QUALITY IN SYSTEMS EXCELLENCE IN CARE





REVIEW 2012/13

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A/PROF BRIAN MCCAUGHAN AM

BOARD CHAIR CLINICAL EXCELLENCE COMMISSION

It has been an absolute pleasure to chair the Board of the Clinical Excellence Commission for the year 2012/13. Together with my energetic fellow Board members, we congratulate the entire staff of the CEC on their commitment and professionalism in making our health system in NSW safer and better.

The Board acknowledges the exemplary leadership of Professor Cliff Hughes and his executive team in sustaining the achievements of previous years as well as progressively introducing new programs. The ongoing success of CEC as it enters its 10th year continues to impress and inspire those both within and outside the organisation.

2012/13 has been a busy and productive time for the CEC as reflected in this Year in Review report. The various programs and projects are highlighted by patient and staff stories, emphasising the key role of CEC initiatives targeted at the clinical level working with and supporting clinicians, managers and consumers to deliver benefits to patients, carers and staff within the health system. There are multiple examples in this report of successful implementation across a wide spectrum of programs and I commend the details of this report to all readers.

Underpinning our approach, the work of the CEC has been guided by our strategic plan and the Service Compact with the Ministry of Health. The CEC has performed well against the components of the Compact encompassing many elements of clinical care and administrative accountabilities. In part this has been achieved by:

- Review of NSW Health Policies relating to environmental cleaning, multi-resistant organisms, incident management, patient identification, pressure injury prevention, infection control, open disclosure and surgical checklist
- Development and rollout of a state-wide discussion paper, to support local health districts to meet the new National Safety and Quality Health Service and Standards
- Publication of state-wide reports related to information management, CHASM, SCIDUA, Chartbook, QSA and Community Update on Quality and Safety
- Completion of interim Between the Flags report
- Piloting and evaluation of the 'In Safe Hands' program at Orange Base Hospital
- Rollout of SEPSIS KILLS Program (Phase 2) to inpatient pilot sites
- Completion of QSA verification visits to 15 LHDs
- Meeting financial activity and service measure targets.

With the increasing awareness of the critical importance of safety and quality in any health care system, the Board is confident that the CEC will maintain and extend its prominent role. As a result the CEC will fulfil its key objectives in making the NSW health system safer and better for patients and a more rewarding work place.

Bane Carpe

A/Prof Brian McCaughan AM



PROF CLIFFORD HUGHES AO

CHIEF EXECUTIVE OFFICER CLINICAL EXCELLENCE COMMISSION

The Clinical Excellence Commission (CEC) is all about making the NSW health care system demonstrably better and safer for patients and their carers and a more rewarding workplace for staff. Ultimately, we are an organisation that is about people. We work closely with our consumer, clinical and management partners, to design, deliver and evaluate the effectiveness of our programs. We want to ensure that our initiatives add value and improve the safety and quality of our health system.

The 2012-13 year has been one of consolidation and growth for the CEC, as it has further assumed its role as the leader of quality and safety within NSW Health.

With an expanded staff base, the CEC has continued to develop well-established programs in key clinical areas, while also responding to emerging priority areas around end-of-life care, pressure injuries, open disclosure, antimicrobial stewardship and accreditation of health services against the National Safety and Quality Health Service Standards. These initiatives have been supplemented by policy, databases, educational tools, workshops, reports and support mechanisms led by the CEC. All help meet our mission of building confidence in health care in NSW.

Key achievements of the last year are outlined in the following pages, showing progress in a number of our established and emerging programs. Particular highlights of the year are below:

- A range of resources and support mechanisms were rolled out across NSW health facilities, to support local health districts and networks to meet accreditation against the National Safety and Quality Health Service Standards
- Almost 10,000 records have been entered into the CEC Sepsis
 Kills database, with the median time to antibiotic administration
 being reduced from four hours two years ago, to be now well
 within the recommended one hour. This has been supplemented
 by a CEC-developed smartphone application, which has been
 downloaded by over 8,000 users.
- The Paediatric Sepsis program was launched by the Minister for Health on 30 May 2013, with attendance by 300 senior clinical leaders, facilitating improved detection and management of sepsis in children across NSW.
- Implementation of standardised detection and response processes for deteriorating patients through *Between the Flags* has seen a 24.9 per cent increase in Rapid Response Calls and 35.6 per cent reduction in cardiorespiratory arrest calls since July 2010 – approximately 900 fewer cardiorespiratory arrests.
- 'TOP 5' (using carer knowledge to personalise care for hospitalised patients with dementia) has benefited over 1,000 patients across 20 hospital sites in NSW.
- Since its inception in 2007, more than 1,300 health professionals have completed the Clinical Leadership Program, including 270 last year. All have undertaken a clinical improvement initiative designed to improve patient safety and clinical quality.

- The CEC hosted international visitors Professors Gordy Schiff, Peter Davey, Mark Graber, Jason Stein and Bryan Castle, providing workshops and networking opportunities for NSW clinicians and health service managers around diagnostic error, antimicrobial stewardship and structured bedside rounds.
- In Safe Hands program was successfully piloted at Orange Base and Canterbury hospitals, with demonstrated improvements in key clinical areas. This was followed by a residential school in June, with 15 additional clinical units signing-up to the program and to the implementation of Structured Interdisciplinary Bedside Rounds.
- The CEC completed and issued its first policy after assuming responsibility for development and review of quality and safety policies under new NSW Health governance arrangements: PD 2012_061 Environmental Cleaning. Other policies relating to open disclosure, pressure injury management, incident management and deteriorating patients are nearing completion.

During 2014, the CEC will celebrate 10 years of improving safety and quality in health care since its inception in 2004 and its beginnings as the Institute of Clinical Excellence in 2001. We look forward to building on developments in the coming year, in line with our role and strategic plan.

Whether you are a patient, a clinician, a manager or an interested observer, I hope you will join us on the patient safety journey, in continuing to make our health care system in NSW demonstrably better and safer.

Prof Clifford Hughes, AO



OUR ORGANISATION

ABOUT US

The Clinical Excellence Commission (CEC) promotes and supports best practice clinical care in safety and quality across the NSW health system by:

- Developing and implementing system-wide programs, projects and initiatives that address serious issues of safety and quality in health care
- Working collaboratively with clinicians, patients, managers, health service partners and the broader community
- Conducting high-level analysis and reviews that identify risks and opportunities for continuous improvement.

The CEC is a board-governed statutory health corporation established in 2004, under the *Health Services Act 1997*.

OUR VISION

The CEC will be the publicly respected voice providing the people of NSW with assurance of improvement in the safety and quality of health care.

OUR MISSION

To build confidence in health care in NSW, by making it demonstrably better and safer for patients and a more rewarding workplace.

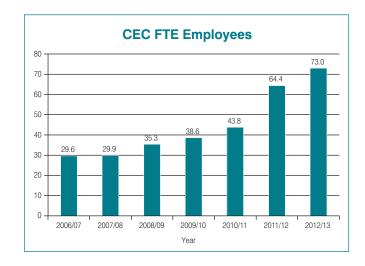
OUR STRATEGY

The Clinical Excellence Commission will add value to the NSW health system by concentrating on 5 key areas. We will:

- Work with consumers, managers and clinicians to improve health care processes and outcomes
- 2. Work with health care services to improve systems of care and the safety of patients
- 3. Identify, monitor and address risks with timely, meaningful and accurate information
- 4. Provide informed strategic advice to support quality and safety improvement
- Ensure that our governance arrangements and partnerships build the effectiveness and credibility of the Clinical Excellence Commission.

OUR STAFF

CEC staff come from a range of professional backgrounds, many with extensive clinical experience. Together, we drive positive change to improve the quality and safety of health care in NSW.



MEETING NATIONAL STANDARDS

The National Safety and Quality Health Services (NSQHS) Standards developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC) started on 1 January 2013. There are ten standards, two of which are overarching governance standards (Governance for Safety & Quality and Partnering with Consumers). Eight are clinical standards (Healthcare Associated Infections, Medication Safety, Patient Identification, Clinical Handover, Blood and Blood Products, Pressure Injuries, Deteriorating Patient and Falls). The standards are divided into actions, made up of 209 core actions, which are required to be "met" to achieve accreditation and 47 developmental actions (non-compliance against which does not count against accreditation).

From 1 January 2013, health services undertaking full assessment will be required to meet all 209 core actions across the ten standards. For mid-cycle/period assessment, health services will be required to meet core actions across Standards 1-3, provide an organisation quality improvement plan and address recommendations from their previous survey. The new national accreditation program is a significant change from previous programs and health services required significant support to address its requirements.

The work of the CEC provides resources and tools to support health services to prepare for their accreditation assessment. They are listed below

- The CEC has developed a website that brings together State and national documents linked to the NSQHS Standards actions at http://www.cec.health.nsw.gov.au/resources/nsqhs
- CEC programs support specific NSQHS Standards. Examples are Partnering with Patients, Healthcare Associated Infection, Medication Safety, Blood Watch and Falls Prevention.
- The CEC's Quality Systems Assessment (QSA) program
 provides a process for independent external assessment of
 health services against a range of clinical issues, including those
 covered by the NSQHS Standards. In addition, the QSA provides
 quality improvement evidence against actions in the NSQHS
 Standards actions.

The CEC has informed the NSW health system about accreditation and the NSQHS Standards through several formats:

- A seminar in December 2012, for health service executives and key staff
- Two presentations to the Senior Executive Forum in December 2012 and March 2013
- Presentation to the Council of Board Chairs in March 2013
- Discussions at directors of clinical governance monthly meetings
- Facilitating an accreditation network of NSW Health staff which met regularly throughout 2013 and often included more than 70 participants on the teleconference.

To date, all the health services that have undertaken national assessment have achieved their accreditation without significant issues being raised.

The CEC has worked closely with health service staff, including through the accreditation network, to identify and develop resources to assist health services. The CEC's role was to facilitate identifying tools and resources and making them available to the accreditation network, usually via the CEC website and through the promotion of sharing of tools and resources.

The ACSQHC has developed a range of resources and support tools for health services undertaking accreditation against the NSQHS Standards. It also operates an advice centre as a source of advice and support for health services, surveyors and accrediting agencies during the transition to the NSQHS Standards. The CEC has worked closely with the ACSQHC in providing advice and feedback on draft resources and participated in the Regulators Working Group, which helped guide the ACSQHC's program.

The CEC has worked with the Health Education and Training Institute (HETI) to identify gaps in training required in the NSQHS Standards and develop the necessary training, including basic life support and aseptic technique training. A small working group is meeting to prioritise future training opportunities.

The CEC has assisted NSW HealthShare procurement section to prepare specifications to develop a Request for Proposal to establish a panel of pre-qualified accreditation survey providers.

The CEC has sought advice from health services that underwent assessment in early 2013, to identify issues raised to guide future assessment preparation. Some include: antimicrobial stewardship, training for aseptic technique, medication reconciliation, consent for blood and blood products, basic life support training, advanced care directives and currency of NSW policies. The CEC has endeavoured to source both internally and with other organisations (e.g. HETI).

Work with the Ministry of Health is developing a State response to "not met" actions or "significant patient safety risks" arising from an accreditation survey. The aim is to ensure that patient safety is always maintained and there is an appropriate local or State response to "not met" actions. The CEC and Ministry of Health are also developing a process to systematically monitor health services' progress towards accreditation.

PATIENT CARE

CHRISTINE'S STORY



In January 2012, Christine's 77-year-old mother went into hospital to have her gall bladder removed. Christine was there when she returned from surgery and the doctor explained that a vein had been accidentally nicked, but he was confident the wound would clot and she would make a normal recovery.

Over a couple of days, Christine noticed her mother becoming more confused and aggressive, which was quite uncharacteristic. Much of this behaviour was attributed to the side-effects of medications, which are common after an operation, particularly with elderly patients. Her haemoglobin had also dropped quite low and bruising around her torso had increased and become quite noticeable.

Christine was concerned by her mother's condition and explained, "being my age, you don't really question what doctors say, but I was quite concerned and so were other members of our family. While the doctors and nurses were giving her very good care, I just wanted to make sure she was getting the best care".

Noticing the REACH brochure near her mother's bed, Christine called the number to get more information and make sure that everything was alright.

REACH is an acronym that stands for Recognise; Engage with your doctor or nurse; Act if you are still concerned; Call for Help; Help is on its way.

REACH is an initiative of the CEC's Partnering with Patients program and enables patients and families to escalate concerns about their or their loved one's condition in hospital.

It acknowledges that patients and families can often recognise signs of deterioration before they are clinically evident and encourages patients and families to engage with their treating team if they are concerned that 'something is not right'.

It enables patients and families to act, by requesting a clinical review and gives an independent avenue to call for a rapid response if they are still concerned and other avenues are exhausted. It provides assurance that help will be on its way.

"Within ten minutes, we had a senior nurse come up and review everything on mum's file, as well as speaking with the registrar and surgeon. She found that mum was still taking her blood thinners and that was why her blood wouldn't clot", says Christine.

"We just got so much relief from these things that they did in the hospital for her. It helped mum's recovery, because she had a lot more faith and she knew what was happening to her. The REACH team continued to come up and review my mum's care for the next six or seven days that she was in hospital and they helped mum through the rest of her stay", says Christine.

"I don't know what would have happened if we hadn't have called REACH. I think it would have taken mum longer to get better."





Patient-based care is focused on the person, rather than their disease or medical condition. It recognises that patients, families and carers should be an integral part of our health care teams.

