

# 2017-18 YEAR IN REVIEW





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# KEY ACHIEVEMENTS



Minimised potential harm by producing 13 Safety Alerts/Notices and five medication shortage communications in response to a range of patient safety issues. Of 376 product recalls risk assessed, 15 were identified as high risk, requiring a system level response led by the Clinical Excellence Commission.



Co-hosted the NSW Patient Experience Symposium, in conjunction with the Ministry of Health and pillars, which was attended by 570 delegates, nearly a third of them consumers involved in program design and implementation. Free consumer registration highlighted the importance of patient, family and carer voices to developing patient safety models.



The Collaborating Hospitals' Audit of Surgical Mortality finalised the Bi-National Audit System (BAS) for online submission of forms, ready for implementation in July 2018. The System enables surgeons to digitally report surgical deaths, peer-review cases and obtain continuing professional development points, while providing increased data accuracy, accessibility and security.



Quality Audit Reporting System (QARS) implemented by all Local Health Districts and specialty networks for clinical audits and surveys. The Clinical Excellence Commission supported all users in the business process. In the past financial year 389,431 audits were conducted in QARS to support hospital accreditation.



Developed an extensive range of audit tools and resources to enhance existing quality systems and help Local Health Districts meet the requirements for compliance with an Australian Standard (AS/ NZS4187:2014 Reprocessing reusable medical devices in health organisations).



Launched a statewide electronic risk assessment tool for venous thromboembolism (VTE), developed by the Clinical Excellence Commission and eHealth NSW. The tool provides guidance to medical officers on the assessment and management of VTE risk in adult inpatients.



Provided a real time analytics platform, Quality Improvement Data System (QIDS), for clinicians and clinical teams. It is now accessed by 4500 clinicians and managers, who can now use real-time data to improve patient safety and healthcare quality. The number of users increases every day.



The Quality Improvement Academy introduced quality improvement tools online to assist NSW Health employees to build leadership in quality improvement. The Academy trained 496 improvement coaches and 34 improvement experts. We delivered eLearning training to 487 staff; 280 participants completed Patient Safety training.



Revised Between the Flags (BTF) Education (released in June 2018) which provides innovative and flexible resources, including a new one-hour workshop for Senior Medical Officers.



Launched the *Master Clinician's Guide to Quality and Safety* in May 2018, providing expert tools and resources to help health care staff foster a culture of safe, high-quality care at the hospital where they work.

# FOREWORD



We are pleased to report that the Clinical Excellence Commission has again delivered on its commitment, as the lead agency on safety and quality, in working with its partners to further improve the safety and quality of care for patients in the NSW health system.

Throughout the year, the Clinical Excellence Commission has been called upon to provide specialist support to the Ministry of Health and local health services. This has often required a responsive, agile service, coupled with the delivery of expertise, advice and good practice on a wide range of safety and quality issues, including critical incidents.

Each year emphasises the strong collaboration between clinicians, frontline staff, patients and families, and the Clinical Excellence Commission.

This work has helped to ensure the Clinical Excellence Commission remains responsive to the continual shifts in a rapidly changing health care environment.

To support these changes, the Clinical Excellence Commission continues to build a critical mass of improvement leaders across NSW Health, through its Quality Improvement Academy. The Academy focuses on building capacity and capability in Quality Improvement, and there is a growing Alumni of clinical leaders now skilled across the system.

During the year, the Clinical Excellence Commission consulted extensively with key partners and stakeholders across the NSW health system, to determine what is already working well, and what we need to do to support delivery of safer care, to inform its new Strategic Plan.

We heard consistently about the need to strengthen the voice, expertise and experience of patients, families and carers into the heart of the health care process.

As we develop our vision for the next three years, we incorporate these learnings to determine how we can continue to meet our continuous improvement responsibility of safer care, for every patient, every time.

This year's Review highlights a snapshot of the safety and improvement work of the talented and committed staff across the NSW health system, and showcases the enabling role the Clinical Excellence Commission has in supporting these efforts.

While the Clinical Excellence Commission has been a catalyst for many of these initiatives, the real champions are the many staff, patients and families who work in partnership with us to improve the experience of care for everyone within the health system.

Lastly, we'd like to pay tribute to the late Betty Johnson AO.

Betty was a consumer advocate who worked closely with the Clinical Excellence Commission as an active and regular member of the Directors' of Clinical Governance forum. She provided an insightful consumer voice to the forum and ensured discussions were grounded in relation to patient needs.

Betty was a spirited, courageous woman with immense capacities for love and empathy, a battler for social justice and a union and health consumer activist.

The NSW health system will remain forever grateful for her passion and for her enduring contribution in giving patients a greater voice in health care.

**Carrie Marr**  
Chief Executive

**Associate Professor  
Brian McCaughan AM**  
Board Chair



# EMPOWERING THE PATIENT, CARER AND FAMILY VOICE



## REACH in Partnership with the Day Family



We have a proud history of working in partnership with Grant and Naomi Day, who have become powerful patient safety advocates and determined supporters of our REACH program since the tragic death of their young son Kyran in 2013.

REACH stands for Recognise Engage Act Call Help is on its Way. It is a rapid response program that encourages patients and families to phone for urgent medical review if they feel a patient's condition is deteriorating and clinical staff are not responding.

An ongoing focus for the Clinical Excellence Commission has been the expansion of the REACH program across NSW Health and the continuation of our partnering relationship with the Day family.

Grant and Naomi were crucial to the extension of the program which encompassed the launch of two new REACH posters and other resources, including a paediatric poster featuring Kyran's image and story.

Chief Executive Carrie Marr said both Grant and Naomi had worked tirelessly to bring humanity and compassion to health care through the REACH program.

"REACH is about listening to families and empowering them to speak up when they bring their loved ones into our hospitals. REACH was born out of the recognition that patients and families were not empowered to raise their concerns when they felt worried about patients in our care," Ms Marr said.

"We all want to be constantly improving the care we can offer patients. Naomi and Grant have dedicated themselves to becoming a voice for patients and families, helping us understand how to better help people in navigating the health system and co-operatively developing resources to support families seeking care in our public hospitals."

Naomi and Grant recounted that after losing Kyran, who was misdiagnosed in hospital, they often wondered what would come next.

"By the time we were at the inquest, I just sat back and thought there must be something we can do, not only to protect kids and babies in hospitals, but also to share Kyran's legacy," Naomi said.

As at June 2018 REACH has been implemented in 170 NSW public hospitals, including all thirteen of the state's major principal referral hospitals. It has also been implemented in four of the state's eight psychiatry hospitals and approximately 20 per cent of mental health inpatient units.

The focus for 2018-19 is embedding REACH in emergency departments and mental health units, developing multilingual resources, and refining reporting and evaluation processes.

In March 2018, Naomi's endless spirit of co-operation and commitment to making health care better was also recognised with her winning the Heart of Women award in her local community on the NSW North Coast.

“

Being involved in the extension of REACH and sharing Kyran's story was very powerful and I think the program really reminds us that babies and children do not have a voice and it's important for health staff to listen closely to parents as they know their children best.

”

## 2018 Patient Experience Symposium



The 2018 Patient Experience Symposium, now in its fifth year, was attended by almost 600 people (one third consumers). The event provided the opportunity for consumers and staff to network and share ideas and projects aimed at improving patient experience.

Over the two days, the concurrent sessions given by staff and consumers addressed a wide range of aspects of patient experience, including Culture and Diversity, Mental Health, Staff Experience and Wellness and Researching Patient Experience.

The 48 oral presentations, 10 workshops and 17 posters told of the huge range of work, mainly across NSW Health, which aims to improve the experience of patients, their carers and families.

## #hellomynameis

The Clinical Excellence Commission had the privilege of hosting Chris Pointon in September 2017. Chris is the co-founder of the successful global campaign, #hellomynameis, which emphasises the importance of staff introducing themselves to patients, carers and families.

Chris was married to the late, inspirational Dr Kate Granger who worked as a geriatrician in the National Health Service (NHS) England.

Kate, who was diagnosed at 29 years of age with terminal cancer, made the stark observation that many staff looking after her did not introduce themselves before delivering care.

Chris delivered a presentation at the Clinical Excellence Commission on using the #hellomynameis message to improve patient care and this was followed by a presentation to a packed auditorium at Sydney's Royal Prince Alfred hospital.

The simplicity of the message means that clinicians can easily implement this approach in their wards.

You can learn more about the #hellomynameis campaign at <https://hellomynameis.org.uk>

## Patient Centred Care Forum for a NSW Health Literacy Framework

The Clinical Excellence Commission held a forum in Sydney in June 2018 to inform the development of a NSW Health Literacy Framework.

Over fifty consumers and representatives from all Local Health Districts and Specialty Health Networks, as well as the Agency for Clinical Innovation, the Health and Education Training Institute, the Ambulance Service of NSW, and representatives from ACT Health attended the Forum.

Participants shared their ideas, approaches and learnings in health literacy. Challenges and priorities were discussed. The forum demonstrated statewide support for a systems approach to health literacy.

The final framework, which is planned for release during 2018-19, will guide and support Local Health Districts and Specialty Health Networks in developing approaches to health literacy, to improve communication with patients and families.

# ENGAGING FOR SAFETY



## Medical Leadership Forums

The NSW Medical Leadership and Engagement Forums and meetings promote networking and sharing of local, interstate and international ideas, learnings and experiences to help support leaders in improving safety and quality in health care. They also support effective medical engagement and leadership across the NSW health system.

The forum membership includes executive medical and clinical directors, directors of medical services, medical heads of departments and services, staff specialists (salaried) and visiting medical officers (non-salaried). This group now acts as an advisory group to the Clinical Excellence Commission.

The Clinical Excellence Commission hosted two full day Medical Leadership Forums - the first in September 2017 focusing on medical leadership, compacts and systems for measuring and reducing surgical morbidity and mortality, and the second in March 2018 focusing on e-health.

In addition, the Clinical Excellence Commission held a medical leaders' half day session with Prof Jason Leitch, National Clinical Director of Healthcare Quality and Strategy, Scotland.

## Hand Hygiene Summit

In November 2017 the Clinical Excellence Commission convened the NSW Hand Hygiene Summit to discuss priorities for NSW in relation to the National Hand Hygiene Initiative.

