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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

Inside this issue

From the Director

Guest editorial:
Simulation based
training

In profile

Safety alerts and
notices

New point of care
information
resource

CUEHL sponsored
HARC seminar

2009 Quality
Exposition and
Scientific program

Pressure Ulcer
Policy update

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From the Director...

Welcome to the May Edition of Quality Matters. It is not uncommon to be asked about what is meant by the words "clinical governance" and this month's edition includes a guest editorial that showcases an important interface between quality, safety and skills development. There is growing understanding of the potential for application of simulation in effective team and individual training, and we are lucky in



HNEH to have
colleagues with dynamic

and innovative ideas about how to move forward in this area. Our thanks to Dr Cate McIntosh for her excellent contribution.

Some of you may be particularly interested in the subject of the June 2009 CUEHL seminar, and so in next month's Quality Matters, there will be an article on this meeting,

Dr Kim Hill
Director Clinical Governance

Focusing on Teams: the Future of Health Care Training

Guest Editorial by Dr Cate McIntosh, Director, Simulation Program

No matter how hard we try or how skilled we are as individuals, we cannot achieve flawless delivery of healthcare on our own. Individual performance is not sufficient to achieve optimum safety. Training must be applied not just to the individual but also to the unit responsible for delivery of healthcare, the 'team'. Simulation based team training is the way forward for organisations seeking to improve the performance of their clinical teams.

Patient safety experts, and recently Commissioner Garling, identify teamwork and, specifically, simulation-based team training as strategies to improve the quality of patient care.¹ Simulation also improves safety by creating and maintaining a culture of safety, facilitating recruitment and retention of skilled personnel, and improving quality and risk management activities (e.g. highlighting system problems in clinical environments, identifying faults at the user interface in new equipment, or by testing local clinical protocols).

Synthetic learning environments (simulation centres and clinical skills laboratories) are useful for personnel from undergraduate level to experienced senior staff. Skills laboratories teach basic clinical skills and drills, such as cannulation and CPR, as well as complex psychomotor activities like surgical skills. Experienced personnel also find skills labs useful to refresh their skills for procedures not often performed. These skills are vital for patient safety. However, studies and analysis of critical incidents consistently highlight communication breakdown as a major source of error. Simulation based team training specifically addresses this by providing opportunities to practise communication skills in realistic, time-pressured situations. This is the major role of the Simulation Program at the HNE Skills and Simulation Centre (HNESSC), which provides team training to 500 medical and nursing staff annually.

For simulation-based team training to be effective, rigorous design must be applied to the development of training programs including the careful crafting of scenarios and incorporation of opportunities for performance assessment of, and feedback to, the individual and team. For the most complex uses of simulation, including the training of relatively experienced personnel, feedback is provided via a detailed post-scenario debriefing session. Allowing the case to play out in real time without interruption, or any risk to patient safety, allows personnel to explore the advantages and disadvantages of their behaviours, decisions and actions.² Feedback is provided by a highly trained group of senior clinical staff expert in the subject matter, as well as specifically trained in simulation-based educational techniques.

Like any other skill, decay in teamwork and crisis management skills will occur over time if not used or rehearsed on a regular basis.³ These skills should be taught systematically, rehearsed, and reinforced throughout clinicians' careers.

Simulation based team training must become a major priority for our health care system.

1. Kohn LT, Corrigan JM, Donaldson MS (Institute of Medicine). To err is human: building a safer health system. Washington, DC: National Academy Press, 2000

2. Gaba DG. The Future Vision of Simulation in Healthcare. Qual Saf Health Care 2004; 13 (Suppl 1): i2 – i10

3. McIntosh CA. Lake Wobegon for Anesthesia...Where Everyone is Above Average Except Those Who Aren't: Variability in the Management of Simulated Intraoperative Critical Incidents. Anesth Analg 2009; 108: 6 – 9



In profile... Mary Byrne *Patient Safety Officer, Clinical Governance*

Mary commenced working in health care in 1984 at St Vincent's Hospital Toowoomba before moving back to Sydney. In 1989 she completed a certificate in Intensive Care Nursing and spent several years working in the Intensive Care Unit at St Vincent's Hospital Sydney. Following further study, Mary worked in the Plunkett Centre for Ethics in Healthcare as a research associate, managed the Nursing Research Unit at St Vincent's Hospital and tutored nursing students at Australian Catholic University.



