



September 2010
Issue no. 45

Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

Inside this Issue:

From the Director

Quality Systems Assessment

Dealing with Difficult Patients

Open Disclosure

Root Cause Analysis

Clinical Unit in Ethics and Health Law Seminar

In Profile....Ms Mary Bond

Editorial team:

Dr Kim Hill,
Professor Anne Duggan, Ms Barbara March, Ms Tracey Currie and Ms Karen Mackaway

Comments and queries welcome:
clinicalgovernance@hnehealth.nsw.gov.au

From the Director...

Welcome to the September 2010 Edition of Quality Matters.

Some of you may have recently participated in a survey on clinical policies and guidelines, and how to improve our systems for accessing and locating them. We had a terrific response to this survey, and the information obtained has been very valuable. As a result of these endeavours, I am now pleased to announce



that the new HNE Health Policy, Procedure and Guideline Directory is about to go live.

In our next Edition, we will be showcasing the Fifth Quality Exposition and Scientific Program, which was held in Tamworth last week. This is will be a special extended edition, in order to share with you some of the highlights from the Program.

Dr Kim Hill
Director Clinical Governance

2010 Quality Systems Assessment Survey September 2010 to November 2010

From September to November 2010, Hunter New England Health is again participating in the Quality Systems Assessment (QSA) Program annual survey. The Quality Systems Assessment Program is a self-assessment survey designed to assess the effectiveness of our current systems and processes in managing risks to patient safety and assuring quality patient care. The QSA is a statewide staff survey undertaken as part of the NSW Patient Safety and Clinical Quality program, and is coordinated via the Clinical Excellence Commission. It was first undertaken in 2007.

The 2010 survey will be undertaken from September 2010 within inpatient clinical units and facilities and at network/cluster and Area level. This year, the QSA will survey quality and safety elements in three key areas:

- Teamwork (including clinical supervision, clinical leadership, essentials of care, multi-disciplinary teams, "Teams First")
- Health Care Associated Infections
- Open Disclosure

For more information please review the attached Quality Systems Assessment fact sheet or contact Dianne Dolan, Acting Area Quality Manager, Clinical Governance, on ext. 23797 or email Dianne.Dolan@hnehealth.nsw.gov.au or Gary Martin, Coordinator Quality Support and Liaison in Clinical Governance on ext 55845 or email Gary.Martin@hnehealth.nsw.gov.au,

Complaints Management - Dealing with Difficult Complaints

Effective complaint handling is part of communicating effectively with patients and their families and is essential to providing quality health care. All staff in HNE Health may from time to time need to play a role in management and/or resolution of a complaint. People who complain about a service want to be assured their complaint is taken seriously, and that they are being treated with respect and dignity. A positive attitude by staff is critical to the success of complaint management.

Some complaints however can be very difficult to resolve despite the best efforts of staff. The NSW Ombudsman has a Fact Sheet for these cases, which can be accessed at:

http://www.ombo.nsw.gov.au/publication/PDF/factsheets/FS_AZ_22_DifficultComplainant_factsheet_Jul10.pdf
For more information or advice on dealing with complaints please contact Dianne Sales, Executive Support Service Manager in Clinical Governance on dianne.sales@hnehealth.nsw.gov.au



This Month's Update is on Open Disclosure

Open disclosure means that patients who experience an adverse event in healthcare are given an apology, an explanation of what happened and the likely effects of the incident, and an assurance that the matter will be investigated to identify what happened and to take steps taken to prevent recurrence.

In the case of the most serious incidents, a detailed investigation of the root causes takes place. When this occurs, an open disclosure conversation takes place with patient and/ or their family or carers before and after such an investigation.

