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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 the final edition *Quality Matters* for 2011

In this month's edition of Quality Matters we focus on clinical documentation. Our *Update on Clinical Documentation* provides some compelling reasons why it should be a focus of attention for all clinical staff. This month's Root Cause Analysis Review provides a reminder that there is still work to be done in 2012 to promote excellence in clinical documentation.

My special thanks to Andi Pramono who provides this month's guest editorial. Andi has been working with Clinical Governance in recent months as part of his management training and has become an important part of the team and a great contributor.

In this last edition of Quality Matters for 2011 I would like to thank the editorial team for their effort and hard work that has ensured that every edition is relevant and focussed on key aspects of our quality and safety agenda; I'd like to thank our contributors for their thought provoking article and you our readership. I hope you found reading Quality Matters worthwhile.

Dr Anne Duggan,
Acting Director Clinical Governance

Clinical Governance: My Journey to Quality and Patient Centered Care Practices

Guest Editorial written by Andi Pramono, Management Trainee of Australasian College of Health Service Management (ACHSM), Graduate Health Management Program (GHMP) 2011.

When I joined Clinical Governance in August 2011 as one of my six-monthly work placements for ACHSM as a GHMP trainee in Hunter New England Local Health District (HNELHD), I was not exactly clear what the role of Clinical Governance in health care was. Initially, I found myself overwhelmed with many words or acronyms that my ears were unfamiliar with such as RCAs, RIB, BTF, IIMS, etc.* Reading the Clinical Governance web page on the HNELHD intranet has given me good explanations of those terms but not a whole picture of how they work. It was only after I was involved in the activities and processes of the programs in Clinical Governance that I began to understand the important responsibilities Clinical Governance possesses.

I have heard colleagues say, "People who work in health care come with good intention". The good intention is to help others, in other words the patients. Programs and initiatives in Clinical Governance enable us to channel the good intention into best practices. Clinical Governance is a framework which is based on the principle that people in healthcare are accountable for quality of patient care and standards of care delivery. Clinical Governance ensures that the accountability is demonstrated.

In Clinical Governance everyone has different roles, tasks and responsibilities, but everyone has the same goal and is committed to the same thing, 'quality of care for patients'. The activities I have been involved in during my placement in Clinical Governance directly or indirectly lead to that same goal, to continuously improve the quality of patient care.

My experience in Clinical Governance has provided me with a foundation for my future career and prepared me well for a longer journey in health care service management. It has given me a clear picture of the reason I am in the health care sector. Providing a quality of patient care to meet our patients' expectation this should not only be an obligation to us but it should be our passion to do so.

Previous to commencing the ACHSM Graduate Health Management Program, among other roles, Andi worked as a Project Coordinator with Father Riley's Youth Off The Streets Overseas Relief Fund in Aceh, Indonesia; managed a Community Health Centre in Pontianak, Indonesia; and worked as a Dentist for the Indonesian Ministry of Heath.

*RCA- Root Cause Analysis; RIB- Reportable Incident Brief; IIMs-Incident Information Management System

QualityMatters

This Month's Update is on…. Clinical Documentation

Written by Maryanne Fernandez, Acting Executive Support Manager

Anyone you speak to in Health can likely tell you what clinical documentation is and probably what should be included, but collectively, as an organisation, we probably all agree that there is room for improvement. Commissioner Garling made a recommendation around completeness and legibility of clinical notes and this was accepted as a Stage One recommendation (i.e. for immediate implementation).

Across Health, there are legal, patient safety and financial implications of poor documentation. In a recent Victorian case study, 752 records were audited with 16% recoded due to poor clinical documentation. More than half had their codes changed. Poor documentation cost that particular facility $575k in funding, over a six month period. The risks to patient safety were not measured. With a move towards Activity Based Funding, getting the coding right is essential for ensuring we have the resources to continue to provide high quality care. With a devolved level of accountability, now is the time to take action to review, monitor and evaluate tools to support our compliance with our standards for documentation.