There is a growing realisation that health outcomes and the patient experience can be improved through partnering with patients, their families and carers.

The CEC's Partnering with Patients program supports local health districts across NSW to transform services, to include patients and family as care team members, and to improve consumer engagement to promote safety and quality in health care.



Excellence in patient-based care is achieved through:

- · improving communication and information sharing
- engaging patients, families and carers and treating them with dignity and respect
- fostering collaboration in governance, program and policy development
- consumer engagement in health service design, delivery and evaluation.

The program provides strategic advice, guidance, program materials, practical support and training. It works across all levels of health to promote patient engagement.

Key Achievements

The Patient-Based Care Challenge

The Patient-Based Care Challenge provides a strategic framework and recommendations to assist health services in improving patient-based care.

It is based on international evidence from leading health services that have improved their patient focus and patient care experience. There are 26 strategies for hospitals and health services to put in place to help improve the patient care and staff experience. Committing to the Challenge helps health services to achieve new performance goals and National Safety and Quality Health Service Standards.

The Partnering with Patients program supports LHDs across NSW to implement a range of strategies to improve patient-based care. As at 30 June 2013, 90 per cent of LHD's had committed to The Patient-Based Care Challenge.

Training in Patient-Based Care

Aligned to the National Safety and Quality Health Service Standards, the training in patient-based care promotes patient-based values and assists staff to develop techniques and skills for championing patient-based care locally. Training continues to be delivered to local health district executives, senior management and clinicians around NSW.



Consumer Advisor Panel

The CEC Consumer Advisor Panel facilitated an increased involvement of patients, family and carers into CEC programs, initiatives and events. The evaluation of CEC consumer engagement showed sustained positive outcomes for 2012/13.

Patient and Family Activated Escalation

The REACH (Recognise, Engage, Act, Call, Help) initiative for patient and family-activated escalation for deteriorating patients has experienced rapid growth in 2013, with 11 lead sites in NSW participating. It has been supported with toolkit resources, training, advice and evaluation tools, developed by the Partnering with Patients team.

Across Australia, up to 40 members of the Patient and Family-Activated Escalation Network, which is supported by the CEC, have indicated their interest in the REACH initiative. The Patlent-Based Care Directorate held a webinar and facilitated a workshop about REACH for clinical and non-clinical leads. Interest in this program has increased following the inclusion of patient-and family-activated escalation in the national standards.

Community Update on Safety and Quality

The CEC released a new edition of the Community Update on Patient Safety and Quality in NSW. It provides information to the broader community on the progress of NSW public hospitals across current focus areas, including hand hygiene, medication safety, handover, healthcare associated infections, sepsis management, and deteriorating patients. It also provides practical ideas on improving personal safety from the perspective of a patient receiving health care.

Partnerships

The Partnering with Patients Program works closely with the Australian Commission on Safety and Quality in Health Care, the NSW Ministry of Health, LHDs and other pillar agencies.

Representatives from the Agency for Clinical Innovation, Bureau of Health Information, Health Consumers NSW, Community Participation Managers Forum, National Health Performance Authority and the World Health Organization's Patients for Patients Safety are involved in the Partnering with Patients Advisory Committee.

The Partnering with Patients Program auspices a health literacy network that includes representatives from the Australian Commission on Safety and Quality in Health Care, NSW Health Care Complaints Commission, the University of Sydney School of Public Health, NPS MedicineWise, and the CEC Consumer Advisor Panel.

Future Directions

An online Patient-Based Care Challenge Guide will be released to support organisation-wide approaches for hospitals and health services to implement the 26 patient-focused strategies. Use of the guide is intended to help health services with practical material and resources to promote the implementation of the Challenge strategies.

The online Health Literacy Guide will be released to support hospitals and health services to identify and address health literacy barriers for patients accessing health care services.

New focus areas for consumer engagement in the coming year include hand hygiene, diagnostic error and medication safety.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/partnering-with-patients

TOP 5 INITIATIVE





For people with cognitive impairment, an acute admission to hospital is an event that often causes distress and anxiety.

The TOP 5 initiative acknowledges the value of carer information about patients who have memory and thinking problems and utilises this information to reduce the levels of distress and anxiety.

It involves talking with carers when the patient is admitted, to gain non-clinical information that will help to personalise the care for the patient. The information is then made available to every member of the team who will interact with the patient.

TOP 5 involves:

Talking to the carer

Obtaining the information

Personalising the care

5 strategies developed



The TOP 5 concept was originally conceived and implemented in the Central Coast Local Health District (CCLHD). Pilot data from CCLHD suggests that TOP 5 reduces the length of stay and improves patient outcomes, the care experience and staff satisfaction.

Supported by a grant from the HCF Health and Medical Research Foundation, the CEC is now implementing and evaluating the initiative in 15 public and five private hospitals in NSW, focusing on patients with dementia.

Key Achievements

Fifteen public hospitals have successfully implemented the TOP 5 initiative in one or more wards. They are in a range of geographical locations in NSW and represent all major peer groups.

Wards that have implemented TOP 5 provide a variety of services, such as medical, surgical, psychogeriatric units and aged care and rehabilitation services.

Four private facilities have successfully introduced the TOP 5 initiative, with one using it in the medical ward and others using the concept throughout the facility.

For the implementation, a local site liaison officer was identified, along with local clinical champions. After the initial education session conducted at each site about the TOP 5 process, the implementation was further supported by a toolkit developed by the CEC.

Brochures and posters were developed based on CCLHD materials to support the implementation. Evaluation packages, containing staff and carer surveys and data logs, were also provided for the sites to collect the data.

Ongoing support has been provided by the CEC, in the form of teleconferences, on-site visits and local site liaison forums.

The concept has enabled care providers to share information between staff, by having tips and strategies available at the patient's bedside. This is used to help staff members communicate with the patient when the carer is not present.



The strategies reduce anxiety for the patient and improve the confidence of the carers when leaving their loved one. Staff satisfaction has also improved, by providing additional strategies to use to allay fears and reduce the distress of patients with dementia.

An evaluation of TOP 5 is underway, investigating its impact on patient outcomes, carer and staff experience, falls, antipsychotic medication usage and cost implications.

Partnerships

The TOP 5 initiative is funded by a grant from the HCF Health and Medical Research Foundation (HCF H&MRF). The current initiative will provide a final report to HCF H&MRF in January 2014.

The initiative has partnerships with LHDs and private health organisations.

Representatives from the Ministry of Health, Agency for Clinical Innovation and the Carers Support Unit (Central Coast Local Health District) are on the TOP 5 Steering Committee, which is chaired by the Director of Clinical Governance from the Mid North Coast Local Health District.

Consumers and clinicians are also represented.

Future Directions

A further grant submission has been made to evaluate the impact of TOP 5 in transferral services such as residential aged care and ambulance services.

Lead sites have stated that the TOP 5 initiative will be sustained as part of normal practice after the current implementation ends.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/partnering-with-patients

EARLY RECOGNITION AND PREVENTION

MARGO'S STORY



Margo Asimus started nursing in 1981. She began as an enrolled nurse in Sydney, before moving back to her home town of Maitland. Across her career, she has worked in aged care, paediatrics, midwifery and surgery. She is now a nurse practitioner in community.

Her interest in wound care and pressure injuries started in 1991, following her experience working as a surgical nurse. In 2008, she realised that the incidence and severity of pressure injuries was getting worse and was determined to do something to improve outcomes for patients.

She approached her area director of nursing, who supported her suggestions and intervention for system change. The plan included improving staff awareness and education, using equipment more effectively and appropriately and reviewing the types of mattresses used across all health care settings.

Margo, though, was still unsure of the extent of the problem. "We didn't know how many patients were affected, whether it was limited to our local facilities and community health setting or whether it was widespread and how we could fix it. To try and answer some of these questions, we undertook an area-wide point prevalence study. We found that nearly 30 per cent of patients had pressure injuries and it wasn't just older people that were affected. It also impacted younger people. The severity of these wounds was alarming."

She has already seen an improvement in patient outcomes.

"Around five years ago, we had a patient who had fractured his hip. He developed a severe pressure injury, which took around 12 months to heal and it had a huge impact on his quality of life. He couldn't apply weight on his heel, so he couldn't do much rehabilitation and was on pain relief, which also placed him at a greater risk of falling. He couldn't even wear shoes for his grand-daughter's wedding. His life was essentially on hold".

"In 2011, the same patient was involved in an incident, where he was admitted with a broken leg and he was very concerned about developing another pressure injury, recalling the affect it had on his quality of life. He was amazed at the difference in the care and attention he was given," reports Margo.

"There were different mattresses, seating and heel pressure relief. The nurses were talking with him about the risks of pressure injuries and what they were going to do to minimise them. They would conduct regular reviews of his skin, removing the stockings and making sure there were no wounds or pressure injuries developing. The attention to pressure prevention was a constant part of the care experience during the hospital stay and on return home."

It is little wonder that Margo is supportive of the CEC's Pressure Injury Prevention project. "With the CEC driving responsibility for pressure injury prevention at a facility-level across the State, the quality of care for patients in NSW is increasing. Implementing care according to the Australian best-practice guidelines is making a difference in keeping our patients safe, further reducing the risks of avoidable adverse events such as pressure injury."

Margo is positive that the Pressure Injury Prevention project will continue to improve the quality of care for patients, while complementing the requirements of the national standards. She believes it is increasingly becoming a part of everyday practice, by hospitals and community health centres, as a partnership between management, clinicians, patients and carers.







Many pressure injuries are highly preventable and it is recognised that their lengthy healing time has consequences for quality of life, including susceptibility to infection, pain, sleep and mood disturbance. They also impact on rehabilitation, mobility and long-term quality of life.

The Australian Commission on Safety and Quality in Health Care (ACSQHC) has recognised pressure injuries as the fifth most costly commonly-occurring preventable condition.

The CEC Pressure Injury Prevention Project was established in October 2012. It aims to promote evidence-based practice for the prevention and management of pressure injuries and increase awareness among health care professionals.

The CEC is supporting local health districts (LHDs) and networks to implement the Pan Pacific Clinical Practice Guideline for the Prevention and Management of Pressure Injury 2012, as evidence-based best practice.



The Pressure Injury Prevention Project supports the objectives of the guideline, by assisting health professionals to:

- Identify patients at risk
- Identify strategies to assess pressure injuries and factors related to their risk
- · Prevent or delay complications
- · Optimise management of pressure injuries
- · Optimise quality of life.

Key Achievements

A steering committee has been established to inform the project and support LHDs and networks to improve pressure injury prevention and management.

It has representation from all LHDs and networks. Five sub-working groups are progressing work to support the implementation of the project. Their roles are detailed below:

- The Policy Group is leading the review of NSW Health Policy: Clinical Practices – Pressure Ulcer Prevention (PD2005_257) in line with evidence-based practice and the ACSQHC National Safety and Quality Health Service Standards – Standard 8: Preventing and Managing Pressure Injuries
- The Education and Training Group supports the development of e-learning modules and materials to promote evidence-based practice
- The Pressure Injury Audit and Reporting Group is developing a framework for the monitoring and auditing requirements to support practice improvement
- The Pressure Injury Prevention Resources (equipment) Group is developing material to facilitate appropriate strategies for the level of pressure injury risk identified
- The Pressure Injury Prevention Information for Patients and Carers Group is developing material for patients, family and carers and is providing oversight to ensure the policy and project remains patient-focused.



In May 2013, the CEC launched the Pressure Injury Prevention Project webpage, with useful links to guidelines, resources and information. It will be a repository of resources to support staff across NSW, providing access to evidence-based material to help improve their practice.

Wounds West is a nationally recognised program. Director of Wounds West, Dr Jenny Prentice, visited NSW in March 2013, as part of Wound Awareness Week. She shared the Wounds West audit results, lessons learned and future directions from a Western Australian perspective, with CEC staff and members of the Pressure Injury Prevention steering committee.

A workshop was held at the CEC in May 2013, for the Pressure Injury Prevention steering committee members. It provided an opportunity for members to share knowledge/experience, progress the review of the current policy and discuss ideas/issues. Presentations were given by:

- Prof Donald MacLellan, Director of Surgery, Anaesthesia and Critical Care from the Agency for Clinical Innovation
- 2. Margo Asimus, Nurse Practitioner Wound Care, from Hunter New England Local Health District.

Partnerships

The importance of working with stakeholders is recognised as a key component to the success of the project, ensuring a sharing of resources, knowledge and skill.

In developing and delivering the program, the CEC has worked closely with the Ministry of Health's Nursing and Midwifery Office (NaMO). The Chief Nursing Officer is the chair of the steering committee and NaMO was instrumental in securing representatives from LHDs and networks as members.

The project team is working with the Health Education Training Institute (HETI) to progress the availability of pressure injury prevention e-learning modules Statewide and educational material to promote evidence-based practice.

Future Directions

The CEC will increase the promotion of evidence-based practice in pressure injury prevention to clinical staff, while ensuring that patients, their family and/or carers are involved in their care planning.

There will be a focus on engaging with and providing support to LHDs and networks to implement the revised policy. This will be achieved by:

- Ensuring education and training material is available for clinical staff to improve their knowledge of pressure injury prevention and management.
- Promoting an annual Pressure Injury Point Prevalence Survey and regular audits, with the data used to inform practice improvement.

