



## What would you do?

It is business as usual on a shift in an orthopaedic ward. A 90 year old woman recovering from surgery that pinned her fractured neck of femur is walking with her Zimmer frame to the shower, accompanied by her nurse who stands by to help if needed. When they reach the shower they discover the commode chair has been removed.

What would you do – walk the old woman back to her bed, then get another chair and start again? Or do you make a quick assessment (mindful of her years and condition and the other patients waiting) and decide that she is able to lean on the frame for just a moment or two while you get that chair, just over there against that wall, and put it in the shower?

A nurse who made the latter decision has recently had to justify her decision before a coroner's court, 3 years after the event. Her patient fell when she turned her back to get the chair, suffered an intracranial haemorrhage and died 10 days later.

The nurse was not found culpable, but her whole experience, the death of her patient and having to face a legal inquisition to justify her actions, must have been devastating.

The question is "How many nurses in a similar situation would have made the

same decision?". Faced with a large number of competing demands (the needs and condition of this patient, the needs of the other patients still waiting for care, assisting one's colleagues...) what would you have done?

Healthcare is a complex ever changing environment. Those working in it routinely make complex judgements many times a day. It is because we do it routinely that we do not see it as such.

But it is in these innocuous everyday decisions that the danger lies. "... in many healthcare activities serious harm is but a few unguarded moments away"<sup>1</sup>.

In the task-driven rush of doing all that needs to be done, be mindful of the "unguarded moment" lest, in the words of Phil Ochs' song, "There but for fortune go you, go I ...".

Managers need to be sympathetic towards the split-second decisions that their staff are required to make every day and give their wholehearted support when things go tragically, unintentionally wrong.

<sup>1</sup> J Reason, Beyond the organisational accident: the need for error wisdom on the frontline. Qual. Saf. Healthcare, 2004, 13 (Supplement II) ii28–ii33.

## Putting Clinical Governance into Action

It is clear that clinical incident reporting via AIMS is now deeply embedded and well established in the WA health system. A recent evaluation done by the Office showed that most clinical staff, especially nurses, know about AIMS, use and report to it and believe that it improves patient safety.

This is excellent and reassuring news and signals a major achievement, but it is not the whole story. If data drives clinical response and improvement behaviours in our hospitals and health services, then we need to make sure that the clinical risks identified by nurses and doctors are reported, managed and treated in a clear and agreed manner.

Evidence from safety management experience in aviation and other health systems around the world, shows that the most benefit to improving patient outcomes will lie in the use of data and subsequent feedback to those who can fix the problems at the patient bedside.

Clinical governance must drive clinical actions. Identifying clinical hazards, reporting clinical incidents and adverse events and managing the clinical risks that emerge are all essential actions. By constantly managing identified clinical risks we will further improve patient safety in our hospitals and health services.

*Dr Dorothy Jones,*

*Office of Safety & Quality in Health Care.*



## CONGRATULATIONS TO THE 2005 PATIENT SAFETY AWARD WINNERS!

Presented by Neale Fong at the 2nd Incident Reporting and Management Seminar on 16th September...

### Team Awards:

**Armadale Health Service Management Team**, Armadale Hospital, South Metropolitan Area Health Service. *For establishing and promoting a positive team environment to improve patient safety*

**Department of Anaesthesia and Pain Medicine**, Royal Perth Hospital, North Metropolitan Area Health Service & **WA Centre for Remote and Rural Medicine**. *Partnership in simulator training for GPs across rural WA leading to improved management of patients.*

**Department of Anaesthesia and Pain Medicine**, Royal Perth Hospital, North Metropolitan Area Health Service. *Improving management of patients with airway emergencies.*

**King Edward Memorial Hospital Medical Advisory Committee**, Women's and Children's Health Service, Clinical Leadership and Clinical Improvement following the Douglas Inquiry.

### Individual Awards:

**Stephen Lim**, Armadale Hospital, South Metropolitan Area Health Service. *For initiatives to improve safe medication management.*

**Pam Suermondt**, King Edward Memorial Hospital, Women's and Children's Health Service. *For quality improvement initiatives in specimen handling.*

### System Awards:

**Ellen Baker and David Blacker**, Sir Charles Gairdner Hospital, North Metropolitan Area Health Service. *Code Stroke Team initiative, resulting in improved care of stroke patients in the ED.*

**Acute Assessment Unit**, Sir Charles Gairdner Hospital, North Metropolitan Area Health Service. *For system improvements in the management of acute care patients.*

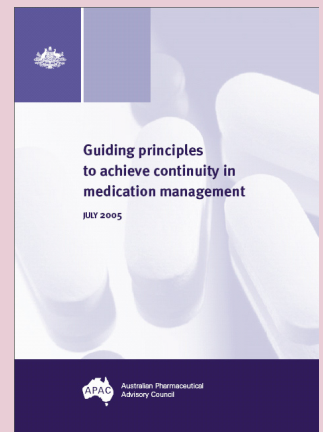
**LOOK FOR THE AWARD WINNERS PHOTOS IN OUR NEXT EDITION!**

## Just Released!

The APAC guiding principles to achieve continuity in medication management have just been released. The Guiding Principles are intended to guide partners in the quality use of medicines in achieving continuity in medication management. They offer a systems approach to medication management: advocating a consistent and standard approach across all health care settings and health care providers. The audience for the Guiding Principles includes government, health care professionals and providers, consumers and/or their carers, and others.