Sixty-five guests from all NSW Local Health Districts and Specialty Health Networks, as well as representatives from Hand Hygiene Australia, the Australian Commission on Safety & Quality in Health Care and attendees from interstate jurisdictions came together to focus on three summit goals:

- To review the strengths and weaknesses of the Hand Hygiene program as it relates to NSW
- To identify the best options to integrate hand hygiene into standard precautions
- To seek consensus on what is included in the future NSW Hand Hygiene program.

Summit attendees were given information by key speakers and guided through interactive workshops to create lists of priorities that they were then able to vote for.

NSW Health clinicians were also given an opportunity to share their experience on current practice and voice in future planning.

## World Hand Hygiene Day

To celebrate 2018 World Hand Hygiene Day, the Clinical Excellence Commission developed a video on the relationship between hand hygiene, sepsis and antimicrobial stewardship.

The video supported the World Health Organization's message of "It's in your hands. Prevent sepsis in health care."

The video received over 1500 hits following the launch.





## 'Making It Happen'

The Clinical Excellence Commission hosted a one-day forum covering Medication Reconciliation and Venous Thromboembolism (VTE) Prevention. The forum was attended by over 80 representatives from across NSW.

The theme of the day was 'Making It Happen', which was complementary to last year's forum with a focus on quality improvement theory. The aim of the day was for attendees to gain practical learnings in order to implement and measure change for medication reconciliation and VTE prevention initiatives.

The forum featured a variety of speakers from across NSW, with presentations detailing how organisations have made improvement happen while also encouraging attendees in their efforts and stimulating new ideas.

In addition to the formal presentations, two breakout sessions were held which gave attendees the opportunity to explore problem areas within medication reconciliation or VTE prevention, and to think about how quality improvement theory could be applied to implement change.



The forum featured a variety of speakers from across NSW, with presentations detailing how organisations have made improvement happen while also encouraging attendees in their efforts and stimulating new ideas.

The forum provided a great opportunity for program leads and clinicians to share learnings, support networking and collaboration and stimulate innovation in these important patient safety areas.

## World Sepsis Day

World Sepsis Day is held annually on 13 September. The international focus for the 2017 event was maternal and neonatal sepsis. This year, as part of Nepean Hospital's World Sepsis Day promotions, the Clinical Excellence Commission was invited to present at Nursing Grand Rounds.

The Clinical Excellence Commission also hosted a statewide webinar to promote the recently released Society of Obstetric Medicine of Australia and New Zealand (SOMANZ) Guidelines for the investigation and management of sepsis in pregnancy.

## Sepsis Summit

The Australian Sepsis Network invited the Clinical Excellence Commission to participate and present at a sepsis roundtable hosted by The George Institute for Global Health in November 2017.

The objective was to report on a coordinated national strategy to raise awareness of sepsis, to reduce the incidence of sepsis, and to reduce death and disability arising from sepsis.

This event followed the recent World Health Organization resolution, co-sponsored by the Australian Government, to make sepsis a global health priority.

The event, *Stopping Sepsis: Creating a national action plan*, brought together national and global experts to address sepsis as a national health priority, and to identify practical solutions to reduce the burden of sepsis in Australia.

The work of NSW clinicians in implementing and sustaining gains was highly regarded and the spread of the program concepts both nationally and internationally was identified.

The recommendations from the summit will include correctable gaps in research and clinical care, and organisations, strategies and guidelines that can affect the necessary changes.

## Antimicrobial Stewardship Forum

In August 2017 the Clinical Excellence Commission hosted the Second NSW Antimicrobial Stewardship Forum.

This event was attended by 120 delegates representing pharmacists, doctors, nurses and quality and safety professionals from public hospitals across NSW.

The forum featured presenters from rural hospitals sharing their achievements in Antimicrobial Stewardship and detailed how to engage clinicians, how improvement science can be used to support timely switch from IV to oral antibiotics, and the challenges for Antimicrobial Stewardship in paediatrics and surgery and how they can be overcome.

The forum also delved into the social aspect of medicine, including the importance of understanding belief and culture to influence optimal antimicrobial prescribing.

## Antibiotic Awareness Week 2017

Antibiotic Awareness Week was held from 13-19 November 2017. To support and promote antibiotic awareness, the Clinical Excellence Commission shared activity ideas and hosted webinars in the lead up to the event.

The webinars included discussion on health care associated infections, antimicrobial stewardship for nurses, antimicrobial stewardship in cancer care settings, sepsis and surgical prophylaxis.

## JMO Workshop on Improving Quality and Safety in Health Care

In July 2017 the Clinical Excellence Commission facilitated a workshop with Junior Medical Officers.

The topic of the workshop was 'Improving Quality and Safety in Health Care'. The session was enthusiastically received and three junior medical officers have volunteered to become members of the Clinical Excellence Commission's Root Cause Analysis Review Sub-Committees.

These Committees review and analyse root cause analysis reports received, determining evolving themes and risk within the clinical environment.

## Safety and Quality Executive Forum

In November 2017, the second Safety and Quality Executive Forum was held with attendees including more than 60 Local Health District and Specialty Health Network executives from nursing, medical, operations and allied health disciplines.

The theme for this forum was 'Building a Culture of Safety and Quality'. The forum supported active collaboration between senior managers and executives to lead safety and quality in NSW Health.

The focus of these forums is how executives can work together to improve patient safety.

## April Falls® 2018

Eating healthy food from a balanced diet with adequate energy and protein is important for maintaining muscle mass and muscle strength. It also reduces the risk of muscle wasting, frailty and fall-related injury.

When people, especially the elderly, don't consume enough food or water, they lose muscle and strength, become unsteady on their feet, and can feel weak and/or dizzy.

Further, older people who are undernourished or have unintentionally lost weight are more likely to be admitted to hospital and have increased incidences of falls, hip fractures, poor wound healing and osteoporosis.

*April Falls Day® 2018* focused on the importance of nutrition and hydration for older people; reducing the risk of malnutrition, dehydration and delirium.

To support the promotion, the Clinical Excellence Commission developed falls prevention resources and education on nutrition and hydration for use in hospitals, community settings and residential aged care facilities.

## Falls Prevention Network Forums

The NSW Falls Prevention Network Forum was held in May 2018 in Sydney and was attended by 369 participants from community, hospital and residential aged care settings. A further 43 participants watched the forum via live web-stream on the day.

The theme was *nutrition, frailty and falls*. Professor Ian Cameron from the University of Sydney delivered a presentation on *frailty and falls* which included an overview of tools to identify those with frailty, and a summary of the findings of the Frailty Intervention Trial (FIT) on reducing frailty and improving mobility.

This year the Clinical Excellence Commission also introduced a People's Choice Award for best poster which went to Anita Dimovski, an exercise physiologist from Southcare at Sutherland Hospital, for her poster entitled '*Steady Steps: Moving towards Better Balance*'.

Rural forums were also held in Kiama in August and in Wagga Wagga in March.

## Tri-Nations Falls Forum

The Clinical Excellence Commission hosted a Tri-Nations Forum in Sydney during September 2017.

It brought fall prevention experts from the UK, New Zealand and NSW together to share and learn from each other, strengthening trans-Tasman relationships and international linkages and providing an international perspective on falls prevention and broader patient safety.

Key presenters included Sandy Blake and Carmela Petagna from New Zealand's Health Quality & Safety Commission, and Dr Frances Healey and Julie Windsor from the UK National Health Service (NHS) Improvement organisation.





# IMPROVEMENT COLLABORATIVES

The Clinical Excellence Commission delivered two Improvement Collaboratives in 2017-18 to support hospitals across NSW and around Australia in reducing harm to patients in hospital.

The Collaboratives provided participating hospitals with access to significant expertise in improvement methodologies, informed by the globally renowned Institute for Healthcare Improvement.

Participating teams were given the opportunity to learn and apply quality improvement science and were supported with monthly coaching to achieve sustained, reliable, and measurable improvements in preventing falls and harm from falls and reducing third and fourth degree perineal tears.

The Collaborative methodology uses techniques for accelerating improvement in learning how to redesign or enhance processes to improve patient outcomes.

This approach capitalises on shared learning. It includes a focus on supporting local leadership, building local capability and capacity for improvement, engaging patients, families and carers, supporting frontline teams, and enabling clinicians and team leaders to drive improvements through a collaborative approach.

## Falls Prevention

As part of Leading Better Value Care, the Clinical Excellence Commission worked with Local Health Districts and Specialty Health Networks in driving safety and quality improvements in the care of older people in hospital, specifically helping to reduce falls and serious harm from falls.

The Clinical Excellence Commission has supported 40 multidisciplinary teams from across NSW who are working on varying themes to reduce falls in hospital. The themes have included intentional rounding, orthostatic blood pressure monitoring, medication review, safe mobilisation, falls risk screening and assessment, safety huddles and handover, and delirium and cognition screening and assessment.

During 2017-18 the Clinical Excellence Commission delivered three one-day learning sets and monthly coaching to the 40 participating teams.

## Women's Healthcare Australasia Collaborative

In 2017 the Clinical Excellence Commission established a strategic improvement partnership with Women's Healthcare Australasia to deliver a Patient Safety Improvement Collaborative focused on women's health.

The aim of the Collaborative is to reduce the number of women harmed by third or fourth degree perineal tears by 20 per cent by the end of 2018.

This national Collaborative has combined quality improvement expertise from the Clinical Excellence Commission with clinical experts engaged by Women's Healthcare Australasia to deliver three two-day learning sets to participating teams.

The Collaborative also involved monthly coaching to build capability and capacity in quality improvement methodologies for the 28 multidisciplinary teams from rural, remote and metro hospitals across Australia, including seven hospitals in NSW.

# DEVELOPING TOOLS & RESOURCES FOR HEALTH CARE WORKERS

## Deteriorating Patient Education



New resources to support the revised Between the Flags Tier Two face to face education for nursing and medical staff were released during 2017-18.

The program has been reduced from eight hours to four and provides greater flexibility for local contextualisation and delivery.

Revision includes a new one hour workshop format directed at senior medical officers.

