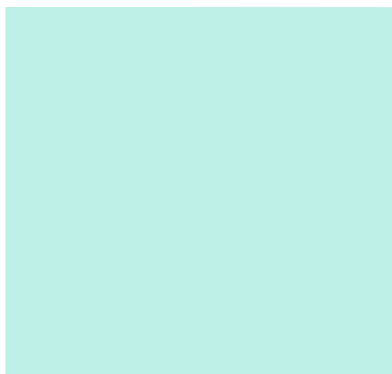
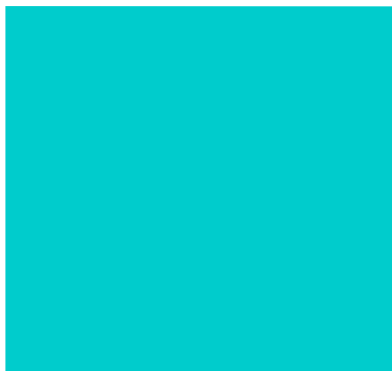
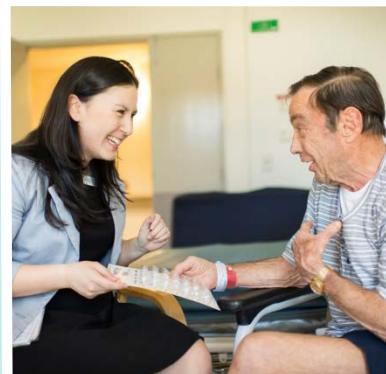


YEAR IN REVIEW 2014-15



CLINICAL
EXCELLENCE
COMMISSION



Leading safety and
quality in health care



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CHAIR'S FOREWORD



With ten years now under its belt, the Clinical Excellence Commission has gained a well-earned reputation based on its track record for leading quality and safety improvements in the NSW health system.

Collaboration with clinicians, managers and health partners (including consumers and carers) has been critical in this success story.

The Clinical Excellence Commission continues to work closely with other pillars – most particularly with the Agency for Clinical Innovation on many projects that focus on significant issues common to both organisations.

I congratulate Professor Cliff Hughes, Dr Nigel Lyons and their staff in leading this increasing collaboration.

Of equal importance has been our relationship with all those at the local health district level (clinicians and managers) as this is where implementation occurs.

We continue to listen and learn from our colleagues in our local health districts.

The 2014-15 financial year was a busy and significant one for the Clinical Excellence Commission, as outlined in the following pages of this review.

The broad range of activities included celebrating its tenth anniversary in August; supporting a system-wide response to Ebola in November; relocating to Haymarket in December; participating in Capacity Assessment Project site visits with the Ministry of Health during March and April; and very importantly, developing a new strategic plan to guide the direction and activities of the organisation over the next three years.

In the midst of these changes and challenges, the Clinical Excellence Commission continued to meet its primary responsibility of identifying and responding to quality and safety risks and supporting clinical improvement initiatives.

In addition to providing updated reports through the clinical incident management portal and eChartbook, the Clinical Excellence Commission released six policy-related documents and seven reports, designed to improve clinical practice.

It responded to new priority areas such as venous thromboembolism (VTE), diagnostic error, human factors, end of life care and catheter-associated urinary tract infection (CAUTI).

It also strengthened its development and roll-out of electronic data reporting and support systems,

including a system-wide Quality Reporting System (QARS) to support reporting against the National Safety and Quality Health Service Standards, and a web-based Death Review Reporting System.

In doing so, it continued to strengthen its relevance and value as system-leader for quality and safety in the NSW health system.

The departure of Professor Cliff Hughes as Chief Executive Officer in April 2015 was a significant milestone, particularly for Clinical Excellence Commission staff and the Board.

Joining as its founding CEO in 2004, Professor Hughes' contribution as organisational leader, architect, mentor and influencer cannot be overstated.

The Clinical Excellence Commission has grown in size, function and reputation during his tenure and I am confident his legacy will continue to guide the staff and its work for some time.

Cliff, as he has been affectionately known by all, has now assumed a new role as President Elect of the International Society for Quality in Health Care (ISQua), where his commitment and influence to the quality and safety agenda will live on.

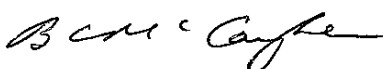
CHAIR'S FOREWORD

I would like to acknowledge and commend Acting Chief Executive, Dr Nigel Lyons, and the committed Clinical Excellence Commission executive and staff, for ensuring the organisation continued to meet its core responsibilities pending recruitment of a new Chief Executive.

That the Clinical Excellence Commission successfully developed a new strategic plan, fulfilled key performance indicators on its Service Agreement and recorded high staff engagement indices on the Your Say survey during this time, is a testament to all involved.

On behalf of the Board, I would like to thank everyone who works with and supports the Clinical Excellence Commission in improving safety and quality in the NSW health system.

We look forward to continuing to work with you as we welcome our new Chief Executive, Carrie Marr, in October.



