Acknowledgements

The Safety and Quality Branch in the Department for Health and Ageing would like to give special thanks to all individuals and groups who have contributed to the development of this report.

This report would not be possible without the commitment of all staff working in the South Australian health care system and their contribution to the incident management process and improving patient safety.
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<td>Contributing factors</td>
<td>Any factor(s) which helped to bring about the incident or that influenced the occurrence.</td>
</tr>
<tr>
<td>Incident</td>
<td>Any event or circumstance that resulted, or could have resulted, in unintended and / or unnecessary harm to a person and / or a complaint, loss or damage.</td>
</tr>
<tr>
<td>ISBAR</td>
<td>The mnemonic for a standardised approach to clinical handover (Identify, Situation, Background, Assessment, Recommendation).</td>
</tr>
<tr>
<td>Open disclosure</td>
<td>The process of providing an open, consistent approach to communicating with consumers and their carer / support person following an incident.</td>
</tr>
<tr>
<td>Principal incident type</td>
<td>The incident type that caused the most harm to, or had the most significant effect on, the subject of the incident.</td>
</tr>
<tr>
<td>Root Cause Analysis (RCA)</td>
<td>A method of investigating an incident and 'drilling down' to assist in the identification of health care system deficiencies that may not be immediately apparent, but which may have contributed to the occurrence of the adverse incident or close call (root cause).</td>
</tr>
<tr>
<td>Safety Assessment Code score (SAC)</td>
<td>A numerical score applied to an incident, based on the type of event, its prevalence and its consequence. The score is determined by the use of the SAC Matrix and guides the level of incident investigation or review that is undertaken.</td>
</tr>
<tr>
<td>Safety Learning System (SLS)</td>
<td>An electronic system for the reporting and management of incidents and consumer feedback across SA Health.</td>
</tr>
<tr>
<td>Sentinel event</td>
<td>A small but significant number of adverse events that may lead to serious patient harm or signal a serious system failure.</td>
</tr>
<tr>
<td>TeamSTEPPS®</td>
<td>An evidence-based teamwork training system developed by the US Department of Defense Patient Safety Program in collaboration with the Agency for Health Care Research and Quality (AHRQ). It has four teamwork competencies comprising of leadership, situation monitoring, mutual support and communication that characterises effective communication and teamwork.</td>
</tr>
</tbody>
</table>
Executive summary

This is the eighth Patient Safety Report to be released since 2004. It builds on last year’s report and has been structured around the ten National Safety and Quality Health Service (NSQHS) Standards\(^1\). The report demonstrates the continued systematic improvement across SA Health in a number of Safety and Quality programs.

SA Health is committed to creating and maintaining a sustainable quality environment which provides services that are consumer centred, driven by information and organised by safety\(^2\), by ensuring that:

- patients can get care when they need it
- health care staff respect and respond to patient choices, needs and values
- partnerships are formed between patients, their family, carers and health care providers
- up to date knowledge and evidence is used to guide decisions about care
- safety and quality data is collected, analysed and fed back for improvement
- action is taken to improve patients’ experience
- safety is made a central feature of how health care facilities are run, how staff work and how funding is organised.

Highlights include:

- Reduction in overall harm (actual SAC 1 and SAC 2) from 2.8% in 2011-12, to 1.7% in 2012-13, and a further reduction to 1.3% in 2013-14. In particular, improvement has been seen in the number and proportion of injuries caused by falling in hospitals from 2.8% in 2011-12, to 2.1% in 2012-13, and a further improvement to 1.5% in 2013-14.
- 100% of public health services assessed against the National Safety and Quality Health Service Standards were awarded Accreditation.
- Increased hand hygiene compliance – rate in June 2014 was 80.1% above both the National (70%) and state targets (75%).
- The Aseptic technique e-learning module was developed and released in September 2013 to promote the principles and application of aseptic technique in clinical practice. Over 8118 staff have completed this online course by 30 June 2014.
- Red cell wastage 2.3% - well below national average of 5.3%
- Measuring a consumer’s experience continued in 2013-14 with 2427 consumers being interviewed. Nearly 88% of patients rated the overall quality of service as ‘very good’ or ‘good’, and 90% said they would recommend the hospital to a relative or friend.
- Measuring Consumer Experience Survey identified the following domains of care that achieved greater than the state benchmark of 85.
  - Treated with respect and dignity – 92
  - Doctors – 88.2
  - Nurses – 89.7
  - Cleanliness – 90.4
  - Pain control – 90.1
  - Privacy – 94.7

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\(^1\) National Safety and Quality Health Service Standards, Australian Commission on Safety and Quality in Health Care, 2012  
\(^2\) Australian Commission on Safety and Quality for Health Care, Australian Safety and Quality Framework 2010.
Governance for Safety and Quality in health service organisations
Health service organisation leaders are required to implement governance systems to set, monitor and improve the performance of the organisation and communicate the importance of the patient experience and quality healthcare management to all members of the workforce.³

National Safety and Quality Health Service Standard 1 – Governance for Safety and Quality in health service organisations outlines the broad criteria needed to achieve the integrated governance system which is essential in order to maintain and improve the reliability and quality of patient care, and improve patient outcomes and includes:

- governance and quality improvement systems
- clinical practice
- performance and skills management
- incident and complaint management
- patient rights and engagement.

1.1 Governance and quality improvement systems

1.1.1 Policy framework

In 2013-14 work has continued to ensure a robust policy framework is available to support the National Safety and Quality Health Care Standards. The policies, guidelines and toolkits that form part of the framework are readily available on the Safety and Quality section of the SA Health website [www.sahealth.sa.gov.au/safetyandquality](http://www.sahealth.sa.gov.au/safetyandquality). Further information about policy development related to specific standards is available in the relevant sections of this report.

1.1.2 Governance for safety and quality in health service organisations accreditation resource

Item 1: Standard 1 Governance for Safety and Quality in health service organisations Accreditation Resource

The [SA Health Governance for Safety in health service organisations accreditation resource guide](http://www.sahealth.sa.gov.au/safetyandquality) was developed to support health services and provides examples of South Australian tools and resources that can be used to demonstrate an action and standard has been met.

The accreditation resource guide is available on the Safety and Quality section of the SA Health website [National Safety and Quality Health Service Standards page](http://www.sahealth.sa.gov.au/safetyandquality).

³ National Safety and Quality Health Service Standards (September 2012), Australian Commission on Safety and Quality in Health Care (ACSQHC)
1. Governance for Safety and Quality in health service organisations

1.1.4 Governance for Safety and Quality: lessons from Mid Staffordshire

In October 2013, the Australian Commission on Safety and Quality in Health Care (ACSQHC), in conjunction with SA Health and SA Council for Safety and Quality in Health Care, and supported by WA Health and the Department of Health and Human Services, Tasmania invited Mr Robert Francis, QC, Chair Mid Staffordshire NHS Foundation Trust Public Inquiry as a guest speaker in Adelaide.

The Governance for Safety and Quality: Lessons from Mid Staffordshire event brought together senior government and clinical leaders to consider lessons from Mid Staffordshire and discuss implications for Australia.

The keynote speaker Mr Robert Francis, QC then joined a panel of distinguished speakers from the Australian healthcare system and consumers to discuss lessons for safety and quality governance in Australia.

The event was held at the Crowne Plaza with 120 delegates attending on the day including senior managers and clinicians from the public and private health sector and consumers.

A live streaming of the event was webcast with 102 intra and interstate registrants participating at the time, and 249 participants viewed the webcast ‘on demand’ post event.

Overall, 471 senior clinicians and consumers across Australia participated in the Governance for Safety and Quality: Lessons from Mid Staffordshire event.

The webcast is available on the SA Health Safety and Quality website Governance for Safety & Quality: Lessons from Mid Staffordshire page at www.sahealth.sa.gov.au/safetyandquality

Picture 1: Governance for Safety and Quality: Lessons from Mid Staffordshire event webcast
1.1.5 Accreditation

SA Health recognises accreditation as an important driver for safety and quality improvement. Through a process of regular assessment and review, accreditation tests that systems are in place and working effectively to promote and support safe patient care and continuous quality improvement.

From 1 January 2013 mandatory accreditation of health services fell under the Australian Health Service Safety and Quality Accreditation (AHSSQA) Scheme. Within this scheme services are accredited against the National Safety and Quality Health Service Standards (NSQHSS).

Table 1: National Safety and Quality Health Service Standards

- Standard 1 – Governance for Safety and Quality in health service organisations
- Standard 2 – Partnering with Consumers
- Standard 3 – Preventing and controlling healthcare associated infections
- Standard 4 – Medication safety
- Standard 5 – Patient Identification and Procedure Matching
- Standard 6 – Clinical Handover
- Standard 7 – Blood and Blood products
- Standard 8 – Preventing and Managing Pressure Injuries
- Standard 9 – Recognising and Responding to Clinical Deterioration in Acute Health Care
- Standard 10 – Preventing Falls and Harm from Falls

Overarching standards:

- National Standard 1 – Governance for Safety and Quality in health service organisations
- National Standard 2 – Partnering with Consumers

Clinical standards:

National Standards 3 to 10 are clinical standards selected because they address areas where:

- the impact of poor safety and quality of care is across a large patient population
- there is known gap between existing delivery of care and best practice
- improvement strategies exist that are evidence based and achievable
- expectation from the community that standards exist to protect the public.
1. Governance for Safety and Quality in health service organisations

1.1.5.1 Accreditation outcomes
From January 2013 to June 2014, 79 public health services were assessed to the National Safety and Quality Health Service Standards.

> 72 hospitals (including mental health services)
> SA Dental Service
> Drug and Alcohol Services SA

Of those;
> 51 were assessed to Standards 1, 2 and 3 (65%)
> 28 were assessed to Standards 1 to 10 (35%)

Approximately 46% of public health services met all core actions at initial assessment, with 96 recommendations.

1.1.5.2 National and state comparison against the NSQHS Standards
The external accrediting agencies use a three-point rating scale to assess a hospital against the NSQHS Standards. These ratings are:

> Not met: The actions required have not been achieved.
> Satisfactorily met: The actions have been achieved.
> Met with merit: In addition the actions required, measures of good quality and a higher level achievement are evident. There is a culture of safety, evaluation and improvement throughout the organisation in relation to action or standard under review.

Graph 1 demonstrates the core actions where improvements were needed before accreditation was awarded by NSQHS Standard at a national level compared to graph 2 at a state level.

SA Health Standards 1, 3, 4, 6, 7, 8, 9 and 10 have all performed well against the national core actions. Further work and improvements in relation to Standard 2 Partnering with Consumers and Standard 5 Patient Identification and procedure matching, will be a focus in 2014-15.

Graph 1: National level of core actions where improvements were needed before accreditation was awarded by NSQHS Standard

Source: Australian Commission on Safety and Quality in Health Care, 2014
Graph 2: SA Health core actions where improvements were needed before accreditation was awarded by NSQHS Standard

Percentage of core actions assessed as 'not met' on initial assessment

<table>
<thead>
<tr>
<th>NSQHS Standard</th>
<th>Std 1</th>
<th>Std 2</th>
<th>Std 3</th>
<th>Std 4</th>
<th>Std 5</th>
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<td>Std 1</td>
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<td>Std 3</td>
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1.1.6 Safety and Quality education framework (e-learning modules)

SA Health is committed to ensuring a safe, high quality, accessible health care system for all South Australians. The Safety and Quality Branch works in partnership with health services and consumers to improve patient safety and quality of care.

Online courses have been developed to support a number of training actions within the ten national safety and quality health service standards, and providing access to this education and training is a core responsibility of health care organisations.

From September 2013, the following online courses were available:

> Aseptic technique
> Clinical handover
> Falls prevention
> Labelling for safety – injectable medicines, fluids and lines.

1.1.6.1 Aseptic technique e-learning module

The Aseptic technique e-learning module promotes the principles and application of aseptic technique in clinical practice. It is intended for multidisciplinary clinical staff that perform any procedures requiring aseptic technique.

Picture 2: Aseptic technique e-learning module
1.1.6.2 Clinical Handover

The Clinical Handover e-learning module promotes best practice clinical handover and will provide a basis for staff to adapt clinical handover processes to meet specific needs and clinical context.

The course is intended for clinical staff involved in direct and indirect patient care but is also valuable for staff that support clinicians in clinical handover, for example ward clerks.

The Clinical Handover module enables staff to:

> gain an understanding of the principles and processes with clinical handover best practice
> gain an understanding of the application of ISBAR* as a communication tool, used in the clinical handover process
> appreciate the importance of and the challenges involved with clinical handover best practice.

*ISBAR: The mnemonic for a standardised approach to clinical handover (Identify, Situation, Background, Assessment, Recommendation).

Picture 3: Clinical Handover e-learning module
1.1.6.3 Falls Prevention e-learning module

The Falls Prevention e-learning module enables staff to recognise the importance of preventing falls and harm from falls;

- identify common risk factors
- high risk situations and conditions
- identify appropriate multifactorial actions
- take action following a fall incident; and
- identify actions to engage consumers and carers.

This course assists in the translation of the national guidelines into practice, and to meet accreditation requirements. This course is for all staff involved in direct care, and includes additional resource materials for Falls Prevention Leaders and others to use as a reference.

Picture 4: Falls prevention e-learning module
1.1.6.4 Labelling for safety e-learning module

The Labelling for safety e-learning module promotes the principles and application of safe labelling of medicines in clinical practice. It complies with the SA Health Policy Directive on user-applied labelling of injectable medicines, fluids and lines based on the national recommendations developed by the Australian Commission on Safety and Quality in Health Care. This course is intended for clinical staff involved in direct patient care; in particular, for staff involved in the preparation and administration of injectable medicines in a clinical or ward area.

Picture 5: Labelling for safety e-learning module

In 2014-15 e-learning modules will be available on:

- introduction to safety and quality
- communicating effectively following an adverse event (open disclosure) – Standard 1
- partnering with consumers – Standard 2
- recognition and management of challenging behaviour.

1.1.7 Safety and Quality metrics

In 2013-14 the Safety and Quality Metric Framework was developed to leverage existing systems and processes for data capture by health services to improve quality and safety across SA Health by providing standardised, accurate and timely information on safety and quality.

The principles include:

- enabling provider level quality improvement: facility, unit and practice level data are the most appropriate levels at which to monitor and improve the appropriateness and effectiveness of health care.
- focus on clinical practice variation: mapping of variation in clinical practice for a given condition is considered an essential baseline for efforts to improve quality.
- leveraging existing health data: existing health care data will be used and analysed where possible, in line with the principle of ‘single provision, multiple use’.
- expert clinical specification of indicators and datasets: clinicians will be involved in the development of any new indicators and or datasets.
- integrated approach to measurement of safety: commitment to develop multifaceted models for local monitoring of patient safety, to be considered by the executive level of governance4.

The Safety and Quality Metrics Framework includes:

1. National Safety and Quality Health Service Standards
2. National Clinical Care Standards
   a. Antimicrobial Stewardship
   b. Acute Coronary Syndrome
   c. Stroke
3. SA Health Strategy
   a. Challenging Behaviour
4. Mental Health
   a. Safety and Quality Minimum Dataset
5. Maternity
   a. Perinatal Practice Guidelines
   b. Severe Acute Maternity Morbidity (SAMM)
6. Surgical / procedural

1.1.7.1 Local Health Networks Analytics and Reporting Service (LARS)

The Local Health Networks Analytics and Reporting Service (LARS) was initially established to meet objectives from the National Health Hospitals Agreement.

The LARS portal delivers local and corporate reporting from a range of SA Health data warehouses that hold data from a number of administrative, financial and clinical systems across SA Health. The portal provides access to predefined reports, performance dashboards and analytical cubes to allow ad-hoc reporting.

LARS provides a single capability for reporting across the system and has the capability to introduce new data sources as and if they become available. There is flexibility in use that enables interrogation of the data at multiple levels, such as state, LHN, health unit or division.

4 Australian Commission on Safety and Quality in Health Care Data Plan 2013-2016 page 5
Safety and quality reports that can be accessed through LARS include:

> Patient Incidents
  - Level 1 Classification (all or by LHN)
  - Medication
  - Patient Identification and procedure matching
  - Blood and blood products
  - Pressure injury
  - Clinical deterioration
  - Falls
  - Challenging behaviour
  - Restraint and seclusion
  - Restraint and seclusion – total duration

> Consumer Feedback
  - Advice, complaint, compliment, suggestion (by method of feedback)
  - Complaints by category and sub category
  - Complaints by Health and Community Services Complaints Commissioner (HCSCC) Charter of Rights category

Access to LARS is available at [http://lars.had.sa.gov.au](http://lars.had.sa.gov.au)

![LARS Screen shot](image_url)
1. Governance for Safety and Quality in health service organisations

1.1.8 Clinical Senate – Safety & Quality metrics

In February 2014, the Clinical Senate on Safety and Quality Metrics: Connecting clinical outcomes and consumer experience was held at the Crowne Plaza Adelaide.

The event was sponsored by the SA Council for Safety and Quality in Health Care and the Health Consumers Alliance (HCA). A series of presentations was given on national and international best practice along with data innovations. The presentations were designed to provide information to participants to assist them with the development of measuring consumer experience for improvement.

Current data collection including the SA Consumer Experience Surveillance System and Safety Learning System Consumer Feedback module, maximise the benefit for consumers and the community.

More than 90 delegates, including clinicians and consumers met to consider the value proposition and formulate recommendations to the Minister for Health and the Department for Health and Ageing on the use and collection of safety and quality metrics.
Clinical Senate value proposition:
Self-reported and surveyed consumer experiences of health care provide valuable information to inform clinical service delivery and improve patient safety. Data provides the opportunity to create public value by designing improved models of patient care. Such processes more successfully meet the needs and expectations of consumers resulting in reduced patient complaints and higher levels of satisfaction.

The potential increase in capacity which might result from dealing with fewer complaints within the health system would release a considerable resource of experienced health care professionals to address alternative priorities. Additional benefits would potentially include a reduction in health related adverse events, decreasing spending on insurance and compensation payments, legal fees and WorkCover or sick leave for staff.

The SA Clinical Senate report and recommendations on Safety & Quality Metrics will be available in 2014-15.
Further information is available on the Clinical Senate section of the SA Health website at www.sahealth.sa.gov.au accessed via Health Reform / Clinical Senate.
1. Governance for Safety and Quality in health service organisations

1.1.9 SA Health Mortality Review

In 2013-14, a mortality review process was established to provide guidance for establishing a consistent approach to the monitoring, review and/or investigation of selected deaths and the recommendations for improvement and actions taken.

The Australian Commission on Safety and Quality in Health Care Core Hospital Based Indicators (CHBOI) were developed for hospitals to routinely monitor and review a succinct set of indicators.

The three types of hospital mortality indicators are as follows:

1. Hospital-standardised mortality ratios (HSMRs) compare a hospital’s mortality against its expected mortality based on the age and health status of patients with a diagnosis that has been pre-identified as accounting for 80% of in-hospital mortality nationally.

2. Deaths in low mortality diagnosis related groups (DRGs) report in-hospital deaths for DRGs where the national mortality rate is less than 0.5%.

3. In-hospital mortality for acute myocardial infarction (AMI), stroke, fractured neck of femur and pneumonia compares a hospital's rate of deaths against its expected mortality based on the age and health of patients admitted to the hospital for a specified condition. These indicators for SA Health are displayed as variable life adjusted displays (VLADs).

These four conditions are monitored because:

> they are high morbidity conditions, which together account for 20% of all hospital deaths
> they have known models of care for patients based on clinical evidence.


Item 2: SA Health flowchart for core hospital outcome based indicators: Mortality Review
Country Health SA Local Health Network (CHSALHN) needed a centralised Morbidity and Mortality Review (MMR) process to support compliance with the SA Health Mortality Review process and relevant National Safety and Quality Health Service Standards. The challenge was to implement a consistent approach to a mortality and morbidity review process across the LHN, which includes 65 hospitals in country SA.

An initial snapshot of CHSALHN identified an inconsistent approach to MMR functions across CHSALHN sites.

The main roles of the CHSALHN Morbidity and Mortality Review Committee (MMRC) include to:

1. Support implementation of the SA Health Mortality Review process across the LHN.
2. Conduct multi-disciplinary review of identified unexpected deaths where steps may not have been taken to prevent it, or where death resulted from medical intervention.
3. Provide recommendations to CHSALHN Clinical Cabinet about health service improvements arising from level 2 mortality review or targeted morbidity reviews.
4. Provide advice on other mortality and morbidity review indicators that require multi-disciplinary assessment.

A multi-disciplinary team was established with representation from executive staff, operations staff, clinical staff (medicine, nursing, allied health), Directors of Medical Services, General Practitioners, surgeons and mental health.

The MMRC has the ability through the chair to invite persons or other representatives who are not members to attend meetings and contribute as required.

To commence the project, a Project Lead was appointed to lead Mortality Reviews and the MMRC was formed, including development of formal Terms of Reference and reporting arrangements to the CHSALHN Clinical Cabinet. Appointments to the MMRC were through an Expression of Interest process.

The initial work of the group was to support the SA Health Mortality Review Process. Currently, work is being done to develop a consistent MMR procedure across the country LHN. A consistent MMR procedure will include an integration of regional governance processes, including clinical governance. This is currently being undertaken through consultation and cooperation with Directors of Medical Services and Directors of Nursing & Midwifery across the 65 health sites in country SA.

CHSALHN has begun undertaking multi-disciplinary level 2 mortality reviews were indicated and is starting to examine a wide range of morbidity indicators including surgical and obstetric complications.

The MMRC also works with regional groups to develop action plans for service improvement.

CHSALHN has examined mortality review cases and, based on early cases, has already identified system based improvements surrounding the management of the deteriorating patient and clinical handover related issues. These improvements in clinical care are currently being implemented.

CHSALHN has established a quarterly communique to share lessons learnt across the network.

The overall goal is to have a consistent approach to MMR and system improvement in place across the country network. CHSALHN hopes to formally evaluate the outcomes and clinical improvements from its MMR processes in early 2015.

Further information is available on the Australian Commission on Safety and Quality in Health Care website Core, Hospital-based Outcome Indicators page at www.safetyandquality.gov.au/our-work/information-strategy/indicators/core-hospital-based-outcome-indicators/
1.1.10 Authorisations under Part 7 of the Health Care Act 2008 (SA)

As outlined in previous Patient Safety Report SA Health assesses, evaluates and makes recommendations about practices, procedures, systems, structures and processes of health services to achieve improvements to the safety and quality of health care. This is done as openly and transparently as possible, however there are some circumstances where the best possible outcomes can only be achieved by restricting public access and public disclosure of information related to these activities.

To facilitate this process there are provisions in Part 7 of the Health Care Act 2008 (SA) (the Act) that allow for the authorisation of activities (or committees):

(a) where the purpose of any such activity is wholly or predominantly to improve the quality and safety of health services; and
(b) where the public disclosure of, or public access to, information is restricted in order to achieve the best possible outcomes associated with the improvement of health services.

The Safety and Quality Branch, Public Health and Clinical Systems processes applications for authorisations from both the private and public sectors for consideration by the Minister for Health and Ageing. As 30 June 2014 there were 42 activities / committees authorised under the Act.

1.2 Clinical Practice

1.2.1 Clinical networks

The Statewide Clinical Network Chairs report to the Executive Director, Policy and Commissioning via the Director, Service Development. The Networks continue to engage clinicians and consumers across the health system to assist in the development of Models of Care (MOC), pathways and statewide policies and guidelines, to assist in the delivery of high quality patient care.

The Clinical Networks’ activities is available on the Clinical Networks section of the SA Health website at www.sahealth.sa.gov.au accessed via Health Reform / Clinical Networks.

Some of the Networks’ key activities for 2013-14 include:

1.2.1.1 Cancer

In late 2013 the strategic role of the Cancer Clinical Network was incorporated into the SA Cancer Service (SACS). SACS continues to provide a central point of contact for cancer related advice and leadership and to ensure that high quality evidence-based cancer services supported by appropriate medical, nursing, supportive care and administrative workforce, infrastructure, information and safety systems are accessible to all South Australians.

1.2.1.2 Cardiology

The Cardiology Clinical Network focused on the following areas which were adding to the work begun last year:

1. Standardised criteria for decision-making:
   - Developed standardised clinical referral pathways for patients with low risk heart failure, chest pain and genetic cardiac conditions. The chest pain and heart failure pathways are complete and are being piloted in the Flinders Medical Centre (FMC) Emergency Department. The genetics pathways have been approved by SA Health Strategic Safety and Quality and Governance Committee and once SA Pathology’s completion of validation of testing for hypertrophic cardiomyopathy and Long QT syndrome the Cardiology Clinical Network can implement the education and dissemination plan.
   - Completed the exercise stress testing training package to complement the Exercise Stress Test (EST) guidelines now residing on the SA Health website.

2. Infrastructure design:
   - Ongoing development of ambulatory health service recommendations to accompany the referral pathways through the emergency clinicians subgroup.
3. Audit / feedback:

- Cardiac rehabilitation minimum dataset – services in metropolitan and country public hospitals have been collecting these data for over 12 months. The Cardiology Clinical Network is currently awaiting ethics approval to conduct the second state-wide audit, and in November 2014 plan to hold a Cardiac Rehabilitation (CR) forum to report the results.

- Applied to the steering committee of the Coronary Angiogram Database of South Australia (CADOSA) seeking data on ST elevation myocardial infarction (MI) performance indicators from the four metropolitan hospitals to evaluate the effectiveness of pre-hospital and in-hospital systems for urgent revascularisation of these patients. This data will be reported at the upcoming meeting of the acute coronary syndrome workgroup.

1.2.1.3 Child health

The Child Health Clinical Network (CHCN) has provided advice to SA Health on a broad range of issues including:

- Child and Adolescent Mental Health Service (CAMHS) Model of Care (MOC)
- Youth Mental Health Service MOC
- Rare Diseases National Plan
- Statewide Eating Disorders Model of Care
- Statewide Education and Training Review
- McCann Review of Out Of Hospital Services
- proposed changes to the Modbury Hospital Paediatric Services
- Women and Children’s Health Network Hospital Budget Performance Review
- Women and Children’s Health Network: Youth Health MOC
- Child Development and Wellbeing Legislation.

The CHCN has:

- initiated a six month trial of the ‘National Paediatric Toolkit’. A patient survey tool, developed in the United Kingdom to support the participation and engagement of children in health services. It provides a unique opportunity for the voices of children to be heard, their experiences of health services and opinions to be collected through a survey tool delivered in a hand held electronic device
- coordinated the development of statewide paediatric clinical practice guidelines. A number of guidelines are now completed and are available on the SA Health website for all clinicians working with children and young people
- supported the implementation of the National Child Protection Framework and is facilitating the development of an agreed statewide assessment process that will ensure a consistent approach to the initial assessment and care plan for children entering out of home care
- reviewed and endorsed statewide observation charts to support recognition and response to clinical deterioration of paediatric patients in acute care settings.

In partnership with SA Health and Local Health Network’s developed:

- a statewide children’s health services framework which will underpin future health service planning
- a new model for transition to adult services for children / young people with chronic diseases. The model aims to improve coordination and collaboration between paediatric and adult services and enhance the patient journey.

In partnership with Child and Family Health Service (CaFHS), coordinated a review of a statewide nursing standard for growth to support new referral pathways for infants aged 0-12 months with failure to thrive.

Involved in:

- the WCHN review and redesign of the SA Personal Health Record / Blue Book to ensure that an improved longitudinal view in the key developmental areas were incorporated
- reviewing the content / topics included in the childhood component of the South Australian Monitoring and Surveillance System (SAMSS) questionnaire. SAMSS is an epidemiological monitoring system that aims to detect trends in the prevalence of chronic conditions, risk and protective factors, and other determinants of health, to provide appropriate data on key indicators for national and state priority health areas.
1.2.1.4 Maternal and neonatal

In 2013-14, the Maternal and Neonatal Network:

- supported best practice with continued development, review and publishing of additional Neonatal and Perinatal Practice Guidelines to the SA Health website, and the “Clinical Practices Guideline” iPhone app. Specific to the Network, the APP continues to assist clinicians in access to the perinatal and neonatal medication clinical practice guidelines. In March 2014, there were reported 271,000 hits to the website. This demonstrates the demand for easily accessible quality information for clinicians.
- facilitated the revision of the Planned Homebirth Policy and the First Stage Labour and Birth in Water Policy.
- facilitated the SA Perinatal Advice Line roster ensuring Obstetricians and Neonatalogists are available to speak to clinicians from across the state seeking clinical advice in regard to an obstetric woman or neonate.
- supported the further development of the SA Health Perinatal Emergency Education Framework Business Plan, in collaboration with the SA Health Quality & Safety Committee, to operationalise an emergency care education program for perinatal health care workers from across the state.
- supported the statewide implementation of the National Maternity Services Plan.
- supported the Director of Neonatal Services to implement the revised SA Neonatal Services Retrieval Plan.

