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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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From the Director...

This is the first Clinical Governance Christmas newsletter, and we are all looking forward with interest to the results of the Christmas Quiz. Thank you to all who have accepted the challenge and entered – it will be drawn during December, in time for Christmas, and we will of course publish the results in next month's newsletter.

This December 2007 edition of *Quality Matters* includes current endeavours in Infection Prevention and Control and in Correct Side/Site/Procedure, including the most recent target areas for practice improvement. It also marks the 12th edition of *Quality Matters* and I would like to thank the



editorial committee for their achievements, especially Assoc. Professor Anne Duggan, without whose energy and enthusiasm this would not have been accomplished.

Christmas brings time for celebration and reflection, and with this in mind, the editorial committee asked some of our colleagues what they will remember about the past year. Some identified clinical practice improvements they have been involved in, some thought of personal achievements in their career development, while others thought of time with family and children that brought special joy. I hope that 2007 has happy memories for you too, and take this opportunity on behalf of the whole Clinical Governance team, to wish you and your family a happy Christmas and a prosperous New Year.

Dr Kim Hill
Director
Clinical Governance

Infection control training pilot project coming to our health service in 2008

Healthcare-associated infections are a major focus of patient safety and healthcare improvement nationally and internationally.

Effective infection prevention and control programs are vital for preventing healthcare-associated infections.

Success relies on all healthcare workers having an awareness of and an ability to comply with evidence-based infection control strategies and the development of system-wide prevention strategies.

Relevant up to date training as part of continuing professional development for all healthcare workers is challenging given the nature and size of the healthcare workforce.

In response to this challenge, the National Health Service in the UK collaborated with content and educational experts to develop a blended learning program that was

launched in October 2005. The program encapsulates the evidence base for infection prevention and control procedures and communicates best practice using a flexible learner-focussed combination of e-learning and instructor-led training for both clinical and non-clinical staff.

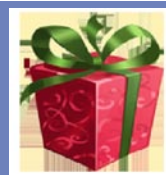
Since its launch, this awarded program has been used by more than 20,000 users from a range of acute, primary and ambulatory care settings in the UK, and has continued to develop both the flexibility of delivery (eg using tablet PCs) and adding to the course content. To our knowledge, there is no other comparable program available.

The Australian Commission on Safety and Quality in Healthcare is supporting a trial of the NHS program in NSW and WA. The program will begin in early 2008 at

four pilot sites in Hunter New England Health - including Cessnock and Kurri hospitals and the Renal Dialysis Units at John Hunter and Maitland hospitals with the objective of 1000 users from a range of healthcare settings evaluating the NHS program.

This scoping stage will provide impetus for the development or adaptation of the program for use across Australia as part of the national response to prevent healthcare-associated infections.

For more information on the program contact Dr John Ferguson Acting Director Infection Prevention and Control, Hunter Area Pathology Service by emailing john.ferguson@hnehealth.nsw.gov.au or phoning 0428 885 573 or to view the NHS program go to: <http://www.infectioncontrol.nhs.uk>



In profile...Allan Baker

Allan has a chequered background, with a Bachelor of Commerce, majoring in information management.

He left Newcastle's sunny shore to work for the Department of Customs where he spent seven years searching and interviewing people and companies about all sort of interesting things. All of which are strictly classified!

He left Sydney to join the Public Health Unit in Port Macquarie as the Communicable Disease Surveillance Officer, where he uncovered all sort of information about various

bugs and disease outbreaks.

He then worked as a Research Officer in the Clinical Governance Unit at North Coast Area Health Service.

His last move was as a Patient Safety Officer based at Manning Hospital in Taree, where he can blend his passion for information and patient safety successfully, well we hope successfully...

Contact Allan on 6592 9589 or allan.baker@hnehealth.nsw.gov.au



Allan Baker, Patient Safety Officer, Manning Hospital and Lower Mid North Coast

Congratulations!

