEH now collect data via the iPMS operating theatre module. The audits have helped by providing regular reports to hospitals on compliance levels for each stage of the "Time Out" process; and in support of strategies to improve compliance. Overall audit results for HNE Health in the last audit were good and showed improvement in several areas, although not yet at 100% compliance. Key results are provided in the table below.

Correct Patient/Procedure last Audit Report period 03/11/2008 to 09/11/2008

Number of Patients audited.....	1199
1. 'Time Out' conducted.....	98.3 %
2. Patient identification correct.....	98.7 %
3. Consent form complete and correct.....	98.5 %
4. Site marking correct.....	93.0 %
5. Medical imaging correct.....	95.6 %
6. Implants/prostheses correct.....	97.3 %
7. Additional equipment correct.....	96.8 %
8. Antibiotic prophylaxis has been assessed.....	98.4 %
9. VTE prophylaxis has been assessed.....	98.6 %

For further information about this initiative, please contact Dr John Fisher, Associate Director Clinical Governance on telephone 02 6767 7237 or Anne Barry on telephone 02 4921 4925.



In profile...

Jay Nielsen, Patient Safety Officer

Jay commenced a career in health in 1993 after graduating from La Trobe University in Victoria. He has worked as a registered nurse in Victoria, Queensland and New South Wales across many disciplines but developed a passion for Emergency Nursing and followed that as his primary professional interest.



Jay joined the Clinical Governance team in 2005 as the Patient Safety Officer for the Tamworth Hospital. He enjoys the role and the new challenges that it entails particularly getting out and interacting with clinical staff. He feels that being accessible to both clinicians and managers is vital to get the message across in relation to the important work Clinical Governance does in Hunter New England.

Outside of work Jay enjoys trying new physical activities. Currently he is playing Oztag, which he says is a bit of a challenge for a Victorian, and learning to water-ski which by any definition is proving somewhat more difficult than it looks.

Root Cause Analysis (RCA) review

A 33 year old male patient underwent wedge resection left and right big toes. The consent form indicated inner right and left big toe nails. The surgeon undertook site marking prior to the procedure and time out was undertaken with all staff in the theatre participating. Following skin preparation and draping the site markings were no longer clearly visible. The operation was commenced and completed. Two days after the operation the patient returned to the surgeon for the post-operative visit and the surgeon identified he had undertaken the wrong operation. A wedge resection had been performed on the inner left big toe nail but also on the outer right big toe nail. When the error was discovered the surgeon immediately undertook open disclosure with the patient and subsequently the correct procedure.

This case highlights the importance of robust systems and processes to support best practice. The Surgical Services Group and Clinical Governance have developed a protocol for site marking that reflects NSW Health PD 2007_079 requirements that surgical site markings remain visible following skin preparation and draping. The local time-out protocol is also being reviewed to ensure that the surgeon leads time-out procedures. Time out should occur immediately prior to the commencement of the procedure, in the room where the procedure will be done. This may occur after the patient has been sedated or anaesthetised (NSW Health PD2007_079).

New interventional procedures to HNEH

The following new interventional procedures have been approved as part of the HNEH New Interventional Procedures and Clinical Practice Innovations policy:

- Endoscopic Ultrasound with Biopsy, Dr Doug Routley, Gastroenterology and Endoscopy, JHH/RNC
- Cardiac Circulatory Assist Device in Percutaneous Cardiac Interventions, Dr Suku Thambar, Cardiology, JHH to assist the treatment of patients with severe reversible myocardial ischaemia requiring cardiac pump support at angioplasty.

Clinical Governance Christmas Quiz

Most entrants were nearly there but no one achieved 100%. To make it easier our web pages have been updated and everyone has a second chance to enter. The closing date is 16th February 2009 and the first 3 correct entries drawn will win. 1st prize is a hamper, 2nd two tickets to the movies and 3rd a \$20 book voucher. To enter go to: <http://SelectSurvey.HNE.HEALTH.NSW.GOV.AU/TakeSurvey.asp?SurveyID=35K3I43089IKG>.

Essentials of Care - Putting Patients at the Centre

The Essentials of Care (EOC) Program provides nurses and other health professionals with a method to explore and understand current clinical practice to create a person centred environment. The Program focuses on what patients, their families and health professionals value about effective and relevant care. The Lead Facilitator, Leigh Darcy, from Nursing and Midwifery and the Clinical Risk Manager, Sue Williams, from Clinical Governance, are working together to provide support programs for EOC Facilitators to develop and monitor action plans, using the Integrated Risk Management System (IRMS).

For more information about the Program please contact Leigh Darcy on 4985 3479 or 0429 002785.

Clinical Unit in Ethics and Health Law Seminars

The next CUEHL seminar will be held on Monday February 2nd 2009, in the Royal Newcastle Centre, Conference Room 1, at 6.00pm for supper, with seminar to begin at 6.30. The topic for discussion is "Crisis - what crisis? Acute Care in NSW and Dr Garling's Prescription". Dr Peter Saul, Intensivist, JHH will chair the session and lead the discussion. All are welcome to join in, entry free, no RSVP necessary.

Please also make a note in your diaries for an upcoming CUEHL seminar of special interest on the 2 March 2009. The invited speaker is Dr George Weisz and he will present 'Nazi Medicine'. Dr. Weisz is a retired Hungarian Orthopaedic surgeon with an interest in medical history. Dr. Weisz has a BA in European History from the University of NSW and an MA in Renaissance Studies from the University of Sydney. He is sure to give a fascinating talk on this dark chapter of medical history. Venue and time will be as usual.