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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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From the Acting Director...

Welcome to this month's *Quality Matters*.

In this edition with great regret we farewell Dr Kim Hill, our Director Clinical Governance for the last five years. Kim has left HNE Health to take up a new role as Executive Medical Director for Western Sydney LHD and we wish her well in her new role. She has left the HNE Health stronger in its understanding of and expertise in Clinical Governance. *Quality Matters* was one of her many ideas to promote education and understanding of quality and safety initiatives and in this its 56th edition we once again bring you our regular features as well as information on another important local professional development event that she initiated: the 6th Annual Quality and Scientific Program. The theme this year's event is "Clinical effectiveness: rethinking treatment and technology. To increase access to those only able to attend for a day the event is held over 2 half days and is at no cost to registrants. Information on the event is included below. I hope you will be able to attend and find the event worthwhile.

Dr Anne Duggan
Acting Director Clinical Governance

Changes to the 2009 Coroner's Act

Guest Editorial by Dr Tim Lyons, Director of Forensic Medicine at John Hunter Hospital.

The 2009 Coroner's act was promulgated in January 2010. The major changes to the Act are in a number of specific areas: anaesthetic and post procedure deaths; deaths relating to the elderly after falls and for a doctor to be entitled to issue a death certificate the time has been extended from 3 to 6 months since last having seen the deceased. The former "24 hour rule" relating to anaesthetic deaths no longer applies. What matters now is whether or not the death was or was not a reasonable expected outcome of the procedure, irrespective of when the procedure and death occurred.

The definition, however, of "not reasonably expected outcome of a procedure", is subject to the treating doctor's interpretation of each particular case and ultimately, it is not the pathologist's opinion but the clinician who has to make the final decision as to whether or not to report a case. For example, it is now possible for clinicians to issue certificates in previously reportable cases such as where the patient died during an operative procedure for a ruptured abdominal aneurysm or massive infarction of the bowel. This is certainly a common sense approach because in these cases surgery has effectively been undertaken as a life saving surgical procedure.

In cases of falls in the elderly, the age for reportable deaths has now been raised from 65 years to 75 years. The death should not be the result of a fall caused by old age or frailty and can occur in any location of residence. The family may object to an autopsy as is their right in NSW but even if there is no objection the coroner might decide an order for a "limited autopsy" (e.g. heart only) or a "staged autopsy" (usually commencing with the heart and lungs and continuing until a cause of death is established).

It does make common sense that for the very elderly who have multiple natural disease processes but not regularly seeing a general practitioner a death certificate can be issued without an autopsy. However, it is our concern that there is potential for suspicious cases to slip through the net. Other problematic cases are also where the cause of the death may "appear obvious". For example a train strikes a person on the railway tracks and the body is multiply injured. The cause of death from multiple injuries might appear clear. However the deceased might have been assaulted prior to being placed on the railway tracks and this might never be uncovered following a superficial examination or none at all.

We are not advocating "autopsy for all", but argue the view that, in many cases, there stills needs to be a strong liaison between the office of the coroner, forensic pathologists, investigating agencies, treating clinicians and next of kin in terms of considering the decision as to whether or not an autopsy should be performed.



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

The NSW Health Patient Safety and Clinical Quality Program requires each Local Health District to have in place a system for screening the medical records of all patients who have died in public hospitals in New South Wales (PD2005_608 Patient Safety and Clinical Quality Program & PD2005_609 Patient Safety and Clinical Quality Program Implementation Plan). The benchmark is 45 days.

In July 2010 Clinical Governance and the HNE Health Clinical Information Services team commissioned the Death in Hospital (DIH) Audit Database to capture information relating to inpatient deaths audits. The web based program links to iPM and has now been in place for 12 months with overwhelming success. The system has markedly improved the efficiency and productivity of the death auditing process

From 01/07/2010 to 30/04/2011 there has been 2253 deaths in HNE Health and 2063 or 92% have been audited by the Patient Safety Officer team of which 76% were audited within 45 days. Ninety five of the cases were escalated for further review and 38 of the total deaths were screened as a SAC 1 outcome. Fifty five percent of deaths were categorized as anticipated due to disease progression; 17% were categorized as expected despite preventative measures and 5% were following cardiac or respiratory arrest before arrival to hospital. Five percent of deaths had been referred to the coroner (110).

The system has generated a lot of external interest and the project team has had the opportunity to showcase the system to the Clinical Excellence Commission (CEC), and several other Health Districts within NSW.

Some of the overwhelming success has been attributed to the **Third Party** function of the DIH, which allows treating clinicians and other appropriate staff to make comment on the deaths currently being reviewed by the Patient Safety team.

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

Please click on the attached link to see images of the new Death Audit Database [Death Audit Database images.pdf](#)

In Profile.....

Maryanne Fernandez

Acting Executive Support Manager

Executive Support Services (ESS)

Maryanne has been in health in various roles since 2000 when she started at Westmead Hospital, later working at Concord Hospital. In 2005-6, Maryanne completed a Diploma Business (Frontline Management) and took on her first role in management in 2006 at Bankstown Hospital where she was required to restructure Administrative Services. This successful model has since been implemented at Royal North Shore and Liverpool Hospitals.

Following this, Maryanne worked for Department of Community Services and most recently at Northern Sydney Central Coast as the Manager Area Executive Unit.

Maryanne is on secondment to Hunter New England Health as Acting Executive Support Service Manager, enjoying the change and the challenges that come with working in Clinical Governance.