The Sepsis Kills program Paediatric Antibiotic Guideline for Severe Sepsis and Septic Shock and Unwell Neonates, and the Newborn Antibiotic Guideline for early and late onset sepsis during birth episode of care were also updated during the year.

The changes reflect updates in source material (NEOMED) and feedback.

## Morbidity and Mortality Guidelines

Effectively run clinical audit and peer review processes, incorporating analysis of morbidity and mortality, contribute to improved patient safety.

Morbidity and Mortality Guidelines provide a framework for:

- A safe space for learning
- Multidisciplinary attendance enhancing active participation across disciplines
- Integrated case selection process drawn from multiple sources of information reflective of adverse events across the spectrum of severity and complications
- Case discussions for the purpose of system improvement
- Documentation of lessons learned and dissemination of recommendations in a robust fashion to ensure action is taken across the system
- Consolidation of pathways of information and reporting used to enhance overall clinical risk management roles of governance bodies.

The Clinical Excellence Commission established a State-Wide Morbidity and Mortality Reference Group in May 2018. The Group, which includes representatives from Local Health Districts, Specialty Health Networks and other health organisations, will provide guidance and expertise in the development of robust morbidity and mortality processes across NSW Health.

## Team Effectiveness

In 2017 the Clinical Excellence Commission developed a framework known as Team Stripes to enhance teamwork and communication for clinical teams working at the point of care.

Based on Human-Centred Design principles, it has been developed to ensure an individualised unit-specific approach to safety and quality improvement, and ultimately culture change and improved patient experience.

To support team effectiveness the Clinical Excellence Commission also developed a set of complementary resources known as Team Safety Fundamentals.

**Team Safety Fundamentals are practical tools, most of which require only a short implementation time and have the potential to bring quick measurable gains.**



## Intravenous to Oral Antibiotic Switch

Antimicrobial stewardship is a key strategy for the prevention and management of health care associated infections and for preventing the development and spread of antimicrobial resistance.

Although intravenous antibiotics are necessary for the treatment of many serious and critical bacterial infections, there are risks associated with the intravenous route (such as thrombophlebitis and line-associated infections) so switching to oral antibiotics should occur when it is safe to do so.

The Clinical Excellence Commission partnered with Sydney Children's Hospital at Randwick to develop and test interventions to support uptake and implementation of an evidence-based guideline supporting timelier intravenous to oral switch for 36 paediatric infectious diseases.

**The project team found a quality improvement approach was an effective way to support timely, safe and appropriate IV-to-oral antibiotic switch in children.**

A moderate improvement in the percentage of patients who were switched within 24 hours of eligibility was achieved, with a reduction in the overall median length of intravenous antibiotic therapy.

Continued education and further evaluation is important to sustain this effect and drive further improvement.

## Non-Vitamin K Antagonist Oral Anticoagulant Guidelines

Non-Vitamin K antagonist oral anticoagulants (NOAC) are medicines that are given to patients with an irregular heart rhythm and to patients who have or are at risk of developing blood clots. They are considered a high-risk medicine because there is a high likelihood of causing injury or harm if they are misused or used in error.

The Clinical Excellence Commission's NOAC Guidelines assist clinicians with the management of patients receiving these high-risk medicines.

In July 2017 the guidelines and point-of-care summary documents were updated to include new clinical information, facilitating the safe use of these high-risk medicines.

## Paediatric Medication Safety Resources and Education

Gentamicin is commonly used to fight serious infections in premature babies, other newborns and children. When medication errors occur, there can be a risk of permanent hearing loss, balance problems or kidney damage.

A study in 2016 highlighted significant variation in gentamicin dosing, with more than half the respondents indicating their unit did not have a standardised guideline for prescribing, and 65 per cent of respondents unaware of a local guideline for monitoring gentamicin levels.

The study also found there were six different guidelines being used across the state for gentamicin use.

In October 2017 the Clinical Excellence Commission released a suite of medication safety resources specifically for the safe prescribing of gentamicin for children and an animation on the 'Rule of 2s' to reduce the risk of medication errors in children.

The gentamicin resources include an age-based prescribing guide which aims to standardise best practice gentamicin use.

The resources were developed with medical, nursing and pharmacy experts working in paediatric health care and are available to download from [www.cec.health.nsw.gov.au](http://www.cec.health.nsw.gov.au).



## Surgical Antibiotic Prophylaxis Improvement Project



Surgical antibiotic prophylaxis refers to the use of antibiotics to prevent infections that can occur following a surgical procedure.

The monitoring of surgical antibiotic prophylaxis is now an accreditation requirement of the National Safety and Quality Health Service Standards.

To support NSW hospitals, the Clinical Excellence Commission presented the Surgical Antibiotic Prophylaxis toolkit to the Surgical Services Taskforce in May 2018.

The toolkit contains guidance on:

- Developing a surgical antibiotic prophylaxis guideline
- Auditing surgical antibiotic prophylaxis
- Existing resources that can be used to improve antibiotic prescribing for surgical prophylaxis.

The toolkit resources are now being tested in two metropolitan and two rural hospitals during 2018-19.

These four hospital teams have since received quality improvement methodology training from the Clinical Excellence Commission to assist with improving the prescribing of antibiotics for prevention of surgical site infections.

## Sterilisation and Reprocessing

The *Preventing and Controlling Healthcare-Associated Infection Standard* of the National Safety and Quality Health Service Standards requires that reprocessing of reusable equipment, instruments and devices is consistent with relevant current national standards and meets current best practice.

The Clinical Excellence Commission has undertaken a significant amount of work during 2017-18 relating to sterilisation and disinfection of reusable medical devices (reprocessing).

An extensive range of audit tools and resources has been produced for organisations to undertake a gap analysis and to develop an individualised implementation plan. A series of workshops has also been conducted to support use of the tools.

This work supports health facilities with accreditation and in meeting the mandatory requirements for compliance with the Australian Standard AS/NZS 4187:2014.



## A TRUSTED IMPROVEMENT PARTNER

### Mental Health Patient Safety

The Clinical Excellence Commission continues to support the review and analysis of critical incidents in Mental Health. In 2017-18 33 per cent of root-cause analysis reports involved mental health, drug and alcohol services.

Due to the number and complexity of the reports and the system issues identified, the Clinical Excellence Commission's Mental Health Root Cause Analysis Committee was restructured to include an additional Review Committee.

This committee included senior mental health clinicians and worked to identify, prioritise and escalate the most significant themes and system improvements required to facilitate better mental health patient, client and carer experience.

Additionally, the *Review of seclusion, restraint and observations of consumers with mental illness in NSW Health facilities* made 19 recommendations for system improvement. This report highlighted the need for further work on improving the health care experience of mental health service consumers.

As a result, the Clinical Excellence Commission worked in collaboration with the NSW Health Chief Psychiatrist to develop and establish a NSW Mental Health Patient Safety Program, which will be led by the Clinical Excellence Commission and commence in 2018-19.

### Clinical Governance Stocktake

The Clinical Governance Stocktake is a facilitated improvement process aimed at strengthening the effectiveness of local clinical governance.

It was developed by the Clinical Excellence Commission to align with NSW Health Patient Safety First, and the National Safety and Quality Health Service Standards (Standard 1 – Governance).

The stocktake tool has been reviewed by clinical governance experts, implemented in a number of organisations and updated in line with the latest literature.

In 2017-18 four Local Health Districts completed a clinical governance stocktake in partnership with the Clinical Excellence Commission.

The South East Sydney Local Health District Clinical Governance Unit and Internal Audit Directorate were delighted to partner with the Clinical Excellence Commission to undertake the Clinical Governance Stocktake in the district.

"Results from the stocktake collected from our workshops highlighted the strengths, improvement opportunities and ideas for action that were raised by participants," said Trish Bradd, Director of Improvement & Innovation at South East Sydney Local Health District.

"It provided useful information about specific areas of alignment or difference between the perceptions of participants across the organisation. It also highlighted areas of strength and opportunity for us moving forward, resulting in a local action plan to address areas that arose," she said.

“Undertaking the Clinical Governance Stocktake was a great way to partner with the Clinical Excellence Commission, as it enables us to access independent feedback and expert advice in order to further enhance our services.”

## Community Pharmacy Palliative Care

Respecting choices at the end of life and ensuring access to quality palliative care regardless of geographical location, economic status or social circumstance are key priorities.

The accessibility of community pharmacists and their role within the community means they are ideally placed to assist in the delivery of community based palliative care services. Community pharmacists are not widely recognised as members of the palliative care team and thus are often an underutilised resource.

The NSW Community Pharmacy Palliative Care Initiative aims to give people greater choice about where they receive care at the end of their life by developing and exploring ways in which community pharmacists can improve the delivery of palliative care for patients and their families.

Phase one consultation activities were conducted over four months from March to June 2018. They included key informant interviews, two regional and rural focus groups and two face to face workshops. More than 100 diverse stakeholders provided a wide range of perspectives.

There was recognition and strong support for strengthened involvement and integration of community pharmacy in palliative care, leveraging the community pharmacist's role as an expert in medication management.

Stakeholders described the need for educational programs, resources and tools to strengthen the capacity of community pharmacists to deliver best practice medication management for people with palliative care needs.

Stakeholders identified the importance of establishing effective relationships and integrated communication pathways (including use of technology) between community pharmacists and the broader palliative care team to support continuity of care.

The need for consistent and properly resourced models of practice within community pharmacy for the provision of palliative care was identified. Improvement ideas were themed into three key focus areas:

1. Building the palliative care knowledge, skills and capabilities of community pharmacists.
2. Enhancing community pharmacy business models to support palliative care.
3. Optimising palliative care medication management pathways across providers to achieve standardisation of practice.

## Organisational Strategy for Improvement Matrix – Wave 1

The Organisational Strategy for Improvement Matrix (OSIM) is grounded on the premise that innovation and excellence in patient care predominantly emerges from the service level, led by the teams that deliver patient care.

It is a diagnostic process which highlights the organisational conditions for quality improvement. The results indicate how the organisation may take a more strategic approach for systems improvement. In other words, how the organisation can make it easy for local teams to initiate, test and develop their local improvement ideas.

The first wave of the OSIM was completed in all participating Local Health Districts and Specialty Health Networks in 2017. Eight districts have elected to share their identified priorities from the process with the other Local Health Districts.





