LEARNING

Patient Safety and Quality Improvement

National Standards – Not just a tick in the box!

Awareness training for all staff

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What are the National Standards?

The National Standards are minimum best practice requirements for the safety and care of our patients, community and environment – which are implemented in every Hospital in Australia.

The National Standards provide guidelines and tools on how to implement and monitor safe and quality care in all Australian healthcare services.

We are ALL responsible for implementing the principles of the National Standards.
- Policies / procedures / systems
- Audits
- Risk Management
- Education and Development
- Patient Safety Culture
- Incident and Compliant Management
- Open Disclosure
- The Australian Charter of Healthcare Rights
How do we explain the Australian Charter of Healthcare Rights to our patients?

**Access** - You have a right to health care. You can access services that address your healthcare needs.

**Safety** – You have a right to receive safe and high quality care provided with professional care, skill and competence.

**Respect** – You have a right to be shown respect, dignity and consideration. The care you receive will show respect to you, your culture, beliefs, values and personal characteristics.

**Communication** – You have a right to be informed about services, treatment, options and costs in a timely, clear and open way.

**Participation** – You have a right to be included in decisions and choices about your care and health service planning.

**Privacy** – You have a right to privacy and confidentiality of your personal information. Your personal privacy is maintained and proper handling of your personal health and other information is assured.

**Comment** – You have a right to comment on or complaint about your care and to have your concerns addressed properly and promptly.
How do we achieve Consumer Partnership?

• Support consumers and carers to actively participate in the improvement of the patient experience and patient health outcomes.

• Provide information on the health service organisation’s performance and encourage feedback.

• Consumer input on document development and Committees

Why do we do this?

*Benefits include:* decreased mortality, readmission rates, healthcare acquired infections and length of stay.
What can we do to prevent infection?

- Adhere to all infection control policies, procedures and guidelines
- Educate consumers and carers on the importance of infection control and hand hygiene
- Maintain your immunisation

**5 Moments for HAND HYGIENE**

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

WASH YOUR HANDS
How can we improve medication safety?

• Adhere to guidelines for prescribing, dispensing, supplying, administering, storing and monitoring the effects of medicine.

• Accurately obtain and record a patient’s medication history.

• Inform patients about their options, risks and responsibilities for an agreed medication management plan.

CHECK, THEN CHECK AGAIN
What can we do?

- Use at least 3 approved patient identifiers when providing care, therapy, services or transferring responsibility of care.
- Adhere to all patient identification and procedure match procedures, policies and guidelines.
- Educate consumers and carers on the importance of wearing their ID band and ensuring their details are correct.

What is a patient identifier?

- Patient name (family and given name)
- Date of birth
- Address
- Gender
- Medical Record Number
Information transferred between healthcare providers during handover should:

- Include relevant data
- Be accurate
- Be unambiguous
- Occur in a timely manner

What can we do?

- Adhere to all policies, procedures and guidelines relating to clinical handover.
- Educate consumers and carers on their right to be included in their clinical handover.
**Situation**

- I am (name), (X) nurse on ward (XX). I am calling about (patient X). I am calling because I am concerned that...
  - (e.g. BP is low/high, pulse is XX, temperature is XX, Early Warning Score is XX)

**Background**

- Patient (X) was admitted on (XX date) with (e.g. MInchest infection).
- They have had (XX operation/procedure/investigation).
- Patient (X)’s condition has changed in the last (XX mins).
- Their last set of obs were (XX).
- Patient (X)’s normal condition is...
  - (e.g. alert/drowsy/confused, pain-free)

**Assessment**

- I think the problem is (XX).
- And I have...
  - (e.g. given O₂/analgesia, stopped the infusion).
- OR
  - I am not sure what the problem is but patient (X) is deteriorating.
  - OR
  - I don’t know what’s wrong but I am really worried.

**Recommendation**

- I need you to...
- Come to see the patient in the next (XX mins).
- AND
  - Is there anything I need to do in the mean time? (e.g. stop the fluid/repeat the obs)

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*The SBAR tool originated from the US Navy and was adapted for use in healthcare by Dr M Leonard and colleagues from Kaiser Permanente, Colorado, USA.*
How can we ensure safe administration of blood products?

- Always adhere to policies, procedures and guidelines for receiving, storing, transporting, administering or disposing of blood and blood products.
- Accurately record a patient’s history of blood and blood product transfusion.

Checking for Clerical Errors

- Was the blood transfused to the intended recipient?
- Was the correct unit tagged?
- Was the correct unit issued?
- Was the correct sample used for testing?

“Accuracy in blood transfusion is a life-and-death issue. The slightest error can have huge consequences.”
—GULAM PATEL
How can we prevent pressure injuries?

- Familiarise yourself with assessment and screening tools, skin protection strategies, specialised equipment and risk factors.

- Adhere to policies, procedures and guidelines for the identification, prevention and management of pressure injuries.

- Educate consumers and carers on risks, prevention and management of pressure injuries.
Ryan Saunders was nearly 3 years old when he died in hospital. His death was, in all likelihood, preventable. Ryan’s Rule was created for people concerned about a patient’s condition.

What can we do?

- Always follow procedures for monitoring patients.
- Understand signs and symptoms of deterioration.
  - Utilise processes for notifying of and responding to deterioration.
  - Communicate clinical concerns.
- Educate consumers and carers about Ryan’s Rule.
How can we prevent falls?