A/Prof Brian McCaughan AM
Board Chair
Clinical Excellence Commission



ENGAGING PATIENTS AND
CONSUMERS IN CARE

ENGAGING PATIENTS AND CONSUMERS IN CARE

Symposium creates forum for sharing strategies to improve patient experience

The 2015 Patient Experience Symposium was held in Sydney on 30 April, as part of Patient Experience Week.

The day was an opportunity for clinicians, managers and consumers to hear from leading experts in patient experience and patient reported outcomes measures, and to share innovations in improving patient experience.

It included keynote addresses from international speakers Patrick Charmel and Dan Wellings, and a local consumer Laila Hallam.

Breakout sessions focused on meaningful measurement and action to improve patient experience at the individual, service and system level.

There was also an interactive panel discussion to enable delegates to share experiences and to apply symposium learnings in practice.

The symposium was hosted by the Clinical Excellence Commission and the Agency for Clinical Innovation, in partnership with the Bureau of Health Information, Cancer Institute NSW, NSW Nursing and Midwifery Office and NSW Kids and Families.

Improving the quality of care for patients with dementia

The TOP 5 program is a simple concept used to improve the safety and quality of care for individuals with dementia in health care settings across NSW.

It encourages staff members to engage with carers so they better understand the five most important non-clinical carer tips to use when caring patients who have dementia.

The concept was conceived by, and piloted, in the Central Coast Local Health District.

It has been implemented in selected hospitals across the State by the Clinical Excellence Commission, as part of a research project funded by a HCF Health and Medical Research Foundation grant.

A report *TOP 5 - Improving the care of patients with dementia 2012-13*, on the findings of the research project, was released in April 2015.

Results found TOP 5 to be a low cost, patient-based communication strategy.

It is associated with significant improvements in patient outcomes, safety, carer experience and staff satisfaction, while providing potential cost savings to health services.

In May 2015, a journal article on the TOP 5 was published in the International Journal for Quality in Health Care.

A second study (also supported by a grant from the HCF Research Foundation) began in July 2014.

It is investigating the use and impact of TOP 5 transfers of care between hospitals, residential aged care facilities and community services.

"Since TOP 5 arrived, I feel more confident in dealing with both patients & carers."

Staff member comment

Consumers and clinicians inform the development of a 'Last Days of Life' toolkit

Over 30,000 patients die in NSW acute care facilities each year. Increasingly, the type of care and services utilised by patients is being examined, especially for care in the last days of life.

A recent pilot of a 'care of the dying' observation chart demonstrated that there is a need for not just an observation chart, but a suite of tools

ENGAGING PATIENTS AND CONSUMERS IN CARE

that will support clinicians in caring for the dying patient.

In June 2015, a planning day involving over 80 clinicians and consumers was convened by the Clinical Excellence Commission, to inform the development of a *Last Days of Life* toolkit.

Expected to be ready for piloting during December 2015, the toolkit provides a standard approach for the identification of the dying patient, symptom assessment and management, and care after death.

It contains resources for staff to use, to ensure:

- all patients receive optimal symptom control
- patients have their social, spiritual and cultural needs addressed, and
- bereavement support for families and carers occurs

It is based on best practice, and will contribute to improving the effectiveness, safety and experience of care, for dying patients and their families and carers.

Patients and families assist in preventing pressure injuries

Patients, families, carers and staff can all help to reduce the risk of a pressure injury.

In 2014, the information brochure *Pressure Injury Prevention: Information for Patients and Families* was released, and is now widely used across the State in inpatient settings.

The brochure has been translated into eight languages and is available to download from the Clinical Excellence Commission website. It was downloaded over 1500 times during 2014-15.

It is used by clinicians to guide discussion, involve patients, their family and carers in the patient's care planning. It also aims to ensure appropriate interventions are put in place to reduce the risk of the patient developing a pressure injury.

Building and maintaining trust between staff and consumers through open disclosure

In the past, the expectations of patients, their family members and health care staff for care and information following a patient safety incident have not always been met.

Open disclosure is a process for ensuring that open, honest, empathic and timely discussions occur between patients (and/or their support person) and health care staff when such an incident occurs.

In 2014, the Clinical Excellence Commission launched the revised Open Disclosure Program with an improved framework for effective open disclosure discussions, and resources to support clinicians and managers to practise open disclosure.

The program includes a new policy directive, a detailed handbook and three online learning modules.

The focus of the program is now moving to deliver practical skills training for clinicians who may be involved in an open disclosure conversation.

Effective open disclosure improves patient, staff and community confidence in how the system responds to patient safety incidents, and is fundamental to maintaining or re-building the trust between health care staff and consumers.



EARLY RECOGNITION
AND PREVENTION

EARLY RECOGNITION AND PREVENTION

CEC supports NSW response to preventing Ebola outbreak

In late 2014 and early 2015, an epidemic of Ebola, a type of viral haemorrhagic fever, occurred in West Africa and there was a potential for travellers to present at NSW hospitals with the virus or suspected symptoms.