# BUILDING QUALITY IMPROVEMENT CAPABILITY



## Executive Clinical Leadership Program

### Case Study: Domestic Violence Routine Screening

A glowing recommendation for the Clinical Excellence Commission's Executive Clinical Leadership Program from a colleague at Royal Prince Alfred Hospital was the catalyst for Dr John Cass-Verco's application for the program in 2017.

As part of the program, participants are required to undertake a Clinical Process Improvement project. Dr Cass-Verco and his team decided to focus on the subject of domestic violence.

"After consulting with the team on the Children's Ward at the Royal Prince Alfred Hospital, we decided this was an important area. With large media interest at the time, it was extremely topical. The climate was right," said Dr Cass-Verco.

"Also of vital importance was the formation of a passionate, 13 person multidisciplinary team which included a consumer and staff from seven departments. The dedication of our ward nursing staff has also been crucial to the project's success," he said.

"Prior to this initiative, no children's wards in Australia routinely screened for domestic violence. Our team saw this as a missed opportunity to assist in identifying domestic violence and to provide assistance. For Australian women between the ages of 15 – 44yrs, domestic violence is the leading contributor to illness, disability and death," he said.

"It is also the leading cause of homelessness for women and children in Australia and has been proven to have significant adverse effects on a child's life and development."

The project has three arms - an education program for staff, domestic violence routine screening for the mothers and female carers of patients, and a response pathway.

As of November 2018, 770 women have been screened, with a disclosure rate of 3.6 per cent. Everyone who discloses they are a victim is offered a compassionate listening ear, discreet written information, a review by a social worker and free legal support through the Health Justice Partnership.

"The feedback from the women we have screened has been very positive," said Dr Cass-Verco.

He also spoke highly of his experience with the Executive Clinical Leadership Program.

"The content was excellent. The comprehensive mixture of topics covered key aspects of how to be an influential leader with skills in successfully implementing change," he said.

"Areas covered included improvement science, negotiation, change management and mastering difficult colleague interactions, to name a few. From my perspective the topics provided insights into the building blocks of effective leadership and were exactly what I needed to lead my project team well."

The Domestic Violence Routine Screening in Paediatrics Project has now been running for 65 weeks and the team is focusing on spreading into other children's wards, other services and other models of care, for example Hospital in the Home.

"I think of our project as baby steps. If every children's ward in Australia were to adopt this program, the impact would be exponential and we would see some truly remarkable outcomes," Dr Cass-Verco said.



## Master Clinician's Guide to Quality and Safety

NSW Health Secretary Elizabeth Koff officially launched the *Master Clinician's Guide to Quality and Safety* on 7 May 2018.

The guide provides expert tools and resources to help health care staff foster a culture of safe, high-quality care at the hospitals where they work. Written by senior clinicians and safety experts and compiled by the Clinical Excellence Commission, it is a follow-on from the 2016 *Clinician's Guide to Quality and Safety* which was aimed at junior members of the medical team.

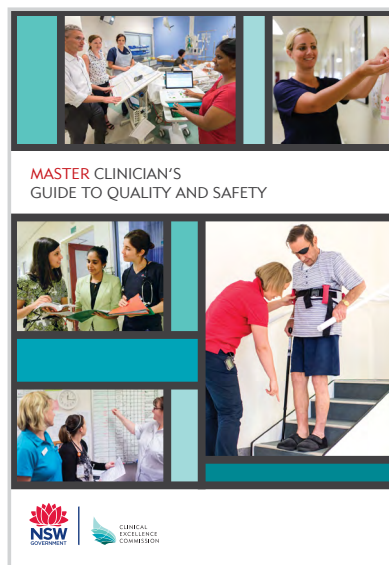
Senior clinicians including South East Sydney Local Health District Medical Executive Director Dr James Mackie and Clinical Excellence Commission Director Paediatric Patient Safety Dr Jonny Taitz supported the launch at the Prince of Wales Hospital, alongside clinicians who helped to develop it.

At the event, Clinical Excellence Commission Chief Executive Carrie Marr said, "The guidance and tools within this guide are being shared with local clinical teams and managers to support their effort and intent to deliver safe, reliable care.

This resource focuses on safe systems, positive safety cultures and meaningful engagement of patients and families in compassionate, respectful care."

“Ultimately, the master's guide exists to help people working in our hospitals and to improve experiences and outcomes for patients.”

The guides can be downloaded from the Clinical Excellence Commission website and hardcopies are available via the clinical governance units at each Local Health District.



### Margaret Murphy 2017 Ian O'Rourke Scholar

Margaret Murphy has over 25 years' experience in emergency nursing, including 20 years as a Clinical Nurse Consultant at Westmead Hospital Sydney. Currently she is enrolled at the University of Sydney as a PhD candidate.

In 2017 Margaret was awarded an Ian O'Rourke Scholarship to support and inform her research, which she used to attend summer school at the Centre for Behaviour Change at the University College, London. The research area was chosen due to Margaret's firsthand experience in trauma centres.

"I witnessed the challenges trauma teams face, with one of the main ones being how strangers are expected to come together and resuscitate a critically injured person, sometimes under severe stress," said Margaret.

"I had a feeling the way they were being trained wasn't exactly benefitting the team, because in fact there are many barriers to actually using the training when you don't know the people you are with."

In London Margaret studied techniques to translate research findings into clinical practice using behaviour change techniques.

"The summer school program provided me with the tools to develop and evaluate interventions to achieve effective change," said Margaret.

“Thanks to the scholarship I was able to learn a framework that is not even available in Australia at the moment, allowing a fast track for change to happen here.”

Since returning Margaret has been able to design an implementation plan that will empower and enable staff to use what they learned during their training in the simulation laboratories in the resuscitation bed.

She has also published several articles following her trip to London, with an appearance in the Medical Journal in Injury, Australasian Emergency Care Journal and a pending journal article in Implementation Science.

Margaret's research will allow trauma teams to work more effectively in emergency and trauma settings all over NSW. Her framework has most recently been presented at the Agency for Clinical Innovation's Redesign School.

## Joel Poder 2017 Ian O'Rourke Scholar

High dose rate brachytherapy is commonly used for the treatment of prostate cancer. It involves the temporary insertion of a small radioactive source about the size of a grain of rice into the prostate.



The aim of the treatment is to deliver an exact amount of radiation to the prostate while limiting the amount of radiation to the surrounding healthy tissues. Successful delivery requires the radioactive source to be driven to and stop in the correct location with very high accuracy. Currently there are no established methods to ensure that these treatments are delivered in the best possible way.

Joel Poder, a Medical Physics Specialist at St George Hospital Cancer Care Centre and a PhD Candidate at the Centre for Medical Radiation Physics, University of Wollongong, is undertaking research under mentorship of Distinguished Professor Anatoly Rozenfeld and Dr Dean Cutajar to develop a method that will help medical staff ensure that the treatment produces the best possible outcome for patients with prostate cancer.

In 2017 Joel was awarded an Ian O'Rourke Scholarship to support and inform his research, which he used to visit the Memorial Sloan Kettering Cancer Centre in New York.

"I consider myself extremely fortunate to have the opportunity to collaborate with the world leading physicists and radiation oncologists at Memorial Sloan Kettering Cancer Centre and to be able to share my research with them," said Joel.

"The experiments conducted there were very successful and through this work we were able to develop a system for end-to-end quality assurance of the high dose rate brachytherapy technique."

As part of his research at the Centre for Medical Radiation Physics at the University of Wollongong, a two-dimensional radiation sensor known as the 'Magic Plate' has been developed. The plate is placed below the patient and the radiation sensor is able to detect the radioactive source in real time as it moves through the prostate and ensure that the treatment is being delivered as planned.

"The team from the Memorial Sloan Kettering Cancer Centre were impressed with the system and the work performed and wish to continue collaboration with us on the project. Their input throughout future stages of development of the system will be invaluable," said Joel.

The ultimate goal for St George Hospital Cancer Care Centre and Memorial Sloan Kettering Cancer Centre will be for a full implementation of the system for all patients receiving high dose rate brachytherapy.

## Quality Improvement for Boards

Health care is complex and therefore understanding what influences safety and reliability of care is crucial to boards. High performing boards in health care understand the relationship between leadership, culture, accountability and quality improvement.

The board plays a key role in creating a positive organisational culture that supports frontline teams to do the right thing for patients and their carers.

In 2017 the Clinical Excellence Commission published a handbook on *Measurement for Quality Improvement for Board Members and Executives*.

The guide has a practical emphasis and focuses on how measurement tools can assist boards to set the right tone of assurance in patient safety.

Local Health District and Specialty Health Network Boards play a key role in ensuring care is safe and harm is reduced through the questions they ask about the organisation's core values and commitment to patient safety.

## Patient Safety and Quality Capability Group Framework

In 2017 the Clinical Excellence Commission developed the Patient Safety and Quality Improvement Capability Group – a complementary resource to the NSW Public Sector Capability Framework.

The capabilities were documented in response to people development framework gaps identified by a number of Local Health Districts during the 2017 Organisational Strategy for Improvement Matrix (OSIM) process.

They define the workforce capabilities required by health care workers to meet their safety and quality responsibilities. The intention is to translate clinical governance concepts to the language used in employee capability frameworks thus creating role clarity.

As at June 2018 five NSW Health organisations are using the Patient Safety and Quality Improvement Capability Group.

## Quality Improvement Academy

The Clinical Excellence Commission provides leadership in safety and quality in NSW to improve health care for patients. Its Quality Improvement Academy supports Local Health Districts and Specialty Health Networks in building and sustaining the capability needed to support joint improvement efforts.

The academy offers training via a variety of modalities such as face to face workshops, on-demand webinars, regular WebEx sessions, e-learning, and via the Health Education Training Institute's (HETI's) My Health Learning platform.

Improvement Science and measurement for quality improvement is incorporated into the teaching in many of the academy's offerings, including the Executive and Foundational Clinical Leadership Programs and Clinical Practice Improvement.

Web pages with quality tools have been added under the Quality Improvement Academy section of the [Clinical Excellence Commission website](#). Each tool has a downloadable template, relevant instructions and information about the tool's use. Examples of quality tools are run charts, driver diagrams, Pareto charts and the 80/20 Rule.

