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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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From the Director...

During August and September 2008, there has and will be some special events covering important topics of interest in quality and safety. The first of these was held in August 2008, and was the Inaugural Royal Newcastle Hospital Memorial Fellowship Lecture, given by Dr David Hunter. A report of this lecture is included in this edition of *Quality*



Matters. A special CUEHL meeting, in honour of John McPhee

and his contribution to clinical ethics, and the HNEH Quality Exposition and Scientific Program will both be held in September 2008, and for those of you who could not attend but would like to share in the outcomes of the events, we will include reports on these events in the October 2008 edition of *Quality Matters*.

Reporting Deaths to the Coroner

Recently an elderly man died after an unwitnessed fall in hospital. The event was identified on routine death audit and a root cause analysis (RCA) was undertaken. It was found that the death had not been notified to the Coroner, and when contacted, the Coroner deliberated about exhuming the body in order to conduct their investigation. It was not deemed necessary, but the family did not have the postmortem report to assist in understanding their relative's death and the RCA Team did not gain the benefit of the postmortem report in their review.

The NSW Health Policy PD2005_352 *Coroners' Cases and Amendments to the Coroners Act 1980*. http://www.health.nsw.gov.au/policies/PD/2005/PD2005_352.html states that a Medical Practitioner should report a death to the Coroner when:

- The person died a violent or unnatural death
- The person died a sudden death and the cause is unknown
- The person died under suspicious or unusual circumstances
- The person died having not been attended by a medical practitioner within the period of 3 months immediately preceding their death
- The person died as a result of, within 24 hours, after the administration of an anaesthetic in the course of a medical, surgical or dental operation or procedure other than a local anaesthetic administered solely for resuscitation.
- The person died within a year and a day after the date of any accident to which the cause of his or her death is, or maybe attributable (including due to a fall)

Note: Special requirements relate to mental health patients and children under 18 years. This information can be found in the policy at the link above.

Clinical Governance has developed a Checklist for HNEH clinical staff to assist in the identification of deaths that should be reported to the coroner. This checklist must be completed for all deaths and the completed Checklist placed in the medical record. Hard copies of the Checklist can be ordered from Salmat. The Checklist can be viewed through the following link:

http://intranet.hne.health.nsw.gov.au/_data/assets/pdf_file/0003/50709/Coroners_Checklist.pdf



In profile ... *Felicity Wardle, Better Practice Officer*



She has worked in many clinical and management roles across Hunter New England, underpinned with her qualifications and experience.

Felicity has qualifications in Intensive Care and Coronary Care Nursing and Midwifery and also has a Masters Degree in Applied Management majoring in Project and Quality Management.

Felicity is based in Armidale. She is able to advise and support clinicians and managers in HNEH wishing to develop or adopt or adapt clinical evidence to guide high quality practice. Felicity enjoys working with clinicians from all backgrounds and specialties, supporting them to improve service delivery.

Felicity can be contacted on 67769686 or at felicity.wardle@hnehealth.nsw.gov.au.

Felicity's primary role is to facilitate the uptake and implementation of evidence-based best practice through the use of clinical practice guidelines across Hunter New England Health.

Royal Newcastle Hospital Memorial Fellowship Lecture a Success

Over 180 people attended the Inaugural **Royal Newcastle Hospital Memorial Fellowship Lecture** in conjunction with the **John Irvine Hunter Memorial Lecture**, which was recently held at the Royal Newcastle Centre. The inaugural lecturer was David Hunter, Professor in Cancer Prevention, at Harvard School of Public Health and grandson of John Irvine Hunter (1898–1924), Challis Professor of Anatomy at Sydney University. The lecture, **Do our genes forecast our medical destiny? How genetics will change the practice of medicine**, was well received, as were David's workshop with local researchers and his presentation at the Division of Medicine Grand Rounds the next day.

The RNH Memorial Fellowship aims to recognise the Royal Newcastle Hospital in perpetuity by awarding an annual Fellowship for innovative and outstanding performance in health scholarship and clinical achievement relevant to the values for which the Royal Newcastle Hospital was known. The RNH philosophy was patient centred care, multidisciplinary teamwork, community involvement and innovation in clinical care and hospital organisation.

To view Professor Hunter's talk click on the icon on the Clinical Governance homepage: <http://intranet.health.nsw.gov.au/cg>

New Interventional Procedures in HNEH

Approval has been given under the New Interventional Procedures and Clinical Innovations process for the introduction of Endobronchial Ultrasound in Respiratory Medicine at John Hunter Hospital. The chief applicant was Dr David Arnold. This procedure assists in the diagnosis of lung cancer.

This Month's Root Cause Analysis (RCA) Review

A previously well 23year old woman presented to hospital feeling faint and short of breath. She was found to have decreased oxygen saturation and received oxygen via nasal prongs prior to further assessment. No cause for her symptoms was found, but she was noted to show evidence of dehydration, in keeping with the hot day and diagnosed with vasovagal syncope. Over hours, her oxygen saturation returned to normal on room air. The patient reported improvement and was discharged and asked to present if symptoms returned. As she was on holidays, she left hospital and drove 3 hours to her next destination. The next morning she collapsed dead. Autopsy showed a massive pulmonary embolus.

This young patient who was previously well recovered promptly following her initial presentation. There was no history of a deep venous thrombosis, and pulmonary embolus was not included in the differential diagnosis.

This case highlights the importance of considering pulmonary embolus as a cause of syncope associated with hypoxia. Supportive tests such as d-Dimer may assist and in-service in pulmonary embolus diagnosis is important. High clinical suspicion in the absence of other definitive diagnosis may help identify this pathology in unclear presentations.

Clinical Ethics Survey

With the last edition of *Quality Matters* we distributed a survey to all clinical staff. Some readers reported difficulty accessing it. It is now available on line at:

<http://selectsurvey.hne.health.nsw.gov.au/TakeSurvey.asp?PageNumber=1&SurveyID=42J8841H788L>

The HNEH Ethics Committee is keen to understand the priorities of all HNEH staff. Here is your opportunity to provide brief feedback. Feedback is needed by 11 October 2008.