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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

Inside this issue

From the Director

Guest editorial:
7th Australasian
Conference on
Safety and Quality
in Health Care

In profile...

Root Cause
Analysis

Clinical Unit in
Ethics and Health
Law

Quality Awards
has flowed into the
NSW Health
Awards

Clinical
Governance
Grand Rounds

Editorial team:
Dr Kim Hill, Professor
Anne Duggan,
Ms Barbara March
and Ms Tracey Currie.

From the Director...

During each year, there are several key professional development events designed to further patient safety and quality, including our own HNEH Quality Exposition and Scientific Program, which was held last month.

The early feedback from this meeting has been that it was one of our most valuable and successful to date, with thoughtful presentations from energetic speakers.



Of course, not everyone can attend on the day, so this year's presentations will be available as slides and in audio on the Clinical Governance intranet site shortly, along with the slide presentations of previous years. I would also like to thank this month's Guest Editor, Nanette Jemmeson, for sharing her reflections on the recent national meeting in this month's edition.

Dr Kim Hill
Director Clinical Governance

Guest Editorial - "Bridging the Gap" - the Australian Association for Quality in Health Care 7th Annual Conference on Safety and Quality in Health Care

Ms Nanette Jemmeson, Primary & Community Networks Accreditation Coordinator, Clinical Governance, provides her reflections on this conference which she attended in Sydney on 7th-9th September, 2009.

Key note speakers included:

Dr Jim Bagian, Veteran NASA astronaut, Director, National Centre for Patient Safety, Dept Veterans Affairs, USA, whose key message was ...*adopt a preventative approach by training managers in effective systems design. Don't wait until the "horse bolts" to review key systems.*

Dr Richard Davis, Vice President for Innovation and Patient Safety, John Hopkins on "Medicine's system-wide effort to improve quality, efficiency & safety of patient care" whose key message was ...*effective communication and listening – managers should go to the workplace and listen to the staff who usually know what the problems are and often how to fix them.*

Beverly H Johnson, President and CEO, Institute for Family-Centred Care, Bethesda, Maryland, USA whose key message was ...*involving patient and family in the patient's journey can have a positive effect on patient outcomes.*

Dr David Mayer, Director, Cardiothoracic Anesthesiology, Co-Executive Director, Institute, Patient Safety Excellence, USA, whose key message was ...*honesty and trust in health care and the importance of patients and families in helping move the Safety Agenda.*

Dr Rob Middleton, Orthopaedic Surgeon, UK whose key message was ...*commitment from senior management is the only way change will occur. Not all systems and processes are what you assume them to be, look for variation, natural and artificial – "walk the pathway", do frequent data analysis e.g. daily.*

Australian key note speakers included Professors Enrico Coiera and Jeffrey Braithwaite, University of NSW on "Patient Safety Using Market-Based Control to Engineer a Safe Health System" - a controversial presentation which suggested that market controls could be used effectively in health, "thinking outside of the square".

Overall, presenters were of high quality by experts in their field. Presentations provided new slants on some old ideas or methodologies, as one presenter commented: "...We sit and listen and go away with good intentions but nothing much changes...".

There were consistent themes throughout many presentations/workshops including the importance of reliable, effective systems and processes and of reducing variances within them, leadership commitment to safety and quality, effective communication and empowering staff.

In-between presentations and workshops over the three days there were panel discussions and posters to view electronically. Electronic posters were not as effective as displaying them on a wall, as it was sometimes difficult to find a computer that was free when I had time to view them. Those I saw were very well presented and informative.



In Profile.....Ms Vicki Martens

*Project Manager
Transfusion Medicine Improvement Program
Clinical Governance*

Vicki completed a Bachelor of Applied Science (Biomedical Science) while working at Prince Henry Hospital Sydney, and then travelled extensively through Europe, Asia and Africa, working briefly in London before returning to live in Newcastle.



Vicki commenced work with the Australian Red Cross Blood Service, and then gained the position of Senior Hospital Scientist, Blood Transfusion at the Royal Newcastle Hospital in 1988. During her time as a hospital scientist, transfusion practice has changed significantly. Vicki has been involved with the development of computer software, now known as e-Blood, which has provided a high level of safety, efficiency and innovative functionality for Blood Transfusion Laboratories across several Pathology Services.

Vicki is currently managing the Transfusion Medicine Improvement Program for Clinical Governance working with Dr Stephen O'Mara. The program aims to improve quality and safety around transfusion of blood and blood products. The focus is on ensuring safe, appropriate transfusion to patients, credentialing of staff, establishing sustainable education through a dedicated transfusion intranet site and reducing waste of a precious product.

Vicki, her husband and two sons have enjoyed travelling and snow skiing around the world. A recent passion for motorbike riding has focused her thoughts around safe blood transfusion!

This Month's Root Cause Analysis

CLINICAL COMMUNICATION – Remember the Patient and Their Family

With the spotlight currently on the importance of clinical communication within health care teams, it is a must that we do not forget to include our patients and their loved ones in the loop.

Failure to ensure timely accurate and appropriate communication with patients and families can be source of distress to the people central to our efforts. This can manifest itself in many negative ways and can have unfortunate consequences for patients' families and staff alike.

A root cause analysis (RCA) team reviewed a case involving an elderly lady admitted to hospital with severe illness complicated by significant co-morbidity. During the course of her admission the potential for getting the palliative care team involved in the patient's management at a later stage was discussed. A short time later the patient transferred to the Palliative Care Unit as a result of bed pressure elsewhere in the hospital, not because they were considered to be a specifically palliative care patient.

This however does not seem to have been conveyed to the patient who became extremely distressed at the move. The patient's family was equally distressed to arrive the next day to find someone else in the bed that their mother had been occupying the previous evening, as they had not been informed of the transfer.

The RCA Team found that the patient's transfers were not clinically significant, but that the patient and her family had been subjected to distress that could have been avoided by effective clinical communication with them.

Clinical Unit in Ethics and Health Law

The next Clinical Unit in Ethics and Health Law (CUEHL) seminar will be presented by Dr. Adrian Walsh, Senior Lecturer in Philosophy at the University of New England.

Adrian, who also teaches clinical ethics and health law to University of New England-based undergraduates in the Joint Medical Program, will present a paper entitled "The sale of human organs as a distinctive moral hazard".

The seminar will be held on Monday 2nd November 2009 in the Royal Newcastle Centre, Conference Room 1, at the usual time (6.00pm for supper, seminar to begin at 6.30pm). All are welcome to join in, no entry fee, and no RSVP necessary.

John Hunter Hospital Grand Rounds - 4 November 2009

Clinical Governance will present the John Hunter Hospital Division of Medicine Grand Rounds on Thursday, 4th November, 2009 at 12.30pm in the Lecture theatre at the Royal Newcastle Centre.

The topic is *The Deteriorating Patient – Finding a Solution*. There will be a case presentation followed by information about the Clinical Excellence Commission (CEC) "Between the Flags" strategy, and a discussion of work in Hunter New England Health to address the related Caring Together Project recommendations.

Outstanding Quality Teams

The success of the 2009 HNE Health Quality Awards has flowed into the NSW Health Awards with 9 projects announced as finalists. This is a major achievement for HNE Health and a positive reflection on the adaptability, resourcefulness and talent within our Area. The NSW Health Expo will be held on 30th October, 2009 followed by the 11th Annual NSW Health Awards.

Clinical Governance is proud to be associated with such talented colleagues and we would like to take this opportunity to wish them all well in the NSW Health awards. The finalists list is at: www.awards-expo.health.nsw.gov.au/expo