The CEC will work to strengthen existing partnerships and build new relationships with stakeholders, to promote pressure injury prevention in NSW.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/pressure-injury-prevention-project

BETWEEN THE FLAGS





Failure to recognise and appropriately manage deteriorating patients is a significant issue, not only in NSW public hospitals, but in hospitals and health care organisations around the world. While many hospitals have cardiac arrest teams, their response is normally only triggered when a patient's condition becomes critical.

The CEC introduced the Between the Flags (BTF) system in 2010, to address this issue. It helps staff to identify early warning signs of deterioration and provide an appropriate response.

It uses the analogy of Surf Life Saving Australia's lifeguards and lifesavers, who keep people safe by ensuring they are under close observation and rapidly rescue them, should they get into trouble.



Between the Flags has a five-element strategy, which is essential to its long-term sustainability.

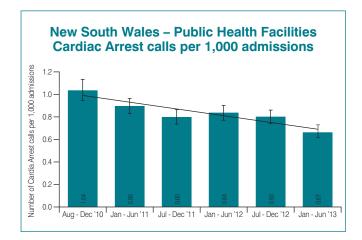
- A governance structure in each local health district and hospital in NSW to oversee the implementation and sustainability of the program.
- Standards for the criteria used for early recognition of the deteriorating patient (clinical observation and 'track and trigger' system), incorporated in standard observation charts e.g., the Standard Adult General Observation Chart (SAGO).
- 3. Standards for a process of escalation of concern and rapid response to the deteriorating patient (Clinical Emergency Response System).
- Education packages for all staff to give them the knowledge and skills to recognise and manage the deteriorating patient confidently.
- Standards for key performance indicators to be collected, collated and used to inform the users of the system and those managing the implementation and continuation of the program.

Key Achievements

In collaboration with NSW HealthShare, electronic versions of the standard observation charts are being introduced into emergency departments and recovery units across NSW. This enables observations to be recorded in the electronic medical records (eMR) and enhances the capability to recognise deterioration and escalate care. It also assists with the transfer of care, as quality information is readily available in a consistent format.

Over 18,000 clinicians care for infants and children in NSW public hospitals. In 2012, the CEC launched DETECT Junior education, as an extension of the Between the Flags program, focusing on the recognition and management of clinical deterioration in paediatric patients. DETECT Junior resources include a manual, online e-learning modules and face-to-face workshop materials.





Since the introduction of Between the Flags in 2010, there has been a reduction in cardiac arrest calls of 35.6 per cent across NSW public hospitals. Based on this, it is estimated that there have been 940 fewer unexpected cardiac arrests in NSW public hospitals than would have been predicted.

Partnerships

Local Health Districts

LHD directors of clinical governance and their teams have been critical to the success of BTF. The CEC supports LHDs in implementing the program, by establishing standards and developing tools and education required. Regular visits to LHDs are made by the BTF team. The CEC also chairs a monthly meeting of directors of clinical governance, clinical leads and Between the Flags project managers, which is an opportunity to provide feedback and recommendations on the effectiveness of the program's implementation at their local level.

NSW Ministry of Health

Representatives from the Ministry of Health provide expert advice on their specialty areas and representation on the steering committee.

NSW HealthShare

The CEC has worked closely with NSW HealthShare to incorporate the Between the Flags system into existing health software programs. This relationship has encompassed work on eMR, First Net, Power Chart and SurgiNet.

Other notable partnerships include:

- Australian Commission for Safety and Quality in Health Care
- Health Education and Training Institute
- Agency for Clinical Innovation
- · Child health networks
- Pregnancy and Newborn Services Network and the Midwifery Services Network
- Ambulance Service of NSW
- Justice & Forensic Mental Health
- Expert advisors on the Between the Flags steering and advisory committees.

Future Directions

Between the Flags is designed to make fundamental changes to clinical practice in NSW and has exposed a number of barriers which inhibit the escalation of patient care. The CEC will work with LHDs to develop strategies to address these barriers progressively.

The CEC will also focus on improving the education component of the program. This will include the evaluation of the current program, developing a strategic approach for education across LHDs, and building a Tier 3 education program which includes Rapid Responder training.

Following the trial of the Care of the Dying chart, the program will link closely with the AMBER care bundle (see page 53) – a new CEC program focusing on end-of-life care.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/between-the-flags





Falls are a significant cause of potentially avoidable harm to older people and place a great burden on the health care system. In NSW in 2011-12, there were 35,547 fall-related overnight hospitalisations in people aged 65 years or over. The average length of stay per fall injury case was estimated to be 15.5 days. Falls among inpatients represent the most common adverse event reported in health care settings.

Projections indicate that, unless preventative measures are taken, the demand on health care services from fall-related presentations will dramatically escalate, due to the rapidly ageing NSW population.

No other single injury, including road trauma, collectively costs the health system more than fall injuries.



The NSW Falls Prevention Program is one of the CEC's longest-running programs, introduced in 2005. It is focused on older people and aims to reduce the incidence and severity of falls. It also aims to reduce the social, psychological and economic impact of falls on families and carers and the community.

The program provides Statewide leadership, co-ordination and collaboration to implement falls evidence-based practice. It also supports the implementation of the National Safety and Quality Health Service Standards (NSQHSS), Standard 10: *Preventing falls and harm from falls* through consultation and development of resources.

Key Achievements

NSW Falls Prevention Network Annual Forum

The CEC was a major contributor to the NSW Falls Prevention Network Annual Forum: *Collaborative approaches to falls prevention*, held in May 2013. It shared current research and initiatives, such as safer environments in hospital, exercise programs in the community, working with people with cognitive impairment and carers. Best practice across the continuum of care – community, hospital and residential aged care was also covered. The forum was attended by 353 participants and by web-stream to other health staff across Australia.

Participants have advised that they would like further forums to include topics on falls prevention strategies for those with Parkinson's Disease, multiple sclerosis, motor neurone disease and other neurological conditions; engaging and motivating older people in falls prevention initiatives; and more information on dementia, delirium and falls prevention marketing initiatives.

NSW Falls Prevention Network Rural Forums

Collaborative forums were held in Dubbo and Broken Hill and provided rural participants with the opportunity to meet with falls and dementia experts. They covered falls initiatives led by the CEC.



Prof Stephen Lord, from Neuroscience Research Australia presented the latest falls research and A/Prof Jacqueline Close, from Prince of Wales Hospital presented on the challenges of preventing falls in people with dementia. New initiatives, such as the 'Care of the Hospitalised Older Person study' (CHOPs), were presented by Anthea Temple from the Agency for Clinical Innovation. The forum provided opportunities for attendees to discuss their experiences with colleagues and to build their network of falls contacts.

April Falls Day® 2013

Staying Active and Healthy to Prevent Falls was the theme for 2013. The importance of staying active and healthy and encouraging people to undertake ongoing exercise was promoted across the month of April.

A video Staying active and healthy to prevent falls – Home based strength and balance exercises was produced, showing physiotherapists demonstrating to two older people exercises that can be done at home to improve balance and strength.

A presentation on key active and healthy living messages, including balance and strength exercises was shown in 46 hospitals across NSW, supporting the *Staying Active* and *Healthy to Prevent Falls message*.

April Falls Day® messages were also included on payslips across NSW Health.

Falls Prevention Information Flyers

Falls prevention information flyers for patients, families and carers were developed, which provide information on specific falls risk factors, such as medication, vision and preventing falls in hospital. A selection has been translated into Greek, Italian, Simplified Chinese, Traditional Chinese, Vietnamese and Arabic.

These flyers also support hospitals in meeting the National Safety and Quality Health Standards Standard 10: Preventing Falls and Harm from Falls.

Partnerships

The Falls Prevention Program has close working relationships with the NSW Ministry of Health, local health districts, falls prevention coordinators, the Agency for Clinical Innovation, the NSW Falls Prevention Network (Neuroscience Research Australia) and other agencies, to implement falls prevention strategies as identified in the NSW Health Falls Policy.

The program is working with the Health and Education Training Institute (HETI), in the development of falls e-learning modules for NSW Health staff.

The Falls Prevention Program also has partnerships with external agencies, to identify people at risk of falls and to implement targeted falls prevention strategies.

Future Directions

Additional materials will be developed to support health care facilities with the implementation of the National Safety and Quality Health Standards Standard 10: Preventing Falls and Harm from Falls, and work to improve clinical practice in health care settings and access to appropriate falls services for older people living in the community.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/falls-prevention

SEPSIS KILLS PROGRAM





RECOGNISE • RESUSCITATE • REFER

Sepsis and septic shock are life-threatening conditions which are difficult to diagnose and require immediate clinical care. Appropriate recognition and timely management of patients with severe infection and sepsis is a significant worldwide problem in health care.

The CEC's SEPSIS KILLS Program is working with clinicians and health service managers to improve the recognition and treatment of severe infection and sepsis, to reduce their impact, mortality and financial costs in NSW. The program was originally launched in May 2011, in all medium and large emergency departments across NSW.

Key elements of the SEPSIS KILLS Program are:

- Recognition of risk factors, signs and symptoms of sepsis
- Resuscitation with rapid intravenous fluids and administration of antibiotics within the first hour of diagnosis of sepsis
- · Referral to senior clinicians and teams



There are strong links with CEC's Between the Flags program, which ensures an integrated and comprehensive approach to recognition and management of the deteriorating patient.

The program has attracted national and international interest from clinicians and clinical managers, seeking to utilise the sepsis resources available on the CEC website.

Key Achievements

Implementation

Small rural and remote emergency departments are progressively joining and 116 hospitals are now participating in the program. Clinical governance units in the LHDs have provided strong support, building capacity to implement and sustain the improvements.

Technology

A sepsis antibiotic smartphone app was released by the CEC during September 2012. It provides information on antibiotic prescribing and administration, to help doctors start sepsis treatment quickly at the bedside.

Sepsis Database

An online database provides valuable benchmark information on sepsis management. The NSW State median time from triage to administration of antibiotics has been significantly reduced from four hours at the start of the program, to consistently less than 60 minutes. This meets international benchmarks.

Paediatrics

The initial focus of the program was on adult patients. In 2013, clinical tools and resources to improve the recognition and timely management of sepsis in children were launched. The paediatric sepsis pathway, antibiotic guidelines and education package are progressively being implemented in all emergency departments across NSW. The paediatric version has leveraged the awareness of the SEPSIS KILLS Program, which promotes awareness and the need for urgent treatment.



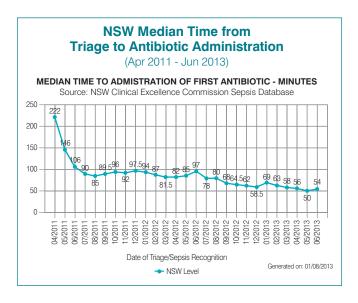
Education

Learning sessions and workshops have been conducted for clinical staff on a range of sepsis-related topics. In addition, an online sepsis learning module is available to all staff. It provides case studies for recognising and managing both adult and paediatric sepsis.

Partnerships

The SEPSIS KILLS Program team works with a range of health care providers and agencies to offer an integrated program. Some of the relationships include:

- Chief executives, directors of clinical governance and clinical staff in all LHDs
- NSW Kids and Families
- · Agency for Clinical Innovation and clinical networks
- Healthcare Education and Training Institute
- Emergency Care Institute
- Ministerial Taskforce on Emergency Care
- Rural Critical Care Taskforce
- Rural Critical Care Clinical Nurse Consultants Group
- NSW Ambulance Service
- NSW Ministry of Health
- Royal Australasian College of Physicians
- The Australasian Resuscitation in Sepsis Evaluation (ARISE) Investigators
- Between the Flags program
- Antimicrobial Stewardship program
- Falls Prevention program
- In Safe Hands program



Future Directions

The next phase of the SEPSIS KILLS Program is focused on improving the recognition and management of sepsis in hospital inpatient wards. It is estimated that approximately 30 per cent of patients who require a Between the Flags rapid clinical response call are septic.

An implementation model is being developed and tested in a number of hospitals in NSW. There is a strong emphasis on integrating the program with other clinical improvement initiatives, such as the Falls Prevention and In Safe Hands programs to maximise the benefit to the patient. The inpatient version will be rolled out Statewide in 2014.

There will be further integration with existing IT systems used in the emergency department and wards, to support sepsis data collection. It is anticipated that an automated reporting template in the online Sepsis Data Collection and Reporting System will be developed, to enable descriptive report generation at facility, local health district and State levels, to ensure ongoing clinician engagement.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/sepsis

IMPROVING CLINICAL PRACTICE

CATHERINE'S STORY



Originally from Belfast in Northern Ireland, Catherine McVeigh started her specialised training in geriatric and general medicine in 2003. During this time she completed an MD, studying the effects of inflammation after stroke on cognitive function. In February 2009, she moved to Australia for an Out of Program year at the Prince of Wales Hospital in Sydney's east, subsequently qualifying as a staff specialist in the field of geriatrics in 2010.

Catherine found many aspects of the NSW health care system similar to the UK, particularly in that it is very patient-focused. She found she quickly adapted to her new surrounds and the program year quickly turned into two. Midway through, she realised that she had fallen in love with Sydney and decided to make it her new home.

During her time at Prince of Wales, she has rotated through the Geriatric Medical Assessment Unit, Orthogeriatrics and, more recently, Aged Care Rehabilitation.

