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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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

From the Director...

This month's edition of Quality Matters highlights transfusion medicine, and the emerging evidence on appropriateness of care in clinical transfusion practice. Dr Stephen O'Mara and the HNEH BloodWatch team are keen to communicate widely the evidence base for appropriate use of blood products, and to work with clinical staff in practice review and the dissemination of clinical



guidelines. This edition also includes a report on the recent National Forum on

Quality and Safety in Health Care, which was held in Adelaide in October 2008. This was an excellent meeting, and Dr Anne Duggan has summarised some of the highlights and sources of further information. I am also pleased to advise that the HNEH poster on Introducing Clinical Procedures and Innovation was awarded second place in its category at this Scientific Meeting.

BLOODWATCH - EVERY DROP COUNTS

Bloodwatch has been a strategy of the Clinical Excellence Commission and Hunter New England Health for two years. The aim was to improve the knowledge, decision making and processes underlying blood transfusion.

Transfusion related immunomodulation, which is the immunosuppression from blood transfusion has become a major area of concern for transfusion science. Simply filtering the blood does not avoid this risk.

Evidence is emerging that Jehovah's Witnesses' health outcomes in Cardiothoracic surgery are better than patients receiving Cardiothoracic Surgery at the best units in the world. A review of over 10,000 cardiothoracic patients in Britain has led to the conclusion that transfusion is an independent risk factor for postoperative infections and ischaemic events such as stroke and heart attack. A review of patients from various trials involving patients with cardiac ischaemia treated medically has found a similar pattern of adverse outcome when patients are transfused as compared to non-transfused patients with the same haemoglobin.

Randomised clinical trials are urgently required, and the National Institute of Health in the USA has made Transfusion Related Immunomodulation one of their urgent research priorities in 2008.

The HNEH Bloodwatch Team believes that a cautious approach to blood product prescribing be taken while the science attempts to catch up with the practice of Transfusion. This is the rationale driving clinical improvement.

If you wish to follow this debate online log on to the following website which contains published evidence and debate about best practice. www.thetransfusionquestion.com.au Please do not hesitate to ask questions. For more information contact Dr Stephen O'Mara, Haematologist and Associate Director Clinical Governance on 6767 7951 or 0418 640 348.



In Profile...

Barbara March, Patient Safety Officer

Barbara has worked as a Registered Nurse, Midwife and Manager across a variety of areas in NSW, Queensland, Tasmania and the ACT. She began her nursing career in 1973 at Royal North Shore Hospital, completing midwifery training there in 1978. After



several years at Westmead Hospital, working in both the Surgical Unit and in charge of a pre- and postnatal ward, Barbara moved back to Tamworth, then to Mackay, the ACT, Tasmania and Nowra. During her time at Armidale, Barbara undertook management roles in the Community Health Centre, Walcha Hospital and in the Surgical Unit at Armidale as Nurse Unit Manager for three years.

Barbara commenced as Patient Safety Officer in Clinical Governance in 2005 and is based in Glen Innes. Her portfolio includes Armidale, Glen Innes and Tenterfield Hospitals as well as Guyra, Emmaville and Armidale Health Centres.

Barbara enjoys the role of Patient Safety Officer, and the opportunity to meet staff from across the area and to engage in activities that make a difference to the experiences of patients who enter the health system. There is a lot of traveling associated with being a PSO across clusters but Barbara also enjoys this aspect of the job. Small towns across the Hunter New England Area have a lot to offer in terms of community spirit and dedication to their health service, and Barbara feels privileged to be involved with these health services as their Patient Safety Officer.

Barbara's interests are music, reading crime fiction, beginner gardening and swimming. She is also an avid collector of depression and carnival glass.

Root Cause Analysis Review

A 67year old man underwent open reduction and internal fixation of a fractured humerus. The operation was complex due to the extensive nature of the fracture and the patient's comorbidities. The fracture was eventually repaired with the fixation of a plate using a precision drill guide, fitted over the plate to ensure optimum placement of the screws. Post-procedure, the patient returned to the ward. The next morning a theatre nurse from the case couldn't recall the removal of the precision drill guide and contacted the Central Sterilising Department who confirmed that the drill guide was missing. The surgeon was contacted and it was confirmed that the drill guide had been inadvertently retained. The surgeon undertook open disclosure with the patient and family and with them, made the decision to surgically remove the guide that afternoon. The procedure was undertaken and the patient made a full recovery.

This case highlights the importance of systems and processes that identify surgical equipment at risk of inadvertent retention and for processes to ensure such items are accounted for prior to case completion. The Surgical Division and Clinical Governance are currently working to revise and establish guidelines and compliance procedures relevant to best practice, to prevent any recurrence.

Correction

For any readers who had difficulty accessing the Speakers' Presentations from the HNEH Scientific Exposition and Scientific Program (see last month's Newsletter), they can now be accessed on the Clinical Governance part of the HNEH intranet at http://intranet.hne.health.nsw.gov.au/cg/Quality_CPI/Awards/quality_exposition_and_scientific_program

The Australian Charter of Health Care Rights

The Australian Charter of Healthcare Rights describes the rights of patients and other people using the health system. The Charter was adopted by the Australian Health Ministers in July 2008. The Charter and other material developed by the Australian Commission on Safety and Quality in Healthcare can be found at their website www.safetyandquality.gov.au. The Charter will also be available in a number of community languages.

National Forum on Quality and Safety in Adelaide

29th to 31st October 2008

The theme of this year's Forum was "Safety and Quality is Everyone's Business". International speakers included Professor G Ross Baker from Toronto University's Health Policy, Management and Evaluation group, who discussed his analysis of five high performing "health care systems that have made the pursuit of quality and safety a core element of their strategies, a part of everyone's work and a way they [the centres] differentiate themselves." His report reviewed a range of centres from Intermountain Health in Utah, U.S.A. to Jonkoping County's system in Sweden and is available at: <http://www.longwoods.com/home.php?cat=571>

Professor Martin Marshall from the U.K. Health Foundation discussed the importance of publically reported information. It was reassuring that conference bags contained a copy of "Windows into Safety and Quality in Healthcare 2008", the Australian Commission on Safety and Quality in Healthcare's annual report into safety and quality of healthcare in Australia, which is also available at [http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/E060D889E298D039CA2574EF00721BD8/\\$File/ACSQHC_National%20Report.pdf](http://www.safetyandquality.gov.au/internet/safety/publishing.nsf/Content/E060D889E298D039CA2574EF00721BD8/$File/ACSQHC_National%20Report.pdf)

Useful displays included that from the Victorian Quality Council, which has developed an array of tools for quality improvement including the booklet "A Guide to Using Data for Healthcare Quality Improvement, available at: http://www.health.vic.gov.au/qualitycouncil/downloads/vqc_guide_to_using_data.pdf