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Quality Matters

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

From the Director…

Welcome to the latest edition of *Quality Matters*.

Many of you will already be familiar with the HNE Health's ISBAR communication initiative, and have even used in ISBAR day-to-day practice. The feedback about the usefulness of ISBAR is very positive, and many comment on its intuitive nature for both written and verbal communication.

I am pleased to announce that the ISBAR Project Team has started rolling out training for managers and supervisors to train their own staff to use the ISBAR tool, starting with Manning Hospital and Lower Mid North Coast Cluster clinicians and managers. Thanks to all those involved, and please keep a lookout for sessions coming to your service.

Dr Kim Hill
Director Clinical Governance

LOOKING IN THE REAR VIEW MIRROR CAN ASSIST US DRIVING FORWARDS

Guest Editorial by Dr Debbie Jaggers, General Manager, Upper Hunter Cluster and Meredith Caelli, Patient Safety Officer, Clinical Governance

Root Cause Analysis (RCA) is a critical and fundamental component of analysing serious adverse events that occur within our healthcare system. Obviously the goal of investigation is to improve future healthcare by reducing the likelihood that serious adverse events will recur and the consequences if an event does occur. In HNEH there is a robust and formalized process for the management of RCA investigations and for the establishment of RCA recommendations.

One issue which greatly concerned the management team across the Upper Hunter Cluster was the *ghost of RCA recommendations past* – have we sustained our recommendations and actions to prevent an event from re-occurring?

In 2009, the Upper Hunter Executive together with our Patient Safety Officer introduced a review program to provide the Management Team with a robust framework to ascertain the sustainability of recommendations from past RCA investigations. All past RCAs and associated recommendations in Upper Hunter since 2002 were collated (some 24 RCAs) and the RCA Look Back program commenced. Each RCA has been allocated to a current Health Service Manager to review the recommendations and provide a presentation to the Executive team regarding:

1. Whether the corrective actions had been fully implemented?
2. What the impact of the corrective actions was?
3. Whether the recommendations/actions been sustained with time and across services?
4. What are the current implications for Upper Hunter services?

Health Service Managers are rostered on a bi-monthly basis to provide reports to the Executive and any current actions to be determined. Maternity and Operating Theatre specific RCAs are reviewed in respective sub-committees.

This process is proving an invaluable one in Upper Hunter and would seem to have applicability to other settings. Review of recommendations has identified some key themes in terms of sustainability. For some RCAs there has been strong and robust sustainability of recommendations and recommendations are embedded across all relevant services.

At the other end of the spectrum there are cases where the lessons of history and resulting recommendations have not been sustained through change in management and the passing of the years. The Look Back process has alerted us to this and provided opportunity to improve our systems and the healthcare we provide. A final group includes those recommendations that are sustained within one facility; however, the practices and systems have not been translated into all relevant settings across Upper Hunter.

We are part-way through the process. One objective is to ascertain if there have been similar RCAs in the timeframe of 2002-2010 and if so the impact recommendations had on the subsequent event. If the incident has not recurred since the implementation of the RCA recommendations, it could be assumed that the root cause was correctly identified and eliminated. The RCA Look Back program has been introduced as a process for ensuring this is the case.

Our focus on RCAs has also led to improvements in our RCA recommendation implementation planning by the use of formal Change Implementation Plans. Fortnightly meetings enable us to maintain a focus on driving forward improvements to systems and practice across our services.

It is important that serious events of the past are used to remind us of what can happen and provide us with the opportunity of continually strengthening our systems and healthcare practice. This benefits our patients, clients, residents and supports out staff in carrying out their work to the best of their ability.

Rights and Responsibilities

The attached report "Are Patients Informed of their Rights and Responsibilities" was presented to the Area Health Care Quality Committee in June 2010. An Action Plan is being developed to improve provision of information to patients and carers on their rights and responsibilities. The Committee also requested the report be circulated to Clinical Leaders, Network and Streams to raise awareness and gain their support in circulating information on rights and responsibilities.

For further information, or any comments on the Rights and Responsibilities paper, please contact Ms Dianne Sales, Executive Support Service Manager in Clinical Governance on Dianne.Sales@hnehealth.nsw.gov.au .

QualityMatters

This Month's Update is on …. the new Death Audit Database (DIH)

Clinical Governance and the HNE Health Clinical Information Services team have designed a Death in Hospital (DIH) Audit Database to capture information relating to inpatient deaths audits. This database was developed as an effective information management tool to support one of the requirements of the NSW Heath Patient Safety and Clinical Quality Program which is for each Area Health Service to have in place a system for screening the medical records of all patients who have died in hospital within 45 days of death (PD2005_608 *Patient Safety and Clinical Quality Program* & PD2005_609 *Patient Safety and Clinical Quality Program Implementation Plan*) .

The Death in Hospital Audit Database is web-based and its design was informed by the death audit processes of North Coast Area Health Services, particularly their audit categories and criteria. It is integrated with the medical record tracking and coding system to minimise data re-entry and data entry error. The system can be accessed from any computer in HNE Health and is security guarded. It also enables interactive feedback, for example for clinical staff feedback. It is fully auditable and also has extensive report functionality to support feedback to clinicians and managers, and for reporting and monitoring of benchmarks.

