



March 2010
Issue no. 39

Quality Matters

The monthly newsletter of Hunter New England Health Clinical Governance

Inside this issue

From the Director

**Surgical
Prophylaxis of
Venous
Thromboembolism
(VTE) in Adults**

Update on...
Falls Injury
Prevention

Root Cause
Analysis review

Clinical Unit in
Ethics and Health
Law

*Sounding
Board...* Journal
Article Reviews

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...

Welcome to the March 2010 Edition of *Quality Matters*.

This month includes a special Guest Editorial from Dr Stephen Smith, who is writing on the important subject of venous thromboembolism prevention. The support of senior clinical leaders in this initiative is of great value, and the energy and enthusiasm of Project Team members and the Area Quality Use of Medicines Committee is key to successful implementation.



Also attached this month is the HNEH *Infection Matters* Newsletter. In coming months, there will be a focus on hand hygiene and infection prevention, to showcase the excellent work being done by HNE Health staff in this area.

And finally, calls are now being made for 2010 HNEH Quality Awards – for further information please go to the Clinical Governance website under the Quality Improvement section.

Dr Kim Hill
Director Clinical Governance

Surgical Prophylaxis of Venous Thromboembolism in Adults

Guest Editorial - Dr Steve Smith, Colorectal and General Surgeon, Network Director, Hunter New England Basic Surgical Training and Conjoint Senior Lecturer, University of Newcastle

As a surgeon there are many risks to consider in recommending surgery for each patient and the risks have to be balanced with the benefits which can be expected.

Venous thromboembolism (VTE), such as deep vein thrombosis (DVT) and pulmonary embolism (PE), is a complication of surgical and medical care which is largely preventable, and can cause substantial morbidity and mortality.

I find that a risk assessment including surgical risk factors such as type and length of surgery, and patient risk factors such as age, obesity, personal or family history of venous thromboembolism, immobility, cancer, and any bleeding or clotting disorders, is important in determining the management plan and use of chemical and/or mechanical prophylaxis (such as compression stockings).

The risk of venous thromboembolism must be balanced with the risk of bleeding from chemical anticoagulants.

Many surgeons will know through their own experience that it is important that the risk assessment and management plan is well documented and communicated with the clinical team so that it is correctly implemented. It is helpful if both the chemical and the mechanical prophylaxis are ordered on the medication chart. The medication chart can be signed each day to confirm their administration / application.

I reinforce with my team that ongoing assessment of the patient is vital to identify the development of VTE or any complication from use of prophylaxis, such as bleeding. These complications require urgent escalation and action.

One of the areas which requires further development is advising patients and family of the risk of venous thromboembolism, signs and symptoms and what to do if they have concerns. VTE can occur during hospitalisation but most VTE complications will occur in the community during the three months after discharge. To help reduce the incidence of venous thromboembolism, HNE Health is providing patients with advice via the "Stop the Clot" patient information brochure.



Monthly Update on... Falls Injury Prevention

Screening tools are used to identify patients who require referral for more detailed investigation to avoid a fall. Assessment involves identification of individual risks to develop management plans to address the particular issues for that person. The selection of the tools is evidence based, which requires using a tool validated in the relevant setting and not changing the tool to ensure standard practice at all HNEH sites.

What tools should be used in different settings?

- **Residential Aged Care** – The *Peninsular FRAT* and the accompanying education package and support material will be rolled out for use in HNEH sites with Residential Aged Care and settings with nursing home-type patients.
- **Community** – The *falls risk screen to be included in Preventive Care (SNAPIF)* has five items. Answering “yes” to three or more items identifies those who require a more detailed QuickScreen© assessment. Peel Cluster will be the first HNE Health cluster to implement this process in early 2010.
- **Acute/Subacute Care** – The *Modified Ontario STRATIFY screen* is included in the Initial Adult Inpatient Screening Tool in this setting.
- **Emergency Department FROP.com screen** – This is a *three-item tool to identify those people who require follow-up* is included in the Emergency Department Adult Assessment, Treatment and Observation form. This is particularly useful for early intervention of at-risk people not admitted to hospital.