Routine evaluation of education programs is undertaken and the feedback from participants is consistently favourable with programs receiving encouraging Net Promoter Scores averaging +56. Over 80 per cent of participants indicated they feel confident in undertaking a quality improvement project after the Improvement Science training.

In 2017-18 the Clinical Excellence Commission trained 496 Improvement Coaches through the Executive and Foundational Clinical Leadership Programs, Improvement Science Workshops, ISQua Fellows and Institute for Healthcare Improvement Collaborative Coaches.

## 2018 Emerging Leaders in Patient Safety



The third Academy for Emerging Leaders in Patient Safety was held in April 2018 at the Q-Station, North Head. The Academy is based on the Telluride model which commenced in the USA, 13 years ago.

Thirty scholars from across Australia were selected on a competitive basis for their commitment and future leadership potential to improve the quality of care and make things safer for patients. They comprised a mixture of junior doctors, senior medical students and pharmacists.

For many of the scholars it was a transformational experience - there was no hierarchy and scholars shared their stories, learned new techniques and discussed problems with faculty.

Each scholar has made a pledge on what they will do to help transform the health system. The faculty will support them throughout the year in this process.

## Executive Clinical Leadership Program Graduation

The Executive Clinical Leadership Program Cohort 18 Graduation was held in February 2018 with 80 guests from NSW Health organisations in attendance.

During the event 28 graduates displayed posters and presented on their Improvement Science project findings before being presented with their certificates from Board Chair A/Prof Brian McCaughan.

Cohort 19 have also recently graduated and Cohort 20 will graduate in February 2019.





# PARTNERING GLOBALLY FOR IMPROVEMENT



## IHI Strategic Partnership

The Institute for Healthcare Improvement is a leading innovator in health and health care improvement worldwide. For more than 25 years it has partnered with an ever-growing community of visionaries, leaders and front-line practitioners around the globe to spark bold, inventive ways to improve the health of individuals and populations.

The institute is dedicated to advancing five focus areas – improvement capability, patient and family engagement, patient safety, quality, cost and value, and Triple Aim for populations.

In early 2018 the Clinical Excellence Commission along with the Queensland Department of Health, ACT Department of Health, Safer Care Victoria and the Institute for Healthcare Improvement entered into a collaboration to drive efforts to sustainably improve the performance of the health care system in each of the four jurisdictions.

This focused on building local quality improvement (QI) capability and capacity in support of achieving patient outcomes, with support from the institute through the delivery of its Improvement Advisor Professional Development Program for 24 staff across the four jurisdictions.

The program included three one-day improvement workshops, twelve supporting conference calls and individual support from the program faculty.

**This partnership has laid the foundation to sustain improvement into the future for the Clinical Excellence Commission and across NSW Health more broadly.**

## ISQua Quality Improvement Network

The International Society for Quality in Healthcare (ISQua) and the Clinical Excellence Commission are strategic partners. This provides opportunities for both organisations to collaborate on a variety of initiatives relating to the improvement of health care quality and safety.

One of these is the ISQua International Quality Improvement (QI) Network, the aims of which are:

- To share examples of good practice and lessons learned from work undertaken in quality improvement and patient safety
- To share challenges and/or successes
- To build a Community of Practice with a focus on continuous learning
- To accelerate positive change and improvement through shared learning.

In 2017 the Clinical Excellence Commission participated in a 12 month pilot of an international Quality Improvement Community of Practice.

As part of the pilot, each international team presented an issue and/or example of success to the group for discussion and learning. Other participants included teams from Brazil, Canada, New Zealand and Italy, as well as representation from the World Health Organization (WHO) and ISQua.

## Dr Jason Leitch

Dr Jason Leitch was appointed as the Scottish Government's National Clinical Director of Healthcare Quality and Strategy in January 2015. He is responsible for patient support and public involvement policy, NHS planning, reducing health inequalities, ensuring effective pharmaceutical services, supporting dentistry in primary and secondary sectors, and implementing quality improvement across the government.

The Clinical Excellence Commission hosted Dr Leitch in April 2018, during which time he met with over 30 senior medical leaders from across NSW to talk about how to improve safety and quality.

Dr Leitch presented on the Scottish Patient Safety Program and Clinical Leadership and there was an interactive session on developing innovative approaches to quality and safety education and improvement.

The session emphasised the critical role of the senior medical practitioner in health care in supporting the identification, design, planning and execution of quality and safety improvements.



## Professor Michael West

Professor Michael West is Senior Fellow at the King's Fund London and Professor of Organisational Psychology at Lancaster University Management School. The focus of Michael's research over 30 years has been culture and leadership in organisations, and team and organisational innovation and effectiveness, particularly in relation to the organisation of health services.

In March 2018 the Clinical Excellence Commission hosted Professor West who delivered a presentation for over 160 NSW Health middle managers on the subject of leading cultures for safe, reliable care.

The well-attended session presented compelling evidence on the relationship between staff management and patient outcomes. The session then examined the effects of teamwork in health care on service quality and patient outcomes.

Participants also explored the six key factors critical for the development of health service cultures that prioritise continually improving, high quality and safe care.

Participants gained a greater understanding of their leadership practice impact on employee and patient outcomes and left with tools to improve their leadership practice and ways to develop as leaders of NSW Health.





# INVESTING IN DIGITAL AND TECHNOLOGY

## Quality Improvement Data System Launch



In September 2017 the Clinical Excellence Commission launched the Quality Improvement Data System (QIDS), with Chief Executives and Directors of Clinical Governance receiving access to the system.

QIDS is a tool for processing data and sharing information to assist with health services, improving patient safety and supporting quality improvement projects.

It uses coded data from the Health Information Exchange, Incident Information Management System and audit data.

The success of the tool has seen Local Health Districts and Specialty Health Networks expand access to managers and clinicians to enable the monitoring of performance and improvement.

## Online Reporting for Surgical Mortality

The Clinical Excellence Commission has been working with the Royal Australasian College of Surgeons to develop and implement the Bi-National Audit System online database.

This system allows surgeons in NSW to report a surgical death and complete a Surgical Case Form or First Line Assessment online. Surgeons are also able to produce their own Continuing Professional Development reports.

Electronic submissions offer greater security and deliver improved efficiency and accuracy by eliminating errors in interpretation of handwriting. The system has been designed with a focus on accessibility and ease for surgeons.

To support the release of the software on 1 July 2018, a step by step user guide and a video presentation of instructions for the 'Fellows Interface' was developed and circulated.

Many surgeons have already submitted Surgical Case Forms and First Line Assessment forms online, with usage expected to increase over the coming months.

## Electronic Sepsis Alert

The pilot of the electronic sepsis alert is a collaboration between the Clinical Excellence Commission, eHealth NSW and Western Sydney Local Health District.

The final report from the Australian Institute of Health Innovation, Macquarie University evaluating the pilot of a sepsis alert in the electronic medical record at Blacktown Hospital was published in 2018.

This project is the first to evaluate the Adult Sepsis Pathway and the electronic sepsis alert in NSW, and to compare the performance between these two tools and the qSOFA score (a risk assessment for mortality and sepsis).

The Clinical Excellence Commission is now working with eHealth NSW on how this can be implemented into electronic medical records across NSW.

## Clinical Incident Management Portal

The Clinical Incident Management Portal reports on aggregated incident data across the NSW health system. These reports are compiled twice a year as part of the commitment of NSW Health and the Clinical Excellence Commission to keep the community informed about incidents relating to patient care.

The online reports build on the previous six monthly reports and contain information gained from incident notifications made by staff via the NSW Incident Information Management System (IIMS).

In 2017 a new tab was added on National Sentinel Events. Sentinel Events are adverse events that result in death or serious harm to a patient and are considered to be preventable.

The portal was updated twice during the financial year with the most recent report including root cause analysis data and data from the IIMS for the six-monthly reporting period for January to June 2017.

Further information is available from the Clinical Excellence Commission website [www.cec.health.nsw.gov.au](http://www.cec.health.nsw.gov.au).

## VTE Risk Assessment Tool Launch

Hospitalisation is strongly associated with the development of blood clots – the majority of which are preventable through assessment of risk factors and appropriate treatment and action.

An electronic tool designed to assess a patient's risk of developing blood clots was launched at Prince of Wales Hospital in February 2018.

A collaboration between eHealth NSW and the Clinical Excellence Commission, the VTE (venous thromboembolism) Risk Assessment Package has been designed to support clinicians in identifying, measuring and documenting the VTE risk for adult patients in the inpatient setting.

Prince of Wales Hospital was the first in NSW to introduce the electronic VTE Risk Assessment, following its trial at Blacktown Hospital in 2017.

All patients over 18 years of age admitted to a NSW public hospital must be assessed and managed for risk of VTE within 24 hours.

The South Eastern Sydney Local Health District's Implementation eMR2 Project Team and Clinical Surgical Stream Nurse Managers, along with the Clinical Excellence Commission project leads, were on site for the launch.

"We are very excited to work with South Eastern Sydney Local Health District, eHealth and the CEC to launch the electronic VTE Risk Assessment Tool here at Prince of Wales Hospital," said Sarah Lyons, Project Manager for South Eastern Sydney Local Health District eMR2 Implementation.

“We know that VTE is a leading cause of death associated with hospitalisation, and introducing an electronic VTE Risk assessment tool is an important step toward preventing VTE in hospitalised patients.”

# STRENGTHENING THE SAFETY OF THE NSW HEALTH SYSTEM



## Critical Response

The Clinical Excellence Commission's Critical Response Unit was established during 2017-18 and is already proving to be highly effective in providing a coordinated, statewide approach in managing and mitigating significant clinical risks.

The unit acts as a dedicated point of contact to raise, discuss and escalate issues of concern, and facilitates improved communication between key staff groups responsible for the safe management of medicines and devices.

The work of the unit to date has included 15 issues assessed as requiring expert input, advice and coordination.

## Safety Alerts

The NSW Health Safety Alert Broadcast System provides a systematic approach to the distribution of patient safety information to the NSW health system and includes a mechanism to ensure the required action and management of patient safety issues by health services.