1.2.1.5 Mental health

The Statewide Mental Health Clinical Network provides a multidisciplinary clinical platform for the review and analysis of mental health issues, to inform policy development and service improvement across the state. In 2013-14 the Network carried out:

- a review of mental health care for people with an intellectual disability.
- a review of presentations by Aboriginal people to community mental health services.

Released for consultation is an overview of current Borderline Personality Disorder services in the public sector across South Australia and a proposed way forward.

1.2.1.6 Older people

In the past 12 months the Older People Clinical Network Steering Committee has developed the draft SA Health Services Plan for People with Dementia (and delirium). The draft plan is with the Department for Health and Ageing awaiting approval to release for final consultation. The plan has been developed and presented in a way that describes what consumers and carers want, how the health system needs to change to better align service provision with what consumers and carers want, and how to maximise the use of existing levers to drive change.

The National Safety and Quality Health Service Standards have been recognised as a critical lever to improve the hospital (and health service) experience for people with dementia. In 2013, the Australian Commission for Safety and Quality in Health Care commenced a process to determine how to better use the existing Standards, and what changes to the Standards may be required, to ensure health services are providing safe, high quality care to people with dementia. The three themes of the Commission’s ‘Handbook for improving safety and providing quality care for people with cognitive impairment in acute care: A Consultation Paper’, are used as a guiding reference for the plan. The three themes are:

1. Identification and assessment
2. Seamless care transitions
3. Effectively managed

The draft recommendations of the plan reflect the requirement to improve performance within existing resources. The Older People Network anticipates the reforms will be driven by the use of service standards to ensure all consumers and carers can access a similar basic standard of care from all of SA Health’s services. When it is possible for services to demonstrate compliance with the basic standard of care, they should be encouraged to innovate, evolve and grow into exemplary dementia care competent organisations.
1.2.1.7 Palliative Care

The Palliative Care Clinical Network has continued to work on the development of initiatives outlined in the Statewide Palliative Care Service Plan 2009-16 (the Plan) during 2013-14. Key achievements are:

> Collaborated and assisted the Health Performance Council in conducting a review into End of Life Care, focusing on progress of the Plan. Findings from the report show that the Plan is relevant and supported by the palliative care sector. It also highlighted that there have been some significant achievements to date, despite uncertainty regarding responsibility and ultimate governance for delivering on initiatives, and it is worth continuing to roll out.

> Co-hosting a SA Palliative Care State Conference with the Palliative Care Council SA and Older People Clinical Network in June 2014.

> Ongoing development of a framework document which outlines the current model of care for specialist palliative care services across the state; key aim is to create greater consistency in access, description of services and data collection.

> Endorsement of an Assessment in Bereavement Report tabled by the Psychosocial Reference Subcommittee; information is being integrated into the model of care framework document.

> Endorsement of a Pain Position Statement which will be used by the Network as a reference document, particularly in relation to supporting the Country partnering initiatives.

> Launch of a state-wide referral form for accessing metropolitan and country specialist palliative care services in March 2014.

> Launch of a state-wide palliative care triage form for use within community specialist palliative care services in March 2014.

> Endorsement of five specific palliative care orders sets for use within EPAS.

> Establishment of a Statewide Research Collaborative. The focus of research is on the enablers and barriers to conducting successful case conferences between specialist palliative care services and general practice; survey has been submitted to ethics for approval and will be distributed in partnership with GP partners Australia.

> Supporting the implementing of a National Broadband Network (NBN) Tele-health project: Tele-health in the Home as a joint collaborative between Flinders University, The Palliative Care, Older Persons and Rehabilitation Clinical Networks. Draft report submitted to the Commonwealth in June 2014 with final report due in September 2014.

1.2.1.8 Rehabilitation

In 2013-14, the Rehabilitation Clinical Network work includes:

> the appointment of a Statewide Transition Coordinator. The incumbent will develop and facilitate the standardised use of procedures and clinical standards to support transition pathways, to enable an embedded process to assist young persons with a disability transition from paediatric to adult health services

> Stroke Rehabilitation Service Improvement Project: The Network has convened an expert sub-committee, comprising representation from acute and rehabilitation stroke services across each Local Health Network, with involvement of the Stroke Clinical Network. There is considerable overlap in managing stroke patients, ie neurologists, geriatricians, rehabilitation physicians, allied health and nursing, and it is important we work together to ensure quality across all areas of stroke. Members are conducting a review of the current procedures for assessing stroke patients for rehabilitation, and implementing standardised processes to ensure the equitable and timely transfer to rehabilitation. Baseline data has been collected and a comparison report will be developed on completion of the project at the end of December 2014. It is anticipated that access to early rehabilitation will result in improved patient outcomes

> Clinical Pathway / Guideline and Standardised Data Collection Process – use of Botulinum Toxin: The clinical pathway and standardised data collection process, developed by the Network for all uses of botulinum toxin outside of PBS-approved indications, continues to be implemented across each Local Health Network. The SA Medicines Evaluation Panel (SAMEP) is collating the 2013 data to assess outcomes to support use. In accordance with data collection recommendations from SAMEP, provision of outcome data must be submitted by prescribers to individual hospital drug committees on an annual basis for the following groups, where there is less published evidence of efficacy to support the use:
  - Usage beyond four doses in upper-limb post-stroke
  - Usage in lower limb post-stroke
  - Usage in adult Cerebral Palsy patients who were not treated with botulinum toxin as a child
  - Usage in all subpopulations for which an IPU is approved
  - The Network continues to monitor and support Local Health Networks in the implementation of the clinical models for rehabilitation for amputee, acquired brain injury, and spinal cord injury.
1.2.9 Renal

The Renal Clinical Network identified the need for a suite of clinically relevant key performance indicators (KPIs) that reflected the range of End Stage Kidney Disease (ESKD) service provision in SA. Eight draft Statewide KPIs for Renal Services were developed. The Renal Network Steering Committee endorsed the draft as a state-wide KPIs in February 2014. In June 2014 they were reviewed and endorsed by the SA Health Safety and Quality Strategic Governance Committee.

1.2.10 Stroke

The Statewide Stroke Clinical Network (SCN) held a motivational interviewing workshop that was facilitated by a clinical psychologist and open to all members of the stroke multidisciplinary team. Interest in the workshop was high, with more than double the number of people wanting to register than places available. Feedback from attendees suggests the workshop was a success.

The SCN established a stroke thrombolysis service in Berri and Whyalla that is available Monday to Friday, adding to the already established Mount Gambier service.

The Network launched the Stroke Management Procedures and Protocols in September 2012. The protocols provide the blueprint for hospitals across the state to provide consistent, best practice care for the first 48 hours, for all patients who present with stroke symptoms. Further work has seen the development of protocols after the first 48 hours, with more focus on nursing and rehabilitation assessment and therapy. A forum will be held in September 2014 to finalise the protocols and develop key performance indicators for education and quality improvement activities.

1.2.2 Clinical Directives and guidelines

Clinical policy directive and guidelines establish best practice across SA Health and assist practitioners and patients to determine appropriate health care for specific clinical circumstances.

Clinical policy directives are mandatory requirements that are implemented across SA Health as ongoing operational practice where it is a short term or permanent direction and must be complied with.

A clinical guideline has flexible requirements and implementation may be developmental or staged according to local circumstances.

All Statewide Clinical Guidelines promote and facilitate standardisation of consistency of practice, using a multidisciplinary approach. The Statewide Clinical Guidelines are based on a review of published evidence and expert opinion.

In 2013-14, the Safety and Quality Branch developed a Clinical Guideline template including a checklist and briefing paper to be submitted to the SA Health Safety and Quality Strategic Governance Committee.

A Guide for Clinical Guideline development, implementation, monitoring and evaluation is currently under development.

The templates and all statewide Clinical Directives and Guidelines are available on the SA Health intranet Clinical Directive and Guidelines web page.
In 2013-14 the following Clinical Guidelines were released including:

**New Clinical Guidelines:**
- SA Child Health Clinical Network – Paediatric Clinical Practice Guidelines
- SA Perinatal Practice Guidelines
- Infection Control Service
- South Australian Medicines Advisory Committee (SAMAC)

**Revised Clinical Guidelines:**
- SA Perinatal Practice Guidelines
- Infection Control Service

For a full list of the new and revised clinical guidelines, refer to appendix 1, on page 156.
1.2.3 Enterprise Patient Administration System (EPAS)

SA Health’s Enterprise Patient Administration System (EPAS) is an integrated enterprise wide patient administration system that provides a consistent and complete electronic health record for patients across SA Health hospitals and health services. It will provide the foundation for delivering South Australia’s state-wide electronic health record (EHR). EPAS is founded on the principal of One Patient, One Record, Better Care. During 2013-14 SA Health rolled out EPAS to eight hospitals / health services including: Noarlunga Hospital, Noarlunga Private Hospital, GP Plus Centres (Noarlunga, Aldinga / Seaford and Morphett Vale), SA Ambulance Headquarters, Port Augusta Hospital and Repatriation General Hospital (RGH).

The implementation of EPAS has brought many benefits to patients, administrative and clinical staff and the state-wide health service as a whole. It has:

> transformed the way clinicians deliver care by providing a fully integrated and accessible health care record system at the patient bedside
> increased patient and staff safety by providing immediate access to a patient’s electronic health record
> helped clinicians improve clinical work practices
> consolidated a number of patient information recording systems into a single, integrated, state-wide system
> enhanced medication prescribing practice through providing alerts relating to drug dosage, drug-drug interactions and drug allergies
> aided clinical communication with clinicians at RGH reporting EPAS enables them to quickly and clearly read clinical notes and care plans
> supported best practice in clinical handover and communication through the introduction of the clinical summary view.

Since the activation of EPAS at the above sites, many benefits have been realised that are contributing to improved patient safety and quality of care for South Australians. The clinical benefits achieved at sites where EPAS has been implemented include:

> Fall assessments – The EPAS solution has a falls assessment tool built into the clinical module. Clinicians receive a prompt when completing admission documentation to ensure that a falls assessment is completed where required. In addition, ongoing care relating to falls prevention and post-fall management is able to be clearly documented in EPAS.
> Reduction in missed medication incidents – EPAS contains an overdue task alert within the clinical module utilised by nursing staff (worklist manager). RGH recorded a sustained reduction in the number of SLS reports relating to missed medication doses in the four months post Go Live, which has also been replicated at Port Augusta Hospital at various times since Go Live.
> Improvements in the ability to monitor completion rates of patient assessment tools such as Falls Assessments, Malnutrition screening (MUST tool) and Pressure Injury Risk (Braden) Assessment scores. Since the introduction of EPAS, there have been 23,829 inpatient visits at EPAS sites. For this patient group, 37% of inpatients had a MUST tool completed, 61% had a Falls Risk Assessment completed and 59% had a Pressure Injury Risk Assessment completed during their inpatient visit. The introduction of EPAS introduces new capabilities for SA Health in terms of electronic monitoring of compliance rates in these key safety and quality initiatives.
> Improved clinical decision support at the time of medication prescribing. The EPAS solution provides alerts to clinicians at the time of order placement and enables clinicians to amend their medication order or document their acknowledgment of the alert. Since the introduction of EPAS, 11289 medication alerts have been generated. Nearly 10,000 of these alerts (87%) related to either incorrect dosage or patient allergy and occurred prior to the order being submitted averting a potential incident.
In 2013-14 the Safety and Quality Branch continued to work with the EPAS program on key priorities to align with SA Health’s state-wide safety and quality policies including:

> Managing the Deteriorating patient – ensuring that EPAS supports the identification of and clinical response to patient deterioration through providing core functionality such as the Deteriorating Patient warning system embedded in EPAS flowsheets. The EPAS program has refined functionality relating to clinician led modification of alerts on select patients.

> Advance Care Directives – ensuring that EPAS incorporates the documentation of Advance Care Directives and key patient decisions made relating to end of life care and resuscitation orders.

> Surgical Team Safety Checklist – the checklist is completed using EPAS, a safety feature that provides a consistent approach for verification of patients and procedures within the procedural team, resulting in reductions to patient morbidity.

> Blood and Blood Products Ordering and Administration – best transfusion practice for clinicians is supported through the revised functionality in the blood / blood products order set.

> Safety and Quality Videos – the EPAS website contains a dedicated safety and quality section where clinicians can view a video series demonstrating how some of the components of EPAS support patient safety and quality care to meet the National Safety and Quality Health Service Standards.
### EPAS Alerts

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<th>Number</th>
<th>Proportion (%)</th>
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<td>0.008</td>
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<tr>
<td>Drug Interaction</td>
<td>21</td>
<td>0.18</td>
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<tr>
<td>Duplicate Order</td>
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<td>Patient has current Nil By Mouth Order</td>
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<td>Patient Intolerance</td>
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<tr>
<td>Medication Dosage</td>
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<td>Patient Allergy</td>
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<td><strong>11289</strong></td>
<td><strong>100</strong></td>
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</table>

### Patient Incidents of missed medication - Worklist Manager with overdue medication alert (in red)

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<thead>
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<th>Date</th>
<th>User</th>
<th>Task Description</th>
<th>Allergies</th>
<th>Action</th>
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<td>2014-02-03</td>
<td>00:15</td>
<td>Nursing Information: Take with or soon after food</td>
<td>Ascorbic Acid</td>
<td>PO</td>
</tr>
<tr>
<td>2014-02-03</td>
<td>00:15</td>
<td>Nursing Information: Take with or soon after food</td>
<td>Ascorbic Acid</td>
<td>PO</td>
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<td>Ascorbic Acid</td>
<td>PO</td>
</tr>
</tbody>
</table>
1. Governance for Safety and Quality in health service organisations

Picture 12: EPAS Website: Safety and Quality Videos

EPAS Safety and Quality Videos

The EPAS Program has collaborated extensively during the Design and Build phase of the Project to ensure that the new electronic systems reflect national and state priorities, and continues to support practitioners in providing a high standard of care across all disciplines while ensuring a safe environment for staff and patients.

The EPAS Safety and Quality video series demonstrates some of the components of EPAS support patient safety and high quality care to meet the National Safety and Quality Health Service Standards.

The following Safety and Quality videos are available:

The Nursing and Midwifery Admission Note
This video includes risk screens such as a malnutrition screen (MUST) and pressure injury screen (Braden), along with risk assessments such as that for falls risk. The key findings from these assessments is able to be ‘pullled’ through to the Assessment and Care Plan. This has the real advantage of reducing duplication and maintaining consistency of documentation. EPAS is then able to support clinicians to provide best care by automatically prompting recommended actions as follow up from this assessment. An example of this is a clinician being alerted to order a physiotherapy consult for a patient who is at risk of falls because they have poor mobility.

View this video

Restraint and Seclusion Documentation
This video demonstrates the process to order restraint, and the Restraint Flowsheet which documents the current patient status, restraint reason and the medical review process. It also demonstrates alternative interventions, including psychosocial, environmental and diversional approaches, and much more.

View this video
**Surgical Safety Checklist**

**IN THEATRE - PRE INCISION**

- Confirm all team members' name and role is displayed on whiteboard or they have been introduced.
- Correct patient?
- Correct site (check site marking)?
- Correct procedure?
- Is consent signed?
- Does patient have an allergy?
- Antibiotic prophylaxis (within last 60 minutes)
- Has thrombo prophylaxis been arranged?
- Is essential imaging available?
- Surgeon review:
  - Are there any critical/ unusual steps?
- What is the expected duration? Hour(s) Minute(s)
- Is there likely to be blood loss requiring transfusion?
- Anaesthesia review:
  - Are there any patient specific concerns?
  - Are there any equipment problems to be addressed?
  - Has any prosthesis (or special equipment) to be used in theatre been checked and confirmed?
1.2.4 Improvement of surgical care through audit of surgically related deaths

The South Australian Audit of Perioperative Mortality (SAAPM) is an external, independent peer review audit of the process of care associated with surgically related deaths in South Australia. SAAPM has protection under both state and federal legislation. The SAAPM Management Committee is authorised under Part 7 of the Health Care Act 2008 (SA) to conduct quality improvement activities (re-gazetted 15 June 2014). SAAPM also has protection under the Commonwealth Qualified Privilege Scheme, under Part VC of the Health Insurance Act 1973 (gazetted 23 August 2011).

1.2.4.1 Methodology

The audit process begins when the SAAPM office is notified of the death of a patient who was under the care of a surgeon in a participating hospital. All cases in which a surgeon was involved in the care of the patient are included in the audit whether or not the patient underwent a surgical procedure.

When the consultant surgeon provides a completed surgical case form to the SAAPM office, it is de-identified and then assessed by a first-line assessor. The first-line assessor will either close the case or advise that the case undergo further analysis, i.e., a ‘second-line assessment’ (case note review).

Cases may be referred for a second-line assessment if:

- areas of concern or adverse events are thought to have occurred during the clinical care of the patient that warrants further investigation
- a report could draw attention to lessons to be learned, either for clinicians involved in the case or as part of a collated assessment (case note review book) for wider distribution
- the surgical case form lacks sufficient information to make an informed judgement.

1.2.4.2 Reduction in deficiencies of care

Of the data collected by SAAPM, one of the most important indicators of the quality of care is the proportion of cases where the assessor identifies areas of concern or adverse events. It is encouraging to note that in 2012-13 the proportion of these cases was less than half the level recorded in 2010-11, having decreased from 16% to 7% of cases.

While areas of concern or adverse events were identified in preoperative, intraoperative and postoperative stages, incidents at the preoperative stage were the most common. The most frequent issue identified was about the decision to operate.

1.2.4.3 Decision to operate

This issue applies to all specialties, and can refer to:

- a delay or failure to operate when doing so would have improved the outcome, or
- an inappropriate decision to operate in a futile situation.

One of the most common adverse events, in this category, identified by assessors relates to a delay in recognising the signs of an ischaemic gut and therefore the lack of a rapid decision to operate. The signs of sepsis and ischaemia were either overlooked or junior staff did not appreciate the significance of post-operative hypotension. The index of suspicion for sepsis and/or ischaemia is high when there has been a major abdominal procedure or major vascular surgery, however in the last few years SAAPM has seen this occur in patients who have had procedures that would not normally be associated with gut ischaemia.

1.2.4.4 New Clinical Governance Report for hospitals

The main focus of SAAPM has been to facilitate improvements to the quality of patient care by informing and educating surgeons, however it has been recognised that the audit also has an opportunity to provide valuable information to hospitals. Therefore, a Clinical Governance Report is being developed with the Australian and New Zealand Audit of Surgical Mortality (ANZASM), in consultation with hospitals both within SA and nationally.

The reports will provide each hospital with de-identified data to monitor trends in clinical indicators and will be provided to local health networks, quality and safety managers, directors of surgery, and SA Health, on an annual basis. The reports were recently trialled at two South Australian hospitals. It is expected they will be distributed to all SA hospitals in 2015.
1.2.4.5 **SAAPM evaluation survey**

SAAPM recently conducted a survey asking all surgeons currently practicing in South Australian hospitals to evaluate the audit process, publications and activities. A 55% response rate was achieved and feedback was largely positive.

The majority of surgeons surveyed (86%) reported that participation in SAAPM had influenced their practice in one or more areas, most commonly the following:

- increasing constructive discussion amongst peer group
- improvement in the quality of documentation in case notes
- attention to post-operative care
- attention to DVT prophylaxis
- attention to supervision issues.

**Conclusion**

SAAPM continues to monitor surgical deaths with an increasing focus on examining themes that emerge from the data. For the surgical community, hospitals and health departments, peer-review of surgical deaths is vitally important to inform, educate and improve the care of patients. Feedback on SAAPM activities and publications has confirmed that information provided to surgeons has had a positive influence on their practice. SAAPM will continue the activities valued by surgeons, and at the same time, introduce Clinical Governance Reports to provide valuable data to hospitals.

1.2.5 Mental health

1.2.5.1 Pathways to care
SA Health launched the Pathways to Care Policy Directive and Policy Guideline in May 2014, after extensive consultation and drafting by the Mental Health Unit with consumers, carers, adult mental health services, child and adolescent mental health services, community mental health services, country mental health services, emergency departments, general health services, General Practitioners, Health and Community Services Complaints Commissioner, non-government organisations, older persons mental health services, Principal Community Visitor, private mental health services, professional bodies, Public Advocate, Royal Flying Doctor Service, SA Ambulance Service, South Australia Police and unions.

The Pathways to Care Policy Directive and Policy Guideline describe best-practice principles and service provision across eight areas, comprising: participation, access, care and treatment, transfer of care, working with other service providers, exiting, re-entry and transport.

1.2.5.2 Seclusion and restraint reduction initiatives
The Office of the Chief Psychiatrist and Mental Health Policy (OCPP) continues to work towards the reduction in the use of restraint and seclusion for mental health patients through participation in the National Safety Priorities in Mental Health project by:

- providing non-violent crisis intervention training to inpatient and community mental health and other interested agencies
- supporting and improving data collection and analysis across the state, and
- assisting individual units with service improvement and incident reviews.
- a policy, guideline, standards, toolkit and education package has been developed in consultation with key stakeholders.

The Chief Psychiatrist is working with the National Safety and Quality Partnerships Subcommittee (SQPS) to improve data collection on restraint incidents and develop a nationally accepted definition of chemical restraint. South Australia will be providing data to the national database on restraint incidents for 2013-14. Only seclusion incidents have been reported previously.

1.2.5.3 South Australian Suicide Prevention Strategy
The South Australian Suicide Prevention Strategy 2012-2016: Every life is worth living (the strategy) has progressed in its implementation with much local activity occurring about the state in 2013-14.

The strategy calls for an all of community response to suicide prevention and Suicide Prevention Networks are developing in local government regions in the areas of Mount Gambier, Gawler, Murray Bridge, Clare and Gilbert Valley, Whyalla, and Playford. Further networks established by Wesley Lifeforce are active in Strathalbyn, Port Adelaide and Port Augusta.

1.2.5.4 Strategic Mental Health Quality Improvement Committee
The Strategic Mental Health Quality Improvement Committee was established in August 2013 for the Local Health Networks and the Mental Health Unit to monitor, review and collaborate on improving safety and quality in mental health services across the state. The Committee considers a monthly Performance Indicator Report and specific events to identify current and future issues, and coordinates actions at the local and statewide level to address those issues.

1.2.5.5 Safety and Quality policy initiatives
The Mental Health Unit carried out extensive development work in 2013-14 on a number of policy initiatives to be consulted or launched in 2014-15, including:

- Sexual Safety in Mental Health Services Policy Guideline.
Case study:

Restraint reduction project

The use of restraint in older persons services is used with the aim of preventing injury to consumers however the evidence suggests that it can cause trauma to the person their family and support persons and increase the risk of falls in aged care settings. Ward 18 at the Repatriation General Hospital (RGH) commenced a program aimed specifically at reducing the use of and time spent in restraint.

A multidisciplinary working party was formed. They visited a similar unit in Victoria with a ‘no restraint’ policy to gain practical information regarding their systems and procedures, then reviewed their local forms and procedures, including, tracking the patient flow to improve the care pathway, improved incident reporting following the introduction of reporting via the Safety Learning System in July 2013 and commencement of a fortnightly Multidisciplinary Panel to review all incidents.

Other strategies included; a new training program on prevention and de-escalation of agitated behaviour, a sensory garden and sensory room and individual assessments of the person to guide nursing staff in developing suitable activities and diversions. These strategies assisted in reducing the levels of agitation patients experience and reduced the chances of escalation occurring.

Graph 3: Restraint incidents in Ward 18 at Repatriation General Hospital: 2012-14

Graph 4: Percentage of restraints > 4 hours in Ward 18: 2012-14
1.3 Credentialling

As outlined in previous patient safety reports, credentialling is the process of verifying qualifications, experience and other relevant professional attributes of health practitioners for the purpose of forming a view about their competence to deliver health care. A scope of clinical practice is defined for each practitioner, which takes account the delineation of the health service where the health care will be provided. This process is designed to protect consumers by ensuring a skilled and competent workforce is delivering their health care in a facility that is equipped for the delivery of that service.

The Credentialling and Scope of Clinical Practice System (CSCPS) is a secure web-based application that facilitates this process and enables the mutual recognition of practitioners’ credentials across Local Health Networks (LHNs). The use of CSCPS to record practitioners’ credentials is mandated across SA Health for all medical doctors, dentists, allied health and scientific officers, and nurse practitioners.

The Safety and Quality Branch provides system administration of CSCPS and each LHN has key contacts providing oversight of the credentialling process. All SA Health staff can log-on to CSCPS to see if an individual health practitioner has a current credential and scope of clinical practice. As of September 2014, there are 7770 specific scopes of practice for medical practitioners and a credentialling record for 2827 Allied Health Practitioners and 57 Nurse Practitioners.

Three additional levels of access enable the viewing of more detailed information for the purposes of auditing for accreditation (View Only) or entering/editing rights (“Head of Unit”, “Credentialling Officer:”). As of September 2014, 468 SA Health staff have additional access to CSCPS data (an estimated 1.3% of the SA Health workforce).

During 2013-14, the following actions have been taken to support the credentialling and scope of practice process:

- Successful data migration of Australian Health Practitioner Registration Agency (AHPRA) registration details into the CSCPS, in alignment with annual registration for each profession. The automatic data importation, using AHPRA’s Multiple Registration Check Service, substantially reduces the amount of data entry required to be made into the system, including registration numbers, professional boards, profession types, specialties, sub-specialties and expiry dates.
- Successful data migration from the CHRIS human resource records into the CSCPS of new starting employees was performed in June 2014, which substantially reduced the amount of data entry to be made into the system in relation to practitioner’s name and contact details.
- Changes were made to the CSCPS to align with the Department of Communities and Social Inclusion’s new Criminal History Screening process and to reflect the distinct kinds of screening, including child related, vulnerable persons related and aged care sector checks.
- Some minor enhancements were made to the reporting functionality to improve the ability of users to select specific data fields they want to appear in reports. Some coding changes were also made to improve the accuracy of the reports.


1.4 Incidents and feedback (complaints) management

1.4.1 Safety Learning System

The use of the Safety Learning System (SLS) for the reporting and management of consumer feedback and patient and staff incidents is now firmly embedded into practice. For the purpose of this report all references to incidents are limited to patient incidents.

As outlined in previous patient safety reports, everyone who provides services on behalf of SA Health is encouraged to report patient related incidents, including near misses, into the Safety Learning System. The most serious incidents, those categorised as Safety Assessment Code (SAC) 1, must be reported.

All incidents reported into the system are reviewed and serious events undergo a more detailed investigation. The findings of the review or investigation are used to undertake practice improvements in an attempt to reduce the recurrence of similar incidents. The system is also used to review trends in reported incidents and identify areas for improvement.

Picture 14: Safety Learning System screen shot

1.4.2 Incident management

Between 1 July 2013 and 30 June 2014, 44048 incidents were reported into the Safety Learning System, a 16.9% increase from 2012-13 (n=6370) and a 34.7% (n=11351) increase from 2011-12. It should be noted that the proportion of near-miss incidents reported during this period has increased.

The most common four types of incidents (by Primary Incident Classification) reported were:
1. patient falls and other injuries
2. medication
3. implementation of care
4. challenging behaviour.

