Quality *Matters*

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Comments and queries welcome: clinicalgovernance@hnehealth.nsw.gov.au

From the Director…

Welcome to the November 2010 Edition of *Quality Matters*.

Our special Guest Editorial this month is from Professor James Isbister who among other roles, was the 2010 Visiting Fellow for the Royal Newcastle Hospital Heritage Trust. His knowledge and expertise has provided us with a thoughtful guest editorial.

As part of the *ISBAR in Our Communication* strategy, this year's Christmas Quiz is a challenge to apply ISBAR to forms, documents and other written words of HNE Health. I hope that you will enjoy this as a chance to use ISBAR innovatively - it will also help in the roll-out of the strategy across HNE Health. See details in this newsletter. Good luck to all entrants!

Dr Kim Hill
Director Clinical Governance

Why are most Red Cell Transfusion "Alternatives" the standard of care?

***Guest Editorial by Professor James Isbister,** Consultant in Haematology and Transfusion Medicine, Clinical Professor of Medicine, University of Sydney and Adjunct Professor, University of Technology, Sydney*

In minimising or avoiding allogeneic red cell transfusion from a patient's perspective, the clinician's primary responsibility is to manage the patient's own blood as a precious and unique resource that should not be wasted. Allogeneic blood transfusion should only be considered when there is no alternative. Central to problem-based transfusion medicine in relationship to red cell transfusions is the diagnosis and management of anaemia. Anaemia is common and generally poorly managed despite good scientific understanding of mechanisms and sophisticated diagnostic methods. In most circumstances anaemia is mild and its significance *per se* in terms of impacting adversely on clinical outcomes in the absence of confounding co-morbidities is questionable. Although there is literature associating anaemia with poorer outcomes in some circumstances there is a dearth of evidence supporting the proposition correcting the anaemia with red cell transfusions improves clinical outcomes.

There is an extensive literature on transfusion alternatives for minimising allogeneic red cell transfusions. Caution is advisable in the use of the term "transfusion alternatives" as only some are indeed truly alternatives. Good patient blood management is regarded by some as an "intervention" and alternative to allogeneic blood transfusion when the real focus is on optimal medical management and standard of care. Timely diagnosis and management of reversible anaemia, meticulous surgical haemostasis, limiting test sampling blood loss and tolerance of anaemia in haemodynamic stable patients are not "alternatives" to red cell transfusions. Indeed, to regard treating iron deficiency anaemia with iron, or not letting a patient bleed unnecessarily, as alternatives to red cell transfusions is incomprehensible, but does happen! On the other hand the use of autologous transfusion techniques, erythroid stimulating agents and anti-fibrinolytics can be regarded as transfusion alternative interventions that may have benefits, but also may bring with them hazards that need balancing in the same manner as the decision to transfuse. It is important that when balancing all the options that it is done on a "level playing field" and red blood cell transfusion should no longer regarded as the default and "safe" option when there is clinical uncertainty.

There is a compelling case for applying the precautionary principle to transfusion medicine. The "tissue transplant" of blood transfusion has always been a potentially hazardous therapeutic intervention, with numerous clearly-understood complications, some avoidable, but many not. As advocated by Bob Beale, a well known Australian blood banker, *"Blood transfusion is like marriage: it should not be entered upon lightly, unadvisedly or wantonly, or more often than is absolutely necessary.* The recognized hazards of allogeneic blood transfusion aside, the case for a precautionary approach is strengthened further with the possible, and now probable, recognition that transfusions *per se* are an independent risk factor for adverse clinical outcomes.

Continued…………,

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Why are most Red Cell Transfusion "Alternatives" the standard of care? *Guest Editorial by Professor James Isbister* - *Continued from page 1…*

Political, financial, and ethical considerations inevitably play a part in decision making in the blood sector, however, there are compelling reasons why there should be greater focus on the precautionary principle on the demand side of transfusion medicine, as there has always been on the supply side. Support for adopting a precautionary approach to the transfusion of labile blood components includes:

1. The evidence for efficacy of many blood components in a range of clinical settings, especially in relationship to haemodynamically stable perioperative patients (a large group of blood recipients), is questionable or non-existent. Randomized controlled trials of a restrictive Red Blood Cell (RBC) transfusion policy have confirmed that restrictive transfusion policies are safe and reduce adverse outcomes.
2. Inappropriate RBC transfusion practices, contrary to guidelines, persist.
3. Benchmarking studies have identified a wide variation in transfusion practices between, countries, hospitals and individual clinicians.
4. More appropriate and alternative therapies and interventions are available to avoid or minimize the use of allogeneic blood components.
5. Implementation of patient blood management is a quality and safety measure that could lead to substantial cost savings.

Primum non nocere - above all do no harm

Clinical Unit in Ethics and Health Law Seminar

Continuing a tradition commenced two years ago, the December 2010 CEUHL seminar will view the ethics video projects completed by Year 2 students in the Bachelor of Medicine Program. These videos have been shortlisted for the John McPhee prize, which will be judged on the night.