Earlier this year, she was approached by the Nurse Manager of Aged, Community and Post-Acute Care Services, to attend an upcoming In Safe Hands residential school in Orange. "We'd heard a fair bit about the concept from the USA and through the Clinical Excellence Commission. We were already one dedicated team working well together on the ward and we thought this type of approach would suit our unit", says Catherine.

The residential school was held during June 2013. It had both international and local presenters. It highlighted the implementation in Orange Health Service, with the team discussing their experiences, along with the outcomes and effectiveness of the program. "We were just amazed at what they'd achieved in Orange and we came back very enthusiastic and keen to implement the program in our ward."

When she returned, she discussed the concept and delivery with her team to see if they believed it was feasible. Part of the pre-work was to understand what was required for the ward and what the team considered important. They re-aligned some of the safety checklists and also identified some of the high-risk priorities for their ward, such as DVT prophylaxis, end-of-life discussions, falls risks and pressure injuries, and how they would adapt the structured team rounds to manage patients with cognitive issues. This was in addition to routine checks.

The next step was to educate the team on the program. Training, in the form of tutorials, presentations and videos was provided for staff, focusing on what to expect and what information each was expected to provide. "Most importantly, everyone had an active role. We'd anticipated that some of the nurses may have been reluctant to participate, as it was quite a different role compared to what they'd been used to, but they've taken to the program like a duck to water", says Catherine. In all, there were just over six weeks of preparation and training done before the program was implemented.

"The dynamic in the ward has really changed. We were a cohesive and communicative team, but we used to see patients separately for the most part. Now everyone is in the same room, the patient is at the centre and everyone is really seeing the value. While I can't speak for everyone, I think it is a much better way to work."

"There is no chasing-up each other, everyone knows what is going on with each patient and everyone has an equal voice. Nursing staff are more engaged and feel empowered. They know what is going on and get information from clinicians on the spot and in real time", says Catherine. "The patients and their families also see that information is being shared and they are seeing the extent of their care."

Catherine has also found the program has helped improve the quality and safety of care in their ward. "Because everyone is working together, there is more chance of an error being detected and corrected. The program has been a positive experience and provides a tremendous learning opportunity, in particular for junior staff. It allows everyone to see that identifying and addressing even some of the smallest of things can have a big impact for the patient."

IN SAFE HANDS PROGRAM





Clinicians caring for the same patients in many clinical units, typically operate in silos or isolation to each other. As a result, teamwork is not cohesive and causes deficiencies in communication and information sharing between clinicians. This may lead to delays in the provision of care, an unco-ordinated approach to care planning, a poor patient experience, inefficiencies in patient flow and an adverse impact on patient safety.

The CEC introduced the In Safe Hands program in 2011, to provide a platform for building and sustaining efficient and effective health care teams within a complex health care environment. It is supported by 10 functions that enable teams to become a cohesive unit, placing patients at the centre of care.

Highly reliable clinical teams are developed and supported with relevant standards, tools, skills and resources. This empowers them to make good decisions based on a full understanding of the patient's clinical condition and care needs.



Greater teamwork and communication improves inpatient unit processes, which has a positive outcome for patient flow and access to care.

The CEC, through the In Safe Hands program, is supporting the NSW Ministry of Health's Whole-of-Hospital Program.

Key Achievements

In Safe Hands has been piloted in the Acute Medical Unit at Orange Health Service and the High-Dependency Unit at Canterbury Hospital. The success at these two sites has generated interest and enthusiasm for the program in other organisations. Visits to the pilot sites by teams interested in implementing In Safe Hands, has demonstrated the effectiveness of teamwork and communication during structured team rounds.

An In Safe Hands residential school was held from 16-19 June 2013 in Orange. It brought clinicians and their executive sponsors together, with the purpose of providing the knowledge, skills and resources to health care teams interested in implementing In Safe Hands through Structured Team Rounds. Fifteen patient care teams attended, with over 100 attendees. Evaluations show an overwhelming positive response, reflecting the energy and enthusiasm that was generated throughout the three-day school.

The CEC has developed a minimum dataset that will enable real-time evaluation of the impact of the program on patient flow, discharge, average length of stay and a selection of quality and safety measures. This aligns with the NSW Ministry of Health's Whole-of-Hospital Program indicators. Ongoing monitoring and evaluation of these measures, will demonstrate system efficiencies and improvements that improve patient care co-ordination and experiences.



Partnerships

In Safe Hands supports the NSW Ministry of Health's Whole-of-Hospital program by focusing on a multidisciplinary team approach to improve inpatient unit processes and patient flow.

A strong partnership has been formed with the Agency for Clinical Innovation, to improve the medical patient journey through criteria-led discharge and clinical management plans.

The CEC is working with the Health Education and Training Institute HETI), in the development of an education package focused on patient flow systems for clinical staff.

A partnership between the University of New South Wales and the University of Sydney's School of Rural Health has been formed to evaluate the implementation of In Safe Hands.

Future Directions

A follow-up workshop, regular teleconferences and site visits are among the activities that will support the 15 units who attended the residential school in Orange, and future participants in the program.

A network of clinicians will be developed, to provide guidance and support for units implementing the program. This will build capacity within facilities to support implementation by other units – drawing on valuable insights and lessons learnt.

The In Safe Hands program will be tailored to support a number of clinical streams, including medical, surgical, paediatric and maternity. These have specific needs and intricacies that need to be considered in the implementation of the program and can provide additional layers of support.

Additional strategies will be developed to target diagnostic error, re-admission and improving weekend discharge.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/insafehands

BLOOD WATCH PROGRAM



There is a strong and expanding body of evidence linking blood transfusion with adverse clinical outcomes, including increased patient morbidity, mortality and hospital length of stay. The association is dose-dependent.

The Blood Watch program was established in 2005. It aims to improve clinical outcomes by reducing patient risks for transfusion, avoid unnecessary use of blood and blood products, improve clinical practice associated with transfusion medicine and reduce associated costs. The program is based on a patient blood management framework and relevant best practice guidelines.

The patient blood management (PBM) framework focuses on the clinical management of the patient. It uses medical and surgical strategies to conserve and appropriately manage a patient's blood. This, in turn, reduces or avoids the need for transfusion and helps to improve patient outcomes. PBM allows transfusion to be reserved for when it is absolutely necessary.



Blood is a precious resource which is freely donated and all health care providers must ensure responsible, sustainable and appropriate use. Additional drivers for change are escalating costs associated with transfusion and supply pressures, due to an ageing, and higher blood using, population.

Key Achievements

NSW Patient Blood Management Forum

In March 2013, the Blood Watch Program hosted a forum on *Towards Patient Blood Management: Future Directions for NSW.*The objectives were to raise awareness of the benefits of PBM in relation to clinical outcomes and cost savings, promote awareness and uptake of national initiatives and to promote engagement beyond the public health sector.

Red cell utilisation

Reductions in red cell usage have three significant implications:

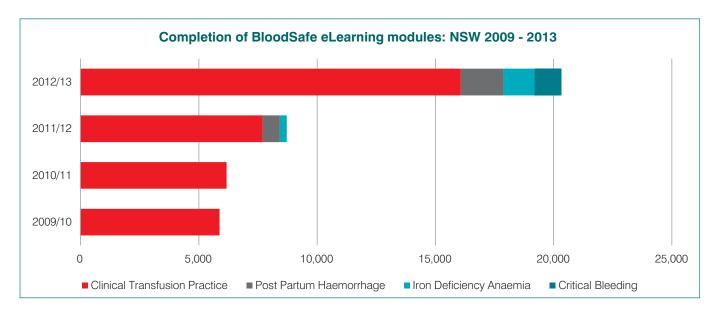
- an overall improvement in appropriate transfusion practice
- reduced patient risk from adverse outcomes
- cost containment for local health district budget allocation for blood products.

Since 2007, the CEC has linked data from NSW Health's Health Information Exchange with local pathology and blood bank databases, allowing comparison of red cell usage and dosage among NSW public hospitals. The data collected during the 2012/13 financial year demonstrated a continued reduction of red cell utilisation in admitted episodes of care (public hospital overnight admissions only).

Education

Since 2012, completion of the BloodSafe eLearning module – Clinical Transfusion Practice (incorporating Specimen Collection and Transporting Blood) – has been required for all NSW clinical staff involved in the collection, storage and transfusion of blood products.





Between June 2009 and June 2013, there have been over 41,000 completions of the BloodSafe modules by NSW health care workers, including the new PBM modules for Post-Partum Haemorrhage, Iron Deficiency Anaemia and Critical Bleeding.

Over the past 18 months, BloodSafe has offered new courses, in line with the Patient Blood Management Guidelines, which have been endorsed by the Blood Watch Program to support PBM practice in NSW.

Partnerships

The Blood Watch Program maintains close working partnerships with:

- · LHDs and networks
- Medical and nursing clinical transfusion experts and program partners
- Providers of scientific and clinical laboratory transfusion medicine services
- NSW Ministry of Health
- Australian Red Cross Blood Service
- National Blood Authority
- Other Australian jurisdictional health departments and associated blood management programs.

understanding of the patterns of blood product usage in NSW and assist in identifying further opportunities to improve the practice of transfusion medicine in NSW.

Blood product inventory management and minimisation of wastage

The Blood Watch program will develop strategies focused on understanding and improving systems related to blood product inventory and minimising wastage. This will be done in collaboration with the Ministry of Health, transfusion laboratories, pathology services, clinical specialty groups, the Australian Red Cross Blood Service and the National Blood Authority.

Haemovigilance

Blood transfusion is not risk-free and the hazards of transfusion are well documented. The Blood Watch program has identified the need to improve the recognition and management of transfusion reactions and transfusion process errors, that impact on the provision of safe and effective care.

Future Directions

Blood Product database

The Blood Product database, currently under development by the CEC, will be available during the 2013/14 financial year. This webenabled database will provide NSW public facilities with access to timely and relevant data on blood product utilisation, including relative usage by facility, specialty group, clinical unit and clinician. This information will support further improvements, allow a broader



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/blood-watch



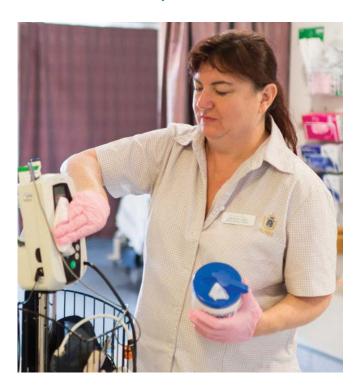




There are around 200,000 healthcare associated infections (HAIs) in Australian health facilities each year. They are the most common complication affecting patients in hospital and are a significant patient safety issue.

HAIs not only cause great suffering to patients, it is estimated that two million bed days are lost in Australia each year as a result.

HAIs can occur in any health care setting, however, it is possible to reduce them significantly through effective infection prevention and control. Infection prevention and control is a responsibility shared by everyone who works in, or visits, a health facility.



The program aims to reduce the risk of acquiring a HAI during care delivery in NSW health facilities.

It provides resources and support to NSW local health districts and networks, to improve prevention and infection control behaviour and to implement consistent infection control processes and surveillance across the system.

Key Achievements

In November 2012, the CEC organised the first education forum for about 50 infection prevention and control professionals from across NSW. Participants were updated on the developments and accreditation requirements under the National Safety and Quality Health Service Standards: Standard 3 (on HAI prevention and control). Ideas and strategies for communicating HAI messages to staff and the community were explored.

Recognising that cleaning is an effective means of reducing HAI transmission in health care facilities, a stand-alone environmental cleaning policy was developed and released during November 2012. It provides standards for cleaning hospitals, based on the risk of infection. It is supported by the Environmental Cleaning Standard Operating Procedures (a detailed description on how to clean hospitals wards and clinics) and a cleaning audit tool, to help wards and hospitals ensure the level of cleaning is appropriate.

Peripheral intravenous cannula (PIVC) insertion is an invasive procedure that has the potential for serious complications, both immediate and delayed. Following extensive consultation, a PIVC guideline is under development and outlines the principles for the safe insertion, management and removal of PIVCs in adult patients in NSW health facilities.



Partnerships

The CEC works closely with local health districts and networks, and the Agency for Clinical Innovation, who lend their input and expertise to the program.

There are a number of HAI experts who provide their input and advice to the steering committee and its sub-committees.

The CEC has worked with the Health Education and Training Institute (HETI), providing input and advice on HAI matters for education and learning material.

The HAI program provides NSW representation on the Australian Commission for Safety and Quality in Health Care Technical Working Group. It provides expert technical advice and assistance on issues relating to the surveillance of HAI in Australia.

Future Directions

During 2014, the HAI program will work with HETI to develop and disseminate e-learning modules on infection control and prevention principles, aseptic technique and cleaning training and competencies. It will provide infection control and prevention education and professional development. This will involve continued participation in Accreditation Network discussions and the facilitation of education forums for infection control and prevention professionals.

A review of the current NSW HAI surveillance system identified a need for a more streamlined, preferably web-based notification system. The CEC is currently working with the NSW Ministry of Health and local health districts on developing specifications for a HAI surveillance system with enhanced performance reporting capabilities. It should be able to provide reporting on HAI data on peer-level performance across hospitals and local health districts.

Catheter-associated urinary tract infections (CAUTI) cause significant morbidity and mortality. Compliance audit tools and other resources, to support the appropriate use of catheterisation and reduce the risk of CAUTIs, will be developed and piloted during 2014.

