

Quality Matters

*The monthly newsletter of the
Hunter New England Health
Clinical Governance Unit*

FROM THE DIRECTOR

This month we continue the theme of clinical practice improvement, particularly around Quality Use of Medicines and Correct Patient, Correct Procedure and Correct Site.



Dr Kim Hill
Director
Clinical Governance

The main focus of the Quality Use of Medicines strategy in past months has been around the introduction of the National Inpatient Medication Chart and it is a tribute to all those involved that Hunter New England Health has successfully identified and addressed many of the complex issues relating to its introduction. Further work in area-wide clinical practice guidelines and medication safety initiatives will be flagged in subsequent editions of *Quality Matters*.

The work on Correct Patient, Correct Procedure and Correct Site has focused on operating theatres and imaging services and I would like to take this opportunity to also thank those involved in this work. Ensuring that every interaction with patient care is consistent with the principles of Correct Patient, Correct Procedure and Correct Site practice remains our priority, as this work continues to expand across our Health Service.

I hope that you will find this month's edition of *Quality Matters* informative and useful.

How are we improving medication safety?

The National Inpatient Medication Chart (NIMC) was implemented across Australia from 1 January 2007. During the implementation phase, an audit was conducted across NSW to assess compliance with specific safety aspects of the NIMC. The audit included 13 sites from across HNE Health. The audit was repeated across HNE Health in February and March this year involving 44 facilities, over 1600 charts and covering close to 14000 medication orders. Results in the five performance areas of the audit compared to the 2006 NSW Health State average indicate HNE Health is close to the state average in several of the indicators

Results indicate the following:

- 47% of medication charts had complete patient identification (NSW Average 49%).

- 68% of medication charts had either allergies/ADRs documented or 'nil known allergy' in the ADR box identified (NSW average 70%).
- Approximately 78% [range 42% - 100%] of medication orders had the frequency of dosing clearly identified and correct (NSW average 80%).
- On 46% of occasions [range 0% - 100%] HNE Health prescribers are entering times for regular medications (NSW average 59%).
- For patients prescribed warfarin, the target INR is documented on 43% of charts (NSW average 63%).

These results will be reported through the Area Quality Use of Medicines Committee and its associated frameworks to develop strategies to improve compliance.

For more information contact: Pauline Dobson CNC, Project Officer HNE Health NIMC ph - 4922 3464.

Note: A paediatric version of the NIMC is now available. For more information contact: JHH Pharmacy ph 4932 13636 or Jennifer.Macdonald@hnehealth.nsw.gov.au

How are we making procedures safer?

Incorrect patient, incorrect procedure, incorrect site and use of incorrect implants are relatively uncommon adverse events in healthcare but are often devastating when they occur, not only for the patient and their families but also for the staff involved.

In November 2004 NSW Health released the [Correct Patient, Correct Procedure, Correct Site Model Policy](#) based on best practice principles identified by the Royal Australasian College of Surgeons, the Veterans Administration and Joint Commission on Accreditation of Healthcare Organisations in the USA.

Editorial team: Dr Kim Hill, A/Prof Anne Duggan, Ms Trish Blackman, Ms Alisa Johnson.
Comments and queries welcome at: clinicalgovernance@hnehealth.nsw.gov.au

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The policy outlines five steps to be taken to ensure that the indicated procedure is performed on the correct patient at the correct site and if applicable, with the correct implant. For more information go to: <http://www.health.nsw.gov.au/quality/correct/faq.html>

There has been an area working group established to develop implementation strategies around the framework. This group has developed a communication strategy, clinical procedures and specific educational tools and audit tools.

NSW Health, with the assistance of the working group, has developed a state-wide audit tool to be used to monitor compliance with the implementation of the policy directive. Strategies are currently being developed in regards to how this is to be implemented across the Area.

The area working group is chaired by Tonia Easton (Area Quality Manager) and focuses on implementation within the operating theatres. A sub group of the area working group has been formed to look at implementation strategies specifically within the diagnostic and imaging services. Dr Naomi Lee (Associate Director - Southern) chairs this group. For more information contact: Naomi.Lee@hnehealth.nsw.gov.au or 49 85 5446 or Tonia.Easton@hnehealth.nsw.gov.au or 6767 7233.

IN PROFILE:

Rosemary Aldrich, Associate Director

A journalist for eight years before qualifying as a doctor and subsequently as a specialist physician in public health, Rosemary has been working in Clinical Governance since 2004. She has extensive experience in health policy and health services research and management and teaches public health as a conjoint senior lecturer at the Universities of Newcastle and NSW. Between 2000 and 2005 Rosemary was a member and later Deputy Chair of the NHMRC Health Advisory Committee - and between 2003 and 2005 a member of the NHMRC Research Committee. She was chair of the steering committee of the Australasian Cochrane Centre from December 2004 until March 2007. In April 2007 Rosemary graduated from UNSW with a PhD in which she had examined the relationship between politicians' values and beliefs and health policy. Among other roles, Rosemary leads the Clinical Governance team supporting organisational policy development and management.



AROUND AND ABOUT:

The Clinical Excellence Commission's Medication Safety Self Assessment is specifically designed to help hospitals take a proactive and system-based approach to medication safety. HNE Health is about to assess its performance against others and identify opportunities for safer medication practices. For more information go to: http://www.cec.health.nsw.gov.au/mssa/ISMP_introduction.html

Quality Improvement Awards 2007

Nominations are currently being called for submission to the following Quality Awards:

1. Hunter New England Health Quality Awards
2. NSW Health Awards
3. Australian Council on Healthcare Standards (ACHS)
4. Premier's Awards

An internal review panel will be convened to review entries consisting of representation from: Clinical Governance, Communication and Stakeholder Engagement, Organisational Capability and Learning, a senior clinician and the Area Executive Team.

Entries that meet the awards criteria will be eligible for entry into the HNE Health Quality Awards, as well as entry into the ACHS and Premier's Awards.

The closing date for all entries is **Friday, 8 June 2007**

For more information about upcoming awards go to: http://intranet.hne.health.nsw.gov.au/cg/quality_improvement_including_continuous_practice_improvement/quality_awards

RCA UPDATE:

In 2006, an RCA team who reviewed a neonatal resuscitation identified communication and procedural issues and made recommendations now adopted:

- Neonatal resuscitation trolleys are now standardised across John Hunter Hospital delivery suite, operating suite and Neonatal Intensive Care Unit (NICU).
- An equipment review led to placement of essential equipment in designated equipment drawers. A standardised equipment checklist underpins this.
- A proforma to standardise and simplify documentation of resuscitations has been developed, supported by an evidence-based flow chart to guide action.
- Communication when back-up is required has been improved with a designated respondent, DECT phone, and proforma for detailing assistance required.

Staff report that resuscitation is now easier and more efficient and a rapid response easier to obtain when backup is needed. This RCA is a good example of a multidisciplinary approach involving several departments. These recommendations will now go area wide and be evaluated in the future.

Safety alerts and notices:

For more information click on the hyperlink

Number	Type	Issues covered	Date of issue
SN:007/07		Therapeutic Goods Administration (TGA) Recalls	18 Apr 07
SN:006/07		Warfarin	12 Apr 07

<http://www.health.nsw.gov.au/quality/sahs/register.html>