The Open Disclosure Policy Compliance Procedure has been re-written to emphasise the importance of ensuring documentation concerning initial and subsequent open disclosure conversations is made in the patient's medical record. The new Policy Compliance Procedure can be found at:

http://intranet.hne.health.nsw.gov.au/_data/assets/pdf_file/0006/35961/Open_Disclosure_PCP_1_Version_2_July_2010.pdf

For more information or to discuss principles and processes of open disclosure please contact Ms Barbara Rodham, Area Patient Safety Manager in Clinical Governance on 4921 4927 or Barbara.Rodham@hnehealth.nsw.gov.au

This Month's Root Cause Analysis Review

An 80 year old man died unexpectedly after acquiring hospital acquired bacteraemia (blood stream infection). This incident underwent Root Cause Analysis.

The patient presented to the Emergency Department of a Rural Referral Hospital with a history of low blood pressure, unintentional weight loss, low back pain and possible bleeding from the bowel. The Emergency Department Attending Medical Officer made a provisional diagnosis of multiple myeloma. Over the next 10 days the patient experienced episodes of fever associated with breathlessness and rapid heart rate. A urine culture identified a urinary tract infection associated with Staphylococcus Aureus. Methicillin-Resistant Staphylococcus Aureus (MRSA) was later cultured in the patient's blood. The patient was transferred to a higher level facility for ongoing management and referred to an Infectious Diseases team for advice regarding ongoing management of his sepsis. The diagnosis of multiple myeloma was confirmed, and despite ongoing investigation and treatment of the patient's sepsis, the patient died.

The Root Cause Analysis team concluded that the prolonged presence of a cannula over five days, the patient's broken skin from a recent scabies infestation and an area of broken skin on the patient's forearm from the recent removal of a skin cancer were all potential sources of infection. The team identified two important contributory factors – the newly diagnosed multiple myeloma would have increased the patient's susceptibility to infection, while the regular use of paracetamol throughout the patient's admission may have delayed diagnosis and therefore treatment of his sepsis.

The RCA Team reviewed the patient's management in light of the HNE Health *Clinical Practice Guideline on Fever and Sepsis in Adults*, which highlight that regular paracetamol use reduces a patient's temperature and may mask the signs of sepsis. Recommendations from the Root Cause Analysis were:

1. The intravenous cannulation training program be extended to increase the number of nursing staff trained to cannulate patients particularly at Rural Referral Hospitals to increase capacity to change cannulas
2. Medical Officers and nursing staff be encouraged to complete online DETECT education as soon as possible and enrol in the face-to-face training as becomes available at their facility.

The HNEH *Clinical Practice Guideline: Fever and Sepsis in Adult* is available at:

http://intranet.hne.health.nsw.gov.au/_data/assets/pdf_file/0010/67744/HNEH_CPG_10_07_Fever_and_Sepsis_in_Adults.pdf

Clinical Unit in Ethics and Health Law Seminar

Ms Ngarie Watson, a Sydney Barrister and Registered Nurse will present the October CUEHL seminar. Ms Watson will be presenting a paper entitled "*Diagnosis Issues within the Nursing Profession*". The seminar will be held on Monday, 4 October 2010 in the Royal Newcastle Centre, Conference Room 1.

Supper will be served at 6.00pm and the seminar will begin at 6.30pm. All are welcome to join us. There is no entry fee and no RSVP is necessary.

In Profile.....Ms Mary Bond Patient Safety Officer



Mary commenced working in health care at the Children's Hospital, Dublin in 1987 and qualified as a Registered Sick Childrens' Nurse in 1990. She then completed a post graduate course in general nursing at St. Vincent's Hospital, Dublin and continued to work there for a number of years in both medicine and surgery.

After a number of years Mary travelled to Saudi Arabia and worked in paediatrics. Mary moved to Australia in 2000 and has worked in the private and public sectors, acute and aged care in a variety of Nursing and management roles. Mary has recently returned to HNE Health from GSAHS Clinical Governance where she worked as Patient Safety & Quality Officer.

Mary is now the Patient Safety Officer for the John Hunter Hospital Division of Surgery and Lower Mid North Coast Cluster and can be contacted on telephone 4921 4213.