

Quality Matters

FROM THE DIRECTOR

One of the most important parts of our quality and safety agenda is to ensure that when incidents occur, we take every opportunity to review what happened, and take action to prevent similar situations from arising again. In this issue, we showcase the role of Root Cause Analysis, and the important role played by the HNE Health Patient Safety Officers, in supporting these endeavours across HNE Health.



Dr Kim Hill
Director
Clinical Governance

Another valuable component is gained from patient feedback, and HNE Health is involved in the NSW Health Patient Survey, where a number of patients who attended our health services in February will be asked to provide feedback about their experiences. This feedback will be collated and provided back to our health service, for use in our quality improvement initiatives.

I hope you enjoy the June 2007 edition of *Quality Matters*.

PATIENT SAFETY AND INCIDENT MANAGEMENT

There is now widespread recognition that improving patient safety means taking a systems perspective in incident management. Current approaches are:

- Focus on system issues and effective change management
- Move toward a culture in which errors are acknowledged and openly discussed with patients and their families (open disclosure)
- Demonstration of a greater understanding of the relationship between cause and error, including the complex human factors involved in clinical care
- Value placed on adverse events, errors, incidents and near misses as flags to improve patient care systems

Analysis of errors is a core component of a patient safety program. One of the strategies used to identify adverse events is facilitated incident reporting. In HNE Health, we use the Incident Information Management System (IIMS). Details about IIMS are at: <https://iims.health.nsw.gov.au> IIMS reported events are assessed using a severity assessment code (SAC). High-level events are SAC1s (clinical and corporate) and are investigated via Root Cause Analysis (RCA) methodology.

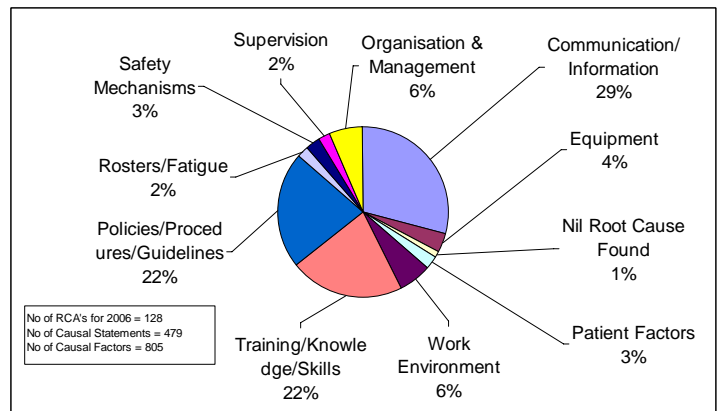
What is a Root Cause Analysis (RCA)?

An RCA investigation is undertaken by experienced clinical staff, supported by trained facilitators from Clinical Governance staff, usually Patient Safety Officers together identify systems matters contributing to events and determine recommendations to prevent similar errors. By looking at all RCAs over time, it is possible to identify priority areas for our quality and safety program.

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What system errors were identified in 2006?



Who are the Patient Safety Officers?

The Patient Safety Officers (PSOs) are part of Clinical Governance and are attached to clinical units and clusters across Hunter New England Health. They are based geographically close to their areas of responsibility and work closely with clinical and management colleagues to examine patient safety issues, and support clinical practice improvement. They are also able to provide information about incidents reported through IIMS and to provide a conduit for information about HNE Health quality and safety initiatives. To find out the name of the PSO for your service please click on the hyperlink: [Patient Safety Officers Contact List](#) which takes you to the relevant section of the Clinical Governance website.

FOR MORE INFORMATION ON PATIENT SAFETY TRY THESE LINKS:

- [Australasian Association for Quality in Health Care \(AAQHC\)](#)
- [Australian Commission on Safety and Quality in Health Care](#)
- [Australian Council on Healthcare Standard \(ACHS\)](#)
- [Canadian Patient Safety Institute](#)
- [Clinical Excellence Commission \(CEC\)](#)
- [Institute for Healthcare Improvement \(IHI\)](#)
- [National Patient Safety Agency \(NPSA\)](#)
- [NSW Health Quality and Safety Branch](#)

Editorial team: Dr Kim Hill, A/Prof Anne Duggan, Ms Trish Blackman, Ms Alisa Johnson.
Comments and queries welcome at: clinicalgovernance@hnehealth.nsw.gov.au

Quality Matters

NEWS NOTES:

The **NSW Health Patient Survey** has been developed to obtain feedback from patients about their experiences, their satisfaction and to identify improvement opportunities and enable benchmarking.

