



May 2010
Issue no. 41

Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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Editorial Team:
Dr Kim Hill,
Professor Anne
Duggan, Ms Barbara
March, Ms Tracey
Currie and Ms Karen
Mackaway

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

From the Director...

This month *Quality Matters* brings a special guest editorial on a challenging subject - medication safety. We are fortunate to have as our guest editor, Professor Rick Day, who is a recognised expert in quality use of medicines, and who presented an excellent Grand Rounds during Medication Safety Week in May 2010.



The Annual HNE Health Quality Exposition and Scientific Program dates have now been set. This year's event will be held on Wednesday 15 and Thursday 16 September 2010 in Tamworth. Further information about the guest speakers and the event will be in next month's edition of *Quality Matters*.

Dr Kim Hill
Director Clinical Governance

How Can We Improve Medication Safety?

Guest Editorial by Professor Richard Day from Clinical Pharmacology at St Vincent's Hospital and the University of NSW. Professor Day presented John Hunter Hospital Grand Rounds as part of Medication Safety Month in May 2010

Medication errors are everyone's business. They are too common, too damaging and too costly to accept as part of usual practice. And we'd all agree that the policies, guidelines and directives to measure various indicators raining down on us from on high and designed to reduce the toll from medication errors have not been successful. The problem is that we do not see it as part of our daily business. We have to take more responsibility as individual clinicians as well as clinical units. We have to build prevention of medication errors into the fabric of daily work. How?

The first step is to accept that medication errors are happening all around us, that all of us have made them, many of us have just been lucky that serious adverse outcomes didn't occur and a few of us have had devastating experiences that we and our patients won't get over. No one in a clinical unit wants to see their patients or their colleagues in the unit damaged, distressed or devastated because of avoidable medication errors.

Leadership is needed from the Chief Executive Officer to all, but most importantly from the leaders in clinical units. 'Walking the talk' is very powerful in changing behaviour and attitudes and that's what is needed. Expectations about excellence in the practice of medicine need to include attention to preventing medical errors.

But when errors occur, our attitude to them and our colleagues involved, needs to be supportive, accepting of system rather than personal failures and focused on understanding the contributing factors and then instituting remedies. Regular attention at the clinical level prevents medication errors. Simple first steps are to discuss medication errors and their prevention and detection, as an important standing agenda item at weekly unit meetings. Identifying which patients, situations and medicines pose the greatest risks for medication errors in your unit? Learn from errors together as a unit in a supportive, open, problem-solving way.

And take a look at some of the suggestions and useful resources available to assist, and that you and your unit may find helpful – please go to http://internal.health.nsw.gov.au/quality/natmed/best_practice_hrd.html



This Month's Update is on Wrong Blood in Tube

Wrong blood in tube (WBIT) errors can occur in the collection of blood samples, for example, pre-transfusion specimens. WBIT refers to the labeling of a blood sample from one patient with the details of a different patient. It can occur as a result of the patient's notes containing addressograph labels belonging to a different patient, or the wrong patient's notes being used to label samples taken away from the patient's bedside. Generally it reflects error in compliance with procedures for correctly identifying the patient and labeling the blood sample.

In routine pathology testing situations, WBIT can produce test results that lead to false diagnosis, wrong treatment and wrong medication, omission of vital treatment, unnecessary surgery, or inappropriate discharge; all potentially leading to patient harm. In the case of pre-transfusion testing WBIT could lead to the transfusion of ABO incompatible blood.

This error is very difficult to detect, unless the patient has other pathology tests on record showing significantly and unexpectedly different results, or a blood group result from a previous episode of care. Any blood provided for transfusion will appear to be compatible, as all labels and paperwork seem perfectly in order.

Using blood grouping statistics it is calculated that WBIT occurs 6.65 times in 10,000 samples collected. While this may seem to be a small number, it translates into around 15 episodes per year in an area health service the size of HNE Health. Only half of these errors may be detected: 6 episodes were recorded in the 08/09 financial year, and 4 episodes to date in the current financial year. It is the undetected, unknown events that are the most concerning.

