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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 *Quality Matters*, which this month is a special four page edition, showcasing the recent HNE Health Quality Exposition and Scientific Program held in Tamworth in September 2010.

This year's event was the most successful to date, based on both attendance and feedback from those present. In addition to our clinical and academic leaders who shared their ideas and insights with us through the Speakers' Program,



this year's event included some impressive poster presentations of some of the best of this year's quality award applicants, along side Expo booths demonstrating initiatives and strategies from across the health service.

This Edition includes perspectives and reviews from some of those staff present, and I thank all of them for sharing their insights as part of this month's *Quality Matters*.

Dr Kim Hill
Director Clinical Governance

Guest Editorial: "We're All Here for Patients"- Impressions from the Fifth Annual Hunter New England Health Quality Exposition and Scientific Program

By Rachel Peake, Stroke Care Co-ordinator, Tamworth Hospital

Prior to attending the 2010 Quality Exposition and Scientific Program, I was in a small rural town two hours from Tamworth discussing the Stroke service with the clinical staff. I was delighted that several staff from that Health Service said they were going to be attending the Hunter New England Health Quality Exposition and Scientific Program. It is often difficult for small rural sites to release staff for conferences as they struggle to replace them on the roster. They were so appreciative of the Program being held at a site that allowed them the opportunity to attend.

It was such a privilege to be at this amazing event featuring such inspirational speakers. The title of the conference itself unified all staff no matter what part they play in a patient's journey. This included care of the patient, predicting risks, the cost of providing health services and identifying the gaps and successes within the Health Service.

The range of topics presented were relevant for all those that work in health. Over the two days the topics included "Putting the patient back into patient care", "Beyond Garling: the future of the Agency for Clinical Innovation Patient Centred Clinical Networks", and "Patient Centred Care: is it really possible in our lifetime?". These topics prompted reflection on how far we have strayed from the most important thing in health, "the Patient". It was highlighted that each and every one of us will be consumers of health one day. It stimulated the audience to believe that if we always place the patient at the centre of our focus we will be more likely to make better decisions regarding their care.

It is reassuring to hear positive feedback about Hunter New England Area Health Service, in particular our dedication to improving access to health care for those in the more rural, remote areas and Aboriginal health care.

Further discussion highlighted the fact that more money does not necessarily ensure better health outcomes. There is not an endless supply of finances, our population is aging, and living longer with expensive, complex health issues. We need to review our current traditions and work practices to better contain the health care dollar and make maximum use of existing resources.

The Garling report has given us the focus to make positive changes to health care. Consumers are becoming more involved in their own care and we, as health service providers, need to learn how to engage and listen. Most importantly we need to use personal experiences and perspectives to improve the patient journey for all who require health care.



This Month's Update is on ISBAR in Our Communication

ISBAR (Introduction, Situation, Background, Assessment and Recommendation) training is now in full swing. Training of managers and supervisors in the Clusters and most acute facilities is almost complete - this training provides managers and supervisors with the tools, resources and ISBAR knowledge to train their own staff in ISBAR communication.

If you are a manager or a supervisor in a service or facility and would like know more about the training coming your way please contact the ISBAR Implementation team (details below) to discuss how you can start training your own staff in ISBAR.

ISBAR training is simple and can occur in as short as a single six minute training session, and can be conducted in various settings – eg at ward handover or as a longer Powerpoint-based presentation during meetings and training days. Clinical Governance is leading the Area-wide implementation of ISBAR as a communication tool, aiming to have most HNE Health staff trained in ISBAR by the end of the year using one of our four training strategies.

The four strategies are: ISBAR in all training, Managers and Supervisors as trainers, dedicated trainers as trainers and on-line training. As an example of ISBAR in all training, if you have done the face-to-face Between The Flags DETECT training you will be counted as having done ISBAR training.

For more information about ISBAR training, please contact Clinical Governance ISBAR Implementation Team via Ms Juliana Ford, ISBAR Implementation Manager on 49855820 or email Juliana.Ford@hnehealth.nsw.gov.au or Dr Rosemary Aldrich, Associate Director Clinical Governance by email or on 49214935.

This Month's Root Cause Analysis Review

A root cause analysis was conducted about the care given to a resident who died following an unwitnessed fall in a residential care facility.

In the early hours of the morning the resident fell whilst attempting to mobilise independently to the toilet. Later that morning the resident was found to be confused and unable to follow simple commands. Her neurological observations were repeated and her mental alertness was found to be reduced. Over the next few hours she deteriorated further until dying later that day.

