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# Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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## From the Director...

Current clinical quality and safety priorities for HNE Health are venous thromboembolism prophylaxis and managing anticoagulation.

There have been recent incident investigations that have highlighted the need to improve systems in this area. As a result, HNE Health is about to



commence a local pilot of its new risk assessment tool and management plan, based on current clinical evidence and guidelines.

This pilot is being overseen by an expert clinical team, and the outcomes will then inform how we implement this Area-wide.

*Dr Kim Hill*

### 2009 Hunter New England Health Quality Awards – Entries Now Open

Entries are now open for the 2009 HNE Health Quality Awards. Quality Awards support and recognize the excellent work of staff to increase the quality and safety of health care provided through continually improving service delivery. Entries must correspond to one of the seven Strategic Directions for Health from the [New NSW State Health Plan – Towards 2010](#) which are:

1. Promoting health
2. Create better patient journeys
  - a. Improving quality and safety
  - b. Improving access to services, when and where needed
  - c. Improving patient experience
3. Improving primary health and care in the community
4. Building partnerships for health
5. Making smart choices
6. Building the health workforce
7. Being ready for new risks and opportunities

Entries close on Friday 22 May 2009.

The HNE Health Awards are also used as a filter for submission to the external NSW Health Quality Awards, NSW Premiers Public Sector Awards, NSW Aboriginal Health Awards and the Australian Council on Health Care Standards (ACHS) Awards. More information on all the Awards as well as application forms for the HNE Quality Awards is available on the Clinical Governance intranet at: <http://intranet.hne.health.nsw.gov.au/cg/Quality/Awards>.

### Who to Contact for Further Information?

For more information about the Quality Awards process please contact Ms Tonia Easton, Area Quality Manager, Clinical Governance, on [tonia.easton@hnehealth.nsw.gov.au](mailto:tonia.easton@hnehealth.nsw.gov.au) or 6767 7233.

For information on the HNE Health, NSW Health Awards or NSW Premier's Awards contract Ms Laura Juratowitch, Quality Assistant, Clinical Governance, on [laura.juratowitch@hnehealth.nsw.gov.au](mailto:laura.juratowitch@hnehealth.nsw.gov.au) or 4921 4041.

For more information about the ACHS Awards please contact Ms Nanette Jemmeson, Accreditation Coordinator, Primary & Community Networks Accreditation, Clinical Governance on [nanette.jemmeson@hnehealth.nsw.gov.au](mailto:nanette.jemmeson@hnehealth.nsw.gov.au) or 6776 9819.

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## ***In Profile...***

### **Susan Diemar Policy Officer, Clinical Governance**

Susan commenced work for HNE Health in October 2006 as a Human Resource Project Officer, tasked with drafting the Area's Child Protection Policy Compliance Procedures. Susan has a Masters Degree in Human Resource Management and Industrial Relations and over fifteen years experience in HR roles within large organisations both in Newcastle and the United Kingdom.



Susan's HR experience encompasses the creation, implementation and monitoring of policies and guidelines both for HNE Health and the University of Newcastle and it is this experience that led her to join Clinical Governance as Policy Officer in March 2008.

Working with Dr Rosemary Aldrich and Felicity Wardle, the team is currently working towards improving access for staff to current and applicable policies, guidelines and procedures via the HNE Health Intranet. In addition, Susan provides ongoing support to HNE Health staff grappling with policy development and management, and has helped develop new processes for monitoring legislative compliance across the organisation.

Susan moved from the United Kingdom to Australia with her Aussie husband fifteen years ago, is taxi driver to two children and attempts to row on Lake Macquarie at unearthly hours of the morning each weekend.

## **Root Cause Analysis Review**

Two patients were admitted to a hospital to two different wards but under the care of the same consultant. Both required radiological investigations as part of their management; one a CT scan of the head, the other, an ultrasound of the abdomen.

During the medical team's round of the consultant's patients, the junior doctors documented the clinical plans in each patient's medical record. After the round they completed the required request forms for all patients, at a location away from the relevant wards. Patient stickers were not used. Instead, each patient's details were hand written and transcribed from a print-out of the consultant's patient list. A transcription error occurred: one patient's clinical history indicating a need for a head CT was recorded on a request form with another patient's name and medical record number.

Imaging scanned the request form which now contained the wrong patient details and called for the patient whose name was on the form. Ward nursing staff did not note the error as it was known that the patient was to undergo some kind of radiological investigation. The patient was released for transfer to Imaging. Imaging staff completed a Time Out procedure. The patient matched the timeout information on the generated forms and the patient agreed to having the test because he thought that it was possible that his abdominal pain might "all be in his head". When the patient returned to the ward after the procedure the nursing staff detected the error. The patient had suffered no adverse events from the procedure. Open disclosure was undertaken and the patient had the intended ultrasound.

The RCA Team recommended that when completing requests, medical staff check the patient identification and intervention requested against the treatment plan in the medical record and communicate these plans particularly to the nursing staff. In addition, the medical record should accompany patients to the Imaging Department so that radiographers can check the treatment plan and medical history prior to performing the requested imaging investigations.

## **Clinical Unit in Ethics and Health Law seminar**

In May 2009, the Clinical Unit in Ethics and Health Law (CUEHL) seminar is about "Catholicism, Judaism, Islam, Buddhism...Is there a common moral thread to the great spiritual traditions or is it a case of 'each to his or her own'?" John Cassey (paediatric surgeon), Marina Vamos (psychiatrist) Fatima Patel (obstetrician and gynaecologist) and Charles Douglas (surgical oncologist) will participate in a hypothetical on some life and death scenarios and invite audience discussion. The seminar will be held on Monday 4<sup>th</sup> May 2009 in the Royal Newcastle Centre Lecture Theatre at the usual time (6.00pm for supper, seminar at 6.30pm). All are welcome and entry is free.

## **A Paperless Periodic Review...almost**

In February 2009 HNE Health underwent ACHS Corporate Office Periodic Review using electronic supporting evidence for the first time. The ACHS Survey Team expressed their appreciation of the ease of access to HNEH's evidence via the specially prepared fileshare and were impressed by the quality of information, as well as the relief of not being surrounded by a room full of folders. Future ACHS surveys in HNEH facilities will involve use of electronic evidence folders to showcase achievements and improvements.

To help in evaluation of processes used in Corporate Office Periodic Review, a survey has been developed to seek comment from those involved. Please participate to help refine survey processes for the future benefit of all.

## **Pilot of Venous Thromboembolism Risk Assessment Tool**

Three HNE Health facilities – Royal Newcastle Centre, Tamworth and Armidale hospitals - are part of a pilot Venous Thromboembolism (VTE) risk assessment tool and management plan. The initiative is designed to reduce the incidence of deep vein thrombosis and pulmonary embolism. The pilot is being guided by the Anticoagulation Working Party, reporting to the Area Quality Use of Medicine Committee, and will run for four weeks from 4 May 2009. For information, please contact Dr Stephen O'Mara, Ms Barbara Rodham or Ms Helen Dowling, or go to [http://intranet.hne.health.nsw.gov.au/\\_data/assets/pdf\\_file/0006/61179/DRAFT\\_VTE\\_Prophylaxis\\_Clinical\\_Practice\\_Guideline\\_V2\\_20\\_April\\_2009.pdf](http://intranet.hne.health.nsw.gov.au/_data/assets/pdf_file/0006/61179/DRAFT_VTE_Prophylaxis_Clinical_Practice_Guideline_V2_20_April_2009.pdf)