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Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

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From the Director...

Welcome to the February 2011 Edition of *Quality Matters*.

This month's edition has been expanded to four pages, as there is much to share about quality and safety initiatives. Dr John Fisher has provided an interesting review of Atul Gawande's recent book, and it is timely as HNE Health explores wider use of checklists in some of our areas of service delivery.



This month, HNE Health will also undergo Australian Council on Healthcare Standards (ACHS) Corporate Office Survey, and I would like to take this opportunity to thank everyone who has been involved in the preparations for Survey Week, and who will be participating in meetings with the ACHS Survey Team.

Dr Kim Hill
Director Clinical Governance

'Checklist Manifesto...(How to get things right)' by Dr. Atul Gawande. by Profile Books Ltd (UK) 2009 Book Review by Dr John Fisher, Associate Director, Clinical Governance

Atul Gawande is a general and endocrine surgeon at the Brigham and Women's Hospital in Boston, and an Associate Professor at Harvard Medical School and Harvard School of Public Health. He writes for *The New Yorker*, and is the best-selling author of two other books: *'Better'* and *'Complications'*. He also leads the World Health Organisation's Safe Surgery Saves Lives Program. His first two books, both about quality and safety in medical care, were well received. His books are eminently readable.

The *Checklist Manifesto* started life as an article in *The New Yorker*, a highly regarded magazine, on 10th December 2007. Gawande described the reasons for failure in treatment of seriously ill patients was probably less likely to be ignorance, despite the increasing complexity of modern medicine, but rather what was formerly termed 'ineptitude' - this meant knowledge applied inconsistently or wrongly, together with factors like memory loss and distraction.

The book goes on to describe the first use of 'checklists', whereby in 1935, pilots of the new Boeing B17 (flying fortress) bomber after an initial crash on take-off, were instructed in the use of a checklist prior to take-off, in order to deal with the complexity and new systems needed to control the powerful and very technically advanced aircraft engines and equipment. These lists were instantly a success, and 13,000 such aircraft were manufactured in WW2.

Gawande then reminds us of the basic charting of 'vital signs', which, it was realised in the early 60's, constituted a 'checklist' if grouped, and provided an accurate way of gauging the progress of a patient. It is interesting to note how we are now 'rediscovering' the enormous benefits of these, in the recognition of the 'deteriorating patient'. Checklists then appeared in Intensive Care Units (2001) and reduced the central line infection rate very successfully (the work of Peter Pronovost at Johns Hopkins Hospital). Checklists proliferated in Critical Care for pain treatment and ventilator care. Others have followed, due to their simple function as a jog to the memory, and to provide a short pause for people concerned to gather their thoughts and concentrate on the task at hand.

Gawande's book illustrates how checklists have made possible some of the most difficult feats. He demonstrates how applying this idea to the complex area of surgery produced a ninety second checklist which contributed to reduced complications and reduced death by more than one third in eight hospitals. The checklist works at almost zero cost and can be applied to almost any operation. The checklist methodology is now being applied across the UK National Health Service and in health services worldwide.

Much space is given to the WHO Safe Surgery Project. The benefits of theatre Checklists are thoroughly explained, yet in a readily understandable manner. Checklists, says Gawande, must be short, simple and contain only the killer items. The reasons why some staff don't take kindly to the concept are discussed, while benefits such as improved team performance and work satisfaction, in addition to improvement in patient safety, and reduced error are emphasised.

(Continued on page 3)



This Month's Update is on ...

The HNE Local Health Network Transfusion Medicine Improvement Program

The HNE Health Transfusion Medicine Improvement Program (TMIP) concluded at the end of 2010 after two years of dedicated project focus. Under the leadership of Clinical Governance, an expert team of clinicians led by Dr Stephen O'Mara and Project Manager Vicki Martens, a number of substantial improvements have been made to improve the way blood transfusion occurs in HNE LHN. These include:

- ✓ Area wide adoption of the Blood and Blood Products administration form, and specific Paediatric and Acute area versions of this form. These forms have succeeded in prompting correct procedures, especially in documenting the reason for transfusion, patient consent and base line observations.
- ✓ A HNE Health Transfusion Website was developed as an education tool for ensuring safer transfusion to patients. All HNE Health staff can access relevant, local information about many aspects of transfusion; blood products, policies and forms including decision support for Medical Officers regarding transfusion practice.
- ✓ Appropriate transfusion (according to the National Guidelines) has improved from 30% to 91% across the LHN.
- ✓ Patient consent is now consistently documented.

Now at the end of the two years, more than 3800 HNE Health staff have completed the training. Nursing, Midwifery, Medical and Laboratory staff as well as patient assistants and porters have all been trained in correct processes relating to blood transfusion relevant to their role. This has ensured that staff are educated about blood transfusion and the BloodSafe e-learning program.