A PowerPoint presentation explaining how to use the inpatient and Emergency Department screens is available on: http://www.hnehealth.nsw.gov.au/hnepf/falls_injury_prevention
The HNE Health Policy Compliance Procedures outlines the use of the Acute/Subacute, ED and RACF tools and is available on the Clinical Governance website under http://intranet.hne.health.nsw.gov.au/ppg/policies/hne_health_policy_compliance_procedures_-_for_nsw_health_policy_directives - PD 2005_353.

For further information please contact Patsy Bourke, Falls Injury Prevention Coordinator on 676 78206 or patsv.bourke@hnehealth.nsw.gov.au.

This Month's Root Cause Analysis Review

This case relates to a patient was admitted for eye surgery. Two medications were to be injected intra-operatively, one into the conjunctiva of the eye and the other into the vitreous of the eye. The medication to be injected conjunctively was accidentally injected intra-vitreally resulting in permanent visual loss in that eye.

The Root Cause Analysis (RCA) identified some system factors that contributed to this case:

- a) The two medications were prepared and checked according to proper procedure by members of the nursing staff.
- b) The two medications were laid side by side on a tray within the surgeon's reach.
- c) Neither medication was labeled
- d) The medication to be injected conjunctively was routinely used, and the other was a non-routine additional procedure. The surgeon did not regularly undertake the additional procedure and the scrub nurse assisting was not familiar with it.
- e) The additional procedure was briefly discussed prior but the order in which the medications were to be administered was not discussed
- f) There was no process in place for double checking medications before the removal of medications from the tray by the surgeon for administration.

Following from the RCA, the process for checking and labeling medications was improved by:

- a) Implementation of labeling of intra-operative medications.
- b) A process has been implemented for double-checking medications before administration, including removal of medication from the tray and a requirement for the surgeon to verbally request medication from nursing staff, to be followed by verbal confirmation of medication by nursing staff as handed to the surgeon.
- c) Implementation of team discussions prior to any procedure to ensure all team members understand the steps to be taken in the procedure, especially when there is a significant variation from the routine procedure.

Clinical Unit for Ethics and Health Law Seminar Policy, Law or Conscience?

The next Clinical Unit for Ethics and Health Law (CUEHL) Seminar will address one of the simmering questions in professional ethics- *should professionals always act according to laws, regulations and policies, or can they act, when they feel necessary, according to conscience?* Should it be 'ethics first, law second', and if so, whose ethics? What level of divergence from a majority view can we accept, and should we try to judge the sincerity and rationality of the conscientious objector?

A panel will take part in this hypothetical, moderated by Charles Douglas. The seminar will be held *after Easter* on Monday 12 April 2010 in the RNC Lecture Theatre, with supper in the RNC foyer at 6.00pm and the seminar at 6.30pm. All welcome, no RSVP needed.

SOUNDING BOARD

Review of Journal Articles

Dr John Fisher and Ms Anne Barry

Balancing "No Blame" with Accountability in Patient Safety

Wachter R, Pronovost P. New England Journal of Medicine 2009; 361:1401-6.

This article explores medical error and the model of 'no blame'. The article suggests it is time to ensure that accountability is brought into any discussion of an adverse event, and to balance this with efforts to ascribe 'no-blame', and at the same time deal with the system issues. The term "just culture" is used to differentiate blameworthy from blameless acts.

A new paradigm for treating infections: "go hard and go home",

Lipman J, Boots R. Critical Care and Resuscitation, Dec. 2009; 11: 276-81.

This article deals with newer ideas on antibiotic therapy in sepsis. The incidence of sepsis now exceeds that of colon cancer, breast cancer, and AIDS, with mortality ranging from 30% to 82%. It is thought that early (correct) antibiotic therapy, in high doses, mostly for 7 days, is more likely to control infection. This applies especially to nosocomial infections.