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# Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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## From the Director...

In this edition we profile the 2009 HNEH Quality Awards finalists. Our congratulations go to the finalists, and to all project teams who participated. This year there were 87 applications, of which 49 applications went forward for our External Judging Panel's view. This was a record number of submissions and the high quality of projects reflects the skill and dedication of HNEH healthcare staff involved in them. The winning



projects will be announced at

the Annual HNEH Quality Awards Dinner, on 10 September 2009.

I would also like to invite you to the 2009 HNEH Quality Exposition and Scientific Program on Thursday 10 September and Friday 11 September 2009. This year's themes are about human factors and their impact on safety and quality. Registration is now open, and I hope to see you there.

**Dr Kim Hill**  
Director Clinical Governance

### And the finalists are....

| Category  | Facility/Service  |
|---|---|
| <b>C1. Promoting Health</b>   |   |
| Postcards reduce repeat suicide attempts                                | Calvary Mater Newcastle                                       |
| Follow-up of Fallers Presenting to ED                                   | Rankin Park Centre<br>Greater Newcastle Cluster               |
| Interactive Hazard House  | McIntyre Cluster – Inverell<br>Community Health               |
| <b>C2a. Improving Quality and Safety</b>                                |   |
| Pressure Ulcer Prevention, a Crystal Clear Solution                     | Hunter New England Health                                     |
| Identification of the deteriorating patient - A rural hospital response | Moree District Health Service                                 |
| The Tamworth Hospital Medical Emergency Team Intervention               | Tamworth Rural Referral Hospital                              |
| Transfusion – savings through safety                                    | Clinical Governance   |
| <b>C2b. Improving access to services, when, and where needed</b>        |   |
| Reducing Length of stay for women who present as outpatients            | John Hunter Hospital  |
| Advancing the Enablement Philosophy at The Maitland Hospital            | The Maitland Hospital   |
| RIMS Managing Outpatient Waitlists                                      | Ambulatory Care/Referral<br>Management Service, RNC           |
| <b>C2c. Improving the patient experience</b>                            |   |
| Improved recognition of pain and distress in oncology outpatient        | Calvary Mater Hospital Newcastle                              |
| Difficult but not impossible - Pathway for improved End of Life         | Lower Hunter Cluster  |
| ISBAR- a tool for improving communication with patients                 | Clinical Governance   |
| <b>C3. Improving Primary Health and Care in the Community</b>           |   |
| Aboriginal Mothers & Babies Service                                     | Armidale Community Health                                     |
| Partners in depression A group education program for families           | Hunter Institute of Mental Health                             |
| Building capacity between HNE Eating Disorder Services and GPs          | Centre for Psychotherapy                                      |
| <b>C4. Building Partnerships for Health</b>                             |   |
| Marrung Tiddas Beautiful Sisters  | Taree Community Health – Sexual<br>Assault Service            |
| <b>C5. Making Smart Choices</b>   |   |
| Efficiency in Occupational Therapy Home Modifications                   | Lower Hunter Cluster  |
| Improving the clinical relevance of cardiac and stroke data             | Cardiac and Stroke Outcomes Unit,<br>Planning and Performance |
| <b>C6. Building the Health Workforce</b>                                |   |
| Building the health workforce - RADIWEB Sharing Education               | Radiology Department JHH                                      |
| Developing a Sustainable Effective Paediatric Service                   | Manning Rural Referral Hospital                               |
| Pilot of Senior Leader Capability Mapping                               | Organisational Capability & Learning                          |
| Unqualified Allied Health Assistants e-Recognition Project              | Organisational Capability & Learning                          |
| <b>C7. Being Ready for New Risks and Opportunities</b>                  |   |
| Exercise Forrest Gump prepares NSW for influenza pandemic               | Population Health   |
| Scope of Clinical Practice Data Base - SCOPRAC                          | Medical Workforce Development                                 |



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

*Mr Chris Smith, Patient Safety Officer*

In 2005 Chris joined Clinical Governance after moving from Sydney. Prior to this Chris worked for 9 years in Sydney in non government services specialising in adolescent and family counselling, and juvenile justice. Following this Chris worked with people with disabilities and mental health issues (dual diagnosis) including developing tools for case management of complex cases in the community.



