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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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Clinical Governance*

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From the Director...

Welcome to our *Quality Matters* for April 2011.

Planning for the 2011 Annual Quality and Scientific Program is now well underway, and a *Save-the-Date* notice for this event is included in this edition. Last year's event was a great success, with eight excellent speakers from a variety of clinical and academic backgrounds.

This year's theme is about Clinical Effectiveness, which is very much



an important component of clinical practice improvement. There will be an opportunity to see poster displays of the best of the Quality Awards entries for 2011, and building on last year's success, there will be a number of booths to visit in breaks.

I do hope that you will be able to join us at this event in 2011.

Dr Kim Hill
Director Clinical Governance

When is a Team not a Team?

Guest Editorial by Dr Tony Austin AM, recently Acting Associate Director Clinical Governance

On 2nd April 2005, a Royal Australian Navy Sea King helicopter crashed on the Indonesian island of Nias. The eleven Australians on board that aircraft were providing health support to the local population following a devastating earthquake. Nine people died in that crash including three friends and colleagues – an Air Force doctor, a nurse and a medic.

These people had been working together, with colleagues from the Navy, for several weeks in very challenging circumstances. They were not new to this type of work and they had quickly bonded to become a highly professional and effective team. They were doing great work and their efforts had captured the world's attention but in a few short minutes this team was destroyed when their aircraft developed such a severe fault that recovery was impossible. Only two people survived the crash and both sustained major injuries that have changed their lives forever.

Why did this happen? It happened because of another place and another team. No one in that team went to work intending to hurt anyone and they were all qualified for the jobs that they were doing but something was missing – they were cutting corners, ignoring policies and assuming that everything would be just fine. Was it just one 'bad apple' in the group? The evidence is that this was not the case, the responsibility was shared.

The consequences were tragic and can never be undone. Yes, there were many systems issues and the final review was damning of many Navy maintenance practices but the fact remains that a team of people who were trying to do a good job got it horribly wrong.

Can I ask you to look around you? What sort of team do you see? What sort of team is yours like? To which team would you like to belong?

This is not a rhetorical question because you can shape that team! It is your attitudes and actions that help to form the ethos of the team and you can make a difference. For the sake of our patients, our families and ourselves, we need to constantly monitor our work teams and our values, and never let either slip. It is a great feeling when you are a member of a great team.



QualityMatters

This Month's Update is on....the HNE Health Annual Quality Awards

The Hunter New England Health Quality Awards recognise the best of staff achievements in improving quality of care and health service delivery each year. All HNE Health staff, contractors and volunteers are eligible to submit entries. In 2011, this will include all who are currently part of HNE Health, as well as those who were previously part of HNE Health and are now part of the Health Reform Transitional Organisation (Northern).

The Hunter New England Health Quality Awards are the internal filter to the NSW Health Awards. Entries for the NSW Health Awards enter into the Hunter New England Health Quality Awards for judging, with selected entries then chosen for entry into the NSW Health Awards. Official advice regarding the 2011 NSW Health awards process is still pending – however, the HNE Health Executive have decided to commence the HNE Health awards now in order to meet the timelines for the Annual HNE Health Achievements Awards.

Clinical Governance coordinates the organisational procedures of Hunter New England Health entries internally, and to all external awards such as the NSW Health Quality Awards, the Australian Council on Healthcare Standards (ACHS) Awards, and NSW Premier's Awards.

More information including application form, information sheet and entry criteria are available on the Clinical Governance webpages at <http://intranet.hne.health.nsw.gov.au/cg/Quality/Awards>. Entries close on Monday 16 May 2011.

For further information contact Clinical Governance:

Elizabeth Dewhurst, Administration Assistant on email Elizabeth.Dewhurst@hnehealth.nsw.gov.au or phone 49214772, or

Dianne Dolan, Acting Area Quality Manager on email Dianne.Dolan@hnehealth.nsw.gov.au or phone 4922 3797.

Clinical Unit in Ethics and Health Law Seminar

In May 2011, Julie Robotham, a medical correspondent for the Fairfax newspapers, will discuss the subject " A journalist's approach to a complex ethical issue: the case of dying in acute care".

This should be an outstanding seminar, and everyone is encouraged to attend. As usual, supper will be provided at 6.00pm in Conference Room 1 at the Royal Newcastle Centre, with the seminar to follow from 6.30pm. There is no entry fee and all are welcome.

HNE Health Quarterly Incident Management Report

The HNE Health Quarterly Incident Management Report provides high level analysis of clinical incidents which have been identified, reported and managed across the Hunter New England Local Health Network in the last quarter. The report also shows trends between the current reporting period and the same periods for the last three years, as well the organisation's performance against state benchmarks. It is published quarterly by Clinical Governance.

