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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 June 2010 Quality Matters, which this month brings news of achievements and some special future events.

The 2010 Annual Quality Awards entries are now under consideration by our judging panels, and again, we have been delighted with the response. There are many excellent examples of quality and patient safety initiatives, and the Annual Awards



process provides one means by which to acknowledge and congratulate staff on excellence and achievements.

There is also preliminary advice about the dates for this year's Quality Exposition and Scientific Program – last year's event was a great success and we hope to see you in Tamworth in 2010.

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

## Between the Flags Welcomed in Paediatric Services

*Guest Editorial by Dr Helen Goodwin, Staff Specialist Paediatrician, Tamworth Base Hospital*

I was recently asked for my opinion as to the role of Between the Flags in paediatrics. Formal activation criteria for our already successful MET service was extended to include paediatrics and labour ward in 2008. There was a lot of initial concern that all of a sudden everyone would need to know about how to resuscitate a child all on their own and that it would increase everyone's workload.

Previously the "MET team" (or rapid response team) was the on call paediatrician and the nurse on the ward who called you when things went pear shaped. In fact many argued we didn't need a MET team in paediatrics at all. Experienced nurses had traditionally, (and will always I hope), gone "straight to the top", calling in the paediatrician from home whenever the observations got in the yellow or red Zone.

What's different now?

- The paediatrician may be a locum who the staff don't know.
- The surgeon whose patient has the tachycardia may also be a locum who the staff don't know.
- The "experienced" Nurse may be 22 years old, trained in another discipline.
- The paediatrician might be busy with a delivery, or live in the city and 40 minutes in the traffic away!

Most of the time the old system worked, but sometimes it fell down and bad things happened, children got sicker than they should have, good staff had a hard time.

The MET activation criteria at our hospital are very similar to those for Between the Flags. Staff continue to call us early before hitting the criteria most of the time. The criteria have given junior staff the confidence to call early and outside their discipline, or the discipline of the treating team. We no longer do "off the record consults" on surgical patients - nurses can say to surgeons without fear of reproach – the obs were heading toward the Rapid Response (MET) call zone so we involved the paediatricians early. One catch of the old system was translating observations. into what's normal for that age child.

After attending a Queensland paediatric update in late 2008, where a universal chart was being developed, my next project with our Nurse Unit Manager was to try and make a local obs. chart that was visual and graphical and easy to use in paediatrics. The great news is that Department of Health has done it for us, so we can get on with the real work!

Bring it on- it's the closest us country folk get to swimming between the flags.

## SAVE THE DATE – Special July 2010 Events

Emeritus Professor James Isbister, a prominent haematologist, will give this year's Royal Newcastle Hospital Heritage Oration *From Witch Doctors to Which Doctors*. The annual Royal Newcastle Hospital Heritage Oration celebrates the contribution of the values and achievements of the "Royal" to the high quality healthcare we provide today. This public lecture will be held on Wednesday 28<sup>th</sup> July at 6.00pm in the RNC lecture theatre. Everyone is welcome.

Professor Isbister will also be part of the Newcastle Hospitals' Congress on Thursday 29 July 2010 to be held in the RNC Lecture Theatre from 9am to 5pm. Professor Isbister will present this year's John Irvine Hunter Memorial Lecture in conjunction with the University of Newcastle Foundation. The John Irvine Hunter Lecture honours a remarkable Australian anatomist and teacher and is part of a bequest from the Irvine John Hunter family. Professor Isbister's Lecture *From Blood Letting to Blood Transfusion to Patient Blood Management* will take place at 12.30pm in place of the Division of Medicine Grand Rounds.



## ***This Month's Update is on ....***

### **2010 Quality Exposition and Scientific Program**

The annual Hunter New England Health Quality Exposition and Scientific Program was established in 2006, and provides an annual opportunity for staff from across the Area to learn from and to share experiences with eminent experts in the fields of clinical governance, quality and safety, and clinical and professional practice.

The Quality Exposition and Scientific Program has now been held for four consecutive years, and feedback from participants continues to be very positive. Each year's Program has had a special theme, and the speakers who are invited to be part of the event are clinical and academic leaders in relevant fields. An important component of the Scientific Program is the opportunity it presents for networking within the Area, and for staff to share perspectives with the speakers.

The Exposition opportunistically showcases the innovations and achievements of that year's Quality Awards finalists, through a poster display. The best poster is chosen by participants at the Quality Exposition and Scientific Program, and is recognised on the second day of the Program.