A recent event outlines the need for diligence. A patient presented to an Emergency Department and required a Group and Save prior to possible surgery. The Medical Officer collected the samples, and sent the labeled sample and request form to the Laboratory. All the labeling details and request form details were correct, and the sample was processed. The patient had no previous blood group history. Some time later the medical officer realised he had labeled the sample from one patient using the details of a different patient. He telephoned the laboratory, and requested that the samples be returned to him for correction of the labeling error. The laboratory staff member insisted the patient sample be re-collected, which is the correct thing to do according to best practice.

Re-collection is the only safe action when the identification of the patient is in doubt. Errors can be perpetuated and have fatal consequences if re-labeling is permitted. For example, if the blood group of the sample collected was incompatible with the patient's blood group, the patient could have received ABO incompatible blood, resulting in severe morbidity/mortality.

For more information go to the Transfusion Website on the Clinical Governance site: http://intranet.hne.health.nsw.gov.au/cg/clinical_practice_improvement/blood_transfusion For mandatory credentialing in Blood Transfusion Processes, access these through the Transfusion Website, or go directly to: <https://www.bloodsafelearning.org.au/index.jsp>

This Month's Root Cause Analysis Review Correct Patient, Correct Procedure and Correct Site

An RCA was undertaken at a regional hospital when a patient had a pleural effusion tap inserted on the wrong side.

The RCA findings were that the principles of the Policy Directive 2007-079 Correct Patient, Correct Procedure and Correct Site were not observed at the time of the procedure. This policy directive is designed to ensure that all departments performing invasive procedures have a checking system that ensures the correct patient is undergoing the correct procedure on the correct site prior to the procedure being performed.

In response, the local Health Service has:

- Ensured that the "time-out" procedure is in place across all clinical units
- Reviewed work practices to ensure clinical handover using the ISBAR principles between clinical team members occurs to ensure timely transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.
- Prepared this case for inclusion in their local Medical Officer training program
- Discussed this case at clinical review meetings.

Correct Patient, Correct Procedure and Correct Site Procedures have been introduced into clinical specialty areas of operating theatre and medical imaging as routine practice. The extension of the procedure to clinical units is continuing noting that the procedures for correct side/site and patient can positively impact on provision of safe practice for all services, staff and areas.

Clinical Unit in Ethics and Health Law Seminar

Dr Dru Haywood, an Intern with Hunter New England Health, will present the June 2010 CUEHL seminar. Dr Haywood will present a paper entitled "Risky Behaviour: Who adds up the cost of smoking, drinking and eating and why?" Also for discussion are views of health care workers on helping people who continue to choose unhealthy lifestyles. The seminar will be held on Monday, 7 June 2010 in the Royal Newcastle Centre Lecture Theatre. Supper is at 6.00pm and the seminar will begin at 6.30pm. All are welcome - no entry fee, no RSVP necessary.

SAVE THIS DATE

**2010 Quality Exposition and Scientific Program – Tamworth
15 and 16 September 2010**

Safety Alerts and Bulletins

Number	Type	Issues covered	Date of issue
SA:004/10		Cuffed Shiley™ Tracheostomy Products – ARTG 100137 - designated lots (see attached advice)	23/4/10
SN:004/10		Important Changes to Medical Gas Cylinders	22/4/10
SN:003/10		TGA Recall	21/4/10
SA:003/10		Unilect ECG Electrodes (various batch numbers)	9/4/10
SN:002/10		TGA Recall	25/3/10
SN:001/10		TGA Recall	9/3/10
SA:002/10		RECALL of Breathing Systems with Intersurgical #1986 Connector	13/1/10
SA:001/10		Recall of Unomedical - Endotracheal Tubes (ET)	8/1/10

For more information, go to the NSW Health Site: <http://internal.health.nsw.gov.au/quality/sabs/>