Table 2: Number of incidents reported by year by Level 1 Classifications 2011-14

<table>
<thead>
<tr>
<th>Primary incident classification</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient falls and other injuries</td>
<td>9260</td>
<td>10052</td>
<td>11520</td>
</tr>
<tr>
<td>Medication</td>
<td>7065</td>
<td>7630</td>
<td>9554</td>
</tr>
<tr>
<td>Implementation of care</td>
<td>3871</td>
<td>4375</td>
<td>3759</td>
</tr>
<tr>
<td>Challenging behaviour</td>
<td>2738</td>
<td>4263</td>
<td>2910</td>
</tr>
<tr>
<td>Treatment, procedure</td>
<td>2233</td>
<td>2660</td>
<td>2679</td>
</tr>
<tr>
<td>Access, appointment, admission, transfer, discharge</td>
<td>1993</td>
<td>2314</td>
<td>2401</td>
</tr>
<tr>
<td>Clinical assessment</td>
<td>1573</td>
<td>2144</td>
<td>2197</td>
</tr>
<tr>
<td>Patient information</td>
<td>2001</td>
<td>1215</td>
<td>1513</td>
</tr>
<tr>
<td>Communication and teamwork</td>
<td>461</td>
<td>1010</td>
<td>1895</td>
</tr>
<tr>
<td>Medical Device / equipment</td>
<td>664</td>
<td>752</td>
<td>1224</td>
</tr>
<tr>
<td>Staffing, facilities, environment</td>
<td>547</td>
<td>611</td>
<td>1073</td>
</tr>
<tr>
<td>Pressure injury / ulcer / sore *</td>
<td>158</td>
<td>461</td>
<td>1333</td>
</tr>
<tr>
<td>Restraint / seclusion *</td>
<td>1</td>
<td>29</td>
<td>1845</td>
</tr>
<tr>
<td>Labour or delivery</td>
<td>132</td>
<td>162</td>
<td>145</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>32697</td>
<td>37678</td>
<td>44048</td>
</tr>
</tbody>
</table>

* - Indicates no category existing during the reporting period
Source: Safety Learning System

Increasing incidents reported and decreasing harm can be interpreted as a good reporting culture with success of strategies. Additional data relating to falls, medication, pressure injury, clinical deterioration and challenging behaviour is included in the relevant sections in this report.
The SAC rating is derived from a matrix matching severity with likelihood of recurrence. It guides the level of investigation and management that is undertaken for each incident. SAC 1 incidents require review and investigation, while incidents with a lower SAC rating (3 and 4) may be aggregated into common incident types and reviewed utilising the clinical practice improvement methodology to achieve system improvement. The number of incidents reported for each SAC score is shown as a percentage of the total number of incidents reported in the table 3.

Table 3: Actual SAC rating as a % of the total incidents reported 2011-14

<table>
<thead>
<tr>
<th>SAC rating</th>
<th>% of total Incidents reported</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2011-12</td>
</tr>
<tr>
<td>SAC 1</td>
<td>0.5%</td>
</tr>
<tr>
<td>SAC 2</td>
<td>2.3%</td>
</tr>
<tr>
<td>SAC 3</td>
<td>43.9%</td>
</tr>
<tr>
<td>SAC 4</td>
<td>50.1%</td>
</tr>
<tr>
<td>Uncoded incidents</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

1.4.3 Sentinel events

Sentinel events are particular types of serious events nominated nationally. These events must be notified to the Safety and Quality Branch. In 2013-14, the total number of sentinel event notifications increased from 2012-13 by 43.3% (n=13). Table 4 shows the sentinel events that have occurred in the last three years.

Table 4: Number of sentinel events reported by year by category 2011-14

<table>
<thead>
<tr>
<th>National sentinel event categories</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Procedures involving the wrong patient or body part resulting in death or major permanent loss of function</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Suicide of a patient in an in-patient unit</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Retained instruments / other material after surgery requiring re-operation or further surgical procedure</td>
<td>5</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Intravascular gas embolism resulting in death or neurological damage</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Haemolytic blood transfusion reaction resulting from ABO (blood type) incompatibility</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Medication error leading to the death of a patient as a result of incorrect administration of drugs</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Maternal death or serious morbidity associated with labour or delivery</td>
<td>17</td>
<td>23</td>
<td>37</td>
</tr>
<tr>
<td>Infant discharged to the wrong family</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24</strong></td>
<td><strong>30</strong></td>
<td><strong>43</strong></td>
</tr>
</tbody>
</table>

Source: Safety Learning System
1.4.3.1  *Suicide of a patient in an in-patient unit*  
The suicide of a patient in an in-patient unit includes patients who were on leave from the in-patient unit and those who had absconded. Of the sentinel events reported in 2013-14, 7.0% (n=3) were suicides of patients in an in-patient unit.

The use of risk assessments have been reviewed and are included in the electronic notes of every mental health consumer. Training on risk assessment is available to all staff. Reviews are currently being conducted into these three events and the outcomes will be used to guide future practices.

1.4.3.2  *Retained instruments or other material after surgery requiring re-operation or further surgical procedure*  
If any instrument or other material is unintentionally left in the patient at the time of closing, the first layer of the incision or at the completion of a procedure that does not require closing (for example an angiogram), this event falls into the classification of a retained instrument or other material.

During 2013-14, 2.3% (n=1) of all sentinel events reported were in this category. This is a significant reduction from previous years.

1.4.3.3  *Intravascular gas embolism resulting in death or neurological damage*  
There was one sentinel event reported in this category, the last reported event was in 2007-08. A root cause analysis has been conducted and eight recommendations were made. These recommendations included the development of site specific instructions and the implementation of mandatory equipment checking processes, re-education and accreditation of staff using the equipment that was involved in the incident and alerting the equipment supplier to the issues identified.

1.4.3.4  *Maternal death or serious morbidity associated with labour or delivery*  
There were 37 sentinel events reported in the category of maternal death or serious morbidity associated with labour or delivery in 2013-14. This is an increase of 14 from the previous year. The majority of these incidents were related to post-partum haemorrhage.

Table 5 shows the sentinel events that have occurred in 2013-14 in relation to maternal death or serious morbidity associated with labour or delivery.

**Table 5: Maternal death or serious morbidity associated with labour or delivery 2013-14**

<table>
<thead>
<tr>
<th>Categories</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-partum haemorrhage &gt; 1500mls &lt; 3000mls</td>
<td>22</td>
</tr>
<tr>
<td>Post-partum haemorrhage 3000mls or greater</td>
<td>11</td>
</tr>
<tr>
<td>Bladder tear</td>
<td>1</td>
</tr>
<tr>
<td>Fourth degree tear</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>37</strong></td>
</tr>
</tbody>
</table>

Source: Safety Learning System
Issues surrounding the classification of maternal sentinel event’s and post-partum haemorrhage were raised by SA Health with the Australian Commission on Safety and Quality in Health Care. A national working group was established to undertake the following:

> review the definition and implications of the current sentinel event ‘Maternal death or serious morbidity associated with labour and delivery’
  
  a. provide national definitions for:
      
      i. maternal deaths associated with labour or delivery
      ii. serious morbidity

  b. to evaluate issues surrounding post-partum haemorrhage
      
      i. to determine a nationally recognised definition
      ii. to identify current trends, including rates, severity and patient profile

  c. to identify best practice review protocols for maternal deaths and serious morbidity.

The recommendations of the working group are currently awaiting endorsement by the Australian Health Ministers’ Advisory Council.

The Pregnancy Outcome Unit of the Epidemiology Branch of the Department for Health and Ageing collects information on each maternal death or occasion of serious morbidity occurring in South Australia. Each event is confidentially reviewed by the Maternal Mortality Subcommittee, a multidisciplinary committee including midwives, obstetricians, physicians, pathologists and an epidemiologist. The cause of death or serious morbidity is determined and broadly classified into direct, indirect and incidental (incidental meaning it cannot be directly or indirectly attributed to pregnancy).

More detailed data on maternal death and serious morbidity can be found in the Pregnancy Outcome in South Australia Report published annually, which can be located at [http://www.health.sa.gov.au/pehs/pregnancyoutcome.htm](http://www.health.sa.gov.au/pehs/pregnancyoutcome.htm)
1.4.4 Open disclosure

Open disclosure is the discussion with the patient / consumer, their family, carers and / or support person following an incident that resulted in harm to a patient while they were receiving health care.

The [SA Health Open Disclosure Policy Directive](#) was released in October 2011 and the [SA Health Incident Management Policy and Guideline](#) updated to incorporate open disclosure in order to establish a consistent approach across the public health sector.

In 2013-14, a work group was established with representation from the Health Consumers Alliance SA, Health and Community Services Complaints Commissioner, LHN and consumer representatives to revise the SA Health Open Disclosure Policy and Guideline to ensure it aligns to the new Australian Open Disclosure Framework released in 2013. A toolkit specific to open disclosure for patients / consumers and clinicians are also being developed.

Statewide consultation of the SA Health Open Disclosure policy, guideline and toolkits will be undertaken in 2014-15.

A number of open disclosure questions are included in the Safety Learning System to facilitate the accurate recording and appropriate management of the open disclosure process.

In 2013-14, an open disclosure question was answered for 99.7% of all incidents reported.

Table 6: Number of incidents reported where open disclosure question was answered 2013-14

<table>
<thead>
<tr>
<th>Open Disclosure</th>
<th>From Notifier report (99.5% of reports include this)</th>
<th>From Manager report (61.4% of reports include this)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>19077 (43.5%)</td>
<td>16652 (61.4%)</td>
</tr>
<tr>
<td>No</td>
<td>24781 (56.5%)</td>
<td>10454 (38.6%)</td>
</tr>
<tr>
<td>Total</td>
<td>44913 responses (100%)</td>
<td>27716 responses (100%)</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

Answers indicated that 58.1% of incidents had been disclosed by the notifier, manager or both. These open disclosures were related to the following primary incident classification types.
Table 7: Number and percentage of open disclosures made by primary incident classification 2013-14

<table>
<thead>
<tr>
<th>Primary incident classification</th>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient falls and other injuries</td>
<td>8945</td>
<td>77.6%</td>
</tr>
<tr>
<td>Medication</td>
<td>4448</td>
<td>46.6%</td>
</tr>
<tr>
<td>Implementation of care</td>
<td>2012</td>
<td>53.5%</td>
</tr>
<tr>
<td>Challenging behaviour</td>
<td>1832</td>
<td>63.0%</td>
</tr>
<tr>
<td>Treatment, procedure</td>
<td>1536</td>
<td>57.3%</td>
</tr>
<tr>
<td>Access, appointment, admission, transfer, discharge</td>
<td>1291</td>
<td>53.8%</td>
</tr>
<tr>
<td>Restraint / seclusion</td>
<td>1171</td>
<td>63.5%</td>
</tr>
<tr>
<td>Pressure injury / ulcer / sore</td>
<td>1006</td>
<td>75.5%</td>
</tr>
<tr>
<td>Clinical assessment</td>
<td>851</td>
<td>38.7%</td>
</tr>
<tr>
<td>Communication and teamwork</td>
<td>826</td>
<td>43.6%</td>
</tr>
<tr>
<td>Medical device / equipment</td>
<td>575</td>
<td>47.0%</td>
</tr>
<tr>
<td>Staffing, facilities, environment</td>
<td>499</td>
<td>46.5%</td>
</tr>
<tr>
<td>Patient information</td>
<td>488</td>
<td>32.3%</td>
</tr>
<tr>
<td>Labour or delivery</td>
<td>127</td>
<td>87.6%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

Information provided for monitoring through the Local Health Networks Analytics and Reporting Services (LARS) and demonstrates compliance to open disclosure.

1.4.5 Coronial findings

Under the Coroners Act 2003 (SA) the Coroner can, and in some circumstances is required to, hold an inquest to determine the cause or circumstances of the death of a person. SA Health uses the coronial findings and recommendations to assist in the identification of themes and trends that inform the development and implementation of systemic changes to improve patient safety.

During 2013-14, the Coroner held 26 inquests relevant to the health portfolio that resulted in 33 recommendations. A report to the Coroner on actions taken is provided within six months from the date of recommendations. The following provides an overview of the key themes and actions reported to the Coroner during 2013-14.

1.4.5.1 Paediatric gastroenteritis

An inquest was held in relation to the death of an 11 month old child who died as a result of dehydration. The inquest raised important issues as to the type of advice and medical response that ought to be given and implemented in cases where a person, particularly an infant, is discharged knowingly to a remote location at which further more urgent medical intervention may not be possible.

The inquest resulted in seven recommendations, which included:

- that medical practitioners practising in rural and remote areas be advised that an examination of an infant or child experiencing gastroenteritis requires a careful and comprehensive assessment of the patient and their circumstances, identifying the illness and its severity and working out a management plan with the parents which fully takes into account the additional problems for patients and health providers posed by the tyranny of distance in remote areas
- that guidelines be promulgated for the use of rural and remote medical practitioners when, in remote locations, examining infants and children who have experienced gastroenteritis.

Key actions taken in response to the Coronal recommendations include:

- the South Australian Paediatric Practice Guidelines – Gastroenteritis in Children, developed by the SA Child Health Clinical Network, were approved by the SA Health Safety and Quality Strategic Governance Committee in October 2013. The guidelines apply to all local health networks and are designed to assist clinicians working in primary care, local, regional, general or tertiary hospitals with decisions about appropriate health care for children with gastroenteritis. The guidelines emphasise that careful consideration should be given to where a child lives and ease of access to medical attention if the condition deteriorates. Patients living in geographic isolation, with limited access to medical care and an inability to return due to lack of transport or distance, are identified as a higher risk.

1.4.5.2 Referral of patients and medical imaging results

Two separate inquests were held into deaths resulting from subarachnoid haemorrhage with contributing cardiomegaly and left pontine haemorrhage respectively. Both cases involved a breakdown in communication in relation to the referral of patients from country areas and the results of medical imaging tests. These inquests resulted in six recommendations, which included:

- that general practitioners who have referred patients suspected of suffering a subarachnoid haemorrhage to hospitals and emergency departments be encouraged to carefully scrutinise discharge summaries and letters to ensure that they are satisfied that all relevant diagnostic information has been taken into account, and in particular to carefully scrutinise and evaluate the discharge diagnosis
- that when urgent, unexpected or sinister findings are reported following medical imaging, the general practitioner should ensure that if the patient concerned is not able to be notified within 48 hours of the finding (or less if clinically indicated), the general practitioner must make contact with the South Australian Ambulance Service or South Australia Police to ensure that a welfare check is conducted and that the patient is advised to contact his or her general practitioner.

Key actions taken in response to the Coronal recommendations include:

- a memo was issued to general practitioners reminding them of the importance of scrutinising discharge summaries and recommending that telephone contact with hospital emergency departments be made when a patient is presenting with subarachnoid haemorrhage
- the Minister for Health wrote to the Royal College of General Practitioners, the Australian Medical Association (SA) and the Chief Executive Officers of the five South Australian Medicare Locals, to bring the recommendations to their attention.
1.4.5.3 **SA Prison Health Services**

> Four separate inquests were held that involved the clinical care provided by the South Australian Prison Health Service (SAPHS) to patients serving a sentence of imprisonment within institutions operated by the Department for Correctional Services. There were six recommendations which focussed on:

> the responsibility of maintaining oversight of the medical treatment and investigation of those prisoners within institutions operated by the Department for Correctional Services who are suspected of suffering from a serious or life threatening illness, especially in circumstances where the medical treatment and investigation of such prisoners is being conducted by medical practitioners who are not employees of the SAPHS.

Key actions taken in response to the Coronial recommendations include:

> SAPHS has established a formal process for liaison with hospitals when patients are admitted and works with the hospital on care and discharge planning for the return to the prison environment or alternative placement if required. This process extends to medical practitioners who are not directly employed by SAPHS, but whom provide services to SAPHS, including general practitioners in country locations. In addition, SAPHS has established a database of patients requiring chronic disease management to support the exchange of information and enhance communications between SAPHS health centres when prisoners are transferred.

> SAPHS also participate in complex case management in partnership with the Department for Correctional Services through a multidisciplinary group which focusses on discussing the requirements of patients with high care or special needs.

1.4.5.4 **Family escalation of care**

An inquest was held into a death resulting from hypoxic-ischaemic encephalopathy complicating cardiac arrest due to retroperitoneal and pelvic haemorrhage complicating pelvic fractures. There were two recommendations which focused on:

> the failure of hospital staff on duty to respond to family members requests that a medical practitioner be summoned.

Key actions taken in response to the Coronial recommendations include:

> The Recognising and Responding to Clinical Deterioration policy directive and guidelines, recognises that families and carers are important in the recognition of deterioration of patients and systems have been established to enable the family escalation of care. Feedback about response processes to deteriorating patients is reported in the consumer feedback module of the Safety Learning System and reviewed in accordance with the SA Health Framework for Active Partnership with Consumers and the Community and the SA Health Guide for Engaging with Consumers and the Community.

1.4.6 Consumer feedback

SA Health encourages consumers, families, carers and the community to provide feedback. Feedback provides an opportunity for health services to observe the quality of health care from the perspective of consumers and carers. It also assists in directing improvement in the quality of these services.

Consumers can provide feedback and express their concerns or compliments in person with the relevant health care service, via telephone, by writing, via the health care service website or with the Consumer / Patient Adviser. Issues that cannot be resolved at the health care service may be forwarded to the Health and Community Services Complaints Commissioner (HCSCC).

The Safety Learning System (SLS) is used to record complaints and compliments in South Australia. The complaints received are categorised against the HCSCC Charter of Rights and national health complaints categories and sub-category definitions.

Between 1 July 2013 and 30 June 2014, 9398 records of consumer feedback were reported into the SLS, a 1% increase from 2012-13 (n=9302).

Graph 5: SA Health consumer feedback received by type and method of feedback 2013-14

Source: Safety Learning System
Table 8 demonstrates the national health complaints categories and subcategories aligned to the HCSCC Charter of Rights.

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>HCSCC Charter of Rights</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>The availability of service in terms of location, waiting lists and other constraints that limit use of the service</td>
<td>Access – Right to health and community services</td>
</tr>
<tr>
<td>Communication</td>
<td>Appropriateness, completeness and reliability of information, the way information is communicated, or special communication needs.</td>
<td>Respect – right to be treated with respect Information – right to be informed.</td>
</tr>
<tr>
<td>Consent</td>
<td>Consumer’s right to be involved in decision making and to be given sufficient information on which to base their consent to treatment or service.</td>
<td>Participation – right to actively participate.</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>Support services such as hotel services, administrative procedures and the standard of facilities including hygiene and safety (excludes billing practices).</td>
<td>Quality – right to high quality services.</td>
</tr>
<tr>
<td>Cost</td>
<td>Fees, discrepancies between advertised and actual costs, charges and rebates, and information about costs and fees.</td>
<td>Information – right to be informed. Participation – right to actively participate.</td>
</tr>
<tr>
<td>Grievances</td>
<td>Action taken by a provider in response to a complaint.</td>
<td>Comment – right to comment and / or complain.</td>
</tr>
<tr>
<td>Privacy / discrimination</td>
<td>Breaches of consumer rights or acts of discrimination in relation to service provisions or breaches of privacy or confidentiality.</td>
<td>Privacy – right to privacy and confidentiality Respect – right to be treated with respect.</td>
</tr>
<tr>
<td>Professional conduct</td>
<td>Unethical and / or illegal practices as well as issues of competence (excludes negligent treatment and referral).</td>
<td>Quality – right to high quality services. Safety – right to be safe from abuse.</td>
</tr>
<tr>
<td>Treatment</td>
<td>Diagnosis, testing, medication and other therapies provided.</td>
<td>Quality – right to high quality services.</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

Between 2013-14 and 2012-13, there has been a 0.8% increase in the number of complaints in relation to communication from 25.9% to 25.9%, complaints received on treatment remained stable at 25% and a 0.1% decrease in relation to access from 24.6% to 24.5%.

Graph 6: SA Health classification of complaints by national health complaints categories 2013-14

Source: Safety Learning System
All consumer feedback is reviewed by the health care service and also analysed on a larger scale to identify patterns. Recurring issues and concerns raised by consumers can then be acted upon.

In 2013-14, data from the Safety Learning System Consumer Feedback module was incorporated into the Local Health Network Analytical Reporting System (LARS) to improve safety and quality across SA Health by providing standardised, accurate and timely information on:

- consumer feedback by type and method
- consumer complaints by complaint category and sub category
- Charter of Health and Community Services Rights (the HCSCC Charter)
- complaints acknowledged <2 working days
- complaints resolved and closed <35 working days.

### 1.4.6.1 Consumer feedback in Measuring Consumer Experience Report

The third SA Public Hospital Inpatient Annual Report on Measuring Consumer Experience includes data gathered through SA Consumer Experience Surveillance System (SACESS) between 1 January to 31 December 2013 (n=2427).

The SA Health overall mean area score for Consumer feedback was 42.4 (se 0.5, 95% CI 41.5-43.3), well below the SA benchmark of 85, with all areas below the benchmark requiring immediate action.

Scores were derived from responses following survey questions:

<table>
<thead>
<tr>
<th>Question</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>While you were in hospital, did you ever see any posters or leaflets explaining how to complain about the care you received?</td>
<td>31.7</td>
</tr>
<tr>
<td>Did you want to complain about the care you received in hospital?</td>
<td>*91.6</td>
</tr>
</tbody>
</table>

* "No" is the sought after response for this question

### 1.4.6.2 Consumer feedback and complaints management strategy

In 2014-15 the Safety and Quality Branch will work with Local Health Networks to focus on areas for improvement and establish a work group with LHN representatives to:

- review the SA Health Consumer Feedback and Complaints Management Policy, Guideline and Toolkit
- identify mechanisms to raise consumer’s awareness on how to provide feedback, raise a concern or complaint and to know their rights
- review the post accreditation status of actions not met in relation to complaints management and patient rights and engagement
- establish a suite of standardised consumer feedback reports
- develop an education, training framework and online e-learning module
- review LHN staffing and resources for the management of consumer feedback and complaints management.

### 1.4.6.3 Ombudsman SA – audit on complaint handling

In December 2013, the Ombudsman SA undertook an audit of state government agency complaint handling including SA Health. The Safety and Quality Branch provided an overview of the complaint handling approaches including the SA Health Consumer Feedback and Complaints Management policy, guideline and toolkit, monitoring and review of complaints and complaints handling practices for service improvements.

Following the agencies responses to the audit, the Ombudsman SA invited SA Health and LHN representatives to meet with the audit team in May 2014. The interview discussed the department’s responses in detail and examined opportunities for quality and system improvements. LHNs provided case studies as examples of service improvements which had been generated by complaints. The final Ombudsman SA report will be released later in the year.

1.5 Patient rights and engagement

1.5.1 Charter of Health and Community Services Rights Policy

The purpose of the SA Health Charter of Health and Community Services Rights Policy Directive is to implement the Charter of Health and Community Services Rights (the HCSCC Charter), and to ensure that services are safeguarding patient rights and complying with the legislation as Part 3 of the Health and Community Services Complaints Act 2004. The policy aims to increase awareness of all staff, consumers and the public about the rights of consumers and the community as set out in the HCSCC Charter.

The HCSCC Charter of Rights have been aligned to the national health complaint category and sub category in the Safety Learning System Consumer Feedback module.

Graph 5 highlights that quality of care, access, information and respect are areas where complaints mostly arise, but that SA Health receive few complaints about privacy, participation, comment and safety, and is consistent when reported in 2012-13.

Between 2013-14 and 2012-13, there has been a 1% decrease in the number of complaints reported which align to the Charter of Rights in relation to quality from 40% to 39%. Complaints in relation to access 24% and information remained stable at 16%.

Graph 7: SA Health complaints aligned to HCSCC Charter 2013-14

Source: Safety Learning System
1.5.2 Charter of Rights analysis of consumer feedback on quality and access

Patient rights relating to quality and access are reported as the highest complaint category by consumers, families and/or carers.

In April 2014, an analysis on the quality and access complaints and de-identified examples of consumer feedback were reported in the SA Consumer and Community Report on Safety and Quality to the SA Safety and Quality in Health Care Consumer and Community Advisory Committee (CACAC), and the SA Health Partnering with Consumers and Community Advisory Group.

Item 3: SA Consumer and Community Report on Safety and Quality – Analysis on consumer feedback on patient rights relating to quality

Further information on the HCSCC Charter is available on the Health and Community Services Complaints Commissioner website at www.hcscc.sa.gov.au

Further information is available on the Safety and Quality section of the SA Health website Charter of Healthcare Rights page at www.sahealth.sa.gov.au/safetyandquality

2 Partnering with consumers
2. Partnering with consumers

SA Health values the positive contributions consumers and the community are making to improve health service quality, equity and management. The importance of developing health systems and health services that are based on partnerships with patients, families, carers and consumers is reflected in national quality and accreditation frameworks.

National Safety and Quality Health Service Standard 2 – Partnering with Consumers includes:

> consumer partnership in service planning
> consumer partnership in designing care
> consumer partnership in service measurement and evaluation.

2.1 Consumer partnerships in service planning

2.1.1 SA Safety and Quality in Health Care Consumer and Community Advisory Committee

The SA Safety and Quality in Health Care Consumer and Community Advisory Committee (CACAC) is a sub-committee of the SA Council on Safety and Quality in Health Care (SACSQHC), and was established in 2007. The CACAC has diverse membership and is instrumental in continuously improving patient safety and quality in providing the consumers’ perspective in service planning, designing care and service measurement and evaluation.

The CACAC continues to work with the SACSQHC with a combined work plan which is underpinned by the Australian Safety and Quality Framework for Health Care that is consumer centred, driven by information and organised for safety.

The CACAC Summary of Achievements report was provided to SACSQHC. Highlights include CACAC’s involvement in the:

> SA Patient Safety Report for Consumers and the Community and fact sheets
> SA Health Same Gender Accommodation Policy, Guideline and Toolkit
> Cultural and Linguistically Diverse (CALD) Consumer Experience pilot and Community Forums
> SA Government Better together: principles of engagement, Case Study 5 on Partnering with Consumers and the Community.

2.1.2 SA Health Partnering with Consumers and the Community Advisory Group

The SA Health Partnering with Consumers and the Community Advisory Group was established in 2013. Representation includes Health Consumers Alliance SA, Health and Community Services Complaints Commissioner, Nursing and Midwifery Office, Mental Health and SubSTANCE Abuse, Service Development, Statewide Clinical Support Services, SA Ambulance Service, and a representative from each local health network, consumers and the SA Health Safety and Quality.

The Advisory Group is the strategic committee for Partnering with Consumers, and work is underpinned by:

> the Australian Safety and Quality Framework in Health Care
> Australian Commission on Safety and Quality in Health Care Patient-centred Care
> Standard 1 - Governance for Safety and Quality in health service organisations (National Safety and Quality in Health Services Standards) in relation to complaints management, patient rights and engagement and open disclosure
> Standard 2 - Partnering with Consumers (National Safety and Quality in Health Services Standards)
> Australian Safety and Quality Goals for Health Care Goal 3 – Partnering with Consumers.

6 National Safety and Quality Health Service Standards (September 2012), Australian Commission on Safety and Quality in Health Care
The role of the Advisory Group is to oversee the coordination and monitoring of the whole of health strategy aimed at standardisation across SA Health in regard to partnering with consumers, described by the [SA Health A Framework for Active Partnership with Consumers and the Community](http://www.sahealth.sa.gov.au/sahealth/standard2) (the Framework) and [A Guide for engaging with Consumers and the Community](http://www.sahealth.sa.gov.au/sahealth/standard2) (the Guide) which were released in early 2013.

In 2013-14, the SA Health Partnering with Consumers and Community Strategic Action Plan includes work being undertaken to address:

- consumer feedback and complaints management
- patient rights and engagement
- open disclosure
- measuring consumer experience
- partnering with consumers
- education and training
- data reporting and monitoring.

### 2.1.3 Partnering with consumers accreditation resource

**Item 4: Standard 2 Partnering with consumers accreditation resource**

The [SA Health Partnering with Consumers accreditation resource guide](http://www.sahealth.sa.gov.au/sahealth/standard2) developed to support health services was revised and updated in 2014. The guide provides examples of South Australian tools and resources that can be used to demonstrate an action and standard has been met.

The accreditation resource guide is available on the Safety and Quality section of the SA Health website [National Safety and Quality Health Service Standards page](http://www.sahealth.sa.gov.au/sahealth/standard2) at www.sahealth.sa.gov.au/safetyandquality
2. Partnering with consumers

2.2 Consumer partnership in designing care

2.2.1 Measuring consumer experience

SA Health is committed to ensuring that the experience of consumers using its services is as positive as possible. The SA Consumer Experience Surveillance System (SACESS) is a telephone survey where consumers are interviewed soon after an overnight stay in a metropolitan or country public hospital using a set of internationally validated questions. Consumers are asked about whether or not certain processes and events occurred during their episode of care, such as whether they felt involved in their care and treatment and in decision-making, if their care was consistent and coordinated, if they felt they were treated with respect and dignity, their privacy, pain control, treatment received from doctors and nurses, and the cleanliness of the hospital and ward they stayed in.

In 2013, the response rate was 75% and 2427 patients were interviewed about their experience in public hospitals, and in 2011-12, 2438 South Australians were interviewed.

The report details the key findings and further analysis of the consumers’ experiences. Ongoing analysis of the consumers’ experience will ensure that the experience of health care continues to improve.

Local Health Networks were provided with an overall and individual hospitals report (greater than 50 interviews). LHNs are asked to address the key performance indicators and domains of care areas that do not reach the benchmark score of 85, and an action plan was required to be developed. Qualitative reports on the satisfied and dissatisfied comments were also provided to the LHNs.


Item 5: Measuring Consumer Experience SA Public Hospital Inpatient Annual Report

2.2.1.1 Domains of care

Measuring consumer experience numerically, health care is divided into ten (10) domains and questions are asked about areas within each domain. The domains and questions were chosen because they provide a meaningful picture of consumer experiences with their care.