**This year's Quality Exposition and Scientific program will be held on Wednesday 15th September 2010 and Thursday 16th September 2010 at the Tamworth Regional Entertainment Centre. The theme of this year's event is "We're all Here for Patients".**

Registrations open in July 2010. Over the coming weeks there will be updates on this page [http://intranet.hne.health.nsw.gov.au/cg/quality\\_improvement\\_in\\_HNEHealth/QE\\_and\\_SP](http://intranet.hne.health.nsw.gov.au/cg/quality_improvement_in_HNEHealth/QE_and_SP).

### **2010 Quality Awards**

Over 90 entries were received for the 2010 Hunter New England Health Quality Awards. The HNE Health Awards are also the internal filter to the NSW Health Awards, NSW Premier's Awards and the Australian Council of Healthcare Standards (ACHS) Awards.

HNE Health Quality Award finalists will be announced at the July 2010 Area Managers Forum in Tamworth. Winners will be announced at the Hunter New England Health Annual Achievement Awards dinner at Tamworth, held in conjunction with the 2010 Quality Exposition and Scientific Program.

Winners and finalists in the NSW Health Awards will be announced at the NSW Health Awards Dinner on Friday 15 October 2010 at Australian Technology Park, Sydney

## **This Month's Root Cause Analysis Review**

This case relates to unexpected death in-utero after artificial membrane rupture.

A 28-year old woman with borderline gestational hypertension and post dates underwent induction of labour at a district health service facility. The woman's labour failed to progress and clinical concerns were escalated by midwifery staff after 10 hours. The attending medical officer discussed the issue with an Obstetrician at the nearest Rural Referral Hospital and a decision was made to transfer the patient. On arrival at the Rural Referral Hospital, the baby was found to have died.

The RCA concluded that continuous foetal heart monitoring of the baby was needed after induction of labour to detect clinical deterioration in the foetus. The RCA made the following recommendations:

- Review of HNE Health facilities where Maternity Services are provided to ensure compliance with NSW Health Safety Alert 004/07: Electronic Foetal Heart Rate Monitoring.
- Review of facilities providing Maternity Services within HNE Health, to ensure compliance with HNE Health Role Delineation (document dated 31<sup>st</sup> December 2005).
- Pharmacy imprest compliance with HNE Health Maternity Pharmacopeia 2009 to be endorsed by HNE Health Women's Health and Maternity (WHAM) Network, with distribution across relevant sites within HNE Health.

These recommendations are due to be completed by December 2010, through the leadership of the HNE Health WHAM Clinical Network.

## **Clinical Unit in Ethics and Health Law Seminar**

Dr Andrew McGee, Lecturer at Queensland University of Technology, will present the July 2010 CUEHL seminar. His paper entitled "*Is the Law on End of Life Decision Making Really Morally and Intellectually Misshapen?*" is a discussion about the correct way to distinguish withholding and withdrawing medical treatment from euthanasia.

The seminar will be held on Monday 5 July 2010 in the RNC Lecture Theatre. Supper is at 6.00pm. The seminar begins at 6.30pm. All are welcome—no entry fee, no RSVP needed.

## **Clinical Guidelines framework under review**

First published in 2008, the HNE Health Clinical Guidelines Framework is under review and is available for comment and feedback.

Any feedback is welcomed by Thursday, 8 July 2010 – please access via

[http://intranet.hne.health.nsw.gov.au/pg/clinical\\_practice\\_guidelines](http://intranet.hne.health.nsw.gov.au/pg/clinical_practice_guidelines) or by contacting Clinical Governance Policy Officer Susan Diemar on [susan.diemar@hnehealth.nsw.gov.au](mailto:susan.diemar@hnehealth.nsw.gov.au)

## **SOUNDING BOARD Review of Journal Articles By Jay Nielsen Patient Safety Officer**

**Attitudes and barriers to incident reporting: a collaborative hospital study** Evans SM, Berry JG, Smith, BJ, Esterman A, Selim P, O'Shaughnessy J, DeWit M, Qual Saf Health Care 2006;15:39-43

The article examines the incidents that medical and nursing staff at a number of South Australian hospitals:

- identified as adverse events,
- thought needed reporting

The results mirrored many of the barriers and attitudes that have been noted anecdotally within our own area health service and identified areas in which barriers to reporting need to be overcome if we are to improve the level of adverse event reporting within our services.