The resident had been admitted to the residential aged care facility and an interim nursing care plan had been completed on admission. At the time she was noted to be frail and requiring a rollator walking frame to mobilise. She was also noted to be receiving more than twelve different medications daily and during her stay increasing amounts of narcotic analgesia were used to manage pain associated with a recent back and leg injury. Two weeks prior to her terminal event she had fallen and sustained a soft tissue injury to her wrist.

The RCA team considered that increased pain in her wrist may have affected her ability to mobilise with her rollator frame and this with her medications increased her falls risk. They recommended that:

1. Case managers and case conferences are introduced for all residents at the Multi-Purpose Service (MPS), and that a case conference form be utilised for recording outcomes.
2. The Falls Risk Assessment Tool (FRAT) currently utilised in Residential Aged care settings was noted to be a passive tool and it was recommended that it requires review to ensure an intuitive response by the user at the completion of the assessment – this philosophy is the basis of the recently introduced "Between the Flags" program and associated observation chart (SAGO).
3. A medication review program be introduced to ensure medications were reviewed by a clinical pharmacist at the time of the resident's admission.
4. The MPS undertake a trial of equipment which alerts staff to residents mobilizing unaided.
5. The MPS provide an activities program to encourage all residents to mobilize and participate in either group or individual activities.
6. Multidisciplinary plans of care be provided for all residents at the MPS.

Clinical Unit in Ethics and Health Law Seminar

Ms Janine McLraith, Lawyer and Co-Author of a number of health law checks, including Australia Medical Liability, AML and Health Care and the Law will present the November 2010 CUEHL seminar. Ms McLraith will present about "Top National Registration of Health Care Professionals This is a discussion around the new National system of registration for health professionals. The seminar will be held on Monday 1st November 2010 in the Royal Newcastle Centre, Conference Room 1. Supper will be served at 6.00pm and the seminar will begin at 6.30pm. All staff are welcome – there is no charge for entry and no RSVP is necessary.

Venous Thromboembolism Prevention

Clinical Governance is proud to announce the launch of the new Clinical Practice Improvement webpage for the Venous Thromboembolism (VTE) Prevention Initiative. Prevention via communication and implementation of VTE risk assessment is recognised both nationally and internationally as a major step forward in patient safety. Awareness of chemical and mechanical prophylactic preventative measures such as early mobilisation, hydration, anticoagulant therapy, anti-embolic stockings and intermittent compression devices are important strategies. At the VTE web page you will be able to readily access the HNE Health Venous Thromboembolism Clinical Practice Guideline, VTE risk assessment tool and many other useful resources. For more information visit: http://intranet.hne.health.nsw.gov.au/cg/clinical_practice_improvement/vte



Reflections on the Fifth Annual Quality Exposition and Scientific Program

By Todd McEwan, General Manager, John Hunter Hospital/Royal Newcastle Centre, Greater Newcastle Acute Hospital Network

I enjoyed this year's program for a number of reasons. The quality of speakers was excellent and they all more than adequately addressed the theme "We're All Here for Patients". Insights from both a system and operational perspective were provided so that over the two days a broad range of complex issues affecting service delivery was discussed from different perspectives.

The presentations on integrated concepts of care and the changing historical clinical paradigm provided a great deal of "food for thought" while the acknowledgement that clinicians need managers and managers need clinicians was a timely reminder that a collaborative approach is needed to achieve high quality service delivery.

The event managed to challenge my thinking in a number of areas. In particular, I am still aware that we keep talking about patient centered care but how do we use and discuss data to influence change? As a result of this year's Scientific Program I hope to incrementally improve on the answer to that question.

I look forward to next year's event.

Tell Us about Your Booth

This year's Scientific Program had a number of booths showcasing matters for attendees – this is a report from one of these booths.

Greater Newcastle Acute Hospitals Network (GNAHN) Medication Safety Working Party and the Hunter Drug Information Service members manned a booth focusing on Medication Safety at the Fifth Annual Quality Exposition and Scientific Program.

Why have a booth?

The plans were to provide access to medication safety resources; to raise medication safety awareness as an issue in patient centered care; and to showcase and share the work done by the GNAHN Medication Safety Working Party as an example for other units who may wish to address similar problems in their areas.

What did you have available?

- A compilation CD of presentations, posters, policies, and projects.
- Brochures, patient-specific medication information, instructive material & national documents
- Information on the Hunter Drug Information Service for all clinicians with medication related enquiries

How was the booth received by Attendees?

Medical, nursing & allied health clinicians from rural and metropolitan, acute and primary care dropped by and took advantage of the resources available, including having a chat to the pharmacists and nurse manning the stall.

Were the booths were a worthwhile addition to the event?

