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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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Ms Barbara March
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From the Director...

The Fourth Annual HNE Health Quality Exposition and Scientific Program held in Newcastle in September 2009 was our most successful event to date, if the feedback from the audience is our measure.

Our eight speakers covered the themes of human factors, error and systems from a wide range of perspectives, including clinical appropriateness, themes from complaints management and the impact of open disclosure. The power and position of nutrition engaged, while



public health and public policy were common themes. This year, the presentations will be available through the Clinical Governance website, as will a recording of each, for those who may wish to listen to the speakers again,

or for those of you who couldn't be there, to hear them for the first time.

This was also our largest meeting, and the booths and poster sessions were the subjects of positive feedback.

To celebrate the event, we have in this month's *Quality Matters*, an excellent guest editorial from one of these speakers, Dr Shelly Jeffcott, who is undertaking research into the field of human factors and systems resilience.

I hope you enjoy this month's edition.

Dr Kim Hill
Director Clinical Governance

What can the Human Factors Concept of "Resilience" offer Healthcare?

Guest Editorial by Dr. Shelly Jeffcott, Senior Research Fellow, Centre of Research Excellence in Patient Safety, Department of Epidemiology and Preventive Medicine, Monash University, Melbourne and Invited Speaker at this year's HNE Health Quality Exposition and Scientific Program

In high-risk industries accidents happen. To err is human. We must accept that human fallibility is inevitable and systems are not perfect. But we can optimize the ways that people work and limit the number of accidents that occur.

So-called 'High Reliability Industries' or HRO's¹ have long been held up as an example for healthcare, since they carry out similarly high consequence processes with very low levels of catastrophic failure. However, as it is increasingly being argued in the safety science literature, the complexity of healthcare - with its high level of variability, production pressure and professional autonomy, alongside comparatively low degrees of regulation and education around error, event reporting and safe culture - presents obstacles which may be insurmountable in terms of achieving such enviable standards of HRO "safe" practice.

Nonetheless, the scientific discipline of human factors, which draws together psychology, engineering and ergonomics (amongst others) to the study of interactions between people, technology and their work environments, can provide much benefit to those interested in tackling key patient safety concerns. A key human factors concept is "resilience", which investigates how individuals, teams and organisations monitor, adapt to and act on failures in high-risk situations.² Although it is a new concept to healthcare, it is well accepted in other high-risk industries. Resilience moves the focus away from "What went wrong?" to "Why does it go right?", that is, it shifts emphasis from simplistic reactions to error-making, toward valuing a proactive focus on error-recovery. Resilience is a better match for healthcare settings than the principles for high reliability because it more effectively addresses the unique complexities of health care and does not seek to standardise or simplify in the way that high reliability approaches often promote.

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***In profile....* Laura Juratowitch Quality Analyst, Clinical Governance**

Laura has been with Clinical Governance for over 5 years. She describes her primary role as assisting the Area Quality Manager in the area of systematic data collection strategies. Laura develops project management tools such as clinical audit tools, surveys and evaluation strategies to assist in providing evidence to meet strategic goals.

To build capacity and facilitate the development of sound data collection, Laura provides information application support as software administrator for paper based electronic automatic data capture systems (Teleforms) and other online survey tools (Select Survey).

Laura has worked in data positions with Stroke and Acute Coronary Syndrome with the Towards a Safer Culture project, the Older Person's Model of Care project, the ISBAR (Introduction, Situation, Background, Assessment, Recommendation) Inter-hospital Transfer Communication project and a brief secondment working with staff on learning and development reporting.

Laura considers the most public aspect of her position is as a contact officer for the annual HNE Health Quality Awards process. "This is an absolute highlight of the year to be part of a process that recognises strategically aligned improvements and innovations across the Area and the staff who made it happen", says Laura.

Prior to working in HNE Health, Laura worked at the Northern Territory University, the Australian National University's North Australian Research Unit and the Northern Territory Department of Education.



Performance Reporting and Australian Council on Healthcare Standards surveys

In line with Hunter New England Health's commitment to open and transparent communication with the community, the Area Health Care Quality Committee has agreed that in addition to the placement of EQUiP accreditation performance statements on the Australian Council of Healthcare Standards (ACHS) website, all HNEH facility accreditation survey reports will be made available on the HNE Health internet.

The Area Health Care Quality Committee has endorsed a HNEH Policy Compliance Procedure to describe the process for approval of ACHS accreditation performance statements prior to their submission to ACHS and to outline the process for review and approval of accreditation survey reports prior to public release. For more information please contact Ms Dianne Dolan in Clinical Governance, on 4922 3797.

Root Cause Analysis

Mental Health – the need for co-ordination and continuing care

The deterioration of a patient, if undetected, can lead to adverse events, even death. In a recent root cause analysis (RCA) involving rural Mental Health, the lessons learned were that identification of the deterioration of a patient may not only rely on close monitoring of the patient's vital signs but also on systems for management of the patient's clinical care and the communication processes for clinical handover.

Leave replacement for unexpected and unplanned staff leave is sometimes difficult, especially in rural areas. The RCA found that in the weeks prior to the patient's death, the service's systems for the identification of the deteriorating patient were greatly dependent on the Community Mental Health Case Manager allocated to the care of the patient. The Service did not have in place processes by which a patient's deterioration was easily identified and the care adjusted accordingly in circumstances where the Case Manager had to take unexpected extended leave.