Each quarter, a detailed analysis is undertaken on one specific type of incident. In this quarterly report, detailed analysis of Medication Incidents has been provided by the Medication Safety Project Pharmacist. The report can be accessed at:

http://intranet.hne.health.nsw.gov.au/cg/patient_safety_incident_management_and_open_disclosure

The provision of reports such as this is in support of continuous improvement in quality and safety initiatives within HNE Health. If you would like further information about this report, or to forward any comments about it or incident management in general, please contact Ms Barbara Rodham, LHN Patient Safety Manager, on telephone 4921 4927 or via email at Barbara.Rodham@hnehealth.nsw.gov.au .



MAY – Medications and You

HNE Health is again focusing on Medication Safety throughout the month of May.

This is a time for all staff to champion any medication related initiatives they have implemented over the past 12 months, and also to learn more about medication safety and patient care. This year the theme will be “*MATCH UP – Medication Reconciliation Prevents Harm*”. Evidence shows that up to two thirds of medication histories have errors, and a third of these errors can cause harm.

Dr Margaret Lynch will be the guest speaker at JHH Adult Medical Grand Rounds on 19th May 2011. Margaret is a Newcastle general practitioner and Clinical Director of GP Access After Hours, and will be providing her perspective of the clinical implications when there is a breakdown in medication reconciliation between community and acute care settings.

JHCH Paediatric Grand Rounds on 17th May 2011 will also focus on medication safety issues and across HNE Health, resources will be made available for education for medical and nursing staff on the use of approved abbreviations and the correct use of medication patches.

This Month’s Root Cause Analysis Review

An 83-year old patient suffered cardio-respiratory arrest and death following probable aspiration of fluids onto the lungs.

By way of background, the patient was brought to hospital having reported vomiting for three days. His medical history included chronic obstructive lung disease, ischaemic heart disease, diabetes and previous surgery of surgery for bowel cancer. On admission, x-rays showed multiple distended bowel loops consistent with small bowel obstruction.

He was admitted to a surgical bed, to remain nil by mouth with a nasogastric tube for bowel decompression; and was prescribed anti-emetics and analgesia for nausea and pain. Over the ensuing days, the patient required clinical review and Rapid Response calls on multiple occasions. Diagnoses made on these occasions included sepsis treated with antibiotics, atrial fibrillation (rapid uncontrolled heart rate) treated with medication to control the heart rate, low urine output due to dehydration treated with intravenous fluids, fluid overload treated with diuretics and a distended stomach due to a blocked nasogastric tube. On the latter occasion the nasogastric tube was removed with the intention of replacing it, and in the interim the patient received his usual sedative to help him sleep. Before the nasogastric tube was replaced, the patient vomited a number of times and a Rapid Response call was made as the patient was unable to maintain his airway and required intubation. The possibility of aspiration of vomitus into the lungs was considered the cause of the patient’s deterioration and a nasogastric tube was re-inserted to reduce further vomiting and aspiration. Plans were made to retrieve the patient to ICU at a tertiary referral hospital but despite ongoing resuscitation efforts the patient deteriorated and died.

The RCA review assessment was that during this patient’s three-day admission, he was seen by medical officers on thirteen occasions, which included four specifically requested clinical reviews and three rapid response calls. A treatment plan was developed following each review and each was considered by the RCA review to be an appropriate immediate response. However, each review was undertaken by a different doctor, and following each review the ongoing clinical management was referred back to the surgical team. There was no referral to a general physician in relation to medical aspects of this patient’s care.

The RCA review recommended changes to the Rapid Response protocol locally, to include a prompt for consideration of referral to a general physician those patients with multiple co-morbidities whose Rapid Response call was due to co-morbidity. It was also recommended that medication reviews be completed for all new inpatients within first 24 hours of admission to reconcile medications taken at home with those prescribed on admission.



Save the Date

2011 HNE Health Quality and Scientific Program

Clinical Effectiveness: Rethinking Treatment and Technology

Tuesday 20 September and Wednesday 21 September 2011
at Cessnock (venue to be confirmed)

This is a professional development opportunity open to all staff
(this activity may attract continuing professional development points for
your nursing, medicine and other clinical disciplines)

For more information visit: Clinical Governance webpage at
[http://intranet.hne.health.nsw.gov.au/cg/quality improvement in HNEHealth/QE and SP](http://intranet.hne.health.nsw.gov.au/cg/quality%20improvement%20in%20HNEHealth/QE%20and%20SP)