Updated policies on infection control, and prevention for multiresistant organisms will be released in 2014. The development of a stand-alone policy and guidelines on reprocessing of re-usable medical devices has also been recommended by the HAI Sterilization Services Working Party.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/hai

HAND HYGIENE PROGRAM



Healthcare associated infections (HAIs) are a significant and growing problem in our health care system. Improving hand hygiene among health care workers is the single most effective intervention to reduce the risk of HAIs in Australia.

Since February 2009, the CEC has been leading the implementation of the National Hand Hygiene Initiative in NSW. It is based on the "5 Moments for Hand Hygiene", promoted by the World Health Organization's World Alliance for Patient Safety Campaign "Clean Care is Safer Care".

The program advocates the need to improve and sustain hand hygiene practices of health care workers, at the right times and in the right way, to help reduce the spread of potentially life-threatening infections in health care facilities.



The Hand Hygiene program is one of a number of initiatives of the Healthcare Associated Infections program and is led nationally by Hand Hygiene Australia.

The 5 Moments for Hand Hygiene are:

- 1. Before touching a patient
- 2. Before a procedure
- 3. After a procedure or body fluid exposure risk
- 4. After touching a patient
- 5. After touching a patient's surroundings.

Key Achievements

Since hand hygiene audits began, rates in NSW have improved dramatically, increasing from 47.1 per cent in 2006 to 80.4 per cent in 2013. Between July 2012 and June 2013, rates improved from 78.9 per cent to 80.4 per cent. Medical officer rates are 65.6 per cent, and nurse and midwife rates are the highest of all health care workers in NSW, at 84.2 per cent.

The 5 Moments for Hand Hygiene education and auditing programs have been expanded over the last year. They now incorporate sub-acute facilities, including aged care, community health, oral health and mental health facilities.

The CEC delivered seven Gold Standard Assessor workshops between July 2012 and June 2013, with 64 new assessors trained. Clinically-based health care workers are invited to attend the GSA workshops, to become validated hand hygiene compliance auditors.

Through a combination of theory and practice, participants gain a detailed understanding of the "5 Moments" and the Hand Hygiene Australia audit tool (HHCApp), enabling them to train local auditors. To become validated, all auditors are required to attain a 90 per cent pass mark in a series of assessments.

As a result, local health districts, networks and sub-acute facilities have more people available to audit and to train others to audit hand hygiene compliance in their workplace.

Over 200 public health facilities from all local health districts and specialist networks in NSW are now regularly submitting hand hygiene data, with most using the online Hand Hygiene compliance program.

Partnerships

In delivering the Hand Hygiene program, the CEC has worked closely with the following organisations:

- Hand Hygiene Australia
- The Australian Commission on Safety and Quality in Health Care
- The Australian Institute for Health and Welfare (providing NSW Hand Hygiene compliance data for publication on the MyHospitals website).

Future Directions

The CEC will be working with local health districts and networks and sub-acute facilities, to ensure sustainability of the hand hygiene program. This includes gaining executive support for health care workers to attend Gold Standard Assessor workshops.

We are examining the potential for using web-enabled devices to collect hand hygiene compliance data in the ward, thus improving efficiency in data collection, verification and submission.

We will be building a campaign that targets both clinicians and patients, to raise awareness of hand hygiene and encourage the use of alcohol-based hand rubs, in line with the "5 Moments for Hand Hygiene".



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/hand-hygiene







Medicines are a vital part of treatment for most patients admitted to hospital. Medicines can have great benefits, but their use is not without risk. There are many steps involved in managing medicines and at each step there is an opportunity for error.

Around 20,000 incidents involving medication are reported to the CEC each year and some cause significant patient harm. The Medication Safety and Quality program aims to reduce the number and severity of incidents occurring.

To achieve this aim, the CEC provides tools that allow hospitals to assess their medicines management systems. The Medication Safety Self Assessment® tools highlight safe medicines management practices and allow facilities to identify areas where they may enhance the safety of their own systems.



By developing safe systems, facilities support the safe practices of their clinicians and reduce the opportunity for error and harm. Many facilities have used the Medication Safety Self Assessment® tools as the basis for efforts to improve medication safety.

As well as providing self-assessment tools, the Medication Safety and Quality team:

- Support the implementation of NSW Ministry of Health policies related to safe use of medicines
- Provide training and education about medication safety to undergraduate health professional students
- Detect emerging risks to medication safety and notify the NSW health system of them.

Key Achievements

The Medication Safety Self Assessment® for Australian Hospitals (MSSA), Medication Safety Self Assessment® for Antithrombotic Therapy in Australian Hospitals (MSSA-AT) and the 2012 ISMP International Medication Safety Self Assessment® for Oncology (MSSA Oncology), were widely used during this reporting period.

Participation in the MSSA program continues to grow, with 268 health care facilities having completed the self-assessment process and submitted their data to the CEC during 2012/13. Of these, 99 have completed the self-assessment more than once. In 2012/13, there were 15 facilities that contributed data for the first time and 26 that completed a repeat assessment. The program now has extensive participation from NSW public hospitals.

Increasing use of the MSSA-AT was noted in previous reports as a challenge to be addressed. In this reporting period, there were 12 new contributors, compared with three last year. The total number of facilities who have submitted data to the CEC, rose from 24 to 36.

The number of Australian facilities participating in the MSSA Oncology was extremely pleasing. A total of 42 Australian facilities, including 24 from NSW, completed the self-assessment and submitted data. This was 7 per cent of the total international participation and the highest number of participants from any country outside the USA.



Partnerships

The CEC continues to support medication safety by contributing to various committees, programs and advisory panels of NSW Ministry of Health and other pillars of the NSW health system. In this capacity, the Medication Safety and Quality team provides expert advice. Where relevant, the CEC provides analyses of medication-related incident data to the NSW Ministry of Health and local health districts, to help inform decisions and quality improvement activities.

The medication safety work of CEC is closely aligned to that of the Australian Commission on Safety and Quality in Health Care. The team represents NSW on the Commission's Health Services Medication Expert Advisory Group, the Anti-coagulation Working Party. It also provides expert representation on the Medication Continuity Expert Advisory Group.

The team continues to have a meaningful relationship with universities across NSW, conducting lectures and workshops and contributing to research projects.

Strong and important relationships have been developed with Business Procurement Services at HealthShare NSW, the Office of the Chief Health Officer of NSW and the Pharmaceutical Services Unit at the NSW Ministry of Health. These have been important in managing safety concerns related to a number of medicines shortages and recalls.

Future Directions

A 2014 version of the MSSA is in development and represents a major focus for the Medication Safety and Quality Program.

During 2014, materials will be developed to support the safe use of high-risk medicines. These medicines are commonly associated with patient harm.

Implementation of a new version of the National Inpatient Medication Chart will also be achieved in the coming year. It will include a dedicated section for documenting a patient's risk of blood clots and for prescribing treatment to prevent them. This will be linked to a broader program of work around clot prevention.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/medication-safety

PAEDIATRIC CLINICAL PRACTICE GUIDELINES PROJECT

Paediatric

CLINICAL PRACTICE GUIDELINES

Last year, there were around 515,000 paediatric emergency presentations to hospitals across NSW – an average of over 1,400 cases per day. Less than one in four are to a specialised paediatric hospital.

The challenge is to ensure that the facilities of NSW which see the majority of children presenting to an emergency department are empowered with tools and resources to deliver the highest quality care, regardless of location.



Paediatric clinical practice guidelines are a key initiative to ensure safe and clinically appropriate care for children.

In 2002, the first paediatric clinical practice guideline – Gastroenteritis – was released, following coronial recommendations. In the two years following, a further 11 guidelines, covering Abdominal Pain, Bronchiolitis, Fever, Head Injury, Seizures, Sore Throat, Asthma, Croup, Meningitis, Otitis Media and Recognition of the Sick Baby or Child, were developed.

The CEC works with the NSW Ministry of Health to review regularly the existing guidelines and develop new ones. All 12 have been reviewed since their initial launch and updated editions have been released.

The CEC conducts "snapshot" audits to assess compliance with the guidelines and assist local health districts to further improve the care of children in emergency departments.

Key Achievements

During 2012/13 the "snapshot" audit data was analysed. A report, based on the audit results for compliance with seven of the guidelines, will form the basis for recommendations to improve paediatric clinical practice further across NSW.

As a part of the audit, medical records in each LHD were reviewed, to assess compliance with the guidelines and variation from best practice. In excess of 1,600 medical records were reviewed. The findings support the paediatric clinical practice guidelines program as a key quality and safety initiative for children's health.

During 2012/13, three new guidelines, covering Community Acquired Pneumonia, Acute and Procedural Pain and Altered Consciousness have been developed by expert clinicians, with the assistance of the CEC. These will complement the existing 12 and provide useful information to frontline clinicians when treating children in emergency departments.



A particularly significant achievement during 2012/13, was the start of harmonising information across all of the guidelines. This will help clinicians and assist in the appropriate flow of care for each scenario. This activity will continue into 2013/14.

A review of each of the guidelines to ensure alignment with CEC's Between the Flags system, started late in 2012/13.

Once finalised, this will further improve the safety and quality of care for children in NSW public hospitals.

Partnerships

The audit is a partnership between the CEC, NSW Kids and Families, the NSW Ministry of Health and the three Child Health Networks.

A key element of implementation of the guidelines is the development of local partnerships with clinicians, particularly the paediatric clinical nurse consultants, and facilities within the LHDs.

Future Directions

While 12 paediatric clinical practice guidelines exist, only seven have an audit tool available to check if recommended practices are being followed. Over the next 12-24 months, the CEC will develop the remaining five, so that a full suite of audit tools for the clinical practice guidelines will be available. A process to develop an audit tool to accompany the release of a new guideline has already been implemented.

During early 2014, the Paediatric Clinical Practice Guidelines Audit Project Final Report will be released, accompanied by a Statewide action plan to address shortfalls in current implementation. The CEC will provide support for the periodic self-assessment of compliance following the release of the report.

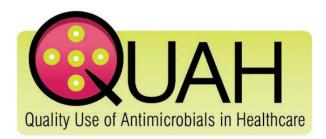
The CEC recognises that many clinical groups develop new clinical tools for children's health care. The CEC will provide support and expert advice to these groups and ensure that the new resources are readily available. The outcome will be further improvement in the quality and safety of children's health across NSW.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/paediatric-cpg

QUALITY USE OF ANTIMICROBIALS IN HEALTHCARE PROGRAM





Antimicrobial resistance is a global problem and an increasing threat to public health. Indiscriminate use of antibiotics has contributed to this problem. A 2009 Cochrane Review estimated that up to 50 per cent of antibiotic use in hospitals may be inappropriate.

Antimicrobial resistance limits the ability to treat infections and there is a dwindling supply of new antibiotics in development. Efforts must be made to improve the use of antimicrobials to preserve their effectiveness.

Quality Use of Antimicrobials in Healthcare (QUAH) is the antimicrobial stewardship (AMS) program at the CEC. It aims to optimise antimicrobial use, to improve patient care and reduce the development of antimicrobial resistance, by facilitating and supporting AMS initiatives in NSW public health facilities.

Quality use of antimicrobials means promoting their use only when needed and using the most appropriate agent in a safe and effective way. In this context, the term 'antimicrobials' encompasses a range of medicines used to treat infections, including antibiotics, antifungals and antivirals.



The aims of the program are to:

- raise awareness of AMS principles in NSW local health districts and hospitals
- develop tools and resources to support NSW health services in implementing effective programs that meet the National Safety and Quality Health Service Standards
- assist in the development of policies and guidelines related to antimicrobial use in the NSW public health system
- create a supportive and collaborative network of clinicians interested in improving quality use of antimicrobials in NSW LHDs and hospitals.

Key Achievements

AMS Expert Advisory Committee

A multidisciplinary committee, consisting of members from local health districts and networks across NSW, was formed to support the QUAH program. The AMS Expert Advisory Committee advises the CEC on the technical content of policies, guidelines and other initiatives and current and emerging issues relevant to AMS. It also provides strategic direction for the program, to ensure it best meets the needs of staff, patients and carers in local health districts and networks across NSW.

Educational Forums and Sessions on AMS

Prof Peter Davey is an international expert on AMS and the lead clinician for clinical quality improvement in the Medical School at the University of Dundee, Scotland. We were fortunate to have him spend three days at the CEC in February 2013, sharing the experiences and lessons learnt from national AMS initiatives in Scotland.

A range of educational sessions and forums was held during his visit, including a lecture at Royal Hospital for Women, Randwick, and a half-day forum with directors of clinical governance and clinicians to discuss AMS, including challenges and evidence for interventions. The CEC also delivered educational sessions on AMS at the University of Sydney Infection Control Professionals Education Forum. We were also involved in education sessions hosted by our partners.



Site Visits

There have been a number of site visits to health facilities across NSW during 2012/13. These allowed the CEC to better understand what local initiatives were in place, the barriers and challenges for staff and what kind of support local health districts and networks would like from the CEC. It also gave the CEC an opportunity to raise awareness of AMS and its importance in the context of patient safety and quality.

Antibiotic Awareness Week

Antibiotic Awareness Week was held from 12-18 November 2012. It provided an opportunity for the CEC to liaise and work with the European Centre for Disease Prevention and Control, Department of Health Victoria, NPS MedicineWise, and the Australian Commission on Safety and Quality in Health Care. The purple 'Resistance Fighter' T-shirts supplied by NPS MedicineWise were widely worn by health care professionals and students and were a popular means of promoting messages about antibiotic resistance.

