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# Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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## From the Director...

This month is the month to put the final plans in place for the Fourth Annual Quality Exposition and Scientific Program, which will be held in Newcastle on 10<sup>th</sup> and 11<sup>th</sup> September 2009.

This year's program includes clinical and academic leaders from nursing, medicine and allied health, who will be talking to us about human factors in health care, systems resilience and on



clinical appropriateness.

Our thanks go to our Guest Editor, Professor Kichu Nair, who has provided a good basis for next month's discussion in his editorial below.

I look forward to seeing you at what promises to be a productive and stimulating event on the 2009 HNE Health professional development calendar.

**Dr Kim Hill**  
*Director Clinical Governance*

### Guest Editorial by Professor Kichu Nair

*Clinical Professor of Medicine and Associate Dean, Continuing Medical Professional Development, School of Medicine and Public Health*

In 1988, the Chief Medical Officer of the National Health in UK said that the NHS has no "inbuilt review of quality". That was some 20 years ago. The question is whether we are any better off now? How do we measure quality and how can it be rewarded in 2009?

The Institute of Medicine report in the USA revealed in 2000, that approximately 98000 Americans die from medical mishaps. How many Jumbos is that? What is more interesting is that these are caused by very intelligent, highly trained, well meaning people in bad systems.

Medical errors are inevitable; to err is human. But it is divine to anticipate and make sure systems are in place to minimize these. In aviation, you do not fly solo until you are certified; even after this there are systems to minimise errors which do happen. Nobody goes to work to do a bad job! When things go wrong, it is usually a system issue. The challenge is to do the right thing and do the things right for our patients.

Traditionally quality was measured by death rate. While it may be a good measure for high risk cardiac surgery, it may not be for elective hernia repair or cataract surgery. The ultimate judge of our quality should be our patients (the customer is always right). The NHS has introduced Patient Reported Outcome Measures (PROMS) where patients are asked to measure how they feel before and after the surgery. It will be NICE to have PROMS for every specialty and specialist.

So what can we do? I believe miscommunication and bad communication are the common reasons for errors in medicine. It may be between the clinician and the patients or within the teams. The "unsinkable" Titanic sank because of bad communication. The ship's communication officer received warning from other ships about the icebergs, but he was busy doing the personal messages for the passengers and did not appreciate the "gravity" of the situation. Such a large ship had only two communication officers and had no proper rosters. The ship used flares in distress, but the other ships nearby thought it was a party in the ship or did not know what the colour of the flare meant. So many lives were lost because of poor rosters, lack of sleep, lack of proper protocols and miscommunication.

It is time to learn from other industries about safety and quality in medicine. If we do not self-regulate, it will be thrust on us. I prefer the former.

The Quality Exposition and Scientific Program is an excellent opportunity to reflect and debate these issues.

(To find out more about the Fourth Annual HNE Health Quality Exposition and Scientific Program, go to: [http://intranet.hne.health.nsw.gov.au/cg/Quality/quality\\_exposition\\_and\\_scientific\\_program/quality\\_exposition](http://intranet.hne.health.nsw.gov.au/cg/Quality/quality_exposition_and_scientific_program/quality_exposition))



## ***In Profile.....***

### **Heather Goldman Executive Support Officer, Executive Support Service**

Heather was quietly taken back when asked for a staff profile ...wondering who would want to know anything about her or what her role demands. And what makes it worse should someone ask Heather what her role is as an Executive Support Officer in the Executive Support Service and she answers "I manage complaints and sometimes compliments in between juggling the Minister's Office staff requests for responses for ministerials, briefs, parliamentary questions, electoral updates and so on and on. "How on earth could you do that all day?" is the usual response!



Heather finds satisfaction in being able to listen to the concerns of a patient who has had a not so favourable outcome from a visit to one of Hunter New England Health facilities, to then provide an apology for a service that on this one occasion may not have met their expectation, and then provide them with advice on how their complaint will be managed.

Complaint management is a major part of Heather's current role and one she has been involved with for a number of years in the employ of The Maitland Hospital, Lower Hunter Sector, Lower Hunter Cluster and now in the Clinical Governance Executive Support Service. Some issues are more complex than others and are wide and varied.

On a daily basis she deals with a wide range of tasks, including Ministerial correspondence, Parliamentary Briefs, Questions and House Notes, complaints management (Members of Parliament, Health Care Complaints Commission and complaints direct from the community), Freedom of Information and submission of Reportable Incidents Briefs to NSW Health. Based in Clinical Governance, The Lodge, Rankin Park Campus, Heather also is the first point of contact for the Hunter New England Health's complaints 1800 number.