Communication was also identified as being a contributory factor in detecting the patient's deteriorating condition, as there was limited information in the patient's medical record, and handover did not occur due to the short notice of the leave. This meant that the person covering was not aware of the case management plan or current mental state of the patient.

This RCA concluded that the loss of continuity of care caused cascading oversights, which ultimately resulted in a serious adverse event. It was recommended that a formal clinical handover process and improved documentation requirements be mandated to prevent any repeat incidents.

Farewell to Tonia Easton

It is with regret that we advise that Tonia Easton has left Hunter New England Health, and her role as our Area Quality Manager.

Tonia was appointed Area Quality Manager in August 2005, and came to the position with vast experience and expertise in quality improvement, clinical audit, clinician engagement and educating for quality, bringing these skills and so much more to her colleagues and workplace.

We will all very much miss Tonia's compassionate, generous and ever-patient support in all matters concerning quality and safety. Tonia and her husband, Ian, have now opened an art gallery in Tamworth, and we know that Tonia will excel in her new career, again centered on her joy in working with people. Please join us in wishing Tonia and Ian Mason a happy and prosperous future.

A farewell has been arranged in Tamworth on 9 November 2009. Further details will be circulated shortly via Clinical Governance.



What can the Human Factors Concept of “Resilience” offer Healthcare?

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Resilience embodies a new philosophy relevant to healthcare because many errors are caught before they reach the patient. Yet, we have little information on the system and process-related factors that help correct these errors.³ Recent studies in healthcare demonstrate the merits of adopting a resilience-based strategy in this domain.⁴

One particular study demonstrated the effectiveness of asking critical care nurses to reflect on their role in preventing, intercepting and correcting errors. Forty-four percent of errors involving medication administration and 31% of procedural errors – both in the Intensive Care Unit over a 28 day period - were discovered, thus preventing harm to patients, by registered nurses. These types of investigations, set within specific “problem” domains and related to high-risk processes, should help to pave the way for deeper examination of how such recovery is achieved, can be better supported and, even trained for, in real and simulated settings.

In summary, resilience can benefit patient safety efforts because it represents a change in emphasis from a traditional, reactive focus on errors, to seeing humans as a defence against failure. Translating this concept into practice requires identifying and testing mechanisms for measuring and for building resilience within complex healthcare processes.⁵

1. Weick K, Sutcliffe K. Managing the Unexpected: Assuring High Performance in an Age of Complexity. San Francisco, USA: Jossey-Bass; 2001.
2. Hollnagel E, Woods D et al. Resilience Engineering. Abingdon, UK: Ashgate; 2006.
3. Leape L, Bates D et al. Systems Analysis of Adverse Drug Events. ADE Prevention Study Group. JAMA1995; 274: 2314-6.
4. Rogers A, Dean G et al. Role of Registered Nurses in Error Prevention, Discovery and Correction. Quality and Safety in Health Care 2008; 17: 117-121.
5. Jeffcott S, Ibrahim J et al. Resilience in Healthcare and Clinical Handover. Quality and Safety in Health Care 2009; 18: 256-260.

Recording Open Disclosure

A recent audit of medical records highlighted that there is poor documentation and compliance around Open Disclosure discussions. At the time of the initial Open Disclosure, the minimum information that should be documented in the patient medical record is *who conducted the Open Disclosure, who did they speak to* and a brief overview of *what was said*. This information is very important for those who may be involved in continuing contact with the family/patient.

Following advice from staff, Clinical Governance is introducing a process to assist staff in recording open disclosure discussions. The first part of the system is completed by the person conducting initial Open Disclosure (Part A) and the second phase (Part B) is completed at the time of feedback of the RCA findings to the patient or family. These records will be held with the final RCA report in Clinical Governance.

For further information go to NSW Health Policy number PD 2007_40 http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_040.pdf.

Junior Doctors on Root Cause Analyses

With the support of Professor Michael Agrez, HNEH Interns have just commenced an exciting new program that will be part of their curriculum. They are currently attending education around Clinical Governance, with particular reference to incident management and its role in quality of clinical care. The practical component of this will be participation in a Root Cause Analysis team. The program is designed to:

- Develop leadership skills
- Improve investigation skills
- Give insight into system error and its impact on patients and families, as well as on staff involved
- Develop reflective practice skills, including system vulnerabilities and human factors that may impact on decision making

Reports available

The Clinical Governance quarterly reports for April 2009 to June 2009 can be viewed by clicking on their hyperlinks:

- [Clinical Quality and Patient Safety Performance Report](#)
- HNE Health [Complaint Performance Indicators Report](#)
- HNEH [Incident Management Report](#)

Safety Alert Bulletins

For more information, go to <http://www.health.nsw.gov.au/quality/sabs/>

Number	Type	Issues covered	Date
SA:004/09		New Version of Adult National Inpatient Medication Chart [NIMC] - SMR140	16 Sep 09
SN:018/09		Reducing Incidents Involving Tracheostomy Tube Care_PD2006_098 Tracheostomy - Unavoidable early (<72 hours) Tracheostomy Tube change To be read in conjunction	16 Sep 09
SN:016/09		Safe Instrumental Birth	28 Jul 09
SN:014/09		Retained or Broken Orthopaedic Surgical Equipment in Patients	9 Jul 09
SA:003/09		Draeger Medical Babylog 8000 Plus Neonatal Ventilator	26 Jun 09