The CEC launched the QUAH program website and circulated key messages on antibiotic use during Antibiotic Awareness Week 2012. The CEC was a contact point for NSW hospitals participating in this campaign, providing information and support. Several NSW hospitals organised local activities for Antibiotic Awareness Week, including delivering educational presentations, conducting antibiotic audits, displaying promotional posters and hosting consumer information stands.

Partnerships

Within the CEC, QUAH has worked with colleagues in:

- · Healthcare Associated Infections
- SEPSIS KILLS
- · Medication Safety and Quality
- In Safe Hands

The program has also achieved its goals by working with a number of organisations and individuals, including:

- NSW Therapeutic Advisory Group
- · Australian Commission on Safety and Quality in Health Care
- Society of Hospital Pharmacists of Australia, particularly the Infectious Diseases Committee of Speciality Practice (SHPA ID-COSP)
- AMS researchers based at Melbourne Health.

Future Directions

The QUAH program is focused on improving the way antimicrobials are used in NSW public health facilities. A toolkit is in development to support facilities implementing AMS programs, including an audit tool to promote rational prescribing of antibiotics, based on our learning from Prof Davey.

The CEC will build and strengthen relationships, particularly with HealthShare NSW, who are working on supporting software to facilitate AMS programs, as part of the Electronic Medication Management program.

Activities and resources for the QUAH program will support NSW local health districts and networks in meeting Standard 3 – Preventing and Controlling Healthcare Associated Infections – from the National Safety and Quality Health Service Standards.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/quah

BUILDING CAPACITY IN HEALTHCARE

KEVIN'S STORY



Kevin McLaughlin started working as a community mental health nurse in 1982, specialising in crisis response and case management in both the UK and Australia, before joining NSW Ambulance in 2007.

When he was enrolled in the Executive Clinical Leadership Program (CLP) during 2011 and 2012, delivered by the CEC, he had no idea he would design an initiative that could potentially save Ambulance upwards of \$1.3m per year.

As part of the CLP run by the CEC, participants are required to undertake a clinical practice improvement project. Kevin's project focused on finding ways to reduce the number of calls made by frequent callers to the Ambulance Service.

"As many of the calls were not medical emergencies, when the patient arrived at hospital, they were triaged as a lower priority and would end up spending a number of hours waiting for treatment" explained Kevin. "Our idea was to work in partnership with the patient and develop alternative pathways that could provide better care."

When the project team started to dig into the data, they found that the top causes of frequent calls were for anxiety-related issues, with breathing problems and chest pains the top two reasons, followed by mental health. It had been expected that the bulk of callers would be mental health patients. What was also surprising was, that over a 12-month period, 497 people had made a total of over 10,500 calls.

The top 18 callers made a total of 1,541 of those calls – an average of 85 calls per person per year.

As a result, the project focused on working with the top 18 callers, liaising with local health districts, GPs and other care providers. In some cases, the GP was not aware that the patient has been calling for an ambulance. "We worked closely with many GPs and presented this as an option for the patient, instead of calling an ambulance. This increased the GP's involvement and relationship with the patient" he said. "We always tried to involve the patient in any meetings we had with other services."

They also developed a process to identify the caller and refer them to other service providers, if they were available and it was appropriate. "The program was not punitive in nature, so if the patient called, we would still respond", says Kevin. "The aim of the program was to work with the patient and drive behavioural change."

Kevin recognises the value of the CLP and how the CPI component laid a great platform for him to address a recurring problem. "It provided a clear methodology and process for the project. We were able to identify the real issues and tie them into various stages of the approach. It was very helpful right through identifying, planning and implementation."

He also sought feedback from other staff and peers who had not been exposed to the issue of frequent callers. It guided the program development and he found it provided a different perspective on many of the thoughts and issues.

Since implementing the project, they have seen a 56 per cent reduction in calls from the group of patients. This has freed-up local ambulance services and also has a positive flow on impact to the service delivery in emergency departments. "Most importantly, the patients are receiving better and more appropriate care."

In October 2013, Kevin was presented the Health Innovation Award 2013, under the Patients as Partners category, following the success of his project.

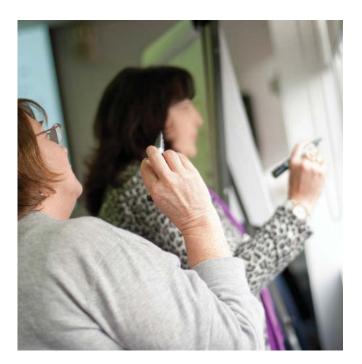
CLINICAL LEADERSHIP PROGRAM



The value of investing in clinical leadership programs is recognised at Statewide, national and international levels. Strategies for sustainable patient safety and system improvement depend on strong clinical leadership.

A central premise of CEC's Clinical Leadership Program (CLP) is that leadership occurs at all levels in health care and is not dependent on the position to which a person is appointed. In this, the CLP supports clinical leaders in the workplace to develop extraordinary leadership skills.

The program recognises the relationship between leadership and patient safety and quality, ensuring that the interests of patients and staff remain at the heart of health care delivery.



The program aims to:

- enhance knowledge of contemporary approaches in relation to patient safety and clinical quality systems
- enhance the skills of clinicians in relation to communication, conflict resolution and team leadership, within an environment of health care resource limitation
- enhance personal and professional clinical leadership skills
- improve the ability of clinicians to influence the direction of health policy
- develop the knowledge of clinicians about the workings of NSW Health.

CLP is offered under two models: Foundational Leadership and Executive Leadership. The foundational leadership program is multidisciplinary, delivered by local facilitators within a local health district or network. The executive leadership program is also multidisciplinary, delivered as six intensive modules in Sydney and is targeted towards senior clinicians. Both programs are delivered over a 12-month period.

Key Achievements

The CEC continues to build a cohort of effective clinical leaders, who progressively become the 'critical-mass' needed for patient-centred system change. In 2012, 270 participants completed the program. As part of the CLP, participants are required to undertake and lead a clinical improvement project (Clinical Services Challenge) with their local clinical teams. The projects deliver benefits, including improved patient safety, staff morale and increased quality of clinical care.



By the end of the 2013, over 1,300 health professionals will have completed the program since its inception in 2007. Over 160 have enrolled in the foundational program and 80 in the executive CLP for 2013. Retention levels remain positive, at over 95 per cent in the executive program and 90 per cent in the foundational program.

An example of a recent project that has demonstrated these benefits, is one led by Dr Angus Ritchie (Concord Hospital) whose team identified over-use of pathology testing as their clinical challenge to address. Its aim was to reduce inpatient pathology activity at Concord Hospital by 10 per cent within 6 months, by improving the quality of pathology orders.

Following the implementation of some innovative interventions to address issues identified by the team, there was a 7 per cent reduction in blood collections per occupied bed day across the hospital. This was equivalent to 1,050 fewer collections and savings of \$117,724.

There has been an increased number of enquiries from organisations throughout Australia for their clinical leaders to participate in the CLP. Currently, the executive CLP includes attendees from the Australian Red Cross Blood Service and the NSW Cancer Institute.

Partnerships

The CEC works with the Ministry of Health, LHDs, networks and external business partners, to deliver the CLP. Key departmental relationships within LHDs and networks include learning and development, clinical operations and clinical governance.

In implementing the CLP, additional partnerships and networks have been forged, particularly among other jurisdictions looking to implement clinical leadership programs of their own. This includes working in partnership with the Health Education and Training Institute (HETI) Rural Clinical Team Leadership Program, which is modelled on the CEC CLP.

Future Directions

The CEC will grow the profile of the CLP across NSW, to encourage wider participation, resulting in an increase in the capacity for improvements in the quality and safety of health care in NSW.

In order to fully understand the impact of the CLP, an independent assessment of the program and outcomes will be undertaken. This will provide validation and guide future direction for the program beyond 2013.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/clinical-leadership

CLINICAL PRACTICE IMPROVEMENT TRAINING PROGRAM





Adverse events are defined as incidents in which harm resulted to a person receiving health care. They include patient misidentification, equipment failure, errors by professionals and communication errors. Many of these adverse events may be preventable.

When there is a process failure which might lead to patient harm, Clinical Practice Improvement (CPI) methodology provides a framework for clinicians to review, identify and understand causes of the failure and design solutions to continuously improve processes of patient care.

Since 2010, the CEC has provided CPI training to participants of the Clinical Leadership Program, as well as front-line clinicians in NSW health facilities.



The CEC works closely with LHDs and networks, Justice & Forensic Mental Health and Ambulance NSW quality managers. The CEC is helping to build the capacity and capability for local facilities to support health care improvement teams and their projects.

The principles of Clinical Practice Improvement are as follows:

- Health care is a process which can be analysed.
- Both the process and the outcomes of clinical work can be measured.
- Profound knowledge of the processes of care exists within individuals who work in the system, in particular 'microsystems'.
- Multi-disciplinary teamwork and the design of innovative solutions are essential in effecting improvements in the health process.
- There is the will and leadership to implement change.

Key Achievements

CPI is one of the modules in the Clinical Leadership Program and forms the basic methodology for the Clinical Services Challenge. During 2012/13, the CEC delivered, or helped facilitate 12 CPI workshops, involving 222 participants, as part of the Clinical Leadership Program.

The CEC provides advice, support, resources and tools to LHD quality managers. This has enabled LHDs to deliver CPI workshops locally. During 2012/13, some LHDs modified their in-house workshops in response to feedback from staff. The modifications recognise the competing demands of clinicians and provide greater flexibility to attend, while still covering the program objectives.

Within the CPI facilitator network, 28 participants undertook a two-day CEC-led workshop on effectively engaging clinical staff in CPI workshops. The facilitator network continues to meet monthly via teleconference, where participants discuss their experiences and share resources that help improve the overall training program.

In 2012, the CEC delivered a pilot CPI program for advanced trainee doctors in collaboration with the Royal Australasian College of Physicians (RACP). Twelve of the participants completed an improvement project during the program. Eight have presented their projects at national and international conferences, and two of these have won LHD awards. One project also been nominated for a NSW Health award.

Partnerships

The CEC has worked in partnership with the Agency for Clinical Innovation to create a forum for collaboration around improvement training. Significant progress has been made in developing a more standardised care process across the NSW health system. This has been achieved by focusing on a more reliable work design and training front-line staff in improvement methodology.

The CEC has worked with the Institute for Health Care Improvement in Boston, which contributes to international best practice in quality and safety education for front-line staff.

Future Directions

The CEC is compiling a CPI resource kit, for facilitators to use within their own LHD or network. Used in conjunction with the existing CPI e-learning modules, this will further support LHDs and networks to deliver their own workshops as a blended model of learning.

Over the next year, CEC will facilitate networking opportunities between the Redesign leads in LHDs and networks and the quality managers (CPI advisors). This is likely to provide improved support to participants undertaking CPI projects.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/clinical-practice





Undergraduate

Quality & Safety Education

The Australian Hospital Statistics 2011-12, published by Australian Institute for Health and Welfare, reports that 6.1 per cent of patients in public hospitals, nationally, have an adverse event while in hospital. It is well accepted that many adverse events go unreported and the true incidence is much higher.

The CEC's Undergraduate Quality and Safety Education program aims to introduce trainee clinicians to key principles of patient safety and clinical quality, throughout their training program and to have these principles applied and reinforced in the clinical setting.

Having a comprehensive and consistent message from the classroom to the clinical setting will help put the importance of quality and safety at the forefront of clinical practice in NSW Health.

While the initial focus was on medical student education, the success of the program has resulted in other professional groups requesting similar teaching for their students.



The CEC's Undergraduate Quality and Safety Education began in 2009. It is taught in four medical schools, three schools of nursing and Sydney University Allied Health – to students from a range of disciplines.

Key Achievements

During 2012/13, undergraduate quality and safety education was introduced into the teaching curriculum for second year medical students at the University of Newcastle and the University of New England. This builds on the teaching these students receive from the CEC program in their first year of medical school.

A significant achievement has been the development of a multicentre research study on medical student patient safety knowledge, at University of Western Sydney, Notre Dame University, University of New England and the University of Newcastle. Patient safety knowledge is assessed by an internationally proven measure, before any teaching starts and will be re-assessed after one and two years in the first instance.

Partnerships

Successful partnerships have been established with the five universities where the undergraduate quality and safety education program is taught, with those universities providing academic staff to facilitate the discussion groups, which are a key part of the program.

Other partners include MedStar Health and the University of Illinois, the University of Wollongong, the IHI Open School and the BMJ Quality program.

Future Directions

It is hoped that the program will be further supported, with a view to expanding the teaching currently provided for final-year medical students at the University of Western Sydney, to other medical schools.

There is also potential to develop an interactive online course to supplement face-to-face teaching and become a substitute where face-to-face teaching is not feasible.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/quality-safety-edu

USING DATA TO DRIVE CHANGE

DEBBIE'S STORY



Debbie Wyburd started her career as an occupational therapist and has a background in rehabilitation for patients with acquired brain injuries and neurological deficits. She was the Director of Allied Health in the former Wentworth Area Health Service and became the Network Director for Sydney West Area Health Service – Allied Health, Pharmacy and Rehabilitation Medicine – before moving into her current role as the Director of Clinical Governance in the Nepean Blue Mountains Local Health District.

Debbie's first experience with the Quality Systems Assessment program (QSA) run by the CEC, was in her role as Network Director doing the self-assessment when it was first introduced in 2007. She has now had a number of years' experience with the QSA and can see the value the surveys provide.