The Safety Alert Broadcast System includes three tiers of notifications to provide NSW health services with early warnings of issues, namely:

- Safety Alerts, requiring immediate attention and action
- Safety Notices, requiring risk assessment at the local level
- Safety Information, ensuring that lessons learned from statewide, national and international sources are shared actively across the NSW health system.

In 2017-18 the Clinical Excellence Commission issued three Safety Alerts (below), ten Safety Notices and two Safety Information Broadcasts.

### **SA:004/17 - HYDROmorphine (high-risk medicine):**

#### **Changes to Dilaudid® injectable preparations**

HYDROmorphine is between five and seven times stronger than morphine. Because of its high strength, errors with this medicine may result in serious patient harm, including death. A safety alert was issued to highlight significant changes in the preparations for dispensing this medication.

The alert stated that hospitals must not use the new highly concentrated version of the Dilaudid® injectable or hold stock of the product. Immediate actions required included distributing the alert, confirming the injectable would not be included in hospital medication formulary, confirming the stock of this product would not be held, and keeping only one strength of the HYDROmorphine in ward areas where it was necessary, such as palliative care.

HYDROmorphine was to be restricted in availability and considerations made to have prefilled products supplied for clinical areas where the need for high doses may be required.

### **SA001/18 - Vaccine storage and cold chain management**

Most vaccines used in Australia are temperature-sensitive and must be stored between +2°C and +8°C at all times to ensure they work effectively. There may be loss of potency if vaccines have been stored at temperatures outside this range.

Action required included Directors of Nursing to report on the number and percentage of staff that are responsible for vaccine storage and cold chain management, notification to be given of any vaccine refrigerators that have a freezer compartment to allow for risk assessment, and ensuring all vaccine fridges had been audited in the last 12 months.

### **SA002/18 - DBL Metronidazole Intravenous Infusion: Contamination and disruption to supply**



DBL Metronidazole Intravenous Infusion is a solution for injection used to treat severe anaerobic infection and is the predominant product used in NSW.

A report was filed in June 2018 stating a single unit of the medication was found to have visible black particles, reported as mould, between the infusion bag and plastic overwrap. This posed a potential risk for patients receiving the infusion, particularly those with a very weak immune system.

The Clinical Excellence Commission proactively managed a system-wide response to this issue, circulating a safety alert that outlined the incident.



The alert stated that the removal and quarantining of the product may cause an acute shortage of the solution in NSW public hospitals and facilities. As part of the response, the Clinical Excellence Commission was able to provide alternate clinical management strategies.

Other actions required were for patients who were on the medication to have their antibiotic therapy reviewed and an alternative used, for reports to be made on all issues in relation to the intravenous infusion, and for all relevant clinical staff to be made aware of the issue.

Following the response across the NSW health system, the Therapeutic Goods Administration issued a recall for multiple batches of the product.

Safety Alert Broadcasts can be viewed and downloaded from [www.health.nsw.gov.au/sabs](http://www.health.nsw.gov.au/sabs).

#### Safety Notices Issued

- SN007/18 Morphine sulfate 5mg/1mL and 10mg/1mL injection shortages
- SN006/18 Ice machines and fires
- SN005/18 Peri-operative risk of SGLT2 inhibitor-associated ketoacidosis
- SN003/18 Complications Associated with Inferior Vena Cava Filters
- SN002/18 Incorrect packaging – Pigeon peristaltic slim neck slow flow teats
- SN001/18 Midazolam injection 5mg/5mL shortage and risk of error
- SN015/17 Transvaginal mesh implants for Pelvic Organ (Vaginal) Prolapse
- SN012/17 Intravenous piperacillin-tazobactam – Disruption to Supply
- SN011/17 Disposable Ventilator Catheter Mounts Failure
- SN009/17 High Concentration Insulin Products.

#### Safety Information Issued

- SI001/18 ABO Compatibility for Blood Products in an Emergency
- SI002/17 Gadolinium-based contrast agents for MRI scans.

## Blood Watch Haemovigilance Report

A haemovigilance report has been completed following review and analysis of 11 years' worth of NSW incident data between 2005 and 2016. The review provides a detailed analysis of adverse events and outcomes and demonstrates:

- The importance of haemovigilance as an ongoing aspect of promoting safe transfusion.
- An increased level of awareness of activities supporting safe transfusion practice through improved outcomes.
- A level of baseline data for Local Health Districts supporting the required actions for the Blood Management Standard relating to reporting and monitoring of adverse events.

## Pressure Injury Point Prevalence Survey

Some Local Health Districts and Specialty Health Networks have been conducting annual pressure injury point prevalence surveys since the late 1990s, while some have only recently completed their first survey.

In May 2018 the Clinical Excellence Commission released a report outlining the results of Pressure Injury Point Prevalence Surveys conducted by Local Health Districts and Specialty Health Networks in 2017.

The 2017 NSW survey was conducted across three settings – inpatient, residential aged care and community and outpatient services.

The survey data provides valuable information on pressure injuries in the NSW public health system to understand the extent of the problem and provides recommendations to improve the care provided and reduce hospital-acquired prevalence rates.

17 Local Health Districts and Specialty Health Networks participated in the survey. These included:

- 72 inpatient facilities
- 67 Residential Aged Care facilities
- 79 community and outpatient services

A total of 13,672 people consented to participate in the survey. The results showed:

- An overall reduction of 1.3% in the hospital or health service-acquired pressure injury rate in those surveyed compared with the 2016 data (5.1% to 3.8%).
- 72% of patients at risk of developing a pressure injury had a documented care plan compared to 58% in 2016.
- The most common locations for hospital or health service-acquired pressure injuries were the sacrum or buttocks (40%) and heel injuries (27%).
- Where a person was recorded as having one or more pressure injuries, 36% had a wound management record or chart documenting every current injury (overall 2016, 51% and 2015, 44%).
- A difference was noted in the severity of pressure injuries that were not hospital or health service-acquired compared to those which developed in the hospital or health service.

The full report can be downloaded from [www.cec.health.nsw.gov.au](http://www.cec.health.nsw.gov.au)



## CHASM Casebook

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.

In 2017 the Clinical Excellence Commission published the 2016 CHASM Casebook – an educational publication which provides surgical learnings for the benefit of all surgeons and trainees.

The 2016 Casebook includes learnings relating to futile surgery, nutrition, continuity of care, aspiration, and preoperative assessment and perioperative care.



## Strengthening processes for Incident Management

During 2017-18 the Clinical Excellence Commission proposed legislative and policy changes to improve and support critical incident management, which passed through both Houses of Parliament in early 2018.

The changes focus on the introduction of a formal risk assessment in the first 24-72 hours following a critical incident. This will help the organisation to understand the events involving the incident, to determine whether immediate action is necessary to protect the patient, and to allow for earlier open disclosure to families.

The introduction of alternate investigation methodologies will mean not all serious (SAC1) incidents will require a root cause analysis.

In addition, there will be a separation of the findings from the recommendations, allowing for open disclosure to occur earlier in the process, and providing the opportunity for alternate team members, including specialists in clinical redesign and human factors, to have input into the recommendations.

Overall, the changes are aimed at strengthening the process, especially in relation to open disclosure and the development of robust recommendations.

The changes are expected to come into effect during 2018-19.

## Supporting Patient Safety and Incident Investigation

Two Patient Safety Manager Forums were held in 2017-18 to promote learning, leadership, collaboration and networking for the continued implementation of the NSW Patient Safety Framework.

In addition, the Clinical Excellence Commission conducted five Root Cause Analysis Methodology workshops to improve serious incident investigation capability and outcomes. Over 100 participants from across NSW Health attended.

Two Root Cause Analysis Team Leader workshops were also held to develop capability and to support leadership and reliability in adherence to serious incident investigation methodology. Over 50 participants across NSW Health attended.

# STAFF ACHIEVEMENTS

## Conference Posters and Presentations

ISQua, The International Society for Quality in Health Care, London, October 2017.

### *Last Days of Life Toolkit: Providing Safe, Individualised Care for Dying Patients*

Poster presentation on the development and implementation of the Last Days of Life Toolkit for use in New South Wales (NSW) public health organisations.

Authors: Bernadette King (CEC), Amanda Walker

The 43rd Society of Hospital Pharmacists of Australia National Conference, November 2017.

### *Doing more to keep our patients safe*

A keynote address.

Presenter: Prof Kim Oates (CEC)

### *NSW Maternity Venous Thromboembolism Risk Assessment Tool and Supporting Resources*

A lightning talk

Presenter: Nina Muscillo (CEC), Lillian George (CEC)

### *Development of a Medication Reconciliation Education Package for Nurses & Midwives*

A poster outlining how the Clinical Excellence Commission successfully developed a comprehensive medication reconciliation education package to support nurses and midwives in undertaking medication reconciliation tasks using review. Feedback was also accepted.

Authors: Kate Roper (CEC), Selina Boughton (CEC), Nina Muscillo (CEC), Dr Harvey Lander (CEC).

### *Project Switch*

An oral presentation titled 'Project Switch' on the Clinical Excellence Commission and Sydney Children's Hospitals Network's quality improvement approach to support timely, safe and appropriate switch from IV to oral antibiotics in children was delivered.

Presenters: Evette Buono (CEC), Dr Brendan McMullan, Lolita Tu (CEC), Mona Mostaghim, Dr Michelle Mahony.

### *Supporting patient safety and antimicrobial stewardship during antimicrobial shortages*

A poster on the model developed by the Clinical Excellence Commission to manage antimicrobial shortages was accepted for the 43rd Society of Hospital Pharmacists of Australia National Conference.

The poster outlined how the model promotes consistency in the approach taken by antimicrobial stewardship teams across the state, and how it ensures an appropriate and timely response while reducing duplication of effort within the NSW public health system.

Authors: Evette Buono (CEC), Lolita Tu (CEC), Nina Muscillo (CEC).

### *Venous Thromboembolism (VTE) Prevention: An Electronic Solution for NSW*

A poster on the development of the adult inpatient electronic VTE risk assessment tool in the electronic medical record.

The poster outlines the collaboration between the Clinical Excellence Commission and eHealth NSW and the key learnings from the project.