A recent audit of Emergency Department records in a local hospital indicated the value of audit and feedback to improve performance. The initial audit found that for 21 of 30 case notes recording the patients' admission no date was recorded. In 10 cases, there was no care plan and in 3 of those, the clinician was unknown. There was however marked improvement in the standard of documentation when the audit was repeated the following month.

Some implications of not getting it right:

- A wrong diagnosis is made; necessitating further investigation and possible increased hospital stay, or conversely, discharge too soon, resulting in possible re-presentation and an increased length of stay.
- Loss of confidence in the health system. Patients expect complete and comprehensive care. If there is no (or poor) documentation, would you as a patient be confident in the care provided.

We all contribute to the patient journey. The documentation of who, what, where, when and why of that journey is key to ensuring that our patients receive the care they deserve and are kept safe.

We can meet their expectations by fulfilling these obligations.

In Profile…..
Elizabeth Dewhurst
Administration Officer, Clinical Governance

Elizabeth started her employment with HNE Health as an administrative assistant to the Area Quality Manager in mid 2010. Due to the breadth of the Quality portfolio Elizabeth has had opportunity to make contact with a wide range of staff across both the geography and disciplines of the health service.

With a vocational and academic background in real estate and aged care, Elizabeth has been well equipped to develop meaningful networks and partnerships.

Elizabeth's people skills are only surpassed by her culinary skills for which her Clinical Governance team is most appreciative.

Elizabeth states "the appreciation works both ways. I have been well supported in my time here and am looking forward to increasing my knowledge of the health service".

ISBAR here to stay!

The ISBAR in Our Communication project led by Clinical Governance has now transitioned into an ongoing program with resources available on-line to support sustainability. The ISBAR in our Communication project has seen the use of the ISBAR communication tool implemented and embedded across HNE Health, with close to 9,000 staff having completed mandatory ISBAR training to date. Annual training in ISBAR is mandatory for all staff.

ISBAR tools and resources can be found at: http://intranet.hne.health.nsw.gov.au/cg/clinical_communication
Any queries relating to ISBAR should be directed to Clinical Governance on 4921 4168.

This Month's Root Cause Analysis Review

Situation

A Root Cause Analysis (RCA) was undertaken when an 88 year old female patient suffered a cardiac arrest and death within two hours of discharge from an Emergency Department (ED) after initially presenting with lower back pain.

Background

The patient presented to the ED of a local hospital by ambulance. She was complaining of lower back pain after a fall the previous day whilst at home. She had spent many hours on the floor post fall until her carer found her and assisted her to bed. The patient had required several injections of narcotic pain relief during transport. The patient's respiratory rate was elevated but this was attributed to her chronic lung disease and she was dehydrated.

The Medical Officer Care plan prescribed some oral pain relief and medications for her lung disease; Ventolin via the nebulizer as well as some steroids to reduce inflammation (prednisone). The lady and her carer were keen to go home and undertook to see the lady's GP the next day.

On arriving home the lady collapsed on the doorstep. Cardio-Pulmonary Resuscitation (CPR) was commenced by the neighbours then continued on route to the nearest hospital (another hospital). This hospital requested an urgent copy of the previous clinical records. In the interim resuscitation was unsuccessful and treatment was withdrawn.

Assessment

The RCA team found no root cause for this incident. The cause of death was considered to be due to her pre-existing heart and lung disease. The team did note that issues around the care provided in her initial presentation to the ED could have affected the lady's care. With the exception of the initial triage record no observations were documented either during her assessment or at the time of discharge. However, some observations and notes were recorded retrospectively after the patient was discharged. The notes also recorded limited documentation of her medical assessment including of the possible causes for her fall or complications post fall and had no discharge plan documented.

The RCA team were of the opinion that the absence of documentation and of a discharge plan for the patient could have hindered the capacity of health professionals to assess her and to optimally continue her care had she survived.