Ten (10) consumer experience domains are based on evidence-based national and international literature and draws heavily on work developed for the Picker Institute, Europe’s ‘Principles of Patient-Centred Care’. The Picker Institute, Europe are responsible for designing, validating and updating all patient experience surveys for the Care Quality Commission and the National Health Service, United Kingdom.

The ten domains of care are:
1. consistency and coordination of care
2. treated with respect and dignity
3. involved in decision making
4. doctors
5. nurses
6. cleanliness
7. pain control
8. privacy
9. food
10. discharge information

7 Picker Institute website: http://pickerinstitute.org/about/picker-principles/
In 2013, additional questions were asked in relation to food and discharge information. The domains of care, questions and mean scores for 2013 are listed in Table 9.

Table 9: Summary of mean scores by core domains of care and questions, SA overall, 2013

<table>
<thead>
<tr>
<th>Question number and actual question</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Consistency and coordination of care</td>
<td>78.7</td>
</tr>
<tr>
<td>Q11 Sometimes in a hospital, a member of staff will say one thing and another will say something different. Did this happen to you?</td>
<td>80.2</td>
</tr>
<tr>
<td>Q41 How would you rate how well doctors and nurses worked together?</td>
<td>77.4</td>
</tr>
<tr>
<td>2 Treated with respect and dignity</td>
<td>92.0</td>
</tr>
<tr>
<td>Q40 Overall, did you feel you were treated with respect and dignity?</td>
<td>92.0</td>
</tr>
<tr>
<td>3 Involved in decision making</td>
<td>79.8</td>
</tr>
<tr>
<td>Q14 Were you involved as much as you wanted to be in decisions about your care and treatment?</td>
<td>82.0</td>
</tr>
<tr>
<td>Q15 How much information about your condition or treatment was given to you?</td>
<td>79.4</td>
</tr>
<tr>
<td>Q33 Did you feel you were involved in decisions about your discharge from hospital?</td>
<td>78.4</td>
</tr>
<tr>
<td>4 Doctors</td>
<td>88.2</td>
</tr>
<tr>
<td>Q25 When you had important questions to ask a doctor, did you get the answers you could understand?</td>
<td>84.5</td>
</tr>
<tr>
<td>Q27 Did you have confidence and trust in the doctors treating you?</td>
<td>91.3</td>
</tr>
<tr>
<td>5 Nurses</td>
<td>89.7</td>
</tr>
<tr>
<td>Q29 When you had important questions to ask a nurse, did you get the answers you could understand?</td>
<td>88.5</td>
</tr>
<tr>
<td>Q30 Did you have confidence and trust in the nurses treating you?</td>
<td>89.8</td>
</tr>
<tr>
<td>Q31 Did the nurses talk in front of you like you weren’t there?</td>
<td>90.7</td>
</tr>
<tr>
<td>6 Cleanliness</td>
<td>90.5</td>
</tr>
<tr>
<td>Q4 In your opinion, how clean was the hospital room or ward you were in?</td>
<td>90.4</td>
</tr>
<tr>
<td>Q5 How clean were the toilets and bathroom that you used while in hospital?</td>
<td>87.8</td>
</tr>
<tr>
<td>Q28 As far as you know, did the doctors wash or clean their hands between touching patients?</td>
<td>91.9</td>
</tr>
<tr>
<td>Q32 As far as you know, did the nurses wash or clean their hands between touching patients?</td>
<td>94.2</td>
</tr>
<tr>
<td>7 Pain control</td>
<td>90.1</td>
</tr>
<tr>
<td>Q7 Do you think the hospital staff did everything they could to help control your pain?</td>
<td>90.1</td>
</tr>
<tr>
<td>8 Privacy</td>
<td>94.7</td>
</tr>
<tr>
<td>Q45 Were you given enough privacy when discussing your condition or treatment?</td>
<td>92.6</td>
</tr>
<tr>
<td>Q46 Were you given enough privacy when being examined?</td>
<td>96.7</td>
</tr>
</tbody>
</table>
The average of the responses to the group of questions from each domain is used to derive a mean score. A score of 85 is designated as the SA Health benchmark, in accordance with the Picker Institute scoring protocol.

- **90** = above average
- **85** = South Australian (SA) benchmark
- **80** = Average (reasonable level – room for improvement / being monitored)
- **70** = Below average (poor level – immediate action required).

The lowest mean score (68.0) was recorded for the ‘discharge information’ and the highest mean score (94.7) for ‘privacy’.

The four domains of care where SA public hospitals scored above 90 are ‘privacy’, ‘treated with respect and dignity’, ‘cleanliness’ and ‘pain control’.

The domains of care where SA public hospitals scored below the SA Health benchmark (mean score of 85) in 2013, are ‘consistency and coordination of care’, ‘involvement in decision making’, ‘food’ and ‘discharge information’.

A Statewide Measuring Consumer Experience Strategic Action Plan has been developed to address the domains of care which scored under the SA Health benchmark.
Graph 8 demonstrates the average score for core domains of care relating to consumer experiences of overnight care at a South Australian metropolitan or country hospital.

**Graph 8: Mean scores for the core domains of care (Picker Institute), SA overall, SACESS 2010-13**

* indicates statistically significant difference between year.

Although a number of these domains remain below the target of 85, there has been improvement from the previous year (involvement in decision making 78.3 and consistent and coordinated care 76.9) in 2013.

### 2.2.1.2 Involvement in care and treatment

A set of six questions around the broad theme ‘involvement in care and treatment’ has been identified as a SA Health key performance indicator (KPI). In 2013, the mean score for SA Health consumers of overnight hospital care for the overall involvement in care and treatment was 74.2 (se: 0.5, 95% CI: 73.2 – 75.2), which was below the SA Health benchmark.

The mean score of this KPI represents the average of responses to the six question items listed below in table 10 ‘involvement in care and treatment’ items, SA overall, SACESS 2013.

Two of the six questions scored above the SA Health benchmark score of 85, and the remaining four were below, indicating a need for improvement.

The measurement of consumer experience and questions relate to dietary needs, cultural or religious beliefs, access to an interpreter, understanding the risks, benefits and alternatives of recommended treatment, and right to have an opinion respected.

The questions and mean score on consumer involvement in care and treatment are shown in table 10.
Table 10: Involvement in care and treatment items, SA overall, 2013

<table>
<thead>
<tr>
<th>Question number and actual question</th>
<th>Mean score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement in care and treatment</td>
<td>74.2</td>
</tr>
<tr>
<td>Q19 Were you asked about your dietary needs when you arrived on the ward?</td>
<td>67.1</td>
</tr>
<tr>
<td>Q20 Did anyone ask whether you had any cultural or religious beliefs that might affect the way you were treated in hospital?</td>
<td>37.1</td>
</tr>
<tr>
<td>Q21 If you needed one, did you have access to an interpreter?</td>
<td>53.9</td>
</tr>
<tr>
<td>Q22 Did you feel that you could have refused to have students (medical or nursing) present during your treatment?</td>
<td>81.7</td>
</tr>
<tr>
<td>Q23 When you gave your consent for medical treatment, did you understand the risks, benefits and alternatives of recommended treatment?</td>
<td>92.5</td>
</tr>
<tr>
<td>Q24 Was your right to have an opinion respected?</td>
<td>86.2</td>
</tr>
</tbody>
</table>


As reported in the Measuring Consumer Experience SA Public Hospital Inpatient Annual Report September 2014, nearly 88% of patients rated the overall quality of the service as ‘very good’ or ‘good’, and 90% said they would recommend the hospital to a relative or friend.

Of those who could recall, 32.9% reported that they were not asked about their dietary needs either on the ward or at pre-admission. Similarly, 62.9% reported that they were not asked about their cultural or religious beliefs that may affect their treatment. About 46% of respondents who needed interpretation service reported that they were not offered or could not access an interpreter. The areas for improvement are therefore around routinely asking about dietary, cultural, religious and language needs, and acting on this information.

Nearly one fifth (18.3%) of respondents felt that they could not comfortably refuse to have a medical student present. More than nine in ten (92.5%) respondents reported that they understood the risks, benefits and alternatives of recommended treatment during the consent process.

The final survey question asked “Finally, was there one issue about your hospital stay that you really want to tell us about?”. Of the 2427 South Australian adults interviewed for the SACCESS survey during 2013, almost half (n=1045 or 43%) provided a comment on their experiences of their hospital stay. Of these comments, 313 (30%) responses were received from respondents who were satisfied, while 732 (70%) were received from respondents who were dissatisfied with the care they received during their hospital stay. These comments were categorised against eight principles of patient-centred care and four additional themes.

Overall, those who chose to provide comment were most commonly:

> positive about the coordination and integration of care; doctors and nurses’ and respect for patients’ values, preferences and expressed needs

> negative about the physical comfort; respect for patients’ values, preferences and expressed needs; and coordination and integration of care.

The Measuring Consumer Experience SA Public Hospital Inpatient Annual Reports are available on the Safety and Quality section of the SA Health website www.sahealth.sa.gov.au/safetyandquality
2. Partnering with consumers

2.2.1.3 Safety Learning System – Measuring Consumer Experience Module

In 2013-14, the Safety and Quality Branch developed a Measuring Consumer Experience Module in the Safety Learning System (SLS) using the Computerised Assisted Personal Interview (CAPI) mechanism.

The module will increase the number of consumers sharing their experience with health services and SA Health, which are currently excluded from the SA Consumer Experience Surveillance System (SACCESS). The module will offer health services organisations multiple options and models to capture consumer experience including via bed-side monitors, hand held devices and hard copy handouts (for data entry into SLS).

In 2014-15, the Local Health Networks will pilot the Measuring Consumer Experience SLS module in inpatients, outpatients, community, mental health, obstetrics, paediatrics, palliative care, dental and renal services.

The Measuring Consumer Experience SLS module pilot will enable SA Health to better understand the consumer and community needs in health care for all consumers including:

- culturally and linguistically diverse (CALD)
- aboriginal and torres strait islander (ATSI)
- patients with a mental illness
- patients aged 16 years and under.

The national set of core common patient experience questions have been incorporated into the SLS Measuring Consumer Experience module and SACCESS.

2.2.2 Same gender accommodation

In 2013-14, the SA Health Safety and Quality in Health Care Consumer and Community Advisory Committee (CACAC) members raised concerns in relation to mixed gender wards occurring in some hospitals, and identified the need for a statewide policy on same gender accommodation.

Following CACAC discussions, the issues were raised at the SA Council for Safety and Quality in Health Care, and Council members agreed and encouraged CACAC to work with the Safety and Quality Branch.

Item 6: Consumer information on Respecting your privacy and dignity with patient centred care principles

Discussions were also undertaken at the SA Safety and Quality Strategic Governance Committee and members endorsed the development of the statewide Same Gender Accommodation Policy, Guideline and Toolkit.

A consumer information booklet on respecting your privacy and dignity with patient centred care principles and a staff information sheet on respecting patients’ privacy and dignity with patient centred care principle were also developed. The draft documents were finalised by CACAC in early 2014.

The final draft SA Health Same Gender Accommodation Policy, Guideline, Toolkit, consumer and staff resources documents will be available for statewide consultation in mid 2014.

8 Australian Commission on Safety and Quality in Health Care (ACSQHC), Patient Experience Information Development Work Group (PIEDWG)
### 2.3 Consumer partnership in service measurement and evaluation

#### 2.3.1 Patient Safety Report for consumers and the community and fact sheets

The second *South Australian Patient Safety Report for Consumers and Community* was released in February 2014. The Executive Summary was developed as a consumer focused report to show some of the main improvements across SA Health and its commitment to creating and maintaining a quality environment which provides health care services that are consumer centred, driven by information and organised for safety.

The Executive Summary highlights:

- Consumer feedback and measuring consumer experience
- Medication safety
- Clinical handover
- Recognising and responding to acute clinical deterioration

Individual fact sheets have also been developed:

- Partnering with Consumers and measuring consumer experience – fact sheet 1
- Medication safety – fact sheet 2
- Clinical handover – fact sheet 3
- Recognising and responding to acute clinical deterioration – fact sheet 4

The Executive Summary and fact sheets were reviewed and endorsed by SA Safety and Quality in Health Care Consumer and Community Advisory Committee in January 2014 and are available on the Safety and Quality section of the SA Health website at [www.sahealth.sa.gov.au/safetyandquality](http://www.sahealth.sa.gov.au/safetyandquality).

The Executive Summary and fact sheets were distributed to all Local Health Networks and consumer organisations.

**Item 7: SA Patient Safety Report for Consumers and Community Executive Summary and fact sheets**


Further information is available on the Safety and Quality section of the SA Health website [Partnering with Consumers and the Community](http://www.sahealth.sa.gov.au/safetyandquality).

Additional information is also available on the Australian Commission on Safety and Quality in Health Care website [Patient and Consumer Centred Care](http://www.safetyandquality.gov.au/our-work/patient-and-consumer-centred-care/).
2. Partnering with consumers

2.3.2 SA Consumer and Community Report on Safety and Quality

In 2013-14, the South Australian Consumer and Community Reports on Safety and Quality were developed as a snapshot of current safety and quality issues and improvements. The reports are produced in a consumer focussed and consumer friendly format, on a bi-monthly basis. Positive feedback has been received by consumers in relation to the format and the ability to understand and interpret the data reported.

The SA Consumer and Community Report on Safety and Quality reports on actions taken and improvements being made across SA Health. Data is used from the Safety Learning System (SLS) Incident and Consumer Feedback modules, LARS, SA Consumer Experience Surveillance System (SACCESS) and Infection Control.

Reports have been circulated and discussed at the SA Safety and Quality in Health Care Consumer and Community Advisory Committee (CACAC), and the SA Health Partnering with Consumers and Community Advisory Group.

The SA Consumer and Community Report on Safety and Quality include:

- **incident management**
  - top 5 incidents, top 5 incidents by overall harm SAC 1 and 2, open disclosure

- **consumer feedback**
  - number of complaints received by month and type of feedback (advice, complaint, compliment, suggestion, complaints by category and sub category and complaints by Health and Community Services Complaints Commission Charter of Rights

- **measuring consumer experience**

- **infection control**
  - recognition and management of challenging behaviour
  - examples of consumer feedback (positive and negative) which are aligned to the HCSCC Charter of Rights.

The SA Consumer and Community Report on Safety and Quality outlines what actions are being taken in relation to open disclosure, recognition and management of challenging behaviour, and the Cultural and Linguistically Diverse (CALD) Advisory Group.

Local Health Network Consumer and Community Reports on Safety and Quality have also been developed based on the SA example. The reports are circulated and discussed at the LHN Consumer Advisory Group meetings.

Item 8: SA Consumer and Community Report on Safety and Quality

Item 9: Noarlunga Hospital Consumer Council Report on Safety and Quality
2.3.3 Cultural and Linguistically Diverse (CALD) consumer experience

In 2012-13, the Cultural and Linguistically Diverse (CALD) Consumer Experience Advisory Group was established. The advisory group has two SA Health Safety and Quality in Health Care Consumer and Community Advisory Committee (CACAC) members from multicultural communities including Multicultural Communities Council SA (MCCSA) and Multicultural Youth SA (MYSA), and other representatives from multicultural communities.

The group is working on a project to trial a variety of methods to enable consumers from the CALD community to feedback their experience, and thereby better understand the health care needs of the CALD community. The purpose of the CALD Consumer Experience pilot will enable CALD consumers the opportunity to share their experiences and provide SA Health with their perspective on health care services.

In 2013-14, the SA Health CALD profile report on patients from a non English speaking background utilising health care services was provided to all Local Health Networks. The CALD profile reported on all metropolitan public hospital overnight inpatients, emergency department attendances, mental health service attendances, by LHN and hospital level. Overall, 14% of all metropolitan public hospital overnight inpatients (19+ years) were from a non English speaking background. The SA Health CALD Paediatrics profile (0-18 years) report was also provided to the Women's and Children's Health Network.

In 2013-14, an analysis of the SA Consumer Experience Surveillance System (SACCESS) questions and demographic profile by CALD status was reported. Overall, there were 284 patients who were interviewed from a CALD background and stayed overnight in a public hospital in South Australia. The satisfied and dissatisfied comments made by CALD patients were also reported and discussed by the CALD Consumer Experience Advisory Group.

As reported in the Measuring Consumer Experience Report 2013, the mean score in relation to the question relating to ‘if you needed one, did you have access to an interpreter’ is 53.9, well below the SA Health benchmark of 85.

Following discussions with the CACAC and CALD Consumer Experience Advisory Group, resources are currently being developed for patients / consumers from a CALD background to assist in accessing interpreting services.

The CALD resources include:

- interpreter card for patients/consumers to advise staff on language and dialect
- language identification card for reception areas
- posters.

A pilot of the CALD resources will be undertaken with Local Health Networks in 2014-15.
2. Partnering with consumers

**Case study: Cultural and Linguistically Diverse (CALD) community consumer experience forums**

The first CALD Consumer and community consumer experience forum was held on 1 October 2013, with the Southern Italians Carer Group, Italian Benevolent Foundation (IBF) and second CALD community forum was held on 2 May 2014, with members of the Limani Dementia Respite Program at the Greek Orthodox Community of SA Inc (GOCSA).

The draft CALD community consumer experience questionnaire was used as a guide to have a conversation with participants and enabled consumers to share their experience on care and treatment, access to interpreter, cultural needs, physical and environmental needs and what was required when leaving hospital.

**Italian community forum**

In October 2013, the Italian community consumer experience forum, consisted of seven females, one male and two staff from the Italian Benevolent Foundation. The Italian Southern Carers group, aged between 65 and 80 years meet once a month on a Tuesday to support culturally and linguistically diverse carers by providing them with access to culturally appropriate resources, education, networks and emotional support.

The Italian Carer Support Group are carers who look after a family member who is frail, aged, has dementia or has a mental or physical disability. Each month guest speakers from various agencies are invited to present different topics to the group.

**Picture 15: Italian Southern Carers Group, Italian Benevolent Foundation**
Greek community forum

In May 2014, the Greek community consumer experience forum consisted of 20 consumers (15 females and five males) including seven carers and two carers attended with family members living with dementia.

11 individuals were aged over 65 years and all born in Greece.

The Greek Orthodox Community of SA Inc Limani Dementia Respite Program provides a stimulating, culturally and linguistically appropriate based day care program for people with memory loss and / or confusion living in the community and their carers.

The aim is to improve the health and lifestyle of older people, respite to the carers and preventative health programs, such as falls, gentle exercise, podiatry and nutrition advice.

Picture 16: Limani Dementia Respite Program at Greek Orthodox Community of SA Inc

The Italian and Greek community consumer experience forums identified the need to look at:

> communicating with consumers from a CALD background
> access to interpreters in the specific dialect of the language
> raising staff awareness of family and carer involvement in discussions and decision making
> providing information on discharge
> raising consumer awareness on how to provide feedback and the role of the Consumer Advisor.

Further CALD community consumer experience forums will be scheduled in 2014-15 with the new and emerging communities, and migrant youth.
Central Adelaide Rehabilitation Services applied to the Registered Nurses Association of Ontario (RNAO) in September 2012 to become Australia’s first Best Practice Spotlight Organisation (BPSO) Candidate, with the support of SA Health and the Australian Nursing and Midwifery Federation (ANMF), and was successfully granted a three year contract. The BPSO program offers structure and tools to:

- implement clinical practice guidelines
- promote a culture of research
- monitor, evaluate and sustain evidence based practice
- empower staff with knowledge
- create an environment that facilitates knowledge translation into practice
- as well as allowing for national/international comparison/benchmarking.

The Central Adelaide Rehabilitation Services agreed to implement at least three into our practice. One of the three Best Practice Guidelines (BPG) chosen was Client Centred Care.

As part of the implementation of the ‘Client Centred Care’ best practice guideline it was noted that Central Adelaide Rehabilitation Services lacked a standardised avenue for collecting feedback from consumers following their discharge from our service. Units were individually attempting to collect feedback using own local processes and collation. The results were not disseminated appropriately and recommendations for improvement of client experience were not implemented or outcomes evaluated.

A BPSO Committee interprofessional team including nurses, medical officers and allied health members was established, with involvement including the Hampstead Rehabilitation Centre Consumer Advisory Committee and Central Adelaide Rehabilitation Services Standard Two Working Group.

Following identification of feedback gaps the ‘Patient Experience Survey’ tool was developed, as were processes on how to distribute survey to consumers on discharge in a timely fashion.

Consumers were encouraged to take away survey for completion and return it in a pre-paid envelope. This allowed consumers time to think / reflect about their responses and also ensured that questions were answered honestly without fear of retribution.

Every three months returned surveys are collated into a database and reports are disseminated to units for celebrations of work well done and for wards to identify strategies to increase patient satisfaction (address issues raised in the patient experience survey).

Improvements were noted in consumer satisfaction following the implementation of the ‘Patient Experience Survey’, facilitated by ongoing staff education on the ‘Client Centred Care’ best practice guidelines, as evidenced in the reports disseminated to the units.

Consumers were more empowered to give feedback about the services when information requested was in an evidence based format. Patients / consumers could also justify providing feedback when they could see that it resulted in action to rectify issues identified and recommendations were made to improve the consumer experience.

Reports are compiled three monthly and tabled at BPSO Steering Committee meetings and Consumer Advisory Committee meetings and ward unit business meetings for discussion, review and planning of improvements strategies for the local unit.

As a BPSO Candidate site we are able to benchmark, compare outcomes, data nationally and internationally in like organisations (eg rehabilitation settings) using the NQuIRE Data Base.

NQuIRE was designed for BPSO’s to systematically monitor the progress and evaluate the outcomes of implementing the RNAO Best Practice Guidelines (BPGs) in their organizations. NQuIRE is the first international quality improvement initiative of its kind, and involves development and measurement of structural, process and outcome indicators related to each of the RNAO BPGs.
The original ‘Patient Experience Survey’ has also been revised following consumer feedback, which ensures the structure and format complies with health literacy best practice.

Graph 9: How often did nurses treat you with courtesy and respect? 2013-14

Graph 10: How often did doctors explain things in a way you could understand? 2013-14

Graph 11: How often did allied health staff listen carefully to you? 2013-14
2. Partnering with consumers

The photographs below are two of many that make up a display board demonstrating the different members of staff involved in the ‘Patient Experience’ throughout the inpatient journey. The display highlights that the patient is not just limited to exposure to clinical staff but also staff from all sectors such as cleaning, maintenance, administration and catering etc, who effect the experience they have whilst in hospital.

The board is displayed in the foyer of the kiosk area at Hampstead Rehabilitation Centre for all patients, family members/substitute decision makers and staff. It is there as a visual prompt to remind us all that our daily interaction with our patients effects their hospital experience, and could mean the difference between a good and bad one.

**Picture 17: Enrolled nurse at Hampstead Rehabilitation Centre**

![Enrolled nurse at Hampstead Rehabilitation Centre](image)

*Image: Enrolled nurse holding a sign saying "I am the patient experience!"

**Picture 18: Physiotherapist at Hampstead Rehabilitation Centre**

![Physiotherapist at Hampstead Rehabilitation Centre](image)

*Image: Physiotherapist holding a sign saying "I am the patient experience".*
Preventing and controlling healthcare associated infections
Infection prevention and control aims to reduce the development of resistant pathogens and minimise risk of transmission through the isolation of infectious organisms or the patient, and by using standard and transmission-based precautions.

National Safety and Quality Health Service Standard 3 – Preventing and Controlling Healthcare Associated Infections includes:

- governance and systems for infection prevention, control and surveillance
- infection prevention and control strategies
- managing patients with infections or colonisations
- antimicrobial stewardship
- cleaning, disinfection and sterilisation
- communicating with patients and carers.

3.1 Governance systems for infection prevention, control and surveillance

3.1.1 Preventing and controlling healthcare associated infections accreditation resource

Item 10: Standard 3 Preventing and controlling healthcare associated infections Accreditation Resource

The SA Health Preventing and controlling healthcare associated infections accreditation resource guide developed to support health services was revised and updated in 2014. The guide provides examples of South Australian tools and resources that can be used to demonstrate an action and standard has been met.

The accreditation resource guide is available on the Safety and Quality section of the SA Health website National Safety and Quality Health Service Standards page at www.sahealth.sa.gov.au/safetyandquality

10 National Safety and Quality Health Service Standards (September 2012), Australian Commission on Safety and Quality in Health Care
3.1.2 Healthcare associated infection framework

Healthcare associated infections represent one of the more significant adverse events for patients who receive healthcare treatment. They are responsible for additional days of stay in hospital as well as additional suffering for the patient. In some cases, particularly with bloodstream infection, there is an increased risk of mortality. Many of these infections can be prevented by the consistent application of a relatively small number of infection prevention measures.

National standards for infection control have been developed and have been adopted by health care service accrediting agencies. It has been mandatory for hospitals to achieve these standards for accreditation since January 2013.

The department’s Infection Control Service has programs of work aimed at improving infection control in hospitals and monitoring the effectiveness of new interventions. These include:

- surveillance of targeted healthcare associated infections
- promotion and implementation of best practice guidelines for infection prevention
- promotion of best practice antimicrobial prescribing (antimicrobial stewardship).

3.1.3 Surveillance

Surveillance is an important ongoing activity for monitoring the effectiveness of interventions aimed at preventing infections in hospitals. The SA Health Infection Control Service is responsible for the collection and analysis of various infection indicators. These currently include: healthcare associated bloodstream infections, central intravenous line-associated bloodstream infections, infections caused by multi-resistant organisms, targeted surgical site infections and *Clostridium difficile* infection (diarrhoea).

Healthcare associated bloodstream infection caused by *Staphylococcus aureus* has been a national indicator of quality of health care since June 2008, with a target of less than two infections per 10,000 patient days. South Australian public hospital rates continue to perform well with this indicator, as shown in graph 12.

Graph 12: Hospital-acquired *Staphylococcus aureus* bloodstream infection 2009-14

Source: SA Health Healthcare Associated Infection Surveillance Program, Communicable Disease Control Branch
3. Preventing and controlling healthcare associated infections

Methicillin-resistant *Staphylococcus aureus* (MRSA) is an important indicator organism for the control of multi-resistant organism transmission within the healthcare setting. Graph 13 shows that efforts to contain the spread of MRSA have been largely successful because, although the overall burden of MRSA has been increasing (this includes patients who have been admitted to hospital already colonised with the bacterium), the rate of new acquisitions has been declining, and the MRSA infection rate has remained stable.

Graph 13: Hospital-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) rates 2009-14

![Graph 13: Hospital-acquired methicillin-resistant *Staphylococcus aureus* (MRSA) rates 2009-14](image)

Source: SA Health Healthcare Associated Infection Surveillance Program, Communicable Disease Control Branch

Multi-resistant gram-negative organisms (MRGN), particularly the extended spectrum beta lactamase (ESBL)-producing *E. coli* and *Enterobacter* species, have increased significantly over the last few years (graph 14). This is a trend that has been noted worldwide and may represent the increased acquisition of these organisms from exposure during travel to countries with high endemic rates of these organisms as well as overuse of antibiotics. There are many campaigns to raise awareness of the importance of restricting antibiotic use in order to preserve their effectiveness. This strategy is known as antimicrobial stewardship (refer section 3.3)

Graph 14: Hospital-acquired multi-resistant Gram-negative bacteria (MRGN) rates 2009-14

![Graph 14: Hospital-acquired multi-resistant Gram-negative bacteria (MRGN) rates 2009-14](image)

Source: SA Health Healthcare Associated Infection Surveillance Program, Communicable Disease Control Branch
*Clostridium difficile* is a bacterium that is responsible for antibiotic-associated gastrointestinal disease, and has been responsible for outbreaks of severe disease in hospitals overseas. National definitions for surveillance have been developed, and South Australia has used these definitions since mid-2009. Surveillance data presented in graph 15 show that the rate of both hospital identified cases and cases with symptom onset >2 days after admission have decreased over the last financial year. The subset of data with onset of symptoms >2 days after admission more closely measures the incidence of hospital-acquired disease.

**Graph 15: Hospital-identified *Clostridium difficile* infection rates 2009-14**

Quarters

<table>
<thead>
<tr>
<th>Quarters</th>
<th>Total hospital identified</th>
<th>onset &gt;2 days post admission</th>
</tr>
</thead>
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<tr>
<td>Q4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013/14</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: SA Health Healthcare Associated Infection Surveillance Program, Communicable Disease Control Branch

### 3.2 Promotion and implementation of best practice guidelines for infection prevention

#### 3.2.1 Building clinician capacity

An annual training workshop for infection control link nurses and ward or area champions in South Australian healthcare facilities continues to provide nurses with basic infection control knowledge. The training has been expanded to include healthcare workers from the primary and ambulatory care sector and staff with a responsibility for infection control in smaller country hospitals.