Mary commenced working in patient safety at St Vincent's Hospital and then moved to Maitland and the Lower Hunter in 2004 after she and her partner purchased a house on the Central Coast. Mary has spent time working in patient safety for facilities in the Lower and Upper Hunter as well as The Maitland Hospital. She is now based in Newcastle providing clinical governance support to Kaleidoscope and the Divisions of Medicine and Obstetrics and Gynaecology at John Hunter Hospital. In her spare time Mary spends time with her partner and their dogs and particularly enjoys taking a caravan to dog friendly camping areas and simply relaxing.

For Mary the two greatest challenges in her work are facilitating investigations of serious incidents so that the focus remains on system issues rather than individuals and developing a better understanding of human error as it occurs in health care so that we can find ways of developing a health care system that is robust enough to absorb error and protect patients.

Safety Alerts and Notices

NSW Health has issued the following alerts and notices to Area Health Services with recommendations about patient safety. Please click on the hyperlink under issues covered for more information. Any assistance in ensuring relevant notices are circulated to staff without access to email is appreciated.

Number	Type	Issues covered	Date of issue
SN:012/09		TGA Recall	14 May 09
SN:011/09		Allopurinol and Azathioprine	7 May 09
SN:010/09		TGA Recalls	4 May 09
SN:009/09		Acute Coronary Syndrome	28 Apr 09
SN:008/09		Insertion of intraocular lens Recommended intraocular lens insertion process To be read in conjunction with SN: 008/09	31 Mar 09
SN:007/09		Nasogastric Feeding Tubes for Infants and Children (revised)	27 Mar 09
SN:006/09		Wrong Route Errors with Oral Medication	25 Mar 09
SN:005/09		TGA Recalls	20 Mar 09
SN:004/09		TGA Recalls	24 Feb 09
SA:001/09		PEEP Valve, Expiration Diverter Assembly	13 Feb 09

New Point of Care Information Resource

The Library is now subscribing to the BMJ's BestPractice database, a point of care diagnosis/treatment resource. It is available to anyone within HNE Health.
<http://bestpractice.bmj.com/best-practice/welcome.html>

CUEHL Seminar June 2009 Forum on "Public Confidence in the Hospital System"

Monday 1st June 2009, 6.30 pm,
RNC Lecture Theatre

The Clinical Unit in Health Law and Ethics (CUEHL) together with Clinical Governance will host a Hospital Alliance for Research Collaboration (HARC) Forum in partnership with the Sax Institute, NSW Clinical Excellence Commission (CEC) and the Greater Metropolitan Clinical Taskforce (GMCT) to consider how we can strengthen public confidence in the hospital system.

The keynote speaker is Dr Diane Watson, an International Visiting Health Services Research Fellow at the Sax Institute who is from the University of British Columbia, Canada. Her lecture will be followed by a panel and audience discussion with representatives from GMCT, the CEC, Newcastle University and HNEH. For further information

[http://intranet.hne.health.nsw.gov.au/_data/assets/pdf_file/0006/62169/InvitationProgram_HARCforum-](http://intranet.hne.health.nsw.gov.au/_data/assets/pdf_file/0006/62169/InvitationProgram_HARCforum-Newcastle020609v4_FINAL_CUEHL.pdf)
[Newcastle020609v4_FINAL_CUEHL.pdf](#)

A light supper will be served from 6pm.

2009 Quality Exposition and Scientific Program

Start clearing your schedule now and blocking the diary to attend this year's HNE Quality Exposition and Scientific Program. This year's theme is around *Human Factors and Error, and their relationship to Health Care Delivery*.

When: Thursday 10th and Friday 11th September 2009

Where: Newcastle, venue to be confirmed.

Next month's Quality Matters will provide details on our invited speakers. For further information contact Ms Tonia Easton, Area Quality Manager, Clinical Governance
tonia.easton@hnehealth.nsw.gov.au

HNEH Pressure Ulcer Policy

The Pressure Ulcer Policy has been updated and is available at:
http://intranet.hne.health.nsw.gov.au/_data/assets/pdf_file/0004/40864/HNEH_PUPP_Policy_April_2009_.pdf