It was clear from experiences in Europe and North America that spread of Ebola to staff was a significant risk, with a high likelihood of death, if contracted.

The development of improved procedures for staff to don and doff Personal Protective Equipment (PPE) was vital.

Working with Health Protection, Ministry of Health, Infection Prevention & Control Practitioners (particularly from Westmead and Sydney Hospitals) and equipment suppliers, the Clinical Excellence Commission developed a safe process to don and doff PPE.

Due to the complexity of these procedures, videos to clearly demonstrate the steps involved were produced.

Further advice was provided on other aspects of infection prevention and control including working with the

NSW Environmental Protection Agency around Ebola infected waste disposal.

The work of the Clinical Excellence Commission received many positive comments from around Australia and internationally.

The PPE videos are available at <http://www.cec.health.nsw.gov.au/resources/videos>

Providing support across NSW to prevent pressure injuries

Pressure injuries can happen quickly, as a result of lying or sitting in the same position for too long. Many pressure injuries are highly preventable, and their lengthy healing time has consequences for quality of life, including susceptibility to infection, pain, sleep and mood disturbance.

They also impact on rehabilitation, mobility and long-term quality of life.

During 2014-15, staff from the Clinical Excellence Commission visited each local health district to promote evidence-based practice for the prevention and management of pressure injuries and to increase awareness of pressure injury prevention.

This promotion included presentations for hospital executives, pressure injury champions and clinicians, supporting exhibition booths at local health district quality awards and conferences, and assisting with pressure injury point prevalence surveys across wards and facilities.

This work also supported the implementation of the NSW Health Pressure Injury Prevention Policy, released in March 2014.

Tall man lettering and barcode scanning leads to reductions in medicine mix-ups

The process of dispensing medication is considered to be relatively accurate, however the high volume of items dispensed through pharmacies each year provides significant opportunity for patient harm.

Many medicines also have names that look like, or sound like, the names of other medicines. This confusion contributes to a significant number of medication errors each year, with some causing significant patient harm.

In 2015, the Clinical Excellence Commission produced educational resources for hospital staff, to

EARLY RECOGNITION AND PREVENTION

support the introduction of 'Tall man lettering' and barcode scanning.

Tall man lettering uses a combination of lower and upper case letters to highlight the differences between look-alike medicine names, helping to make them more easily distinguishable, while barcode scanning at the point of dispensing has been shown to reduce the rate of pharmacy dispensing errors.

These strategies can reduce the risks of patient harm associated with medicine confusion.

'Sepsis alert' supports the early recognition and treatment of patients with sepsis

Sepsis is one of the leading causes of death in hospital patients worldwide.

It can be difficult to recognise and delayed treatment is associated with high mortality rates, significant morbidity and high costs to the health care system.

The Clinical Excellence Commission and eHealth NSW worked collaboratively with Western Sydney Local Health District and Blacktown Hospital to develop and trial a 'sepsis alert' in the electronic medical record (eMR).

Vital signs and pathology results are entered into the eMR by clinicians. An algorithm runs continuously in the background to identify patients at risk of sepsis.

When a number of known sepsis risk factors are identified in a patient, the sepsis alert is triggered so treatment can begin quickly.

The pilot at Blacktown Hospital has been a success.

Patients deteriorating with sepsis are being recognised and treated earlier due to the sepsis alert.

Plans are underway to refine the tool and roll it out across NSW hospitals in 2016.

Clinicians in NSW public hospitals are consistently administering antibiotics in less than one hour, following identification of sepsis.

'Humpty Dumpty' helps clinicians to prevent children from falling, while in hospital

Children falling in hospital is a relatively rare occurrence, however if a child does fall the consequences may be serious.

International best practice recognises that all children should have a falls risk assessment completed on admission and every three days thereafter, unless their condition changes.

In 2014, the Clinical Excellence Commission evaluated a range of falls risk assessment tools, to provide a standardised approach to falls prevention for children in NSW public hospitals.

The Humpty Dumpty Risk Assessment Tool, developed by Miami Children's Hospital, was selected.

The tool provides a structure for clinicians to assess a child's risk of a fall, guide care actions and points for review during the hospital stay.

A range of supporting resources, including education for clinicians, guidance on completing the tool, and flyers for clinicians and parents outlining ways to help prevent children falling, while in hospital, were also produced.

As well as reducing the risk of a fall and making a hospital stay safer for children, the tool is consistent with the requirements under Standard 10 of the National Safety and Quality Health Service Standards.

EARLY RECOGNITION AND PREVENTION

Supporting hospitals to stop clots and stop harm

Venous Thromboembolism (also known as a blood clot) is one of the leading causes of preventable death in Australia. It causes more deaths than breast cancer, bowel cancer or road traffic accidents.

Approximately 14,000 Australians develop a VTE each year. Around 5000 of these cases result in death.

