

## Coronial Liaison - Ropivacaine Cluster

Ropivacaine (Naropin) is a long acting local anaesthetic chemically homologous and similar to bupivacaine. It was introduced into Australian clinical practice in the early nineties and marketed as a safer alternative (less central nervous system and cardiac toxicity) to bupivacaine. Its uptake has been high in Western Australia and appears to have been introduced successfully.

The Office of the State Coroner recently alerted the Coronial Liaison Team within the Office of Safety and Quality in Healthcare that a possible case of ropivacaine toxicity may have been identified. He commented on two previous cases reported to his Office in 2004 and 2005 where the deaths were potentially related to ropivacaine.

Concern for patient safety prompted the Coronial Liaison Team to investigate whether this was a cluster of cases, which would indicate widespread, unrecognized or undisclosed cases of ropivacaine toxicity. This investigation involved collection of information from clinicians and Coronial Services in WA and interstate.

The results of the investigation show that there is NO reliable evidence to demonstrate widespread unrecognized or undisclosed cases of ropivacaine toxicity in WA. However, given the circumstances surrounding the death of previous cases, there are some important recommendations for hospitals with respect to ropivacaine and local anaesthetics:

1. limit the ropivacaine dose to 0.4mg/kg/hr in sites where systemic absorption is high or clearance may be compromised;
2. establish a system for recording dosage and use of local anaesthesia by surgeons during operative procedures; and
3. wherever large doses of local anaesthetics are used there should be access to advanced resuscitation facilities and skills.

## Root Cause Analysis (RCA) Training Dates 2007

12 June (FULL)

11 September

27 November

All courses are held at the Department of Health  
189 Royal Street, East Perth  
8.30am to 4.00pm

Email Lauren Elliott at [lauren.elliott@health.wa.gov.au](mailto:lauren.elliott@health.wa.gov.au) to book your place!

## Handover/Handoff - Issues of Communication: What's Happening?

The December 2006 issue of The Sentinel highlighted contributing factors to hospital process issues. Communication, transfer and access to information relating to patient care were frequently identified as the root causes in these sentinel events. Such issues are not unique to WA but are demanding international attention.

The World Health Organisation (WHO) Patient Safety Alliance High Five Initiative involves developing international solutions to Clinical Handover. The Australian Commission on Safety and Quality in Health Care is the lead agency for Australian participation in the WHO initiative. For more information on the WHO initiative contact Anabelle May at the Office of Safety and Quality in Healthcare (OSQH) on 92224017.

At a national level, a Patient Safety Seminar focussing on Clinical Handover was held in Brisbane in February 2007. The presentations given at the seminar can be found at [www.crepatientsafety.org.au/seminars/clinical-handover/](http://www.crepatientsafety.org.au/seminars/clinical-handover/) It was generally agreed that handover and communication required solutions and that work needed to commence locally.

Western Australia has recognised this need for some time and has several innovative projects aimed at improving communication across the care continuum. More recently the OSQH commissioned health professionals to develop a Clinical Handover Policy Framework for WA. A Clinical Handover Statewide Working Group has been established to guide this development.

For more information please contact Sam Perryman at Royal Perth Hospital on 9224 2590.

Did you miss the last edition of SNIPTs? All past editions are available on the OSQH website. Visit [www.safetyandquality.health.wa.gov.au](http://www.safetyandquality.health.wa.gov.au) and click on the SNIPTs link under News and Events.

HPF0323 MAY'07 Z2150



Autumn Edition

May 2007

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# SNIPTs

Sharing News In Patient Safety



Delivering a Healthy WA

## Professor John Ovretveit Visits Perth

Professor John Ovretveit from the Karolinska Institute in Stockholm visited Perth in March 2007 to talk about implementing change in health care.

Professor Ovretveit is the Director of Research at the Institute's Medical Management Centre. He is also Professor of Health Policy and Management at the Nordic School of Public Health, Gothenberg in Sweden and at Bergen University Medical School in Norway.

During his two-week visit, the Professor provided an intellectual forum through a series of workshops, presentations and debates on the critical need to consider evidence in implementation of change in health care.



ABOVE: Professor John Ovretveit at the Third Annual Incident Reporting and Management Seminar on 2 March 2007.

*"Systems awareness and systems design are important for health professionals, but are not enough. They are enabling mechanisms only. It is the ethical dimension of individuals that is essential to a system's success."*  
Avedis Donabedian

As much as Donabedian defined the nature of modern health care provision as a system in his life's work, he believed in the critical role of individuals that define the quality of care provided to society and performance of our health care system as a whole.

Some key messages from Professor Ovretveit's visit include the challenge of ensuring quality and safety of care, balanced against the rising cost of care and demand for more services.

As we seek to achieve a fundamental shift in how we provide care into the future, Professor Ovretveit's visit has provided an informed debate into aligning the social case for quality and safety with both the economics of health care and the business case for service improvement.

The Western Australian health care system is informed by a robust incident reporting and management environment and Professor Ovretveit provided the keynote address for Western Australia's Third Annual Incident Reporting and Management Seminar on 2nd March 2007.

This year's symposium brought together our community of practitioners from across the system committed to embedding what we know to be excellent clinical governance practice into our State.

## Patient Safety Award Winners 2007

### And the winners are...

The annual Patient Safety Awards are awarded to health care professionals who have demonstrated excellence in their dedication to patient safety.