Authors: Selvana Awad (CEC), Nina Muscillo (CEC), Dr Harvey Lander (CEC), Susan Isemonger, Helen Crowther, Catriona Middleton-Rennie.

Australasian College of Infection Prevention and Control, November 2017

### *Do you know what they are doing with povidone-iodine in the operating theatre?*

A poster outlining the evaluation on the effectiveness of the Clinical Excellence Commission working group recommendations and Safety Notice in changing practice in operating theatres following a supply shortage of Povidone-Iodine (PVI), and the alternate product not registered with the Therapeutic Goods Administration (TGA) for use as a pre-operative skin antiseptic was accepted.

Authors: Joe-Anne Bendall (CEC), Amy Bisson (CEC), Jane McArthur (Intern UNSW), Dr Kate Clezy (CEC), Tracy Clarke (CEC), Dr Paul Curtis (CEC)

The Australian Society for Antimicrobials 19th Annual Scientific Meeting, February 2018

*Aligning NSW sepsis pathways with antimicrobial stewardship principles to improve patient care*

A poster detailing the Clinical Excellence Commission's approach to the enhancements made to the statewide adult sepsis pathway and the improvements to antibiotic use and clinical care by integrating antimicrobial stewardship principles was accepted.

Authors: Evette Buono (CEC), Mary Fullick (CEC), Lisa Coombs (CEC), Lolita Tu (CEC) and Dr Harvey Lander (CEC).

*Drop the lines, go oral in time!*

A poster presentation titled 'Drop the lines, go oral in time!' about the Clinical Excellence Commission and Sydney Children's Hospitals Network's quality improvement approach to support timely, safe and appropriate switch from IV to oral antibiotics in children was accepted.

Authors: Evette Buono (CEC), Dr Brendan McMullan, Lolita Tu (CEC), Mona Mostaghim, Dr Michelle Mahony.

*Taking the confusion and harm out of gentamicin dosing and monitoring in children*

A poster outlining the Clinical Excellence Commission's approach to gain consensus for dosing and monitoring of intravenous gentamicin in paediatric patients which has in turn enabled the endorsement of key references and the development of supporting resources to reduce confusion and standardise practice across NSW public facilities was accepted.

Authors: Evette Buono (CEC), Lolita Tu (CEC), Paul Hunstead (CEC).

Patient Experience Symposium, April 2018

*Towards a Health Literacy Framework for NSW Health*

An oral presentation sharing the rationale for creating the framework and inviting consultation and discussion from those working in NSW Health and consumers.

Presenter: Kay de Ridder (CEC)

*Maximising the use of your patient story*

An oral presentation on how, when and where to tell a patient story.

Presenters: Kay de Ridder (CEC), Kelly Foran (Consumer, member of the CEC Consumer Council).

Australasian Society for Infectious Diseases Annual Scientific Meeting, May 2018

*Improving intravenous-to-oral antibiotic switch in children*

A poster presentation on the Clinical Excellence Commission and Sydney Children's Hospitals Network's quality improvement approach to support timely, safe and appropriate switch from IV to oral antibiotics in children was accepted.

Presenters: Dr Michelle Mahony, Evette Buono (CEC), Lolita Tu (CEC), Dr Sophie White, Mona Mostaghim, Dr Brendan McMullan.

## Published Papers

*Lactate  $\geq 2$  mmol/L plus qSOFA improves utility over qSOFA alone in emergency department patients presenting with suspected sepsis*

CEC Staff Members: Malcolm Green, Dr Harvey Lander

Role: Co-authors

Chief Investigator: Dr Amith Shetty

Journal: Emergency Medicine Australasia, Vol. 29, Iss. 6 (2017)

*Serum lactate cut-offs as a risk stratification tool for in-hospital adverse outcomes in emergency department patients screened for suspected sepsis*

CEC Staff Members: Malcolm Green, Mary Fullick, Dr Harvey Lander

Role: Co-authors

Chief Investigator: Dr Amith Shetty

Journal: BMJ Open, Vol. 8, Iss. 1 (2018)

*Comparison of the Between the Flags calling criteria to the MEWS, NEWS and the electronic Cardiac Arrest Risk Triage (eCART) score for the identification of deteriorating ward patients*

CEC Staff Members: Malcolm Green, Dr Harvey Lander, Paul Hudson

Role: Co-authors

Chief Investigator: Malcolm Green

Journal: Resuscitation, Vol. 123 (2018)

*Comparison of neonatal red cell transfusion reporting in neonatal intensive care units with blood product issue data: a validation study*

CEC Staff Member: Sally Francis

Role: Co-authors

Chief Investigators: Jillian A. Patterson

Journal: BMC Paediatrics

*Strategies to prevent medication errors between acute and primary care*

CEC Staff members: Selina Boughton, Kate Roper, Patricia Conaghan

Role: Co-Authors

Journal: Medicine Today, Vol 19, Number 3, March 2018



## Kim Oates and Vietnam

We are proud to report that our Director Undergraduate Quality and Safety Education Professor Kim Oates received the 'For People's Health' Medal from the Vietnamese Government during a special ceremony in Hanoi in March.

Professor Oates is a leader in NSW health care and has been sharing his expertise with students and health staff in Vietnam for about a decade.

Professor Oates said his work in Vietnam initially focused on research, communication and teaching methods but more recently had aligned with his Australian focus on growing leadership and patient safety skills among health workers in this developing country.

"Patient safety is now a national priority in Vietnam and it has been wonderful to work with clinicians, students and administrators in that country to share our knowledge and work toward better outcomes for patients," Professor Oates said. The award from the Vietnamese Government recognises Professor Oates' significant contributions to public health.

Clinical Excellence Commission Chief Executive Carrie Marr said patient safety and improving health care was a global priority and it was wonderful to see the expertise of Professor Oates and his dedication to health care in Vietnam recognised and rewarded.

"The improvements we make in health care and the knowledge we gain must be shared because at the end of the day clinicians want the same outcomes for our patients – safe, reliable care," Ms Marr said.

## HARC Scholarships

In 2017 one Clinical Excellence Commission staff member completed their HARC Scholarship with another two awarded the scholarship for 2018.

### Amy Bisson

Clinical Excellence Commission Healthcare Associated Infection Project Officer Amy Bisson was awarded a HARC scholarship for 2017.

The area of study was Responding to CPE (Carbapenemase-producing Enterobacteriaceae): reducing unwarranted clinical variation and harm from multi-drug resistant organisms for patients in NSW health facilities.

This study has contributed to ongoing statewide work on multi-resistant organisms that impact on patient morbidity and mortality, and increased resources required for treatment options.

### Fiona Bailey

Clinical Excellence Commission Medication Safety Project Officer Fiona Bailey was awarded a HARC Scholarship for 2018 to investigate sustainable measures to reduce risk of harm from high-risk medicines.

Fiona's project will involve a series of meetings with medication safety and high-risk medicine safety experts from the NHS and Scottish Patient Safety Program.

The aim of these meetings is to gain an understanding of the Scottish Patient Safety Program high-risk medicines framework that supports local teams to prioritise improvement activities related to high-risk medicines.

### Selvana Awad

Clinical Excellence Commission Medication Safety Project Officer Selvana Awad was also awarded a HARC Scholarship for 2018.

Her project will explore how using effective electronic clinical decision support tools and quality improvement science methodology can reduce harm from medication errors and venous thromboembolism.

By connecting with international world-leaders in these areas, this project will provide insight into user-centred and human factors design of electronic solutions, and methodologies and strategies for the effective implementation of such solutions.

Key learnings will inform and enhance work at the Clinical Excellence Commission in the areas of medication safety, VTE prevention and quality improvement application.

# OUR BOARD AND COMMITTEES

## Board

The Clinical Excellence Commission is a board-governed statutory health corporation established under the Health Services Act 1997. The board is responsible for providing guidance and strategic oversight of the organisation's performance. This includes setting directions within the bounds of statutory, government and Ministry of Health requirements and available resources.

## Members

A/Prof Brian McCaughan  
AM

### Board Chair

Professor Brian McCaughan is a Clinical Associate Professor at the University of Sydney and cardiothoracic surgeon at Royal Prince Alfred Hospital. His major clinical interest is the management of lung cancer. He has held a number of positions with the Royal Australasian College of Surgeons and was President of the NSW Medical Board for five years.

Mr Ken Barker  
PSM

Ken Barker has many years' experience in the NSW public sector, including financial management and strategic expertise. As former Chief Financial Officer of NSW Health, he has extensive knowledge of the NSW health system and its position within the broader Australian context. He was awarded the Public Service medal in 2002.

Ken is a Graduate of the Australian Institute of Company Directors and a Fellow of the National Institute of Accountants. He is currently Deputy Chair of the Justice Health and Forensic Mental Health Network Board, Chair of the National Blood Authority Audit Committee and a member of the National Health Funding Body Audit Committee.

Dr Leon Clark

Prior to his appointment as Group Chief Executive Officer of Adventist HealthCare in 2012, Dr Leon Clark FAICD was Chief Executive Officer of Sydney Adventist Hospital for ten years from April 2002.

With a strong clinical background as well as administrative expertise, he was originally an Obstetrician and Gynaecologist, and pioneer in his chosen sub-specialty of in vitro fertilisation.

A past president of the Australian Private Hospitals Association, he currently serves on the boards of several not-for-profit organisations including The Novus Foundation and Medi-Aid Centre Foundation Limited.

Prof Jacqueline Close

Professor Jacqui Close is a consultant in Orthogeriatrics at the Prince of Wales Hospital in Sydney and Clinical Director of the Falls, Balance and Injury Research Centre at Neuroscience Research Australia. She trained in the UK and moved to Australia in 2005. Her research interests range from injury epidemiology to intervention studies and implementation research.

Jacqui has published over 150 papers and her research is currently focused on injury prevention in dementia, hip fracture care and care of older people in surgery.

She sits on a number of State and National committees in relation to Older People and is the Co-Chair of the ANZ Hip Fracture Registry Steering Group.



### Dr Andrew Cooke

Dr Andrew Cooke is currently an Advanced Trainee in Emergency Medicine, specialising in adult and paediatric emergency care. He works in the South Eastern Sydney Local Health District and at the Sydney Children's Hospital, NSW.