Hospitalisation is strongly associated with the development of VTEs - the majority of which are preventable.

In September 2014, the Clinical Excellence Commission launched the VTE Prevention program to reduce incidence in NSW public hospitals. The aim is to ensure that all patients are assessed for VTE risk and given the appropriate prophylaxis.

The program provides local health districts, individual facilities and clinicians with the tools and resources required to address this patient safety issue, as well as the support and advice required to implement the elements into workflow.

Manage confusion and reduce the risk of falls

People with confusion (memory or thinking problems) have an increased risk of falling when in hospital, due to cognitive impairment such as dementia and/or delirium, physical illness and being in unfamiliar surroundings.

Changes in a patient's level of cognition, such as increased confusion, agitation, disorientation or changes in levels of consciousness, may indicate increased confusion and a heightened risk of a fall.

It is important to investigate and manage a range of possible contributors including urinary tract infection, dehydration, constipation or urinary retention.

To highlight the importance of improving clinical care and managing a patient's confusion, the theme for this year's April Falls Prevention campaign was *Don't let confusion cloud the risk of falls*.

This theme was promoted in local health districts' activities and forums.

A series of resources (power point presentations, and posters) were developed for staff and patient education in hospital, residential care and community care settings.

The patient's brain health (level of cognition) was a focus as it is as important for monitoring, as other vital signs.

Keeping newborns between the flags provides a safety net against clinical deterioration

The Standard Newborn Observation Chart (SNOC) was designed to improve the recognition and response to newborn babies who are clinically deteriorating.

In early 2014, the *Between the Flags Maternal and Newborn Reference Group* led the revision of the chart, to align with the Recognition and Management of Patients who are Clinically Deteriorating policy (PD2013_049).

The reference group included clinical experts and representatives from NSW Kids and Families, the Pregnancy and Newborn Services Network, the Nursing and Midwifery Office and the Clinical Excellence Commission.

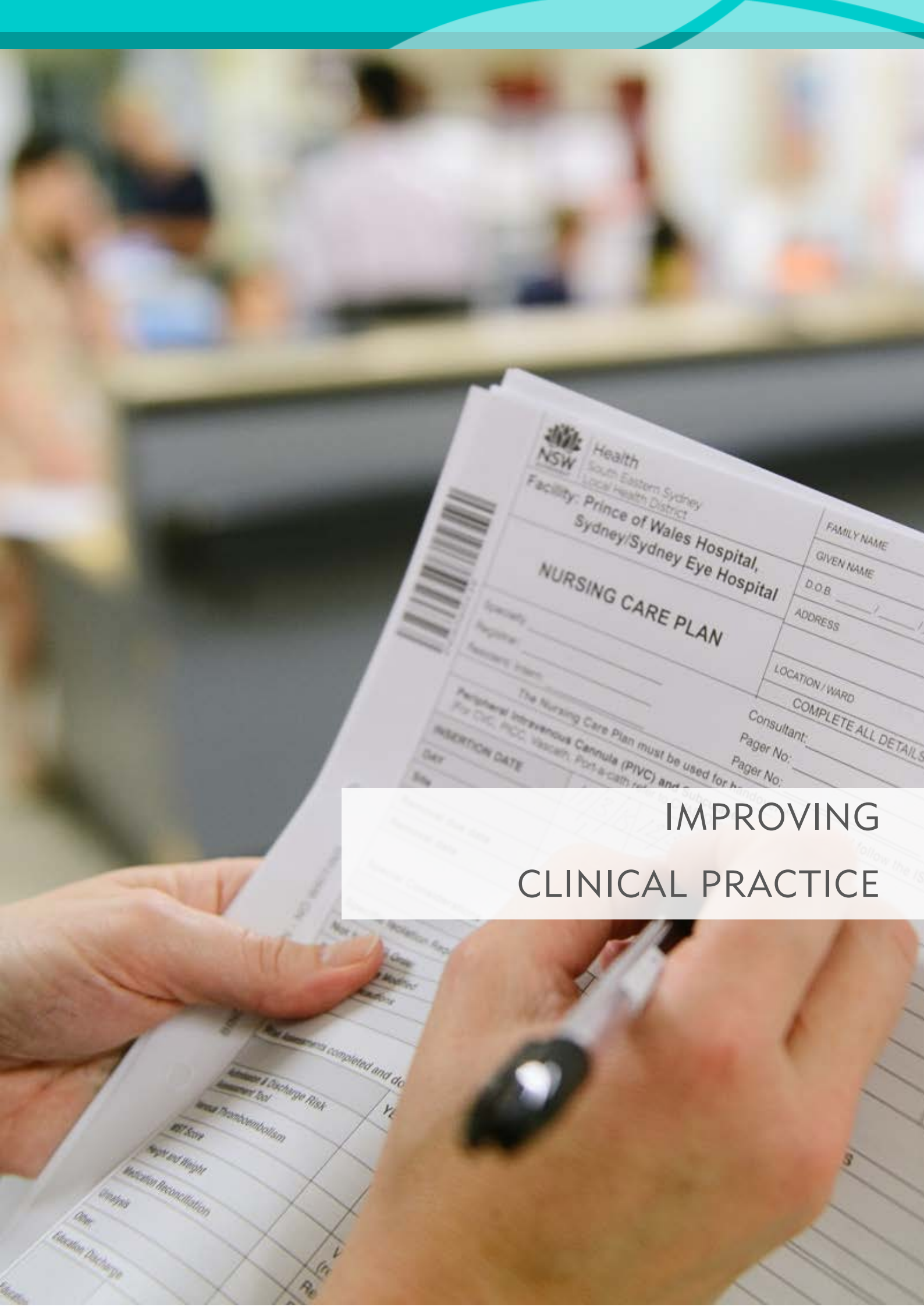
A significant addition to the chart is the inclusion of the *Newborn Risk Assessment*, to assist clinicians in identifying babies at risk of deterioration.