At the recent 2007 TMF Risk Management Awards Hunter New England Health was named the winner in the category Integrating Risk Management into Organisational Planning.

This award recognises excellence in the application of risk management as a key decision support tool into the organisation's planning processes. Congratulations to Area Clinical Risk Manager in Clinical Governance Sue Williams and Area Corporate Risk Manager David Wilkie - as well as their colleagues involved in this significant project.

Newsflash...

Avoiding incorrect patient and incorrect site procedures is one of the most important clinical priorities for HNE Health.

NSW Health has recently reviewed its Policy Directive and the Correct Patient, Correct Procedure, Correct Site Policy Directive (PD2007_079) is now available on the NSW Health website at http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_079.pdf.

This policy replaces the Patient Identification, Correct Patient, Correct Procedure and Correct Site Model Policy (PD2005_380) of November 2004. The changes particularly relate to non-surgical areas, however, the release of the new policy directive requires that clinical areas that undertake invasive procedures review their current processes in relation patient identification and the prevention of incorrect procedure and site incidents to ensure they continue to comply.

A significant change is the introduction of the following performance indicators:

i) Documented local policies and procedures consistent with this policy directive are to be implemented in each health service by 31 December 2007.

Action: HNE Health

facilities already have in place procedures in response to the 2004 released policy directive. These procedures should be reviewed to ensure they continue to comply. Clinical Governance will contact facilities to request copies of procedures in December prior to Christmas 2007.

ii) Antibiotic prophylaxis assessment at "time out" (100%) and venous thromboembolism prophylaxis assessment at "time out" (100%).

Action: Local Quality and Patient Safety Committees will be required to report these two indicators to the Area Clinical Quality and Patient Safety Committee from January 2008.

Clinical Governance staff are available for advice and assistance in implementing these new arrangements. Associate Director Dr John Fisher (ph 6767 7237) or Area Quality Manager Tonia Easton (6767 7233) are the contacts for Operating Theatres; and Associate Director Dr Naomi Lee (ph 4985 5446) is the contact for other clinical areas, eg Imaging.

Queries relating to reporting of indicators to the Area Clinical Quality and Patient Safety Committee should be directed to Tonia Easton.

Ophthalmology incidents

NSW Health was recently advised by the Clinical Excellence Commission of ophthalmic clinical incidents involving the insertion of wrong diopter intra-ocular lenses.

A review of incident management data from the period 1 July 2006 to 7 November 2007 identified eight ophthalmology incidents of which seven were concerned with insertion of wrong lens and one with regional anaesthesia to the wrong eye.

The failure to insert the correct lens results in impaired vision for the patients.

Secondary surgery, with its inherent risks, is required as a consequence of insertion of the wrong lens.

A review by the incident committee is in process, and will be followed shortly by a Safety Alert to area health services from the NSW Health Quality and Safety Branch.

RCA Update

Importance of correct patient, procedure and site policy

A recent RCA again highlighted the importance of adhering to the principles and processes detailed in the NSW Health Correct Patient, Correct Procedure, Correct Site Policy Directive (see related article under 'Newsflash' to the right).

A patient was referred to Radiology for a Computed Tomography (CT) angiogram of their renal arteries.

The request form only stated CT angiogram and did not specify a site.

On the daily booking sheet the patient was incorrectly entered as 'CT pulmonary artery'.

The full 'Time Out' procedure was not adhered to and the site of examination was not confirmed by the staff or with the patient.

The patient underwent a CT angiogram of the pulmonary instead of renal arteries.

The radiologist identified the error only on reporting the films and reading the clinical indication on the request form.

The RCA team concluded that lack of adherence to correct patient/site/procedure practices was the reason why the incorrect anatomical location was scanned.

It was considered likely that had the time out process been followed, the lack of an anatomical site on the request form would have been identified.

Also, by not undertaking 'time out' processes, the initial booking error was perpetuated and the patient underwent the incorrect site radiological examination.

The incident highlights the value of regularly applying correct site/site/procedure practices in all aspects of clinical care.