The seminar will be held on Monday, 6 December 2010 in the Royal Newcastle Centre, in Conference Room 1. Supper will be served at 6.00pm and the seminar will begin at 6.30pm. All are welcome to join us. There is no entry fee and no RSVP is necessary.

This Month's Update is on …. *The Venous Thromboembolism Prevention Initiative*

The HNE Health Venous Thromboembolism Prevention Initiative Project is a major quality and safety strategy designed to ensure all adult surgical patients receive appropriate venous thromboembolism (VTE) risk assessment and thromboprophylaxis. The project team has worked with many people across HNE Health to develop tools and guidelines that are directed towards decreasing the risk of deep vein thrombosis and pulmonary embolism. These tools and guidelines are now available on the HNE Health website at: http://intranet.hne.health.nsw.gov.au/cg/clinical_practice_improvement/vte, and include:

- ✓ A Clinical Practice Guideline (CPG) *Surgical Prophylaxis of Venous Thromboembolism in Adult Patients.* The CPG includes a VTE risk assessment tool to promote rapid patient risk stratification and risk reduction. The HNE Health VTE risk assessment tool is also now available to all HNE Health sites via Salmat.
- ✓ A Frequently Asked Questions information sheet and links to other internal and external resources.
- ✓ "*Stop the Clot*", a patient information brochure developed by the National Institute for Clinical Studies (NICS) This important educational resource for patients to reduce their risk of VTE on discharge is available to patients throughout HNE Health facilities in a number of languages. This brochure is also available via Salmat.
- ✓ A VTE education package which includes a PowerPoint presentation and accompanying study notes for the use of educators, quality managers and clinical staff.
- ✓ A handy VTE information pamphlet highlighting VTE prevention awareness for staff
- ✓

With the assistance of a dedicated project officer for six 6 months the project team was able to achieve a number of additional outcomes, including:

- ✓ Multiple VTE prevention education presentations to staff, including Belmont, Armidale, Singleton, Taree and Tamworth hospitals
- ✓ Addition of VTE education to the Junior Medical Officers' Orientation Handbook
- ✓ Development of audit mechanisms including selected *Indicators for Quality Use of Medicines in Australian Hospitals.*
- ✓ In conjunction with Area Pharmacy, support to sites engaged in the Australian Commission on Safety and Quality in Healthcare's National Inpatient Medication Chart VTE Pilot Study (Belmont, Armidale and Tamworth hospitals) to evaluate monitoring systems.
- ✓ Identification of clinical leaders within HNE Health to engage and support improved patient safety delivering the VTE risk assessment through provision of tools and education packages.
- ✓ Inclusion of a VTE section to the Electronic Discharge Referral as an internal audit and reminder prompt ensuring better practice

There has been substantial progress in establishing VTE awareness in HNE Health and the achievement of many sustainable initiatives. The leadership for the VTE prevention Initiative has returned to the Area Quality Use of Medicines Committee, who have been driving this as one of their key areas of interest.

For further information please visit the VTE web page: http://intranet.hne.health.nsw.gov.au/cg/clinical_practice_improvement/vte .

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Transport of Health Care Records within and between Health Care facilities

A new policy compliance procedure (PCP) "***Transport of Health Care Records within and between Health Care facilities"*** has been approved for implementation by all facilities and services throughout HNE Health. The document describes the procedures for transporting health care records within and between health care facilities to ensure continuity of care and confidentiality of the information contained in the record." To view the document, please go to: http://intranet.hne.health.nsw.gov.au/__data/assets/pdf_file/0003/74901/PD2005_127_PCP1_and_PD2005_339_PCP_1_Transport_of_Medical_Records.pdf

This Month's Root Cause Analysis Review

A root cause analysis was recently undertaken following the death of a patient associated with an unwitnessed fall in a residential care facility.

In the early hours of the morning, the resident was found on the floor by his bed. The initial assessment showed he had sustained skin tears to both knees and left elbow, and around 8:30am, he complained of significant left-sided chest pain with tenderness around the rib area which had arisen since the fall. The resident's family was contacted about the change in the resident's condition. During the course of the next 5-hours the resident was administered analgesia for pain, and he died at 15:30pm.

The resident had been admitted to the Residential Aged Care Facility in 2009 initially for a 4-week respite, but over time this became his permanent home due to deterioration in his health. During the first month of his stay the resident underwent three separate falls risk assessments using three different tools and risk ratings and was reported to have sustained four falls. During this period, there had also been a three-week admission to a rural referral hospital for management of a urinary infection. It was noted on his return from hospital that the resident's condition had deteriorated and he now required a higher level of nursing care. By the end of January 2010 he had slightly improved physically but it was noted that at times his behaviour was inappropriate.