Our team felt this was a great avenue to share knowledge and receive feedback. We would love to be involved again next year as we thought it was a very valuable activity to promote medication safety across HNE Health.



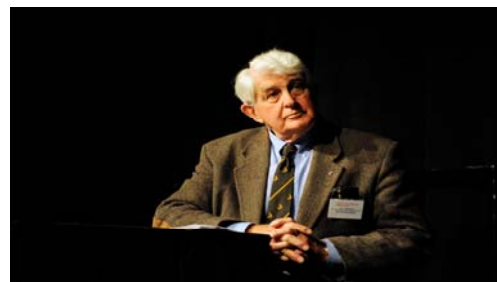
Ms Diane Watson, CEO Bureau of Health Information.



Ms Sandra Berenger and colleagues manning the Infection Prevention and Control booth



Morning Tea in the Poster Viewing area.



Dr Peter Wakeford Day 1 Chair.

Photos by Paul Matthews



Reflections on the Fifth Annual Quality Exposition and Scientific Program

Guest Editorial by Dr Chris Wake, Director of Newborn Services, John Hunter Children's Hospital

The Fifth Annual Quality Exposition and Scientific Program held in Tamworth recently was as enjoyable and thought provoking as always - this was my 3rd attendance. As a clinician, professional conferences are usually clinically orientated with much less time given to less tangible aspects of care that improve overall quality. The Annual Exposition gives the opportunity to hear, talk about and reflect on some of those other aspects.

The theme of the exposition was "We're All Here for Patients" and most of the talks were clearly focused around this theme. The speakers all included the unpaid, unappointed branch of healthcare, 'the Carers', when presenting.

Diane Watson of the NSW Bureau of Health Information reminded us that patient care experiences are how the public learn about and judge the performance of the health service. The new Bureau aims to provide timely, accurate and comparable information about NSW Health system performance. Hunter Watt from the Agency for Clinical Innovation reinforced the value of Networking. Tim Smyth asked the question or threw down the gauntlet with his talk 'is patient centred care really possible in our lifetime?' Ian Scott from Queensland gave an excellent talk on 'Clinician led quality and safety improvement: converting the vision into reality'. His talk centred on what we do in answer to questions patients ask, 'what's wrong with me?', 'who's looking after me?', 'can I be fixed?', 'will it hurt?' etc. It shifted my thinking about quality improvement initiatives. Betty Johnson a very experienced patient and consumer representative gave some enlightening insights into consumer value in her talk on 'patient led quality and safety improvement.' And a video presentation from one of the leaders of quality improvement in healthcare, Don Berwick, was also a highlight on Day 2.

As usual the posters of the quality award finalists were on display from a variety of teams across professions and geography. There are always ideas to be gleaned from these to apply or modify to your own situation and I came away with a little list of current projects in my area that should be written up in the next year or 2 for entry into the awards and ideas for other projects.

And I came away with a handful of informative and useful goodies from the displays: information about medication safety (and a pen), ISBAR cards (for some of the NICU staff), various pamphlets, a torch, pedometer, hand gels, etc. Add to that a few hours of piece and quiet and good music in the car, it was a very pleasant and useful 2 days.










Lucky Door Prize Winner

Chris Hughes Quality Co-ordinator at Inverell was the lucky winner. Chris won a \$50 account kindly donated by Newcastle Permanent, a Quality Exposition and Scientific Program and Awards Sponsor.

Quality at its Best

Congratulations to all HNE Health Quality Award Finalists and Winners. Thank you to those who displayed posters of their projects at the Quality Exposition and Scientific Program. Our visitors to this year's event (our speakers and members of the external awards judging panel), spoke highly of the innovative work being done in HNEH and were impressed with the professionalism of the poster display. Our thanks and congratulations go to all who were part of this year's event!

NSW Health Safety Alerts: Safety Alert Safety Notice Safety information

Number	Type	Issues covered	Date of issue
SN:013/10		TGA Recall	11 Oct 10
SN:012/10		TGA Recall	27 Sep 10
SN:011/10		Medication Incidents Involving Hydromorphone (Opioid)	14 Sep 10 (revised on 16 Sep 10)
SN:010/10		Correct identification of medication and solutions for epidural anaesthesia and analgesia	25 Aug 10
SN:009/10		TGA Recall	28 July 10
SN:008/10		TGA Recall	27 July 10
SA:005/10		Extreme Caution - Esmolol hydrochloride 2500mg in 10ml for injection Attachment 1 (pdf) Approved product information for Brevibloc Injection, Attachment 2 (pdf) Summary	25 June 10
SN:007/10		TGA Recall	17 June 10
SN:006/10		Pathology Testing - Caesarean Section Operations	16 June 10