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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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From the Director...

Welcome to the first edition of *Quality Matters* for 2010.

This is always a special time of the year, as new medical, nursing and allied health graduates start their new careers at HNE Health. It was a pleasure to meet some of them last week, to join others in welcoming them as new members of staff, and in wishing them every success in their chosen profession.

January 2010 also saw the official



roll-out of Between the Flags. Our thanks go to Dr Anne Duggan, who has kindly provided the article below, outlining current implementation and e-links to the awareness training and detailed education about this initiative, which focuses on detection of clinical deterioration in patients.

To all our readers, best wishes for a happy and successful 2010

Dr Kim Hill
Director Clinical Governance

Detecting the Deteriorating Patient – Between the Flags Initiative Implementation of the new Statewide Adult General Observation Chart

The NSW Health/Clinical Excellence Commission "Between the Flags" initiative, which is part of the Caring Together program, is designed to improve systems for early recognition and rapid response for patients whose condition is deteriorating. The key elements of the initiative are:

- A standardised general observation chart
- A two-tiered critical/rapid response
- A training program, known as DETECT
- Key performance indicators to measure outcomes
- A set of standards (to be outlined in a NSW Health policy directive)

Last Wednesday, the new Statewide Adult General Observation Chart was implemented in HNE Health hospitals and multi-purpose services. Currently the charts relate to adults only. Later this year children's services, maternity, intensive care units and emergency departments will roll out specially designed charts for their areas.

Clinical leads and managers are working with the Project Team on site-based two-tiered rapid response systems for patients whose observations fall outside the accepted range. An important component of the chart is on the front page of each chart, where there is a box that records a treating doctor's decision to identify altered calling criteria/frequency of observations. This is to meet the needs of patients such as those with chronic illness (eg respiratory disease), or who may have altered but acceptable observations for a specific reason, (eg during the postoperative period).

The Awareness Training Package provides an overview of the initiative and the importance of its implementation for the management of patients who may be deteriorating. All staff (including non-clinical) should view the program. It is available on the HNE Health myLink site in the All Staff section. Clinical staff need to also undertake the DETECT education program, available at the same web address. The site can be accessed from any HNE Health networked computer. At the end of both programs be sure to complete the declaration of learning.

In the near future training sessions will be organized across the Area to provide face-to-face training for key clinical staff managing deteriorating patients.

Further information on Between the Flags initiative can be found at the Clinical Governance website at: http://intranet.hne.health.nsw.gov.au/cg/clinical_communication/deteriorating_patient
For information about your local implementation, please contact your local site/facility manager.



2009 Clinical Governance Christmas Quiz Winners

This year's Christmas Quiz seemed to be trickier than previous years. Nevertheless there were 2 successful entrants. The first two correct entries drawn were:

- 1st prize: Ms Alison Bowman, Nelson Bay Community Health Centre
2nd prize: Mr Brendan Goswell, Hunter Area Pathology Service

Congratulations to both Alison and Brendan, and thanks to all our readers who entered. *And the answers were...*

1. According to the NHMRC Guidelines for appropriate blood transfusion the decision to transfuse should not be determined by haemoglobin level alone. Patient gender, symptoms and co-morbidities are important in determining appropriate transfusion triggers, which may be at 80g/dL if other symptoms are present. Patients don't leave hospital sooner because they have been transfused to a haemoglobin level of at least 10g/dL.
2. The most common and most immediately dangerous complications of blood transfusion are bacterial contaminations, incompatible transfusion reaction and transfusion related acute lung injuries. Not surprisingly transfused critically ill patients have higher rates of nosocomial infections, longer lengths of stay in hospital and higher overall mortality than their non-transfused counterparts.
3. A complaint form should be completed in the Incident Information Management System (IIMS) when a patient or community member has a complaint about health services. Acknowledgement should occur within 5 calendar days.
4. Clinical handover should occur at shift change, to escalate concern about a deteriorating patient and before all patient transfers.
5. Checklists are used to confirm correct patient/procedure/site - best through "Time Out" with the whole team before a procedure, verifying the patient's identification, procedure and site using open-ended questions such as "what is your name?"
6. "Between the Flags" is an initiative of the Clinical Excellence Commission and NSW Health to address the internationally recognized need for clinicians to identify and manage early, deteriorating patients.
7. And how long does it take an individual blood cell to make a complete circuit of the body? About 1 minute!

This month's Root Cause Analysis Review

There has been considerable focus in recent times on ensuring that procedures undertaken in operating theatres, procedural or interventional suites and radiology departments are the correct procedure at the right site and for the correct patient. A recent Root Cause Analysis (RCA) has highlighted that this focus is equally needed in the ward environment.

The focus of the RCA was a procedure involving the wrong patient undertaken in an inpatient ward, and the substantive issue related to correct identification of the patient. In this case one patient in a four bed room appeared to respond when the correct name was called out. Unfortunately it was not the patient for whom the procedure was intended, although she was in the same room as the correct patient. Other staff members on the ward were not aware that the patient was to undergo a procedure, and this meant that no one else identified the mistake.

All of these issues are addressed in the NSW Health Policy *Correct Patient, Correct Procedure and Correct Site* (PD2007_079). In such a situation as above, the best practice is to ask the patient to state their name in confirmation. The RCA team recommended development of a process whereby any invasive procedure for a patient is booked with the team leader or nurse unit manager, and that the expected standard for correct identification is employed. This will ensure all the staff members caring for the patient are aware of the proposed procedure. It will also allow planning for the care of the patient in relation to the procedure.

Clinical Unit for Ethics and Health Law Seminar

The first Clinical Unit for Ethics and Health Law (CUEHL) Seminar for 2010 will be presented by Dr Susan Miles, Respiratory Physician. Sue will present on the history of asbestos production, asbestos-related disease, and related ethical issues. Her presentation will be followed by a presentation from the Slater and Gordon legal team who have represented exposed individuals seeking compensation. Professor John Hamilton will chair the meeting which will be held in the Royal Newcastle Centre, Lecture Theatre, at the usual time (6.00pm for supper, seminar to begin at 6.30pm). All are welcome to join us, no entry fee and no RSVP necessary.

Welcome to New Staff commencing with HNE Health

Clinical Governance welcomes new staff commencing with HNE Health in 2010. Clinical Governance staff enjoyed participating in new clinical staff orientation programs.

On Monday 11 January 2010, Dr Kim Hill welcomed new junior doctors, most of for whom it was their first day as a doctor having graduated from their respective medical schools at the end of 2009, and introduced the Clinical Governance team. Associate Directors Dr Rosemary Aldrich and Professor Anne Duggan and Area Patient Safety Manager Ms Barbara Rodham then took small groups and spent some time training them in clinical communication using the ISBAR format, and the action to take in the event of an adverse event. We were very impressed by the maturity and capability of the new medical officers, and wish to reinforce our offers of support as they embark on a very exciting career.

As with all staff, junior doctors can contact Clinical Governance via their local patient safety officers, or on 4921 4168 if seeking advice about health system governance, quality and patient safety.