- Be aware of your environment and any hazards.
- Screen patients for risk of falls when applicable.
- Educate consumers and carers on the risk of falls and prevention strategies.
What do we need to know?

- We must provide the community with information on health services appropriate to their needs.
  - We must provide the community with access to services prioritised according to their healthcare needs.
- Consumers must be informed of the consent process, understand this process and provide consent for their health care.
- Health care services must be evaluated to ensure that they are appropriate and effective.
- We must meet the needs of consumers and carers with diverse needs and from diverse backgrounds.
- We must promote better health and wellbeing to consumers, staff, carers and the wider community.
What do we need to know?

- We must implement **assessment and care planning** to ensure the current and ongoing needs of the consumer are identified.

- We must ensure that the **nutritional needs** of the consumer are met.

- We must implement systems for the coordination of ongoing care and **discharge or transfer** of consumers to effectively meet their needs.

- We must manage the care of **dying and deceased patients** with dignity and comfort and provide support to their families and carers.
What do we need to know?

- We must each ensure that our **skill mix and competencies** are current to meet the needs of the organisation and to provide quality safe patient care.

- **Workforce planning** must support the organisation’s current and future ability to address needs.

- The **recruitment** process must meet the needs of the organisation.

- **Employee support systems and workplace relations** assist the organisation to achieve its goals.
What do we need to know?

• We must ensure that we accurately update, analyse and track all health records.

• Adhere to all confidentiality, record keeping and data entry policies, procedures and guidelines.

• Adhere to all information, communication and technology policies and procedures and guidelines.
Standard 15 relates to the organisation’s requirements to:

- Implement **strategic and operational plans**
- Implement **formal structures and delegation** practices
- Manage **external service providers**
- Manage **research governance**
- Manage **safety management systems**
- Manage **buildings, plant and equipment**

*Familiarise yourself with, and always adhere to, guidelines regarding:*

- **Emergency management** procedures (fire, evacuation)
- **Physical and personal security** procedures (code black)
- **Waste and environmental management** procedures
Patient Safety: Clinical Incidents

- A ‘clinical incident’ is any event or circumstance which has actually, or could potentially, lead to unintended and/or unnecessary mental or physical harm to a patient.
- A clinical incident is not necessarily a mistake or an error.
- Some clinical incidents occur simply due to chance – for example, a previously completely unknown allergy to a medication.
- Staff to report all clinical incidents, not just those that they believe are due to error.
Reporting System: PRIME CI

Start PRIME Application
PRIME is used to report clinical incidents and consumer feedback. If this incident report also involves concerns about staff injury; the conduct or competence of a colleague(s), other reporting obligations exist.

Click here to access further information.
Start PRIME Application
Click on the button to report a clinical incident.
You do not need to enter a username and password.
Click on Report Incident to report a new incident.
Options for the Patient Outcome Field

Based on the Patient Outcome field, the system will automatically allocate a SAC rating (Severity Assessment Code).

**SAC 1**
- Death
- **Likely permanent harm**
  (ie where full recovery is not expected, includes physical and psychological harm.)

**SAC 2**
- **Temporary harm**
  (ie full recovery is expected over a period of time, this includes physical and psychological harm.)

**SAC 3**
- **Minimal harm**
  (No long term physical effect to patient, eg first aid provided. Short term pain, distress)
- **No harm**
Summary

- Follow the yellow brick road (mandatory fields are highlighted in yellow)

- Report a clinical incident or near miss as soon as possible

- If in doubt ask your Line Manager or Quality Facilitator/Quality & Safety Coordinator
Consumer Feedback

- Consumer feedback is extremely valuable in the provision of safe, quality healthcare.

- It provides us with an opportunity to identify areas for improvement and recognise areas of achievement with the ultimate aim of enhancing the safety and quality of health care provided by CISS.
Consumer Feedback

- The information provided to us will be used to improve the experience of all clients, visitors and carers now and into the future.

- Consumers are encouraged to:
  - Register concerns and have them investigated fairly.
  - Convey appreciation to staff and advise CISS of any aspects of care and treatment found to be of an exceptional standard.
  - Receive confidential advice and resolution for concerns.
  - Obtain information regarding health complaint services and options.

- [MNHHS Policy: Consumer Feedback, Compliments and Complaints](#)
PRIME CF

- PRIME CF provides Queensland Health with a tool to collect, classify, analyse and learn from consumer feedback (compliments, complaints and comments).
- System access (i.e. user name and password) is required for all staff who will be reporting compliments/complaints in Prime CF.
- In CISS this is usually limited to AOs and Line Managers
- Access for Administration staff is limited to Feedback Recorder
- For access contact Heather Ronay 3049 1235 with your Novell Login details.
What do I need to remember …..

1. Standards are everyone’s business

2. Quality care is not an option

3. Quality care is efficient care

4. Where to find more info ..
Where can I find more information?
Contact details - Safety and Quality

RBWH
Phone: 3646 8893

Redcliffe
Phone: 3883 7554

TPCH
Phone: 3139 5052

Caboolture & Kilcoy
Phone: 3049 6747

Community, Indigenous Sub acute Service (CISS) – Phone: 3631 7660

www.safetyandquality.gov.au
National Safety and Quality Health Service Standards

Not just a tick in the box!

*It's building a culture so "safety is how we do business".*
Any questions?