The TMIP program also reduced blood wastage across HNE LHN. Prior to the project due to the large geographical area and the need to hold blood in case of emergencies blood "use by" dates were expiring in many small facilities. A system of temperature monitored blood transport from low use areas to high use areas was successfully introduced, together with a review of stock numbers held in some areas. Waste has been significantly reduced, resulting in substantial savings.

Across HNE Health trained staff will continue to provide audit data about transfusion to the Area Transfusion Committee, to local clinicians and other quality groups. This will ensure the positive gains made during the term of the TMIP Project can be maintained for many years.

For more information on blood transfusions go to:

http://intranet.hne.health.nsw.gov.au/cg/clinical_practice_improvement/blood_transfusion

Clinical Unit in Ethics and Health Law Seminar

The next CUEHL meeting will be held on Monday 7 March 2011 at 6pm in the Royal Newcastle Centre, Lecture Theatre.

The topic for discussion will be Religion and Ethics lead by Mr Kevin Mulligan, Director of Mission at the Calvary Mater Newcastle. We will be having our annual look at the interface between religion and ethics and how a Catholic public hospital manages conflict between Catholic and mainstream ethics.

Please join us at 6pm for supper in the foyer with the seminar to follow at 6.30pm.

Everyone is welcome and no RSVP is required.

Please note that CUEHL will continue to be held on the 1st Monday of each month in 2011 except if there is a public holiday, when it will be held on the second Monday of the month.

This Month's Root Cause Analysis Review

A 72 year-old male patient required surgical removal of two retained raytec gauzes after cardiac surgery.

The patient presented to the ED with a history of increasing shortness of breath on exacerbation. A number of tests were performed and he was diagnosed with an Aortic Dissection. He underwent a cardio-thoracic surgical procedure. During this procedure, he experienced excessive bleeding and required packed gauzes around the surgical site. Two radio-opaque gauzes were not accounted for on final count and searches for the missing gauzes, including fluoroscopy was unsuccessful. Due to the patient's unstable condition the procedure was stopped and he was transferred to the Intensive Care Unit where hard film x-ray was taken, and which revealed the gauzes. The patient was returned to the operating theatre and once stable the gauzes were removed successfully.

This incident demonstrates that there will be an occasion when a count is performed which identifies a discrepancy and the patient's condition may not allow normal procedures such as thorough search and x-ray to be followed. When this occurs, there are clear processes to follow as explained in sections 13.2 and 14.1 of NSW Health Policy Directive PD2005_571 [Operating Suite & Other Procedural Areas - Handling of Accountable Items - Standard Procedures - NSW Department of Health](#)

A local communication has been circulated to all relevant staff making reference to Sections 13.2 and 14.1 of the Policy and emphasizing the importance of documentation and communication amongst the clinical teams.



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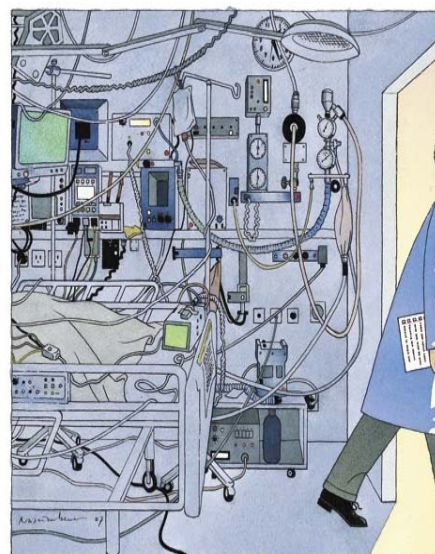
'Checklist Manifesto....(How to get things right)' by Dr. Atul Gawande

Book Review by Dr John Fisher (continued from page 1)

Gawande reveals how the checklist methodology can be applied more broadly, across many disciplines and aspects of life. This book is a gripping exploration of the nature of complexity in our lives. The Checklist Manifesto is a timely reminder that writing a simple 'to-do' list to get the little things right can make a profound difference.

This book should be compulsory reading for all those whose work involves patient care, together with Gawande's other works. It is highly readable, interesting and shows why in a short space of time Gawande has become recognised as improving healthcare delivery.

The Library has five copies they are available at John Hunter, Mater, Belmont, Maitland and Taree Hospital branches – please contact your local HNE Health Libraries branch or visit the website www.gardinerlibrary.com to reserve a copy.



If a new drug were as effective at saving lives as Peter Pronovost's checklist, there would be a nationwide marketing campaign urging doctors to use it.

The Importance of Involving Complainants in an Investigation by Dianne Sales, Manager Operations and Executive Support, Clinical Governance

The importance of involving complainants in an investigation of their concerns is highlighted by the NSW Ombudsman following a review of the way a complaint was handled in HNE LHN. While not making any recommendations in relation to the complaint, the Ombudsman did make some valuable comments.