EARLY RECOGNITION AND PREVENTION

This simple tool is one of the most significant changes in practice for the care of newborn babies in NSW public hospitals in recent years.

Now, all newborns in NSW hospitals must have a full set of observations and risk assessment completed prior to leaving the birthing environment.

There have been ~2100 fewer unexpected cardiac arrest calls in NSW public hospitals, since the Between the Flags system was introduced in 2010.



IMPROVING CLINICAL PRACTICE



Health
South Eastern Sydney
Local Health District

Facility: Prince of Wales Hospital,
Sydney/Sydney Eye Hospital

FAMILY NAME
GIVEN NAME
D.O.B. ____/____/____
ADDRESS
LOCATION / WARD

NURSING CARE PLAN

Specialty: _____
Register: _____
Resident: Inpatient

The Nursing Care Plan must be used for:
Peripheral Intravenous Cannula (PIVC) and
For CVC, PICC, Vascath, Port-a-cath, etc.

INSERTION DATE
DATE

Consultant: _____
Pager No: _____
Pager No: _____

COMPLETE ALL DETAILS

Observation	Time	Notes
Respiratory		
Cardiovascular		
Neurological		
Musculoskeletal		
Integumentary		
Genitourinary		
Endocrine		
Other		

IMPROVING CLINICAL PRACTICE

Master Class brings health care teams to the bedside and keeps patients in safe hands

Clinicians working as unit-based interdisciplinary teams have demonstrated improvements in communication, patient safety and staff satisfaction.

The patient's experience is enhanced by bringing patients together according to their diagnosis and caring for them using an integrated approach.

The Clinical Excellence Commission's *In Safe Hands* program provides a platform for building and sustaining efficient and effective health care teams within a complex environment.

On 6 March 2015, the Clinical Excellence Commission held an *In Safe Hands Master Class* - an education day for over 100 clinicians and system managers.

It focused on the implementation of Structured Interdisciplinary Bedside Rounds - a structured process of bringing the interdisciplinary health care team to the patient's bedside to discuss their care plan.

As a result of the Master Class, the *In Safe Hands* program continues to spread, with more than 70 units

having implemented the program across the state.

Units that have implemented the program have experienced improvements in measures associated with process, staff and patient experience, and patient safety.

Reducing patient harm from errors involving high-risk medicines

Anticoagulant medicines are medicines that prevent the blood from clotting. They are considered high-risk medicines.

Errors with these medicines are not necessarily higher than with any other medicines, however when problems occur, the consequences can be more significant.

Anticoagulant medicines were identified as one of the main classes of medicines involved in serious medication incidents reported during 2013-14.

An anticoagulant medicines working party was established in 2014 to develop guidelines that support clinicians to use anticoagulant medicines safely and effectively.

The first guidelines - expected to be available from late 2015 - will focus on the newer agents, because the effects of some of the newer anticoagulant medicines can be difficult to reverse.

5x5 Antimicrobial Audit contributes to quality use of antimicrobials

Improving the quality of antimicrobial prescribing leads to safer, more effective treatment of infections.

In health care, this is referred to as antimicrobial stewardship.

During 2014-15, fifteen facilities from NSW local health districts and networks were involved in a 12-month pilot project for the 5x5 Antimicrobial Audit - a sustainable model of audit, intervention and feedback designed to improve the quality of antimicrobial prescribing in targeted areas of clinical practice.

In this audit activity, health care professionals collect data on five questions per patient, for five patients per week (i.e. 5x5), noting whether antimicrobial indications have been documented, and whether the choice of therapy is consistent with prescribing guidelines.

IMPROVING CLINICAL PRACTICE

They are then prompted to make interventions that promote best practice prescribing, and results are fed back to prescribers and other relevant groups of people in the hospital.

Over 4600 courses of antimicrobial therapy were assessed in the pilot, prompting more than 1000 point-of-care interventions.