40 nurses attended the 2014 workshop. In addition, an infection control update day held in November 2013 provided more than 100 infection control practitioners, link nurses and ward/area champions with contemporary information and updates.

A workshop was also held to assist infection control staff understand surveillance requirements and ensure that data collection is done in a consistent manner and according to standard definitions and protocols.

#### 3.2.2 Infection prevention resources

##### 3.2.2.1 Aseptic Technique e-learning module

Documents and resources which support the implementation of the National Safety and Quality Health Service Standards, Standard 3 – Preventing and Controlling Healthcare Associated Infections continue to be developed and facilitated.

An aseptic technique online learning package was developed for SA Health staff and in conjunction with the aseptic technique workbook has been well received by healthcare workers. Information, documents and links to resources have been developed for the new SA Health website which can be found via: [www.sahealth.sa.gov.au/infectionprevention](http://www.sahealth.sa.gov.au/infectionprevention)
3. Preventing and controlling healthcare associated infections

Picture 19: Aseptic Technique e-learning module completions

Picture 20: Aseptic Technique e-learning module
3.2.3 Improving hand hygiene compliance

The World Health Organization’s ‘5 moments’ for hand hygiene program was implemented in South Australian hospitals during 2009. SA Health continues to commit to this initiative by monitoring compliance and submitting data to Hand Hygiene Australia. Hospitals are asked to provide compliance data three times per year collected by specially trained auditors. Over 450 auditors have been trained to date within South Australia.

The state’s performance has continued to improve over time. The latest data displayed in graph 16 show that the state rate is similar to the national average, with the overall state hand hygiene compliance rate now standing at 80.1%. (June 2014 national data not available at the time of report).

Graph 16: South Australian hand hygiene compliance rates 2012-14

Data shows that healthcare worker compliance with hand hygiene before and after touching a patient continues to steadily increase. Healthcare workers tend to comply better with hand hygiene after patient care and this trend is similar to both international and national data.

Future challenges will be to continue to make improvements before patient care, ie moment 1 - before patient care and moment 2 - before performing a patient procedure. Improvement in these ‘moments’ will ensure continual improvement in what are already excellent results.
3. Preventing and controlling healthcare associated infections

Graph 17: South Australian hand hygiene compliance rates by moment 2013-14

3.2.4 Promoting hand hygiene in the community

The Wash, Wipe, Cover – don’t infect another! campaign continues to promote good hygiene practices of washing hands, covering sneezes and coughs and frequently wiping surfaces to prevent the spread of colds, influenza and gastroenteritis. An advertising campaign was held prior to the influenza season which included key messages posted at bus shelters and restrooms throughout shopping centres and hotels / entertainment venues across South Australia.

These materials continue to be popular and are freely available for download from the SA Health website at www.sahealth.sa.gov.au/washwipecover

3.3 Antimicrobial stewardship

Optimising the utilisation of antimicrobial agents in hospitals through safe and appropriate prescribing is a major strategy to prevent the development of multi-resistant organisms in healthcare facilities. Interventions that promote the appropriate use of antimicrobials are known collectively as antimicrobial stewardship (AMS).

The department’s Infection Control Service conducts surveillance of hospital use of antimicrobial agents at both the state and national level. The National Antimicrobial Utilisation Surveillance Program (NAUSP), which is conducted on behalf of the Commonwealth, collects data from over 120 Australian hospitals. Measurement of antibiotic consumption is an important aspect of antimicrobial stewardship as a means of monitoring usage following interventions designed to reduce or modify antibiotic use, and for comparing South Australian usage patterns with that of other similar Australian hospitals.

As part of AMS and good clinical practice, prescribers are encouraged to use the narrowest spectrum antibiotic agent which is effective against the bacterial pathogen isolated in infections. Overuse of broad-spectrum antibiotics can lead to emergence of resistance and limited choices of effective and safe alternatives.

Surveillance data are used to analyse changes in the relative usage of broad versus narrow spectrum agents over time. Graph 18 shows the small but encouraging change to a lower percentage of broad spectrum agents used in South Australian public hospitals in recent years.
Graph 18: Broad spectrum antibiotic* usage as a proportion of total antibiotic usage in 13 SA public hospitals
2004-13

In particular, classes of antibiotics such as the fluoroquinolones and third generation cephalosporins have been linked with emergence of multi-resistant bacteria. Graph 19 shows these classes plotted as a percent of total use over a ten year period.

Graph 19: Fluoroquinolone and third generation cephalosporin usage as a proportion of annual total antibiotic usage in 13 SA public hospitals 2004-13

The Infection Control Service assists AMS initiatives in South Australian hospitals through production of guidelines which provide clinicians with evidence-based information for effective antibiotic therapy at a statewide level. These guidelines are produced through working collaboratively with the South Australian expert Advisory Group (SAAGAR). 16 surgical antibiotic prophylaxis guidelines for a range of surgeries, a guideline for switching from intravenous to oral antibiotics and a statewide policy directive for AMS were made available on the SA Health website this year.

Further information is available on the SA Health Infection Control section of the SA Health website at www.sahealth.sa.gov.au/infectionprevention

Additional information is also available on the Australian Commission on Safety and Quality in Health Care website Healthcare Associated Infection page www.safetyandquality.gov.au/our-work/healthcare-associated-infection/
3. Preventing and controlling healthcare associated infections
4 Medication safety
4. Medication safety

SA Health is committed to improving the safety and quality of medicines use to promote optimal patient outcomes through enhanced medicines management.

National Safety and Quality Health Service Standard 4 – Medication Safety includes:

- governance and systems for medication safety
- documentation of patient information
- medication management processes
- continuity of medication management
- communicating with patients and carers.

The SA Health Medication Safety Program focuses on the prevention of adverse medication events by supporting clinicians and empowering patients to achieve best practice in medication management through implementation of proven and sustainable strategies integrated across all health settings.

Many solutions to prevent medication errors are found in standardisation and systemisation of processes. Other recognised solutions for reducing common causes of medication errors include improving clinician-workforce and clinician-patient communication; using technology to support information recording and transfer; providing better access to patient information; and clinical decision support at the point of care.

4.1 Governance and systems for medication safety

SA Health has a robust governance structure aimed at improving the safety and quality of medicines use. At the statewide level, this involves the peak advisory group on medicines, the South Australian Medicines Advisory Committee (SAMAC) and its subgroups. The subgroups include the SA Medication Safety Advisory Group (SAMSAG), the principal group promoting the safe use of medicines, and the SA Quality Use of Medicines (QUMSA) working group. Local Health Networks have established internal governance arrangements for medication safety involving the Drug and Therapeutics Committees and Clinical Governance groups.

SAMSAG provides statewide leadership and promotes action at the local level to reduce the potential for medication-related errors and harm. A key outcome is linkage of national and state agendas and priorities. Efforts to enhance communication and input across health services and engagement with consumers have continued throughout 2013-14 including a consultation process involving the SAMSAG chair and executive officer and LHN representatives.

Underpinning SA Health’s commitment to medication safety is the SA Health Medication Safety Program and its supporting work plan for 2013-15. The program is aligned with the National Safety and Quality Health Service (NSQHS) Standards and is informed by state, national and international goals. It utilises a proactive systems approach to bring together a range of initiatives that focus on reducing risk of harm from medication incidents and errors; improving safety of the medication use processes; improving the effectiveness of medicines use; and improving continuity and efficiency of medication management.

11 National Safety and Quality Health Service Standards (September 2012), Australian Commission on Safety and Quality in Health Care
4.1.1 Medication safety accreditation resource

A key part of the medication safety work plan is supporting health services in achieving accreditation to the NSQHS Standards.

Item 11: Standard 4 Medication Safety accreditation resource

The SA Health Medication Safety accreditation resource guide, developed to support health services, was revised and updated in 2014. The guide provides examples of South Australian tools and resources that can be used to demonstrate an action and standard has been met. The resource guide is a live document, with further information and resources to be added to the document as they arise.


4.1.2 SA Health Medication Safety web site

The SA Health Medication Safety section on the SA Health website at www.sahealth.sa.gov.au/medicationsafety provides a number of resources and information on the medication safety program and initiatives including:

- accreditation and standards
- medication charts and audit materials
- standardised medication terminology
- labelling of medicines, fluids and lines
- medication safety news
- medication alerts and notices
- high risk medicines
- links to resources and other medication safety websites.

One of the new features on the web site is the Medication Safety education and training web page. The information provided includes links to online training courses on:

- medication charts
- quality use of medicines
- continuity of care
- continuity in medication management
- medication safety.

The web site also contains information on how to access SA Health Medication Safety e-learning courses including ‘Labelling for Safety’, a course about the National Recommendations for User-applied Labelling of Injectable Medicines, Fluids and Lines.
4. Medication safety

4.1.3 Medication incidents

Medication incidents are reported through the Safety Learning System (SLS) and are routinely reviewed at state and local levels to monitor patterns and identify potential areas for action. Medication related incidents were the second highest type of incident reported in 2013-14. Medication incidents equated to 21.2% (n=9554) of the total incidents reported in South Australia for the period 1 July 2013 to 30 June 2014. Tables 11 and 12 highlight the type of medication incident and level of harm as measured by the total SAC 1 and SAC 2 incidents. Compared to the number of medication doses administered, the number of medication incidents reported is very low with the vast majority associated with little or no patient harm.

Table 11: Number of medication incidents reported by year by level 2 classification and SAC 2013-14

<table>
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<tr>
<th>Level 2 Classification</th>
<th>SAC 1</th>
<th>SAC 2</th>
<th>SAC 3</th>
<th>SAC 4</th>
<th>Total</th>
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<td>1680</td>
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<td>Advice and information transfer</td>
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<td>Monitoring or follow up of medicine use</td>
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<td>66</td>
<td>120</td>
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<tr>
<td>Other medication error</td>
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<td>Patient's reaction to medication</td>
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<td>Supply/dispensing of medicines</td>
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Percentage %

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<tr>
<td>0.0%</td>
<td>0.2%</td>
<td>29.6%</td>
<td>66.7%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System
Table 12: Top ten medication related incidents by level 3 classification and SAC 2013-14

<table>
<thead>
<tr>
<th>Type of Medication Incidents</th>
<th>SAC 1</th>
<th>SAC 2</th>
<th>SAC 3</th>
<th>SAC 4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other medication incident</td>
<td>1</td>
<td>2</td>
<td>657</td>
<td>1706</td>
<td>2366</td>
</tr>
<tr>
<td>Medication omitted</td>
<td>0</td>
<td>2</td>
<td>708</td>
<td>1393</td>
<td>2103</td>
</tr>
<tr>
<td>Wrong dose</td>
<td>0</td>
<td>2</td>
<td>248</td>
<td>499</td>
<td>749</td>
</tr>
<tr>
<td>Wrong frequency</td>
<td>0</td>
<td>0</td>
<td>141</td>
<td>348</td>
<td>489</td>
</tr>
<tr>
<td>Wrong medicine</td>
<td>0</td>
<td>6</td>
<td>132</td>
<td>293</td>
<td>431</td>
</tr>
<tr>
<td>Delayed or not dispensed</td>
<td>0</td>
<td>0</td>
<td>94</td>
<td>214</td>
<td>308</td>
</tr>
<tr>
<td>Duplicate medication</td>
<td>0</td>
<td>0</td>
<td>90</td>
<td>197</td>
<td>287</td>
</tr>
<tr>
<td>Medication not prescribed or charted</td>
<td>0</td>
<td>1</td>
<td>111</td>
<td>161</td>
<td>273</td>
</tr>
<tr>
<td>Invalid order</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>189</td>
<td>249</td>
</tr>
<tr>
<td>Incorrect rate</td>
<td>0</td>
<td>1</td>
<td>64</td>
<td>134</td>
<td>199</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

The Medication Safety Work Plan 2013-15 incorporates priority areas for action such as medication omissions and high risk medicines, including the top ten drugs as shown in graph 20.

Graph 20: Top ten drugs reported in medication incidents 2013-14
4. Medication safety

4.2 Documentation of patient information

4.2.1 New National Inpatient Medication Chart (NIMC) with a venous thromboembolism (VTE) prophylaxis section

SA Health supports the implementation of the National Inpatient Medication Chart (NIMC), a suite of nationally approved medication charts to promote safe use of medicines through standardisation of documentation. A standard chart ensures the same chart is used wherever a healthcare professional works and wherever a patient is within a hospital. Use of the NIMC is mandatory for all Australian health services and required for accreditation purposes under the NSQHS Standard 4 - Medication Safety.

The prevention of venous thromboembolism (VTE) is a priority patient safety issue both nationally and internationally, and this is reflected in the Australian Safety and Quality Goals for Health Care 1.1.3 Adults experience fewer venous thromboembolisms associated with hospitalisation.12

Following guidance from the Australian Commission on Safety and Quality in Health Care, a new version of the National Inpatient Medication Chart (NIMC), which incorporates a section for recording VTE prophylaxis, has been made available in SA. The chart is designed to reduce the rate of healthcare associated VTE by providing a prompt to prescribers to assess all adult patients for risk of VTE on admission and to prescribe appropriate prophylaxis, both chemical and mechanical, where appropriate. SA hospitals and health services have implemented or are in the process of implementing the new chart. Participation in the National NIMC Audit in August and September 2014 will assist health services to assess their use of the VTE section of the NIMC.

Item 12: Fact sheet – New National Inpatient Medication Chart (NIMC)

A range of resources and tools to assist hospitals to implement VTE prevention programs, such as clinical guidelines, policies, educational tools, including an e-learning tool, and patient information, are also available from the Australian Commission on Safety and Quality in Health Care VTE Prevention Resource Centre or at http://www.safetyandquality.gov.au/our-work/medication-safety/vte-prevention-resource-centre/

12 Australian Safety and Quality Goals for Health Care, Australian Commission on Safety and Quality in Health Care
4.2.2 Preventing adverse drug events

Medicines are a key component of disease management and prevention. Their use is not without risk, however, and documentation of side effects and adverse drug reactions (ADRs) is a key patient safety requirement. Incomplete or absent documentation of known prior side effects and ADRs in clinical information can predispose patients to poorer outcomes. Preventing these types of errors is dependent on the correct information being available and referred to at the point of care.

In August 2013, SA Health released a policy directive and guideline ‘Preventing Adverse Drug Events – documenting, monitoring and communicating adverse drug reactions and allergies’ to ensure adverse drug reaction (ADR) documentation is complete and referred to at the point of care. The SA Health policy directive will assist health service organisations to comply with national goals and standards:

> NSQHS Standard 4, Action item 4.7: ‘The clinical workforce documenting the patient’s previously known adverse drug reactions on initial presentation and updating this if an adverse reaction to a medicine occurs during the episode of care’.  

> Australian Safety and Quality Goals for Health Care Priority area 1.1 Medication safety: Reduce harm to people from medications through safe and effective medication management.


---

13 National Safety and Quality Health Service Standards (September 2012), Australian Commission on Safety and Quality in Health Care

14 Australian Safety and Quality Goals for Health Care, Australian Commission on Safety and Quality in Health Care
4. Medication safety

4.3 Medication management processes

4.3.1 High risk medicines

High risk medicines are acknowledged as those medicines which cause an increased risk of harm when used in error. Mistakes may not necessarily be more common with these medicines however the consequences of an error can be more devastating. Safeguards to minimise opportunities for errors associated with high risk medicines are integral to patient safety. Ensuring health care staff awareness of the high risk medicines used in their practice and the safeguards in place is essential for safe management of high risk medicines.

The Medication Safety NSQHS Standard requires health care service organisations to implement systems to reduce the occurrence of medication incidents and improve the safety and quality of medicine use. The risks for storing, prescribing, dispensing and administration of high risk medicines should be regularly reviewed and action taken to reduce identified risks.

4.3.1.1 High Risk Medicines Management policy directive and guideline

The SA Health High Risk Medicines Management policy directive and guideline have been developed through consultation with SAMSAG and other SA Health stakeholders. The aim of the policy is to facilitate improved patient safety and minimisation of patient harm through the safe storage, prescribing, dispensing, and administration of high risk medicines. Key elements include ensuring health services:

- identify high risk medicines within their organisation
- identify and manage risks associated with the use of high risk medicines
- improve staff awareness of high risk medicines, the risks associated with their use, and the strategies implemented to address these risks.

4.3.1.2 High risk medicines supporting resources

The development of e-learning modules to support the clinical workforce in the safe management and use of high risk medicines is an ongoing priority of the Medication Safety Program. The first of the modules, ‘Introduction to High Risk Medicines’, has been developed and is discussed in more detail below. Further modules on individual high risk medicine groups are being developed, with the next two modules to focus on Insulin and Anticoagulants.

The SA Health Medication Safety website at www.sahealth.sa.gov.au/medicationsafety also provides a High Risk Medicines webpage containing information and links to related resources.

4.3.2 E-learning resources

The Medicines and Technology Policy and Programs Branch is developing a suite of interactive e-learning modules to support health professionals to use medicines better. The modules are aligned with the NSQHS Standards, in particular Standard 4 - Medication Safety. The modules are designed to: support and empower health care staff to practice safely; complement statewide guidance; and support health service accreditation to NSQHS Standard 4 – Medication Safety. The modules are focused, interactive, and appropriate to adult learning needs.

4.3.2.1 Labelling for safety

SA Health is committed to improving the safety and quality of medicines use to promote optimal patient outcomes through enhanced medicines management.

Labelling of injectable medicines, fluids and lines has been identified as a significant patient safety issue and is a recognised risk in the safe administration of injectable medicines. Clear, standardised labelling of injectable medicines and fluids by the user at the point of delivery should help to reduce the risk of medicine administration errors.

The Labelling for Safety e-learning module was released in October 2013 and there has been significant and consistent uptake from SA Health staff since this time.
The course is intended for clinical staff involved in direct patient care; in particular, for staff involved in the preparation and administration of injectable medicines in a clinical or ward area. Through an interactive and informative approach it:

> outlines the risks of inadequate labelling of injectable medicines, fluids and lines
> provides minimum requirements for user-applied labelling of injectable medicines
> promotes safe use of injectable medicines.

Picture 21: Labelling for Safety e-learning module completions

Picture 22: Learning outcomes of the Labelling for Safety e-learning module
Picture 23: An example of an assessment and feedback in the Labelling for Safety e-learning module
4.3.2.2 Introduction to high risk medicines

Ensuring health care staff awareness of the high risk medicines used in their practice and the safeguards in place is essential for safe management of high risk medicines.

The Medication Safety NSQHS Standard requires health care service organisations to implement systems to reduce the occurrence of medication incidents and improve the safety and quality of medicine use. The risks for storing, prescribing, dispensing and administration of high risk medicines should be regularly reviewed and action taken to reduce identified risks.

An e-learning module ‘Introduction to High Risk Medicines’ has been developed and is planned for release in the second half of 2014. The module will complement the High Risk Medicines Management policy directive and guideline, with the learning outcomes on completion of the module being that staff will be able to:

> identify what makes a medicine ‘high risk’
> identify high risk medicines
> explain how medication errors occur
> explain strategies to improve management of high risk medicines
> describe resources / tools available to help in the safe management of high risk medicines.

Picture 24: Screenshot from Introduction to High Risk Medicines e-learning module
4. Medication safety

Picture 25: An interactive activity from Introduction to High Risk Medicines e-learning module

APRONCH list

In Australia, the acronym APRONCH is used to classify groups of medicines universally considered to be high risk. Again, medicines are included based on analysis of incident data and review of existing high risk medicines lists and the published literature.¹

- Anti-infectives
- Potassium and other electrolytes
- Insulin
- Narcotics (e.g. opioids) and other sedatives
- Chemotherapeutic (cytotoxic) agents
- Heparin and other anticoagulants

Activity

Drag the medicine to the correct group of high risk medicines

- Anti-infectives
- Potassium and other electrolytes
- Chemotherapeutic agents
- Narcotics and other sedatives
- Heparin and other anticoagulants
- Insulin
- Narcotics (e.g. opioids) and other sedatives
- Chemotherapeutic (cytotoxic) agents
- Potassium and other electrolytes
- Anti-infectives
- Insulin
4.3.2.3  Medication safety notices

The Medicines and Technology Policy and Programs Branch disseminates Medication Safety Alerts and Notices as required to provide important safety information to healthcare professionals and services across the South Australian health system.

In February 2014, a Medication Safety Notice was issued to remind staff of safety issues surrounding potassium chloride injection. Inappropriate intravenous administration of potassium chloride can lead to significant patient harm and death. The safe use of injectable forms of potassium chloride and other potassium salts is a priority for health services and safety notices provide advice about implementation of recommendations or solutions to improve quality and safety.

**Item 14: Medication Safety Notice – Intravenous potassium can be fatal if given inappropriately**

![Medication Safety Notice](image)

In response to a report and recommendation from the South Australian Coroner released in April 2014, a safety notice entitled ‘Colchicine toxicity can be fatal’ was released in June 2014. The safety notice highlights the risks associated with use of colchicine and ambiguities in the published dosing guidelines.

**Item 15: Medication Safety Notice – Colchicine toxicity can be fatal**

![Medication Safety Notice](image)

Medication safety notices are available on the SA Health website at [www.sahealth.sa.gov.au](http://www.sahealth.sa.gov.au)
4. Medication safety

4.4 Continuity of medication management

4.4.1 Pharmaceutical reforms
Pharmaceutical reforms were introduced in South Australian public hospitals to make it easier and safer for patients to get the medicines they need.

Following success of the Pharmaceutical Reforms model introduced into SA metropolitan public hospitals since 2009, further roll out has continued at Modbury Hospital in 2013-14. Implementation of reforms resulted in a dramatic expansion of pharmacy services at Modbury Hospital with an expanded team, altered workflows, new clinical services and the relocation of the on-site pharmacy to a new, refurbished location. A major benefit of the reforms is a significant increase in the employment of clinical pharmacists at Modbury Hospital who:

> review patient medications on admissions to and discharge from hospital
> provide expert clinical and pharmacological advice to clinicians on the ward to assist them with treatment decisions for their patients
> provide advice to patients and their carers on the safe use of medicines.

A new pharmacy has been built at the Riverland General Hospital, Berri, and pharmaceutical reforms will be implemented in August 2014.

4.4.2 Quality use of medicines
The Quality Use of Medicines working group (QUMSA) is the principal working group of the SA Medicines Advisory Committee (SAMAC) in the area of quality use of medicines (QUM). In 2012 SA Health commissioned a review to examine barriers and facilitators to QUM along the continuum of care, resulting in a series of recommendations for achieving improvements in QUM to enhance patient safety and health outcomes. QUMSA is continuing the work plan developed from the recommendations with particular focus on:

> multi-disciplinary health professional education and training in QUM
> engaging with and empowering consumers and carers
> electronic systems
> QUM guiding principles and position statements.

4.5 Communicating with patients and carers

4.5.1 Helping patients understand their medicines
The Quality Use of Medicines working group (QUMSA) has commenced a strategy to engage and empower consumers in their own medicines management in order to improve their health outcomes. QUMSA has developed consumer information for the SA Health website aimed at improving consumer medicines literacy and ensuring that consumers are competent to make decisions regarding medicines management, better able to inform healthcare providers of their medicines needs and be more active in their own medication management.

Currently, there is information on the SA Health website which explains basic concepts in relation to optimal medicines management as well as more detailed information on specific topics and links to reliable sources of information that consumers can use to improve their understanding of the medicines they are using, or considering for use.

The website has been updated in 2013-14. Further information can be accessed from the SA Health website at www.sahealth.sa.gov.au/medicines

Further information is available on the Medication Safety, Safety and Quality section of the SA Health website at www.sahealth.sa.gov.au/safetyandquality.

Additional information is available on the Australian Commission on Safety and Quality in Health Care website Medication Safety page www.safetyandquality.gov.au/our-work/medication-safety/
Case study:

Women’s and Children’s Health Network introduce new, safer enteral feeding and oral medication equipment

In July 2013 the Women’s and Children’s Health Network (WCHN) introduced a range of new equipment for enteral feeding and administration of medication to reduce the risk of patients’ feeds (liquid food) and medicines entering the body by the incorrect route.

There have been numerous incidents reported worldwide of harm occurring as a result of medicine being administered via the wrong route. This has often been due to the equipment having the same connector for a variety of administration routes.

WCHN is one of the first health services in Australia to address this issue for all patient groups, including those who require medication on discharge and those who use feeding equipment in the home environment.

To address this significant patient safety risk, a range of oral dispensers / enteral feeding and associated equipment has been developed to decrease the risk of oral liquid medications / enteral feeds being administered via the intravenous route.

The equipment includes:

> oral dispensers
> medication preparation equipment
> nasogastric tubes
> associated feeding equipment
> enteral feeding pumps - specially designed for neonatal patients

Picture 26: Examples of new, safer enteral feeding and oral medication equipment introduced at the Women’s and Children’s Health Network

The new equipment features a special connector, not compatible with intravenous equipment, which means that oral dispensers and enteral feeding equipment is unable to be connected to any intravenous ports.

Extensive education sessions for the nursing / midwifery staff were conducted at the time of implementation to ensure the staff were comfortable using the new equipment. The equipment will be included on each ward imprest, and at all points of patient care.

A WCHN procedure mandating the use of the oral / enteral specific equipment has been developed.
4. Medication safety
Patient identification and procedure matching

5
Safe, high quality health care can only be provided to patients if they are correctly identified and matched to their intended care.

The SA Health Patient Identification Policy and Guideline promotes a uniform approach to patient identification across SA Health. The principles within these documents are consistent with the National Safety and Quality Health Service Standard 5 – Patient identification and procedure matching\cite{15} which requires that:

- at least three approved patient identifiers are used when providing care, therapy or services
- a patient’s identity is confirmed using three approved identifiers when transferring; responsibility for care
- health service organisations have explicit processes to correctly match patients with their intended care.

5.1 Identification of individual patients

SA Health continues to work towards ensuring that standard patient identification and matching processes are not only consistently integrated into routine practice but are evaluated for their effectiveness in achieving the objective of correctly identifying patients at any point and time during an admission or course of treatment.

5.1.1 Patient identification and procedure matching accreditation resource

Item 16: Standard 5 Patient identification and procedure matching accreditation resource

The SA Health Patient identification and procedure matching accreditation resource guide, developed to support health services was revised and updated in 2014. The guide provides examples of South Australian tools and resources that can be used to demonstrate an action and standard has been met.

The accreditation resource guide is available on the Safety and Quality section of the SA Health website National Safety and Quality Health Service Standards page at www.sahealth.sa.gov.au/safetyandquality

5.1.2 Patient identification incidents

While there has been no patient identification incident resulting in serious harm to a patient in SA Health since 2007-08, staff are still encouraged to report all patient identification incidents or near misses into the Safety Learning System. The classification system within the Safety Learning System and its accessibility via LARS enables trends in this data to be easily identified. This information is then used to evaluate the effectiveness of patient identification and matching processes and facilitate system wide improvements.

\cite{15} National Safety and Quality Health Service Standards (September 2012), Australian Commission on Safety and Quality in Health Care
Table 13: Five most frequent patient identification type of incidents and result 2013-14

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>SAC 1</th>
<th>SAC 2</th>
<th>SAC 3</th>
<th>SAC 4</th>
<th>UnSAC’d</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Images / specimens - mislabelled</td>
<td>0</td>
<td>1</td>
<td>139</td>
<td>127</td>
<td>27</td>
<td>294</td>
</tr>
<tr>
<td>Patient incorrectly identified</td>
<td>0</td>
<td>1</td>
<td>39</td>
<td>137</td>
<td>10</td>
<td>187</td>
</tr>
<tr>
<td>Test results / reports - mislabelled</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>12</td>
<td>0</td>
<td>16</td>
</tr>
<tr>
<td>Wrong body part / side / site</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Healthcare record / card - mislabelled</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>26</td>
<td>3</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td>0</td>
<td>3</td>
<td>192</td>
<td>306</td>
<td>41</td>
<td>542</td>
</tr>
<tr>
<td>%</td>
<td>0.0%</td>
<td>0.6%</td>
<td>35.4%</td>
<td>56.4%</td>
<td>7.6%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: LARS

5.1.3 Patient arm band standard

Identification bands are an important tool used to ensure patients are correctly identified and matched to their intended care. To ensure that all identification bands used in SA Health comply with national specifications, the Department for Health and Ageing, Safety and Quality Branch in conjunction with the Local Health Networks undertook a project, which was finalised in February 2014, to standardise patient identification bands across SA Health.