Maryanne in her spare time plays piano, practices her spanish with her in-laws and is looking to pursue law in 2012.

Clinical Unit in Ethics and Health Law Seminar

The next CUEHL Seminar will be held on Monday 5 September 2011 in the Royal Newcastle Centre, Lecture Theatre. Supper will be served at 6:00pm and the seminar will begin at 6:30pm.

This month will be the fourth annual seminar in memory of John McPhee with the theme for the evening being 'Lane Change: From Curative to palliative care.'

Professor David Currow will also be speaking on the topic of 'a difficult clinical dilemma'.

All are welcome to join us. There is no entry fee and no RSVP is necessary.

For further information please refer to the attached flyer [John McPhee Flyer.pdf](#)





This Month's Root Cause Analysis Review

For many years Hunter New England has had a checklist to assist clinicians to identify clinical cases which should be referred to the Coroner. In December 2009 the Coroner's Act in NSW was changed and subsequently the Policy Directive from the NSW Department of Health was updated. In accordance with this update NSW Health developed a Coronial Checklist, using references to the new Act and Policy Directive and this checklist was made available to all sites through our document ordering system. The Coronial Checklist should be used for all deaths to ensure that relevant cases are referred to the coroner.

RCA's undertaken within HNE Health have, on occasion, identified that a death should have been referred to the coroner but was not. In these cases the opportunity to conduct a coronial post mortem has been lost. In many of these cases the Coronial Checklist has not been completed. Lack of a definitive cause of death has a number of impacts including hampering the RCA team's capacity to identify a possible system improvement opportunity.

A recent RCA highlighted this issue. A 50 year old patient was admitted to the emergency department of a district hospital. Over a period of 6 hours his condition deteriorated. While being transferred to the ambulance trolley for transfer to another hospital he had a cardiac arrest and could not be resuscitated. A death certificate was issued with the cause of death given as sepsis. However the RCA team could not find any evidence that this was known at the time or that any treatment for sepsis was given during the time in the emergency department. The RCA team identified failure to use the Coronial Checklist as a system improvement opportunity and was of the opinion that this death fitted one of the categories described in the Coroner's Act 2009 for referring a death to the Coroner, that is, 'a sudden death, the cause of which is unknown'

The RCA team recommended that the use of Coronial Checklists be made widely available to promote identification of all potential coronial referrals. Copies of the coroner's checklist should be available on all wards and in "Management of Death" resource folders. Copies can be ordered through Salmat (SMR 010.513). In cases where doubt exists as to whether the death is reportable to the coroner, there is opportunity to contact the Northern Forensic Hub, Newcastle or local coroner to discuss the case.

Information Privacy - things you need to know

Two pieces of legislation operate in NSW for government agencies. The Health Records and Information Privacy Act 2002 regulates personal health related information (for example, the patient's medical records) and the Privacy and Personal Information Protection Act 1998 regulates personal non health related information (for example, your personnel record).

Everyone working in health care delivery needs to consider the nature of the information they are collecting and how it will be used and who it will be shared with. The following basic key elements can assist you to ensure patient privacy:

- Only use the information provided for the purposes for which it was collected. Any other use must be done with the person's consent (there are exemptions that apply; speak to the Privacy Contact Officer for more information)
- Do not disclose the information to third parties unless it is a directly related purpose (for example; if a patient presents to the Emergency Department and transfers to a ward, it is reasonable that their information will go with them to the ward and potentially to other services post discharge - for continuum of care)
- Ensure that personal information is secured against loss, misuse and unauthorised access
- Ensure that information held is complete, up-to-date and not misleading and this must be checked for accuracy when possible (for example; when a patient presents each time, or makes contact with our service to make an appointment)
- Understand that all information can be accessed by the person providing it
- Ensure that patients understand the consequences of not providing information (for example; it may be difficult to assist a person over the phone if they won't tell you their name)

In order to meet these obligations, HNE Health is committed to:

- Ongoing training on Privacy principles, via online training or, in some cases, face to face
- Having a Privacy Contact Officer to assist with privacy queries
- Investigating privacy complaints pursuant to legislation and NSW Health Policy

If you wish to seek further assistance, please do not hesitate to contact HNE Health's Privacy Contact Officer, Mr Greg Jackson on 55810 or Ms Maryanne Fernandez, Acting Executive Support Manager, Executive Support Service (ESS) .



QualityMatters

Register Now for the 2011 Hunter New England Health Quality and Scientific Program



Where: Cypress Lakes, Pokolbin
When: Tuesday 20 September 2011 and
Wednesday 21 September 2011
Theme: "Clinical Effectiveness: Rethinking Treatment and Technology"

To register click on the link [Registration 3279I&Preview=true](#)

For more information on registering contact Penny Plumridge, Administration Officer, Clinical Governance on 49214168



Images from 2010 Quality and Scientific Program

Quality Awards Update

Congratulations to the 22 finalists that have been chosen from an initial field of 71 entries in the 2011 HNE Health Quality Awards. Winners will be announced at the Annual Achievement Awards Dinner on 20 September 2011.

On Friday 22nd July 2011 nine projects were entered into the NSW Health (Baxter) Awards and another eight are being prepared for the Australian Councils of Healthcare Standards Awards and twelve are being readied for the NSW Premier and Cabinet Awards.

This is a major opportunity for HNE Health to showcase the depth of commitment to quality improvement across our Health District. Good Luck to all teams.