Results indicate this initiative can improve the quality of antimicrobial prescribing in a wide variety of hospital inpatient settings.

Concordance with antimicrobial guidelines increased from 74 per cent to 86 per cent by the end of the pilot period.

Preventing unintended changes to patients' medicines

Around half of all hospital medication errors occur at admission or at discharge, with approximately 30 per cent of these having the potential to cause harm.

Formalised medication reconciliation processes have been recognised internationally as a strategy to improve patient safety.

In January 2015, the Clinical Excellence Commission released the Medication Reconciliation Toolkit to help prevent unintentional changes in patients' medicines.

This helps prevent patient harm and improves medication management when patients transfer between and within health care settings.

The toolkit has been divided into five sections:

- Establishing governance
- Improving practice
- Education
- Monitoring practice
- Sustaining and spreading practice.

It acts as a guide for incorporating medication reconciliation processes into everyday practice.

Building a framework to reduce diagnostic errors

In NSW, there are approximately 500 reported incidents a year that represent a missed or delayed diagnosis.

Of these, around 50 are recorded as having serious adverse outcomes for patients.

Current literature recommends strategies that address the cognitive

aspects of decision making to reduce the risk of error in diagnosis, such as the use of checklists and cognitive thought algorithms.

Despite this, limitations exist in the application in the clinical environment and there is little in the way of proven strategies that are effective in reducing errors.

In 2015, the Clinical Excellence Commission developed the *Take 2 – Think, Do* framework, to help reduce the risk of diagnostic error.

The framework helps clinicians recognise when there may be a high risk for diagnostic error to occur and provides a structured process that facilitates a more detailed case review at key times in the patient's journey.

It is currently undergoing testing to evaluate the practicality of use in the clinical environment. A pilot of the strategies will begin in early 2016.



 BUILDING CAPACITY
IN HEALTH CARE

BUILDING CAPACITY IN HEALTH CARE

Providing support to clinicians and managers to review serious incidents

Following a serious clinical incident, NSW Health facilities are required to undertake a root cause analysis (RCA) investigation, to identify the root causes and factors that contributed to the incident.

As part of the Clinical Excellence Commission's provision of support to clinicians and managers who review and manage serious incidents, four RCA training courses for RCA team leaders were held during 2014-15. A total of 79 participants attended the sessions.

The training provided clinicians and managers with guidance on effective team leadership, the investigation processes and methodology to be followed, thereby ensuring that serious incidents are investigated effectively and opportunities for improvement are identified.

A high standard of investigation and good quality RCA report allows the Clinical Excellence Commission to undertake more effective and accurate trend analyses and identify opportunities to improve the overall safety of health care in NSW public hospitals.

The Clinical Excellence Commission's RCA Review Committees reviewed over 500 RCA reports during 2014-15.

Embedding a safety culture in future generations of health professionals

The Clinical Excellence Commission has become an international leader in teaching patient safety and quality in undergraduate medical, nursing and allied health schools, providing more patient safety and quality education than most other centres.

The Undergraduate Education program introduces Health Science students to crucial concepts in patient safety in the early years of their undergraduate courses.

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

Globally, there has been very limited evaluation of patient safety teaching.

During 2015-16, the Clinical Excellence Commission continued to progress a multicentre study, with the support of the medical schools, to

evaluate the effectiveness of patient safety teaching.

The study seeks feedback from medical students on their attitudes to patient safety and quality, prior to commencement of teaching, at 12 and 24 months, and then two years after teaching has stopped.

It will identify the extent that knowledge in patient safety has translated into behaviours and cultures.

This study is one of several long term projects aimed at changing the culture of the next generation of medical and nursing graduates, to improve the safety and quality of health care in NSW and beyond.

Enhancing health systems usability through user-centred design

Although patient data now moves more efficiently between facilities, the accuracy of that data is questionable, due to the often-low usability of Health IT platforms.

Notably, users have expressed frustration regarding the difficulty of entering and retrieving key patient information.

BUILDING CAPACITY IN HEALTH CARE

Over the past year, the Clinical Excellence Commission has worked with eHealth, to integrate user-centred design processes into Health IT software projects.

In particular, the Clinical Excellence Commission has provided Human Factors expertise, to change the way in which Health IT projects are developed and designed.

By implementing user-centred design processes for health software, the efficiency and accuracy of data capture should improve greatly and result in safer, high-quality patient care.

Death review program provides standardised approach to mortality review

Mortality review is a process in which the circumstances surrounding the care of a patient, who died during hospitalisation, are systematically examined.

Having a standardised mortality review approach in a system focused on quality can set the stage for, and facilitate, the improvement process.

In 2014, the Clinical Excellence Commission released *Mortality Review in NSW: The Way Forward Compendium* which provided

direction and supporting resources for clinicians and managers within the NSW health system, to facilitate a standardised approach and improvements to mortality review.

A death review program, encompassing the *Admitted Patient Death Screening Tool* and supporting database, were developed by the Clinical Excellence Commission and successfully piloted between May and August 2014.