5.2 Processes to transfer care

To ensure that patients are correctly matched to their intended treatment it is vital that they are correctly identified whenever the responsibility for their care is being transferred. This is facilitated by the use of ISBAR (identify, situation, background, assessment and recommendation) and ensuring clinical handover is comprehensive. For further information see Standard 6 Clinical Handover.

Additional information is also available on the Australian Commission on Safety and Quality in Health Care website Clinical Handover page at http://www.safetyandquality.gov.au/our-work/clinical-communications/clinical-handover/

5.3 Processes to match patients and their care

5.3.1 Surgical team safety checklist

As outlined in previous Patient Safety Reports the SA Health Surgical Team Safety Checklist and policy directive with accompanying tool kit to support its implementation was released in March 2011.

The tool kit including the Surgical Team Safety Checklist DVD can be viewed via the SA Health Safety and Quality web area www.sahealth.sa.gov.au/safetyandquality or on the SA Health YouTube channel http://www.youtube.com/watch?v=mUaUoYpc6HI.

The surgical team safety checklist has been imbedded into EPAS. For those sites where EPAS has been implemented, the electronic storage of the checklist enables audits of compliance to be conducted easily.

Further information is available on the Safety and Quality section of the SA Health website Patient Identification page at www.sahealth.sa.gov.au/safetyandquality

Additional information is also available on the Australian Commission on Safety and Quality in Health Care website Patient Identification page at www.safetyandquality.gov.au/our-work/patient-identification
6 Clinical handover
Clinical leaders and senior managers of a health service organisation are required to implement documented systems for effective and structured clinical handover\(^{16}\). 

National Safety and Quality Health Service Standard 6 – Clinical handover includes:

> governance and leadership for effective clinical handover
> clinical handover processes
> patient and carer involvement in clinical handover.

Effective communication is essential to safe patient care. Clinical handover is a process that structures the communication of a patient’s information to enable staff involved in their care to have the right information for clinical decision making and progressing the plan of care. Clinical handover is defined as the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis\(^ {17}\).

### 6.1 Governance and leadership for effective clinical handover

The [SA Health Clinical Handover Policy Directive](https://www.sahealth.sa.gov.au/) defines accountability for ensuring organisational structures are in place for ensuring clinical handover procedures and processes are in place.

#### 6.1.1 Clinical handover accreditation resource

**Item 17: Standard 6 Clinical Handover accreditation resource**

The [SA Health Clinical Handover accreditation resource guide](https://www.sahealth.sa.gov.au/safetyandquality), developed to support health services was revised and updated in 2014. The guide provides examples of South Australian tools and resources that can be used to demonstrate an action and standard has been met.


#### 6.1.2 Clinical handover e-learning module

The Clinical Handover e-learning module promotes best practice clinical handover and will provide a basis for staff to adapt clinical handover processes to meet specific needs and clinical context.

The course is intended for clinical staff involved in direct and indirect patient care but is also valuable for staff that support clinicians in clinical handover, for example ward clerks.

\(^{16}\) National Safety and Quality Health Service Standards (September 2012), Australian Commission on Safety and Quality in Health Care

\(^{17}\) Australian Medical Association, Safe Handover: Safe Patients. Guidance on clinical handover for clinicians and managers, 2006
Picture 27: Clinical Handover e-learning module course completions

Picture 28: Clinical Handover e-learning module
6.1.3 Communication and teamwork related incidents

The 2013-14 Safety Learning System incident classification ranks communication and teamwork related incidents as the ninth most frequently reported incident. We know however, that communication and teamwork are also primary contributing factors to all other incident types and that teams can be the ‘safety net’ for the prevention of harm from human and systems error. The top 10 communication and teamwork related incidents are outlined in table 14 below.

Table 14: Top 10 communication and teamwork related incidents and result 2013-14

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>SAC 1</th>
<th>SAC 2</th>
<th>SAC 3</th>
<th>SAC4</th>
<th>UnSAC'd</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication inadequate</td>
<td>0</td>
<td>6</td>
<td>184</td>
<td>390</td>
<td>31</td>
<td>611</td>
</tr>
<tr>
<td>Incomplete / absent handover</td>
<td>0</td>
<td>1</td>
<td>99</td>
<td>143</td>
<td>9</td>
<td>252</td>
</tr>
<tr>
<td>Communication - other</td>
<td>0</td>
<td>1</td>
<td>62</td>
<td>166</td>
<td>16</td>
<td>245</td>
</tr>
<tr>
<td>Information not available / incomplete / verified</td>
<td>0</td>
<td>1</td>
<td>36</td>
<td>88</td>
<td>12</td>
<td>137</td>
</tr>
<tr>
<td>Accountability for action or follow up not clear</td>
<td>0</td>
<td>0</td>
<td>29</td>
<td>58</td>
<td>13</td>
<td>100</td>
</tr>
<tr>
<td>Information / concern / risk not escalated</td>
<td>0</td>
<td>1</td>
<td>23</td>
<td>40</td>
<td>5</td>
<td>69</td>
</tr>
<tr>
<td>Communication failure with patient, parent or carer</td>
<td>0</td>
<td>1</td>
<td>15</td>
<td>48</td>
<td>5</td>
<td>69</td>
</tr>
<tr>
<td>Roles and responsibilities of staff not clear</td>
<td>0</td>
<td>1</td>
<td>20</td>
<td>31</td>
<td>2</td>
<td>54</td>
</tr>
<tr>
<td>Instructions not clear</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>41</td>
<td>3</td>
<td>54</td>
</tr>
<tr>
<td>Patient risk / deterioration not communicated</td>
<td>0</td>
<td>1</td>
<td>21</td>
<td>22</td>
<td>5</td>
<td>49</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>0</td>
<td>13</td>
<td>499</td>
<td>1027</td>
<td>101</td>
<td>1640</td>
</tr>
<tr>
<td><strong>%</strong></td>
<td>0.0%</td>
<td>0.8%</td>
<td>30.4%</td>
<td>62.6%</td>
<td>6.2%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

A key initiative has been to improve reporting of clinical handover incidents. Improvement in reporting is key to creating a safety culture. Robust safety processes enable clinical teams to learn what “single” communication and teamwork error and what prevents error from progressing to patient harm. The overall reporting of communication and teamwork incidents has nearly doubled from last year (873 in 2012-13 and 1637 in 2013-14). In this data, over half of all communication and teamwork related incidents involve incomplete communication or incomplete / absent handover. Each health service has established governance structures and processes for analysis of clinical handover incidents.

6.2 Clinical handover processes

TeamSTEPPS® is a communication and teamwork improvement program. It is a major strategy in SA Health for improving patient safety through teams. Health care teams review their own safety and quality data and teamwork and communication performance in partnership with consumers and together, design improvements.
Case study:

Teamwork, communication, safety – it’s a culture thing in the ICCU at FMC

Flinders Medical Centre Intensive and Critical Care Unit (FMC ICCU) began the TeamSTEPPS® program in early 2013. All staff in ICCU, 32 bed Unit are trained in teamwork and communication (450 trained to date). An ICCU Consumer Advocate and Representative is a member of their Collaborative Practice Team and participates in patient safety and quality improvement planning and initiatives. In their first year, the ICCU team selected and designed interventions to improve communication and teamwork:

- Multi-disciplinary morning brief
- Multi-disciplinary bedside handover
- Nursing Bedside ISBAR handover
- Medical emergency team clinical handover
- Pre-intubation brief
- Medical emergency team brief
- Huddles
- Engage patient / family in bedside handover where possible
- Engaging consumers in sharing experiences and feedback

The FMC ICCU team made significant improvements in overall teamwork in one year.

Graph 21: Observational assessment pre and one year post TeamSTEPPS® 2013-14

![Observational assessment graph]

Patient Safety Report 2013-2014
6. Clinical handover

6.2.1 ISBAR clinical handover structure and process

Health services have been auditing clinical handover processes and writing procedures for clinical handover in different contexts.

One example of improving clinical handover process is the Royal Adelaide Hospital ISBAR Telephone Handover Form. The form sets criteria for escorting a patient in transfer from one area of the hospital to another. It contains an agreed minimum dataset of clinical handover information in the SA Health clinical handover structure ‘Identify-Situation-Background-Assessment-Recommendation’.

Item 18: ISBAR Telephone Handover Form

6.2.2 Clinical handover processes research

One focus of improvement in clinical handover has been through participation in Effective Communication in Clinical Handover (ECCHo), an Australian Resuscitation Council research linkage project. The three year research project was completed in 2013-14 with the research report to be published in the form of a book in 2014-15. Key findings include:

- recognition of clinical handover as a generative process over time
- the importance of planning communication in the designing the structure of the clinical team, the model of care, and in facility design
- importance of mapping communication and team processes to better understand how communication occurs
- how the patient ‘voice’ is expressed in mental health clinical handover in the physical absence of the patient in handover
- and how the use of language and interactional behaviours effect the quality of handover.

Based on the data from the study, a mental health clinical handover audit tool was developed and is currently being trialled.
6.3 Patient and carer involvement in clinical handover

Patient and carer involvement in clinical handover is an essential element of the National Safety and Quality Health Service Standard 6, Clinical Handover. Patients and carers involvement in the communication of the clinical plan for care, particularly at points of transition of care is an important safeguard in care.

Case study:

The Flinders Medical Centre Intensive and Critical Care Unit (ICCU) is a ‘Best practice site for TeamSTEPPS®’ and its application in partnering with consumers.

**The aims of the consumer engagement in intervention are:**

1. better engagement of consumers in order to better understand their perspectives and needs so that these could be better addressed
2. better understanding of consumers through sharing their thoughts in a positive way with ICCU staff on their ICCU experience
3. acting timely and appropriately on consumer feedback whether as a one-off issue or whether identifying themes to be addressed.

**Brief description of activity**

The Consumer Representative role in ICCU was established. As a member of the ICCU team structure, they have established a working relationship with staff. Their role includes partnering with staff to enhance the care experience for both consumers and staff by supporting the patient ‘voice’ to improve the safety and quality of care in the ICCU.

Actions taken by Consumer Representative to engage consumers:

> take stories and request feedback from consumers
> report feedback to senior staff on the day where possible to address immediate issues
> to communicate to ICCU staff through multiple methods, the consumer feedback and stories
> gain staff feedback from the consumer stories and experiences to use in ICCU collaborative practice team meetings to monitor trends and design strategies for improvement.

**Outcomes**

> Giving consumers a ‘voice’ has enabled some consumers to feel empowered by being able to ‘give back’ to the ICCU. For example, appreciation expressed by consumers about being asked for their feedback.
> Feedback is shared with all staff by (a) stories (on the intranet or via e-mail); and (b) a monthly tabulated summary
> Feedback is shared with senior staff generally on the day of receipt to ensure a swift response, if appropriate.
> The monthly feedback circulated to all staff is annotated with action taken by the ICCU so that all are aware of status of response.
> Themes are reported to the TeamSTEPPS® Collaborative Practice Team (CPT) for consideration for an intervention. For example, the consumer bed block story has led to the CPT investigating an intervention to bring ward based treatments to bed blocked ICCU patients.

The stories and conversations personalise the consumer experience for staff. For example, a bedside nurse’s comments: “I like getting these reports as it is a reminder to always think of the patient.” The feedback supports staff in their practice.
7 Blood and blood products
Clinical leaders and senior managers of a health service organisation implement systems to ensure the safe, appropriate, efficient and effective use of blood and blood products. Clinicians and other members of the workforce use the blood and blood product safety systems.

National Safety and Quality Health Service Standard 7 – Blood and blood products criteria include:

- governance and systems for blood and blood products prescribing and clinical use
- documenting patient information
- managing blood and blood product safety
- communicating with patients and carers.

Blood and blood products are a vital resource, sourced from generous donors and commercial manufacturers. While the use of blood and blood products can be lifesaving, there are also risks associated with their administration.

The scope of this Standard covers all elements in the clinical transfusion process including the principles of patient blood management, which includes avoiding unnecessary exposure to blood components through appropriate management of the patient and the use of other non-blood treatments.

### 7.1 Governance and systems for blood and blood product prescribing in clinical use

Health service organisations have systems in place for the safe and appropriate prescribing and clinical use of blood and blood products.

#### 7.1.1 South Australian Blood Management Council

The South Australian Blood Management Council (the Council) is the peak advisory body on blood sector matters in South Australia (SA) and has the responsibility of taking a strategic statewide lead on blood management activities.

Chaired by Associate Professor Peter Bardy, the Council has representatives from anaesthesia, critical care, gastroenterology, haematology, medical, surgical, obstetrics and gynaecology, oncology, orthopaedics, paediatrics, pathology and medical science. The Council receives a significant amount of input from the local BloodSafe Program and its medical lead, Dr Kathryn Robinson, as well as linking in with activities occurring at hospital and regional based transfusion committees.

During 2013-14, the Council focussed on the following key areas of activity:

- review of SA Intra-operative cell salvage service provision
- transfusion thresholds upper gastrointestinal (UGI) bleeding
- guidelines on adult and paediatric cryoprecipitate dosing
- transfusion education and training for staff involved in the transfusion process: recommendations regarding completion of BloodSafe eLearning Australia Courses
- SA legislation and policy in relation to the refusal of blood transfusion
- demand for cytomegalovirus negative blood products
- provision of clinical input into the development of transfusion order sets in EPAS
- access to intravenous (IV) iron, including the use and cost of IV iron products
- feedback regarding consultation on the review of IV iron products being considered for the SA Medicines Formulary
- contributed to a prioritisation of patient blood management activities in the SA BloodSafe Nurse work plans
- review of the SA public sector red cell utilisation data and transfusion rates by specialty related group and procedure and ensured the distribution of this information to local blood management committees.

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18 National Safety and Quality Health Service Standards (September 2012), Australian Commission on Safety and Quality in Health Care
Two subgroups progress work in the Council’s key priority areas of clinical practice, research and evaluation, and education and training:

1. Translating Evidence into Practice Sub-Committee
2. Research Sub-Committee

The work of these groups is focussed on four key areas of patient blood management:

- new testing methods (thromboelastometry or TEM) to drive transfusion practice
- cell salvage which allows collection and replacement of blood lost perioperatively
- pre-operative anaemia management
- improving access to iron therapy.

To facilitate progression of research in these areas, the Council endorsed the following clinical practice improvement projects to be undertaken by end of June 2015:

1. CHSALHN
   - IV iron in management iron deficiency anaemia (IDA)
   - Implementation CHS critical bleeding guideline
   - Port Augusta review transfusion processes in the context of EPAS and best practice

2. NALHN
   - Antenatal IV iron infusion clinic
   - Cell Salvage education: Achieving goals

3. WCHN
   - Implementation major obstetrics haemorrhage guidelines
   - IV iron obstetrics

4. CALHN
   - Implementation of TEM in cardiothoracic surgery

7.1.2 Blood and blood products accreditation resource

Item 19: Standard 7 Blood and blood products accreditation resource

The SA Health blood and blood products accreditation resource guide developed to support health services, was reviewed and updated in 2014. The guide contains a combination of resources and tools developed by SA Health to assist health services to demonstrate an action and Standard has been met. It is intended to be used in addition to the Australian Commission on Safety and Quality in Health Care’s resources when implementing the National Safety and Quality Health Service Standards.

The accreditation resource guide is available on the Safety and Quality section of the SA Health website National Safety and Quality Health Service Standards page at www.sahealth.sa.gov.au/safetyandquality.
7. Blood and blood products

7.1.3 National systems

Governance of the blood sector in SA links into national governance arrangements established by the National Blood Authority (NBA) such as the Advisory Group for High Cost Products and the National Immunoglobulin Governance Advisory Council. This governance arrangement provides South Australia with the opportunity to have approaches to governance of blood and blood products that are nationally consistent (through the development of national guidelines) and allows for benchmarking with other jurisdictions.

SA also makes use of systems and resources accessible through the NBA website at www.nba.gov.au including, but not limited to:

1. BloodNet – a web based system that allows health providers across Australia to order and receipt blood and blood products in a standardised way, easily and securely from the Australian Red Cross Blood Service. BloodNet has been implemented at all SA public and private pathology service sites.

2. The Australian Bleeding Disorders Registry - a clinical registry used by clinicians in all Australian haemophilia treatment centres to assist in managing the treatment of people with bleeding disorders, understanding of the incidence and prevalence of bleeding disorders and understanding demand for clotting factor product. For consumers and carers, the MyABDR website and smartphone application assists with the recording of home treatments and bleeding episodes.

As part of their National Blood Sector Education and Training Strategy 2013-2016, the NBA collaborates with key stakeholders in the blood sector to deliver education opportunities. In 2013, the NBA and Australian Commission on Safety and Quality in Health Care (ACSQHC) hosted a National Blood Symposium in Adelaide which provided an update on Standard 7. SA Health provided support in organising the event and invited representatives from the SA Blood Management Committee, SA Health, Red Cross Blood Service and BloodSafe programs to present on their areas of expertise in relation to Standard 7.

7.1.4 Blood utilisation patterns

The SA blood utilisation database is an electronic database containing clinical, administrative and blood product data for SA public sector hospitals. The database has been established by linking patient morbidity records and blood transfusion related pathology details in order to have a complete record of transfusion episodes for further analysis. Patient de-identified data for 28 public sector hospitals has now been linked with associated pathology datasets for red cells across a seven year period (1 July 2006 to 30 December 2013). This database has provided a better understanding of SAs (public sector) blood usage patterns across a number of medical and surgical specialties such as cardio-thoracic, colorectal and orthopaedic surgery. This data is then provided to research groups, transfusion committees and the South Australian Blood Management Council to help identify areas for focus for clinical practice improvement efforts.
Clinical education

BloodSafe eLearning Australia delivers online education that aims to build an individual’s knowledge of patient blood management and to encourage safe transfusion practice for the improvement of patient outcomes. There are web based training courses suitable for a range of professionals including nurses and midwives, doctors, laboratory scientists and technicians, along with couriers, porters and assistants. Originally developed in SA, the program now attracts joint national funding with the current contract approved to September 2015. A range of courses are now available online, including:

- clinical transfusion practice
- collecting blood specimens
- transporting blood
- postpartum haemorrhage
- iron deficiency anaemia (including an algorithm for iPhone, iPad and Android)
- critical bleeding (see picture 30)
- patient blood management and
- perioperative.
The suite of eight courses has proven to be very popular with an average of 10,500 course completions per month across Australia. Of the 39,231 medical, nursing and midwifery staff registered with the Australian Health Practitioner Regulation Agency in SA, over 36,500 have registered to complete a course with BloodSafe eLearning Australia. BloodSafe eLearning Australia continues to review and improve the courses based on feedback to ensure continuous improvement of the clinical education.

The following enhancements were made to BloodSafe eLearning Australia during 2013-14:

- Release of two new courses that are also mobile device friendly:
  - Perioperative which is based on the National Patient Blood Management Guidelines: Module 2 Perioperative.
  - Patient Blood Management which has been well received with over 1,000 completions of in the first six months of release.
- Review and update of the BloodSafe eLearning Australia website including being mobile responsive (see picture 24).
- Conversion of the critical bleeding course to a version that is mobile device friendly (other courses will follow shortly).
7.2 Documenting patient information

The clinical workforce accurately records a patient’s blood and blood product transfusion history and indications for use of blood and blood products.

7.2.1 BloodSafe audits

BloodSafe nurses undertake regular audits of transfusion episodes, principally to assess documented consent and appropriate use. Auditing against the NBA patient blood management (PBM) guidelines commenced in 2013, prior to this, audits were performed against the National Health and Medical Research Council (NHMRC) / Australasian Society of Blood Transfusion (ASBT) guidelines. The aim of these audits is to enable informed decisions as each transfusion episode relates to specific individual patient needs.

In large SA public metropolitan hospitals, the red cell audits focus on five key areas of blood transfusion:

> red cells transfused outside of the guidelines (NHMRC / ASBT from 2002-12 and NBA PBM in 2013)
> greater than four hours to administer
> indication not documented haemoglobin and comment
> no documented consent
> two checking signatures.
Graph 23 shows the results of the red cell audits undertaken at the Royal Adelaide Hospital, The Queen Elizabeth Hospital, Flinders Medical Centre and the Women’s and Children’s Hospital from 2002 to 2013.

Graph 23: Red cell audits against NHMRC / ASBT and NBA PBM Guidelines in SA major public metropolitan hospitals 2002-13

7.2.2 EPAS transfusion workgroup

In preparing for the rollout of EPAS, the transfusion working group reviewed EPAS blood order sets and standard electronic transfusion management processes at a multi-disciplinary process mapping meeting with the ALLSCRIPTS developers and SA Health representatives. The group provided expert medical, scientific and nursing input into the development of initial blood order sets, pathology collection forms and blood administration fields which meet national transfusion guidelines and legislative requirements.

Following the implementation of EPAS at Noarlunga Hospital (NH), the transfusion working group, with the assistance of the NH laboratory and clinical users, conducted an assessment of the useability of blood order sets and limitations of its current design were identified. An audit of all products administered was undertaken and safety issues were risk rated and reviewed. Based on both the findings and clinician feedback, the group prioritised changes to the blood order set / collection process / documents to streamline clinicians ordering and reduce duplication and errors. This enabled a smoother rollout of EPAS at Repatriation General Hospital and reduced order duplication and related errors.

The transfusion working group is currently developing critical bleeding, antenatal and reaction management order sets / pathways. Improvements are also being made to the information received in transfusion laboratories to more accurately reflect blood and blood product prescriptions.
7.2.3 Haemovigilance

Health service organisations are required to ensure that serious transfusion related adverse events are reported in their incident management and investigation systems. The Safety Learning System (SLS) is used for the reporting and management of incidents and consumer feedback across the public sector. SA Health data from this system is submitted annually to the National Blood Authority for inclusion in the National Haemovigilance Report.

Adverse reactions to blood products are analysed on an individual hospital / health service basis. SA is required to report the following serious transfusion related adverse events to the National Blood Authority:

- Acute transfusion reaction:
  - Febrile non-haemolytic transfusion reactions (FNHTR)
  - Allergic reactions
  - Anaphylactoid / anaphylaxis reactions.
  - Haemolytic transfusion reaction (HTR)
- Transfusion-associated circulatory overload (TACO)
- Transfusion-related acute lung injury (TRALI)
- Delayed haemolytic transfusion reactions (DHTR)
- Post-transfusion purpura (PTP)
- Transfusion transmitted infection
- Transfusion-associated graft versus host disease (TA-GVHD)
- Incorrect blood component transfused (IBCT).

The various categories of incidents relating to transfusion of products in 2013-14 are shown in graph 24.

Graph 24: Incidents relating to transfusion of blood and blood products 2013-14

Source: Safety Learning System
7.3 Managing blood and blood product safety

Health service organisations have systems in place to receive, store, transport and monitor wastage of blood and blood products safely and efficiently.

7.3.1 Minimising wastage

Minimising wastage of blood and blood products is a key requirement of the Statement of National Stewardship Expectations for the Supply of Blood and Blood Products and National Safety and Quality Health Service Standard 7 - Blood and Blood Products. There has been a steady improvement in red cell wastage for public sector which now sits at approximately 2.3%. SA still has the lowest jurisdictional (combined public and private sector) red cell wastage in Australia which remains well below the national average of 5.3%. This is the result of some key activities undertaken both nationally and locally such as BloodMove, improving education and better inventory management practices. Platelet wastage in SA public hospitals is being addressed through the BloodMove Platelet pilot project (Section 7.3.3).

Graph 25: Red cell wastage for public sector 2008-14

Source: BloodNet and Electronic Returns Information Capture (ERIC) system
7.3.2 BloodMove

The Country Health SA Local Health Network (CHSALHN) BloodMove project oversees 62 hospitals in country SA and continues to be a major initiative in 2013-14. It is managed and facilitated by a project team which consists of one Medical Scientist Lead, one Nurse Management Facilitator Lead and six Regional Director of Nursing and Midwifery Leads and seven Regional BloodSafe Clinical Nurses. This team is further supported by a designated contact nurse for each hospital.

The main aims of the project are to:

- reduce the level of blood product wastage in country areas through a particular focus on inventory management, return and reissue of product through the supply chain, supporting systems for tracking and quality measurement and increasing the awareness of the value of blood and also nurturing a culture of blood stewardship
- link into aspects of the SA BloodSafe program aimed at improving the safety, quality and efficiency of blood and blood product usage through audits, education, guidelines, and interventions to improve clinical practice and haemovigilance
- provide state-wide clinical leadership on blood related matters, including the provision of advice to the Department for Health and Ageing.

Progress to date in the areas of governance, policy, audits, education and practice improvement are as follows:

1. Governance:

   - CHSALHN Transfusion Committee continued to meet on a bimonthly basis with particular focus on reducing blood wastage, emergency blood and blood product placement, development of procedures and implementing new Patient Blood Management Guidelines.
   - CHSALHN Critical Bleeding Sub Committee met bimonthly focusing on the development of Critical Bleeding Guideline, this is due to be released across the whole of CHSALHN in 2014-15.
2. Policy procedures and protocols:
   > Release of a standardised procedures relating to administration of blood, transfusion specimen collection, care of Jehovah's Witness patients and blood transfusion consent across whole of CHSALHN
   > Implementation of a whole of country blood transfusion consent form that has resulted in increased compliance with consent to 94% (2013) from 65% (2008-09).
   > Development of the CHSALHN BloodMove Wiki page which is available to all staff to assist with finding information regarding BloodMove Program.

3. Audits:
   > A retrospective Red Blood Cell Audit report conducted at all hospitals which noted an overall improvement with administration of blood products when compared to previous years, gaps identified are being addressed in 2014-15
   > Completed a retrospective blood fridge audit at hospitals with a blood fridge
   > Completed a retrospective blood register audit in 2013.

4. Education:
   > On site education sessions conducted at all hospitals which focussed on blood administration, specimen taking, blood fridge maintenance and shipper packing and unpacking, audits, blood fridge assessments and provision of educational resources
   > Increasing participation in BloodSafe eLearning throughout CHSALHN
   > Regional education days for the clinical and site nurses was commenced in May 2014 with the aim to complete at all regions by the end of 2014
   > BloodMove was recognised both internationally, nationally and locally with invitation to present talks and posters at the following conferences:
     - International Society of Blood Transfusion (ISBT), Seoul Korea, June 2014
     - Haematology Society of Australia and New Zealand / Australian and New Zealand Society of Blood Transfusion (HAA/ANZSBT) Gold Coast, October 2013

5. Practice improvement:
   > Red cell wastage reduced to 1.1% (FYTD June 2014) which was 0.5% less than the previous financial year. The reduction in wastage since project commence is shown in graph 23.
   > Three clinical practice improvement projects were endorsed by the SA Blood Management Council. Project One focused on transfusion safety in relation to EPAS role out at Port Augusta Hospital (completed March 2014). The remaining two projects will focus on IV Iron Management and Critical Bleeding in 2014-15
   > Six new blood fridges were purchased, commissioned and installed in 2013-14.

6. BloodMove program was awarded the 2013 SA Health Award for Excellence in Non Clinical Service and the 2013 Australian College of Health Service Management (SA Branch) Award for Innovation and Excellence.

Graph 27: Country Health SA LHN blood wastage reduction 2007-14

Source: BloodNET System
7.3.3 BloodMove Platelet

Following on the achievements of BloodMove, Blood, Organ and Tissue Programs provided funding for a pilot project to address platelet wastage in metropolitan public hospitals. At present the rate of platelet wastage in SA Health ranges between 16% and 18% per annum in spite of regular monitoring and an increased focus on blood stewardship.

The objective of the BloodMove Platelet project is to minimise platelet wastage by encouraging transfusion services in large metropolitan public hospitals to share information on platelet inventory and move near expiry platelets to a hospital where they are most likely to be transfused.

BloodMove Platelet will address the barriers to moving platelets between hospitals, decrease platelet wastage and drive efficiencies which should result in savings for the blood budget.

The outcomes of the pilot will result in sustainable arrangements for the efficient use of platelets beyond 2015, and a strategy to meet the National Blood Authority’s national wastage target of 12% by 2016-17.

7.3.4 Private hospital audit

The BloodSafe Program provides resources to support SA private hospitals in their management of blood and blood products. A number of private hospitals are involved in red cell administration and usage audits that are coordinated by the BloodSafe transfusion nurse.

In 2014, a group of the smaller private hospitals (already benchmarking against each other for other clinical areas such as infection control) engaged in an ongoing audit program with BloodSafe. By the end of 2014, all participating hospitals will have completed one standardised audit allowing comparison of results against each other, as well as being able to compare against previous audits undertaken in the public hospitals.