Recommendations

The RCA team's key recommendations included that the ED:

- comply with the requirements for taking and recording patient observations and for contemporaneous documentation of clinical notes in the health record for each patient / clinician interaction
- complete discharge summaries prior to the patient's discharge and be given to the patient or transmitted electronically to the General Practitioner nominated by the patient at the time of discharge
- develop a Contingency Plan to manage ED capacity.

Christmas Quiz Winner…..

Thank you to everyone who entered this year's Christmas Quiz. We received some very creative Christmas acronyms and judged all in this section of our quiz to eligible for entry into the draw!

There can only be one winner and this year the winner was **Jackie Blanch, Tamworth Hospital** will be enjoying a $50.00 voucher from Maclean's Bookshop**.**

Special mention goes to Dr Peter Finlayson for the best Christmas acronym.

Christmas
Holiday
Rosters
Initiate
Safe
Treatment by
Managing
Absent
Staff!

Well done Peter!

The answers to the quiz are in the attached document.

Safety Alert Broadcast System (SABS)- recent notifications

NSW Health's Safety Alert Broadcast System (SABS) has been adapted from the UK's National Health Service Safety Alert Broadcast System. Its aim is to provide a systematic approach to the distribution and management of patient safety information to NSW health services. Each alert specifies action to be taken by health services, the timeframe in which such action must occur, and specific responsibility for the actions. For more information please click on the relevant hyperlink.

The **Safety Alert Broadcasting System Policy Directive PD2006_102** describes how SABS works. Basically, there are three types of notification:

Safety Alert (Red), requiring immediate attention and action.

Safety Notice (Amber), requiring risk assessment at the local level.

Safety Information (Green), ensuring that lessons learned from statewide, national and international sources are shared actively across the NSW health system.

The SABS register

Number	Type Issues Covered	Date of Issue
SN:016/11	N TGA Recall SN 016/11	15 Nov 11
SN:015/11	N Bathing of Newborn Babies and Infection Prevention	10 Nov 11
SN:014/11	N Newer Oral Anticoagulants	9 Nov 11
SN:013/11	N Management of medication for patients with Parkinson's Disease (PD)	7 Nov 11
SN:012/11	N TGA Recall SN 012/11	7 Nov 11
SN:011/11	N Recall of activated Drotrecogin alfa (Xigris)	26 Oct 11
SN:010/11	N TGA Recall SN 010/11	26 Oct 11
SN:009/11	N TGA Recall SN 009/11	10 Oct 11
SA:006/11	Supply of Minijet® injections	7 Oct 11
SI:001/11	Safe Use of Alcohol Based Skin Preparations for Surgical and Anaesthetic Procedures (supersedes Safety Information SI: 001/07 issued on 27 June 2007)	7 Oct 11

What is the current best evidence available to support your clinical decisions?

HNE Health Libraries brings you McMasterPlus; a search engine designed to find the best evidence-based answers to your clinical questions. With a single click and in a search time of only a few seconds, McMasterPlus simultaneously searches the leading evidence-based texts including; UpToDate, BMJ BestPractice, ACP Journal Club and DARE (Database of Abstracts of Reviews of Effectiveness), and articles in PubMed Clinical Queries.

Registration

First-time users need to register. Registration takes approximately 2 minutes and is necessary for tailoring clinical alerts to your profile and research interests.

Registration Routes

Register directly at http://plus.mcmaster.ca/au/Registration.aspx (Just click **Register**) Follow the quick and easy steps!

Access Routes Once Registered

Once registered, you can access McMasterPLUS by going to: http://plus.mcmaster.ca/au/ You can bookmark the URL for your convenience. The site can also be accessed via the library website visit www.gardinerlibrary.com

Please note that to access this resource you need to use a computer logged on the District network. For information contact Steve Mears in the Library Steve.Mears@hnehealth.nsw.gov.au