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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

Inside this Issue:

From the Acting
Director

Guest Editorial:
By Darrin Gray,
Acting Director
HNE Imaging &
Breast Screen

Update On
Pathology

In Profile.....
Tammy Hodges

IIMS Reporting

HNE Health
Libraries latest
news

Root Cause
Analysis Review

HNE LHD Quality
Awards 2012

Editorial Team

Professor Anne
Duggan, Dr John
Fisher, Ms Barbara
March, Ms Colleen
Wall

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queries welcome:
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From the Acting Director...

Welcome to the first edition *Quality Matters* for 2012



The theme of this month's *Quality Matters* is the use of diagnostic tests. My thanks to Darrin Gray and Stephen Braye for their highly relevant and insightful articles. Both authors allude to an important point; that a key component of providing safe and high quality healthcare is the appropriate use of diagnostic tests.

The recently published NSW Health Care Atlas provides interesting data on the extent to which practice variation exists in NSW in the use of inpatient hospital services, including some diagnostic tests and treatments. The study indicates that aspects of the health care system may drive some of this variation, rather than underlying morbidity alone. I recommend the report to you. It is available at: http://www.health.nsw.gov.au/pubs/2010/nsw_health_care_atlas.html

I hope you find the report and this month's *Quality Matters* informative and useful reading.

Dr Anne Duggan,
Acting Director Clinical Governance

Just Looking at the Pictures or Reading the Story?

Guest Editorial written by Darrin Gray, Acting Director Hunter New England Imaging and Breast Screen NSW HNE.

The diagnostic radiology cycle is necessarily a closed loop. Clinicians requesting diagnostic tests anticipate that an examination will be completed and a report issued in a clinically appropriate timeframe. The Radiologist expects that the report will be read and acted upon by the requestor. Failure points in this cycle expose patients to potential missed or misdiagnoses, which may have an impact along a continuum from nil to catastrophic.

We often turn to technology solutions, but in fact the immediate solution requires commitment and action from clinical teams and radiology providers. Without this foundation for work, technological solutions will be ineffective. The capacity to request and the technological ability to perform radiology tests far outweighs the capacity to produce diagnostic reports and the ability for clinicians to read and act upon them. This growing imbalance is self-perpetuating and the root cause of delays in producing diagnostic reports.

A more recent trend is to request CT, US, and X-Ray of the patient concurrently, even though the diagnosis may be apparent from the first exam. Clearly this scattergun approach compounds the problem of timely production of radiology reports.

There are a very small number of immediately critical findings on radiological images and it is common practice to contact the requestor immediately that these are discovered. More commonly, abnormal findings are less critical or are significant but not immediately life-threatening. The standard mechanism of communicating all radiology results is via a formal written report. Important information can be missed if the report is not read.

Radiological images however are available almost instantly and clinical teams often evaluate these and reach their own diagnostic conclusions. The patient may receive treatment, transfer of care or be discharged prior to the production or review of a diagnostic report. A Clinician who no longer has the patient under their direct care may have a lower investment in following up the formal diagnostic result and there is a heightened risk that the result will never be reviewed.

Technology will assist in result notification and highlighting results that have not been read, but the fundamental solution is to ensure that every diagnostic examination requested is clinically necessary which in turn provides the capacity for the radiologist to provide timely reports and ensures the requestor has a high investment in the reviewing the formal report.



This month's update is onPathology

Written by Dr Stephen Braye, Cluster Director - Hunter Pathology North

Pathology diagnostic services are the most uniformly regulated, certified and scrutinized area of medical practice. All of these above processes are directed toward maintenance of quality standards in laboratory performance. Some of the quality programs in which pathology participates include:

- SAI Global ISO 9001 organisational and quality system accreditation. Certification of HAPS by SAI Global to the AS/NZS ISO 9001:2008 Quality Management Systems Standard demonstrates continuous improvement and customer focus in line with ISO 9001:2008 management principles.
- Internal audit program – 170 episodes in 2011 with 94 benchmarked against Standards Australia guidelines.
- National Association of Testing Authority (NATA) accreditation which re-assesses triennially to international and national laboratory standards, eg ISO 15189, AS 4308.
- Quovis (HAPS Occurrence Management System) includes complaint management, HAPS Business Improvement Reports (BIR's), staff mandatory training records.
- Key Incident Management Monitoring System (KIMMS) this is used to actively manage improvement in all areas of laboratory service, but more specifically pre and post analytic services.
- Royal College of Pathologists Australasia (RCPA) accreditation reviews (of training and service), which occur triennially.
- RCPA Benchmarking in Pathology. An obligatory program for NSW public pathology services and element of the RCPA Quality use of Pathology Program.
- National Pathology Activity Advisory Committee guidelines. All laboratory services in Australia must conform to all guidelines appropriate to the services offered and these guidelines form the basis for NATA accreditation and review.