By way of background, the patient reported they had lost some personal valuables while in the Emergency Department and subsequently complained to the hospital. The patient was dissatisfied with the response and referred the complaint to the Ombudsman. The Ombudsman suggested a review of the complaint be undertaken by HNE Health which was agreed. Subsequently an independent review of the complaint handling was undertaken which supported the original findings by the hospital. In reviewing the matter, the assessment by the Ombudsman was that it was not possible to ascertain whether the missing items was lost or under what circumstances. However, the Ombudsman made comments on the investigation as follows:

1. The process was deficient in that it did not offer the complainant the opportunity to participate in the process. Nor did the review of the complaint handling involve the complainant. At no point in either the investigation or complaint process was the complainant interviewed or asked to respond.
2. The 'thorough investigation' involved a limited search, a discussion with staff on duty and a lost item notification. This does not meet the NSW Health Complaint Management Guidelines nor the HNE Health Complaint Management Policy
3. The findings of the investigation were procedurally unfair as they were based on an assessment of the patient without any discussion with the patient. The investigation relied on the opinion of the staff involved without comment from the patient or any independent third party.
4. The only recommendation to come from the HNE Health investigation was to review the definition of a "valuable".

It is a requirement in HNEH that complainants are contacted and involved in the complaint resolution. It is important these steps are followed to ensure the greatest chance of a satisfactory resolution to the complaint for all parties. For more information, you can contact Di Sales at Dianne.Sales@hnehealth.nsw.gov.au or phone 02 65929777



Are you interested in working in Risk Management?

Is this the position for you? An exciting opportunity exists for a highly motivated individual to join the Clinical Governance team as the Clinical Risk Manager for HNE Local Health Network (LHN). Responsibilities of the position include implementing HNE LHN strategies and procedures for risk management, educating and supporting staff in risk management, and to help the Director Clinical Governance and LHN Executive in monitoring, reviewing and feeding back to staff about risk management outcomes.

Applicants should have a tertiary qualification in a health discipline, high level communication, interpersonal, computer and organisational skills and an ability to show appropriate initiative while working with minimal supervision. Of course, as part of our LHN, a willingness to travel as needed to sites within the LHN is necessary.

To apply for this position go to <https://nswhealth.erecruit.com.au/> and search HNE Health Jobs. Applications close 4 March 2011. For more information please contact Dr Anne Duggan, Associate Director, Clinical Governance on email Anne.Duggan@hnehealth.nsw.gov.au or on 4985 5446

New Interventional Procedures and Clinical Innovations Introduced in 2010

Date	Procedure	Chief Applicant	Facility
February 2010	Transcatheter Aortic Valve Implantation	Professor Peter Fletcher	John Hunter Hospital
April 2010	Nurse Initiated Thrombolysis	Professor Peter Fletcher	Singleton, Cessnock, Tomaree
May 2010	Capsule Endoscopy	Gastroenterology Dr Robert Gibson	John Hunter Hospital
July 2010	Intravesical Botox Injection in Neurogenic Bladder	Paediatrics Dr John Cassey	John Hunter Children's Hospital
November 2010	CT Colonography	Dr Siva Rajaratnam	John Hunter Hospital

For more information on the process for introducing New Interventional Procedures and Clinical Innovations into HNE LHN go to: http://intranet.hne.health.nsw.gov.au/cg/new_interventional_procedures_and_clinical_innovation or contact Dr Anne Duggan, Associate Director, Clinical Governance on 49855446 or anne.duggan@hnehealth.nsw.gov.au

Notification of Salmonella and Specimen Collection

During February 2011, HNE Health Population Health identified three Salmonellosis outbreaks in the Greater Newcastle area through reports made by the general public and the NSW Food Authority. Two outbreaks, affecting approximately 50 people, were catered for by the same caterer, and a smaller outbreak, affecting 8 people, was associated with a commercial food premises.

A number of the affected people presented to local emergency departments for treatment indicating that they were amongst a group of people affected by gastrointestinal disease following events. Unfortunately only blood tests were ordered and no stool samples were taken in emergency departments.

The *Public Health Act 1991* (NSW) requires doctors and hospital chief executive officers/general managers to notify Population Health of food-borne illness in two or more related cases within 24 hours of diagnosis. A stool specimen should also be collected. Laboratory confirmation of the causative pathogen may not always affect clinical management; however, it is essential for appropriately investigating potential outbreaks of food-borne illness.

To report a suspected outbreak of food-borne illness or to obtain further advice, please contact: Hunter New England Population Health in Newcastle on (02) 4924 6477 or Tamworth on (02) 6767 8630.