One day is never the same as the previous day; however the demands are still high and the expectation to meet determined deadlines for all matters adds further pressure on all members of staff within the ESS. In managing complaints and concerns relating to all the acute hospital facilities, including Calvary Mater Newcastle, Heather appreciates the support and cooperation which is continually provided by all the managers and their support staff and seeks their continued ever ready assistance.

## **Root Cause Analysis (RCA) review – Human Factors and Incident Review**

Since the introduction of the Department of Health Policy, Correct Patient, Correct Procedure, Correct Site (PD2007\_079) the frequency of reporting incidents involving surgery or procedures related to any of the above factors has increased. A number of major investigations (RCAs) have been commissioned to determine root causes for incidents where patients have had either an incorrect radiological procedure, or have had a procedure meant for another person.

It is interesting to note also how often human factors play a part in the occurrence of such incidents. From the National Commission on Safety and Quality Fact Sheet on Human Error "...*human factors apply wherever humans work. Human factors acknowledge the universal nature of human fallibility. The traditional approach to human error might be called the "perfectibility" model that assumes that if workers care enough, work hard enough, and are sufficiently well trained, errors will be avoided.*" Research and anecdotal evidence show the perfectibility model is idealistic rather than realistic.

Taking a recent RCA as an example, it can be clearly shown that errors can occur despite the enormous goodwill of the staff to ensure that they do not happen. In this example, the patient presented to the Radiology Department for x-ray of the left foot. It was written on the request form as left foot but it was obvious that the right foot was damaged and it seemed more likely to need the x-ray. The radiographer displayed good practice and contacted the prescriber of the test and it was confirmed that the left foot was to be x-rayed. It was subsequently discovered that in fact the x-ray request should have been for the right foot, and the patient needed another x-ray. This case illustrates that sometimes, despite good processes, human factors can still influence adverse outcomes.

### **CUEHL seminar**

Ms Maree Booth will present the September CUEHL seminar on the topic "Patient Autonomy, What does it mean at Law? What are the Limits?" . Maree is a Catherine Henry Partners, Newcastle. The seminar will be held on Monday 7<sup>th</sup> September 2009, in the usual place (Royal Newcastle Centre, Conference Room 1), at the usual time (6.00pm for supper, 6.30pm for seminar). All are welcome to join us, entry free, no RSVP necessary.

### **AAQHC Conference**

The Australasian Association for Quality in Health Care will hold its Annual Conference in Sydney 7-9<sup>th</sup> September 2009. This year's conference has an impressive line up of international and national speakers as well as workshops relating to quality and safety in health care delivery. For more information go to: <http://www.aaqhc.org.au/>

### **ACHS Corporate Accreditation**

The Corporate EQUiP Steering Committee is coordinating and collating information for self assessment due by December 2009 for approval to upload to the electronic assessment tool. Staff in Area and Corporate Office departments should:-

- ◆ Include accreditation on every agenda
- ◆ Link agenda items with EQUiP criteria numbers to reinforce memory of standards and criteria.
- ◆ Each meeting, make a list of current projects and planned improvements to include as evidence.
- ◆ Update Support and Mandatory Criteria as progress is made.
- ◆ Address recommendations from Corporate Office Periodic Review
- ◆ Reduce duplication by linking EQUiP to your Quality System Assessment and Caring Together projects.

For further information, contact Deborah Lawson Clinical Governance 498 55845  
[Deborah.Lawson@hnehealth.nsw.gov.au](mailto:Deborah.Lawson@hnehealth.nsw.gov.au)

### **Farewell to Felicity Wardle**

After some years as part of the team, Felicity has left Clinical Governance to return to a management position in the Tablelands Cluster. Felicity started as the Towards a Safer Culture (TASC) Project Officer, moving onto supporting Clinical Practice Guidelines when TASC concluded. While in Clinical Governance Felicity brought her clinical and management expertise to the development of several clinical guidelines, and was a valued part of the team. We thank Felicity for all her efforts and wish her well in her future role. Susan Diemar has now taken on the role of support person for Clinical Practice Guidelines and can be contacted on telephone 4921 3927 or on [susan.diemar@hnehealth.nsw.gov.au](mailto:susan.diemar@hnehealth.nsw.gov.au)