Andrew holds a Master of Laws and has practised as a solicitor with public and private sector experience in NSW and Victoria. He received the Sydney University Medical School Travelling Fellowship in 2008 and is also a recipient of a Full Commonwealth Scholarship to Cambridge University to undertake graduate training in law. Andrew is a member of the Australian College of Legal Medicine.

### Ms Laila Hallam

With over 25 years in senior sales and marketing roles in mostly large organisations across a range of diverse industries, Laila has commenced postgraduate research in understanding Patient-Centred Care.

Laila also works with Sydney Local Health District to better understand patient and family needs and their place in treatment. Her focus is to work with health care organisations to understand, recognise and facilitate the immense value and knowledge that patients and their families can contribute to their own personal healthcare – for better health outcomes.

Laila became an advocate for her father over 10 years ago when he became tortured with a rapidly failing body and began losing his ability to speak. Laila took on her father's voice as he lost his.

### Ms Carrie Marr

Prior to her October 2015 appointment as our Chief Executive, Carrie was the Executive Director, Organisation Effectiveness at Western Sydney Local Health District. Prior to this Carrie held a number of leading executive and consultant positions in the UK for a variety of organisations including the National Health Service, Scotland.

Carrie is a graduate of the renowned advanced training program in Quality Improvement at Intermountain Health Care, Utah, US. She also holds a Bachelor of Science (Nursing), a Diploma in Education (Nurse Teaching) and a Master of Science (Organisation Consulting).

### Prof Sandy Middleton

Professor Sandy Middleton is Professor of Nursing and Director of the Nursing Research Institute, a joint initiative between St Vincent's Health Australia (Sydney) and Australian Catholic University. She has led large multisite cluster randomised controlled trials in stroke and implementation research.

She is a member of the National Health and Medical Research Council Research Committee and the Stroke Foundation Clinical Council, a Director of the St Vincent's Clinic Board, and Chair of the Steering Committee of the Australian Stroke Clinical Registry.

### Ms Susan Pearce

Susan is the Deputy Secretary of the System Purchasing and Performance Division at the Ministry of Health. She is responsible for front end system management across NSW and acts as the interface between the Ministry, Local Health Districts, Specialty Health Networks and health organisations to support and monitor overall system performance.

Susan started her career as a registered nurse across rural, remote and metropolitan areas of NSW and has held several senior executive positions in NSW Health.

Susan's commitment to drive change in the public health system makes a positive difference to patients' health outcomes and care.

### Mr Tomas Ratoni

Tomas Ratoni is a Paediatric Clinical Nurse Consultant. He has a background primarily in paediatric critical care and paediatric and neonatal retrieval medicine. More recently Tomas has discovered a taste for general paediatrics. He has a passion for teaching and is an instructor for Australian Paediatric Life Support.

### Prof Andrew Wilson

Professor Andrew Wilson is Director of the Menzies Centre for Health Policy at the University of Sydney and leads the Australian Prevention Partnership Centre. His research interests concern the application of epidemiology to informing decision-making in clinical medicine, public health, and health service policy and planning. His specific areas of interest are chronic disease prevention and management.

Andrew's previous non-academic roles include Deputy Director-General, Policy, Planning and Resourcing, Queensland Health, and Chief Health Officer and Deputy Director-General, Public Health, NSW Health.

## Finance and Performance Committee

The primary role of the Finance and Performance Committee is to ensure the operating funds, capital works funds and service outputs required of the Clinical Excellence Commission are being achieved in an appropriate and efficient manner.

Members:

**Ken Barker**

(Chair)

**Leon Clark**

**Andrew Cooke**

**Brian McCaughan**

## Research and Education Committee

The primary role of the Research and Education Committee is to provide leadership to and governance oversight of research and education conducted by the Clinical Excellence Commission, to improve the safety and quality of care for patients in NSW public hospitals, and to advise the board on the priority, quality and relevance of research and education undertaken or proposed to be undertaken by/on behalf of the commission.

Members:

**Prof Andrew Wilson**

(Chair)

**Dr Andrew Cooke**

**A/Prof Mary Haines**

**Prof Philip Harris AO**

**A/Prof Brian McCaughan**

**Prof Sandy Middleton**

**A/Prof David Peiris**

**Dr John French**

## Consumer Council

In 2018 the Clinical Excellence Commission and the Agency for Clinical Innovation established a joint Consumer Council.

It is made up of 16 consumers who have experienced health care either as a patient, carer or family member and are keen to contribute to improvement within the NSW health system.

The purpose of the Consumer Council is to create a stronger consumer voice for safety, quality and innovation in health across both organisations.

It provides advice to the Clinical Excellence Commission and board on strategies for promoting partnerships with consumers, raising community awareness, and facilitating consumer and patient engagement in patient safety and quality improvement.

Members:

**Laila Hallam**

(Co-Chair)

**Tomas Ratoni**

(Co-Chair)

**Craig Cooper**

**Kathy Dempsey**

**Luke Escombe**

**Zoe Fernance**

**Kelly Foran**

**Maria Heaton**

**Harry Iles-Mann**

**Fay Jackson**

**Adam Johnson**

**Helen Mantziaris**

**Michael Morris**

**Brad Rossiter**

**Ro-Anne Stirling-Kelly**

**Dr Coralie Wells**

## Audit and Risk Management Committee

The Audit and Risk Management Committee plays a key role in assisting the board and the Chief Executive to perform their duties under the Health Services Act 1997 with particular relation to the organisation's financial reporting, internal control, risk management and internal and external audit functions.

Members:

**Peter Scarlett**

(Independent Chair)

**Gabrielle Trainor AO**

(Independent Member)

**John Kelly**

(Independent Member)

## Our Executive

**Carrie Marr**

Chief Executive

**Jenine Wosinski**

Director, Corporate Services  
(from February 2018)

**Lisa Cox**

Director, Corporate Services  
(up to September 2017)

**Alison Starr**

Director, Development

**Dr Paul Curtis**

Director, Governance and Assurance

**Dr Deborah Browne**

Director, Improvement Collaboratives

**André Jenkins**

Director, Information Management and Information Communication Technology

**Dr Jonny Taitz**

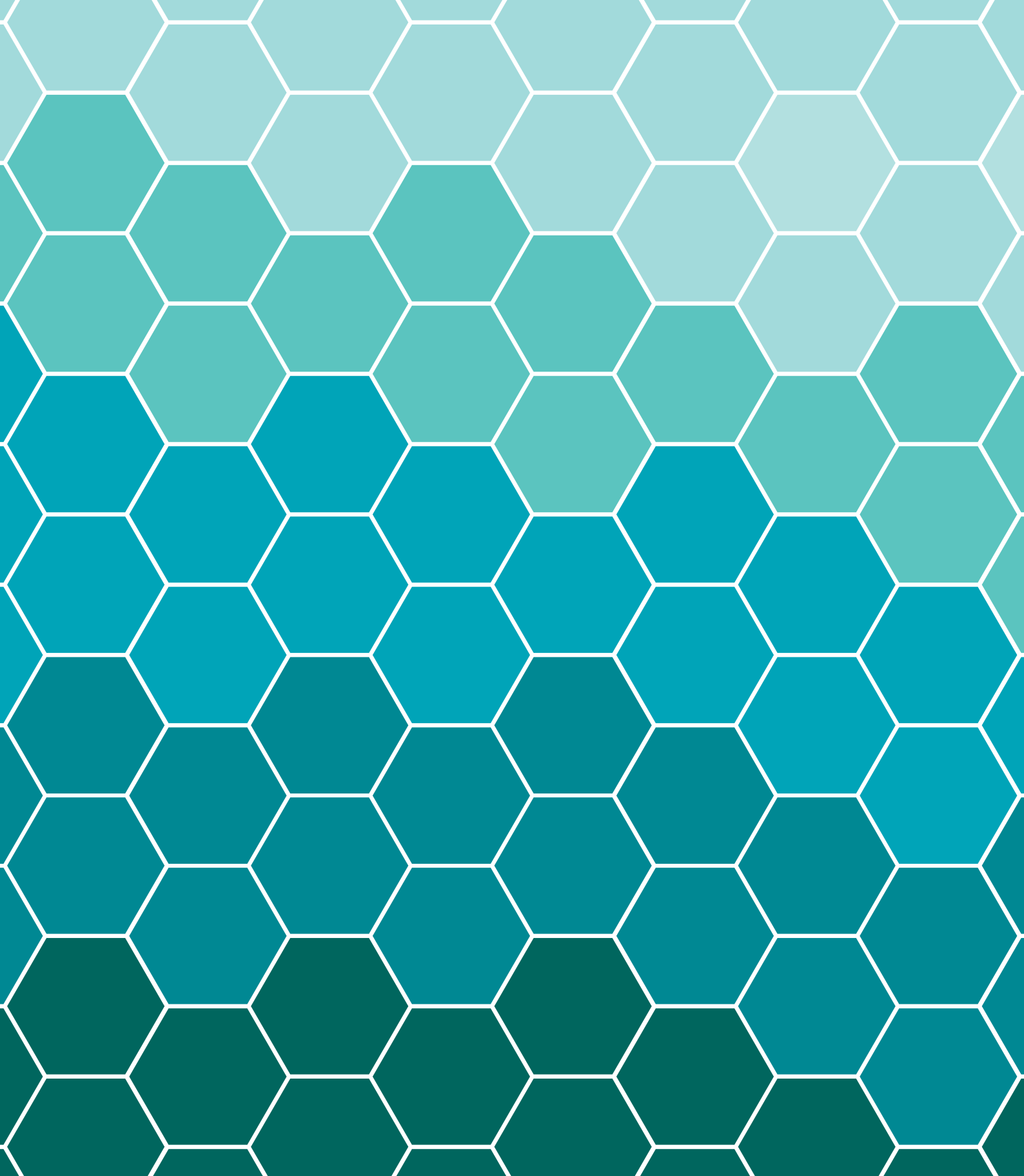
Director, Paediatric Patient Safety

**Dr Berni Eather**

Director, Patient Safety  
(up to February 2018)

**Dr Harvey Lander**

Director, Systems Improvement



CLINICAL  
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COMMISSION

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