Pathology, more than any other clinical practice, is the appliance of service in medicine. Its scientific bases are exemplified by the stringent application of quality practice across all elements of service. The organisational quality achievements are manifest in the SAI Global ISO 9001 certification achieved and maintained by HAPS. HAPS is the only public pathology practice in NSW in receipt of this organisational business certification. This is a sacrament of significant organisational and business quality system maturity.

Careful review of RCA's, in which diagnostic services feature, suggest to me that there are hardly any circumstances, in the small number of pathology derived RCA's, where pathology results were acknowledged as incorrect. Most of the RCA's seem to identify communication or interpretation failure as the source of problems. Given our understanding that diagnostic services is about the provision and dissemination of information, in an "information hungry" age, this is an area where more focused attention should be directed.

Clinical Unit in Ethics and Health Law Seminar

The next CUEHL Seminar will be held on Monday 6 February 2012 in the Royal Newcastle Centre, Conference Room 1.

Dr Nicole Gerrand will present "Alternatives to Active Consent in Research"

Supper will be served at 6.00pm and the seminar will begin at 6.30pm.

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

Clinical Excellence Commission Leadership Program Call for Applications

The Executive Clinical Leadership program is designed for senior clinician leaders, typically at the level of head of department, clinical stream director, director of nursing, allied health professional director,

All interested parties should apply through my link/Leadership Development Program.

In Profile.....Tammy Hodges, Administration Officer (ESS), Clinical Governance

Tammy commenced working for Hunter New England Health in 1993. Her first role was as an Administration Officer in the Cardiology Department at John Hunter Hospital where she worked for 10 years. After having two children, Tammy went to work in the private medical sector on a part-time basis which also enabled her to spend more quality time with her children. In 2010, Tammy returned to full-time work at Hunter New England Local Health District.

Last year, Tammy completed a Certificate IV in Business (Frontline Management) and this year will complete the Graduate Certificate in Business Administration through the University of Newcastle. In September 2011, Tammy took on the role of Administrative Support Officer in the Executive Support Service, Clinical Governance, with the aim of improving her business administration knowledge and skills. A component of Tammy's role is to manage the Clinical Governance's website. She is particularly interested in this type of work and is currently in the process of updating the Clinical Governance web pages.



When not at work, Tammy enjoys spending time with family and friends, going to the beach, horse riding, bike riding and walking the family dog, Milo.



IIMS Reporting - use of the complaints module - information for all staff

SITUATION

The complaints module in the Incident Information Management System (IIMS) is generally used appropriately, however there are, on occasion, incidents that are reported in this module which are not appropriate and the management of these issues is delayed by incorrect reporting.

BACKGROUND

There are four types of modules that can be used to report incidents in IIMS and these are:

- Complaint
- Staff, Visitor, Contractor
- Clinical Incident
- Property, Security, Hazard

Staff are familiar with using IIMS to report on near misses, adverse events and other incidents that affect the safety of our patients, staff, visitors and contractors. The complaints module is for patient related complaints.

ASSESSMENT

Staff complaints about parking, other staff, workplace grievances or other associated workplace issues cannot be managed in the IIMS system. When incidents are incorrectly reported in the IIMS complaints module they need to be copied into the appropriate module delaying the management and timely resolution of the incident.

Staff related issues need to be raised with line management in the first instance and managed in accordance with the appropriate Human Resource related policies and procedures.

Refresher training on the use of IIMS is currently under development and will consist of a short online session to assist staff with identifying different types of incidents and how to notify them in IIMS. The eLearning program will be available in the next few weeks.

RECOMMENDATION

It is recommended that staff only use the complaints module for its intended purpose *"An expression of dissatisfaction by a complainant, which may have one or more associated issues.* This definition of 'complainant' is a patient, relative of patient, visitor or other external stakeholder of HNELHD.