The Report can be downloaded from:

[http://www.health.gov.au/internet/wcms/publishing.nsf/Content/nmp-guiding/\\$FILE/guiding.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/Content/nmp-guiding/$FILE/guiding.pdf)



### Contact SNIPT'S

If you wish to subscribe to the SNIPT'S newsletter, or wish to submit an article for publication, please contact:

Marece Bentley, 9222 0294 or [safetyandquality@health.wa.gov.au](mailto:safetyandquality@health.wa.gov.au)

### Photo Competition: best photo of

## !HAZARDS!

Use a digital camera to improve patient safety...

Got a great photo?

Seen a hazard worth reporting?

Take a photo and send it to your manager and to us:

[safetyandquality@health.wa.gov.au](mailto:safetyandquality@health.wa.gov.au) or  
[Marece.Bentley@health.wa.gov.au](mailto:Marece.Bentley@health.wa.gov.au)

There will be a prize for the best photo published!

# Check your doses!—IM Bicillin L-A for rheumatic fever

The Visiting Nurse Service at PMH is a Paediatric Community Nursing service. The staff have been administering intramuscular Bicillin L-A for prophylaxis of rheumatic fever in the domiciliary setting for several years. This is usually prescribed as 1.2 megaunits or 900 milligrams every four weeks.

Until 18 months ago, the Bicillin L-A came in a manufactured, prefilled syringe containing 2.4 megaunits (1.8 grams). This information was on the syringe and in the accompanying manufacturers literature. The

Bicillin was decanted to a 2ml syringe by the Visiting Nurse and a 21g needle attached before administration. The Bicillin L-A now comes from the manufacturer in the correct dose (900 mg), which is written on the syringe. The dosage of 1.2 megaunits is written in the accompanying literature

In July 2005, an experienced relieving nurse was working a weekend shift and inadvertently gave 1.2 grams as the medication chart did not state 900 mgs.

Since this incident, all medication

charts have been rewritten with the dosage 900 mgs instead of 1.2 megaunits to minimise drug error.

Anne Finley, Nurse Manager for Visiting Nurses, PMH.



Sharing lessons learned is extremely valuable to all those who work in clinical settings. If you know of anything implemented in your workplace as a result of incident reporting, please let us know and we will publish your lessons learned.

**Please contact Marece Bentley: 9222 0294.**

## Managing the risks of lifting in an Area Health Service—“Manutention”

The NMAHS supports a “minimal lift” approach, whereby all manual handling is to be evaluated and modified wherever practicable, to eliminate or reduce the need for manual lifting.

The ‘Safer Manual Handling Programme’ offers regular scheduled generic sessions in the area of Loads and Patient Handling for all new staff, delivered at orientation. It also provides annual refreshers and competency based updates for both clinical and non-clinical staff across all sites and services. Two day Manual Handling Assessor Training courses are offered to suitable staff in the areas of Patient, Theatre and Load handling, to assist with annual workplace competency assessments. Individual manual handling re-training after injury or as part of a return to work programme, as well as needs based training and problem solving specific clinical situations are offered.

Initiatives such as a hospital wide purchase of electric beds, hoists, slings, slide sheets and equipment

for the heavy client, supported the ‘Safer Manual Handling Programme’, as did the clear communication of non-recommended patient transfer techniques. The introduction and training of Manual Handling Assessors attached to each Ward / Departmental area improved the profile of safe manual handling and facilitated compliance with refresher training and workplace competency assessments.

Based on the Manutention Method, the training approach emphasises prior assessment of the environment and consideration of safety issues, normal movement patterns (Patient Handling), practical skills acquisition and incorporates the use of appropriate equipment.

The flexible approach facilitates the design of task specific tailored manual handling training sessions for all staff in all areas.

Participants are issued with a statement of attainment upon request, which is valid for 12 months. All recorded training activities and

materials are stored in compliance with Registered Training Organisation standards.

OSH statistics show a steady decline of injury rates and lost time injuries since the inception of the programme, which achieved an EA rating by the ACHS in June 2005.

The vision of the Manual Handling Education Programme of the NMAHS West is to collaborate with other Public Health service sites in the Perth Metropolitan Area to achieve a supportive, uniform, yet flexible model for the delivery of manual handling training for all staff in all areas of work.

All enquiries are welcome.

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