The program was then rolled out across all local health districts and the Justice & Forensic Mental Health Network in late 2014.

Since implementation, over 86 per cent of facilities have used the tool and database for screening deaths.

The major benefits of the death review program is that it provides the capacity for clinicians and managers at all levels of an organisation to evaluate patient care, determine if care was appropriate, and to identify opportunities to improve care in the future.

Study on quality of care for Indigenous patients informs new Aboriginal Health Plan

Australian Aboriginal people experience at least eight times the

incidence of chronic kidney disease progressing to end-stage kidney disease than non-Aboriginal Australians.

In rural and remote regions, people are often forced to relocate to regional centres for life-sustaining renal dialysis.

In 2014, PhD candidate Ms Elizabeth Rix completed her study on how service delivery for Aboriginal people receiving haemodialysis in a rural region of New South Wales might be improved, based on patients' and providers' experience with the system.

The study was supported by the Clinical Excellence Commission, through the Ian O'Rourke PhD Scholarship in Patient Safety.

The study identified four themes - better screening for early detection, flexible family-focused care, system redesign to demonstrate cultural understanding, and managing patient fear of mainstream services.

The study found that, by addressing these themes, there is potential for significant reductions in the cost of acute hospital services.

It can also help to reduce the physical, social, emotional and spiritual 'costs' to Aboriginal renal

BUILDING CAPACITY IN HEALTH CARE

patients, their families and communities.

These recommendations have since been included in the Aboriginal Health Plan 2015 - 2020.

The full title of Ms Rix's PhD is *'Avoiding the 'Costly' Crisis': Informing Renal Services Design and Delivery for Aboriginal People in Rural /Regional New South Wales, Australia.*

New audit tools evaluate care delivery and compliance with blood management guidelines

Patient blood management involves preventing and managing anaemia, optimising haemostasis (the body's response to prevent bleeding), minimising blood loss and reducing unnecessary use of blood and blood products.

The national, evidence-based Patient Blood Management Guidelines have been introduced progressively since 2011, with five modules now available for implementation.

During 2014-15, the Clinical Excellence Commission worked with local clinicians and experts in transfusion and quality improvement, to establish a methodology to assess and monitor the capacity for hospitals

to provide elements of patient blood management.

Audit tools addressing individual elements of each module of the Guidelines have been developed and tested, evaluating care delivery and compliance in defined patient groups.

This is particularly significant as it identifies specific areas that require attention, as well as capturing the overall capacity of hospitals to provide patient blood management.

The audits are the first of their kind, and two pilot audit phases have been completed in Category "A" and "B" hospitals across the state.

The overall results of the audit will be used to inform a strategy and will include recommendations for Statewide improvements.

Opportunities will be available during 2015-16 for clinicians to participate in collaborative improvement projects.

Supporting professional development that leads to quality improvement

The Clinical Excellence Commission's Foundational and Executive Clinical Leadership programs improve patient safety and clinical quality through enhanced leadership practices.

In December 2014, an evaluation of the programs was completed. The review surveyed 34 past participants and covered a number of areas, including their perception on the most valuable aspects of the program, and the extent to which the program enhanced their leadership development.

All respondents agreed, or strongly agreed, that the program enhanced their development as a leader, with seventeen indicating that participating in the program had helped them gain a new role.

Where it was applicable, nearly 80 per cent indicated that the gains from the improvement project they completed as a part of the program, had been sustained.

Most encouragingly, 90 per cent of participants indicated they had led, or been involved in, at least two improvement projects, since completing the program.

Since 2007, nearly 3500 staff have completed one of the Clinical Excellence Commission's clinical leadership and improvement programs.



USING DATA TO
DRIVE CHANGE

USING DATA TO DRIVE CHANGE

Alerting clinicians to system-wide safety issues

One of the ways the Clinical Excellence Commission communicates safety issues is via the Safety Alert Broadcast System (SABS).

The SABS provides a systematic approach to the distribution and management of patient safety information to NSW health services.

The SABS is a three-tiered notification process. The notifications are inclusive of specific actions, timeframes and stipulation of who is specifically responsible for actions.

During 2014-15, four safety notices were issued, notifying the system of:

- supply disruption of potassium chloride
- risk of air embolism from the removal of central venous access devices
- supply disruption of Suxamethonium Chloride Injection during March and April 2015
- risk of air embolus with multi-lumen access devices

Patient Safety Watch reports are a further mechanism used by the Clinical Excellence Commission to notify clinicians of issues arising from incident trends, emerging themes and contributing factors identified from RCA reports.

They also contain information on suggested preventative actions and risk minimisation strategies

Two Patient Safety Watch reports - *Delayed Management of Torsion of the Testis*, and *Removal of Central Venous Access Devices* - were released during 2014-15.

Clinical Analytics project reduces unnecessary diagnostic tests

Paper medical records are being replaced with new electronic clinical systems that are capable of providing a wealth of information.