For further information contact the System Administrator Damion Brown, Patient Safety Officer, Clinical Governance on Damion.Brown@hnehealth.nsw.gov.au.

This Month's Root Cause Analysis Review

Situation

A 73 year old female patient died from a pulmonary embolism after having been discharged from the Emergency Department (ED) five days previously after referral for Hospital-In-The-Home (HITH) management of a deep venous thrombosis (DVT).

Background

The patient presented to a Rural Referral Hospital with a DVT. A decision was made to refer the patient to the HITH program for anticoagulant therapy following a telephone consult with senior medical staff and without reviewing the patient. The patient was discharged home from the ED and a referral form faxed to the HITH program. The patient was accepted onto the HITH program on the next working day. The patient received education from HITH staff about self-administration of medication and after three days was discharged from the HITH program. At some time over the next two days the patient received a massage on her affected limb to ease the pain. Two days following discharge from the HITH program the patient represented to the Emergency Department and was diagnosed with pulmonary embolism. The patient died the following day.

The patient had complex underlying medical issues including a Grade IV Glioblastoma Multiforma. During a recent admission to a Tertiary Referral Hospital (TRH) a decision had been made, in consultation with the patient and her family, to cease her anticoagulation therapy because of the aggressive nature of the underlying tumour, the risk of bleeding into the brain with anti-coagulation and the longer term ineffectiveness of the anti-thrombotic therapy (balancing a possible increased risk of bleeding and the inability to prevent clot formation in the longer term).

Assessment

The following systems issues were identified:

- the provision of telephone advice in lieu of physical patient assessment was not consistent with best patient care practice in this case
- documentation of the previous decision to stop the patient's anti-thrombotic therapy and the rationale for discontinuation of therapy was not easily available to the staff of the Rural Referral Hospital.
- exclusion criteria for referral of patients to HITH were not observed for this patient.
- exclusion criteria for referral to HITH were unclear, specifically as to the interpretation of the term intracranial lesion.
- the HITH patient information brochure did not include a statement regarding avoidance of massage to an affected limb/site of patients with a DVT.

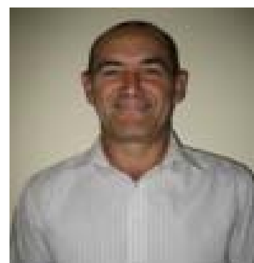
Recommendation

1. Clinical teams receiving requests for admission from ED Medical Staff attend the Emergency Department to assess the patient.
2. The Hospital-In-The-Home DVT Guidelines for Outpatient Management be reviewed in light of this case and the terminology used in the pathway exclusion criteria reviewed.
3. The HITH Lower Hunter Information for Patients with DVT brochure is reviewed to include advice about criteria for massaging affected limbs.
4. Inpatient discharge summaries for complex medical patients include the risk assessment for VTE and rationale for treatment decisions ensure the relevant medical information is accessible by all healthcare professionals involved in the patient's care.
5. VTE Risk assessment and prophylaxis be completed.
6. Haematologist advice considered in high risk cases, and if sought, documented by either ED medical staff or if inpatient care, by the inpatient clinical team

This Month's Clinical Unit in Ethics and Health Law Seminar

Ms Julie Hughes a Solicitor at Newcastle Health Law Firm, Catherine Henry Partners and Legal member of the Mental Health Review Tribunal will present the September 2010 CUEHL seminar. Ms Hughes will be presenting a paper entitled "*What chance for loss of chance?*" This is a discussion focusing on the practical implications of the recent High Court decision in *Gett v Tabet* in which a plaintiff patient unsuccessfully sued a Doctor for the loss of a chance of a better outcome. The case had been followed closely by lawyers and doctors around the country and has followed overseas trends in negligence litigation. The seminar will be held on Monday, 6 September 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 in. Entry is free and no RSVPs necessary.

In Profile……….Welcome to Gary Martin Coordinator, Quality Support and Liaison, Clinical Governance



Gary commenced his employment with Clinical Governance in June 2010. Prior to this he worked as a Performance Analyst in the HNE Health Planning and Performance Unit. Previous to working with HNEH Gary was employed by the Department of Community Services as a Program Officer monitoring the departmental performance agreements of 43 non-government organisations across Newcastle.

Variety in Gary's vocational history include his work as a therapist, as a regional manager with responsibility for 22 community service centres, a member of the clergy and upon leaving school, as an industrial chemist with BHP. He holds degrees in Theology and Social Sciences with Masters Degrees in Public Health, Psychotherapy and Social Science.

Working for many years in the resource poor private sector, Gary developed an appreciation for efficiency derived from program evaluation and continuous quality improvement. In his current appointment with Clinical Governance he will be assisting staff in the coordination of both the Quality Systems Assessment (QSA) and Australian Council of Healthcare Standards (ACHS) EQuIP processes. These activities support clinical quality and patient safety and are a part of the very important accreditation cycle.