"I've come to appreciate what it provides the organisation at a grass-roots level. It gives context to quality and safety, shows what should be in place, and makes quality and safety real for clinicians on the floor", says Debbie. Within her own LHD, she has found the program has helped to keep quality and safety on the agenda. "It has helped to standardise the language used on the floor and the reports help drive consistency in performance", she explains.

"The information from the QSA helps with two things: we address the recommendations to improve quality and safety in our facilities and it becomes evidence for national accreditation. The fact that real clinicians are the ones doing the QSA makes it a positive experience. They share ideas and best practices and provide positive, real-time feedback on areas for improvement to our teams."

"Some clinicians view the QSA as an internal review process, which can cause some anxiety in the lead-up, but the clinicians tend to be quite positive during and after the survey."

Debbie also recognises that the QSA has helped to focus on improvement in a number of areas within the LHD.

As a result of previous QSA results, morbidity and mortality meetings have been reviewed and the format has been standardised. The LHD has reviewed the policy and procedure and developed templates ensuring morbidity and mortality meetings are now outcome-focused. They have also developed medication safety action plans and increased the awareness of high-risk medicines.

"One of our areas for improvement has been around open disclosure. The QSA found that staff had a poor understanding of what it meant. We now have a renewed focus on open disclosure in the LHD and a much greater appreciation of the benefits it provides", says Debbie.

The QSA has supported a number of other changes, including a review of how the paediatric clinical pathways are being used by clinicians. A working group on delirium has been formed to support implementation of the initiative from Nepean Hospital to all hospitals in the LHD.

When asked about the overall influence the QSA has had in improving quality and safety in her LHD, Debbie responds "It allows us to capture the opinion and perception of clinicians, compared to management and gives us a true picture of where the organisation really sits. It uses simple language, provides a structured framework and helps to improve the quality of care for our patients".

QUALITY SYSTEMS ASSESSMENT



In most health systems around the world, policies, procedures and best practices outline the standards of care for patients.

The Quality Systems Assessment (QSA) is a clinical risk management program led by the CEC. It provides clinical teams and managers with a means of assessing compliance with policy and standards, identifying clinical risks and deficiencies in practice and highlighting and sharing exemplary practice relating to clinical quality and patient safety.

A feature of the QSA is that it is undertaken at multiple levels of an organisation, allowing a comparison of responses at the different levels to assess the effectiveness of governing and reporting structures.



There are four components of the QSA:

- Self-assessment
- · Feedback and reporting
- Improvement plans to address gaps identified through self-assessment
- · Verification.

The QSA helps to support sustainable improvements and cultural change in health care through self-assessment, resulting in higher standards of patient care.

Key Achievements

2012 Self-assessment

The 2012 self-assessment was undertaken by over 1,500 respondents across NSW public health organisations and at various levels of the health system, with an overall response rate of 96 per cent.

In 2012, the CEC had the opportunity to undertake a second system-wide census of quality and safety activities, as well as a review of end-of-life care and management, across the whole of the NSW health system.

All NSW public health organisations, including LHDs and networks, Ambulance NSW and Justice and Forensic Mental Health Network, have participated in each of the five annual self-assessments from 2007/08 to 2012.

2012 Reporting from Self-Assessment Results

Reporting to all levels of the health system is a key to achieving the objectives of the QSA. Two major reports have come out of the 2012 self-assessment.

The Care for the Dying in NSW report provides clinicians' perspectives into the issues around care for the dying in NSW public health organisations. A key outcome in the report is the recommendation to develop standardised, evidence-based and consensus-focused best practice systems around managing all aspects of end-of-life care in NSW.



In response to the *Care for the Dying in NSW* report, the CEC will work with the Ministry of Health and the Agency for Clinical Innovation in the Statewide approach to end-of-life care and has taken the lead in implementing the AMBER care bundle in NSW.

The Safer Systems Better Care 2012 report presents the second system-wide census of key quality and safety activities undertaken in NSW. Three themes emerged across all public health organisations:

- The need to improve communication and feedback at all levels
- The need to continue to invest in developing organisational capacity and excellence in quality and safety
- The need to improve patient outcomes through building effective clinical teams.

Recommendations in the *Safer Systems Better Care 2012* report have been made to the system. The progress and implementation will be reviewed annually through each organisation's improvement plan.

Improvement plans

All participating NSW public health organisations are required to develop improvement plans for the recommendations found through the self-assessment. A formal annual review has confirmed that all have developed, and are acting on, their localised improvement plan.

A total of 49 Statewide recommendations have been made from the four self-assessments between 2007 and 2011. In 2013, 86 per cent of the recommendations from 2007 and 46 per cent from 2011 had been fully implemented.

2012 Onsite verification program

This year, the CEC undertook the fourth on-site verification program across all public health organisations. Overall, 3,756 self-assessment responses were verified, with an accuracy rate of 94.2 per cent.

Since the program started in 2007, each facility in NSW has had at least one visit to verify its self-assessment. We can now demonstrate that a verification program that relies on peer review is feasible and can be successful.

Partnerships

Key relationships for the QSA include LHDs and networks, clinical governance directors and their staff, the NSW Ministry of Health, and the Agency for Clinical Innovation.

Future Directions

There is a need to ensure that the QSA is seen as complementary to the National Safety and Quality Health Services Standards, rather than a duplication of work. It is important to ensure that the QSA remains flexible and responsive, to address contemporary systems and issues in health care delivery, as the health care landscape evolves.

The QSA will support NSW public health organisations with accreditation, by providing evidence and facilitating data comparison across NSW.

The 2013 QSA topics will cover transition of care, falls and medication safety.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/qsa

COLLABORATING HOSPITALS' AUDIT OF SURGICAL MORTALITY





Mortality review is a long-recognised method of monitoring the quality of health care and is undertaken worldwide. In NSW, the Collaborating Hospitals' Audit of Surgical Mortality (CHASM) audits the deaths of patients who were under the care of a surgeon at some time during their hospital stay in NSW, regardless of whether an operation was performed.

CHASM is an education program led by surgeons for surgeons. It uses a systematic peer review methodology and provides feedback on the review findings to the treating surgeons for their consideration and learning.

The peer review methodology is based on the Scottish Audit of Surgical Mortality established in 1994.

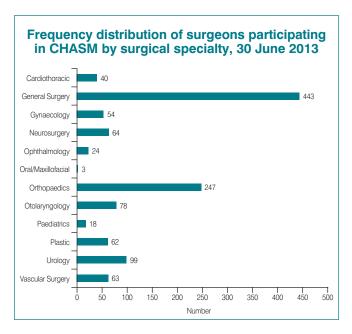
CHASM is overseen by an expert committee, appointed by the Director-General under section 20 of the *Health Administration* Act 1982. Information collected for CHASM is privileged by section 23 of the same Act and the Commonwealth Qualified Privilege Scheme under Part VC of the Health Insurance Act 1973.



The Royal Australasian College of Surgeons requires all surgeons who are in operative-based practice and have a surgical death, to participate in the Australian and New Zealand Audit of Surgical Mortality, which includes CHASM in NSW, for its Continuing Professional Development Program.

Key Achievements

At 30 June 2013, 1195 surgical fellows of the Royal Australian College of Surgeons were participating in CHASM, with 452 of them also agreeing to be first-line assessors and 341 second-line assessors.



From 1 July 2012 to 30 June 2013, CHASM recorded 1,851 deaths notified by all LHDs, received 1,370 completed surgical case forms from surgeons and completed audits on 1,329 notified deaths.



During this reporting period, an individualised program report for each LHD was developed. CHASM also published its fourth case book, with a key theme on clinical leadership, distributed its fourth batch of individualised annual feedback reports to participating surgeons and submitted de-identified audit data from 2009 to 2012 to Australian and New Zealand Audit of Surgical Mortality for national reporting.

Partnerships

CHASM is funded by NSW Health, administered by the CEC and co-managed by the NSW State Committee of the Royal Australian College of Surgeons.

It works collaboratively with LHDs, which notify surgical deaths to CHASM and provide medical notes for assessment and local support to surgeons.

At the national level, CHASM is a partner of Australian and New Zealand Audit of Surgical Mortality, which was formed by the Royal Australian College of Surgeons in 2005, to co-ordinate the development and implementation of surgical mortality audits in the two countries.

Future Directions

A major focus for CHASM is to expand the audit to private hospitals.

The program will work to improve the audit process, based on feedback from surgeons and LHDs. A major focus is to improve database functionality for a more efficient and cost-effective audit process. There will also be further support for LHDs to utilise CHASM data for service improvement.

As part of the program's commitment to education, CHASM will participate in educational activities organised by the NSW Office of the Royal Australian College of Surgeons and will provide support to surgical trainees, in their fellowship training, through research projects.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/chasm

PATIENT SAFETY PROGRAM



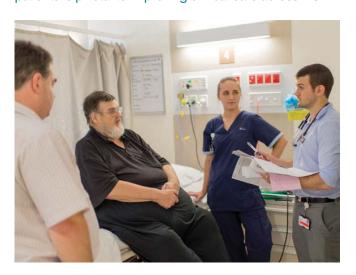


A clinical incident is any unplanned event which causes, or has the potential to cause, harm to a patient. Staff working in NSW health services are required to report all clinical incidents, so that risks to patient safety are recognised and action is taken to prevent them occurring in the future.

The Patient Safety program is a key component of the CEC's commitment to improving safety and quality of clinical care across the NSW health system and is closely aligned with all the CEC programs and projects.

It includes monitoring, analysis, feedback and reporting about clinical incidents reported in the Statewide Incident Information Management System (IIMS) and associated root cause analysis (RCA) reports. These insights help to determine where Statewide improvements to clinical care can be made.

The program is based upon a core philosophy that openness and sharing of information about risks to patients is pivotal to improving clinical care across NSW.



NSW Health has one of the world's largest clinical incident reporting systems with over 100,000 incidents reported and 600 RCAs completed annually. It is recognised internationally as a leader in analysing what went wrong and acting on the findings to improve patient care.

Key Achievements

Safety Publications

A part of CEC's role is to undertake aggregated analysis of clinical incidents in IIMS, and root cause analysis (RCA) reports in relation to issues identified through monitoring and RCA review processes. The findings are distributed across the health system in the form of Clinical Focus Reports, Safety Alert Broadcasts and in a new Patient Safety Watch format. These publications highlight risks to patient safety and recommended strategies to reduce the likelihood of re-occurrence. There were two clinical focus reports published during 2012/13, titled "Patient Controlled Analgesia" and "Fetal Monitoring: Are we getting it right?" Patient Safety Watches on "Issues with settings and operation of defibrillators", "Removal of central venous access devices" and "Management of patients with sleep apnoea", were also distributed to chief executives during the year.

The team has also facilitated the revision of the Incident Management Policy Directive.

Project

Three new projects started within the Patient Safety program during the year. The first relates to the review and enhancement of NSW Open Disclosure (OD) and early incident response processes, beginning with review of OD policy, guidelines and training.

The second relates to an earlier clinical focus report on Diagnostic Test Results Management. It aims to identify and implement system-wide practices, to ensure all clinical tests are reviewed and the results are communicated and acted on.



The third is a major project which will result in replacement of the current ageing, but well-utilised, incident reporting system, by a web-based platform with enhanced functionality, to assist with the reporting and management of clinical and corporate incidents. The CEC has conducted 56 workshops, with over 500 staff directly involved and a Statewide survey for the project.

Partnerships

The Patient Safety program works closely with groups of clinicians across Statewide groups, such as clinician networks through the Agency for Clinical Innovation, as well as directors of clinical governance and clinical governance units within LHDs.

The CEC also provides the secretariat function for the Clinical Risk Action Group – the peak quality and safety group within NSW Health.

The CEC has collaborated with NSW HealthShare in developing the replacement incident reporting system.

Future Directions

The Patient Safety program will work to identify emerging clinical risks in health care across NSW. During 2013/14, two new clinical focus reports will be prepared for publication. One will cover vacuum extraction (maternity); the second will be on diagnosis and clinical management of abdominal pain.

Opportunities to convert the Incident Management Report series to an electronic data dashboard format will also be explored.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/patient-safety

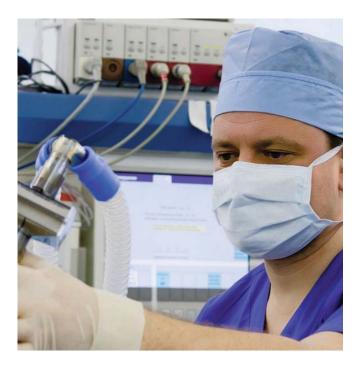
SPECIAL COMMITTEE INVESTIGATING DEATHS UNDER ANAESTHESIA



The Special Committee Investigating Deaths Under Anaesthesia (SCIDUA) reviews deaths which occur while under, as a result of, or within 24 hours ollowing the administration of anaesthesia or sedation for procedures of a medical, surgical, dental or investigative nature.

It aims to identify any area of clinical management where alternative methods could have led to a more favourable result. SCIDUA has been reviewing anaesthesia-related deaths since 1960.

Initially, the committee looked for errors of management, when the mortality was one in 3,500 cases and there were large numbers of children and pregnant women dying.



Today, anaesthesia is much safer, with a mortality rate of one in 32,000 cases. Anaesthesia-related deaths largely occur in very sick or elderly patients. The estimated number of anaesthesia-related deaths occurring in fit and healthy patients, such as children and pregnant women, is less than one in 500,000. But there is still room for improvement.