Data from these systems can be transformed into meaningful information, which enables decision support and quality and safety intelligence to be provided to clinicians.

During 2014-15, the Clinical Excellence Commission worked with clinicians from four LHDs on a pilot project, using electronic data to analyse their diagnostic ordering practices.

As part of the project, data dashboards were developed to facilitate the review of ordering practices for pathology and medical imaging.

By the end of the project, a significant reduction in unnecessary diagnostic testing had been achieved.

Arising from this project, a workshop was held in April, to discuss and review appropriate ordering practices.

Over 100 clinicians attended the workshop, providing valuable insights to priority areas to be addressed during 2015-16.

Report encourages re-consideration of surgery in elderly and frail patients

Anaesthesia in Australia is very safe. Its administration however, produces physiological changes that may lead to morbidity and mortality.

During 2014, the Clinical Excellence Commission published the report, *Activities of the Special Committee Investigating Deaths Under Anaesthesia, 2012-2013*, documenting the committee's audit activities and findings during the reporting period.

The report highlighted the increasing age and frailty of patients now undergoing surgery.

Orthopaedic surgery performed on elderly patients contributed the

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majority of cases reviewed by the committee.

The report encourages the community, medical practitioners, the patient and their families to consider what surgery is appropriate.

The estimated mortality of anaesthetic deaths with correctable factors in 2012-13 was 1 in 74,581 procedures.

System-wide review highlights ways to reduce the risk of VTE during hospitalisation

Hospitalisation has been found to be a major risk factor in the development of venous thromboembolism (VTE).

The incidence of VTE among hospitalised patients was found to be more than 100 times greater than the incidence among community residents.

VTE accounts for approximately seven per cent of all deaths in Australian hospitals.

A detailed review of available data was conducted to identify cases of deep vein thrombosis and pulmonary embolism occurring during hospitalisation.

This review was then used to inform the development of a strategy and make appropriate recommendations to improve the assessment and management of patients' risk of VTE.

In April 2015, the Clinical Excellence Commission released the Clinical Focus Report – Hospital Associated Venous Thromboembolism.

The report included recommendations and areas for improvement to reduce the incidence of VTE in NSW Health facilities.

Hospital-associated VTE can be prevented by ensuring all patients are assessed for VTE risk and are given appropriate prophylaxis.

Mortality review provides feedback to surgeons, leading to advances in patient care

The Collaborating Hospitals' Audit of Surgical Mortality (CHASM) Committee is administered by the Clinical Excellence Commission.

It reviews deaths of patients who were under the care of a surgeon, or where a surgeon had major input to care, irrespective of whether or not an operation was performed.

It provides constructive feedback to surgeons and local health districts to facilitate reflective learning and improvement in surgical care.

In 2014, the Clinical Excellence Commission published the summary report of the NSW audit of surgical mortality (CHASM) data for the six-year period, from 1 January 2008 to 31 December 2013.

There were 6083 audited cases that had completed the peer review, either by a first- or second-line assessment.

The report highlighted issues in clinical management, as identified by participating surgeons, and first- and second-line assessors, together with potentially preventable deficiencies of care.

The proportion of audited deaths with potentially preventable deficiencies of care declined from 15 per cent in 2008, to 10 per cent in 2013.

New data indicators support improvement in quality care

Access to timely, meaningful and accurate data is essential for health services to deliver improvements in the quality and safety of health care.

During 2014-15, the Clinical Excellence Commission sought feedback to improve the relevance,

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timeliness and usefulness of data presented in the eChartbook program.

As a result, four new indicators – pressure injury prevention, VTE, and surgical site infections for joints and coronary artery bypass grafts - were developed.

Early indicator data has also been made available to local health districts through the directors of clinical governance, enabling an earlier response to emerging trends.

The eChartbook now has 27 clinical indicators that help health professionals identify and act on opportunities for improving processes and outcomes, and for clinicians to rapidly respond to new trends and developments.

Systems assessment identifies opportunities for better care

Topics reviewed during the 2014 Quality Systems Assessment (QSA) cycle included health care teams, nutrition care, pressure injury prevention and wound management systems.

The QSA uses an online self-assessment followed by an onsite visit process, to support local teams to identify and improve upon clinical risks.

Almost 1800 self-assessment responses were received and more than 250 onsite improvement conversations were shared with groups of clinicians and managers.

There were three Statewide issues identified during the QSA:

- Clinical units indicated key elements of providing quality of care were less available outside “traditional business hours”.
- Clinical units reported having difficulty accessing some types of clinical information, being clear on what parts of the patient's record were in the eMR and what information was in the paper medical record.
- There was variability reported both between, and within organisations, on the implementation of processes to support effective governance of pressure injury prevention.

A formal recommendation relating to nutrition governance and improving nutrition care for patients was also provided, following the 2014 QSA.

The full report on the 2014 Quality Systems Assessment is expected to be released in late 2015.

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