The RCA team identified organisational systems issues associated with the model of care provided for the residents of this care facility, which required enhancement. They made the following recommendations:

1. To ensure that appropriate direction is provided to the multidisciplinary team in the resident admission process and that the individual needs of the resident are identified on entry to the facility resident admission, protocols should be developed using the RACGP "The Medical Care of Older Persons In Residential Aged Care Facilities – The Silver Book".
2. This admission process redesign should also include mechanisms for active collaboration between health care professionals, residents, their families and other carers.
3. A process to be developed locally based on APAC Guidelines for Medication Management in Residential Aged Care Facilities for the quality use and administration of medications for residents of this Aged Care Facility.
4. A formal review of the clinical leadership mechanisms at this residential aged care facility be undertaken to ensure that a structure was in place to foster strong relationships between the clinical team and with the residents.
5. Review of local clinical protocols to reflect the need for residents requiring acute ongoing management of illness or injury to be relocated to the acute care setting.

Clinical Governance Journal Club

In 2009 Clinical Governance commenced a monthly journal club for continuous professional development. Its objectives are to:

- ✓ enhance the learning environment within the department
- ✓ promote individual reflective practice
- ✓ develop analytical and critical appraisal skills in relation to Clinical Governance literature
- ✓ identify opportunities for quality improvement of current relevance to Clinical Governance and/or to Hunter New England Health

A list of the articles reviewed in 2010 is available at http://tintranet.hne.health.nsw.gov.au/cg/training_education_and_knowledge_development/clinical_governance_journal_club

These articles can be accessed via NSW Health Clinical Information Access Program, CIAP http://internal.health.nsw.gov.au:2001 or the HNEH library service http://www.gardinerlibrary.com/default.aspx

Our Farewells and Very Best Wishes to …

This month Clinical Governance farewells a number of staff who have recently completed their secondments, and who have seen their endeavours become part of routine practice and gain a life of their own.

During the six months that Pru Clark was with Clinical Governance she made significant achievements in progressing the Venous Thromboembolism Prevention Initiative in HNE Health, including the dissemination of the Clinical Practice Guidelines and Flow Chart and an on-line VTE education program for staff (this can be accessed at: http://intranet.hne.health.nsw.gov.au/cg/clinical_practice_improvement/vte as per *This Month's Update* on in this edition of Quality Matters). Pru returns to the Neonatal Intensive Care Unit at John Hunter Hospital. Thank you Pru for all your hard work and your continuing efforts to 'Stop the Clot'.

The HNE Health Transfusion Medicine Improvement Program has also reached maturity and we farewell Vicki Martens, who as Project Manager helped make significant achievements in the way blood transfusion is conducted across HNE Health. Vicki has returned to a role as Transfusion Scientist in Hunter Area Pathology Service, where she continues to work in this area. We wish to thank Vicki for her team work, drive and enthusiasm. The HNE Health Transfusion Medicine Improvement Program has proven a remarkable accomplishment with many quality initiatives. These can be reviewed on its website at: http://intranet.hne.health.nsw.gov.au/cg/clinical_practice_improvement/blood_transfusion

Alison Fullbrook returns to her substantive position as a Nurse Unit Manager of Operating Theatres at John Hunter Hospital after a short secondment as a Patient Safety Officer. We will miss Alison's enthusiasm and sound clinical knowledge. We wish her well and look forward to continuing to work with her in improving patient safety in operating theatres.

This month we also farewell Dr Stephen O'Mara. In 2008 Stephen joined Clinical Governance as an Associate Director while continuing his practice as a Clinical Haematologist in Tamworth. Stephen brought to the job keen clinical expertise and enthusiasm. One of Stephen's achievements was clinical leadership to our Transfusion Medicine Improvement Program, which led to substantial reductions in inappropriate transfusion and blood product wastage; increased patient awareness and consent to transfusion and reduced error in relation to management of transfusion requests. These substantial improvements were recognised when the initiative was awarded the Minister's Excellence Award in the 2009 NSW Health Quality Awards. We wish Stephen well in his Clinical Haematology practice at Tamworth Hospital, and are glad that he will continue to be involved in HNE Health transfusion medicine through the Area Transfusion Committee.

Finally, this month we say farewell to Ms Karen Mackaway, Administration Officer, Clinical Governance. Karen has moved house and so is moving on to a new role within HNE Health. She has played an important role in production of *Quality Matters*, the HNE Health Quality Exposition and Scientific Program and the day-to-day administrative support to the department. She will be sadly missed by Clinical Governance, and we wish her well in her new role and her new home.

Christmas Quiz

ISBAR? Yes we can!

For all creative types, here's a way to unleash your potential *and* have some impact!
The quiz this year is a competition for the staff member, student, volunteer or contractor who best re-styles into an ISBAR format, an information sheet, or a form of some sort, or a sign, or any other kind of health-related written communication.

One prize will be for the *"most improved"* category - where complexity of expression has been made simpler, or where the important message, perhaps originally buried beneath words, has been made clear. The second prize will be for the *"most creative"* category - if a picture is worth a thousand words, have a go to come up with five lines of introduction, situation, background, assessment and recommendation….You may see your creative genius reproduced for all to use! Prizes will be movie tickets or a book voucher.

Please send your "before" and "after" and the nominated category (*"most improved"* or *"most creative")* by 17 December 2010 to clinicalgovernance@hnehealth.nsw.gov.au. The judges' decision will be final. For more information please contact Juliana Ford, ISBAR Project Manager, Clinical Governance on 4985 5820.