Should you have any queries, please do not hesitate to contact your Patient Safety Officer or Ms Maryanne Fernandez, Acting Executive Support Service Manager on 4985 5836 or 0428 105 903 or maryanne.fernandez@hnehealth.nsw.gov.au



Fight FUTON (Full-text on the Net) and other full-text bias - A cautionary word from Angela Smith HNE Health Libraries

Do you find yourself limiting your search of the published health information to full-text only or free full-text when searching Medline, PubMed, the Internet or other information sources? This is tempting practice as we attempt to save time by reducing the quantity of citations we have to look through.

By limiting to full-text only or free full-text however we are creating bias which some research claims reduces the quantity of relevant papers by around 70% or an even larger number if we were to limit ourselves to recently published articles.

The question is, does ignoring relevant studies not available in full-text really matter?

Consistently missing high quality evidence when searching undermines the process of Evidence Based Practice. If your aim is to critically appraise a topic, to educate, to discuss or inform current best medical practice, limiting to full-text only or free full-text will impact information retrieval and will ultimately affect clinical decision making. (Krieger et al.)

If you need to improve your searching skills we can help. Contact Carolyn Vanleeuwarden on ext. 13988 or email carolyn.vanleeuwarden@hnehealth.nsw.gov.au or your local HNE Health Library can help.

References:

Kreiger, M. et al. (2008). An exploratory analysis of PubMed's free full-text limit on citation retrieval for clinical questions. Journal of the Medical Library Association 96(4), 351-355.

FUTON Bias: Or why limiting to free full text might not always be a good idea. (Laikaspotnik.wordpress.com).



This Month's Root Cause Analysis Review

Situation

A Root Cause Analysis (RCA) was undertaken when a young child underwent the incorrect outpatient medical imaging procedure.

Background

A general practitioner (GP) completed a request form for an ultrasound examination for a young child suspected of hip dysplasia. The mother of the child contacted the medical imaging department at the local hospital and requested a booking for an x-ray. At the appointment the child's identity was confirmed by the radiographer against the booking registered in the electronic radiology system and a hip x-ray was undertaken. The mistaken procedure was identified when the radiologist was reviewing the x-ray request form at the time of undertaking the formal report.

Assessment

This RCA highlights some of the unique challenges associated with ensuring that correct procedures are undertaken with outpatient bookings. On review the RCA team found that the wrong test was booked at the initial contact. Further clarification was not sought when the mother requested an x-ray, which is both a term for a specific procedure and a generic term used by lay people to encompass most medical imaging procedures.

When the mother and child attended it was noted that the original request form was a request for an ultrasound scan, while the electronic booking was for an x-ray. It was considered reasonable to undertake both an x-ray and an ultrasound scan for diagnosing hip dysplasia and the x-ray was performed. The child and the mother left the department at the conclusion of the x-ray and had to be recalled for the ultrasound a week later when it was discovered that the ultrasound had not been performed.

Recommendations

The RCA team recommended that Imaging ensure staff receiving phone bookings from patients or carers ask them to confirm the exact test that is recorded on the clinical request form. The RCA team also recommended that all Imaging Departments confirm that it is their department's requirement for the clinician undertaking a medical imaging procedure to review the actual clinical request form to ensure that the specifically requested examination was undertaken.

Recognition of Excellence – HNE LHD Quality Awards

Quality Awards recognise innovation and demonstrable benefits, particularly real-life impacts, using sustainable approaches that can be taken up by other health services. The excellent work of HNE LHD staff to increase the quality and safety of health care through continually improving service delivery is recognised annually via the Quality Awards process. **This process is open to all HNE Health employees, contractors and volunteers.**

The opening date for entries to the 2012 HNE Health Quality Awards will be announced in the coming weeks

Now is the time to start thinking about your entry

Entry categories will be derived from NSW Government priorities and core values which have been adapted for the purpose of the Awards as follows:

1. Keeping people Healthy to Avoid Unnecessary Hospitalisation
2. Improving Access to Timely Health Care
3. Empowering Patients
4. Improving primary health care in the community
5. Collaboration – Working as a team
6. Building the health workforce

Judging criteria include: potential real life impacts, transferability, extent of benefits, innovation, stakeholder engagement and rigour.

The HNE LHD Quality Awards process is also a filter for submission to the external NSW Health Quality Awards, NSW Premiers Public Sector Awards, NSW Aboriginal Health Awards and the Australian Council on Health Care Standards Awards.

For further information contact:

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Colleen Wall, Administration Assistant, Clinical Governance. Ph: 676 78881, email ClinGovAdmin@hnehealth.nsw.gov.au

or your local Quality Manager