With Standard 7 requirements driving private hospitals to examine and monitor wastage, some private hospitals together with BloodSafe are auditing and reviewing the quantity of preoperative cross matched red cells and related transfusion rates. The aim of this activity is to assist the private transfusion service providers with managing inventory and minimising wastage due to product expiry. In circumstances where it has been identified that transfusion rates for a procedure are low, and red cells can be accessed in sufficient time, the pre-operative crossmatched blood delivered to private hospitals has been reduced.

The auditing process undertaken at Burnside War Memorial Hospital has been recognised as a case study example by the NBA and will be published on its website at www.nba.gov.au.

Item 20: Burnside War Memorial Hospital case study of blood audit 2014
7. Blood and blood products

7.4 Communicating with patients and carers

Patients and carers are informed about the risks and benefits of using blood and blood products, and the available alternatives when a plan for treatment is developed.

7.4.1 BloodSafe website

Patients should be engaged in decisions regarding the management of their own blood (patient blood management strategies), and if they are to receive blood and blood products, it should be done appropriately and safely. Unless a blood transfusion is required in an emergency situation, the patient (or a family member) should be asked to give fully informed consent. Providing clear and easy to understand information helps with this process.

The BloodSafe website has a dedicated section for consumers which contains information and fact sheets on receiving blood transfusions, giving consent, a paediatric kit for children receiving transfusions, and specific information on immunoglobulin infusions and consent. The importance of these useful resources has been recognised by the National Blood Authority who has adapted SA’s resources for use at a national level.

Also included on the website are fact sheets about a common tool used in patient blood management – boosting iron levels. Fact sheets on the importance of iron therapy, including risks, benefits and possible side effects from both iron tablets and intravenous iron infusions have been made available in the following languages:

- English
- Arabic
- Greek
- Italian
- Polish
- Turkish
- Vietnamese
- Croatian
- Persian
- Simplified Chinese.

The provision of safe and effective use of iron has become particular important since the approval of federal funding for IV iron products.

Further information is available on the BloodSafe section of the SA Health website at www.sahealth.sa.gov.au/bloodsafe
8 Preventing and managing pressure injury
8. Preventing and managing pressure injury

Pressure injuries can affect people of all ages, and can lead to prolonged recovery, pain and disfigurement. They are largely preventable and there is good evidence about best practice for prevention, and also for wound care that promotes optimal healing\(^9\).

National Safety and Quality Health Service Standard 8 – Preventing and managing pressure injuries includes:
- governance and systems for the prevention and management of pressure injuries
- preventing pressure injuries
- managing pressure injuries
- communicating with patients and carers.

8.1 Governance and systems for the prevention and management of pressure injuries

Each Local Health Network has a governance structure for pressure injury prevention, usually combined with wound management and other skin integrity issues. An example of the terms of reference, roles and functions for local committee is now available on the Safety and Quality section of the SA Health website Preventing and managing pressure injuries page at www.sahealth.sa.gov.au/safetyandquality. This illustrates how an effective committee can be a key driver for implementing best practice and demonstrating that standards are met.

8.1.1 Policy directive, guideline and toolkit

The SA Health Prevention and management of pressure injuries clinical policy directive and guideline were revised early in 2014, mainly to reflect changes to the assessment of risk of pressure injury and align with the requirements of Standard 8.

New components of the toolkit that accompanies the policy and guideline are constantly under development, and this year two medical records forms, the Pressure Injury Risk Assessment Form (MR95), and the Pressure Injury Prevention Plan (MR95A) were finalised.

Definitions of the three major classification of pressure injuries recorded in SLS (at Level 2) were agreed this year. These differentiate the location where the pressure injury arose, and are:
- New - acquired during the current admission to this health service.
- Present on admission from home or external service provider - acquired prior to admission to an SA Health service.
- Worsening of existing (deteriorated by one or more stages during current admission), or observed after internal transfer (acquired prior to transfer in from another SA Health service).

Activities aimed at prevention are targeted efforts at pressure injury that are new, worsening, or acquired during internal transfer.

\(^9\) National Safety and Quality Health Service Standards (September 2012), Australian Commission on Safety and Quality in Health Care
8.1.2 Preventing and managing pressure injuries accreditation resource

Item 21: Standard 8 Preventing and managing pressure injuries accreditation resource

The SA Health preventing and managing pressure injuries accreditation resource guide was developed to support health services. The guide contains a combination of resources and tools developed by SA Health to assist health services to demonstrate an action and Standard has been met. It is intended to be used in addition to the Australian Commission on Safety and Quality in Health Care’s resources when implementing the National Safety and Quality Health Service Standards.

The accreditation resource guide is available on the Safety and Quality section of the SA Health website National Safety and Quality Health Service Standards page at www.sahealth.sa.gov.au/safetyandquality

8.1.3 Pressure injury incidents

Reporting pressure injuries into the Safety Learning System (SLS) is still relatively new. The capabilities of the SLS to provide rich, clinically relevant information are being realised.

Last year, a set of questions was incorporated into the SLS for reporting pressure injuries, and to accompany this there was guidance developed for clinicians and managers in both reporting to SLS, and also analysis of incidents and other data.

In 2012-13 there were 461 reports of pressure injury into the SLS, and this year that has increased to 1333 incidents. The increase in numbers is due largely to increased rate of notification. This has been mediated by two factors - the changes to SLS (pressure injury moved from a level 2 classification to level 1 and is therefore more visible); and each LHN committee has improved awareness of the requirement to notify pressure injury into SLS. The majority of pressure injuries this year were rated SAC 3 (61.6%) and SAC 4 (35.4%).

Over half (56%) of all reports included information about the number of pressure injuries on the person. Of these 64.1% reported only one, 23.2% reported two, and the remaining 12.8% reported three or more pressure injuries present on the patient.

Pressure injuries are classified according to their depth and severity using an international system devised by National Pressure Ulcer Advisory Panel (NPUAP). 75% of pressure injuries are stages 1 or 2 which are the least severe (Table 15).

Table 15: Stage of the pressure injury 2013-14

<table>
<thead>
<tr>
<th>Stage of the pressure injury (NPUAP)</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>443</td>
<td>33.2%</td>
</tr>
<tr>
<td>Stage 2</td>
<td>557</td>
<td>41.8%</td>
</tr>
<tr>
<td>Stage 3</td>
<td>77</td>
<td>5.8%</td>
</tr>
<tr>
<td>Stage 4</td>
<td>32</td>
<td>2.4%</td>
</tr>
<tr>
<td>Unstageable</td>
<td>107</td>
<td>8.0%</td>
</tr>
<tr>
<td>Not known</td>
<td>103</td>
<td>7.7%</td>
</tr>
<tr>
<td>Suspected deep</td>
<td>14</td>
<td>1.0%</td>
</tr>
<tr>
<td>Total</td>
<td>1333</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

Pressure injuries are discussed with patient, families and carers over 75% of the time (table 7).
Table 16 indicates that 60% of all reported pressure injuries were newly acquired during an episode of health care; and over 30% were present when the person was first admitted to an SA Health service. The remainder deteriorated or worsened during their admission, frequently at times of internal transfer. The latter suggests that pressure risk and prevention should be included routinely in handover.

### Table 16: Pressure injuries by level 2 classification

<table>
<thead>
<tr>
<th>Pressure injuries by level 2 classification</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>798</td>
<td>59.9%</td>
</tr>
<tr>
<td>Present on admission from home or external service provider</td>
<td>410</td>
<td>30.8%</td>
</tr>
<tr>
<td>Worsening of existing / observed after internal transfer</td>
<td>125</td>
<td>9.4%</td>
</tr>
<tr>
<td>Total</td>
<td>1333</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

The following table 17 shows that, although more numerous, pressure injuries that develop during an admission tend to be less deep and less serious than those that are worsening or present on admission. For new pressure injury 81% were Stage 1 or 2, whereas there are lower proportions for these stages for other categories (59% and 67% respectively).

It is possible that new pressure injuries are identified and reported earlier.

### Table 17: Percentage of pressure injury by stage and whether the injury is new, worsening or was present on admission

<table>
<thead>
<tr>
<th>Stage / status of the pressure injury</th>
<th>New %</th>
<th>Worsening %</th>
<th>Present on admission %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 1</td>
<td>41.2%</td>
<td>22.0%</td>
<td>21.5%</td>
</tr>
<tr>
<td>Stage 2</td>
<td>41.0%</td>
<td>36.7%</td>
<td>45.1%</td>
</tr>
<tr>
<td>Stage 3</td>
<td>2.0%</td>
<td>16.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Stage 4</td>
<td>0.7%</td>
<td>5.7%</td>
<td>4.6%</td>
</tr>
<tr>
<td>Unstageable</td>
<td>5.9%</td>
<td>10.6%</td>
<td>11.5%</td>
</tr>
<tr>
<td>Suspected deep</td>
<td>1.0%</td>
<td>1.6%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Not known</td>
<td>8.2%</td>
<td>7.1%</td>
<td>6.3%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

### 8.1.3.1 New pressure injuries - developed during the current admission to this health service

Analyses relating to ‘new’ pressure injuries have been done separately, to assist in understanding where to target efforts for quality improvement.

In 2013-14 there were 798 reports of new pressure injuries. Of these 83% were NPUAP stages 1 or 2 (least serious); 9.5% were deeper, and for 8% the stage was unknown at the time of the report.

55% of these reports included the number of pressure injuries identified on the person. For these 67% reported one, 24% had two and 9% reported three or more pressure injuries on the patient.
The health service location where new pressure injuries were reported indicated that;

- the majority (69%) occurred in acute wards
- 18% of the new pressure injuries were reported by SA Health residential care settings
- 13% were in a variety of services such as intensive care and palliative care; rehabilitation and community settings; neonate, maternity and paediatrics; operating theatres and recovery suites.

Data from the additional (optional) questions in SLS about a pressure injury were also analysed. The question ‘Patient factors contributing to pressure injury’ was completed for 515 incidents (64% of all new incidents). An average of 3.2 patient factors was selected per incident.

Impaired mobility, inactivity and poor nutritional status were the most commonly reported patient factors. Body habitus and impaired sensation were included in under 30% of reports (table 18).

Table 18: Patient factors contributing to new pressure injury

<table>
<thead>
<tr>
<th>Patient factors</th>
<th>Number of reports where this was selected</th>
<th>% of reports where this was selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impaired mobility</td>
<td>343</td>
<td>66.6%</td>
</tr>
<tr>
<td>Low levels of activity</td>
<td>284</td>
<td>55.1%</td>
</tr>
<tr>
<td>Poor nutritional status / malnutrition</td>
<td>186</td>
<td>36.1%</td>
</tr>
<tr>
<td>Underweight or obese</td>
<td>150</td>
<td>29.1%</td>
</tr>
<tr>
<td>Impaired body sensation</td>
<td>144</td>
<td>28.0%</td>
</tr>
<tr>
<td>Difficulty complying with prevention strategies</td>
<td>107</td>
<td>20.8%</td>
</tr>
<tr>
<td>Palliative, frail</td>
<td>105</td>
<td>20.4%</td>
</tr>
<tr>
<td>Impaired circulation or perfusion</td>
<td>104</td>
<td>20.2%</td>
</tr>
<tr>
<td>Oedema, swelling</td>
<td>82</td>
<td>15.9%</td>
</tr>
<tr>
<td>Long period of anaesthesia or sedation</td>
<td>57</td>
<td>11.1%</td>
</tr>
<tr>
<td>History of pressure injury(s) in the last two years</td>
<td>44</td>
<td>8.5%</td>
</tr>
<tr>
<td>Rash, dermatological condition(s)</td>
<td>20</td>
<td>3.9%</td>
</tr>
<tr>
<td>None of the above</td>
<td>24</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

The question ‘environmental factors contributing to pressure injury’ was completed for 500 incidents (63% of all new incidents). An average of 2.1 environmental factors was reported per incident.

Exposure to pressure was reported commonly (74%). Friction, shearing forces and moisture were all identified as a contributing factor in approximately 30% of reports. Devices in contact with skin were implicated in over 20% of reports. Devices included tubing, splinting materials and anti-embolic stockings.
Table 19: Environmental factors contributing to new pressure injury

<table>
<thead>
<tr>
<th>Environmental factor</th>
<th>Number of reports where this was selected</th>
<th>% of reports where this was selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to pressure</td>
<td>370</td>
<td>74.0%</td>
</tr>
<tr>
<td>Exposure to friction</td>
<td>185</td>
<td>37.0%</td>
</tr>
<tr>
<td>Exposure to shearing forces</td>
<td>147</td>
<td>29.4%</td>
</tr>
<tr>
<td>Exposure to moisture</td>
<td>140</td>
<td>28.0%</td>
</tr>
<tr>
<td>Presence of device(s) in contact with skin</td>
<td>104</td>
<td>20.8%</td>
</tr>
<tr>
<td>Exposure to poor hygiene / skin irritants</td>
<td>50</td>
<td>10.0%</td>
</tr>
<tr>
<td>Exposure to high skin temperatures</td>
<td>24</td>
<td>4.8%</td>
</tr>
<tr>
<td>None of the above</td>
<td>33</td>
<td>6.6%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

The question ‘What intervention strategies were in use / in place’ was completed for 498 (62%) of incident reports, with an average of 4.7 intervention strategies selected for each.

At the time that a pressure injury is identified and reported a current assessment is the most common intervention in place (selected for 73% of reports). A current prevention plan and handover were in place for 45%. This may indicate that assessment findings have not been translated into a care plan, and implemented.

Considering that mobility, inactivity and poor nutritional status were the most common patient factors, and exposure to pressure, friction, shearing forces, moisture and devices in contact with skin were the most environmental factors, relatively few interventions to address these factors were in place. This may indicate why the pressure injuries developed. This information is relevant to clinical improvement. Interdisciplinary care, discharge planning and involvement of the consumer and their families are low.

The intent of the SA Health Pressure Injury Prevention and Management Policy Directive and the requirements of Standard 8 is that there is always a current assessment of pressure risk and skin, and the resultant care plan is implemented in a timely manner.
### Table 20: Intervention strategies in use / in place when new pressure injury identified

<table>
<thead>
<tr>
<th>Intervention strategies in place</th>
<th>Number of reports where this was selected</th>
<th>% of reports where this was selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current assessment of pressure risk and skin</td>
<td>615</td>
<td>73%</td>
</tr>
<tr>
<td>Pressure - eliminate or redistribute using equipment or other</td>
<td>478</td>
<td>57%</td>
</tr>
<tr>
<td>Re-positioning routine</td>
<td>505</td>
<td>60%</td>
</tr>
<tr>
<td>Encourage and assist patient positioning and mobility</td>
<td>404</td>
<td>48%</td>
</tr>
<tr>
<td>Current pressure injury prevention plan and handover</td>
<td>377</td>
<td>45%</td>
</tr>
<tr>
<td>Skin hygiene and moisture reduction strategies</td>
<td>353</td>
<td>42%</td>
</tr>
<tr>
<td>Friction - eliminate or reduce using equipment or other</td>
<td>250</td>
<td>30%</td>
</tr>
<tr>
<td>Pain assessment and management</td>
<td>212</td>
<td>25%</td>
</tr>
<tr>
<td>Manual handling technique(s) to reduce skin trauma</td>
<td>221</td>
<td>26%</td>
</tr>
<tr>
<td>Shearing - eliminate or reduce using equipment or other</td>
<td>204</td>
<td>24%</td>
</tr>
<tr>
<td>Oral nutrition supplements, feeding assistance</td>
<td>159</td>
<td>19%</td>
</tr>
<tr>
<td>Referral(s) and multidisciplinary team involved</td>
<td>174</td>
<td>21%</td>
</tr>
<tr>
<td>Consumer, family, carers involved</td>
<td>154</td>
<td>18%</td>
</tr>
<tr>
<td>Discharge planning</td>
<td>61</td>
<td>7%</td>
</tr>
<tr>
<td>None of the above</td>
<td>31</td>
<td>4%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

---

**8.2 Preventing pressure injuries**

**8.2.1 Screening, assessment and care-planning**

The new medical records form Pressure Injury Risk Assessment Form (MR95) will assist health services without EPAS to achieve the requirements of Standard 8 for a comprehensive assessment.

These forms include the screening tool, a skin assessment (inspection), a pain assessment, and a review of the consumer's conditions that are known to be associated with elevated risk of pressure injury. This allows clinicians to elevate the risk indicated by the screening tool, if these other assessment elements indicate.

**8.3 Managing pressure injuries**

A key strategy has been the development of a panel contract for pressure mattresses and chair cushions. The provision of hospital bed surfaces as a preventative and management strategy is now supported through the establishment in 2014 of a whole of health statewide panel contract for purchase or rental of alternating pressure mattress replacements and chair cushions. This has allowed LHN Pressure Injury / Skin Integrity Committees and procurement officers to commence a revision of their purchasing / rental arrangements, to achieve savings and high quality equipment. Most LHNs have commenced this process.

In addition, many sites now purchase, as a minimum, standard mattresses that comply with the requirements of the Australian Wound Management Association (AWMA) guideline for hospital beds, and have established routine assessment of these, to ensure they are replaced when under-performing.

Care planning using both the medical records form (Pressure Injury Prevention Plan (MR95A)) and EPAS will support consistent practice across SA.
8. Preventing and managing pressure injuries

Achieving consistency in wound care terminology

The Enterprise Patient Administration System (EPAS) is one of SA Health’s most prominent clinically driven health reforms. The founding principle of One Patient, One Record, Better Care paves the way to care delivery that is timely, safe and supports best clinical practice.

The implementation of such significant change on a state wide level requires the achievement of state-wide agreement on much of the content, in this case the Wound Care documentation component of the system.

To negate inconsistencies between sites an EPAS Wound Care Network was founded. Membership included expert clinicians from metropolitan and rural health with both adult and paediatric experience. The Network reviewed and revised all wound related content in EPAS, to ensure that the system functionality and terminology best met the requirements of Standard 8 and the SA Health Pressure Injury Prevention and Management Policy Directive and the national Standards for Wound Management (Australian Wound Management Association, 2010).

A group of members reviewed the current content under the ‘SKIN’ parameter and recommended changes to the wound descriptors for burns, drains, incisions, pressure injury, wounds, rash and surrounding skin. The group also achieved agreement on statewide terminology for goals of treatment for wounds.

These agreements drive clinical documentation and workflow in a direction that promotes consistent use of terms, to reflect the best and safest practice.

This agreed content is currently being built into EPAS. On completion it will be available to current sites and ready for the next ‘Go Live’ site. EPAS has capability to report on much of the clinical content, and so the uptake will be able to be monitored.

8.4 Communicating with patients and carers

SA Health released a consumer fact sheet ‘Preventing pressure injuries’, in collaboration with the South Australian Safety and Quality in Health Care Consumer and Community Advisory Committee, other consumer groups, clinicians and Local Health Networks.

Item 22: Preventing pressure injuries consumer fact sheet

Further information is available on the Safety and Quality section of the SA Health website Preventing and managing pressure injuries page at www.sahealth.sa.gov.au/safetyandquality

Additional information is also available on the Australian Commission on Safety and Quality in Health Care website at http://www.safetyandquality.gov.au/
Recognising and responding to clinical deterioration
Patients in acute health care often have complex health issues and their condition may deteriorate. Traditionally, response systems such as ‘code blue’ teams have been in place for such events. Through careful study, we have learned that patients who have cardiac or respiratory arrest or die unexpectedly, often have early signs of deterioration that could be acted on earlier and may have resulted in improved outcomes for the patient. Having robust systems for overcoming the organisational and human factors that may interfere with recognition of or rapid response to acute clinical deterioration is the aim of the Recognising and Responding to Clinical Deteriorating in Acute Health Care Standard.

National Safety and Quality Health Service Standard 9 – Recognising and Responding to Clinical Deterioration includes:

- establishing recognition and response systems
- recognising clinical deterioration and escalating care
- responding to clinical deterioration
- communicating with patients and carers.

9.1 Establishing recognition and response systems
The Recognising and Responding to Deteriorating Patient Advisory Group led the foundational requirements to advance a consistent approach to improve the recognition and response to acute clinical deterioration of patients.

9.1.1 Recognising and responding to clinical deterioration policy and guideline
With the Guidance of the Recognising and Responding to Deteriorating Patient Advisory Group and following consultation, the SA Health Recognising and responding to clinical deterioration policy directive and guideline were released in January 2013.

The policy and guideline outline the governance and requirements for ensuring systems and processes are effective in SA Health for the recognising and responding to acute clinical deterioration.

9.1.2 Recognising and responding to clinical deterioration in acute health care accreditation resource

Item 23: Standard 9 Recognising and Responding to Clinical Deterioration in Acute Health Care accreditation resource

The SA Health Recognising and Responding to Clinical Deterioration accreditation resource guide developed to support health services, was reviewed and updated in 2014. The guide contains a combination of resources and tools developed by SA Health to assist health services to demonstrate an action and Standard has been met. It is intended to be used in addition to the Australian Commission on Safety and Quality in Health Care’s resources when implementing the National Safety and Quality Health Service Standards.

The accreditation resource guide is available on the Safety and Quality section of the SA Health website National Safety and Quality Health Service Standards page at www.sahealth.sa.gov.au/safetyandquality.
9.1.3 Recognising and responding to clinical deterioration incidents

Reporting incidents related to the recognition and response to clinical deterioration into Safety Learning System (SLS) provides the opportunity to identify systems, teamwork and communication, skill or education issues that may compromise quality care. The types of incidents related to recognise and respond to clinical deterioration are outlined below in table 21.

Table 21: Recognition and response related incidents by level 3 classification and results 2013-14

<table>
<thead>
<tr>
<th>Incident Type</th>
<th>SAC 1</th>
<th>SAC 2</th>
<th>SAC 3</th>
<th>SAC 4</th>
<th>UnSAC'd</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delay or failure to monitor</td>
<td>1</td>
<td>4</td>
<td>354</td>
<td>520</td>
<td>40</td>
<td>919</td>
</tr>
<tr>
<td>Lack of clinical or risk assessment</td>
<td>0</td>
<td>8</td>
<td>271</td>
<td>409</td>
<td>26</td>
<td>714</td>
</tr>
<tr>
<td>Delay / difficulty in obtaining clinical assistance</td>
<td>0</td>
<td>3</td>
<td>94</td>
<td>112</td>
<td>12</td>
<td>221</td>
</tr>
<tr>
<td>Delay in diagnosis</td>
<td>2</td>
<td>8</td>
<td>100</td>
<td>78</td>
<td>5</td>
<td>193</td>
</tr>
<tr>
<td>Delay / failure in acting on complication of treatment</td>
<td>0</td>
<td>1</td>
<td>37</td>
<td>32</td>
<td>1</td>
<td>71</td>
</tr>
<tr>
<td>Failure to act on adverse symptoms</td>
<td>1</td>
<td>3</td>
<td>34</td>
<td>41</td>
<td>0</td>
<td>79</td>
</tr>
<tr>
<td>Failure to act on adverse test results or images</td>
<td>0</td>
<td>1</td>
<td>22</td>
<td>11</td>
<td>2</td>
<td>36</td>
</tr>
<tr>
<td>Failure to follow up</td>
<td>0</td>
<td>1</td>
<td>75</td>
<td>129</td>
<td>14</td>
<td>219</td>
</tr>
<tr>
<td>Failure / delay to order correct tests, image etc.</td>
<td>0</td>
<td>1</td>
<td>49</td>
<td>36</td>
<td>2</td>
<td>88</td>
</tr>
<tr>
<td>Other incident to do with assessment</td>
<td>4</td>
<td>9</td>
<td>153</td>
<td>269</td>
<td>30</td>
<td>465</td>
</tr>
<tr>
<td>Patient risk / deterioration not communicated</td>
<td>0</td>
<td>1</td>
<td>21</td>
<td>22</td>
<td>5</td>
<td>49</td>
</tr>
<tr>
<td>Unplanned admission / transfer to specialist care unit</td>
<td>0</td>
<td>1</td>
<td>10</td>
<td>22</td>
<td>3</td>
<td>36</td>
</tr>
<tr>
<td>Cardiac arrest</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Respiratory arrest</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>8</strong></td>
<td><strong>43</strong></td>
<td><strong>1222</strong></td>
<td><strong>1681</strong></td>
<td><strong>141</strong></td>
<td><strong>3095</strong></td>
</tr>
</tbody>
</table>

%: 0.3% 1.4% 39.5% 54.3% 4.5% 100.0%

Source: Safety Learning System
9. Recognising and responding to clinical deterioration

9.1.4 Establishing recognition and response systems Rapid Detection and Response (RDR) observation charts

The implementation of a state-wide standard for observation charts is a core to the establishment of recognition and response systems. The RDR charts were developed in alignment with the Australian Commission on Safety and Quality in Health Care Observation and Response Charts. Health services across the state are all now using the charts to improve recognition and response to clinical deterioration.

The SA Health metropolitan Emergency Departments identified the need to design a RDR Chart to meet the specific needs of consumers in the emergency department setting. Through collaboration, senior staff from these emergency departments worked with Department of Health staff in the development and implementation of the Emergency Department Adult RDR Chart. The chart will assist in identifying patients that may be deteriorating in the emergency setting and ensuring a rapid clinical response. The chart also matches the charts used across all other areas so is understood by all clinicians.

Item 24: Emergency Department Adult RDR Chart

Further information is available on the Safety and Quality section of the SA Health website Recognising and responding to clinical deterioration page at www.sahealth.sa.gov.au/safetyandquality

Preventing falls and harm from falls
Falls are a significant cause of potentially avoidable harm, and older people are those most affected. As South Australia’s population ages, the need for effective systems to identify who is at risk, and to provide high quality care is increasing.

There is strong evidence that many falls are preventable, and the best practice guidelines on Preventing Falls and Harm from Falls in Australian Hospitals, Residential Aged Care and Community Care (Australian Commission on Safety and Quality in Health Care in 2009) summarise that evidence and are guiding changes to the way that care is delivered.

There is considerable work ongoing to develop systems and gather evidence of the shift in practice towards that recommended by the best practice guidelines, in order to meet Standard 10.

National Safety and Quality Health Service Standard 10 – Preventing falls and harm from falls\(^2\) includes:

> governance and systems for the prevention of falls
> screening and assessing risks of falls and harm from falling
> preventing falls and harm from falling
> communicating with patients and carers.

**10.1 Governance and systems for the prevention of falls**

Each LHN now has a system of committees that oversee activities.

The SA Health Safety and Quality webpage Preventing falls and harm from falls at www.sahealth.sa.gov.au/safetyandquality has been revised this year to reflect the addition of new resources.

**10.1.1 Preventing Falls and Harm from Falls accreditation resource**

Item 25: Standard 10 Preventing Falls and Harm from Falls accreditation resource

The SA Health Preventing Falls and Harm from Falls accreditation resource guide developed to support health services, was reviewed and updated in 2014. The guide contains a combination of resources and tools developed by SA Health to assist health services to demonstrate an action and Standard has been met. It is intended to be used in addition to the Australian Commission on Safety and Quality in Health Care’s resources when implementing the National Safety and Quality Health Service Standards.

The accreditation resource guide is available on the Safety and Quality section of the SA Health website National Safety and Quality Health Service Standards page at www.sahealth.sa.gov.au/safetyandquality

**10.1.2 Fall incidents during care**

Under the Primary Incident Classification (table 7) patient falls and other injuries is the most common classification with 11520 incidents. As well as falls, this classification includes 1801 other patient injuries such as collisions, lifting or sharps incidents and exposure to hazardous substances.

\(^2\) National Safety and Quality Health Service Standards (September 2012), Australian Commission on Safety and Quality in Health Care
The following relates to the 9719 falls incidents, of which 506 (5.2%) were classified as near misses.

There has been a 53% decrease in the proportion of falls resulting in serious harm (SAC 1 and 2), between 2010-11 and 2013-14. Despite the number of reports of falls incidents rising, both the number and proportion that are harmful (rated SAC 1 or SAC 2) continues to decline, from 3.2% (n=227) in 2010-11 to 1.5% (n=144) this year.

Table 22: Falls incidents reported by SAC codes 2010-14

<table>
<thead>
<tr>
<th>Actual SAC</th>
<th>2010-11</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAC 1</td>
<td>80</td>
<td>48</td>
<td>17</td>
<td>14</td>
</tr>
<tr>
<td>SAC 2</td>
<td>147</td>
<td>169</td>
<td>160</td>
<td>130</td>
</tr>
<tr>
<td>SAC 3</td>
<td>4973</td>
<td>4208</td>
<td>4617</td>
<td>4934</td>
</tr>
<tr>
<td>SAC 4</td>
<td>1341</td>
<td>2765</td>
<td>3418</td>
<td>4360</td>
</tr>
<tr>
<td>Uncoded incidents</td>
<td>531</td>
<td>167</td>
<td>199</td>
<td>281</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7072</strong></td>
<td><strong>7357</strong></td>
<td><strong>8411</strong></td>
<td><strong>9719</strong></td>
</tr>
<tr>
<td>% of SAC 1 and SAC 2</td>
<td>227 (3.2%)</td>
<td>217 (2.9%)</td>
<td>177 (2.1%)</td>
<td>144 (1.5%)</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

Notifiers are asked to indicate if they believe that there was harm to the individual. Where this is recorded 33.6% indicate that there was harm, which can range from a transient red mark to rare serious injuries.

