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# Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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## From the Director...

As this is the 2009 Christmas edition of *Quality Matters*, we have continued our relatively new tradition of the Annual *Quality Matters* Christmas Quiz. For those who would like to take part, the link to the Quiz is on the second page – winners will be announced in the January 2010 Edition.

This month we have a special Guest Editorial from Dr Liz Hill who has a story to tell about an occasion where IIMS has proven



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

very useful. Our thanks go to Liz for sharing this story with us all.

I would also like to thank our Editorial Team – Anne, Barbara and Tracey – for their energy and enthusiasm, and for again achieving a full 12 editions in 2009.

On behalf of the Editorial Team and HNE Health Clinical Governance, I wish you all the best for the Festive Season, and a happy, prosperous 2010.

## Guest Editorial: A New View of Reporting in the Incident Information Management System

*by Dr Liz Hill, Staff Specialist Anaesthetist, Belmont, Royal Newcastle Centre and John Hunter Hospitals*

Three days prior to the story below I quipped to a colleague "I haven't had a case of anaphylaxis yet"...

Nice easy minor orthopaedic list at Belmont Hospital. Second patient was a healthy 42 year old man for a knee arthroscopy. He had "morphine" written down as an allergy but in fact the reaction had been drowsiness. Otherwise an unremarkable history.

He had 3mg midazolam in the anaesthetic bay and then we transferred him into theatre. I preoxygenated him and gave him a standard orthopaedic induction of 100mcg fentanyl, 50mg lignocaine, 200mg propofol and 1mg cephalosporin. I inserted a laryngeal mask and noticed immediately that he became tachycardic and tachypnoeic. I turned the volatile agent on to keep him asleep. Meanwhile his pulse was 130b/min.

He looked slightly flushed but he had a fair complexion. After two minutes I asked for some hydrocortisone from the pharmacy cupboard (in a different room).

I checked his blood pressure minutely but it wasn't until 5 minutes of tachycardia that he became hypotensive – BP was 58mmHg systolic! It was quite obvious at this stage that he had anaphylaxis. I gave him 2x1mg metaraminol for his blood pressure but then quickly changed to adrenaline boluses of 50-100mcg.

It took 10-15 minutes to get his BP into the 70's, and around 30 minutes totally to stabilise him. In that time we used about 4mg adrenaline (boluses and infusion). With an improvement in BP his complexion was very very red! I was lucky to have 3 excellent anaesthetic nurses and another calm, wise anaesthetist to help.

He was retrieved to ICU and recovered quickly. He was discharged home the following day. Tryptase levels at 2 and 6 hours post-event were 149 and 75 respectively.

The theatre NUM asked me to do an IIMS form and so with the usual grumbling and moaning I completed one. It turned out to be very helpful, and allowed identification of 8 cases of anaphylaxis within 11 days associated with the same batch of cephalosporin!

So no more whinging about IIMS forms!!!



## In Profile.....Mr David Scotman

David was born in the old Royal Newcastle Hospital (year unknown according to David) and grew up in Belmont, attending Belmont High School.

David has always been in administrative roles, and commenced with Hunter New England Health in May 2002 as part of the casual pool at the Wallsend campus. He worked with a variety of departments before moving to the position of Executive Assistant Communication and Stakeholder Engagement in late January 2006.



David shares his time between the Communication Unit and the Executive Support Service in Clinical Governance. In the Communication Unit he is the Executive Assistant to Carina Bates and provides administrative support to the Communication Managers and Communication Officers, as well as responding to all emails sent to HNE Health through the Health and Webmaster email accounts. Within the Executive Support Service he assists with the Oral Health and Population Health portfolios when it comes to Ministerial requests, complaints and MP Correspondence. David also looks after a number of corporate Freedom of Information requests.

David has just recently returned from five weeks travelling through Jordan and Italy and reports that "it was all fantastic". Apparently it does not take much to get him rambling on about his travels, especially about Arabic sweets in Jordan and gelato in Italy.

## Clinical Governance 2009 Christmas Quiz

It's on again! Entries close Sunday 10 January 2010, and winners will be announced in the January 2010 edition of Quality Matters. The 1<sup>st</sup> three correct entries drawn out will win one of the following great prizes:  
1<sup>st</sup> prize – Christmas hamper  
2<sup>nd</sup> prize – 2 movie tickets  
3<sup>rd</sup> prize - \$20 book voucher from Maclean's bookshop, Beaumont St Hamilton

For your chance to win click on print off the attached quiz or do the quiz on line at:

<http://intranet.hne.health.nsw.gov.au/cgsurvey>

## Safety Alerts Bulletins

The latest safety alerts and notices are listed below. For details go to:

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

## This Month's Root Cause Analysis Review

Patient misidentification continues to occur across HNE Health. Incidents are reported in many settings and situations, such as ordering of pathology and radiology tests, labeling of specimens and the prescribing of medication. Application of incorrect addressograph labels on forms is one of the most common factors. In the last month there have been five reported cases where the incorrect patient had an unnecessary invasive procedure or the incorrect medical imaging test.

In a recent case a patient was exposed to radiation unnecessarily as the result of having their knee x-rayed. The RCA identified that one of the doctors caring for the patient asked another doctor on the treating team to request a right knee X-ray for the patient in Bed 8. Patient A (who was incorrectly X-rayed) was in Bed 8 on the day of the incident. Patient B (for whom the X-ray request was intended) was also, according to inpatient records, in Bed 8 earlier in the day on the day of the incident. Both Patient A and Patient B had been moved to different beds within the same ward during that day.

The incident was picked up after Radiology staff had completed the X-ray, at which time it was noted that the request and clinical history did not match.

The main system considerations are patient identification and clinical communication. Consideration of what information is needed to identify patients in such circumstances is pivotal - minimum information to be conveyed includes the patient's full name, medical record number (MRN) and/or date of birth. Bed numbers or locations cannot be assumed to be reliable or consistent indicators. Getting into the habit of always checking the patient's name and date of birth can reduce error and save lives.

No.	Type	Issues covered	Date of issue
SN:02 3/09		<a href="#">TGA Recall</a>	21 Dec 09
SN:02 2/09		<a href="#">Safe use of Midazolam</a>	18 Dec 09
SA:00 7/09		<a href="#">Recall of Cefazolin Sandoz BATCH AH 5067</a>	6 Nov 09
SA:00 6/09		<a href="#">Emergency/ Arrest Buttons</a>	4 Nov 09
SA:00 5/09		<a href="#">Relenza (zanamivir) Inhalation Powder Safety Advisory</a>	21 Oct 09
SN:01 9/09		<a href="#">Managing Pigtail Drains Safely</a>	8 Oct 09