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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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From the Director...

*Welcome to the May 2011
Edition of Quality Matters.*

This month's edition focuses on medication safety and quality use of medicines. Our thanks go to our Guest Editor, Dr Margaret Lynch, who provides a timely reminder of the importance of communication to medication safety.



The date of the next Annual Quality and Scientific Program is nearing (20-21 September 2011), and all our speakers are now all locked in. The 2011 theme is *Clinical Effectiveness*, and the details of speakers will be published shortly. More information about this event will be in the June 2011 edition of Quality Matters

Dr Kim Hill
Director Clinical Governance

Matching Medications

Guest Editorial by Dr Margaret Lynch, Clinical Director GP Access After Hours
Medication Safety Week provides a timely reminder of the importance of clear communication, and the need for checking and clarification, of what medications patients *should* be taking, in what way, at what time, and comparison with what medications *are* being taken, in what way and at what time. This is most important at transition points in care, especially on admission to, or discharge from, hospital, where the risk of medication error is highest, resulting in significant patient morbidity, mortality, and substantial cost to the health system.¹

In an ideal world patients would have an understanding of what medications they were taking, and why, and would communicate this clearly with treating clinicians. They would appreciate that generic medications may have many different brand names but the same active ingredient. They would never inadvertently take a double dose of beta blockers after a different generic brand was dispensed and they had two packets of beta blockers, each with a different brand name.

In the same ideal world, hospital discharge summaries would reach the patient's GP on the day of discharge, clearly outlining reasons for any changes in medications. Patients would understand the need to see their GP for review before the hospital supplied medication ran out, and they would have no problem obtaining an appointment for this. They would always see the same GP, or same practice. They would always have their prescriptions dispensed by the same community pharmacy. The GP and the community pharmacy would have effective systems in place to ensure changes in medication regimes were communicated to all parties, clarified where necessary and current medication lists kept up to date and provided for the patient to carry.

The challenge for all clinicians is to implement the "ideal", where possible, in the real world, but also to be able to compensate when patient understanding, access to care, and continuity of care are less than ideal.

¹ Primary Health Care Research & Information Service. (2010). RESEARCH ROUNDup: Continuity and safety in care transitions: communication at the hospital/community care interface. Ed: S Muecke, L Kalucy. Adelaide: PHC RIS, Issue 11, May [Online] http://www.phcris.org.au/phplib/filedownload.php?file=/elib/lib/downloaded_files/publications/pdfs/news_8330.pdf



This Month's Update is on....***MATCH UP - Medication Reconciliation Prevents Harm***

HNE Health is again focusing on Medication Safety throughout the month of May. This month's focus is on raising awareness of the importance of medication reconciliation. Evidence shows that up to two thirds of medication histories have errors, and a third of these errors can cause harm. To help promote awareness of this important issue, Angela Smith from the HNE Health Libraries has supplied these reference articles. (Simply click on the link to access the full-text.)

Don't forget the Library is an invaluable resource for assisting you with a full range of information services including, database searching, article provision and research services tailored to your individual needs. Please contact the Library on x13779 or visit www.gardinerlibrary.com.

[Making inpatient medication reconciliation patient centred](#) *Joint Commission Journal on Quality and Patient Safety*. 2010;36: 504-13.

[A Reengineered hospital discharge program to decrease rehospitalisation](#). *Annals of Internal Medicine*. 2009; 150:178-97

[A literature review of the individual and systems factors that contribute to medication errors in nursing practice](#). *J. Nursing Management* 2009; 17:679-697.

[Medication Reconciliation: what every nurse needs to know](#). *AORN Journal*. 2007; 85: 193-196 [Medication Reconciliation](#). UpToDate

Note: If a link opens at an index page, please follow the instructions below:

1. Accept subscription and licence agreement
2. Type Medication Reconciliation into the search engine
3. Click on Hospital Discharge and then on Medication Reconciliation on the topic outline toolbar.

Clinical Unit in Ethics and Health Law Seminar

Dr Peter Saul, Intensivist at John Hunter Hospital will present the June 2011 CUEHL seminar. Dr Saul will be presenting a paper entitled "Futility...increasingly a waste of time". This is a discussion around the challenges facing clinicians about ensuring that the medical treatment they provide is patient-specific and not just disease-specific. In a climate of increasing technology and treatment options, Dr Saul questions whether there is increasing pressure to do more rather than better.

The seminar will be held on Monday 6th June 2011, in Conference Room 1 at the Royal Newcastle Centre. Supper is at 6.00pm and the seminar will begin at 6.30pm. All are welcome – there is no entry fee, and no RSVP is needed.

This Month's Root Cause Analysis Review

In this month's root cause analysis report, a 72 year old man had a needle inserted into the chest on the wrong side during treatment of a pneumothorax.

In June 2010, this patient presented to an Emergency Department reporting a sudden onset of shortness of breath. Chest x-ray confirmed a spontaneous right-sided pneumothorax (collapsed lung). It was decided to insert an intercostal catheter to promote re-inflation of the lung.

Following intravenous sedation prior to the procedure, the patient developed respiratory depression, and a rapid response call was activated. During the rapid response, it was thought the patient's reported pneumothorax may have been under tension. However, the large bore needle was initially inserted into the incorrect (left) side of the patient's chest. Subsequently, insertion of right-sided intercostal catheter was completed. A further X-ray showed a new left pneumothorax as a result of the needle decompression and a left intercostal catheter was then inserted.

The RCA review noted that the Emergency Department had been operating at capacity at the time of the episode. There had been miscommunication about the correct side of the pneumothorax during the rapid response call. Senior staff were delayed in providing direct supervision due to the resuscitation of a critically ill patient in another resuscitation bay. The treating doctor considered that administration of a sedating agent was routine practice prior to the insertion of an intercostal catheter.

As a result of this RCA, the following recommendations/actions have been addressed:

1. Local guidelines and protocols have been reviewed to ensure that NSW Health Policy Directive 2007_079 "Correct Patient, Correct Procedure, Correct Site" is implemented successfully within the Emergency Department. (A copy is available at http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_079.pdf)
2. A narcotics learning package for ED nursing staff has been introduced
3. The hospital will review the Junior Medical Officer Package on safe prescribing and administration of intravenous sedation and the need for supervision when giving sedation in the Emergency Department.
4. An intercostal catheter learning package for ED nursing and medical staff has been introduced.