It is useful to establish the circumstances during care in which falls, particularly harmful falls, occur. This is sometimes unknown because only 27% of falls are witnessed. Harmful falls most commonly occur when the patient is attempting to sit/stand, walking, getting in or out of bed and toileting, and of these falls while walking is most commonly associated with harm.

Table 23: Most frequent activities at the time of fall 2013-14

<table>
<thead>
<tr>
<th>Most frequent activities at the time of fall 2013-14</th>
<th>Harm caused to an individual or organisation</th>
<th>No harm caused to an individual or organisation</th>
<th>Near Miss</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attempting to sit / stand</td>
<td>464</td>
<td>910</td>
<td>128</td>
<td>1502</td>
</tr>
<tr>
<td>Walking</td>
<td>582</td>
<td>750</td>
<td>98</td>
<td>1430</td>
</tr>
<tr>
<td>Getting in / out of bed</td>
<td>311</td>
<td>718</td>
<td>73</td>
<td>1102</td>
</tr>
<tr>
<td>Toileting, or attempting to toilet</td>
<td>314</td>
<td>439</td>
<td>55</td>
<td>808</td>
</tr>
<tr>
<td>Bending / leaning / reaching over</td>
<td>242</td>
<td>434</td>
<td>36</td>
<td>712</td>
</tr>
<tr>
<td>Standing</td>
<td>177</td>
<td>264</td>
<td>43</td>
<td>484</td>
</tr>
<tr>
<td>Sitting</td>
<td>64</td>
<td>193</td>
<td>35</td>
<td>292</td>
</tr>
<tr>
<td>Rolling on bed</td>
<td>68</td>
<td>173</td>
<td>15</td>
<td>256</td>
</tr>
<tr>
<td>Climbing over / around bedrails</td>
<td>66</td>
<td>137</td>
<td>16</td>
<td>219</td>
</tr>
<tr>
<td>Showering</td>
<td>34</td>
<td>73</td>
<td>7</td>
<td>114</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2322</strong></td>
<td><strong>4091</strong></td>
<td><strong>506</strong></td>
<td><strong>6919</strong></td>
</tr>
</tbody>
</table>

Source: Safety Learning System
10. Preventing falls and harm from falls

10.2 Screening and assessing risk of falls and harm from falling

This year the medical records form MR58b Falls Risk Screen was released. It was designed for emergency departments, outpatient and ambulatory clinics, day procedure services and other sites where a quick screening process is required and only those at high risk need to be referred for a more comprehensive referral.

Case study: Falls risk screening pre-operatively at Royal Adelaide Hospital

The Royal Adelaide Hospital (RAH) Pre-operative Assessment Clinic provides a multidisciplinary patient assessment for elective surgical and medical procedures.

In 2013, the clinic was the first RAH department to commence using the ‘Falls risk screen’ medical records form. The form suits our patients / consumers, and the clinic to seek specific information in regard to mobility, discuss falls prevention and provide appropriate patient information and resources to patients and their families.

The resources provided include a list of services and organisations that can provide advice or assistance; SA Health consumer fact sheets for Falls and Fall Injury Prevention one to nine; the ‘Falls Prevention Service Directory’, and the ‘Don’t fall for it’ guide to preventing falls for older people in SA. Falls Fact sheet number five: ’Keeping safe and independent in hospital’ is commonly given to our patients following discussions about preparing for surgery, and falls prevention.

In the patient waiting area we also have a display board focussed on falls prevention as well as copies of the Falls Prevention Directories and booklets.

Discussion around prevention of falls is now a part of assessment for every patient.

Picture 32: Falls risk screen e-learning screen shot
Case study:

Northern Adelaide Local Health Network (NALHN) Falls risk assessment in Rehabilitation in the Home (RITH)

There is a greater risk of falling in the early stages of going home after a hospital admission.

A number of initiatives have been put into place with the aim to reduce the incidence of falls and harm from falls.

The project commenced in November 2012, and evaluation in January 2014 noted the following results;

> The Northern Adelaide Rehabilitation Service has a trained falls leader.
> 99.5% of RITH clients are screened on day one, using an evidence-based and validated screening tool (FROP-Com).
> 99.5% of RITH clients who scored as a ‘high falls risk’ using the screening tool received an Occupational Therapy, Physiotherapy and a Clinical Nurse assessment within 48 hours of admission.
> 92% of RITH clients received a home environmental assessment, within 48 hours of admission, with recommendations provided on extrinsic falls risk factors.
> High risk clients received a written falls action plan 87% of the time.
> A falls resource kit has been developed which can be taken to clients’ homes to support falls education. High risk clients received a one on one falls education session, including the “Don’t falls for it” information booklet
> Multi-disciplinary post falls team huddles are occurring on the day of the incident in 100% of cases.
> Falls are routinely reported into Safety Learning System.

10.3 Preventing falls and harm from falling

Intervention is guided by the national Best Practice Guidelines for preventing falls in Australian hospitals, community care and residential aged care (2009, Australian Commission for Safety and Quality in Health Care).

Case study:

Yorke and Northern Rural Region (YNRR) Falls Prevention Working Party

The YNRR Falls Working Party developed a regional action plan to address prevention of falls and harm from falls, increase consumer awareness and consumer participation. The group meets via videoconference and members are from 16 sites.

Key achievements to date:

> Completing a gap analysis of the Country Health SA (CHSA) action plan and national safety and quality health service standard 10.
> Falls audits across the region, with follow-up action.
> Six monthly review of the plan completed and six monthly reports to CHSALHN.
> Review of SAC 1 and 2 incidents and forward recommendations to Clinical Review
> Build partnerships through Aboriginal Health Advisory Committee and Communities by including them in education sessions and by providing written resources and fact sheets.
> Innovative April Falls Month activities across the region, including residential aged care facilities and community services.

Work in progress includes the implementation of Fall and Fall Injury Risk Review Medical Records form (MR58B) at all 16 sites, and further staff education.

Outcomes:

> 5.2% decrease in falls incidents for the region compared with previous year July 2013 to April 2014.
> A gradual decline in harm resulting from falls.
10.4 Falls prevention and management e-learning module

A health workforce with skills, knowledge and understanding is required to deliver effective falls prevention.

> The new Falls Prevention and Management e-learning module was launched in April 2014, and there are now over 450 Falls Prevention Leaders in SA.

Picture 33: Falls e-learning module completions

Both the Preventing falls and harm from falls section of the SA Health Safety and Quality website and the Falls SA website have considerable information for staff in health and other settings.
10.5 Communicating with patients and carers

Engagement with consumers continues to be a strong element of falls prevention. The April Falls Awareness month activities and consumer information sheets continue to build the community’s understanding of falls prevention messages and services.

In April 2014 there were several articles covered by the print media, and radio interviews. Health services held a range of activities for their consumers and workers.

**Case study:**

**Consumer fact sheets for maternity wards in Northern Adelaide Local Health Network (NALHN)**

Last year there were 32 falls in maternity units across Lyell McEwin Hospital, Modbury Hospital, Flinders Medical Centre and Womens and Childrens Hospital. The existing suite of SA Health falls fact sheets targets older individuals who are at risk of falling.

Staff working in the Birthing Unit and Womens Health Unit at the Lyell McEwin Hospital indicated that there was a gap in resources for their patient group – namely mothers who may be temporarily at increased risk of falling following childbirth and those who are learning how to handle their babies safely.

The NALHN Standard 10 Falls Prevention Committee worked with the Women’s and Children’s Division to identify resources available elsewhere in Australia. One fact sheet had recently been developed in New South Wales (NSW) and this was circulated among clinicians for their feedback. Permission to use the fact sheet was obtained from the NSW Clinical Excellence Commission.

This resource was laminated and placed in each bedroom. As a result, falls risk is re-assessed and handed over between nursing shifts.

Concurrently, a NALHN fact sheet was developed by clinicians, the Hospital Falls Working Parties and the Standard 10 Committee. It was endorsed by the NALHN Consumer Advisory Committee and is available both as a handout and as a poster in the NALHN Maternity Wards.

“The midwives were especially thrilled to see something that met the needs of a very different population group.”

Maeve Downes, Nursing Director, Women’s & Children’s Division, NALHN

Item 26: Mums can fall too fact sheet  Item 27: Keeping your baby safe from falling fact sheet

Further information is available on the Safety and Quality section of the SA Health website Preventing falls and harm from falls page at www.sahealth.sa.gov.au/safetyandquality

Additional information is also available on the Australian Commission on Safety and Quality in Health Care website Falls Prevention page at http://www.safetyandquality.gov.au/our-work/falls-prevention
11 Recognition and management of challenging behaviour
SA Health recognises that consumers, carers, volunteers and workers all want health services to be delivered and received without personal threat or risk.

Challenging behaviour is not one of the National Safety and Quality Health Service Standards, however, it is a common and serious incident type and so SA Health has a program of work aimed at reduction of these incidents.

‘Challenging behaviour’ means actions and/or behaviours that may, or have potential to, physically or psychologically harm another person or self, or property.

Challenging behaviours and/or actions can take different forms, any of which can;
>
- result in a person or people feeling unsafe or threatened or feeling that intervention, or withdrawal, is warranted to avoid physical or psychological harm to someone, or property
>
- potentially or actually stop, interrupt or limit the ability for health service or care to be provided in a way that is safe for both consumer and staff.

The program has two overarching aims - caring for consumers and caring for staff. SA Health recognises that consumers, carers, volunteers and workers all want health services in which health care can be both delivered, and received, without personal threat or risk.

A key approach that provides care for staff is the proactive risk management approach, under the *Work Health and Safety Act, 2012 (SA)*. These include consideration of the services physical layout and workflow. Also important are strategies to increase the skills, knowledge and ability of staff to work as a team to resolve these situations and maintain safety and good care.

Approaches that provide caring for consumers include supporting health care rights, patient/consumer-centred care and engagement of both consumer and carer; and minimising the use of restraint and seclusion. This will build on pre-existing work by mental health services.

### 11.1 Governance and systems for the recognition and management of challenging behaviours

The Recognition and management of challenging behaviour program is in its second year and has five streams of work. The major activities for each for 2013-14 are:

#### 11.1.1 Policy framework

The policy document ‘Framework for Recognition and Management of Challenging Behaviour’ (the Framework) underwent extensive consultation and 51 written responses were received. A revised version is under preparation. To ensure that the intent is well communicated, it will be informed by the feedback and also market research that has occurred this year.

In 2014, work commenced to revise some of the relevant Work Health and Safety policies, to align with the Framework, and to review existing SA Health policies around restraint and seclusion, including those under development through the Office of the Chief Psychiatrist, under the Mental Health Standards.

#### 11.1.2 Communication strategy

Several steps towards the development of a communications plan have been undertaken in 2014. An external advertising agency was engaged to assist in the development of key messages and examples of how this could be displayed in each of the high risk settings. This includes mapping, messaging and/or pictograms including mediums to best suit the high risk area settings, the target audiences and their specific needs, for example those from a cultural and linguistically diverse (CALD) background.
11.1.3 Systems of data collection and analysis

A review of existing systems of data collection and analysis has been undertaken, including SLS, EPAS and Health Watch, with the intent of developing an integrated reporting system.

Changes to both of the patient incident and worker incident modules of Safety Learning System will improve data quality and incident management.

Incidents involving challenging behaviour and also the use of restraint and seclusion are now displayed on LARS in the Safety and Quality metrics / indicator set. It is intended that the measures will include the following categories of challenging behaviours;

> verbal abuse or disruption
> actual or threat of physical abuse / assault / aggression
> damage to property or disregard for hospital by-laws
> intrusive behaviour
> self harm - this can be actual or threatened, deliberate or intentional, and unintentional
> absconding / attempting to leave where there is risk to the person in doing so
> resisting provision of lawful treatment (such as assessment and treatment procedures, and transport for treatment).

11.1.4 Education, training and competencies

Last year’s survey of existing training in use across SA indicated that there was a need for education and training for all staff as an introduction to the prevention and management of challenging behaviour and to support the release of the policy framework.

Work has commenced on the development of an interactive e-learning module. Videos have been made and the content, is being developed by a group including Work Health and Safety, Safety and Quality, Mental Health, and drawing on other expertise as required. The learning objectives include;

> Identify main types, key causes, triggers, risk factors, contributing factors of challenging behaviours.
> Identify the stages of a challenging behaviour and the strategies that can be applied at each to prevent and de-escalate.
> Compare the consumer perspective and staff perspective in challenging behaviour situations and apply good communication skills.
> Identify actions post incident to optimise recovery of both consumer and staff.
> Identify the key legislation, policies and codes relevant to challenging behaviours.

It is recognised that staff need for specific skills and knowledge depends on their role and the consumers for whom they provide care. The release of the e-learning module is planned for late 2014.
11. Recognition and management of challenging behaviours

Picture 35: In development - Challenging Behaviour e-learning module screen shot

- **Introduction**
  - This course is structured around the stages of an incident of challenging behaviour.
  - These stages are Prevention, Early developing, During and After.
  - The recommended prevention and management strategies for each stage are shown in the diagram and described in more detail in the course.
  - Press or click on the parts of the diagram or the thumbnail images below to show a summary of each section.

- **Types of challenging behaviour**
  - The main types of challenging behaviour are:
    - Verbal abuse or disruption
    - Actual or threat of physical violence
    - Damage to property or disregard for hospital by-laws
    - Intrusive behaviour
    - Self Harm: Actual, threatened, intentional or unintentional
    - Abandoning or attempting to leave where there is risk to the person in doing so
    - Resisting provision of lawful treatment.
11.1.5 Clinical management
As part of the development of the e-learning module, a variety of scenarios were developed by clinical experts that describe evidence-based best practice to prevention and management.

**Case study:**

Nurse practitioner consultation and challenging behaviours at the Repatriation General Hospital

Nurses in the acute care areas of Repatriation General Hospital (RGH) identified an opportunity to develop their confidence, practice and knowledge regarding the management of patients with mental illness and challenging behaviours in the ward setting.

This project was developed by the Nurse Practitioner Candidate (NPC) and Older Persons Mental Health Services in consultation with, the RGH Nursing Executive ward CSC’s, and the RGH Psychiatric Consultation Liaison Service.

It aimed to provide a psychiatric nursing consultation service to nurses working within the RGH general wards to achieve comprehensive nursing care for patients with mental illness and concerning behaviours. This included patients with dementia and / or delirium.

The Nurse Practitioner Candidate specialising in Older Persons Mental Health has been able to provide the consultancy service. This involves the NPC reviewing and discussing the patient presentation with the nurses concerned, and together developing a plan of care.

An initial referral based service was underutilised, so the approach was modified with the NPC visiting three medical wards on a regular basis and reviewing patients being ‘specialled’ or patients who had ‘Code Black’ events. Evaluation has been ongoing and including feedback from nursing staff.

The regular presence of the NPC in the ward has allowed nurses to raise concerns about other patients, and enables the NPC to provide timely and relevant information and education to nurses to identify and assist with the development of therapeutic interventions. The review of patient’s requiring continuous observation (specialling) has enhanced the therapeutic outcomes from this intervention, and supported efficient management of a costly intervention. The role most importantly supports the improved patient outcomes, with the development of specific nursing skills and general empathy for patient’s experiencing mental illness and / or cognitive decline.

11.2 Challenging behaviour incidents

During 2013-14 there was extensive review of the Safety Learning System category for challenging behaviour incidents affecting patients. In addition incidents affecting workers were introduced, in collaboration with Work Health and Safety.

The total number of incidents in this patient incident category has therefore decreased since 2013 (table 24) because incidents that previously would have been reported as ‘patient behaviour to staff’ are now reported as incidents affecting workers. Please refer to section 11.3.

**Table 24: Challenging behaviour level 1 classification 2011-14**

<table>
<thead>
<tr>
<th>Challenging behaviour level 1 classification</th>
<th>2011-12</th>
<th>2012-13</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of incidents reported in this category</td>
<td>2738</td>
<td>4263</td>
<td>2910</td>
</tr>
<tr>
<td>Total number of incidents reported</td>
<td>32697</td>
<td>37678</td>
<td>44048</td>
</tr>
<tr>
<td>Percentage of total incidents reported to the SLS</td>
<td>8.4%</td>
<td>11.3%</td>
<td>6.6%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System
A small number of these 2910 incidents are SAC 1 or SAC 2 (3.4%). However, high levels of serious harm fall under the category of deliberate or unintentional self harm (25.5% were SAC 1 or 2) (table 25). Of the 730 incidents that were identified as ‘patient to patient behaviour’ 44.5% were further classified as physical abuse, assault or violence.

Table 25: Challenging behaviour level 2 classification 2013-14

<table>
<thead>
<tr>
<th>Challenging behaviour level 2 classification</th>
<th>SAC 1</th>
<th>SAC 2</th>
<th>SAC 3</th>
<th>SAC 4</th>
<th>Un SAC’d</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Behaviour to patient</td>
<td>0</td>
<td>0</td>
<td>22</td>
<td>29</td>
<td>8</td>
<td>59</td>
</tr>
<tr>
<td>Patient behaviour to other persons</td>
<td>2</td>
<td>7</td>
<td>618</td>
<td>365</td>
<td>16</td>
<td>1008</td>
</tr>
<tr>
<td>Patient behaviour to patient</td>
<td>0</td>
<td>2</td>
<td>494</td>
<td>223</td>
<td>11</td>
<td>730</td>
</tr>
<tr>
<td>Self Harm</td>
<td>60</td>
<td>17</td>
<td>175</td>
<td>57</td>
<td>4</td>
<td>313</td>
</tr>
<tr>
<td>Absconded</td>
<td>1</td>
<td>9</td>
<td>505</td>
<td>259</td>
<td>7</td>
<td>781</td>
</tr>
<tr>
<td>Persistent damage to object(s) or disregard for hospital by-laws</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>9</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>63</td>
<td>35</td>
<td>1824</td>
<td>942</td>
<td>46</td>
<td>2910</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

11.3 Challenging behaviour incidents affecting workers

During 2013-14 incidents affecting workers were introduced into Safety Learning System, in collaboration with Work Health and Safety. This makes it possible for staff across SA Health, with the exception of SAAS, to report challenging behaviour incidents where the person affected was a worker (staff member, volunteer, student, contractor). It should be noted that, in previous years, incidents that would have been reported as ‘patient behaviour to staff’ in the ‘incidents affecting patient’ section are now reported properly as incidents affecting workers.

Under the Types of Occurrence classification system for occupational incident reporting, there are two level 1 mechanisms by which challenging behaviour is classified. These are ‘Being hit by another person’ and ‘Mental stress from physical or verbal abuse’. These are combined to form the Challenging behaviour to worker code.

Table 26: Challenging behaviour level 1 classification 2013-14

<table>
<thead>
<tr>
<th>Challenging behaviour level 1 classification</th>
<th>Being hit</th>
<th>Mental stress</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of incidents reported in this category</td>
<td>1456</td>
<td>1271</td>
<td>2727</td>
</tr>
<tr>
<td>Percentage of total incidents reported to the SLS about worker incidents</td>
<td>16.8%</td>
<td>14.7%</td>
<td>31.6%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

For incidents where both mechanisms are mentioned, only the primary mechanism is reported.

A small number of these incidents are risk rated as extreme or high whilst 32.9% were not risk rated.
Table 27: Challenging behaviour level 1 classification and risk rating 2013-14

<table>
<thead>
<tr>
<th>Challenging behaviour level 1 classification</th>
<th>Extreme</th>
<th>High</th>
<th>Moderate</th>
<th>Low</th>
<th>No value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being hit</td>
<td>4</td>
<td>68</td>
<td>455</td>
<td>550</td>
<td>379</td>
</tr>
<tr>
<td>Mental stress</td>
<td>3</td>
<td>32</td>
<td>288</td>
<td>431</td>
<td>517</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>100</td>
<td>743</td>
<td>981</td>
<td>896</td>
</tr>
<tr>
<td>Total %</td>
<td>0.26%</td>
<td>3.7%</td>
<td>27.2%</td>
<td>36%</td>
<td>32.9%</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

A total of 99 workers compensation claims were made by workers for injury arising from Challenging Behaviour in 2013-14. Mechanisms of injury were being assaulted (73 claims) and exposure to workplace violence (26 claims).

Table 28: Challenging behaviour level 2 classification risk rating 2013-14

<table>
<thead>
<tr>
<th>Challenging behaviour level 2 classification</th>
<th>Extreme / high</th>
<th>moderate</th>
<th>Low</th>
<th>No value</th>
<th>total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being assaulted by person</td>
<td>71</td>
<td>434</td>
<td>491</td>
<td>370</td>
<td>1366</td>
</tr>
<tr>
<td>Hit by person accidentally</td>
<td>1</td>
<td>20</td>
<td>59</td>
<td>8</td>
<td>88</td>
</tr>
<tr>
<td>Exposure to violent event (mental stress)</td>
<td>35</td>
<td>276</td>
<td>404</td>
<td>500</td>
<td>1215</td>
</tr>
<tr>
<td>Racial or sexual behaviour</td>
<td>0</td>
<td>3</td>
<td>15</td>
<td>16</td>
<td>34</td>
</tr>
<tr>
<td>Not classified</td>
<td>0</td>
<td>10</td>
<td>12</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>107</td>
<td>743</td>
<td>981</td>
<td>896</td>
<td>2727</td>
</tr>
</tbody>
</table>

Source: Safety Learning System

11.4 Challenging behaviour incidents involving code black calls

Code Black calls are made by staff who perceive that their safety, or that of the patient and/or other people, is at risk. The behaviours can be exhibited by a patient or by other person(s). Most metropolitan services have a team comprising clinical and security staff (Emergency Response teams) that attends in response to a Code Black call, and works with the home team to de-escalate the situation, provide expert care and restore a safe environment. Many of these incidents do not require the Emergency Response team or the security officers to take any action other than attend, and provide advice or support.

There are two current data sources, and there is considerable overlap, that is, the one incident is likely to be reported in both datasets.

Security Services operate at many health services and have a variety of roles. In 2013-14 security officers in metropolitan health services (CALHN, SALHN, NALHN and WCHLN) responded to 7757 Code Black situations. Of these 3464 situations (45%) were in Emergency Departments. As planned preventative measures, security officers also provide additional assistance to staff to move, or provide planned care or treatment to a patient who may become aggressive.

A search of the text descriptions of all incidents entered into SLS in 2013-14 found 542 patient incidents, and 384 staff incidents where Code Black was mentioned. Of the patient incidents 83% were categorised as either challenging behaviour (28%) or restraint /seclusion (55%) incidents.
Case study:

Reducing challenging behaviours and improving staff confidence through training

The Adolescent Services Enfield Campus (ASEC) Group Program is a joint initiative between Child Adolescent Mental Health Services (CAMHS) and Department of Education and Child Development (DECD) – Hospital Education Services. The program provides intensive and specialised assessment and therapeutic services through group programs (onsite and offsite), individual and family work through a variety of mediums. It provides direct therapeutic support to the metropolitan area and consultative work for country regions.

The ASEC Group Program is a tertiary service for young people (12–16/17 years) who have significant mental health issues and as a result have significant levels of impairment with behaviours that are significantly impacting on their life domains (eg education / vocational, family, peers, relationships). These adolescents are often developmentally younger and all are still interacting with an accredited educational program. They may exhibit behaviours (internal / external) which respond well to group program activities, and are motivated to engage within a peer and therapeutic group setting.

The program was experiencing a high rate of challenging behaviours directed towards staff. In 2011-12 the Non Violent Crisis Intervention training framework was implemented in the context of incident management at the Enfield site. Success was evaluated by comparing data from Employee Incident Form (EIF) about number and type of incidents for the years 2009 to 2012. Safety Learning System is now used for reporting and for 2013 there were 10 incidents reported – 6 were patient incidents of challenging behaviour, and 4 were incidents where worker was affected.

Overall, the total number of incidents was nearly halved, and injury / harm to staff decreased. The use of this approach has continued, as has the reduction to rates of challenging behaviour directed towards staff.

"I feel more confident in evaluating potentially risky situations and how to prevent / or be proactive in de-escalating" – anonymous staff feedback.

Table 29: Reduction in challenging behaviour incidents: 2009-13

<table>
<thead>
<tr>
<th>Enfield site</th>
<th>2009 EIF</th>
<th>2010 EIF</th>
<th>2011 EIF</th>
<th>2012 EIF</th>
<th>2013 SLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury / harm to staff</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>No injury / harm to staff</td>
<td>13</td>
<td>39</td>
<td>6</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Near miss</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Property damage</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>47</td>
<td>9</td>
<td>7</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: Employee Incident Form (EIF) and Safety Learning System (SLS)

Further information about the background and work of this program is available on the Safety and Quality section of the SA Health website Recognition and Management of Challenging Behaviour Program page at www.sahealth.sa.gov.au/safetyandquality.
Further information regarding this report or the safety and quality program is available from the Safety and Quality section of the SA Health website at [www.sahealth.sa.gov.au/safetyandquality](http://www.sahealth.sa.gov.au/safetyandquality).

Additional information on the safety and quality program is available on the Australian Commission on Safety and Quality in Health Care website at [www.safetyandquality.gov.au](http://www.safetyandquality.gov.au).
List of new and revised clinical guidelines

In 2013-14 the following Clinical Guidelines were released including:

New Clinical Guidelines:

**SA Child Health Clinical Network – Paediatric Clinical Practice Guidelines**
- Acute otitis media in children
- Anaphylaxis in children
- Constipation in children
- Seizures in children

- Atenolol
- Calcium carbonate
- Diazoxide
- Ferrous sulphate
- Fluconazole
- Folic acid
- Gaviscon infant
- Management of women with a low PAPP-A and normal chromosomes
- Multivitamins
- Nevirapine
- Nystatin
- Phosphate
- Propranolol
- Thyroxine
- Vercuronium
- Vitamin E

**SA Perinatal Practice Guidelines**
- Blood transfusion
- Hypoxic Ischaemic Encephalopathy (HIE) including neonatal hypothermic neuroprotection
- Infant of drug dependant women
- Maternal anaphylaxis
- Neonatal hypoglycaemia
- Normal pregnancy, labour and puerperium management
- Perinatal advice and emergency transport
- Perinatal loss
- Standards for the Management of Termination of Pregnancy in South Australia
- Substance use in pregnancy
- Syphilis in pregnancy
- Vaginal Birth after Caesarean Section Consumer Brochure
- Varicella zoster (chicken pox) in pregnancy

**Infection Control Service**
- Management of Patients with Methicillin-resistant Staphylococcus aureus (MRSA) Guideline
- Respiratory Protection against Airborne Infectious Diseases Guideline

**South Australian Medicines Advisory Committee (SAMAC)**
- Opioids: Guidelines for prescribing on discharge
Revised Clinical Guidelines:

**SA Perinatal Practice Guidelines**

- Anti-D prophylaxis
- Birth options after caesarean section
- Breech presentation
- Caesarean section
- Cord presentation and prolapse
- Cryptosporidiosis
- Eating disorders and pregnancy
- First (1st) trimester medical and surgical termination of pregnancy
- Giardiasis in pregnancy
- Hepatitis C in pregnancy
- Histopathology management of the placenta
- Iron infusion
- Managing women in distress after a traumatic birth experience
- Malaria in pregnancy
- Maternal anaphylaxis
- Medical induction for 2nd trimester termination of pregnancy and miscarriage
- Miscarriage
- Nifedipine for preterm labour
- Neonatal sepsis (including maternal group B streptococcal colonisation)
- Preconception advice
- Peripartum prophylactic antibiotics
- Prelabour rupture of the membranes >37 weeks
- Preterm labour
- Planned Home Birth Policy
- Rubella infection (maternal) in pregnancy
- South Australian Pregnancy Record Guideline
- Suicidal ideation and self-harm
- Third and fourth degree tear management
- Tocolysis for uterine hypercontractility
- Toxoplasmosis in pregnancy
- Tuberculosis in pregnancy
- Umbilical cord blood gas sampling
- Unstable lie of the fetus
- Uterine inversion
- Uterine rupture
- Vaginal Birth after Caesarean Section
- Women with significant psychosocial needs
- Worms

**Infection Control Service**

- Hand Hygiene Policy Directive
- Hand Hygiene Guideline