This year, seven individuals have been formally recognised for their outstanding personal contribution, innovation or leadership in improving patient safety.

Professor Bryant Stokes presented the winners with a certificate and trophy in front of 150 of their peers at the Third Annual Incident Management and Reporting Seminar on Friday 2nd March 2007.

**Congratulations to all winners!**

The Patient Safety Awards provide an excellent opportunity to have your peers' hard work recognised. We encourage nominations from both the private and public health sectors.

Nominations for 2008 can be emailed to Lauren Elliott at [lauren.elliott@health.wa.gov.au](mailto:lauren.elliott@health.wa.gov.au)



*Leadership In Clinical Governance*  
Del McGuiness, KEMH and PMH



*Individual Contribution to Patient Safety*  
Deborah Wilson, SCGH



*Innovation in Patient Safety*  
Dr Gavin Leslie and Noreen McLaughlin



*System Improvement*  
Dr Tony Taylor, Armadale HS



*Individual Contribution to Patient Safety*  
Richard Johnson accepting on behalf of Vivienne Why, Osborne Park



*Individual Contribution to Patient Safety*  
Jodie Fiume, SJOG Geraldton

## Borrowed Scope Equipment Leads to Cross-Contamination Risk

A Western Australian hospital recently identified a risk of cross-contamination when using borrowed scope equipment.

One patient was potentially exposed to blood-borne viruses after a borrowed scope was incorrectly identified as having three channels instead of four.

This additional fourth channel was not identified until after the scope had been used on two patients. This revealed a cross-contamination risk, as only three of the four channels had been cleaned between patients.

The first patient was screened following disclosure of the incident and was found to be free of any blood-borne viruses.

To prevent this risk occurring in the future, a Root Cause Analysis was conducted and determined that the process for receipt of borrowed goods needed to be improved.

All scope equipment is now checked for the number of channels and cleaned at the point of receipt prior to use, rather than accepting the certificate provided by the previous facility.

Members of staff now receive ongoing education about all models of scope equipment that are available from the supplying company, not solely the hospital's current models. The hospital's Quality Improvement Committee monitors these new processes.

This type of incident reminds us that raised awareness and review of our own policies and practices regarding scope equipment can reduce the risk of cross-contamination.

## Every Patient... Every Time

In its continued commitment to safety and quality in health care in Western Australia, the Department of Health has launched a three-year \$24 million Safety and Quality Investment for Reform (SQuIRe) Program.

Established in July 2006, the SQuIRe Program builds on previous clinical governance initiatives and is designed to facilitate the delivery of safe, high quality, evidence-based health care to patients and the community.

The Clinical Practice Improvement (CPI) Program within SQuIRe consists of eight evidence-based interventions that were selected on the basis that they are patient safety priorities in WA and that proven successful interventions exist.

The CPI Program focuses on how hospitals improve patient care, rather than what they achieve. The program reminds clinicians to conduct safe practices for every patient, every time.

Based on proven change management techniques, such as the Institute for Healthcare Improvement's 'Model for Improvement,' the CPI Program requires hospitals to set measurable objectives, make incremental changes, monitor their progress frequently and provide timely feedback to project teams in a flexible reporting environment.

Each CPI intervention will be undertaken by multidisciplinary clinical teams, that will be supported by the Office of Safety and Quality in Healthcare and a network of clinical experts responsible for providing clinical and technical support to the project teams.

For more information about the SQuIRe Program, please visit the SQuIRe website: [www.safetyandquality.health.wa.gov.au/squire](http://www.safetyandquality.health.wa.gov.au/squire), or contact your Area Health Service Clinical Governance Network representative.

## An Anticoagulant Medication Chart for WA

### Background

The high-risk nature of treatment with anticoagulants in WA is evidenced by the finding that:

- heparin and warfarin are ranked 7th and 8th respectively in medicines most frequently involved in incidents reported through the Advanced Incident Management System (AIMS); and
- anticoagulants are the most common drug group associated with an Adverse Drug Reaction-related hospital admission in WA.

The WA Medication Safety Group (WAMSG) convened an expert working group to improve the safety of anticoagulant use. This has led the working group to develop a standard Anticoagulation Medication Chart for use in Western Australian public hospitals.

The chart addresses each of the steps in the medication management cycle often associated with medication

errors and impacts the clinical practice of doctors, pharmacists and nurses.

### Features of the Anticoagulant Chart

- Prescribing
  - decision support to assist in making appropriate treatment decisions;
  - standardisation of some aspects of the prescription; and
  - provision for documenting the warfarin treatment plan.
- Administration
  - standard time for warfarin administration.
- Monitoring
  - recording of test results at the point of prescription.
- Discharge planning
  - check list for education completed; and
  - communicating the treatment plan.

## Area Health Service Clinical Governance Network

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### Where to from here?

The chart is currently in the pilot phase with roll-out across the state expected within the next 12 months. For further information contact the Project Coordinator of the WAMSG on 9431 3168 or email [wamsg@health.wa.gov.au](mailto:wamsg@health.wa.gov.au)

## Medication Safety: Reconciling the Difference

3rd Annual Medication Safety Symposium

Thursday June 14th 2007

9am - 4pm

University Club, UWA, Nedlands

Register at  
[wamsg@health.wa.gov.au](mailto:wamsg@health.wa.gov.au)

For further information on the symposium or medication chart, please contact Dr Margherita Veroni on 9431 3168