During this time Chris completed undergraduate degrees in Social Welfare and Social Sciences and a Master of Commerce Employment Relations looking at improving client outcomes through profiling attitudes staff brought to decision making processes in the day to day care and management of their clients. The Department of Community Service's Change Management team subsequently recruited him to help review behavioural programs and service management and to identify opportunities for better services for clients with disabilities.

In 2000 Chris moved to the Spastic Centre of NSW and assisted the delivery of service to people with cerebral palsy and other disabilities.

Chris is interested in identifying the reasons for human error in clinical care and how to better assist clinicians and services to implement practice changes and improve service delivery to reduce harm.

## **Root Cause Analysis (RCA) review**

### **Incorrect Labeling: A Common Communication Error**

*Mixing up labels on forms and specimen containers continues to be a major cause of incidents, at times with serious repercussions. Dr John Fisher, FRACS, Associate Director Clinical Governance, reviews recent root cause analyses on incorrect labeling*

Labeling errors can lead to adverse events and sometimes poor outcomes. Those that have occurred include:

- Incorrect label leading to the wrong patient undergoing the test, x-ray or treatment
- Incorrect label leading to a patient missing out on a test, x-ray or treatment
- Patient identification errors leading to the wrong patient having a transfusion
- Patient identification errors leading to a patient having the wrong medication
- Patient identification errors leading to a patient having an incorrect x-ray or CT scan with concurrent administration of contrast media

Why do these errors occur? A number of factors have been found to contribute to such errors, relating to both systems and human factors. It is safer system-wise for labels to be applied and forms completed at the bedside, not taken to a distant desk! Haste, e.g. during ward rounds, only increases the risk of inadvertent mix up of forms, names, labels and specimen containers. There is no doubt that unnecessary haste in an operating theatre can increase the chance of error. It is easy to forget that a request form for a pathology or radiology test or a consent form constitutes a legal document in terms of patient care. The medical officer signing the form (whether senior or junior) is responsible for what is ordered on the request form. Incorporating request writing into ward rounds is a good first step to reducing error.

Of all the above, the haste factor is the commonest factor in the causation of labeling mix-ups. Haste can be due to a need to re-organise one's time, and inappropriate prioritization of resources to matters of importance. There is no point in waiting for the medical records to all be computerized – even if there was time to wait, this is no magic bullet! It is our responsibility now to carry out this aspect of care of our patients with as much care and diligence we might show when doing other dramatic and interesting things in medical practice, such as operating, delivering a baby, or making a very clever diagnosis.

## **Clinical Unit in Ethics and Health Law (CUEHL) seminar**

Professor Larry Gostin, Visiting Professor of Global Health Law at Sydney University and Linda D. and Timothy J. O'Neill Professor of Global Health Law; Faculty Director, O'Neill Institute for National and Global Health Law and Professor of Public Health at the Johns Hopkins University will present the August CUEHL seminar and the second annual John McPhee Memorial Seminar. Professor Gostin will discuss "**Influenza A (H1N1) (Swine Origin): Pandemic Preparedness under the Rule of International Law**". The seminar will be held on Monday 10<sup>th</sup> August 2009 in the John Hunter Large Lecture Theatre (near the library). Supper will be provided as usual from 6.00pm, in the common room next to the library, with the seminar to commence at 6.30pm. All are welcome to join us and entry is free.

*Please note this month's venue and date changes as above*

## **Quality System Assessment (QSA) Program**

The Quality Systems Assessment Program (QSA) is a self-assessment survey designed to assess the effectiveness of current systems and processes in managing risks to patient safety and assuring quality patient care.

This year's questions focus on medication safety, the deteriorating patient, clinical handover and communication – areas the 2007 survey identified as high priority.

This year's self assessment occurs in August 2009. Clinical unit, facility and network managers will be asked to complete the self assessment in consultation with doctors, nurses, allied health and support staff. Junior clinical staff involvement is encouraged.

For more information on the QSA click on [Fact Sheet](#) here or on the Clinical Governance website, or Debora Lawson, on 49855845 or at [debora.lawson@hnehealth.nsw.gov.au](mailto:debora.lawson@hnehealth.nsw.gov.au)