NSW Health has contracted Ipsos Australia Pty Ltd and NRC+Picker to conduct the survey annually for three years. HNE Health is administering the project on behalf of NSW Health and the Project Manager, Ms Helen Byrnes, is based in Clinical Governance. Ms Tonia Easton, Area Quality Manager is the HNE Health Project Contact Officer.

The survey includes the eight Area Health Services and Westmead Children's Hospital. The questionnaires are based on eight dimensions of patient centered care: Access to Care, Patient's Preferences, Information and Education, Coordination of Care, Physical Comfort, Continuity and Transition, Emotional Support and Family and Friends.

After each survey State, Area Health Service and facility reports will be generated to provide data to inform health care and systems improvement initiatives. For more information contact: Helen.byrnes@hnehealth.nsw.gov.au

Open Disclosure is an important part of clinical communication and means that patients and families those affected by an adverse event receive information about what happened, an apology, findings of an investigation of the event, and what will be done to prevent its recurrence. Participants were able to learn what to do and have their questions answered at a skills and knowledge workshop, on 27 June at the Royal Newcastle Centre (and videoconferenced to other sites as well as web streamed). More information about Open Disclosure will follow. For more information contact Dr Rosemary Aldrich, Associate Director Clinical Governance on rosemary.aldrich@hnehealth.nsw.gov.au or 4921 4935.

IN PROFILE

Di Dolan
Acting Area Patient Safety Manager

Di is a Registered Nurse having obtained her qualifications from The Liverpool Hospital and she has Certificate in Perioperative Nursing and Management (NSW College of Nursing), Bachelor in Health Service Management and Graduate Certificate in Adult Education (University of New England). Di lives in Belmont and came to Newcastle from the Central West where the challenges of working in a rural facility strengthened her belief that it can get hotter than 40 degrees and colder than -5 just when you think it can't. Also that kangaroos can spot an ambulance at 100 paces! Di enjoys the challenges of the Patient Safety Officer role and shares her time with good friends and family and believes life is too short to drink bad wine!



Correct Site Surgery- Getting it right in NSW

In 2004, the Quality and Safety Branch of the NSW Health in conjunction with the NSW Branch of the Royal Australasian College of Surgeons, the NSW Regional Committee of the Australian and New Zealand College of Anaesthetists, and the NSW Operating Theatre Association developed the model policy for implementation into NSW Health services. [Patient Identification - Correct Patient, Correct Procedure and Correct Site Model Policy](#) was released and disseminated to NSW health facilities. In 2006, NSW Health included incidents involving non-interventional wrong site, wrong procedure situations as serious events and health services are now required to report these to NSW Health as Severity Assessment Code (SAC) 1 incidents.

State-wide specialist working groups were established to represent surgical/rural taskforce, radiology, nuclear medicine, radiation oncology and dental to discuss policy concerns and to develop strategies to reduce these incidents to zero. Following feedback from these working groups, the Clinical Excellence Commission (CEC) and Area Health Services' representatives, the 2004 policy was revised and a new Policy Directive is due to be released soon and will be accessible on the NSW Health website. We will provide an update when it is available.

To assist with the Policy Directive's implementation a Clinician's Correct Patient/Procedure/Site Safety Toolkit is currently under development. The toolkit will be based on materials already in use across NSW facilities. There are five kits: Radiation Oncology, Nuclear Medicine, Radiology, Oral Health and Surgical Services. These can be accessed at: <http://www.health.nsw.gov.au/quality/correct/safetykit.html>

A timely example: An Angiogram instead of Finger Operation

Sequence of events leading to the incident: In the peri-operative unit, for theatres and radiology, the patient gave a thumbs up signal when the name of another patient was called out. The patient then underwent angiography instead of an operation on their finger.

Major contributing factors: Staff were attending an emergency situation elsewhere in the department and may have been distracted. The patient's identity was not confirmed against their identification name band.

How did the health service address this incident?

The key issue was that the policy for patient's identification and correct site surgery was not followed. Medical and nursing staff involved were educated on the policy requirements. A pre-operative checklist was implemented urgently in radiology.

How did the service communicate with the patient about this incident? Staff apologised to the patient and the scheduled finger procedure was carried out successfully next day.

Notices:

 Safety Alert  Safety Notice  Safety Information

Number	Type	Issues covered	Date of issue
SN:009/07		Therapeutic Goods Administration (TGA) Recalls	31 May 07

For more information click on the hyperlink:

<http://www.health.nsw.gov.au/quality/sabs/register.html>