SCIDUA is the longest-serving committee of its kind in the world. It is an expert committee appointed by the Director-General under section 20 of the Health Administration Act 1982. Information collected for SCIDUA is privileged from subpoena under section 23 of the same Act.

The program focuses on safety and quality improvement through education. Feedback from the investigation is provided to the anaesthetist to support practice improvement.

Key Achievements

From 1 July 2012 to 30 June 2013, SCIDUA recorded 296 deaths notified under the *Public Health Act 1991* and *Public Health Act 2010*, reviewed 283 notified deaths and classified 270 notified deaths.

To support implementation of the *Public Health Act 2010*, which came into force on 1 September 2012, SCIDUA developed an information sheet on the notification requirements of deaths arising after anaesthesia or sedation, for operations or procedures.

The NSW Ministry of Health published this information sheet on its Public Health Legislation webpage and distributed it to all NSW hospitals, NSW universities offering medical education and health professional organisations and colleges in Australia.

The CEC also published its report, *Activities of the Special Committee Investigating Deaths Under Anaesthesia 2010.* This report documented the committee's audit activities and findings from 2006 to 2010.



Copies of the report were distributed to heads of anaesthetic departments, directors of clinical governance and the chairs of the Australian and New Zealand College of Anaesthetists, Australian Society of Anaesthetists, Royal College of Surgeons and the Australian Medical Association.

Partnerships

SCIDUA is a long-standing partner of the Australian and New Zealand College of Anaesthetists and provides data annually for the College's triennial report on safety of anaesthesia in the two countries. SCIDUA works collaboratively with local health districts to ensure notification of anaesthesia-related deaths, as stipulated in the *Public Health Act 1991*.

Future Directions

Over the next 12 months, SCIDUA will establish a new committee of nine members, after the expiry of the current committee's appointment term.

An online reporting application for notification of deaths is currently under development and should be available for use during the new year.

SCIDUA will contribute to the national triennial report on safety of anaesthesia, by submitting de-identified audit data to the Australian and New Zealand College of Anaesthetists.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/scidua

EMERGING PROGRAMS

TRICIA'S STORY



Tricia Parker became involved in palliative care after seeing a small advertisement in her local paper. She has now been a community and hospital palliative care volunteer for 18 years, working in the South Western Sydney Local Health District (SWSLHD). She has also been a SWSLHD consumer representative for the last 11 years and sits on five committees.

Several years ago, she had her own family experience with end-of-life care, after her elderly father was rushed to hospital.

"Dad was admitted to an acute care hospital via the emergency department and spent Thursday night in intensive care before being transferred to a ward bed the next morning", recalls Tricia. "Knowing that dad wasn't well, I went to the ward desk to see if I could discuss his treatment and care. I was told that no one would be available until Monday to talk about what was going to happen. We were really surprised and quite anxious that no one could explain what was going on."

Tricia spoke to a number of the nursing staff about her father's condition and asked that if it deteriorated he be moved to a private space and that they contact her, not her mother. She also asked for this to be included in her father's notes. A few days later, his condition did deteriorate and he declined any further active treatment.

"Hours before his death, he was still in a shared room in the ward – it was visiting hours and the only privacy we had were the curtains. He knew what was happening and sent us home to protect us", tells Tricia. "We just felt so helpless that we couldn't do anything that he'd wanted. Even when he died he was still in the shared room."

Reflecting on the experience, Tricia comments "it just seemed as though the care in the ward was so detached. While they were providing care, they were doing it without much regard for the patient or family and they weren't listening to us. It was like the nurses didn't know what to say to us or how to speak about what was happening. It's the culture that was in that place at that time".

In 2012, the CEC's Quality Systems Assessment identified that one of the major challenges for clinicians was initiating patient and family discussions when caring for patients towards the end of life. To help address this, the CEC is piloting the AMBER care bundle in nine facilities across NSW during the second half of 2013.

The program provides an approach for clinicians to follow, when they are uncertain whether a patient may recover and are concerned that he or she may only have a few months left to live. It encourages clinicians to involve patients and families actively in the discussions about the treatment and care options and to understand the patient's wishes and have them documented. These decisions can help to take away some of the potential stress from family members and carers towards the end of the patient's life.

The program has been localised by the CEC, from the AMBER care bundle © Guy's and St Thomas' NHS Foundation Trust, UK 2013, originally developed with funding from Guy's and St. Thomas' Charity.

Tricia is happy to see the program being launched in NSW. "The more that health professionals are doing it, the more natural it becomes. Providing good end-of life-care is a different kind of medicine, but it's equally as important – it's about 'good care'. There is only one chance to get it right for the patient."

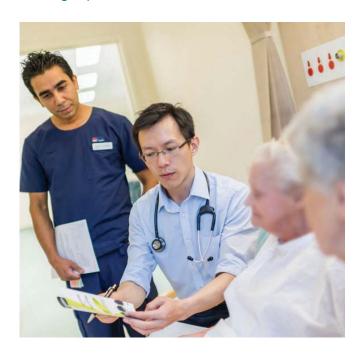


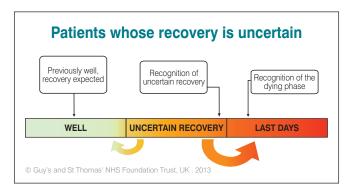


The AMBER care bundle is a clinical care bundle developed at the Guy's and St Thomas' Hospitals in the United Kingdom. It is used to identify patients at risk of dying in the next two months who have presented to acute care facilities.

The AMBER care bundle is designed to prompt and support clinicians to identify those patients for whom recovery is uncertain, develop a management plan according to appropriate goals of care, discussing it with health care team members, as well as with patients and carers.

The AMBER care bundle prompts teams to consider the patient's preferred place of care and if the condition improves, to make plans for future care, potentially avoiding re-presentation to acute care facilities.





While the recovery of these inpatients is uncertain, they may still be receiving active treatment i.e., the AMBER care bundle is not an end-of-life care plan.

The AMBER care bundle will be piloted in nine facilities across NSW during the second half of 2013.

Partnerships

In launching the AMBER care bundle, the CEC has worked closely with a number of organisations. Key relationships include Guy's and St Thomas' NHS Foundation Trust (UK), the Palliative Care Network at the Agency for Clinical Innovation and the Advance Care Planning for Quality Care at the End of Life, at the Ministry of Health.

The project aligns with CEC programs, including SEPSIS KILLS, Between the Flags, Patient-Based Care, In Safe Hands, and Quality Systems Assessment.

Program Benefits

The AMBER care bundle provides many benefits for patients and clinicians. It assists clinicians to better identify and communicate with patients whose recovery is uncertain. It improves team communication and provides clarity regarding treatment goals.

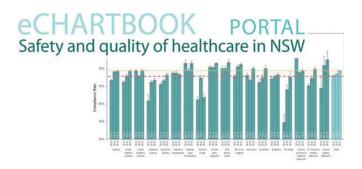
The patients, their family and/or carers are involved in the development of the medical plan and possible outcomes. The likelihood of the patient dying in the preferred place is increased.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/programs/amber-care

eCHARTBOOK PROGRAM





The eChartbook program builds on the success of the previous paper-based publication series, Chartbook. It provides comparative reports on clinical indicator data and variation at LHD and Statewide levels.

It also provides information to patients and the NSW community about safety and quality issues, changes over time and the implications for their health care services.

The eChartbook portal is intended to identify issues and stimulate action across the health system, that will improve quality and safety and drive change in health care.

The portal provides expert informed analysis and commentary on a range of CEC project and program-based indicators of safety and quality. It presents more timely data through the use of dynamic charts, updated in real time and encourages and facilitates feedback through its web-based format.



Partnerships

During 2012, the Chartbook Advisory Group endorsed a project to redesign the existing Chartbook program to a web-based product. The CEC has worked closely with a large number of organisations and individuals to evaluate the existing program and the transition to the new portal.

Key relationships include the Ministry of Health, the Bureau of Health Information, the Agency for Clinical Innovation, the Cancer Institute NSW, the Centre for Health Record Linkage, the Pregnancy and Newborn Services Network and the Australian and New Zealand Intensive Care Society.

Subject matter experts from within and outside NSW have provided commentary and suggestions, most notably Prof Sheila Leatherman, Prof Bruce Barraclough, Prof David Ben-Tovim, A/Prof Brian McCaughan and Dr Diane Watson.

The portal has also been developed with input from CEC programs, including Blood Watch, Between the Flags, CHASM, HAI, Hand Hygiene, Incident Management, Medication Safety, Patient Based Care, SCIDUA, SEPSIS KILLS and the Quality Systems Assessment – with assistance from the CEC Data Management Team, the board and clinical council and the DCGs group.

Program Benefits

The eChartbook will be an important tool to facilitate self-reflection by doctors, nurses, health professionals and managers and to inform improvement programs in health care.

The more accessible, timely and relevant that information is, the more likely health professionals will use it to identify and take up opportunities for improvement.

With increased accessibility, the public can remain informed about the safety and quality issues of health care in NSW and how the health system is responding to these challenges.



For further information, scan the QR code with your smartphone or visit: http://www.cec.health.nsw.gov.au/echartbook

INTERNATIONAL PRESENTERS

In line with our commitment to improving quality and safety in health care, a number of international leaders in their field visited the CEC during 2012/13, sharing their knowledge and experience with clinicians and staff across NSW Health.

Dr Gordon D. Schiff, MD

Dr Gordon Schiff, General Internist, Brigham and Women's Hospital, Boston and internationally-recognised expert on robust diagnostic test result management systems, participated in a series of presentations and workshops at the CEC in November 2012, sharing valuable insights into challenges and strategies associated with diagnostic error. This included "Lessons from Three Decades of Diagnostic Error Research", and "Getting Results: Reliably Communicating and Acting on Critical Test Results".

Dr Schiff is Associate Professor of Medicine at Harvard Medical School. He worked at Chicago's Cook County Hospital for more than three decades where he directed the General Medicine Clinic and Chaired the institution's Quality Assurance/Quality Improvement, and P&T (Formulary) Committees, he was Professor of Medicine at Rush Medical College.

Prof Peter Davey

Prof Davey, an international expert on antimicrobial stewardship and the Lead Clinician for Clinical Quality Improvement in the Medical School at the University of Dundee, Scotland, visited the CEC in February 2013. He participated in discussions and presentations concerning Antimicrobial Stewardship, Hospital Acquired Infection and Undergraduate Education. Prof Davey's visit also included networking with South Eastern Sydney LHD, AMS Expert Advisory Group, the CEC Clinical Council and the directors of clinical governance at the monthly DCG forum held at the CEC.

Prof Davey trained in Infectious Diseases in Birmingham and completed a MD at the University of London, before going to Dundee in 1980. He was appointed to a NASCA Senior Lectureship in Clinical Pharmacology and Infectious Diseases at the University of Dundee in 1986.

Dr Mark Graber

The visit of Dr Mark Graber in May 2013, created a lot of discussion around diagnostic clinical decision-making and diagnostic error and how we can try to develop tools to help reduce diagnostic error.

As well as presenting to CEC staff, Dr Graber participated in and presented at the Sax Institute's HARC Forum, the CEC's Clinical Leadership Program and a one-day forum on diagnostic error. He travelled with CEC staff to visit the Hunter New England Local Health District, and participated in the Mid North Coast Health Innovation Awards and Health Expo at Coffs Harbour.

He is a graduate of Yale College and the Stanford University School of Medicine. He received Fellowship Training in Nephrology at Boston University School of Medicine. For 20 years he was Chief of Medicine at the Department of Veterans Affairs Medical Center in New York.

Dr Graber has a long-standing interest in patient safety. In 2002, he founded Patient Safety Awareness Week, which is now recognised internationally. His main interests centre on improving the quality, safety and value of health care. He is regarded as an international authority on diagnostic error in medicine.

Dr Jason Stein

Dr Stein is the Associate Director for Quality Improvement and Director of the Clinical Research Program for the Section of Hospital Medicine, at Emory University School of Medicine.

He completed Internal Medicine residency at Barnes-Jewish Hospital at Washington University in St. Louis and the Advanced Training Program in Health Care Delivery Improvement at Intermountain Health Care. He is Director of the Department of Medicine Quality Program, Medical Director of Emory Healthcare's Clinical Data Warehouse and Director of the Society of Hospital Medicine's Quality Course.

Bryan Castle

Bryan Castle completed his undergraduate training at Atlantic Union College and received his MBA in Health Care from the University of Hartford. He has been a nurse for over 30 years with front-line experience in a range of hospital settings, including medical/surgical, oncology and cardiac surgery units. Bryan has also held a variety of nursing leadership positions in intermediate and intensive care units.

Jason Stein and Bryan Castle work together at Emory University Hospital, Atlanta. They co-facilitated with Dr Gabriel Shannon, a two-and-a-half day residential school in Orange, NSW, from 17 to 19 June 2013, introducing members from 18 patient care teams across the State, to the structure and process of the In Safe Hands program.

The purpose of the In Safe Hands residential school was to address the current system of health professionals working in silos (which impedes quality of care, patient safety and patient flow), and to give patient care teams the structure and tools to re-design their units into strong, interdisciplinary teams, that work together with the shared goal of delivering highly reliable, planned care to all patients.

THANK YOU

Thank you to all the staff of the CEC and local health district media units, who helped with the report and to the health professionals, volunteers, patients and their families who feature in it.



